CSI - Ohio

The Common Sense Initiative

Business Impact Analysis

Agency Name: Ohio Department of Medicaid (ODM)

Regulation/Package Title: Durable Medical Equipment, Prostheses, Orthoses, and Supplies (DMEPOS) [ERF packages 128477, 128488, 134119, 134120]

Rule Number(s):

SUBJECT TO BUSINESS IMPACT ANALYSIS:

To Be Rescinded: 5160-10-01, 5160-10-02, 5160-10-03 w/appendix, 5160-10-04 w/appendix, 5160-10-09, 5160-10-11 w/appendix, 5160-10-14 w/appendix, 5160-10-15 w/appendix, 5160-10-20 w/appendix, 5160-10-21 w/appendix, 5160-10-22 w/appendices, 5160-10-24 w/appendices, 5160-10-27, 5160-10-28 w/appendix, 5160-10-31, 5160-10-32, 5160-10-33, 5160-10-34, 5160-10-35

New: 5160-10-01 w/appendix, 5160-10-09, 5160-10-14, 5160-10-21, 5160-10-22, 5160-10-31, 5160-10-34 w/appendix, 5160-10-35

NOT SUBJECT TO BUSINESS IMPACT ANALYSIS, INCLUDED FOR INFORMATION ONLY:

To Be Rescinded: 5160-4-27, 5160-10-05, 5160-10-06, 5160-10-08, 5160-10-10, 5160-10-12, 5160-10-13 w/appendix, 5160-10-18 w/appendices, 5160-10-19, 5160-10-23 w/appendix, 5160-10-25 w/appendix, 5160-10-29 w/appendix, 5160-10-30

New: 5160-10-02, 5160-10-10, 5160-10-11, 5160-10-13 w/appendix, 5160-10-15, 5160-10-17, 5160-10-18, 5160-10-19, 5160-10-23, 5160-10-24, 5160-10-25, 5160-10-27, 5160-10-28, 5160-10-29, 5160-10-30, 5160-10-32, 5160-10-33

Date: March 21, 2018

Rule Type:

- ☑ New
- ☐ Amended
- ☑ 5-Year Review
- ☑ Rescinded

The Common Sense Initiative was established by Executive Order 2011-01K and placed within the Office of the Lieutenant Governor. Under the CSI Initiative, agencies should balance the critical objectives of all regulations with the costs of compliance by the regulated parties. Agencies should promote transparency, consistency, predictability, and flexibility in regulatory activities. Agencies should prioritize compliance over punishment, and to that end, should utilize plain language in the development of regulations.

77 SOUTH HIGH STREET | 30TH FLOOR | COLUMBUS, OHIO 43215-6117
CSIOhio@governor.ohio.gov

Regulatory Intent

1. **Please briefly describe the draft regulation in plain language.**
   Please include the key provisions of the regulation as well as any proposed amendments.

   With the exception of rules 5160-10-16 (wheelchairs) and 5160-10-26 (enteral nutrition products), all of the existing rules in Chapter 5160-10 of the Ohio Administrative Code concerning durable medical equipment, prostheses, orthoses, and supplies (DMEPOS) are being rescinded and replaced by new rules.

   The content of the rules has been reorganized, streamlined, and clarified. Unnecessary definitions and superfluous provisions have been removed. Associated certificates of medical necessity (CMNs) have been completely reworked; references to these forms in the body of the rules have been retained (and, in one case, added), but the practice of including forms themselves as appendices has been discontinued. References to the Ohio Department of Medicaid or to other Medicaid rules have been modified to comport with the new agency name and designation in the Ohio Administrative Code. The new rules are consistent with the provision in Section 5002 of the Twenty-First Century Cures Act that limits aggregate Medicaid DMEPOS payment to Medicare levels.

   Existing rules 5160-4-27*, 5160-10-01, 5160-10-02, 5160-10-03, 5160-10-05*, 5160-10-06*, and 5160-10-20 have been consolidated into a single new, overarching rule 5160-10-01, "Durable medical equipment, prostheses, orthoses, and supplies (DMEPOS): general provisions." New rule 5160-10-01 incorporates provisions that are common to many of the other existing rules in Chapter 5160-10, such as the statement that payment for a particular durable medical equipment item or medical supply furnished to a resident of a long-term care facility (LTCF) is the responsibility of the LTCF or the obligation placed on a provider to ensure proper instruction on equipment use and procedures (which has been expanded to include, when appropriate, instruction for someone assisting the individual recipient). The default maximum length of time from the date of a prescription to the first date of service is specified as sixty days.
   (*Rule not subject to BIA)

   The existing payment schedules that have been published previously as appendices to rules 5160-10-03 and 5160-10-20 have been combined into a single schedule, which is published as an appendix to new rule 5160-10-01.

   Specific Rule Changes

   Existing rule 5160-10-01, "Eligible providers," describes those eligible providers that may receive payment for dispensing durable medical equipment, prostheses, orthoses, or medical supplies. This rule has been incorporated into new rule 5160-10-01.

Existing rule 5160-10-02, "Coverage and limitations for medical supplier services," sets forth definitions, coverage and payment policies, and limitations pertaining to medical supplier services. This rule has been incorporated into new rule 5160-10-01.

Existing rule 5160-10-03, "Medical supplies and the medicaid supply list," sets forth definitions, coverage and payment policies, and limitations pertaining to medical supplier services. Information about individual items is listed in the rule appendix. The body of this rule has been incorporated into new rule 5160-10-01, and the information in the appendix has been incorporated into the appendix to new rule 5160-10-01.

Existing rule 5160-10-04, "Pneumatic compression devices and accessories," sets forth coverage and payment policies for pneumatic compression devices and accessories. The associated CMN is form ODM 02929.

Existing rule 5160-10-09, "Apnea monitors," sets forth coverage and payment policies for apnea monitors used in the home. The new rule is titled "DMEPOS: apnea monitors." The associated CMN is form ODM 02900.

Existing rule 5160-10-11, "Hearing aids," sets forth coverage and payment policies for hearing aids. The associated CMN is form ODM 01915.

Existing rule 5160-10-14, "Compression garments," sets forth coverage and payment policies for compression garments. The new rule is titled "DMEPOS: compression garments." The associated CMN is form ODM 01905. A requirement predicating payment to a provider of custom-made garments on an employment or contract relationship with a certified fitter has been removed. Specification of a particular, limited purpose for using a burn compression garment (i.e., to reduce hypertrophic scarring and joint contractures) has been discontinued.

Existing rule 5160-10-15, "Transcutaneous electrical nerve stimulators (TENS)," sets forth coverage and payment policies for transcutaneous electrical nerve stimulation (TENS) units. The associated CMN is form ODM 03402.

Existing rule 5160-10-20, "Orthotic devices, prostheses, and related services," sets forth coverage and payment policies pertaining to orthotic devices, prostheses, and related services. Information about individual items is listed in the rule appendix. The body of this rule has been incorporated into new rule 5160-10-01, and the information in the appendix has been incorporated into the appendix to new rule 5160-10-01.

Existing rule 5160-10-21, "Incontinence garments and related supplies," sets forth coverage and payment policies for incontinence garments and related supplies. The new rule is titled "DMEPOS: incontinence garments and related supplies." The associated CMN is form ODM 02912. The current policy on payment for incontinence items used because of stress incontinence has been rephrased in the negative: No payment is made if no specific physiological, psychological, or

physiopsychological cause can be attributed to the stress incontinence. The quantity of items the Medicaid-eligible individual currently has on hand has been added to the list of information the provider must verify before dispensing additional items.

Existing rule 5160-10-22, "Volume ventilators, positive and negative pressure ventilators, continuous positive airway pressure (CPAP), alternating positive airway pressure (APAP), and intermittent positive pressure ventilation (IPPV)," sets forth coverage and payment policies for ventilators and positive airway pressure devices. This single rule has been replaced by two rules: New rule 5160-10-19 is titled "DMEPOS: positive airway pressure devices," and new rule 5160-10-22 is titled "DMEPOS: ventilators." The associated CMNs are forms ODM 01903 and ODM 01902 respectively; form ODM 01903 can now be used for all positive airway pressure devices, not just devices prescribed in lieu of a ventilator. Redundant provisions have been struck. Correct use has been removed from the list of prescription attestations for a positive airway pressure device; instead, a provision has been added stating that prior authorization may be withheld if a device is not being used appropriately and may not be subsequently granted without the support of a prescriber. The restriction that sleep studies involving a positive airway pressure device must be performed in a fixed facility (laboratory) rather than in the home or in a mobile facility has been eliminated. To prevent any misapprehension that having a wheelchair is a prerequisite for ventilator use outside the home, mention of a mobility device has been removed from the criteria for a second ventilator.

Existing rule 5160-10-24, "Speech generating devices," sets forth coverage and payment policies for speech-generating devices (SGDs). The associated CMNs are forms ODM 02924, ODM 02925, and ODM 02926.

Existing rule 5160-10-27, "Continuous Passive Motion (CPM) Devices," sets forth coverage and payment policies for continuous passive motion (CPM) devices.

Existing rule 5160-10-28, "Noninvasive Bone (Osteogenesis) Stimulators," sets forth coverage and payment policies for osteogenesis stimulators applied externally. The associated CMN is form ODM 07134.

Existing rule 5160-10-31, "Therapeutic Footwear for Consumers with Diabetes," sets forth coverage and payment policies for therapeutic footwear for individuals who have diabetes. This rule has been incorporated along with existing rule 5160-10-12 (not subject to BIA) into new rule 5160-10-31, titled "DMEPOS: footwear and foot orthoses." The associated CMN is form ODM 01912. A provision allowing payment to a prescriber for dispensing therapeutic footwear only if the prescriber practices in a defined rural area or a defined health professional shortage area has been removed. A provision has been added allowing payment for specialized non-orthopedic shoes for children, designed to be worn over an orthotic device, if no commercially available shoe fits properly.

Existing rule 5160-10-32, "Ostomy and Urological Supplies," sets forth coverage and payment policies for stoma maintenance supplies and urination aids.

Existing rule 5160-10-33, "Commodes," sets forth coverage and payment policies for commodes (toilet chairs).

Existing rule 5160-10-34, "Surgical Dressings and Related Supplies," sets forth coverage and payment policies for wound dressings (covers and fillers) and related supplies (e.g., tape, elastic bandages). The new rule is titled "DMEPOS: wound dressings and related supplies." Definitions concerning the stages of tissue breakdown are removed from the rule. Clinical indications, contraindications, and application guidelines for certain types of wound dressing are extracted from the rule body and summarized instead in a new appendix to the rule. Overly detailed requirements concerning wound evaluation are removed. Type of wound has been added to the list of clinical information that must be reported on a prescription. A provision that appears to require providers to maintain copies of treatment records in their own files has been removed. Payment for an amount in excess of the established limit is subjected to need verification rather than prior authorization.

Existing rule 5160-10-35, "Cranial Orthotic Remolding Devices," sets forth coverage and payment policies for orthotic devices (helmets) designed for the progressive reshaping of the developing skull structure of a young child. The new rule is titled "DMEPOS: cranial remolding devices."

2. **Please list the Ohio statute authorizing the Agency to adopt this regulation.**

   The Ohio Department of Medicaid (ODM) is promulgating these rules under section 5164.02 of the Ohio Revised Code.

3. **Does the regulation implement a federal requirement? Is the proposed regulation being adopted or amended to enable the state to obtain or maintain approval to administer and enforce a federal law or to participate in a federal program?**
   If yes, please briefly explain the source and substance of the federal requirement.

   Under 42 C.F.R. 440.70 (home health services), medical supplies and equipment are mandatory services that must be covered by a state Medicaid program. The changes in these rules are not mandated by a federal requirement.

4. **If the regulation includes provisions not specifically required by the federal government, please explain the rationale for exceeding the federal requirement.**

   These rules do not exceed federal requirements.

5. **What is the public purpose for this regulation (i.e., why does the Agency feel that there needs to be any regulation in this area at all)?**

   Medicaid rules perform several core business functions: They establish and update coverage and payment policies for medical goods and services. They set limits on the types of entities that can receive Medicaid payment for these goods and services. They publish payment formulas or schedules for the use of providers and the general public.

   For the entire range of covered DMEPOS items and services, these functions must be carried out through administrative rule. No alternative is readily apparent.

6. **How will the Agency measure the success of this regulation in terms of outputs and/or outcomes?**

   The success of these rules will be measured by the extent to which providers can submit claims and receive correct payment.

Development of the Regulation

7. **Please list the stakeholders included by the Agency in the development or initial review of the draft regulation.**
   If applicable, please include the date and medium by which the stakeholders were initially contacted.

   In early September 2015, information about this initiative was shared with the executive director of the Ohio Association of Medical Equipment Services (OAMES), who passed it on to the OAMES governing board. The information was also presented at an OAMES general membership meeting and training seminar.

ODM staff members and OAMES representatives got together in working meetings to discuss the draft rules in detail on at least 29 occasions:

Monday, 02/08/2016	Tuesday, 02/16/2016
Monday, 02/22/2016	Tuesday, 03/08/2016
Monday, 03/14/2016	Monday, 03/21/2016
Monday, 04/04/2016	Monday, 04/11/2016
Monday, 04/25/2016	Monday, 05/02/2016
Monday, 05/09/2016	Monday, 06/06/2016
Tuesday, 07/05/2016	Wednesday, 07/13/2016
Monday, 07/18/2016	Monday, 08/01/2016
Tuesday, 08/16/2016	Friday, 08/19/2016
Thursday, 09/22/2016	Friday, 10/07/2016
Friday, 10/28/2016	Friday, 012/09/2016
Wednesday, 01/18/2017	Monday, 02/27/2017
Monday, 03/20/2017	Monday, 04/10/2017
Thursday, 04/27/2017	Friday, 07/07/2017
Monday, 07/10/2017	

ODM staff members and OAMES representatives communicated by e-mail more than 150 times. At five OAMES membership meetings in the spring of 2016, early fall of 2016, late fall of 2016, spring of 2017, and fall of 2017, an ODM staff member discussed the progress of the rule revision.

On Wednesday, 09/06/2017, ODM staff members and OAMES representatives met to discuss a proposed payment structure for DMEPOS items and services.

On several occasions, ODM staff members also met with individual providers or groups of providers to discuss rule provisions pertaining to specific categories of DMEPOS.

8. What input was provided by the stakeholders, and how did that input affect the draft regulation being proposed by the Agency?

OAMES and provider representatives thoroughly reviewed each rule. They pinpointed provisions of concern and suggested changes to the rules. The vast majority of the suggestions were accepted and incorporated.

9. What scientific data was used to develop the rule or the measurable outcomes of the rule? How does this data support the regulation being proposed?

The use of scientific data does not apply to the development of these rules.

10. **What alternative regulations (or specific provisions within the regulation) did the Agency consider, and why did it determine that these alternatives were not appropriate? If none, why didn't the Agency consider regulatory alternatives?**

    These rules involve the coverage of and payment for DMEPOS. Whatever the policy may be, the form of the rule is the same; no alternative is readily apparent.

11. **Did the Agency specifically consider a performance-based regulation? Please explain.** ***Performance-based regulations define the required outcome, but don't dictate the process the regulated stakeholders must use to achieve compliance.***

    The concept of performance-based regulation does not apply to these items and services.

12. **What measures did the Agency take to ensure that this regulation does not duplicate an existing Ohio regulation?**

    Rules involving Medicaid providers are housed exclusively within agency 5160 of the Ohio Administrative Code. Within this division, rules are generally separated out by topic. These rules have been reviewed by legal services and policy staff members to prevent duplication.

13. **Please describe the Agency's plan for implementation of the regulation, including any measures to ensure that the regulation is applied consistently and predictably for the regulated community.**

    The policies set forth in these rules will be incorporated into the Medicaid Information Technology System (MITS) as of the effective date of the new rule. They therefore will be applied by the Department's electronic claim-payment system automatically and consistently whenever an appropriate provider submits a claim for an applicable service.

Adverse Impact to Business

14. **Provide a summary of the estimated cost of compliance with the rule. Specifically, please do the following:**

    a. **Identify the scope of the impacted business community;**

       Changes to policies, payment formulas, or payment amounts affect Medicaid providers of durable medical equipment, prostheses, orthoses, and supplies (DMEPOS).

b. Identify the nature of the adverse impact (e.g., license fees, fines, employer time for compliance); and

The draft rule package does not require insurance or surety products as a condition of compliance. ODM therefore took no measures to determine the availability of a financial responsibility instrument.

Existing rules 5160-10-01, 5160-10-02, 5160-10-03, and 5160-10-20 are incorporated into new rule 5160-10-01. This new rule will require that providers of certain DMEPOS items or services possess the appropriate licensure and that providers notify a recipient when an item has in effect been purchased through rental.

Existing rule 5160-10-01 specifies that DMEPOS providers must verify licensure, registration, or exemption from licensure.

Existing rule 5160-10-02 specifies that prescribers must have certain licensure.

Existing rule 5160-10-03 specifies that DMEPOS providers must possess appropriate licensure.

Existing rule 5160-10-20 specifies that providers must possess appropriate licensure.

Existing rule 5160-10-04 requires that providers have an accessible, full-time telephone number that can be used in case of emergency.

Both existing rule 5160-10-09 and new rule 5160-10-09 predicate payment for a pneumogram on the licensure status of the prescriber.

Existing rule 5160-10-11 predicates payment for certain services on the licensure status of the provider.

Both existing rule 5160-10-14 and new rule 5160-10-14 require that providers of custom-made or custom-fitted compression garments must either employ or contract with a certified fitter.

Existing rule 5160-10-15 requires that providers have a physical location available for the initial face-to-face fitting and instruction.

Both existing rule 5160-10-21 and new rule 5160-10-21 require that providers contact customers to verify needed quantities.

Both existing rule 5160-10-22 and new rule 5160-10-22 predicate payment for certain professional services on the licensure status of the individual provider.

Existing rule 5160-10-24 predicates payment for evaluation on the licensure status of the provider, and it specifies that a speech-language pathologist (SLP) must comply with all applicable federal and state licensing laws. In addition, existing rule 5160-10-24 places responsibility on providers to notify an individual

who has gained ownership of a speech-generating device (SGD) after completion of the pertinent rental period.

Existing rule 5160-10-27 requires that providers have an accessible, full-time telephone number that can be used in case of emergency.

Existing rule 5160-10-28 requires that providers have an accessible, full-time telephone number that can be used in case of emergency.

Existing rule 5160-10-31 is incorporated into new rule 5160-10-31. Both existing rule 5160-10-31 and new rule 5160-10-31 require that therapeutic footwear be fitted and dispensed by any of several specified licensed individuals.

Existing rule 5160-10-32 places responsibility on providers to determine the quantity of ostomy supplies or urological supplies needed by an individual each month and to determine whether the individual has acquired additional ostomy supplies or urological supplies from a different provider during that month.

Existing rule 5160-10-33 places responsibility on providers to determine whether the individual has already acquired a commode.

Both existing rule 5160-10-34 and new rule 5160-10-34 require that providers gauge the quantity of dressings actually being used by an individual and adjust the dispensing of dressings accordingly.

Existing rule 5160-10-35 predicates payment on the licensure status of the provider.

c. **Quantify the expected adverse impact from the regulation.**
The adverse impact can be quantified in terms of dollars, hours to comply, or other factors; and may be estimated for the entire regulated population or for a "representative business." Please include the source for your information/estimated impact.

The adverse impact of a particular rule depends on the type of obligation it places on the provider.

The requirement to hold a DMEPOS license or to be exempt from licensure is a condition of doing business in Ohio as a DMEPOS provider; the cost it entails cannot be attributed to these Medicaid rules.

The requirement to hold any other license is a condition of doing business in that profession; the cost it entails cannot be attributed to these Medicaid rules.

The requirement to have a full-time emergency telephone number in essence restates paragraph (A)(5) of Home Medical Equipment Service Providers rule 4761:1-5-02 (11/05/2013); the cost it entails cannot be attributed to these Medicaid rules. (The non-specific reference to the Americans with Disabilities Act has no impact.)

It is infeasible for ODM to attempt quantification of an adverse impact that cannot be attributed to an ODM rule addressed in this BIA.

The requirement that providers of TENS units have a physical location available for the initial face-to-face fitting and instruction dates back at least ten years. This provision was instituted not so much as a business requirement as a program integrity measure to ensure that providers operated from an actual location and not merely a post office box. Because the costs associated with acquiring and maintaining office space are specific to each enterprise and depend on many variables, it is not feasible to quantify the impact even for a hypothetical representative provider. Today, the objective of ensuring a physical presence is addressed through the Medicaid provider enrollment process. The provision has been omitted from the new TENS unit rule.

A requirement to notify a recipient that a condition has been met or an event has occurred (e.g., that an item has in effect been purchased through rental) or to obtain information from a recipient (e.g., about quantities of supplies the recipient has on hand) necessitates a phone call, e-mail message, or other basic form of contact. Such communication is a general administrative expense, and the cost is minimal. The median statewide hourly wage for a receptionist, according to Labor Market Information (LMI) data published by the Ohio Department of Job and Family Services, is $11.96; for an administrative assistant, it is $16.67. With an additional 30% for fringe benefits, sixty seconds of communication costs between $0.26 and $0.36.

15. Why did the Agency determine that the regulatory intent justifies the adverse impact to the regulated business community?

The requirement that providers of TENS units have a physical location was instituted as a program integrity measure.

The requirement that providers contact recipients helps to ensure that individuals get the appropriate quantity of the supplies they need. This periodic communication is a standard business practice among DMEPOS providers; it is efficient, user-specific, and not overly burdensome.

Regulatory Flexibility

16. Does the regulation provide any exemptions or alternative means of compliance for small businesses? Please explain.

These rules outline actions all providers must take in order to receive Medicaid payment. No exception is made on the basis of an entity's size.

17. How will the agency apply Ohio Revised Code section 119.14 (waiver of fines and penalties for paperwork violations and first-time offenders) into implementation of the regulation?

These rules impose no sanctions on providers.

18. What resources are available to assist small businesses with compliance of the regulation?

Providers that submit claims through an electronic clearinghouse (a "trading partner") can generally rely on the clearinghouse to know current Medicaid claim-submission procedures.

Information sheets and instruction manuals on various claim-related topics are readily available on the ODM website.

The Bureau of Provider Services renders technical assistance to providers through its hotline, (800) 686-1516.

Policy questions may be directed via e-mail to the Non-Institutional Policy section of ODM's policy bureau, at *noninstitutional_policy@medicaid.ohio.gov*.

For questions about program coverage of and limitations on DME, ODM maintains the DME Question Line and Voice Mailbox, (614) 466-1503.

TO BE RESCINDED

5160-4-27 **Physician reimbursement of medical supplies and durable medical equipment.**

(A) Medical supplies and durable medical equipment are items and equipment as defined in rule 5101:3-10-02 of the Administrative Code.

(B) A physician may not be separately reimbursed for medical supplies or durable medical equipment utilized in a physician's office, clinic, or patient's home during a physician's visit.

(C) A physician may be reimbursed for medical supplies or durable medical equipment dispensed in the physician's office, clinic, or patient's home, for use in the patient's home, if the physician has a "supplies and medical equipment" category of service.

(D) All physician's who have a valid "medicaid provider agreement" are eligible to apply for and receive a "supplies and medical equipment" category of service.

(E) Scope and extent of coverage.

(1) The scope and extent of coverage of medical supplies or durable medical equipment services are detailed in Chapter 5101:3-10 of the Administrative Code.

(2) All medical supplies or durable medical equipment require a written prescription by a physician, which must be kept on file for six years in the physician's office in accordance with rule 5101:3-1-17.2 of the Administrative Code.

(F) Reimbursement.

All claims for medical supplies or durable medical equipment must be billed in accordance with rule 5101:3-10-05 of the Administrative Code.

Effective:

Five Year Review (FYR) Dates:

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Certification

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Date

Promulgated Under:	119.03
Statutory Authority:	5164.02
Rule Amplifies:	5162.03, 5164.02, 5164.70
Prior Effective Dates:	4/7/77, 12/21/77, 12/30/77, 1/8/79, 2/1/80, 5/19/86, 7/1/87, 4/1/88, 9/1/89, 11/20/07

TO BE RESCINDED

5160-10-01 **Eligible providers.**

The following provider types are eligible for reimbursement for medical supplies, durable medical equipment (DME), orthoses, and prostheses:

(A) Those providers who have a valid provider agreement, in accordance with eligible provider rules 5101:3-1-17 to 5101:3-1-17.4 of the Administrative Code, as provider type "medical equipment supplier."

(B) The following provider types who have a valid provider agreement, in accordance with eligible provider rules 5101:3-1-17 to 5101:3-1-17.4 of the Administrative Code, may also be approved for the category of service "supplies and medical equipment."

(1) Hospital;

(2) Physician;

(3) Podiatrist;

(4) Advanced practice nurses;

(5) Clinic; and

(6) Pharmacy.

(C) Upon the provision of verification to the Ohio department of job and family services of licensure, registration, or exemption from licensure, providers identified in paragraphs (A) and (B) of this rule are eligible to rent, sell or seek reimbursement for certain equipment considered by the Ohio respiratory care board to be subject to licensure or registration in compliance with Chapter 4752. of the Revised Code or the rules promulgated thereunder.

Effective:

Five Year Review (FYR) Dates:

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Certification

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Date

Promulgated Under:	119.03
Statutory Authority:	5164.02
Rule Amplifies:	5162.03, 5164.02
Prior Effective Dates:	04/07/1977, 03/01/1984, 05/01/1990, 10/15/2006, 08/02/2011

TO BE RESCINDED

5160-10-02 **Coverage and limitations for medical supplier services.**

(A) Definitions.

(1) "Medically necessary services."

Those health services that are necessary for the diagnosis or treatment of disease, illness, or injury and meet accepted standards of medical practice.

(2) "Medical supplies."

Items that are consumable, disposable, or have a limited life expectancy. Examples are: atomizers and nebulizers, catheters, hypodermic syringes and needles.

(3) "Durable medical equipment (DME)."

Equipment that can stand repeated use, is primarily and customarily used to serve a medical purpose, is not useful to a person in the absence of illness or injury, and is appropriate for use in the home. Examples are: hospital beds, wheelchairs, and ventilators.

(4) "Orthoses."

Devices that assist in correcting or strengthening a distorted body part. Examples are: arm braces, leg braces, hearing aids.

(5) "Prostheses."

Devices that replace all or part of a body organ to prevent or correct physical deformity or malfunction. Examples are: artificial arms, artificial legs.

(6) "Medical equipment."

Durable medical equipment, orthoses, and prostheses.

(7) "Medical supplier services."

Any covered medical supply, durable medical equipment, orthosis, prosthesis, or related service provided by an eligible provider to an eligible recipient.

(8) "Personal residence."

Recipient's place of residence if such residence is not a hospital, nursing facility (NF) or intermediate care facility for the mentally retarded (ICF-MR).

(9) "Professional service."

Service provided by a physician, home health agency, orthotist, prosthetist, certified therapist, or other health care professional, including supplies furnished as incident to the service and that are commonly either furnished as a part of the service without charge or included in the professional charge.

(B) Scope of coverage.

The medical supplier services listed as covered in appendix A to rule 5101:3-10-03 and appendix A to rule 5101:3-10-20 of the Administrative Code have been designated as being within the scope of the medicaid program. Any services not included on the list or designated as noncovered, are outside the scope of the program, or are components of other services. For those within the scope of the program, the department will cover the rental and/or purchase of medical supplier services after third party resources have been exhausted pursuant to rule 5101:3-1-08 of the Administrative Code, and when the item requested:

(1) Is prescribed by a physician (M.D. or D.O.) ,a doctor of podiatric medicine (D.P.M.), an advanced practice nurse (APN) or an individual who is a certified nurse-midwife, certified nurse practitioner, clinical nurse specialist or a certified nurse anesthetist who is legally authorized under Ohio law to prescribe and/or order the covered medical supplier services;

(2) Is determined by the department or its designee to be medically necessary;

(3) Is provided to an eligible recipient;

(4) Is not a component of a service that is reimbursed by:

(a) A DRG payment;

(b) Per diem rate, such as in NFs; or

(c) Any other payment mechanism that is designed to include coverage of the requested item;

(5) Is not incidental to a professional service;

(6) Is not covered under manufacturer or dealer warranty;

(7) Unless otherwise stated, is not duplicative of any similar equipment or service currently in possession of the recipient;

(8) Is the most cost-effective alternative that will meet the recipient's need as defined in paragraph (F) (8) of rule 5101:3-10-05 of the Administrative Code; and

(9) Is for a recipient who is a resident of a NF or ICF-MR and the item is eligible for direct reimbursement as set forth in appendix A to rule 5101:3-10-03 and appendix A to rule 5101:3-10-20 of the Administrative Code, and will be used exclusively by the recipient for whom it is requested.

(C) Service limitations.

(1) Certain devices and equipment are considered presumptively nonmedical in nature and therefore not within the scope of the medicaid fee-for-service program. Devices and equipment presumptively nonmedical include but are not limited to:

(a) Environmental control devices (e.g., air cleaners, air conditioners);

(b) Comfort and convenience devices (e.g., seat lift chairs, elevators);

(c) Physical fitness equipment (e.g., exercycle);

(d) First aid or precautionary-type equipment (e.g., preset portable oxygen units, emergency alert systems);

(e) Training equipment (e.g., speech teaching machines);

(f) Communication aids, except as covered in rule 5101:3-10-24 of the Administrative Code;

(g) Educational aids; and

(h) Hygiene equipment (e.g., bidets, bed baths).

(2) Routine and minor first aid needs, such as band aids, antiseptics, etc., are not a benefit of the program. Likewise, personal hygiene items such as soap, or diapers for children under the age of three are not a benefit of the program.

(3) Only standard equipment will be authorized and must be dispensed, unless specific medical information indicates a need, and prior approval has been given, for specialized equipment.

(4) Requests for medical supplier services must originate with the recipient's prescriber, and must proceed with the recipient's full knowledge and consent.

(a) It is not the intent of the medicaid program that large groups of recipients in institutional or group settings be examined for defects or disabilities to determine the need for medical supplier services, whether examinations are performed in facilities of different types or in a provider's office or store.

(b) When requests for prior authorization of services, submitted either intermittently or en masse, indicate that group examinations have been made, such requests will be referred to the office of research, assessment and accountability. This office, at its discretion, will do an on-site review of mass requests. Those requests determined to be a part of mass screenings will be denied and returned to providers.

(5) Devices and services generally considered by the medical profession, or designated by the federal food and drug administration, as experimental or investigational, are not covered by the program.

(6) Equipment, devices, applications, or services are presumed to be not covered until they have been reviewed by the department for medical applications and appropriateness, safety and effectiveness, and have been designated "covered" or "noncovered" in appendix DD to rule 5101:3-1-60 of the Administrative Code.

Effective:

Five Year Review (FYR) Dates:

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Certification

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Date

Promulgated Under:	119.03
Statutory Authority:	5164.02
Rule Amplifies:	5162.03, 5164.02
Prior Effective Dates:	04/07/1977, 12/21/1977, 12/30/1977, 01/01/1980, 03/01/1984, 10/01/1988, 05/01/1990, 12/10/1993, 12/12/2002, 04/16/2007

TO BE RESCINDED

5160-10-03 **Medical supplies and the medicaid supply list.**

(A) This rule sets forth in its appendix (the "medicaid supply list") a table of medical/surgical supplies, durable medical equipment, and supplier services, along with coverage and payment information.

(B) In order to be eligible for payment for medical supplier services rendered, a provider must either meet the conditions set forth in Chapter 4752. of the Revised Code or be exempt from licensure under Chapter 4752. of the Revised Code.

(C) Medical supplier services must be prescribed by a practitioner actively involved in managing the recipient's medical care through a comprehensive plan of care that addresses the need for medical supplier services, and the medical necessity of the services must be documented in the recipient's medical record. By signing a prescription, the ordering prescriber attests to the medical necessity of the services.

(D) The following documentation must be submitted with all requests for prior authorization:

(1) A fully completed form ODM 01913, "Certificate of Medical Necessity/Prescription; Medical Supplies" (01/2016), that is signed and dated no more than thirty days before the first date of service; and

(2) Any other document required or requested by the department for certain specific medical supplier services, as detailed in Chapter 5160-10 of the Administrative Code.

(E) Requests that exceed the specified maximum for an item but do not otherwise require prior authorization must be submitted to the department for review before payment for the item will be considered.

(F) The submitted charge for gauze pads and for items described as "wound fillers/packing" must not exceed the manufacturer's suggested list price for the item. Providers must maintain a detailed record in the recipient's file of all such items that have been dispensed and for which claims have been submitted to medicaid.

(G) The charge submitted on a claim must reflect any rebate or discount (a reduction in the amount charged to a buyer for a purchase made either directly or through a wholesaler or a group purchasing organization) received by the provider.

Effective:

Five Year Review (FYR) Dates:

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Certification

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Date

Promulgated Under:	119.03
Statutory Authority:	5164.02
Rule Amplifies:	5164.02
Prior Effective Dates:	03/01/1984, 12/30/1984, 10/01/1988, 12/01/1989, 05/01/1990, 06/20/1990 (Emer), 09/05/1990, 02/17/1991, 05/25/1991, 12/30/1991, 04/01/1992 (Emer), 07/01/1992, 11/16/1992, 12/31/1992 (Emer), 04/01/1993, 07/08/1993, 12/10/1993, 12/30/1993 (Emer), 03/31/1994, 07/01/1994, 02/01/1995, 12/29/1995 (Emer), 03/21/1996, 12/31/1996 (Emer), 03/31/1997, 08/01/1997, 08/01/1998, 12/31/1998 (Emer), 03/31/1999, 01/04/2000 (Emer), 03/20/2000, 12/29/2000 (Emer), 03/30/2001, 12/31/2001 (Emer), 03/29/2002, 03/24/2003, 10/01/2004, 12/30/2004 (Emer), 03/28/2005, 12/30/2005 (Emer), 03/27/2006, 10/15/2006, 12/29/2006 (Emer), 03/29/2007, 07/30/2007, 12/16/2007, 12/31/2007 (Emer), 03/30/2008, 04/01/2009, 07/31/2009 (Emer), 10/29/2009, 12/31/2009 (Emer), 02/01/2010 (Emer), 03/31/2010, 12/30/2010 (Emer), 03/30/2011, 03/29/2012, 12/31/2013, 04/01/2016

Appendix to rule 5160-10-03

BR -- Payment by report
NC -- No coverage
PA -- Payment by prior authorization

C -- Items to which the same limit applies both individually and in combination
X -- Items that are mutually exclusive

HCPCS CODE	DESCRIPTION	UNIT	LIMIT	PRIOR AUTHORIZATION	CURRENT MAXIMUM PAYMENT AMOUNT	EFFECTIVE DATE	PREVIOUS MAXIMUM PAYMENT AMOUNT	RENTAL OR PURCHASE	RESIDENCE	RELATIONSHIP [C / X]	NOTES
DRESSINGS / TAPE / GAUZE / BANDAGES											
A4450	TAPE, NON-WATERPROOF, PER 18 SQUARE INCHES	18 square inches	200 per month	No	$0.08	10/01/2004		Purchase only	Non-institutional only	X -- A4450, A4452	
A4452	TAPE, WATERPROOF, PER 18 SQUARE INCHES	18 square inches	200 per month	No	$0.32	10/01/2004		Purchase only	Non-institutional only	X -- A4450, A4452	
A6021	COLLAGEN DRESSING, LESS THAN 16 SQ IN	Each	10 per month	Yes	$16.82	04/01/2006	PA	Purchase only	Non-institutional only	X -- A6021, A6022	
A6022	COLLAGEN DRESSING, MORE THAN 16 SQ IN, LESS THAN OR EQUAL TO 48 SQ IN	Each	10 per month	Yes	$18.91	04/01/2006	PA	Purchase only	Non-institutional only	X -- A6021, A6022	
A6023	COLLAGEN DRESSING, MORE THAN 48 SQ IN	Each	20 per month	Yes	$171.27	04/01/2006	PA	Purchase only	Non-institutional only		
A6154	WOUND POUCH, FOR SURGICAL WOUND DRAINAGE, PER WOUND	Each	15 per month	No	$11.40	01/01/1997	NC	Purchase only	Non-institutional only		
A6196	ALGINATE OR OTHER FIBER GELLING DRESSING, WOUND COVER, PAD SIZE 16 SQ. IN. OR LESS	Each	30 per month	No	$6.00	01/01/1997		Purchase only	Non-institutional only	C -- A6196, A6197	
A6197	ALGINATE OR OTHER FIBER GELLING DRESSING, WOUND COVER, PAD SIZE MORE THAN 16 BUT LESS THAN OR EQUAL TO 48 SQ. IN.	Each	30 per month	No	$12.50	01/01/1997		Purchase only	Non-institutional only	C -- A6196, A6197	
A6198	ALGINATE OR OTHER FIBER GELLING DRESSING, WOUND COVER, PAD SIZE MORE THAN 48 SQ. IN.	Each	30 per month	Yes	$31.40	04/01/2006	PA	Purchase only	Non-institutional only		
A6203	COMPOSITE DRESSING, PAD SIZE 16 SQ. IN. OR LESS, WITH ANY SIZE ADHESIVE BORDER	Each	12 per month	No	$3.02	01/01/1997		Purchase only	Non-institutional only	C -- A6203, A6204	
A6204	COMPOSITE DRESSING, PAD SIZE MORE THAN 16 BUT LESS THAN OR EQUAL TO 48 SQ. IN., WITH ANY SIZE ADHESIVE BORDER	Each	12 per month	No	$4.50	01/01/1997		Purchase only	Non-institutional only	C -- A6203, A6204	
A6205	COMPOSITE DRESSING,PAD SIZE MORE THAN 48 SQ.IN.,WITH ANY SIZE ADHESIVE BORDER	Each	12 per month	Yes	PA	01/01/1997		Purchase only	Non-institutional only		
A6206	CONTACT LAYER, 16 SQ. IN. OR LESS	Each	4 per month	Yes	PA	01/01/1997		Purchase only	Non-institutional only		
A6207	CONTACT LAYER, MORE THAN 16 BUT LESS THAN OR EQUAL TO 48 SQ. IN.	Each	4 per month	No	$5.30	01/01/1997		Purchase only	Non-institutional only		
A6208	CONTACT LAYER, MORE THAN 48 SQ. IN.	Each	4 per month	Yes	$11.98	04/01/2006	PA	Purchase only	Non-institutional only		
A6209	FOAM DRESSING, WOUND COVER, PAD SIZE 16 SQ. IN. OR LESS, WITHOUT ADHESIVE BORDER	Each	12 per month	No	$6.17	01/01/1997		Purchase only	Non-institutional only	C -- A6209, A6210, A6211, A6212, A6214	
A6210	FOAM DRESSING, WOUND COVER, PAD SIZE MORE THAN 16 BUT LESS THAN OR EQUAL TO 48 SQ. IN., WITHOUT ADHESIVE BORDER	Each	12 per month	No	$14.35	01/01/1997		Purchase only	Non-institutional only	C -- A6209, A6210, A6211, A6212, A6214	
A6211	FOAM DRESSING, WOUND COVER, PAD SIZE MORE THAN 48 SQ. IN., WITHOUT ADHESIVE BORDER	Each	12 per month	No	$25.21	01/01/1999		Purchase only	Non-institutional only	C -- A6209, A6210, A6211, A6212, A6214	
A6212	FOAM DRESSING, WOUND COVER, PAD SIZE 16 SQ. IN., OR LESS, WITH ANY SIZE ADHESIVE BORDER	Each	12 per month	No	$7.00	01/01/1997		Purchase only	Non-institutional only	C -- A6209, A6210, A6211, A6212, A6214	
A6213	FOAM DRESSING, WOUND COVER, PAD SIZE MORE THAN 16 BUT LESS THAN OR EQUAL TO 48 SQ. IN., WITH ANY SIZE ADHESIVE BORDER	Each	12 per month	Yes	$12.54	04/01/2006	PA	Purchase only	Non-institutional only		
A6214	FOAM DRESSING, WOUND COVER, PAD SIZE MORE THAN 48 SQ. IN., WITH ANY SIZE ADHESIVE BORDER	Each	12 per month	No	$7.45	01/01/1997		Purchase only	Non-institutional only	C -- A6209, A6210, A6211, A6212, A6214	
A6216	GAUZE, NON-IMPREGNATED, PAD SIZE 16 SQ. IN. OR LESS, WITHOUT ADHESIVE BORDER	Each	$50 per month	No	$0.05	04/01/2006	$50.00	Purchase only	Non-institutional only	C -- A6216, A6217, A6218, A6219, A6220, A6221	
A6217	GAUZE, NON-IMPREGNATED, PAD SIZE MORE THAN 16 BUT LESS THAN OR EQUAL TO 48 SQ. IN., WITHOUT ADHESIVE BORDER	Each	$50 per month	No	$0.64	04/01/2006	$50.00	Purchase only	Non-institutional only	C -- A6216, A6217, A6218, A6219, A6220, A6221	
A6218	GAUZE, NON-IMPREGNATED, PAD SIZE MORE THAN 48 SQ. IN., WITHOUT ADHESIVE BORDER	Each	$50 per month	No	$1.27	04/01/2006	$50.00	Purchase only	Non-institutional only	C -- A6216, A6217, A6218, A6219, A6220, A6221	
A6219	GAUZE, NON-IMPREGNATED, PAD SIZE 16 SQ. IN. OR LESS WITH ANY SIZE ADHESIVE BORDER	Each	$50 per month	No	$0.95	04/01/2006	$50.00	Purchase only	Non-institutional only	C -- A6216, A6217, A6218, A6219, A6220, A6221	
A6220	GAUZE, NON-IMPREGNATED, PAD SIZE MORE THAN 16 BUT LESS THAN OR EQUAL TO 48 SQ. IN., WITH ANY SIZE ADHESIVE BORDER	Each	$50 per month	No	$2.58	04/01/2006	$50.00	Purchase only	Non-institutional only	C -- A6216, A6217, A6218, A6219, A6220, A6221	
A6221	GAUZE, NON-IMPREGNATED, PAD SIZE MORE THAN 48 SQ. IN., WITH ANY SIZE ADHESIVE BORDER	Each	$50 per month	No	$0.52	04/01/2006	$50.00	Purchase only	Non-institutional only	C -- A6216, A6217, A6218, A6219, A6220, A6221	
A6222	GAUZE, IMPREGNATED, OTHER THAN WATER, HYDROGEL OR NORMAL SALINE, PAD SIZE 16 SQ. IN. OR LESS, WITHOUT ADHESIVE BORDER	Each	30 per month	No	$1.65	01/01/1997		Purchase only	Non-institutional only	C -- A6222, A6223, A6224	
A6223	GAUZE, IMPREGNATED, OTHER THAN WATER, HYDROGEL OR NORMAL SALINE, PAD SIZE MORE THAN 16 BUT LESS THAN OR EQUAL TO 48 SQ. IN., WITHOUT ADHESIVE BORDER	Each	30 per month	No	$1.75	01/01/1997		Purchase only	Non-institutional only	C -- A6222, A6223, A6224	
A6224	GAUZE, IMPREGNATED, OTHER THAN WATER, HYDROGEL OR NORMAL SALINE, PAD SIZE MORE THAN 48 SQ. IN., WITHOUT ADHESIVE BORDER	Each	30 per month	No	$2.60	01/01/1997		Purchase only	Non-institutional only	C -- A6222, A6223, A6224	
A6231	GAUZE, IMPREGNATED, HYDROGEL, 16 SQ IN OR LESS	Each	12 per month	No	$1.65	01/01/2001		Purchase only	Non-institutional only	C -- A6231, A6232, A6233, A6234, A6235, A6236, A6237, A6238	
A6232	GAUZE, IMPREGNATED, HYDROGEL, MORE THAN 16 BUT LESS THAN OR EQUAL TO 48 SQ IN	Each	12 per month	No	$1.75	01/01/2001		Purchase only	Non-institutional only	C -- A6231, A6232, A6233, A6234, A6235, A6236, A6237, A6238	
A6233	GAUZE, IMPREGNATED, HYDROGEL, MORE THAN 48 SQ IN	Each	12 per month	No	$2.60	01/01/2001		Purchase only	Non-institutional only	C -- A6231, A6232, A6233, A6234, A6235, A6236, A6237, A6238	
A6234	HYDROCOLLOID DRESSING, WOUND COVER, PAD SIZE 16 SQ. IN. OR LESS, WITHOUT ADHESIVE BORDER	Each	12 per month	No	$4.80	01/01/1997		Purchase only	Non-institutional only	C -- A6231, A6232, A6233, A6234, A6235, A6236, A6237, A6238	
A6235	HYDROCOLLOID DRESSING, WOUND COVER, PAD SIZE MORE THAN 16 BUT LESS THAN OR EQUAL TO 48 SQ. IN., WITHOUT ADHESIVE BORDER	Each	12 per month	No	$12.15	01/01/1997		Purchase only	Non-institutional only	C -- A6231, A6232, A6233, A6234, A6235, A6236, A6237, A6238	
A6236	HYDROCOLLOID DRESSING, WOUND COVER, PAD SIZE MORE THAN 48 SQ. IN., WITHOUT ADHESIVE BORDER	Each	12 per month	No	$19.65	01/01/1997		Purchase only	Non-institutional only	C -- A6231, A6232, A6233, A6234, A6235, A6236, A6237, A6238	
A6237	HYDROCOLLOID DRESSING, WOUND COVER, PAD SIZE 16 SQ. IN. OR LESS, WITH ANY SIZE ADHESIVE BORDER	Each	12 per month	No	$5.80	01/01/1997		Purchase only	Non-institutional only	C -- A6231, A6232, A6233, A6234, A6235, A6236, A6237, A6238	
A6238	HYDROCOLLOID DRESSING, WOUND COVER, PAD SIZE MORE THAN 16 BUT LESS THAN OR EQUAL TO 48 SQ. IN., WITH ANY SIZE ADHESIVE BORDER	Each	12 per month	No	$16.75	01/01/1997		Purchase only	Non-institutional only	C -- A6231, A6232, A6233, A6234, A6235, A6236, A6237, A6238	
A6239	HYDROCOLLOID DRESSING, WOUND COVER, PAD SIZE MORE THAN 48 SQ. IN., WITH ANY SIZE ADHESIVE BORDER	Each	12 per month	Yes	PA	01/01/1997		Purchase only	Non-institutional only		
A6242	HYDROGEL DRESSING, WOUND COVER, PAD SIZE 16 SQ. IN. OR LESS, WITHOUT ADHESIVE BORDER	Each	30 per month	No	$4.80	01/01/1997		Purchase only	Non-institutional only	C -- A6242, A6243, A6244	

NC -- No coverage
PA -- Payment by prior authorization

C -- Items to which the same limit applies both individually and in combination
X -- Items that are mutually exclusive

HCPCS CODE	DESCRIPTION	UNIT	LIMIT	PRIOR AUTHORIZATION	CURRENT MAXIMUM PAYMENT AMOUNT	EFFECTIVE DATE	PREVIOUS MAXIMUM PAYMENT AMOUNT	RENTAL OR PURCHASE	RESIDENCE	RELATIONSHIP [C / X]	NOTES
A6243	HYDROGEL DRESSING, WOUND COVER, PAD SIZE MORE THAN 16 BUT LESS THAN OR EQUAL TO 48 SQ. IN., WITHOUT ADHESIVE BORDER	Each	30 per month	No	$8.75	01/01/1997		Purchase only	Non-institutional only	C -- A6242, A6243, A6244	
A6244	HYDROGEL DRESSING, WOUND COVER, PAD SIZE MORE THAN 48 SQ. IN., WITHOUT ADHESIVE BORDER	Each	30 per month	No	$28.30	01/01/1997		Purchase only	Non-institutional only	C -- A6242, A6243, A6244	
A6245	HYDROGEL DRESSING, WOUND COVER, PAD SIZE 16 SQ. IN. OR LESS, WITH ANY SIZE ADHESIVE BORDER	Each	12 per month	No	$5.90	01/01/1997	$100.00	Purchase only	Non-institutional only	C -- A6245, A6246, A6247	
A6246	HYDROGEL DRESSING, WOUND COVER, PAD SIZE MORE THAN 16 BUT LESS THAN OR EQUAL TO 48 SQ. IN., WITH ANY SIZE ADHESIVE BORDER	Each	12 per month	No	$7.15	01/01/1997	$100.00	Purchase only	Non-institutional only	C -- A6245, A6246, A6247	
A6247	HYDROGEL DRESSING, WOUND COVER, PAD SIZE MORE THAN 48 SQ. IN., WITH ANY SIZE ADHESIVE BORDER	Each	12 per month	No	$17.15	01/01/1997		Purchase only	Non-institutional only	C -- A6245, A6246, A6247	
A6251	SPECIALTY ABSORPTIVE DRESSING, WOUND COVER, PAD SIZE 16 SQ. IN. OR LESS WITHOUT ADHESIVE BORDER	Each	30 per month	No	$0.90	01/01/1997		Purchase only	Non-institutional only	C -- A6251, A6252, A6253, A6254, A6255, A6256	
A6252	SPECIALTY ABSORPTIVE DRESSING, WOUND COVER, PAD SIZE MORE THAN 16 BUT LESS THAN OR EQUAL TO 48 SQ. IN., WITHOUT ADHESIVE BORDER	Each	30 per month	No	$2.35	01/01/1997		Purchase only	Non-institutional only	C -- A6251, A6252, A6253, A6254, A6255, A6256	
A6253	SPECIALTY ABSORPTIVE DRESSING, WOUND COVER, PAD SIZE MORE THAN 48 SQ. IN., WITHOUT ADHESIVE BORDER	Each	30 per month	No	$4.60	01/01/1997	$100.00	Purchase only	Non-institutional only	C -- A6251, A6252, A6253, A6254, A6255, A6256	
A6254	SPECIALTY ABSORPTIVE DRESSING, WOUND COVER, PAD SIZE 16 SQ. IN. OR LESS, WITH ANY SIZE ADHESIVE BORDER	Each	30 per month	No	$0.90	01/01/1997	$100.00	Purchase only	Non-institutional only	C -- A6251, A6252, A6253, A6254, A6255, A6256	
A6255	SPECIALTY ABSORPTIVE DRESSING, WOUND COVER, PAD SIZE MORE THAN 16 BUT LESS THAN OR EQUAL TO 48 SQ. IN., WITH ANY SIZE ADHESIVE BORDER	Each	30 per month	No	$2.20	01/01/1997		Purchase only	Non-institutional only	C -- A6251, A6252, A6253, A6254, A6255, A6256	
A6256	SPECIALTY ABSORPTIVE DRESSING, WOUND COVER, PAD SIZE MORE THAN 48 SQ. IN. WITH ANY SIZE ADHESIVE BORDER	Each	30 per month	Yes	PA	01/01/1997		Purchase only	Non-institutional only	C -- A6251, A6252, A6253, A6254, A6255, A6256	
A6257	TRANSPARENT FILM, 16 SQ. IN. OR LESS	Each	12 per month	No	$1.10	01/01/1997		Purchase only	Non-institutional only	C -- A6257, A6258, A6259	
A6258	TRANSPARENT FILM, MORE THAN 16 BUT LESS THAN OR EQUAL TO 48 SQ. IN.	Each	12 per month	No	$3.10	01/01/1997		Purchase only	Non-institutional only	C -- A6257, A6258, A6259	
A6259	TRANSPARENT FILM, MORE THAN 48 SQ. IN.	Each	12 per month	No	$7.90	01/01/1997		Purchase only	Non-institutional only	C -- A6257, A6258, A6259	
A6266	GAUZE, IMPREGNATED, OTHER THAN WATER, NORMAL SALINE, OR ZINC PASTE, ANY WIDTH	Linear yard	100 yards per month	No	$1.75	08/01/1997		Purchase only	Non-institutional only		
A6402	GAUZE, NON-IMPREGNATED, STERILE, PAD SIZE 16 SQ. IN. OR LESS, WITHOUT ADHESIVE BORDER	Each	$50 per month	No	$0.12	04/01/2006	$50.00	Purchase only	Non-institutional only	C -- A6402, A6403, A6404	Submitted charge must not exceed manufacturer's suggested list price.
A6403	GAUZE, NON-IMPREGNATED, STERILE, PAD SIZE MORE THAN 16 BUT LESS THAN OR EQUAL TO 48 SQ. IN. WITHOUT ADHESIVE BORDER	Each	$50 per month	No	$0.43	04/01/2006	$50.00	Purchase only	Non-institutional only	C -- A6402, A6403, A6404	Submitted charge must not exceed manufacturer's suggested list price.
A6404	GAUZE, NON-IMPREGNATED, STERILE, PAD SIZE MORE THAN 48 SQ. IN., WITHOUT ADHESIVE BORDER	Each	$50 per month	No	$0.61	04/01/2006	$50.00	Purchase only	Non-institutional only	C -- A6402, A6403, A6404	Submitted charge must not exceed manufacturer's suggested list price.
A6441	PADDING BANDAGE, NON-ELASTIC, NON-WOVEN/NON-KNITTED, WIDTH GREATER THAN OR EQUAL TO THREE INCHES AND LESS THAN FIVE INCHES, PER YARD	Linear yard	100 per month	No	$0.54	01/01/2005		Purchase only	Non-institutional only		
A6442	CONFORMING BANDAGE, NON-ELASTIC, KNITTED/WOVEN, NON-STERILE, WIDTH LESS THAN THREE INCHES, PER YARD	Linear yard	150 per month	No	$0.14	01/01/2005		Purchase only	Non-institutional only	C -- A6442, A6443, A6444, A6445, A6446, A6447	
A6443	CONFORMING BANDAGE, NON-ELASTIC, KNITTED/WOVEN, NON-STERILE, WIDTH GREATER THAN OR EQUAL TO THREE INCHES AND LESS THAN FIVE INCHES, PER YARD	Linear yard	150 per month	No	$0.23	01/01/2005		Purchase only	Non-institutional only	C -- A6442, A6443, A6444, A6445, A6446, A6447	
A6444	CONFORMING BANDAGE, NON-ELASTIC, KNITTED/WOVEN, NON-STERILE, WIDTH GREATER THAN OR EQUAL TO FIVE INCHES, PER YARD	Linear yard	150 per month	No	$0.45	01/01/2005		Purchase only	Non-institutional only	C -- A6442, A6443, A6444, A6445, A6446, A6447	
A6445	CONFORMING BANDAGE, NON-ELASTIC, KNITTED/WOVEN, STERILE, WIDTH LESS THAN THREE INCHES, PER YARD	Linear yard	150 per month	No	$0.26	01/01/2005		Purchase only	Non-institutional only	C -- A6442, A6443, A6444, A6445, A6446, A6447	
A6446	CONFORMING BANDAGE, NON-ELASTIC, KNITTED/WOVEN, STERILE, WIDTH GREATER THAN OR EQUAL TO THREE INCHES AND LESS THAN FIVE INCHES, PER YARD	Linear yard	150 per month	No	$0.33	01/01/2005		Purchase only	Non-institutional only	C -- A6442, A6443, A6444, A6445, A6446, A6447	
A6447	CONFORMING BANDAGE, NON-ELASTIC, KNITTED/WOVEN, STERILE, WIDTH GREATER THAN OR EQUAL TO FIVE INCHES, PER YARD	Linear yard	150 per month	No	$0.54	01/01/2005		Purchase only	Non-institutional only	C -- A6442, A6443, A6444, A6445, A6446, A6447	
A6448	LIGHT COMPRESSION BANDAGE, ELASTIC, KNITTED/WOVEN, WIDTH LESS THAN THREE INCHES, PER YARD	Linear yard	18 per 3 months	No	$1.04	10/01/2004		Purchase only	Non-institutional only	C -- A6448, A6449, A6450, A6451, A6452, A6453, A6454, A6455	
A6449	LIGHT COMPRESSION BANDAGE, ELASTIC, KNITTED/WOVEN, WIDTH GREATER THAN OR EQUAL TO THREE INCHES AND LESS THAN FIVE INCHES, PER YARD	Linear yard	18 per 3 months	No	$1.05	10/01/2004		Purchase only	Non-institutional only	C -- A6448, A6449, A6450, A6451, A6452, A6453, A6454, A6455	
A6450	LIGHT COMPRESSION BANDAGE, ELASTIC, KNITTED/WOVEN, WIDTH GREATER THAN OR EQUAL TO FIVE INCHES, PER YARD	Linear yard	18 per 3 months	No	$1.60	01/01/2005		Purchase only	Non-institutional only	C -- A6448, A6449, A6450, A6451, A6452, A6453, A6454, A6455	
A6451	MODERATE COMPRESSION BANDAGE, ELASTIC, KNITTED/WOVEN, LOAD RESISTANCE OF 1.25 TO 1.34 FOOT POUNDS AT 50 PERCENT MAXIMUM STRETCH, WIDTH GREATER THAN OR EQUAL TO THREE INCHES AND LESS THAN FIVE INCHES, PER YARD	Linear yard	18 per 3 months	No	$3.19	01/01/2005		Purchase only	Non-institutional only	C -- A6448, A6449, A6450, A6451, A6452, A6453, A6454, A6455	
A6452	HIGH COMPRESSION BANDAGE, ELASTIC, KNITTED/WOVEN, LOAD RESISTANCE GREATER THAN OR EQUAL TO 1.35 FOOT POUNDS AT 50% MAXIMUM STRETCH, WIDTH GREATER THAN OR EQUAL TO THREE INCHES AND LESS THAN FIVE INCHES, PER YARD	Linear yard	18 per 3 months	No	$5.32	10/01/2004		Purchase only	Non-institutional only	C -- A6448, A6449, A6450, A6451, A6452, A6453, A6454, A6455	
A6453	SELF-ADHERENT BANDAGE, ELASTIC, NON-KNITTED/NON-WOVEN, WIDTH LESS THAN THREE INCHES, PER YARD	Linear yard	18 per 3 months	No	$0.55	10/01/2004		Purchase only	Non-institutional only	C -- A6448, A6449, A6450, A6451, A6452, A6453, A6454, A6455	
A6454	SELF-ADHERENT BANDAGE, ELASTIC, NON-KNITTED/NON-WOVEN, WIDTH GREATER THAN OR EQUAL TO THREE INCHES AND LESS THAN FIVE INCHES, PER YARD	Linear yard	18 per 3 months	No	$0.69	10/01/2004		Purchase only	Non-institutional only	C -- A6448, A6449, A6450, A6451, A6452, A6453, A6454, A6455	
A6455	SELF-ADHERENT BANDAGE, ELASTIC, NON-KNITTED/NON-WOVEN, WIDTH GREATER THAN OR EQUAL TO FIVE INCHES, PER YARD	Linear yard	18 per 3 months	No	$1.25	10/01/2004		Purchase only	Non-institutional only	C -- A6448, A6449, A6450, A6451, A6452, A6453, A6454, A6455	
WOUND FILLERS											
A6010	COLLAGEN BASED WOUND FILLER, DRY FORM, PER GRAM	Gram	$100 per month	No	$30.96	09/01/2005	$100.00	Purchase only	Non-institutional only	C -- A6010, A6011, A6199, A6215, A6240, A6241, A6248, A6261, A6262	Submitted charge must not exceed manufacturer's suggested list price.
A6011	COLLAGEN BASED WOUND FILLER, GEL/PASTE, PER GRAM	Gram	$100 per month	No	$1.82	01/01/2005		Purchase only	Non-institutional only	C -- A6010, A6011, A6199, A6215, A6240, A6241, A6248, A6261, A6262	Submitted charge must not exceed manufacturer's suggested list price.
A6199	ALGINATE OR OTHER FIBER GELLING DRESSING, WOUND FILLER, PER 6 IN.	6 inches	$100 per month	No	$5.29	09/01/2005	$100.00	Purchase only	Non-institutional only	C -- A6010, A6011, A6199, A6215, A6240, A6241, A6248, A6261, A6262	Submitted charge must not exceed manufacturer's suggested list price.
A6215	FOAM DRESSING, WOUND FILLER,PER GRAM	Gram	$100 per month	No	$1.23	04/01/2006	$100.00	Purchase only	Non-institutional only	C -- A6010, A6011, A6199, A6215, A6240, A6241, A6248, A6261, A6262	Submitted charge must not exceed manufacturer's suggested list price.

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A6240	HYDROCOLLOID DRESSING, WOUND FILLER, PASTE, PER FLUID OZ.	Fluid ounce	$100 per month	No	$5.00	07/26/2007	$12.24	Purchase only	Non-institutional only	C -- A6010, A6011, A6199, A6215, A6240, A6241, A6248, A6261, A6262	Submitted charge must not exceed manufacturer's suggested list price.
A6241	HYDROCOLLOID DRESSING, WOUND FILLER, DRY FORM, PER GRAM	Gram	$100 per month	No	$2.57	09/01/2005	$100.00	Purchase only	Non-institutional only	C -- A6010, A6011, A6199, A6215, A6240, A6241, A6248, A6261, A6262	Submitted charge must not exceed manufacturer's suggested list price.
A6248	HYDROGEL DRESSING, WOUND FILLER, GEL, PER FLUID OZ.	Fluid ounce	$100 per month	No	$5.76	07/26/2007	$16.24	Purchase only	Non-institutional only	C -- A6010, A6011, A6199, A6215, A6240, A6241, A6248, A6261, A6262	Submitted charge must not exceed manufacturer's suggested list price.
A6261	WOUND FILLER, NOT ELSEW CLASSIFIED, GEL/PASTE, PER FLUID OZ.	Month	$100 per month	No	$100.00	01/01/1997		Purchase only	Non-institutional only	C -- A6010, A6011, A6199, A6215, A6240, A6241, A6248, A6261, A6262	Submitted charge must not exceed manufacturer's suggested list price.
A6262	WOUND FILLER, NOT ELSEWHERE CLASSIFIED, DRY FORM, PER GRAM	Month	$100 per month	No	$100.00	01/01/1997		Purchase only	Non-institutional only	C -- A6010, A6011, A6199, A6215, A6240, A6241, A6248, A6261, A6262	Submitted charge must not exceed manufacturer's suggested list price.
SYRINGES / NEEDLES											
A4207	SYRINGE WITH NEEDLE, STERILE 2 CC	Each	100 per month	No	$0.23	05/01/1990		Purchase only	Non-institutional only	X -- A4207, A4208, A4209	
A4208	SYRINGE WITH NEEDLE, STERILE 3 CC	Each	100 per month	No	$0.17	05/01/1990		Purchase only	Non-institutional only	X -- A4207, A4208, A4209	
A4209	SYRINGE WITH NEEDLE, STERILE 5CC OR GREATER	Each	100 per month	No	$0.27	05/01/1990		Purchase only	Non-institutional only	X -- A4207, A4208, A4209	
A4212	NON-CORING (HUBER-TYPE) NEEDLE	Each	30 per month	No	$3.60	04/01/1997		Purchase only	Non-institutional only		
A4213	SYRINGE W/O NEEDLE, STERILE 20 CC OR GREATER	Each	50 per year	No	$0.60	11/22/1990	$0.25	Purchase only	Non-institutional only		
ANTISEPTIC SOLUTION											
A4244	PEROXIDE/ALCOHOL, PER PINT	16 ounces	15 per month	No	$0.56	05/01/1990		Purchase only	Non-institutional only		
A4246	BETADINE, POVIDONE IODINE, OR PHISOHEX SOLUTION, PER PINT	16 ounces	6 per month	No	$10.00	06/20/1990		Purchase only	Non-institutional only	X -- A4246, A4247	
A4247	BETADINE/POVIDONE IODINE WIPE/SWAB, PER BOX	Box	2 per month	No	$19.00	01/01/2005	$0.19	Purchase only	Non-institutional only	X -- A4246, A4247	
DISTILLED WATER / STERILE SALINE											
A4216	STERILE WATER/SALINE, 10 ML	10-milliliter vial	90 per month	No	$0.25	10/01/2004		Purchase only	Non-institutional only		
A4217	STERILE WATER/SALINE, 500 ML	500-milliliter bottle	36 per month	No	$2.50	10/01/2004		Purchase only	Non-institutional only		
A7018	WATER, DISTILLED, 1000 ML	Liter	16 per month	No	$0.28	01/01/2001		Purchase only	Non-institutional only		
INCONTINENCE GARMENTS AND RELATED SUPPLIES											
T4521	ADULT SIZED DISPOSABLE INCONTINENCE PRODUCT, BRIEF/DIAPER, SMALL, EACH	Each	300 per month, 3-20 years; 200 per month, 21+ years	No	$0.55	01/01/2010	$0.61	Purchase only	Non-institutional only	C -- T4521, T4522, T4523, T4524, T4525, T4526, T4527, T4528, T4529, T4530, T4531, T4532, T4533, T4534, T4535, T4538	
T4522	ADULT SIZED DISPOSABLE INCONTINENCE PRODUCT, BRIEF/DIAPER, MEDIUM, EACH	Each	300 per month, 3-20 years; 200 per month, 21+ years	No	$0.63	01/01/2010	$0.70	Purchase only	Non-institutional only	C -- T4521, T4522, T4523, T4524, T4525, T4526, T4527, T4528, T4529, T4530, T4531, T4532, T4533, T4534, T4535, T4538	
T4523	ADULT SIZED DISPOSABLE INCONTINENCE PRODUCT, BRIEF/DIAPER, LARGE, EACH	Each	300 per month, 3-20 years; 200 per month, 21+ years	No	$0.71	01/01/2010	$0.79	Purchase only	Non-institutional only	C -- T4521, T4522, T4523, T4524, T4525, T4526, T4527, T4528, T4529, T4530, T4531, T4532, T4533, T4534, T4535, T4538	
T4524	ADULT SIZED DISPOSABLE INCONTINENCE PRODUCT, BRIEF/DIAPER, EXTRA LARGE, EACH	Each	300 per month, 3-20 years; 200 per month, 21+ years	No	$0.79	01/01/2010	$0.88	Purchase only	Non-institutional only	C -- T4521, T4522, T4523, T4524, T4525, T4526, T4527, T4528, T4529, T4530, T4531, T4532, T4533, T4534, T4535, T4538	
T4525	ADULT SIZED DISPOSABLE INCONTINENCE PRODUCT, PROTECTIVE UNDERWEAR/PULL-ON, SMALL SIZE, EACH	Each	300 per month, 3-20 years; 200 per month, 21+ years	No	$0.55	01/01/2010	$0.61	Purchase only	Non-institutional only	C -- T4521, T4522, T4523, T4524, T4525, T4526, T4527, T4528, T4529, T4530, T4531, T4532, T4533, T4534, T4535, T4538	
T4526	ADULT SIZED DISPOSABLE INCONTINENCE PRODUCT, PROTECTIVE UNDERWEAR/PULL-ON, MEDIUM SIZE, EACH	Each	300 per month, 3-20 years; 200 per month, 21+ years	No	$0.63	01/01/2010	$0.70	Purchase only	Non-institutional only	C -- T4521, T4522, T4523, T4524, T4525, T4526, T4527, T4528, T4529, T4530, T4531, T4532, T4533, T4534, T4535, T4538	
T4527	ADULT SIZED DISPOSABLE INCONTINENCE PRODUCT, PROTECTIVE UNDERWEAR/PULL-ON, LARGE SIZE, EACH	Each	300 per month, 3-20 years; 200 per month, 21+ years	No	$0.71	01/01/2010	$0.79	Purchase only	Non-institutional only	C -- T4521, T4522, T4523, T4524, T4525, T4526, T4527, T4528, T4529, T4530, T4531, T4532, T4533, T4534, T4535, T4538	
T4528	ADULT SIZED DISPOSABLE INCONTINENCE PRODUCT, PROTECTIVE UNDERWEAR/PULL-ON, EXTRA LARGE SIZE, EACH	Each	300 per month, 3-20 years; 200 per month, 21+ years	No	$0.79	01/01/2010	$0.88	Purchase only	Non-institutional only	C -- T4521, T4522, T4523, T4524, T4525, T4526, T4527, T4528, T4529, T4530, T4531, T4532, T4533, T4534, T4535, T4538	
T4529	PEDIATRIC SIZED DISPOSABLE INCONTINENCE PRODUCT, BRIEF/DIAPER, SMALL/MEDIUM SIZE, EACH	Each	300 per month, 3-20 years; 200 per month, 21+ years	No	$0.40	01/01/2005		Purchase only	Non-institutional only	C -- T4521, T4522, T4523, T4524, T4525, T4526, T4527, T4528, T4529, T4530, T4531, T4532, T4533, T4534, T4535, T4538	
T4530	PEDIATRIC SIZED DISPOSABLE INCONTINENCE PRODUCT, BRIEF/DIAPER, LARGE SIZE, EACH	Each	300 per month, 3-20 years; 200 per month, 21+ years	No	$0.40	01/01/2005		Purchase only	Non-institutional only	C -- T4521, T4522, T4523, T4524, T4525, T4526, T4527, T4528, T4529, T4530, T4531, T4532, T4533, T4534, T4535, T4538	
T4531	PEDIATRIC SIZED DISPOSABLE INCONTINENCE PRODUCT, PROTECTIVE UNDERWEAR/PULL-ON, SMALL/MEDIUM SIZE, EACH	Each	300 per month, 3-20 years; 200 per month, 21+ years	No	$0.40	01/01/2005		Purchase only	Non-institutional only	C -- T4521, T4522, T4523, T4524, T4525, T4526, T4527, T4528, T4529, T4530, T4531, T4532, T4533, T4534, T4535, T4538	
T4532	PEDIATRIC SIZED DISPOSABLE INCONTINENCE PRODUCT, PROTECTIVE UNDERWEAR/PULL-ON, LARGE SIZE, EACH	Each	300 per month, 3-20 years; 200 per month, 21+ years	No	$0.40	01/01/2005		Purchase only	Non-institutional only	C -- T4521, T4522, T4523, T4524, T4525, T4526, T4527, T4528, T4529, T4530, T4531, T4532, T4533, T4534, T4535, T4538	
T4533	YOUTH SIZED DISPOSABLE INCONTINENCE PRODUCT, BRIEF/DIAPER, EACH	Each	300 per month, 3-20 years; 200 per month, 21+ years	No	$0.46	01/01/2005		Purchase only	Non-institutional only	C -- T4521, T4522, T4523, T4524, T4525, T4526, T4527, T4528, T4529, T4530, T4531, T4532, T4533, T4534, T4535, T4538	

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T4534	YOUTH SIZED DISPOSABLE INCONTINENCE PRODUCT, PROTECTIVE UNDERWEAR/PULL-ON, EACH	Each	300 per month, 3-20 years; 200 per month, 21+ years	No	$0.46	01/01/2005		Purchase only	Non-institutional only	C -- T4521, T4522, T4523, T4524, T4525, T4526, T4527, T4528, T4529, T4530, T4531, T4532, T4533, T4534, T4535, T4538	
T4535	DISPOSABLE LINER/SHIELD/GUARD/PAD/UNDERGARMENT, FOR INCONTINENCE, EACH	Each	300 per month, 3-20 years; 200 per month, 21+ years	No	$0.40	01/01/2005		Purchase only	Non-institutional only	C -- T4521, T4522, T4523, T4524, T4525, T4526, T4527, T4528, T4529, T4530, T4531, T4532, T4533, T4534, T4535, T4538	
T4536	INCONTINENCE PRODUCT, PROTECTIVE UNDERWEAR/PULL-ON, REUSABLE, ANY SIZE, EACH	Each	12 per year	No	$11.00	01/01/2005		Purchase only	Non-institutional only		
T4537	INCONTINENCE PRODUCT, PROTECTIVE UNDERPAD, REUSABLE, BED SIZE, EACH	Each	6 per year	No	$20.00	01/01/2005		Purchase only	Non-institutional only		
T4538	DIAPER SERVICE, REUSABLE DIAPER, EACH	Each	300 per month, 3-20 years; 200 per month, 21+ years	No	$0.53	01/01/2005		Purchase only	Non-institutional only	C -- T4521, T4522, T4523, T4524, T4525, T4526, T4527, T4528, T4529, T4530, T4531, T4532, T4533, T4534, T4535, T4538	
T4540	INCONTINENCE PRODUCT, PROTECTIVE UNDERPAD, REUSABLE, CHAIR SIZE, EACH	Each	6 per year	No	$10.00	01/01/2005		Purchase only	Non-institutional only		
T4541	INCONTINENCE PRODUCT, DISPOSABLE UNDERPAD, LARGE, EACH	Each	300 per 2 months	No	$0.28	01/01/2005		Purchase only	Non-institutional only	C -- T4541, T4542	
T4542	INCONTINENCE PRODUCT, DISPOSABLE UNDERPAD, SMALL SIZE, EACH	Each	300 per 2 months	No	$0.28	01/01/2005		Purchase only	Non-institutional only	C -- T4541, T4542	
T4543	DISP BARIATIC BRIEF/DIAPER	Each	150 per month	No	$2.12	01/01/2010	$2.35	Purchase only	Non-institutional only		
T4539	INCONTINENCE PRODUCT, DIAPER/BRIEF, REUSABLE, ANY SIZE, EACH	Each	12 per year	No	$11.00	01/01/2005	PA	Purchase only	Non-institutional only		
UROLOGICAL SUPPLIES											
A4310	FOLEY CATH INSERTION TRAY WITHOUT DRAINAGE BAG, WITHOUT CATHETER	Each	3 per month	No	$3.90	05/01/1990		Purchase only	Non-institutional only	X -- A4310, A4311, A4312, A4313, A4314, A4315, A4316	
A4311	INSERTION TRAY WITHOUT DRAINAGE BAG, WITH INDWELLING CATHETER, FOLEY TYPE, TWO WAY LATEX WITH COATING (TEFLON, SILICONE, SILICONE ELASTOMER OR HYDROPHILIC, ETC.)	Each	3 per month	No	$6.75	05/01/1990		Purchase only	Non-institutional only	X -- A4310, A4311, A4312, A4313, A4314, A4315, A4316	
A4312	INSERTION TRAY WITHOUT DRAINAGE BAG, WITH INDWELLING CATHETER, FOLEY TYPE, TWO WAY, ALL SILICONE	Each	3 per month	No	$10.00	05/01/1990		Purchase only	Non-institutional only	X -- A4310, A4311, A4312, A4313, A4314, A4315, A4316	
A4313	INSERTION TRAY WITHOUT DRAINAGE BAG, WITH INDWELLING CATHETER, FOLEY TYPE, THREE WAY, FOR CONTINUOUS	Each	3 per month	No	$14.00	05/01/1990		Purchase only	Non-institutional only	X -- A4310, A4311, A4312, A4313, A4314, A4315, A4316	
A4314	INSERTION TRAY WITH DRAINAGE BAG WITH INDWELLING CATHETER, FOLEY TYPE, TWO-WAY LATEX WITH COATING (TEFLON, SILICONE, SILICONE ELASTOMER OR HYDROPHILIC, ETC.)	Each	3 per month	No	$10.75	05/01/1990		Purchase only	Non-institutional only	X -- A4310, A4311, A4312, A4313, A4314, A4315, A4316	
A4315	INSERTION TRAY WITH DRAINAGE BAG WITH INDWELLING CATHETER, FOLEY TYPE, TWO WAY, ALL SILICONE	Each	3 per month	No	$14.00	05/01/1990		Purchase only	Non-institutional only	X -- A4310, A4311, A4312, A4313, A4314, A4315, A4316	
A4316	INSERTION TRAY WITH DRAINAGE BAG WITH INDWELLING CATHETER, FOLEY TYPE, 3 WAY, FOR CONTINUOUS IRRIGATION	Each	3 per month	No	$18.00	05/01/1990		Purchase only	Non-institutional only	X -- A4310, A4311, A4312, A4313, A4314, A4315, A4316	
A4320	IRRIGATION TRAY WITH BULB OR PISTON SYRINGE	Each	30 per month	No	$2.50	04/01/1992		Purchase only	Non-institutional only		
A4322	IRRIGATION SYRINGE, WITH BULB OR PISTON	Each	30 per month	No	$1.60	06/20/1990	$2.50	Purchase only	Non-institutional only		
A4349	MALE EXTERNAL CATHETER, WITH OR WITHOUT ADHESIVE, DISPOSABLE, EACH	Each	60 per month	No	$1.39	01/01/2005		Purchase only	Non-institutional only		A4349 replaces A4324, A4325, and A4247.
A4326	MALE EXTERNAL CATHETER SPECIALTY TYPE WITH INTEGRAL COLLECTION CHAMBER, EACH	Each	5 per year	No	$9.00	08/01/1997		Purchase only	Non-institutional only		
A4327	FEMALE EXTERNAL URINARY COLLECTION DEVICE; METAL CUP	Each	2 per year	No	$37.00	08/01/1997		Purchase only	Non-institutional only		
A4328	FEMALE EXTERNAL URINARY COLLECTION DEVICE; POUCH	Each	1 per month	No	$8.33	04/01/2001	$7.79	Purchase only	Non-institutional only		
A4330	PERIANAL FECAL COLLECTION POUCH WITH ADHESIVE	Each	20 per month	No	$5.80	04/01/2001	$11.06	Purchase only	Non-institutional only		
A4331	EXTENSION DRAINAGE TUBING, ANY TYPE OR LENGTH, WITH CONNECTOR/ADAPTOR, FOR USE WITH URINARY LEG BAG OR UROSTOMY POUCH, EACH	Each	2 per month	No	$3.04	04/01/2001	$2.90	Purchase only	Non-institutional only		
A4333	URINARY CATHETER ANCHORING DEVICE, ADHESIVE SKIN ATTACHMENT, EACH	Each	12 per month	No	$1.37	04/01/2001	$1.27	Purchase only	Non-institutional only		
A4334	URINARY CATHETER ANCHORING DEVICE, LEG STRAP	Each	1 per month	No	$3.00	01/01/2001		Purchase only	Non-institutional only		
A4335	INCONTINENCE SUPPLY; MISCELLANEOUS	Each		Yes	PA	05/01/1990		Purchase only	Non-institutional only		
A4338	INDWELLING CATHETER; FOLEY TYPE, 2-WAY LATEX WITH COATING (TEFLON, SILICONE, SILICONE ELASTOMER, OR HYDROPHILIC, ETC)	Each	3 per month	No	$4.20	05/01/1990		Purchase only	Non-institutional only	X - A4338, A4340, A4344, A4346, A4351, A4353	
A4340	INDWELLING CATHETER; SPECIALTY TYPE; (EG; COUDE, MUSHROOM, WING, ETC)	Each	3 per month	No	$24.00	08/01/1997		Purchase only	Non-institutional only	X - A4338, A4340, A4344, A4346, A4351, A4353	
A4344	INDWELLING CATHETER, FOLEY TYPE, TWO WAY, ALL SILICONE	Each	3 per month	No	$9.39	04/01/1992		Purchase only	Non-institutional only	X - A4338, A4340, A4344, A4346, A4351, A4353	
A4346	INDWELLING CATHETER; FOLEY TYPE, THREE WAY, FOR CONTINUOUS IRRIGATION	Each	3 per month	No	$12.50	05/01/1990		Purchase only	Non-institutional only	X - A4338, A4340, A4344, A4346, A4351, A4353	
A4351	INTERMITTENT URINARY CATHETER, STRAIGHT TIP	Each	200 per month	No	$0.79	01/01/1996		Purchase only	Non-institutional only	X - A4338, A4340, A4344, A4346, A4351, A4353	
A4352	INTERMITTENT URINARY CATHETER; COUDE (CURVED) TIP	Each	200 per month	No	$2.00	01/01/1996		Purchase only	Non-institutional only	X - A4338, A4340, A4344, A4346, A4351, A4353	
A4353	INTERMITTENT URINARY CATHETER, WITH INSERTION SUPPLIES	Each	60 per month	No	$3.49	10/01/2004		Purchase only	Non-institutional only	X - A4338, A4340, A4344, A4346, A4351, A4353	Payment for A4353 includes lubricant.
A4354	CATHETER INSERTION TRAY WITH DRAINAGE BAG BUT WITHOUT CATHETER	Each	3 per month	No	$7.40	05/01/1990		Purchase only	Non-institutional only		
A4355	IRRIGATION TUBING SET 3-WAY INDWELLING FOLEY CATHETER	Each	3 per month	No	$2.70	05/01/1990	$1.39	Purchase only	Non-institutional only		
A4356	EXTERNAL URETHRAL CLAMP OR COMPRESSION DEVICE, (NOT TO BE USED FOR CATHETER CLAMP)	Each	1 per year	No	$30.01	05/01/1990		Purchase only	Non-institutional only		
A4357	BEDSIDE DRAINAGE BAG, DAY OR NIGHT, WITH OR WITHOUT ANTI-REFLUX DEVICE, WITH OR WITHOUT TUBE	Each	2 per month	No	$6.00	06/20/1990		Purchase only	Non-institutional only		
A4358	URINARY LEG/ABDOMINAL BAG, VINYL, WITH OR WITHOUT TUBE WITH STRAPS	Each	4 per month	No	$6.26	04/01/2001	$3.35	Purchase only	Non-institutional only		
A4402	LUBRICANT (FOR NON-STERILE CATHETERIZATION)	Ounce	8 per month	No	$0.65	08/01/1998	$1.50	Purchase only	Non-institutional only		

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HCPCS CODE	DESCRIPTION	UNIT	LIMIT	PRIOR AUTHORIZATION	CURRENT MAXIMUM PAYMENT AMOUNT	EFFECTIVE DATE	PREVIOUS MAXIMUM PAYMENT AMOUNT	RENTAL OR PURCHASE	RESIDENCE	RELATIONSHIP [C / X]	NOTES
A5102	BEDSIDE DRAINAGE BOTTLE, RIGID OR EXPANDABLE	Each	2 per year	No	$21.39	04/01/2001	$23.00	Purchase only	Non-institutional only		
A5105	URINARY SUSPENSORY; WITH LEG BAG, WITH OR WITHOUT TUBE	Each	2 per year	No	$40.32	07/01/2002	$59.00	Purchase only	Non-institutional only	X -- A5105, A5112	
A5112	URINARY LEG BAG; LATEX	Each	3 per year	No	$31.16	07/01/2002	$31.25	Purchase only	Non-institutional only	X -- A5105, A5112	
A5113	LEG STRAP; LATEX, REPLACEMENT ONLY, PER SET (FOR USE WITH URINARY LEG BAG)	Each	4 per year	No	$1.30	11/15/1993		Purchase only	Non-institutional only	X -- A5113, A5114	
A5114	LEG STRAP; FOAM OR FABRIC, REPLACEMENT ONLY, PER SET (FOR USE WITH URINARY LEG BAG)	Each	4 per year	No	$4.25	04/01/2001	$4.00	Purchase only	Non-institutional only	X -- A5113, A5114	
A5131	APPLIANCE CLEANER, INCONTINENCE AND OSTOMY APPLIANCES, PER 16 OZ.	16 ounces	1 per 3 months	No	$12.25	01/01/1998	$12.00	Purchase only	Non-institutional only		
OSTOMY SUPPLIES											
A4361	OSTOMY, FACE PLATE	Each	4 per year	No	$17.52	04/01/2001	$23.34	Purchase only	Non-institutional only		Only one code may be reported each month in the categories of ostomy supplies, urinary ostomy supplies, ostomy faceplates, skin barriers, and irrigation supplies.
A4362	SKIN BARRIER; SOLID, 4 X 4 OR EQUIVALENT; EACH	Each	20 per month	No	$3.22	04/01/2001	$3.16	Purchase only	Non-institutional only		Only one code may be reported each month in the categories of ostomy supplies, urinary ostomy supplies, ostomy faceplates, skin barriers, and irrigation supplies.
A4364	ADHESIVE FOR FACIAL PROSTHESIS ONLY; LIQUID OR EQUAL, PER OZ.	Ounce	4 per 2 months	No	$2.38	04/01/2001	$3.05	Purchase only	Non-institutional only		Only one code may be reported each month in the categories of ostomy supplies, urinary ostomy supplies, ostomy faceplates, skin barriers, and irrigation supplies.
A4367	OSTOMY BELT	Each	2 per 6 MOS	No	$6.96	04/01/2001	$6.65	Purchase only	Non-institutional only		Only one code may be reported each month in the categories of ostomy supplies, urinary ostomy supplies, ostomy faceplates, skin barriers, and irrigation supplies.
A4369	OSTOMY SKIN BARRIER, LIQUID (SPRAY, BRUSH, ETC.) PER OZ.	Ounce	4 per month	No	$2.30	01/01/2000		Purchase only	Non-institutional only		Only one code may be reported each month in the categories of ostomy supplies, urinary ostomy supplies, ostomy faceplates, skin barriers, and irrigation supplies.
A4371	OSTOMY SKIN BARRIER, POWDER, PER OZ	Ounce	4 per month	No	$3.48	04/01/2001	$3.30	Purchase only	Non-institutional only		Only one code may be reported each month in the categories of ostomy supplies, urinary ostomy supplies, ostomy faceplates, skin barriers, and irrigation supplies.
A4372	OSTOMY SKIN BARRIER, SOLID, 4X4 OR EQUIV. STANDARD WEAR W/ BUILT-IN CONVEXITY	Each	20 per month	No	$3.78	01/01/2000		Purchase only	Non-institutional only		Only one code may be reported each month in the categories of ostomy supplies, urinary ostomy supplies, ostomy faceplates, skin barriers, and irrigation supplies.
A4373	OSTOMY SKIN BARRIER, WITH FLANGE (SOLID, FLEXIBLE OR ACCORDIAN), WITH BUILT-IN CONVEXITY, ANY SIZE, EACH	Each	20 per month	No	$5.99	04/01/2001	$5.69	Purchase only	Non-institutional only		Only one code may be reported each month in the categories of ostomy supplies, urinary ostomy supplies, ostomy faceplates, skin barriers, and irrigation supplies.
A4375	OSTOMY POUCH, DRAINABLE, WITH FACEPLATE ATTACHED, PLASTIC	Each	5 per month	No	$15.56	01/01/2000		Purchase only	Non-institutional only		Only one code may be reported each month in the categories of ostomy supplies, urinary ostomy supplies, ostomy faceplates, skin barriers, and irrigation supplies.
A4376	OSTOMY POUCH, DRAINABLE, WITH FACEPLATE ATTACHED, RUBBER	Each	5 per month	No	$43.11	01/01/2000		Purchase only	Non-institutional only		Only one code may be reported each month in the categories of ostomy supplies, urinary ostomy supplies, ostomy faceplates, skin barriers, and irrigation supplies.
A4377	OSTOMY POUCH, DRAINABLE, FOR USE ON FACEPLATE, PLASTIC	Each	10 per month	No	$3.89	01/01/2000		Purchase only	Non-institutional only		Only one code may be reported each month in the categories of ostomy supplies, urinary ostomy supplies, ostomy faceplates, skin barriers, and irrigation supplies.
A4378	OSTOMY POUCH, DRAINABLE, FOR USE ON FACEPLATE, RUBBER	Each	10 per month	No	$27.86	01/01/2000		Purchase only	Non-institutional only		Only one code may be reported each month in the categories of ostomy supplies, urinary ostomy supplies, ostomy faceplates, skin barriers, and irrigation supplies.
A4379	OSTOMY POUCH, URINARY, WITH FACEPLATE ATTACHED, PLASTIC	Each	5 per month	No	$13.61	01/01/2000		Purchase only	Non-institutional only		Only one code may be reported each month in the categories of ostomy supplies, urinary ostomy supplies, ostomy faceplates, skin barriers, and irrigation supplies.
A4380	OSTOMY POUCH, URINARY, WITH FACEPLATE ATTACHED, RUBBER	Each	5 per month	No	$33.82	01/01/2000		Purchase only	Non-institutional only		Only one code may be reported each month in the categories of ostomy supplies, urinary ostomy supplies, ostomy faceplates, skin barriers, and irrigation supplies.
A4381	OSTOMY POUCH, URINARY, FOR USE ON FACEPLATE, PLASTIC	Each	10 per month	No	$4.18	01/01/2000		Purchase only	Non-institutional only		Only one code may be reported each month in the categories of ostomy supplies, urinary ostomy supplies, ostomy faceplates, skin barriers, and irrigation supplies.
A4382	OSTOMY POUCH, URINARY, FOR USE ON FACEPLATE, HEAVY PLASTIC	Each	10 per month	No	$22.31	01/01/2000		Purchase only	Non-institutional only		Only one code may be reported each month in the categories of ostomy supplies, urinary ostomy supplies, ostomy faceplates, skin barriers, and irrigation supplies.
A4383	OSTOMY POUCH, URINARY, FOR USE ON FACEPLATE, RUBBER	Each	10 per month	No	$25.55	01/01/2000		Purchase only	Non-institutional only		Only one code may be reported each month in the categories of ostomy supplies, urinary ostomy supplies, ostomy faceplates, skin barriers, and irrigation supplies.
A4384	OSTOMY FACEPLATE EQUIVALENT, SILICONE, RING	Each	4 per year	No	$8.72	01/01/2000		Purchase only	Non-institutional only		Only one code may be reported each month in the categories of ostomy supplies, urinary ostomy supplies, ostomy faceplates, skin barriers, and irrigation supplies.
A4385	OSTOMY SKIN BARRIER, SOLID 4X4 OR EQUIVALENT, EXTENDED WEAR, WITHOUT BUILT-IN CONVEXITY	Each	5 per month	No	$4.00	04/01/2001	$4.62	Purchase only	Non-institutional only		Only one code may be reported each month in the categories of ostomy supplies, urinary ostomy supplies, ostomy faceplates, skin barriers, and irrigation supplies.
A4387	OSTOMY POUCH, CLOSED, WITH STANDARD WEAR BARRIER ATTACHED, WITH BUILT-IN CONVEXITY (1 PIECE)	Each	45 per month	No	$2.74	04/01/2001	$3.64	Purchase only	Non-institutional only		Only one code may be reported each month in the categories of ostomy supplies, urinary ostomy supplies, ostomy faceplates, skin barriers, and irrigation supplies.
A4388	OSTOMY POUCH, DRAINABLE, WITH EXTENDED WEAR BARRIER ATTACHED, WITHOUT BUILT-IN CONVEXITY (1 PIECE)	Each	10 per month	No	$3.87	04/01/2001	$3.95	Purchase only	Non-institutional only		Only one code may be reported each month in the categories of ostomy supplies, urinary ostomy supplies, ostomy faceplates, skin barriers, and irrigation supplies.
A4389	OSTOMY POUCH, DRAINABLE, WITH BARRIER ATTACHED, WITH BUILT-IN CONVEXITY (1 PIECE), EACH	Each	20 per month	No	$5.55	04/01/2001	$5.63	Purchase only	Non-institutional only		Only one code may be reported each month in the categories of ostomy supplies, urinary ostomy supplies, ostomy faceplates, skin barriers, and irrigation supplies.
A4390	OSTOMY POUCH, DRAINABLE, WITH EXTENDED WEAR BARRIER ATTACHED, WITH BUILT-IN CONVEXITY (1 PIECE), EACH	Each	5 per month	No	$8.94	04/01/2001	$8.71	Purchase only	Non-institutional only		Only one code may be reported each month in the categories of ostomy supplies, urinary ostomy supplies, ostomy faceplates, skin barriers, and irrigation supplies.
A4391	OSTOMY POUCH, URINARY, WITH EXTENDED WEAR BARRIER ATTACHED, WITHOUT BUILT-IN CONVEXITY (1 PIECE)	Each	10 per month	No	$6.04	04/01/2001	$6.40	Purchase only	Non-institutional only		Only one code may be reported each month in the categories of ostomy supplies, urinary ostomy supplies, ostomy faceplates, skin barriers, and irrigation supplies.
A4392	OSTOMY POUCH, URINARY, WITH STANDARD WEAR BARRIER ATTACHED, WITH BUILT-IN CONVEXITY (1 PIECE)	Each	20 per month	No	$6.34	04/01/2001	$6.02	Purchase only	Non-institutional only		Only one code may be reported each month in the categories of ostomy supplies, urinary ostomy supplies, ostomy faceplates, skin barriers, and irrigation supplies.
A4393	OSTOMY POUCH, URINARY, WITH EXTENDED WEAR BARRIER ATTACHED, WITH BUILT-IN CONVEXITY (1 PIECE)	Each	5 per month	No	$7.81	04/01/2001	$8.31	Purchase only	Non-institutional only		Only one code may be reported each month in the categories of ostomy supplies, urinary ostomy supplies, ostomy faceplates, skin barriers, and irrigation supplies.
A4396	OSTOMY BELT WITH PERISTOMAL HERNIA SUPPORT	Each	1 per 3 months	No	$24.20	10/01/2004	NC	Purchase only	Non-institutional only		Only one code may be reported each month in the categories of ostomy supplies, urinary ostomy supplies, ostomy faceplates, skin barriers, and irrigation supplies.
A4397	IRRIGATION SUPPLY; SLEEVE	Each	10 per month	No	$4.41	04/01/2001	$4.35	Purchase only	Non-institutional only		Only one code may be reported each month in the categories of ostomy supplies, urinary ostomy supplies, ostomy faceplates, skin barriers, and irrigation supplies.
A4398	IRRIGATION SUPPLY; BAG	Each	4 per year	No	$13.17	04/01/2001	$21.88	Purchase only	Non-institutional only		Only one code may be reported each month in the categories of ostomy supplies, urinary ostomy supplies, ostomy faceplates, skin barriers, and irrigation supplies.
A4399	IRRIGATION SUPPLY; CONE/CATHETER	Each	1 per 6 months	No	$9.95	01/01/1998	$8.96	Purchase only	Non-institutional only		Only one code may be reported each month in the categories of ostomy supplies, urinary ostomy supplies, ostomy faceplates, skin barriers, and irrigation supplies.
A4400	OSTOMY IRRIGATION SET	Each	2 per year	No	$45.00	08/01/1997	$42.00	Purchase only	Non-institutional only		Only one code may be reported each month in the categories of ostomy supplies, urinary ostomy supplies, ostomy faceplates, skin barriers, and irrigation supplies.
A4402	LUBRICANT, PER OUNCE	Ounce	8 per month	No	$0.65	08/01/1998	$1.50	Purchase only	Non-institutional only		Only one code may be reported each month in the categories of ostomy supplies, urinary ostomy supplies, ostomy faceplates, skin barriers, and irrigation supplies.
A4404	OSTOMY RING, EACH	Each	5 per month	No	$1.47	04/01/2001	$1.45	Purchase only	Non-institutional only		Only one code may be reported each month in the categories of ostomy supplies, urinary ostomy supplies, ostomy faceplates, skin barriers, and irrigation supplies.
A4405	OSTOMY SKIN BARRIER, NON-PECTIN BASED PASTE	Ounce	4 per month	No	$3.27	04/01/2003		Purchase only	Non-institutional only		Only one code may be reported each month in the categories of ostomy supplies, urinary ostomy supplies, ostomy faceplates, skin barriers, and irrigation supplies.
A4406	OSTOMY SKIN BARRIER, PECTIN BASED PASTE	Ounce	4 per month	No	$3.27	04/01/2003		Purchase only	Non-institutional only		Only one code may be reported each month in the categories of ostomy supplies, urinary ostomy supplies, ostomy faceplates, skin barriers, and irrigation supplies.
A4407	OSTOMY SKIN BARRIER WITH FLANGE (SOLID, FLEXIBLE, OR ACCORDION), EXTENDED WEAR, WITH BUILT-IN CONVEXITY; 4X4 OR SMALLER	Each	5 per month	No	$7.67	04/01/2003		Purchase only	Non-institutional only		Only one code may be reported each month in the categories of ostomy supplies, urinary ostomy supplies, ostomy faceplates, skin barriers, and irrigation supplies.
A4408	OSTOMY SKIN BARRIER WITH FLANGE (SOLID, FLEXIBLE OR ACCORDION), EXTENDED WEAR, WITH BUILT-IN CONVEXITY; LARGER THAN 4X4	Each	5 per month	No	$7.67	04/01/2003		Purchase only	Non-institutional only		Only one code may be reported each month in the categories of ostomy supplies, urinary ostomy supplies, ostomy faceplates, skin barriers, and irrigation supplies.
A4409	OSTOMY SKIN BARRIER, WITH FLANGE (SOLID, FLEXIBLE OR ACCORDION), EXTENDED WEAR WITHOUT BUILT-IN CONVEXITY, 4X4 OR SMALLER	Each	5 per month	No	$5.68	04/01/2003		Purchase only	Non-institutional only		Only one code may be reported each month in the categories of ostomy supplies, urinary ostomy supplies, ostomy faceplates, skin barriers, and irrigation supplies.

