# DELAWARE HEALTH AND SOCIAL SERVICES

# DIVISION OF MEDICAID & MEDICAL ASSISTANCE

# DELAWARE MEDICAL ASSISTANCE PROGRAM

# DURABLE MEDICAL EQUIPMENT PROVIDER SPECIFIC POLICY MANUAL

*DELAWARE HEALTH AND SOCIAL SERVICES*

DIVISION OF MEDICAID & MEDICAL ASSISTANCE

*Delaware Medical Assistance Program*

# Durable Medical Equipment Provider Specific Policy

## Revision Table

| Revision Date | Sections Revised | Description |
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| 7/1/02 | All | Complete manual revision to reflect changes related to the MMIS and HIPAA compliance. |
| 7/1/02 | 9.0, 3.1.7 | Revised Appendix B. Added a fax # for submitting Appendix B |
| 7/1/02 | Opening Disclaimer | Added Diamond State Partners language. |
| 11/15/02 | 1.0, 1.1.4, 1.3.31, 1.3.6, 2.0, 3.1.4, 3.1.5, 3.1.6, 3.1.9, 3.1.11, 5.1.3, 5.8.2, 5.26, 7.1, 7.1.1, 8.1.4, 9.0, 10.0, 12.0 | Medicare Certificates of Medical Necessity were added for providers to use when requesting prior authorization for specific durable medical equipment. Language was added, changed, or moved to direct providers in the use of these forms. Significant changes were made and providers are encouraged to review the entire manual for changes that may affect how they request prior authorization. |
| 11/18/02 | 1.3.3.1 | Changing "nursing home" to "nursing facility' making language consistent throughout this section. |
| 1/1/03 | 8.0 | Adding new supply codes, revising definitions of current codes and deleting supply codes as per 2003 HCPCS book. |
| 1/17/03 | 3.1.4 | Clarification of policy. When using the Medicare Certificate of Medical Necessity (CMN) providers must supply Medicaid with the requested dates of service and number of units being requested. This information must be indicated in Section C of the CMN. Prior authorization cannot be given without this information. |
| 7/15/03 | 8.7 | Currently, the DMAP uses a miscellaneous code for a trach tube holder. Effective for dates of service 7/15/03 providers shall use the temporary HCPCS code S8181. |
| 9/17/03 | 8.14 | Code A7042 is in the MMIS with a PAC 9 (non-covered service) and was erroneously added to Section 8.14. It is being removed effective immediately. |
| 1/1/03 | 8.0, 8.1, 8.6, 8.9 | Changed Titles in Appendix A to match those as listed in the HCPCS book. Modified the 3-month limit for code A4927 to be consistent with the definition in the 2003 HCPCS book. |
| 1/1/04 | Appendix A | Several sections in Appendix A are being updated to include 2004 HCPCS codes. |
| 5/3/04 | 8.14 | Codes A7520-A7526 will require prior authorization instead of allowing a 3-month limit of 15 units. |
| 06/23/04 | 9.0 Appendix B | For clarification, the TOS column is being changed to MOD. Also, TOS-Type of Service is changed to MOD-Modifier. |

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| 07/28/04 | 8.1 | Adding codes A4221 and A4222 to Section 8.1. |
| 9/24/04 | 7.1 and 12.0 | Providers requesting prior authorization for oxygen must use the Medicare Certificate of Medical Necessity form. This form is added to Appendix E. |
| 11/18/04 | 8.9 | DMAP is requiring Code A4670 to be prior authorized. |
| 1/12/05 | 8.1, 8.3, 8.6, 8.12, and 8.14 | Several sections in Appendix A are being updated to include 2005 HCPCS supply codes. |
| 11/4/05 | 3.6.3 | Changed modifier from "NU" new equipment to RR Rental (DME). |
| 1/5/06 | 8.0 Appendix A – Medical and Surgical Supplies | Deleted the following HCPCS codes: A4254, A5119, A5509, A5511 and A6551<br><br>Added the following HCPCS codes: A4218, A4233, A4234, A4235, A4236, A4363, A4411, A4412, A4604, A5120, A5512, A5513, A6457, A6513, A6530, A6531, A6532, A6533, A6534, A6535, A6536, A6537, A6538, A6539, A6540, A6541, A6542, A6543, A6544, A6549, A9275 |
| 1/19/06 | 8.0 Appendix A – Medical and Surgical Supplies | Corrected the definition of the following HCPCS codes: A4218, A4248, A4233, A4234, A4235, A4236, A4412, A5120, A6549 |
| 9/22/06 | Section 5.1.3 & Appendix C | Added documentation requirements and forms for coverage of<br>renal supplements. |
| 9/22/06 | Appendix B | Changed the heading to<br>Division of Medicaid and Medical Assistance and removed wording specific to enteral supplements. |
| 1/22/07 | 3.5.7 | Clarification of payment of equipment rental fees |
| 1/22/07 | Appendix A | Several sections in Appendix A are being updated to include 2007 HCPCS supply codes. |
| 5/3/07 | 3.1.7 | Updated fax phone number to (302) 255-4481 |
| 8/9/07 | 10.1, 10.2 | Combined multiple Renal Supplement forms. |
| 9/4/07 | 5.16.1 | Removed incorrect prior authorization wording. |
| 1/4/08 | 8.1, 8.8, 8.10, 8.15 and 8.16 | Sections in Appendix A are being updated to include 2008 HCPCS supply codes; the description for code A4216 from 2007 HCPCS is being revised and code A4635 is being added back as previously deleted in error. |
| 5/30/08 | 5.1.3 | Added wording to oral nutrition authorization request. |
| 6/3/08 | 1.2, 8.1, and 8.16 | Changes made to the fee schedule and pricing for glucose monitors and supplies effective 10/01/2006. |
| 6/20/08 | 8.9 and 5.13 | Corrected the Dialysis Supplies heading. Changed the abbreviated definition of modifier BO to the full definition. |
| 8/6/08 | 5.11 and 8.6 | Clarification of incontinence product usage and reimbursement and code table updates. |
| 8/29/08 | 9.0—Appendix B | Updated Medicaid Certificate of Medical Necessity |
| 9/18/08 | Overview | Removed obsolete numbering. |
| 10/24/08 | 5.11 | Added sizing definition for incontinence underpads. Deleted prohibition on coverage of pull-up disposable training pants as pediatric and youth pull-on incontinence products are now |

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| | | covered and reimbursed at the same rate as the corresponding size brief/diaper code. |
| 10/24/08 | 8.6 | Added pediatric and youth pull-on incontinence product codes and clarified incontinence product three month limits. |
| 2/5/09 | 8.14 | Updated to include the 2009 HCPC supply code, A6545 |
| 4/1/09 | 8.0 | Added the asterisk indicator notifying providers that no prior authorization is required for the following codes; A4218, A4233, A4234, A4235, A4236. |
| 8/5/09 | 3.7.2.2 | Clarification made regarding EPIC Plus (pricing software) timeframes for their automated updates. |
| 8/5/09 | 3.7.3.3 | Clarified and defined list price. |
| 1/19/10 | 8.4, 8.6 and 8.14 | Updates made to various procedure codes to reflect the 2010 HCPC updates. |
| 7/12/10 | 3.1.12 | Addition of subsection regarding items not primary medical in nature |
| 7/12/10 | 1.2.4 | Addition of bullet point regarding diapers routinely used for children under four years of age |
| 7/12/10 | 3.1.4, 3.7.2.1 through 3.7.6 | Added cost/price sheets as a requirement when submitting a Medicare or Medicaid Certificate of Medical Necessity (CMN), and EPIC Plus clarification |
| 7/12/10 | 8.17 | Code limit changes to reflect updated Prior Authorization policy |
| 8/10/10 | 8.0 | The requirement for prior authorization for some procedure codes has been updated. |
| 12/8/10 | 3.5.4 | Updated the Purchase Versus Rental information |
| 3/4/11 | 8.0 | Updates to codes: A4565, A4566, A4399, A5112, A6261, A6262, A7013, A7020 |
| 3/16/11 | 3.1.1, 4.1.2 | Updated wording, added sections 4.1.2.1, 4.1.2.1.1, 4.1.2.1.2. |
| 6/24/11 | 12.0 | Removed obsolete Certificate of Medical Necessity (CMN) forms no longer used by Medicare. |
| 7/14/11 | 8.6 | Added row to Additional Miscellaneous Supplies section. |
| 10/4/11 | 7.1 | Based on the removal of the Prior Authorization requirement for commodes, nebulizers, and walkers DMAP policy updated. |
| 11/17/11 | 3.7 | Added DMAP reimbursement current practices. |
| 1/3/12 | 1.2 and 7.1.3 | Defined home and removed the website address for Region A Durable Medical Equipment Regional Center. |
| 2/8/12 | 8.0 | Added additional supplies and corresponding codes (A5056, A5057, and A9272) |
| 8/14/12 | 8.6 | Updated the quantity limits for code A4604 |
| 1/15/13 | 8.5 | Adding code A4435* to section 8.5 |
| 1/15/13 | 8.14 | Deleted references to “pad” and replaced with “sterile”, due to revised descriptions for procedure codes A6021-A6023. |
| 2/25/14 | 8.6 | Adding code A4555 to section 8.6, updated prior authorization language for consistency. |
| 2/25/14 | 8.10 | Update description for code A5081 from Continent device; plug for continent stoma to Stoma plug or seal, any type. |
| 2/25/14 | 8.15 | Adding code A7047 to section 8.16. |
| 2/25/14 | 8.16 | Update description for code A9272 from Mechanical wound |