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HCPCS CODE	DESCRIPTION	UNIT	LIMIT	PRIOR AUTHORIZATION	CURRENT MAXIMUM PAYMENT AMOUNT	EFFECTIVE DATE	PREVIOUS MAXIMUM PAYMENT AMOUNT	RENTAL OR PURCHASE	RESIDENCE	RELATIONSHIP [C / X]	NOTES
A4410	OSTOMY SKIN BARRIER, WITH FLANGE (SOLID, FLEXIBLE OR ACCORDION), EXTENDED WEAR, WITHOUT BUILT-IN CONVEXITY; LARGER THAN 4X4	Each	5 per month	No	$5.68	04/01/2003		Purchase only	Non-institutional only		Only one code may be reported each month in the categories of ostomy supplies, urinary ostomy supplies, ostomy faceplates, skin barriers, and irrigation supplies.
A4414	OSTOMY SKIN BARRIER, WITH FLANGE (SOLID, FLEXIBLE OR ACCORDION, WITHOUT BUILT-IN CONVEXITY; 4X4 OR SMALLER	Each	20 per month	No	$4.24	04/01/2003		Purchase only	Non-institutional only		Only one code may be reported each month in the categories of ostomy supplies, urinary ostomy supplies, ostomy faceplates, skin barriers, and irrigation supplies.
A4415	OSTOMY SKIN BARRIER, WITH FLANGE (SOLID, FLEXIBLE OR ACCORDION), WITHOUT BUILT-IN CONVEXITY; LARGER THAN 4X4	Each	20 per month	No	$4.24	04/01/2003		Purchase only	Non-institutional only		Only one code may be reported each month in the categories of ostomy supplies, urinary ostomy supplies, ostomy faceplates, skin barriers, and irrigation supplies.
A4421	OSTOMY SUPPLY; MISCELLANEOUS	Each		Yes	PA	05/01/1990		Purchase only	Non-institutional only		Only one code may be reported each month in the categories of ostomy supplies, urinary ostomy supplies, ostomy faceplates, skin barriers, and irrigation supplies.
A5051	OSTOMY POUCH, CLOSED; WITH BARRIER ATTACHED (1 PIECE)	Each	45 per month	No	$1.91	04/01/2001	$2.00	Purchase only	Non-institutional only		Only one code may be reported each month in the categories of ostomy supplies, urinary ostomy supplies, ostomy faceplates, skin barriers, and irrigation supplies.
A5052	OSTOMY POUCH, CLOSED; WITHOUT BARRIER ATTACHED (1 PIECE)	Each	45 per month	No	$1.36	04/01/2001	$1.55	Purchase only	Non-institutional only		Only one code may be reported each month in the categories of ostomy supplies, urinary ostomy supplies, ostomy faceplates, skin barriers, and irrigation supplies.
A5053	OSTOMY POUCH, CLOSED; FOR USE ON FACEPLATE	Each	45 per month	No	$1.58	01/01/1998	$1.49	Purchase only	Non-institutional only		Only one code may be reported each month in the categories of ostomy supplies, urinary ostomy supplies, ostomy faceplates, skin barriers, and irrigation supplies.
A5054	OSTOMY POUCH, CLOSED FOR USE ON BARRIER W/FLANGE (2 PC)	Each	45 per month	No	$1.35	04/01/2001	$1.30	Purchase only	Non-institutional only		Only one code may be reported each month in the categories of ostomy supplies, urinary ostomy supplies, ostomy faceplates, skin barriers, and irrigation supplies.
A5055	STOMA CAP	Each	30 per month	No	$1.27	04/01/2001	$1.52	Purchase only	Non-institutional only		Only one code may be reported each month in the categories of ostomy supplies, urinary ostomy supplies, ostomy faceplates, skin barriers, and irrigation supplies.
A5061	POUCH, DRAINABLE WITH BARRIER ATTACHED (1 PIECE)	Each	30 per month	No	$2.45	04/01/2001	$2.89	Purchase only	Non-institutional only		Only one code may be reported each month in the categories of ostomy supplies, urinary ostomy supplies, ostomy faceplates, skin barriers, and irrigation supplies.
A5062	OSTOMY POUCH, DRAINABLE; WITHOUT BARRIER ATTACHED (1 PIECE), EACH	Each	20 per month	No	$1.90	08/01/1997	$1.83	Purchase only	Non-institutional only		Only one code may be reported each month in the categories of ostomy supplies, urinary ostomy supplies, ostomy faceplates, skin barriers, and irrigation supplies.
A5063	OSTOMY POUCH, DRAINABLE; FOR USE ON BARRIER WITH FLANGE (2 PIECE SYSTEM)	Each	10 per month	No	$2.13	04/01/2001	$2.11	Purchase only	Non-institutional only		Only one code may be reported each month in the categories of ostomy supplies, urinary ostomy supplies, ostomy faceplates, skin barriers, and irrigation supplies.
A5071	OSTOMY POUCH URINARY; WITH BARRIER ATTACHED, (1 PIECE)	Each	20 per month	No	$4.15	04/01/2001	$4.53	Purchase only	Non-institutional only		Only one code may be reported each month in the categories of ostomy supplies, urinary ostomy supplies, ostomy faceplates, skin barriers, and irrigation supplies.
A5072	OSTOMY POUCH URINARY; WITHOUT BARRIER ATTACHED (1 PIECE)	Each	20 per month	No	$3.10	04/01/2001	$3.16	Purchase only	Non-institutional only		Only one code may be reported each month in the categories of ostomy supplies, urinary ostomy supplies, ostomy faceplates, skin barriers, and irrigation supplies.
A5073	OSTOMY POUCH URINARY; FOR USE ON BARRIER WITH FLANGE (2 PIECE)	Each	10 per month	No	$2.98	04/01/2001	$3.35	Purchase only	Non-institutional only		Only one code may be reported each month in the categories of ostomy supplies, urinary ostomy supplies, ostomy faceplates, skin barriers, and irrigation supplies.
A5081	OSTOMY CONTINENT DEVICE; PLUG FOR CONTINENT STOMA	Each	40 per month	No	$3.00	01/01/1998	$2.83	Purchase only	Non-institutional only		Only one code may be reported each month in the categories of ostomy supplies, urinary ostomy supplies, ostomy faceplates, skin barriers, and irrigation supplies.
A5082	OSTOMY CONTINENT DEVICE; CATHETER FOR CONTINENT STOMA	Each	1 per 2 months	No	$10.75	01/01/1998	$10.21	Purchase only	Non-institutional only		Only one code may be reported each month in the categories of ostomy supplies, urinary ostomy supplies, ostomy faceplates, skin barriers, and irrigation supplies.
A5093	OSTOMY ACCESSORY; CONVEX INSERT	Each	10 per month	No	$1.58	04/01/2001	$1.51	Purchase only	Non-institutional only		Only one code may be reported each month in the categories of ostomy supplies, urinary ostomy supplies, ostomy faceplates, skin barriers, and irrigation supplies.
A5120	SKIN BARRIER, WIPES OR SWABS, EACH	Each	50 per month	No	$0.17	01/01/2006		Purchase only	Non-institutional only		Only one code may be reported each month in the categories of ostomy supplies, urinary ostomy supplies, ostomy faceplates, skin barriers, and irrigation supplies.
A5121	OSTOMY SKIN BARRIER; SOLID 6 X 6, OR EQUIVALENT	Each	5 per month	No	$6.70	05/01/1990		Purchase only	Non-institutional only		Only one code may be reported each month in the categories of ostomy supplies, urinary ostomy supplies, ostomy faceplates, skin barriers, and irrigation supplies.
A5122	OSTOMY SKIN BARRIER; SOLID, 8 X 8 OR EQUIVALENT	Each	6 per month	No	$12.26	04/01/2001	$11.65	Purchase only	Non-institutional only		Only one code may be reported each month in the categories of ostomy supplies, urinary ostomy supplies, ostomy faceplates, skin barriers, and irrigation supplies.
A5126	ADHESIVE OR NON-ADHESIVE; DISK OR FOAM PAD	Each	20 per month	No	$1.11	07/01/2002	$1.15	Purchase only	Non-institutional only		Only one code may be reported each month in the categories of ostomy supplies, urinary ostomy supplies, ostomy faceplates, skin barriers, and irrigation supplies.
A5131	APPLIANCE CLEANER, INCONTINENCE AND OSTOMY APPLIANCES, PER 16 OZ.	Each	1 per 3 months	No	$12.25	01/01/1998	$12.00	Purchase only	Non-institutional only		Only one code may be reported each month in the categories of ostomy supplies, urinary ostomy supplies, ostomy faceplates, skin barriers, and irrigation supplies.
SURGICAL STOCKINGS AND BURN GARMENTS											
A4490	PRESSURE GRADIENT SURGICAL STOCKING, ABOVE KNEE LENGTH	Each	6 per year	Yes	$25.00	10/15/2006	$50.00	Purchase only	Non-institutional only	X -- A4490, A4495, A4500, A4510	
A4495	PRESSURE GRADIENT SURGICAL STOCKING, THIGH LENGTH	Each	6 per year	Yes	$25.00	10/15/2006	$50.00	Purchase only	Non-institutional only	X -- A4490, A4495, A4500, A4510	
A4500	PRESSURE GRADIENT SURGICAL STOCKING, BELOW KNEE LENGTH	Each	6 per year	Yes	$22.00	10/15/2006	$44.00	Purchase only	Non-institutional only	X -- A4490, A4495, A4500, A4510	
A4510	PRESSURE GRADIENT SURGICAL STOCKING, FULL LENGTH, LEOTARD	Each	3 per year	Yes	$75.00	01/01/2008	$37.50	Purchase only	Non-institutional only	X -- A4490, A4495, A4500, A4510	
A6501	COMPRESSION BURN GARMENT, BODYSUIT (HEAD TO FOOT), CUSTOM FABRICATED	Each	3 per year	Yes	PA	10/01/2004		Purchase only	Non-institutional only		
A6502	COMPRESSION BURN GARMENT, CHIN STRAP, CUSTOM FABRICATED	Each	3 per year	Yes	PA	10/01/2004		Purchase only	Non-institutional only		
A6503	COMPRESSION BURN GARMENT, FACIAL HOOD, CUSTOM FABRICATED	Each	3 per year	Yes	PA	10/01/2004		Purchase only	Non-institutional only		
A6504	COMPRESSION BURN GARMENT, GLOVE TO WRIST, CUSTOM FABRICATED	Each	4 per year	Yes	PA	10/01/2004		Purchase only	Non-institutional only	X -- A6504, A6505, A6506	
A6505	COMPRESSION BURN GARMENT, GLOVE TO ELBOW, CUSTOM FABRICATED	Each	4 per year	Yes	PA	10/01/2004		Purchase only	Non-institutional only	X -- A6504, A6505, A6506	
A6506	COMPRESSION BURN GARMENT, GLOVE TO AXILLA, CUSTOM FABRICATED	Each	4 per year	Yes	PA	10/01/2004		Purchase only	Non-institutional only	X -- A6504, A6505, A6506	
A6507	COMPRESSION BURN GARMENT, FOOT TO KNEE LENGTH, CUSTOM FABRICATED	Each	4 per year	Yes	PA	10/01/2004		Purchase only	Non-institutional only	X -- A6507, A6508	
A6508	COMPRESSION BURN GARMENT, FOOT TO THIGH LENGTH, CUSTOM FABRICATED	Each	4 per year	Yes	PA	10/01/2004		Purchase only	Non-institutional only	X -- A6507, A6508	
A6509	COMPRESSION BURN GARMENT, UPPER TRUNK TO WAIST INCLUDING ARM OPENINGS (VEST), CUSTOM FABRICATED	Each	3 per year	Yes	PA	10/01/2004		Purchase only	Non-institutional only	X -- A6509, A6510, A6511	
A6510	COMPRESSION BURN GARMENT, TRUNK, INCLUDING ARMS DOWN TO LEG OPENINGS (LEOTARD), CUSTOM FABRICATED	Each	3 per year	Yes	PA	10/01/2004		Purchase only	Non-institutional only	X -- A6509, A6510, A6511	
A6511	COMPRESSION BURN GARMENT, LOWER TRUNK INCLUDING LEG OPENINGS (PANTY), CUSTOM FABRICATED	Each	3 per year	Yes	PA	10/01/2004		Purchase only	Non-institutional only	X -- A6509, A6510, A6511	
A6512	COMPRESSION BURN GARMENT, NOT OTHERWISE CLASSIFIED	Each	4 per year	Yes	PA	10/01/2004		Purchase only	Non-institutional only		
ELASTIC SUPPORTS											
A4466	GARMENT, BELT,SLEEVE OR OTHER COVERING, ELASTIC ANY TYPE	Each	2 per year	No	$40.00	12/07/2010	NC	Purchase only	Non-institutional only	X -- A4466, A6530, A6531, A6532, A6533, A6534, A6535, A6536, A6537, A6538, A6539, A6540, A6541, A6549	
A6530	COMPRESSION STOCKING BK18-30, EACH	Each	6 per year	Yes	$21.64	07/26/2007	$43.27	Purchase only	Non-institutional only	X -- A4466, A6530, A6531, A6532, A6533, A6534, A6535, A6536, A6537, A6538, A6539, A6540, A6541, A6549	
A6531	COMPRESSION STOCKING BK30-40	Each	6 per year	Yes	$26.06	07/26/2007	$43.27	Purchase only	Non-institutional only	X -- A4466, A6530, A6531, A6532, A6533, A6534, A6535, A6536, A6537, A6538, A6539, A6540, A6541, A6549	

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A6532	COMPRESSION STOCKING BK40-50	Each	6 per year	Yes	$30.48	07/26/2007	$60.96	Purchase only	Non-institutional only	X -- A4466, A6530, A6531, A6532, A6533, A6534, A6535, A6536, A6537, A6538, A6539, A6540, A6541, A6549	
A6533	GC STOCKING THIGHLNGTH 18-30	Each	6 per year	Yes	$24.64	07/26/2007	$43.27	Purchase only	Non-institutional only	X -- A4466, A6530, A6531, A6532, A6533, A6534, A6535, A6536, A6537, A6538, A6539, A6540, A6541, A6549	
A6534	GC STOCKING THIGHLNGTH 30-40	Each	6 per year	Yes	$29.06	07/26/2007	$43.27	Purchase only	Non-institutional only	X -- A4466, A6530, A6531, A6532, A6533, A6534, A6535, A6536, A6537, A6538, A6539, A6540, A6541, A6549	
A6535	GC STOCKING THIGHLNGTH 40-50	Each	6 per year	Yes	$33.48	07/26/2007	$60.96	Purchase only	Non-institutional only	X -- A4466, A6530, A6531, A6532, A6533, A6534, A6535, A6536, A6537, A6538, A6539, A6540, A6541, A6549	
A6536	GC STOCKING FULL LNGTH 18-30	Each	6 per year	Yes	$43.27	01/01/2006		Purchase only	Non-institutional only	X -- A4466, A6530, A6531, A6532, A6533, A6534, A6535, A6536, A6537, A6538, A6539, A6540, A6541, A6549	
A6537	GC STOCKING FULL LNGTH 30-40	Each	6 per year	Yes	$52.12	07/26/2007	$43.27	Purchase only	Non-institutional only	X -- A4466, A6530, A6531, A6532, A6533, A6534, A6535, A6536, A6537, A6538, A6539, A6540, A6541, A6549	
A6538	GC STOCKING FULL LNGTH 40-50	Each	6 per year	Yes	$60.96	01/01/2006		Purchase only	Non-institutional only	X -- A4466, A6530, A6531, A6532, A6533, A6534, A6535, A6536, A6537, A6538, A6539, A6540, A6541, A6549	
A6539	GC STOCKING WAISTLNGTH 18-30	Each	3 per year	Yes	$50.00	07/26/2007	$43.27	Purchase only	Non-institutional only	X -- A4466, A6530, A6531, A6532, A6533, A6534, A6535, A6536, A6537, A6538, A6539, A6540, A6541, A6549	
A6540	GC STOCKING WAISTLNGTH 30-40	Each	3 per year	Yes	$62.50	07/26/2007	$43.29	Purchase only	Non-institutional only	X -- A4466, A6530, A6531, A6532, A6533, A6534, A6535, A6536, A6537, A6538, A6539, A6540, A6541, A6549	
A6541	GC STOCKING WAISTLNGTH 40-50	Each	3 per year	Yes	$75.00	07/26/2007	$60.96	Purchase only	Non-institutional only	X -- A4466, A6530, A6531, A6532, A6533, A6534, A6535, A6536, A6537, A6538, A6539, A6540, A6541, A6549	
A6549	G COMPRESSION STOCKING, NOS	Each	6 per year	Yes	PA	01/01/2011	BR	Purchase only	Non-institutional only	X -- A4466, A6530, A6531, A6532, A6533, A6534, A6535, A6536, A6537, A6538, A6539, A6540, A6541, A6549	
S8420	CUSTOM GRADIENT SLEEVE/GLOVE	Each	4 per year	Yes	PA	10/15/2006	NC	Purchase only	Non-institutional only	X -- A4466, S8420, S8421, S8422, S8423, S8424	
S8421	READY GRADIENT SLEEVE/GLOV	Each	4 per year	Yes	PA	10/15/2006	NC	Purchase only	Non-institutional only	X -- A4466, S8420, S8421, S8422, S8423, S8424	
S8422	CUSTOM GRAD SLEEVE MED	Each	4 per year	Yes	PA	10/15/2006	NC	Purchase only	Non-institutional only	X -- A4466, S8420, S8421, S8422, S8423, S8424	
S8423	CUSTOM GRAD SLEEVE HEAVY	Each	4 per year	Yes	PA	10/15/2006	NC	Purchase only	Non-institutional only	X -- A4466, S8420, S8421, S8422, S8423, S8424	
S8424	READY GRADIENT SLEEVE	Each	4 per year	Yes	PA	10/15/2006	NC	Purchase only	Non-institutional only	X -- A4466, S8420, S8421, S8422, S8423, S8424	
S8425	CUSTOM GRAD GLOVE MED	Each	4 per year	Yes	PA	10/15/2006	NC	Purchase only	Non-institutional only	X -- A4466, S8420, S8421, S8425, S8426, S8427, S8428	
S8426	CUSTOME GRAD GLOVE HEAVY	Each	4 per year	Yes	PA	10/15/2006	NC	Purchase only	Non-institutional only	X -- A4466, S8420, S8421, S8425, S8426, S8427, S8428	
S8427	READY GRADIENT GLOVE	Each	4 per year	Yes	PA	10/15/2006	NC	Purchase only	Non-institutional only	X -- A4466, S8420, S8421, S8425, S8426, S8427, S8428	
S8428	READY GRADIENT GAUNTLET	Each	4 per year	Yes	PA	10/15/2006	NC	Purchase only	Non-institutional only	X -- A4466, S8420, S8421, S8425, S8426, S8427, S8428	
FAMILY PLANNING SUPPLIES											
A4266	DIAPHRAGM FOR CONTRACEPTIVE USE	Each	1 per year	No	$25.46	04/01/2003		Purchase only	Non-institutional only		
A4267	CONTRACEPTIVE SUPPLY, CONDOM, MALE	Each	36 per month	No	$0.40	04/01/2003		Purchase only	Non-institutional only		
A4268	CONTRACEPTIVE SUPPLY, CONDOM, FEMALE	Each	36 per month	No	$2.10	04/01/2003		Purchase only	Non-institutional only		
A4269	CONTRACEPTIVE SUPPLY, SPERMICIDE	Each	1 per month	No	$10.05	04/01/2003		Purchase only	Non-institutional only		
MISCELLANEOUS SUPPLIES											
A4455	ADHESIVE REMOVER OR SOLVENT (FOR TAPE, CEMENT OR OTHER ADHESIVE) NOT COVERED FOR USE WITH UROLOGICAL SUPPLIES	Ounce	8 per month	No	$1.36	04/01/2001	$8.80	Purchase only	Non-institutional only		
A4458	ENEMA BAG WITH TUBING, REUSABLE	Each	1 per 2 years	No	$8.00	10/01/2004		Purchase only	Non-institutional only		
A4561	PESSARY, RUBBER, ANY TYPE	Each	1 per year	No	$10.24	01/01/2001		Purchase only	Non-institutional only	X -- A4561, A4562	
A4562	PESSARY, NON-RUBBER, ANY TYPE	Each	1 per year	No	$10.24	01/01/2001		Purchase only	Non-institutional only	X -- A4561, A4562	
A4565	SLINGS	Each	2 per year	No	$6.30	07/01/2002	$8.00	Purchase only	Non-institutional only		
A4570	SPLINT	Each	1 per year	No	$10.00	05/01/1990		Purchase only	Non-institutional only		
A4580	CAST SUPPLIES (E.G. PLASTER), REPAIR ONLY	Roll	1 per year	No	$2.55	11/01/1992		Purchase only	Non-institutional only		
A4590	CASTING MATERIAL, SPECIAL (E.G. FIBERGLASS), REPAIR ONLY	Roll	1 per year	No	$15.00	11/01/1992		Purchase only	Non-institutional only		
A4649	SURGICAL SUPPLY, MISCELLANEOUS (DO NOT USE FOR OSTOMY SUPPLIES)	Each		Yes	PA	05/01/1990		Purchase only	Non-institutional only		
A4927	GLOVES, NON-STERILE	100	2 per month	No	$8.69	04/01/2003	$0.22	Purchase only	Non-institutional only		

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A4930	GLOVES, STERILE	Pair	100 pair per month	No	$0.55	04/01/2003		Purchase only	Non-institutional only		
E0190	POSITIONING CUSHION/PILLOW/WEDGE, ANY SHAPE OR SIZE, INCLUDES ALL COMPONENTS AND ACCESSORIES	Each	1 per 2 years	No	$100.00	04/01/2009	$232.00	Purchase only	Non-institutional only		
E0602	BREAST PUMP, MANUAL, ANY TYPE	Each	1 per 2 years	No	$15.00	10/01/2004		Purchase only	Non-institutional only	X -- E0602, E0603, E0604	
E0603	BREAST PUMP, ELECTRIC (AC AND/OR DC), ANY TYPE	Each	1 per 5 years	No	$202.50	07/26/2007	$31.00	Purchase only	Non-institutional only	X -- E0602, E0603, E0604	
E0604	BREAST PUMP, HEAVY DUTY, HOSPITAL GRADE, PISTON OPERATED, PULSATILE VACUUM SUCTION/RELEASE CYCLES, VACUUM REGULATOR, SUPPLIES, TRANSFORMER, ELECTRIC (AC AND/OR DC) (RENTAL ONLY)	Day	90 days	No	$2.25	01/01/2002		Rental only	Non-institutional only	X -- E0602, E0603, E0604	
E0700	SAFETY EQUIPMENT (E.G., BELT, HARNESS OR VEST)	Each	2 per year	No	$10.82	05/01/1990		Purchase only	Non-institutional only		
E0705	TRANSFER BOARD OR DEVICE, ANY TYPE, EACH	Each	1 per 2 years	No	$46.62	01/01/2006		Purchase only	Non-institutional only		
E1399	DURABLE MEDICAL EQUIPMENT, MISCELLANEOUS			Yes	PA	05/01/1990			Non-institutional only		
Y9167	SHARPS CONTAINER FOR DISPOSAL, CAPACITY 200	Each	1 per 2 months	No	$4.00	06/20/1990		Purchase only	Non-institutional only		
K0730	CONTROLLED DOSE INHALATION DRUG DELIVERY SYSTEM	Each	1 per 5 years	No	$1,379.20	10/15/2006		Purchase only	Non-institutional only		
DECUBITUS CARE EQUIPMENT											
A4640	REPLACEMENT PAD FOR USE WITH MEDICALLY NECESSARY ALTERNATING PRESSURE PAD OWNED BY CONSUMER	Each	1 per year	No	$31.28	05/25/1991		Purchase only	Non-institutional only	X -- A4640, E0181, E0185, E0197, E0198, E0199, E0371, E0372	
E0181	PRESSURE PAD, ALTERNATING, WITH PUMP, HEAVY DUTY	Each	1 per 4 years	No	$148.00	05/01/1990		Purchase only	Non-institutional only	X -- A4640, E0181, E0185, E0197, E0198, E0199, E0371, E0372	
E0182	PUMP FOR ALTERNATING PRESSURE PAD	Each	1 per 4 years	No	$105.00	11/01/1992		Purchase only	Non-institutional only		
E0184	DRY PRESSURE MATTRESS	Each	1 per 4 years	No	$194.70	09/01/2005	$463.00	Purchase only	Non-institutional only	X -- E0184, E0186, E0187, E0196, E0277, E0373	
E0185	GEL PRESSURE PAD FOR MATTRESS	Each	1 per 2 years	No	$102.00	05/01/1990		Purchase only	Non-institutional only	X -- A4640, E0181, E0185, E0197, E0198, E0199, E0371, E0372	
E0186	AIR PRESSURE MATTRESS	Each	1 per 2 years	Yes	$219.74	04/01/2006	PA	Purchase only	Non-institutional only	X -- E0184, E0186, E0187, E0196, E0277, E0373	
E0187	WATER PRESSURE MATTRESS (E.G., AQUAPEDIC)	Each	1 per 2 years	No	$231.00	12/15/2002	$463.00	Purchase only	Non-institutional only	X -- E0184, E0186, E0187, E0196, E0277, E0373	
E0188	SYNTHETIC SHEEPSKIN PAD, WHEELCHAIR SIZE	Each	2 per 6 months	No	$5.00	05/01/1990	$53.00	Purchase only	Non-institutional only		
E0189	LAMBSWOOL/SHEEPSKIN PAD, ANY BED SIZE	Each	2 per year	No	$43.95	07/01/2002	$463.00	Purchase only	Non-institutional only		
E0191	HEEL OR ELBOW PROTECTOR	Each	4 per 6 months	No	$9.00	04/01/2001	$5.55	Purchase only	Non-institutional only		
E0193	POWERED FLOTATION BED (LOW AIR LOSS THERAPY)	Day	180 per year	No	$32.50	01/01/1992		Rental only	Non-institutional only	X -- E0193, E0194	
E0194	AIR FLUIDIZED BED (BEAD BED)	Day	180 per year	Yes	$38.00	01/01/1992		Rental only	Non-institutional only	X -- E0193, E0194	
E0196	GEL PRESSURE MATTRESS	Each	1 per 4 years	No	$351.69	04/01/2006	PA	Purchase only	Non-institutional only	X -- E0184, E0186, E0187, E0196, E0277, E0373	
E0197	AIR PRESSURE PAD FOR MATTRESS	Each	1 per 4 years	No	$199.42	04/01/2006	PA	Purchase only	Non-institutional only	X -- A4640, E0181, E0185, E0197, E0198, E0199, E0371, E0372	
E0198	WATER PRESSURE PAD FOR MATTRESS	Each	1 per 4 years	Yes	$177.26	07/26/2007	PA	Purchase only	Non-institutional only	X -- A4640, E0181, E0185, E0197, E0198, E0199, E0371, E0372	
E0199	DRY PRESSURE PAD FOR MATTRESS, STANDARD MATTRESS LENGTH AND WIDTH (E.G., EGG CRATE)	Each	1 per year	No	$20.00	05/25/1991		Purchase only	Non-institutional only	X -- A4640, E0181, E0185, E0197, E0198, E0199, E0371, E0372	
E0277	ALTERNATING PRESSURE MATTRESS	Each	1 per 4 years	Yes	$7,615.20	04/01/2006	PA	Rental / purchase	Non-institutional only	X -- E0184, E0186, E0187, E0196, E0277, E0373	
E0371	NONPOWER ADVANCED PRESSURE-REDUCING MATTRESS OVERLAY	Each	1 per 4 years	Yes	$4,644.81	04/01/2006	PA	Rental / purchase	Non-institutional only	X -- A4640, E0181, E0185, E0197, E0198, E0199, E0371, E0372	
E0372	POWERED AIR OVERLAY FOR MATTRESS, STANDARD MATTRESS LENGTH & WIDTH	Each	1 per 4 years	Yes	$5,838.28	04/01/2006	PA	Rental / purchase	Non-institutional only	X -- A4640, E0181, E0185, E0197, E0198, E0199, E0371, E0372	
E0373	NON-POWERED , ADVANCED PRESSURE-REDUCING MATTRESS	Each	1 per 4 years	Yes	$6,651.27	04/01/2006	PA	Rental / purchase	Non-institutional only	X -- E0184, E0186, E0187, E0196, E0277, E0373	
HOSPITAL BEDS											
E0255	HOSPITAL BED, VARIABLE HEIGHT, HI-LO, WITH ANY TYPE SIDE RAILS, WITH MATTRESS	Each	1 per 8 years	Yes	$677.00	05/25/1991		Rental / purchase	Non-institutional only	X -- E0255, E0256, E0260, E0261, E0271, E0272, E0292, E0293, E0294, E0295, E0301, E0302, E0303, E0304, E0328, E0329	
E0256	HOSPITAL BED, VARIABLE HEIGHT, HI-LO, WITH ANY TYPE SIDE RAILS, WITHOUT MATTRESS	Each	1 per 8 years	No	$580.00	05/25/1991		Rental / purchase	Non-institutional only	X -- E0255, E0256, E0260, E0261, E0292, E0293, E0294, E0295, E0301, E0302, E0303, E0304, E0328, E0329	
E0260	HOSPITAL BED,SEMI ELECTRIC (HEAD & FOOT ADJUSTMENT),WITH ANY TYPE SIDE RAILS, WITH MATTRESS	Each	1 per 8 years	Yes	$989.00	05/01/1990		Rental / purchase	Non-institutional only	X -- E0255, E0256, E0260, E0261, E0271, E0272, E0292, E0293, E0294, E0295, E0301, E0302, E0303, E0304, E0328, E0329	
E0261	HOSPITAL BED,SEMI ELECTRIC (HEAD & FOOT ADJUSTMENT),WITH ANY TYPE SIDE RAILS, WITHOUT MATTRESS	Each	1 per 8 years	Yes	$892.00	05/25/1991		Rental / purchase	Non-institutional only	X -- E0255, E0256, E0260, E0261, E0292, E0293, E0294, E0295, E0301, E0302, E0303, E0304, E0328, E0329	
E0271	MATTRESS, INNERSPRING	Each	1 per 4 years	No	$97.00	05/01/1990		Purchase only	Non-institutional only	X -- E0255, E0260, E0271, E0272, E0292, E0294, E0302, E0303, E0304	
E0272	MATTRESS, FOAM RUBBER	Each	1 per 4 years	No	$92.00	05/01/1990		Purchase only	Non-institutional only	X -- E0255, E0260, E0271, E0272, E0292, E0294, E0302, E0303, E0304	
E0275	BED PAN, STANDARD, METAL OR PLASTIC	Each	1 per 4 years	No	$4.00	05/01/1990		Purchase only	Non-institutional only	X -- E0275, E0276	
E0276	BED PAN, FRACTURE, METAL OR PLASTIC	Each	1 per 4 years	No	$3.00	05/01/1990		Purchase only	Non-institutional only	X -- E0275, E0276	

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E0292	HOSPITAL BED, VARIABLE HEIGHT, HI-LO, WITHOUT SIDE RAILS, WITH MATTRESS	Each	1 per 8 years	Yes	$567.00	05/25/1991		Rental / purchase	Non-institutional only	X -- E0255, E0256, E0260, E0261, E0271, E0272, E0292, E0293, E0294, E0295, E0301, E0302, E0303, E0304, E0328, E0329	
E0293	HOSPITAL BED, VARIABLE HEIGHT, HI-LO, WITHOUT SIDE RAILS, WITHOUT MATTRESS	Each	1 per 8 years	Yes	$470.00	05/25/1991		Rental / purchase	Non-institutional only	X -- E0255, E0256, E0260, E0261, E0292, E0293, E0294, E0295, E0301, E0302, E0303, E0304, E0328, E0329	
E0294	HOSPITAL BED, SEMI-ELECTRIC (HEAD & FOOT ADJUSTMENTS), WITHOUT SIDE RAILS, WITH MATTRESS	Each	1 per 8 years	Yes	$879.00	05/25/1991		Rental / purchase	Non-institutional only	X -- E0255, E0256, E0260, E0261, E0271, E0272, E0292, E0293, E0294, E0295, E0301, E0302, E0303, E0304, E0328, E0329	
E0295	HOSPITAL BED, SEMI-ELECTRIC (HEAD & FOOT ADJUSTMENTS), WITHOUT SIDE RAILS, WITHOUT MATTRESS	Each	1 per 8 years	Yes	$782.00	05/25/1991		Rental / purchase	Non-institutional only	X -- E0255, E0256, E0260, E0261, E0292, E0293, E0294, E0295, E0301, E0302, E0303, E0304, E0328, E0329	
E0301	HOSPITAL BED, HEAVY DUTY, EXTRA WIDE, WITH WEIGHT CAPACITY GREATER THAN 350 POUNDS, BUT LESS THAN OR EQUAL TO 600 POUNDS, WITH ANY TYPE SIDE RAILS, WITHOUT MATTRESS	Each	1 per 8 years	Yes	$2,096.80	01/01/2005	$97.00	Rental / purchase	Non-institutional only	X -- E0255, E0256, E0260, E0261, E0292, E0293, E0294, E0295, E0301, E0302, E0303, E0304, E0328, E0329	
E0302	HOSPITAL BED, HEAVY DUTY, EXTRA WIDE, WITH WEIGHT CAPACITY GREATER THAN 600 POUNDS, WITH ANY TYPE SIDE RAILS, WITHOUT MATTRESS	Each	1 per 8 years	Yes	$5,723.50	01/01/2005		Rental / purchase	Non-institutional only	X -- E0255, E0256, E0260, E0261, E0292, E0293, E0294, E0295, E0301, E0302, E0303, E0304, E0328, E0329	
E0303	HOSPITAL BED, HEAVY DUTY, EXTRA WIDE, WITH WEIGHT CAPACITY GREATER THAN 350 POUNDS, BUT LESS THAN OR EQUAL TO 600 POUNDS, WITH ANY TYPE SIDE RAILS, WITH MATTRESS	Each	1 per 8 years	Yes	$2,431.80	01/01/2005		Rental / purchase	Non-institutional only	X -- E0255, E0256, E0260, E0261, E0271, E0272, E0292, E0293, E0294, E0295, E0301, E0302, E0303, E0304, E0328, E0329	
E0304	HOSPITAL BED, HEAVY DUTY, EXTRA WIDE, WITH WEIGHT CAPACITY GREATER THAN 600 POUNDS, WITH ANY TYPE SIDE RAILS, WITH MATTRESS	Each	1 per 8 years	Yes	$6,165.40	01/01/2005		Rental / purchase	Non-institutional only	X -- E0255, E0256, E0260, E0261, E0271, E0272, E0292, E0293, E0294, E0295, E0301, E0302, E0303, E0304, E0328, E0329	
E0328	HOSPITAL BED, PEDIATRIC, MANUAL, 360 DEGREE SIDE ENCLOSURES, TOP OF HEADBOARD, FOOTBOARD AND SIDE RAILS UP TO 24 INCHES ABOVE THE SPRING, INCLUDES MATTRESS	Each	1 per 8 years	Yes	$5,560.00	09/01/2013	$1,300.00	Rental / purchase	Non-institutional only	X -- E0255, E0256, E0260, E0261, E0271, E0272, E0292, E0293, E0294, E0295, E0301, E0302, E0303, E0304, E0328, E0329	
E0329	HOSPITAL BED, PEDIATRIC, ELECTRIC OR SEMI-ELECTRIC, 360 DEGREE SIDE ENCLOSURES, TOP OF HEADBOARD, FOOTBOARD AND SIDE RAILS UP TO 24 INCHES ABOVE THE SPRING, INCLUDES MATTRESS	Each	1 per 8 years	Yes	$6,000.00	09/01/2013	$1,600.00	Rental / purchase	Non-institutional only	X -- E0255, E0256, E0260, E0261, E0271, E0272, E0292, E0293, E0294, E0295, E0301, E0302, E0303, E0304, E0328, E0329	
TRACTION EQUIPMENT AND HOSPITAL BED ACCESSORIES											
E0305	BED, SIDE RAILS, HALF LENGTH, ATTACHMENT	Each	2 per 8 years	No	$185.01	01/01/2010	$185.02	Purchase only	Non-institutional only	X -- E0305, E0310	Only one code may be reported in the categories of side rails, cervical traction frames/stands, pelvic traction frames/stands, trapeze bars, and fracture frames.
E0310	BED, SIDE RAILS, FULL LENGTH, ATTACHMENT	Each	2 per 8 years	No	$143.74	04/01/2009	$155.31	Purchase only	Non-institutional only	X -- E0305, E0310	Only one code may be reported in the categories of side rails, cervical traction frames/stands, pelvic traction frames/stands, trapeze bars, and fracture frames.
E0325	URINAL; MALE, JUG TYPE, ANY MATERIAL	Each	1 per 4 years	No	$2.50	05/01/1990		Purchase only	Non-institutional only		Only one code may be reported in the categories of side rails, cervical traction frames/stands, pelvic traction frames/stands, trapeze bars, and fracture frames.
E0326	URINAL; FEMALE, JUG TYPE, ANY MATERIAL	Each	1 per 4 years	No	$3.50	05/01/1990		Purchase only	Non-institutional only		Only one code may be reported in the categories of side rails, cervical traction frames/stands, pelvic traction frames/stands, trapeze bars, and fracture frames.
E0840	TRACTION FRAME ATTACHED TO HEADBOARD, CERVICAL TRACTION	Each	1 per 8 years	No	$58.62	07/26/2007	$42.21	Purchase only	Non-institutional only	X -- E0840, E0850, E0860, E0920, E0930, E0946, E0948	Only one code may be reported in the categories of side rails, cervical traction frames/stands, pelvic traction frames/stands, trapeze bars, and fracture frames.
E0850	TRACTION STAND, FREE STANDING, CERVICAL TRACTION	Each	1 per 8 years	No	$84.05	07/26/2007	$64.56	Purchase only	Non-institutional only	X -- E0840, E0850, E0860, E0920, E0930, E0946, E0948	Only one code may be reported in the categories of side rails, cervical traction frames/stands, pelvic traction frames/stands, trapeze bars, and fracture frames.
E0860	TRACTION EQUIPMENT, OVERDOOR, CERVICAL, COMPLETE	Each	1 per 8 years	No	$30.82	07/26/2007	$15.35	Purchase only	Non-institutional only	X -- E0840, E0850, E0860, E0920, E0930, E0946, E0948	Only one code may be reported in the categories of side rails, cervical traction frames/stands, pelvic traction frames/stands, trapeze bars, and fracture frames.
E0870	TRACTION FRAME, ATTACHED TO FOOTBOARD, EXTREMITY TRACTION (E.G. BUCK'S)	Each	1 per 8 years	No	$93.05	07/26/2007	$115.73	Purchase only	Non-institutional only	X -- E0870, E0880, E0920, E0930	Only one code may be reported in the categories of side rails, cervical traction frames/stands, pelvic traction frames/stands, trapeze bars, and fracture frames.
E0880	TRACTION STAND, FREE STANDING, EXTREMITY TRACTION (E.G. BUCK'S)	Each	1 per 8 years	No	$100.43	07/26/2007	$94.00	Purchase only	Non-institutional only	X -- E0870, E0880, E0920, E0930	Only one code may be reported in the categories of side rails, cervical traction frames/stands, pelvic traction frames/stands, trapeze bars, and fracture frames.
E0890	TRACTION FRAME, ATTACHED TO FOOTBOARD, PELVIC TRACTION	Each	1 per 8 years	No	$96.33	07/26/2007	$75.25	Purchase only	Non-institutional only		Only one code may be reported in the categories of side rails, cervical traction frames/stands, pelvic traction frames/stands, trapeze bars, and fracture frames.
E0900	TRACTION STAND, FREE STANDING, PELVIC TRACTION (E.G., BUCK'S)	Each	1 per 8 years	No	$102.50	07/26/2007	$79.39	Purchase only	Non-institutional only		Only one code may be reported in the categories of side rails, cervical traction frames/stands, pelvic traction frames/stands, trapeze bars, and fracture frames.
E0910	TRAPEZE BAR, BED MOUNTED WITH GRAB BAR	Each	1 per 8 years	No	$208.00	07/26/2007	$101.00	Purchase only	Non-institutional only	X -- E0910, E0912, E0940	Only one code may be reported in the categories of side rails, cervical traction frames/stands, pelvic traction frames/stands, trapeze bars, and fracture frames.
E0912	TRAPEZE BAR, HEAVY DUTY, FREE STANDING	Each	1 per 8 years	No	$1,190.49	07/26/2007	$91.58	Purchase only	Non-institutional only	X -- E0910, E0912, E0940	Only one code may be reported in the categories of side rails, cervical traction frames/stands, pelvic traction frames/stands, trapeze bars, and fracture frames.
E0920	FRACTURE FRAME, ATTACHED TO BED, INCLUDES WEIGHTS	Each	1 per 8 years	No	$479.86	07/26/2007	$315.00	Purchase only	Non-institutional only	X -- E0870, E0880, E0920, E0930	Only one code may be reported in the categories of side rails, cervical traction frames/stands, pelvic traction frames/stands, trapeze bars, and fracture frames.
E0930	FRACTURE FRAME, FREESTANDING, INCLUDES WEIGHTS	Each	1 per 8 years	No	$475.17	07/26/2007	$352.00	Purchase only	Non-institutional only	X -- E0870, E0880, E0920, E0930	Only one code may be reported in the categories of side rails, cervical traction frames/stands, pelvic traction frames/stands, trapeze bars, and fracture frames.
E0935	PASSIVE MOTION EXRCISE DEVICE, (Total Knee Replacement only)	Day	21 per medical event	No	$18.18	04/01/2006	$75.00	Rental only	Non-institutional only		Only one code may be reported in the categories of side rails, cervical traction frames/stands, pelvic traction frames/stands, trapeze bars, and fracture frames.
E0940	TRAPEZE BAR, FREESTANDING, COMPLETE W/GRAB BAR	Each	1 per 8 years	No	$361.61	07/26/2007	$130.00	Purchase only	Non-institutional only	X -- E0910, E0912, E0940	Only one code may be reported in the categories of side rails, cervical traction frames/stands, pelvic traction frames/stands, trapeze bars, and fracture frames.
E0941	GRAVITY ASSISTED TRACTION DEVICE, ANY TYPE	Each	1 per year	No	$451.46	07/26/2007	$430.54	Rental / purchase	Non-institutional only		Only one code may be reported in the categories of side rails, cervical traction frames/stands, pelvic traction frames/stands, trapeze bars, and fracture frames.
E0942	CERVICAL HEAD HARNESS/HALTER	Each	1 per medical event	No	$15.88	07/26/2007	$7.44	Purchase only	Non-institutional only		Only one code may be reported in the categories of side rails, cervical traction frames/stands, pelvic traction frames/stands, trapeze bars, and fracture frames.
E0944	PELVIC BELT/HARNESS/BOOT	Each	1 per medical event	No	$36.70	07/26/2007	$22.40	Purchase only	Non-institutional only		Only one code may be reported in the categories of side rails, cervical traction frames/stands, pelvic traction frames/stands, trapeze bars, and fracture frames.
E0945	EXTREMITY BELT/HARNESS	Each	1 per medical event	No	$35.46	07/26/2007	$37.07	Purchase only	Non-institutional only		Only one code may be reported in the categories of side rails, cervical traction frames/stands, pelvic traction frames/stands, trapeze bars, and fracture frames.
E0946	FRACTURE FRAME, DUAL WITH CROSS BARS, ATTACHED TO BED (E.G. BALKEN, 4 POSTER)	Each	1 per medical event	Yes	$615.26	07/26/2007	$509.18	Rental / purchase	Non-institutional only	X -- E0840, E0850, E0860, E0946, E0948	Only one code may be reported in the categories of side rails, cervical traction frames/stands, pelvic traction frames/stands, trapeze bars, and fracture frames.
E0947	FRACTURE FRAME, ATTACHMENTS FOR COMPLEX PELVIC TRACTION	Each	1 per medical event	Yes	$485.17	07/26/2007	$463.94	Rental / purchase	Non-institutional only		Only one code may be reported in the categories of side rails, cervical traction frames/stands, pelvic traction frames/stands, trapeze bars, and fracture frames.
E0948	FRACTURE FRAME, ATTACHMENTS FOR COMPLEX CERVICAL TRACTION	Each	1 per medical event	Yes	$469.27	07/26/2007	$448.74	Rental / purchase	Non-institutional only	X -- E0840, E0850, E0860, E0946, E0948	Only one code may be reported in the categories of side rails, cervical traction frames/stands, pelvic traction frames/stands, trapeze bars, and fracture frames.
E1820	REPLACEMENT SOFT INTERFACE MATERIAL, DYNAMIC ADJUSTABLE EXTENSION/ FLEXION DEVICE	Each	1 per medical event	No	$65.39	04/01/2006	NC	Purchase only	Non-institutional only		Only one code may be reported in the categories of side rails, cervical traction frames/stands, pelvic traction frames/stands, trapeze bars, and fracture frames.

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X -- Items that are mutually exclusive

HCPCS CODE	DESCRIPTION	UNIT	LIMIT	PRIOR AUTHORIZATION	CURRENT MAXIMUM PAYMENT AMOUNT	EFFECTIVE DATE	PREVIOUS MAXIMUM PAYMENT AMOUNT	RENTAL OR PURCHASE	RESIDENCE	RELATIONSHIP [C / X]	NOTES
EQUIPMENT AND SUPPLIES FOR ESRD											
Y2090	HOME HEMODIALYSIS FOR ESRD	Each	1 per month	No	$1,200.00	05/01/1990		Rental only	Non-institutional only	X -- Y2090, Y2091, Y2092	All supplies and equipment for home dialysis are to be reported under a single code.
Y2091	CAPD HOME DIALYSIS	Each	1 per month	No	$1,200.00	05/01/1990		Rental only	Non-institutional only	X -- Y2090, Y2091, Y2092	All supplies and equipment for home dialysis are to be reported under a single code.
Y2092	CCPD HOME DIALYSIS	Each	1 per month	No	$1,500.00	09/05/1990		Rental only	Non-institutional only	X -- Y2090, Y2091, Y2092	All supplies and equipment for home dialysis are to be reported under a single code.
ENTERAL AND PARENTERAL NUTRITION THERAPY (FORMULA, SOLUTION, FEEDING TUBES, SUPPLIES)											
B4034	ENTERAL FEEDING SUPPLY KIT; SYRINGE, PER DAY	Each	1 per day	No	$3.72	01/01/2010	$3.84	Purchase only	Non-institutional only	X -- B4034, B4035, B4036	
B4035	ENTERAL FEEDING SUPPLY KIT; PUMP FED, PER DAY	Each	1 per day	No	$6.79	01/01/2010	$7.00	Purchase only	Non-institutional only	X -- B4034, B4035, B4036	
B4036	ENTERAL FEEDING SUPPLY KIT; GRAVITY FED (PER DAY, INCLUDES BAGS/CONTAINERS)	Each	1 per day	No	$4.85	01/01/2010	$5.00	Purchase only	Non-institutional only	X -- B4034, B4035, B4036	
B4081	NASOGASTRIC TUBING WITH STYLET	Each	2 per month	No	$19.19	01/01/2010	$19.78	Purchase only	Non-institutional only	X -- B4081, B4082, B4087, B4088	Nasogastric tubes are incompatible with parenteral codes B4220, B4222, and B4224.
B4082	NASOGASTRIC TUBING WITHOUT STYLET	Each	2 per month	No	$14.29	01/01/2010	$14.73	Purchase only	Non-institutional only	X -- B4081, B4082, B4087, B4088	Nasogastric tubes are incompatible with parenteral codes B4220, B4222, and B4224.
B4083	STOMACH TUBE, LEVINE TYPE	Each	8 per month	No	$2.05	01/01/2010	$2.11	Purchase only	Non-institutional only		
B4087	GASTROSTOMY/JEJUNOSTOMY TUBE, STANDARD	Each	4 per year	No	$29.66	01/01/2010	$30.58	Purchase only	Non-institutional only	X -- B4081, B4082, B4087, B4088	
B4088	GASTROSTOMY/JEJUNOSTOMY TUBE, LOW-PROFILE	Each	4 per year	No	$108.64	01/01/2010	$112.00	Purchase only	Non-institutional only	X -- B4081, B4082, B4087, B4088	
B4100	FOOD THICKENER, ORAL, PER OUNCE	Each	30 units per day	No	$0.65	01/01/2016	PA	Purchase only	Non-institutional only		
B4150	ENTERAL FORMULA, 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	100 calories	20 units per day	No	$0.61	01/01/2010	$0.63	Purchase only	Non-institutional only		Administration by mouth rather than by feeding tube is indicated by modifier BO, which is reported on a claim by instruction of the Prior Authorization unit.
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	100 calories	20 units per day	No	$0.51	01/01/2010	$0.53	Purchase only	Non-institutional only		Administration by mouth rather than by feeding tube is indicated by modifier BO, which is reported on a claim by instruction of the Prior Authorization unit.
B4153	ENTERAL FORMULA, NUTRITIONALLY COMPLETE, HYDROLYZED PROTEINS (AMINO ACIDS ANDPEPTIDE CHAIN), INCLUDES FATS, CARBOHYDRATES, VITAMINS AND MINERALS, MAY INCLUDE FIBER, ADMINISTERED THROUGH AN ENTERAL FEEDING TUBE, 100 CALORIES = 1UNIT	100 calories	20 units per day	No	$1.75	01/01/2010	$1.80	Purchase only	Non-institutional only		Administration by mouth rather than by feeding tube is indicated by modifier BO, which is reported on a claim by instruction of the Prior Authorization unit.
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	100 calories	20 units per day	No	$1.12	01/01/2010	$1.15	Purchase only	Non-institutional only		Administration by mouth rather than by feeding tube is indicated by modifier BO, which is reported on a claim by instruction of the Prior Authorization unit.
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 = 1 UNIT	100 calories	20 units per day	No	$0.87	01/01/2010	$0.90	Purchase only	Non-institutional only		Administration by mouth rather than by feeding tube is indicated by modifier BO, which is reported on a claim by instruction of the Prior Authorization unit.
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	100 calories	20 units per day	No	PA	01/01/2005		Purchase only	Non-institutional only		Administration by mouth rather than by feeding tube is indicated by modifier BO, which is reported on a claim by instruction of the Prior Authorization unit.
B4158	ENTERAL FORMULA, FOR PEDIATRICS, 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 CALORIES = 1 UNIT	100 calories	20 units per day	Yes	PA	01/01/2005		Purchase only	Non-institutional only		Administration by mouth rather than by feeding tube is indicated by modifier BO, which is reported on a claim by instruction of the Prior Authorization unit.
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 CALORIES = 1 UNIT	100 calories	20 units per day	No	PA	01/01/2005		Purchase only	Non-institutional only		Administration by mouth rather than by feeding tube is indicated by modifier BO, which is reported on a claim by instruction of the Prior Authorization unit.
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 CALORIES = 1 UNIT	100 calories	20 units per day	Yes	PA	01/01/2005		Purchase only	Non-institutional only		Administration by mouth rather than by feeding tube is indicated by modifier BO, which is reported on a claim by instruction of the Prior Authorization unit.
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 CALORIES = 1 UNIT	100 calories	20 units per day	Yes	PA	01/01/2005	$0.00	Purchase only	Non-institutional only		Administration by mouth rather than by feeding tube is indicated by modifier BO, which is reported on a claim by instruction of the Prior Authorization unit.
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 CALORIES = 1 UNIT	100 calories	20 units per day	No	PA	01/01/2005		Purchase only	Non-institutional only		Administration by mouth rather than by feeding tube is indicated by modifier BO, which is reported on a claim by instruction of the Prior Authorization unit.
B4220	PARENTERAL NUTRITION SUPPLY KIT; PREMIX, COMPLETE - PER DAY	Each	1 per day	No	$4.53	01/01/2010	$4.67	Purchase only	Non-institutional only	X -- B4220, B4222	Nasogastric tubes are incompatible with parenteral codes B4220, B4222, and B4224. The supplier must have on file a current order for parenteral products specific to the individual.
B4222	PARENTERAL NUTRITION SUPPLY KIT; HOMEMIX, COMPLETE - PER DAY	Each	1 per day	No	$6.95	01/01/2010	$7.17	Purchase only	Non-institutional only	X -- B4220, B4222	Nasogastric tubes are incompatible with parenteral codes B4220, B4222, and B4224. The supplier must have on file a current order for parenteral products specific to the individual.
B4224	PARENTERAL NUTRITION ADMINISTRATION KIT, PER DAY, COMPLETE	Each	1 per day	No	$14.55	01/01/2010	$15.00	Purchase only	Non-institutional only		Nasogastric tubes are incompatible with parenteral codes B4220, B4222, and B4224. The supplier must have on file a current order for parenteral products specific to the individual.

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HCPCS CODE	DESCRIPTION	UNIT	LIMIT	PRIOR AUTHORIZATION	CURRENT MAXIMUM PAYMENT AMOUNT	EFFECTIVE DATE	PREVIOUS MAXIMUM PAYMENT AMOUNT	RENTAL OR PURCHASE	RESIDENCE	RELATIONSHIP [C / X]	NOTES
ENTERAL AND PARENTERAL NUTRITION PUMPS (INCLUDING POLES)											
B9000	ENTERAL NUTRITION INFUSION PUMP - WITHOUT ALARM	EACH	1 per 8 years	No	$485.00	01/01/2010	$500.00	Rental / purchase	Non-institutional only	X -- B9000, B9002, B9004, B9006	
B9002	ENTERAL NUTRITION INFUSION PUMP - WITH ALARM	EACH	1 per 8 years	No	$679.00	01/01/2010	$700.00	Rental / purchase	Non-institutional only	X -- B9000, B9002, B9004, B9006	
B9004	PARENTERAL NUTRITION INFUSION PUMP - PORTABLE	EACH	1 per 8 years	No	$2,170.86	01/01/2010	$2,238.00	Rental / purchase	Non-institutional only	X -- B9000, B9002, B9004, B9006	
B9006	PARENTERAL NUTRITION INFUSION PUMP - STATIONARY	EACH	1 per 8 years	No	$2,170.86	01/01/2010	$2,238.00	Rental / purchase	Non-institutional only	X -- B9000, B9002, B9004, B9006	
B9998	ENTERAL SUPPLIES, NOT OTHERWISE SPECIFIED			Yes	PA	05/01/1990		Purchase only	Non-institutional only		
B9999	PARENTERAL SUPPLIES, NOT OTHERWISE SPECIFIED			Yes	PA	05/01/1990		Purchase only	Non-institutional only		
INFUSION PUMP EQUIPMENT (NON-NUTRITION) AND ACCESSORIES											
A4305	DISPOSABLE DRUG DELIVERY SYSTEM, FLOW RATE 50 ML OR MORE PER HOUR	Each	1 per day	No	$12.73	04/01/1993		Purchase only	Non-institutional only		
A4306	DISPOSABLE DRUG DELIVERY SYSTEM, FLOW RATE 5 ML OR LESS PER HOUR	Each	1 per day	No	$12.73	04/01/1993		Purchase only	Non-institutional only		
E0776	IV POLE (IF PUMP IS AUTHORIZED, PAYMENT FOR POLE IS INCLUDED IN PUMP RENTAL)	Each	1 per 8 years	No	$75.00	05/01/1990		Purchase only	Non-institutional only		
E0781	AMBULATORY INFUSION PUMP, SINGLE OR MULTIPLE CHANNELS, ELECTRIC OR BATTERY OPERATED, WITH ADMINISTRATIVE EQUIPMENT, WORN BY PATIENT	Each	1 per day	No	$8.73	01/01/1992	$4.35	Rental only	Non-institutional only		
E0784	EXTERNAL AMBULATORY INFUSION PUMP, INSULIN	Each	1 per 8 years	Yes	$4,000.00	01/01/1996		Rental / purchase	Non-institutional only		
E0791	PARENTERAL INFUSION PUMP,STATIONARY, SINGLE OR MULTI-CHANNEL (NON-NUTRITION) (INCLUDING POLE)	Each	1 per day	No	$8.73	05/01/1990		Rental only	Non-institutional only		
INFUSION SUPPLIES											
A4221	SUPPLIES FOR MAINTENANCE OF A DRUG INFUSION CATHETER, PER WEEK	Set	4 per month	No	$20.55	01/01/1998		Purchase only	Non-institutional only		
A4222	INFUSION SUPPLIES FOR EXTERNAL DRUG INFUSION PUMP, PER CASSETTE OR BAG (LIST DRUG SEPARATELY)	Set	60 per month	No	$40.00	01/01/2005	$22.00	Purchase only	Non-institutional only		
A4223	INFUSION SUPPLIES NOT USED WITH EXTERNAL INFUSION PUMP, PER CASSETTE OR BAG (LIST DRUGS SEPARATELY)	Set	30 per month	No	$15.00	01/01/2005		Purchase only	Non-institutional only		
A4230	INFUSION SET FOR EXTERNAL INSULIN PUMP, NON NEEDLE CANNULA TYPE	Set	30 per month	No	$8.66	03/29/2007	$4.00	Purchase only	Non-institutional only	X -- A4230, A4231	
A4231	INFUSION SET FOR EXTERNAL INSULIN PUMP, NEEDLE STYLE	Set	30 per month	No	$5.27	03/29/2007	$4.00	Purchase only	Non-institutional only	X -- A4230, A4231	
A4232	SYRINGE W/ NEEDLE FOR EXTERNAL INSULIN PUMP, STERILE 3CC	Each	30 per month	No	$4.00	10/15/2006	NC	Purchase only	Non-institutional only		
A4719	"Y SET" TUBING FOR PERITONEAL DIALYSIS	Set	30 per month	No	$5.00	10/01/2004		Purchase only	Non-institutional only		
K0552	SUPPLIES FOR EXT. DRUG INFUSION PUMP, SYRINGE, CART, EA	Each	30 per month	No	$2.65	10/15/2006	NC	Purchase only	Non-institutional only		
HEAT / COLD APPLICATION											
A4265	PARAFFIN FOR USE IN MEDICALLY NECESSARY UNIT APPROVED BY THE DEPARTMENT, REFILL	Pound	2 per month	No	$3.37	12/15/2002	$18.31	Purchase only	Non-institutional only		
E0202	PHOTOTHERAPY (BILIRUBIN) LIGHT WITH PHOTOMETER	Each	1 per lifetime	No	$95.50	01/01/1998		Rental only	Non-institutional only		
E0210	ELECTRIC HEAT PAD, STANDARD	Each	1 per 5 years	No	$15.09	05/01/1990		Purchase only	Non-institutional only	X -- E0210, E0215	
E0215	ELECTRIC HEAT PAD, MOIST	Each	1 per 5 years	No	$25.00	05/01/1990		Purchase only	Non-institutional only	X -- E0210, E0215	
A9273	HOT WATER BOTTLE, ICE CAP OR COLLAR, HEAT AND/OR COLD WRAP, ANY TYPE	Each	1 per 5 years	No	$7.50	01/01/2011		Purchase only	Non-institutional only		
E0235	PARAFFIN BATH UNIT, PORTABLE COMPLETE WITH WAX	Each	1 per 5 years	No	$133.00	05/01/1990		Purchase only	Non-institutional only		
COMMODE CHAIRS											
E0163	COMMODE CHAIR, STATIONARY WITH FIXED ARMS	Each	1 per 5 years	No	$52.80	05/01/1990		Purchase only	Non-institutional only	X -- E0163, E0165, E0168	
E0165	COMMODE CHAIR, STATIONARY WITH DETACHABLE/DROP ARMS	Each	1 per 5 years	No	$104.00	05/01/1990		Purchase only	Non-institutional only	X -- E0163, E0165, E0168	
E0167	PAIL OR PAN FOR USE WITH COMMODE CHAIR (REPLACEMENT ONLY)	Each	1 per year	No	$5.25	05/01/1990		Purchase only	Non-institutional only		
E0168	EXTRA WIDE/HEAVY DUTY COMMODE CHAIR	Each	1 per 5 years	No	$129.56	01/01/2001		Purchase only	Non-institutional only	X -- E0163, E0165, E0168	Extra-wide/heavy-duty commode chairs are covered only for individuals weighing at least 300 pounds. The supplier must maintain documentation of the individual's weight.
BATH AND TOILET AIDS											
E0241	BATHROOM WALL RAIL, STRAIGHT	Each	1 per 5 years	No	$24.00	01/01/1997		Purchase only	Non-institutional only		
E0243	TOILET RAIL	Each	1 per 5 years	No	$40.00	04/01/1999	$34.59	Purchase only	Non-institutional only		
E0244	RAISED TOILET SEAT	Each	1 per 5 years	No	$49.25	04/01/1999		Purchase only	Non-institutional only		
E0245	TUB STOOL OR BENCH (ANY TYPE)	Each	1 per 5 years	No	$45.00	01/01/1997		Purchase only	Non-institutional only		
E0246	TRANSFER TUB RAIL ATTACHMENT	Each	1 per 5 years	No	$57.90	04/01/2006		Purchase only	Non-institutional only		
E0247	TRANSFER BENCH FOR TUB OR TOILET	Each	1 per 5 years	No	$80.00	10/01/2004		Purchase only	Non-institutional only	X -- E0247, E0248	
E0248	TRANSFER BENCH, HEAVY DUTY, FOR TUB OR TOILET	Each	1 per 5 years	No	$80.00	10/01/2004	NC	Purchase only	Non-institutional only	X -- E0247, E0248	
TRACHEOSTOMY CARE											
A4483	MOISTURE EXCHANGER, DISPOSABLE, FOR USE WITH INVASIVE MECHANICAL VENTILATION	Each	100 per month	No	$4.15	01/01/2005	NC	Purchase only	Non-institutional only		
A4623	TRACHEOSTOMY, INNER CANNULA (REPLACEMENT ONLY)	Each	30 per month	No	$4.38	01/01/1994		Purchase only	Non-institutional only		
A4625	TRACHEOSTOMY CARE KIT FOR NEW TRACHEOSTOMY (CLEANING STARTER KIT)	Each	30 per month	No	$3.55	01/01/1996	$2.40	Purchase only	Non-institutional only		This item is covered only for the first two weeks following open surgical tracheostomy.
A4626	TRACHEOSTOMY CLEANING BRUSH	Each	10 per month	No	$1.38	01/01/1993		Purchase only	Non-institutional only		
A4629	TRACHEOSTOMY CARE KIT FOR ESTABLISHED TRACHEOSTOMY	Each	30 per month	No	$2.55	01/01/1996		Purchase only	Non-institutional only		

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A7504	FILTER FOR USE IN A TRACHEOSTOMY HEAT AND MOISTURE EXCHANGE SYSTEM	Each	100 per month	No	$0.54	10/01/2004	NC	Purchase only	Non-institutional only		
A7505	HOUSING, REUSABLE WITHOUT ADHESIVE, FOR USE IN A HEAT AND MOISTURE EXCHANGE SYSTEM AND/OR WITH A TRACHEOSTOMA VALVE	Each	4 per month	No	$3.74	10/01/2004	NC	Purchase only	Non-institutional only		
A7506	ADHESIVE DISC FOR USE IN A HEAT AND MOISTURE EXCHANGE SYSTEM AND/OR WITH TRACHEOSTOMA VALVE, ANY TYPE	Each	100 per month	No	$0.26	10/01/2004	NC	Purchase only	Non-institutional only		
A7507	FILTER HOLDER AND INTEGRATED FILTER WITHOUT ADHESIVE, FOR USE IN A TRACHEOSTOMA HEAT AND MOISTURE EXCHANGE	Each	100 per month	No	$1.99	10/01/2004	NC	Purchase only	Non-institutional only	X -- A7507, A7509	
A7508	HOUSING AND INTEGRATED ADHESIVE, FOR USE IN A TRACHEOSTOMA HEAT AND MOISTURE EXCHANGE SYSTEM AND/OR WITH A TRACHEOSTOMA VALVE	Each	100 per month	No	$2.30	10/01/2004	NC	Purchase only	Non-institutional only		
A7509	FILTER HOLDER AND INTEGRATED FILTER HOUSING, AND ADHESIVE, FOR USE AS A TRACHEOSTOMA HEAT AND MOISTURE EXCHANGE SYSTEM	Each	100 per month	No	$1.13	10/01/2004	NC	Purchase only	Non-institutional only	X -- A7507, A7509	
A7520	TRACHEOSTOMY/LARYGECTOMY TUBE, NON-CUFFED, PVC, SILICONE OR EQUAL	Each	2 per month	No	$47.48	10/01/2004		Purchase only	Non-institutional only	X -- A7520, A7521, A7522	
A7520	TRACHEOSTOMY/LARYGECTOMY TUBE, NON-CUFFED, PVC, SILICONE OR EQUAL -- *CUSTOM-MADE*	Each	2 per month	Yes	$389.55	04/01/2016		Purchase only	Non-institutional only	X -- A7520, A7521, A7522	
A7521	TRACHEOSTOMY/LARYGECTOMY TUBE, CUFFED, PVC, SILICONE OR EQUAL	Each	2 per month	No	$47.05	10/01/2004		Purchase only	Non-institutional only	X -- A7520, A7521, A7522	
A7521	TRACHEOSTOMY/LARYGECTOMY TUBE, CUFFED, PVC, SILICONE OR EQUAL -- *CUSTOM-MADE*	Each	2 per month	Yes	$404.25	04/01/2016		Purchase only	Non-institutional only	X -- A7520, A7521, A7522	
A7522	TRACHEOSTOMY/LARYNGECTOMY TUBE, STAINLESS STEEL OR EQUAL (STERILIZABLE AND REUSABLE)	Each	2 per month	No	$45.16	10/01/2004		Purchase only	Non-institutional only	X -- A7520, A7521, A7522	
A7525	TRACHEOSTOMY MASK	Each	4 per month	No	$1.39	10/01/2004		Purchase only	Non-institutional only		
A7526	TRACHEOSTOMY TUBE COLLAR/HOLDER	Each	15 per month	No	$3.00	10/01/2004		Purchase only	Non-institutional only		This item is not payable in conjunction with twill tape. Only one type of tracheostomy tie is medically necessary.
MISCELLANEOUS RESPIRATORY CARE SUPPLIES											
A4616	TUBING, AEROSOL, (PER FOOT)	Foot	15 per month	No	$0.05	01/01/2008	$0.25	Purchase only	Non-institutional only		
A7003	ADMINISTRATION SET, WITH SMALL VOLUME NONFILTERED PNEUMATIC NEBULIZER, DISPOSABLE	Each	4 per month	No	$2.15	01/01/2000		Purchase only	Non-institutional only		
A7004	SMALL VOLUME NONFILTERED PNEUMATIC NEBULIZER, DISPOSABLE	Each	4 per month	No	$1.44	10/01/2004		Purchase only	Non-institutional only		
A7005	ADMINISTRATION SET, WITH SMALL VOLUME NONFILTERED PNEUMATIC NEBULIZER, NON-DISPOSABLE	Each	2 per year	No	$20.00	01/01/2000		Purchase only	Non-institutional only		
A7006	ADMINISTRATION SET, WITH SMALL VOLUME FILTERED PNEUMATIC NEBULIZER	Each	4 per month	No	$8.00	01/01/2000		Purchase only	Non-institutional only		
A7007	LARGE VOLUME NEBULIZER, DISPOSABLE, UNFILLED, USED WITH AEROSOL COMPRESSOR	Each	4 per month	No	$4.00	10/01/2004		Purchase only	Non-institutional only		
A7012	WATER COLLECTION DEVICE, USED WITH LARGE VOLUME NEBULIZER	Each	4 per month	No	$1.80	01/01/2000		Purchase only	Non-institutional only		
A7015	AEROSOL MASK, USED WITH DME NEBULIZER	Each	4 per month	No	$1.63	07/01/2002	$1.67	Purchase only	Non-institutional only		
E0605	VAPORIZER, ROOM TYPE	Each	1 per 4 years	No	$20.00	05/01/1990		Purchase only	Non-institutional only		
S8101	HOLDING CHAMBER OR SPACER FOR USE WITH AN INHALER OR NEBULIZER, WITH MASK (SEE A4627 FOR SPACER)	Each	1 per year	No	$8.00	04/01/2006	NC	Purchase only	Non-institutional only		
VENTILATORS, CPAP, AND OTHER RESPIRATORY EQUIPMENT											
A4604	TUBING WITH INTEGRATED HEATING ELEMENT FOR PAP	Each	1 per year	No	$53.40	02/08/2016		Purchase only	Non-institutional only		
A4611	BATTERY, HEAVY DUTY; REPLACEMENT FOR PATIENT-OWNED VENTILATOR	Each	1 per year	Yes	$100.00	05/01/1990		Purchase only	Non-institutional only		
A4612	BATTERY CABLES; REPLACEMENT FOR PATIENT-OWNED VENTILATOR	Each	1 per 2 years	Yes	$60.00	05/01/1990		Purchase only	Non-institutional only		
A4613	BATTERY CHARGER; REPLACEMENT FOR PATIENT-OWNED VENTILATOR	Each	1 per 3 years	Yes	$60.00	05/01/1990		Purchase only	Non-institutional only		
A4618	BREATHING CIRCUITS, IPPB (FOR CONSUMER-OWNED IPPB ONLY)	Each	4 per month	Yes	$2.60	05/01/1990		Purchase only	Non-institutional only		
A7025	HIGH FREQUENCY CHEST WALL OSCILLATION SYSTEM VEST, ONLY FOR ADDITIONAL FAMILY MEMBER USING EQUIPMENT	Each	1 per lifetime	Yes	$400.00	10/01/2004		Purchase only	Non-institutional only		
A7030	FULL FACEMASK INTERFACE, CPAP	Each	1 per year	No	$113.18	04/01/2006	NC	Purchase only	Non-institutional only		
A7031	FACE MASK INTERFACE, REPLACEMENT FULL FACE MASK	Each	1 per year	No	$51.12	02/08/2016		Purchase only	Non-institutional only		
A7032	REPLACEMENT CUSHION FOR NASAL APPLICATION DEVICE, EACH	Each	2 per year	No	$21.36	10/01/2004		Purchase only	Non-institutional only		
A7033	REPLACEMENT PILLOWS FOR NASAL APPLICATION DEVICE, PAIR	Pair	2 per year	No	$21.36	10/01/2004		Purchase only	Non-institutional only		
A7034	NASAL INTERFACE (MASK OR CANNULA TYPE) USED WITH POSITIVE AIRWAY PRESSURE DEVICE, WITH OR WITHOUT HEAD STRAP	Each	1 per year	No	$66.71	10/01/2004		Purchase only	Non-institutional only		
A7035	HEADGEAR USED WITH POSITIVE AIRWAY PRESSURE DEVICE	Each	1 per year	No	$34.95	04/01/2003		Purchase only	Non-institutional only		
A7036	CHINSTRAP, USED WITH POSITIVE AIRWAY PRESSURE DEVICE	Each	2 per year	No	$13.60	04/01/2003		Purchase only	Non-institutional only		
A7037	TUBING USED WITH POSITIVE AIRWAY PRESSURE DEVICE	Each	1 per year	No	$28.75	04/01/2003		Purchase only	Non-institutional only		
A7038	FILTER, DISPOSABLE, USED WITH POSITIVE AIRWAY PRESSURE DEVICE	Each	1 per month	No	$3.25	04/01/2003		Purchase only	Non-institutional only		
A7039	FILTER, NON-DISPOSABLE, USED WITH POSITIVE AIRWAY PRESSURE DEVICE	Each	4 per year	No	$12.30	04/01/2003		Purchase only	Non-institutional only		
Y2032	BACK-UP VENTILATOR (UNDER SPECIFIED CONDITIONS)	Each	1 per month	Yes	$375.00	05/01/1990		Rental only	All		
E0457	CHEST SHELL (CUIRASS)	Each	1 per 8 years	No	$450.00	05/01/1990		Purchase only	Non-institutional only		
E0459	CHEST WRAP	Each	1 per 8 years	No	$352.00	05/01/1990		Purchase only	Non-institutional only		
E0465	HOME VENTILATOR, ANY TYPE, USED WITH INVASIVE INTERFACE, (E.G. TRACHEOSTOMT TUBE)	Each	1 per month	No	$900.00	01/01/2016		Rental only	All		
E0466	HOME VENTILATOR, ANY TYPE, USED WITH NON-INVASIVE INTERFACE (E.G. MASK, CHEST SHELL)	Each	1 per month	No	$900.00	01/01/2016		Rental only	All		

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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--CPAP)	Each	1 per 5 years	Yes	$1,900.00	10/01/2004		Rental / purchase	Non-institutional only		
E0471	RESPIRATORY ASSIST DEVICE, BI-LEVEL PRESSURE CAPABILITY, WITH BACKUP RATE FEATURE, USED WITH NONINVASIVE INTERFACE, E.G., NASAL OR FACIAL MASK (INTERMITTENT ASSIST DEVICE WITH CONTINUOUS POSITIVE AIRWAY PRESSURE DEVICE--	Each	1 per month	Yes	$320.00	10/01/2004		Rental only	Non-institutional only	X -- E0471, E0472	
E0472	RESPIRATORY ASSIST DEVICE, BI-LEVEL PRESSURE CAPACITY, WITH BACKUP RATE FEATURE, USED WITH INVASIVE INTERFACE, E.G., TRACHEOSTOMY TUBE (INTERMITTENT ASSIST DEVICE WITH CONTINUOUS POSITIVE AIRWAY PRESSURE DEVICE--CPAP)	Each	1 per month	No	$320.00	10/01/2004		Rental only	Non-institutional only	X -- E0471, E0472	
E0480	PERCUSSOR, ELECTRIC OR PNEUMATIC, HOME MODEL	Each	1 per 3 years	No	$321.00	05/01/1990		Purchase only	Non-institutional only		
E0481	INTRAPULMONARY PERCUSSIVE VENTILATION SYSTEM AND RELATED ACCESSORIES	Each	1 per 8 years	No	$4,724.50	10/01/2004		Rental / purchase	Non-institutional only		
E0482	COUGH STIMULATING DEVICE, ALTERNATING POSITIVE AND NEGATIVE AIRWAY PRESSURE	Each	1 per 8 years	Yes	$3,440.00	01/01/2005	NC	Rental / purchase	Non-institutional only		
E0483	HIGH FREQUENCY CHEST WALL OSCILLATION AIR-PULSE GENERATOR SYSTEM (INCLUDES HOSES AND VEST)	Each	1 per lifetime	No	$12,190.00	10/01/2004		Rental / purchase	Non-institutional only		This item may be covered only for individuals with a diagnosis of cystic fibrosis when other treatments have not been effective.
E0500	IPPB MACHINE, ALL TYPES, WITH BUILT-IN NEBULIZATION	Each	1 per month	No	$65.00	04/01/1992		Rental only	Non-institutional only		
E0561	HUMIDIFIER, NON-HEATED, USED WITH POSITIVE AIRWAY PRESSURE DEVICE	Each	1 per 4 years	No	$92.00	04/01/2009	$106.30	Purchase only	Non-institutional only	X -- E0561, E0562	
E0562	HUMIDIFIER, HEATED, USED WITH POSITIVE AIRWAY PRESSURE DEVICE	Each	1 per 4 years	Yes	$225.92	10/01/2004		Purchase only	Non-institutional only	X -- E0561, E0562	
E0601	NASAL CONTINUOUS AIRWAY PRESSURE (CPAP) DEVICE	Each	1 per 4 years	Yes	$775.00	04/01/1992		Rental / purchase	Non-institutional only		
OXYGEN SUPPLIES											
A4617	MOUTH PIECE	Each	1 per 2 months	No	$1.00	05/01/1990		Purchase only	Non-institutional only		
A4619	OXYGEN FACE TENT	Each	6 per month	No	$1.21	01/01/2002	$1.89	Purchase only	Non-institutional only		
A4620	VARIABLE CONCENTRATION MASK	Each	6 per month	No	$0.62	04/01/2009	$0.69	Purchase only	Non-institutional only		
E0455	OXYGEN TENT/CANOPY (REPLACEMENT FOR RECIPIENT- OWNED EQUIPMENT)	Each	6 per month	No	$8.00	05/01/1990		Purchase only	Non-institutional only		
HUMIDIFIERS / NEBULIZERS FOR USE WITH OXYGEN IPPB EQUIPMENT AND COMPRESSORS											
E0484	OSCILLATORY POSITIVE EXPIRATORY PRESSURE DEVICE, NON-ELECTRIC, ANY TYPE, EACH	Each	1 per 8 years	No	$27.70	09/01/2005	$36.92	Purchase only	Non-institutional only		
E0565	COMPRESSOR, AIR POWER SOURCE FOR EQUIPMENT NOT SELF-CONTAINED OR CYLINDER	Each	1 per 4 years	Yes	$525.00	04/01/1996	$155.00	Rental / purchase	Non-institutional only		
E0570	NEBULIZER, W/COMPRESSOR, (PULMO-AID)	Each	1 per 5 years	No	$133.00	01/01/1992	$123.00	Purchase only	Non-institutional only		This item is covered without prior authorization for individuals who have a documented, relevant respiratory system diagnosis. A nebulizer may be covered only in association with a prescribed medication; an applicable diagnosis and specific medications must be listed on the prescription.
E0575	NEBULIZER, ULTRASONIC, LARGE VOLUME	Each	1 per 4 years	No	$430.00	04/01/1996	$500.00	Purchase only	Non-institutional only		A nebulizer may be covered only in association with a prescribed medication; an applicable diagnosis and specific medications must be listed on the prescription.
E0580	NEBULIZER, DURABLE, GLASS OR AUTOCLAVABLE PLASTIC, BOTTLE TYPE, FOR USE WITH REGULATOR OR FLOWMETER	Each	2 per year	No	$115.00	05/01/1990		Purchase only	Non-institutional only		A nebulizer may be covered only in association with a prescribed medication; an applicable diagnosis and specific medications must be listed on the prescription.
E1372	IMMERSION EXTERNAL HEATER FOR NEBULIZER	Each	1 per 4 years	No	$118.00	05/01/1990		Purchase only	Non-institutional only		
SUCTION PUMPS AND SUCTIONING SUPPLIES											
A4605	TRACHEAL SUCTION CATHETER, CLOSED SYSTEM, EACH	Each	10 per month	No	$13.12	01/01/2005		Purchase only	Non-institutional only	X -- A4624, A4605	A claim may be submitted for only one type of tracheal suction catheter per month.
A4624	TRACHEAL SUCTION CATHETER, ANY TYPE OTHER THAN CLOSED SYSTEM, ADULT	Each	150 per month	No	$0.80	05/01/1990		Purchase only	Non-institutional only	X -- A4624, A4605	A claim may be submitted for only one type of tracheal suction catheter per month.
A4628	OROPHARYNGEAL SUCTION CATHETER	Each	4 per month	No	$2.70	01/01/1996		Purchase only	Non-institutional only		
A7000	CANISTER, DISPOSABLE, USED WITH SUCTION PUMP	Each	3 per month	No	$7.50	01/01/2000		Purchase only	Non-institutional only		
A7002	TUBING, USED WITH SUCTION PUMP, INCLUDING CONNECTOR/ADAPTOR	Each	4 per month	No	$3.75	01/01/2000		Purchase only	Non-institutional only		
E0600	SUCTION PUMP, HOME MODEL, PORTABLE OR STATIONARY, COMPLETE	Each	1 per 4 years	No	$217.00	05/01/1990		Purchase only	Non-institutional only		
MONITORING EQUIPMENT											
A4556	ELECTRODES, PER PAIR (E.G., APNEA MONITOR)	Pair	1 per month	No	$9.41	10/01/2004		Purchase only	Non-institutional only		No separate payment is made for apnea monitor supplies during any month in which an apnea monitor is rented.
A4557	LEAD WIRES, PER PAIR (E.G. APNEA MONITOR)	Pair	1 per month	No	$16.36	10/01/2004		Purchase only	Non-institutional only		No separate payment is made for apnea monitor supplies during any month in which an apnea monitor is rented.
A4558	CONDUCTIVE PASTE OR GEL	Each	1 per month	No	$4.23	10/01/2004		Purchase only	Non-institutional only		No separate payment is made for apnea monitor supplies during any month in which an apnea monitor is rented.
A4606	OXYGEN PROBE FOR USE WITH OXIMETER DEVICE, REPLACEMENT	Each	4 per year	Yes	PA	10/01/2004		Purchase only	Non-institutional only		
A4660	SPHYGMOMANOMETER/BLOOD PRESSURE APPARATUS WITH CUFF & STETHOSCOPE	Set	1 per 8 years	No	$30.00	05/01/1990		Purchase only	Non-institutional only	X -- A4660, A4670	
A4663	BLOOD PRESSURE CUFF ONLY (REPLACEMENT)	Each	1 per 8 years	No	$13.00	05/01/1990		Purchase only	Non-institutional only		
A4670	AUTOMATIC BLOOD PRESSURE MONITOR	Each	1 per 8 years	No	$47.00	05/01/1990		Purchase only	Non-institutional only	X -- A4660, A4670	
E0445	OXIMETER DEVICE FOR MEASURING BLOOD OXYGEN LEVELS NON-INVASIVELY.	Each	1 per 5 years	Yes	$2,250.00	03/29/2007	PA	Rental / purchase	Non-institutional only		
E0618	APNEA MONITOR WITHOUT RECORDING FEATURE; INCLUDING ALARMS, MAINTENANCE, & SUPPLIES	Each	1 per 5 years	No	$2,626.50	10/15/2006	$250.00	Rental / purchase	Non-institutional only	X -- E0618, E0619	
E0619	APNEA MONITOR WITH RECORDING FEATURE; INCLUDING ALARMS, MAINTENANCE, SUPPLIES & DOWNLOADS	Each	1 per 5 years	Yes	$2,833.65	10/15/2006	$265.00	Rental / purchase	Non-institutional only	X -- E0618, E0619	

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PNEUMATIC COMPRESSORS AND APPLIANCES (LYMPHEDEMA PUMP)											
E0650	PNEUMATIC COMPRESSOR, NONSEGMENTAL, HOME MODEL (LYMPHEDEMA PUMP)	Each	1 per 5 years	No	$510.00	01/01/1994		Rental / purchase	Non-institutional only	X -- E0650, E0651	
E0651	PNEUMATIC COMPRESSOR, SEGMENTAL HOME MODEL WITHOUT CALIBRATED GRADIENT PRESSURE	Each	1 per 5 years	No	$776.80	07/01/2002		Rental / purchase	Non-institutional only	X -- E0650, E0651	
E0655	NON-SEGMENTAL PNEUMATIC APPLIANCE FOR USE WITH PNEUMATIC COMPRESSOR, HALF ARM	Each	1 per 2 years	Yes	$77.50	01/01/1994		Purchase only	Non-institutional only		
E0660	NON-SEGMENTAL PNEUMATIC APPLIANCE FOR USE WITH PNEUMATIC COMPRESSOR, FULL LEG	Each	1 per 2 years	No	$135.12	07/01/2002		Purchase only	Non-institutional only		
E0665	NON-SEGMENTAL PNEUMATIC APPLIANCE FOR USE WITH PNEUMATIC COMPRESSOR, FULL ARM	Each	1 per 2 years	Yes	$101.50	01/01/1994		Purchase only	Non-institutional only		
E0666	NON-SEGMENTAL PNEUMATIC APPLIANCE FOR USE WITH PNEUMATIC COMPRESSOR, HALF LEG	Each	1 per 2 years	No	$95.00	01/01/1994		Purchase only	Non-institutional only		
E0667	SEGMENTAL PNEUMATIC APPLIANCE FOR USE WITH PNEUMATIC COMPRESSOR, FULL LEG	Each	1 per 2 years	No	$172.30	01/01/1994		Purchase only	Non-institutional only		
E0668	SEGMENTAL PNEUMATIC APPLIANCE FOR USE WITH PNEUMATIC COMPRESSOR, FULL ARM	Each	1 per 2 years	No	$150.00	01/01/1994		Purchase only	Non-institutional only		
E0669	SEGMENTAL PNEUMATIC APPLIANCE FOR USE WITH PNEUMATIC COMPRESSOR, HALF LEG	Each	1 per 2 years	No	$143.75	01/01/1994		Purchase only	Non-institutional only		
PORTABLE LIFTS											
E0621	SLING OR SEAT FOR PATIENT LIFT, CANVAS OR NYLON (REPLACEMENT ONLY)	Each	1 per 2 years	No	$89.70	01/01/1999	$75.00	Purchase only	Non-institutional only		This item is covered only for a lift owned by the individual.
E0625	PATIENT LIFT, BATHROOM OR TOILET, NOT OTHERWISE CLASSIFIED	Each	1 per 6 years	No	$447.00	05/01/1990		Purchase only	Non-institutional only		
E0630	PATIENT LIFT, HYDRAULIC, WITH SEAT OR SLING, PORTABLE, COMPLETE	Each	1 per 6 years	No	$952.00	01/01/1996	$800.00	Purchase only	Non-institutional only		
TENS UNITS AND OTHER STIMULATORS											
A4595	TENS SUPPLIES, FOR 2 OR 4 LEAD (FOR A RECIPIENT-OWNED UNIT)	Each	1 per month	No	$25.00	01/01/1996		Purchase only	Non-institutional only		No separate payment is made for TENS supplies during any month in which a TENS unit is rented.
E0720	TENS UNIT, TWO LEAD, LOCALIZED STIMULATION (INCLUDES SUPPLIES DURING RENTAL)	Each	1 per 4 years	No	$300.00	05/01/1990		Rental / purchase	Non-institutional only	X -- E0720, E0730	All TENS units must include a battery charger and battery pack.
E0730	TENS UNIT, FOUR LEAD, LARGE AREA/MULTIPLE NERVE STIMULATION (INCLUDES SUPPLIES DURING RENTAL)	Each	1 per 4 years	No	$322.39	03/31/1994		Rental / purchase	Non-institutional only	X -- E0720, E0730	All TENS units must include a battery charger and battery pack.
E0747	OSTEOGENESIS STIMULATOR, NONINVASIVE, OTHER THAN SPINAL APPLICATIONS	Each	1 per 8 years	Yes	$1,750.00	04/01/1992		Purchase only	Non-institutional only	X -- E0747, E0748, E0760	
E0748	OSTEOGENESIS STIMULATOR, ELECTRICAL, NON-INVASIVE, SPINAL	Each	1 per 8 years	Yes	$1,750.00	08/01/1997		Purchase only	Non-institutional only	X -- E0747, E0748, E0760	
E0760	OSTEOGENESIS STIM, LOW INTEN U/S NON INVASIS	Each	1 per 8 years	Yes	$1,750.00	10/15/2006	NC	Purchase only	Non-institutional only	X -- E0747, E0748, E0760	
CANES, CRUTCHES, AND WALKERS											
E0100	CANE, ALL MATERIALS, ADJUSTABLE OR FIXED, WITH TIP	Each	1 per 3 years	No	$10.19	05/01/1990		Purchase only	Non-institutional only		
E0105	CANES, QUAD OR TRI PRONGED, ALL MATERIALS, ADJUSTABLE OR FIXED, WITH TIPS	Each	1 per 3 years	No	$39.28	04/01/2006	$27.50	Purchase only	Non-institutional only		
E0110	CRUTCHES, FOREARM, ALL MATERIALS, ADJUSTABLE OR FIXED, WITH TIPS AND HANDGRIPS	Pair	1 per 2 years	No	$50.00	01/01/1992		Purchase only	Non-institutional only	X -- E0110, E0111, E0112, E0113, E0114, E0116	
E0111	CRUTCH, FOREARM, ALL MATERIALS, ADJUSTABLE OR FIXED, WITH TIPS AND HANDGRIPS	Each	1 per 2 years	No	$25.00	01/01/1992		Purchase only	Non-institutional only	X -- E0110, E0111, E0112, E0113, E0114, E0116	
E0112	CRUTCHES, UNDERARM, WOOD, ADJUSTABLE OR FIXED, WITH PADS, TIPS AND HANDGRIPS	Pair	1 per 2 years	No	$19.25	05/01/1990		Purchase only	Non-institutional only	X -- E0110, E0111, E0112, E0113, E0114, E0116	
E0113	CRUTCH, UNDERARM, WOOD ADJUSTABLE OR FIXED, WITH PADS, TIPS AND HANDGRIPS	Each	1 per 2 years	No	$10.30	05/01/1990		Purchase only	Non-institutional only	X -- E0110, E0111, E0112, E0113, E0114, E0116	
E0114	CRUTCHES, UNDERARM, ALUMINUM, ADJUSTABLE OR FIXED, WITH PADS, TIPS & HANDGRIPS	Pair	1 per 2 years	No	$23.85	05/01/1990		Purchase only	Non-institutional only	X -- E0110, E0111, E0112, E0113, E0114, E0116	
E0116	CRUTCH, UNDERARM, ALUMINUM, ADJUSTABLE OR FIXED WITH PADS, TIPS & HANDGRIPS	Each	1 per 2 years	No	$11.95	05/01/1990		Purchase only	Non-institutional only	X -- E0110, E0111, E0112, E0113, E0114, E0116	
E0130	WALKER, RIGID (PICKUP), ADJUSTABLE OR FIXED HEIGHT, WITH TIPS AND HANDGRIPS	Each	1 per 5 years	No	$35.00	05/01/1990		Purchase only	Non-institutional only	X -- E0130, E0135, E0140, E0141, E0143, E0144	
E0135	WALKER, FOLDING (PICKUP), ADJUSTABLE OR FIXED HEIGHT, WITH TIPS AND HANDGRIPS	Each	1 per 5 years	No	$47.00	02/17/1991		Purchase only	Non-institutional only	X -- E0130, E0135, E0140, E0141, E0143, E0144	
E0140	WALKER WITH TRUNK SUPPORT, ADJUSTABLE OR FIXED HEIGHT, ANY TYPE	Each	1 per 5 years	No	$200.00	09/01/2005		Purchase only	Non-institutional only	X -- E0130, E0135, E0140, E0141, E0143, E0144	
E0141	WALKER, RIGID, WHEELED, ADJUSTABLE OR FIXED HEIGHT	Each	1 per 5 years	No	$58.00	11/01/1992		Purchase only	Non-institutional only	X -- E0130, E0135, E0140, E0141, E0143, E0144	
E0143	WALKER, FOLDING, WHEELED, ADJUSTABLE OR FIXED HEIGHT	Each	1 per 5 years	No	$66.00	05/01/1990		Purchase only	Non-institutional only	X -- E0130, E0135, E0140, E0141, E0143, E0144	
E0144	WALKER, ENCLOSED, FOUR SIDED FRAMED, RIGID OR FOLDING, WHEELED WITH POSTERIOR SEAT	Each	1 per 5 years	No	$150.00	10/01/2004	$100.00	Purchase only	Non-institutional only	X -- E0130, E0135, E0140, E0141, E0143, E0144	
E0147	WALKER, HEAVY DUTY, MULTIPLE BRAKING SYSTEM, VARIABLE WHEEL RESISTANCE	Each	1 per 5 years	No	$150.00	05/01/1990	$59.00	Purchase only	Non-institutional only	X -- E0147, E0148, E0149	Heavy-duty walkers are covered only for individuals weighing at least 300 pounds. The supplier must maintain documentation of the individual's weight.
E0148	WALKER , HEAVY DUTY, WITHOUT WHEELS, RIGID OR FOLDING, ANY TYPE, EACH	Each	1 per 5 years	No	$109.07	01/01/2001		Purchase only	Non-institutional only	X -- E0147, E0148, E0149	Heavy-duty walkers are covered only for individuals weighing at least 300 pounds. The supplier must maintain documentation of the individual's weight.
E0149	WALKER, HEAVY DUTY, WHEELED , RIGID OR FOLDING, ANY TYPE	Each	1 per 5 years	No	$135.00	01/01/2001		Purchase only	Non-institutional only	X -- E0147, E0148, E0149	Heavy-duty walkers are covered only for individuals weighing at least 300 pounds. The supplier must maintain documentation of the individual's weight.
PARTS AND ACCESSORIES FOR CANES, CRUTCHES, AND WALKERS											
A4635	UNDERARM PAD, CRUTCH, REPLACEMENT, EACH	Each	2 per year	No	$1.50	05/25/1991		Purchase only	Non-institutional only		
A4636	HANDGRIP, REPLACEMENT, CANE, CRUTCH, OR WALKER, EACH	Each	4 per year	No	$1.66	05/25/1991		Purchase only	Non-institutional only		
A4637	REPLACEMENT TIP, CANE, CRUTCH, WALKER, EACH	Each	4 per year	No	$1.90	05/25/1991		Purchase only	Non-institutional only		
E0154	PLATFORM ATTACHMENT, WALKER	Each	2 per 3 years	No	$51.44	01/01/1999	$31.25	Purchase only	Non-institutional only		
E0155	WHEEL ATTACHMENT, RIGID PICK-UP WALKER , PAIR	Pair	4 per 3 years	No	$16.25	05/01/1990		Purchase only	Non-institutional only		
E0156	SEAT ATTACHMENT, WALKER	Each	1 per 3 years	No	$15.00	05/01/1990		Purchase only	Non-institutional only		
E0157	CRUTCH ATTACHMENT, WALKER	Each	2 per 3 years	No	$62.50	05/01/1990		Purchase only	Non-institutional only		
E0158	LEG EXTENSIONS FOR WALKER , PER SET OF FOUR	Set of 4	4 per 3 years	No	$12.64	05/01/1990		Purchase only	Non-institutional only		
E0159	BRAKE ATTACHMENT FOR WHEELED WALKER, REPLACEMENT, EACH	Each	2 per 5 years	No	$15.00	10/01/2004		Purchase only	Non-institutional only		

NC -- No coverage
PA -- Payment by prior authorization

C -- Items to which the same limit applies both individually and in combination
X -- Items that are mutually exclusive

HCPCS CODE	DESCRIPTION	UNIT	LIMIT	PRIOR AUTHORIZA-TION	CURRENT MAXIMUM PAYMENT AMOUNT	EFFECTIVE DATE	PREVIOUS MAXIMUM PAYMENT AMOUNT	RENTAL OR PURCHASE	RESIDENCE	RELATIONSHIP [C / X]	NOTES
STANDING FRAMES AND GAIT TRAINERS											
E0638	STANDING FRAME SYSTEM, ANY SIZE W/WO WHEELS	Each	1 per 5 years	Yes	PA	04/01/2006	NC	Purchase only	Non-institutional only		
E8000	GAIT TRAINER, PED, POST SUPP, INCL ACCES AND COMP	Each	1 per 5 years	Yes	PA	04/01/2006	NC	Purchase only	Non-institutional only	X -- E8000, E8001, E8002	This item may be covered only for individuals younger than 14 years.
E8001	GAIT TRAINER, PED, UP SUPP, INCL ACCES AND COMP	Each	1 per 5 years	Yes	PA	04/01/2006	NC	Purchase only	Non-institutional only	X -- E8000, E8001, E8002	This item may be covered only for individuals younger than 14 years.
E8002	GAIT TRAINER, PED, ANT SUPP, INCL ACCES AND COMP	Each	1 per 5 years	Yes	PA	04/01/2006	NC	Purchase only	Non-institutional only	X -- E8000, E8001, E8002	This item may be covered only for individuals younger than 14 years.
WHIRLPOOL EQUIPMENT											
E1300	WHIRLPOOL, PORTABLE (OVERTUB TYPE)	Each	1 per 8 years	No	$170.00	05/01/1990		Purchase only	Non-institutional only		
REPAIR OF NON-WHEELCHAIR ITEMS											
E1340	NON-ROUTINE SERVICING OF DME, LABOR, PER 15 MIN.	Each			$11.00	07/01/2008	$9.02				
E1399	MINOR REPAIR OF DME, <=$100, WITHIN FREQUENCY LIMIT	Each	1 per 120 days	No	Supplier charge	05/01/1990			All		
E1399	MINOR REPAIR OF DME, <=$100, OUTSIDE FREQUENCY LIMIT	Each	1 per 120 days	Yes	PA	05/01/1990			All		
E1399	MAJOR REPAIR OF DME, >$100	Each		Yes	PA	05/01/1990			Non-institutional only		
E1399	MAJOR REPAIR OF DME, >$100, LTCF	Each		Yes	PA	05/01/1990			LTCF only		
K0739	REPAIR OF DME OTHER THAN OXYGEN EQUIPMENT, LABOR, PER 15 MIN.	Each			$11.00	01/01/2014			All		

TO BE RESCINDED

5160-10-04 **Pneumatic compression sevices and accessories.**

(A) Definitions

(1) Lymphedema is the swelling of subcutaneous tissues due to the accumulation of excessive lymph fluid. The accumulation of lymph fluid results from impairment to the normal clearing function of the lymphatic system and/or from an excessive production of lymph. Lymphedema is divided into two broad classes according to etiology. Primary lymphedema is a relatively uncommon, chronic condition which may be due to such causes as Milroy's disease or congenital anomalies. Secondary lymphedema, which is much more common, results from the destruction of or damage to formerly functioning lymphatic channels, such as radical surgical procedures with removal of regional groups of lymph nodes (for example, after radical mastectomy), post-radiation fibrosis, and spread of malignant tumors to regional lymph nodes with lymphatic obstruction, among other causes.

(2) Chronic venous insufficiency (CVI) of the lower extremities is a condition caused by abnormalities of the venous wall and valves, leading to obstruction or reflux of blood flow in veins. Signs of CVI include hyperpigmentation, status dermatitis, chronic edema, and venous ulcers.

(B) Coverage determination

(1) Pneumatic compression devices and accessories are only covered in a private residence for the treatment of lymphedema or the treatment of chronic venous insufficiency with venous stasis ulcers.

(2) Pneumatic compression devices and accessories are covered in a private residence for the treatment of lymphedema if the consumer has undergone a four-week trial of conservative therapy and the prescriber determines that there has been no significant improvement or if significant symptoms remain after the trial. The trial of conservative therapy must include use of an appropriate compression bandage system or compression garment, exercise, and elevation of the limb. The compression garment may be prefabricated or custom-fabricated but must provide adequate graduated compression.

(3) Pneumatic compression devices and accessories are covered in a private residence for the treatment of CVI of the lower extremities only if the

consumer has one or more venous stasis ulcer(s) which have failed to heal after a six month trial of conservative therapy directed by the treating prescriber. The trial of conservative therapy must include a compression bandage system or compression garment, appropriate dressings for the wound, exercise, and elevation of the limb.

(4) For either lymphedema or CVI with venous stasis ulcers, pneumatic compression devices are covered only when prescribed by a prescriber and when they are used with appropriate prescriber oversight, i.e., prescriber evaluation of the consumer's condition to determine medical necessity of the device, assuring 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.

(5) Any prescription for a pneumatic compression device and accessories must be prescribed by a prescriber actively involved in managing the consumer's medical condition as defined in paragraph (A)(2) of rule 5101:3-10-05 of the Administrative Code and who should be treating the consumer under a comprehensive plan of care which addresses the underlying medical need for any equipment and accessories referenced in this rule.

(C) Non-coverage determination

(1) Pneumatic compression devices and accessories are not separately reimbursable for consumers in long term care facilities (LTCFs) as this equipment and supplies are included in the facility's per diem payment.

(2) Accessories used for pneumatic compression of the chest or trunk will be denied as non-covered.

(D) Authorization

(1) In addition to a fully completed prior authorization form JFS 03142 (rev. 2/2003), a fully completed "Certificate of Medical Necessity/Prescription Pneumatic Compression Devices" form JFS 02929 3/2009 (appendix A to this rule) signed and dated by the treating prescriber must be obtained by the provider no more than thirty days prior to the first date of service in order to request authorization for any pneumatic compression device and/or accessories and must specify:

(a) The consumer's diagnosis and prognosis;

(b) The symptoms and objective findings, including measurements which establish the severity of the condition;

(c) The reason the device is required, including the treatments which have been tried and failed; and

(d) The clinical response to an initial treatment with the device via rental which includes the change in pre-treatment measurements, ability to tolerate the treatment session and prescribed parameters, and the ability of the consumer (or caregiver) to apply the device for continued use in the home. The initial rental period of this device cannot be less than thirty days or more than ninety days before request for purchase is made by the provider.

(2) When a pneumatic compression device is covered, a non-segmented device or segmented device without manual control of the pressure in each chamber is generally sufficient to meet the clinical needs of the consumer.

(3) A non-segmented compressor with a segmented appliance/sleeve is considered functionally equivalent to a compressor with a segmented appliance/sleeve.

(E) Dispensing

(1) The following components are considered "inclusive" with any pneumatic compression device payment made by medicaid on behalf of a consumer and cannot be submitted to medicaid for separate payment:

(a) Any supporting wires, cables, or attachment kits;

(b) Education, training, monitoring, or counseling in support of the consumer's ordered treatment plan;

(c) Maintenance, repair, or cleaning charges incurred by the provider during a rental period; and

(d) Delivery, set up, or pick up charges associated with the equipment or supplies.

(2) The provider of a pneumatic compression device must assure that the consumer (or the consumer's caregiver) is properly instructed on how to use the device

and is aware of and understands any emergency procedures regarding the use of the device. The provider must maintain written documentation regarding the consumer's instruction on the use of the device in the consumer's medical record.

(3) Upon the dispensing of a pneumatic compression device, the consumer (or the consumer's caregiver) must be supplied by the provider with a twenty-four hour, seven-day-a-week telephone number to be utilized in case of an emergency during the rental period. This telephone number must meet all requirements of the Americans with Disabilities Act of 1990.

(F) Reimbursement

(1) Pneumatic compression devices and accessories are reimbursed according to the department fee schedule contained in appendix DD to rule 5101:3-1-60 of the Administrative Code or the provider's usual and customary charge, whichever is less.

(2) The department does not purchase previously utilized, refurbished or loaner pneumatic compression devices.

Effective:

Five Year Review (FYR) Dates:

_____

Certification

_____

Date

Promulgated Under:	119.03
Statutory Authority:	5164.02
Rule Amplifies:	5162.03, 5164.02
Prior Effective Dates:	01/01/2015

Ohio Department of Medicaid

CERTIFICATE OF MEDICAL NECESSITY/PRESCRIPTION
PNEUMATIC COMPRESSION DEVICES AND ACCESSORIES

SECTION A: Consumer/Provider Information

Certification Type: ☐ Initial ☐ Revised ☐ Recertification			
Consumer's Name		Provider's Name	
Consumer DOB	Consumer Sex ☐ Female ☐ Male	Consumer HT (in.)	Consumer WT (lbs.)
(If consumer is not residing at home address) Facility Name		Prescriber's Name	
		Prescriber's NPI Number	
Facility Address		Prescriber's Telephone	
Facility City, State and Zip Code		Prescriber's Medicaid Legacy Number (Optional)	

SECTION B: Information below may not be completed by the provider of the Items/Supplies

Est. Length of Need (# of Months) 1-99 (99=LIFETIME)	Diagnosis Codes (ICD-9)
Last Consumer Medical Examination (MM/DD/YR)	

ANSWERS	ANSWER QUESTIONS 1-5 FOR PNEUMATIC COMPRESSION DEVICES (Check Y for Yes, N for No, or D for Does Not Apply, Unless Otherwise Noted, please provide additional information on any Y responses in section (C) (2) of this form)
☐ Y ☐ N ☐ D	1. Does the consumer have chronic venous insufficiency with venous stasis ulcers?
☐ Y ☐ N ☐ D	2. If the consumer has venous stasis ulcers, have you seen the consumer regularly over the past six months and treated the ulcers with a compression bandage system or compression garment?
☐ Y ☐ N ☐ D	3. Has the consumer had radical cancer surgery or radiation for cancer that interrupted normal lymphatic drainage of the extremity?
☐ Y ☐ N ☐ D	4. Does the consumer have a malignant tumor with obstruction of the lymphatic drainage of an extremity?
☐ Y ☐ N ☐ D	5. Has the consumer had lymphedema since childhood or adolescence?

NAME OF PERSON ANSWERING SECTION B QUESTIONS, IF OTHER THAN PRESCRIBER (Please Print)

Name	Title	Employer

SECTION C: Narrative Description of Equipment, Cost and Medical Necessity

(1) Narrative description of all items, accessories and options ordered; (2) Provider charge; and (3) Medicaid Fee Schedule Allowance for <u>each</u> item, accessory, and option.

(2) Narrative description of all Y answers reflected in section B of this document and any additional clinical information necessary to support medical necessity of equipment and accessories being prescribed.

I certify that I am the prescriber identified above. I certify that the information on this certificate of medical necessity and any information on any attached documents signed and dated by me is true to the best of my knowledge. I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability. (SIGNATURE AND DATE STAMPS ARE NOT ACCEPTABLE)

Prescriber's Signature	
Date	Provider's NPI Number

ODM 02929 (7/2014)
Formerly JFS 02929 (3/2009)

5160-10-05 **Reimbursement for covered services.**

(A) Unless otherwise specified, for each claim for reimbursement, providers must keep in their files a legible prescription, including a diagnosis, signed and dated not more than sixty days prior to the first date of service by the consumer's prescriber. For incontinence garments and related supplies, a legible prescriber's prescription, signed and dated not more than thirty days prior to the first date of service must be maintained on file by the provider; prescriptions for incontinence garments and related supplies must include all information required in accordance with rule 5101:3-10-21 of the Administrative Code.

(1) Providers are required to maintain proof of delivery documentation for durable medical equipment (DME), medical supplies and orthotics and prosthetics dispensed to consumers. . Accepted criteria for proof of delivery documentation are as follows:

(a) Providers, their employees, or anyone else having a financial interest in the delivery of DME, medical supplies or orthotic and prosthetic items are prohibited from signing and accepting an item on behalf of a consumer; and

(b) Any person accepting a delivery of DME, medical supplies or orthotic and prosthetic items on behalf of a consumer will note on the delivery slip their relationship to the consumer. . The signature of the person accepting the delivery should be legible. If the signature is not legible, the provider/ shipping service will note the name of the person accepting the delivery on the delivery slip; or

(c) If the provider utilizes a shipping service or mail order, an example of proof of delivery would include the service's tracking slip, and the supplier's own invoice. If possible, the supplier's records will also include the delivery service's package identification number. The tracking slip will reference each individual package, the delivery address, the corresponding package identification number, and the date delivered. The provider shall use the shipping date as the date of service on the claim. Providers may also utilize a return postage-paid delivery invoice from the consumer or consumer's designee as a form of proof of delivery. The descriptive information concerning the DME, medical supplies or orthotic and prosthetic item (i.e., the consumer's name, the quantity, detailed description, brand name, and serial number) as well

as the required signatures from either the consumer or the consumer's designee must be included on this invoice as well; and

(d) For residents of a long term care facility, providers will obtain legible copies of the necessary documentation from the nursing facility to document proof of delivery or usage by the consumer (e.g., nurse's notes).

(2) Prescriptions for DME, medical supplies, orthotics or prosthetics listed at http://jfs.ohio.gov/OHP/bhpp/FSRDisclaimer.stm must have originated as a result of a face-to-face encounter between the prescriber and the consumer. This encounter must occur no more than one hundred and eighty days prior to the prescription being written and cannot occur following the date the prescription is written.

(3) During the face-to-face encounter, the prescriber must have evaluated the consumer, conducted a needs assessment or actively treated the consumer for the medical condition that supports the need for each covered item of DME, medical supply or orthotics or prosthetics. The face-to-face encounter must be documented in the consumer's medical record.

(4) When the face-to-face encounter is conducted by a physician assistant, a clinical nurse specialist or a certified nurse practitioner, it must be documented by a physician signing the pertinent portion of the medical record.

(5) A single face- to-face encounter can support the need for multiple covered items as long as it is clearly documented in the medical record that the consumer was evaluated or treated for a condition that supports the need for each covered item.

(6) Except as provided in this paragraph, prescriptions for DME, medical supplies, orthotics or prosthetics not referenced in paragraph (A)(2) of this rule must originate as a result of a face-to-face encounter between the prescriber and the consumer. A separate examination for each subsequent item prescribed is not necessary if:

(a) The prescriber has reviewed the medical record generated from a face-to-face encounter conducted within the previous twelve months and the DME, medical supply or orthotic or prosthetic item or items prescribed are related to diagnoses established in that face-to-face encounter; or

(b) The prescription is written based on the judgment of a prescriber who has reviewed the consumer's medical record from a face-to-face encounter conducted within the previous twelve months by a different prescriber, and the item or items are related to diagnoses that were established in that face-to-face encounter.

Prescriptions for a long-term supply of disposable items (e.g., incontinence garments or wound supplies) can be renewed no sooner than ninety days prior to the expiration of the current prescription. DME, orthotic or prosthetic and medical supply prescriptions are valid for a maximum of one year from the originating date of the prescription.

(B) The reimbursement for DME, medical supplies, orthotics or prosthetics includes at a minimum the following:

(1) The manufacturer's and dealer's warranty; and

(2) Any costs associated with assembling items or parts used for the assembly of items; and

(3) Any adjustments and/or modifications required within ninety days of the dispensing date (for purchases) or during the total rental period (for rentals), except those occasioned by major changes in the consumer's condition; and

(4) Instruction to the consumer in the safe use of the item or items; and

(5) Cost of delivery to the consumer's residence and, when appropriate, to the room in which the item or items will be used.

(6) For further details on specific items, see Chapter 5101:3-10 of the Administrative Code.

(C) Unless prior authorization has been obtained for used DME, all DME must be new at the time of purchase or have been new at the time of rental. Used DME, if clearly designated on the prior authorization request form as used, in good working order, and covered by the same warranty as new, may be provided if approved by the department. Reimbursement for used DME will be the lower of eighty per cent of the medicaid maximum or the billed charge. The modifier code UE must be used when billing for used DME.

(D) Replacement items or parts will only be reimbursed for consumer-owned DME. See rule 5101:3-10-08 of the Administrative Code for details regarding reimbursement for DME repair.

(E) Automatic refills of DME, medical supplies or orthotic or prosthetic items are not eligible for reimbursement. Providers shall not dispense DME, medical supplies or orthotic or prosthetic items in excess of one month's supply for the duration of the prescribed period. No DME, medical supplies or orthotic or prosthetic shall be billed before they have been provided.

(F) Unless otherwise stated, payment for DME (including custom wheelchairs, power wheelchairs and all wheelchair parts and accessories), medical supplies orthotics or prosthetics is reimbursed utilizing the following criteria:

(1) When the item or items appear in appendix DD to rule 5101:3-1-60 of the Administrative Code, the provider shall bill the department the provider's usual and customary charge and will receive the lesser of the usual and customary charge or the medicaid maximum rate that appears in this appendix; or

(2) When the item or items do not appear in this appendix or appear but without a medicaid maximum rate and the provider has submitted a list price for payment, the provider shall bill the usual and customary charge and will receive the lesser of the usual and customary charge or seventy-two per cent of the list price; or

(3) When the item or items in question do not appear in this appendix or appear but without a medicaid maximum rate and the provider has submitted an invoice price for payment, the provider shall bill the usual and customary charge and will receive the lesser of the usual and customary charge or one hundred forty-seven per cent of the invoice price less any discounts or rebates applicable at the time of billing but exclusive of any discounts or rebates the provider may receive subsequent to the time of billing; or

(4) In circumstances where paragraphs (F)(1), (F)(2) and (F)(3) of this rule occur concurrently, the department will reimburse the amount determined to be the most cost effective.

(5) The "list price" is defined as the most current price recommended by the manufacturer for retail sale. This price cannot be established nor obscured or deleted by the provider on any documentation supplied for consideration of reimbursement. A provider may set list price for custom products where the

provider is both the manufacturer and the provider so long as the list price is equal to or less than comparable products. Documentation submitted to support this price is subject to approval by the department.

(6) The "invoice price" is defined as the price delivered to the consumer and reflects the provider's net costs in accordance with rule 5101:3-10-03 of the Administrative Code. This information cannot be obscured or deleted on any documentation supplied for consideration of reimbursement. Documentation submitted to support this price is subject to approval by the department.

(7) Costs of delivery and service calls related to DME, medical supplies, orthotics or prosthetics are considered an integral part of the provider's cost of doing business. A charge for these services will not be recognized when billed separately.

(8) The consumer must be supplied with the most cost effective DME, medical supply or orthotic or prosthetic that meets their clinical needs.

Cost effective is defined to mean items which meet the consumer's clinical and lifestyle requirements at the lowest available cost.

(9) A supplier of custom items may be reimbursed when the consumer for whom they were intended expires prior to dispensing under the following conditions:

(a) The "Healthcare Common Procedure Coding System" code used to describe the item indicates it is designed or intended for a specific individual; and

(b) The item cannot be modified for use by another individual; and

(c) The provider can document measurements of the consumer were taken for fitting prior to the end of life; and

(d) The provider can document the consumer's health status at the time the item was requested did not indicate the end of life was imminent; and

(e) The provider uses the date the consumer's measurements were taken as the date of service for the item.

(G) Duplicate equipment, supplies, or services, or conflicting equipment prescribed for a consumer are not reimbursable.

(1) "Conflicting equipment" is defined as equipment which serves the same or a similar purpose regardless of payment source. Examples include a wheelchair followed by a power-operated vehicle or more than one wheelchair.

(2) Suppliers are responsible for ascertaining whether there is conflicting equipment. All providers are expected to know whether requested equipment is contraindicated by equipment supplied by a different provider.

(3) If change in a consumer's condition warrants a change in equipment, the existing equipment must be noted when prior authorization is requested for the new equipment.

(H) The department will not reimburse for materials or services covered under the manufacturer's or dealer's warranty. Providers must keep a copy of the warranty in their files. A copy of the warranty must be provided upon request of the department and must be submitted with any prior authorization request for repairs.

Any repair or servicing done on equipment that is consumer owned must be documented, kept in the providers file, and provided to the department upon request.

(I) Purchase or rental of durable medical equipment.

A prescription must accompany each request for the prior authorization of DME. The department reserves the right to determine whether an item will be rented or purchased. Rental of equipment is valid only as long as medical necessity exists.

(1) Rental only.

Certain DME requiring servicing to ensure the health and safety of recipients will be designated as "rental only." Rental only equipment is designated RO in appendix A to rule 5101:3-10-03 of the Administrative Code. The rental payment amount is specified in appendix DD to rule 5101:3-1-60 of the Administrative Code. Unless otherwise specified, no modifier code is used in billing "rental only" items.

(2) Routinely purchased items, lump sum purchase.

Most items on the "Medicaid Supply List" are categorized as "routinely purchased items" and would ordinarily be purchased and become the property of the consumer.

(3) Short-term rental and rent-to-purchase.

(a) The rental of DME may be approved when it is determined to be more cost-effective than purchase. The approved rental period under one prior authorization number shall not exceed six months, unless specified elsewhere in Chapter 5101:3-10 of the Administrative Code. Payment for short- term rental will be made at ten per cent per month of the maximum amount allowable. Providers should use the modifier RR when billing short-term rental.

(b) If a prior authorization request is received for a second rental period, the department will make a determination on whether to purchase the item. Upon a decision to purchase, all prior rental payments will apply toward the purchase price and the provider will receive one final payment for the remainder of the item's maximum allowable amount as specified in appendix DD to rule 5101:3-1-60 of the Administrative Code. The provider will notify the consumer when an item has been purchased on their behalf.

(c) The reimbursement for items purchased within ninety days of the end of a rental period, inclusive of all rental payments and the remaining purchase price, cannot exceed the medicaid maximum amount.

(d) Prior authorization is required prior to reimbursment for those DME items designated as R/P in appendix A to rule 5101:3-10-03 of the Administrative Code.

(J) For items authorized for monthly rental on a monthly basis, payment will be made through the end of the month in which: the consumer becomes ineligible; the item is no longer medically necessary; or, the maximum amount allowable is reached. For items authorized for rental on a daily basis, the items are billiable only those days when the consumer is eligible and the item is medically necessary.

(K) Medicare-covered services provided to residents of long-term care facilities who are dually eligible for medicare and medicaid must be billed directly to medicare. Following payment by medicare, medicaid payment will be made directly to the provider.

(L) Reimbursement for a back-up ventilator may be allowed upon provision of the documentation required in rule 5101:3-10-22 of the Administrative Code.

(M) With the exception of nonmolded helmets and splints, all covered orthotic and

prosthetic devices listed in appendix A to rule 5101:3-10-20 of the Administrative Code may be submitted for reimbursement when provided to eligible residents of nursing facilities.

(N) RT (right side) and LT (left side) modifiers

Use of either the RT or LT modifiers is required when billing for the codes listed at http://jfs.ohio.gov/OHP/bhpp/FSRDisclaimer.stm. For items having the same billing code and dispensed bilaterally on the same date of service for the same consumer, both the RT and the LT modifier must be used.

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TO BE RESCINDED

5160-10-06 **Prior authorization.**

Unless otherwise specified, reimbursement for some medical supplier services is available only upon prior authorization from the Ohio department of job and family services. (See Chapter 5101:3-1 of the Administrative Code for details about prior authorization.)

(A) Requests for prior authorization for medical supplier services must include:

(1) . A current manufacturer's price list when the item in question does not have a medicaid maximum rate listed in appendix DD to rule 5101:3-1-60 of the Administrative Code.

(2) A description, including approximate age and ownership, of any similar equipment or service currently in possession of the recipient and the reason for the new request.

(3) A prescription issued in accordance with Chapter 5101:3-10 of the Administrative Code. The prescription must contain a diagnosis consistent with the medical necessity of the requested item and indicate the quantity requested.

Medical supplier services must be prescribed by a prescriber actively involved in managing the consumer's medical care through a comprehensive plan of care which addresses the need for medical supplier services. This prescription must contain the original signature of the ordering prescriber that attests to the medical necessity of these services.

(4) As specified in Chapter 5101:3-10 of the Administrative Code, prior authorization requests for certain medical supplier services require the submission of a fully completed certificate of medical necessity (CMN) that has been signed and dated by an eligible prescriber no more than thirty days before the first date of service. Prior authorization requests for medical supplier services submitted without a fully completed and signed certificate of medical necessity as specified in Chapter 5101:3-10 of the Administrative Code will be denied due to lack of required documentation.

(5) Other documentation as required or requested by the department for certain specific medical supplier services, as detailed in Chapter 5101:3-10 of the Administrative Code.

(6) Any requests for items that exceed the specified maximum allowable indicator referenced in rule 5101:3-10-03 of the Administrative Code and do not otherwise require prior authorization (PA) must be submitted for review by the department before reimbursement for such items will be considered.

(7) The following documentation must be submitted with all PA requests for items referenced in paragraph (A)(6) of this rule:

(a) A fully completed form JFS 01913 "Certificate of Medical Necessity/Prescription General Medical Supplies: Overage" (CMN) (appendix B to rule 5101:3-10-03 of the Administrative Code) that is signed and dated no more than thirty days before the first date of service.

(b) Any other documentation as required or requested by the department for certain specific medical supplier services, as detailed in Chapter 5101:3-10 of the Administrative Code.

(B) Reevaluation and prior authorization requests must be made at appropriate intervals of not more than twelve months, unless otherwise specified in Chapter 5101:3-10 of the Administrative Code.

(C) Providers should not submit the billing claim form with the prior authorization request.

(D) For items that require multiple fittings and special construction, the first service date may be used as the dispensing date for prior authorization. However, the invoice/claim form shall not be submitted for payment until the consumer has received the item/service. Providers are required to maintain proof of delivery documentation for durable medical equipment (DME) items dispensed to consumers in their files. Accepted criteria for proof of delivery documentation are detailed in rule 5101:3-10-05 of the Administrative Code.

(E) The item or service actually supplied to a recipient must be the item/service in the quantity specifically approved by the department on the "Prior Authorization" (PA) form. Unless otherwise specified, no item/service substitutions are allowed without explicit authorization by the department.

(F) Providers using a healthcare common procedure coding system (HCPCS) miscellaneous code on a prior authorization request for a bundled service must itemize all bundled components for which they are requesting reimbursement using the miscellaneous code in question.

(G) When a provider is requesting authorization of a service greater than the department established maximum allowable units for that service, a complete history that includes the date and amount of all services provided and billed previously must be included. A detailed explanation must be provided of the medical necessity for the additional services. Requests for authorization of additional services will not be considered without this information.

(H) Prior authorization requests for replacement medical equipment will be considered based on medical necessity. However, cases suggesting malicious damage, neglect, culpable irresponsibility, or wrongful disposition of the medical equipment in question will be investigated and prior authorization may be denied where the department determines it is unreasonable to make further program payment under the circumstances presented to the department in support of the equipment replacement request. Providers will provide any information regarding requests for the replacement of medical equipment that the department deems necessary in order to evaluate the replacement request.

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TO BE RESCINDED

5160-10-08 **Repair of medical equipment.**

(A) Durable medical equipment covered under rule 5160-10-03 of the Administrative Code and speech generating devices.

(1) Department coverage for repair of medical equipment has been established for major and minor repairs.

(a) "Major repairs" are those repairs for which the combined charges for materials and labor exceed one hundred dollars. Prior authorization is required for major repairs to durable medical equipment. Prior authorization requests must include complete itemization of parts and labor.

(b) "Minor repairs" are those repairs for which the combined charges for materials and labor are one hundred dollars or less. For a maximum of one repair per recipient per one hundred twenty-day period, prior authorization is not required for minor repairs to durable medical equipment. Prior authorization must be obtained for minor repairs in excess of one per recipient per one hundred twenty-day period and for minor repairs within ninety days after the dispensing date of equipment or prior to the expiration of any applicable warranty. Prior authorization requests must include complete itemization of parts and labor.

(c) Providers must submit the appropriate procedure code(s) including modifiers as required for all equipment repair claims submissions and prior authorization requests. For the reimbursement of repairs requiring materials and labor, the appropriate procedure codes must be submitted together on the same claim for the same date of service.

(i) For the reimbursement of repairs or replacement parts without a specific procedure code, use code E1399 modified with the RB modifier in combination with labor code E1340 as appropriate.

(ii) For the reimbursement of repairs requiring only the time of a technician, without a specific labor code, use labor code K0739.

(iii) For the reimbursement of repairs or replacement of parts of wheelchairs without a specific procedure code, use code K0108

modified with the RB modifier in combination with labor code K0739 as appropriate.

(d) All wheelchair and power operated vehicle (POV) repairs must be billed in accordance with rule 5160-10-16 of the Administrative Code.

(2) Unless otherwise specified, a fully completed "Certificate of Medical Necessity/Prescription Repair of Durable Medical Equipment (DME)," form JFS 01904 (rev. 04/2009), is required if the item requiring repair:

(a) Was not paid for by the department; or

(b) Was originally approved through the department's prior authorization procedure and the repair would substantially change the appearance or function of the item; or

(c) Did not require prior authorization but was paid for by the department and is a major repair.

(3) A written prescription is required if the item requiring repair did not require prior authorization but was paid for by the department and is a minor repair. This documentation must be kept in the consumer's medical record.

(4) "Labor" is the time required by a technician to repair, refurbish, or provide nonroutine service on medical equipment more than ninety days after the dispensing date of that equipment and after the expiration of any applicable warranty.

(5) Requests for prior authorization of repairs (both minor repairs in excess of one per one hundred twenty days and major repairs) must itemize parts and labor separately. Prior-authorized labor will be reimbursed at the lesser of the billed hourly rate or the medicaid maximum rate for labor listed in appendix DD to rule 5160-1-60 of the Administrative Code, prorated for periods of less than one hour.

(6) Requests for prior authorization of major repairs for durable medical equipment must specify who owns the equipment, the date of purchase or the approximate age of the equipment, and the applicable warranty period.

(7) No reimbursement may be made for:

(a) Any repairs covered under manufacturer or dealer warranty; or

(b) Repair of rental equipment covered by the rental payment; or

(c) Costs associated with providing temporary replacement equipment due to repair; or

(d) Costs associated with postage, pick-up, delivery and set-up or installation.

(8) Reimbursement may be provided for major repair of medical equipment not purchased by the department only if that equipment is determined by the department to be medically necessary, evidence of expiration of warranty is submitted with the "Prior Authorization" request, and the department has not provided reimbursement for repair of duplicate or conflicting equipment in the prior twelve months.

(9) The department will not cover new items when simple repairs are all that are necessary. However, providers shall advise the department when, in their professional opinion, replacement of an item would be more cost-effective than repair.

(10) Claims may be submitted to the department for repairs made to durable medical equipment owned by recipients residing in long-term care facilities (LTCFs) except minor wheelchair repairs.

(11) No charge for labor will be reimbursed for repair or replacement of items identified by an asterisk in the appendix to rule 5160-10-20 of the Administrative Code.

(12) Routine maintenance on equipment owned by the recipient is the responsibility of the recipient or the recipient's caretaker. "Routine maintenance" is any action described in the equipment owner's manual as routine and necessary to maintain optimum functioning of the equipment, and which do not require a skilled or trained technician to perform.

(B) Hearing aids.

(1) "Major repair of hearing aids" is a repair for which the combined charges for materials and labor exceed one hundred dollars. No more than one major repair may be reimbursed in any three hundred sixty-five-day period. Prior authorization is required for major repairs to hearing aids. Payment for a

major repair of a hearing aid includes a warranty described in rule 5160-10-11 of the Administrative Code to cover all repairs and all related service calls and follow-up during the warranty period. Charges billed to the department shall not exceed:

(a) The provider's usual and customary combined charges when the provider performs the repairs; or

(b) One hundred twenty-five per cent of the provider's cost as indicated on the invoice for repair issued to the provider when the provider does not perform the repairs.

(2) "Minor repair of hearing aids" is a repair for which the combined charges for materials and labor is equal to or less than the medicaid maximum for a hearing aid repair listed in rule 5160-1-60 of the Administrative Code. No more than one minor repair may be reimbursed in any one hundred twenty day period without prior authorization. Charges billed to the department shall not exceed:

(a) The provider's usual and customary combined charges when the provider performs the repairs; or

(b) One hundred twenty-five per cent of the provider's cost as indicated on the invoice for repair issued to the provider when the provider does not perform the repairs.

(3) The cost of postage, pick-up, or delivery of a hearing aid is considered a cost of doing business and may not be billed separately.

(4) Routine maintenance of hearing aids is the responsibility of the recipient or the recipient's caretaker. "Routine maintenance of hearing aids" is any action described in the owner's manual as routine and necessary to maintain optimum functioning of the hearing aid, including cleaning and checking.

(5) Requests for prior authorization of repairs (both minor repairs in excess of one every one hundred twenty days and major repairs) must specify the nature of the repair, the date of purchase or the approximate age of the equipment, and previous dates of both major and minor repair services.

(C) Orthotic and prosthetic devices.

(1) In addition to the requirements of paragraphs (A)(2) to (A)(12) of this rule,

coverage and claims submission for the repair or replacement of parts for orthotic devices is specifically defined in rule 5160-10-20 of the Administrative Code.

(2) In addition to the requirements of paragraphs (A)(2) to (A)(12) of this rule, coverage and claims submission for the repair or replacement of parts for prosthetic devices is specifically defined in rule 5160-10-20 of the Administrative Code.

(D) Prior authorization requests for the repair of medical equipment will be considered based on medical necessity. However, cases suggesting malicious damage, neglect, culpable irresponsibility, or wrongful disposition of the medical equipment in question will be investigated and prior authorization may be denied for the repair when the department determines it is unreasonable to make further program payment under the circumstances presented to the department in support of the equipment repair request. Providers will provide any information regarding requests for the repair of medical equipment that the department deems necessary in order to evaluate the repair request.

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TO BE RESCINDED

5160-10-09 **Apnea monitors.**

(A) Definitions.

(1) "Apnea monitors" are defined as cardiorespiratory monitoring devices capable of providing continuous or periodic two channel monitoring of heart rate and respiratory rate and must meet current food and drug administration guidelines for products in this class. Apnea monitors must have alarming mechanisms to alert caregivers of cardiorespiratory distress or other events that require immediate intervention and must be capable of recording and storing events (sometimes known as memory monitoring) and of providing event recording downloads or printouts of such data.

(2) "Download" is defined as a printout of the two channel (or greater) event recordings from a memory monitor. Normally a download contains waveform printouts, event logs, and compliance and utilization information.

(3) "Sudden infant death syndrome (SIDS)" is defined as the sudden death of any infant or young child under one year of age that remains unexplained after the performance of a complete postmortem investigation, including an autopsy, an examination of the scene of death, and a review of the case history.

(4) "Apparent life threatening event (ALTE)" is defined as an episode that is frightening to the observer and that is characterized by some combination of apnea (central or obstructive), color change (usually cyanotic or pallid but occasionally erythematous), marked changes in muscle tone (usually limpness), choking or gagging. In some cases, the observer fears the infant has died. Terminology such as aborted crib death or near miss SIDS should be abandoned because it implies a possible misleading close association between an ALTE and SIDS.

(B) Apnea monitors are reimbursed on a rent-to-purchase basis in accordance with rule 5101:3-10-05 of the Administrative Code. The medicaid fee includes payment for professional time, event recording (download), and all maintenance and supplies.

(C) The following criteria must be met for coverage of an apnea monitor:

(1) The provider must maintain on file a certificate of medical necessity (CMN) signed by the attending physician documenting at least one or more of the

following:

(a) One or more apparent life-threatening events (ALTES) requiring mouth-to-mouth resuscitation or vigorous stimulation;

(b) Symptomatic preterm infant (active medical management of apnea of prematurity);

(c) Sibling of one or more sudden infant death syndrome (SIDS) victims;

(d) Infant requires home oxygen therapy or invasive or non-invasive ventilatory support (technology dependent);

(e) Tracheotomized infant (technology dependent);

(f) Infant with abnormal pneumogram at discharge;

(g) Multiple birth SIDS survivor(s);

(h) Infants with severe gastroesophageal reflux with associated apneas;

(i) Infants with severe upper airway abnormalities (e.g., achondroplasia, Pierre-Robin syndrome, etc.); or

(j) Infants with other disorders, specified on the CMN, that demonstrate a need for close cardiorespiratory monitoring to facilitate a more timely discharge to home.

(2) Requirements for use of home monitoring include but are not limited to the following:

(a) Infant cardiopulmonary resuscitation (CPR) training of caregivers by certified trainers;

(b) Education regarding mechanical aspects of monitors;

(c) In-hospital experience;

(d) Twenty-four hour availability of monitor service staff; and

(e) Attestation by the attending physician that the caregivers are capable of being trained to use the monitor properly.

(3) The following diagnoses or conditions alone are not indications for monitoring:

(a) Seizure disorders (without life threatening events);

(b) Hydrocephalus, uncomplicated;

(c) Mental retardation;

(d) Irreversible terminal conditions;

(e) Congenital heart defects, with or without associated arrhythmias;

(f) Distant family history of apnea or SIDS (other than an immediate sibling);

(g) History of apnea monitor use with other siblings;

(h) History of apnea with other sibling(s);

(i) Parental anxiety or family request for a monitor; and

(j) Monitoring of blood oxygen saturation.

(D) Length of need. Coverage of apnea monitors is generally limited to four months. Apnea monitors should be discontinued as soon as there is no medical indication to support the need for continued home monitoring. If the attending physician recommends continued monitoring beyond the initialrental , evidence to support the medical need must be submitted with the request for subsequent rental or purchase authorization in accordance with paragraphs (D)(1) to (D)(3) of this rule.

(1) Nontechnology dependent infants. Requests for authorization should include:

(a) Evidence that there has been clinically significant apnea or bradycardia within two months before the date of the prior authorization request. Supportive evidence may include a copy of a recent download noting apneas or bradycardias; documentation of a recent pneumogram noting apneas or bradycardias; documentation of a recent emergency room

visit or hospital admission for an ALTE;

(b) Download report or download summary information with download report available on request by the department; and

(c) Certificate of medical necessity signed by the attending physician stating the need for continued home monitoring.

(2) Technology dependent child. Requests for authorization should include:

(a) Evidence that the patient is still in need of the high technology products/services. Supportive evidence may include copies of recent clinician follow-up reports noting equipment and services still in use, copies of home nursing agency visits reports noting equipment and services still in use, etc.;

(b) Download report or download summary information with download report available on request by the department; and

(c) Certificate of medical necessity signed by the attending physician stating the need for continued home monitoring.

(3) SIDS sibling. Requests for authorization should include:

(a) Same criteria as noted in paragraph (D)(1)(a) of this rule; or

(b) Patient is not beyond age of the death of the sibling who died of SIDS;

(c) Download report or download summary information with download report available on request by the department; and

(d) Certificate of medical necessity signed by the attending physician documenting the need for continued home monitoring.

(E) Downloads. Recording monitor downloads are covered for recipients receiving home apnea monitor services as part of any payment for service rendered by the department. Downloads are normally used to determine the presence of continued symptoms (apnea/bradycardia) and document such information. They may also be used to document compliance with home monitoring requirements. Download reports provide appropriate, objective medical information that may aid the physician in deciding to discontinue home monitoring or document the need for

continued home monitoring.

(F) Pneumograms. For dates of service beginning on or after April 1, 2006, consumers requiring a pneumogram must seek the care of a qualified licensed prescriber in order to have the pneumogram reimbursed by the department. The order for a pneumogram must be based on the presence of appropriate symptoms or conditions as defined by accepted medical standards. Pneumograms used as screening tests without the presence of appropriate symptoms for conditions are not reimbursable by the department.

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TO BE RESCINDED

5160-10-10 **Dialysis equipment.**

(A) Unless otherwise indicated, equipment and all related medical supplies necessary for the home dialysis consumer are covered under the Ohio medicaid program when billed by suppliers/providers, except when the consumer elects to receive dialysis under "Method I," as referenced in rule 5101:3-13-01.9 of the Administrative Code.

(B) Dialysis equipment and supplies are reimbursed according to the department fee schedule contained in appendix DD to rule 5101:3-1-60 of the Administrative Code.

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TO BE RESCINDED

5160-10-11 **Hearing aids.**

(A) Definitions.

(1) "Audiologist."

A person licensed to practice audiology in Ohio under Chapter 4753. of the Revised Code, or who is licensed and practicing in another state and is employed by an eligible Ohio medicaid provider. This individual is authorized to provide hearing screening consistent with the provisions detailed in rule 4753-6-01 of the Administrative Code and audiologic evaluation consistent with the provisions detailed in section 4753.01 of the Revised Code.

(2) "Licensed hearing aid dealer/fitter."

A person licensed in Ohio under Chapter 4747. of the Revised Code, or who is licensed and practicing in another state and is an eligible Ohio medicaid provider. This individual is authorized to provide hearing screening and testing consistent with the provisions detailed in rules 4747-01-02 and 4747-01-19 of the Administrative Code.

(3) "Programmable."

A hearing aid that utilizes analog technology that is controlled by modifying the frequency and output characteristics using a computer. It may contain multiple microphones, multiple memories and multiple channels, and may operate with a remote control.

(4) "Digital."

A digital hearing aid analyzes incoming sound, transforms it by converting the sound into digital bits and manipulates the frequency and output characteristics of the sound before the sound is amplified. Digital hearing aids are programmed with a computer and contain multiple memories, microphones, and channels. The digital processor permits the hearing aid to change its parameters, to reduce background noise, and/or manage feedback without adversely affecting the benefits for the user.

(5) "Conventional."

Conventional hearing aids have a microphone that gathers sound, an amplifier that increases the volume of sound, and a receiver that transmits this amplified sound to the ear. These instruments may have a manual volume control for the user. These devices have screw-set controls mounted onto the hearing aids for the licensed provider to adjust.

(B) Hearing aids of any type must be prior authorized before being eligible for reimbursement by Ohio medicaid. The prior authorization (PA) request must include all of the following documentation:

(1) A fully completed and legible JFS 01915 "Certificate of Medical Necessity/Prescription Hearing Aids" (appendix A to this rule) signed by the prescriber and dated no more than ninety days before dispensing of the hearing aid.

(2) Documentation of a hearing evaluation that supports the consumer's need for a hearing aid and includes all of the following components:

(a) A hearing test that was performed and signed by a physician specializing in otology or otolaryngology, an audiologist, or a hearing aid fitter;

(b) The hearing test report which reflects the specific hearing values resulting from the test; and

(c) A written summation of the hearing test results, performed and signed by a physician specializing in otology or otolaryngology, or an audiologist.

The individual performing either the hearing test, the written summation of the hearing test results, or both, must provide a legible name and provider type with his or her documentation (i.e., physician, audiologist or hearing aid fitter). This information must accompany the provider signature. The hearing evaluation must not have been performed more than six months prior to the date of the PA request; and

(3) Any other documentation that demonstrates medical necessity.

(4) Documentation for the prior authorization of a hearing aid must be submitted to the office with the appropriate healthcare common procedure coding system codes.

(C) Required hearing evaluation.

(1) Hearing tests for consumers twenty-one years or older shall include, at a minimum, all of the following for a basic hearing test:

(a) At least four thresholds for air conducted stimuli of five hundred Hz, one thousand Hz, two thousand Hz, and four thousand Hz;

(b) Air conducted speech awareness, or speech reception threshold;

(c) Most comfortable and uncomfortable listening level; and

(d) Bone-conducted pure-tone evaluation, unless the consumer's cognitive abilities do not permit such testing.

Hearing test results shall be obtained bilaterally unless the recipient's behavior/condition does not permit bilateral evaluation. If bilateral testing cannot be done, supporting documentation regarding this issue must be provided. All tests shall be performed in an appropriate sound environment in accordance with the standards accepted by the American national standards institute.

(2) Hearing test results for consumers aged twenty-one years or older must indicate a best pure-tone average of thirty-one dB HL or greater and, when interpreted in conjunction with the remainder of the hearing test results that constitute a basic hearing test, must demonstrate the need for a hearing aid. If physical or developmental limitations preclude these evaluation results, an explanation and alternative evaluation results must be provided.

(3) Hearing tests for consumers age twenty years or younger shall include, at a minimum, all of the following for a basic hearing test:

(a) At least four thresholds for air conducted stimuli of five hundred Hz, one thousand Hz, two thousand Hz, and four thousand Hz;

(b) Air conducted speech awareness, or speech reception threshold;

(c) Most comfortable and uncomfortable listening level;

(d) Bone-conducted pure-tone evaluation, unless the consumer's cognitive abilities do not permit such testing;

(e) Tympanometry;

(f) Acoustic reflex battery; and

(g) Otoacoustic emissions testing.

Hearing test results shall be obtained bilaterally unless the recipient's behavior/condition does not permit bilateral testing. If bilateral testing cannot be done, supporting documentation regarding this issue must be provided. All tests shall be performed in an appropriate sound environment in accordance with the standards accepted by the American national standards institute.

(4) Hearing test results for consumers aged twenty years or younger must show a best pure-tone average of twenty six dB HL or greater and when interpreted in conjunction with the remainder of the hearing test results, that constitute a basic hearing test, must demonstrate the need for a hearing aid. If physical or developmental limitations preclude these evaluation results, an explanation and alternative evaluation results must be provided.

Hearing test results for consumers are valid only if the testing was conducted by a provider authorized to perform the complete battery of hearing tests that are listed in this rule as part of their respective scope of practice.

(D) The following types of hearing aids are not covered by Ohio medicaid:

(1) All types of "in the canal" and "completely in the canal" hearing aids;

(2) All types of disposable hearing aids;

(3) "Used" or reconditioned hearing aids, which are defined as hearing aids that have been previously utilized by another individual.

(E) Conventional hearing aids.

(1) Hearing evaluation results referenced in this rule must clearly demonstrate the need for a hearing aid.

(2) All conventional hearing aids dispensed must be covered by a one-year warranty to include coverage provisions for all parts (except earmolds and batteries), comprehensive loss, damage, and labor.

(3) Providers must maintain copies of the final manufacturer's invoice, including

discounts and shipping costs, in the consumer's record and make them available to the office upon request.

(4) All provisions of this rule apply to conventional hearing aids with the exception of paragraph (F) of this rule.

(5) Payment for a conventional hearing aid is the lesser of the medicaid maximum listed in rule 5101:3-1-60 of the Administrative Code for a conventional aid or the provider's acquisition cost, which consists of the manufacturer's invoice price minus any discounts received by the vendor plus shipping costs.

(6) If the manufacturer's final invoice price does not match the cost estimate submitted as part of the prior authorization request for the conventional hearing aid for any reason, the provider must submit a new prior authorization request reflecting the changed price in order to be eligible for reimbursement.

(7) Providers must maintain copies of the manufacturer's cost estimate and the final manufacturer's invoice including discounts and shipping costs in the patient's record and make them available to the office upon request.

(F) Programmable and digital hearing aids.

(1) Programmable and digital hearing aids are only eligible for reimbursement if the programmable and digital hearing aid is medically necessary as defined in paragraph (B) of this rule.

(2) Hearing evaluation results referenced in this rule must clearly demonstrate the need for a hearing aid.

(3) All programmable and digital hearing aids dispensed must be covered by a one-year warranty to include coverage provisions of all parts (except earmolds and batteries), comprehensive loss, damage, and labor.

(4) Payment for a digital or programmable hearing aid is the lesser of the medicaid maximum listed in rule 5101:3-1-60 of the Administrative Code for a programmable or digital aid or the provider's acquisition cost, which consists of the manufacturer's invoice price minus any discounts received by the vendor plus shipping costs.

(5) Reimbursement for codes V5256, V5257, V5260 and V5261 for consumers twenty-two years of age or older is the lesser of the amount indicated in

appendix DD to rule 5101:3-1-60 of the Administrative Code reduced by fifty per cent or the providers usual and customary charge.

(6) If the manufacturer's final invoice price does not match the programmable or digital hearing aid cost estimate submitted as part of the prior authorization request due to any reason, the provider must submit a new prior authorization request reflecting the changed price in order to be eligible for reimbursement.

(7) Providers must maintain copies of the manufacturer's cost estimate and the final manufacturer's invoice including discounts and shipping costs in the patient's record and make them available to the office upon request.

(8) Payment for a programmable or digital hearing aid includes two adjustments per year for the duration of the warranty for comprehensive loss, damage and repair. If adjustment is necessary due to documented changes in measured hearing sensitivity or the growth of the ear canal, payment for adjustment will be authorized as a repair if this is the third adjustment during a warranty period for comprehensive loss, damage, and repair. In addition, the repair provisions stated in rule 5101:3-10-08 of the Administrative Code must be met.

(G) "CROS" and "BiCROS" hearing aids are not routinely covered by the medicaid program but may be authorized for consumers twenty years of age or younger with special documented needs or with difficulty hearing in adverse or noisy environments.

"CROS" and "BiCROS" hearing aids for consumers twenty years of age or younger require prior authorization.

(H) Hearing aids may be dispensed by a prescriber, a licensed audiologist, or a licensed hearing aid fitter who is enrolled as a durable medical equipment (DME) provider or enrolled as a prescriber or clinic type provider who has also been assigned a DME category of service.

(I) All earmolds must be warranted for ninety days. After the warranty period, necessary earmolds or repairs that are within the maximum allowances specified in rule 5101:3-10-20 of the Administrative Code will not require prior authorization. Prior authorization requests for earmolds in excess of the maximum allowed will be considered for special cases when appropriate documentation of medical necessity is provided. Visits to a hospital, home, nursing facility (NF), or intermediate care facility for the mentally retarded (ICF-MR) for the purpose of taking an earmold impression are covered but subject to limitations specified in rule 5101:3-10-20 of the Administrative Code.

(J) Each recipient of a hearing aid shall be scheduled for a recheck to assess the performance and acceptability of the aid within thirty days of receipt of the aid. A copy of the recheck report, countersigned by the consumer or an explanation of why the recheck was not performed, shall be maintained in the provider's file for a period of four years. No claim for payment should be made prior to a recheck or thirty days from the initial fitting of the aid, whichever comes first.

(K) When a recheck is performed within thirty days and the hearing aid is deemed unacceptable by the hearing aid provider and/or the consumer, the cost of the earmold and batteries will be reimbursed by the office. On the rare occasions that this may happen, the original authorization form must be forwarded to the office in order for the provider to receive a revised authorization reflecting the new cost. If payment has been made on the original authorization, the provider must arrange a cost adjustment which reflects the correct amount for the services rendered.

(L) Payment for all types of hearing aids includes all of the following:

(1) Hearing aid, cleaning kit, earmold insert when required for behind the ear style hearing aids, and a one-month supply of batteries;

(2) Shipping and handling;

(3) All required warranty costs; and

(4) Hearing tests as specified in this rule. Only providers specified in paragraph (B) of this rule may bill the office for hearing tests in conjunction with the fitting and dispensing of any type of hearing aid.

(M) Requests for two hearing aids on the same date of service will be reimbursed using binaural reimbursement codes only.

(N) Payment for any hearing aid dispensing fee includes all of the following:

(1) Earmold impression(s);

(2) Hearing aid selection and fitting(s);

(3) Up to three hours of counseling;

(4) All visits necessary for the dispensing and fitting of the aid (regardless of place

of service);

(5) All service calls and follow-up during the warranty period; and

(6) Charges for travel to dispense the hearing aid.

(O) Providers must document that the consumer and/or the consumer's primary care giver have been instructed in the proper use, wear and care of the hearing aid. Documentation of this instruction must be maintained by the provider.

(P) Conventional (analog) hearing aids can be replaced every four years. Digital hearing aids can be replaced every five years. Requests for replacements any sooner can be made through the prior authorization process. Replacement requests can be denied in instances of malicious damage, neglect, culpable irresponsibility or wrongful disposition. The office will not be responsible for any replacement charges, including deductibles, upon the loss of a hearing aid still covered under warranty.

(Q) A copy of the manufacturer's warranty and any applicable insurance coverage shall be maintained in the provider's file for a period of five years and copies shall be provided to the office on request.

(R) No hearing aid will be authorized for replacement until the office has received proof that replacement is not covered by the manufacturer's warranty or insurance. A request for prior authorization of a replacement hearing aid outside of the warranty period must meet all the requirements of this rule. No hearing aid will be authorized for replacement if repair or reconditioning would be more cost-effective.

(S) A provider may bill the office for necessary repair of a hearing aid only if the following conditions exist:

(1) The aid had been acquired through the office; or

(2) The office has determined that the aid, not acquired through the program, is medically necessary; and

(3) The repair is not covered by warranty or insurance; and

(4) The repair is not associated with routine maintenance or cleaning of the hearing aid; and

(5) All of the requirements for repairs listed in rule 5101:3-10-08 of the

Administrative Code are met.

Effective:

Five Year Review (FYR) Dates:

_____

Certification

_____

Date

Promulgated Under:	119.03
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Rule Amplifies:	5162.03, 5164.02
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Ohio Department of Medicaid

CERTIFICATE OF MEDICAL NECESSITY/PRESCRIPTION
HEARING AIDS

Instructions: The Certificate of Medical Necessity (CMN) must be used for all hearing aid fittings under the Ohio Medicaid Program. This form must be completed and carry the proper signature, where indicated, before requests will be considered for prior authorization.

Name of Consumer	Billing Number

Street Address	City/State/Zip	Date of Birth

Does recipient own any other hearing aids? ☐Yes ☐No If yes, how many does he/she own?	If yes, what is the age of the hearing aid(s)? Hearing aid #1 Hearing aid #2

Describe the hearing aid(s)	Were hearing aid(s) purchased through Medicaid? ☐Yes ☐No

Why is recipient requesting new hearing aid(s)

Section A - Completed by Prescriber and/or Audiologist

Hearing aid evaluation

- ☐ Supports consumer's need for a hearing aid
- ☐ Performed and signed by a physician specializing in otology or otolaryngology, an audiologist, or a hearing aid fitter
- ☐ Reflects the specific hearing values resulting from the test
- ☐ Includes a written summation of the hearing test results, performed and signed by a physician specializing in otology or otolaryngology, or an audiologist
- ☐ Documentation includes a **legible name and provider type** for person performing either the hearing test, the written summation of the hearing test results, or both. This information accompanies the provider signature.
- ☐ **Testing performed not more than 6 months prior to the date of the prior authorization request.**

For consumer's <u>21 years of age or older</u>, the evaluation includes

- ☐ At least 4 thresholds for air conducted stimuli or **500 Hz, 1000 Hz, 2000 Hz and 4000 Hz**
- ☐ Best pure-tone average of **31 dB HL or greater**
- ☐ Air conducted speech awareness, or speech reception threshold
- ☐ Most comfortable and uncomfortable listening level
- ☐ Bone-conducted pure-tone evaluation, unless the consumer's cognitive abilities do not permit such testing
- ☐ Hearing test is obtained bilaterally unless recipient's behavior/condition does not permit bilateral evaluation
- ☐ Supporting documentation is provided as to why bilateral test is not done.

For consumer's <u>20 years of age or younger</u>, the evaluation includes

- ☐ At least 4 thresholds for air conducted stimuli or **500 Hz, 1000 Hz, 2000 Hz and 4000 Hz**
- ☐ Best pure-tone average of **26 dB HL or greater**
- ☐ Air conducted speech awareness, or speech reception threshold
- ☐ Most comfortable and uncomfortable listening level
- ☐ Bone-conducted pure-tone evaluation, unless the consumer's cognitive abilities do not permit such testing
- ☐ Tympanometry Acoustic reflex
- ☐ battery Otoacoustic emissions
- ☐ testing
- ☐ Hearing test is obtained bilaterally unless recipient's behavior/condition does not permit bilateral evaluation
- ☐ Supporting documentation is provided as to why bilateral test is not done.

Digital/programmable hearing aid and physician documents

- ☐ Digital/programmable hearing aid will offer superior performance over a conventional hearing aid for the specific consumer
- ☐ The digital/programmable hearing aid is necessary for the consumer's success in educational development
- ☐ This particular consumer requires functions that are not found in a conventional hearing aid (i.e., automatic feedback reduction, automatic noise reduction, programmable control)

This consumer requires the following <u>digital hearing aid</u> features

- ☐ Adaptive directionality, automatically changing polar plot
- ☐ Adjust MPO without affecting gain curve
- ☐ Automatic directionality
- ☐ Data logging, collection of user's wearing history and program use
- ☐ Digital feedback management, phase cancellation
- ☐ Digital noise reduction
- ☐ Digital wide dynamic range compression
- ☐ Digital volume control with an option to disable
- ☐ Low battery warning indicator
- ☐ Multiple bands or channels
- ☐ Multiple programs
- ☐ Multiple signal processing strategies
- ☐ Open ear fitting
- ☐ In-situ hearing thresholds to determine gain
- ☐ Switchless telephone or telecoil program
- ☐ Wide fitting range to accommodate progressive hearing changes
- ☐ Other:

Medical Clearance

- ☐ The consumer needs a hearing aid based on the hearing test results which clearly demonstrate hearing loss.
- ☐ If consumer needs a digital/programmable hearing aid, I have checked the Medicaid guidelines in Section A which support this type of hearing aid.
- ☐ The above patient has been medically evaluated and his/her hearing loss is not due to a temporary, correctable physical condition, e.g., ear infection or impacted wax.

Additional Information:

Section B - Prescriber Attestation and Signature/Date

Prescriber Name *(printed)*	Prescriber signature and date are no more than 90 days prior to the stamped date of the PA Request.

I certify that I am the prescriber identified above. I certify that the information I have completed in this certificate is of medical necessity and any information on any attached documents signed and dated by me is true to the best of my knowledge. I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.

gnature (No stamps)	Ohio Medicaid Provider #

TO BE RESCINDED

5160-10-12 **Orthopedic shoes and foot orthoses.**

(A) Definitions.

(1) "Orthopedic shoes" are shoes that are specially constructed to aid in the correction of a deformity of the muscular skeletal structure of the foot; and for the preservation and restoration of the function of the skeletal system of the foot.

(2) "Molded shoes" are orthopedic shoes that are directly molded of leather, plastic, or a similar material, to a patient model.

(3) "Mismated shoes" are one pair of orthopedic shoes in which one shoe is a whole size and/or width larger than the other.

(B) Covered services and limitations.

(1) Prior authorization is required before orthopedic shoes will be considered for payment. Prior authorization requests must contain a precise description of the shoe to be dispensed and must include the manufacturer and/or laboratory, style and size of the item.

(2) Orthopedic shoes are covered only if the shoe is an integral part of a brace with the following exceptions: molded, mismated, and club foot shoes or shoes for children under the age of eight, diagnosed as having a deformity or condition as listed in paragraph (C) of this rule.

(3) Shoe modifications or additions shall be covered if they are medically necessary and are prescribed by a physician (D.P.M., D.O. or M.D.), or an advanced practice nurse (APN) subject to the limitations as specified in appendix A to rule 5101:3-10-20 of the Administrative Code.

(4) Reimbursement for foot orthoses includes all casting and shall only be billed by the individual who performs the actual casting.

(5) For medicaid-eligible recipients age eight and older, a maximum of two pairs of shoes every three hundred sixty-five days shall be considered for payment.

(6) For children under the age of eight, to accommodate growth, a maximum of three pairs of shoes every three hundred sixty-five days shall be considered for payment.

(7) Depth inlay shoes are covered only if the shoe is an integral part of a brace.

(C) Orthopedic shoes, not attached to a brace, for children under the age of eight, will be covered only for the following diagnoses:

(1) Talipes equino varus (club foot).

(2) Metatarsus adductus.

(3) Femoral torsion.

(4) Tibial torsion.

(5) Vertical talus.

(6) Fracture (major bones).

(7) Osteochondroses.

(8) Post-surgical control.

(D) Non-coverage determination.

Orthopedic shoes are denied as non-covered if the shoe is put on over a partial foot prosthesis or other lower extremity prosthesis that is attached to the residual limb.

Effective:

Five Year Review (FYR) Dates:

_____

Certification

_____

Date

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TO BE RESCINDED

5160-10-13 **Oxygen services.**

(A) Definitions.

(1) "Blood gas study" is the measurement of such characteristics of blood as the partial pressure of oxygen (PO2) or oxygen saturation. The term applies either to an arterial blood gas (ABG) study, which is performed on blood from an artery, or to pulse oximetry, which is the noninvasive measurement of hemoglobin oxygen saturation

(2) "Group I" and "group II" criteria are sets of clinical indicators used to determine the coverage of oxygen services without prior authorization.

(a) Group I criteria.

(i) If the individual is tested while awake and at rest, the following measures apply:

(a) Arterial PO2 of fifty-five mm Hg or less; or

(b) Arterial oxygen saturation at or below eighty-eight per cent.

(ii) If the individual is tested while exercising (ambulating), the following measures apply:

(a) Arterial PO2 of fifty-five mm Hg or less during ambulation without oxygen, with documented improvement during ambulation with oxygen; or

(b) Arterial oxygen saturation at or below eighty-eight per cent during ambulation without oxygen, with documented improvement during ambulation with oxygen.

(iii) If the individual is tested while asleep, the following measures apply:

(a) Arterial PO2 of fifty-five mm Hg or less;

(b) Arterial oxygen saturation at or below eighty-eight per cent;

(c) A decrease in arterial PO2 of more than ten mm Hg, associated with symptoms of or signs reasonably attributable to hypoxemia; or

(d) A decrease in arterial oxygen saturation of more than five per cent, associated with symptoms of or signs reasonably attributable to hypoxemia.

(b) Group II criteria.

(i) Either of the following measures applies:

(a) Arterial PO2 of at least fifty-six mm Hg and not more than fifty-nine mm Hg; or

(b) Arterial oxygen saturation at or above eighty-nine per cent.

(ii) In addition, at least one of the following conditions applies:

(a) Dependent edema suggestive of congestive heart failure;

(b) Pulmonary hypertension or cor pulmonale, determined by measurement of pulmonary artery pressure, gated blood pool scan, echocardiogram, or the presence of P pulmonale on an EKG; or

(c) Erythrocythemia with a hematocrit greater than fifty-six per cent.

(3) "Transfill unit" is a device that transfers oxygen from a source such as an oxygen concentrator or liquid oxygen canister to portable tanks.

(B) Prescribers and suppliers of oxygen services.

(1) The following eligible medicaid providers may prescribe oxygen services:

(a) An independent physician;

(b) An advanced practice nurse with a relevant specialty (e.g., clinical nurse specialist, nurse practitioner); or

(c) A physician assistant.

(2) The following eligible medicaid providers may render oxygen services:

(a) A durable medical equipment (DME) supplier;

(b) A pharmacy;

(c) An independent physician;

(d) An advanced practice nurse with a relevant specialty (e.g., clinical nurse specialist, nurse practitioner);

(e) A physician assistant; or

(f) An ambulatory health care clinic.

(3) The following eligible medicaid providers may receive medicaid payment for submitting a claim for an oxygen service on behalf of a rendering supplier:

(a) A DME supplier;

(b) A pharmacy;

(c) An independent physician;

(d) An advanced practice nurse with a relevant specialty (e.g., clinical nurse specialist, nurse practitioner);

(e) A physician assistant;

(f) An ambulatory health care clinic; or

(g) A professional medical group.

(C) Certificate of medical necessity.

(1) Payment for oxygen services can be made only if an authorized provider certifies on a form, the certificate of medical necessity (CMN), that the services are medically necessary for an individual. For purposes of this rule, the CMN is form JFS 01909, "Certificate of medical necessity/prescription: oxygen services" (rev. 06/2005). A completed CMN must be signed and dated by the prescriber before a claim for a service is submitted. The certification period is limited to a maximum of twelve months after the first date of service for an individual meeting group I criteria and three months after the first date of service for an individual meeting group II criteria. According to the purpose for which a CMN is used, it may be called an initial CMN, a recertifying CMN, or a revised CMN.

(2) An initial CMN is used to document certification for new service.

(a) An initial CMN must be completed in the following circumstances:

(i) The supplier will be rendering oxygen services to an individual for the first time on a fee-for-service basis, even if the individual was using oxygen before gaining medicaid eligibility or oxygen was previously supplied through a medicaid managed care plan;

(ii) Oxygen was previously supplied to the individual on a fee-for-service basis, but a change in the individual's condition has suspended the need for oxygen for at least two full calendar months; or

(iii) Existing equipment must be replaced because it has reached the end of its expected useful life or has been irreparably damaged, lost, or stolen.

(b) If the CMN is needed solely because equipment is being replaced, then neither a prescriber visit nor a new blood gas study is required. (The results and test date of the most recent qualifying blood gas study may be entered on the form.)

(c) If the CMN is needed for purposes other than equipment replacement alone, then the individual must be seen and evaluated by a prescriber within a specified period before the date of certification, and a blood gas study is required.

(i) If the individual started using oxygen while enrolled in a medicaid managed care plan, then the evaluation period is twelve months, and the most recent blood gas study performed while the person was in the managed care plan must be used.

(ii) If the individual is a hospital inpatient or a resident of a long-term care facility (LTCF), then the evaluation period is thirty days, and the earliest blood gas study performed within forty-eight hours before discharge must be used.

(iii) Otherwise, the evaluation period is thirty days, and the most recent blood gas study performed within thirty days before the date of certification must be used.

(3) A recertifying CMN is used to renew certification. Within ninety days before the end of the existing certification period, the individual must be seen and evaluated by a prescriber, and a blood gas study is required. (The new certification period cannot begin until both the prescriber evaluation and the blood gas study have been completed.)

(4) A revised CMN is used to modify an existing certification. No prescriber evaluation is required.

(a) The most recent blood gas study performed within thirty days before the revision date must be used for the following modifications:

(i) The prescribed maximum flow rate has changed. If the new rate is greater than four liters per minute (LPM), then a new blood gas study must be performed while the individual is receiving four LPM.

(ii) The length of need must be extended (if the prescriber has specified a length of need less than lifetime on the most recent CMN).

(iii) Certification has been given for a portable oxygen delivery system to supplement a stationary system for which certification was previously given. If the most recent qualifying study was performed during sleep, then a new blood gas study must be performed while the individual is awake, either at rest or exercising.

(b) No additional blood gas study is required for the following modifications:

(i) There is a new treating practitioner, but the oxygen order is the same.

(ii) There is a new supplier, and the new supplier does not have the most recent CMN.

(D) Coverage.

(1) Payment may be made for the following oxygen services:

(a) Stationary gaseous oxygen system (private residence only);

(b) Portable gaseous oxygen system (private residence only);

(c) Stationary liquid oxygen system (private residence only);

(d) Portable liquid oxygen system (private residence only);

(e) Oxygen contents, gaseous, including supplies (LTCF only);

(f) Oxygen contents, liquid, including supplies (LTCF only);

(g) Oxygen concentrator, single delivery port;

(h) Oxygen concentrator, dual delivery port;

(i) Portable oxygen concentrator (private residence only); and

(j) Transfill unit (private residence only).

(2) A supplier must furnish the least expensive oxygen delivery system that meets an individual's medical and personal needs.

(3) Separate payment for a portable oxygen delivery system may be made in addition to payment for a stationary system only if the following criteria are met:

(a) The individual must have a demonstrable need for a separate portable system, either to maintain mobility in a private residence or to accomplish out-of-home activities;

(b) The individual's stationary oxygen delivery system cannot be used as a portable delivery system; and

(c) The prescribed oxygen flow is four LPM or less. If the prescribed oxygen flow is greater than four LPM, then no separate payment is made for the portable oxygen delivery system.

(4) Separate payment will not be made, however, for both a stationary and a portable oxygen concentrator.

(5) Prior authorization is not required when a supplier has obtained a properly completed CMN and renders oxygen services to an individual who either meets group I or group II criteria or is a resident of a LTCF.

(6) Prior authorization is required when a supplier has obtained a properly completed CMN and renders oxygen services to an individual who meets neither group I nor group II criteria and is not a resident of a LTCF. If approval is given, then the length of the approval period will be based on medical necessity and cannot exceed the timeframe indicated by the prescriber. The request for prior authorization must include a copy of the completed CMN.

(7) An oxygen service will be denied as not medically necessary if it is prescribed for any of the following conditions:

(a) Angina pectoris in the absence of hypoxemia;

(b) Dyspnea without cor pulmonale or evidence of hypoxemia;

(c) Severe peripheral vascular disease that results in clinically evident desaturation in one or more extremity but does not produce systemic hypoxemia; or

(d) A terminal illness that does not affect the respiratory system.

(E) Payment.

(1) All appropriate procedure codes and modifiers must be reported on claims.

(2) Payment for oxygen services is made on a monthly basis and includes the following related items and services:

(a) Setup and instruction on use;

(b) Equipment and supplies;

(c) Maintenance and repair, including the replacement of any part or attachment (such as tubing, cannula, mask, or filter) that is integral to the oxygen system or the operation of the system;

(d) Transportation or delivery charges;

(e) Emergency service, including the provision of backup equipment and supplies;

(f) Oxygen consumed (when applicable); and

(g) Equipment monitoring visits.

(3) The maximum fee for an oxygen service is the amount set forth in the appendix to this rule.

(a) When the prescribed oxygen flow is greater than four LPM, the payment amount is increased by fifty per cent.

(b) When the prescribed oxygen flow is greater than four LPM and portable oxygen is also prescribed, the payment amount is increased by fifty per cent.

Effective:

Five Year Review (FYR) Dates:

_____

Certification

_____

Date

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Appendix to rule 5160-10-13

STATUS CODE:
1 -- Initial maximum fee
2 -- Change in maximum fee as of the Effective Date
3 -- Discontinuation of coverage

PROCEDURE CODE	REQUIRED MODIFIER	DESCRIPTION	EFFECTIVE DATE	STATUS CODE	CURRENT MAXIMUM FEE	PREVIOUS MAXIMUM FEE
E0424		Stationary gaseous oxygen system, residence	01/01/2014	2	130.00	167.00
E0439		Stationary liquid oxygen system, residence	01/01/2014	2	130.00	167.00
E0431		Portable gaseous oxygen system, residence	01/01/2014	2	40.00	28.25
E0434		Portable liquid oxygen system, residence	01/01/2014	2	40.00	28.25
E1390	U1	Oxygen concentrator, single port, stationary only, residence	01/01/2014	2	130.00	165.93
E1391	U1	Oxygen concentrator, dual port, stationary only, residence	01/01/2014	2	130.00	165.93
E1392		Oxygen concentrator, stationary and portable capabilities, residence	01/01/2014	2	170.00	221.09
K0738		Oxygen concentrator, stationary with transfill unit and canisters, residence	01/01/2014	2	170.00	221.09
E1390		Oxygen concentrator, single port, stationary only, LTCF	01/01/2014	2	65.00	153.64
E1391		Oxygen concentrator, dual port, stationary only, LTCF	01/01/2014	2	65.00	153.64
E0441		Oxygen contents, gaseous, including supplies, LTCF	01/01/2014	2	65.00	162.98
E0442		Oxygen contents, liquid, including supplies, LTCF	01/01/2014	2	65.00	162.98
E0425		Stationary gaseous oxygen system, purchase	10/01/2004	1	NC	
E0430		Portable gaseous oxygen system, purchase	10/01/2004	1	NC	
E0433		Portable liquid oxygen system, rental; home liquefier	01/01/2010	1	NC	
E0435		Portable liquid oxygen system, purchase	10/01/2004	1	NC	
E0440		Stationary liquid oxygen system, purchase	10/01/2004	1	NC	
E0443		Portable oxygen contents, gaseous	01/01/2001	1	NC	
E0444		Portable oxygen contents, liquid	01/01/2001	1	NC	

NC = Not covered

MODIFIER	DESCRIPTION	APPLICABLE PROCEDURE CODES	FEE MULTIPLIER
QF	Prescribed oxygen flow greater than 4 LPM, both stationary and portable	E0424, E0431, E0434, E0439, E0441, E0442	1.50
QG	Prescribed oxygen flow greater than 4 LPM, stationary only	E0424, E0439, E0441, E0442	1.50
U1	Oxygen concentrator used in a private residence	E1390, E1391	N/A

TO BE RESCINDED

5160-10-14 **Compression garments.**

(A) Compression garments.

(1) Compression garments are specialized garments prescribed for ambulatory persons with diagnoses listed under paragraph (A)(2) of this rule. Compression garments must be obtained through prior authorization. Only compression garments equal to or greater than 18mm Hg. will be considered for approval. All prior authorization requests for compression garments must contain the manufacturer and catalogue number.

(2) Coverage of compression garments is limited to the following diagnoses:.

(a) Lymphedema.

(b) Elephantiasis.

(c) Milroy's disease.

(d) Orthostatic hypotension.

(e) Pregnancy with associated symptomatic venous insufficiency.

(f) Stasis dermatitis.

(g) Stasis ulcers.

(h) Symptomatic chronic venous insufficiency (for example, pain, swelling, ulcers, severe varicose veins).

(i) Thrombophlebitis.

(j) Post-thrombotic syndrome.

(B) Surgical stockings are specialized stockings covered when ordered by a prescriber to prevent embolisms in the legs of non-ambulatory (e.g., bed-confined) consumers. Surgical stockings are used as a short-term treatment (up to three months) after a

surgical event. Surgical stockings must be obtained through prior authorization. If required for treatment during an inpatient hospital stay or outpatient hospital visit, the product will be reimbursed in accordance with Chapter 5101:3-2 of the Administrative Code.

(C) Compression burn garments are covered only when they are used to reduce hypertrophic scarring and joint contractures following a burn injury. Compression burn garments must be obtained through prior authorization.

(D) Providers fitting and dispensing compression garments, surgical stockings, or compression burn garments that are custom-made or custom-fitted must be certified to do so according to industry standards. A provider will not be eligible for reimbursement for custom-made or custom-fitted garments if the provider does not have a certified fitter on staff or under contract. Providers must keep on file documentation subject to review by ODJFS verifying that they have a trained fitter on staff or under contract.

(E) In addition to a fully completed prior authorization form JFS 03142 (rev. 2/2003), a fully completed form JFS 01905 (11/2006), "Certificate of Medical Necessity/Prescription Compression Garments (CMN)" (appendix A to this rule) that is signed and dated no more than thirty days prior to the first date of service must be submitted for prior authorization before reimbursement for compression garments, surgical stockings, or compression burn garments will be considered.

Effective:

Five Year Review (FYR) Dates:

_____

Certification

_____

Date

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Ohio Department of Medicaid

Certificate of Medical Necessity/Prescription
Compression Garments

Instructions: The Certificate of Medical Necessity (CMN) must be used for compression garments under the Ohio Medicaid Program. This form must be completed and carry the proper signature, where indicated, before requests will be considered for prior authorization.

Name of Recipient	Billing Number

Street Address	City/State/Zip	Date of Birth

Section A—Must be completed by Physician

Diagnosis(es)

- ☐ Elephantiasis Milroy's
- ☐ Disease Orthostatic
- ☐ hypertension Stasis
- ☐ dermatitis
- ☐ Stasis ulcers
- ☐ Symptomatic chronic venous insufficiency
- ☐ Pregnancy with associated chronic venous insufficiency
- ☐ Lymphedema
- ☐ Thrombophlebitis
- ☐ Post-thrombotic syndrome
- ☐ Other, explain:

Compression Garments

Brand Name _____

Hg mm Compression of Product _____

Specify the garments ordered for this patient _____

_____

_____

_____

If custom, explain _____

_____

_____

MANUFACTURER'S PRICE LIST AND THE GARMENT CATALOGUE NUMBER MUST BE ATTACHED

Section B—Physician Attestation and Signature/Date

Physician Name (printed)

I certify that I am the physician identified above. I certify that the information in Section B of this certificate of medical necessity and any information on any attached documents signed and dated by me, is true to the best of my knowledge. I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.

Physician Signature	Date	Prescriber's NPI Number
		Prescriber's Medicaid Legacy Number

ODM 01905 (7/2014)
Formerly JFS 01905

TO BE RESCINDED

5160-10-15 Transcutaneous electrical nerve stimulators (TENS).

(A) Unless otherwise stated, the dispensing for a TENS unit to a medicaid consumer must include the following documentation to be kept in the provider's records:

(1) A fully completed form JFS 03402 (rev. 10/2008) "Certificate of Medical Necessity/Prescription Transcutaneous Electrical Nerve Stimulator (TENS)" (CMN) (appendix A to this rule) that is signed and dated by an eligible prescriber no more than thirty days prior to the first date of service that documents nerve-related chronic intractable pain of at least six months duration. The CMN must specify a complete diagnosis; "chronic intractable pain" in itself is not a sufficient diagnosis to warrant coverage; and

(2) Attestation by the prescriber that a non-reimbursable trial period of at least thirty days resulted in substantial relief from pain (except for postoperative consumers). When a TENS unit is used specifically for acute post-operative pain, the medical necessity of the TENS unit is limited and reimbursable by the department for thirty days from the day of surgery, and no further reimbursement for this reason is authorized.

(B) Only the following conditions are recognized by the Ohio department of job and family services (ODJFS) as being eligible for consideration for the use of a TENS unit due to medical necessity after other appropriate treatment modalities have been tried and have failed. Use of a TENS unit and related services other than for those listed as covered in this rule are not eligible for reimbursement because the medical effectiveness of such therapy has not been established:

(1) Herpes zoster with other nervous system complications;

(2) Reflex sympathetic dystrophy;

(3) Other nerve root and plexus disorders;

(4) Mononeuritis of upper limb and mononeuritis multiplex;

(5) Mononeuritis of lower limb and unspecified site;

(6) Osteoarthrosis and allied disorders;

(7) Spondylosis of unspecified site;

(8) Intervertebral disc disorders;

(9) Brachial neuritis or radiculitis, not otherwise specified;

(10) Spinal stenosis, other than cervical;

(11) Lumbago;

(12) Sciatica;

(13) Myalgia and myositis, unspecified;

(14) Neuralgia, neuritis, and radiculitis, unspecified; or

(15) Other postsurgical status when used for acute post-operative pain for thirty days from the day of surgery.

(C) The conditions listed in this rule may not be associated with consumers treated with acupuncture, nor may they be associated with any variation of acupuncture techniques.

(D) A rental period of thirty days will be authorized for the initial use of the TENS unit. An additional period of ninety days minimum may be billed to the department if the following criteria are met and documentation is kept in the provider's records:

(1) All criteria listed in paragraph (A) of this rule, and

(2) Documentation of specific reduction in medications, e.g., muscle relaxants, narcotics, analgesics directly resulting from the use of the TENS unit.

(E) TENS units are covered as rental only for a maximum of four months. All rental payments made by ODJFS for the use of a TENS unit by a medicaid consumer are applied to any subsequent purchase of the TENS unit by ODJFS.

(F) Payment for rental includes all necessary accessories and supplies, and includes fitting and instructions/education in the proper use of the TENS unit. The provider must have a physical location available to the consumer for the initial face to face

fitting and instruction/education efforts.

(G) The provider of the TENS unit must assure that the consumer utilizing the device is properly instructed in how to use the device in support of his or her ordered treatment plan and is aware of and understands any emergency procedures regarding the use of the TENS unit. The provider must maintain written documentation regarding the consumer's instruction on the use of the TENS unit in the consumer's medical record.

(H) TENS units provided to recipients must have two or four leads with more than one modality and must be covered by a warranty of two years or more when purchased on behalf of a medicaid consumer. Purchases or rentals of used TENS units are not authorized by the department unless the TENS unit was specifically utilized previously by the consumer whom the purchase or rental is being billed for. No sharing of TENS units is allowed by ODJFS. If a TENS unit is ordered for use with four leads, the medical record must document why two leads are insufficient to meet the consumer's needs.

(I) A purchase of a TENS unit may be billed to the department minus any previous rental payments received by the provider only after three months rental and must be documented in the provider's records and accompanied by the prescriber's current signed statement of efficacy of TENS treatment, medical necessity of continued treatment, and documentation of the criterion specified in paragraphs (A) and (D)(2) of this rule.

(J) Supplies for a TENS unit owned by a consumer must be dispensed and billed on a monthly basis in quantities no greater than actually needed by the recipient as no automatic shipments or stockpiling of these supplies are allowed. No supplies shall be billed before they have been provided to the consumer. Reimbursement for supplies shall be made under a single all-inclusive code, subject to a monthly maximum as specified in appendix DD to rule 5101:3-1-60 of the Administrative Code. TENS supplies may not be billed for any month for which rental payment is requested.

Effective:

Five Year Review (FYR) Dates:

_____

Certification

_____

Date

Promulgated Under:	119.03
Statutory Authority:	5164.02
Rule Amplifies:	5162.03, 5164.02
Prior Effective Dates:	04/04/1977, 12/21/1977, 12/30/1977, 01/01/1980, 03/01/1984, 05/01/1990, 06/20/1990 (Emer), 09/05/1990, 04/16/2007

Ohio Department of Medicaid

CERTIFICATE OF MEDICAL NECESSITY/PRESCRIPTION
TRANSCUTANEOUS ELECTRICAL NERVE STIMULATOR (TENS)

SECTION A: Consumer/Provider Information

Certification Type ☐ Initial ☐ Revised ☐ Recertification			
Consumer's Name		Provider's Name	
Consumer DOB	Consumer Sex ☐ Female ☐ Male	Consumer HT (in.)	Consumer WT (lbs.)
(If consumer is not residing at home address) Facility Name		Prescriber's Name	
		Prescriber's NPI Number	
Facility Address		Prescriber's Telephone	
Facility City, State and Zip Code		Prescriber's Medicaid Legacy Number	

SECTION B: Information below may not be completed by the provider of the Items/Supplies

Est. Length of Need (# of Months) 1 - 99 (99 = LIFETIME)	Diagnosis Codes (ICD-9) and Descriptions
Last Consumer Medical Examination (MM/DD/YR)	

ANSWERS	ANSWER QUESTIONS 1-9 FOR RENTAL OF TENS UNIT, AND 3-12 FOR PURCHASE OF TENS UNIT. (Check Y for Yes, N for No, or D for Does Not Apply, Unless Otherwise Noted)
☐Y ☐N ☐D	1. Does the consumer have acute post-operative pain?
	2. What is the date of surgery resulting in acute post-operative pain?
☐Y ☐N ☐D	3. Does the consumer have chronic, intractable pain?
[months]	4. How long has the consumer had intractable pain? (Enter number of months, 1 - 99)
☐1 ☐2 ☐3 ☐4 ☐5	5. Is the TENS unit being prescribed for any of the following conditions? (Check the appropriate number) 1- Headache; 2 - Visceral abdominal pain; 3 - Pelvic pain; 4 -Temporomandibular joint (TMJ) pain; 5 - None of the above
☐Y ☐N ☐D	6. Is there documentation in the medical record of multiple medications and/or other therapies that have been tried and failed?
☐Y ☐N ☐D	7. Has the consumer received a TENS unit trial?
Begin/Ended	8. What are the dates that the trial of TENS unit began and ended?
	9. What is the date you reevaluated the consumer at the end of the trial period?
☐1 ☐2 ☐3	10. How often has the consumer been using the TENS unit? (Check the appropriate number) 1 = Daily; 2 = 3 to 6 days per week; 3 = 2 or less days per week
☐Y ☐N ☐D	11. Do you and the consumer agree that there has been a significant improvement in the pain and the long term use of a TENS unit is warranted?
☐2 ☐4	12. Number of TENS unit leads (i.e., separate electrodes) routinely needed and used by the consumer at any one time. (Check appropriate number) 2 = 2 leads 4 = 4 leads

NAME OF PERSON ANSWERING SECTION B QUESTIONS, IF OTHER THAN PRESCRIBER (Please Print)

Name	Title	Employer

SECTION C: Narrative Description of Equipment and Cost

(1) Narrative description of all items, accessories and options ordered; (2) Provider charge; and (3) Medicaid Fee Schedule Allowance for <u>each</u> item, accessory, and option.

I certify that I am the prescriber identified above. I certify that the information on this certificate of medical necessity and any information on any attached documents signed and dated by me is true to the best of my knowledge. I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability. (SIGNATURE AND DATE STAMPS ARE NOT ACCEPTABLE)

Prescriber's Signature	Date

TO BE RESCINDED

5160-10-18 **Hospital beds, pressure-reducing support surfaces and accessories.**

(A) Hospital beds.

Unless otherwise stated, coverage of hospital beds will be limited to consumers who meet the following criteria.

(1) Variable height hospital bed.

A "variable height" hospital bed is one with manual height, head and leg elevation adjustments. A request for prior authorization must include accompanying documentation signed by the prescriber which specifies the medical condition, severity and frequency of symptoms and the estimated duration of need and documents that:

(a) The consumer's diagnosis/condition (including but not limited to the weight of the consumer) warrants the consistent need for a variable height hospital bed in ways not feasible with an ordinary bed in order to provide elevation in excess of thirty degrees to the consumer due to congestive heart failure, chronic pulmonary disease, or documented problems with aspiration. Pillows or wedges must have been considered and ruled out as elevation of the head or upper body at less than thirty degrees does not require the use of a hospital bed, or

(b) The consumer requires traction equipment which can only be attached to a hospital bed, or

(c) The bed is required to assist the consumer with mobility and/or transfers (e.g., to a chair, wheelchair or standing position), or

(d) The bed is required to facilitate frequent interventions by a care giver in order to alleviate pain and prevent bed sores (e.g., turning the consumer every two hours).

(2) Semi-electric bed.

A "semi-electric" bed is one with manual height adjustment and with electric head and leg elevation adjustments. A semi-electric hospital bed may be approved with supporting documentation when the consumer meets the

general requirements in paragraph (A)(1) of this rule and requires frequent changes in body position and has an immediate need for a change in body positon.

(3) Total electric bed.

A "total electric" bed is one with electric height, head and leg elevation adjustments. Total electric beds and other institutional type beds are not covered by the medicaid program.

(4) A heavy duty extra wide hospital bed is covered if the consumer meets the general requirements in paragraph (A)(1) of this rule and the consumer's weight is more than three hundred fifty pounds, but does not exceed six hundred pounds.

(5) An extra heavy duty hospital bed is covered if the consumer meets the general requirements in paragraph (A)(1) of this rule and the consumer's weight exceeds six hundred pounds.

(B) Bed accessories.

(1) Trapeze equipment is covered if the consumer needs this device to sit up because of a respiratory condition, to change body position for other medical reasons, or to get in or out of bed.

(2) Heavy duty trapeze equipment is covered if the consumer meets the criteria in paragraph (B)(1) of this rule and the consumer's weight is more than two hundred fifty pounds.

(3) Side rails are covered when they are required by the consumer's condition and they are an integral part of, or an accessory to, a covered hospital bed.

(4) A replacement innerspring mattress or foam rubber mattress is covered for a consumer-owned hospital bed if a consumer's condition requires it.

(C) Hospital beds, accessories or support surfaces are not separately reimbursed for consumers in LTCFs (long term care facilities) as this equipment is reimbursed to the specific facility through the facility's cost report.

(D) Any prescription for hospital beds, accessories or support surfaces must be prescribed by a prescriber actively involved in managing the consumer's medical condition as

defined in paragraph (A) (2) of rule 5101-3-10-05 of the Administrative Code and should be treating the consumer under a comprehensive plan of care which addresses the underlying medical need for any equipment referenced in this rule.

(E) Pressure-reducing support surfaces.

Coverage of pressure-reducing support surfaces is limited to those group 1, group 2, and group 3 codes specified on the medicaid supply list found in appendix A to rule 5101:3-10-03 of the Administrative Code. A support surface must have a group 1, group 2 or group 3 healthcare common procedure coding system (HCPCS) code as defined in rule 5101:3-1-19.3 of the Administrative Code in order to be considered for coverage. Prior authorization is required for all group 2 and group 3 surfaces.

(1) Group 1.

(a) Definition.

"Group 1" pressure reducing support surfaces are typically defined as non-powered pressure reducing mattress overlays. These devices are designed to be placed on top of an ordinary hospital bed or home mattress. Group 1 pressure reducing support surfaces may be, but are not limited to, gel or gel-like overlays, air pressure or dry pressure, synthetic sheepskin, or lambswool sheepskin overlays. Group 1 may also include some powered pressure reducing mattress overlay systems (alternating pressure or low air loss), which are not included in group 2 pressure reducing support surfaces.

(b) Coverage criteria.

A group 1 mattress overlay or mattress is covered if any of the following apply:

(i) Consumer is completely immobile, i.e., cannot make changes in body position without assistance, or

(ii) Consumer has limited mobility, i.e., cannot independently make changes in body position significant enough to alleviate pressure, or

(iii) Consumer has any stage pressure ulcer on the trunk or pelvis, or

(iv) The consumer has compromised circulatory status.

Any support surface or bed provided by the department will be one in which the consumer does not "bottom out." Bottoming out is the finding that an outstretched hand, placed palm up between the undersurface of the overlay or mattress and the consumer's bony prominence (coccyx or lateral trochanter), can readily palpate the bony prominence. This bottoming out criterion will be tested by the provider with the consumer in the supine position with their head flat, in the supine position and their head slightly elevated (no more than thirty degrees), and in the side-lying position.

(2) Group 2.

(a) Definition.

"Group 2" pressure reducing support surfaces are typically defined as: a powered air floatation bed (low air loss therapy); a powered pressure-reducing air mattress; a nonpowered advanced pressure reducing overlay for a mattress of standard length and width; a powered air overlay for a mattress of standard length and width; or a nonpowered advanced pressure reducing mattress.

A "low air loss bed" is defined as a hospital bed with a fully integrated power pressure reducing mattress which has all of the following characteristics:

(i) An air pump or blower which provides either sequential inflation and deflation of the air cells or a low interface pressure throughout the mattress;

(ii) Air cells with an inflated cell height through which the air being circulated of five inches or greater;

(iii) Height of the air chambers, proximity of the air chambers to one another, frequency of air cycling (for alternating pressure mattresses), and air pressure provide adequate patient lift, reduce pressure and prevent bottoming out;

(iv) A surface designed to reduce friction and shear; and,

(v) Can be placed directly on a hospital bed frame or ordinary bed frame.

(b) Coverage criteria.

Generally, a group 2 support surface (i.e., an air-floatation bed) for use by an eligible consumer in a private residence may be prior-authorized when the consumer has:

(i) Pressure sore(s) in stage III or stage IV of tissue breakdown, as defined in appendix A to this rule, located on the trunk, or

(ii) Burns of third degree with or without graft sites, or

(iii) Multiple wounds at stage II, or

(iv) Had a recent surgical procedure (within sixty days prior to the date of the authorization request) of wound closure involving skin grafts and/or skin flaps. (Note: for the first thirty days following a skin graft and/or a skin flap procedure, an original copy of a provider's prescription shall be considered sufficient documentation for medical necessity. Subsequent approvals must meet the requirements of this rule.)

(3) Group 3.

(a) Definition.

"Group 3" pressure reducing support surfaces are typically defined as air-fluidized beds. An "air-fluidized bed" is a device employing the circulation of filtered air through silicone coated ceramic beads creating the characteristics of fluid. It is utilized for the treatment of a patient who has stage III or stage IV pressure sores.

(b) Coverage criteria.

A group 3 support surface (i.e., an air-fluidized bed) may be prior authorized when the patient has a stage III wound or a stage IV wound. The department's prior authorization unit will review the request and determine if an alternative support surface, such as a group 2 support surface, may be more appropriate.

(F) Pressure reducing support surfaces and hospital beds - medical necessity documentation requirements.

The following current (within the last thirty days), signed and dated documentation must be submitted to the department with a fully completed medical necessity form:

(1) JFS 02904 (4/2009), "Certificate of Medical Necessity/Prescription Decubitus Care Equipment (Pressure Reducing Support Surfaces)" (CMN) appendix B to this rule for all group 2 and group 3 support surfaces except for support surfaces prescribed for the first thirty days after skin graft/skin flap surgery, as per paragraph (E)(2)(b)(iv) of this rule; or

(2) JFS 02190 (4/2009), "Certificate of Medical Necessity/Prescription Hospital beds" (CMN) appendix C to this rule for all hospital beds.

Each additional piece of documentation submitted to the department as an attachment to the CMN must be labeled clearly and legibly with the consumer's name and medicaid identification number.

(3) A current prescriber's prescription or order for the support surface or hospital bed; and

(4) A current prescriber's prescription or order for treatment of wounds for a support surface; and

(5) The consumer's current diagnosis for a support surface or hospital bed; and

(6) The consumer's weight history for at least sixty days prior and up to the request for a support surface; and

(7) The consumer's current comprehensive nutritional assessment by a licensed/registered dietitian for a support surface; and

(8) Laboratory reports of blood tests, performed within twenty one days prior to submission of the authorization request for a support surface, showing, at a minimum:

(a) Serum protein,

(b) Serum albumin/prealbumin,

(c) Hemoglobin, and

(d) Hematocrit.

(9) A detailed current wound description of the consumer's with a comprehensive history describing wound appearance, length, width, depth, and location, prepared by a licensed health practitioner, and describing wound stage as defined in appendix A to this rule if applicable for a support surface.