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| | | suction, disposable, includes dressing, all accessories and components, each to Wound suction, disposable, includes dressing, all accessories and components, any type, each. |
| 5/15/14 | 8.6 | Updated procedure code description for T4543 and adding new procedure code T4544 to section 8.6 |
| 01/01/2016 | Introduction | Updated policy manual to reflect the removal of Diamond State Partners (DSP) language, program ended 12/31/2014. |
| 1/15/2017 | 8.1 | Adding codes A4224*, A4425*, A4467* and A4553. |
| 3/1/2019 | 8.6 | Added code A4563 |
| 3/1/2019 | 8.13 | Added code A5514 |
| 3/1/2019 | 8.14 | Added codes A6460* and A6461, added * to code A6457* |
| 3/1/2019 | All | Manual updated to align with the Delaware Medicaid Enterprise System (DMES) and the Delaware Medical Assistance Portal. |
| 02/15/2020 | 1.0 | Updated medical necessity and face-to-face requirements for DME and supplies in compliance with 42 CFR 440.70. |
| 02/15/2020 | 1.2 | Section updated to align with 42 CFR 414.202 and 42 CFR 440.70. |
| 02/15/2020 | 1.3 | Updated section in accordance to 42 CFR 414.202 and 42 CFR 440.70. |
| 02/15/2020 | 3.1.5 | Added face-to-face requirement policy in accordance to 42 CFR 440.70. |
| 02/15/2020 | 3.1.12 | Section updated to permit limited exceptions on a case-by-case basis in compliance with medical necessity. |
| 02/15/2020 | 3.3 | Language updated to align with Long Term Care Community Support Services (LTCCSS) Program. |
| 02/15/2020 | 4.0 | Clarification added regarding payment for inpatient services. Clarification added regarding Place of Service billing requirements. |
| 02/15/2020 | 4.2 | Section updated to permit limited exceptions on a case-by-case basis in compliance with medical necessity. |
| 02/15/2020 | 5.20.3 | Removal of language to align with the Long Term Care Community Support Services (LTCCSS) Program. |
| 02/15/2020 | 5.11.1.6 | Section updated to permit limited exceptions on a case-by-case basis in compliance with medical necessity. |
| 02/15/2020 | 7.1 | Updated section in accordance to 42 CFR 414.202 and 42 CFR 440.70. |
| 02/15/2020 | 8.0 | Clarifications added regarding the prior authorization requirement for non-listed billing codes. |
| 02/15/2020 | 8.0 | Added code A4226 with prior authorization. |
| 02/21/2022 | 8.9 | Updated code A4670 to 1 Per Lifetime. |
| 03/09/2022 | 5.25 | Updated breast pump policy and applicable billing codes to align with the American Academy of Pediatrics recommendations of human breast milk for infants. |
| 03/09/2022 | 8.1 | Billing codes for breast pump replacement parts A4281, A4282, A4283, A4284, A4285, A4286 moved from section 8.1 to section 5.25. |

*DELAWARE HEALTH AND SOCIAL SERVICES*

DIVISION OF MEDICAID & MEDICAL ASSISTANCE

*Delaware Medical Assistance Program*

# Supplies and Durable Medical Equipment Program Provider Manual

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# Durable Medical Equipment (DME) Supplier Specific Policy

Health care services are provided to the majority of Medicaid members through the Diamond State Health Plan (DSHP), Medicaid's managed care program. Durable medical equipment and supplies are included in the managed care benefits package. Refer to the Managed Care section of the General Policy for information related to DSHP.

This manual reflects the policies as they relate to Medicaid members who are exempt from managed care coverage and who are eligible for DME services fee-for-service.

This manual is to be used in conjunction with the General Policy Manual and the General Billing Manual which are located on the Delaware Medical Assistance Portal for providers.

## 1.0 Overview

The Delaware Medical Assistance Program (DMAP) covers medically necessary supplies and equipment under the Durable Medical Equipment (DME) program. Prior authorization is required for some services. Some items are not generally a covered service under the DME program or may have age limitations; however, Medicaid will review every request case by case for determination of medical necessity and conformity with the definition of durable medical equipment.

### 1.1 Medical Necessity

1.1.1 The DMAP will only pay for services considered *medically* necessary. Refer to Appendix H in the General Policy for the DMAP definition of medical necessity. For approval a request must meet all nine of the listed essential criteria of the definition of medical necessity and at least one of the five outcomes. Failure to meet any one of the essential criteria or none of the outcomes is justification for denial of the item as not medically necessary.

1.1.2 In accordance with 42 CFR 440.70 the DMAP requires a physician to review a member's need for medical supplies, equipment, and appliances annually. The frequency of further physician review of a member's continuing need for the items is determined on a case-by-case basis, based on the nature of the item prescribed.

1.1.3 All DME services for beneficiaries eligible for payment fee-for-service (FFS) must be prescribed by a physician, meet the face-to-face encounter requirement defined in section 3.1.5, the General Information section of this manual and be based on medical need. The DME provider must keep the prescription on file and the beneficiary's medical record must contain information supporting the medical necessity, as well as documentation of the face-to-face encounter for the item ordered.

1.1.4 The physician's order must be in sufficient detail and include the primary and relevant narrative medical description or ICD-10 diagnosis code that necessitates the need. The order must specify the item and any related supplies or accessories needed, and as appropriate, the order must specify the quantity needed, frequency of change and duration of need.

1.1.5 Medicaid often references Medicare Medical Review Policies for coverage criteria and providers are permitted to submit any of the Medicare Certificates of Medical Necessity (CMN) to comply with medical documentation. Refer to Appendix E for Medicare CMNs.

1.1.6 Prior to DMAP's approval of a requested item, documentation may be required from the attending practitioner indicating *how* the above criteria are met. Supportive documentation from other related therapies is also acceptable.

1.1.7 DME is covered when medically necessary and prescribed by the licensed, attending medical practitioner to carry out his/her plan of care. Items requested for the convenience of the patient or caretaker, or items that do not maintain or improve the health status of the patient generally are not considered as medically necessary. Documentation of the written order, including the face-to-face encounter requirement documentation must be maintained in the DME provider's member-specific file. The fact that a practitioner may order, recommend, or advise a supply or a piece of equipment does not in itself make the request a covered service.

1.1.8 No payment will be made for DME or Supplies, as defined in this manual, unless the physician, or authorized practitioner documents that there was a face-to-face encounter with the beneficiary that meets specific requirements defined in 42 CFR 440.70 (f) and listed in section 3.0 Authorization and Documentation of this manual.

## 1.2 Supplies

1.2.1 Supplies are defined as health care related items that are consumable or disposable, or cannot withstand repeated use by more than one individual as provided in 42 CRF 440.202.

1.2.2 Supplies are covered when medically necessary and when required to carry out the written plan of care of a licensed medical practitioner.

1.2.3 Supplies must be purchased economically and the quantity used must be reasonable for the billing period. The DME provider shall not dispense more than a one-month supply of any item at a given time.

1.2.4 Examples of non-covered supplies include, but are not limited to:

- Bandages, Band-Aids, mouthwash, razors, etc. normally purchased for routine home use.
- Diapers routinely used for children under four years of age. The DMAP may consider the coverage for diapers that exceed the normal use for children under the age of four years if the attending practitioner details the child's diagnosis, the medical necessity for the diapers, and why the use is outside normal range. This service may be covered through the Early, Periodic, Screening, Diagnostic and Treatment (EPSDT) program. The DME provider

will be required to submit a CMN signed and dated by the attending practitioner and the practitioner's letter of medical necessity. The practitioner's letter of medical necessity must address the child's diagnosis and why the excessive usage is medically necessary.

1.2.5 Supplies may be dispensed and billed to the DMAP when the primary use is intended for any setting in which normal life activities take place, other than a hospital; nursing facility; intermediate care facility for individuals with intellectual disabilities; or any setting in which payment is or could be made under Medicaid for inpatient services that include room and board. The DMAP will not reimburse a DME supplier for a duplicate item to be used in other settings.

1.2.6 The Delaware Medical Assistance Program covers glucose monitors, test strips and lancets under the pharmacy benefit using a preferred supplier. The pharmacy team will authorize approval of medically necessary non-preferred products.

## 1.3 Durable Medical Equipment

1.3.1 DME is defined as equipment that:

1.3.1.1 Can withstand repeated use;

1.3.1.2 Is primarily and customarily used to serve a medical purpose;

1.3.1.3 Generally is not useful to a person in the absence of an illness or injury;

1.3.1.4 Is needed to maintain the member in any setting in which normal life activities take place, other than a hospital; nursing facility; intermediate care facility for individuals with intellectual disabilities; or any setting in which payment is or could be made under Medicaid for inpatient services that include room and board.

1.3.1.5 Can be reusable and removable.

1.3.2 Requests for items that are not primarily medical in nature are not covered. Most durable medical equipment is presumptively medical, such as hospital beds, wheelchairs, respirators, crutches, nebulizers, etc. However, some items are not primarily medical in nature, such as physical fitness equipment, self-help devices, air conditioners, room heaters, humidifiers attached to home heating systems, or other environmental control items, etc. Additionally, the DMAP does not cover lifts for stairs or vans, wheelchair ramps, generators, or home/bathroom modifications under the DME scope of services. Even though non-medical equipment may have some remote medically related use, the primary and customary use of such items is a non-medical one and thus they will not be covered.

1.3.3 Durable medical equipment may not be dispensed and billed to the DMAP when the primary use is intended for a setting other than the member's home. The DMAP will not reimburse a durable medical provider for a duplicate item to be used in other settings. Examples of places for which the items may not be provided are:

1.3.3.1 Nursing facilities - the DMAP will make an exception if a power wheelchair or other custom DME is medically necessary for a nursing facility resident who is Medicaid eligible. The nursing facility is responsible for submitting the necessary documentation to the DME supplier. The nursing facility must document why an item cannot be provided by the per diem rate and/or why facility owned equipment is not appropriate.

NOTE: Standard, non-customized durable medical equipment, including wheelchairs, is included in the nursing facility per diem rate for both children and adults who are residents of long term care facilities. Medicaid will review the medical necessity of customized DME for fee-for-service payment outside the per diem rate.

1.3.3.2 Inpatient or outpatient hospitals (equipment will *not* be purchased or rented for use in any inpatient or outpatient treatment setting)

1.3.3.3 Physicians'/practitioners' offices

1.3.3.4 Prescribed Pediatric Extended Care Centers

1.3.4 Medicaid considers durable medical equipment to be customized if it is medically necessary that the device be designed so that only the individual member can use it. In contrast, non-customized DME can be used by other members either without modification or following the removal or attachment of accessories. In general, Medicaid does not consider a wheelchair or other durable medical equipment to be customized if the selection of the equipment and all significant adaptations can be coded using HCPCS procedure codes. However, the fact that a piece of equipment or an adaptation cannot be coded using HCPCS codes does not necessarily indicate that it meets the definition of customized DME.

1.3.5 Reserved

1.3.6 Reserved

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## 2.0 Qualified Providers

Any entity which is established to provide supplies or durable medical equipment and which is properly licensed, in the State in which it is located for this purpose, may enroll at the discretion of DMAP as a provider. Failure to be properly licensed/certified at the time service was provided will result in penalties and denial of payment by the DMAP. Only DME suppliers may bill for durable medical supplies and/or durable medical equipment.

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# 3.0 Authorization/Required Documentation

## 3.1 General Information

3.1.1 Prior authorization gives the supplier of durable medical equipment/supplies the capability to bill the DMAP for services provided to eligible members. Authorization must be obtained prior to the delivery of the DME item and is valid as long as the member is eligible at the time of service and meets all third party liability requirements. Members must follow the rules of their primary insurance(s). Providers must seek authorization from all other insurance prior to submitting to Medicaid for those items that are presumptively medical in nature and there is a reasonable expectation that the item will be covered. Remittance information from other insurance must be submitted when you file your claim with the DMAP.

3.1.2 The DMAP may be billed directly for some durable medical supplies. These items are marked with an asterisk (*) on the listing of billable HCPCS codes that appears in Appendix A. Appendix A is not an exclusive list of covered supplies.

3.1.3 The DMAP has established a 3-month general limit on medically necessary supplies. These limits represent maximum usage for very ill patients and will be waived only in extraordinary circumstances. If, at the time of the practitioner's order, it is expected that the patient's need will exceed the supply limit, the DME provider is required to submit a letter from the attending practitioner to the Medical Review Team, prior to dispensing the supplies. The letter must document the patient's diagnoses, HCPCS procedure code of the item, the name and number of units required per day/week/month, why the excessive number is medically necessary, and the period of time for which the supply is being ordered (up to six-month). The letter will be returned to the DME provider if these requirements are not documented. If approved, the DMAP will forward a letter to the DME provider indicating the number of units approved and the time period which the approval will cover. When billing for the specific code, the DME provider must attach this approval letter to ALL claims. Claims will be denied if this approval letter is not attached.

3.1.4 Prior authorization may be obtained by submitting a completed Medicare or Medicaid Certificate of Medical Necessity (CMN) along with a current cost/price sheet of the item requested. Refer to Appendix B or Appendix E for a copy of the appropriate CMN. The Medicare CMN and cost/price sheet are required when requesting prior authorization for durable medical equipment for which there is a specific Medicare CMN. The Medicare CMN and cost/price sheet are to be submitted for ALL members, not only those who are Medicare eligible.

NOTE: For Medicaid purposes, DME providers must indicate the dates of service and the number of units requested for each code in Section C of the Medicare CMN.

For all other requests the Medicaid CMN should be submitted along with a current cost/price sheet of the item requested. Providers shall not submit a CMN

requesting prior authorization for durable medical equipment after Medicare or other insurance has paid the purchase price. Medicaid will not make additional payments. Whenever indicated, the DME provider may also be required to attach a Letter of Medical Necessity (LMN) from the attending practitioner. A sample of a practitioner's form letter of medical necessity may be found in Appendix D. The DME provider may forward a copy of this form letter to the practitioner to complete or to use as a guide in letter writing. The DME provider should not complete the form letter before sending it to the practitioner. The practitioner may compose his/her own letter as long as the required information is addressed. Any form or letter that is not completed will be returned to the DME supplier or the practitioner (whichever is applicable). The Medical Review Team may elect to visit a member to secure additional information in processing a request. A request may be sent to the Medical Management/Delegated Services Unit and/or the Medicaid Medical Director for more in-depth review. A letter of medical necessity written by the attending physician must include the estimated duration of use.

3.1.4.1 Diagnosis and medical condition prognosis

3.1.4.2 Present physical condition and functional limitations

3.1.4.3 Severity and frequency of the symptoms of the condition

3.1.4.4 Medical treatment plan (medications, therapies, equipment, nursing services, etc.)

3.1.4.5 Reason for use of the requested item (state when the equipment will be used, i.e., continuous, periodic, etc.)

3.1.4.6 Estimated duration of use

3.1.4.7 Reason(s) for excessive usage (if applicable)

3.1.4.8 Expected therapeutic effect of requested item.

3.1.4.9 Pertinent laboratory/pulmonary function test results, and;

3.1.4.10 Summaries from other professionals involved in the care of the child.

3.1.5 Face-to-Face Requirements

In compliance with 42 CFR 440.70 a face-to-face encounter is required for DME and Supplies. The DMAP will not reimburse providers for DME and Supplies described in this manual unless a physician or authorized non-physician practitioner provides documentation that the face-to-face encounter with the beneficiary meets the following requirements:

For the initiation of medical equipment or supplies, the face-to-face encounter must be related to the primary reason the beneficiary requires DME or supplies and must occur no more than 6 months prior to the start of services.

- The face-to-face encounter may be conducted by one of the following practitioners as defined in federal regulations:

  The ordering or certifying physician; or

  An authorized non-physician practitioner (NPP) such as nurse practitioners, clinical nurse specialists working in collaboration with the physician, a certified nurse-midwife, as authorized by state law or a physician assistant under the supervision of a physician; or

  An attending or post-acute physician for members admitted to home health services immediately after an acute or post-acute stay.
- The authorized non-physician practitioner, performing the face-to-face encounter must communicate the clinical findings of that face-to-face encounter to the ordering physician. Those clinical findings must be incorporated into a written or electronic document included in the beneficiary's medical record.
- To assure a clinical correlation between the face-to-face encounter and the associated ordering of DME or Supplies, the physician responsible for ordering the DME or Supplies must:
  - Document the face-to-face encounter related to the primary reason the patient requires the DME or Supplies occurred within the required timeframes prior to the start of home health services; and
  - Must indicate the practitioner who conducted the encounter, and the date of the encounter.
- The face-to-face encounter may occur through telehealth; as implemented by DMAP. In addition, the face-to-face encounter occurred through telehealth may be performed by any of the practitioners described above with the exception of certified nurse-midwives.

3.1.6 The DMAP permits the DME provider to complete the Medicaid CMN, but the attending practitioner must complete the Medicare CMN. In each instance, Medicaid waives the requirement of a practitioner's "live" signature. The items for which prior authorization is requested must be those items prescribed by the attending practitioner and must be visible on the CMN when signed by the prescribing practitioner. The CMN is not to be altered after the practitioner's signature. When requesting a prior authorization number, the DME provider is required to submit a completed CMN. The diagnosis must be identified using an ICD-10 code on the CMN and be specifically related to the supplies and/or equipment ordered. The CMN will be returned to the provider if the information is not complete or appropriate.

3.1.7 The DME provider must submit a CMN prior to submitting a bill for services to:

DME Medical Review Team
Division of Social Services
P. O. Box 906
Lewis Building
New Castle, DE 19720

OR

Fax to: (302) 255-4481

3.1.8 Upon approval, the provider will be sent a prior authorization number, which must appear on any bill submitted for the service that was approved.

3.1.9 Each request for prior authorization will be individually reviewed for medical necessity and conformity with the definition of durable medical equipment.

3.1.10 Prior authorization must be requested before the delivery of the equipment/supplies and before payment can be made for supplies and durable medical equipment. The authorization number does need to be received by the provider before services that are clearly defined in this manual are dispensed. The DMAP recognizes special situations that necessitate the dispensing of an item prior to obtaining authorization. The Medical Review Team cannot guarantee approval of dispensed items and must conduct a complete medical necessity review before authorizing any item. DME providers are cautioned that they must have a practitioner's prescription/referral and a prior authorization number on file before dispensing any special item.

3.1.11 If Medicare is primary and the provider expects approval, authorization by DMAP is not a requirement. If Medicare denies a service, or there is any other insurance, then the request must be submitted to Medicaid in its entirety for medical necessity determination. Medicaid will generally not approve requests that have been denied by Medicare as "not medically necessary". However, there are some services that Medicare does not cover but are covered by Medicaid. In those instances, annual notification of the Medicare denial is required.

3.1.12 Requests for items that are not primarily medical in nature are not covered. Most durable medical equipment is presumptively medical, such as hospital beds, wheelchairs, respirators, crutches, nebulizers, etc. However, some items are not primarily medical in nature, such as physical fitness equipment, self-help devices, air conditioners, room heaters, humidifiers attached to home heating systems, or other environmental control items, etc. Additionally, the DMAP does not cover lifts for stairs or vans, wheelchair ramps, generators, or home/bathroom modifications under the DME scope of services. Even though non-medical equipment may have some remote medically related use, the primary and customary use of such items is a non-medical one and thus they will not be covered. Prescribers should not consider this section to be a complete list of exclusions as the DMAP will review all requests for DME equipment and supplies on a case-by-case basis according to medical necessity.

## 3.2 Out-of-Region Services

3.2.1 All services provided outside of Delaware, New Jersey, Pennsylvania, Maryland, or Washington, DC require prior authorization for payment. For exceptions refer to the General Policy, Services Requiring Prior Authorization, Out-of-State Services.