(G) When the medical necessity for the pressure-reducing support surface or hospital bed has been established, the consumer's overall health status and any complicating conditions will be considered when authorizing the most appropriate and cost-effective support surface (air-fluidized or low air loss) or hospital bed.

(H) For those support surfaces requiring prior authorization, the initial and any subsequent periods of coverage will be authorized at the discretion of the department.

(I) Hospital beds, accessories or support surfaces are reimbursed according to the department fee schedule contained in appendix DD to rule 5101:3-1-60 of the Administrative Code or the provider's usual and customary charge, whichever is less.

Effective:

Five Year Review (FYR) Dates:

_____

Certification

_____

Date

Promulgated Under:	119.03
Statutory Authority:	5164.02
Rule Amplifies:	5162.03, 5164.02
Prior Effective Dates:	05/01/1990, 02/17/1991, 12/29/1995 (Emer), 03/21/1996, 01/01/2000, 10/01/2004, 04/09/2009

Appendix A-Pressure Sores-Four Stages of Tissue Breakdown

Tissue breakdown proceeds through four recognizable stages. The four stages as described below should be referenced when submitting documentation for Medicaid reimbursement.

Stage I

Stage I of tissue breakdown is reversible when pressure is removed. The important characteristics of stage I are:

- Erythema (redness that lasts a minimum of fifteen minutes after pressure is removed), that turns white upon finger pressure;
- Warmth;
- Tenderness; and
- Occasional blistering.

Threat of further breakdown is present when erythema fails to dissipate upon removal of pressure. However, stage I is usually considered a transient circulatory disturbance, and the affected area should return to normal within twenty-four hours if pressure is removed. The affected area may be painful, firm, soft, warmer or cooler as compared to adjacent tissue and occurs usually over a bony prominence.

Stage II

Stage II of tissue breakdown is generally reversible, but involves more profound circulation impairment than stage I. Stage II involves actual tissue damage presenting as partial thickness loss of dermis with a shallow open ulcer with a red pink wound bed, without slough. May also present as an intact or open/ruptured serum-filled blister. Characteristics of stage II include:

- Distinct break in epidermal integrity (may extend into dermis);
- Erythema;
- Disturbance in skin temperature;
- Tenderness; and
- Local swelling or edema.

In addition, stage II ulcers may have drainage. In stage II, there is a distinct break in skin integrity which may appear as excoriation or ulceration. The border of erythema is more sharply defined. The area of erythema does not blanch upon application of fingertip pressure and presents as a shiny or dry shallow ulcer without slough or bruising. This stage should not be used to describe skin tears, tape burns, perineal dermatitis, maceration or excoriation.

The skin may be either unusually warmer or cooler to the touch. Additionally, local swelling or edema may be observed. Stage II tissue damage can be reversed with timely intervention; it generally heals quickly and easily.

Stage III

Stage III tissue damage involves more serious destruction with full thickness tissue loss and increased potential for complications. Subcutaneous fat may be visible but bone, tendon or muscle are not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunneling. Stage III is characterized by the following and varies by anatomical location:

- Epidermal and dermal destruction that penetrates subcutaneous tissue;
- Infection and cellulitis;
- Eschar;
- Pain; and
- Drainage.

Stage III pressure sores are contaminated and may be infected. The presence of eschar (black, gangrenous, necrotic tissue) is not uncommon.

If the subcutaneous layer is involved, whitish, fatty tissue is visible at the base of the wound. When properly attended, progression of a stage III ulcer can be halted and, under optimal conditions, the wound can heal in two to four weeks.

Stage IV

Stage IV wounds involve more extensive damage than is immediately apparent. These ulcers represent serious destruction and opportunities for grave complications with full thickness tissue loss with exposed bone, tendon or muscle. Slough or eschar may be present on some parts of the wound bed. Often include undermining and tunneling.

Stage IV pressure sores are characterized by the following and varies by anatomical location:

- Tissue destruction of the epidermis and dermis and penetration of the deep subcutaneous layers;
- Muscle or bone destruction; and
- Possible undermining of the subcutaneous tissue.

Ohio Department of Medicaid

CERTIFICATE OF MEDICAL NECESSITY/PRESCRIPTION DECUBITUS CARE EQUIPMENT (PRESSURE REDUCING SUPPORT SURFACES)

Instructions: The Certificate of Medical Necessity (CMN) must be used for all approved pressure reducing support surfaces under the Ohio Medicaid Program. This form must be completed and carry the proper signature, where indicated, before requests will be considered for prior authorization.

Name of Consumer	Provider NPI#	
Consumer Medicaid #	Provider Medicaid Legacy # (Optional)	
Consumer Address	City/State/Zip	Date of Birth

Section A - Must be completed by Prescriber

Diagnosis(es) with ICD-9 code (Mandatory) and optional description

☐ Yes ☐ No Skin grafts/flaps? If yes, date of surgery	☐ Yes ☐ No Burns, 3rd degree? If yes, date If yes, describe burns

Prescriber order for pressure-reducing support surface. Specify product make/model (Prescription may be attached to this form in lieu of completing this item)

NOTE: If requesting approval for 30-day coverage post flap/graft surgery, completion of the remainder of section A is NOT REQUIRED.

Number of requested days	Prescriber ordered wound treatment protocol (Prescription may be attached in lieu of completing this section of the form)
Date of initial placement of patient on surface	

Note: Date of order(s) must be written within 30 days of prior authorization (PA) submission or placement of consumer on the surface.

Lab Reports (current within 21 days of PA submission or placement of consumer on surface. May be attached to this form)

Albumin	Date	Pre-Albumin	Date	Tot. Protein	Date	Hbg.	Date	HCT	Date

Wound Description—excluding extremities (Current within 21 days prior to PA submission or placement of patient on surface.)

	Date	Location	Appearance	Length	Width	Depth	Stage	Signature-Licensed Individual
1								
2								
3								
4								

Weight History—For at least 60 days prior to submission of PA request or placement on surface. Wound graph from chart may be submitted in lieu of completing this section of this form.

Date	Wt.	Date	Wt.	Date	Wt.	Date	Wt.

Section B - Prescriber Attestation and Signature/Date

Prescriber Name (PRINTED)	Prescriber NPI#

I certify that I am the prescriber identified above. I certify that the information in Section A of this certificate of medical necessity and any information on the attached documents signed and dated by me, are true to the best of my knowledge. I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.

Prescriber Signature	Date	Prescriber Medicaid Legacy # (Optional)

ODM 02904 (7/2014)
Formerly JFS 02904 (4/2009)

Ohio Department of Medicaid

CERTIFICATE OF MEDICAL NECESSITY/PRESCRIPTION HOSPITAL BEDS

Instructions: The Certificate of Medical Necessity (CMN) must be used for all eligible hospital beds under the Ohio Medicaid Program. This form must be completed and carry the proper signature, where indicated, before requests will be considered for prior authorization.

Name of Consumer		Provider NPI #	
Consumer Medicaid #		Provider Medicaid Legacy Number# (Optional)	
Consumer Address		City/State/Zip	Date of Birth
☐ Rental ☐ Purchase	Were pillows or wedges considered prior to requesting bed? ☐ Yes ☐ No	Were rental dates previously approved? ☐ Yes ☐ No If "yes", list Prior Authorization # _____ Authorized dates _____	Consumer's Weight Consumer's Height

Section A - Must be completed by Prescriber

Diagnosis(es) (ICD-9 Code)	Diagnosis(es) (ICD-9 Description) (Optional)	☐ Congestive heart failure Chronic ☐ pulmonary disease Documented ☐ problems with aspiration

Check/Complete all that apply

☐ Consumer's diagnosis/physical condition requires positioning of the body in ways not feasible in an ordinary bed due to a medical condition which is expected to last at least one month. (Include severity and frequency of symptoms.) Explain

☐ The consumer requires, for the alleviation of pain, positioning of the body in ways not feasible with an ordinary bed.

☐ The consumer's medical condition requires the head of the bed to be elevated more than 30 degrees most of the time due to congestive heart failure, chronic pulmonary disease, or aspiration.

☐ Bed is medically necessary during post-surgical period. Date of Surgery

☐ Consumer requires traction equipment which can only be attached to a hospital bed.

☐ The consumer requires a bed height different than a fixed height hospital bed to permit transfers to chair, wheelchair, or standing position

☐ Bed is required to facilitate frequent interventions by a care giver (e.g., turning the consumer every two hours).
Explain - describe interventions/treatments and specify type of care giver.

	Independent	With assistance		Independent	With assistance
Transferring	☐	☐	Re-positioning	☐	☐
Other, specify				☐	☐

Length of time needed ☐ Short-term (less than 10 months) Specify # of months _____	☐ Long-term (10 months or more)
Type of bed requested (specify if bed is Heavy Duty or Pediatric) ☐ Variable height, manual ☐ Semi-electric ☐ Other, specify _____	Explain why "variable-height, manual" bed will NOT meet medical needs.

Section B - Prescriber Attestation and Signature/Date

Prescriber Name (PRINTED)

Prescriber NPI#

I certify that I am the prescriber identified above. I certify that the information I have completed in this certificate is of medical necessity and any information on any attached documents signed and dated by me is true to the best of my knowledge. I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.

Prescriber Signature	Date	Prescriber Medicaid Legacy # (Optional)

ODM 02910 (7/2014)
Formerly JFS 02910 (4/2009)

TO BE RESCINDED

5160-10-19 **Definitions of terms associated with orthotic and prosthetic services.**

The following are definitions used in rule 5101:3-10-20 of the Administrative Code.

(A) "Base procedure" - The basic procedure which indicates the simplest form of service being provided.

(B) "Additions to" - The "add-on" codes are added to the base procedure code if additional and more complicated services are provided. Normally the value assigned to the "add-on" codes does not represent the actual value of the component but only the difference in value between the base component found in the base procedure code and the "add-on" component being substituted. Those codes with asterisks can be billed either as "add-on" or as replacement items.

(C) "Molded socket" - In orthotics, this means an impression was taken, modified, and a socket of thermoplastic or other materials was made over the model. This same phrase in prosthetics indicates generally accepted fitting procedures, such as a PTB or quadrilateral socket that have been molded over a modified patient model.

(D) "Molded to consumer model" - A plaster cast is taken of the involved portion of the consumer's body from which a positive cast is then developed. This positive mold represents the patient model from which the ultimate appliance is fabricated.

(E) "Molded to consumer" - Direct molding of plastic or similar material on involved portion of consumer's body. This material is ultimately used in the appliance being fabricated.

(F) "Direct formed" - Direct molding of plastic or similar material on involved portion of consumer's body. This material is ultimately used in the appliance being fabricated.

(G) "Nonmolded" - No casting or molding techniques used in the fabrication of the appliance in question. It can be a stock item or made from measurements and/or patterns only.

(H) "Premolded" - No casting or molding techniques used in the fabrication of the appliance in question. It can be a stock item or made from measurements and/or patterns only.

(I) "Custom fitted" - No casting or molding techniques are used in the fabrication of the appliance in question. It is normally a stock item that is fitted and adjusted to the patient. All custom-fitted items that require prior authorization must include make and model number.

(J) "Custom fabricated" - The appliance in question has been made for the consumer from measurements and/or patterns only.

(K) "Interface material" - Lining material used in any appliance. It is inserted between the body and the structural support.

(L) "Flexible" - Normally refers to surgical garments or corsets made from material, with reinforcing stays and para-spinal spring steels.

(M) "Thermoplastic or equal" - The device is fabricated from one of the various forms of thermoplastic materials that are commercially available, or in some instances may even refer to a thermosetting plastic resin approach.

(N) "Endoskeletal" - In prosthetics, this implies the modular approach and is all-inclusive of the various manufacturers of endoskeletal components.

(O) "Exoskeletal" - The traditional plastic laminated approach to finishing a prosthesis.

(P) "Immediate fit" - The application of a prosthesis in the operating or recovery room, and the appropriate cast changes.

(Q) "Initial prosthesis" - The application of a plaster direct formed BK or AK prosthesis that was not an immediate fit, and is not intended for extensive use. This is a noncovered service by medicaid.

(R) "Preparatory prosthesis" - A device that will allow for extensive gait training for lower limb amputees, and extensive functional training for upper limb amputees. A patient with a preparatory prosthesis need not be in the hospital, but is still undergoing changes to the amputation that preclude the fitting of the definitive prosthesis. Preparatory prostheses for lower limb amputees with the potential to be ambulatory will be considered for coverage by medicaid only when extensive training is medically necessary prior to the fitting of the definitive prosthesis.

(S) "Medical event" - A physical occurrence or aberration which necessitates medical intervention requiring the one-time use of an orthosis specific to the diagnosis as prescribed by a physician.

(T) "NC" - A noncovered service by medicaid.

Effective:

Five Year Review (FYR) Dates:

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Certification

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Date

Promulgated Under:	119.03
Statutory Authority:	5164.02
Rule Amplifies:	5162.03, 5164.02, 5164.70
Prior Effective Dates:	10/01/1988, 05/01/1990, 10/01/2004, 01/07/2010

TO BE RESCINDED

5160-10-20 **Orthotic devices, prostheses, and related services.**

(A) Providers. To furnish and receive medicaid payment for an orthotic device, prosthesis, or related service that is subject to provisions of Chapter 4779. of the Revised Code, a supplier must meet the criteria set forth in section 4779.02 of the Revised Code.

(B) Coverage.

(1) Coverage information about individual orthotic devices, prostheses, and related items is listed in the appendix to this rule.

(2) Payment for certain orthotic devices and prostheses requires prior authorization (PA).

(a) A request for PA of a "not otherwise specified," "miscellaneous," or "unlisted" item or service must include a complete description of the item or service, a list of all bundled components, and an itemization of all charges.

(b) A request for PA of a preparatory prosthesis must include the reason for the amputation, the date of the amputation, and an explanation of the benefit to be derived from having the recipient use a preparatory prosthesis before a definitive prosthesis is designed.

(3) The purchase of torsion cables may be authorized only for the treatment of children with neuromuscular diseases and related conditions. Requests for torsion cables to treat positional deformities will be denied because of anticipated resolution that occurs with maturation.

(4) The repair or replacement of parts is subject to applicable requirements listed in paragraphs (A)(2) to (A)(12) of rule 5160-10-08 of the Administrative Code.

(5) No separate payment will be made for either of the following items or services:

(a) Repairs, adjustments, or modifications that are made within ninety days after delivery, unless necessitated by major changes in the recipient's physiological condition or functional need; or

(b) Labor, measuring, casting, fitting, travel by the supplier, and shipping or mailing associated with a covered orthotic device or prosthesis.

Effective:

Five Year Review (FYR) Dates:

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Certification

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Date

Promulgated Under:	119.03
Statutory Authority:	5164.02
Rule Amplifies:	5164.02
Prior Effective Dates:	03/01/1984, 12/30/1984, 10/01/1988, 04/13/1989 (Emer), 05/15/1989, 05/01/1990, 06/20/1990 (Emer), 02/17/1991, 04/01/1992 (Emer), 07/01/1992, 12/10/1993, 12/30/1993 (Emer), 03/31/1994, 08/01/1995, 12/29/1995 (Emer), 03/21/1996, 01/04/2000 (Emer), 03/20/2000, 12/29/2000 (Emer), 03/30/2001, 12/31/2001 (Emer), 03/29/2002, 10/01/2004, 11/01/2004 (Emer), 01/16/2005, 09/01/2005, 12/30/2005 (Emer), 03/27/2006, 10/15/2006, 12/29/2006 (Emer), 03/29/2007, 12/16/2007, 12/31/2007 (Emer), 03/30/2008, 12/31/2008 (Emer), 03/31/2009, 12/30/2010 (Emer), 03/30/2011, 09/01/2011, 12/30/2011 (Emer), 03/29/2012, 04/01/2016

Appendix to rule 5160-10-20

PA = payment determined through prior authorization

HCPCS CODE	CATEGORY	APPLICATION	DESCRIPTION	EFFECTIVE DATE	CURRENT MAXIMUM PAYMENT AMOUNT	PREVIOUS MAXIMUM PAYMENT AMOUNT	NEED FOR PRIOR AUTHORIZA-TION	LIMIT
A4566	Orthotic device	Shoulder	Shoulder slint or vest design, Abduction Restrainer	01/01/2011	95.00		No	1 per medical event
A5500	Orthopedic footwear and modification	Orthopedic shoes	Diabs only,fitting,custom prep, offshelf, per shoe	01/01/2010	46.07	47.49	Yes	1 per foot per year
A5501	Orthopedic footwear and modification	Orthopedic shoes	For Diabetics Only, Custom Molded Shoe	01/01/2010	160.19	165.14	Yes	1 per foot per year
A5512	Orthopedic footwear and modification	Orthopedic shoes	Diabs only, mult density insert, direct form	01/01/2010	18.80	19.38	Yes	1 per foot per year
A5513	Orthopedic footwear and modification	Orthopedic shoes	Diabs only,mult density insert, custom	01/01/2010	28.04	28.91	Yes	1 per foot per year
A8000	Orthotic device	Cranium	Soft protect helmet prefab	01/01/2010	103.41	106.61	No	1 per year
A8001	Orthotic device	Cranium	Hard protect helmet prefab	01/01/2010	103.41	106.61	No	1 per year
A8002	Orthotic device	Cranium	Soft protect helmet custom	01/01/2010	441.26	454.91	No	1 per medical event
A8003	Orthotic device	Cranium	Hard protect helmet custom	01/01/2010	441.26	454.91	No	1 per medical event
L0120	Orthotic device	Cervical spine	Flexible, Non/Adj, (Foam Collar)	01/01/2010	16.89	17.41	No	1 per year
L0140	Orthotic device	Cervical spine	Semi-Rigid,Adj(Plastic Collar)	01/01/2010	38.25	39.43	No	1 per year
L0170	Orthotic device	Cervical spine	Collar, Molded To Patient Model	01/01/2010	513.69	529.58	No	1 per medical event
L0172	Orthotic device	Cervical spine	Cervical Collar Semirigid Thrm/Plas 2Pc	01/01/2010	90.48	93.28	No	1 per year
L0174	Orthotic device	Cervical spine	Cer.Coll.Semi Rig.Therm.2Pc.W Thora.	01/01/2010	177.92	183.42	No	1 per year
L0180	Orthotic device	Cervical spine	Mult Post Collar, Occ/Man Support Adj	01/01/2010	288.26	297.18	No	1 per medical event
L0190	Orthotic device	Cervical spine	Mult Collar,Occip/Mand Supp(Somi,Etc)	01/01/2010	339.95	350.46	No	1 per medical event
L0200	Orthotic device	Cervical spine	Mult P/Collar Occ/Man Sup,Adj Bar Th/Ext	01/01/2010	394.31	406.50	No	1 per medical event
L0220	Orthotic device	Thoracic spine	Rib Belt, Custom Fabricated	01/01/2010	82.55	85.10	Yes	1 per year
L0450	Orthotic device	Thoracic spine	TLSO, upper thoracic, prefabricated	01/01/2010	126.91	130.83	No	2 per year
L0452	Orthotic device	Thoracic spine	TLSO, upper thoracic, custom fabricated	01/01/2010	202.07	208.32	No	2 per year
L0454	Orthotic device	Thoracic spine	TLSO, from sacrococcygeal to T-9 vertebra, prefabricated	01/01/2010	195.52	201.57	No	1 per year
L0466	Orthotic device	Thoracic spine	TLSO, sagittal control, prefabricated	01/01/2010	242.40	249.90	No	1 per 2 years
L0468	Orthotic device	Thoracic spine	TLSO, sagittal-coronal control, prefabricated	01/01/2010	303.78	313.18	No	1 per 2 years
L0470	Orthotic device	Thoracic spine	TLSO, from sacrococc to scap, lateral strength by pelv, prefab	01/01/2010	413.62	426.41	No	1 per 2 years
L0472	Orthotic device	Thoracic spine	TLSO, hyperext, from symph pubis to sternal notch, prefab	01/01/2010	258.66	266.66	No	1 per medical event
L0480	Orthotic device	Thoracic spine	TLSO, 1-pc rigid plastic w/o liner, carved plaster or CAD-CAM	01/01/2010	965.02	994.87	No	1 per medical event
L0482	Orthotic device	Thoracic spine	TLSO, 1- pc rigid plastic w/ liner, carved plaster or CAD-CAM	01/01/2010	1,077.94	1,111.28	No	1 per medical event
L0484	Orthotic device	Thoracic spine	TLSO, 2-pc w/o liner, carved plaster or CAD-CAM	01/01/2010	1,164.14	1,200.14	No	1 per medical event
L0486	Orthotic device	Thoracic spine	TLSO, 2-pc w/ liner, carved plaster or CAD-CAM	01/01/2010	1,307.38	1,347.81	No	1 per medical event
L0488	Orthotic device	Thoracic spine	TLSO, 1-pc, restr motion in sagitt/coron/trnsvrs planes, prefab	12/07/2010	727.15	933.69	No	1 per medical event
L0621	Orthotic device	Sacroiliac joints	SIO flex pelvisacral prefab	01/01/2010	55.09	56.79	No	2 per year
L0625	Orthotic device	Lumbar spine	LO flexibl L1-below L5 pre	12/07/2010	39.90	84.72	No	2 per year
L0626	Orthotic device	Lumbar spine	LO sag stays/panels pre-fab	12/07/2010	56.46	74.77	No	2 per year
L0627	Orthotic device	Lumbar spine	LO sagitt rigid panel prefab	01/01/2006	147.95		No	2 per year
L0628	Orthotic device	Lumbar spine	LO flex w/o rigid stays pre	12/07/2010	60.76	78.05	No	2 per year
L0629	Orthotic device	Lumbar spine	LSO flex w/rigid stays cust	01/01/2010	164.66	169.75	No	2 per year
L0630	Orthotic device	Lumbar spine	LSO post rigid panel pre	01/01/2010	143.51	147.95	No	2 per year
L0631	Orthotic device	Lumbar spine	LSO sag-coro rigid frame pre	01/01/2010	143.51	147.95	No	2 per year
L0632	Orthotic device	Lumbar spine	LSO sag rigid frame cust	01/01/2010	143.51	147.95	No	2 per year
L0633	Orthotic device	Lumbar spine	LSO flexion control prefab	01/01/2010	246.18	253.79	No	1 per 2 years
L0634	Orthotic device	Lumbar spine	LSO flexion control custom	01/01/2010	246.18	253.79	Yes	1 per 2 years

HCPCS CODE	CATEGORY	APPLICATION	DESCRIPTION	EFFECTIVE DATE	CURRENT MAXIMUM PAYMENT AMOUNT	PREVIOUS MAXIMUM PAYMENT AMOUNT	NEED FOR PRIOR AUTHORIZA-TION	LIMIT
L0635	Orthotic device	Lumbar spine	LSO sagit rigid panel prefab	01/01/2010	271.88	280.29	No	1 per 2 years
L0636	Orthotic device	Lumbar spine	LSO sagittal rigid panel cus	01/01/2010	271.88	280.29	No	1 per 2 years
L0639	Orthotic device	Lumbar spine	LSO s/c shell/panel prefab	01/01/2010	827.69	853.29	No	1 per medical event
L0640	Orthotic device	Lumbar spine	LSO s/c shell/panel custom	12/07/2010	757.98	973.29	No	1 per medical event
L0700	Orthotic device	Cervical-thoracic-lumbar-sacral spine	CTLSO, Minerva	01/01/2010	1,271.88	1,311.22	No	1 per medical event
L0710	Orthotic device	Cervical-thoracic-lumbar-sacral spine	CTLSO,Mld To Pat Model, Interface	01/01/2010	1,398.16	1,441.40	No	1 per medical event
L0810	Orthotic device	Halo procedure	Halo Proc,Cerv Halo On Thoracic Jacket	01/01/2010	1,707.70	1,760.52	No	1 per medical event
L0859	Orthotic device	Halo procedure	Halo/ MRI compatible system	01/01/2006	750.27		No	1 per medical event
L0970	Orthotic device	Spine, addition to orthosis	TLSO, Corset Front	01/01/2010	68.28	70.39	Yes	1 per medical event
L0972	Orthotic device	Spine, addition to orthosis	LSO, Corset Front	01/01/2010	62.14	64.06	No	1 per medical event
L0974	Orthotic device	Spine, addition to orthosis	TLSO, Full Corset	01/01/2010	111.65	115.10	Yes	1 per medical event
L0976	Orthotic device	Spine, addition to orthosis	LSO, Full Corset	01/01/2010	95.52	98.47	No	1 per medical event
L0978	Orthotic device	Spine, addition to orthosis	Axillary Crutch Extension	01/01/2010	120.22	123.94	Yes	1 per medical event
L0980	Orthotic device	Spine, addition to orthosis	Peritioneal Straps, Pair	01/01/2010	10.93	11.27	No	2 per year
L0984	Orthotic device	Spine, addition to orthosis	Protective Body Sock , Each	01/01/2010	43.25	44.59	No	6 per year
L0999	Orthotic device	Spine, addition to orthosis	Add to spinal orthosis, NOS	09/01/2005	PA		Yes	
L1000	Orthotic device	Spine, scoliosis, cervical-thoracic-lumbar-sacral spine (Milwaukee)	Ctlso,Milwaukee,Incl Init Orth,Incl Modl	01/01/2010	1,295.56	1,335.63	No	1 per 2 years
L1010	Orthotic device	Spine, scoliosis, cervical-thoracic-lumbar-sacral spine (Milwaukee)	Add To CLSO(Scoliosis Orth) Axilla Sling	01/01/2010	53.46	55.11	No	1 per 2 years
L1020	Orthotic device	Spine, scoliosis, cervical-thoracic-lumbar-sacral spine (Milwaukee)	Add To CLSO Or Scol/Orth,Kyphosis Pad	01/01/2010	68.85	70.98	No	1 per 2 years
L1025	Orthotic device	Spine, scoliosis, cervical-thoracic-lumbar-sacral spine (Milwaukee)	Add To CTLSO Or Scoli.Kypha.Pad Float	01/01/2010	99.32	102.39	Yes	1 per 2 years
L1030	Orthotic device	Spine, scoliosis, cervical-thoracic-lumbar-sacral spine (Milwaukee)	Add To CTLSO Or Scol/Orth,Lumb Bolst Pad	01/01/2010	50.01	51.56	No	1 per 2 years
L1040	Orthotic device	Spine, scoliosis, cervical-thoracic-lumbar-sacral spine (Milwaukee)	Add To CTLSO Or Scol/Or,Lumb Rib Pad	01/01/2010	56.65	58.40	No	1 per 2 years
L1050	Orthotic device	Spine, scoliosis, cervical-thoracic-lumbar-sacral spine (Milwaukee)	Add To CTLSO,Scol/Or, Sternal Pad	01/01/2010	64.10	66.08	No	1 per 2 years
L1060	Orthotic device	Spine, scoliosis, cervical-thoracic-lumbar-sacral spine (Milwaukee)	Add To CTLSO Or Scol/Or, Thoracic Pad	01/01/2010	69.19	71.33	No	1 per 2 years
L1070	Orthotic device	Spine, scoliosis, cervical-thoracic-lumbar-sacral spine (Milwaukee)	Add To CTLSO Or Scol/Or, Trapeze Sling	01/01/2010	71.67	73.89	Yes	1 per 2 years
L1080	Orthotic device	Spine, scoliosis, cervical-thoracic-lumbar-sacral spine (Milwaukee)	Add To CTLSO Or Scol/Or, Outrigger	01/01/2010	33.43	34.46	No	1 per 2 years
L1085	Orthotic device	Spine, scoliosis, cervical-thoracic-lumbar-sacral spine (Milwaukee)	Add CTLSO Or Scoli.Outrig Bial. Vert.Ext	01/01/2010	111.91	115.37	Yes	1 per 2 years
L1090	Orthotic device	Spine, scoliosis, cervical-thoracic-lumbar-sacral spine (Milwaukee)	Add To CTLSO Or Scol/Or, Lumbar Sling	01/01/2010	64.30	66.29	Yes	1 per 2 years
L1100	Orthotic device	Spine, scoliosis, cervical-thoracic-lumbar-sacral spine (Milwaukee)	Add To CTLSO, Ring Flange, Plas Or Leath	01/01/2000	125.08	108.74	No	1 per 2 years
L1110	Orthotic device	Spine, scoliosis, cervical-thoracic-lumbar-sacral spine (Milwaukee)	Add To,Ring Flang,Plas/Leath Mld To Pat	01/01/2010	203.43	209.72	Yes	1 per 2 years
L1120	Orthotic device	Spine, scoliosis, cervical-thoracic-lumbar-sacral spine (Milwaukee)	Add To, Covers For Upright, Each	01/01/2010	24.29	25.04	No	6 per year
L1200	Orthotic device	Spine, scoliosis, thoracic-lumbar-sacral spine (low profile)	TLSO Initial Orthosis Only (Low/Profile)	01/01/2010	1,143.33	1,178.69	No	1 per 2 years
L1210	Orthotic device	Spine, scoliosis, thoracic-lumbar-sacral spine (low profile)	Add To TLSO (Low Profile)Lat Thor Extnen	01/01/2010	156.32	161.15	No	1 per 2 years
L1220	Orthotic device	Spine, scoliosis, thoracic-lumbar-sacral spine (low profile)	Add To TLSO (Low Prof) Ant Thor Exten	01/01/2010	152.14	156.85	No	1 per 2 years
L1230	Orthotic device	Spine, scoliosis, thoracic-lumbar-sacral spine (low profile)	Add To TLSO,Low Prof,Milwake Type Super	01/01/2010	426.24	439.42	Yes	1 per 2 years
L1240	Orthotic device	Spine, scoliosis, thoracic-lumbar-sacral spine (low profile)	Add TLSO Lumbar Derotation Pad	01/01/2010	58.10	59.90	No	1 per 2 years
L1250	Orthotic device	Spine, scoliosis, thoracic-lumbar-sacral spine (low profile)	Add TLSO Anterior Asis Pad	01/01/2010	50.51	52.07	No	1 per 2 years
L1260	Orthotic device	Spine, scoliosis, thoracic-lumbar-sacral spine (low profile)	Add TLSO Anter.Thoracic Derotat.Pad	01/01/2010	60.27	62.13	No	1 per 2 years
L1270	Orthotic device	Spine, scoliosis, thoracic-lumbar-sacral spine (low profile)	Add TLSO Abdominal Pad	01/01/2010	52.97	54.61	No	1 per 2 years
L1280	Orthotic device	Spine, scoliosis, thoracic-lumbar-sacral spine (low profile)	Add TLSO Rib Gusset Elastic Ea	01/01/2010	55.80	57.53	No	1 per 2 years
L1290	Orthotic device	Spine, scoliosis, thoracic-lumbar-sacral spine (low profile)	Add TLSO Lateral Trochanteric Pad	01/01/2010	49.64	51.18	No	1 per 2 years
L1300	Orthotic device	Spine, scoliosis, other	Scol Proc, Body Jacket Mld To Pat Model	01/01/2010	1,101.13	1,135.19	No	1 per 2 years
L1310	Orthotic device	Spine, scoliosis, other	Scol Proc, Psot-Op Jkt Mld To Model	01/01/2010	1,146.93	1,182.40	No	1 per medical event

HCPCS CODE	CATEGORY	APPLICATION	DESCRIPTION	EFFECTIVE DATE	CURRENT MAXIMUM PAYMENT AMOUNT	PREVIOUS MAXIMUM PAYMENT AMOUNT	NEED FOR PRIOR AUTHORIZA-TION	LIMIT
L1499	Orthotic device	Spine, scoliosis, other	Spinal orthosis, NOS	10/01/1988	PA		Yes	
L1600	Orthotic device	Hip	Flex HO,Abd Hip Jts, Frejka Type/Cover	01/01/2010	82.33	84.88	No	1 per lifetime
L1620	Orthotic device	Hip	Flex HO, Abd Hip Jts, Pavlik Harness	01/01/2010	100.40	103.50	No	1 per lifetime
L1630	Orthotic device	Hip	HO Abduction Cont.Hip Jnt .Semi-Flex	01/01/2010	134.98	139.15	Yes	1 per lifetime
L1640	Orthotic device	Hip	HO,Abd Hp Jts,Static,Pelv Band,Thigh Cuf	01/01/2010	302.44	311.79	No	1 per lifetime
L1650	Orthotic device	Hip	HO,Abd Hp Jts, Static, Adj, Prefab	01/01/2010	157.56	162.43	No	1 per medical event
L1660	Orthotic device	Hip	HO,Abd Hp Jts, Static,Plas, Prefab	01/01/2010	115.46	119.03	No	1 per medical event
L1680	Orthotic device	Hip	HO,Abd Hp Jsts, Dynamic, Adj Hip Action	01/01/2010	727.88	750.39	No	1 per medical event
L1685	Orthotic device	Hip	HO Abduct Contr Of Hip Int Post Oper	01/01/2010	710.59	732.57	No	1 per medical event
L1686	Orthotic device	Hip	HO Post-Op Hip Abduction Prefab	01/01/2010	598.67	617.19	No	1 per medical event
L1690	Orthotic device	Hip	Combo, bilateral, lumbo-sacral, hip, femur orthosis	01/01/2010	1,438.91	1,483.41	No	1 per medical event
L1720	Orthotic device	Hip, Legg-Calvé-Perthes disease	LCP Orthosis, Trilateral (Tachdijan Type)	01/01/2010	942.49	971.64	Yes	1 per medical event
L1730	Orthotic device	Hip, Legg-Calvé-Perthes disease	LCP Orthosis, Scottish Rite Type	01/01/2010	795.67	820.28	No	1 per medical event
L1755	Orthotic device	Hip, Legg-Calvé-Perthes disease	LCPrthosis, Patten Bottom Type	01/01/2010	1,143.95	1,179.33	Yes	1 per medical event
L1810	Orthotic device	Knee	KO, Elastic With Joints	01/01/2010	65.77	67.80	No	2 per year
L1820	Orthotic device	Knee	KO, Elastic With Condyle Pads And Joints	01/01/2010	90.80	93.61	No	2 per year
L1830	Orthotic device	Knee	KO, Immobilizer, Canvas Longitudinal	01/01/2010	53.13	54.77	No	2 per year
L1832	Orthotic device	Knee	KO Adj Knee Jts Rigid Support, Prefab	01/01/2010	473.52	488.16	No	1 per 2 years
L1834	Orthotic device	Knee	KO Without Knee Jt Rigid Mold Pt Model	01/01/2010	463.73	478.07	No	1 per 2 years
L1840	Orthotic device	Knee	KO,Derotation, Fab To Pat Model (Lenox Hl	01/01/2010	600.83	619.41	Yes	1 per 2 years
L1843	Orthotic device	Knee	KO, Single Upright, Thigh and Calf, adj. flexion, ext. joint	01/01/2010	345.00	355.67	No	1 per 2 years
L1844	Orthotic device	Knee	KO, Single Upright, Thigh and Calf, Flex and Extension	01/01/2010	972.95	1,003.04	No	1 per 2 years
L1845	Orthotic device	Knee	KO Dbl, Thigh Calf Adjust Filex, Prefab	01/01/2010	535.18	551.73	No	1 per 2 years
L1846	Orthotic device	Knee	KO Dbl, Thigh Calf Adjus. Flexmold To Pat	01/01/2010	716.46	738.62	No	1 per 2 years
L1847	Orthotic device	Knee	KO, double upright with adjust. joint w/air support cham.	01/01/2010	427.98	441.22	No	1 per 2 years
L1850	Orthotic device	Knee	KO, Swedish Type	01/01/2010	182.02	187.65	No	1 per 2 years
L1860	Orthotic device	Ankle-foot	KO, All Plastic Form Patient Model (Sk)	01/01/2010	796.69	821.33	Yes	1 per 2 years
L1900	Orthotic device	Ankle-foot	AFO, Spring Wire, Dorsiflex Assist Calf	01/01/2010	182.28	187.92	No	1 per 2 years
L1902	Orthotic device	Ankle-foot	AFO Ankle Gauntlet, Prefab	01/01/2010	47.69	49.16	No	2 per year
L1906	Orthotic device	Ankle-foot	AFO Multiligament Us Ank Supp(Air Cast)	01/01/2010	71.85	74.07	No	1 per medical event
L1907	Orthotic device	Ankle-foot	AFO, Supremalleolar, custom fabricated	04/01/2009	364.11	NC	No	1 per 2 years
L1920	Orthotic device	Ankle-foot	AFO, Sing Uprite/Static/Adj Stop (Phelps)	01/01/2010	262.46	270.58	No	1 per 2 years
L1930	Orthotic device	Ankle-foot	AFO, Plastic or Other Material,Premolded, Prefab	01/01/2010	197.76	203.88	No	1 per 2 years
L1940	Orthotic device	Ankle-foot	AFO,Molded To Patient Model, Plastic or Other Material	01/01/2010	311.11	320.73	No	1 per 2 years
L1945	Orthotic device	Ankle-foot	AFO Molded Pt Model Plas Floor Reaction	01/01/2010	717.14	739.32	No	1 per 2 years
L1960	Orthotic device	Ankle-foot	AFO, Post/Solid/Ankle,Mld To Pat Model	01/01/2010	396.02	408.27	No	1 per 2 years
L1970	Orthotic device	Ankle-foot	AFO,Plastic Mld To P/Model, With Ank/Jts	01/01/2010	442.20	455.88	No	1 per 2 years
L1980	Orthotic device	Ankle-foot	AFO, (Single Bar "Bk" Orthosis)	01/01/2010	257.98	265.96	No	1 per 2 years
L1990	Orthotic device	Ankle-foot	AFO (Basic/Double Bar "Bk" Orthosis)	01/01/2010	298.57	307.80	No	1 per 2 years
L2000	Orthotic device	Knee-ankle-foot	KAFO (Single Bar"Ak" Orthosis) Free K/A	01/01/2010	714.72	736.82	No	1 per 2 years
L2010	Orthotic device	Knee-ankle-foot	KAFO (Single Bar"Ak"Orth) W/O Knee Joint	01/01/2010	557.47	574.71	No	1 per 2 years
L2020	Orthotic device	Knee-ankle-foot	KAFO (Double Bar "Ak"Orth) Free Knee/Ank	01/01/2010	704.06	725.84	No	1 per 2 years
L2030	Orthotic device	Knee-ankle-foot	KAFO,(Double Bar "Ak"Orth)W/O Knee Joint	01/01/2010	692.05	713.45	No	1 per 2 years

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L2034	Orthotic device	Knee-ankle-foot	KAFO pla sin up w/wo k/a cus	01/01/2010	1,419.88	1,463.79	No	1 per 2 years
L2035	Orthotic device	Knee-ankle-foot	KAFO, full plastic, stat. prefab. pediatric size	01/01/2010	110.68	114.10	No	1 per 2 years
L2036	Orthotic device	Knee-ankle-foot	KAFO Full Plastic Mold To Patient Model	01/01/2010	1,184.49	1,221.12	No	1 per 2 years
L2037	Orthotic device	Knee-ankle-foot	KAFO Plas Sgl Uprt Free Knee, Mold Model	01/01/2010	1,059.50	1,092.27	No	1 per 2 years
L2038	Orthotic device	Knee-ankle-foot	KAFO Plas W/ Knee Jt Mold Model Lively	01/01/2010	854.11	880.53	No	1 per 2 years
L2040	Orthotic device	Hip-knee-ankle-foot	HKAFO, Bilat Elastic Str.Pelv Band/Belt	01/01/2010	129.25	133.25	No	1 per year
L2050	Orthotic device	Hip-knee-ankle-foot	HKAFO, Bilat Torsion Cables,Hp Jt.Pelvic	01/01/2010	311.34	320.97	No	1 per year
L2060	Orthotic device	Hip-knee-ankle-foot	HKAFO,Bilat Cable, Ball/Bear Hip Jt	01/01/2010	389.41	401.45	No	1 per year
L2106	Orthotic device	Lower limb, fracture	AFO Frac.Orth.Tib.Cast Thermpla Type	01/01/2010	503.59	519.17	No	1 per medical event
L2108	Orthotic device	Lower limb, fracture	AFO Frac Ortho. Tib Frac.Cast Hold Mod.	01/01/2010	734.51	757.23	No	1 per medical event
L2112	Orthotic device	Lower limb, fracture	AFO Frac.Orth Tib Frac. Soft, Prefab	01/01/2010	322.32	332.29	No	1 per medical event
L2114	Orthotic device	Lower limb, fracture	AFO Frac.Orth Tib.Frac Semi Rigid Fit	01/01/2010	403.71	416.20	No	1 per medical event
L2116	Orthotic device	Lower limb, fracture	AFO Frac.Orth.Tib.Frac.Rig., Prefab	01/01/2010	492.44	507.67	No	1 per medical event
L2126	Orthotic device	Lower limb, fracture	KAFO Frac. Orth.Thermpla. Type Pt Mold	01/01/2010	815.82	841.05	No	1 per medical event
L2128	Orthotic device	Lower limb, fracture	KAFO Frac.Orth.Molded To Patient Model	01/01/2010	1,024.38	1,056.06	No	1 per medical event
L2132	Orthotic device	Lower limb, fracture	KAFO Frac Orth. Soft, Prefab	01/01/2010	621.78	641.01	Yes	1 per medical event
L2134	Orthotic device	Lower limb, fracture	KAFO Frac. Orth.Semi Rigid, Prefab	01/01/2010	736.26	759.03	Yes	1 per medical event
L2136	Orthotic device	Lower limb, fracture	KAFO Frac. Orth. Rigid, Prefab	01/01/2010	805.72	830.64	Yes	1 per medical event
L2180	Orthotic device	Lower limb, fracture, addition to orthosis	Add Low Extre. Frac. Plas. Shoe Insert	01/01/2010	84.69	87.31	No	1 per medical event
L2182	Orthotic device	Lower limb, fracture, addition to orthosis	Add Low Extre Frac. Orth.Drop Lock Kn.	01/01/2010	73.00	75.26	No	2 por orthosis
L2184	Orthotic device	Lower limb, fracture, addition to orthosis	Add Low Extre. Frac. Limit Mot. Kn. Jnt.	01/01/2010	74.00	76.29	Yes	2 por orthosis
L2186	Orthotic device	Lower limb, fracture, addition to orthosis	Add Low Extre. Frac. Adjust. Mot. Knee	01/01/2010	98.43	101.47	No	2 por orthosis
L2188	Orthotic device	Lower limb, fracture, addition to orthosis	Add Low Extreme Frac. Orth. Quan. Brim	01/01/2010	178.92	184.45	Yes	1 per orthosis
L2190	Orthotic device	Lower limb, fracture, addition to orthosis	Add Low Extrem. Erac. Orth. Waist Belt	01/01/2010	54.50	56.19	Yes	1 per year
L2192	Orthotic device	Lower limb, fracture, addition to orthosis	Add Low Extre. Frac Hip Jnt. Pelv. Belt	01/01/2010	213.01	219.60	No	1 per orthosis
L2200	Orthotic device	Lower limb, fracture, addition to orthosis	Limited Ankle Motion, Each Joint	01/01/2010	32.22	33.22	No	2 per year
L2210	Orthotic device	Lower limb, fracture, addition to orthosis	Doriflexion Assist (Plantar Flex Resist	01/01/2010	40.16	41.40	No	2 per year
L2220	Orthotic device	Lower limb, fracture, addition to orthosis	Doriflex And Plant/Flex Assist/Resist	01/01/2010	51.69	53.29	No	2 per year
L2230	Orthotic device	Lower limb, fracture, addition to orthosis	Split Flat Caliper Stirrups & Plate Attac	01/01/2010	61.12	63.01	No	1 per orthosis
L2240	Orthotic device	Lower limb, fracture, addition to orthosis	Round Caliper And Plate Attachment	01/01/2010	60.81	62.69	No	1 per year
L2250	Orthotic device	Lower limb, fracture, addition to orthosis	Foot Plate, Mlded To Pat,Stirrup Attach	01/01/2010	213.41	220.01	No	1 per orthosis
L2260	Orthotic device	Lower limb, fracture, addition to orthosis	Reinfor Solid Stirrup (Scott-Craig Type	01/01/2010	119.75	123.45	No	1 per orthosis
L2265	Orthotic device	Lower limb, fracture, addition to orthosis	Add On Lower Extrem Long Tongue Stirrup	01/01/2010	85.86	88.52	No	1 per orthosis
L2270	Orthotic device	Lower limb, fracture, addition to orthosis	Varus/Valgus "T"Strap,Padded/Lined	01/01/2010	39.38	40.60	No	2 per year
L2275	Orthotic device	Lower limb, fracture, addition to orthosis	Addition to Lower Extremity, Torsion Control, Ank. Jt.	01/01/2010	83.28	85.86	No	2 per orthosis
L2280	Orthotic device	Lower limb, fracture, addition to orthosis	Molded Inner Boot	01/01/2010	360.68	371.83	No	1 per 3 years
L2300	Orthotic device	Lower limb, fracture, addition to orthosis	Abd Bar (Bilateral) Jointed, Adjustable	01/01/2010	160.85	165.82	No	1 per 2 years
L2310	Orthotic device	Lower limb, fracture, addition to orthosis	Abduction Bar-Straight,Non-Adjustable	01/01/2010	73.50	75.77	No	1 per 2 years
L2320	Orthotic device	Lower limb, fracture, addition to orthosis	Non Molded Lacer	01/01/2010	123.23	127.04	No	1 per orthosis
L2330	Orthotic device	Lower limb, fracture, addition to orthosis	Lacer Molded To Patient Model	01/01/2010	234.57	241.82	No	1 per orthosis
L2335	Orthotic device	Lower limb, fracture, addition to orthosis	Add Low Extreme. Anter. Swing Band	01/01/2010	179.60	185.15	Yes	1 per orthosis
L2340	Orthotic device	Lower limb, fracture, addition to orthosis	Per-Tibial Shell, Mlded To Patient Model	01/01/2010	267.00	275.26	No	1 per orthosis
L2350	Orthotic device	Lower limb, fracture, addition to orthosis	Pros Type(Bk) Skt Mlded To Pat Model Ptb	01/01/2010	532.31	548.77	No	1 per orthosis

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L2360	Orthotic device	Lower limb, fracture, addition to orthosis	Extended Steel Shank	01/01/2010	32.96	33.98	No	2 per year
L2370	Orthotic device	Lower limb, fracture, addition to orthosis	Add Low Extreme. Patten Bottom	01/01/2010	204.48	210.80	No	1 per orthosis
L2375	Orthotic device	Lower limb, fracture, addition to orthosis	Add Low Extreme Torsi On Contr.Ank. Jnt.	01/01/2010	78.60	81.03	Yes	2 per orthosis
L2380	Orthotic device	Lower limb, fracture, addition to orthosis	Add Low Extrem.Tors.Contr.Knee Ea	01/01/2010	82.45	85.00	No	2 per orthosis
L2385	Orthotic device	Lower limb, fracture, addition to orthosis	Add Low Extre. Stra.Knee Jnt Heavy Duty	01/01/2010	93.88	96.78	No	2 per orthosis
L2390	Orthotic device	Lower limb, fracture, addition to orthosis	Add Low Extre.Offset Knee Jnt Ea Jnt	01/01/2010	65.39	67.41	No	2 per orthosis
L2395	Orthotic device	Lower limb, fracture, addition to orthosis	Add Low Extrem. Offset Knee Heavy Duty	01/01/2010	93.47	96.36	No	2 per orthosis
L2397	Orthotic device	Lower limb, fracture, addition to orthosis	Addition to Lower Extremity, Orthosis, Suspen. Sleeve	01/01/2010	77.99	80.40	No	4 per year
L2405	Orthotic device	Knee joint, addition to orthosis	Add Knee Jnt.Drop Lock Ea.Jnt.	01/01/2010	40.54	41.79	No	2 per year
L2415	Orthotic device	Knee joint, addition to orthosis	Add Knee Lock W/Integrated Release MechEa Jnt	01/01/2010	93.85	96.75	No	2 per orthosis
L2425	Orthotic device	Knee joint, addition to orthosis	Add Knee Jnt Disc Dial Lock Adjust Knee	01/01/2010	110.73	114.15	No	2 per orthosis
L2430	Orthotic device	Knee joint, addition to orthosis	Add Low Extrem, orthosis, incr lock at knee joint	01/01/2010	62.82	64.76	No	2 per orthosis
L2492	Orthotic device	Knee joint, addition to orthosis	Add Knee Jnt. Lift Loop Drop Lock Ring	01/01/2010	74.93	77.25	No	1 per orthosis
L2500	Orthotic device	Thigh, addition to orthosis	Gluteal/Ischial Wt Bearing ,Ring	01/01/2010	199.94	206.12	No	1 per orthosis
L2510	Orthotic device	Thigh, addition to orthosis	Quadrilateral Brim, Mlded To Patient Mod	01/01/2010	515.28	531.22	No	1 per orthosis
L2520	Orthotic device	Thigh, addition to orthosis	Quarilateral Brim, Custom Fitted	01/01/2010	343.40	354.02	No	1 per orthosis
L2525	Orthotic device	Thigh, addition to orthosis	Add On L Ext I Cont/Ml Brim Pt Model	01/01/2010	728.22	750.74	No	1 per orthosis
L2526	Orthotic device	Thigh, addition to orthosis	Add On Ext L Cont/Ml Brim Custom Fit	01/01/2010	409.18	421.84	Yes	1 per orthosis
L2530	Orthotic device	Thigh, addition to orthosis	Lacer, Non-Molded	01/01/2010	153.22	157.96	No	1 per orthosis
L2540	Orthotic device	Thigh, addition to orthosis	Lacer, Molded To Patient Model	01/01/2010	289.92	298.89	No	1 per orthosis
L2550	Orthotic device	Thigh, addition to orthosis	High Roll Cuff	01/01/2010	217.39	224.11	No	1 per orthosis
L2570	Orthotic device	Pelvic and thoracic control, addition to orthosis	2 Postion Locking Hip Joint	01/01/2010	284.54	293.34	No	1 per orthosis
L2580	Orthotic device	Pelvic and thoracic control, addition to orthosis	Pelvic/Buttock Bands/Sling,Bilateral	01/01/2010	277.26	285.83	No	1 per 2 years
L2600	Orthotic device	Pelvic and thoracic control, addition to orthosis	Pelv Contrl,Hp Jt,Clevis Type, Free,Each	01/01/2010	136.26	140.47	No	1 per orthosis
L2610	Orthotic device	Pelvic and thoracic control, addition to orthosis	Pelv Control, Hp Jt, Clevis, Lock,Each	01/01/2010	150.57	155.23	No	1 per orthosis
L2620	Orthotic device	Pelvic and thoracic control, addition to orthosis	Pelv Contrl, Hp Jt, Heavy Duty, Each	01/01/2010	159.73	164.67	No	1 per orthosis
L2622	Orthotic device	Pelvic and thoracic control, addition to orthosis	Add Low Extrem Pelvic Contr.Hip Jnt Ea	01/01/2010	203.30	209.59	No	1 per orthosis
L2624	Orthotic device	Pelvic and thoracic control, addition to orthosis	Add Low Extrem.Pelvic Contr.Abduccon Ea.	01/01/2010	249.28	256.99	No	1 per orthosis
L2627	Orthotic device	Pelvic and thoracic control, addition to orthosis	Add L Ext Rgo Plastic Pelvic Hip Jt Cabl	01/01/2010	1,365.48	1,407.71	No	1 set per 2 years
L2628	Orthotic device	Pelvic and thoracic control, addition to orthosis	Add Rgo Metal Pelvic & Hips & Cables	01/01/2010	1,000.88	1,031.83	No	1 set per 2 years
L2630	Orthotic device	Pelvic and thoracic control, addition to orthosis	Pelv Contrl, Band & Belt, Unilateral	01/01/2010	147.93	152.50	No	1 per orthosis
L2640	Orthotic device	Pelvic and thoracic control, addition to orthosis	Pelv Contrl,Band & Belt, Bilateral	01/01/2010	200.76	206.97	No	1 per 2 years
L2650	Orthotic device	Pelvic and thoracic control, addition to orthosis	Pelv & Thoracic Contrl,Gluteal Pad, Each	01/01/2010	88.42	91.15	No	1 per 2 years
L2660	Orthotic device	Pelvic and thoracic control, addition to orthosis	Thoracic Control, Thoracic Band	01/01/2010	114.48	118.02	No	1 per 2 years
L2680	Orthotic device	Pelvic and thoracic control, addition to orthosis	Thoracic Control, Lateral Supp Uprights	01/01/2010	93.48	96.37	No	1 set per 2 years
L2755	Orthotic device	General, addition to orthosis	Add Low Extrem Orthosis,Hi-Str, Lt-Wt Mat	01/01/2010	83.49	86.07	No	4 per year
L2760	Orthotic device	General, addition to orthosis	Extension, Per Bar (Adj For Growth)	01/01/2010	36.30	37.42	No	4 per year
L2785	Orthotic device	General, addition to orthosis	Add Low Extre Orth. Drop Lock Retain Ea	01/01/2010	18.93	19.52	No	2 per year
L2795	Orthotic device	General, addition to orthosis	Add Low Extreme Orth Knee Contr. Full	01/01/2010	52.37	53.99	No	1 per year
L2800	Orthotic device	General, addition to orthosis	Add Low Extrem.Orth.Knee Contr.Knee Cap	01/01/2010	64.35	66.34	No	1 per orthosis
L2810	Orthotic device	General, addition to orthosis	Add Low Extrem.Orth.Knee Condylar Pad	01/01/2010	52.18	53.79	No	1 per year
L2820	Orthotic device	General, addition to orthosis	Add Low Extrem.Orth.Soft Interface Mold	01/01/2010	51.88	53.48	No	1 per year
L2830	Orthotic device	General, addition to orthosis	Add Low Extre. Orth Soft Above Knee Sec	01/01/2010	56.12	57.86	No	1 per year

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L2840	Orthotic device	General, addition to orthosis	Add On Tibial Length Fracture Sock Each	01/01/2010	27.56	28.41	No	3 per year
L2850	Orthotic device	General, addition to orthosis	Add On Femoral Length Fracture Sock,Each	01/01/2010	38.64	39.84	No	3 per medical event
L2999	Orthotic device	General, addition to orthosis	Lower Extremity Orthosis, NOS	10/01/1988	PA		Yes	
L3000	Orthopedic footwear and modification	Foot	Insert, Remov, Mlded To Pat Mod,Ucb Type	01/01/2010	134.48	138.64	No	1 per foot per 2 years
L3001	Orthopedic footwear and modification	Foot	Insert, Remov,Mlded To Pat Mod,Spenco,Ea	01/01/2010	12.19	12.57	No	2 per foot per year
L3002	Orthopedic footwear and modification	Foot	Insert,Remov,Mlded To Pat, Plastazote,Ea	01/01/2010	64.08	66.06	No	2 per foot per year
L3010	Orthopedic footwear and modification	Foot	Ins,Remov,Mld/Pat,Longitud Arch Supp, Ea	01/01/2010	96.11	99.08	No	1 per foot per 2 years
L3020	Orthopedic footwear and modification	Foot	Ins,Remov,Mld/Pat,Long/Metatar Supp,Ea	01/01/2010	102.52	105.69	No	1 per foot per 2 years
L3030	Orthopedic footwear and modification	Foot	Ins,Remov, Formed To Pat Foot, Each	01/01/2010	66.97	69.04	No	2 per foot per year
L3040	Orthopedic footwear and modification	Foot	Arch Supp, Remov, Premld, Longitud, Each	01/01/2010	12.81	13.21	No	2 per foot per year
L3050	Orthopedic footwear and modification	Foot	Arch Supp, Remov, Premld, Metatarsal, Ea	01/01/2010	12.81	13.21	No	2 per foot per year
L3060	Orthopedic footwear and modification	Foot	Arch Supp/Rem, Premld, Long/Metatar, Ea	01/01/2010	34.30	35.36	No	2 per foot per year
L3100	Orthopedic footwear and modification	Foot	Hallus-Valgus Night Dynamic Splint	01/01/2010	25.63	26.42	No	1 per medical event
L3140	Orthopedic footwear and modification	Foot	Abd/Rot Bars(Dennis Browne) ,Att To Shoe	01/01/2010	38.44	39.63	No	2 per year
L3150	Orthopedic footwear and modification	Foot	Abd/Rot Bars(Dennis Browne)Clapped To Sh	01/01/2010	43.81	45.17	No	2 per foot per year
L3160	Orthopedic footwear and modification	Foot	Foot, Adjust. Shoe-Styled Positioning Device	01/01/2010	96.11	99.08	Yes	2 per orthosis
L3170	Orthopedic footwear and modification	Foot	Plastic Heel Stabilizer	01/01/2010	10.25	10.57	No	2 per foot per year
L3201	Orthopedic footwear and modification	Orthopedic shoes	Orthopedic Shoe Oxford Supin Infant	01/01/2010	55.38	57.09	No	3 pairs per year
L3202	Orthopedic footwear and modification	Orthopedic shoes	Orthopedic Shoe Oxford Child	01/01/2010	55.38	57.09	No	3 pairs per year
L3203	Orthopedic footwear and modification	Orthopedic shoes	Orthopedic Shoes Oxford Junior	01/01/2010	57.67	59.45	No	3 pairs per year
L3204	Orthopedic footwear and modification	Orthopedic shoes	Orthopedic Shoes Hightop Infant	01/01/2010	57.67	59.45	No	3 pairs per year
L3206	Orthopedic footwear and modification	Orthopedic shoes	Orthopedic Shoes Hightop Child	01/01/2010	54.24	55.92	No	3 pairs per year
L3207	Orthopedic footwear and modification	Orthopedic shoes	Orthopedic Shoes Hightop Junior	01/01/2010	53.12	54.76	No	3 pairs per year
L3208	Orthopedic footwear and modification	Orthopedic shoes	Surgical Boot Each Infant	01/01/2010	26.91	27.74	No	2 per foot per year
L3209	Orthopedic footwear and modification	Orthopedic shoes	Surgical Boot Each Child	01/01/2010	26.91	27.74	No	2 per foot per year
L3211	Orthopedic footwear and modification	Orthopedic shoes	Surgical Boot Each Junior	01/01/2010	26.91	27.74	No	2 per foot per year
L3215	Orthopedic footwear and modification	Orthopedic shoes	Ortho Footwear, Ladies Shoes, Oxford	01/01/2010	90.40	93.20	No	2 pairs per year
L3216	Orthopedic footwear and modification	Orthopedic shoes	Orthopedic Shoes Ladies Depth Inlay	01/01/2010	102.52	105.69	Yes	2 pairs per year
L3217	Orthopedic footwear and modification	Orthopedic shoes	Orthopedic Shoes Ladies Hightop Dpth Inl	01/01/2010	114.05	117.58	No	2 pairs per year
L3219	Orthopedic footwear and modification	Orthopedic shoes	Ortho Footwear, Mens Shoes, Oxford	01/01/2010	90.40	93.20	No	2 pairs per year
L3221	Orthopedic footwear and modification	Orthopedic shoes	Orthopedic Mens Shoes Depth Inlay	01/01/2010	112.77	116.26	Yes	2 pairs per year
L3222	Orthopedic footwear and modification	Orthopedic shoes	Orthopedic Mens Shoes Hightop Dpt Inlay	01/01/2010	117.89	121.54	No	2 pairs per year
L3224	Orthopedic footwear and modification	Orthopedic shoes	Orthopedic footwear, woman's oxford, part of brace	01/01/2010	43.17	44.51	No	1 per foot per year
L3225	Orthopedic footwear and modification	Orthopedic shoes	Orthopedic footwear, men's shoe, oxford, part of brace	01/01/2010	47.15	48.61	No	1 per foot per year
L3230	Orthopedic footwear and modification	Orthopedic shoes	Orthopedic Custom Shoes Depth Inlay	09/01/2011	160.19	320.37	Yes	1 per foot per year
L3251	Orthopedic footwear and modification	Orthopedic shoes	Foot Shoe Molded To Patient Silic Ea	01/01/2010	160.19	165.14	No	1 per foot per year
L3252	Orthopedic footwear and modification	Orthopedic shoes	Custom Made Shoe/Made Over Pat Model	01/01/2010	84.76	87.38	No	1 per foot per year
L3253	Orthopedic footwear and modification	Orthopedic shoes	Foot Molded Shoe Plastazote Cus Fit Ea	01/01/2010	64.08	66.06	No	1 per foot per year
L3257	Orthopedic footwear and modification	Orthopedic shoes	Orthopedic Shoes Split Size Mismates	01/01/2010	138.57	142.86	No	2 pairs per year (adult)
L3300	Orthopedic footwear and modification	Lift	Elevat,Heel Tapered To Metar/Per Inch	01/01/2010	43.57	44.92	No	2 modifications per year
L3310	Orthopedic footwear and modification	Lift	Elevat, Heel&Sole,Neoprene/Per Inch	01/01/2010	51.25	52.84	No	2 modifications per year
L3320	Orthopedic footwear and modification	Lift	Elevat, Heel & Sole, Cork, Per Inch	01/01/2010	64.08	66.06	No	2 modifications per year
L3332	Orthopedic footwear and modification	Lift	Elevat,Inside Shoe,Tapered,Up To 1/2 In	01/01/2010	25.79	26.59	No	2 modifications per year

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L3334	Orthopedic footwear and modification	Lift	Elevation, Heel Per Inch	01/01/2010	30.12	31.05	No	2 modifications per year
L3340	Orthopedic footwear and modification	Wedge	Heel Wedge, Sach	01/01/2010	19.22	19.81	No	4 wedges per year
L3350	Orthopedic footwear and modification	Wedge	Heel Wedge	01/01/2010	10.25	10.57	No	4 wedges per year
L3360	Orthopedic footwear and modification	Wedge	Sole Wedge, Outside Sole	01/01/2010	17.95	18.50	No	4 wedges per year
L3370	Orthopedic footwear and modification	Wedge	Sole Wedge, Between Sole	01/01/2010	26.91	27.74	No	4 wedges per year
L3380	Orthopedic footwear and modification	Wedge	Clubfoot Wedge	01/01/2010	15.82	16.31	No	4 wedges per year
L3390	Orthopedic footwear and modification	Wedge	Outflare Wedge	01/01/2010	26.91	27.74	No	4 wedges per year
L3400	Orthopedic footwear and modification	Wedge	Metatarsal Bar Wedge, Rocker	01/01/2010	32.04	33.03	No	4 wedges per year
L3410	Orthopedic footwear and modification	Wedge	Metatarsal Bar Wedge, Between Sole	01/01/2010	37.17	38.32	No	4 wedges per year
L3420	Orthopedic footwear and modification	Wedge	Full Sole And Heel Wedge, Between Sole	01/01/2010	43.57	44.92	No	4 wedges per year
L3430	Orthopedic footwear and modification	Heel	Heel, Counter, Plastic Reinforced	01/01/2010	38.44	39.63	No	2 heels per year
L3440	Orthopedic footwear and modification	Heel	Heel, Counter, Leather Reinforced	01/01/2010	33.19	34.22	No	2 heels per year
L3455	Orthopedic footwear and modification	Heel	Heel, New Leather, Standard	01/01/2010	15.38	15.86	No	2 heels per year
L3460	Orthopedic footwear and modification	Heel	Heel. New Rubber, Standard	01/01/2010	14.09	14.53	No	2 heels per year
L3465	Orthopedic footwear and modification	Heel	Heel, Thomas With Wedge	01/01/2010	17.64	18.19	No	2 heels per year
L3470	Orthopedic footwear and modification	Heel	Heel, Thomas Extended To Ball	01/01/2010	37.30	38.45	No	2 heels per year
L3480	Orthopedic footwear and modification	Heel	Heel, Pad And Depression For Spur	01/01/2010	19.22	19.81	No	2 per foot per year
L3500	Orthopedic footwear and modification	Miscellaneous shoe addition	Misc. Shoe Add, Insole, Leather	01/01/2010	16.65	17.17	No	2 insoles per year
L3510	Orthopedic footwear and modification	Miscellaneous shoe addition	Misc Shoe Add, Insole, Rubber	01/01/2010	11.59	11.95	No	2 insoles per year
L3520	Orthopedic footwear and modification	Miscellaneous shoe addition	Misc Shoe Add, Insole, Felt Cov/Leather	01/01/2010	22.39	23.08	No	2 insoles per year
L3530	Orthopedic footwear and modification	Miscellaneous shoe addition	Misc Shoe Additions, Sole, Half	01/01/2010	19.33	19.93	No	2 half soles per year [for ODM-authorized shoes]
L3540	Orthopedic footwear and modification	Miscellaneous shoe addition	Misc Shoe Additions, Sole, Full	01/01/2010	23.85	24.59	No	2 full soles per year [for ODM-authorized shoes]
L3550	Orthopedic footwear and modification	Miscellaneous shoe addition	Misc Shoe Add, Toe Tap, Standard	01/01/2010	5.13	5.29	No	4 taps per year
L3570	Orthopedic footwear and modification	Miscellaneous shoe addition	Misc Modified Gusset (Leather W/Eye)	01/01/2010	69.16	71.30	No	4 per year (adults), 6 per year (children) [for ODM-authorized shoes]
L3580	Orthopedic footwear and modification	Miscellaneous shoe addition	Misc Shoe Add, Conv Instep To Velcro Cls	01/01/2010	25.63	26.42	No	4 per year (adults), 6 per year (children)
L3595	Orthopedic footwear and modification	Miscellaneous shoe addition	Misc Shoe Additions, March Bar	01/01/2010	32.04	33.03	No	4 bars per year
L3600	Orthopedic footwear and modification	Transfer	Trans Of Orth/Fr Shoes,Caliper Existing	01/01/2010	37.44	38.60	No	2 transfers per orthosis per year
L3610	Orthopedic footwear and modification	Transfer	Trans Orth/Between Shoes, New Caliper Pl	01/01/2010	57.67	59.45	No	2 transfers per orthosis per year
L3620	Orthopedic footwear and modification	Transfer	Trans Orthosis/Shoes,Solid Stirrup Exist	01/01/2010	48.56	50.06	No	2 transfers per orthosis per year
L3630	Orthopedic footwear and modification	Transfer	Trans Orthosis/Shoes,New Solid Stirrup	01/01/2010	63.26	65.22	No	2 transfers per orthosis per year
L3649	Orthopedic footwear and modification	Miscellaneous procedure	Unlisted Proc For Ortho Shoe,Modif&Trans	10/01/1988	PA		Yes	
L3650	Orthotic device	Shoulder	SO, Figure '8' Design Abd Restrainer	01/01/2010	41.90	43.20	No	1 per medical event
L3670	Orthotic device	Shoulder	SO,Acromio/Clavicular (Canv&Web Type)	01/01/2010	66.10	68.14	No	1 per medical event
L3674	Orthotic device	Shoulder	Shoulder orthosis, abd pos, thoracic	01/01/2011	778.74		No	1 per medical event
L3675	Orthotic device	Shoulder	SO, vest type abduction restrainer, canvas or equal	01/01/2010	118.84	122.52	No	1 per medical event
L3710	Orthotic device	Elbow	EO, Plastic With Metal Joints	01/01/2010	83.03	85.60	No	2 per year
L3720	Orthotic device	Elbow	EO, Dbl Up W/Forearm/Arm Cuff,Free Motion	01/01/2010	397.27	409.56	No	1 per 2 years
L3730	Orthotic device	Elbow	EO, Dbl Up W/Forearm/Arm Cuff,F/E Assist	01/01/2010	526.97	543.27	No	1 per 2 years
L3740	Orthotic device	Elbow	EO/Forearm-Arm Cuff-Active Contrl Lock	01/01/2010	624.77	644.09	No	1 per 2 years
L3760	Orthotic device	Elbow	EO/Adjustable Posistion Locking Joint, Prefabricated	01/01/2010	285.67	294.51	No	1 per 2 years
L3763	Orthotic device	Elbow	EWHO rigid w/o jnts CF	12/07/2010	493.34	764.50	No	1 per 2 years
L3764	Orthotic device	Elbow	EWHO w/joint(s) CF	12/07/2010	516.30	809.54	No	1 per 2 years
L3807	Orthotic device	Wrist-hand-finger	WHFO, Without Joints, Prefab	04/01/2009	147.26	NC	No	1 per 2 years

HCPCS CODE	CATEGORY	APPLICATION	DESCRIPTION	EFFECTIVE DATE	CURRENT MAXIMUM PAYMENT AMOUNT	PREVIOUS MAXIMUM PAYMENT AMOUNT	NEED FOR PRIOR AUTHORIZA-TION	LIMIT
L3808	Orthotic device	Wrist-hand-finger	WHFO, rigid w/o joints	01/01/2010	168.26	173.46	No	1 per 2 years
L3900	Orthotic device	Wrist-hand-finger	WHFO,Dyn Flex Hng,Wrist Driven	01/01/2010	941.93	971.06	No	1 per 2 years
L3901	Orthotic device	Wrist-hand-finger	WHFO,Dyn Flex Hng, Cable Driven	01/01/2010	1,234.46	1,272.64	No	1 per 2 years
L3906	Orthotic device	Wrist-hand-finger	WHFO, Wrist(Gauntlet) Mld To Pat Model	01/01/2010	294.66	303.77	No	1 per medical event
L3908	Orthotic device	Wrist-hand-finger	WHFO,Wrist Ext Cont (Cock-Up) Non/Mlded	01/01/2010	43.66	45.01	No	1 per 180 days
L3912	Orthotic device	Wrist-hand-finger	WHFO, Flex Glove W/Elastic Finger Contrl	01/01/2010	61.27	63.16	No	1 per 2 years
L3923	Orthotic device	Wrist-hand-finger	HFO, w/o joint(s), prefabricated, any type	01/01/2010	27.65	28.51	No	1 per medical event
L3925	Orthotic device	Wrist-hand-finger	Finger Orthosis, prox, PIP	01/01/2010	39.04	40.25	No	1 per medical event
L3929	Orthotic device	Wrist-hand-finger	Hand Finger Orthosis	01/01/2010	66.19	68.24	No	1 per medical event
L3931	Orthotic device	Wrist-hand-finger	Wrist Hand Finger Orthosis	01/01/2010	142.53	146.94	No	1 per medical event
L3956	Orthotic device	Wrist-hand-finger	Add Joint Upper Extrem Orthosis, any mat. per joint	01/01/2010	187.75	193.56	No	1 per medical event
L3960	Orthotic device	Shoulder-elbow-wrist-hand	Sewho,Abd Posit, Airplane Design	01/01/2010	463.75	478.09	No	1 per medical event
L3971	Orthotic device	Shoulder-elbow-wrist-hand	SEWHO cap design w/jnt(s) CF	01/01/2010	975.27	1,005.43	No	1 per 2 years
L3980	Orthotic device	Upper limb, fracture	Fx Orthosis, Humeral	01/01/2010	224.94	231.90	No	1 per medical event
L3982	Orthotic device	Upper limb, fracture	Fx Orth, Radius/Ulnar	01/01/2010	228.40	235.46	No	1 per medical event
L3984	Orthotic device	Upper limb, fracture	Fx Orthosis, Wrist	01/01/2010	201.21	207.43	No	1 per medical event
L3995	Orthotic device	Upper limb, fracture	Add On Upper Extremity Fracture Sock, Ea	01/01/2010	23.88	24.62	No	3 per medical event
L3999	Orthotic device	Upper limb, fracture	Unlisted Procedures For Upper Limb Orth	10/01/1988	PA		Yes	
L4000	Orthotic device	Specific repair or replacement, including parts and labor	Replace Girdle For Spinal Orthosis	01/01/2010	844.25	870.36	Yes	1 per 4 years
L4010	Orthotic device	Specific repair or replacement, including parts and labor	Replace Trilateral Socket Brim	01/01/2010	513.16	529.03	Yes	1 per lifetime
L4020	Orthotic device	Specific repair or replacement, including parts and labor	Replace Quad/Socket Brim,Mld To Pat Modl	01/01/2010	616.43	635.49	Yes	1 per 2 years
L4030	Orthotic device	Specific repair or replacement, including parts and labor	Replace Quad/Socket Brim, Custom Fitted	01/01/2010	391.73	403.85	Yes	1 per 2 years
L4040	Orthotic device	Specific repair or replacement, including parts and labor	Replace Molded Thigh Lacer	01/01/2010	265.30	273.50	No	1 per 2 years
L4045	Orthotic device	Specific repair or replacement, including parts and labor	Replace Non-Molded Thigh Lacer	01/01/2010	195.96	202.02	No	1 per 2 years
L4050	Orthotic device	Specific repair or replacement, including parts and labor	Replace Molded Calf Lacer	01/01/2010	262.73	270.86	Yes	1 per 2 years
L4055	Orthotic device	Specific repair or replacement, including parts and labor	Replace Non-Molded Calf Lacer	01/01/2010	159.70	164.64	No	1 per 2 years
L4060	Orthotic device	Specific repair or replacement, including parts and labor	Replace High Roll Cuff	01/01/2010	211.11	217.64	No	1 per 2 years
L4070	Orthotic device	Specific repair or replacement, including parts and labor	Replace Prox & Dist Upright Kafo	01/01/2010	183.88	189.57	No	1 per 2 years
L4080	Orthotic device	Specific repair or replacement, including parts and labor	Replace Metal Bands Kafo, Prox Thigh	01/01/2010	64.32	66.31	No	1 per 2 years
L4090	Orthotic device	Specific repair or replacement, including parts and labor	Replace Bands,Kafo-Afo,Distal Thi/Calf	01/01/2010	53.98	55.65	No	1 per 2 years
L4100	Orthotic device	Specific repair or replacement, including parts and labor	Replace Leather Cuff Kafo, Prox Thigh	01/01/2010	64.88	66.89	No	1 per 2 years
L4110	Orthotic device	Specific repair or replacement, including parts and labor	Repl Leather Cuff Kafo-Afo,Calf/Dist Thg	01/01/2010	50.66	52.23	No	1 per 2 years
L4130	Orthotic device	Specific repair or replacement, including parts and labor	Replace Retibial Shell	01/01/2010	306.22	315.69	No	1 per 2 years
L4205	Orthotic device	Repair	Repair of Orthotic Device, labor, per 15 minutes	01/01/2010	10.67	11.00	No	1 per 120 days
L4210	Orthotic device	Repair	Repair or Replace Minor Parts of Orthotic Device	01/01/2006	Supplier charge (without PA), PA (with PA)		No if < $120 and within time limit, Yes otherwise	1 per 120 days
L4350	Orthotic device	Splint	Pneumatic Ankle Control Splint Air Cast	01/01/2010	61.83	63.74	No	1 per medical event
L4360	Orthotic device	Splint	Pneumatic Walking Splint Aircast Or Equa	01/01/2010	165.41	170.53	Yes	1 per medical event
L4370	Orthotic device	Splint	Pneumatic Full Leg Splint Aircast Or Eq	01/01/2010	150.37	155.02	No	1 per medical event
L4386	Orthotic device	Splint	Non-pneumatic walking splint	01/01/2010	99.06	102.12	No	1 per medical event
L4392	Orthotic device	Splint	Repl Soft Int-face Mat Static AFO	01/01/2010	15.04	15.50	No	1 per medical event
L4396	Orthotic device	Splint	Static AFO incl soft intface mat; Adjustable; Prefab	01/01/2010	107.22	110.54	No	1 per medical event
L4631	Orthotic device	Splint	Ankle foot orthosis, walking boot type, rocker bottom	01/01/2011	1,066.77		Yes	1 per medical event
L5000	Prosthetic device	Lower limb	P/F,Shoe Insw/Longitud Arch, Toe Filler	01/01/2010	366.87	378.22	No	1 per 4 years

HCPCS CODE	CATEGORY	APPLICATION	DESCRIPTION	EFFECTIVE DATE	CURRENT MAXIMUM PAYMENT AMOUNT	PREVIOUS MAXIMUM PAYMENT AMOUNT	NEED FOR PRIOR AUTHORIZA-TION	LIMIT
L5010	Prosthetic device	Lower limb	P/F,Ankle Height With Toe Filler	01/01/2010	1,025.10	1,056.80	No	1 per 4 years
L5020	Prosthetic device	Lower limb	P/F, Tibial Tubercle Height	01/01/2010	1,605.99	1,655.66	No	1 per 4 years
L5050	Prosthetic device	Lower limb	Symes, Molded Socket, Sach Foot	01/01/2010	1,754.04	1,808.29	No	1 per 4 years
L5060	Prosthetic device	Lower limb	Symes,Metal Fr,Mld Leath Sock,Art/Foot	01/01/2010	2,162.23	2,229.10	Yes	1 per 4 years
L5100	Prosthetic device	Lower limb	Molded Socket, Shin, Sach Foot	01/01/2010	1,746.54	1,800.56	No	1 per 4 years
L5105	Prosthetic device	Lower limb	Bk Plastic Sock Jts Thi Lacer Sach Foot	01/01/2010	2,464.74	2,540.97	Yes	1 per 4 years
L5150	Prosthetic device	Lower limb	Mld Sock,Ext Knee Jts,Shin,Sach Foot	01/01/2010	2,740.21	2,824.96	Yes	1 per 4 years
L5160	Prosthetic device	Lower limb	Mld Sock,Bent Knee Config,Ext Kn Jts,Shn	01/01/2010	3,008.61	3,101.66	Yes	1 per 4 years
L5200	Prosthetic device	Lower limb	Mld Skt,Sing Ax,Cons Frict Kn,Sach Foot	01/01/2010	2,326.94	2,398.91	No	1 per 4 years
L5210	Prosthetic device	Lower limb	Short Pros,No Kn/Ank Jt"Stubbies"W/Ft Bl	01/01/2010	1,847.59	1,904.73	No	1 per 4 years
L5220	Prosthetic device	Lower limb	Above Knee Short Prost W Articu Ank +Ft	01/01/2010	2,035.24	2,098.19	No	1 per 4 years
L5230	Prosthetic device	Lower limb	Pffd Ak Pros, Cons Frict Kn/Sach Foot	01/01/2010	3,052.57	3,146.98	No	1 per 4 years
L5250	Prosthetic device	Lower limb	Canad Type,Mld Sock,Hp Jt ,1 Axis/Frict/K	01/01/2010	3,579.21	3,689.91	No	1 per 4 years
L5280	Prosthetic device	Lower limb	Hemipelvectomy, Canadian Type,Mld Skt,Hp	01/01/2010	3,876.41	3,996.30	Yes	1 per 4 years
L5301	Prosthetic device	Lower limb	B/K Mld Skt, Shin, Sach, Endo system	01/01/2010	2,073.45	2,137.58	Yes	1 per 4 years
L5321	Prosthetic device	Lower limb	A/K Mld Skt, Open End, Endo Sys, Single Axis	01/01/2010	2,764.88	2,850.39	Yes	1 per 4 years
L5331	Prosthetic device	Lower limb	Canad Type,Endo Sys,Hp Jt,Sach,Sing Axis	01/01/2010	4,049.55	4,174.79	Yes	1 per 4 years
L5341	Prosthetic device	Lower limb	Hemipelvect, Canad Type, Endo Sys, Hip Joint, Sach Foot	01/01/2010	4,304.60	4,437.73	Yes	1 per 4 years
L5400	Prosthetic device	Immediate post-surgiery or early fitting	B/K,Post Surg,Initial,Incl One Cast Chg	01/01/2010	1,021.32	1,052.91	Yes	1 per amputation
L5410	Prosthetic device	Immediate post-surgiery or early fitting	B/K,Immed/Fit,Each Additional Cast Chang	01/01/2010	282.16	290.89	Yes	1 per amputation
L5420	Prosthetic device	Immediate post-surgiery or early fitting	A/K,Kn/Dis,Init Fit,Align Incl 1 Cast Ch	01/01/2010	1,289.89	1,329.78	Yes	1 per amputation
L5430	Prosthetic device	Immediate post-surgiery or early fitting	Imm post Surg Rigid Dress Ea Cast Change	01/01/2010	350.13	360.96	Yes	1 per amputation
L5510	Prosthetic device	Preparatory prosthesis	PTB, plastic socket, molded to model	01/01/2010	1,377.79	1,420.40	Yes	Medical justification
L5535	Prosthetic device	Preparatory prosthesis	PTB, prefabricated, open end socket	01/01/2010	1,513.49	1,560.30	No	Medical justification
L5540	Prosthetic device	Preparatory prosthesis	PTB, laminated socket, molded to model	01/01/2010	1,603.02	1,652.60	No	Medical justification
L5560	Prosthetic device	Preparatory prosthesis	Prep, above knee, plaster socket, molded to model	01/01/2010	1,826.51	1,883.00	Yes	Medical justification
L5580	Prosthetic device	Preparatory prosthesis	Prep, above knee, thermoplastic or equal, molded to model	01/01/2010	2,200.15	2,268.20	No	Medical justification
L5585	Prosthetic device	Preparatory prosthesis	Prep, above knee, prefabricated adjustable open end socket	01/01/2010	2,576.61	2,656.30	Yes	Medical justification
L5590	Prosthetic device	Preparatory prosthesis	Prep, above knee, laminated socket, molded to model	01/01/2010	2,293.95	2,364.90	No	Medical justification
L5595	Prosthetic device	Preparatory prosthesis	Prep Hd Thermoplastic Of Equal Mld Model	01/01/2010	2,933.02	3,023.73	Yes	1 per amputation
L5600	Prosthetic device	Preparatory prosthesis	Prep Hd Laminated Socket Molded Pt Model	01/01/2010	3,338.21	3,441.45	Yes	1 per amputation
L5610	Prosthetic device	Addition to lower limb	Above Knee, Hydracadence	01/01/2010	1,610.00	1,659.79	Yes	1 per 4 years
L5611	Prosthetic device	Addition to lower limb	Add On Ak/Kd Ohc 4-Bar Frict Swing Cntrl	01/01/2010	1,025.44	1,057.15	No	1 per 4 years
L5613	Prosthetic device	Addition to lower limb	Add Ak/Kd Ohc 4-Bar Hydraulic Swing Ctrl	01/01/2010	1,559.75	1,607.99	No	1 per 4 years
L5614	Prosthetic device	Addition to lower limb	Add to Lower Extremity, K-K Dis., 4-Bar Link w/ PSPC	01/01/2010	1,080.22	1,113.63	No	1 per 4 years
L5616	Prosthetic device	Addition to lower limb	A/K Univ Multiplex Sys,Friction Sw/Phase	01/01/2010	940.49	969.58	No	1 per 4 years
L5617	Prosthetic device	Addition to lower limb	Addition to Lower Extremity, Quick Change, Self Align.	01/01/2010	358.18	369.26	No	1 per 4 years
L5618	Prosthetic device	Addition to lower limb	Test Socket, Symes	01/01/2010	213.89	220.50	No	1 per preparatory prosthesis, 2 per definitive prosthesis
L5620	Prosthetic device	Addition to lower limb	Test Socket, Below Knee	01/01/2010	189.77	195.64	No	1 per preparatory prosthesis, 2 per definitive prosthesis
L5622	Prosthetic device	Addition to lower limb	Test Socket, Knee Disarticulation	01/01/2010	255.66	263.57	No	1 per preparatory prosthesis, 2 per definitive prosthesis
L5624	Prosthetic device	Addition to lower limb	Test Socket,Above Knee	01/01/2010	255.59	263.49	No	1 per preparatory prosthesis, 2 per definitive prosthesis
L5626	Prosthetic device	Addition to lower limb	Test Socket, Hip Disartiulation	01/01/2010	404.60	417.11	No	1 per preparatory prosthesis, 2 per definitive prosthesis
L5628	Prosthetic device	Addition to lower limb	Test Socket, Hemipelvectomy	01/01/2010	409.72	422.39	No	1 per preparatory prosthesis, 2 per definitive prosthesis

HCPCS CODE	CATEGORY	APPLICATION	DESCRIPTION	EFFECTIVE DATE	CURRENT MAXIMUM PAYMENT AMOUNT	PREVIOUS MAXIMUM PAYMENT AMOUNT	NEED FOR PRIOR AUTHORIZA-TION	LIMIT
L5629	Prosthetic device	Addition to lower limb	Add On Bk Acrylic Socket	01/01/2010	202.26	208.52	No	1 per prosthesis
L5630	Prosthetic device	Addition to lower limb	Symes Type,Expandable Wall Socket	01/01/2010	351.43	362.30	No	1 per 4 years
L5631	Prosthetic device	Addition to lower limb	Add On Ak/Kd Acrylic Socket	01/01/2010	279.65	288.30	No	1 per prosthesis
L5632	Prosthetic device	Addition to lower limb	Symes Type,"Ptb" Brim Design Socket	01/01/2010	172.35	177.68	No	1 per 4 years
L5634	Prosthetic device	Addition to lower limb	Symes Type, Post Open(Canadian) Socket	01/01/2010	215.55	222.22	No	1 per 4 years
L5636	Prosthetic device	Addition to lower limb	Symes Type, Medial Opening Socket	01/01/2010	164.75	169.85	No	1 per 4 years
L5637	Prosthetic device	Addition to lower limb	Add On Bk Total Contact	01/01/2010	245.16	252.74	No	1 per 4 years
L5638	Prosthetic device	Addition to lower limb	Below Knee, Leather Socket	01/01/2010	412.99	425.76	Yes	1 per 4 years
L5639	Prosthetic device	Addition to lower limb	Add On Bk Wood Socket	01/01/2010	713.58	735.65	Yes	1 per prosthesis
L5640	Prosthetic device	Addition to lower limb	Knee Disarticulation,Leather Socket	01/01/2010	469.04	483.55	Yes	1 per 4 years
L5642	Prosthetic device	Addition to lower limb	Above Knee, Leather Socket	01/01/2010	434.79	448.24	No	1 per 4 years
L5643	Prosthetic device	Addition to lower limb	Add L Extrm Hip Disart Flex Sock Ext Frm	01/01/2010	1,282.40	1,322.06	No	1 per 4 years
L5645	Prosthetic device	Addition to lower limb	Add L Extrm Bk Flex In Sock Extern Frame	01/01/2010	623.61	642.90	No	1 per 4 years
L5646	Prosthetic device	Addition to lower limb	Below Knee, Air Cushion Socket	01/01/2010	398.77	411.10	Yes	1 per 4 years
L5647	Prosthetic device	Addition to lower limb	Add L Extrm,Bk,Suction Socket	01/01/2010	506.27	521.93	No	1 per 4 years
L5648	Prosthetic device	Addition to lower limb	Above Knee, Air Cushion Socket	01/01/2010	475.45	490.15	Yes	1 per 4 years
L5649	Prosthetic device	Addition to lower limb	Add L Extrm Cat Cam Socket	01/01/2010	1,569.04	1,617.57	No	1 per 4 years
L5650	Prosthetic device	Addition to lower limb	Total Contact,A/K Or Kn Disartic Socket	01/01/2010	310.70	320.31	No	1 per 4 years
L5651	Prosthetic device	Addition to lower limb	Add L Extrm Ak Flex In Sock Extrn Frame	01/01/2010	910.35	938.50	No	1 per 4 years
L5652	Prosthetic device	Addition to lower limb	Suction Suspen,A/K Or Knee Disartic Skt	01/01/2010	277.48	286.06	No	1 per 4 years
L5653	Prosthetic device	Addition to lower limb	Knee Disartic, Expandable Wall Socket	01/01/2010	432.93	446.32	No	1 per 4 years
L5654	Prosthetic device	Addition to lower limb	Socket Insert,Symes(Pelite Plastaz,Etc)	01/01/2010	250.96	258.72	No	1 per year
L5655	Prosthetic device	Addition to lower limb	Skt Ins,B/K(Kembol,Pelite,Aliplast,Etc)	01/01/2010	181.21	186.81	No	1 per year
L5656	Prosthetic device	Addition to lower limb	Skt Ins, Kn/Disart(Kemblo,Aliplast,Etc)	01/01/2010	275.31	283.82	No	1 per year
L5658	Prosthetic device	Addition to lower limb	Skt Ins,A/K (Kemplo,Pelite,Aliplast,Etc)	01/01/2010	290.59	299.58	No	1 per year
L5661	Prosthetic device	Addition to lower limb	Add Low Extre Sock Inser Multi Dvromet	01/01/2010	416.91	429.80	Yes	1 per year
L5665	Prosthetic device	Addition to lower limb	Add Low Extre Sock Laser Knee Bk Mlt Du	01/01/2010	370.67	382.13	No	1 per year
L5666	Prosthetic device	Addition to lower limb	Below Knee,Cuff Suspension	01/01/2010	49.07	50.59	No	1 per year
L5668	Prosthetic device	Addition to lower limb	Below Knee, Molded Distal Cushion	01/01/2010	73.12	75.38	No	1 per year
L5670	Prosthetic device	Addition to lower limb	B/K,Mold Supracondl Susp (Pts Or Sim)	01/01/2010	172.71	178.05	No	1 per 4 years
L5671	Prosthetic device	Addition to lower limb	Add lower extremity, suspens locking mech, excl socket insert	04/01/2009	358.93	NC	No	1 per 4 years
L5672	Prosthetic device	Addition to lower limb	Below Knee,Removable Medial Brim Suspen	01/01/2010	228.53	235.60	No	1 per 4 years
L5673	Prosthetic device	Addition to lower limb	Add to Lower Extrem, Below Knee/Above Knee, Socket Insert	01/01/2010	614.95	633.97	Yes	2 per year
L5676	Prosthetic device	Addition to lower limb	Below Knee, Knee Joints, Pair	01/01/2010	230.63	237.76	No	1 per 4 years
L5677	Prosthetic device	Addition to lower limb	Add Low Extre Below Knee Polycen Pair	01/01/2010	353.23	364.15	No	1 per 4 years
L5678	Prosthetic device	Addition to lower limb	Below Knee, Joint Covers, Pair	01/01/2010	25.27	26.05	No	1 per 2 years
L5679	Prosthetic device	Addition to lower limb	Add to Lower Extrem, Below Knee/Above Knee, Socket Insert	01/01/2010	512.45	528.30	Yes	2 per year
L5680	Prosthetic device	Addition to lower limb	Below Knee, Thigh Lacer, Non-Molded	01/01/2010	193.72	199.71	No	1 per 4 years
L5681	Prosthetic device	Addition to lower limb	Add to Lower Extrem, Below Knee/Above Knee, Socket Insert	01/01/2010	1,029.21	1,061.04	No	1 per year
L5682	Prosthetic device	Addition to lower limb	B/K.Thigh Lacer,Lguteal/Ishcial, Molded	01/01/2010	398.03	410.34	No	1 per 4 years
L5683	Prosthetic device	Addition to lower limb	Add to Lower Extrem, Below Knee/Above Knee, Socket Insert	01/01/2010	1,029.21	1,061.04	No	1 per year
L5684	Prosthetic device	Addition to lower limb	Below Knee, Fork Strap	01/01/2010	30.63	31.58	No	1 per 2 years
L5685	Prosthetic device	Addition to lower limb	Add Low Extrem Pros, Lower Knee, Susp/Seal Sleeve	01/01/2010	55.13	56.84	No	6 per year