3.2.2 Reserved

3.2.3 Reserved

3.2.4 Reserved

3.2.5 Reserved

3.2.6 If out-of-region services are provided before authorization is obtained, it is the responsibility of the provider to obtain authorization before billing. Services that do not comply with the DMAP rules and regulations will not be authorized for payment even if they have already been rendered.

## 3.3 Exceptions

3.3.1 Long Term Care Community Support Services (LTCCSS) Program: Most supplies and equipment for members under the LTCCSS Program will be handled in the same manner as for regular Medicaid members. However, supplies, equipment, orthotics and prosthetics not generally covered for Medicaid members, but ordered by a case manager for a member covered under the LTCCSS Program, must be authorized by the case manager ordering the service.

3.3.2 Supplies that are noted with an asterisk (*) on the procedure code list will not require authorization, however, will require an order from the attending practitioner to be maintained in the DME provider's file.

3.3.3 Out-Of-Region Providers: For providers located outside of Delaware, New Jersey, Pennsylvania, Maryland or Washington, DC, the prescribing practitioner must request prior authorization by sending a letter with the following information to the Out-of-State Medicaid Coordinator at the above address:

- Name of the patient
- Patient's Delaware Medicaid ID number
- Date of birth
- Detailed medical history that documents the need for out-of-state care

## 3.4 Authorization for Specialized Wheelchairs

3.4.1 When requesting prior authorization for specialized/custom wheelchairs, the DME supplier must indicate specific HCPCS codes for the wheelchair and each component. This information must be listed on the CMN or on an attachment.

3.4.2 When a HCPCS code is not available for a component the provider may use the appropriate miscellaneous HCPCS code and indicate the complete name of the manufacturer, serial/product number, a detailed description of the components, and the cost for *each component*. A CMN without this breakdown will be returned to the provider for correction.

3.4.3 After the CMN for a specialized custom wheelchair is reviewed and approved, prior authorization will be given under HCPCS Code E1220 so the equipment may be billed as a one line item. When billing, the provider must use code E1220 and indicate the total cost of the specialized/custom wheelchair.

## 3.5 Purchase Versus Rental

3.5.1 In determining the most cost-effective method of providing the equipment, the provider must take into consideration:

3.5.1.1 The length of time the patient is expected to need the equipment

3.5.1.2 The length of time the patient is expected to be Medicaid eligible

3.5.1.3 The potential for Medicare eligibility

3.5.1.4 A comparison of the purchase cost and monthly rental fee

3.5.1.5 The most economical model that meets the medical needs of the patient

3.5.2 For example:

A 23 year old quadriplegic is expected to be a "Medicaid-only" member for life and needs a wheelchair. The DMAP should be billed a purchase price.

The provider has been told that the member will be receiving a disability pension in the next few months that will make him ineligible for Medicaid. He is expected to need a hospital bed for at least a year. Assuming that the total cost of the bed is more than the cost of rental during the period of eligibility, Medicaid should be billed monthly rental fees.

Medicare eligibility is expected to start next month. Medicaid should be billed the monthly rental fee. The provider would then follow Medicare guidelines for obtaining the equipment after Medicare eligibility has been established.

3.5.3 The DME provider must maintain detailed documentation of the logic used in determining the most cost effective method of providing the equipment.

3.5.4 Items specified below, purchased by DMMA, shall be the property of DMMA. Other equipment purchased by DMMA will become the property of the member after the DMAP reimbursement is made.

- Augmentative Communication Devices
- Bath Benches
- Bi-Paps
- C-Paps
- Car Seats
- Commodes
- Feeder Seats
- Feeding Pumps
- Gait Trainers
- Hospital Beds and Hospital Bed Accessories
- Nebulizers
- Oxygen Concentrators
- Patient Lifts
- Quad Canes
- Scooters
- Shower Chairs
- Standers
- Strollers
- Walkers
- Wheelchairs and Wheelchair Accessories

3.5.5 If rental is determined to be the most economical method of providing the equipment, it is the responsibility of the DME provider to review and re-document every six months the logic of the economy of continuing to bill a rental fee. Unless otherwise indicated, the rental reimbursement will include overhead, maintenance, and the supplies that are necessary to operate the rented piece of equipment.

3.5.6 If the DME provider requests and receives a 6 month authorization for the rental of a piece of medical equipment, then determines that a purchase is more cost effective, the provider may submit a CMN to the DMAP using a modifier “UE” (purchased used equipment). An explanation that justifies the reason for the change from rental to purchase must be attached to the CMN. The CMN will be returned to the provider if an explanation is not attached.

3.5.7 The DMAP will pay equipment rental fees up to 15 months as long as the equipment is deemed medically necessary. Certification of the medical necessity must be done at the following intervals:

3.5.7.1 Prior to initial billing

3.5.7.2 Prior to the 7th month of billing, and

3.5.7.3 Prior to the 13th month of billing

3.5.8 Oxygen (stationary and portable) systems, ventilators, concentrators, IPPB machines and compressors are also considered as capped rental items. All supplies necessary to operate these pieces of equipment will be considered as part of the rental payment.

## 3.6 Equipment Maintenance

3.6.1 When the purchased price is reached, the DME provider is required to maintain the rented equipment for as long as the equipment is usable, needed by the patient, and the patient remains Medicaid eligible. Maintenance fees equal to no more than one month's rental fee may be charged to the DMAP, no more frequently than 6 month intervals after the purchase price is reached (i.e., at the 21st and 27th months). If, at the end of the 27th month, the equipment is still in usable condition, the DME provider may charge maintenance fees at 3 month intervals, beginning with the 30th month that the equipment is in the patient's home, until the equipment needs to be replaced or is no longer needed.

3.6.2 Replacement of a piece of equipment will require documentation from the attending practitioner. The DME provider will be required to justify why continued rental is the most economical method of providing the service.

3.6.3 When requesting approval for maintenance, the provider will complete a CMN using the appropriate HCPCS code with the modifier “RR” Rental (DME), indicate the HCPCS code of equipment being maintained, and describe the maintenance performed. The DME provider may sign the CMN when requesting prior authorization for maintenance. The provider should not bill for maintenance if the equipment is simply inspected and no work is actually performed.

## 3.7 Reimbursement for Services

3.7.1 The DMAP will reimburse DME providers for the purchase/rental of medical equipment and the purchase of medical supplies in accordance with this policy.

3.7.2 Reimbursement is determined by the DMAP in hierarchical order, based on one of the following:

3.7.2.1 The Medicare fee schedule received yearly from the Region A - Durable Medical Equipment Regional Carrier (DMERC). This fee schedule is used to determine payment. If no rate is found in the DMERC fee schedule, the EPIC Plus pricing software is used.

3.7.2.1.1 If the Medicare fee schedule is available for rental (RR) only for an item that may be purchased new (NU) under DMAP policy, the DMAP will reimburse new equipment at 10 times the rental rate.

3.7.2.1.2 If the Medicare fee schedule is available for new (NU) only for an item that may be purchased used (UE) under DMAP policy, the DMAP will reimburse used equipment at 0.75 times the new equipment rate.

3.7.2.1.3 If the Medicare fee schedule is available for rental (RR) only for an item that may be purchased used (UE) under DMAP policy, the DMAP will reimburse used equipment at 7.5 times the rental rate.

3.7.2.2 The EPIC Plus is a pricing software package produced by the Medical Data Institute (MDI) located in Langhorne, PA. The EPIC Plus is updated periodically to ensure that the DMAP has the most current products and supplier information available. The EPIC Plus is used to determine payment for items not listed in the Region A – DMERC fee schedule. If no rate is found in the DMERC or the EPIC Plus, the cost/price sheet is used.

3.7.2.3 Information received from the DME provider such as catalog pages should include the manufacturer's name, model number, brief description of item, and costs; or, a copy of the company's invoice may be used that describes the item and gives and itemized explanation of all charges. (It is not permissible for the DME provider to "roll in" other expenses such as labor, delivery, fittings, etc.). The DMAP will use this information to determine reimbursement for items not listed on the DMERC fee schedule and for items that do not appear in EPIC Plus.

3.7.3 When the EPIC Plus or information received from the DME provider is used to determine payment, the DMAP will reimburse the lesser of the following:

3.7.3.1 Provider charges (Cost/price sheet or invoice) or;

3.7.3.2 Cost + 20% (includes administration fee—this is used for EPIC Plus and wholesale/dealer pricing only—not for the actual bill/invoice).

3.7.3.3 List price is considered the Manufacture Suggested Retail Price (MSRP) minus 40% plus 20%. (The only exception would be powered wheelchairs; e.g. MSRP minus 30% plus 20%.)

3.7.3.4 Standard Industry Discount + 20% administration fee.

3.7.4 Equipment rental is priced according to Medicare's fee schedule. If no Medicare fee is available, the DMAP will reimburse equipment rental as follows:

3.7.4.1 Purchase price (as defined above) ÷ 10 = monthly payment.

3.7.5 Generally, the monthly rental is paid up to the purchase price.

3.7.6 All rates established will be effective as of the starting date of service on the Appendix B. If the price of an item changes, no adjustments to the established rate will be made by Medicaid.

If there is an error with pricing because of the EPIC Plus, we will review the error on a case-by-case basis.

There is a four-month statute of limitations to request re-pricing. The four months will begin with the date DMMA approved the request.

DMAP will not pay for more than what is requested on the Appendix B.

# 4.0 Billing Policies - Procedures/Repairs

## 4.1 Basic Rules

4.1.1 It is the responsibility of the DME provider to bill the DMAP in the most cost-effective manner.

4.1.2 Medicaid can only make payment for equipment and/or supplies after all other available insurance coverages have been billed.

4.1.2.1 If the item is non-covered by other insurance, the item does not need to be billed to that insurance (see below for details),

4.1.2.1.1 When Medicare is the primary insurance and the DME item/service can be confirmed by DMAP to be non-covered.

4.1.2.1.2 When the provider submits a dated letter from the other insurance company on official letterhead that includes the name, address and contact information for the insurance company, the name and date of birth of the recipient, the procedure code and description of the requested item, a statement of non-coverage and the effective date(s) of the coverage determination.