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L5686	Prosthetic device	Addition to lower limb	Below Knee, Back Check(Extension Control	01/01/2010	36.84	37.98	No	1 per 2 years
L5688	Prosthetic device	Addition to lower limb	Below Knee, Waist Belt, Webbing	01/01/2010	39.13	40.34	No	1 per year
L5690	Prosthetic device	Addition to lower limb	Below Knee, Waist Belt, Padded And Lined	01/01/2010	79.87	82.34	No	1 per year
L5692	Prosthetic device	Addition to lower limb	A/K, Pelvic Control Belt,Light Duty	01/01/2010	84.57	87.19	No	1 per year
L5694	Prosthetic device	Addition to lower limb	A/K,Pelic Control Belt, Padded/Lined	01/01/2010	115.47	119.04	No	1 per year
L5695	Prosthetic device	Addition to lower limb	Add On Ak Pelvic Ctrl Sleeve Suspen Tes	01/01/2010	103.79	107.00	No	2 per year
L5696	Prosthetic device	Addition to lower limb	A/K Or Knee Disartic, Pelvic Joint	01/01/2010	125.38	129.26	No	1 per 4 years
L5697	Prosthetic device	Addition to lower limb	A/K Or Knee Disartic, Pelvic Band	01/01/2010	59.55	61.39	No	1 per 4 years
L5698	Prosthetic device	Addition to lower limb	A/K Or Knee Disartic, Silesian Belt	01/01/2010	76.38	78.74	No	1 per year
L5699	Prosthetic device	Addition to lower limb	All Low/Extrem Prosthesis, Shldr Harness	01/01/2010	130.54	134.58	No	1 per year
L5700	Prosthetic device	Addition to lower limb	Replace. Socket, Below K, Molded to Patient Model	01/01/2010	1,963.56	2,024.29	Yes	Medical justification
L5701	Prosthetic device	Addition to lower limb	Replace. Socket, Hip Dis., Inc. Att. Plate, Molded	01/01/2010	2,435.96	2,511.30	Yes	Medical justification
L5702	Prosthetic device	Addition to lower limb	Replace. Socket, Hip Dis., Including Hip Joint, Molded	01/01/2010	3,070.16	3,165.11	No	Medical justification
L5704	Prosthetic device	Addition to lower limb	Custom Shaped Prot. Cover, Above Knee	01/01/2010	400.36	412.74	No	Medical justification
L5705	Prosthetic device	Addition to lower limb	Custom Shaped Prot. Cover, Above Knee	01/01/2010	733.99	756.69	No	Medical justification
L5706	Prosthetic device	Addition to lower limb	Custom Shaped Prot. Cover, Knee Dis.	01/01/2010	715.93	738.07	No	Medical justification
L5707	Prosthetic device	Addition to lower limb	Cust. Shaped Prot. Cover, Hip Dis.	01/01/2010	961.85	991.60	No	Medical justification
L5710	Prosthetic device	Addition to lower limb	Single Axis,Manual Lock	01/01/2010	228.91	235.99	Yes	1 per 4 years
L5711	Prosthetic device	Addition to lower limb	Add Exoske Knee Shin Single Ultra Light	01/01/2010	384.17	396.05	Yes	1 per 4 years
L5712	Prosthetic device	Addition to lower limb	Friction Swing & Stance,Safety Knee	01/01/2010	274.25	282.73	No	1 per 4 years
L5714	Prosthetic device	Addition to lower limb	Single Axis,Variable Frict,Sw/Ph Cont	01/01/2010	279.04	287.67	Yes	1 per 4 years
L5716	Prosthetic device	Addition to lower limb	Polycentric,Mechanical Stance Phase Lock	01/01/2010	551.77	568.84	No	1 per 4 years
L5718	Prosthetic device	Addition to lower limb	Polycentric Friction Sw/Stance Ph Contrl	01/01/2010	590.02	608.27	Yes	1 per 4 years
L5722	Prosthetic device	Addition to lower limb	Single Axis, Pneumatic Swing Phase	01/01/2010	717.50	739.69	Yes	1 per 4 years
L5724	Prosthetic device	Addition to lower limb	Single Axis, Fluid Swing Control	01/01/2010	1,105.92	1,140.12	Yes	1 per 4 years
L5728	Prosthetic device	Addition to lower limb	Single Axis,Fluid Control,Swing & Stance	01/01/2010	1,542.94	1,590.66	No	1 per 4 years
L5785	Prosthetic device	Addition to lower limb	Add Endoske Below Knee Ultra Light Mat	01/01/2010	330.67	340.90	No	1 per 4 years
L5790	Prosthetic device	Addition to lower limb	Add Exoske Above Knee Ultra Light Mat	01/01/2010	477.25	492.01	No	1 per 4 years
L5795	Prosthetic device	Addition to lower limb	Add Exoske Hip Disart Ultra Light Mat	01/01/2010	683.36	704.49	No	1 per 4 years
L5810	Prosthetic device	Addition to lower limb	Add Endoske Knee Single Manual Lock	01/01/2010	364.10	375.36	No	1 per 4 years
L5811	Prosthetic device	Addition to lower limb	Add Endosk Knee Sing Manual Ultra Light	01/01/2010	502.44	517.98	No	1 per 4 years
L5812	Prosthetic device	Addition to lower limb	Add Endoske Knee Sing Fric Swng Safe Kn	01/01/2010	378.10	389.79	No	1 per 4 years
L5814	Prosthetic device	Addition to lower limb	Add Endoske Knee Shin, Polycentric, Hyd Swing Phase	01/01/2010	2,377.43	2,450.96	No	1 per 4 years
L5816	Prosthetic device	Addition to lower limb	Add Endoske Knee Shin Polycen Mechanical	01/01/2010	541.27	558.01	No	1 per 4 years
L5818	Prosthetic device	Addition to lower limb	Add Endoske Knee Polyce Fric Swing Cnt	01/01/2010	611.21	630.11	No	1 per 4 years
L5822	Prosthetic device	Addition to lower limb	Add Endosk Knee Sing Pneu Swing Fric	01/01/2010	1,121.22	1,155.90	No	1 per 4 years
L5824	Prosthetic device	Addition to lower limb	Add Endosk Knee Sing. Fluid Swing Phase	01/01/2010	1,059.89	1,092.67	Yes	1 per 4 years
L5826	Prosthetic device	Addition to lower limb	Add Endosk Knee-Shin, Sing. Axis Hyd. Swing Phase	01/01/2010	1,999.12	2,060.95	No	1 per 4 years
L5828	Prosthetic device	Addition to lower limb	Add Endosk. Sing. Fluid Swing + Stance	01/01/2010	1,886.34	1,944.68	No	1 per 4 years
L5830	Prosthetic device	Addition to lower limb	Add Endosk,. Knee Sing. Pneu. Hydrapneu.	01/01/2010	1,271.88	1,311.22	No	1 per 4 years
L5840	Prosthetic device	Addition to lower limb	Add., Endoskel., Knee-Shin System, Multiaxial PSPC	01/01/2010	2,496.40	2,573.61	No	1 per 4 years
L5845	Prosthetic device	Addition to lower limb	Add., Endoskel, knee-shin, stance flex., adjustable	01/01/2010	1,147.38	1,182.87	No	1 per 4 years
L5850	Prosthetic device	Addition to lower limb	Add Endosk Above Knee Hip Disart. Ext As	01/01/2010	81.42	83.94	No	1 per 4 years

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L5855	Prosthetic device	Addition to lower limb	Add Endoskel Sys, Hip Dis., Mech. Hip Ext. Assist	01/01/2010	196.55	202.63	No	1 per 4 years
L5857	Prosthetic device	Addition to lower limb	Add., Endoskel, knee-shin, microprocessor control, Swing only	01/01/2010	3,470.01	3,577.33	Yes	1 per 4 years
L5910	Prosthetic device	Addition to lower limb	Add Endosk System Below Knee Align Sys	01/01/2010	230.50	237.63	Yes	1 per 4 years
L5920	Prosthetic device	Addition to lower limb	Add Endosk Sys Above Knee Hip Dis Alng	01/01/2010	337.70	348.14	No	1 per 4 years
L5925	Prosthetic device	Addition to lower limb	Add. Endoskel. Sys., Above K, K Dis., or Hip Dis.	01/01/2010	213.86	220.47	No	1 per 4 years
L5930	Prosthetic device	Addition to lower limb	Add., Endoskel., High Activity Knee Control Frame	01/01/2010	2,154.68	2,221.32	Yes	1 per 4 years
L5940	Prosthetic device	Addition to lower limb	Add Endosk Below Knee Ultra Light	01/01/2010	319.25	329.12	No	1 per 4 years
L5950	Prosthetic device	Addition to lower limb	Add Endosk Above Knee Ultra Light	01/01/2010	495.17	510.48	No	1 per 4 years
L5960	Prosthetic device	Addition to lower limb	Add Endosk Hip Disart Ultra Light Mat	01/01/2010	740.39	763.29	No	1 per 4 years
L5962	Prosthetic device	Addition to lower limb	Add Endoskel., Sys., Below K, Flex Prot Outer Surf.	01/01/2010	374.10	385.67	No	1 per 2 years
L5964	Prosthetic device	Addition to lower limb	Add Endoskel., Sys. Above K, Flex Prot Outer Surf.	01/01/2010	717.60	739.79	No	1 per 2 years
L5966	Prosthetic device	Addition to lower limb	Add Endoskel., Sys., Hip Dis., Flex Prot Outer Surf.	01/01/2010	924.38	952.97	No	1 per 2 years
L5970	Prosthetic device	Addition to lower limb	All Low/Ext Pros,Feet Ext Keel Sach Ft	01/01/2010	139.06	143.36	No	1 per 2 years
L5972	Prosthetic device	Addition to lower limb	All Lower Extremity Protheses Safe Foot	01/01/2010	253.31	261.14	No	1 per 2 years
L5974	Prosthetic device	Addition to lower limb	All Low/Ext Pros Feet Sgl Ax Ank/Foot	01/01/2010	148.31	152.90	No	1 per 2 years
L5975	Prosthetic device	Addition to lower limb	All lower ext pros, combo single axial ankle	01/01/2010	345.64	356.33	No	1 per 2 years
L5976	Prosthetic device	Addition to lower limb	All Lower Extreme Pros Energy Stor. Ft	01/01/2010	376.20	387.84	No	1 per 2 years
L5978	Prosthetic device	Addition to lower limb	All Low/Ext, Feet,Multiax Ank/Ft(Greiss)	01/01/2010	199.35	205.52	No	1 per 2 years
L5979	Prosthetic device	Addition to lower limb	All Lower Extrem. Prostheses, Multiax., A/F, Dyn Resp	01/01/2010	1,596.06	1,645.42	No	1 per 4 years
L5980	Prosthetic device	Addition to lower limb	All Lower Extremity Flex Foot System	01/01/2010	2,431.74	2,506.95	No	1 per 4 years
L5981	Prosthetic device	Addition to lower limb	All Lower Entremity Prosthesis, flex walk system	01/01/2010	2,184.31	2,251.87	No	1 per 4 years
L5982	Prosthetic device	Addition to lower limb	All Low/Ext, Axial Rotation Unit (Weber)	01/01/2010	410.34	423.03	No	1 per 2 years
L5984	Prosthetic device	Addition to lower limb	All Endoskel Low Exter Pros Axial Rota	01/01/2010	411.61	424.34	No	1 per 2 years
L5985	Prosthetic device	Addition to lower limb	All Endoskel Lower Ext. Prosth., Dynamic Prosth. Pylon	01/01/2010	180.77	186.36	No	1 per 2 years
L5986	Prosthetic device	Addition to lower limb	All Low/Ext Multi-Axial Rot Unit (Mcp/=)	01/01/2010	496.50	511.86	No	1 per 2 years
L5987	Prosthetic device	Addition to lower limb	All Lower Extremity Prosthesis, Shank Foot System	01/01/2010	4,605.07	4,747.49	Yes	1 per 2 years
L5988	Prosthetic device	Addition to lower limb	All lower ext pros, combo vertical shock	01/01/2010	1,489.41	1,535.47	No	1 per 2 years
L6000	Prosthetic device	Upper limb	Robin Aids, Thumb Remaining Or Equal	01/01/2010	1,127.52	1,162.39	Yes	1 per 4 years
L6010	Prosthetic device	Upper limb	Robin Aids, Some Fingers Remaining	01/01/2010	1,254.75	1,293.56	Yes	1 per 4 years
L6020	Prosthetic device	Upper limb	Robin Aids, No Fingers Remaining	01/01/2010	1,169.86	1,206.04	No	1 per 4 years
L6050	Prosthetic device	Upper limb	Mld Skt, Flex Elbow Hinges, Tricep Pad	01/01/2010	1,591.24	1,640.45	No	1 per 4 years
L6055	Prosthetic device	Upper limb	Wrist Disart Mold Sock W Expan Interfa	01/01/2010	2,029.71	2,092.48	Yes	1 per 4 years
L6100	Prosthetic device	Upper limb	Mdl Skt, Flex Elbow Hng. Triceps Pad	01/01/2010	1,610.29	1,660.09	No	1 per 4 years
L6110	Prosthetic device	Upper limb	Molded Socket (Muenster/Nw Suspension)	01/01/2010	1,703.56	1,756.25	No	1 per 4 years
L6120	Prosthetic device	Upper limb	Mlmld Dbl Wall,Step/Up Hng,Half Cuff	01/01/2010	1,926.74	1,986.33	No	1 per 4 years
L6130	Prosthetic device	Upper limb	Mld Dbl Wall Stump Activated Lkg/Hinge	01/01/2010	2,032.76	2,095.63	Yes	1 per 4 years
L6200	Prosthetic device	Upper limb	Mld Skt,Outside Locking Hinge,Forearm	01/01/2010	2,093.98	2,158.74	Yes	1 per 4 years
L6205	Prosthetic device	Upper limb	Elbow Disart Mold Sock W Expan Interfa	01/01/2010	2,888.62	2,977.96	Yes	1 per 4 years
L6250	Prosthetic device	Upper limb	Mld Dbl Wall Skt,Int Lk/Elbow, Forearm	01/01/2010	2,060.12	2,123.84	No	1 per 4 years
L6300	Prosthetic device	Upper limb	Mld Skt,Sh Bulk/Hhum Sect,Int Lk/Elb,Fr	01/01/2010	2,841.46	2,929.34	Yes	1 per 4 years
L6310	Prosthetic device	Upper limb	Passive Restoration(Complete Prothesis)	01/01/2010	2,575.16	2,654.80	Yes	1 per 4 years
L6320	Prosthetic device	Upper limb	Passive Restorative (Shoulder Cap Only)	01/01/2010	1,342.11	1,383.62	Yes	1 per 4 years
L6350	Prosthetic device	Upper limb	Mld Skt, Sh B/H,Hum Sect,Int L/K Elb,F/A	01/01/2010	3,113.36	3,209.65	No	1 per 4 years

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L6360	Prosthetic device	Upper limb	Passive Restoration (Complete Prothesis	01/01/2010	2,702.94	2,786.54	Yes	1 per 4 years
L6370	Prosthetic device	Upper limb	Passive Restoration (Shoulder Cap Only)	01/01/2010	1,567.52	1,616.00	Yes	1 per 4 years
L6400	Prosthetic device	Upper limb	Mld Skt,Endo Sys, Inc Soft Pros Cover	01/01/2010	1,741.93	1,795.80	No	1 per 4 years
L6450	Prosthetic device	Upper limb	Mld Skt,Endo Sys,Incl Soft Rpos Cover	01/01/2010	2,276.62	2,347.03	Yes	1 per 4 years
L6500	Prosthetic device	Upper limb	Mld Skt,Endo Sys,Incl Soft Pros Cover	01/01/2010	2,235.58	2,304.72	No	1 per 4 years
L6550	Prosthetic device	Upper limb	Mld Skt,Endo Sys,Incl Soft Pros Cover	01/01/2010	2,895.52	2,985.07	Yes	1 per 4 years
L6570	Prosthetic device	Upper limb	Mld Ski,Endo Sys,Incl Soft Pros Cover	01/01/2010	3,232.48	3,332.45	Yes	1 per 4 years
L6600	Prosthetic device	Addition to upper limb	Polycentric Hinge, Pair	01/01/2010	145.21	149.70	No	1 per 4 years
L6605	Prosthetic device	Addition to upper limb	Single Pivot Hinge, Pair	01/01/2010	149.46	154.08	No	1 per 4 years
L6610	Prosthetic device	Addition to upper limb	Flexible Metal Hinge, Pair	01/01/2010	141.28	145.65	Yes	1 per 4 years
L6615	Prosthetic device	Addition to upper limb	Disconnect Locking Wrist Unit	01/01/2010	137.13	141.37	No	1 per 4 years
L6616	Prosthetic device	Addition to upper limb	Add On Up Ext Additional Disc Inserts	01/01/2010	41.28	42.56	No	3 per 4 years
L6620	Prosthetic device	Addition to upper limb	Flexion-Friction Wrist Unit	01/01/2010	239.75	247.17	No	1 per 4 years
L6623	Prosthetic device	Addition to upper limb	Upper Extreme Add Spring Assisted Wrst	01/01/2010	456.72	470.85	No	1 per 4 years
L6625	Prosthetic device	Addition to upper limb	Rotation Wrist Unit With Cable Lock	01/01/2010	338.50	348.97	Yes	1 per 4 years
L6628	Prosthetic device	Addition to upper limb	Upper Extreme Add Quick Discon Hook Adap	01/01/2010	364.35	375.62	No	1 per 4 years
L6629	Prosthetic device	Addition to upper limb	Upper Extrem Quick Discon Lamin Collar	01/01/2010	124.16	128.00	No	1 per 4 years
L6630	Prosthetic device	Addition to upper limb	Stainless Steel, Any Wrist	01/01/2010	182.89	188.55	No	1 per 4 years
L6632	Prosthetic device	Addition to upper limb	Upper Extrem Add Latex Suspen Sleeve Ea	01/01/2010	41.35	42.63	No	6 per year
L6635	Prosthetic device	Addition to upper limb	List Assist For Elbow	01/01/2010	132.19	136.28	No	1 per 4 years
L6637	Prosthetic device	Addition to upper limb	Upper Extrem Add Nudge Control Elbow	01/01/2010	258.81	266.81	No	1 per 4 years
L6640	Prosthetic device	Addition to upper limb	Shoulder Abduction Joint, Pair	01/01/2010	215.53	222.20	Yes	1 per 4 years
L6641	Prosthetic device	Addition to upper limb	Upper Extrem Add Excurs Amplif Pulley	01/01/2010	125.51	129.39	Yes	1 per 4 years
L6642	Prosthetic device	Addition to upper limb	Upper Extrem Add Excur Amplier Lever	01/01/2010	184.52	190.23	No	1 per 4 years
L6645	Prosthetic device	Addition to upper limb	Shoulder Flexion-Abduction Joint, Each	01/01/2010	233.08	240.29	No	1 per 4 years
L6650	Prosthetic device	Addition to upper limb	Shoulder Universal Joint Each	01/01/2010	252.80	260.62	No	1 per 4 years
L6655	Prosthetic device	Addition to upper limb	Standard Control Cable, Extra	01/01/2010	49.02	50.54	No	1 per year
L6660	Prosthetic device	Addition to upper limb	Heavy Duty Control Cable	01/01/2010	65.62	67.65	No	1 per year
L6665	Prosthetic device	Addition to upper limb	Teflon, Or Equal, Cable Lining	01/01/2010	29.31	30.22	No	1 per year
L6670	Prosthetic device	Addition to upper limb	Hook To Hand, Cable Adapter	01/01/2010	30.53	31.47	No	1 per year
L6672	Prosthetic device	Addition to upper limb	Harness, Chest Or Shoulder, Saddle Type	01/01/2010	140.08	144.41	No	1 per year
L6675	Prosthetic device	Addition to upper limb	Harness, Firgure "8",For Single Control	01/01/2010	76.43	78.79	No	1 per year
L6676	Prosthetic device	Addition to upper limb	Harness, Figure "8", For Dual Control	01/01/2010	79.96	82.43	No	1 per year
L6680	Prosthetic device	Addition to upper limb	Test Skt, Wrist Disartic Or Below/Elbow	01/01/2010	196.88	202.97	No	2 per prosthesis
L6682	Prosthetic device	Addition to upper limb	Test Skt, Elbow Disartic Or Above/Elbow	01/01/2010	217.68	224.41	No	2 per prosthesis
L6684	Prosthetic device	Addition to upper limb	Test Skt,Sh Disartic Or In/Scap Thoracic	01/01/2010	295.80	304.95	No	2 per prosthesis
L6686	Prosthetic device	Addition to upper limb	Upper Extrem Add Suction Socket	01/01/2010	438.93	452.50	No	1 per 4 years
L6687	Prosthetic device	Addition to upper limb	Upper Extrem Frame Type Below Elbow Add	01/01/2010	367.11	378.46	No	1 per 4 years
L6688	Prosthetic device	Addition to upper limb	Upper Extrem Add Frame Type Above Elb	01/01/2010	406.28	418.85	No	1 per 4 years
L6689	Prosthetic device	Addition to upper limb	Up Extrm Add Frm Sock Should Disartic	01/01/2010	484.22	499.20	Yes	1 per 4 years
L6690	Prosthetic device	Addition to upper limb	Upper Extrem Add Frame Type Interscap	01/01/2010	570.12	587.75	No	1 per 4 years
L6691	Prosthetic device	Addition to upper limb	Upper Extrem Add Removable Insert Ea	01/01/2010	225.03	231.99	No	1 per year
L6692	Prosthetic device	Addition to upper limb	Add On Up Ext Silicone Gell Insert/Equal	01/01/2010	409.41	422.07	No	1 per 2 years

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L6693	Prosthetic device	Addition to upper limb	Upper Extremity Addition, external locking elbow	01/01/2010	2,522.97	2,601.00	No	1 per 2 years
L6704	Prosthetic device	Addition to upper limb, terminal device	Term dev, sport/rec/work att	01/01/2010	352.81	363.72	No	1 per 4 years
L6706	Prosthetic device	Addition to upper limb, terminal device	Term dev mech hook vol open	01/01/2010	261.92	270.02	No	1 per 4 years
L6707	Prosthetic device	Addition to upper limb, terminal device	Term dev mech hook vol close	01/01/2010	740.62	763.53	No	1 per 4 years
L6708	Prosthetic device	Addition to upper limb, terminal device	Term dev mech hand vol open	01/01/2010	589.16	607.38	No	1 per 4 years
L6709	Prosthetic device	Addition to upper limb, terminal device	Term dev mech hand vol close	01/01/2010	795.89	820.50	No	1 per 4 years
L6805	Prosthetic device	Addition to upper limb, terminal device	Modifer Wrist Flexion Unit	01/01/2010	245.52	253.11	No	1 per 4 years
L6810	Prosthetic device	Addition to upper limb, terminal device	Terminal Device Pincher Tool Otto Bock=	01/01/2010	130.51	134.55	Yes	1 per 4 years
L6890	Prosthetic device	Addition to upper limb, terminal device	Ter Device, Produc Glove For Above Hand	01/01/2010	127.85	131.80	No	2 per year
L6900	Prosthetic device	Addition to upper limb, terminal device	Incl Cst ,Shad&Measure)W/Glove,Th/Fin	01/01/2010	1,241.44	1,279.84	Yes	1 per 4 years
L6905	Prosthetic device	Addition to upper limb, terminal device	H/R, W/Glove, Multiple Fingers Remaining	01/01/2010	1,228.68	1,266.68	Yes	1 per 4 years
L6910	Prosthetic device	Addition to upper limb, terminal device	H/R, W/Glove, No Fingers Remaining	01/01/2010	1,207.87	1,245.23	No	1 per 4 years
L6915	Prosthetic device	Addition to upper limb, terminal device	H/R, Replacment Glove For Above	01/01/2010	518.99	535.04	Yes	1 per 2 years
L7368	Prosthetic device	Supply	Lithium Ion Battery Charger	09/01/2011	366.30	NC	No	1 per 5 years
L7510	Prosthetic device	Repair	Repair or repl minor parts of prosthetic device	01/01/2006	Supplier charge (without PA), PA (with PA)	NC	No if < $120 and within time limit, Yes otherwise	1 per 120 days
L7520	Prosthetic device	Repair	Repair prosthetic device, labor, per 15 minutes	01/01/2010	10.67	11.00	No	1 per 120 days
L8000	Prosthetic device	Breast prosthesis	Mastectomy Bra	01/01/2010	29.10	30.00	No	2 per year
L8010	Prosthetic device	Breast prosthesis	Mastectomy Sleeve	01/01/2010	46.67	48.11	No	3 per year
L8015	Prosthetic device	Breast prosthesis	External Breast Prosthesis Garment	01/01/2010	42.21	43.52	No	3 per year
L8020	Prosthetic device	Breast prosthesis	Mastectomy Form, Each	01/01/2010	144.73	149.21	No	1 per 2 years
L8030	Prosthetic device	Breast prosthesis	Breast Prothesis, Silicone Or Equal	01/01/2010	232.80	240.00	No	1 per 2 years
L8035	Prosthetic device	Breast prosthesis	Custom breast prosthesis	01/01/2010	2,579.86	2,659.65	Yes	1 per 2 years
L8300	Orthotic device	Truss	Truss, Single With Standard Pad	01/01/2010	59.12	60.95	No	2 per year
L8310	Orthotic device	Truss	Truss, Double With Standard Pads	01/01/2010	95.12	98.06	No	2 per year
L8320	Orthotic device	Truss	Truss Addition To Standard Pad,Water Pad	01/01/2010	41.52	42.80	Yes	2 per year
L8330	Orthotic device	Truss	Truss Addition To Standard Pads,Scrot Pd	01/01/2010	31.42	32.39	No	2 per year
L8400	Prosthetic device	Sock	Prosthetic Sheath, B/K,Each	01/01/2010	10.02	10.33	No	12 per year
L8410	Prosthetic device	Sock	Prosthetic Sheath, A/K, Each	01/01/2010	13.19	13.60	No	12 per year
L8415	Prosthetic device	Sock	Prosthetic Sheath Upper Limb Ea	01/01/2010	13.65	14.07	No	12 per year
L8417	Prosthetic device	Sock	Prosthetic sock/sheath, gel liner, bel or abv knee	01/01/2010	48.14	49.63	No	12 per year
L8420	Prosthetic device	Sock	Prosthetic Sock, Wool, B/K, Each	01/01/2010	13.36	13.77	No	12 per year
L8430	Prosthetic device	Sock	Prosthetic Sock, Wool, A/K, Each	01/01/2010	15.11	15.58	No	12 per year
L8435	Prosthetic device	Sock	Prosthtic Sock Wool Upper Limb Ea	01/01/2010	14.37	14.81	No	12 per year
L8440	Prosthetic device	Sock	Prosthetic Shrinker, B/K, Each	01/01/2010	29.85	30.77	No	2 per year
L8460	Prosthetic device	Sock	Prosthetic Shrinker, A/K, Each	01/01/2010	42.42	43.73	No	2 per year
L8465	Prosthetic device	Sock	Prosthetic Shrinker Upper Limb Ea	01/01/2010	39.22	40.43	No	2 per year
L8470	Prosthetic device	Sock	Stump Sock, Sing Ply, Fitting B/K, Each	01/01/2010	4.25	4.38	No	24 per year
L8480	Prosthetic device	Sock	Stump Sock, Sing Ply, Fitting, A/K, Each	01/01/2010	5.86	6.04	No	24 per year
L8485	Prosthetic device	Sock	Stump Sock, Single Ply, Fitting, Upper Limb, Each	01/01/2010	7.89	8.13	No	24 per year
L8500	Prosthetic device	Speech aid	Artificial Larynx	01/01/2010	421.25	434.28	No	1 per 4 years
L8501	Prosthetic device	Speech aid	Tracheostomy Speaking Valve	01/01/2010	83.66	86.25	No	1 per 4 months
L8621	Prosthetic device	Supply	Zinc air battery, coch implant dev, repl, ea	09/01/2011	0.45	NC	No	25 per month per implant
L8622	Prosthetic device	Supply	Alkaline battery, coch implant dev, any size, repl	09/01/2011	0.24	NC	No	31 per month per implant

HCPCS CODE	CATEGORY	APPLICATION	DESCRIPTION	EFFECTIVE DATE	CURRENT MAXIMUM PAYMENT AMOUNT	PREVIOUS MAXIMUM PAYMENT AMOUNT	NEED FOR PRIOR AUTHORIZA-TION	LIMIT
L8623	Prosthetic device	Supply	Lith ion batt CID,non-earlvl	09/01/2011	46.94	NC	No	2 per year per implant
L8624	Prosthetic device	Supply	Lith ion batt CID, ear level	09/01/2011	117.04	NC	No	2 per year per implant
S1040	Orthotic device	Remolding device	Cranial remolding orthosis	09/01/2011	2,000.00	NC	No	1 per lifetime
V5014	Prosthetic device	Repair of hearing aid	Repair, modification of hearing aid	01/01/2006	Supplier charge (without PA), PA (with PA)	NC	No if < $100 and within time limit, Yes otherwise	1 per 120 days (less than $100), 1 per year ($100 or greater)
V5030	Prosthetic device	Hearing aid	Body-worn hearing aid air	01/01/2010	339.50	350.00	Yes	1 per 4 years
V5040	Prosthetic device	Hearing aid	Body-worn hearing aid bone	01/01/2010	339.50	350.00	Yes	1 per 4 years
V5050	Prosthetic device	Hearing aid	Hearing aid monaural in ear	01/01/2010	242.50	250.00	Yes	1 per 4 years
V5060	Prosthetic device	Hearing aid	Behind ear hearing aid	01/01/2010	242.50	250.00	Yes	1 per 4 years
V5070	Prosthetic device	Hearing aid	Glasses air conduction	01/01/2010	242.50	250.00	Yes	1 per 5 years
V5080	Prosthetic device	Hearing aid	Glasses bone conduction	01/01/2010	242.50	250.00	Yes	1 per 5 years
V5130	Prosthetic device	Hearing aid	In ear binaural hearing aid	01/01/2010	485.00	500.00	Yes	1 per 4 years
V5140	Prosthetic device	Hearing aid	Behind ear binaur hearing aid	01/01/2010	485.00	500.00	Yes	1 per 4 years
V5150	Prosthetic device	Hearing aid	Glasses binaural hearing aid	01/01/2010	485.00	500.00	Yes	1 per 5 years
V5160	Prosthetic device	Hearing aid	Dispensing fee binaural	01/01/2010	291.00	300.00	No	1 per 5 years
V5170	Prosthetic device	Hearing aid	Within ear cros hearing aid	01/01/2010	339.50	350.00	Yes	1 per 4 years
V5180	Prosthetic device	Hearing aid	Behind ear cros hearing aid	01/01/2010	339.50	350.00	Yes	1 per 4 years
V5190	Prosthetic device	Hearing aid	Glasses cros hearing aid	01/01/2010	242.50	250.00	Yes	1 per 5 years
V5200	Prosthetic device	Hearing aid	Cros hearing aid dispens fee	01/01/2010	194.00	200.00	No	1 per 5 years
V5210	Prosthetic device	Hearing aid	In ear bicros hearing aid	01/01/2010	339.50	350.00	Yes	1 per 4 years
V5220	Prosthetic device	Hearing aid	Behind ear bicros hearing aid	01/01/2010	339.50	350.00	Yes	1 per 4 years
V5230	Prosthetic device	Hearing aid	Glasses bicros hearing aid	01/01/2010	242.50	250.00	Yes	1 per 5 years
V5240	Prosthetic device	Hearing aid	Dispensing fee bicros	01/01/2010	194.00	200.00	No	1 per 5 years
V5241	Prosthetic device	Hearing aid	Dispensing fee, monaural	01/01/2010	194.00	200.00	No	1 per 5 years
V5246	Prosthetic device	Hearing aid	Hearing aid, prog, mon, ite	01/01/2010	339.50	350.00	Yes	1 per 5 years
V5247	Prosthetic device	Hearing aid	Hearing aid, prog, mon, bte	01/01/2010	339.50	350.00	Yes	1 per 5 years
V5252	Prosthetic device	Hearing aid	Hearing aid, prog, bin,ite	01/01/2010	679.00	700.00	Yes	1 per 5 years
V5253	Prosthetic device	Hearing aid	Hearing aid, prog, bin, bte	01/01/2010	679.00	700.00	Yes	1 per 5 years
V5256	Prosthetic device	Hearing aid	Hearing aid, digit, mon, ite	01/01/2010	727.50	750.00	Yes	1 per 5 years
V5257	Prosthetic device	Hearing aid	Hearing aid, digit, mon, bte	01/01/2010	727.50	750.00	Yes	1 per 5 years
V5260	Prosthetic device	Hearing aid	Hearing aid, digit, bin, ite	01/01/2010	1,455.00	1,500.00	Yes	1 per 5 years
V5261	Prosthetic device	Hearing aid	Hearing aid, digit,bin,bte	01/01/2010	1,455.00	1,500.00	Yes	1 per 5 years
V5264	Prosthetic device	Hearing aid	Ear mold, insert	01/01/2010	24.25	25.00	Yes	4 per year (younger than 5), 1 per 2 years per ear (5 or older)
V5266	Prosthetic device	Hearing aid	Battery for hearing aid device	01/01/2010	0.97	1.00	Yes	4 per month per hearing aid
V5267	Prosthetic device	Hearing aid	Hearing aid supplies/ accessories	11/01/2004	PA	NC	Yes	1 per year

TO BE RESCINDED

5160-10-21 **Incontinence garments and related supplies.**

(A) Incontinence garments and related supplies, including disposable underpads, are covered by the medicaid program under the following conditions:

(1) The medicaid consumer is thirty-six months of age or more; and

(2) The consumer is not a resident of a nursing facility or an intermediate-care facility for the mentally retarded. Coverage of incontinence garments and related supplies to these consumers is provided as part of the per diem payment already paid to the facility by the department for this consumer's monthly care; and

(3) The type of incontinence is:

(a) Secondary to disease that results in irreversible loss of control of the urinary bladder and/or anal sphincter; or

(b) Secondary to injury of the brain or the spinal cord that results in irreversible loss of control of the urinary bladder and/or anal sphincter; or

(c) Attributed to developmental delay or developmental disability.

(B) Stress incontinence is considered a type of incontinence, but does not meet the definition of disease or injury as specified in paragraph (A)(3) of this rule. Consumers with stress incontinence that is secondary to other disease or injury causing irreversible loss of control of the urinary bladder and/or anal sphincter may be eligible for incontinence garments and related supplies provided that all other requirements of this rule are met.

(C) Unless otherwise specified, a fully completed "Certificate of Medical Necessity/Prescription Incontinence Supplies," JFS 02912 (appendix A to this rule) that is written, signed with an original signature, and dated by the treating prescriber must be obtained at least every twelve months from the date of the prescriber's attestation signature and kept on file by the provider. Existing prescriptions that are in force prior to the effective date of this rule do not require the use of JFS 02912 until the existing prescription is renewed or modified due to medical necessity. The JFS 02912 must be obtained by the provider prior to the first

date of service in the applicable twelve-month period and must specify:

(1) The applicable diagnosis of the specific disease or injury causing the incontinence; or

(2) The developmental delay or disability, including applicable diagnoses;

(3) The type of incontinence; and

(4) The type of incontinence garments or incontinence supplies being prescribed.

(D) A JFS 02912 that only lists incontinence or incontinence supplies and does not specify the disease or injury that has resulted in the incontinence in accordance with paragraph (C) of this rule does not meet the requirements of this rule.

(E) Providers must verify from the consumer or the consumer's designated caregiver on a monthly basis the required type and number of incontinence garments and/or related supplies.

(1) The provider must maintain on file written documentation of the required type and amount of incontinence garments and/or related supplies requested for each month. The documentation must include the date that the provider verified the required type and amount from the consumer or consumer's care giver. The date that the provider verified the required type and amount must be prior to but not more than fourteen days prior to the date that the incontinence supplies are dispensed.

(2) The type and amount required may be verified orally or in writing from the consumer or the consumer's designated caregiver. For each month's worth of incontinence garments and supplies, the date of service entered on the medicaid claim (dispensing date) should not be prior to the date that the provider verified the type and amount of incontinence supplies required for the month.

(3) Documentation of the type and amount of incontinence garments and/or related supplies requested must include the first and last name of the provider's employee that took the request and the first and last name of the consumer, or consumer's care giver, making the request.

(4) Documentation of the type and amount of incontinence garments and/or related supplies required by a consumer on a monthly basis must be obtained and on file prior to dispensing the incontinence garments and/or related supplies.

Under no circumstances may the amount of the incontinence garments and/or related supplies exceed the amount prescribed by the consumer's prescriber as originally documented on the JFS 02912. A new JFS 02912 is required when changes in a consumer's medical condition require an increased amount of incontinence garments or related supplies within twelve months of the date of the most recent prior prescriber's attestation signature.

(5) Any prescription for incontinence garments and related supplies must be prescribed by a prescriber actively involved in managing the consumer's medical condition as defined in paragraph (A)(2) of rule 5101:3-10-05 of the Administrative Code. This prescriber should be treating the consumer under a comprehensive plan of care that addresses the underlying medical need for any supplies referenced in this rule.

(6) Any request for incontinence supplies that exceeds the limitation amounts currently referenced in appendix A to rule 5101:3-10-03 of the Administrative Code requires that the provider submit a fully completed JFS 02912 as referenced in paragraph (C) of this rule to the department for prior authorization before payment is authorized for the dispensing of these excess supplies.

(7) Incontinence garments and related supplies are reimbursed according to the department fee schedule contained in appendix DD to rule 5101:3-1-60 of the Administrative Code or the provider's usual and customary charge, whichever is less.

Effective:

Five Year Review (FYR) Dates:

_____

Certification

_____

Date

Promulgated Under:	119.03
Statutory Authority:	5164.02
Rule Amplifies:	5162.03, 5164.02
Prior Effective Dates:	05/01/1990, 09/01/1998, 10/01/2004, 04/25/2011

Name of Provider
Provider NPI #
Provider Medicaid Legacy (Optional) #

Ohio Department of Medicaid

CERTIFICATE OF MEDICAL NECESSITY/PRESCRIPTION INCONTINENCE SUPPLIES

Instructions: The Certificate of Medical Necessity (CMN) must be used for incontinence garments and disposable supplies under the Ohio Medicaid Program. This form must be completed and carry the proper signature, where indicated, before requests which require prior authorization will be considered.

Name of Consumer	Consumer Medicaid Number	
Street Address	City/State/Zip	Date of Birth

Section A

Diagnosis(es): Include ICD-9 codes (mandatory) and description (optional)

Supply Requested

Type of incontinence garment/disposable supply needed	# Needed per month X 12 months

Section B - Prescriber Attestation and Signature/Date

Prescriber Name (printed)	Date of Last Face to Face Examination of Consumer

I certify that I am the prescriber identified above. I certify that the information in Section A of medical necessity and any information on any attached documents signed and dated by me, is true to the best of my knowledge. I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.

Prescriber Signature (No stamps)	Date	Prescriber NPI #

ODM 02912 (7/2014)
Formerly JFS 02912 (4/2011)

TO BE RESCINDED

5160-10-22 **Volume ventilators, positive and negative pressure ventilators, continuous positive airway pressure (CPAP), alternating positive airway pressure (APAP), and intermittent positive pressure ventilation (IPPV).**

(A) Any provider billing for ventilatory support services (including volume ventilators, positive and negative pressure ventilators, CPAP, APAP and IPPV) shall have on staff or under contract a licensed respiratory care professional (LRCP) available on a twenty-four-hour basis, seven days a week to provide respiratory care, technical support and clinical ventilator services.

(B) Mechanical ventilator services are covered for consumers residing in a personal residence, a nursing facility (NF), or an intermediate care facility for the mentally retarded (ICF-MR). The monthly rental fee includes reimbursement for the use of a mechanical ventilator, all service and maintenance, related ventilator supplies and equipment listed in paragraph (B)(6)(a) of this rule, and the LRCP services listed in paragraph (B)(6)(b) of this rule. For a pressure ventilator used as an alternative to a volume ventilator, noninvasive applications are covered when a tracheostomy is not medically necessary.

(1) Ventilator definitions

(a) "Invasive mechanical ventilator." An invasive application requires the ventilator be interfaced directly with the consumer via an artificial airway (e.g., tracheostomy tube). Invasive mechanical ventilators (volume and/or pressure) are life support devices designed specifically for invasive mechanical ventilation applications and must accommodate direct current (DC) backup power supply and include disconnect, high pressure, low pressure and power loss alarms.

(b) "Non-invasive mechanical ventilator." Non-invasive mechanical ventilators (volume, or positive or negative pressure) may be used as an alternative to invasive mechanical ventilator services for consumers with appropriate medical necessity and when the consumer's attending prescriber has deemed a tracheostomy not medically necessary.

(2) Mechanical ventilator coverage criteria

(a) To be considered for coverage, consumers must require periodic or

continuous mechanical ventilation (volume, or positive or negative pressure). A consumer must demonstrate appropriate medical necessity supporting the need for mechanical ventilatory support as treatment for respiratory insufficiency and/or respiratory failure resulting from one or more of the following conditions:

(i) Chronic respiratory failure

(ii) Spinal cord injury

(iii) Neuromuscular diseases

(iv) Chronic pulmonary disorders

(v) Other neurological disorders and thoracic restrictive diseases

(3) Medical necessity for pressure support ventilator with volume control is the same as above and also includes the following supportive information:

(a) Statement from the prescriber that the consumer has tried unsuccessfully to be managed with a volume ventilator, and

(b) Statement from the prescriber that the advanced technology offered by this pressure ventilator is required for the safe and appropriate management of the .consumer

(4) Invasive mechanical ventilator services, with backup rate feature, do not require prior authorization for the first three months of use by any particular consumer. Other ventilator services may be prior authorized for up to six months at the time of initial prior authorization. Consumers with chronic nonreversible respiratory insufficiency and/or failure may receive lifetime authorization for rental or purchase at the discretion of the department. All requests for prior authorization of ventilator services must include a fully completed "Certificate of Medical Necessity/Prescription Mechanical Ventilators" form JFS 01902, rev. 06/2007 (appendix to this rule) within thirty days prior to the first date of service being requested. The certification of medical necessity, must include:

(a) Medical history (not required if request is for continuation of services),

(b) Diagnosis and degree of impairment,

(c) Degree of ventilatory support required (e.g., continuous, nocturnal only),

(d) Ventilator settings/parameters including mode and type of ventilator ordered at time of prior authorization request,

(e) List of other respiratory equipment in use,

(f) Documentation that recipient is being weaned (if applicable),

(g) Documentation of initial LRCP services described in (B)(6)(b) of this rule, when performed before prior authorization request, and

(h) Documentation (e.g., copy of a recent checksheet) that a LRCP routinely checks or changes ventilator settings in compliance with prescriber ordered parameters or protocol (not applicable to initial prior authorization request).

(5) Any change in the type of equipment provided, other than invasive mechanical ventilators with backup rate feature used with invasive interface, will require a new prior authorization request with supporting documentation as described in paragraph (B)(4) of this rule.

(6) The monthly rental payment for ventilator services includes reimbursement for the following equipment and supplies and respiratory services:

(a) Equipment and supplies

(i) Mechanical ventilator and accessories, including inlet ventilator filters,

(ii) Humidifier bacteria filters,

(iii) Humidifier tubing (ventilator to humidifier),

(iv) Heated humidifiers,

(v) Permanent or reusable consumer circuits (disposable consumer circuits are billable only to NFs and ICFs-MR), and

(vi) Related accessory and supply items including tracheostomy flex tubes, and peep valves.

(b) Licensed respiratory care professional (LRCP) services

(i) Home evaluation (prior to discharge), and home equipment set-up.

(ii) In-home training of the caregiver(s) (e.g. ventilator operation, tracheostomy care, cleaning/sterilization techniques).

(iii) LRCP visits to include multiple visits in the first week of service and subsequent visits no less frequent than once per month for the first six months, then not less than every sixty days thereafter, at a frequency determined by the LRCP, in consultation with the consumer's prescriber, to be appropriate to the consumer's condition.

(iv) Routine maintenance as specified by manufacturer or company protocol and in compliance with industry standards.

(v) Twenty-four-hour on call respiratory therapist services with two-hour response for emergency visits to include equipment servicing, repair or replacement.

(7) Reimbursement for a secondary or back-up mechanical ventilator for a medically necessary mechanical ventilator may be allowed when the consumer meets the following criteria and only when appropriate documentation is provided:

(a) Statement from the prescriber that the consumer cannot maintain spontaneous ventilation for four or more hours, or

(b) Statement from the prescriber that the consumer requires mechanical ventilation during regular mobility (e.g. attends school or outpatient therapy) as prescribed in their plan of care and needs a second ventilator attached to their wheelchair or mobility device, or

(c) Statement from the supervisor of the emergency team(s) responsible for serving the consumer's address that the emergency medical team estimated response time is more than two hours.

(8) When ventilators are provided to medicaid eligible residents of a NF or ICF-MR, reimbursement shall not be provided for more than one back-up ventilator per eight primary ventilators present in the same facility.

(C) Service and maintenance on consumer owned ventilators requires prior authorization and may be billed once per month. The prior authorization request and documentation of medical necessity must include a prescriber prescription for mechanical ventilatory support, consumer diagnosis and degree of impairment. Payment will be authorized only when the department determines that the ventilator is medically necessary.

(D) Sleep therapy

(1) Definitions

(a) "Apnea" is the cessation of airflow for at least ten seconds documented on a polysomnogram.

(b) "Hypopnea" is an abnormal respiratory event lasting at least ten seconds associated with at least a thirty per cent reduction in thoracoabdominal movement or airflow as compared to baseline, and with at least a four per cent decrease in oxygen saturation.

(c) The "apnea-hypopnea index" (AHI) is the average number of episodes of apneas and hypopneas per hour and must be based on a minimum of two hours of recording time without the use of a positive airway pressure device, reported by polysomnogram. The AHI may not be extrapolated or projected.

(2) With prior authorization, payment can be made for a continuous positive airway pressure (CPAP) home system. The CPAP system was designed for consumers with obstructive sleep apnea. Rental for a six-month period or purchase may be authorized only when a trial period has proven to be beneficial. Documentation will be necessary to substantiate ongoing rental or purchase.

(a) A request for prior authorization must contain all of the following information:

(i) A statement of medical necessity from the consumer's attending prescriber indicating:

(a) Diagnosis of obstructive sleep apnea (OSA).

(b) Surgery is a likely alternative.

(ii) Sleep study reports from both a diagnostic and a titration sleep study (these may be performed as two separate studies or consecutively as a split study) conforming to the following:

(a) The sleep studies must be performed in an attended, facility-based sleep study laboratory which is eligible for reimbursement by the department for the study, and not in the home or in a mobile facility. A DME supplier may not perform the study.

(b) During at least two hours of recorded sleep for the diagnostic study,

(i) The AHI is equal to or greater than fifteen events per hour, or

(ii) The AHI is from five to fourteen events per hour with documented symptoms of excessive daytime sleepiness, impaired cognition, mood disorders, insomnia or hypertension, ischemic heart disease, or history of stroke.

(c) The titration study of at least three hours duration shows efficacy of the CPAP system by decreasing the number of airway obstructions per hour and

(i) Shows a percentage increase in oxygen saturation of at least fifteen per cent (e.g., eighty per cent to ninety-two per cent), or

(ii) Shows an increase in oxygen saturation to eighty-nine per cent or greater, or

(iii) At the discretion of the department, shows other clinical improvement.

(d) If oxygen is needed in addition to CPAP, documentation of effectiveness must be shown by the sleep study.

(iii) A statement from the attending prescriber documenting any correctable causes of the consumer's sleep apnea which are present, (e.g., alcohol, bedtime sedatives/hypnotics, weight) and whether or not they are being treated or have been abolished. It must be specified if none exist.

(iv) A statement from the attending prescriber, indicating whether the consumer is symptomatic or asymptomatic and what impairment(s) secondary to sleep apnea is (are) present. If the consumer is symptomatic, improvement must be documented and significant to be considered for coverage.

(v) A statement from the attending prescriber certifying that the consumer is using the device regularly as prescribed.

(b) If any of the information in paragraph (D)(2)(a) of this rule is missing or provided by the supplier instead of the attending prescriber, prior authorization will be denied. A new request for authorization may be resubmitted with the required information.

(3) When determined medically appropriate based on a facility-based sleep study, a bi-level/alternating positive airway pressure (APAP) system may be prior authorized for obstructive sleep apnea when a fully completed "Certificate of Medical Necessity/Prescription IPPV or APAP in lieu of a Volume Ventilator" form JFS 01903, rev. 6/2007 (appendix to this rule) is provided that demonstrates:

(a) CPAP has been tried and is ineffective.

(b) APAP was titrated during the sleep study, or a one-week trial period using a respiratory support system bi-level/APAP was effective; and

(c) The attending prescriber certifies in writing the effectiveness of the system and that the consumer is using the device regularly as prescribed.

(E) If there is discontinuation of the use of any respiratory assist device at any time, the supplier is expected to ascertain this, and stop billing for the equipment and related

accessories and supplies.

Effective:

Five Year Review (FYR) Dates:

_____

Certification

_____

Date

Promulgated Under:	119.03
Statutory Authority:	5164.02
Rule Amplifies:	5162.03, 5164.02, 5164.70
Prior Effective Dates:	12/30/1991, 07/01/1993, 07/01/1994, 01/01/1995, 08/01/1998, 10/01/2004, 01/01/2008

Ohio Department of Medicaid

CERTIFICATE OF MEDICAL NECESSITY/PRESCRIPTION MECHANICAL VENTILATORS

Certification Type ☐ **Initial** ☐ **Revised** ☐ **Recertification**		
Instructions: The Certificate of Medical Necessity (CMN) must be used for approved ventilators under the Ohio Medicaid Program. This form must be completed and carry the proper signature, where indicated, before requests will be considered for prior authorization.		
Name of consumer	Medicaid billing#	
Street address	City/State/Zip	Date of birth
List other respiratory equipment in use	Previous dates of service PA # of previous approval	

Section A—Must be completed by prescriber

Diagnosis(es) include ICD-9 code and description	
Date of last examination by prescriber (must be within 30 days prior to first date of service)	Consumer has permanent tracheostomy ☐ Yes ☐ No
Medical history (attach hospital discharge summary, if applicable)	
Ventilatory support requirements ☐ Continuous ☐ Nocturnal only ☐ Other, explain:	Ventilator settings/parameters O2 setting

Section B—Prescriber's Attestation and Signature/Date

Prescriber's name (PRINTED)		
I certify that I am the prescriber identified above. I certify that the information I have completed in this certificate is of medical necessity and any information on any attached documents signed and dated by me is true to the best of my knowledge. I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.		
Prescriber's signature	Date	Ohio Medicaid Legacy # NPI #

Section C—Must be completed by Licensed Respiratory Care Professional (LRCP)

Complete this section if the ventilator was dispensed prior to submitting prior authorization request

Licensed respiratory care professional services: Date placed on ventilator ☐ Yes ☐ No Home evaluation prior to hospital discharge? ☐ Yes ☐ No Home set up? ☐ Yes ☐ No In-home training provided to care givers? If "yes", check all that apply: ☐ Ventilator operation ☐ Tracheostomy care ☐ Cleaning/sterilizing technique	Home visits first week: ☐ 5-7 ☐ 3-4 ☐ 1-2 Home visits after the first week (at least monthly) Dates: 1) 2) 3) 4) 5) 6) ☐ Yes ☐ No Is the consumer being weaned?

Section D—Respiratory Therapist Attestation and Signature/Date

LRCP name (PRINTED)		
I certify that I am the respiratory therapist identified above. I certify that the information I have completed in this certificate is of medical necessity and any information on any attached documents signed and dated by me is true to the best of my knowledge. I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.		
LRCP signature	Date	License #

ODM 01902 (7/2014)
Formerly JFS 01902

Ohio Department of Medicaid

CERTIFICATE OF MEDICAL NECESSITY/PRESCRIPTION
IPPV OR APAP IN LIEU OF A VOLUME VENTILATOR

Certification Type: ☐ **Initial** ☐ **Revised** ☐ **Recertification**

Instructions: The Certificate of Medical Necessity (CMN) must be used for approved ventilators under the Ohio Medicaid Program. This form must be completed and carry the proper signature, where indicated, before requests will be considered for prior authorization.

Name of consumer	Medicaid billing#

Street address	City/State/Zip	Date of birth

List other respiratory equipment in use

Section A—Must be completed by prescriber

Diagnosis(es) Include ICD-9 code and description

Date of last examination by prescriber (must be within 30 days prior to first date of service)	Consumer has permanent tracheostomy ☐ Yes ☐ No

Medical history (attach hospital discharge summary, if applicable)

☐ APAP or ☐ IPPV device is required for ventilatory support/only effective alternative to a volume ventilator	Length of need ☐ Short term, # of months ☐ Chronic/permanent

Ventilatory support requirements	Ventilator settings/parameters
☐ Continuous ☐ Nocturnal only ☐ Other, explain:	O2 setting

Prescriber's name (PRINTED)

I certify that I am the prescriber identified above. I certify that the information I have completed in this certificate is of medical necessity and any information on any attached documents signed and dated by me is true to the best of my knowledge. I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.

Prescriber's signature	Date	Ohio Medicaid Legacy # NPI #

Section B—Must be completed by Licensed Respiratory Care Professional (LRCP)

Complete this section if the ventilator was dispensed prior to submitting prior authorization request

Licensed respiratory care professional services

Date placed on ventilator

☐ Yes ☐ No Home evaluation prior to hospital discharge?

☐ Yes ☐ No Home set up?

☐ Yes ☐ No In-home training provided to care givers?

If "yes", check all that apply:

☐ Ventilator operation

☐ Tracheostomy care

☐ Cleaning/sterilizing technique

Home visits first week

☐ 5-7 ☐ 3-4 ☐ 1-2

Home visits after the first week (at least monthly)

Dates: 1)
2)
3)
4)
5)
6)

Is the consumer being weaned? ☐ Yes ☐ No

LRCP name (PRINTED)

I certify that I am the respiratory therapist identified above. I certify that the information I have completed in this certificate is of medical necessity and any information on any attached documents signed and dated by me is true to the best of my knowledge. I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.

LRCP signature	Date	License #

TO BE RESCINDED

5160-10-23 **Pulse oximeters.**

(A) A pulse oximeter is a covered medical equipment item eligible for reimbursement when used in a personal residence as an alternative to hospitalization to manage the care of oxygen dependent pediatric recipients. Home pulse oximetry is covered when used to monitor oxygen saturation in order to determine appropriate supplemental oxygen levels. Home pulse oximetry is not covered for the purpose of qualifying or requalifying a patient for home oxygen.

(1) All oximeters approved for coverage must have printing capabilities that document an adequate number of sampling hours, per cent of oxygen saturation and an aggregate of the results.

(2) The oximeter must be preset, self-sealed and not adjustable by the consumer or anyone in the home.

(3) All oximeter printouts must be reliable, legible and maintained in the consumer's medical record.

(4) The consumer and/or the consumer's caregiver must be trained in the proper use of the pulse oximeter, the proper recording of measurements, and in whatever action is necessary to reverse a low oxygen saturation level. Documentation of this training must be kept in the provider's files.

(B) The following methods of home pulse oximetry services are covered:

(1) "Diagnostic monitoring," which is defined as monitoring for periods of up to twenty-four hours in length. Coverage is limited to a maximum of four monitoring periods per month. Prior authorization is required for diagnostic monitoring.

(2) "Continuous monitoring," which is defined as twenty-four-hour monitoring, seven days a week. Prior authorization is required for rental or purchase of an oximeter for use in continuous monitoring and may be requested for three months at a time when equipment is rented.

(C) All prior authorization requests must include a fully completed JFS 03401 (rev. 6/2006) "Certificate of Medical Necessity/Prescription Pulse Oximeter" (CMN) (appendix A to this rule) that is signed by an eligible prescriber and dated no more

than thirty days prior to the first date of service. Additionally, the following criteria and documentation requirements must be met to establish medical necessity:

(1) Diagnostic monitoring.

(a) Diagnostic monitoring may be approved for payment to assess oxygen saturation:

(i) When a consumer is weaning from oxygen and/or prior to weaning; or

(ii) On a periodic basis for oxygen dependent, clinically unstable consumers.

(b) Prior authorization requests must include legible oximeter printouts of any prior oximeter monitoring and documentation of the resulting impact on the management of the consumer's care.

(c) Diagnostic monitoring may be considered for authorization when provided to a consumer in response to a significant clinical event or exacerbation of clinical status that results in a critical change in oxygen saturation or that requires diagnostic monitoring in order to assess oxygen saturation. Since oximeter monitoring under these circumstances must be provided immediately after the clinical event in order to assure timely assessment of oxygen requirements, authorization for payment will only be considered after the service has been provided.

(2) Continuous monitoring.

Continuous oximeter monitoring in the home may be appropriate in the management of pediatric consumers with prolonged oxygen dependency who are at risk of a critical fluctuation in oxygen saturation. Requests for prior authorization of continuous home oximeter monitoring will include documentation by the managing prescriber that the consumer is clinically unstable with chronically compromised respiration and frequently varying oxygen requirements, at risk for critical fluctuations in oxygen saturation, and experiencing one or more of the following:

(a) Frequent bradycardia;

(b) Frequent oxygen desaturation;

(c) Chronic lung disease;

(d) Ventilator dependent;

(e) Poor growth and development and suspect for inadequate oxygenation; or

(f) Other risk factors that may result in sudden, critical fluctuations in oxygen saturation (hyperoxia, hypoxia).

(D) Rental payments will be made for oximeters used for diagnostic and continuous monitoring. Oximeters will be considered for purchase when continuous monitoring is authorized for periods in excess of ten months; subsequent monthly rental payments, less the cost of the probes, will be applied to the purchase price. The monthly rental payment amount includes reimbursement for:

(1) Set up and instructions;

(2) Maintenance and repair;

(3) Emergency service visits or other interim visits;

(4) Supplies and accessories (cable, printer/printer tape, carrying case, etc.); and

(5) Permanent, reusable, or disposable probes (transducers) and probe wraps or tape.

(E) Oximeter probes may be purchased when prior authorized for use in conjunction with continuous monitoring when a monitor is purchased by the Ohio department of job and family services (ODJFS) and when a monitor is owned by the consumer, if continuous monitoring has been determined to be medically necessary in accordance with this rule. Oximeter probes must be billed using the codes established for that purpose and listed in appendix A to rule 5101:3-10-03 of the Administrative Code.

Effective:

Five Year Review (FYR) Dates:

_____

Certification

_____

Date

Promulgated Under:	119.03
Statutory Authority:	5164.02
Rule Amplifies:	5162.03, 5164.02, 5164.70
Prior Effective Dates:	07/01/1993, 04/16/2007

Ohio Department of Medicaid

Certificate of Medical Necessity/Prescription
Pulse Oximeter

SECTION A: Consumer/Provider Information

Certification Type: ☐ Initial ☐ Revised ☐ Recertification			
Consumer Name		Provider's Name	
Consumer DOB	Consumer Sex: ☐ Female ☐ Male	Consumer HT (in.)	Consumer WT (lbs.)
(If consumer is not residing at home address) Facility Name		Prescriber's Name	
		Prescriber's NPI Number	
Facility Address		Prescriber's Telephone	
Facility City, State and Zip Code		Prescriber's Medicaid Legacy Number	

SECTION B: Information below may not be completed by the provider of the Items/Supplies

Est. Length of Need (# of Months) 1-99 (99=LIFETIME)	Diagnosis Codes (ICD-9) and Descriptions
Last Consumer Medical Examination (MM/DD/YR)	

ANSWERS	ANSWER QUESTIONS 1-6. (Check Y for Yes, N for No, or D for Does Not Apply, Unless Otherwise Noted)
☐ Y ☐ N ☐ D	1. Does the consumer have a documented serious respiratory diagnosis, which requires short-term oximetry to rule out hypoxemia and/or to determine the need for supplemental oxygen?
☐ Y ☐ N ☐ D	2. Is the consumer dependent on a ventilator with supplemental oxygen?
☐ Y ☐ N ☐ D	3. Does the consumer have a tracheostomy and dependent on supplemental oxygen?
☐ Y ☐ N ☐ D	4. Does the consumer require supplemental oxygen and has unstable saturations?
☐ Y ☐ N ☐ D	5. Is the beneficiary being weaned off of supplemental oxygen?
☐ Y ☐ N ☐ D	6. Does the consumer require monitoring during a specific event such as a weaning attempt from oxygen or ventilator, feeding times for an infant, or other times for which the prescriber needs documentation of the consumer's blood oxygen saturation?

NAME OF PERSON ANSWERING SECTION B QUESTIONS, IF OTHER THAN PRESCRIBER (Please Print):
NAME TITLE EMPLOYER

SECTION C: Narrative Description of Equipment and Cost

(1) Narrative description of all items, accessories and options ordered; (2) Provider charge; and (3) Medicaid Fee Schedule Allowance for each item, accessory, and option.

I certify that I am the prescriber identified above. I certify that the information on this certificate of medical necessity and any information on any attached documents signed and dated by me is true to the best of my knowledge. I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability. (SIGNATURE AND DATE STAMPS ARE NOT ACCEPTABLE)

Prescriber's Signature:	Date

TO BE RESCINDED

5160-10-24 **Speech generating devices (SGD).**

Unless otherwise specified, the licensing of persons authorized to conduct a formal evaluation of a consumer's communication and related cognitive and physical abilities for the purpose of dispensing an SGD to a medicaid consumer is administered according to Chapter 4753. of the Revised Code. Any provider seeking reimbursement for this service must meet the provisions contained within Chapter 4753. of the Revised Code in order to be eligible for reimbursement for services provided.

(A) Definitions

(1) Speech generating device (SGD): Any electronic aid or device approved for use as an SGD that provides external assistance for communication and is an integral part of a speech-language pathology treatment plan for a consumer with a communication disability who is unable to satisfy his or her basic communication needs.

Basic communication needs are defined as a consumer's ability to communicate needs and wants, transfer information, achieve social closeness, and demonstrate social etiquette.

(2) Speech: The ability to vocalize by coordinating the muscles controlling the vocal apparatus (lips, tongue, jaw and vocal folds). It is the mechanical aspect of oral communication.

(3) Language: Refers to symbolic communication and permits the ability to converse, comprehend, repeat, read, and write. Language ability depends on central processing for either comprehension or formulation for expressing the sounds and symbols of prepositional communication. Difficulty in articulation or vocalization implies a speech disorder, whereas the inability to find words, comprehend, read, or write is indicative of a language disorder.

(4) Speech language pathologist (SLP): The SLP is a licensed health professional, educated at the graduate level in the study of human communication, its development and its disorders. The SLP must comply with all applicable federal and state licensing laws.

(5) Date of service (DOS): The effective DOS for this rule is defined as the date that the consumer is evaluated by the provider for the use of an SGD device.

(B) Coverage determination

(1) Before the delivery of the SGD, the consumer must have a documented face-to-face evaluation of his or her communication abilities by an SLP. The SLP performing the consumer evaluation may not be an employee or have a financial relationship with the supplier of the SGD. The formal, written evaluation must include all of the following elements:

(a) Current communication impairment, including the type, severity, language skills, and anticipated course of the impairment;

(b) An assessment of whether the consumer's daily communication needs could be met using other natural or aided modes of communication;

(c) Clinical documentation supporting the assessment that the consumer possesses the linguistic capability to formulate a message independently;

(d) Clinical documentation supporting the assessment that the consumer possesses cognitive and physical abilities to effectively use the selected device and any accessories to communicate;

(e) A description of the functional communication goals expected to be achieved and treatment options;

(f) Rationale for selection of a specific device and any accessories;

(g) Demonstration that the consumer possesses a comprehensive treatment plan that includes a training schedule for the selected device;

(h) For any subsequent upgrade to a previously issued SGD, information regarding the functional benefit to the consumer of the upgrade compared to the initially provided SGD to include a full device description of the most current SGD being requested;

(i) A full disclosure of any SGD equipment that the consumer already possesses to include a statement as to why the current equipment does not currently meet the consumer's needs which is supported by clinical documentation from the consumer's medical record;

(j) Documentation supporting the medical necessity of any accessory or add-on equipment, supplies or SGD features being requested;

(k) The evaluation must be signed and dated by all parties of the consumer's evaluation team to include professional licensure numbers;

(l) The consumer's medical condition is one resulting in a severe expressive speech impairment that is supported by documentation in the consumer's medical record;

(m) The consumer's speaking needs cannot be met using natural communication methods;

(n) Other forms of speech impairment treatment have been considered and ruled out; and

(o) The consumer's speech impairment and communication ability will benefit clinically from the device ordered.

(2) A copy of the SLP's written evaluation and recommendation must be forwarded to the consumer's treating prescriber before the device is ordered and kept in the consumer's medical records.

(3) Mounting brackets used in association with the installation of the SGD to a consumer's wheelchair can be billed to the department for separate reimbursement using the appropriate billing codes for these devices.

(C) Eye control SGD accessory

(1) Eye control technology for use with an SGD commonly employs infrared illumination of the pupil or cornea with digital camera tracking integrated into the SGD.

(2) Eye control technology for an SGD must only be considered as a last choice after all other methods of operating the SGD device have been evaluated and determined by the evaluating SLP not to meet the consumers needs. The SLP must document on the prior authorization form and in the consumer's medical record that alternative SGD control devices other than eye control were evaluated before requesting eye control technology for a specific SGD device.

(3) The consumer must have a specific documented medical necessity that supports the request for an eye control SGD accessory including but not limited to the following:

(a) Consumer has a documented history of a brainstem stroke;

(b) Consumer has Guillain Barre syndrome;

(c) Consumer is in the final stages of amyotrophic lateral sclerosis (ALS);

(d) Consumer has a documented occurrence of a severe traumatic brain injury that resulted in the complete loss of head movement.

(4) Approval for an eye control SGD accessory for a consumer is based on medical necessity as determined by the department.

(5) In order for a request for an eye control SGD accessory to be considered the provider must document that the consumer is able to use an eye control SGD accessory independently and successfully in the environments and situations in which the consumer is using the SGD device.

(6) Any SGD eye control accessory associated with the consumer's use of an SGD device will not be reimbursed by the department for an amount greater than five thousand six hundred dollars.

(7) The consumer must be provided with the most cost-effective SGD available to meet the medical needs of the consumer.

(D) Non-coverage determination

(1) Claims for more than one SGD at a time per qualifying consumer will be denied as not medically necessary.

(2) Environmental control devices are not separately reimbursable.

(3) Any non-medical software, accessory, application or hardware to include internet capabilities used in conjunction or compatible with the SGD are not separately reimbursable without the department's prior authorization.

(4) Personal computers and related hardware are not reimbursable unless the system

has been adapted for use primarily as an SGD. The documentation supporting this adaptation must be maintained in the provider's records and on the prior authorization form.

(5) There will be no separate billing of any interfaces, printers, printer paper, cables, adapters, interconnects, or any other standard component necessary for the accessory to interface with any SGD in conjunction with the initial dispensing of this equipment to the consumer that is non-medical in nature without the department's prior authorization.

(6) Consumer training expenses related to the operation of the SGD are not separately reimbursable.

(E) Authorization

(1) The following documentation must be submitted for prior authorization (PA) before reimbursement for an initial SGD will be considered:

(a) A fully completed and legible JFS 02924 "Certificate of Medical Necessity/Prescription Speech Generating Device (SGD) Initial Certification" (appendix A to this rule) that is signed by the applicable licensed providers and dated no more than ninety days before submission for prior authorization; and

(b) Any other documentation required or requested by the department.

(2) Documentation for the prior authorization of an SGD must be submitted with the appropriate reimbursement codes.

(F) Trial use period

When recommended by the prescribing SLP, a trial use period must be conducted before the department will consider authorizing the purchase of an SGD. Monthly rental payments, limited to the lower of the provider's usual and customary monthly rental charge, are not to exceed ten per cent of the authorized purchase price of the prescribed SGD, and will be paid during the trial use period. Payments authorized during the trial use period are limited to four monthly payments. Long-term rental may be considered for authorization up to a maximum of ten months. If long-term rental is required, documentation must support why a long-term rental is necessary as an alternative to a trial period and/or purchase. Rental payments require prior authorization in accordance with paragraph (E) of this rule. Authorization for rental of SGDs for a trial use period or long-term rental will be limited to one device per month per consumer.

(G) Requesting purchase of an SGD at the end of a trial use period or subsequent to any rental period.

The following documentation must be submitted for review by PA before reimbursement for an SGD following a trial use period or subsequent to any rental period:

(1) A fully completed and legible JFS 02925 "Certificate of Medical Necessity/Prescription Speech Generating Device (SGD) Recertification" (appendix B to this rule).

(2) Documentation for the prior authorization of an SGD must be submitted with the appropriate reimbursement codes.

(3) Documentation that details any previous rental payments received by the SGD provider made on behalf of the consumer by the department in relation to providing the consumer with an SGD device.

(4) Any other documentation required or requested by the department.

(H) Repair, upgrade and replacement

(1) Repair

Medicaid reimbursement for repairs is available for no more than one SGD per recipient as detailed in rule 5101:3-10-08 of the Administrative Code. Repair costs for an SGD not originally covered by the department are to be considered on a case-by-case basis and are approved with a prior authorization. Repairs to consumer-owned SGD equipment that meet or exceed one thousand dollars in a twelve-month period will be deemed to extend the useful life of the consumer-owned SGD by one year from the date of the last repair request. No follow-up requests for a new SGD device in association or in conjunction with a repair request will be considered for a consumer during this extension period.

The repair of an SGD (including battery pack replacement) requires prior authorization. The following documentation, including the appropriate reimbursement codes, must be submitted when requesting prior authorization:

(a) A fully completed and legible JFS 02926 "Certificate of Medical Necessity/Prescription Speech Generating Device (SGD)" (appendix C to this rule); and

(b) Any other documentation required or requested by the department.

Requests for minor repairs as defined in rule 5101:3-10-08 of the Administrative Code do not require prior authorization. However, the SGD provider must maintain the documentation detailed in this rule in the consumer's medical record in order to document the need for the repair.

(2) Replacement or modification of a consumer-owned SGD that was originally covered by the department will be authorized only if it is determined by the department that the current SGD does not meet the recipient's basic communication needs in accordance with this rule, regardless of the age of the current equipment, and the current SGD cannot be repaired or modified to meet basic communication needs due to situations such as a change in a consumer's cognitive, communication or physical status. If the current SGD can be modified or repaired, replacement will only be considered when modification or repair of the current equipment is judged by the department to be more costly than replacement. A request for prior authorization for replacement or modification of a recipient-owned SGD must meet all the requirements specified in paragraphs (H)(1)(a) and (H)(1)(b) of this rule. In addition, a description, model number, and the condition of a recipient's current equipment must be specified on the documentation submitted for prior authorization of additional or replacement equipment. (See rule 5101:3-10-05 of the Administrative Code regarding duplicate and conflicting equipment.)

(I) Reimbursement

(1) SGDs are reimbursed according to the department fee schedule contained in appendix DD to rule 5101:3-1-60 of the Administrative Code, or the provider's usual and customary charge, whichever is less.

(2) Under no circumstances will the department pay more than the amount of the cumulative sum of ten rental payments for any SGD made to a provider by the department on behalf of a medicaid consumer. Ownership of any SGD that has had ten rental payments made to the SGD provider by the department on behalf of a consumer immediately transfers to the consumer upon receipt of the tenth rental payment to the SGD provider by the department. The SGD provider is responsible to notify the consumer that the ownership of the SGD was transferred upon completion of the rental or trial agreement as explained in this rule.

(3) Any compensation paid to an SGD provider on a consumer's behalf in association with the dispensing, repair, replacement or modification of an

SGD is inclusive of all professional, technical or administrative services required to supply the SGD to the consumer. These costs cannot be billed to the department separately.

Effective:

Five Year Review (FYR) Dates:

_____

Certification

_____

Date

Promulgated Under:	119.03
Statutory Authority:	5164.02
Rule Amplifies:	5162.03, 5164.02
Prior Effective Dates:	09/10/1993, 12/10/1993, 12/29/1995 (Emer), 03/21/1996, 10/01/2004, 05/01/2012

Ohio Department of Medicaid

CERTIFICATE OF MEDICAL NECESSITY/PRESCRIPTION SPEECH GENERATING DEVICE (SGD) INITIAL CERTIFICATION

Name of Provider _____
Provider NPI # _____
Medicaid Legacy # ____

Instructions: The Certificate of Medical Necessity (CMN) must be used for speech generating devices under the Ohio Medicaid Program. This form must be completed and carry the proper signature, where indicated, before requests will be considered for prior authorization.

Name of Consumer	Billing Number	Date of Birth
☐ Trial/Rental period ☐ Purchase		

Section A - Must be completed by Prescriber

Diagnosis (ICD-9 Code and Description)	Consumer's Diagnosis/Prognosis

Include consumer's name on all attachments.

Section B - OT/PT Assessment of consumer

Explain if OT/PT Assessment NOT warranted.

Motor function (range of motion, tone, active motion).

Postural/positioning.

Mobility status.

Integration of mobility and positioning with the SGD.

OT/PT Signature (No stamps)	Date	License #

Section C - Cognitive status assessment

Explain if Cognitive status assessment is not warranted.

Estimate of developmental and intellectual age or range.

Describe method of assessing cognitive status.

Document consumer's most recent cognitive assessment (done by speech-language pathologist).

Section D - Sensory Status (Describe assessment methods)

Explain if Sensory Status is not warranted.

Visual abilities.

Auditory abilities.

Section E - Speech, language, and communication status

Specific description of communications disability, including speech diagnosis.

Speech skills and prognosis.

Language skills: expressive and receptive.

Description of communication behaviors and interaction skills.

Description of consumer's use of current SGD, if applicable. (Include date current SGD acquired by consumer).

Emotional status as it relates to communication.

State why current communication behaviors prevent the consumer from communicating basic needs.

Identify primary communication partners (family members, caregivers, etc.) and any associated limitations and needs.

Message needs (pragmatics).

Vocabulary (semantics).

Communication environments. (Include description of vocational and education status).

Section F - SGD Assessment

A. Assessment of consumer's needs

1. Representational systems (symbol system)

2. Vocabulary encoding (i.e., minspeak, levels plus location, traditional orthography, etc.).

3. Vocabulary expandability and message generation (i.e., pre-programmed, fully programmable, combination of pre-programmed and programmable, additional memory, messages stored as letters, words, phrases, sentences, etc.).

4. Rate enhancement techniques (i.e., simple symbol selection, symbol sequencing, key linking, dynamic displays, abbreviation-expansion, word lists, word prediction, icon prediction, minsets, macros, etc.).

5. Access techniques and strategies.

6. Overlay or keyboard organization and features (i.e., key size, keys per overlay, spacing between keys, overlay size, keyguard, multiple location overlay, etc.).

7. Device output modes (i.e., speech synthesis, printed output, display characteristics, auditory and visual prompting, auditory and visual feedback, etc.).

8. Portability concerns.

(Attach product description information, as needed.)

B. Comparison of SGD specifications

1. List specifications for the SGD that most effectively and efficiently meets the consumer's basic communication needs.
2. Document why nonrequested comparable SGDs were considered to be inappropriate to meet the consumer's basic communication needs and capabilities.

3. If a higher tech SGD requested, document why a lower tech SGD is inadequate.

Section G - Treatment plan and follow-up

Short and long-term communication goals.

Individual speech-language pathologist and/or organization/facility responsible for SGD training.

Necessary modification of SGD to suit the individual consumer's access needs.

Schedule for evaluating the outcome of the trial use period. (Must be used when requesting authorization for rental during a trial use period).

Section H - Prescription for SGD

Name of Requested SGD

List all required components, accessories, peripheral devices, supplies.

Device vendor(s)

Signatures/Dates

Equipment Vendor (Print)	Vendor Signature/Date
Name/title of Speech-Language Pathologist (Print)	Signature/Date
Date of Assessment	License #

Prescriber Attestation and Signature/Date

Prescriber's Name (Printed)

I certify that I am the prescriber identified above. I certify that the information I have completed in this certificate is of medical necessity and any information on any attached documents signed and dated by me is true to the best of my knowledge. I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.

Prescriber Signature (No stamps)	Date	Ohio Medicaid Prescriber #

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Ohio Department of Medicaid

CERTIFICATE OF MEDICAL NECESSITY/PRESCRIPTION SPEECH GENERATING DEVICES (SGD) RECERTIFICATION

Name of Provider _____
Provider NPI # _____
Medicaid Legacy # _____

Instructions: The Certificate of Medical Necessity (CMN) must be used for all speech generating devices under the Ohio Medicaid Program. This form must be completed and carry the proper signature, where indicated, before requests will be considered for prior authorization.

Name of Consumer			Billing Number
☐ Trial/Rental ☐ Purchase	Were rental dates previously approved? ☐ Yes ☐ No	If "Yes", List Prior Authorization #'s Authorized Dates	Date of Birth

Rental

Dates of trial period

From to

Describe the outcome of the trial use period.

If long-term rental is required, document why it is necessary as an alternative to a trial use period and/or purchase.

Purchase

Is consumer compliant with SGD use? ☐ Yes ☐ No - Explain:

Is patient continuing to benefit from the device? ☐ Yes ☐ No - Explain:

How is the SGD meeting the needs of the consumer?

Are there factors which prevent the consumer's successful utilization of the SGD?

Speech-Language Pathologist (SLP) Attestation and Signature/Date

Name (Printed)

I certify that I am the SLP identified above. I certify that the information I have completed in this certificate is of medical necessity and any information on any attached documents signed and dated by me is true to the best of my knowledge. I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.

SLP Signature (No stamps)	Date	License#

Prescriber Attestation and Signature/Date

Prescriber Name (Printed)

I certify that I am the prescriber identified above. I certify that the information I have completed in this certificate is of medical necessity and any information on any attached documents signed and dated by me is true to the best of my knowledge. I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.

Prescriber Signature (No stamps)	Date	Medicaid Provider #

ODM 02925 (7/2014)
Formerly JFS 02925 (1/2012)

Ohio Department of Medicaid

CERTIFICATE OF MEDICAL NECESSITY/PRESCRIPTION SPEECH GENERATING DEVICE (SGD)

☐ **Repair** ☐ **Modification** ☐ **Upgrade**

Name of Provider _____
Provider NPI # _____
Medicaid Legacy # _____

Instructions: The Certificate of Medical Necessity (CMN) must be used for speech generating devices under the Ohio Medicaid Program. This form must be completed and carry the proper signature, where indicated, before requests will be considered for prior authorization.

Name of Consumer		Billing Number
Funding Source of SGD	SGD is necessary to meet the consumer's basic communication needs. ☐ Yes ☐ No	Date of Birth
Make, model and Serial # of SGD (include PA # for purchase, if known)	Date Purchased	Are parts requested still under warranty? ☐ Yes ☐ No **Attach copy of warranty.**

Section A - Repair of SGD

Type of repair: ☐ Major ☐ Minor

Was this SGD purchased through Medicaid? ☐ Yes ☐ No

Description of required parts needed to complete repair. Include manufacturer price lists.

Part Code	Name of Part	Reason part needs to be replaced/repaired

Describe the nature of the damage to the SGD:

Section B - SGD Modifications (attach additional documentation, if needed.)

Consumer's initial condition

Current condition warranting modification

How will modification correct change in condition?

Section C - SGD Upgrade

Consumer's initial condition

Section C - SGD Upgrade (continued)

Current condition warranting upgrade

How will upgrade correct change in condition?

Speech-Language Pathologist (SLP) Attestation and Signature/Date

Name (PRINTED)

I certify that I am the SLP identified above. I certify that the information I have completed in this certificate is of medical necessity and any information on any attached documents signed and dated by me is true to the best of my knowledge. I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.

SLP Signature	Date	License #

Prescriber Attestation and Signature/Date

Prescriber Name (PRINTED)

I certify that I am the prescriber identified above. I certify that the information I have completed in this certificate is of medical necessity and any information on any attached documents signed and dated by me is true to the best of my knowledge. I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.

Prescriber signature (No stamps)	Date	Medicaid Provider #

TO BE RESCINDED

5160-10-25 **Lactation pumps.**

(A) Lactation pumps are covered by the medicaid program under the following conditions:

(1) The requested lactation pump is subject to the coverage and limitations for medical supplies as defined in rule 5101:3-10-02 of the Administrative Code.

(2) The requested lactation pump is prescribed by an eligible prescriber involved in the consumer's or infant's care.

(3) The lactation pump is deemed medically necessary by the ordering prescriber when one or more of the following conditions exist:

(a) The infant is unable to initiate breast feeding due to a medical condition such as prematurity, oral defect, etc.; or

(b) Temporary weaning (i.e., direct breast feeding is not possible) due to:

(i) Mother/infant separation; or

(ii) Mother is required to take a medication or undergo a diagnostic test that is contraindicated with breast feeding; or

(c) Inadequate milk supply; or

(d) Engorgement; or

(e) Breast infection.

(4) In addition to the aforementioned criteria, the lactation pump must have been authorized by a prescriber who is actively involved in managing the consumer's or infant's medical care through a comprehensive plan of care that addresses the medical need for a lactation pump.

(B) Prior authorization is not needed for the purchase of a lactation pump. Providers must keep on file a fully completed JFS 01901, "Certificate of Medical

Necessity/Prescription Lactation Pumps" (CMN) (appendix A to this rule) that is signed and dated no more than thirty days prior to the first date of service. This documentation must be available for review at the request of ODJFS.

(C) Hospital grade (HG) rental lactation pumps do not require an initial prior authorization. The rental period is ninety consecutive days. The rental period may be extended beyond the initial ninety days with prior authorization. Total rental period for a lactation pump will not exceed one hundred eighty consecutive days to include the initial rental period.

(D) Reimbursement for the purchase of either an electric or a manual lactation pump will include a one-year manufacturer's warranty that covers product malfunction, repair or replacement.

(E) Prior authorization (PA) requests for extension of the initial HG lactation pump rental period must be compliant with rule 5101: 3-10-06 of the Administrative Code. The PA request must include the following documentation:

(1) A fully completed JFS 01901, "Certificate of Medical Necessity/Prescription Lactation Pumps" (CMN) (appendix A to this rule) that is signed and dated no more than thirty days prior to the first date of service.

(2) A description, including approximate age and ownership, of any similar equipment currently in possession of the recipient and the reason for the new request if similar equipment ownership is established.

(3) Any other documentation as required or requested by ODJFS for certain specific medical supplier services, as detailed in Chapter 5101:3-10 of the Administrative Code.

(F) In order for an HG lactation pump to be eligible for program reimbursement, the following criteria must also be met:

(1) The pump must utilize suction and rhythm equivalent to the equipment commonly found in hospital settings. This means it must have an adjustable suction pressure between one hundred and two hundred fifty mm Hg and a mechanism to prevent suction beyond two hundred fifty mm Hg.

(2) The pump must have an adjustable pumping speed capable of reaching fifty-two cycles per minute.

(3) The pump must be cleaned and serviced as needed between rentals.

(G) Rental payments for lactation pumps are considered "bundled," which includes but is not limited to the following components:

(1) Set up and instructions as to pump and attachment kit usage and cleaning.

(2) Maintenance and repair during rental period.

(3) Any required attachment kit, which must be new and will become the property of the consumer upon issuance.

(4) Applicable cleaning/return service charges, unless the unit is returned excessively dirty, which is defined as the unit requires extensive cleaning before it can be utilized by another consumer, in which case the durable medical equipment (DME) vendor may seek reasonable cleaning charges from the consumer.

(H) “ ”Bundled accessories are the responsibility of the DME provider to dispense during the consumer's initial rental period. No replacements for lost or damaged supplies and or accessories are billable to Ohio medicaid during the rental period. Any lost or damaged supplies and/or accessories are the responsibility of the consumer to replace.

(I) Any manual lactation pump that was supplied to a consumer as part of a pump attachment kit cannot be billed to the Ohio medicaid program as a separate item by a DME vendor.

(J) Any consumer that acquires a manual lactation pump as part of a vendor supplied pump attachment kit cannot purchase an additional manual lactation pump at Ohio medicaid program expense.

(K) All DME providers that submit claims to Ohio medicaid for reimbursement of a rental lactation pump must keep in the consumer's medical record documentation to demonstrate that the lactation pump was actively being utilized by the consumer during the time frame for which compensation is sought. The type of documentation that meets this requirement is left to the discretion of the DME provider. This documentation must be available for review at the request of ODJFS.

(L) Inpatient lactation services or those provided to a resident of a long term care facility (LTCF) or an intermediate-care facility for the mentally retarded and/or DME equipment are not covered under this rule and cannot be billed separately. These services are considered a component of the diagnostic related group (DRG) or

facility per diem payment.

(M) Lactation pumps are reimbursed at the lesser of the department's fee schedule contained in appendix DD to rule 5101:3-1-60 of the Administrative Code or the provider's usual and customary charge.

Effective:

Five Year Review (FYR) Dates:

_____

Certification

_____

Date

Promulgated Under:	119.03
Statutory Authority:	5164.02
Rule Amplifies:	5162.03, 5164.02
Prior Effective Dates:	09/05/2005, 04/25/2011

Ohio Department of Medicaid

CERTIFICATE OF MEDICAL NECESSITY/PRESCRIPTION
LACTATION PUMPS

Instructions: The Certificate of Medical Necessity (CMN) must be used for lactation pumps under the Ohio Medicaid Program. This form must be completed and carry the proper signature, where indicated, before requests will be considered for prior authorization.

Name of Consumer	Consumer OH Medicaid Number		Consumer DOB
Consumer Address	City	State	Zip

Section A - Must be completed by Prescriber

Infant's Name	Infant's DOB
Location of infant	

☐ At this time the infant is too ill, immature or separated from the mother to nurse directly at the breast. Pumping with the lactation pump is the only way for a mother to keep up her milk supply, when separated from her infant or until the infant can nurse effectively at the breast.

Medical need for breast milk for the infant is due to:

Breast Pump Start Date
Estimated length of need

☐ E0602 Manual Breast Pump = no prior authorization needed, bill direct.
☐ E0603 Electric Breast Pump = no prior authorization required. Document why an electric pump is necessary in lieu of a manual lactation pump.
☐ E0604 HD Breast Pump Hospital Grade (Rental Only) = Prior authorization required after 90 day initial rental period.

☐ The electric pump is not a convenience for the mother, it is a medical necessity to provide nutrition for the infant.

Section B - Prescriber Attestation and Signature/Date

Prescriber Name (printed)

I certify that I am the prescriber identified above. I certify that the information in Section A of medical necessity and any information on any attached documents signed and dated by me, is true to the best of my knowledge. I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.

Prescriber Signature	Date
Ohio Medicaid Legacy #	NPI #

TO BE RESCINDED

5160-10-27 Continuous passive motion (CPM) devices.

(A) Definition

The continuous passive motion (CPM) device is a treatment modality in which knee joint motion is provided by a machine without causing active contraction of muscle groups. The CPM device allows passive movements to be performed to a knee joint for hours at a time. The knee joint area is secured in the CPM machine, and the machine is programmed to passively flex and extend the knee joint through a pre-selected range of motion and rate of repetition. Movement is slow and controlled, and the patient does not actively exert muscle force to move the knee joint.

(B) Coverage determination

The CPM device, when initiated during the immediate post-operative period (beginning within forty-eight hours after surgery), will be considered for coverage if the CPM device is to be utilized following total knee replacement or revision of a total knee replacement and is being sought for use in the consumer's personal residence.

(C) Non-coverage determination

(1) CPM therapy is not covered for joints other than the knee.

(2) A CPM device is not separately reimbursable for consumers who are hospitalized or in a long term care facility (LTCF).

(3) CPM is not covered as a substitute to conventional provider delivered physical therapy.

(4) CPM therapy is not appropriate for consumers unable to independently turn the device on and off, or who are not willing to participate in a course of rehabilitation in relation to the medical event prompting the request for CPM therapy.

(D) Authorization

(1) The use of a CPM device does not require a prior authorization when utilized

for a single knee surgery. However, the provider of the CPM device is required to maintain on file a legible written prescription issued by a licensed prescriber that is signed and dated no more than thirty days prior to the first date of service that defines the specific "from" and "to" dates that reflect the actual days the CPM device is to be utilized.

(2) The maximum days allowable for the utilization of a CPM device is twenty-one per medical event, per knee.

(3) If the consumer has the surgery mentioned in paragraph (B) of this rule on both knees concurrently, the following documentation must be submitted for prior authorization (PA) before reimbursement for services rendered with two machines will be authorized in accordance with the provisions set forth in rule 5101:3-1-31 of the Administrative Code:

(a) A legible written prescription issued by a licensed prescriber that is signed and dated no more than thirty days prior to the first date of service that defines the specific "from" and "to" dates that reflect the actual days the CPM device is to be utilized.

(b) Any other documentation as required or requested by ODJFS for certain specific medical supplier services, as detailed in Chapter 5101:3-10 of the Administrative Code.

(4) CPM devices must be prescribed by a prescriber actively involved in managing the consumer's medical care through a comprehensive plan of care that addresses the medical need for the CPM device.

(E) Dispensing

(1) CPMs are expected to be dispensed with one complete set of supporting soft goods per CPM unit dispensed unless the consumer currently owns the supporting soft goods resulting from a previous medical event.

Soft goods are defined as including at a minimum, thigh and calf pads, foot bootie pad, thigh straps and hook and loop contact closures constructed of quilted sheepskin or moisture wicking materials.

(2) The following components are considered "bundled" with any CPM payment made by ODJFS on behalf of a consumer and cannot be submitted to ODJFS for separate payment:

(a) Any supporting wires, cables, or attachment kits;

(b) Consumer education, training, monitoring, or counseling;

(c) Maintenance, repair, or cleaning charges; or

(d) Delivery, set up, or pick up charges.

(3) The provider of a CPM device must assure that the consumer or the consumer's caregiver is properly instructed on how to use the device and understands any emergency procedures regarding the use of the device. The provider must maintain written documentation in the consumer's medical record regarding the consumer's or the consumer's caregiver's instruction on the use of the CPM device.

(4) The prescriber of a CPM device must assure and document in the medical record that the continued use of the CPM device is resulting in the clinical improvement of the consumer. The use of the CPM device must be discontinued immediately and an alternative therapy method considered if the consumer demonstrates no progressive clinical improvement during the CPM rental period.

(5) The provider of a CPM device must supply the consumer or the consumer's caregiver with a twenty-four hour, seven-day-a-week telephone number to be utilized in case of an emergency. This telephone number must meet all federal Americans with Disabilities Act (ADA) of 1990 requirements.

(F) Reimbursement

CPM devices and associated soft goods are reimbursed according to the ODJFS fee schedule contained in appendix DD to rule 5101:3-1-60 of the Administrative Code, or the providers usual and customary charge, whichever is less.

Effective:

Five Year Review (FYR) Dates:

_____

Certification

_____

Date

Promulgated Under:	119.03
Statutory Authority:	5164.02
Rule Amplifies:	5162.03, 5164.02
Prior Effective Dates:	04/01/2006, 04/25/2011

TO BE RESCINDED

5160-10-28 **Non-invasive bone (osteogenesis) stimulators.**

(A) Definition

(1) An electrical bone (osteogenesis) spinal or nonspinal stimulator is a device that provides electrical stimulation to augment bone repair. A non-invasive electrical bone stimulator is characterized by an external power source that is attached to a coil or electrodes placed on the skin or on a cast or brace over a fracture or fusion site.

(2) An ultrasonic bone (osteogenesis) stimulator is a non-invasive device that emits low intensity, pulsed ultrasound. The ultrasound signal is applied to the skin surface at the fracture location via ultrasound conductive coupling gel in order to stimulate fracture healing.

(B) Coverage determination

(1) A nonspinal electrical bone stimulator is covered only if any of the following criteria are met:

(a) Nonunion of a long bone fracture, defined by radiographic evidence that fracture healing has ceased for three or more months prior to starting treatment with the bone stimulator and documented by a minimum of two sets of radiographs obtained prior to starting treatment with the bone stimulator, separated by a minimum of ninety 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) Failed fusion of a joint other than the spine where a minimum of nine months has elapsed since the last surgery; or

(c) Congenital pseudarthrosis.

(2) A nonspinal electrical bone stimulator will be denied as not medically necessary if none of the criteria listed in paragraph (B)(1) of this rule are met.

(3) A spinal electrical bone stimulator is covered only if any of the following

criteria are met:

(a) Failed spinal fusion where a minimum of nine months has elapsed since the last surgery;

(b) The consumer has undergone a multilevel spinal fusion surgery; or

(c) The consumer has undergone spinal fusion surgery where there is a history of a previously failed spinal fusion at the same site.

(4) A spinal electrical bone stimulator will be denied as not medically necessary if none of the criteria listed in paragraph (B)(3) of this rule are meet.

(5) An ultrasonic bone stimulator is covered only if all of the following criteria are met:

(a) Nonunion of a long bone fracture documented by a minimum of two sets of radiographs obtained prior to starting treatment with the bone stimulator, separated by a minimum of ninety 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.

(6) An ultrasonic bone stimulator will be denied as not medically necessary if all of the criteria listed in paragraph (B)(5) of this rule are not met.

(7) In order to qualify for the use of any bone stimulator, a consumer that is twenty years of age or younger must meet all of the following criteria in addition to the medical criteria for the applicable bone stimulator prescribed listed in paragraphs (B)(1), (B)(3) and (B)(5) of this rule:

(a) There is radiological documentation that skeletal maturity has been attained;

(b) The fracture gap is not more than one-half of the diameter of the bone to be treated; and

(c) The fracture does not involve a vertebrae.

(C) Non-coverage determination

(1) Bone (osteogenesis) stimulators are considered noncovered if any of the following contraindications exist:

(a) Fracture of short or flat bones or epiphyses;

(b) Fracture as a result of cancer;

(c) Fractures that need additional reduction or are comminuted;

(d) Fractures with post-reduction displacement of greater than fifty per cent;

(e) Fractures with internal or external fixation;

(f) Fracture gaps greater than one centimeter;

(g) Avascularity, vascular insufficiency or other vascular problems (e.g., thrombophlebitis) or severe osteoporosis;

(h) When stimulator is to be used in conjunction with medications that may interfere with or alter bone metabolism and healing;

(i) When osteomyelitis, active infections or necrotic bone is present;

(j) Paget's disease, renal disease or diabetes;

(k) Sensory paralysis; or

(l) Synovial pseudoarthritis.

(2) Consumers with demand type pacemakers in proximity to the proposed treatment site are not eligible for electric bone stimulators.

(D) Prior authorization

A fully completed form JFS 07134 (rev. 2/2006), "Certificate of Medical

Need/Prescription Non-Invasive Bone Growth (Osteogenesis) Stimulator" (CMN) (appendix A to this rule) that is signed and dated no more than thirty days prior to the first date of service must be submitted for prior authorization (PA) before reimbursement for a bone stimulator will be considered.

(E) Dispensing

(1) The following components are considered "inclusive" with any bone stimulator device payment made by the department on behalf of a consumer and cannot be submitted to the department for separate reimbursement:

(a) Any supporting wires, power supply, cables, attachment kits or disposable items such as electrodes, or in the case of the ultrasound stimulator, coupling gel;

(b) Stimulator education, training, monitoring, or counseling in support of the consumer's ordered treatment;

(c) Maintenance, repair, or cleaning services; or

(d) Delivery or set-up services.

(2) The provider of the bone stimulator must assure that the consumer utilizing the device is properly instructed on how to use the device in support of the ordered treatment and is aware of and understands any emergency procedures regarding the use of the bone stimulator device. The provider must maintain written documentation regarding the consumer's instruction on the use of the bone stimulator in the consumer's medical record.

(3) A bone stimulator may not be used concurrently with any other bone stimulator device on the same fracture site.

(4) Upon dispensing of a bone stimulator device, the consumer must be supplied by the provider with a twenty-four hour, seven day a week telephone number to be utilized in case an emergency situation arises concerning the device. This telephone number must meet all federal Americans with Disabilities Act (ADA) of 1990 requirements.

(F) Reimbursement

Bone stimulator devices are reimbursed according to the department fee schedule

contained in appendix DD to rule 5101:3-1-60 of the Administrative Code or the provider's usual and customary charge, whichever is less.

Effective:

Five Year Review (FYR) Dates:

_____

Certification

_____

Date

Promulgated Under:	119.03
Statutory Authority:	5164.02
Rule Amplifies:	5162.03, 5164.02
Prior Effective Dates:	10/15/2006

Ohio Department of Medicaid

Certificate of Medical Necessity/Prescription
Osteogenesis Bone Stimulators

SECTION A: Consumer/Provider Information

Certification Type:	☐ **Initial**	☐ **Revised**	☐ **Recertification**
Consumer Name:		Provider's Name:	
Consumer DOB:	Consumer Sex: ☐ Female ☐ Male	Consumer HT (in.):	Consumer WT (lbs.):
(If consumer is not residing at home address) Facility Name:		Prescriber's Name:	
		Prescriber's NPI Number:	
Facility Address:		Prescriber's Telephone:	
Facility City, State and Zip Code:		Prescriber's Medicaid Legacy Number:	

SECTION B: Information below may not be completed by the provider of the Items/Supplies

Est. Length of Need (# of Months): 1-99 (99=**LIFETIME**)	Diagnosis Codes (ICD-9) and Descriptions: **Pacemaker:** ☐ **Y** ☐ **N**
Last Consumer Medical Examination (MM/DD/YR):	

NON-SPINAL STIMULATORS

Non-union of long bone fracture? ☐ Yes ☐ No

If yes, joint/s affected and date of surgery: A): ____________________ Date: ______________

B): ____________________ Date: ______________ C): ____________________ Date: __________

Note: Date of fracture must be a minimum of 3 months prior to initiating treatment.