4.1.3 Providers must coordinate with home health agencies, rehabilitation agencies, medical practitioners, and public health agencies that are actively working with a member to assure that there is appropriate training in use of supplies and equipment.

4.1.4 Providers are prohibited from billing when the member is in any setting in which payment is or could be made under DMAP for inpatient services that include room and board for more than a month. If a break in coverage occurs, a new approval must be obtained.

4.1.5 Providers are prohibited from billing for items that are not medically necessary, not needed, or not dispensed, regardless of prior authorization of service units.

4.1.6 The DME provider must identify whether the equipment is new, used or a rental by identifying the appropriate modifier on the billing form. These modifiers are:

4.1.6.1 NU = New Equipment

4.1.6.2 RR = Rental (use the “RR” modifier when DME is to be rented)

4.1.6.3 UE = Used durable medical equipment

4.1.6.4 Reserved

4.1.7 For all rental equipment, any portion of a month of rental will be considered a full month for billing purposes.

4.1.8 Providers must bill no more than their usual and customary charge for each line item billed to the DMAP.

4.1.9 Providers must indicate as a "Place of Service"(POS) code describing the place that the item is to be used. Unless otherwise directed, the POS should be for a setting in which normal life activities take place, other than a hospital; nursing facility; intermediate care facility for individuals with intellectual disabilities; or any setting in which payment is or could be made under Medicaid for inpatient services that include room and board.

4.1.10 Repairs of medically necessary patient-owned durable medical equipment are covered by the DMAP. If similar equipment is found in the home, the DMAP will cover only repairs on the primary DME. DMAP does not cover repairs to facility owned equipment.

4.1.11 Repair of purchased equipment may be billed to the DMAP if the total cost (material and labor) of repair does not exceed 75% of the cost of a replacement. Fittings and/or assembly of equipment at the initial set-up are considered part of the purchase /rental cost and will not be reimbursed separately.

4.1.12 Miscellaneous codes may only be used when:

4.1.12.1 There is not an appropriate HCPCS code; OR

4.1.12.2 Parts/Materials used for repairs of purchased DME cannot be appropriately coded; OR

4.1.12.3 Components needed for specialized/customized wheelchairs cannot be appropriately coded.

4.1.13 The DME provider must maintain documentation from the attending medical practitioner, required to support the level of service billed, in member specific records.

## 4.2 HCPCS Procedure Codes

4.2.1 The attached Appendix A is a reference list of the HCPCS procedure codes for supplies generally covered by the DMAP. Items that are determined by DMAP to be primarily for the convenience of the patient or their family will be reviewed on a case-by-case basis as medically necessary for the purpose of Medicaid reimbursement.

4.2.2 The level of service billed must correspond to the definition of the particular code rather than the expected reimbursement amount.

# 5.0 Criteria for Coverage

## 5.1 Oral Nutrition

5.1.1 Oral nutrition is considered reasonable and necessary for a patient who requires supplementation of their daily protein and caloric intake.

5.1.2 Patients who can adequately obtain nutrition orally will not be approved for nutrition therapy with the following exceptions:

5.1.2.1 Pregnant women with phenylketonuria (PKU)

5.1.2.2 Failure to thrive-documentation must be attached that details the diagnosis of failure to thrive

5.1.2.3 Individuals with birth defects, cerebral palsy, cystic fibrosis, metabolic diseases, or other medical conditions that prevent them from obtaining sufficient nutrition from a normal diet.

5.1.3 When requesting authorization for oral nutrition, the DME provider must submit specific documentation and use modifier BO (Orally Administered Nutrition Not by Feeding Tube) which is available on the MMIS and in Appendix 2 of the Level II HCPCS book.

5.1.3.1 When requesting authorization for oral nutrition for a patient with renal disease, the provider must obtain the following forms from the dialysis center: a Renal Supplement Application/Renewal Form (Appendix C), a Medicare Enteral Nutrition CMN (Appendix E), and a Medicare Denial for Medicare Part B enrollees. These forms must be submitted with a Medicaid Certificate of Medical Necessity (Appendix B).

5.1.3.2 When requesting authorization for oral nutrition for other patients, the provider must submit a Medicare Enteral Nutrition CMN (Appendix E) and a Medicaid Certificate of Medical Necessity (Appendix B) that are completed and signed by the physician. In addition, a physician's letter of medical necessity and prescription must be submitted. The letter must document the primary diagnosis and any other related medical conditions that prevent the individual from obtaining sufficient nutrition from a normal diet and must include the following, as appropriate:

5.1.3.2.1 Physical findings: Height, Weight and Ideal Body Weight or Body Mass Index. Explanation of weight loss with specific dates and measurements. Other physical examination findings.

5.1.3.2.2 Significant laboratory data (for example, Serum Albumin)

5.1.3.2.3 Discussion of any risk factors found related to undernutrition in any of the following areas: clinical features, eating habits, living environment, functional status, mental/cognitive status.

## 5.2 Intravenous Drug Therapy Supplies

5.2.1 Intravenous drug therapy is the administration of sterile preparations of medications and fluids.

5.2.2 The DMAP covers intravenous drug therapy supplies when prescribed by a physician and authorized by the Medical Review Team. The DME provider is required to complete the CMN utilizing appropriate HCPCS procedure code(s).

5.2.3 Items that require a prescription (federal legend drugs) must be billed by a pharmacy provider using a National Drug Code (NDC).

## 5.3 Reserved

## 5.4 Reserved

## 5.5 Reserved

## 5.6 Reserved

## 5.7 Reserved

## 5.8 Apnea Monitor and Supplies

5.8.1 Medicaid will cover the rental of an apnea monitor or smart/event monitor for those infants who are deemed by the physician to have extreme cardiorespiratory instability or whose physician prescribes monitoring as treatment of choice for the individual patient. Routine monitoring or screening of normal term or preterm infants has not been recommended. Examples for coverage include but are not limited to, the following:

- Infants born at 35 weeks gestational age or less
- Infants who have had life threatening event
- Later siblings of infants who died of SIDS
- Documented episodes of oxygen desaturation below 90%
- Documented gastro-esophogealeal reflux (GERD) which results in apnea, bradycardia, or oxygen desaturation
- Documented apnea of greater than 20 seconds in duration,

etc.

5.8.2 Medicaid will approve the rental of an apnea monitor or smart/event monitors for a period of up to 3 months. Additional months rentals may be requested with medical documentation to substantiate continued use; however, rental will be capped at 15 months or converted to purchase dependent on duration of need. Generally coverage will continue until the infant is event free for six weeks. DME providers may bill the DMAP for maintenance after the 15-month rental period, and it is expected that the DME provider will have a prescription on file from the attending practitioner that will document the continued need for the apnea/memory monitor. The Medical Review Team may request a copy of this prescription before approving any requested maintenance.

5.8.3 The DME provider is required to describe the type of monitor prescribed on a completed Medicaid CMN and attach the physician's letter of medical necessity. Rental reimbursement will include overhead, maintenance, and the supplies necessary to operate the apnea monitor. Supplies include the monitor, battery charger, cable, 1 set of carbon or 1 box of sticky electrodes, 1 belt, 1 set of lead wires and 1 set of emergency replacement supplies.

5.8.4 If supply usage exceeds the routine limits, the DME provider may seek authorization via the Medicaid CMN for additional supplies based on physician's description of medical need.

5.8.5 A DME provider can only bill for supplies needed or used despite approval with billing authorization number.

5.8.6 Because of the capabilities of a smart monitor, continuing sleep studies and pneumograms are not typically necessary. Pneumograms may be ordered by a physician during the use of the memory monitor, however, the DMAP may convert coverage to a regular monitor after discussion with the physician.

5.8.7 Medicaid will pay for two pneumograms during a six-month period for those on a regular apnea monitor. If more are required, documentation of medical necessity from the attending practitioner is required with the CMN. The CMN and the claim form must show the type of pneumogram as "12 hour with interpretation" or 24 hour with interpretation".

## 5.9 Reserved

## 5.10 Reserved

## 5.11 Incontinence Products

5.11.1 Coverage for Members Age 4 Years and Over

5.11.1.1 Incontinence products for members age four years and older may be covered by the DMAP when prescribed by a physician as medically necessary for the treatment of incontinence related to a diagnosed condition. Treatment of incontinence aims to control the condition through bladder or bowel retaining, or other behavior management techniques, diet modification, drug therapy, and possibly surgery. All reasonable attempts at control treatment are expected to be made.

5.11.1.2 The DMAP may cover disposable incontinence products for members age four years and over. The DME supplier must maintain the physician's prescription for an incontinent product in their member files and the prescription must be renewed every six months.

5.11.1.3 The physician must prescribe the most appropriate type of incontinence products for the member and the DME supplier must dispense the least costly appropriate product of that type. Physicians are expected to prescribe an accurate daily allowance, and DME suppliers are cautioned not to routinely dispense the Medicaid maximum allowance of eight units per day unless medically necessary.

5.11.1.4 The DMAP considers the following types of incontinence products suitable for members who have incontinence: diapers/briefs, protective underwear/pull-ons, incontinent undergarments, guards, pads, liners, shields and under pads. Medicaid recognizes that some patients may require more than one type of incontinence product to meet their needs, but the **daily combined** usage of all products is not to exceed the expected daily allowance of eight units per day.

5.11.1.5 The DME supplier must use the appropriate HCPCS procedure code for disposable incontinence products that are medically necessary and when reusable incontinent products are prescribed for the treatment of incontinence.

5.11.1.5.1 The DME supplier must use a procedure code defined as an incontinence product for underpads dispensed for the treatment of incontinence.

5.11.1.5.2 The DMAP defines small incontinence underpads as up to and including 500 square inches.

5.11.1.5.3 The DMAP defines large incontinence underpads as over 500 square inches.

5.11.1.6 The DMAP will review requests for menstruation sanitary supplies, or additional incontinent supplies for menstruation on a case-by-case basis for medical necessity.

5.11.1.7 Reserved

5.11.2 Coverage of Diapers for Children Under 4 Years of Age

5.11.2.1 Individual consideration may be given for the coverage of disposable diapers for those children under four years of age when the use is outside the normal range. (The DMAP considers eight diapers per day to be normal usage.)

5.11.2.2 A letter from the attending practitioner must be submitted to the Medical Review Team detailing medical necessity. The letter must address the child's diagnosis, the effects of the condition, the duration of the condition, the functional level of the child, the number of diapers used per day, why the excessive number is medically necessary, and if attempted, the results of toilet training.

5.11.2.3 Authorization is required for the coverage of diapers for children under four years of age. If the service is approved, the DME provider will be required to submit a CMN using the appropriate HCPCS procedure code.

5.11.3 Exceeded Units of Incontinence Products

5.11.3.1 The DMAP has established an upper limit on medically necessary incontinence products for members age four years and over. This limit (8 per day) represents the maximum usage and will be waived only in extraordinary circumstances.

5.11.3.2 If the member's need exceeds the limit, the DME supplier is required to submit a letter from the attending practitioner documenting the member's diagnosis, why the excessive number is medically necessary, the total number of incontinence products needed, and the period of time for which the approval is being requested. The letter will be returned to the DME provider if these requirements are not met.

## 5.12 External Ambulatory Infusion Pump, Insulin

5.12.1 The purchase of an external ambulatory infusion pump, insulin, may be covered by the DMAP only in situations where there is medical documentation that the use is reasonable and medically necessary for the individual patient. A detailed letter of medical necessity from an endocrinologist is required and to obtain the prior authorization, the letter must address the following:

5.12.1.1 Duration and success of MDI (multi dose injection) therapy; inability to safely achieve adequate glycemic control;

5.12.1.2 Pertinent laboratory testing, including Glycated Hemoglobin results;

5.12.1.3 Number of diabetic related incidences (in the past year) that required hospitalization and/or assistance of another person;

5.12.1.4 Description of any existing diabetic complications (Retinopathy, Nephropathy, Neuropathy);

5.12.1.5 Member's level of understanding, motivation, and involvement in disease treatment plan; willingness to adhere to a proper diet and exercise regimen; ability to self monitor blood glucose levels;

5.12.1.6 Ability to operate device with a brief description of training; and

5.12.1.7 Medical treatment plan that includes use of device and planned follow-up.

5.12.2 When requesting prior authorization for the purchase of an external ambulatory infusion pump, insulin, the DME provider is required to submit a CMN. If approved, the following supplies may be billed separately:

5.12.2.1 Syringe with needle for external insulin pump, sterile, 3cc;

5.12.2.2 Infusion set for external insulin pump, needle type; and

5.12.2.3 Infusion set for external insulin pump, non-needle cannula type.

5.12.3 Any additional medically necessary supplies, related to the use of the external ambulatory infusion pump, insulin, must be prior authorized. A letter detailing the medical necessity of the additional supplies must be submitted to the Medical Review Team.

## 5.13 Airway Clearance System (ABI Vest)

5.13.1 With prior authorization, Medicaid will consider up to the purchase price capped rental of an ABI Vest only in situations where there is medical documentation that the ABI Vest is reasonable and necessary for the individual patient and after all available chest physical therapy have been tried and proved insufficient. A detailed letter of medical necessity from a specialist in pulmonary disease is required and the documentation must meet the following review criteria:

5.13.1.1 Medical diagnosis consistent with need for airway clearance. (Examples would include cystic fibrosis, bronchiectasis, muscular dystrophy, cerebral palsy, spinal cord injuries, asthma, etc), and

5.13.1.2 Physician's plan of care that calls for external manipulation of the thorax at least every day as a result of retained secretions, evidence that the patient is having difficulty with the secretion clearance, or presence of atelectasis caused by mucus plugging. and

5.13.1.3 Written evidence of failure (description of medically related incidences in the past year that required treatment and/or hospitalization) of all standard airway clearance therapies, including chest physical therapy, or explanation that a measure is inappropriate for an individual patient. Chest therapy includes postural drainage, percussion, vibration, assisted coughing, and in the older

patient, active cycle of breathing, autogenic drainage, flutter valve device, positive expiratory pressure mask, or

5.13.1.4 Evidence that the caregivers are unable to provide therapy due to their physical condition, time limitations, severity of patient's disease, and

5.13.1.5 Evidence that the patient/caregivers have been compliant with treatment procedures and motivated to use the device, and have the ability to operate the device safely, and

5.13.1.6 There are no known contraindications to the device use, such as under 2 years of age; unstable head and/or neck injury; active hemorrhage; subcutaneous emphysema; recent spinal fusion; recent skin grafts, or flaps on the thorax; burns, open wounds, and skin infections of the thorax; recently place pacemaker; suspected tuberculosis; lung contusion; complaint of chest wall pain.

## 5.14 Pulse Oximeter

5.14.1 The DMAP may approve the rental of a pulse oximeter. The rental of the pulse oximeter will be covered to the purchase price after which time the DME provider may bill the DMAP for maintenance (refer to Equipment Maintenance in this manual).

5.14.2 It is expected that the DME provider have a prescription on file from the attending practitioner that will document the continued need for the pulse oximeter. The Medical Review Team may request a copy of this prescription before approving any requested maintenance.

5.14.3 The reimbursement amount will include all services and maintenance required during the rental period.

5.14.4 When requesting approval for the first 6 months the durable medical provider must submit a letter of medical necessity from the attending practitioner. Refer to requirements listed in Authorization/Required Documentation section. The CMN will be returned to the DME provider if this letter is not attached. Documentation from the practitioner will not be necessary on subsequent requests.

5.14.5 The initial set-up will include the oximeter, 1 box of oxibands and 1 probe, plus 1 extra probe for emergency. Additional supplies such as oxibands and oxisensor/probes may be approved if the respiratory therapist is able to justify the need on the CMN or on an attachment to the CMN. Usage is not expected to exceed 4-5 disposable probes per month. If a child requires more than this allowance, it is the responsibility of the respiratory therapist to determine and document the need and appropriateness for a permanent probe. The respiratory therapist must sign and date the justification, however, the CMN may be signed and dated by the DME provider. Approval for additional supplies will NOT be given prior to the dates of service. If the respiratory therapist determines that a

permanent probe should be dispensed, and the Medical Review Team approves the permanent probe, the DMAP will not approve any disposable probes for a period of six months.

## 5.15 Reserved

## 5.16 Peak Flow Meter

5.16.1 The DMAP will cover Peak Flow Meters and related supplies for use in the home. The service must be medically necessary to be covered.

5.16.2 A Peak Flow Meter is considered medically necessary when the member requires frequent or multiple medications to control symptoms, particularly those in whom the asthma is unstable (i.e., requires frequent changes in medication, have numerous emergency room visits, or must make frequent visits to the physician's office), and when the peak flow meter is used to monitor the status of airflow limitation at home in order to:

5.16.2.1 Detect early stages of airway obstruction and facilitate early intervention

5.16.2.2 Monitor the course of treatment using peak flow rate data to make therapeutic changes

5.16.2.3 Help determine when emergency medical care is needed

5.16.2.4 Identify specific allergens or irritants of acute symptoms

5.16.2.5 Recognize variations of peak flow rates which suggest bronchial hyperactivity.

5.16.2.6 Reimbursement for peak flow meters is currently limited to the following provider specialties: pediatricians, family practitioners, internists, allergists, durable medical equipment providers, and EPSDT non-state plan providers of specialized equipment.

5.16.2.7 Purchase of peak flow meters is limited to one per child per lifetime. Mouthpiece replacements are limited to one box of 100 mouthpieces per 6-month period.

## 5.17 Hearing Aids

5.17.1 The DMAP may cover hearing aids for individuals who are under 21 years of age.

5.17.2 Requests for hearing aids require prior authorization. A physician’s letter that documents medical necessity and supportive documentation, as appropriate, must address the following areas:

5.17.2.1 Complete medical diagnosis

5.17.2.2 Copy of Audiologist's evaluation

5.17.2.3 Speech/Language evaluation or progress reports

5.17.2.4 Discussion of trial assessment with the device, including hearing testing

5.17.2.5 Explanation of why this device was selected over other hearing aid devices

5.17.2.6 Full description of the device that includes the make and model number

5.17.2.7 Itemized explanation of all charges

5.17.2.8 Copy of the company invoice for the hearing aid appliance

5.17.3 Reimbursement for hearing aids is made according to the actual cost to the provider for the appliance(s), plus a dispensing fee of no more than $400.00 per hearing aid. The dispensing fee includes: taking ear mold impressions, fitting/orientation sessions, periodic conformity and performance evaluations, periodic cleaning and testing of hearing aids, coordination of servicing under warranty, and all in-house repairs for the life of the aid. When requesting authorization for the hearing aid the provider must indicate the appropriate HCPCS procedure code on the CMN. When requesting authorization for the dispensing fee the provider must indicate the HCPCS code for the "dispensing fee of an unspecified hearing aid."

5.17.4 When the warranty expires, providers may bill the DMAP for repairs/replacement parts/labor of the purchased hearing aid(s) that cannot be completed in-house, if the total cost (material and labor) of repair does not exceed 75% of the cost of a total replacement.

## 5.18 Reserved

## 5.19 Phototherapy Blanket

5.19.1 The DMAP will cover phototherapy blankets to treat abnormal bilirubin levels in newborns.

5.19.2 When requesting prior authorization for the phototherapy blanket the DME provider should use the appropriate HCPCS procedure code.

5.19.3 Rental may be authorized for up to, but not to exceed, 7 days. The DME provider may only bill for days the unit was in use and must attach all bilirubin laboratory

data to the CMN. A separate physician's letter of medical necessity will be required when use exceeds the 7-day limit.