Failed joint/s fusion? ☐ Yes ☐ No

If yes, joint/s affected and date of surgery: A): ____________________ Date: ______________

B): ____________________ Date: ______________ C): ____________________ Date: __________

Note: Date of fracture must be a minimum of 3 months prior to initiating treatment.

Congenital Pseudarthrosis? ☐ Yes ☐ No

If yes, explain in detail:

SPINAL STIMULATORS

Failed spinal fusion? ☐ Yes ☐ No

If yes, date of surgery: and level of fusion:

Multilevel (3 or more vertebrae) spinal fusion? ☐ Yes ☐ No

If yes, date of surgery: and level of fusion:

Spinal fusion with history of previously failed spinal fusion? ☐ Yes ☐ No

If yes, date of current surgery: ____________________ Level of fusion: ______________________________

Date of failed spinal fusion:

NAME OF PERSON ANSWERING SECTION B QUESTIONS, IF OTHER THAN PRESCRIBER (Please Print):

NAME: TITLE: EMPLOYER:

SECTION C: PRESCRIBER ATTESTATION

I certify that I am the prescriber identified above. I certify that the information on this certificate of medical necessity and any information on any attached documents signed and dated by me, is true to the best of my knowledge. I understand that my falsification, omission, or concealment of material fact may subject me to civil or criminal liability. (SIGNATURE AND DATE STAMPS ARE NOT ACCEPTABLE)

Prescriber's Signature:	Date:

5160-10-29 External insulin infusion pump.

(A) Definition

A standard portable external insulin infusion pump is a small battery-operated pump about the size of a personal pager, is filled with insulin, and is connected to thin tubing ending in a needle. The needle is inserted into the skin around the abdomen, and supplies a regulated dose of insulin to the user for a day or more at a time. The pump may be carried in a pocket or in a case worn attached to a belt fastened around a consumer's waist.

(B) Coverage determination

(1) Ohio medicaid covers standard portable external insulin infusion pumps for patients with type 1 diabetes mellitus documented by a C-peptide level less than 0.5 and when all of the following medical necessity criteria are met:

(a) The consumer has completed a diabetes education program within the last twenty four months of being prescribed an insulin infusion pump;

(b) The consumer has been on a program of multiple daily injections of insulin (i.e., at least three injections per day), with frequent self-adjustments of insulin dose, for at least six months before initiation of the insulin infusion pump;

(c) The consumer had documented frequency that is kept in the consumer's medical record of glucose self-testing an average of at least four times per day during the two months before initiation of the insulin infusion pump;

(d) The consumer is at high risk for preventable complications of diabetes. Early signs of diabetic complications include micro-albuminuria and/or documented in the consumer's medical record persistent difficulty in achieving optimal control of blood sugar levels despite good compliance with an intensive multiple injection regimen.

(2) In addition to the aforementioned criteria, the consumer needs to meet at least one of the following criteria in order to be eligible for a standard portable external insulin infusion pump:

(a) Glycated hemoglobin level (HbA1c) greater than seven per cent;

(b) History of recurring hypoglycemia;

(c) Wide fluctuations in blood glucose before mealtime;

(d) Dawn phenomenon with fasting blood sugars frequently exceeding two hundred mg/dL; or

(e) History of severe glycemic excursions.

(C) Non-coverage determination

(1) Standard portable external insulin infusion pumps are not covered if any of the following contraindications exist:

(a) Consumer has non-insulin dependent (NIDDM or IR-NIDDM, Type II) diabetes, even if insulin is taken;

(b) Consumer has end-stage complications such as renal failure;

(c) Consumer is unable, because of behavioral, psychological problems or functional ability, to technically operate the pump and perform frequent blood glucose monitoring; or

(d) Consumer is being prescribed pump therapy to be used for convenience purposes.

(2) The department will not cover jet pressure or surgically implanted infusion devices or systems, chronic intermittent intravenous insulin therapy (CIIIT), or pulsatile IV insulin therapy (PIVIT).

(D) Prior authorization

(1) The following documentation must be submitted for prior authorization (PA) before reimbursement for a standard portable external insulin infusion pump will be considered:

A fully completed form JFS 07136 (rev. 3/2008) "Certificate of Medical Necessity/Prescription External Infusion Pump" (CMN) (appendix to this

rule) that is signed and dated no more than thirty days before the first date of service.

(2) Prior authorization for a standard portable external insulin infusion pump must include a three-month trial rental period conducted in which the consumer has undergone a successful trial period with a pump that demonstrates that the consumer is capable of managing the pump and that the desired improvement in metabolic control can be achieved. If a prescriber certification is submitted to the department at the conclusion of a successful trial rental period, the device will be considered for purchase by the department in accordance with paragraph (I) of rule 5101:3-10-05 of the Administrative Code.

(E) Dispensing

(1) The following components are considered "inclusive" with any portable external infusion insulin pump rental or purchase payment made by the department on behalf of a consumer and cannot be submitted to the department for separate reimbursement:

(a) Any supporting wires, power supply, cables, attachment kits, or disposable items associated with the operation of the pump;

(b) Pump education, training, monitoring, or counseling in support of the consumer's ordered treatment;

(c) Maintenance, repair, or cleaning charges in association with the three-month trial rental period; or

(d) Delivery, set-up, or pick-up charges.

(2) The provider of the portable external infusion insulin pump must assure that the consumer utilizing the device is properly instructed on how to use the device in support of his or her ordered treatment and is aware of and understands any emergency procedures regarding the use of the pump. The provider must maintain written documentation regarding the consumer's instruction on the use of the pump in the provider's records.

(3) The prescriber of the portable external infusion insulin pump must assure and document in the consumer's medical record that the continued use of the device is resulting in the clinical improvement of the consumer utilizing the device. The use of the device must be discontinued immediately and an alternative treatment method considered if the consumer demonstrates no

progressive clinical improvement during the rental period of the device.

(4) When the department determines that the purchase of a portable external infusion insulin pump is appropriate, the consumer must be provided with a product warranty that covers any required maintenance or repairs for a duration of at least one year and commences on the date the infusion pump was authorized for purchase.

(F) Reimbursement

(1) Portable external infusion insulin pumps are reimbursed according to the department fee schedule contained in appendix DD to rule 5101:3-1-60 of the Administrative Code or the providers' usual and customary charges, whichever is less.

(2) Previously utilized or loaner portable external infusion insulin pumps are not eligible for purchase by the department.

Effective:

Five Year Review (FYR) Dates:

_____

Certification

_____

Date

Promulgated Under:	119.03
Statutory Authority:	5164.02
Rule Amplifies:	5162.03, 5164.02
Prior Effective Dates:	08/18/2008

Name of provider _____

Provider NPI # _____

Medicaid Legacy # _____

Ohio Department of Medicaid

CERTIFICATE OF MEDICAL NECESSITY/PRESCRIPTION
EXTERNAL INSULIN INFUSION PUMP

☐ INITIAL Prescription Date: _____ ☐ RECERTIFICATION _____ PA#: _____ ☐ REVISED _____ PA#:_____

Instructions: The Certificate of Medical Necessity (CMN) must be used for all External Insulin Infusion Pumps under the Ohio Medicaid Program. This form must be completed and carry the proper signature, where indicated, before requests will be considered for prior authorization.

Name of consumer	Consumer sex ☐ Male ☐ Female Consumer Ht (in)/ WT (lbs)	Date of Birth

Service requested

☐ **3 month trial rental**

Dates _____ **to** _____

☐ **Additional months of rental** _____

☐ **Purchase**

Section A - Must be completed by prescriber

Pertinent diagnosis(es): Include ICD-9 code and description	C-peptide level

☐ Y ☐ N Consumer has Type I Diabetes

☐ Y ☐ N The consumer has completed a diabetes education program within the last 24 months of being prescribed an insulin infusion pump

☐ Y ☐ N The consumer has been on a program of multiple daily injections of insulin, with frequent self-adjustments of insulin dose, for at least 6 months before initiation of the insulin infusion pump

☐ Y ☐ N The consumer had documented frequency that is kept in the consumer's medical record of glucose self-testing an average of at least 4 times per day during the 2 months before initiation of the insulin infusion pump

☐ Y ☐ N The consumer is at high risk for preventable complications of diabetes

☐ Y ☐ N Consumer's glycated hemoglobin level (HbA1c) is greater than 7%

☐ Y ☐ N Consumer has a history of recurring hypoglycemia

☐ Y ☐ N Consumer has wide fluctuations in blood glucose before mealtime

☐ Y ☐ N Consumer's dawn phenomenon with fasting blood sugars frequently exceeds 200 mg/dL

☐ Y ☐ N Consumer has a history of severe glycemic excursions

Explain all "No" responses

Reason external insulin infusion pump is being ordered

Section B - Documentation of compliance (complete after trial period) Must be completed by prescriber

☐ **Purchase after 3 month trial rental**

☐ Y ☐ N Consumer is compliant in the use of the pump

☐ Y ☐ N Consumer is able to manage pump

☐ Y ☐ N There is a desired improvement in metabolic control

☐ Y ☐ N Consumer has received a 1 year product warranty for the pump (one year from date of purchase)

Section C – Prescriber Attestation and Signature/Date (Signed/dated no more than 30 days before the first date of service)

Prescriber's name (Printed) and Phone Number to include Area Code

I certify that I am the prescriber identified above. I certify that the information I have completed in this certificate is of medical necessity and any information on any attached documents signed and dated by me is true to the best of my knowledge. I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.

Prescriber's signature (No stamps)	Date	Prescriber's NPI and Medicaid Legacy Number

TO BE RESCINDED

5160-10-30 **Canes, crutches and walkers.**

(A) Definitions

(1) Mobility-related activities of daily living (MRADL): MRADL's are considered to be activities relating to toileting, feeding, dressing, grooming, and bathing performed in customary locations in the home.

(2) Mobility limitation: The consumer is considered to possess a mobility limitation if one of the following criteria is met:

(a) The consumer is prevented from accomplishing MRADL's entirely; or

(b) The consumer is placed at a reasonably determined heightened risk of morbity or mortality secondary to the attempts to perform MRADL's; or

(c) The consumer is prevented from completing MRADL's within a reasonable time frame.

(B) Canes and crutches

(1) Coverage determination

(a) Canes and crutches are covered if all of the following criteria are met:

(b) The consumer has a mobility limitation, documented in the consumer's medical record, that significantly impairs his or her ability to participate in one or more MRADL's in the home; and

(c) The consumer is able to safely use the cane or crutch; and

(d) The functional mobility deficit can be sufficiently resolved by use of a cane or crutch.

(2) In addition to the aforementioned criteria, the cane or crutch must have been authorized by a prescriber who is actively involved in managing the consumer's mobility difficulties and should be treating the consumer under a

comprehensive plan of care that addresses the consumer's mobility difficulties.

(C) Walkers

(1) Coverage determination

(a) Walkers are covered if all of the following criteria are met:

(i) The consumer has a mobility limitation, documented in the consumer's medical record, that significantly impairs his or her ability to participate in one or more MRADL's in the home; and

(ii) The consumer is able to safely use the walker; and

(iii) The functional mobility deficit can be sufficiently resolved by use of a walker.

(b) In addition to the aforementioned criteria, the walker must have been authorized by a prescriber who is actively involved in managing the consumer's mobility difficulties and should be treating the consumer under a comprehensive plan of care that addresses the consumer's mobility difficulties.

(2) Heavy duty walkers

(a) A heavy duty walker is covered only for consumers who meet the criteria in paragraph (C) of this rule for a standard walker and who weigh more than three hundred pounds.

(b) A heavy duty, multiple braking system, variable wheel resistance walker is covered for consumers who meet the criteria in paragraph (C) of this rule for a standard walker, who weigh more than three hundred pounds and who are unable to use a standard walker due to a documented severe neurologic disorder or other condition causing the restricted use of one hand. Obesity, by itself, is not a sufficient reason for this type of walker.

(3) Enclosed frame walker

In order to justify reimbursement for an enclosed frame walker, providers

must document in the consumer's medical record why this type of walker is medically necessary in place of a standard walker. This documentation must contain the original signature of the ordering prescriber that attests to this medical necessity.

(4) Trunk support walker

In order to justify reimbursement for a walker with trunk support, providers must document in the consumer's medical record why this type of walker is medically necessary in place of a standard walker. This documentation must contain the original signature of the ordering prescriber that attests to this medical necessity.

(5) Walker leg extensions

Walker leg extensions are covered only for consumers six feet tall or more when standing.

(D) Canes, crutches and walker limitations

(1) It is the provider's responsibility to assure that the consumer receives the appropriate mobility assistive device consistent with his or her present medical condition and diagnosis and to verify that the consumer has not previously acquired a duplicate mobility assistive device that exceeds the limitations set forth in appendix A to rule 5101:3-10-03 of the Administrative Code from a different provider.

(2) Canes, crutches and walkers for consumers residing in long term care facilities are reimbursed through the facility's cost report.

(E) Reimbursement

Canes, crutches and walkers are reimbursed the lesser of the department's fee schedule contained in appendix DD to rule 5101:3-1-60 of the Administrative Code or the provider's usual and customary charge.

Effective:

Five Year Review (FYR) Dates:

_____

Certification

_____

Date

Promulgated Under:	119.03
Statutory Authority:	5164.02
Rule Amplifies:	5162.03, 5164.02
Prior Effective Dates:	08/17/2009

TO BE RESCINDED

5160-10-31 Therapeutic footwear for consumers with diabetes.

Unless otherwise specified, the licensing of persons authorized to fit or dispense therapeutic footwear for consumers with diabetes is administered and enforced by Chapter 4779. of the Revised Code. Any provider seeking reimbursement for therapeutic footwear must meet the provisions contained within this rule when applicable in order to be eligible for reimbursement for services provided.

(A) Coverage determination

For a consumer to be eligible for therapeutic footwear the following criteria must be met:

(1) The consumer has diabetes mellitus ("International Classification of Diseases, Ninth Revision" (ICD-9) diagnosis codes 250.00-250.93); and

(2) The consumer has one or more of the following conditions:

(a) Previous amputation of the other foot, or part of either foot;

(b) History of previous foot ulceration of either foot;

(c) History of pre-ulcerative calluses on either foot;

(d) Peripheral neuropathy with evidence of callus formation of either foot;

(e) Foot deformity of either foot; or

(f) Poor circulation in either foot; and

(3) The certifying prescriber who is managing the consumer's systemic diabetes condition has certified that the indications in paragraphs (A)(1) and (A)(2) of this rule are met and that he or she is treating the consumer under a comprehensive plan of care for his or her diabetes and that the consumer needs therapeutic footwear.

(B) Non-coverage determination

(1) Items represented by code A5510 refer to inserts that are compression molded to the consumer's foot over time through the heat and pressure generated by wearing a shoe with the insert present. Since these inserts are not considered total contact at the time of dispensing, they do not meet the requirements of the benefit category and will be denied as noncovered.

(2) Inserts used in noncovered shoes are noncovered.

(3) Deluxe features of diabetic shoes (A5508) are noncovered.

(4) Shoes, inserts and/or modifications that are provided to patients who do not meet the coverage criteria are noncovered.

(C) Authorization

(1) The following documentation must be submitted for prior authorization (PA) before reimbursement for therapeutic footwear will be considered in accordance with the provisions set forth in rule 5101:3-10-31 of the Administrative Code:

(a) Documentation to establish medical necessity of the requested item or service; and

(b) Any other documentation as required or requested by ODJFS for certain specific medical supplier services, as detailed in Chapter 5101:3-10 of the Administrative Code.

(2) Documentation for the prior authorization of therapeutic footwear must be submitted with the appropriate healthcare common procedure coding system (HCPCS) codes.

(D) Dispensing

(1) The particular type of footwear that is necessary must be prescribed by a podiatrist or other qualified prescriber knowledgeable in the fitting of therapeutic footwear. The footwear must be fitted and dispensed by a podiatrist, pedorthist, orthotist, or prosthetist meeting the qualifications specified in Chapter 4779. of the Revised Code. Documentation that the provider is authorized to fit and dispense therapeutic footwear pursuant to Chapter 4779. of the Revised Code must be kept in the provider's records.

(2) The certifying prescriber (i.e., the prescriber who manages the systemic diabetic condition) may not furnish the footwear unless he or she practices in a defined rural area or a defined health professional shortage area.

(3) Separate inserts may be covered and dispensed independently of diabetic shoes if the provider of the shoes verifies in writing that the consumer has appropriate footwear into which the insert can be placed. This footwear must meet the industry definition for a depth or custom-molded shoe.

(4) A custom molded shoe (A5501) is covered when the consumer has a foot deformity that cannot be accommodated by a depth shoe. The nature and severity of the deformity must be well documented in the provider's records and such records may be requested by the Ohio department of job and family services (ODJFS) for review. If there is insufficient justification for a custom molded shoe but the general coverage criteria are met, reimbursement for services will be based on the allowance for the least costly medically appropriate alternative (A5500).

(E) Reimbursement

(1) There is no separate reimbursement for the fitting of shoes, inserts or modifications or for the certification of need or prescription of the footwear.

(2) Therapeutic footwear is reimbursed according to the ODJFS fee schedule contained in appendix DD to rule 5101:3-1-60 of the Administrative Code, or the provider's usual and customary charge, whichever is less.

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TO BE RESCINDED

5160-10-32 **Ostomy and urological supplies.**

(A) Ostomy supplies

(1) Coverage determination

(a) The quantity of ostomy supplies needed by a consumer is determined primarily by the type of ostomy, its location and construction, and the condition of the skin surface surrounding the stoma. The department recognizes that there will be variation according to individual consumer need and that this need may vary over time.

(b) The provider must maintain documentation in the consumer's medical record that clearly supports the medical necessity for ostomy supplies.

(c) Ostomy supplies must be prescribed by a prescriber actively involved in managing the consumer's medical care through a comprehensive plan of care that addresses the need for ostomy supplies on a continual basis. This prescription must contain the original signature of the ordering prescriber that attests to this medical necessity and clearly designates the quantity and type of ostomy supplies being prescribed.

(d) Any change to a consumer's care plan regarding the quantity or type of ostomy supplies requires a new prescription be obtained by the provider that details the changes to the care plan. The provider must keep any new orders regarding the consumer's ostomy care plan in the consumer's medical record to be available for review by the department upon request.

(2) Coverage limitations

(a) Provision of ostomy supplies is limited to a one-month supply per calendar month. Consumers are eligible for re-supply on a calendar month basis starting with the initial dispensing date. The provider is responsible for determining the appropriate amount of ostomy supplies on any given month based on consumer need. The stockpiling of ostomy supplies by a consumer is not allowed.

(b) Providers are responsible for determining whether additional ostomy

supplies have been acquired by the consumer from a different provider during any given month. Ostomy supplies dispensed over and above the stated maximum allowables as listed in appendix A to rule 5101:3-10-03 of the Administrative Code will not be reimbursed without prior authorization.

(c) Ostomy supplies for consumers residing in long term care facilities are reimbursed through the facility's cost report.

(d) When a liquid barrier is necessary, either liquid or spray or individual wipes or swabs is appropriate. Only a single type is reimbursable by the department at a given time.

(e) Consumers with continent stomas may use either a stoma cap, stoma plug, or gauze pads to prevent/manage drainage. Only a single type is reimbursable by the department at any given time.

(f) Consumers with urinary ostomies may use either a bag or bottle for drainage at night. Only a single type is reimbursable by the department at any given time.

(B) Urological supplies

(1) Coverage determination

(a) The provider must document in the consumer's medical record the medical necessity for urological supplies.

(b) Urological supplies must be prescribed by a prescriber actively involved in managing the consumer's medical care through a comprehensive plan of care that addresses the need for urological supplies on a continual basis. This prescription must contain the original signature of the ordering prescriber that attests to this medical necessity and clearly designates the quantity and type of urological supplies being prescribed.

(c) Any change to a consumer's care plan regarding the quantity and type of urological supplies requires that a new prescription be obtained by the provider that details the changes to the care plan. The provider must maintain any new orders regarding the consumer's urological care plan in the consumer's medical record to be available for review by the department upon request.

(d) Indwelling catheters

(i) No more than one catheter per month is covered for routine catheter maintenance. Non-routine catheter changes are covered when documentation substantiates medical necessity, such as for the following indications:

(a) Catheter is accidentally removed (e.g., pulled out by consumer); or

(b) Malfunction of catheter (e.g., balloon does not stay inflated, hole in catheter); or

(c) Catheter is obstructed by encrustation, mucous plug or blood clot; or

(d) History of recurrent obstruction or urinary tract infection for which it has been established by the prescriber that an acute event is prevented by a scheduled change frequency of more than once per month.

(ii) When a specialty indwelling catheter or an all-silicone catheter is used, documentation must be maintained in the consumer's medical record that attests to the medical necessity for that catheter rather than a straight foley type catheter with coating.

(iii) A three-way indwelling catheter either alone or with other components will be covered based on medical necessity documentation in the consumer's medical record.

(e) Catheter insertion tray

(i) One insertion tray will be covered per episode of indwelling catheter insertion. More than one tray per episode will not be reimbursed by the department.

(ii) One intermittent catheter with insertion supplies will be covered per catheterization episode based on supporting documentation of medical necessity in the consumer's medical record.

(f) Urinary drainage collection system

(i) Coverage is authorized for the routine changes of the urinary collection system based on supporting documentation of medical necessity in the consumer's medical record.

(ii) Leg bags are covered for consumers who are ambulatory or are chair or wheelchair bound. The use of leg bags for bedridden consumers is not authorized.

(iii) If there is a catheter change and an additional drainage bag change within a month, the combined utilization for these supplies should be considered by the provider when determining if prior authorization is necessary due to the consumer's medical need to exceed the monthly maximum allowable that is designated for these supplies in appendix A to rule 5101:3-10-03 of the Administrative Code.

(iv) Payment will not be made for concurrent use of a vinyl and a latex bag.

(g) Intermittent irrigation of indwelling catheters

(i) Supplies for the intermittent irrigation of an indwelling catheter are covered by the department when they are used on an as-needed (non-routine) basis in the presence of acute obstruction of the catheter. Documentation supporting medical necessity must be maintained in the medical record and available for review by the department. Routine intermittent irrigations of a catheter are not reimbursable by the department. Routine irrigations are defined as those performed at predetermined intervals.

(ii) Covered supplies for non-routine irrigation of a catheter include either an irrigation tray or an irrigation syringe, and sterile water/saline. Syringes, trays, sterile saline or water are not reimbursable by the department when used for routine irrigation. Irrigation solutions containing antibiotics and chemotherapeutic agents and solutions such as acetic acid or hydrogen peroxide used for the treatment or prevention of urinary obstruction are not reimbursable by the department.

(h) Continuous irrigation of indwelling catheters

(i) Supplies for continuous irrigation of a catheter are covered if there is a history of obstruction of the catheter and the patency of the catheter cannot be maintained by intermittent irrigation in conjunction with medically necessary catheter changes. Supplies used as a result of continuous irrigation being utilized as a primary preventive measure are not reimbursable by the department. Documentation that verifies the medical necessity of catheter irrigation and in particular continuous irrigation as opposed to intermittent irrigation must be maintained in the consumer's medical record. This documentation must indicate the rate of solution administration and the consumer's duration of need.

(ii) Covered supplies for medically necessary continuous bladder irrigation include a three-way foley catheter, irrigation tubing set, and sterile water/saline. The department does not reimburse for more than one irrigation tubing set per day for continuous catheter irrigation.

(iii) Irrigation solutions containing antibiotics and chemotherapeutic agents are not reimbursable by the department. Reimbursement claims for irrigating solutions such as acetic acid or hydrogen peroxide should be billed using the appropriate healthcare common procedure coding system (HCPCS) code for sterile water/saline.

(iv) Continuous irrigation is considered by the department to be a temporary measure. Continuous irrigation for more than two weeks duration requires supporting medical necessity documentation in the consumer's medical record.

(i) Intermittent catheterization

(i) Intermittent catheterization is covered by the department when the basic coverage criteria in paragraph (B)(1)(i)(ii) of this rule are met and the consumer or consumer's caregiver can perform the procedure. Documentation supporting the capability of the consumer or consumer's caregiver to perform this procedure must be included in the consumer's medical record.

(ii) For each episode of covered catheterization, the department will reimburse for one catheter or one sterile catheter kit if the

following additional coverage criteria are met:

(a) The consumer is immunosuppressed; or

(b) The consumer has radiologically documented vesico-ureteral reflux while on a program of intermittent catheterization; or

(c) The consumer is a spinal-cord injured female with neurogenic bladder who is pregnant (covered for duration of pregnancy only); or

(d) The consumer has had distinct, recurrent urinary tract infections, while on a program of sterile intermittent catheterization, two or more times within the twelve months prior to the initiation of using sterile intermittent catheter kits.

(iii) A consumer is considered to have a urinary tract infection if he or she has a documented urine culture with greater than ten thousand colony forming units of a urinary pathogen and concurrent presence of one or more of the following signs, symptoms or laboratory findings:

(a) Fever (oral temperature greater than thirty-eight degrees Celsius or 100.4 degrees Fahrenheit); or

(b) Systemic leukocystosis; or

(c) Change in urinary urgency, frequency, or incontinence; or

(d) Appearance of new or increase in autonomic dysreflexia (sweating, bradycardia, blood pressure elevation); or

(e) Physical signs of prostatitis, epididymitis, orchitis; or

(f) Increased muscle spasms; or

(g) Pyuria (greater than five white blood cells (WBCs) per high powered field).

(iv) If the medical necessity of sterile catheterization is not documented

in the consumer's medical record, sterile supplies associated with this procedure are not reimbursable by the department.

(v) Use of a coude (curved) tip catheter in females is considered to be rarely necessary. When a coude tip catheter is used (for either males or females), there must be documentation of medical necessity in the consumer's medical record for the use of this type of catheter rather than a straight tip catheter.

(j) External catheters or urinary collection devices

(i) Male external catheters (condom-type) or female external urinary collection devices are covered for consumers who have permanent urinary incontinence when used as an alternative to an indwelling catheter.

(ii) Male external catheters or female external urinary collection devices will not be reimbursable if the consumer is currently also using an indwelling catheter.

(iii) Specialty type male external catheters such as those that inflate or that include a faceplate or extended wear catheter systems are covered only when documentation in the consumer's medical record establishes the medical necessity for such a catheter.

(iv) For female external urinary collection devices, more than one metal cup per week or one pouch per day is not reimbursable.

(k) Miscellaneous supplies

(i) Appliance cleaner (A5131) is covered when used to clean the inside of certain urinary collecting appliances (e.g., A5102 or A5112). Reimbursement is not approved for this cleaner unless the consumer is also using one of the specified corresponding appliances.

(ii) Adhesive catheter anchoring devices and catheter leg straps for indwelling urethral catheters are covered. A catheter/tube anchoring device is covered and separately reimbursable only when it is used to anchor a covered suprapubic tube or nephrostomy tube.

(2) Coverage limitations

(a) Provision of urological supplies is limited to a one-month supply per calendar month. Consumers are eligible for re-supply on a calendar month basis starting with the initial dispensing date. The provider is responsible for determining the appropriate amount of urological supplies on any given month based on consumer need. The stockpiling of urological supplies by a consumer is not allowed.

(b) Providers are responsible for determining whether additional urological supplies have been acquired by the consumer from a different provider during any given month. Urological supplies dispensed over and above the stated maximum allowables as listed in appendix A to rule 5101:3-10-03 of the Administrative Code will be not be reimbursed without prior authorization.

(c) Urological supplies for consumers in long term care facilities are reimbursed through the facility's cost report.

(C) Reimbursement

Ostomy and urological supplies are reimbursed at the lesser of the department's fee schedule contained in appendix DD to rule 5101:3-1-60 of the Administrative Code or the provider's usual and customary charge.

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TO BE RESCINDED

5160-10-33 **Commodes.**

(A) Coverage determination

(1) The provider must document medical necessity in the consumer's medical record that clearly supports the need for a commode.

(2) Commodes must be prescribed by a prescriber actively involved in managing the consumer's medical care through a comprehensive plan of care that addresses the need for a commode. This prescription must contain the original signature of the ordering prescriber that attests to the medical necessity of the commode.

(3) A commode is covered when the consumer is physically incapable of utilizing regular toilet facilities and is physically able to use a commode, otherwise a bedpan is indicated. This limitation must be documented in the consumer's medical record and available for review upon request by the department. One or more of the following situations must be present in order for a commode to be justified for reimbursement:

(a) The consumer is confined to a single room due to a documented medical condition; or

(b) The consumer is confined to one level of the home due to a documented medical condition and there is no toilet on that level; or

(c) The consumer is confined to the home due to a documented medical condition and there are not toilet facilities in the home.

(4) An extra wide/heavy duty commode chair is covered for consumers who weigh three hundred pounds or more. If a consumer weighs less than three hundred pounds, the consumer's medical record must document the medical necessity of this type of commode chair.

(5) A commode chair with detachable arms is covered only if this feature is necessary to facilitate transferring the consumer or if the consumer has a body configuration that requires extra width. The consumer's medical record must document the medical necessity of this type of commode chair.

(B) Coverage limitations

(1) Providers are responsible, prior to dispensing a commode, to determine whether the consumer previously acquired this item from another provider.

(2) Commodes for consumers residing in long term care facilities are reimbursed through the facility's cost report.

(3) Providers cannot bill for the concurrent supply of both a commode and a bedpan.

(C) Reimbursement

Commodes are reimbursed at the lesser of the department's fee schedule contained in appendix DD to rule 5101:3-1-60 of the Administrative Code or the provider's usual and customary charge.

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TO BE RESCINDED

5160-10-34 **Surgical dressings and related supplies.**

(A) Definitions

Unless otherwise specified, the staging of pressure ulcers used in this rule is as follows:

(1) Suspected deep tissue injury: Purple or maroon localized area of discolored intact skin or blood-filled blister due to damage of underlying soft tissue from pressure and/or shear. The area may be preceded by tissue that is painful, firm, mushy, boggy, warmer or cooler as compared to adjacent tissue.

(2) Stage I: Intact skin with non-blanchable redness of a localized area usually over a bony prominence. Darkly pigmented skin may not have visible blanching; its color may differ from the surrounding area.

(3) Stage II: Partial thickness loss of dermis presenting as a shallow open ulcer with a red pink wound bed, without slough. May also present as an intact or open/ruptured serum-filled blister.

(4) Stage III: Full thickness loss. Subcutaneous fat may be visible but bone, tendon or muscle are not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunneling.

(5) Stage IV: Full thickness tissue loss with exposed bone, tendon or muscle. Slough or eschar may be present on some parts of the wound bed. Often includes undermining and tunneling.

(6) Unstageable: Full thickness tissue loss in which the base of the ulcer is covered by slough (yellow, tan, gray, green or brown) and/or eschar (tan, brown or black) in the wound bed.

(B) Coverage determination

(1) Surgical dressings are covered for as long as medical necessity exists. Dressings over a percutaneous catheter or tube (e.g., intravascular, epidural, nephrostomy, etc.) are covered as long as the catheter or tube remains in place and after removal until the wound heals.

(2) Any prescription for surgical dressings and related supplies must be prescribed by a prescriber actively involved in managing the consumer's medical condition as indicated in paragraph (A)(2) of rule 5101:3-10-05 of the Administrative Code. The prescriber should be treating the consumer under a comprehensive plan of care which addresses the underlying medical need for any supplies referenced in this rule.

(3) When a wound cover with an adhesive border is being used, no other dressing is needed on top of it and additional tape is usually not required. Reasons for use of additional tape must be documented by the provider. An adhesive border is usually more binding than that obtained with separate taping and is therefore indicated for use with wounds requiring less frequent dressing changes.

(4) Use of more than one type of wound filler or more than one type of wound cover in a single wound is rarely medically necessary. The reasons for use of more than one type of wound filler or wound cover must be well documented by the provider. An exception is an alginate or other fiber gelling dressing or a saline, water, or hydrogel impregnated gauze dressing which might need an additional wound cover.

(5) It may not be appropriate to use some combinations of a hydrating dressing on the same wound at the same time as an absorptive dressing (e.g., hydrogel and alginate).

(6) When used as a secondary dressing, composite dressings, foam and hydrocolloid wound covers, and transparent film are meant to be changed at frequencies less than daily and appropriate clinical judgment must be used to avoid their use with primary dressings which require more frequent dressing changes. When claims are submitted for these dressing for changes greater than once every other day, the quantity in excess of that amount will not be reimbursable by the department for a period not to exceed thirty days during the initial treatment. While a highly exudative wound might require such a combination initially, with continued proper management the wound usually progresses to a point where the appropriate selection of these products results in the less frequent dressing changes which they are designed to allow. An example of an inappropriate combination is the use of a specialty absorptive dressing on top of non-impregnated gauze being used as a primary dressing.

(7) Dressing size must be based on and appropriate to the size of the wound. For wound covers, the pad size is usually about two inches greater than the dimensions of the wound.

(8) The quantity and type of dressings dispensed at any one time must take into account the current status of the wound(s), the likelihood of change, and the recent use of dressings.

(9) Dressing needs may change frequently (e.g., weekly) in the early phases of wound treatment and/or with heavily draining wounds. Providers are expected to have a mechanism for determining the quantity of dressings that the consumer is actually using and to adjust their provision of dressings accordingly. No more than one month's supply of dressings may be provided at one time. The stockpiling of surgical dressings and related supplies by a consumer is not allowed.

(10) Providers are responsible for determining whether additional surgical dressings and related supplies have been acquired by the consumer from a different provider during any given month. Surgical dressings and related supplies dispensed over and above the stated maximum allowables as listed in appendix A to rule 5101:3-10-03 of the Administrative Code will be not be reimbursed without prior authorization.

(11) Surgical dressings must be tailored to the specific needs of an individual consumer. When surgical dressings are provided in kits, only those components of the kit that meet the definition of a surgical dressing and are specifically ordered by a prescriber and are medically necessary are covered. Components included in a kit such as scissors and/or tape may not be billed separately to the department.

(C) Alginate or other fiber gelling dressing

Alginate or other fiber gelling dressing covers are covered for moderately to highly exudative full thickness wounds (e.g., stage III or IV ulcers), and alginate or other fiber gelling dressing fillers for moderately to highly exudative full thickness wound cavities (e.g., state III or IV ulcers). They are not medically necessary on dry wounds or wounds covered with eschar. Usual dressing change is up to once per day. One wound cover sheet of the approximate size of the wound or up to two units of wound filler (one unit equals six inches of alginate or other fiber gelling dressing rope) is usually used at each dressing change. It is usually inappropriate to use alginates or other fiber gelling dressings in combination with hydrogels.

(D) Composite dressing

Usual composite dressing change is up to three times per week, one wound cover per dressing change.

(E) Contact layer dressing

Contact layer dressings are used to line the entire wound and are not intended to be changed with each dressing change. Usual dressing change is up to once per week.

(F) Foam dressing

Foam dressings are covered when used on full thickness wounds (e.g., stage III or IV ulcers) with moderate to heavy exudate. Usual dressing changes for a foam wound cover used as a primary dressing is up to three times per week. When a foam wound cover is used as a secondary dressing for wounds with a very heavy exudate, dressing change may be up to three time per week. Usual dressing change for foam wound fillers is up to once per day.

(G) Gauze, non-impregnated dressing

Usual non-impregnated gauze dressing change is up to three times per day for a dressing without a border and once per day for a dressing with a border. It is usually not necessary to stack more than two gauze pads on top of each other in any one area.

(H) Gauze dressing, impregnated, with other than water, normal saline, hydrogel, or zinc paste

Usual dressing change for this type of dressing is up to once per day.

(I) Hydrocolloid dressing

Hydrocolloid dressings are covered for use on wounds with light to moderate exudate. Usual dressing change for hydrocolloid wound covers or hydrocolloid wound fillers is up to three times per week.

(J) Hydrogel dressing

Hydrogel dressings are covered when used on full thickness wounds with minimal or no exudate (e.g., stage III or IV ulcers). Hydrogel dressings are not usually medically necessary for stage II ulcers. Documentation must substantiate the medical necessity for use of hydrogel dressing for stage II ulcers (e.g., location of ulcer in sacrococcygeal area). Usual dressing change for hydrogel wound covers without adhesive border or hydrogel wound fillers is up to once per day. Usual dressing change for hydrogel wound covers with adhesive border is up to three times per week.

The quantity of hydrogel filler used for each wound must not exceed the amount needed to line the surface of the wound. Additional amounts used to fill a cavity are not medically necessary. Provider documentation must substantiate the medical necessity for this product billed in excess of three units (fluid ounces) per wound in thirty days.

Use of more than one type of hydrogel dressing (filler, cover, or impregnated gauze) on the same wound at the same time is not medically necessary.

(K) Specialty absorptive dressing

Specialty absorptive dressings are covered when used for moderately or highly exudative wounds (e.g., stage III or IV ulcers). Usual specialty absorptive dressing change is up to once per day for a dressing without an adhesive border and up to every other day for a dressing with a border.

(L) Transparent film dressing

Transparent film dressings are covered when used on open partial thickness wounds with minimal exudate or closed wounds. Usual dressing changes is up to three times per week.

(M) Wound filler, not elsewhere classified

Usual dressing change is up to once per day.

(N) Wound pouch

Usual dressing change is up to three time per week.

(O) Tape

Tape is covered when needed to secure a wound cover, elastic roll gauze or non-elastic roll gauze. Tape is usually not required when a wound cover with an adhesive border is used. The medical necessity for tape in these situations must be documented by the provider. Tape change is determined by the frequency of change of the wound cover. Quantities of tape must reasonably reflect the size of the wound cover being secured. Usual use for wound covers measuring sixteen square inches or less is up to two units per dressing change; for wounds covers measuring sixteen to forty-eight square inches, up to three units per dressing change; for wound covers measuring greater that forty-eight square inches, up to four units per dressing change.

(P) Light compression bandage, moderate/high compression bandage, self-adherent bandage, conforming bandage, padding bandage

Most compression bandages are reusable. Usual frequency of replacement would be no more than one per week unless they are a part of a multi-layer compression bandage system.

Conforming bandage dressing change is determined by the frequency of change of the selected underlying dressing.

(Q) Non-coverage determination

(1) Surgical dressings are not separately reimbursable for consumers in long term care facilities (LTCFs) as these supplies are included the facility's cost report.

(2) Gauze, impregnated, water or normal saline

There is no medical necessity for these dressings compared to non-impregnated gauze moistened with bulk saline or sterile water. These dressings are not separately reimbursed by the department.

(3) Providers can not bill the department for any surgical dressing or a related supply item past the date of medical necessity.

(R) Authorization

(1) A fully completed and legible prescription signed by an eligible prescriber must be kept on file by the provider and made available for review upon request by the department and sent to the department for review as a part of a prior authorization request for surgical dressings or supplies.

(2) The prescription must specify the type of dressing being prescribed, the size of the dressing being prescribed, the number/amount to be used at one time (if more than one), the frequency of dressing change, and the expected duration of need for the surgical dressings and related supplies.

(3) A new prescription is needed if any new dressing is added or if the quantity used of an existing dressing is increased. A new prescription is not needed if the quantity of dressings used is decreased. However, a new prescription is required at least every three months for each dressing being used even if the quantity used has remained the same or decreased.

(4) The prescription for the dressing must identify the number of wounds being treated and the reasons for the dressing (e.g., a primary or secondary dressing to cover a surgical or debrided wound, or for wound cleansing). Dressing use or the use of a related supply item must be documented in the provider's records and include the date and source of this information (e.g., prescriber or home care nurse).

(5) The prescription must contain clinical information not more than one year old supporting the necessity of the type and quantity of surgical dressings provided and must be maintained in the consumer's medical records. An evaluation of the consumer's wound (s) must be performed at least on a monthly basis by a qualified health care provider unless there is documentation in the consumer's medical record which justifies why an evaluation could not be done within this timeframe and what other monitoring methods were used to evaluate the continuing need for dressings. Evaluation is expected on a more frequent basis (e.g., weekly) if a consumer has a heavily draining or infected wound. The wound evaluation must include the type of each wound (e.g., surgical wound, pressure ulcer, burn, etc.), its location, size (length and width in centimeters) and depth, the amount of drainage, and any other relevant clinical information. This information must be available for review upon department request.

(S) Reimbursement

Surgical dressings and related supplies are reimbursed at the lesser of the department's fee schedule contained in appendix DD to rule 5101:3-1-60 of the Administrative Code or the provider's usual and customary charge.

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TO BE RESCINDED

5160-10-35 **Cranial orthotic remolding devices.**

Any provider seeking reimbursement for this service must meet the provisions contained within Chapter 4779. of the Revised Code in order to be eligible for reimbursement for services provided.

(A) Definitions

(1) A cranial orthotic remolding device is an orthotic helmet that can progressively mold the shape of the cranium. Treatment is typically initiated around five to six months of age and continues for an average of four to six months.

(2) Cephalic index is the ratio of the maximum width of the head multiplied by one hundred divided by its maximum length (i.e., in the horizontal plane, or front to back).

(B) Coverage determination

(1) A cranial orthotic remolding device is covered for treatment of positional (non-synostotic) plagiocephaly only if all of the following criteria are met:

(a) Consumer is at least three months of age but not greater than eighteen months of age; and

(b) Marked asymmetry has not been substantially improved following conservative therapy of at least two months duration with cranial repositioning therapy and/or physical therapy; and

(c) Asymmetry of the cranial base as documented by any of the following:

(i) Skull base asymmetry: At least six millimeter (mm) right/left discrepancy measured subnasally to the tragus, defined as the cartilaginous projection of the auricle at the front of the ear; or

(ii) Cranial vault asymmetry: At least a ten mm right/left discrepancy measured from the frontozygomaticus point (identified by palpation of the suture line above the upper outer corner of the orbit) to the euryon, defined as the most lateral point on the head

located in the parietal region; or

(iii) Asymmetry of the orbitotragial distances, as documented by at least a four mm right/left asymmetry.

(2) A cranial orthotic remolding device is covered for treatment of positional (non-synostotic) braciocephaly if the cephallic index is greater than ninety-one per cent.

(3) A cranial orthotic remolding device is covered for the treatment of positional (non-synostotic) scaphocephaly if the cephallic index is less than seventy-five per cent.

(4) A cranial orthotic remolding device is covered for treatment of synostotic deformity if all of the following criteria are met:

(a) Consumer is between the ages of birth and eighteen months; and

(b) Premature closing of the cranial structures is documented by treating prescriber and surgery with post-operative treatment including remolding orthotic helmeting is medically indicated and documented in the consumers medical record.

(5) All documentation supporting the above medical criteria must be kept in the provider's file and be available for review at the request of the Ohio department of job and family services (ODJFS).

(6) Cranial orthotic remolding devices must be prescribed by a prescriber actively involved in managing the consumer's medical care through a comprehensive plan of care which addresses the need for a cranial orthotic remolding device. This prescription must contain the original signature of the ordering prescriber that attests to medical necessity of this device.

(C) Non-coverage determination

A cranial orthotic remolding device is non covered for consumers who cannot document an appropriate medical need based on the provisions of this rule.

(D) Prior authorization

No prior authorization is necessary for the dispensing of a cranial orthotic remolding device.

(E) Dispensing

(1) The following components are considered "inclusive" with any payment made by the department for a cranial orthotic remolding device on behalf of a consumer, cannot be submitted to the department for separate reimbursement and must be dispensed and/or maintained by the billing provider:

(a) Labor;

(b) Orthotic remolding device;

(c) Casting, fitting, or measuring fees;

(d) Charges for travel; and

(e) Charges for shipping and mailing.

(2) Providers must document that the consumer's primary care giver is instructed as to the proper use and wear of the cranial orthotic remolding device and documentation of this instruction must be kept in the provider's file.

(3) Any dispensed cranial orthotic remolding device must be of a type and fabricated at a facility approved for consumer use as an approved class II medical device by the food and drug administration (FDA).

(4) Any provider dispensing and fitting a cranial remolding orthotic device must have the appropriate documentation on file that demonstrates the appropriate training necessary to fit the device properly.

(5) Consumers are eligible for only one cranial orthotic remolding device per lifetime.

(F) Reimbursement

Cranial orthotic remolding devices are reimbursed according to the department fee schedule contained in appendix DD to rule 5101:3-1-60 of the Administrative Code or the providers usual and customary charge, whichever is less.

Effective:

Five Year Review (FYR) Dates:

_____

Certification

_____

Date

Promulgated Under:	119.03
Statutory Authority:	5164.02
Rule Amplifies:	5162.03, 5164.02
Prior Effective Dates:	09/01/2011

5160-10-01 **Durable medical equipment, prostheses, orthoses, and supplies (DMEPOS): general provisions.**

(A) This rule sets forth general coverage and payment policies for durable medical equipment (DME), prostheses, orthotic devices, medical/surgical supplies, and supplier services. Policies set forth in other rules in this chapter of the Administrative Code supersede any provisions in this rule with which they conflict.

(B) Definitions that apply to rules in this chapter of the Administrative Code.

(1) "Certificate of medical necessity (CMN)" is a written statement by a practitioner attesting that a particular item or service is medically necessary for an individual.

(a) Unless a separate prescription is required, a CMN may serve also as a prescription for medicaid payment purposes.

(b) If no other form or format is specified, the CMN form specified in the relevant rule in this chapter of the Administrative Code is the default that must be used.

(c) A rendering or billing provider must obtain a required CMN before a claim can be submitted.

(d) A CMN is not invalidated by a change in an individual's status from one medicaid eligibility category to another (e.g., from fee-for-service medicaid to medicaid managed care).

(e) Renewal of lifetime certification is not required.

(f) An illegible CMN will not be accepted.

(2) "Department" is the Ohio department of medicaid or its designee. The address of the department's web site is http://medicaid.ohio.gov.

(3) "DMEPOS item" is a collective term for a covered durable medical equipment (DME) item, prosthetic device, orthotic device, or medical supply item furnished by an eligible provider to an eligible recipient.

(4) "DMEPOS service" is a covered service, such as labor for repair or replacement, that is furnished by an eligible provider and is related directly to a DMEPOS item.

(5) "Invoice price" is the price printed on the invoice sent by the manufacturer to the provider. The provider must not enter, modify, obscure, or obliterate the invoice price on any supporting document submitted to the department. Documentation of an invoice price is subject to approval by the department.

(6) "List price" is the most current price recommended by the manufacturer for retail sale. A provider that is also a manufacturer may set the list price for a custom product so long as this figure is not greater than the prices of comparable products. The provider must not enter, modify, obscure, or obliterate the list price on any supporting document submitted to the department. Documentation of a list price is subject to approval by the department.

(7) "Need verification" is a process by which the department determines whether to make payment for a DMEPOS item or service that exceeds the established cost threshold or frequency guideline. Because need verification is applied only to items or services for which medical necessity has been established or presumed, no extensive or in-depth clinical assessment is necessary (as it is with prior authorization). One purpose of need verification is to enable the department to consider whether the purchase of a new piece of equipment might be more cost-effective than continued repair.

(8) "Private residence" is a recipient's place of residence other than a hospital or a long-term care facility (LTCF).

(C) Providers.

(1) Prescribers. Eligible medicaid providers of the following types having prescriptive authority under Ohio law may certify the medical necessity of a DMEPOS item:

(a) A physician;

(b) A podiatrist;

(c) An advanced practice registered nurse with a relevant specialty (e.g., clinical nurse specialist, certified nurse practitioner); or

(d) A physician assistant.

(2) Rendering providers. The following eligible providers may furnish a DMEPOS item or service:

(a) For equipment considered by the state of Ohio board of pharmacy to be subject to licensure or certification in accordance with Chapter 4752. of the Revised Code or the rules promulgated under it, a provider enrolled

in medicaid as a DME supplier with specialized state of Ohio board of pharmacy certification or licensure;

(b) For orthotic or prosthetic devices requiring compliance with section 4779.02 of the Revised Code, a provider enrolled in medicaid as a DME supplier with orthotic/prosthetic specification; or

(c) For all other items and services, a provider enrolled as a basic DME supplier.

(3) Billing providers. The following eligible providers may receive medicaid payment for submitting a claim for a DMEPOS item or service:

(a) For equipment considered by the state of Ohio board of pharmacy to be subject to licensure or certification in accordance with Chapter 4752. of the Revised Code or the rules promulgated under it, a provider enrolled in medicaid as a DME supplier with specialized state of Ohio board of pharmacy certification or licensure;

(b) For orthotic or prosthetic devices requiring compliance with section 4779.02 of the Revised Code, a provider enrolled in medicaid as a DME supplier with orthotic/prosthetic specification; or

(c) For all other items and services, a provider enrolled as a basic DME supplier.

(4) Additional provider requirements specific to a particular DMEPOS item or service may be set forth in other rules in this chapter of the Administrative Code.

(D) Coverage.

(1) In most cases, the provision of or payment for a medically necessary DME item or medical supply for a resident of a LTCF is the responsibility of the LTCF. In turn, the LTCF receives medicaid per diem payment on the basis of its cost report. Therefore, claims submitted for such items or supplies furnished to LTCF residents will be denied. Any exceptions are set forth in other rules in this chapter of the Administrative Code.

(2) Separate payment may be made for a prosthesis or orthotic device supplied to a resident of a LTCF.

(3) The provision of a medically necessary DMEPOS item requires a prescription.

(a) Before writing a prescription for certain DMEPOS items, a practitioner must conduct a face-to-face encounter with the medicaid recipient. A list of

such DMEPOS items may be found on the website of the centers for medicare and medicaid services (CMS) at http://www.cms.gov.

(b) The date of a prescription cannot precede the date of the related encounter nor can it be more than one hundred eighty days afterward.

(c) The encounter must be documented in the recipient's medical record.

(d) Unless a different length of time is specified, the date of a prescription cannot precede the first date of service by more than sixty days.

(e) The medical practitioner acting as prescriber must be actively involved in managing the recipient's medical care. The department may disallow a prescription written by a practitioner who has no professional relationship with the recipient.

(f) The prescribed DMEPOS item must be directly related to a medical condition of the recipient that the practitioner evaluates, assesses, or actively treats during the encounter.

(g) With proper documentation, a single encounter can serve as the basis for more than one prescription.

(h) No additional face-to-face encounter is necessary for a separate DMEPOS item if an encounter conducted within the preceding twelve months addresses the medical condition for which the DMEPOS item is being prescribed.

(i) Each prescription must specify a quantity (e.g., "TID," "thirty per month"). An unstated quantity is assumed to be one unit.

(4) Certain DMEPOS items require prior authorization (PA). A list of such items is posted on the department's web site.

(a) The following DMEPOS items always require PA:

(i) A custom or a specialized DMEPOS item;

(ii) A "not otherwise specified," "miscellaneous," or "unlisted" item or service; and

(iii) Used DME.

(b) When PA is given, it may specify a quantity, manufacturer, model, part number, or other information identifying a particular item. When such identifying information is present, a provider may supply and subsequently submit claims for the specified items only. No changes or substitutions are allowed without explicit authorization by the department.

(c) The department, on the basis of clinical indications, may grant PA for an item other than one that has been requested.

(d) For items requiring PA, the provider must submit the following documentation:

(i) A certification, signed and dated not more than sixty days before the first date of service, in the form of a fully completed CMN or, if the need for a CMN is not specified, a prescription;

(ii) Pertinent related information, such as a full description of any similar item currently in possession of the recipient or an explanation of a change in the recipient's condition that warrants a change in equipment;

(iii) For a "not otherwise specified," "miscellaneous," or "unlisted" item, a complete description of the item (including, as applicable, the manufacturer, model or style, and size), a list of all bundled components, and an itemization of all charges; and

(iv) Any other information required or requested by the department, as detailed in this chapter of the Administrative Code.

(e) A request for PA of a preparatory prosthesis must include the reason for the amputation, the date of the amputation, and an explanation of the benefit to be derived from having the recipient use a preparatory prosthesis before a definitive prosthesis is designed.

(f) A claim for an item or service that exceeds the specified maximum quantity or frequency but does not otherwise require PA may be subject to need verification before payment will be considered.

(g) A request for PA or need verification may be denied in cases involving malicious damage, neglect, culpable irresponsibility, or wrongful disposition.

(5) For items not requiring PA, the provider must keep on file a certification, signed and dated not more than sixty days before the first date of service, in the form of a fully completed CMN or, if the need for a CMN is not specified, a prescription.

(6) For an item that is shipped directly to a recipient, the shipping date is the dispensing date.

(7) For an item that requires multiple fittings and special construction, the first date of service is the dispensing date.

(8) If a recipient dies after measurements for a prescribed custom item have been taken but before the item has been dispensed, then payment for the item may be made under the following conditions:

(a) The code set description for the item indicates that it is designed or intended for a specific individual;

(b) The item is substantially complete and cannot be modified for use by another individual;

(c) No information available to the provider indicated that the death of the recipient was imminent;

(d) The provider can document the date of measurement; and

(e) On the claim, the provider reports the date of measurement as the date of service.

(9) Any request for a DMEPOS item or service must originate with an individual recipient, the recipient's authorized representative, or a medical practitioner acting as prescriber and must be made with the recipient's full knowledge and consent.

(10) A request that is determined by the department to have resulted from a mass screening or examination will be denied.

(11) When instruction must be given in the safe and appropriate use of a particular DMEPOS item, it is the responsibility of the provider to ensure that the recipient or someone authorized to assist the recipient has received such instruction.

(12) Payment for repair of a DME item, prosthetic device, or orthotic device or for purchase of a related medical supply item or service can be made only if the medical necessity of the DME item, prosthetic device, or orthotic device itself has been established. The medical necessity of an item purchased by

the department is established during the purchasing process. For an item not purchased by the department, medical necessity may be documented on an appropriate medicaid certificate of medical necessity, on a prescription that addresses all specified criteria, or on any other form that is acceptable to the department. No additional documentation of medical necessity is necessary for subsequent repairs made to an item. The determination that an item not purchased by the department is medically necessary does not indicate that the item would be authorized for purchase.

(13) Payment may be made for covered repair, maintenance, parts, accessories, or supplies for a DME item that is owned by an individual but has not been purchased by the department. Payment for the initial service or delivery requires PA; payment for subsequent service or deliveries does not require PA.

(14) Unless otherwise specified elsewhere in this chapter of the Administrative Code, for each claim submitted for payment, a provider must keep the following supporting documents on file:

(a) A completed CMN, if required;

(b) If no CMN is required, a legible prescription that specifies a diagnosis;

(c) Any other information, such as practitioner orders or chart notes, used to establish the medical necessity of the DMEPOS item;

(d) Any record indicating a change in an individual's needs or plan of care;

(e) Proof of delivery;

(f) Confirmation that the recipient or the recipient's authorized representative has been instructed in the safe use of the DMEPOS item, if applicable;

(g) A copy of the manufacturer's or dealer's warranty, if applicable; and

(h) A record of any repair or service that has been performed on equipment not paid for by medicaid, if applicable.

(15) The default CMN form for general DME items and supplies is the ODM 01913, "Certificate of Medical Necessity / Request for Need Verification: General Medical Supplies and Equipment" (rev. 7/2018).

(16) Proof is required to show that a DMEPOS item has been delivered to the intended recipient.

(a) Providers, their employees, and anyone else having a financial interest in the delivery of DMEPOS items are prohibited from accepting delivery of an item on behalf of a medicaid recipient.

(b) If a provider delivers directly to a recipient, then proof of delivery must include the signature of the recipient or the recipient's authorized representative. For a DMEPOS item delivered to a resident of a LTCF, the LTCF is responsible for furnishing proof of delivery.

(c) If a provider uses a third-party shipper, then acceptable proof of delivery includes the shipper's tracking slip or a returned postage-paid delivery invoice.

(d) If a signature obtained physically at the time of delivery is not legible, then the provider or shipper must record the name of the person accepting delivery and the relationship of the person to the recipient. If the provider or shipper records such information for a particular person and maintains it in a readily accessible format, then on subsequent deliveries only the signature is required.

(17) No unnecessary extra payment will be made for a DMEPOS item or service. If more than one DMEPOS item or service will meet a recipient's needs equally well, then the maximum payment amount may not exceed the lowest of the respective costs.

(18) No separate payment will be made under this chapter of the Administrative Code for the following items or services:

(a) Items presumed to be nonmedical in nature and for which no medical necessity can therefore be demonstrated, including but not limited to the following examples:

(i) Environmental control devices;

(ii) Items that have no medical benefit but are intended solely for the comfort or convenience of the user;

(iii) Physical fitness equipment;

(iv) Precautionary items (e.g., emergency alert systems);

(v) Training equipment (e.g., speech-teaching machines);

(vi) Communication aids, except as specified elsewhere in this chapter of the Administrative Code;

(vii) Educational aids; and

(viii) Hygiene equipment (e.g., bidets);

(b) Routine over-the-counter treatment supplies (e.g., adhesive bandages, antiseptic solutions, antibiotic ointments) and personal hygiene items (e.g., soap, diapers for children younger than three years of age);

(c) Medical supplies or DME items that are used during a visit with a medical practitioner (i.e., that are incident to a professional service) in the practitioner's office, in a clinic, or in the recipient's private residence;

(d) Items or services that are covered under manufacturer or dealer warranty;

(e) Items or services for which full remuneration is made through other payment mechanisms (e.g., diagnosis-related groups, per diem payments, workers' compensation, commercial insurance);

(f) Costs of delivery (including postage), setup and assembly, pickup, and routine cleaning and maintenance associated with a covered DME item;

(g) Labor, measuring, casting, fitting, travel by the supplier, and shipping or mailing associated with a covered orthotic device or prosthesis;

(h) Maintenance and repair of equipment during a rental period;

(i) Supporting wires, power supplies, cables, or attachment kits;

(j) Related supplies and accessories that are furnished either during a rental period or with the dispensing or delivery of a purchased equipment item and for which no payment amount exists for separate purchase or rental;

(k) A service call in addition to materials and labor;

(l) Repairs, adjustments, or modifications that are made within ninety days after delivery or during the total rental period, unless necessitated by major changes in the recipient's condition;

(m) Instruction of the recipient or the recipient's authorized representative in the safe use of an item; and

(n) Education, training, instruction, counseling, or monitoring conducted in support of an individual's ordered treatment plan.

(19) Payment is not available for DMEPOS items that duplicate or conflict with another item currently in the recipient's possession, regardless of payment or supply source. Providers are responsible for ascertaining whether duplication or conflict exists.

(20) Certain DMEPOS items may be dispensed on a recurring basis. A provider must confirm a recipient's current need before the next delivery. If DMEPOS items are routinely delivered without necessary confirmation of need, then any payment for excess quantities is subject to recovery.

(21) No prescription for disposable items dispensed on a recurring basis (e.g., incontinence garments, wound dressings) can be renewed earlier than ninety days before the expiration of the current prescription.

(22) Most covered DME items are purchased and become the property of the recipient. Some covered DME items that require ongoing servicing are rented exclusively. Some covered DME items may be rented on a short-term basis, purchased, or rented and then purchased.

(a) The short-term rental of a covered DME item other than a wheelchair requires PA, which may be given if rental is determined to be more cost-effective than purchase.

(b) Unless a different length of time is specified elsewhere in this chapter of the Administrative Code, the initial rental period must not exceed six months.

(c) PA may be given for additional rental periods.

(d) Regardless of its authorized length, a rental period ends when the rented item is no longer medically necessary.

(e) A monthly rental payment secures the rented item for the entire calendar month.

(f) During a rental period and for ninety days afterward, all rental amounts paid apply toward purchase.

(g) The department reserves the right to determine whether an item will be rented or purchased.

(h) The provider must notify the recipient when an item in effect has been purchased through rental.

(23) Certain medical supply items (e.g., gauze pads, wound fillers/packing) are dispensed in bulk. No payment amount per unit has been established for such items; instead, an overall payment limit per period is specified. The charge submitted by the provider must not exceed the manufacturer's suggested list price for the quantity of the item.

(24) The purchase of torsion cables may be authorized only for the treatment of children with neuromuscular diseases and related conditions. Requests for torsion cables to treat positional deformities will be denied because of anticipated resolution that occurs with maturation.

(25) No provider may submit a claim for a DMEPOS item or service before the item or service has been supplied.

(E) Claim payment.

(1) The payment amount specified in another rule in this chapter of the Administrative Code supersedes any payment amount established by provisions in this rule.

(2) For a covered DMEPOS item or service represented by a new healthcare common procedure coding system (HCPCS) procedure code that takes effect at the beginning of a calendar year, the initial maximum payment amount is established in accordance with rule 5160-1-60 of the Administrative Code.

(3) For any other covered DMEPOS item or service, the payment amount is the lesser of the submitted charge (which must reflect any discounts or rebates available to the provider at the time of claim submission but need not reflect subsequent discounts or rebates) or the first applicable medicaid maximum from the following ordered list:

(a) For a "by report" DMEPOS item or service, an amount determined on a case-by-case basis;

(b) For a supply item for which payment is determined by PA, whichever of the following two figures applies or the lesser of the two if both apply:

(i) Seventy-two per cent of the list price; or

(ii) One hundred forty-seven per cent of the invoice price (minus discounts or rebates);

(c) For a non-supply DMEPOS item or service for which payment is determined by PA, an amount determined on a case-by-case basis;

(d) For a bulk item having an overall payment limit per period, the submitted charge;

(e) For the authorized purchase of a DMEPOS item in used condition, eighty per cent of the payment amount for the item in new condition;

(f) For monthly payment for a "rental/purchase" DME item, ten per cent of the medicaid maximum specified for purchase;

(g) For a professional service for which separate payment is made (e.g., a certain type of evaluation), the applicable amount listed in appendix DD to rule 5160-1-60 of the Administrative Code; or

(h) The amount listed in the appendix to this rule.

Replaces: 5160-10-01, 5160-10-02, 5160-10-03, 5160-10-05, 5160-10-06, 5160-10-20, 5160-4-27

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Durable medical equipment, prostheses, orthoses, and supplies (DMEPOS)
Appendix to rule 5160-10-01

BR -- Payment by report
NC -- No coverage
PA -- Payment by prior authorization

HCPCS CODE	DESCRIPTION	UNIT	CATEGORY	SUBCATEGORY / APPLICATION	CURRENT MAXIMUM PAYMENT AMOUNT	PAYMENT AMOUNT EFFECTIVE DATE	RESIDENCE	RENTAL OR PURCHASE	LIMIT	NOTES
A4207	SYRINGE WITH NEEDLE, STERILE 2 CC	Each	C01d	Syringes / needles	$0.23	05/01/1990	Non-institutional only	Purchase only	100 per month	
A4208	SYRINGE WITH NEEDLE, STERILE 3 CC	Each	C01d	Syringes / needles	$0.17	05/01/1990	Non-institutional only	Purchase only	100 per month	
A4209	SYRINGE WITH NEEDLE, STERILE 5CC OR GREATER	Each	C01d	Syringes / needles	$0.27	05/01/1990	Non-institutional only	Purchase only	100 per month	
A4212	NON-CORING (HUBER-TYPE) NEEDLE	Each	C01d	Syringes / needles	$3.60	04/01/1997	Non-institutional only	Purchase only	30 per month	
A4213	SYRINGE W/O NEEDLE, STERILE 20 CC OR GREATER	Each	C01d	Syringes / needles	$0.60	11/22/1990	Non-institutional only	Purchase only	50 per year	
A4216	STERILE WATER/SALINE, 10 ML	10-milliliter vial	C01d	Distilled water / sterile saline	$0.25	10/01/2004	Non-institutional only	Purchase only	90 per month	
A4217	STERILE WATER/SALINE, 500 ML	500-milliliter bottle	C01d	Distilled water / sterile saline	$2.50	10/01/2004	Non-institutional only	Purchase only	36 per month	
A4221	SUPPLIES FOR MAINTENANCE OF A DRUG INFUSION CATHETER, PER WEEK	Set	C29	Infusion pump (non-nutrition) supplies	$20.55	01/01/1998	Non-institutional only	Purchase only	4 per month	
A4222	INFUSION SUPPLIES FOR EXTERNAL DRUG INFUSION PUMP, PER CASSETTE OR BAG (LIST DRUG SEPARATELY)	Set	C29	Infusion pump (non-nutrition) supplies	$40.00	01/01/2005	Non-institutional only	Purchase only	60 per month	
A4223	INFUSION SUPPLIES NOT USED WITH EXTERNAL INFUSION PUMP, PER CASSETTE OR BAG (LIST DRUGS SEPARATELY)	Set	C29	Infusion pump (non-nutrition) supplies	$15.00	01/01/2005	Non-institutional only	Purchase only	30 per month	
A4224	SUPPLIES FOR MAINTENANCE OF INSULIN INFUSION CATHETER, PER WEEK	Set	C29	Infusion pump (non-nutrition) supplies	$15.52	01/01/2017	Non-institutional only	Purchase only	1 per week	
A4225	SUPPLIES FOR EXTERNAL INSULIN INFUSION PUMP, SYRINGE TYPE CARTRIDGE, STERILE, EACH	Each	C29	Infusion pump (non-nutrition) supplies	$2.08	01/01/2017	Non-institutional only	Purchase only	4 per month	
A4230	INFUSION SET FOR EXTERNAL INSULIN PUMP, NON NEEDLE CANNULA TYPE	Set	C29	Infusion pump (non-nutrition) supplies	$8.66	03/29/2007	Non-institutional only	Purchase only	30 per month	
A4231	INFUSION SET FOR EXTERNAL INSULIN PUMP, NEEDLE STYLE	Set	C29	Infusion pump (non-nutrition) supplies	$5.27	03/29/2007	Non-institutional only	Purchase only	30 per month	
A4232	SYRINGE W/ NEEDLE FOR EXTERNAL INSULIN PUMP, STERILE 3CC	Each	C29	Infusion pump (non-nutrition) supplies	$4.00	10/15/2006	Non-institutional only	Purchase only	30 per month	
A4244	PEROXIDE/ALCOHOL, PER PINT	16 ounces	C01d	Antiseptic solution	$0.56	05/01/1990	Non-institutional only	Purchase only	15 per month	
A4246	BETADINE, POVIDONE IODINE, OR PHISOHEX SOLUTION, PER PINT	16 ounces	C01d	Antiseptic solution	$10.00	06/20/1990	Non-institutional only	Purchase only	6 per month	
A4247	BETADINE/POVIDONE IODINE WIPE/SWAB, PER BOX	Box	C01d	Antiseptic solution	$19.00	01/01/2005	Non-institutional only	Purchase only	2 per month	
A4265	PARAFFIN FOR USE IN MEDICALLY NECESSARY UNIT APPROVED BY THE DEPARTMENT, REFILL	Pound	C01d	Heat / cold application	$3.37	12/15/2002	Non-institutional only	Purchase only	2 per month	
A4266	DIAPHRAGM FOR CONTRACEPTIVE USE	Each	C01d	Family planning supplies	$25.46	04/01/2003	Non-institutional only	Purchase only	1 per year	
A4267	CONTRACEPTIVE SUPPLY, CONDOM, MALE	Each	C01d	Family planning supplies	$0.40	04/01/2003	Non-institutional only	Purchase only	36 per month	
A4268	CONTRACEPTIVE SUPPLY, CONDOM, FEMALE	Each	C01d	Family planning supplies	$2.10	04/01/2003	Non-institutional only	Purchase only	36 per month	
A4269	CONTRACEPTIVE SUPPLY, SPERMICIDE	Each	C01d	Family planning supplies	$10.05	04/01/2003	Non-institutional only	Purchase only	1 per month	
A4305	DISPOSABLE DRUG DELIVERY SYSTEM, FLOW RATE 50 ML OR MORE PER HOUR	Each	C29	Infusion pump (non-nutrition) equipment	$12.73	04/01/1993	Non-institutional only	Purchase only	1 per day	
A4306	DISPOSABLE DRUG DELIVERY SYSTEM, FLOW RATE 5 ML OR LESS PER HOUR	Each	C29	Infusion pump (non-nutrition) equipment	$12.73	04/01/1993	Non-institutional only	Purchase only	1 per day	
A4310	FOLEY CATH INSERTION TRAY WITHOUT DRAINAGE BAG, WITHOUT CATHETER	Each	C32b	Insertion tray	$3.90	05/01/1990	Non-institutional only	Purchase only	3 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.)	Each	C32b	Insertion tray	$6.75	05/01/1990	Non-institutional only	Purchase only	3 per month	
A4312	INSERTION TRAY WITHOUT DRAINAGE BAG, WITH INDWELLING CATHETER, FOLEY TYPE, TWO WAY, ALL SILICONE	Each	C32b	Insertion tray	$10.00	05/01/1990	Non-institutional only	Purchase only	3 per month	
A4313	INSERTION TRAY WITHOUT DRAINAGE BAG, WITH INDWELLING CATHETER, FOLEY TYPE, THREE WAY, FOR CONTINUOUS	Each	C32b	Insertion tray	$14.00	05/01/1990	Non-institutional only	Purchase only	3 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.)	Each	C32b	Insertion tray	$10.75	05/01/1990	Non-institutional only	Purchase only	3 per month	
A4315	INSERTION TRAY WITH DRAINAGE BAG WITH INDWELLING CATHETER, FOLEY TYPE, TWO WAY, ALL SILICONE	Each	C32b	Insertion tray	$14.00	05/01/1990	Non-institutional only	Purchase only	3 per month	
A4316	INSERTION TRAY WITH DRAINAGE BAG WITH INDWELLING CATHETER, FOLEY TYPE, 3 WAY, FOR CONTINUOUS IRRIGATION	Each	C32b	Insertion tray	$18.00	05/01/1990	Non-institutional only	Purchase only	3 per month	
A4320	IRRIGATION TRAY WITH BULB OR PISTON SYRINGE	Each	C32b	Insertion tray	$2.50	04/01/1992	Non-institutional only	Purchase only	30 per month	

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A4322	IRRIGATION SYRINGE, WITH BULB OR PISTON	Each	C32b	Insertion syringe	$1.60	06/20/1990	Non-institutional only	Purchase only	30 per month	
A4326	MALE EXTERNAL CATHETER SPECIALTY TYPE WITH INTEGRAL COLLECTION CHAMBER, EACH	Each	C32b	Catheter	$9.00	08/01/1997	Non-institutional only	Purchase only	5 per year	
A4327	FEMALE EXTERNAL URINARY COLLECTION DEVICE; METAL CUP	Each	C32b	Cup	$37.00	08/01/1997	Non-institutional only	Purchase only	2 per year	
A4328	FEMALE EXTERNAL URINARY COLLECTION DEVICE; POUCH	Each	C32b	Pouch	$8.33	04/01/2001	Non-institutional only	Purchase only	1 per month	
A4330	PERIANAL FECAL COLLECTION POUCH WITH ADHESIVE	Each	C32b	Pouch	$5.80	04/01/2001	Non-institutional only	Purchase only	20 per month	
A4331	EXTENSION DRAINAGE TUBING, ANY TYPE OR LENGTH, WITH CONNECTOR/ADAPTOR, FOR USE WITH URINARY LEG BAG OR UROSTOMY POUCH, EACH	Each	C32b	Tubing	$3.04	04/01/2001	Non-institutional only	Purchase only	2 per month	
A4333	URINARY CATHETER ANCHORING DEVICE, ADHESIVE SKIN ATTACHMENT, EACH	Each	C32b	Anchoring device	$1.37	04/01/2001	Non-institutional only	Purchase only	12 per month	
A4334	URINARY CATHETER ANCHORING DEVICE, LEG STRAP	Each	C32b	Anchoring device	$3.00	01/01/2001	Non-institutional only	Purchase only	1 per month	
A4335	INCONTINENCE SUPPLY; MISCELLANEOUS	Each	C32b	Supply	PA	05/01/1990	Non-institutional only	Purchase only		
A4338	INDWELLING CATHETER; FOLEY TYPE, 2-WAY LATEX WITH COATING (TEFLON, SILICONE, SILICONE ELASTOMER, OR HYDROPHILIC, ETC)	Each	C32b	Catheter	$4.20	05/01/1990	Non-institutional only	Purchase only	3 per month	
A4340	INDWELLING CATHETER; SPECIALTY TYPE; (EG; COUDE, MUSHROOM, WING, ETC)	Each	C32b	Catheter	$24.00	08/01/1997	Non-institutional only	Purchase only	3 per month	
A4344	INDWELLING CATHETER, FOLEY TYPE, TWO WAY, ALL SILICONE	Each	C32b	Catheter	$9.39	04/01/1992	Non-institutional only	Purchase only	3 per month	
A4346	INDWELLING CATHETER; FOLEY TYPE, THREE WAY, FOR CONTINUOUS IRRIGATION	Each	C32b	Catheter	$12.50	05/01/1990	Non-institutional only	Purchase only	3 per month	
A4349	MALE EXTERNAL CATHETER, WITH OR WITHOUT ADHESIVE, DISPOSABLE, EACH	Each	C32b	Catheter	$1.39	01/01/2005	Non-institutional only	Purchase only	60 per month	A4349 replaces A4324, A4325, and A4247.
A4351	INTERMITTENT URINARY CATHETER, STRAIGHT TIP	Each	C32b	Catheter	$0.79	01/01/1996	Non-institutional only	Purchase only	200 per month	
A4352	INTERMITTENT URINARY CATHETER; COUDE (CURVED) TIP	Each	C32b	Catheter	$2.00	01/01/1996	Non-institutional only	Purchase only	200 per month	
A4353	INTERMITTENT URINARY CATHETER, WITH INSERTION SUPPLIES	Each	C32b	Catheter	$3.49	10/01/2004	Non-institutional only	Purchase only	60 per month	Payment for A4353 includes lubricant.
A4354	CATHETER INSERTION TRAY WITH DRAINAGE BAG BUT WITHOUT CATHETER	Each	C32b	Insertion tray	$7.40	05/01/1990	Non-institutional only	Purchase only	3 per month	
A4355	IRRIGATION TUBING SET 3-WAY INDWELLING FOLEY CATHETER	Each	C32b	Tubing	$2.70	05/01/1990	Non-institutional only	Purchase only	3 per month	
A4356	EXTERNAL URETHRAL CLAMP OR COMPRESSION DEVICE, (NOT TO BE USED FOR CATHETER CLAMP)	Each	C32b	Clamp	$30.01	05/01/1990	Non-institutional only	Purchase only	1 per year	
A4357	BEDSIDE DRAINAGE BAG, DAY OR NIGHT, WITH OR WITHOUT ANTI-REFLUX DEVICE, WITH OR WITHOUT TUBE	Each	C32b	Bag	$6.00	06/20/1990	Non-institutional only	Purchase only	2 per month	
A4358	URINARY LEG/ABDOMINAL BAG, VINYL, WITH OR WITHOUT TUBE WITH STRAPS	Each	C32b	Bag	$6.26	04/01/2001	Non-institutional only	Purchase only	4 per month	
A4361	OSTOMY, FACE PLATE	Each	C32a	Face plate	$17.52	04/01/2001	Non-institutional only	Purchase only	4 per year	Only one code may be reported each month in the categories of ostomy supplies, urinary ostomy supplies, ostomy faceplates, skin barriers, and irrigation supplies.
A4362	SKIN BARRIER; SOLID, 4 X 4 OR EQUIVALENT; EACH	Each	C32a	Barrier	$3.22	04/01/2001	Non-institutional only	Purchase only	20 per month	Only one code may be reported each month in the categories of ostomy supplies, urinary ostomy supplies, ostomy faceplates, skin barriers, and irrigation supplies.
A4364	ADHESIVE FOR FACIAL PROSTHESIS ONLY; LIQUID OR EQUAL, PER OZ.	Ounce	C32a	Adhesive	$2.38	04/01/2001	Non-institutional only	Purchase only	4 per 2 months	Only one code may be reported each month in the categories of ostomy supplies, urinary ostomy supplies, ostomy faceplates, skin barriers, and irrigation supplies.
A4367	OSTOMY BELT	Each	C32a	Belt	$6.96	04/01/2001	Non-institutional only	Purchase only	2 per 6 MOS	Only one code may be reported each month in the categories of ostomy supplies, urinary ostomy supplies, ostomy faceplates, skin barriers, and irrigation supplies.
A4369	OSTOMY SKIN BARRIER, LIQUID (SPRAY, BRUSH, ETC.) PER OZ.	Ounce	C32a	Barrier	$2.30	01/01/2000	Non-institutional only	Purchase only	4 per month	Only one code may be reported each month in the categories of ostomy supplies, urinary ostomy supplies, ostomy faceplates, skin barriers, and irrigation supplies.
A4371	OSTOMY SKIN BARRIER, POWDER, PER OZ	Ounce	C32a	Barrier	$3.48	04/01/2001	Non-institutional only	Purchase only	4 per month	Only one code may be reported each month in the categories of ostomy supplies, urinary ostomy supplies, ostomy faceplates, skin barriers, and irrigation supplies.
A4372	OSTOMY SKIN BARRIER, SOLID, 4X4 OR EQUIV. STANDARD WEAR W/ BUILT-IN CONVEXITY	Each	C32a	Barrier	$3.78	01/01/2000	Non-institutional only	Purchase only	20 per month	Only one code may be reported each month in the categories of ostomy supplies, urinary ostomy supplies, ostomy faceplates, skin barriers, and irrigation supplies.
A4373	OSTOMY SKIN BARRIER, WITH FLANGE (SOLID, FLEXIBLE OR ACCORDIAN), WITH BUILT-IN CONVEXITY, ANY SIZE, EACH	Each	C32a	Barrier	$5.99	04/01/2001	Non-institutional only	Purchase only	20 per month	Only one code may be reported each month in the categories of ostomy supplies, urinary ostomy supplies, ostomy faceplates, skin barriers, and irrigation supplies.
A4375	OSTOMY POUCH, DRAINABLE, WITH FACEPLATE ATTACHED, PLASTIC	Each	C32a	Pouch	$15.56	01/01/2000	Non-institutional only	Purchase only	5 per month	Only one code may be reported each month in the categories of ostomy supplies, urinary ostomy supplies, ostomy faceplates, skin barriers, and irrigation supplies.

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A4376	OSTOMY POUCH, DRAINABLE, WITH FACEPLATE ATTACHED, RUBBER	Each	C32a	Pouch	$43.11	01/01/2000	Non-institutional only	Purchase only	5 per month	Only one code may be reported each month in the categories of ostomy supplies, urinary ostomy supplies, ostomy faceplates, skin barriers, and irrigation supplies.
A4377	OSTOMY POUCH, DRAINABLE, FOR USE ON FACEPLATE, PLASTIC	Each	C32a	Pouch	$3.89	01/01/2000	Non-institutional only	Purchase only	10 per month	Only one code may be reported each month in the categories of ostomy supplies, urinary ostomy supplies, ostomy faceplates, skin barriers, and irrigation supplies.
A4378	OSTOMY POUCH, DRAINABLE, FOR USE ON FACEPLATE, RUBBER	Each	C32a	Pouch	$27.86	01/01/2000	Non-institutional only	Purchase only	10 per month	Only one code may be reported each month in the categories of ostomy supplies, urinary ostomy supplies, ostomy faceplates, skin barriers, and irrigation supplies.
A4379	OSTOMY POUCH, URINARY, WITH FACEPLATE ATTACHED, PLASTIC	Each	C32a	Pouch	$13.61	01/01/2000	Non-institutional only	Purchase only	5 per month	Only one code may be reported each month in the categories of ostomy supplies, urinary ostomy supplies, ostomy faceplates, skin barriers, and irrigation supplies.
A4380	OSTOMY POUCH, URINARY, WITH FACEPLATE ATTACHED, RUBBER	Each	C32a	Pouch	$33.82	01/01/2000	Non-institutional only	Purchase only	5 per month	Only one code may be reported each month in the categories of ostomy supplies, urinary ostomy supplies, ostomy faceplates, skin barriers, and irrigation supplies.
A4381	OSTOMY POUCH, URINARY, FOR USE ON FACEPLATE, PLASTIC	Each	C32a	Pouch	$4.18	01/01/2000	Non-institutional only	Purchase only	10 per month	Only one code may be reported each month in the categories of ostomy supplies, urinary ostomy supplies, ostomy faceplates, skin barriers, and irrigation supplies.
A4382	OSTOMY POUCH, URINARY, FOR USE ON FACEPLATE, HEAVY PLASTIC	Each	C32a	Pouch	$22.31	01/01/2000	Non-institutional only	Purchase only	10 per month	Only one code may be reported each month in the categories of ostomy supplies, urinary ostomy supplies, ostomy faceplates, skin barriers, and irrigation supplies.
A4383	OSTOMY POUCH, URINARY, FOR USE ON FACEPLATE, RUBBER	Each	C32a	Pouch	$25.55	01/01/2000	Non-institutional only	Purchase only	10 per month	Only one code may be reported each month in the categories of ostomy supplies, urinary ostomy supplies, ostomy faceplates, skin barriers, and irrigation supplies.
A4384	OSTOMY FACEPLATE EQUIVALENT, SILICONE, RING	Each	C32a	Face plate	$8.72	01/01/2000	Non-institutional only	Purchase only	4 per year	Only one code may be reported each month in the categories of ostomy supplies, urinary ostomy supplies, ostomy faceplates, skin barriers, and irrigation supplies.
A4385	OSTOMY SKIN BARRIER, SOLID 4X4 OR EQUIVALENT, EXTENDED WEAR, WITHOUT BUILT-IN CONVEXITY	Each	C32a	Barrier	$4.00	04/01/2001	Non-institutional only	Purchase only	5 per month	Only one code may be reported each month in the categories of ostomy supplies, urinary ostomy supplies, ostomy faceplates, skin barriers, and irrigation supplies.
A4387	OSTOMY POUCH, CLOSED, WITH STANDARD WEAR BARRIER ATTACHED, WITH BUILT-IN CONVEXITY (1 PIECE)	Each	C32a	Pouch	$2.74	04/01/2001	Non-institutional only	Purchase only	45 per month	Only one code may be reported each month in the categories of ostomy supplies, urinary ostomy supplies, ostomy faceplates, skin barriers, and irrigation supplies.
A4388	OSTOMY POUCH, DRAINABLE, WITH EXTENDED WEAR BARRIER ATTACHED, WITHOUT BUILT-IN CONVEXITY (1 PIECE)	Each	C32a	Pouch	$3.87	04/01/2001	Non-institutional only	Purchase only	10 per month	Only one code may be reported each month in the categories of ostomy supplies, urinary ostomy supplies, ostomy faceplates, skin barriers, and irrigation supplies.
A4389	OSTOMY POUCH, DRAINABLE, WITH BARRIER ATTACHED, WITH BUILT-IN CONVEXITY (1 PIECE), EACH	Each	C32a	Pouch	$5.55	04/01/2001	Non-institutional only	Purchase only	20 per month	Only one code may be reported each month in the categories of ostomy supplies, urinary ostomy supplies, ostomy faceplates, skin barriers, and irrigation supplies.
A4390	OSTOMY POUCH, DRAINABLE, WITH EXTENDED WEAR BARRIER ATTACHED, WITH BUILT-IN CONVEXITY (1 PIECE), EACH	Each	C32a	Pouch	$8.94	04/01/2001	Non-institutional only	Purchase only	5 per month	Only one code may be reported each month in the categories of ostomy supplies, urinary ostomy supplies, ostomy faceplates, skin barriers, and irrigation supplies.
A4391	OSTOMY POUCH, URINARY, WITH EXTENDED WEAR BARRIER ATTACHED, WITHOUT BUILT-IN CONVEXITY (1 PIECE)	Each	C32a	Pouch	$6.04	04/01/2001	Non-institutional only	Purchase only	10 per month	Only one code may be reported each month in the categories of ostomy supplies, urinary ostomy supplies, ostomy faceplates, skin barriers, and irrigation supplies.
A4392	OSTOMY POUCH, URINARY, WITH STANDARD WEAR BARRIER ATTACHED, WITH BUILT-IN CONVEXITY (1 PIECE)	Each	C32a	Pouch	$6.34	04/01/2001	Non-institutional only	Purchase only	20 per month	Only one code may be reported each month in the categories of ostomy supplies, urinary ostomy supplies, ostomy faceplates, skin barriers, and irrigation supplies.
A4393	OSTOMY POUCH, URINARY, WITH EXTENDED WEAR BARRIER ATTACHED, WITH BUILT-IN CONVEXITY (1 PIECE)	Each	C32a	Pouch	$7.81	04/01/2001	Non-institutional only	Purchase only	5 per month	Only one code may be reported each month in the categories of ostomy supplies, urinary ostomy supplies, ostomy faceplates, skin barriers, and irrigation supplies.
A4396	OSTOMY BELT WITH PERISTOMAL HERNIA SUPPORT	Each	C32a	Belt	$24.20	10/01/2004	Non-institutional only	Purchase only	1 per 3 months	Only one code may be reported each month in the categories of ostomy supplies, urinary ostomy supplies, ostomy faceplates, skin barriers, and irrigation supplies.
A4397	IRRIGATION SUPPLY; SLEEVE	Each	C32a	Irrigation	$4.41	04/01/2001	Non-institutional only	Purchase only	10 per month	Only one code may be reported each month in the categories of ostomy supplies, urinary ostomy supplies, ostomy faceplates, skin barriers, and irrigation supplies.
A4398	IRRIGATION SUPPLY; BAG	Each	C32a	Irrigation	$13.17	04/01/2001	Non-institutional only	Purchase only	4 per year	Only one code may be reported each month in the categories of ostomy supplies, urinary ostomy supplies, ostomy faceplates, skin barriers, and irrigation supplies.
A4399	IRRIGATION SUPPLY; CONE/CATHETER	Each	C32a	Irrigation	$9.95	01/01/1998	Non-institutional only	Purchase only	1 per 6 months	Only one code may be reported each month in the categories of ostomy supplies, urinary ostomy supplies, ostomy faceplates, skin barriers, and irrigation supplies.
A4400	OSTOMY IRRIGATION SET	Each	C32a	Irrigation	$45.00	08/01/1997	Non-institutional only	Purchase only	2 per year	Only one code may be reported each month in the categories of ostomy supplies, urinary ostomy supplies, ostomy faceplates, skin barriers, and irrigation supplies.
A4402	LUBRICANT, PER OUNCE	Ounce	C01d	Other supply item	$0.65	08/01/1998	Non-institutional only	Purchase only	8 per month	
A4404	OSTOMY RING, EACH	Each	C32a	Ring	$1.47	04/01/2001	Non-institutional only	Purchase only	5 per month	Only one code may be reported each month in the categories of ostomy supplies, urinary ostomy supplies, ostomy faceplates, skin barriers, and irrigation supplies.
A4405	OSTOMY SKIN BARRIER, NON-PECTIN BASED PASTE	Ounce	C32a	Barrier	$3.27	04/01/2003	Non-institutional only	Purchase only	4 per month	Only one code may be reported each month in the categories of ostomy supplies, urinary ostomy supplies, ostomy faceplates, skin barriers, and irrigation supplies.