## 5.20 Orthotics and Prosthetics

5.20.1 The DMAP may cover orthotics and prosthetics for children under the age of 21 by prior authorization with the CMN. It is important that the supplier include ICD-10 CM diagnosis(es) that are relevant to the procedure code(s) listed on the CMN.

5.20.2 Although orthotics and prosthetics are not generally covered for adults, Medicaid will review case by case for medical necessity. Orthotics/prosthetics for adults requires a CMN AND a physician letter of medical necessity, in order to obtain a prior authorization.

5.20.3 The DME provider must request prior authorization by using appropriate HCPCS procedure codes. The DME provider must not re-define the procedure code and must use a code that describes the exact item dispensed. If the use of a miscellaneous code is necessary, the provider must include a description of the device and itemized explanation of all charges.

5.20.4 The DMAP will not cover orthopedic shoes that are not specifically molded and dispensed by a DME provider.

5.20.5 The supplier may be requested to submit documentation of measurements and/or adjustments for replacement of an orthotic or prosthetic due to growth.

## 5.21 Vascular, Burn and other Specialty Needs

5.21.1 The DMAP may cover items for vascular, burn, and other special needs (i.e., Jobst garments, stockings, etc.). Requests for these items require prior authorization and a practitioner's letter of medical necessity.

5.21.2 The DMAP recognizes special situations that necessitate the dispensing of an item prior to obtaining authorization. The Medical Review Team cannot guarantee approval of dispensed items and must conduct a complete medical necessity review before authorizing any item. DME providers are cautioned that they should have at least a practitioner's prescription/referral on file before dispensing any special item.

## 5.22 Reserved

## 5.23 Orthopedic Equipment

5.23.1 Orthopedic equipment may be covered by the DMAP. These items must be prior authorized and a letter of medical necessity is required from the attending practitioner. The practitioner's letter of medical necessity must include the diagnosis, functional levels, treatment plans, etc. It is also important to include information in relation to the following, as applicable:

5.23.1.1 Who will be responsible for training the family in the proper use of the device?

5.23.1.2 Who will provide on-going guidance and monitoring?

5.23.1.3 Why is home use necessary? What assistance, if any, will the family need to provide? Are they willing/able?

5.23.1.4 What are the directions for use? Frequency and duration?

5.23.1.5 How long do you expect equipment to last? Can device be adjusted for growth?

5.23.1.6 Physical therapy evaluations and progress regarding the patient's experience with the device.

## 5.24 Reserved

## 5.25 Breast Pumps

In compliance with the American Academy of Pediatrics, DMAP supports the recommendation of human milk as the preferred standard for infant feeding and nutrition for the first six months of life with rare contraindications (AAP: Breastfeeding and the Use of Human Milk, 2012).

The DMAP will furnish personal-use manual or double electric breast pumps for nursing mothers and their infants when the mother expresses a desire to breastfeed. Coverage for breast pumps is in alignment with the recommendations of the United State Preventive Services Task Force (USPSTF) and Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) initiatives.

5.25.1 **Requirements and Limitations for Covered Equipment and Supplies**

5.25.1.1 Manual Breast Pumps

Manual breast pumps do not require prior authorization.

Manual breast pumps must be prescribed or ordered by a physician or other qualified licensed practitioner.

Manual breast pumps can be requested up to 60 days prior to the anticipated delivery date.

The purchase of the pump includes the cost of the pump kit.

5.25.1.2 Double-Electric Breast Pumps

Double-electric breast pumps must be prescribed or ordered by a physician or other qualified licensed practitioner.

Double-electric breast pumps can be requested up to 60 days prior to the anticipated delivery date.

Double-electric breast pump purchases are limited to one (1) unit every 36 months per household.

Prior authorization is required for any additional double-electric breast pump purchase request occurring less than 36 months of the purchase of previous double-electric breast pump.

5.25.1.3 Hospital Grade Electronic Breast Pump

Hospital grade electric breast pumps do not require prior authorization.

Hospital grade electric breast pumps must be prescribed or ordered by a physician or other qualified licensed practitioner.

Hospital grade electric breast pumps are covered as a rental item only based on medical necessity as determined by the physician or qualified licensed practitioner.

5.25.1.4 Replacement Tubing and Parts

Replacement tubing and parts are limited to once (1) per year.

Prior authorization is required for additional replacement tubing and parts requests occurring less than one (1) year of the purchase of previous replacement tubing and parts.

5.25.1.5 DMAP encourages the use of the double-electric breast pump; however, the mother may elect to receive a manual pump. The mother may also elect to receive both a manual pump and a double-electric breast pump concurrently.

5.25.1.6 The purchase of the pump includes the cost of the pump kit.

### 5.25.2 Reimbursement and Billing Codes

Breast pumps must be billed under the maternal Medicaid coverage or under the infant's Medicaid coverage in compliance with EPSDT guidelines.

| Billing Codes | Description | Prior Authorization |
|---|---|---|
| E0602 | Manual Breast Pump | No |
| E0603 | Double-Electric Breast Pump | No – For additional requests for units received greater than 36 months per family unit.<br><br>Yes – For additional requests for units received less than 36 months per family unit. |
| E0604 | Hospital Grade Electric Breast Pump | No |
| A4281 | Tubing for breast pump, replacement | No – For replacement tubing and parts greater than one (1) year of the purchase of previous replacement tubing and parts<br><br>Yes – Prior authorization is required for additional replacement tubing and parts requests occurring less than one (1) year of the purchase of previous replacement tubing and parts. |
| A4282 | Adapter or breast pump, replacement | |
| A4283 | Cap for breast pump bottle, replacement | |
| A4284 | Breast shield and splash protector for use with breast pump, replacement | |
| A4285 | Polycarbonate bottle for use with breast pump, replacement | |
| A4286 | Locking ring for breast pump, replacement | |

## 5.26 Oxygen Equipment

Oxygen equipment must be prior authorized before the service is delivered. Refer to Section 3.0 of this manual for Authorization/Required Documentation.

## 5.27 Bathroom Equipment

Bathroom safety items, such as raised toilet seat, shower bench, stool or chair, and transfer bench, etc. may be covered as related to a diagnosed condition resulting in impaired ability to ambulate; and providing the member requires a mobility assist device such as a cane, walker, or wheelchair to manage in the home, and providing the physician documents the medical need for safety in the bathroom in the patient chart.

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# 6.0 Augmentative and Alternative Communication Devices and Services

## 6.1 Scope of Coverage

6.1.1 Augmentative and alternative communication (AAC) devices are defined as electronic or non-electronic aids, devices, or systems that assist a Medicaid beneficiary to overcome or ameliorate (reduce to the maximum degree possible) the communication limitations that preclude or interfere with meaningful participation in current and projected daily activities. Meaningful participation means effective and efficient communication of messages that takes into account the beneficiary's preferences. Examples of AAC devices include:

6.1.1.1 Communication boards or books

6.1.1.2 Electrolarynxes

6.1.1.3 Speech amplifiers; and

6.1.1.4 Electronic devices that produce speech and/or written output.

6.1.2 AAC devices include devices that are constructed for use as communication devices as well as systems that may include a computer, when an important use of the computer will be as the beneficiary's communication device. AAC devices also include related components and accessories, including software programs, symbol sets, overlays, mounting devices, switches, cables and connectors, auditory, visual, and tactile output devices, and necessary supplies, such as rechargeable batteries.

6.1.3 AAC services are treatment to assist Medicaid beneficiaries in meeting the full range of their communication needs. AAC services are within the scope of practice of speech-language pathologists. The goal of AAC services will be accomplished by:

6.1.3.1 Developing and improving expressive communication and/or language comprehension skills and abilities that may be adversely affected by e.g., congenital or developmental disabilities;

6.1.3.2 Maintaining and protecting beneficiaries' existing expressive communication and/or language comprehension skills and abilities from loss or deterioration due to e.g., progressive impairments and disabilities; and

6.1.3.3 Restoring beneficiaries' expressive communication and/or language comprehension skills and abilities damaged or lost due to e.g., diseases, disability, or traumatic injury.

6.1.4 The scope of AAC services includes diagnostic, screening, preventive, and corrective service provided by or under the direction of a speech-language pathologist. Specific activities include evaluation for, recommendation of, design, set-up- customization and training related to the use of AAC devices.

6.1.5 **Settings in Which AAC Services May be Provided**

6.1.5.1 AAC services are covered under multiple Medicaid categories, including, but not limited to:

- An individual's home as part of home health services, which includes supplies, equipment, and appliances suitable for use in the home;
- Inpatient hospital services;
- Out-patient hospital services;
- Nursing facility services; and
- Intermediate care facilities for persons with mental retardation, developmental disabilities and related condition.

6.1.5.2 Because all AAC devices are customized to overcome or ameliorate each beneficiary's communication limitations, and are for the sole and exclusive use of a single beneficiary, the cost of AAC devices for residents of nursing facilities and/or ICF/MR-DD facilities is not included in the facility's "per diem" or daily rate for that beneficiary.

6.1.6 **Treatment Plan and Physician Endorsement of Medical Necessity Required**

6.1.6.1 Assessment is necessary prior to the development of the treatment plan and physician endorsement. For detailed information refer to Section B, Assessment, Data Reporting and Procedural Requirements.

6.1.6.2 A speech-language pathology treatment plan is required for all requests for DMAP funding for AAC devices and AAC services. Other health professionals, as appropriate, may participate in the development of the treatment plan. The treatment plan must be prepared by a speech by a speech-language pathologist who:

6.1.6.2.1 Has a certificate of clinical competence from the American Speech-Language-Association;

6.1.6.2.2 Has completed the equivalent educational requirements and work experience necessary for the certificate; or

6.1.6.2.3 Has completed the academic program and is acquiring supervised work experience to qualify for the certificate.

6.1.6.3 A physician must document endorsement of such plan through either completion of a DMAP approved form or letter of medical necessity.