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A4406	OSTOMY SKIN BARRIER, PECTIN BASED PASTE	Ounce	C32a	Barrier	$3.27	04/01/2003	Non-institutional only	Purchase only	4 per month	Only one code may be reported each month in the categories of ostomy supplies, urinary ostomy supplies, ostomy faceplates, skin barriers, and irrigation supplies.
A4407	OSTOMY SKIN BARRIER WITH FLANGE (SOLID, FLEXIBLE, OR ACCORDION), EXTENDED WEAR, WITH BUILT-IN CONVEXITY; 4X4 OR SMALLER	Each	C32a	Barrier	$7.67	04/01/2003	Non-institutional only	Purchase only	5 per month	Only one code may be reported each month in the categories of ostomy supplies, urinary ostomy supplies, ostomy faceplates, skin barriers, and irrigation supplies.
A4408	OSTOMY SKIN BARRIER WITH FLANGE (SOLID, FLEXIBLE OR ACCORDION), EXTENDED WEAR, WITH BUILT-IN CONVEXITY; LARGER THAN 4X4	Each	C32a	Barrier	$7.67	04/01/2003	Non-institutional only	Purchase only	5 per month	Only one code may be reported each month in the categories of ostomy supplies, urinary ostomy supplies, ostomy faceplates, skin barriers, and irrigation supplies.
A4409	OSTOMY SKIN BARRIER, WITH FLANGE (SOLID, FLEXIBLE OR ACCORDION), EXTENDED WEAR WITHOUT BUILT-IN CONVEXITY, 4X4 OR SMALLER	Each	C32a	Barrier	$5.68	04/01/2003	Non-institutional only	Purchase only	5 per month	Only one code may be reported each month in the categories of ostomy supplies, urinary ostomy supplies, ostomy faceplates, skin barriers, and irrigation supplies.
A4410	OSTOMY SKIN BARRIER, WITH FLANGE (SOLID, FLEXIBLE OR ACCORDION), EXTENDED WEAR, WITHOUT BUILT-IN CONVEXITY; LARGER THAN 4X4	Each	C32a	Barrier	$5.68	04/01/2003	Non-institutional only	Purchase only	5 per month	Only one code may be reported each month in the categories of ostomy supplies, urinary ostomy supplies, ostomy faceplates, skin barriers, and irrigation supplies.
A4414	OSTOMY SKIN BARRIER, WITH FLANGE (SOLID, FLEXIBLE OR ACCORDION, WITHOUT BUILT-IN CONVEXITY; 4X4 OR SMALLER	Each	C32a	Barrier	$4.24	04/01/2003	Non-institutional only	Purchase only	20 per month	Only one code may be reported each month in the categories of ostomy supplies, urinary ostomy supplies, ostomy faceplates, skin barriers, and irrigation supplies.
A4415	OSTOMY SKIN BARRIER, WITH FLANGE (SOLID, FLEXIBLE OR ACCORDION), WITHOUT BUILT-IN CONVEXITY; LARGER THAN 4X4	Each	C32a	Barrier	$4.24	04/01/2003	Non-institutional only	Purchase only	20 per month	Only one code may be reported each month in the categories of ostomy supplies, urinary ostomy supplies, ostomy faceplates, skin barriers, and irrigation supplies.
A4421	OSTOMY SUPPLY; MISCELLANEOUS	Each	C32a	Supply	PA	05/01/1990	Non-institutional only	Purchase only		Only one code may be reported each month in the categories of ostomy supplies, urinary ostomy supplies, ostomy faceplates, skin barriers, and irrigation supplies.
A4450	TAPE, NON-WATERPROOF, PER 18 SQUARE INCHES	18 square inches	C34	Dressings / tape / gauze / bandages	$0.08	10/01/2004	Non-institutional only	Purchase only	200 per month	
A4452	TAPE, WATERPROOF, PER 18 SQUARE INCHES	18 square inches	C34	Dressings / tape / gauze / bandages	$0.32	10/01/2004	Non-institutional only	Purchase only	200 per month	
A4455	ADHESIVE REMOVER OR SOLVENT (FOR TAPE, CEMENT OR OTHER ADHESIVE) NOT COVERED FOR USE WITH UROLOGICAL SUPPLIES	Ounce	C01d	Supply	$1.36	04/01/2001	Non-institutional only	Purchase only	8 per month	
A4458	ENEMA BAG WITH TUBING, REUSABLE	Each	C01d	Bag	$8.00	10/01/2004	Non-institutional only	Purchase only	1 per 2 years	
A4467	BELT, STRAP, SLEEVE, GARMENT, OR COVERING, ANY TYPE	Each	C14a	Elastic supports	$40.00	01/01/2017	Non-institutional only	Purchase only	2 per year	A4467 replaces A4466.
A4483	MOISTURE EXCHANGER, DISPOSABLE, FOR USE WITH INVASIVE MECHANICAL VENTILATION	Each	C01d	Tracheostomy supplies	$4.15	01/01/2005	Non-institutional only	Purchase only	100 per month	
A4490	PRESSURE GRADIENT SURGICAL STOCKING, ABOVE KNEE LENGTH	Each	C14a	Surgical stockings and burn garments	$25.00	10/15/2006	Non-institutional only	Purchase only	6 per year	
A4495	PRESSURE GRADIENT SURGICAL STOCKING, THIGH LENGTH	Each	C14a	Surgical stockings and burn garments	$25.00	10/15/2006	Non-institutional only	Purchase only	6 per year	
A4500	PRESSURE GRADIENT SURGICAL STOCKING, BELOW KNEE LENGTH	Each	C14a	Surgical stockings and burn garments	$22.00	10/15/2006	Non-institutional only	Purchase only	6 per year	
A4510	PRESSURE GRADIENT SURGICAL STOCKING, FULL LENGTH, LEOTARD	Each	C14a	Surgical stockings and burn garments	$75.00	01/01/2008	Non-institutional only	Purchase only	3 per year	
A4556	ELECTRODES, PER PAIR (E.G., APNEA MONITOR)	Pair	C01d	Electrodes	$9.41	10/01/2004	Non-institutional only	Purchase only	1 per month	No separate payment is made for apnea monitor supplies during any month in which an apnea monitor is rented.
A4557	LEAD WIRES, PER PAIR (E.G. APNEA MONITOR)	Pair	C01d	Lead wires	$16.36	10/01/2004	Non-institutional only	Purchase only	1 per month	No separate payment is made for apnea monitor supplies during any month in which an apnea monitor is rented.
A4558	CONDUCTIVE PASTE OR GEL	Each	C01d	Supply	$4.23	10/01/2004	Non-institutional only	Purchase only	1 per month	No separate payment is made for apnea monitor supplies during any month in which an apnea monitor is rented.
A4561	PESSARY, RUBBER, ANY TYPE	Each	C01d	Supply	$10.24	01/01/2001	Non-institutional only	Purchase only	1 per year	
A4562	PESSARY, NON-RUBBER, ANY TYPE	Each	C01d	Supply	$10.24	01/01/2001	Non-institutional only	Purchase only	1 per year	
A4565	SLING	Each	C01d	Limb support	$6.30	07/01/2002	Non-institutional only	Purchase only	2 per year	
A4566	SHOULDER SLINT OR VEST DESIGN, ABDUCTION RESTRAINER	Each	C01c	Shoulder	$95.00	01/01/2011	All	Purchase only	1 per medical event	
A4570	SPLINT	Each	C01d	Limb support	$10.00	05/01/1990	Non-institutional only	Purchase only	1 per year	
A4580	CAST SUPPLIES (E.G. PLASTER), REPAIR ONLY	Roll	C01d	Casting	$2.55	11/01/1992	Non-institutional only	Purchase only	1 per year	
A4590	CASTING MATERIAL, SPECIAL (E.G. FIBERGLASS), REPAIR ONLY	Roll	C01d	Casting	$15.00	11/01/1992	Non-institutional only	Purchase only	1 per year	
A4595	TENS SUPPLIES, FOR 2 OR 4 LEAD (FOR A RECIPIENT-OWNED UNIT)	Each	C15	TENS supplies	$25.00	01/01/1996	Non-institutional only	Purchase only	1 per month	No separate payment is made for TENS supplies during any month in which a TENS unit is rented.
A4604	TUBING WITH INTEGRATED HEATING ELEMENT FOR PAP	Each	C19	Tubing	$53.40	02/08/2016	Non-institutional only	Purchase only	1 per year	
A4605	TRACHEAL SUCTION CATHETER, CLOSED SYSTEM, EACH	Each	C01d	Respiratory care supplies	$13.12	07/01/2018	Non-institutional only	Purchase only	10 per month	A claim may be submitted for only one type of tracheal suction catheter per month.
A4606	OXYGEN PROBE FOR USE WITH OXIMETER DEVICE, REPLACEMENT	Each	C23	Probe	PA	10/01/2004	Non-institutional only	Purchase only	4 per year	
A4611	BATTERY, HEAVY DUTY; REPLACEMENT FOR PATIENT-OWNED VENTILATOR	Each	C22	Ventilator battery	$100.00	05/01/1990	Non-institutional only	Purchase only	1 per year	

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A4612	BATTERY CABLES; REPLACEMENT FOR PATIENT-OWNED VENTILATOR	Each	C22	Ventilator battery	$60.00	05/01/1990	Non-institutional only	Purchase only	1 per 2 years	
A4613	BATTERY CHARGER; REPLACEMENT FOR PATIENT-OWNED VENTILATOR	Each	C22	Ventilator battery	$60.00	05/01/1990	Non-institutional only	Purchase only	1 per 3 years	
A4616	TUBING, AEROSOL, (PER FOOT)	Foot	C01d	Respiratory care supplies	$0.05	01/01/2008	Non-institutional only	Purchase only	15 per month	
A4617	MOUTH PIECE	Each	C13	Respiratory care supplies	$1.00	05/01/1990	Non-institutional only	Purchase only	1 per 2 months	
A4618	BREATHING CIRCUITS, IPPB (FOR CONSUMER-OWNED IPPB ONLY)	Each	C19	Breathing circuits	$2.60	05/01/1990	Non-institutional only	Purchase only	4 per month	
A4619	OXYGEN FACE TENT	Each	C13	Respiratory care supplies	$1.21	01/01/2002	Non-institutional only	Purchase only	6 per month	
A4620	VARIABLE CONCENTRATION MASK	Each	C13	Respiratory care supplies	$0.62	04/01/2009	Non-institutional only	Purchase only	6 per month	
A4623	TRACHEOSTOMY, INNER CANNULA (REPLACEMENT ONLY)	Each	C01d	Tracheostomy supplies	$4.38	01/01/1994	Non-institutional only	Purchase only	30 per month	
A4624	TRACHEAL SUCTION CATHETER, ANY TYPE OTHER THAN CLOSED SYSTEM, ADULT	Each	C01d	Respiratory care supplies	$0.80	05/01/1990	Non-institutional only	Purchase only	150 per month	A claim may be submitted for only one type of tracheal suction catheter per month.
A4625	TRACHEOSTOMY CARE KIT FOR NEW TRACHEOSTOMY (CLEANING STARTER KIT)	Each	C01d	Tracheostomy supplies	$3.55	01/01/1996	Non-institutional only	Purchase only	30 per month	This item is covered only for the first two weeks following open surgical tracheostomy.
A4626	TRACHEOSTOMY CLEANING BRUSH	Each	C01d	Tracheostomy supplies	$1.38	01/01/1993	Non-institutional only	Purchase only	10 per month	
A4628	OROPHARYNGEAL SUCTION CATHETER	Each	C01d	Respiratory care supplies	$2.70	01/01/1996	Non-institutional only	Purchase only	4 per month	
A4629	TRACHEOSTOMY CARE KIT FOR ESTABLISHED TRACHEOSTOMY	Each	C01d	Tracheostomy supplies	$2.55	01/01/1996	Non-institutional only	Purchase only	30 per month	
A4635	UNDERARM PAD, CRUTCH, REPLACEMENT, EACH	Each	C30	Ambulation accessory	$1.50	05/25/1991	Non-institutional only	Purchase only	2 per year	
A4636	HANDGRIP, REPLACEMENT, CANE, CRUTCH, OR WALKER, EACH	Each	C30	Ambulation accessory	$1.66	05/25/1991	Non-institutional only	Purchase only	4 per year	
A4637	REPLACEMENT TIP, CANE, CRUTCH, WALKER, EACH	Each	C30	Ambulation accessory	$1.90	05/25/1991	Non-institutional only	Purchase only	4 per year	
A4640	REPLACEMENT PAD FOR USE WITH MEDICALLY NECESSARY ALTERNATING PRESSURE PAD OWNED BY CONSUMER	Each	C18b	Pad	$31.28	05/25/1991	Non-institutional only	Purchase only	1 per year	
A4649	SURGICAL SUPPLY, MISCELLANEOUS (DO NOT USE FOR OSTOMY SUPPLIES)	Each	C01d	Supply	PA	05/01/1990	Non-institutional only	Purchase only		
A4660	SPHYGMOMANOMETER/BLOOD PRESSURE APPARATUS WITH CUFF & STETHOSCOPE	Set	C01a	Blood pressure monitor and accessories	$30.00	05/01/1990	Non-institutional only	Purchase only	1 per 8 years	
A4663	BLOOD PRESSURE CUFF ONLY (REPLACEMENT)	Each	C01a	Blood pressure monitor and accessories	$13.00	05/01/1990	Non-institutional only	Purchase only	1 per 8 years	
A4670	AUTOMATIC BLOOD PRESSURE MONITOR	Each	C01a	Blood pressure monitor and accessories	$47.00	05/01/1990	Non-institutional only	Purchase only	1 per 8 years	
A4719	"Y SET" TUBING FOR PERITONEAL DIALYSIS	Set	C29	Infusion pump (non-nutrition) supplies	$5.00	10/01/2004	Non-institutional only	Purchase only	30 per month	
A4927	GLOVES, NON-STERILE	100	C01d	Supply	$8.69	04/01/2003	Non-institutional only	Purchase only	2 per month	
A4930	GLOVES, STERILE	Pair	C01d	Supply	$0.55	04/01/2003	Non-institutional only	Purchase only	100 pair per month	
A5051	OSTOMY POUCH, CLOSED; WITH BARRIER ATTACHED (1 PIECE).	Each	C32a	Pouch	$1.91	04/01/2001	Non-institutional only	Purchase only	45 per month	Only one code may be reported each month in the categories of ostomy supplies, urinary ostomy supplies, ostomy faceplates, skin barriers, and irrigation supplies.
A5052	OSTOMY POUCH, CLOSED; WITHOUT BARRIER ATTACHED (1 PIECE)	Each	C32a	Pouch	$1.36	04/01/2001	Non-institutional only	Purchase only	45 per month	Only one code may be reported each month in the categories of ostomy supplies, urinary ostomy supplies, ostomy faceplates, skin barriers, and irrigation supplies.
A5053	OSTOMY POUCH, CLOSED; FOR USE ON FACEPLATE	Each	C32a	Pouch	$1.58	01/01/1998	Non-institutional only	Purchase only	45 per month	Only one code may be reported each month in the categories of ostomy supplies, urinary ostomy supplies, ostomy faceplates, skin barriers, and irrigation supplies.
A5054	OSTOMY POUCH, CLOSED FOR USE ON BARRIER W/FLANGE (2 PC)	Each	C32a	Pouch	$1.35	04/01/2001	Non-institutional only	Purchase only	45 per month	Only one code may be reported each month in the categories of ostomy supplies, urinary ostomy supplies, ostomy faceplates, skin barriers, and irrigation supplies.
A5055	STOMA CAP	Each	C32a	Cap	$1.27	04/01/2001	Non-institutional only	Purchase only	30 per month	Only one code may be reported each month in the categories of ostomy supplies, urinary ostomy supplies, ostomy faceplates, skin barriers, and irrigation supplies.
A5061	POUCH, DRAINABLE WITH BARRIER ATTACHED (1 PIECE)	Each	C32a	Pouch	$2.45	04/01/2001	Non-institutional only	Purchase only	30 per month	Only one code may be reported each month in the categories of ostomy supplies, urinary ostomy supplies, ostomy faceplates, skin barriers, and irrigation supplies.
A5062	OSTOMY POUCH, DRAINABLE; WITHOUT BARRIER ATTACHED (1 PIECE), EACH	Each	C32a	Pouch	$1.90	08/01/1997	Non-institutional only	Purchase only	20 per month	Only one code may be reported each month in the categories of ostomy supplies, urinary ostomy supplies, ostomy faceplates, skin barriers, and irrigation supplies.

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A5063	OSTOMY POUCH, DRAINABLE; FOR USE ON BARRIER WITH FLANGE (2 PIECE SYSTEM)	Each	C32a	Pouch	$2.13	04/01/2001	Non-institutional only	Purchase only	10 per month	Only one code may be reported each month in the categories of ostomy supplies, urinary ostomy supplies, ostomy faceplates, skin barriers, and irrigation supplies.
A5071	OSTOMY POUCH URINARY; WITH BARRIER ATTACHED, (1 PIECE)	Each	C32a	Pouch	$4.15	04/01/2001	Non-institutional only	Purchase only	20 per month	Only one code may be reported each month in the categories of ostomy supplies, urinary ostomy supplies, ostomy faceplates, skin barriers, and irrigation supplies.
A5072	OSTOMY POUCH URINARY; WITHOUT BARRIER ATTACHED (1 PIECE)	Each	C32a	Pouch	$3.10	04/01/2001	Non-institutional only	Purchase only	20 per month	Only one code may be reported each month in the categories of ostomy supplies, urinary ostomy supplies, ostomy faceplates, skin barriers, and irrigation supplies.
A5073	OSTOMY POUCH URINARY; FOR USE ON BARRIER WITH FLANGE (2 PIECE)	Each	C32a	Pouch	$2.98	04/01/2001	Non-institutional only	Purchase only	10 per month	Only one code may be reported each month in the categories of ostomy supplies, urinary ostomy supplies, ostomy faceplates, skin barriers, and irrigation supplies.
A5081	OSTOMY CONTINENT DEVICE; PLUG FOR CONTINENT STOMA	Each	C32a	Plug	$3.00	01/01/1998	Non-institutional only	Purchase only	40 per month	Only one code may be reported each month in the categories of ostomy supplies, urinary ostomy supplies, ostomy faceplates, skin barriers, and irrigation supplies.
A5082	OSTOMY CONTINENT DEVICE; CATHETER FOR CONTINENT STOMA	Each	C32a	Catheter	$10.75	01/01/1998	Non-institutional only	Purchase only	1 per 2 months	Only one code may be reported each month in the categories of ostomy supplies, urinary ostomy supplies, ostomy faceplates, skin barriers, and irrigation supplies.
A5093	OSTOMY ACCESSORY; CONVEX INSERT	Each	C32a	Insert	$1.58	04/01/2001	Non-institutional only	Purchase only	10 per month	Only one code may be reported each month in the categories of ostomy supplies, urinary ostomy supplies, ostomy faceplates, skin barriers, and irrigation supplies.
A5102	BEDSIDE DRAINAGE BOTTLE, RIGID OR EXPANDABLE	Each	C32b	Bottle	$21.39	04/01/2001	Non-institutional only	Purchase only	2 per year	
A5105	URINARY SUSPENSORY; WITH LEG BAG, WITH OR WITHOUT TUBE	Each	C32b	Suspensory	$40.32	07/01/2002	Non-institutional only	Purchase only	2 per year	
A5112	URINARY LEG BAG; LATEX	Each	C32b	Bag	$31.16	07/01/2002	Non-institutional only	Purchase only	3 per year	
A5113	LEG STRAP; LATEX, REPLACEMENT ONLY, PER SET (FOR USE WITH URINARY LEG BAG)	Each	C32b	Strap	$1.30	11/15/1993	Non-institutional only	Purchase only	4 per year	
A5114	LEG STRAP; FOAM OR FABRIC, REPLACEMENT ONLY, PER SET (FOR USE WITH URINARY LEG BAG)	Each	C32b	Strap	$4.25	04/01/2001	Non-institutional only	Purchase only	4 per year	
A5120	SKIN BARRIER, WIPES OR SWABS, EACH	Each	C32a	Wipes	$0.17	01/01/2006	Non-institutional only	Purchase only	50 per month	Only one code may be reported each month in the categories of ostomy supplies, urinary ostomy supplies, ostomy faceplates, skin barriers, and irrigation supplies.
A5121	OSTOMY SKIN BARRIER; SOLID 6 X 6, OR EQUIVALENT	Each	C32a	Barrier	$6.70	05/01/1990	Non-institutional only	Purchase only	5 per month	Only one code may be reported each month in the categories of ostomy supplies, urinary ostomy supplies, ostomy faceplates, skin barriers, and irrigation supplies.
A5122	OSTOMY SKIN BARRIER; SOLID, 8 X 8 OR EQUIVALENT	Each	C32a	Barrier	$12.26	04/01/2001	Non-institutional only	Purchase only	6 per month	Only one code may be reported each month in the categories of ostomy supplies, urinary ostomy supplies, ostomy faceplates, skin barriers, and irrigation supplies.
A5126	ADHESIVE OR NON-ADHESIVE; DISK OR FOAM PAD	Each	C32a	Pad	$1.11	07/01/2002	Non-institutional only	Purchase only	20 per month	Only one code may be reported each month in the categories of ostomy supplies, urinary ostomy supplies, ostomy faceplates, skin barriers, and irrigation supplies.
A5131	APPLIANCE CLEANER, INCONTINENCE AND OSTOMY APPLIANCES, PER 16 OZ.	16 ounces	C32a	Cleaner	$12.25	01/01/1998	Non-institutional only	Purchase only	1 per 3 months	
A5500	DIABS ONLY,FITTING,CUSTOM PREP, OFFSHELF, PER SHOE	Each	C31a	Diabetic shoes	$46.07	01/01/2010	All	Purchase only	1 per foot per year	
A5501	FOR DIABETICS ONLY, CUSTOM MOLDED SHOE	Each	C31a	Diabetic shoes	$160.19	01/01/2010	All	Purchase only	1 per foot per year	
A5512	DIABS ONLY, MULT DENSITY INSERT, DIRECT FORM	Each	C31a	Diabetic shoes	$18.80	01/01/2010	All	Purchase only	1 per foot per year	
A5513	DIABS ONLY,MULT DENSITY INSERT, CUSTOM	Each	C31a	Diabetic shoes	$28.04	01/01/2010	All	Purchase only	1 per foot per year	
A6010	COLLAGEN BASED WOUND FILLER, DRY FORM, PER GRAM	Gram	C34	Wound fillers	$30.96	09/01/2005	Non-institutional only	Purchase only	$100 per month	Submitted charge must not exceed manufacturer's suggested list price.
A6011	COLLAGEN BASED WOUND FILLER, GEL/PASTE, PER GRAM	Gram	C34	Wound fillers	$1.82	01/01/2005	Non-institutional only	Purchase only	$100 per month	Submitted charge must not exceed manufacturer's suggested list price.
A6021	COLLAGEN DRESSING, LESS THAN 16 SQ IN	Each	C34	Dressings / tape / gauze / bandages	$16.82	04/01/2006	Non-institutional only	Purchase only	10 per month	
A6022	COLLAGEN DRESSING, MORE THAN 16 SQ IN, LESS THAN OR EQUAL TO 48 SQ IN	Each	C34	Dressings / tape / gauze / bandages	$18.91	04/01/2006	Non-institutional only	Purchase only	10 per month	
A6023	COLLAGEN DRESSING, MORE THAN 48 SQ IN	Each	C34	Dressings / tape / gauze / bandages	$171.27	04/01/2006	Non-institutional only	Purchase only	20 per month	
A6154	WOUND POUCH, FOR SURGICAL WOUND DRAINAGE, PER WOUND	Each	C34	Dressings / tape / gauze / bandages	$11.40	01/01/1997	Non-institutional only	Purchase only	15 per month	
A6196	ALGINATE OR OTHER FIBER GELLING DRESSING, WOUND COVER, PAD SIZE 16 SQ. IN. OR LESS	Each	C34	Dressings / tape / gauze / bandages	$6.00	07/01/2018	Non-institutional only	Purchase only	30 per month	
A6197	ALGINATE OR OTHER FIBER GELLING DRESSING, WOUND COVER, PAD SIZE MORE THAN 16 BUT LESS THAN OR EQUAL TO 48 SQ. IN.	Each	C34	Dressings / tape / gauze / bandages	$12.50	07/01/2018	Non-institutional only	Purchase only	30 per month	
A6198	ALGINATE OR OTHER FIBER GELLING DRESSING, WOUND COVER, PAD SIZE MORE THAN 48 SQ. IN.	Each	C34	Dressings / tape / gauze / bandages	$31.40	04/01/2006	Non-institutional only	Purchase only	30 per month	
A6199	ALGINATE OR OTHER FIBER GELLING DRESSING, WOUND FILLER, PER 6 IN.	6 inches	C34	Wound fillers	$5.29	09/01/2005	Non-institutional only	Purchase only	$100 per month	Submitted charge must not exceed manufacturer's suggested list price.

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A6203	COMPOSITE DRESSING, PAD SIZE 16 SQ. IN. OR LESS, WITH ANY SIZE ADHESIVE BORDER	Each	C34	Dressings / tape / gauze / bandages	$3.02	01/01/1997	Non-institutional only	Purchase only	12 per month	
A6204	COMPOSITE DRESSING, PAD SIZE MORE THAN 16 BUT LESS THAN OR EQUAL TO 48 SQ. IN., WITH ANY SIZE ADHESIVE BORDER	Each	C34	Dressings / tape / gauze / bandages	$4.50	01/01/1997	Non-institutional only	Purchase only	12 per month	
A6205	COMPOSITE DRESSING,PAD SIZE MORE THAN 48 SQ.IN.,WITH ANY SIZE ADHESIVE BORDER	Each	C34	Dressings / tape / gauze / bandages	PA	01/01/1997	Non-institutional only	Purchase only	12 per month	
A6206	CONTACT LAYER, 16 SQ. IN. OR LESS	Each	C34	Dressings / tape / gauze / bandages	PA	01/01/1997	Non-institutional only	Purchase only	4 per month	
A6207	CONTACT LAYER, MORE THAN 16 BUT LESS THAN OR EQUAL TO 48 SQ. IN.	Each	C34	Dressings / tape / gauze / bandages	$5.30	01/01/1997	Non-institutional only	Purchase only	4 per month	
A6208	CONTACT LAYER, MORE THAN 48 SQ. IN.	Each	C34	Dressings / tape / gauze / bandages	$11.98	04/01/2006	Non-institutional only	Purchase only	4 per month	
A6209	FOAM DRESSING, WOUND COVER, PAD SIZE 16 SQ. IN. OR LESS, WITHOUT ADHESIVE BORDER	Each	C34	Dressings / tape / gauze / bandages	$6.17	07/01/2018	Non-institutional only	Purchase only	12 per month	
A6210	FOAM DRESSING, WOUND COVER, PAD SIZE MORE THAN 16 BUT LESS THAN OR EQUAL TO 48 SQ. IN., WITHOUT ADHESIVE BORDER	Each	C34	Dressings / tape / gauze / bandages	$14.35	07/01/2018	Non-institutional only	Purchase only	12 per month	
A6211	FOAM DRESSING, WOUND COVER, PAD SIZE MORE THAN 48 SQ. IN., WITHOUT ADHESIVE BORDER	Each	C34	Dressings / tape / gauze / bandages	$25.21	07/01/2018	Non-institutional only	Purchase only	12 per month	
A6212	FOAM DRESSING, WOUND COVER, PAD SIZE 16 SQ. IN., OR LESS, WITH ANY SIZE ADHESIVE BORDER	Each	C34	Dressings / tape / gauze / bandages	$7.00	07/01/2018	Non-institutional only	Purchase only	12 per month	
A6213	FOAM DRESSING, WOUND COVER, PAD SIZE MORE THAN 16 BUT LESS THAN OR EQUAL TO 48 SQ. IN., WITH ANY SIZE ADHESIVE BORDER	Each	C34	Dressings / tape / gauze / bandages	$12.54	07/01/2018	Non-institutional only	Purchase only	12 per month	
A6214	FOAM DRESSING, WOUND COVER, PAD SIZE MORE THAN 48 SQ. IN., WITH ANY SIZE ADHESIVE BORDER	Each	C34	Dressings / tape / gauze / bandages	$7.45	01/01/1997	Non-institutional only	Purchase only	12 per month	
A6215	FOAM DRESSING, WOUND FILLER,PER GRAM	Gram	C34	Wound fillers	$1.23	04/01/2006	Non-institutional only	Purchase only	$100 per month	Submitted charge must not exceed manufacturer's suggested list price.
A6216	GAUZE, NON-IMPREGNATED, PAD SIZE 16 SQ. IN. OR LESS, WITHOUT ADHESIVE BORDER	Each	C34	Dressings / tape / gauze / bandages	$0.05	04/01/2006	Non-institutional only	Purchase only	$50 per month	
A6217	GAUZE, NON-IMPREGNATED, PAD SIZE MORE THAN 16 BUT LESS THAN OR EQUAL TO 48 SQ. IN., WITHOUT ADHESIVE BORDER	Each	C34	Dressings / tape / gauze / bandages	$0.64	04/01/2006	Non-institutional only	Purchase only	$50 per month	
A6218	GAUZE, NON-IMPREGNATED, PAD SIZE MORE THAN 48 SQ. IN., WITHOUT ADHESIVE BORDER	Each	C34	Dressings / tape / gauze / bandages	$1.27	04/01/2006	Non-institutional only	Purchase only	$50 per month	
A6219	GAUZE, NON-IMPREGNATED, PAD SIZE 16 SQ. IN. OR LESS WITH ANY SIZE ADHESIVE BORDER	Each	C34	Dressings / tape / gauze / bandages	$0.95	04/01/2006	Non-institutional only	Purchase only	$50 per month	
A6220	GAUZE, NON-IMPREGNATED, PAD SIZE MORE THAN 16 BUT LESS THAN OR EQUAL TO 48 SQ. IN., WITH ANY SIZE ADHESIVE BORDER	Each	C34	Dressings / tape / gauze / bandages	$2.58	04/01/2006	Non-institutional only	Purchase only	$50 per month	
A6221	GAUZE, NON-IMPREGNATED, PAD SIZE MORE THAN 48 SQ. IN., WITH ANY SIZE ADHESIVE BORDER	Each	C34	Dressings / tape / gauze / bandages	$0.52	04/01/2006	Non-institutional only	Purchase only	$50 per month	
A6222	GAUZE, IMPREGNATED, OTHER THAN WATER, HYDROGEL OR NORMAL SALINE, PAD SIZE 16 SQ. IN. OR LESS, WITHOUT ADHESIVE BORDER	Each	C34	Dressings / tape / gauze / bandages	$1.65	01/01/1997	Non-institutional only	Purchase only	30 per month	
A6223	GAUZE, IMPREGNATED, OTHER THAN WATER, HYDROGEL OR NORMAL SALINE, PAD SIZE MORE THAN 16 BUT LESS THAN OR EQUAL TO 48 SQ. IN., WITHOUT ADHESIVE BORDER	Each	C34	Dressings / tape / gauze / bandages	$1.75	01/01/1997	Non-institutional only	Purchase only	30 per month	
A6224	GAUZE, IMPREGNATED, OTHER THAN WATER, HYDROGEL OR NORMAL SALINE, PAD SIZE MORE THAN 48 SQ. IN., WITHOUT ADHESIVE BORDER	Each	C34	Dressings / tape / gauze / bandages	$2.60	01/01/1997	Non-institutional only	Purchase only	30 per month	
A6231	GAUZE, IMPREGNATED, HYDROGEL, 16 SQ IN OR LESS	Each	C34	Dressings / tape / gauze / bandages	$1.65	01/01/2001	Non-institutional only	Purchase only	12 per month	
A6232	GAUZE, IMPREGNATED, HYDROGEL, MORE THAN 16 BUT LESS THAN OR EQUAL TO 48 SQ IN	Each	C34	Dressings / tape / gauze / bandages	$1.75	01/01/2001	Non-institutional only	Purchase only	12 per month	
A6233	GAUZE, IMPREGNATED, HYDROGEL, MORE THAN 48 SQ IN	Each	C34	Dressings / tape / gauze / bandages	$2.60	01/01/2001	Non-institutional only	Purchase only	12 per month	
A6234	HYDROCOLLOID DRESSING, WOUND COVER, PAD SIZE 16 SQ. IN. OR LESS, WITHOUT ADHESIVE BORDER	Each	C34	Dressings / tape / gauze / bandages	$4.80	01/01/1997	Non-institutional only	Purchase only	12 per month	
A6235	HYDROCOLLOID DRESSING, WOUND COVER, PAD SIZE MORE THAN 16 BUT LESS THAN OR EQUAL TO 48 SQ. IN., WITHOUT ADHESIVE BORDER	Each	C34	Dressings / tape / gauze / bandages	$12.15	01/01/1997	Non-institutional only	Purchase only	12 per month	
A6236	HYDROCOLLOID DRESSING, WOUND COVER, PAD SIZE MORE THAN 48 SQ. IN., WITHOUT ADHESIVE BORDER	Each	C34	Dressings / tape / gauze / bandages	$19.65	01/01/1997	Non-institutional only	Purchase only	12 per month	
A6237	HYDROCOLLOID DRESSING, WOUND COVER, PAD SIZE 16 SQ. IN. OR LESS, WITH ANY SIZE ADHESIVE BORDER	Each	C34	Dressings / tape / gauze / bandages	$5.80	01/01/1997	Non-institutional only	Purchase only	12 per month	
A6238	HYDROCOLLOID DRESSING, WOUND COVER, PAD SIZE MORE THAN 16 BUT LESS THAN OR EQUAL TO 48 SQ. IN., WITH ANY SIZE ADHESIVE BORDER	Each	C34	Dressings / tape / gauze / bandages	$16.75	01/01/1997	Non-institutional only	Purchase only	12 per month	
A6239	HYDROCOLLOID DRESSING, WOUND COVER, PAD SIZE MORE THAN 48 SQ. IN., WITH ANY SIZE ADHESIVE BORDER	Each	C34	Dressings / tape / gauze / bandages	PA	01/01/1997	Non-institutional only	Purchase only	12 per month	
A6240	HYDROCOLLOID DRESSING, WOUND FILLER, PASTE, PER FLUID OZ.	Fluid ounce	C34	Wound fillers	$5.00	07/26/2007	Non-institutional only	Purchase only	$100 per month	Submitted charge must not exceed manufacturer's suggested list price.
A6241	HYDROCOLLOID DRESSING, WOUND FILLER, DRY FORM, PER GRAM	Gram	C34	Wound fillers	$2.57	09/01/2005	Non-institutional only	Purchase only	$100 per month	Submitted charge must not exceed manufacturer's suggested list price.
A6242	HYDROGEL DRESSING, WOUND COVER, PAD SIZE 16 SQ. IN. OR LESS, WITHOUT ADHESIVE BORDER	Each	C34	Dressings / tape / gauze / bandages	$4.80	01/01/1997	Non-institutional only	Purchase only	30 per month	

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A6243	HYDROGEL DRESSING, WOUND COVER, PAD SIZE MORE THAN 16 BUT LESS THAN OR EQUAL TO 48 SQ. IN., WITHOUT ADHESIVE	Each	C34	Dressings / tape / gauze / bandages	$8.75	01/01/1997	Non-institutional only	Purchase only	30 per month	
A6244	HYDROGEL DRESSING, WOUND COVER, PAD SIZE MORE THAN 48 SQ. IN., WITHOUT ADHESIVE BORDER	Each	C34	Dressings / tape / gauze / bandages	$28.30	01/01/1997	Non-institutional only	Purchase only	30 per month	
A6245	HYDROGEL DRESSING, WOUND COVER, PAD SIZE 16 SQ. IN. OR LESS, WITH ANY SIZE ADHESIVE BORDER	Each	C34	Dressings / tape / gauze / bandages	$5.90	01/01/1997	Non-institutional only	Purchase only	12 per month	
A6246	HYDROGEL DRESSING, WOUND COVER, PAD SIZE MORE THAN 16 BUT LESS THAN OR EQUAL TO 48 SQ. IN., WITH ANY SIZE ADHESIVE BORDER	Each	C34	Dressings / tape / gauze / bandages	$7.15	01/01/1997	Non-institutional only	Purchase only	12 per month	
A6247	HYDROGEL DRESSING, WOUND COVER, PAD SIZE MORE THAN 48 SQ. IN., WITH ANY SIZE ADHESIVE BORDER	Each	C34	Dressings / tape / gauze / bandages	$17.15	01/01/1997	Non-institutional only	Purchase only	12 per month	
A6248	HYDROGEL DRESSING, WOUND FILLER, GEL, PER FLUID OZ.	Fluid ounce	C34	Wound fillers	$5.76	07/26/2007	Non-institutional only	Purchase only	$100 per month	Submitted charge must not exceed manufacturer's suggested list price.
A6251	SPECIALTY ABSORPTIVE DRESSING, WOUND COVER, PAD SIZE 16 SQ. IN. OR LESS WITHOUT ADHESIVE BORDER	Each	C34	Dressings / tape / gauze / bandages	$0.90	01/01/1997	Non-institutional only	Purchase only	30 per month	
A6252	SPECIALTY ABSORPTIVE DRESSING, WOUND COVER, PAD SIZE MORE THAN 16 BUT LESS THAN OR EQUAL TO 48 SQ. IN., WITHOUT ADHESIVE BORDER	Each	C34	Dressings / tape / gauze / bandages	$2.35	01/01/1997	Non-institutional only	Purchase only	30 per month	
A6253	SPECIALTY ABSORPTIVE DRESSING, WOUND COVER, PAD SIZE MORE THAN 48 SQ. IN., WITHOUT ADHESIVE BORDER	Each	C34	Dressings / tape / gauze / bandages	$4.60	01/01/1997	Non-institutional only	Purchase only	30 per month	
A6254	SPECIALTY ABSORPTIVE DRESSING, WOUND COVER, PAD SIZE 16 SQ. IN. OR LESS, WITH ANY SIZE ADHESIVE BORDER	Each	C34	Dressings / tape / gauze / bandages	$0.90	01/01/1997	Non-institutional only	Purchase only	30 per month	
A6255	SPECIALTY ABSORPTIVE DRESSING, WOUND COVER, PAD SIZE MORE THAN 16 BUT LESS THAN OR EQUAL TO 48 SQ. IN., WITH ANY SIZE ADHESIVE BORDER	Each	C34	Dressings / tape / gauze / bandages	$2.20	01/01/1997	Non-institutional only	Purchase only	30 per month	
A6256	SPECIALTY ABSORPTIVE DRESSING, WOUND COVER, PAD SIZE MORE THAN 48 SQ. IN. WITH ANY SIZE ADHESIVE BORDER	Each	C34	Dressings / tape / gauze / bandages	PA	01/01/1997	Non-institutional only	Purchase only	30 per month	
A6257	TRANSPARENT FILM, 16 SQ. IN. OR LESS	Each	C34	Dressings / tape / gauze / bandages	$1.10	01/01/1997	Non-institutional only	Purchase only	12 per month	
A6258	TRANSPARENT FILM, MORE THAN 16 BUT LESS THAN OR EQUAL TO 48 SQ. IN.	Each	C34	Dressings / tape / gauze / bandages	$3.10	01/01/1997	Non-institutional only	Purchase only	12 per month	
A6259	TRANSPARENT FILM, MORE THAN 48 SQ. IN.	Each	C34	Dressings / tape / gauze / bandages	$7.90	01/01/1997	Non-institutional only	Purchase only	12 per month	
A6261	WOUND FILLER, NOT ELSEW CLASSIFIED, GEL/PASTE, PER FLUID OZ.	Month	C34	Wound fillers	$100.00	01/01/1997	Non-institutional only	Purchase only	$100 per month	Submitted charge must not exceed manufacturer's suggested list price.
A6262	WOUND FILLER, NOT ELSEWHERE CLASSIFIED, DRY FORM, PER GRAM	Month	C34	Wound fillers	$100.00	01/01/1997	Non-institutional only	Purchase only	$100 per month	Submitted charge must not exceed manufacturer's suggested list price.
A6266	GAUZE, IMPREGNATED, OTHER THAN WATER, NORMAL SALINE, OR ZINC PASTE, ANY WIDTH	Linear yard	C34	Dressings / tape / gauze / bandages	$1.75	08/01/1997	Non-institutional only	Purchase only	100 yards per month	
A6402	GAUZE, NON-IMPREGNATED, STERILE, PAD SIZE 16 SQ. IN. OR LESS, WITHOUT ADHESIVE BORDER	Each	C34	Dressings / tape / gauze / bandages	$0.12	04/01/2006	Non-institutional only	Purchase only	$50 per month	Submitted charge must not exceed manufacturer's suggested list price.
A6403	GAUZE, NON-IMPREGNATED, STERILE, PAD SIZE MORE THAN 16 BUT LESS THAN OR EQUAL TO 48 SQ. IN. WITHOUT ADHESIVE	Each	C34	Dressings / tape / gauze / bandages	$0.43	04/01/2006	Non-institutional only	Purchase only	$50 per month	Submitted charge must not exceed manufacturer's suggested list price.
A6404	GAUZE, NON-IMPREGNATED, STERILE, PAD SIZE MORE THAN 48 SQ. IN., WITHOUT ADHESIVE BORDER	Each	C34	Dressings / tape / gauze / bandages	$0.61	04/01/2006	Non-institutional only	Purchase only	$50 per month	Submitted charge must not exceed manufacturer's suggested list price.
A6441	PADDING BANDAGE, NON-ELASTIC, NON-WOVEN/NON-KNITTED, WIDTH GREATER THAN OR EQUAL TO THREE INCHES AND LESS THAN FIVE INCHES, PER YARD	Linear yard	C34	Dressings / tape / gauze / bandages	$0.54	01/01/2005	Non-institutional only	Purchase only	100 per month	
A6442	CONFORMING BANDAGE, NON-ELASTIC, KNITTED/WOVEN, NON-STERILE, WIDTH LESS THAN THREE INCHES, PER YARD	Linear yard	C34	Dressings / tape / gauze / bandages	$0.14	01/01/2005	Non-institutional only	Purchase only	150 per month	
A6443	CONFORMING BANDAGE, NON-ELASTIC, KNITTED/WOVEN, NON-STERILE, WIDTH GREATER THAN OR EQUAL TO THREE INCHES AND LESS THAN FIVE INCHES, PER YARD	Linear yard	C34	Dressings / tape / gauze / bandages	$0.23	01/01/2005	Non-institutional only	Purchase only	150 per month	
A6444	CONFORMING BANDAGE, NON-ELASTIC, KNITTED/WOVEN, NON-STERILE, WIDTH GREATER THAN OR EQUAL TO FIVE INCHES, PER YARD	Linear yard	C34	Dressings / tape / gauze / bandages	$0.45	01/01/2005	Non-institutional only	Purchase only	150 per month	
A6445	CONFORMING BANDAGE, NON-ELASTIC, KNITTED/WOVEN, STERILE, WIDTH LESS THAN THREE INCHES, PER YARD	Linear yard	C34	Dressings / tape / gauze / bandages	$0.26	01/01/2005	Non-institutional only	Purchase only	150 per month	
A6446	CONFORMING BANDAGE, NON-ELASTIC, KNITTED/WOVEN, STERILE, WIDTH GREATER THAN OR EQUAL TO THREE INCHES AND LESS THAN FIVE INCHES, PER YARD	Linear yard	C34	Dressings / tape / gauze / bandages	$0.33	01/01/2005	Non-institutional only	Purchase only	150 per month	
A6447	CONFORMING BANDAGE, NON-ELASTIC, KNITTED/WOVEN, STERILE, WIDTH GREATER THAN OR EQUAL TO FIVE INCHES, PER YARD	Linear yard	C34	Dressings / tape / gauze / bandages	$0.54	01/01/2005	Non-institutional only	Purchase only	150 per month	
A6448	LIGHT COMPRESSION BANDAGE, ELASTIC, KNITTED/WOVEN, WIDTH LESS THAN THREE INCHES, PER YARD	Linear yard	C34	Dressings / tape / gauze / bandages	$1.04	10/01/2004	Non-institutional only	Purchase only	18 per 3 months	
A6449	LIGHT COMPRESSION BANDAGE, ELASTIC, KNITTED/WOVEN, WIDTH GREATER THAN OR EQUAL TO THREE INCHES AND LESS THAN FIVE INCHES, PER YARD	Linear yard	C34	Dressings / tape / gauze / bandages	$1.05	10/01/2004	Non-institutional only	Purchase only	18 per 3 months	
A6450	LIGHT COMPRESSION BANDAGE, ELASTIC, KNITTED/WOVEN, WIDTH GREATER THAN OR EQUAL TO FIVE INCHES, PER YARD	Linear yard	C34	Dressings / tape / gauze / bandages	$1.60	01/01/2005	Non-institutional only	Purchase only	18 per 3 months	
A6451	MODERATE COMPRESSION BANDAGE, ELASTIC, KNITTED/WOVEN, LOAD RESISTANCE OF 1.25 TO 1.34 FOOT POUNDS AT 50 PERCENT MAXIMUM STRETCH, WIDTH GREATER THAN OR EQUAL TO THREE INCHES AND LESS THAN FIVE INCHES, PER YARD	Linear yard	C34	Dressings / tape / gauze / bandages	$3.19	01/01/2005	Non-institutional only	Purchase only	18 per 3 months	

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A6452	HIGH COMPRESSION BANDAGE, ELASTIC, KNITTED/WOVEN, LOAD RESISTANCE GREATER THAN OR EQUAL TO 1.35 FOOT POUNDS AT 50% MAXIMUM STRETCH, WIDTH GREATER THAN OR EQUAL TO THREE INCHES AND LESS THAN FIVE INCHES, PER YARD	Linear yard	C34	Dressings / tape / gauze / bandages	$5.32	10/01/2004	Non-institutional only	Purchase only	18 per 3 months	
A6453	SELF-ADHERENT BANDAGE, ELASTIC, NON-KNITTED/NON-WOVEN, WIDTH LESS THAN THREE INCHES, PER YARD	Linear yard	C34	Dressings / tape / gauze / bandages	$0.55	10/01/2004	Non-institutional only	Purchase only	18 per 3 months	
A6454	SELF-ADHERENT BANDAGE, ELASTIC, NON-KNITTED/NON-WOVEN, WIDTH GREATER THAN OR EQUAL TO THREE INCHES AND LESS THAN FIVE INCHES, PER YARD	Linear yard	C34	Dressings / tape / gauze / bandages	$0.69	10/01/2004	Non-institutional only	Purchase only	18 per 3 months	
A6455	SELF-ADHERENT BANDAGE, ELASTIC, NON-KNITTED/NON-WOVEN, WIDTH GREATER THAN OR EQUAL TO FIVE INCHES, PER YARD	Linear yard	C34	Dressings / tape / gauze / bandages	$1.25	10/01/2004	Non-institutional only	Purchase only	18 per 3 months	
A6501	COMPRESSION BURN GARMENT, BODYSUIT (HEAD TO FOOT), CUSTOM FABRICATED	Each	C14b	Surgical stockings and burn garments	PA	10/01/2004	Non-institutional only	Purchase only	3 per year	
A6502	COMPRESSION BURN GARMENT, CHIN STRAP, CUSTOM FABRICATED	Each	C14b	Surgical stockings and burn garments	PA	10/01/2004	Non-institutional only	Purchase only	3 per year	
A6503	COMPRESSION BURN GARMENT, FACIAL HOOD, CUSTOM FABRICATED	Each	C14b	Surgical stockings and burn garments	PA	10/01/2004	Non-institutional only	Purchase only	3 per year	
A6504	COMPRESSION BURN GARMENT, GLOVE TO WRIST, CUSTOM FABRICATED	Each	C14b	Surgical stockings and burn garments	PA	10/01/2004	Non-institutional only	Purchase only	4 per year	
A6505	COMPRESSION BURN GARMENT, GLOVE TO ELBOW, CUSTOM FABRICATED	Each	C14b	Surgical stockings and burn garments	PA	10/01/2004	Non-institutional only	Purchase only	4 per year	
A6506	COMPRESSION BURN GARMENT, GLOVE TO AXILLA, CUSTOM FABRICATED	Each	C14b	Surgical stockings and burn garments	PA	10/01/2004	Non-institutional only	Purchase only	4 per year	
A6507	COMPRESSION BURN GARMENT, FOOT TO KNEE LENGTH, CUSTOM FABRICATED	Each	C14b	Surgical stockings and burn garments	PA	10/01/2004	Non-institutional only	Purchase only	4 per year	
A6508	COMPRESSION BURN GARMENT, FOOT TO THIGH LENGTH, CUSTOM FABRICATED	Each	C14b	Surgical stockings and burn garments	PA	10/01/2004	Non-institutional only	Purchase only	4 per year	
A6509	COMPRESSION BURN GARMENT, UPPER TRUNK TO WAIST INCLUDING ARM OPENINGS (VEST), CUSTOM FABRICATED	Each	C14b	Surgical stockings and burn garments	PA	10/01/2004	Non-institutional only	Purchase only	3 per year	
A6510	COMPRESSION BURN GARMENT, TRUNK, INCLUDING ARMS DOWN TO LEG OPENINGS (LEOTARD), CUSTOM FABRICATED	Each	C14b	Surgical stockings and burn garments	PA	10/01/2004	Non-institutional only	Purchase only	3 per year	
A6511	COMPRESSION BURN GARMENT, LOWER TRUNK INCLUDING LEG OPENINGS (PANTY), CUSTOM FABRICATED	Each	C14b	Surgical stockings and burn garments	PA	10/01/2004	Non-institutional only	Purchase only	3 per year	
A6512	COMPRESSION BURN GARMENT, NOT OTHERWISE CLASSIFIED	Each	C14b	Surgical stockings and burn garments	PA	10/01/2004	Non-institutional only	Purchase only	4 per year	
A6530	COMPRESSION STOCKING BK18-30, EACH	Each	C14a	Elastic supports	$21.64	07/26/2007	Non-institutional only	Purchase only	6 per year	
A6531	COMPRESSION STOCKING BK30-40	Each	C14a	Elastic supports	$26.06	07/26/2007	Non-institutional only	Purchase only	6 per year	
A6532	COMPRESSION STOCKING BK40-50	Each	C14a	Elastic supports	$30.48	07/26/2007	Non-institutional only	Purchase only	6 per year	
A6533	GC STOCKING THIGHLNGTH 18-30	Each	C14a	Elastic supports	$24.64	07/26/2007	Non-institutional only	Purchase only	6 per year	
A6534	GC STOCKING THIGHLNGTH 30-40	Each	C14a	Elastic supports	$29.06	07/26/2007	Non-institutional only	Purchase only	6 per year	
A6535	GC STOCKING THIGHLNGTH 40-50	Each	C14a	Elastic supports	$33.48	07/26/2007	Non-institutional only	Purchase only	6 per year	
A6536	GC STOCKING FULL LNGTH 18-30	Each	C14a	Elastic supports	$43.27	01/01/2006	Non-institutional only	Purchase only	6 per year	
A6537	GC STOCKING FULL LNGTH 30-40	Each	C14a	Elastic supports	$52.12	07/26/2007	Non-institutional only	Purchase only	6 per year	
A6538	GC STOCKING FULL LNGTH 40-50	Each	C14a	Elastic supports	$60.96	01/01/2006	Non-institutional only	Purchase only	6 per year	
A6539	GC STOCKING WAISTLNGTH 18-30	Each	C14a	Elastic supports	$50.00	07/26/2007	Non-institutional only	Purchase only	3 per year	
A6540	GC STOCKING WAISTLNGTH 30-40	Each	C14a	Elastic supports	$62.50	07/26/2007	Non-institutional only	Purchase only	3 per year	
A6541	GC STOCKING WAISTLNGTH 40-50	Each	C14a	Elastic supports	$75.00	07/26/2007	Non-institutional only	Purchase only	3 per year	
A6549	G COMPRESSION STOCKING, NOS	Each	C14a	Elastic supports	PA	01/01/2011	Non-institutional only	Purchase only	6 per year	
A7000	CANISTER, DISPOSABLE, USED WITH SUCTION PUMP	Each	C01a	Suction pump	$7.50	01/01/2000	Non-institutional only	Purchase only	3 per month	
A7002	TUBING, USED WITH SUCTION PUMP, INCLUDING CONNECTOR/ADAPTOR	Each	C01a	Suction pump	$3.75	01/01/2000	Non-institutional only	Purchase only	4 per month	
A7003	ADMINISTRATION SET, WITH SMALL VOLUME NONFILTERED PNEUMATIC NEBULIZER, DISPOSABLE	Each	C01d	Respiratory care supplies	$2.15	01/01/2000	Non-institutional only	Purchase only	4 per month	
A7004	SMALL VOLUME NONFILTERED PNEUMATIC NEBULIZER, DISPOSABLE	Each	C01d	Respiratory care supplies	$1.44	10/01/2004	Non-institutional only	Purchase only	4 per month	
A7005	ADMINISTRATION SET, WITH SMALL VOLUME NONFILTERED PNEUMATIC NEBULIZER, NON-DISPOSABLE	Each	C01d	Respiratory care supplies	$20.00	01/01/2000	Non-institutional only	Purchase only	2 per year	
A7006	ADMINISTRATION SET, WITH SMALL VOLUME FILTERED PNEUMATIC NEBULIZER	Each	C01d	Respiratory care supplies	$8.00	01/01/2000	Non-institutional only	Purchase only	4 per month	

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A7007	LARGE VOLUME NEBULIZER, DISPOSABLE, UNFILLED, USED WITH AEROSOL COMPRESSOR	Each	C01d	Respiratory care supplies	$4.00	10/01/2004	Non-institutional only	Purchase only	4 per month	
A7012	WATER COLLECTION DEVICE, USED WITH LARGE VOLUME NEBULIZER	Each	C01d	Respiratory care supplies	$1.80	01/01/2000	Non-institutional only	Purchase only	4 per month	
A7015	AEROSOL MASK, USED WITH DME NEBULIZER	Each	C01d	Respiratory care supplies	$1.63	07/01/2002	Non-institutional only	Purchase only	4 per month	
A7018	WATER, DISTILLED, 1000 ML	Liter	C01d	Distilled water / sterile saline	$0.28	01/01/2001	Non-institutional only	Purchase only	16 per month	
A7025	HIGH FREQUENCY CHEST WALL OSCILLATION SYSTEM VEST, ONLY FOR ADDITIONAL FAMILY MEMBER USING EQUIPMENT	Each	C08	HFCWO system	$400.00	10/01/2004	Non-institutional only	Purchase only	1 per lifetime	
A7030	FULL FACEMASK INTERFACE, CPAP	Each	C19	Face mask	$113.18	04/01/2006	Non-institutional only	Purchase only	1 per year	
A7031	FACE MASK INTERFACE, REPLACEMENT FULL FACE MASK	Each	C19	Replacement supply	$51.12	02/08/2016	Non-institutional only	Purchase only	1 per year	
A7032	REPLACEMENT CUSHION FOR NASAL APPLICATION DEVICE, EACH	Each	C19	Replacement supply	$21.36	10/01/2004	Non-institutional only	Purchase only	2 per year	
A7033	REPLACEMENT PILLOWS FOR NASAL APPLICATION DEVICE, PAIR	Pair	C19	Replacement supply	$21.36	10/01/2004	Non-institutional only	Purchase only	2 per year	
A7034	NASAL INTERFACE (MASK OR CANNULA TYPE) USED WITH POSITIVE AIRWAY PRESSURE DEVICE, WITH OR WITHOUT HEAD STRAP	Each	C19	Nasal interface	$66.71	10/01/2004	Non-institutional only	Purchase only	1 per year	
A7035	HEADGEAR USED WITH POSITIVE AIRWAY PRESSURE DEVICE	Each	C19	PAP headgear	$34.95	04/01/2003	Non-institutional only	Purchase only	1 per year	
A7036	CHINSTRAP, USED WITH POSITIVE AIRWAY PRESSURE DEVICE	Each	C19	PAP chinstrap	$13.60	04/01/2003	Non-institutional only	Purchase only	2 per year	
A7037	TUBING USED WITH POSITIVE AIRWAY PRESSURE DEVICE	Each	C19	Tubing	$28.75	04/01/2003	Non-institutional only	Purchase only	1 per year	
A7038	FILTER, DISPOSABLE, USED WITH POSITIVE AIRWAY PRESSURE DEVICE	Each	C19	Filter	$3.25	04/01/2003	Non-institutional only	Purchase only	1 per month	
A7039	FILTER, NON-DISPOSABLE, USED WITH POSITIVE AIRWAY PRESSURE DEVICE	Each	C19	Filter	$12.30	04/01/2003	Non-institutional only	Purchase only	4 per year	
A7048	VACUUM DRAINAGE COLLECTION UNIT AND TUBING KIT, INCLUDING ALL SUPPLIES NEEDED FOR COLLECTION UNIT CHANGE, FOR USE WITH IMPLANTED CATHETER	Each	C19	Vacuum	$37.58	01/01/2015	Non-institutional only	Purchase only	4 per year	
A7504	FILTER FOR USE IN A TRACHEOSTOMY HEAT AND MOISTURE EXCHANGE SYSTEM	Each	C01d	Tracheostomy supplies	$0.54	10/01/2004	Non-institutional only	Purchase only	100 per month	
A7505	HOUSING, REUSABLE WITHOUT ADHESIVE, FOR USE IN A HEAT AND MOISTURE EXCHANGE SYSTEM AND/OR WITH A TRACHEOSTOMA VALVE	Each	C01d	Tracheostomy supplies	$3.74	10/01/2004	Non-institutional only	Purchase only	4 per month	
A7506	ADHESIVE DISC FOR USE IN A HEAT AND MOISTURE EXCHANGE SYSTEM AND/OR WITH TRACHEOSTOMA VALVE, ANY TYPE	Each	C01d	Tracheostomy supplies	$0.26	10/01/2004	Non-institutional only	Purchase only	100 per month	
A7507	FILTER HOLDER AND INTEGRATED FILTER WITHOUT ADHESIVE, FOR USE IN A TRACHEOSTOMA HEAT AND MOISTURE EXCHANGE	Each	C01d	Tracheostomy supplies	$1.99	10/01/2004	Non-institutional only	Purchase only	100 per month	
A7508	HOUSING AND INTEGRATED ADHESIVE, FOR USE IN A TRACHEOSTOMA HEAT AND MOISTURE EXCHANGE SYSTEM AND/OR WITH A TRACHEOSTOMA VALVE	Each	C01d	Tracheostomy supplies	$2.30	10/01/2004	Non-institutional only	Purchase only	100 per month	
A7509	FILTER HOLDER AND INTEGRATED FILTER HOUSING, AND ADHESIVE, FOR USE AS A TRACHEOSTOMA HEAT AND MOISTURE EXCHANGE SYSTEM	Each	C01d	Tracheostomy supplies	$1.13	10/01/2004	Non-institutional only	Purchase only	100 per month	
A7520	TRACHEOSTOMY/LARYGECTOMY TUBE, NON-CUFFED, PVC, SILICONE OR EQUAL	Each	C01d	Tracheostomy supplies	$47.48	10/01/2004	Non-institutional only	Purchase only	2 per month	
A7520	TRACHEOSTOMY/LARYGECTOMY TUBE, NON-CUFFED, PVC, SILICONE OR EQUAL -- *CUSTOM-MADE*	Each	C01d	Tracheostomy supplies	$389.55	04/01/2016	Non-institutional only	Purchase only	2 per month	Modifier U1 is used to differentiate this item.
A7520	TRACHEOSTOMY/LARYGECTOMY TUBE, NON-CUFFED, PVC, SILICONE OR EQUAL -- *STOCK WITH MODIFICATIONS--PEDIATRIC*	Each	C01d	Tracheostomy supplies	$100.00	07/01/2018	Non-institutional only	Purchase only	2 per month	Modifier U2 is used to differentiate this item.
A7520	TRACHEOSTOMY/LARYGECTOMY TUBE, NON-CUFFED, PVC, SILICONE OR EQUAL -- *STANDARD OR STOCK WITH	Each	C01d	Tracheostomy supplies	$60.00	07/01/2018	Non-institutional only	Purchase only	2 per month	Modifier U3 is used to differentiate this item.
A7521	TRACHEOSTOMY/LARYGECTOMY TUBE, CUFFED, PVC, SILICONE OR EQUAL	Each	C01d	Tracheostomy supplies	$47.05	10/01/2004	Non-institutional only	Purchase only	2 per month	
A7521	TRACHEOSTOMY/LARYGECTOMY TUBE, CUFFED, PVC, SILICONE OR EQUAL -- *CUSTOM-MADE*	Each	C01d	Tracheostomy supplies	$404.25	04/01/2016	Non-institutional only	Purchase only	2 per month	Modifier U1 is used to differentiate this item.
A7521	TRACHEOSTOMY/LARYGECTOMY TUBE, CUFFED, PVC, SILICONE OR EQUAL -- *STANDARD OR STOCK, WITH MODIFICATIONS--	Each	C01d	Tracheostomy supplies	$220.00	07/01/2018	Non-institutional only	Purchase only	2 per month	Modifier U2 is used to differentiate this item.
A7521	TRACHEOSTOMY/LARYGECTOMY TUBE, CUFFED, PVC, SILICONE OR EQUAL -- *CUFFED, STANDARD OR STOCK WITH MODIFICATIONS--PEDIATRIC OR ADULT *	Each	C01d	Tracheostomy supplies	$75.00	07/01/2018	Non-institutional only	Purchase only	2 per month	Modifier U3 is used to differentiate this item.
A7522	TRACHEOSTOMY/LARYNGECTOMY TUBE, STAINLESS STEEL OR EQUAL (STERILIZABLE AND REUSABLE)	Each	C01d	Tracheostomy supplies	$45.16	10/01/2004	Non-institutional only	Purchase only	2 per month	
A7525	TRACHEOSTOMY MASK	Each	C01d	Tracheostomy supplies	$1.39	10/01/2004	Non-institutional only	Purchase only	4 per month	
A7526	TRACHEOSTOMY TUBE COLLAR/HOLDER	Each	C01d	Tracheostomy supplies	$3.00	10/01/2004	Non-institutional only	Purchase only	15 per month	This item is not payable in conjunction with twill tape. Only one type of tracheostomy tie is medically necessary.
A8000	SOFT PROTECT HELMET PREFAB	Each	C01c	Cranium	$103.41	01/01/2010	All	Purchase only	1 per year	
A8001	HARD PROTECT HELMET PREFAB	Each	C01c	Cranium	$103.41	01/01/2010	All	Purchase only	1 per year	
A8002	SOFT PROTECT HELMET CUSTOM	Each	C01c	Cranium	$441.26	01/01/2010	All	Purchase only	1 per year	

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A8003	HARD PROTECT HELMET CUSTOM	Each	C01c	Cranium	$441.26	01/01/2010	All	Purchase only	1 per year	
A9273	HOT WATER BOTTLE, ICE CAP OR COLLAR, HEAT AND/OR COLD WRAP, ANY TYPE	Each	C01d	Heat / cold application	$7.50	01/01/2011	Non-institutional only	Purchase only	1 per 5 years	
B4034	ENTERAL FEEDING SUPPLY KIT; SYRINGE, PER DAY	Each	C26	Feeding kit	$3.72	01/01/2010	Non-institutional only	Purchase only	1 per day	
B4034	ENTERAL FEEDING SUPPLY KIT; SYRINGE, PER DAY-USED WITH INLINE LIPASE CARTRIDGE	Each	C26	Feeding kit	$34.92	07/01/2018	Non-institutional only	Purchase only	1 per day	Modifier U1 is used to differentiate this item.
B4035	ENTERAL FEEDING SUPPLY KIT; PUMP FED, PER DAY	Each	C26	Feeding kit	$6.79	01/01/2010	Non-institutional only	Purchase only	1 per day	
B4035	ENTERAL FEEDING SUPPLY KIT; PUMP FED, PER DAY-USED WITH INLINE LIPASE CARTRIDGE	Each	C26	Feeding kit	$37.99	07/01/2018	Non-institutional only	Purchase only	1 per day	Modifier U1 is used to differentiate this item.
B4036	ENTERAL FEEDING SUPPLY KIT; GRAVITY FED (PER DAY, INCLUDES BAGS/CONTAINERS)	Each	C26	Feeding kit	$4.85	01/01/2010	Non-institutional only	Purchase only	1 per day	
B4036	ENTERAL FEEDING SUPPLY KIT; GRAVITY FED (PER DAY, INCLUDES BAGS/CONTAINERS)-USED WITH INLINE LIPASE CARTRIDGE	Each	C26	Feeding kit	$36.05	07/01/2018	Non-institutional only	Purchase only	1 per day	Modifier U1 is used to differentiate this item.
B4081	NASOGASTRIC TUBING WITH STYLET	Each	C26	Tubing	$19.19	01/01/2010	Non-institutional only	Purchase only	2 per month	Nasogastric tubes are incompatible with parenteral codes B4220, B4222, and B4224.
B4082	NASOGASTRIC TUBING WITHOUT STYLET	Each	C26	Tubing	$14.29	01/01/2010	Non-institutional only	Purchase only	2 per month	Nasogastric tubes are incompatible with parenteral codes B4220, B4222, and B4224.
B4083	STOMACH TUBE, LEVINE TYPE	Each	C26	Tubing	$2.05	01/01/2010	Non-institutional only	Purchase only	8 per month	
B4087	GASTROSTOMY/JEJUNOSTOMY TUBE, STANDARD	Each	C26	Tubing	$29.66	01/01/2010	Non-institutional only	Purchase only	4 per year	
B4088	GASTROSTOMY/JEJUNOSTOMY TUBE, LOW-PROFILE	Each	C26	Tubing	$108.64	01/01/2010	Non-institutional only	Purchase only	4 per year	
B4100	FOOD THICKENER, ORAL, PER OUNCE	Ounce	C26	Nutritional supplement	$0.65	01/01/2016	Non-institutional only	Purchase only	30 units per day	
B4100	FOOD THICKENER, ORAL, CONCENTRATED FORMULA, PER OUNCE	Ounce	C26	Nutritional supplement	$1.62	02/01/2018	Non-institutional only	Purchase only	12 units per day	Modifier U1 is used to differentiate this item.
B4102	EF ADULT FLUIDS AND ELECTROLYTES	Each	C26	Nutritional supplement	$0.60	06/01/2014	Non-institutional only	Purchase only	Medical necessity	This item is normally covered under the pharmacy benefit. In some circumstances, it may be covered as a medical supply.
B4103	EF PED FLUID AND ELECTROLYTES	Each	C26	Nutritional supplement	$0.60	06/01/2014	Non-institutional only	Purchase only	Medical necessity	This item is normally covered under the pharmacy benefit. In some circumstances, it may be covered as a medical supply.
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	100 calories	C26	Formula	PA	07/01/2018	Non-institutional only	Purchase only	Medical necessity	Administration by mouth rather than by feeding tube is indicated by modifier BO, which is reported on a claim by instruction of the Prior Authorization unit.
B4150	ENTERAL FORMULA, 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	100 calories	C26	Formula	$0.61	01/01/2010	Non-institutional only	Purchase only	20 units per day	Administration by mouth rather than by feeding tube is indicated by modifier BO, which is reported on a claim by instruction of the Prior Authorization unit.
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	100 calories	C26	Formula	$0.51	01/01/2010	Non-institutional only	Purchase only	20 units per day	Administration by mouth rather than by feeding tube is indicated by modifier BO, which is reported on a claim by instruction of the Prior Authorization unit.
B4153	ENTERAL FORMULA, NUTRITIONALLY COMPLETE, HYDROLYZED PROTEINS (AMINO ACIDS ANDPEPTIDE CHAIN), INCLUDES FATS, CARBOHYDRATES, VITAMINS AND MINERALS, MAY INCLUDE FIBER, ADMINISTERED THROUGH AN ENTERAL FEEDING TUBE, 100 CALORIES = 1UNIT	100 calories	C26	Formula	$1.75	01/01/2010	Non-institutional only	Purchase only	20 units per day	Administration by mouth rather than by feeding tube is indicated by modifier BO, which is reported on a claim by instruction of the Prior Authorization unit.
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	100 calories	C26	Formula	$1.12	01/01/2010	Non-institutional only	Purchase only	20 units per day	Administration by mouth rather than by feeding tube is indicated by modifier BO, which is reported on a claim by instruction of the Prior Authorization unit.
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 = 1 UNIT	100 calories	C26	Formula	$0.87	01/01/2010	Non-institutional only	Purchase only	20 units per day	Administration by mouth rather than by feeding tube is indicated by modifier BO, which is reported on a claim by instruction of the Prior Authorization unit.
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	100 calories	C26	Formula	PA	01/01/2005	Non-institutional only	Purchase only	20 units per day	Administration by mouth rather than by feeding tube is indicated by modifier BO, which is reported on a claim by instruction of the Prior Authorization unit.

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B4158	ENTERAL FORMULA, FOR PEDIATRICS, 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 CALORIES = 1 UNIT	100 calories	C26	Formula	PA	01/01/2005	Non-institutional only	Purchase only	20 units per day	Administration by mouth rather than by feeding tube is indicated by modifier BO, which is reported on a claim by instruction of the Prior Authorization unit.
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 CALORIES = 1 UNIT	100 calories	C26	Formula	PA	01/01/2005	Non-institutional only	Purchase only	20 units per day	Administration by mouth rather than by feeding tube is indicated by modifier BO, which is reported on a claim by instruction of the Prior Authorization unit.
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 CALORIES = 1 UNIT	100 calories	C26	Formula	PA	01/01/2005	Non-institutional only	Purchase only	20 units per day	Administration by mouth rather than by feeding tube is indicated by modifier BO, which is reported on a claim by instruction of the Prior Authorization unit.
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	100 calories	C26	Formula	PA	01/01/2005	Non-institutional only	Purchase only	20 units per day	Administration by mouth rather than by feeding tube is indicated by modifier BO, which is reported on a claim by instruction of the Prior Authorization unit.
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 CALORIES = 1 UNIT	100 calories	C26	Formula	PA	01/01/2005	Non-institutional only	Purchase only	20 units per day	Administration by mouth rather than by feeding tube is indicated by modifier BO.
B4220	PARENTERAL NUTRITION SUPPLY KIT; PREMIX, COMPLETE - PER DAY	Each	C26	Supply kit	$4.53	01/01/2010	Non-institutional only	Purchase only	1 per day	Nasogastric tubes are incompatible with parenteral codes B4220, B4222, and B4224. The supplier must have on file a current order for parenteral products specific to the individual.
B4222	PARENTERAL NUTRITION SUPPLY KIT; HOMEMIX, COMPLETE - PER DAY	Each	C26	Supply kit	$6.95	01/01/2010	Non-institutional only	Purchase only	1 per day	Nasogastric tubes are incompatible with parenteral codes B4220, B4222, and B4224. The supplier must have on file a current order for parenteral products specific to the individual.
B4224	PARENTERAL NUTRITION ADMINISTRATION KIT, PER DAY, COMPLETE	Each	C26	Administration kit	$14.55	01/01/2010	Non-institutional only	Purchase only	1 per day	Nasogastric tubes are incompatible with parenteral codes B4220, B4222, and B4224. The supplier must have on file a current order for parenteral products specific to the individual.
B9003	ENTERAL NUTRITION INFUSION PUMP - WITH ALARM	Each	C26	Pump	$679.00	01/01/2010	Non-institutional only	Rental / purchase	1 per 8 years	
B9004	PARENTERAL NUTRITION INFUSION PUMP - PORTABLE	Each	C26	Pump	$2,170.86	01/01/2010	Non-institutional only	Rental / purchase	1 per 8 years	
B9006	PARENTERAL NUTRITION INFUSION PUMP - STATIONARY	Each	C26	Pump	$2,170.86	01/01/2010	Non-institutional only	Rental / purchase	1 per 8 years	
B9998	ENTERAL SUPPLIES, NOT OTHERWISE SPECIFIED		C26	Supply	PA	05/01/1990	Non-institutional only	Purchase only		
B9999	PARENTERAL SUPPLIES, NOT OTHERWISE SPECIFIED		C26	Supply	PA	05/01/1990	Non-institutional only	Purchase only		
E0100	CANE, ALL MATERIALS, ADJUSTABLE OR FIXED, WITH TIP	Each	C30	Cane	$10.19	05/01/1990	Non-institutional only	Purchase only	1 per 3 years	
E0105	CANES, QUAD OR TRI PRONGED, ALL MATERIALS, ADJUSTABLE OR FIXED, WITH TIPS	Each	C30	Cane	$39.28	04/01/2006	Non-institutional only	Purchase only	1 per 3 years	
E0110	CRUTCHES, FOREARM, ALL MATERIALS, ADJUSTABLE OR FIXED, WITH TIPS AND HANDGRIPS	Pair	C30	Crutches	$50.00	01/01/1992	Non-institutional only	Purchase only	1 per 2 years	
E0111	CRUTCH, FOREARM, ALL MATERIALS, ADJUSTABLE OR FIXED, WITH TIPS AND HANDGRIPS	Each	C30	Crutches	$25.00	01/01/1992	Non-institutional only	Purchase only	1 per 2 years	
E0112	CRUTCHES, UNDERARM, WOOD, ADJUSTABLE OR FIXED, WITH PADS, TIPS AND HANDGRIPS	Pair	C30	Crutches	$19.25	05/01/1990	Non-institutional only	Purchase only	1 per 2 years	
E0113	CRUTCH, UNDERARM, WOOD ADJUSTABLE OR FIXED, WITH PADS, TIPS AND HANDGRIPS	Each	C30	Crutches	$10.30	05/01/1990	Non-institutional only	Purchase only	1 per 2 years	
E0114	CRUTCHES, UNDERARM, ALUMINUM, ADJUSTABLE OR FIXED, WITH PADS, TIPS & HANDGRIPS	Pair	C30	Crutches	$23.85	05/01/1990	Non-institutional only	Purchase only	1 per 2 years	
E0116	CRUTCH, UNDERARM, ALUMINUM, ADJUSTABLE OR FIXED WITH PADS, TIPS & HANDGRIPS	Each	C30	Crutches	$11.95	05/01/1990	Non-institutional only	Purchase only	1 per 2 years	
E0130	WALKER, RIGID (PICKUP), ADJUSTABLE OR FIXED HEIGHT, WITH TIPS AND HANDGRIPS	Each	C30	Walker	$35.00	05/01/1990	Non-institutional only	Purchase only	1 per 5 years	
E0135	WALKER, FOLDING (PICKUP), ADJUSTABLE OR FIXED HEIGHT, WITH TIPS AND HANDGRIPS	Each	C30	Walker	$47.00	02/17/1991	Non-institutional only	Purchase only	1 per 5 years	
E0140	WALKER WITH TRUNK SUPPORT, ADJUSTABLE OR FIXED HEIGHT, ANY TYPE	Each	C30	Walker	$200.00	09/01/2005	Non-institutional only	Purchase only	1 per 5 years	
E0141	WALKER, RIGID, WHEELED, ADJUSTABLE OR FIXED HEIGHT	Each	C30	Walker	$58.00	11/01/1992	Non-institutional only	Purchase only	1 per 5 years	
E0143	WALKER, FOLDING, WHEELED, ADJUSTABLE OR FIXED HEIGHT	Each	C30	Walker	$52.80	07/01/2018	Non-institutional only	Purchase only	1 per 5 years	

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E0144	WALKER, ENCLOSED, FOUR SIDED FRAMED, RIGID OR FOLDING, WHEELED WITH POSTERIOR SEAT	Each	C30	Walker	$150.00	10/01/2004	Non-institutional only	Purchase only	1 per 5 years	
E0147	WALKER, HEAVY DUTY, MULTIPLE BRAKING SYSTEM, VARIABLE WHEEL RESISTANCE	Each	C30	Walker	$150.00	05/01/1990	Non-institutional only	Purchase only	1 per 5 years	Heavy-duty walkers are covered only for individuals weighing at least 300 pounds. The supplier must maintain documentation of the individual's weight.
E0148	WALKER , HEAVY DUTY, WITHOUT WHEELS, RIGID OR FOLDING, ANY TYPE, EACH	Each	C30	Walker	$109.07	01/01/2001	Non-institutional only	Purchase only	1 per 5 years	Heavy-duty walkers are covered only for individuals weighing at least 300 pounds. The supplier must maintain documentation of the individual's weight.
E0149	WALKER, HEAVY DUTY, WHEELED , RIGID OR FOLDING, ANY TYPE	Each	C30	Walker	$135.00	01/01/2001	Non-institutional only	Purchase only	1 per 5 years	Heavy-duty walkers are covered only for individuals weighing at least 300 pounds. The supplier must maintain documentation of the individual's weight.
E0154	PLATFORM ATTACHMENT, WALKER	Each	C30	Ambulation accessory	$51.44	01/01/1999	Non-institutional only	Purchase only	2 per 3 years	
E0155	WHEEL ATTACHMENT, RIGID PICK-UP WALKER , PAIR	Pair	C30	Ambulation accessory	$16.25	05/01/1990	Non-institutional only	Purchase only	4 per 3 years	
E0156	SEAT ATTACHMENT, WALKER	Each	C30	Ambulation accessory	$15.00	05/01/1990	Non-institutional only	Purchase only	1 per 3 years	
E0157	CRUTCH ATTACHMENT, WALKER	Each	C30	Ambulation accessory	$62.50	05/01/1990	Non-institutional only	Purchase only	2 per 3 years	
E0158	LEG EXTENSIONS FOR WALKER , PER SET OF FOUR	Set of 4	C30	Ambulation accessory	$12.64	05/01/1990	Non-institutional only	Purchase only	4 per 3 years	
E0159	BRAKE ATTACHMENT FOR WHEELED WALKER, REPLACEMENT, EACH	Each	C30	Ambulation accessory	$15.00	10/01/2004	Non-institutional only	Purchase only	2 per 5 years	
E0163	COMMODE CHAIR, STATIONARY WITH FIXED ARMS	Each	C33	Fixed arms	$52.80	05/01/1990	Non-institutional only	Purchase only	1 per 5 years	
E0165	COMMODE CHAIR, STATIONARY WITH DETACHABLE/DROP ARMS	Each	C33	Detachable arms	$104.00	05/01/1990	Non-institutional only	Purchase only	1 per 5 years	
E0167	PAIL OR PAN FOR USE WITH COMMODE CHAIR (REPLACEMENT ONLY)	Each	C33	Pail	$5.25	05/01/1990	Non-institutional only	Purchase only	1 per year	
E0168	EXTRA WIDE/HEAVY DUTY COMMODE CHAIR	Each	C33	Heavy duty	$129.56	01/01/2001	Non-institutional only	Purchase only	1 per 5 years	Extra-wide/heavy-duty commode chairs are covered only for individuals weighing at least 300 pounds. The supplier must maintain documentation of the individual's weight.
E0181	PRESSURE PAD, ALTERNATING, WITH PUMP, HEAVY DUTY	Each	C18b	Pad	$148.00	05/01/1990	Non-institutional only	Purchase only	1 per 4 years	
E0182	PUMP FOR ALTERNATING PRESSURE PAD	Each	C18b	Pump	$105.00	11/01/1992	Non-institutional only	Purchase only	1 per 4 years	
E0184	DRY PRESSURE MATTRESS	Each	C18b	Mattress	$194.70	09/01/2005	Non-institutional only	Purchase only	1 per 4 years	
E0185	GEL PRESSURE PAD FOR MATTRESS	Each	C18b	Mattress	$102.00	05/01/1990	Non-institutional only	Purchase only	1 per 2 years	
E0186	AIR PRESSURE MATTRESS	Each	C18b	Mattress	$219.74	04/01/2006	Non-institutional only	Purchase only	1 per 2 years	
E0187	WATER PRESSURE MATTRESS (E.G., AQUAPEDIC)	Each	C18b	Mattress	$231.00	12/15/2002	Non-institutional only	Purchase only	1 per 2 years	
E0188	SYNTHETIC SHEEPSKIN PAD, WHEELCHAIR SIZE	Each	C18b	Pad	$5.00	05/01/1990	Non-institutional only	Purchase only	2 per 6 months	
E0189	LAMBSWOOL/SHEEPSKIN PAD, ANY BED SIZE	Each	C18b	Pad	$43.95	07/01/2002	Non-institutional only	Purchase only	2 per year	
E0190	POSITIONING CUSHION/PILLOW/WEDGE, ANY SHAPE OR SIZE, INCLUDES ALL COMPONENTS AND ACCESSORIES	Each	C01a	Positioning cushion	$100.00	04/01/2009	Non-institutional only	Purchase only	1 per 2 years	
E0191	HEEL OR ELBOW PROTECTOR	Each	C18b	Pressure-reducing supply	$9.00	04/01/2001	Non-institutional only	Purchase only	4 per 6 months	
E0193	POWERED FLOTATION BED (LOW AIR LOSS THERAPY)	Day	C18b	Bed	$32.50	01/01/1992	Non-institutional only	Rental only	180 per year	
E0194	AIR FLUIDIZED BED (BEAD BED)	Day	C18b	Bed	$38.00	01/01/1992	Non-institutional only	Rental only	180 per year	
E0196	GEL PRESSURE MATTRESS	Each	C18b	Mattress	$351.69	04/01/2006	Non-institutional only	Purchase only	1 per 4 years	
E0197	AIR PRESSURE PAD FOR MATTRESS	Each	C18b	Mattress	$199.42	04/01/2006	Non-institutional only	Purchase only	1 per 4 years	
E0198	WATER PRESSURE PAD FOR MATTRESS	Each	C18b	Mattress	$177.26	07/26/2007	Non-institutional only	Purchase only	1 per 4 years	
E0199	DRY PRESSURE PAD FOR MATTRESS, STANDARD MATTRESS LENGTH AND WIDTH (E.G., EGG CRATE)	Each	C18b	Pad	$20.00	05/25/1991	Non-institutional only	Purchase only	1 per year	
E0202	PHOTOTHERAPY (BILIRUBIN) LIGHT WITH PHOTOMETER	Each	C01a	Heat / cold application	$95.50	01/01/1998	Non-institutional only	Rental only	1 per lifetime	
E0210	ELECTRIC HEAT PAD, STANDARD	Each	C01a	Heat / cold application	$15.09	05/01/1990	Non-institutional only	Purchase only	1 per 5 years	
E0215	ELECTRIC HEAT PAD, MOIST	Each	C01a	Heat / cold application	$25.00	05/01/1990	Non-institutional only	Purchase only	1 per 5 years	
E0235	PARAFFIN BATH UNIT, PORTABLE COMPLETE WITH WAX	Each	C01a	Heat / cold application	$133.00	05/01/1990	Non-institutional only	Purchase only	1 per 5 years	
E0240	BATH/SHOWER CHAIR, WITH OR WITHOUT WHEELS, ANY SIZE	Each	C01d	Bath and toilet aids	BR	01/01/2004	Non-institutional only	Purchase only	1 per 5 years	

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E0241	BATHROOM WALL RAIL, STRAIGHT	Each	C01d	Bath and toilet aids	$24.00	01/01/1997	Non-institutional only	Purchase only	1 per 5 years	
E0243	TOILET RAIL	Each	C01d	Bath and toilet aids	$40.00	04/01/1999	Non-institutional only	Purchase only	1 per 5 years	
E0244	RAISED TOILET SEAT	Each	C01d	Bath and toilet aids	$49.25	04/01/1999	Non-institutional only	Purchase only	1 per 5 years	
E0245	TUB STOOL OR BENCH (ANY TYPE)	Each	C01d	Bath and toilet aids	$45.00	01/01/1997	Non-institutional only	Purchase only	1 per 5 years	
E0246	TRANSFER TUB RAIL ATTACHMENT	Each	C01d	Bath and toilet aids	$57.90	04/01/2006	Non-institutional only	Purchase only	1 per 5 years	
E0247	TRANSFER BENCH FOR TUB OR TOILET	Each	C01d	Bath and toilet aids	$80.00	10/01/2004	Non-institutional only	Purchase only	1 per 5 years	
E0248	TRANSFER BENCH, HEAVY DUTY, FOR TUB OR TOILET	Each	C01d	Bath and toilet aids	$80.00	10/01/2004	Non-institutional only	Purchase only	1 per 5 years	
E0255	HOSPITAL BED, VARIABLE HEIGHT, HI-LO, WITH ANY TYPE SIDE RAILS, WITH MATTRESS	Each	C18a	Hospital bed	$677.00	05/25/1991	Non-institutional only	Rental / purchase	1 per 8 years	
E0256	HOSPITAL BED, VARIABLE HEIGHT, HI-LO, WITH ANY TYPE SIDE RAILS, WITHOUT MATTRESS	Each	C18a	Hospital bed	$580.00	05/25/1991	Non-institutional only	Rental / purchase	1 per 8 years	
E0260	HOSPITAL BED,SEMI ELECTRIC (HEAD & FOOT ADJUSTMENT),WITH ANY TYPE SIDE RAILS, WITH MATTRESS	Each	C18a	Hospital bed	$791.20	07/01/2018	Non-institutional only	Rental / purchase	1 per 8 years	
E0261	HOSPITAL BED,SEMI ELECTRIC (HEAD & FOOT ADJUSTMENT),WITH ANY TYPE SIDE RAILS, WITHOUT MATTRESS	Each	C18a	Hospital bed	$892.00	05/25/1991	Non-institutional only	Rental / purchase	1 per 8 years	
E0271	MATTRESS, INNERSPRING	Each	C18a	Mattress	$97.00	05/01/1990	Non-institutional only	Purchase only	1 per 4 years	
E0272	MATTRESS, FOAM RUBBER	Each	C18a	Mattress	$92.00	05/01/1990	Non-institutional only	Purchase only	1 per 4 years	
E0275	BED PAN, STANDARD, METAL OR PLASTIC	Each	C01a	Bed pan	$4.00	05/01/1990	Non-institutional only	Purchase only	1 per 4 years	
E0276	BED PAN, FRACTURE, METAL OR PLASTIC	Each	C01a	Bed pan	$3.00	05/01/1990	Non-institutional only	Purchase only	1 per 4 years	
E0277	ALTERNATING PRESSURE MATTRESS	Each	C18b	Mattress	$3,046.08	07/01/2018	Non-institutional only	Rental / purchase	1 per 4 years	
E0292	HOSPITAL BED, VARIABLE HEIGHT, HI-LO, WITHOUT SIDE RAILS, WITH MATTRESS	Each	C18a	Hospital bed	$567.00	05/25/1991	Non-institutional only	Rental / purchase	1 per 8 years	
E0293	HOSPITAL BED, VARIABLE HEIGHT, HI-LO, WITHOUT SIDE RAILS, WITHOUT MATTRESS	Each	C18a	Hospital bed	$470.00	05/25/1991	Non-institutional only	Rental / purchase	1 per 8 years	
E0294	HOSPITAL BED, SEMI-ELECTRIC (HEAD & FOOT ADJUSTMENTS), WITHOUT SIDE RAILS, WITH MATTRESS	Each	C18a	Hospital bed	$703.20	07/01/2018	Non-institutional only	Rental / purchase	1 per 8 years	
E0295	HOSPITAL BED, SEMI-ELECTRIC (HEAD & FOOT ADJUSTMENTS), WITHOUT SIDE RAILS, WITHOUT MATTRESS	Each	C18a	Hospital bed	$625.60	07/01/2018	Non-institutional only	Rental / purchase	1 per 8 years	
E0301	HOSPITAL BED, HEAVY DUTY, EXTRA WIDE, WITH WEIGHT CAPACITY GREATER THAN 350 POUNDS, BUT LESS THAN OR EQUAL TO 600 POUNDS, WITH ANY TYPE SIDE RAILS, WITHOUT MATTRESS	Each	C18a	Hospital bed	$1,677.44	07/01/2018	Non-institutional only	Rental / purchase	1 per 8 years	
E0302	HOSPITAL BED, HEAVY DUTY, EXTRA WIDE, WITH WEIGHT CAPACITY GREATER THAN 600 POUNDS, WITH ANY TYPE SIDE RAILS, WITHOUT MATTRESS	Each	C18a	Hospital bed	$4,578.80	07/01/2018	Non-institutional only	Rental / purchase	1 per 8 years	
E0303	HOSPITAL BED, HEAVY DUTY, EXTRA WIDE, WITH WEIGHT CAPACITY GREATER THAN 350 POUNDS, BUT LESS THAN OR EQUAL TO 600 POUNDS, WITH ANY TYPE SIDE RAILS, WITH MATTRESS	Each	C18a	Hospital bed	$1,945.44	07/01/2018	Non-institutional only	Rental / purchase	1 per 8 years	
E0304	HOSPITAL BED, HEAVY DUTY, EXTRA WIDE, WITH WEIGHT CAPACITY GREATER THAN 600 POUNDS, WITH ANY TYPE SIDE RAILS, WITH MATTRESS	Each	C18a	Hospital bed	$4,932.32	07/01/2018	Non-institutional only	Rental / purchase	1 per 8 years	
E0305	BED, SIDE RAILS, HALF LENGTH, ATTACHMENT	Each	C18a	Hospital bed accessories	$185.01	01/01/2010	Non-institutional only	Purchase only	2 per 8 years	Only one code may be reported in the categories of side rails, cervical traction frames/stands, pelvic traction frames/stands, trapeze bars, and fracture frames.
E0310	BED, SIDE RAILS, FULL LENGTH, ATTACHMENT	Each	C18a	Hospital bed accessories	$143.74	04/01/2009	Non-institutional only	Purchase only	2 per 8 years	Only one code may be reported in the categories of side rails, cervical traction frames/stands, pelvic traction frames/stands, trapeze bars, and fracture frames.
E0325	URINAL; MALE, JUG TYPE, ANY MATERIAL	Each	C01a	Urinal	$2.50	05/01/1990	Non-institutional only	Purchase only	1 per 4 years	
E0326	URINAL; FEMALE, JUG TYPE, ANY MATERIAL	Each	C01a	Urinal	$3.50	05/01/1990	Non-institutional only	Purchase only	1 per 4 years	
E0328	HOSPITAL BED, PEDIATRIC, MANUAL, 360 DEGREE SIDE ENCLOSURES, TOP OF HEADBOARD, FOOTBOARD AND SIDE RAILS UP TO 24 INCHES ABOVE THE SPRING, INCLUDES MATTRESS	Each	C18a	Hospital bed	$5,560.00	09/01/2013	Non-institutional only	Rental / purchase	1 per 8 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 THE SPRING, INCLUDES	Each	C18a	Hospital bed	$6,000.00	09/01/2013	Non-institutional only	Rental / purchase	1 per 8 years	
E0371	NONPOWER ADVANCED PRESSURE-REDUCING MATTRESS OVERLAY	Each	C18b	Overlay	$4,644.81	04/01/2006	Non-institutional only	Rental / purchase	1 per 4 years	
E0372	POWERED AIR OVERLAY FOR MATTRESS, STANDARD MATTRESS LENGTH & WIDTH	Each	C18b	Overlay	$5,838.28	04/01/2006	Non-institutional only	Rental / purchase	1 per 4 years	
E0373	NON-POWERED, ADVANCED PRESSURE-REDUCING MATTRESS	Each	C18b	Mattress	$5,321.02	07/01/2018	Non-institutional only	Rental / purchase	1 per 4 years	

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E0445	OXIMETER DEVICE FOR MEASURING BLOOD OXYGEN LEVELS NON-INVASIVELY.	Each	C23	Pulse oximeter	$2,250.00	03/29/2007	Non-institutional only	Rental / purchase	1 per 5 years	
E0455	OXYGEN TENT/CANOPY (REPLACEMENT FOR RECIPIENT- OWNED EQUIPMENT)	Each	C13	Respiratory care supplies	$8.00	05/01/1990	Non-institutional only	Purchase only	6 per month	
E0457	CHEST SHELL (CUIRASS)	Each	C22	Shell	$450.00	05/01/1990	Non-institutional only	Purchase only	1 per 8 years	
E0459	CHEST WRAP	Each	C22	Wrap	$352.00	05/01/1990	Non-institutional only	Purchase only	1 per 8 years	
E0465	HOME VENTILATOR, ANY TYPE, USED WITH INVASIVE INTERFACE, (E.G. TRACHEOSTOMT TUBE)	Each	C22	Invasive	$900.00	01/01/2016	All	Rental only	1 per month	
E0466	HOME VENTILATOR, ANY TYPE, USED WITH NON-INVASIVE INTERFACE (E.G. MASK, CHEST SHELL)	Each	C22	Non-invasive	$900.00	01/01/2016	All	Rental only	1 per month	
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--CPAP)	Each	C19	Respiratory assist device	$1,900.00	10/01/2004	Non-institutional only	Rental / purchase	1 per 5 years	
E0471	RESPIRATORY ASSIST DEVICE, BI-LEVEL PRESSURE CAPABILITY, WITH BACKUP RATE FEATURE, USED WITH NONINVASIVE INTERFACE, E.G., NASAL OR FACIAL MASK (INTERMITTENT ASSIST DEVICE WITH CONTINUOUS POSITIVE AIRWAY PRESSURE DEVICE--	Each	C19	Respiratory assist device	$320.00	10/01/2004	Non-institutional only	Rental only	1 per month	
E0472	RESPIRATORY ASSIST DEVICE, BI-LEVEL PRESSURE CAPACITY, WITH BACKUP RATE FEATURE, USED WITH INVASIVE INTERFACE, E.G., TRACHEOSTOMY TUBE (INTERMITTENT ASSIST DEVICE WITH CONTINUOUS POSITIVE AIRWAY PRESSURE DEVICE--CPAP)	Each	C19	Respiratory assist device	$320.00	10/01/2004	Non-institutional only	Rental only	1 per month	
E0480	PERCUSSOR, ELECTRIC OR PNEUMATIC, HOME MODEL	Each	C01a	Percussors	$321.00	05/01/1990	Non-institutional only	Purchase only	1 per 3 years	
E0481	INTRAPULMONARY PERCUSSIVE VENTILATION SYSTEM AND RELATED ACCESSORIES	Each	C01a	Percussors	$4,724.50	10/01/2004	Non-institutional only	Rental / purchase	1 per 8 years	
E0482	COUGH STIMULATING DEVICE, ALTERNATING POSITIVE AND NEGATIVE AIRWAY PRESSURE	Each	C01a	Percussors	$3,956.00	07/01/2018	Non-institutional only	Rental / purchase	1 per 8 years	
E0483	HIGH FREQUENCY CHEST WALL OSCILLATION AIR-PULSE GENERATOR SYSTEM (INCLUDES HOSES AND VEST)	Each	C08	HFCWO system	$12,190.00	10/01/2004	Non-institutional only	Rental / purchase	1 per lifetime	
E0484	OSCILLATORY POSITIVE EXPIRATORY PRESSURE DEVICE, NON-ELECTRIC, ANY TYPE, EACH	Each	C01a	Respiratory care equipment	$27.70	09/01/2005	Non-institutional only	Purchase only	1 per 8 years	
E0500	IPPB MACHINE, ALL TYPES, WITH BUILT-IN NEBULIZATION	Each	C19	IPPB machine	$65.00	04/01/1992	Non-institutional only	Rental only	1 per month	
E0561	HUMIDIFIER, NON-HEATED, USED WITH POSITIVE AIRWAY PRESSURE DEVICE	Each	C19	Humidifier	$92.00	04/01/2009	Non-institutional only	Purchase only	1 per 4 years	
E0562	HUMIDIFIER, HEATED, USED WITH POSITIVE AIRWAY PRESSURE DEVICE	Each	C19	Humidifier	$225.92	10/01/2004	Non-institutional only	Purchase only	1 per 4 years	
E0565	COMPRESSOR, AIR POWER SOURCE FOR EQUIPMENT NOT SELF-CONTAINED OR CYLINDER	Each	C01a	Respiratory care equipment	$525.00	04/01/1996	Non-institutional only	Rental / purchase	1 per 4 years	
E0570	NEBULIZER, W/COMPRESSOR, (PULMO-AID)	Each	C01a	Respiratory care equipment	$133.00	01/01/1992	Non-institutional only	Purchase only	1 per 5 years	This item is covered without prior authorization for individuals who have a documented, relevant respiratory system diagnosis. A nebulizer may be covered only in association with a prescribed medication; an applicable diagnosis and specific medications must be listed on the prescription.
E0575	NEBULIZER, ULTRASONIC, LARGE VOLUME	Each	C01a	Respiratory care equipment	$430.00	04/01/1996	Non-institutional only	Purchase only	1 per 4 years	A nebulizer may be covered only in association with a prescribed medication; an applicable diagnosis and specific medications must be listed on the prescription.
E0580	NEBULIZER, DURABLE, GLASS OR AUTOCLAVABLE PLASTIC, BOTTLE TYPE, FOR USE WITH REGULATOR OR FLOWMETER	Each	C01a	Respiratory care equipment	$115.00	05/01/1990	Non-institutional only	Purchase only	2 per year	A nebulizer may be covered only in association with a prescribed medication; an applicable diagnosis and specific medications must be listed on the prescription.
E0600	SUCTION PUMP, HOME MODEL, PORTABLE OR STATIONARY, COMPLETE	Each	C19	Pump	$434.00	07/01/2018	Non-institutional only	Purchase only	1 per 4 years	
E0601	NASAL CONTINUOUS AIRWAY PRESSURE (CPAP) DEVICE	Each	C19	Nasal PAP device	$775.00	04/01/1992	Non-institutional only	Rental / purchase	1 per 4 years	
E0602	BREAST PUMP, MANUAL, ANY TYPE	Each	C25	Breast pump	$15.00	10/01/2004	Non-institutional only	Purchase only	1 per 2 years	
E0603	BREAST PUMP, ELECTRIC (AC AND/OR DC), ANY TYPE	Each	C25	Breast pump	$202.50	07/26/2007	Non-institutional only	Purchase only	1 per 5 years	
E0604	BREAST PUMP, HEAVY DUTY, HOSPITAL GRADE, PISTON OPERATED, PULSATILE VACUUM SUCTION/RELEASE CYCLES, VACUUM REGULATOR, SUPPLIES, TRANSFORMER, ELECTRIC (AC AND/OR DC) (RENTAL ONLY)	Day	C25	Breast pump	$2.25	01/01/2002	Non-institutional only	Rental only	90 days	
E0605	VAPORIZER, ROOM TYPE	Each	C01d	Respiratory care supplies	$20.00	05/01/1990	Non-institutional only	Purchase only	1 per 4 years	
E0618	APNEA MONITOR WITHOUT RECORDING FEATURE; INCLUDING ALARMS, MAINTENANCE, & SUPPLIES	Each	C09	Monitor without recording feature	$2,626.50	10/15/2006	Non-institutional only	Rental / purchase	1 per 5 years	
E0619	APNEA MONITOR WITH RECORDING FEATURE; INCLUDING ALARMS, MAINTENANCE, SUPPLIES & DOWNLOADS	Each	C09	Monitor with recording feature	$2,833.65	10/15/2006	Non-institutional only	Rental / purchase	1 per 5 years	

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E0621	SLING OR SEAT FOR PATIENT LIFT, CANVAS OR NYLON (REPLACEMENT ONLY)	Each	C01a	Portable lifts	$89.70	01/01/1999	Non-institutional only	Purchase only	1 per 2 years	This item is covered only for a lift owned by the individual.
E0625	PATIENT LIFT, BATHROOM OR TOILET, NOT OTHERWISE CLASSIFIED	Each	C01a	Portable lifts	$447.00	05/01/1990	Non-institutional only	Purchase only	1 per 6 years	
E0630	PATIENT LIFT, HYDRAULIC, WITH SEAT OR SLING, PORTABLE, COMPLETE	Each	C01a	Portable lifts	$761.60	07/01/2018	Non-institutional only	Purchase only	1 per 6 years	
E0637	COMBINATION SIT TO STAND SYSTEM	Each	C01a	Portable lifts	PA	09/01/2005	Non-institutional only	Purchase only	1/per 5 years	
E0638	STANDING FRAME SYSTEM, ANY SIZE W/WO WHEELS	Each	C01a	Standing frames / gait trainers	PA	04/01/2006	Non-institutional only	Purchase only	1 per 5 years	
E0650	PNEUMATIC COMPRESSOR, NONSEGMENTAL, HOME MODEL (LYMPHEDEMA PUMP)	Each	C17	Home model	$510.00	01/01/1994	Non-institutional only	Rental / purchase	1 per 5 years	
E0651	PNEUMATIC COMPRESSOR, SEGMENTAL HOME MODEL WITHOUT CALIBRATED GRADIENT PRESSURE	Each	C17	Home model	$776.80	07/01/2002	Non-institutional only	Rental / purchase	1 per 5 years	
E0655	NON-SEGMENTAL PNEUMATIC APPLIANCE FOR USE WITH PNEUMATIC COMPRESSOR, HALF ARM	Each	C17	Half arm	$77.50	01/01/1994	Non-institutional only	Purchase only	1 per 2 years	
E0660	NON-SEGMENTAL PNEUMATIC APPLIANCE FOR USE WITH PNEUMATIC COMPRESSOR, FULL LEG	Each	C17	Full leg	$135.12	07/01/2002	Non-institutional only	Purchase only	1 per 2 years	
E0665	NON-SEGMENTAL PNEUMATIC APPLIANCE FOR USE WITH PNEUMATIC COMPRESSOR, FULL ARM	Each	C17	Full arm	$101.50	01/01/1994	Non-institutional only	Purchase only	1 per 2 years	
E0666	NON-SEGMENTAL PNEUMATIC APPLIANCE FOR USE WITH PNEUMATIC COMPRESSOR, HALF LEG	Each	C17	Half leg	$95.00	01/01/1994	Non-institutional only	Purchase only	1 per 2 years	
E0667	SEGMENTAL PNEUMATIC APPLIANCE FOR USE WITH PNEUMATIC COMPRESSOR, FULL LEG	Each	C17	Full leg	$172.30	01/01/1994	Non-institutional only	Purchase only	1 per 2 years	
E0668	SEGMENTAL PNEUMATIC APPLIANCE FOR USE WITH PNEUMATIC COMPRESSOR, FULL ARM	Each	C17	Full arm	$150.00	01/01/1994	Non-institutional only	Purchase only	1 per 2 years	
E0669	SEGMENTAL PNEUMATIC APPLIANCE FOR USE WITH PNEUMATIC COMPRESSOR, HALF LEG	Each	C17	Half leg	$143.75	01/01/1994	Non-institutional only	Purchase only	1 per 2 years	
E0700	SAFETY EQUIPMENT (E.G., BELT, HARNESS OR VEST)	Each	C01a	Safety Equipment	$10.82	05/01/1990	Non-institutional only	Purchase only	2 per year	
E0705	TRANSFER BOARD OR DEVICE, ANY TYPE, EACH	Each	C01a	Transfer board	$46.62	01/01/2006	Non-institutional only	Purchase only	1 per 2 years	
E0720	TENS UNIT, TWO LEAD, LOCALIZED STIMULATION (INCLUDES SUPPLIES DURING RENTAL)	Each	C15	Two lead	$525.00	07/01/2018	Non-institutional only	Rental / purchase	1 per 4 years	All TENS units must include a battery charger and battery pack.
E0730	TENS UNIT, FOUR LEAD, LARGE AREA/MULTIPLE NERVE STIMULATION (INCLUDES SUPPLIES DURING RENTAL)	Each	C15	Four lead	$564.18	07/01/2018	Non-institutional only	Rental / purchase	1 per 4 years	All TENS units must include a battery charger and battery pack.
E0747	OSTEOGENESIS STIMULATOR, NONINVASIVE, OTHER THAN SPINAL APPLICATIONS	Each	C28	Non-spinal	$1,750.00	04/01/1992	Non-institutional only	Purchase only	1 per 8 years	
E0748	OSTEOGENESIS STIMULATOR, ELECTRICAL, NON-INVASIVE, SPINAL	Each	C28	Spinal	$1,750.00	08/01/1997	Non-institutional only	Purchase only	1 per 8 years	
E0760	OSTEOGENESIS STIM, LOW INTEN U/S NON INVASIS	Each	C28	Low intensity	$1,750.00	10/15/2006	Non-institutional only	Purchase only	1 per 8 years	
E0776	IV POLE (IF PUMP IS AUTHORIZED, PAYMENT FOR POLE IS INCLUDED IN PUMP RENTAL)	Each	C29	Infusion pump (non-nutrition) equipment	$75.00	05/01/1990	Non-institutional only	Purchase only	1 per 8 years	
E0781	AMBULATORY INFUSION PUMP, SINGLE OR MULTIPLE CHANNELS, ELECTRIC OR BATTERY OPERATED, WITH ADMINISTRATIVE EQUIPMENT, WORN BY PATIENT	Each	C29	Infusion pump (non-nutrition) equipment	$8.73	01/01/1992	Non-institutional only	Rental only	1 per day	
E0784	EXTERNAL AMBULATORY INFUSION PUMP, INSULIN	Each	C29	Infusion pump (non-nutrition) equipment	$4,000.00	01/01/1996	Non-institutional only	Rental / purchase	1 per 8 years	
E0791	PARENTERAL INFUSION PUMP,STATIONARY, SINGLE OR MULTI-CHANNEL (NON-NUTRITION) (INCLUDING POLE)	Each	C29	Infusion pump (non-nutrition) equipment	$8.73	05/01/1990	Non-institutional only	Rental only	1 per day	
E0840	TRACTION FRAME ATTACHED TO HEADBOARD, CERVICAL TRACTION	Each	C18a	Hospital bed accessories	$58.62	07/26/2007	Non-institutional only	Purchase only	1 per 8 years	Only one code may be reported in the categories of side rails, cervical traction frames/stands, pelvic traction frames/stands, trapeze bars, and fracture frames.
E0850	TRACTION STAND, FREE STANDING, CERVICAL TRACTION	Each	C18a	Hospital bed accessories	$84.05	07/26/2007	Non-institutional only	Purchase only	1 per 8 years	Only one code may be reported in the categories of side rails, cervical traction frames/stands, pelvic traction frames/stands, trapeze bars, and fracture frames.
E0860	TRACTION EQUIPMENT, OVERDOOR, CERVICAL, COMPLETE	Each	C18a	Hospital bed accessories	$30.82	07/26/2007	Non-institutional only	Purchase only	1 per 8 years	Only one code may be reported in the categories of side rails, cervical traction frames/stands, pelvic traction frames/stands, trapeze bars, and fracture frames.
E0870	TRACTION FRAME, ATTACHED TO FOOTBOARD, EXTREMITY TRACTION (E.G. BUCK'S)	Each	C18a	Hospital bed accessories	$93.05	07/26/2007	Non-institutional only	Purchase only	1 per 8 years	Only one code may be reported in the categories of side rails, cervical traction frames/stands, pelvic traction frames/stands, trapeze bars, and fracture frames.
E0880	TRACTION STAND, FREE STANDING, EXTREMITY TRACTION (E.G. BUCK'S)	Each	C18a	Hospital bed accessories	$100.43	07/26/2007	Non-institutional only	Purchase only	1 per 8 years	Only one code may be reported in the categories of side rails, cervical traction frames/stands, pelvic traction frames/stands, trapeze bars, and fracture frames.
E0890	TRACTION FRAME, ATTACHED TO FOOTBOARD, PELVIC TRACTION	Each	C18a	Hospital bed accessories	$96.33	07/26/2007	Non-institutional only	Purchase only	1 per 8 years	Only one code may be reported in the categories of side rails, cervical traction frames/stands, pelvic traction frames/stands, trapeze bars, and fracture frames.

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E0900	TRACTION STAND, FREE STANDING, PELVIC TRACTION (E.G., BUCK'S)	Each	C18a	Hospital bed accessories	$102.50	07/26/2007	Non-institutional only	Purchase only	1 per 8 years	Only one code may be reported in the categories of side rails, cervical traction frames/stands, pelvic traction frames/stands, trapeze bars, and fracture frames.
E0910	TRAPEZE BAR, BED MOUNTED WITH GRAB BAR	Each	C18a	Hospital bed accessories	$208.00	07/26/2007	Non-institutional only	Purchase only	1 per 8 years	Only one code may be reported in the categories of side rails, cervical traction frames/stands, pelvic traction frames/stands, trapeze bars, and fracture frames.
E0912	TRAPEZE BAR, HEAVY DUTY, FREE STANDING	Each	C18a	Hospital bed accessories	$1,190.49	07/26/2007	Non-institutional only	Purchase only	1 per 8 years	Only one code may be reported in the categories of side rails, cervical traction frames/stands, pelvic traction frames/stands, trapeze bars, and fracture frames.
E0920	FRACTURE FRAME, ATTACHED TO BED, INCLUDES WEIGHTS	Each	C18a	Hospital bed accessories	$479.86	07/26/2007	Non-institutional only	Purchase only	1 per 8 years	Only one code may be reported in the categories of side rails, cervical traction frames/stands, pelvic traction frames/stands, trapeze bars, and fracture frames.
E0930	FRACTURE FRAME, FREESTANDING, INCLUDES WEIGHTS	Each	C18a	Hospital bed accessories	$475.17	07/26/2007	Non-institutional only	Purchase only	1 per 8 years	Only one code may be reported in the categories of side rails, cervical traction frames/stands, pelvic traction frames/stands, trapeze bars, and fracture frames.
E0935	PASSIVE MOTION EXRCISE DEVICE (TOTAL KNEE REPLACEMENT ONLY)	Day	C27	CPM device	$18.18	04/01/2006	Non-institutional only	Rental only	21 per medical event	Only one code may be reported in the categories of side rails, cervical traction frames/stands, pelvic traction frames/stands, trapeze bars, and fracture frames.
E0940	TRAPEZE BAR, FREESTANDING, COMPLETE W/GRAB BAR	Each	C18a	Hospital bed accessories	$361.61	07/26/2007	Non-institutional only	Purchase only	1 per 8 years	Only one code may be reported in the categories of side rails, cervical traction frames/stands, pelvic traction frames/stands, trapeze bars, and fracture frames.
E0941	GRAVITY ASSISTED TRACTION DEVICE, ANY TYPE	Each	C18a	Hospital bed accessories	$451.46	07/26/2007	Non-institutional only	Rental / purchase	1 per year	Only one code may be reported in the categories of side rails, cervical traction frames/stands, pelvic traction frames/stands, trapeze bars, and fracture frames.
E0942	CERVICAL HEAD HARNESS/HALTER	Each	C18a	Hospital bed accessories	$15.88	07/26/2007	Non-institutional only	Purchase only	1 per medical event	Only one code may be reported in the categories of side rails, cervical traction frames/stands, pelvic traction frames/stands, trapeze bars, and fracture frames.
E0944	PELVIC BELT/HARNESS/BOOT	Each	C18a	Hospital bed accessories	$36.70	07/26/2007	Non-institutional only	Purchase only	1 per medical event	Only one code may be reported in the categories of side rails, cervical traction frames/stands, pelvic traction frames/stands, trapeze bars, and fracture frames.
E0945	EXTREMITY BELT/HARNESS	Each	C18a	Hospital bed accessories	$35.46	07/26/2007	Non-institutional only	Purchase only	1 per medical event	Only one code may be reported in the categories of side rails, cervical traction frames/stands, pelvic traction frames/stands, trapeze bars, and fracture frames.
E0946	FRACTURE FRAME, DUAL WITH CROSS BARS, ATTACHED TO BED (E.G. BALKEN, 4 POSTER)	Each	C18a	Hospital bed accessories	$615.26	07/26/2007	Non-institutional only	Rental / purchase	1 per medical event	Only one code may be reported in the categories of side rails, cervical traction frames/stands, pelvic traction frames/stands, trapeze bars, and fracture frames.
E0947	FRACTURE FRAME, ATTACHMENTS FOR COMPLEX PELVIC TRACTION	Each	C18a	Hospital bed accessories	$485.17	07/26/2007	Non-institutional only	Rental / purchase	1 per medical event	Only one code may be reported in the categories of side rails, cervical traction frames/stands, pelvic traction frames/stands, trapeze bars, and fracture frames.
E0948	FRACTURE FRAME, ATTACHMENTS FOR COMPLEX CERVICAL TRACTION	Each	C18a	Hospital bed accessories	$469.27	07/26/2007	Non-institutional only	Rental / purchase	1 per medical event	Only one code may be reported in the categories of side rails, cervical traction frames/stands, pelvic traction frames/stands, trapeze bars, and fracture frames.
E1300	WHIRLPOOL, PORTABLE (OVERTUB TYPE)	Each	C01a	Whirlpool	$170.00	05/01/1990	Non-institutional only	Purchase only	1 per 8 years	
E1340	REPAIR, NON-ROUTINE SVC, DME LABOR, PER 15 MIN	Each	C01e	Labor	$11.00	07/01/2008	All		1 per 120 days	
E1372	IMMERSION EXTERNAL HEATER FOR NEBULIZER	Each	C01a	Respiratory care equipment	$118.00	05/01/1990	Non-institutional only	Purchase only	1 per 4 years	
E1399	DURABLE MEDICAL EQUIPMENT, MISCELLANEOUS	Each	C01a	Miscellanea or repair	PA	05/01/1990	Non-institutional only			
E1399	DURABLE MEDICAL EQUIPMENT, NOS	Each	C01e	Labor	Supplier charge (without PA), PA (with PA)	05/01/1990	All		1 per 120 days	
E1399	MAJOR REPAIR OF DME, >$100	Each	C01e	Labor	PA	05/01/1990	Non-institutional only			
E1399	MAJOR REPAIR OF DME, >$100, LTCF	Each	C01e	Labor	PA	05/01/1990	LTCF only			
E1399	MINOR REPAIR OF DME, <=$100, OUTSIDE FREQUENCY LIMIT	Each	C01e	Labor	PA	05/01/1990	All		1 per 120 days	
E1399	MINOR REPAIR OF DME, <=$100, WITHIN FREQUENCY LIMIT	Each	C01e	Labor	Supplier charge	05/01/1990	All		1 per 120 days	
E1820	REPLACEMENT SOFT INTERFACE MATERIAL, DYNAMIC ADJUSTABLE EXTENSION/ FLEXION DEVICE	Each	C18a	Hospital bed accessories	$65.39	04/01/2006	Non-institutional only	Purchase only	1 per medical event	Only one code may be reported in the categories of side rails, cervical traction frames/stands, pelvic traction frames/stands, trapeze bars, and fracture frames.
E2500	SPEECH GEN DEVICE <= 8 MIN	Each	C24	8 minutes or less recording time	$266.75	01/01/2010	All	Rental / purchase	1 per 5 years	
E2502	SPEECH GEN DEVICE, > 8 MIN BUT <= 20 MIN	Each	C24	8-20 minutes recording time	$811.95	01/01/2010	All	Rental / purchase	1 per 5 years	
E2504	SPEECH GEN DEVICE, > 20 BUT < 40 MIN	Each	C24	20-40 minutes recording time	$1,071.06	01/01/2010	All	Rental / purchase	1 per 5 years	

BR -- Payment by report
NC -- No coverage
PA -- Payment by prior authorization

HCPCS CODE	DESCRIPTION	UNIT	CATEGORY	SUBCATEGORY / APPLICATION	CURRENT MAXIMUM PAYMENT AMOUNT	PAYMENT AMOUNT EFFECTIVE DATE	RESIDENCE	RENTAL OR PURCHASE	LIMIT	NOTES
E2506	SPEECH GEN DEVICE, > 40 MIN	Each	C24	40+ minutes recording time	$2,129.15	01/01/2010	All	Rental / purchase	1 per 5 years	

5160-10-02 **DMEPOS: repair.**

(A) Definitions.

(1) "Major repair" is a repair for which the combined medicaid allowed amounts for materials and labor exceed one hundred twenty dollars for an orthotic or prosthetic device or one hundred dollars for any other item.

(2) "Minor repair" is a repair for which the combined medicaid allowed amounts for materials and labor do not exceed one hundred twenty dollars for an orthotic or prosthetic device or one hundred dollars for any other item. Reporting a major repair on a claim as a series of minor repairs is not permitted.

(B) Coverage.

(1) Provisions governing the repair of wheelchairs are set forth in rule 5160-10-16 of the Administrative Code.

(2) Need verification is required before payment can be made for the following repairs made to a particular item:

(a) The initial repair made to an item that was not purchased by the department;

(b) Major repairs; and

(c) Minor repairs in excess of one per one hundred twenty days.

(3) If no other form or format is specified, a request for need verification must be submitted on form ODM 01904, "Request for Need Verification: Repair of Durable Medical Equipment (Other Than Wheelchairs), Prostheses, or Orthotic Devices" (rev. 7/2018), and must include the following information:

(a) Specification of the item, including manufacturer, model, and serial number (if applicable);

(b) The date on which the item was originally purchased or dispensed or, if the date is not known, the approximate age of the item;

(c) Any warranty period and the type of warranty (manufacturer or dealer);

(d) A full description of the wear, damage, or malfunction;

(e) A full description of the repair;

(f) A description, with dates, of previous repairs (both major and minor);

(g) A complete itemization of parts; and

(h) An estimate of labor time needed.

(4) Providers should advise the department when, in their professional opinion, replacement of an item would be more cost-effective than repair.

(5) No separate payment will be made for the following items or services:

(a) Temporary replacement ("loaner") equipment provided while an individual's own equipment is being repaired; and

(b) Repair of an item if within the preceding twelve months the department has paid for the repair of a duplicate or conflicting item currently in the recipient's possession, regardless of payment or supply source.

Replaces: 5160-10-08

Effective:

Five Year Review (FYR) Dates:

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Certification

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Date

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Statutory Authority:	5164.02
Rule Amplifies:	5164.02
Prior Effective Dates:	04/07/1977, 12/21/1977, 01/01/1980, 03/01/1984, 10/01/1988, 05/15/1989, 05/01/1990, 12/10/1993, 01/01/1995, 09/01/2002, 10/01/2004, 01/13/2006, 04/09/2009, 07/31/2009 (Emer), 10/29/2009

5160-10-09 **DMEPOS: apnea monitors.**

(A) Provider requirements. A provider of apnea monitors for use in the home must be capable of performing all of the following services:

(1) Arranging to have certified individuals provide infant cardiopulmonary resuscitation (CPR) training to caregivers;

(2) Providing education and instruction on the mechanical aspects of monitors; and

(3) Providing a technician twenty-four hours a day to service monitoring equipment.

(B) Coverage.

(1) Payment may be made for an apnea monitor on a rental/purchase basis.

(2) The monitoring unit must meet current United States food and drug administration guidelines.

(3) The default certificate of medical necessity (CMN) form is the ODM 02900, "Certificate of Medical Necessity: Apnea Monitors" (rev. 7/2018).

(4) Payment for the initial rental of an apnea monitor is limited to four months. For this initial rental period, the CMN must include the following elements:

(a) At least one clinical indication from the following list:

(i) The occurrence of at least one apparent life-threatening event (ALTE) requiring mouth-to-mouth resuscitation or vigorous stimulation;

(ii) A need for active medical management of apnea of prematurity;

(iii) The occurrence of sudden infant death syndrome (SIDS) in a sibling;

(iv) A need for home oxygen therapy or ventilatory support (either invasive or non-invasive) and associated technology-dependence;

(v) Tracheotomy and associated technology-dependence;

(vi) An abnormal pneumogram at discharge from a medical facility;

(vii) Severe gastroesophageal reflux and associated apnea;

(viii) Severe upper airway abnormality (e.g., achondroplasia, Pierre Robin syndrome); or

(ix) Another, specified disorder necessitating close cardiorespiratory monitoring to facilitate a more timely discharge to home from a medical facility; and

(b) An attestation that appropriate caregivers are capable of being trained to use the monitor properly.

(5) After the first four months, payment may be made either for additional rental or for purchase. The following documentation is required:

(a) A revised copy of the previously completed CMN, on which the prescriber attests to the need for continued home monitoring and supplies the following information pertinent to the child's circumstances:

(i) For a child who is technology-dependent, documentation that the equipment or service on which the child depends is still necessary and is still being used (evidenced, for example, by a copy of a recent clinician follow-up report or home health agency visit report noting equipment and services);

(ii) For a child who is not technology-dependent, documentation of recent, clinically significant apnea or bradycardia (evidenced, for example, by a copy of recent monitor data or a recent pneumogram showing instances of apnea or bradycardia) or documentation of a recent emergency department visit or hospital admission for an ALTE; and

(iii) For a child whose sibling died of SIDS, the birth and death dates of the sibling (for the purpose of indicating whether the child is currently younger than the sibling was at the time of death); and

(b) Either a full report of the information recorded by the apnea monitor during the initial rental period or a summary of the information accompanied by a statement that a full report is available on request.

(6) Payment for an apnea monitor includes professional time, data recording, transmission or printing, maintenance, and supplies.

(C) Requirements, constraints, and limitations.

(1) The following diagnoses, conditions, or circumstances are not by themselves indications for monitoring:

(a) Seizures or seizure disorders in the absence of ALTEs;

(b) Uncomplicated hydrocephalus;

(c) Mental retardation or other developmental disability;

(d) Terminal illness;

(e) Congenital heart defect, with or without associated arrhythmia;

(f) History of apnea in immediate siblings;

(g) History of monitor use with immediate siblings;

(h) History of apnea or SIDS in family members other than immediate siblings;

(i) Parental anxiety or family request for a monitor; and

(j) Need to monitor blood oxygen saturation.

(2) Apnea monitoring in the home does not include pneumograms. A medically necessary pneumogram must be ordered by a qualified licensed prescriber and must be based on the presence of appropriate symptoms or conditions. No payment will be made for a pneumogram that is used as a screening test in the absence of appropriate symptoms or conditions.

Replaces: 5160-10-09

Effective:

Five Year Review (FYR) Dates:

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Certification

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Date

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5160-10-10 **DMEPOS: home dialysis equipment and supplies.**

(A) Payment may be made to a durable medical equipment (DME) provider for covered home dialysis equipment and related supplies except for items supplied by an end-stage renal disease dialysis clinic under "Method I" (a medicare term for a payment option in which the end-stage renal disease dialysis clinic assumes responsibility for furnishing all equipment, supplies, and support services).

(B) Separate payment may be made for dialysis equipment and supplies furnished to a resident of a long-term care facility (LTCF).

(C) The indicated medicaid maximum monthly payment for covered dialysis equipment and supplies may be made for the following types of dialysis:

(1) Hemodialysis, one thousand two hundred dollars;

(2) Continuous ambulatory peritoneal dialysis (CAPD), one thousand two hundred dollars; or

(3) Continuous cycling peritoneal dialysis (CCPD), one thousand five hundred dollars.

Replaces: 5160-10-10

Effective:

Five Year Review (FYR) Dates:

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Certification

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Date

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Prior Effective Dates:	03/01/1984, 09/01/2002, 04/16/2007, 01/01/2008

5160-10-11 **DMEPOS: hearing aids.**

(A) Definition. "Basic hearing test" is an evaluation of an individual's ability to hear that includes the following components:

(1) Testing of air-conducted stimuli at thresholds of five hundred hertz (Hz), one thousand Hz, two thousand Hz, and four thousand Hz;

(2) Assessment of air-conducted speech awareness or speech reception threshold;

(3) Establishment of most comfortable and most uncomfortable listening levels;

(4) Pure-tone bone conduction audiometry (unless the individual's age or capability precludes such testing); and

(5) For an individual younger than twenty-one years of age, the following components:

(a) Tympanometry;

(b) Acoustic reflex battery; and

(c) Otoacoustic emissions testing.

(B) Coverage.

(1) The default certificate of medical necessity (CMN) form is the ODM 01915, "Certificate of Medical Necessity: Hearing Aids" (rev. 7/2018).

(2) A completed CMN, signed and dated not more than ninety days before the requested dispensing date, must be accompanied by a hearing evaluation report, compiled not more than six months before the requested dispensing date, made up of the following components:

(a) A detailed description of the hearing test, signed by the physician specializing in otology or otolaryngology, audiologist, or licensed hearing aid fitter who administered it;

(b) A copy of the hearing test results; and

(c) A written summation of the hearing test results, prepared and signed by a physician specializing in otology or otolaryngology or by an audiologist.

(3) Separate payment may be made for the hearing test itself. All hearing tests must be administered by authorized individuals working within their scope of practice and must be conducted in an appropriate sound environment in accordance with nationally accepted standards. Hearing tests should be performed on both ears; a detailed explanation must be included in a PA request if bilateral testing cannot be done.

(4) The need for a hearing aid is demonstrated when the results of a basic hearing test performed on one ear indicate the following minimum best pure-tone average hearing loss:

(a) Thirty-one decibels (dB); or

(b) In an individual younger than twenty-one years of age, twenty-six dB.

(5) To assess the performance and acceptability of the hearing aid, the provider must attempt to schedule a follow-up visit with the individual within thirty days after delivery. No claim for payment should be submitted during this period. The provider must keep on file, for at least four years, either a confirmation of the follow-up visit signed by the individual or an explanation of why the visit was not conducted. If as a result of the follow-up visit the hearing aid is deemed unacceptable by either the provider or the individual, then payment is limited to the cost of the earmold insert and batteries. In such an instance, if payment has already been made for the hearing aid, then the provider must arrange for adjustment of the claim.

(6) The following warranty periods apply:

(a) For a covered hearing aid, it is the greater of the manufacturer's warranty period or one year from the date of delivery; and

(b) For an earmold insert, it is ninety days.

(7) A warranty comprehensively covers the following services:

(a) Repair, including labor and parts (except earmold inserts and batteries);

(b) Replacement necessitated by damage or loss; and

(c) Two adjustments per year for changes in hearing sensitivity or growth of the ear canal (after which additional adjustments made during the year will be treated as repairs).

(8) A programmable hearing aid, such as a hearing aid employing contralateral routing of signal (CROS) or binaural contralateral routing of signal (BiCROS), may be indicated if an individual has a documented need for such technology in noisy or otherwise adverse hearing environments.

(9) Separate payment may be made for the taking of an impression for an earmold insert (other than an insert dispensed with a hearing aid). Such payment is limited neither by the place of service nor by the individual's living arrangement.

(10) Regardless of how a hearing aid was purchased, payment may be made for necessary repair only if the following conditions are satisfied:

(a) The medical necessity of the hearing aid has been established;

(b) The repair is not covered by warranty or insurance; and

(c) The repair is not associated with routine maintenance or cleaning of the hearing aid.

(C) Requirements, constraints, and limitations.

(1) The provider must keep on file a copy of the manufacturer's original cost estimate, a copy of the manufacturer's final invoice detailing discounts and shipping costs, and (if applicable) an explanation of any differences between the figures.

(2) No payment will be made for the following hearing aids:

(a) A hearing aid designed to be worn inside the ear canal;

(b) A disposable hearing aid; and

(c) A hearing aid that has been previously used by another individual.

(3) No payment (including payment of a deductible amount) will be made for replacement if either of the following conditions is satisfied:

(a) The hearing aid is covered by warranty or insurance; or

(b) Repair or reconditioning would be more cost-effective.

(4) Concurrent requests or claims for two separate hearing aids will be treated as a single request or claim for a binaural hearing aid.

(5) Payment for a hearing aid includes the following items:

(a) A cleaning kit;

(b) An initial earmold insert (applicable to behind-the-ear hearing aids); and

(c) One month's supply of batteries.

(6) Payment for hearing aid dispensing includes the following services:

(a) The taking of initial earmold impressions;

(b) Assistance with selection of the hearing aid;

(c) Up to three hours of counseling;

(d) All visits (including travel) necessary for the dispensing and fitting of the hearing aid (regardless of place of service); and

(e) All service calls and follow-up visits during the warranty period.

(D) Claim payment.

(1) Payment for an analog hearing aid is the lesser of two figures:

(a) The medicaid maximum amount listed in the appendix to rule 5160-10-01; or

(b) The provider's acquisition cost, which is the sum of the manufacturer's final invoice price and shipping less any discounts received.

(2) Payment for a digital hearing aid is the lesser of two figures:

(a) A percentage of the medicaid maximum amount listed in the appendix to rule 5160-10-01, determined by the age of the individual:

(i) For an individual younger than twenty-one years of age, one hundred per cent; or

(ii) For an individual twenty-one years of age or older, fifty per cent; or

(b) The provider's usual and customary charge.

(3) Payment for repair of a hearing aid is the submitted charge, which must represent one of the following amounts:

(a) If the provider performed the repair, the provider's usual and customary total charge; or

(b) If the provider subcontracted the repair, one hundred twenty-five per cent of the amount shown on the invoice sent to the provider.

Replaces: 5160-10-11

Effective:

Five Year Review (FYR) Dates:

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Certification

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Date

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5160-10-13 **DMEPOS: oxygen.**

(A) Definitions.

(1) "Blood gas study" is the measurement of such characteristics of blood as the partial pressure of oxygen (PO2) or oxygen saturation. The term applies either to pulse oximetry or to an arterial blood gas (ABG) study.

(2) "Group I" and "group II" criteria are sets of clinical indicators used to determine the coverage of oxygen without prior authorization.

(a) Group I criteria.

(i) If the individual is tested while awake and at rest, either of the following measures applies: (a) Arterial PO2 of fifty-five millimeters of mercury (mm Hg) or less; or (b) Arterial oxygen saturation at or below eighty-eight per cent.

(ii) If the individual is tested while ambulating, either of the following measures applies:

(a) Arterial PO2 of fifty-five mm Hg or less during ambulation without oxygen, with documented improvement during ambulation with oxygen; or

(b) Arterial oxygen saturation at or below eighty-eight per cent during ambulation without oxygen, with documented improvement during ambulation with oxygen.

(iii) If the individual is tested while asleep, any of the following measures applies:

(a) Arterial PO2 of fifty-five mm Hg or less;

(b) Arterial oxygen saturation at or below eighty-eight per cent;

(c) A decrease in arterial PO2 of more than ten mm Hg, associated with symptoms of or signs reasonably attributable to hypoxemia; or

(d) A decrease in arterial oxygen saturation of more than five per cent, associated with symptoms of or signs reasonably attributable to hypoxemia.

(b) Group II criteria.

(i) Either of the following measures applies:

(a) Arterial PO2 of at least fifty-six mm Hg and not more than fifty-nine mm Hg; or

(b) Arterial oxygen saturation at or above eighty-nine per cent.

(ii) In addition, at least one of the following conditions applies:

(a) Dependent edema suggestive of congestive heart failure;

(b) Pulmonary hypertension or cor pulmonale, determined by measurement of pulmonary artery pressure, gated blood pool scan, echocardiogram, or the presence of P pulmonale on an EKG; or

(c) Erythrocythemia with a hematocrit greater than fifty-six per cent.

(3) "Transfill unit" is a device that transfers oxygen from a source such as an oxygen concentrator to portable tanks.

(B) Providers.

(1) The following eligible medicaid providers may prescribe oxygen:

(a) A physician;

(b) An advanced practice registered nurse with a relevant specialty (e.g., clinical nurse specialist, certified nurse practitioner); or

(c) A physician assistant.

(2) The following eligible medicaid providers may supply oxygen:

(a) A durable medical equipment (DME) provider;

(b) A pharmacy;

(c) A physician;

(d) An advanced practice registered nurse with a relevant specialty (e.g., clinical nurse specialist, certified nurse practitioner);

(e) A physician assistant; or

(f) A service-based ambulatory health care clinic.

(3) The following eligible medicaid providers may receive medicaid payment for submitting a claim for oxygen:

(a) A DME provider;

(b) A pharmacy;

(c) A physician;

(d) An advanced practice registered nurse with a relevant specialty (e.g., clinical nurse specialist, certified nurse practitioner);

(e) A physician assistant;

(f) A service-based ambulatory health care clinic; or

(g) A professional medical group.

(C) Certification of medical necessity.

(1) Payment for oxygen can be made only if a prescriber certifies that the oxygen is medically necessary for an individual. A completed certificate of medical necessity (CMN) must be signed and dated by the prescriber before a claim is submitted. The default form is the ODM 01909, "Certificate of Medical Necessity: Oxygen" (rev. 7/2018).

(2) On the CMN, the prescriber must specify an estimated length of need (certification period), which may range from one month to a lifetime.

(a) For an individual meeting group I criteria, each certification period is limited to a maximum of twelve months after the first date of service.

(b) For an individual meeting group II criteria, each certification period is limited to a maximum of three months after the first date of service.

(3) An initial CMN is used to document certification for new service.

(a) An initial CMN must be completed if oxygen has not been supplied under medicaid to an individual for at least two full calendar months.

(b) The individual must be seen and evaluated by a prescriber within a specified period before the date of certification, and a blood gas study is required.

(i) If the individual is a hospital inpatient or resident of a long-term care facility (LTCF) who is being discharged or will be discharged, then the evaluation period is thirty days, and the most recent blood gas study performed within forty-eight hours before discharge must be used.

(ii) Otherwise, the evaluation period is thirty days, and the most recent blood gas study performed within thirty days before the date of certification must be used.

(4) A renewing CMN is used to extend certification.

(a) If the need for oxygen was established through a sleep study in which a positive airway pressure device was shown to be effective only when supplemental oxygen was administered simultaneously, then the need for oxygen is presumed to last as long as the need for the positive airway pressure device, and no further sleep study is required to confirm a continued need for oxygen.

(b) Otherwise, within ninety days before the end of the existing certification period, the individual must be seen and evaluated by a prescriber, and a blood gas study is required. (The new certification period cannot begin until both the prescriber evaluation and the blood gas study have been completed.).

(5) A revised CMN is used to modify an existing certification. No prescriber evaluation is required.

(a) The most recent blood gas study performed within thirty days before the revision date must be used for any of the following modifications:

(i) The prescribed maximum flow rate has changed. If the new rate is greater than four liters per minute (LPM), then a new blood gas study must be performed while the individual is receiving four LPM.

(ii) Certification has been given for a portable oxygen delivery system to supplement a stationary system for which certification was

previously given. If the most recent qualifying study was performed during sleep, then a new blood gas study must be performed while the individual is awake, either at rest or ambulating.

(b) No additional blood gas study is required for the following modifications:

(i) There is a new prescriber, but the oxygen order is the same.

(ii) There is a new provider, and the new provider does not have the most recent CMN.

(D) Coverage.

(1) Payment may be made for oxygen supplied in the following forms:

(a) Stationary gaseous oxygen system (private residence only);

(b) Portable gaseous oxygen system (private residence only);

(c) Stationary liquid oxygen system (private residence only);

(d) Portable liquid oxygen system (private residence only);

(e) Oxygen contents, gaseous, including supplies (LTCF only);

(f) Oxygen contents, liquid, including supplies (LTCF only);

(g) Oxygen concentrator, single delivery port;

(h) Oxygen concentrator, dual delivery port;

(i) Portable oxygen concentrator (private residence only); and

(j) Transfill unit (private residence only).

(2) Separate payment for a portable oxygen delivery system may be made in addition to payment for a stationary system only if the following criteria are met:

(a) The individual must have a demonstrable need for a separate portable system, either to maintain mobility in a private residence or to accomplish out-of-home activities;

(b) The individual's stationary oxygen delivery system cannot be used as a portable delivery system; and

(c) The prescribed oxygen flow is four LPM or less. If the prescribed oxygen flow is greater than four LPM, then no separate payment is made for the portable oxygen delivery system.

(3) Separate payment will not be made, however, for both a stationary and a portable oxygen concentrator.

(4) Prior authorization (PA) is not required when a supplier has obtained a properly completed CMN and furnishes oxygen to an individual who either meets group I or group II criteria or is a resident of a LTCF.

(5) PA is required when a supplier has obtained a properly completed CMN and furnishes oxygen to an individual who meets neither group I nor group II criteria and is not a resident of a LTCF. If authorization is given, then the length of the authorization period will be based on medical necessity and cannot exceed the timeframe indicated by the prescriber. The PA request must include a copy of the completed CMN.

(6) Oxygen is not medically necessary if it is prescribed for any of the following conditions:

(a) Angina pectoris in the absence of hypoxemia;

(b) Dyspnea without cor pulmonale or evidence of hypoxemia;

(c) Severe peripheral vascular disease that results in clinically evident desaturation in one or more extremity but does not produce systemic hypoxemia; or

(d) A terminal illness that does not affect the respiratory system.

(E) Claim payment.

(1) Payment for oxygen is made on a monthly basis and includes the following related items and services:

(a) Setup and instruction on use;

(b) Equipment and supplies;

(c) Maintenance and repair, including the replacement of any part or attachment (such as tubing, cannula, mask, or filter) that is integral to the oxygen system or the operation of the system;

(d) Transportation or delivery charges;

(e) Emergency service, including the provision of backup equipment and supplies;

(f) Oxygen consumed (when applicable); and

(g) Equipment monitoring visits.

(2) The maximum payment for oxygen is the amount set forth in the appendix to this rule. When the prescribed oxygen flow is greater than four LPM, the payment amount is increased by fifty per cent.

Replaces: 5160-10-13

Effective:

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Certification

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Date

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Appendix to rule 5160-10-13

Procedure Code	Required Modifier	Description	Current Maximum Payment	Effective Date of Maximum Payment	Previous Maximum Payment
E0424		Stationary gaseous oxygen system, residence	$100.00	07/01/2018	$130.00
E0439		Stationary liquid oxygen system, residence	By report	07/01/2018	$130.00
E0431		Portable gaseous oxygen system, residence	$40.00	01/01/2014	$40.00
E0434		Portable liquid oxygen system, residence	$40.00	01/01/2014	$40.00
E1390	U1	Oxygen concentrator, single port, stationary only, residence	$100.00	07/01/2018	$130.00
E1391	U1	Oxygen concentrator, dual port, stationary only, residence	$100.00	07/01/2018	$130.00
E1392		Oxygen concentrator, portable capability, residence	$40.00	07/01/2018	$170.00
K0738*		Transfill unit, including portable canisters and accessories, residence	$40.00	07/01/2018	$170.00
E1390		Oxygen concentrator, single port, stationary only, LTCF	$50.00	07/01/2018	$65.00
E1391		Oxygen concentrator, dual port, stationary only, LTCF	$50.00	07/01/2018	$65.00
E0441		Oxygen contents, gaseous, including supplies, LTCF	$50.00	07/01/2018	$65.00
E0442		Oxygen contents, liquid, including supplies, LTCF	$50.00	07/01/2018	$65.00

*Note: K0738 formerly represented the combination of a stationary oxygen concentrator and a transfill unit.

Modifier	Description	Applicable Procedure Codes	Payment Multiplier
QF	Prescribed oxygen flow greater than 4 LPM, both stationary and portable	E0424, E0431, E0434, E0439, E0441, E0442	1.50
QG	Prescribed oxygen flow greater than 4 LPM, stationary only	E0424, E0439, E0441, E0442	1.50
U1	Oxygen concentrator used in a private residence	E1390, E1391	N/A

5160-10-14 **DMEPOS: compression garments.**

(A) Provider requirement. A provider of custom-made or custom-fitted compression garments must either employ or contract with a certified fitter and must keep documentation of this relationship on file.

(B) Coverage.

(1) The default certificate of medical necessity (CMN) form is the ODM 01905, "Certificate of Medical Necessity: Compression Garments" (rev. 7/2018).

(2) Payment may be made only for compression garments generating a pressure of at least eighteen millimeters of mercury (mm Hg).

(3) For a gradient compression garment, the provider must specify at least one clinical indication such as but not limited to the conditions specified in the following list:

(a) Elephantiasis;

(b) Lymphedema;

(c) Milroy's disease;

(d) Orthostatic hypotension;

(e) Post-thrombotic syndrome;

(f) Stasis dermatitis;

(g) Stasis ulcers;

(h) Symptomatic chronic venous insufficiency (characterized by, for example, pain, swelling, ulcers, or severe varicose veins);

(i) Symptomatic venous insufficiency associated with pregnancy; or

(j) Thrombophlebitis.

(4) Payment for an anti-embolism compression garment may be limited to three months, because such garments are generally used for short-term treatment after surgery.

(5) Payment for a post-burn compression garment cannot be made if no burn injury has occurred.

(6) It is understood that because of the nature of certain applications, authorization for payment may be granted after an item has been dispensed.

Replaces: 5160-10-14

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Rule Amplifies:	5164.02
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5160-10-15 **DMEPOS: transcutaneous electrical nerve stimulation (TENS) units.**

(A) Definitions.

(1) "Accessories" is a collective term that encompasses but is not necessarily limited to the following items:

(a) Adapters;

(b) Clips;

(c) Additional connecting cable for lead wires;

(d) Carrying pouches; and

(e) Covers.

(2) "Supplies" is a collective term that encompasses but is not necessarily limited to the following items:

(a) Electrodes of any type;

(b) Lead wires;

(c) Conductive paste or gel;

(d) Adhesive;

(e) Adhesive remover;

(f) Skin preparation materials;

(g) Batteries; and

(h) Battery charger for rechargeable batteries.

(B) Provider requirement. A provider of transcutaneous electrical nerve stimulation (TENS) units must have a physical location available for face-to-face fitting and instruction purposes.

(C) Coverage.

(1) Payment may be made for a TENS unit on a rental/purchase basis.

(2) The default certificate of medical necessity (CMN) form is the ODM 03402, "Certificate of Medical Necessity: Transcutaneous Electrical Nerve Stimulation (TENS) Units" (rev. 7/2018). The CMN must include one of the following statements of need:

(a) For neurogenic pain, the following information:

(i) An attestation that the individual is experiencing intractable, nerve-related pain that has lasted at least six months;

(ii) An appropriate supporting diagnosis; and

(iii) An attestation that the use of a comparable TENS unit for a trial period of at least thirty days produced substantial relief from pain and, if applicable, enabled a significant reduction in medication (e.g., muscle relaxants, narcotics, analgesics); or

(b) For post-operative pain, the following information:

(i) An attestation that treatment lasting no longer than thirty days is needed for acute pain following surgery; and

(ii) The date of surgery.

(3) Payment may be made for the purchase of a TENS unit if the prescriber attests to the medical necessity of continued treatment.

(4) After a TENS unit has been purchased for an individual, regardless of payment source, separate payment may be made for necessary supplies, which must be dispensed only when they are needed, at a frequency not to exceed once per month. The payment made for supplies is an all-inclusive lump sum and does not depend on the number or nature of items in a particular shipment. No separate payment is allowed for individual supply items.

(5) After a TENS unit has been purchased, no separate payment is allowed for accessories.

(D) Requirements, constraints, and limitations.

(1) A diagnosis of "chronic intractable pain" is not in itself sufficient to warrant coverage.

(2) Rental of a TENS unit to treat intractable, nerve-related pain is limited to four months.

(3) Rental of a TENS unit to treat post-operative pain is limited to a single thirty-day period and may not be extended.

(4) The warranty period for a purchased TENS unit is two years from the date of delivery.

(5) Payment may be made for the rental or purchase of a used TENS unit only if the particular unit was previously used by the individual for whom it is currently prescribed.

(6) Payment for a TENS unit does not indicate or imply coverage of a conductive TENS garment.

(7) Payment is limited to the maximum amount for a two-lead unit unless the provider obtains and maintains documentation in the individual's file establishing the medical necessity of a four-lead unit.

(8) The medical necessity of a TENS unit not purchased by the department must be established before payment is made for supplies or repair.

(E) Claim payment. The lump-sum payment for TENS supplies is twenty-five dollars.

Replaces: 5160-10-15

Effective:

Five Year Review (FYR) Dates:

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Certification

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Date

Promulgated Under:	119.03
Statutory Authority:	5164.02
Rule Amplifies:	5164.02
Prior Effective Dates:	04/04/1977, 12/21/1977, 12/30/1977, 01/01/1980, 03/01/1984, 05/01/1990, 06/20/1990 (Emer), 09/05/1990, 04/16/2007, 04/01/2012

5160-10-17 **DMEPOS: pneumatic compression devices and accessories.**

(A) Payment may be made directly to a provider for a pneumatic compression device or a related accessory only if the equipment and supplies are used to treat either lymphedema in the extremities or chronic venous insufficiency (CVI) with venous stasis ulcers. Accessories used for pneumatic compression of the chest or trunk are not covered. Before prescribing a pneumatic compression device, a practitioner must have found either that there was no significant improvement or that significant symptoms persisted when one of the following treatments was applied:

(1) For lymphedema in the extremities, four weeks of therapy involving the use of an appropriate compression bandage system or compression garment (either prefabricated or custom-fabricated), exercise, and elevation of the limb; or

(2) For CVI, six months of therapy involving the use of an appropriate compression bandage system or compression garment, appropriate wound dressings, exercise, and elevation of the limb.

(B) Payment may be made for the purchase of a pneumatic appliance. Payment may be made on a rental/purchase basis for a pneumatic compressor.

(C) The default form is the ODM 02929, "Certificate of Medical Necessity: Pneumatic Compression Devices and Accessories" (rev. 7/2018). The CMN must include the following information:

(1) A statement that previous treatment produced no significant improvement or that significant symptoms persisted;

(2) The date of the most recent evaluation;

(3) Identification by diagnosis code of the condition or conditions necessitating a pneumatic compression device;

(4) The expected length of time (expressed as the number of months or as 'lifetime') during which the individual will need the pneumatic compression device;

(5) A listing of symptoms observed, measurements taken, and any other data that serve to establish the severity of the condition or conditions;

(6) Specification of the pneumatic compression device and any accessories to be supplied;

(7) Documentation of the individual's clinical response to treatment during evaluation (including changes in measurement results);

(8) A brief summary of the treatment plan, including the pressure to be used, the frequency and duration of use, and a provisional monitoring schedule;

(9) An assessment of the individual's capacity for tolerating the prescribed treatment; and

(10) A statement about the ability of the individual (or someone authorized to assist the individual) to use the device correctly and consistently.

(D) The initial rental of a pneumatic compression device starts a trial period of at least thirty days and not more than ninety days. If the prescriber determines during this trial period that the device satisfactorily meets the individual's needs, then the provider may obtain a revised CMN during the trial period. Unless the expected length of need is so short that additional rental would cost less than purchase, the revised CMN will automatically be considered to support purchase of the device.

Replaces: 5160-10-04

Effective:

Five Year Review (FYR) Dates:

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Certification

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Date

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Statutory Authority:	5164.02
Rule Amplifies:	5164.02
Prior Effective Dates:	01/07/2010

5160-10-18 **DMEPOS: hospital beds, bed accessories, and pressure-reducing support surfaces.**

(A) Definitions and explanations.

(1) "Group 1," "group 2," and "group 3" are classes of pressure-reducing support surface.

(a) Group 1 surfaces are generally non-powered pads or overlays that are designed to be placed on top of a hospital bed or standard mattress. They achieve their effect through the application of, for example, a gel layer, air pressure, natural lamb's wool, or synthetic sheepskin. Group 1 may also include some powered systems (alternating pressure or low air loss) that are not classified as group 2.

(b) Group 2 surfaces generally encompass powered air flotation beds, powered air mattresses, and non-powered advanced overlays that are designed to be placed on top of a hospital bed frame or standard bed frame.

(c) Group 3 surfaces are generally air-fluidized beds, which simulate the characteristics of fluid by circulating air through a medium such as silicone-coated ceramic beads. They are used for the treatment of stage III or stage IV pressure sores.

(2) "Stage I," "stage II," "stage III," and "stage IV" are classes of tissue breakdown associated with pressure sores.

(a) Stage I is characterized by erythema (redness lasting at least fifteen minutes after pressure is removed), warmth, tenderness, and sometimes blistering. The affected area is usually located over a bony prominence. Further breakdown may be occurring if erythema fails to dissipate when pressure is removed; however, stage I is usually considered a transient circulatory disturbance, and the affected area generally returns to normal within twenty-four hours.

(b) Stage II involves actual tissue damage and appears as a shallow, open ulcer with a red or pink wound bed without slough or as an intact or ruptured serum-filled blister. It is characterized by a distinct break in epidermal integrity (which may extend into the dermis), erythema, disturbance in skin temperature, tenderness, local swelling or edema, and sometimes drainage. (This stage should not be confused with skin tears, tape burns,

perineal dermatitis, maceration, or excoriation.) Stage II tissue damage generally heals quickly and easily.

(c) Stage III is characterized by epidermal and dermal destruction that penetrates subcutaneous tissue, infection, cellulitis, eschar, pain, and drainage. Subcutaneous fat may be visible; however, bone, tendon, and muscle are not exposed. Slough may be present but does not obscure the depth of tissue loss. There may be undermining and tunneling of surrounding subcutaneous tissue. With proper attention under optimal conditions, a stage III wound can heal in two to four weeks.

(d) Stage IV is characterized by destruction of the epidermis and dermis, penetration of the deep subcutaneous layers, exposure of subcutaneous structures, destruction of muscle or bone, and possible undermining of surrounding subcutaneous tissue. Slough or eschar may be present.

(B) Coverage of hospital beds.

(1) Payment may be made for a hospital bed on a rental/purchase basis.

(2) The default certificate of medical necessity (CMN) form is the ODM 02910, "Certificate of Medical Necessity: Hospital Beds and Bed Accessories" (rev. 7/2018). The CMN must include an attestation that at least one of the following criteria is met:

(a) The individual's condition (e.g., congestive heart failure, chronic obstructive pulmonary disease, problems with aspiration, disease aggravated by excessive body weight) necessitates elevation of the head or upper body to at least thirty degrees, and such elevation cannot be achieved with pillows or wedges in a standard bed;

(b) The individual uses or will use traction equipment that can be attached only to a hospital bed;

(c) The individual needs additional height or support for safe transfer to a chair, wheelchair, or standing position; or

(d) The elevating functions of a hospital bed will facilitate frequent intervention by an assistant or caregiver to alleviate pain or prevent pressure sores.

(3) Documentation of medical necessity must be submitted for any additional feature that is requested (e.g., powered elevation, powered height adjustment, heavy-duty or extra-heavy-duty construction, extra width).

(a) A heavy-duty hospital bed may be indicated for an individual weighing more than three hundred fifty pounds.

(b) An extra-heavy-duty hospital bed may be indicated for an individual weighing more than six hundred pounds.

(C) Coverage of bed accessories.

(1) Payment for the rental or purchase of a bed accessory (e.g., trapeze, side rail, replacement mattress) does not require PA. The provider, however, must keep on file a completed CMN. The default form is the ODM 02910.

(2) If an accessory is to be used with a hospital bed, then the medical necessity of the hospital bed must also have been established.

(D) Coverage of pressure-reducing support surfaces.

(1) The default CMN form is the ODM 02904, "Certificate of Medical Necessity: Pressure-Reducing Support Surfaces" (rev. 7/2018).

(2) For a group 1 surface, the CMN must include an attestation that at least one of the following criteria is met:

(a) The individual cannot make changes in body position without assistance;

(b) The individual cannot independently make changes in body position sufficient to alleviate pressure;

(c) The individual has a pressure sore (of any stage) on the trunk or pelvis; or

(d) The individual's circulation is compromised.

(3) For a group 2 surface, the CMN must include the following information:

(a) If the individual underwent a surgical procedure involving the closure of a wound with a skin graft or skin flap within the thirty days preceding placement of the surface, an attestation to the surgery;

(b) An attestation that at least one of the following criteria is met:

(i) The individual has a stage III or stage IV pressure sore on the trunk;

(ii) The individual has multiple stage II wounds;

(iii) The individual has third-degree burns (irrespective of whether grafting has been performed); or

(iv) Within the sixty days preceding submission of the PA request or placement of the surface, the individual underwent a surgical procedure involving the closure of a wound with a skin graft or skin flap; and

(c) A description of the treatment protocol.

(4) For a group 3 surface, the following information must be included on the CMN directly or by attachment:

(a) An attestation that the individual is being treated for a stage III or stage IV wound;

(b) A detailed description of the wound, prepared by a qualified health practitioner within the twenty-one days preceding placement of the surface, that specifies location, length, width, depth, and overall appearance and characteristics;

(c) A record of the individual's body weight taken intermittently over a period of at least sixty days preceding placement of the surface;

(d) The results of blood tests (which must have been performed within the twenty-one days preceding placement of the surface), including the following levels:

(i) Serum protein;

(ii) Serum albumin or prealbumin;

(iii) Hemoglobin; and

(iv) Hematocrit; and

(e) A current, comprehensive nutritional assessment of the individual, performed by a registered dietitian or licensed dietitian.

(5) The department may determine the length of an initial rental period and any subsequent rental periods.

(E) Requirements, constraints, and limitations.

(1) A bed does not qualify as a hospital bed if it has no elevating function or if its elevating function is not needed.

(2) PA of payment for a group 3 support surface may be denied if its use is contraindicated by factors such as but not limited to the following examples:

(a) Treatment protocols that involve significant quantities of moisture;

(b) Inability of the individual or an assistant to operate the equipment safely;

(c) Inadequate structure to support the weight of the equipment; or

(d) Insufficient electrical supply.

Replaces: 5160-10-18

Effective:

Five Year Review (FYR) Dates:

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Certification

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Date

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Prior Effective Dates:	05/01/1990, 02/17/1991, 12/30/1991, 12/29/1995 (Emer), 03/21/1996, 01/01/2000, 10/01/2004, 04/09/2009

5160-10-19 **DMEPOS: positive airway pressure devices.**

(A) Definition. "Apnea-hypopnea index (AHI)" is the mean number of episodes of apnea or hypopnea per hour recorded over a period of at least two hours without the use of a positive airway pressure device, reported by polysomnogram. The AHI may not be extrapolated or projected.

(B) Coverage.

(1) The default certificate of medical necessity (CMN) form is the ODM 01903, "Certificate of Medical Necessity: Positive Airway Pressure Devices" (rev. 7/2018). The CMN must include the following information:

(a) A diagnosis of obstructive sleep apnea;

(b) The results of a sleep study comprising components for diagnosis and titration, performed either separately as two studies or consecutively as a split study; and

(c) An estimated length of need.

(2) Payment for a positive airway pressure device may be made only if the following criteria are met:

(a) The diagnosis component of the sleep study, performed during at least two hours of recorded sleep without a positive airway pressure device, yields the following results:

(i) An AHI of at least fifteen; or

(ii) An AHI of at least five coupled with documented evidence of any of the following conditions:

(a) Excessive sleepiness during waking hours;

(b) Insomnia;

(c) Mood disorder;

(d) Impaired cognition;

(e) Hypertension;

(f) Ischemic heart disease; or

(g) A history of stroke.

(b) The titration component of the sleep study, performed with a positive airway pressure device, yields the following results:

(i) A decrease in the number of airway obstructions per hour; and

(ii) At least one of the following indications of effectiveness:

(a) An absolute increase in oxygen saturation to at least eighty-nine per cent;

(b) A relative increase in oxygen saturation of at least fifteen per cent; or

(c) Other clinical improvement recognized by the department.

(3) Payment for a variable or bilevel positive airway pressure device (i.e., a positive airway pressure device that produces different inspiratory and expiratory pressure levels) may be made only if the following criteria are met:

(a) A positive airway pressure device that produces a single pressure level has been tried and found to be ineffective; and

(b) Evidence gathered during the titration component of the sleep study or during a one-week trial period indicates that a variable or bilevel positive airway pressure device is effective.

(4) A need for oxygen is established if a positive airway pressure device is effective during a sleep study only when supplemental oxygen is administered simultaneously. That need for oxygen is presumed to last as long as the need for the positive airway pressure device, and no further sleep study is required to confirm a continued need for oxygen.

(C) Constraint. The provider of a positive airway pressure device may not perform the qualifying sleep study.

Replaces: Part of 5160-10-22

Effective:

Five Year Review (FYR) Dates:

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Certification

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Date

Promulgated Under:	119.03
Statutory Authority:	5164.02
Rule Amplifies:	5164.02
Prior Effective Dates:	12/30/1991, 07/01/1993, 07/01/1994, 01/01/1995, 08/01/1998, 10/01/2004, 01/01/2008

5160-10-21 **DMEPOS: incontinence garments and related supplies.**

(A) Coverage.

(1) The default certificate of medical necessity (CMN) is the ODM 02912, "Certificate of Medical Necessity: Incontinence Items" (rev. 7/2018). The CMN must include the following elements:

(a) An indication that the individual is at least thirty-six months of age;

(b) The applicable diagnosis of the specific disease, injury, developmental delay, or developmental disability causing the incontinence;

(c) The type of incontinence; and

(d) The type and quantity of incontinence garments or incontinence supplies being prescribed.

(2) Payment cannot be made for items related to stress incontinence to which no specific physiological, psychological, or physiopsychological cause can be attributed.

(3) A certification period cannot exceed twelve months.

(4) A new certification is required for an increase in the quantity of an incontinence item already prescribed or for a change in the type of incontinence item. (No new certification is needed for a decrease in quantity.)

(B) Requirements, constraints, and limitations.

(1) Incontinence items are dispensed in quantities representing one month's supply. A provider must not dispense additional incontinence items to an individual who already has at least a month's supply on hand. Before dispensing additional items, therefore, providers must make contact, either orally or in writing, with each individual (or the individual's authorized representative) to verify the current need. Providers must keep on file a summary of this contact, including in particular the following information:

(a) The quantity of items requested;

(b) The quantity of items currently on hand;

(c) The verification date, which must not be more than fourteen days before the dispensing date;

(d) The full name of the provider's representative who recorded the quantities reported; and

(e) The full name of the person (the individual or the individual's authorized representative) who reported the quantities.

(2) Payment will not be made for an incontinence item in excess of the quantity prescribed.

Replaces: 5160-10-21

Effective:

Five Year Review (FYR) Dates:

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Certification

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Date

Promulgated Under:	119.03
Statutory Authority:	5164.02
Rule Amplifies:	5164.02
Prior Effective Dates:	05/01/1990, 09/01/1998, 10/01/2004, 04/25/2011

5160-10-22 **DMEPOS: ventilators.**

(A) Provider requirement. A provider of ventilators for use in the home must make available a licensed respiratory care professional (LRCP) twenty-four hours a day to provide respiratory care, technical support, and clinical ventilator services and to perform emergency servicing of equipment on two-hour notice.

(B) Coverage.

(1) Separate payment may be made for a ventilator furnished to a resident of a long-term care facility (LTCF).

(2) Payment may be made for a ventilator on a rental basis only. The default certificate of medical necessity (CMN) form is the ODM 01902, "Certificate of Medical Necessity: Ventilators" (rev. 7/2018).

(3) For the rental of a primary ventilator, the CMN must include the following information:

(a) Diagnosis;

(b) Specification of the condition or conditions for which ventilatory support is needed;

(c) An estimated length of need;

(d) The continuity of ventilatory support required (e.g., constant, during the day, at night, for sleep only);

(e) The ventilator type, mode, and settings or parameters;

(f) A list of other respiratory equipment in use; and

(g) If applicable, documentation showing that the individual is being weaned.

(4) For the rental of a secondary or back-up ventilator, the CMN must include appropriate attestation to at least one of the following statements:

(a) The individual cannot maintain spontaneous respiration for at least four hours;

(b) Because of regular activities outside the home (e.g., school, outpatient therapy), the individual needs a second ventilator with a suitable power source; or

(c) The average emergency medical team response time to the individual's address is estimated to be more than two hours.

(C) Requirements, constraints, and limitations.

(1) A ventilator with an invasive interface must include backup power capability and alarms indicating disconnection, high pressure, low pressure, and power loss.

(2) Rental of a ventilator includes the following items and services:

(a) Ventilator accessories, including inlet ventilator filters, permanent or reusable ventilator circuits, whisper swivels, exhalation ports, tracheostomy tube elbows, and circuit extensions and adapters;

(b) A humidifier, either heated or unheated;

(c) Humidifier bacteria filters;

(d) Tubing to connect the humidifier to the ventilator;

(e) Evaluation of the individual's residence to ensure compatibility with the equipment and to forestall problems with its use; and

(f) Visits made at an appropriate frequency determined by a LRCP in consultation with the individual's prescribing practitioner, at least one visit during the first week, not less often than once per month for the first six months, and not less often than every sixty days thereafter.

(3) No separate payment is made to a provider for keeping a LRCP on call or for performing emergency servicing of equipment.

Replaces: Part of 5160-10-22

Effective:

Five Year Review (FYR) Dates:

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Certification

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Date

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Statutory Authority:	5164.02
Rule Amplifies:	5164.02, 5165.47
Prior Effective Dates:	12/30/1991, 07/01/1993, 07/01/1994, 01/01/1995, 08/01/1998, 10/01/2004, 01/01/2008

5160-10-23 **DMEPOS: pulse oximeters.**

(A) Coverage.

(1) Any pulse oximeter for which payment is made must meet the following criteria:

(a) It is correctly calibrated, preset, and sealed such that its settings cannot be adjusted by the average user; and

(b) It is capable either of converting data (e.g., number of sampling hours, oxygen saturation level, aggregated results) directly to electronic or printed form or of recording and storing data for later conversion.

(2) Payment may be made for a pulse oximeter on a rental/purchase basis. The default certificate of medical necessity (CMN) form is the ODM 03401, "Certificate of Medical Necessity: Pulse Oximeters" (rev. 7/2018). The CMN must include an attestation by a prescriber that a need exists either for diagnostic monitoring or for continuous monitoring:

(a) For diagnostic monitoring undertaken in response to an acute clinical event or the exacerbation of an existing condition, the prescriber includes the following information:

(i) An attestation that at least one of the following two criteria has been met:

(a) The individual was currently being weaned or was about to be weaned from an oxygen supply; or

(b) The individual was oxygen-dependent and was in a clinically unstable condition; and

(ii) Any previously recorded oximeter data accompanied by an assessment of the resulting impact on the management of the individual's care.

(b) For continuous monitoring twenty-four hours per day, the prescriber attests to three statements:

(i) The individual exhibits clinical instability (evidenced by chronically compromised respiration and frequently varying oxygen requirements);

(ii) The individual is at risk for critical fluctuations in oxygen saturation (e.g., hyperoxia, hypoxia), and

(iii) At least one of the following conditions is present:

(a) Frequent bradycardia;

(b) Frequent oxygen desaturation;

(c) Chronic lung disease;

(d) Ventilator-dependency;

(e) Poor growth and development suggesting inadequate oxygenation; or

(f) Another specific risk factor that causes sudden, critical fluctuations in oxygen saturation.

(3) The rental or purchase of a pulse oximeter includes the following items and services:

(a) Service calls;

(b) Supplies and accessories (e.g., cable, printer, printer tape, carrying case); and

(c) Probe wraps or tape.

(4) Separate payment may be made for probes.

(B) Requirements, constraints, and limitations.

(1) It is understood that because of the nature of diagnostic monitoring, authorization for payment can generally be granted only after the service has been provided.

(2) No single rental period can be longer than three months.

Replaces: 5160-10-23

Effective:

Five Year Review (FYR) Dates:

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Certification

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Date

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Rule Amplifies:	5164.02
Prior Effective Dates:	07/01/1993, 04/16/2007

5160-10-24 **DMEPOS: speech-generating devices.**

(A) Coverage.

(1) Separate payment may be made for a speech-generating device (SGD) furnished to a resident of a long-term care facility (LTCF).

(2) The default certificate of medical necessity (CMN) form is the ODM 02924, "Certificate of Medical Necessity: Speech-Generating Devices" (rev. 7/2018). The CMN must include the following elements:

(a) A formal, written report of a face-to-face evaluation of the individual's communication abilities performed by a speech-language pathologist (SLP);

(b) Exact specifications for a SGD and the rationale for selection;

(c) Clinical documentation that the individual's cognitive and physical abilities will enable effective use of the specified SGD;

(d) Full disclosure of any SGD equipment currently in the individual's possession and an explanation of why that equipment does not meet the individual's needs;

(e) Documentation of the medical necessity of any accessory or add-on equipment, supplies, or SGD features being requested; and

(f) An explanation of the necessity or functional benefit of any requested upgrade, modification, or replacement.

(3) The formal, written evaluation report must include all of the following components:

(a) A description of the individual's current communication impairment, including the type, severity, and prognosis;

(b) An assessment of the individual's speech skills and capacity for receptive and expressive language;

(c) An explanation of how the individual's cognition, emotions, physical abilities, and behaviors affect the communication of basic needs;

(d) Identification of the persons with whom the individual communicates most frequently and any associated limitations and needs;

(e) Identification of the environments in which the individual communicates most frequently (including vocational and educational settings);

(f) A description of the types of messages the individual generally needs to convey and the range of vocabulary used;

(g) An assessment of the extent to which the individual's daily communication needs could be met by a SGD incorporating less complex technology or by a means of communication other than a SGD;

(h) A description of the functional communication goals expected to be achieved with a SGD;

(i) Recommendations for the following SGD features and functions:

(i) Representational systems (symbols);

(ii) Vocabulary encoding (e.g., icon, level-plus-location, traditional orthography);

(iii) Vocabulary expandability and message generation (e.g., programmed or programmable words or parts of sentences, additional memory);

(iv) Rate-enhancement techniques (e.g., simple symbol selection, symbol sequencing, key linking, dynamic display, abbreviation-expansion, word lists, word prediction, icon prediction, macros);

(v) Access techniques and strategies;

(vi) Keyboard organization (e.g., key size and spacing, overlay size and number, key guard);

(vii) Device output modes (e.g., speech synthesis, printed output, character display, auditory and visual prompting, auditory and visual feedback); and

(viii) Portability;

(j) A description of a comprehensive treatment plan that includes a training schedule for the selected SGD; and

(k) The signature and license number of the SLP and any other member of the evaluation team.

(4) Payment will not be made for a SGD until a trial period of at least four weeks has been completed, during which the prescriber determines that the device satisfactorily meets the individual's needs. If the device does not meet the individual's needs, then the provider may choose to submit a request for payment of one month's rental.

(5) The department will consider coverage of SGDs in any of several forms, including but not limited to the following examples:

(a) A standalone unit running dedicated, proprietary software;

(b) Commercially available software and, if necessary, hardware to run it (e.g., a portable or tablet computer);

(c) A software application that may be loaded onto devices already owned by an individual; or

(d) A combination of components that provides functionality for the user.

(6) Separate payment may be made for the following items and services:

(a) A face-to-face evaluation performed by a SLP;

(b) Mounting brackets for installation of a SGD on an individual's wheelchair; and

(c) An adaptive interface or other accessory if the evaluating SLP provides documentation that the item is necessary for the independent use of a SGD by a particular individual.

(7) Payment for the upgrade, modification, or replacement of a fully functional SGD during its useful life may be made only if the SGD no longer meets the individual's basic communication needs. (In the appendix to rule 5160-10-01 of the Administrative Code, the useful life of a SGD is expressed as a limit or frequency.)

(a) Replacement during the useful life of a SGD will be considered only when it is more cost-effective than modification.

(b) Repair does not extend the useful life of a SGD.

(B) Requirements, constraints, and limitations.

(1) Payment may be made only for the type of SGD used by an individual during a trial period. No item can be substituted for one that has been explicitly prescribed.

(2) Payment for a SGD includes the following items and services:

(a) Supplies, equipment (e.g., interface, printer, cables, adapters, connectors), and any standard component or requested accessory that is dispensed with a SGD; and

(b) All professional, technical, and administrative services performed by the provider in relation to a SGD.

(3) No separate payment will be made for the following items:

(a) A second SGD used concurrently by an individual; and

(b) Additional software, applications, accessories, components, peripheral devices, or pieces of hardware that are not related to the main purpose of the SGD.

(C) Claim payment.

(1) The payment amount for a portable/tablet computer with software, for portable/tablet computer software, or for an accessory (e.g., mounting bracket, adaptive interface) is determined through the prior authorization (PA) process.

(2) Payment for a face-to-face evaluation is the lesser of the submitted charge or the amount listed in appendix DD to rule 5160-1-60 of the Administrative Code.

Replaces: 5160-10-24

Effective:

Five Year Review (FYR) Dates:

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Date

Promulgated Under:	119.03
Statutory Authority:	5164.02
Rule Amplifies:	5164.02
Prior Effective Dates:	09/10/1993, 12/10/1993, 12/29/1995 (Emer), 03/21/1996, 10/01/2004, 05/01/2012

5160-10-25 **DMEPOS: lactation pumps.**

(A) Definitions and explanations.

(1) "Multiple-user lactation pump" is a lactation pump that is safe for use by multiple individuals; it comes with a separate set of accessories (e.g., breast shields, tubing) for each individual, which reduces the risk of contamination. Such a pump is sometimes referred to as "hospital-grade," but this term is not recognized by the United States food and drug administration. A multiple-user lactation pump is characterized, but not defined, by the following capabilities:

(a) Adjustable suction pressure from one hundred to two hundred fifty millimeters of mercury (mm Hg);

(b) A mechanism to prevent suction greater than two hundred fifty mm Hg; and

(c) An adjustable pumping speed capable of reaching fifty-two cycles per minute.

(2) The prescriber of a lactation pump may be involved in the care of the individual woman, of the infant, or of both.

(B) Coverage.

(1) Payment may be made for the purchase of a single-user manual or electric lactation pump as a medical supply item or for the rental of a multiple-user lactation pump for a period of ninety days.

(2) The default certificate of medical necessity (CMN) form is the ODM 01901, "Certificate of Medical Necessity: Lactation Pumps" (rev. 7/2018). The CMN must include an attestation to at least one of the following statements of need:

(a) The infant is unable to initiate breastfeeding because of a medical condition (e.g., prematurity, oral defect);

(b) Breastfeeding is not possible because the woman and the infant are separated;

(c) The woman is or will be taking a medication or undergoing a diagnostic test that contraindicates breastfeeding;

(d) The milk supply is inadequate for breastfeeding;

(e) The breasts are engorged; or

(f) Infection of the breast is present.

(3) After the initial rental period, payment may be made for additional rental of a multiple-user lactation pump. The additional rental period is limited to ninety days; overall rental cannot exceed one hundred eighty days. During the initial rental period, the provider must obtain a revised copy of the previously completed CMN, on which the prescriber includes the following information:

(a) A description, including approximate age and ownership, of any similar equipment currently in the individual's possession;

(b) An explanation of why additional rental of the multiple-user lactation pump is warranted; and

(c) The length of the additional rental period.

(C) Requirements, constraints, and limitations.

(1) The warranty period for a covered manual or electric lactation pump is one year from the date of delivery.

(2) When a manual lactation pump is supplied as part of a pump accessory kit, separate payment will not be made for the manual lactation pump, nor will separate payment be made for an additional manual lactation pump.

(3) Separate payment will not be made for more than one set of accessories nor for cleaning of a rental unit. Replacement of a lost or damaged accessory or payment of a reasonable charge for extensive cleaning (if a unit is returned in unusable condition) is the responsibility of the individual.

Replaces: 5160-10-25

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Five Year Review (FYR) Dates:

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Promulgated Under:	119.03
Statutory Authority:	5164.02
Rule Amplifies:	5164.02
Prior Effective Dates:	09/01/2005, 04/25/2011

5160-10-27 **DMEPOS: continuous passive motion (CPM) devices.**

(A) Coverage.

(1) Payment may be made for the rental of a continuous passive motion (CPM) device to be used in a personal residence, beginning within forty-eight hours after total knee replacement surgery or the surgical revision of a total knee replacement, for a period not to exceed twenty-one days. The prescription for the device must indicate the first date and last date of use.

(2) Separate payment may be made for the purchase of one complete set of accessories (e.g., pads, straps, hook-and-loop closures) if the individual does not already have such accessories as a result of previous use of a CPM device.

(B) Requirements, constraints, and limitations. No payment is made for a CPM device in any of the following circumstances:

(1) The device is used on a joint other than the knee;

(2) The device is used as a substitute for conventional physical therapy; or

(3) Neither the individual nor anyone assisting the individual is able to operate the device or is willing to follow the necessary post-surgery rehabilitation regimen.

Replaces: 5160-10-27

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Five Year Review (FYR) Dates:

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Date

Promulgated Under:	119.03
Statutory Authority:	5164.02
Rule Amplifies:	5164.02
Prior Effective Dates:	04/01/2006, 04/25/2011

5160-10-28 **DMEPOS: osteogenesis stimulators.**

(A) Coverage.

(1) Payment may be made for the purchase only of a noninvasive osteogenesis stimulator.

(2) The default certificate of medical necessity (CMN) form is the ODM 07134, "Certificate of Medical Necessity: Osteogenesis Stimulators" (rev. 7/2018). The CMN must include an attestation that appropriate coverage criteria are met.

(3) Payment may be made for a spinal electrical osteogenesis stimulator only if at least one of the following criteria is met:

(a) The individual has undergone multilevel spinal fusion surgery;

(b) The individual has undergone spinal fusion surgery that has failed, and at least nine months have elapsed since the most recent operation; or

(c) The individual has undergone spinal fusion surgery, and previous attempts at spinal fusion at the same site have failed.

(4) Payment may be made for a non-spinal electrical osteogenesis stimulator only if at least one of the following criteria is met:

(a) The fracture is in a long bone and has failed to unite for at least three months, which the provider substantiates with the following documentation:

(i) At least two sets of images including multiple views of the fracture site, the first and last of which were taken at least ninety days apart; and

(ii) A written statement by a qualified interpreting practitioner that there has been no clinically significant evidence of fracture healing during the period when the images were taken.

(b) The individual has congenital pseudarthrosis; or

(c) The individual has undergone joint fusion surgery that has failed, and at least nine months have elapsed since the most recent operation.

(5) Payment may be made for an ultrasonic osteogenesis stimulator only if all of the following criteria are met:

(a) The fracture is in a long bone;

(b) The fracture is not tumor-related; and

(c) The fracture has failed to unite for at least three months, which the provider substantiates with the following documentation:

(i) At least two sets of images including multiple views of the fracture site, the first and last of which were taken at least ninety days apart; and

(ii) A written statement by a qualified interpreting practitioner that there has been no clinically significant evidence of fracture healing during the period when the images were taken.

(6) Payment may be made for either an electrical or an ultrasonic osteogenesis stimulator for an individual who is younger than twenty-one years of age only if all of the following additional criteria are also met:

(a) There is radiological documentation that skeletal maturity has been attained;

(b) The fracture gap is not greater than one half of the diameter of the bone to be treated; and

(c) The fracture does not involve a vertebra.

(B) Requirements, constraints, and limitations.

(1) Contraindications to treatment include but are not limited to the following examples:

(a) Fracture of a short bone, a flat bone, or an epiphysis;

(b) Fracture that results from cancer;

(c) Fracture that needs additional reduction or is comminuted;

(d) Fracture with post-reduction displacement of greater than fifty per cent;

(e) Fracture with internal or external fixation;

(f) Fracture gap greater than one centimeter or greater than one half of the diameter of the bone;

(g) Avascularity, vascular insufficiency, or other vascular problems (e.g., thrombophlebitis);

(h) Severe osteoporosis;

(i) The taking of medication that may interfere with or alter bone metabolism and healing;

(j) Infection or necrosis in the bone;

(k) Paget's disease, renal disease, or diabetes;

(l) Sensory paralysis; or

(m) Synovial pseudarthrosis.

(2) Payment will not knowingly be made for an electrical osteogenesis stimulator used in proximity to vital equipment, such as a pacemaker, that may be adversely affected by changes in electromagnetic fields.

(3) Separate payment will not be made for the concurrent use of more than one osteogenesis stimulator on the same fracture site.

Replaces: 5160-10-28

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Five Year Review (FYR) Dates:

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Date

Promulgated Under:	119.03
Statutory Authority:	5164.02
Rule Amplifies:	5164.02
Prior Effective Dates:	10/15/2006

5160-10-29 **DMEPOS: insulin pumps.**

(A) Definitions.

(1) "Sensor-augmented insulin pump system" is an insulin infusion pump equipped with a continuous glucose monitoring (CGM) sensor. The pump uses the glucose readings taken by the CGM sensor to modify the amount of insulin infused.

(2) "Insulin pump," for purposes of this rule, is a collective term encompassing a portable external insulin infusion pump and a sensor-augmented insulin pump system.

(B) Coverage.

(1) Payment may be made for a portable external insulin infusion pump on a rental/purchase basis. The initial rental period is limited to three months.

(2) The default certificate of medical necessity (CMN) form is the ODM 07136, "Certificate of Medical Necessity: Insulin Pumps" (rev. 7/2018). The CMN must include an attestation that appropriate documentation is kept in the individual's medical record to demonstrate that the following criteria are met:

(a) The individual has type 1 diabetes mellitus;

(b) The individual has at least one of the following symptoms or conditions:

(i) Glycated hemoglobin level (HbA1c) greater than seven per cent;

(ii) A history of recurring hypoglycemia;

(iii) Wide fluctuations in blood glucose before mealtime;

(iv) A marked early-morning increase in fasting blood sugar (the "dawn phenomenon"), in which the glucose level frequently exceeds two hundred milligrams per deciliter; or

(v) A history of severe glycemic excursions;

(c) The individual has completed a diabetes education program within the preceding twenty-four months;

(d) The individual has been on a maintenance program for at least six months involving at least three injections of insulin per day and frequent self-adjustments of insulin dosage;

(e) The individual has performed glucose self-testing at least four times per day on average during the preceding month; and

(f) The individual is at high risk for preventable complications of diabetes, early signs of which include micro-albuminuria and persistent difficulty in controlling blood sugar levels despite good compliance with an intensive multiple-injection regimen.

(3) After the first three months, payment may be made for the purchase of an insulin pump. During the initial rental period, the provider must obtain a revised copy of the previously completed CMN, on which the prescriber attests that the individual (or someone assisting the individual) is capable of managing the pump and that the desired improvement in metabolic control can be achieved.

(C) Requirements, constraints, and limitations.

(1) The use of an insulin pump is contraindicated by any of the following conditions or circumstances:

(a) The individual has type 2 (non-insulin-dependent) diabetes mellitus, either treated or not treated with insulin;

(b) The individual has end-stage complications such as renal failure; or

(c) Neither the individual nor anyone assisting the individual is able to operate a pump or to perform frequent blood glucose monitoring.

(2) The following insulin-delivery devices are not covered:

(a) A portable external insulin infusion pump that is requested purely as a matter of convenience or individual preference;

(b) Surgically implanted infusion devices or systems;

(c) Jet pressure devices;

(d) Devices associated with chronic intermittent intravenous insulin therapy (CIIIT), or

(e) Devices associated with pulsatile intravenous insulin therapy (PIVIT).

(3) The warranty period for a covered insulin pump is at least one year from the date of purchase authorization.

(4) No payment may be made for the purchase of an insulin pump that has been previously used by another individual.

Replaces: 5160-10-29

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Date

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Statutory Authority:	5164.02
Rule Amplifies:	5164.02
Prior Effective Dates:	10/15/2006, 08/18/2008

5160-10-30 **DMEPOS: ambulation aids.**

(A) Definitions.

(1) "Ambulation aid" is a collective term for a cane, crutch, or walker.

(2) "Ambulatory limitation" is an impediment to walking that has either of two effects:

(a) It prevents an individual from completing activities of daily living within a reasonable time (or at all); or

(b) It places an individual at a demonstrably higher risk of injury, exacerbation of illness, or death when activities of daily living are performed.

(B) Coverage.

(1) Payment may be made for a covered ambulation aid if all of the following criteria are met:

(a) The individual has an ambulatory limitation that is documented in the individual's medical record;

(b) The ambulation aid has been prescribed by a qualified practitioner;

(c) The individual is able to use the ambulation aid safely; and

(d) The ambulation aid reduces the ambulatory limitation enough to permit the individual to complete activities of daily living in a reasonable amount of time and with a reasonable degree of safety.

(2) Additional coverage criteria are specific to particular ambulation aids:

(a) For a heavy-duty walker, the individual weighs at least three hundred pounds.

(b) For a heavy-duty walker with multiple braking system and variable wheel resistance (a four-wheeled walker having at least two wheels with hand-operated brakes that can be independently adjusted and lock the wheels when either or both hand levers are released), the individual both weighs at least three hundred pounds and is unable to use a standard heavy-duty walker because the use of one hand is restricted.

(c) For an enclosed-frame walker, the prescriber describes and attests in

writing to the medical necessity, and the provider keeps a copy of this document in the individual's file.

(d) For a trunk-support walker, the prescriber describes and attests in writing to the medical necessity, and the provider keeps a copy of this document in the individual's file.

(e) For walker leg extensions, the individual stands at least six feet tall.

Replaces: 5160-10-30

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Date

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Statutory Authority:	5164.02
Rule Amplifies:	5164.02
Prior Effective Dates:	08/17/2009

5160-10-31 **DMEPOS: footwear and foot orthoses.**

(A) Orthopedic shoes.

(1) Payment may be made for an orthopedic shoe only if at least one of the following conditions is met:

(a) The shoe is an integral part of an orthotic device (brace);

(b) The shoe has been molded specifically for the recipient;

(c) The shoe is one of a mismated pair;

(d) The shoe is used to treat talipes equino varus (club foot);

(e) For a recipient younger than eight years of age, the shoe is used independently of an orthotic device for one of the following purposes:

(i) Treatment of metatarsus adductus, femoral torsion, tibial torsion, vertical talus, fracture of a major bone, or osteochondrosis; or

(ii) Post-surgical control;

(f) For a recipient eight years of age or older, the shoe is used for treatment of moderate or severe peripheral neuropathy or peripheral arterial disease; or

(g) A modification or addition to the shoe is medically necessary and has been prescribed by a physician, an advanced practice registered nurse, or a physician assistant.

(2) Greater frequency of shoe replacement may be allowed for recipients younger than eight years of age. Payment for shoe replacement beyond an established frequency for recipients younger than twenty-one years of age requires prior authorization (PA).

(3) No payment is made for an orthopedic shoe that is to be worn over a prosthesis.

(4) Payment for a foot orthosis includes the acquisition (by casting or other means) of the model on which the orthosis is constructed.

(B) Specialized non-orthopedic shoes. Payment may be made for a specially constructed non-orthopedic shoe for a recipient younger than twenty-one years of age only if both of the following conditions are met:

(1) The shoe is to be worn over an orthotic device; and

(2) Commercially available shoes that fit over the orthotic device would be unacceptably long or otherwise ill-suited to ambulation.

(C) Therapeutic footwear for individuals with diabetes.

(1) The default certificate of medical necessity (CMN) form is the ODM 01912, "Certificate of Medical Necessity: Therapeutic Footwear for Individuals with Diabetes" (rev. 7/2018). The CMN must include an attestation that all of the following statements are true:

(a) The recipient has diabetes mellitus;

(b) The conditions of coverage are met;

(c) The prescriber is treating the recipient for diabetes under a comprehensive plan of care;

(d) Therapeutic footwear is medically necessary for the recipient because of diabetes; and

(e) All relevant information is documented in the recipient's medical record.

(2) Therapeutic footwear must be prescribed by a podiatrist or other qualified practitioner who manages the recipient's diabetes.

(3) Therapeutic footwear must be fitted and dispensed by a podiatrist, pedorthist, orthotist, or prosthetist.

(4) Payment may be made for therapeutic footwear (shoes, inserts, or shoe modifications) only if the recipient has diabetes mellitus and at least one of the following conditions is met:

(a) Either an entire foot or part of either foot has been amputated; or

(b) In either foot, the recipient has a history of ulceration, pre-ulcerative calluses, peripheral neuropathy with evidence of callus formation, foot deformity, or poor circulation.

(5) Payment may be made for a custom-molded shoe only if the recipient has a foot deformity that cannot be accommodated by a depth shoe. The nature and severity of the deformity must be well documented in the provider's records. If there is insufficient evidence of need for a custom-molded shoe, then

payment will be limited to the cost of the least expensive medically appropriate alternative.

(6) No payment is made for the following items:

(a) Inserts that are compression-molded to the foot over time by the heat and pressure of being worn inside a shoe;

(b) Inserts used in noncovered shoes; and

(c) Deluxe features.

(7) Payment for a therapeutic shoe includes fitting, necessary inserts, and any required modification. Separate payment may be made for inserts if the provider confirms in writing that the recipient has appropriate footwear meeting the industry definition of a depth or custom-molded shoe, into which the insert can be placed.

Replaces: 5160-10-12, 5160-10-31

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Prior Effective Dates:	04/07/1977, 12/21/1977, 12/30/1977, 01/01/1980, 03/01/1984, 10/01/1988, 02/17/1991, 12/30/1993 (Emer), 03/31/1994, 10/15/2006, 01/01/2007, 08/02/2011

5160-10-32 **DMEPOS: ostomy supplies and urological supplies.**

(A) Stoma maintenance supplies.

(1) Stoma maintenance supplies may be dispensed on a monthly basis.

(2) If more than one type of supply serve the same function, then payment may be made only for the dispensing of one type at a time (e.g., skin barrier applied as a liquid, in a spray, or with a wipe or swab; drainage management with a stoma cap, a stoma plug, or gauze pads).

(B) Urination aids.

(1) Indwelling catheters.

(a) Frequency limits imposed on catheter replacement may be exceeded without prior authorization (PA) for any of the following reasons:

(i) Accidental removal of a catheter;

(ii) Malfunction of a catheter;

(iii) Obstruction of a catheter by encrustation, mucus plug, or blood clot; or

(iv) A history of recurrent obstruction or infection, as a precaution against which the prescriber has specified more frequent changing of the catheter.

(b) Additional documentation of medical necessity is needed for either of the following items:

(i) A specialty indwelling catheter or all-silicone catheter used in lieu of a standard coated Foley catheter; or

(ii) A three-way indwelling catheter used either alone or with other components.

(c) Payment will not be made for more than one insertion tray per episode of indwelling catheter insertion.

(2) Supplies for intermittent irrigation of indwelling catheters.

(a) Payment may be made for either an irrigation tray or an irrigation syringe used on an as-needed basis to clear an obstruction from an indwelling catheter by irrigation.

(b) Payment may be made for sterile water or saline solution for irrigation. No additional payment is made if the irrigation solution contains acetic acid or hydrogen peroxide. No payment is made for an irrigation solution containing antibiotics or chemotherapeutic agents.

(c) No payment is made for supplies used for the irrigation of an indwelling catheter at predetermined intervals (routine irrigation).

(3) Supplies for continuous irrigation of indwelling catheters.

(a) Payment may be made for an irrigation tubing set, as well as for a three-way Foley catheter, if there is a history of catheter obstruction and catheter patency cannot be maintained by intermittent irrigation and necessary changing of the catheter. Payment will not be made for more than one irrigation tubing set per day.

(b) Payment may be made for sterile water or saline solution for irrigation. No additional payment is made if the irrigation solution contains acetic acid or hydrogen peroxide. No payment is made for an irrigation solution containing antibiotics or chemotherapeutic agents.

(c) No payment is made for supplies if continuous irrigation is used as a preventive measure.

(d) Additional documentation is needed to establish the medical necessity of continuous irrigation used instead of intermittent irrigation. This documentation must indicate the rate of administration and the duration of need.

(e) Additional documentation is needed to establish the medical necessity of continuous irrigation lasting more than two weeks.

(4) Intermittent catheters and related supplies.

(a) Payment may be made for a sterile intermittent catheter and related supplies (or a catheter kit) only if at least one of the following additional criteria is met:

(i) The individual is immunosuppressed;

(ii) The individual has neurogenic bladder dysfunction because of a spinal cord injury or defect and is currently pregnant;

(iii) The individual currently performs intermittent catheterization but has documented vesicoureteral reflux; or

(iv) The individual currently performs sterile intermittent catheterization and had at least two distinct urinary tract infections in the year before starting sterile intermittent catheterization.

(b) Payment will not be made for more than one kit containing an intermittent catheter with insertion supplies per episode of intermittent catheterization.

(c) Additional documentation is needed to establish the medical necessity of a coudé catheter used instead of a straight catheter. The use of a coudé catheter by a female is rarely necessary.

(5) External urinary collection devices.

(a) Payment may be made for a medically necessary external urinary collection device (e.g., a condom-style catheter for a male, a meatal cup or a pouch for a female) as an alternative to an indwelling catheter for an individual who has permanent urinary incontinence.

(b) Payment will not be made for the concurrent dispensing of both an external urinary collection device and an indwelling catheter.

(c) Additional documentation is needed to establish the medical necessity of a specialty external urinary collection device (e.g., an inflatable condom-style catheter, a pouch with a faceplate).

(d) Payment will not be made for more than one meatal cup per week or one pouch per day.

(6) Urinary drainage systems.

(a) Payment may be made for the routine changing of a urinary drainage system.

(b) Payment will not be made for the concurrent dispensing of a vinyl and a latex bag.

(c) Payment will not be made for leg bags for individuals who do not leave their bed.

(d) Payment will not be made for more than one type of leg bag or leg bag strap within a twelve-month period.

(7) Miscellaneous supplies.

(a) Payment may be made for cleaner for a urinary collection device or drainage system only if the individual is using the collection device or drainage system.

(b) Payment may be made for a medically necessary adhesive anchoring device used to secure an indwelling urethral catheter, a suprapubic catheter, or a nephrostomy tube.

(c) Payment may be made for a medically necessary leg strap used to secure an indwelling urethral catheter.

Replaces: 5160-10-32

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Prior Effective Dates:	08/17/2009, 08/02/2011

5160-10-33 **DMEPOS: commodes.**

(A) Payment may be made for a commode if both of the following criteria are met:

(1) A medical condition, documented in the individual's medical record, prevents the individual from accessing the toilet facilities of the individual's place of residence; and

(2) The commode has been prescribed by a qualified practitioner.

(B) Additional coverage criteria are specific to particular commodes, and the satisfaction of these criteria must be documented in the individual's medical record:

(1) For an extra-wide or heavy-duty commode, either the individual weighs at least three hundred pounds or, if the individual weighs less than three hundred pounds, the medical necessity of the commode is established in detail.

(2) For a commode with detachable arms, the individual has a documented functional need (such as extra open space for transferring to and from the commode).

(C) Payment will not be made for the concurrent dispensing of both a commode and a bedpan.

Replaces: 5160-10-33

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Date

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Rule Amplifies:	5164.02
Prior Effective Dates:	08/17/2009

5160-10-34 **DMEPOS: wound dressings and related supplies.**

(A) Coverage.

(1) Payment may be made for wound dressings and related supplies as long as medical necessity exists.

(2) Payment may be made for dressings placed over a percutaneous catheter or tube as long as the catheter or tube remains in place and after removal until the insertion point heals.

(3) Clinical indications, contraindications, and application guidelines for certain types of wound dressing are summarized in the appendix to this rule.

(B) Documentation.

(1) A prescription for a wound dressing or related supply must necessarily be based on an evaluation of the wound performed by a qualified health care provider. Frequent evaluation is expected if a wound is heavily draining or infected. The evaluation report must include wound type; wound location; wound length, width, and depth; the amount of drainage; and any other relevant clinical information. Any such report must be made available to the department on request.

(2) The provider must keep the prescription for dressings or related supplies on file. The prescription must include the following clinical information, which must not be more than one year old:

(a) The type and number of wounds;

(b) The type, size, and quantity of each dressing;

(c) The purpose of each dressing (e.g., primary or secondary covering for a surgical or debrided wound, wound cleansing);

(d) The quantity to be applied at one time (if more than one unit);

(e) The frequency of dressing change; and

(f) The expected duration of need.

(3) A prescription is valid for not longer than three months. A new prescription is required for the addition of a dressing or for an increase in the quantity of a dressing already prescribed. (No new prescription is needed for a decrease in quantity.)

(C) Requirements, constraints, and limitations.

(1) Providers should not dispense dressings that will be used together but have conflicting characteristics (e.g., a hydrating dressing with an absorptive dressing, a primary dressing that must be changed daily with a secondary dressing that needs to be changed less frequently).

(2) The use of more than one type of wound filler or more than one type of wound cover on a single wound is rarely medically necessary. (An additional, dry wound cover is not incompatible, however, with an alginate or other fiber-gelling dressing or saline-, water-, or hydrogel-impregnated gauze.)

(3) Providers must gauge the quantity of dressings actually being used by an individual and adjust the dispensing of dressings accordingly. Not more than one month's supply of dressings may be dispensed at one time.

(4) No payment is made for gauze impregnated with water or normal saline, because there is no medical necessity for it. Standard gauze may instead be moistened with bulk saline or sterile water.

Replaces: 5160-10-34

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Appendix to rule 5160-10-34

Wound Dressing or Related Supply	Coverage Indications or Customary Use	Usual Quantity per Dressing Change	Maximum Frequency of Change	Contraindications or Inappropriate Uses
Alginate or other fiber-gelling dressing	Cover: full-thickness wound (e.g., stage III or IV) with moderate to heavy exudate Filler: full-thickness wound cavity (e.g., stage III or IV) with moderate to heavy exudate	One wound cover sheet of the approximate size of the wound or up to two units of wound filler (one unit = 6 inches)	Once per day	Dry wounds or wounds covered with eschar Use in combination with hydrogels
Composite dressing		One wound cover	Three times per week	
Contact layer dressing	Lining of a wound		Once per week	More frequent change along with other dressing changes
Foam dressing	Full-thickness wound (e.g., stage III or IV) with moderate to heavy exudate		Cover used as primary dressing: three times per week Cover used as secondary dressing for a wound with very heavy exudate: three time per week Filler: once per day	
Gauze dressing, non-impregnated			Dressing with adhesive border: once per day Dressing without adhesive border: three times per day	Stacking more than two gauze pads in any one area (usually)
Gauze dressing, impregnated with something other than water, normal saline, hydrogel, or zinc paste			Once per day	
Hydrocolloid dressing	Wound with light to moderate exudate		Three times per week	

Wound Dressing or Related Supply	Coverage Indications or Customary Use	Usual Quantity per Dressing Change	Maximum Frequency of Change	Contraindications or Inappropriate Uses
Hydrogel dressing	Full-thickness wound (e.g., stage III or IV) with minimal or no exudate	Amount needed to line the surface of the wound: three units per 30 days per wound (one unit = 1 fluid ounce)	Cover with adhesive border: three times per week Cover without adhesive border: once per day Filler: once per day	Stage II ulcer without documentation of medical necessity (e.g., need to treat sacrococcygeal ulcer) Additional amount used to fill a cavity Use of more than one type of hydrogel dressing (filler, cover, or impregnated gauze) on the same wound at the same time
Specialty absorptive dressing	Wound (e.g., stage III or IV) with moderate to heavy exudate		Dressing with adhesive border: once every other day Dressing without adhesive border: once per day	
Transparent film dressing	Open partial-thickness wound with minimal exudate; closed wound		Three times per week	
Wound filler, not elsewhere classified			Once per day	
Wound pouch			Three times per week	
Tape	Securement of a wound cover, elastic roll gauze, or non-elastic roll gauze	For a wound cover: Up to 16 sq. in., two units 16 to 48 sq. in., three units Over 48 sq. in., four units	Determined by the frequency of change of the wound cover	Use of tape with a wound cover having an adhesive border (unless need is documented by the provider)
Bandage, light-compression, moderate-compression, high-compression, self-adherent, conforming, or padding			Compression bandage: once per week unless it is part of a multi-layer system Conforming bandage: determined by the frequency of change of the underlying dressing	

5160-10-35 **DMEPOS: cranial remolding devices.**

(A) Any cranial remolding device for which payment is requested must meet the standards established by the United States food and drug administration for a class II medical device.

(B) Payment may be made for the purchase of a cranial remolding device to treat any of the following conditions if the associated criteria are met.

(1) Positional (non-synostotic) plagiocephaly:

(a) The individual is at least three months old but not older than eighteen months;

(b) Any of the following asymmetries is present:

(i) A right/left discrepancy in the skull base of at least six millimeters, measured subnasally to the tragus;

(ii) A right/left discrepancy in the cranial vault of at least ten millimeters, measured from the frontozygomaticus point to the euryon; or

(iii) A right/left discrepancy in the orbitotragial distances of at least four millimeters; and

(c) The asymmetry has not substantially improved after two months of conservative cranial repositioning therapy or physical therapy.

(2) Positional (non-synostotic) braciocephaly: The cephalic index (the ratio of the maximum width of the head to its maximum length) is greater than ninety-one per cent.

(3) Positional (non-synostotic) scaphocephaly: The cephalic index is less than seventy-five per cent.

(4) Synostotic deformity:

(a) The individual is not older than eighteen months;

(b) Premature closing of the cranial structures has been documented; and

(c) Surgery with post-operative remolding is medically indicated.

Replaces: 5160-10-35

Effective:

Five Year Review (FYR) Dates:

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Certification

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Date

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