6.1.6.4 The AAC devices and AAC services must be an integral part of the treatment plan. The treatment plan must address each beneficiary's unique communication abilities and the expressive communication or receptive (language comprehension) limitations that preclude or interfere with meaningful participation in current and projected daily activities. It must:

6.1.6.4.1 Conform to the scope of coverage stated in this policy;

6.1.6.4.2 Be based on the evaluation criteria and data reporting requirements stated in this policy;

6.1.6.4.3 Satisfy the medical need criteria stated in the policy; and

6.1.6.4.4 Indicate that the beneficiary has demonstrated potential to benefit from AAC devices and/or services at a basic and reasonable level.

6.1.7 **Eligible Individuals**

6.1.7.1 AAC services will be provided to beneficiaries with significant expressive communication or receptive (language comprehension) impairments: beneficiaries who currently lack adequate functional communication skills and abilities through gestures, speech and/or writing. These impairments include but are not limited to, apraxia of speech, dysarthria, and cognitive communication disabilities.

6.1.8 **Trial Use Periods for AAC Devices**

6.1.8.1 A trial use period for AAC devices is not required but may be recommended by the speech-language pathologist who conducts the AAC evaluation as described in Review Criteria section of this policy. The results of trial use periods are often instructive in determining the most appropriate AAC intervention, and thus are preferred. If the results of the assessment are clinically inconclusive, Medicaid may require a trial use period.

6.1.8.2 Medicaid prior authorization for rental of AAC device(s) will be approved for trial use periods when the speech-language pathologist prepares a request consistent with the requirements as described in the Trial Use Period Request section of this policy. The reasons for a trial use period request include, but are not limited to: the characteristics of the beneficiary's communication limitations; lack of familiarity with a specific AAC device; and concern that the beneficiary

has not had sufficient experience with the requested device to permit determination of the device's appropriateness.

6.1.8.3 Trial Use Period Request

6.1.8.3.1 If a speech-language pathologist or Medicaid seeks a trial use period, a plan for this period must be developed by the speech-language pathologist that includes:

6.1.8.3.1.1 The duration of the trial period;

6.1.8.3.1.2 Description of the speech-language pathologist's qualifications that satisfy Medicaid's provider participation requirements defined in this policy;

6.1.8.3.1.3 Description of the speech-language pathologist's AAC services training and experience (and the AAC services experience of all other professionals, as appropriate) involved in the assessments of the beneficiary's functioning and communication limitations;

6.1.8.3.1.4 Beneficiary identifying information, such as name, Medical Assistance ID#, date of the assessment, medical diagnosis (primary, secondary, tertiary), and significant medical history;

6.1.8.3.1.5 The AAC device(s) to be examined during the trial period, including all the necessary components (e.g., mounting device, software, switches or access control mechanism);

6.1.8.3.1.6 Description of the AAC devices assessment components, such as vocabulary requirements, representational system(s), display organization and features, rate enhancement techniques, message characteristics, speech synthesis, printed output, display characteristics, feedback, auditory and visual output, access techniques and strategies, and portability and durability concerns, if any.

6.1.8.3.1.7 The identification of the service provider(s), e.g., speech-language pathologists, educators, residential providers, etc. who will assist the beneficiary in learning and using the AAC device(s) during the trial period;

6.1.8.3.1.8 The identification of the AAC service provider(s) who will assess the trial period; and

6.1.8.3.1.9 The data collection schedule and the evaluation criteria, specific to the beneficiary, that will be used to determine the success or failure of the trial period.

6.1.8.3.2 Trial use period proposals must request Medicaid funding for rental of, or otherwise state the source of all necessary components of the AAC devices, including AAC services provider(s) who will assist the beneficiary during the trial use period.

6.1.8.3.3 Trial periods may be extended and/or different AAC devices provided, when requested by the speech-language pathologist responsible for evaluating the trial use period.

6.1.8.4 Trial Use Period Results

6.1.8.4.1 Results of trial use periods must be submitted with a prior approval request. The results must include the following:

6.1.8.4.1.1 Identification of the requested AAC devices including all required components, accessories, peripheral devices, supplies, and the device vendor;

6.1.8.4.1.2 Identification of the beneficiary's and communications partner's AAC devices preference, if any;

6.1.8.4.1.3 Justification stating why the recommended AAC device (including description of the significant characteristics and features) is better able to overcome or ameliorate the communicate limitations that preclude or interfere with the beneficiary's meaningful participation in current and projected daily activities, as compared to the other AAC devices considered; and

6.1.8.4.1.4 Justification stating why the recommended AAC device (including description of the significant characteristics and features) is the least costly, equally effective alternative form of treatment to overcome or ameliorate the communication limitations that preclude or interfere with the beneficiary's meaningful participation in current and projected daily activities.

6.1.9 **Purchase or Rental**

6.1.9.1 The speech-language pathologist is required to estimate whether it is more cost effective to rent or purchase the requested AAC device. In addition to price, material factors in determining cost effectiveness include availability, expected useful life, upgradability, and warranty availability, and terms.

6.1.9.2 The determination to rent or purchase will be based upon cost effectiveness and must also take into account the comparative delay in providing the device to the beneficiary. No AAC device will be denied approval solely because it is not available for rental. The final determination on rental vs. purchase will be made by the DMAP Medical Director

6.1.9.3 AAC devices purchased by the Medicaid program become the property of the beneficiary.

6.1.10 **Repair and Replacement**

6.1.10.1 AAC Device(s) Repair

6.1.10.1.1 Medicaid will pay for repair to keep AAC device(s), accessories and other system components ("devices") in working condition. Repair will be covered for the anticipated useful lifetime of the device(s), and for as long thereafter as the device(s) continue to be the appropriate treatment for the beneficiary. Medicaid payment for repair will include diagnostic testing of the device, parts, labor and shipping, when not otherwise available without charge pursuant to a manufacturer's warranty. Medicaid AAC device repair will be subject to the following procedure:

6.1.10.1.1.1 When a device ceases to function properly, the beneficiary, a person acting on behalf of a beneficiary, or Medicaid staff will notify the device manufacturer or the manufacturer's designee for the purpose of repair, and follow the manufacturer's or designee's instructions to send the device for assessment.

6.1.10.1.1.2 When a device is received by the manufacturer or manufacturer's designee for the purpose of repair, the manufacturer or designee will conduct an assessment of the device to determine whether it can be repaired, and if so, prepare a written estimate of the diagnostics, parts, labor, shipping, and total cost of the repair, as well as the effectiveness (i.e., estimated durability) of the repair.

6.1.10.1.2 If Medicaid was the original payment source for the device, the manufacturer or manufacturer's designee for the purpose of repair will:

6.1.10.1.2.1 Repair the device if the total cost of the repair is less than or equal to $300.00; or

6.1.10.1.2.2 Notify the beneficiary or the person acting on the beneficiary's behalf that the total cost of the (non-battery) repair, including shipping, will be greater than $300.00, and that prior approval must first be obtained before the repair can proceed.

When the repair is completed, the manufacturer or representative for the purpose of repair will return the repair device to the beneficiary.

6.1.10.1.3 If Medicaid was not the original payment source for the device, the manufacturer or manufacturer's designee for the purpose of repair will notify the beneficiary or the person acting on the beneficiary's behalf of the repair cost and that prior approval must first be obtained before the repair can proceed.

6.1.10.1.4 If the manufacturer or manufacturer's designee for repair concludes the device is not able to be repaired, written notice will be provided to the beneficiary or person acting on the beneficiary's behalf that prior approval must be sought to replace the device.

6.1.10.2 Procedure for Repair or Replacement of AAC Device Batteries

6.1.10.2.1 If the assessment conducted by the manufacturer or manufacturer's designee for repair identifies the device battery as the malfunctioning or non-functioning part, the following procedure will be followed;

6.1.10.2.1.1 Repair of the battery will occur independent of the $300.00 period approval threshold; and

6.1.10.2.1.2 Device, or replacement of the battery will occur without the need of prior approval.

6.1.10.2.2 Repair or replacement of an AAC device battery will be performed, and the device returned to the beneficiary, or person acting on the beneficiary's behalf, as soon as possible.

6.1.10.3 Rental of AAC Device During Assessment, Repair and/or Replacement Period

When the manufacturer or manufacturer's designee receives notification from the beneficiary or a person acting on the beneficiary's behalf that an AAC device is malfunctioning or non-functioning, and is being returned for assessment, the manufacturer is authorized to provide the beneficiary, on a rental basis, an AAC device during the assessment, repair and/or replacement period. The rental period is authorized to continue without regard to the need for prior approval for the repair and/or replacement of the beneficiary's AAC device. Rental of an AAC device during the assessment, repair and/or replacement period is not limited to devices for which Medicaid was the original payment source.

6.1.10.4 AAC Device Repairs Greater Than $300.00 and AAC Device Replacement

6.1.10.4.1 Requests for prior approval for AAC device repairs greater than $300.00 and for AAC device replacements must be accompanied by the following information:

6.1.10.4.1.1 Description of the speech-language pathologist's AAC services training and experience (and the AAC services experience of all other professionals, as appropriate) involved in the assessments of the beneficiary's functioning and communication limitations; and

6.1.10.4.1.2 Beneficiary identifying information, such as name, Medical Assistance ID#, date of the assessment, medical diagnosis (primary, secondary, tertiary), and significant medical history.

6.1.10.4.2 The speech-language pathologist also must report whether there have been any significant changes in any of the subject areas identified in the Required Assessment & Data Reporting section of this policy. The information must include the items specifically listed in the Sensory Status, Postural, Mobility & Motor Status, Current Speed, Language & Expressive Communication Status, Communication Needs Inventory, Summary of Communication Limitations, AAC Devices Assessment Components, and the Treatment Plan and Follow-Up sections and whether the device remains the speech -language pathologist's recommendation for beneficiary's use.

6.1.10.5 AAC Devises Replacement or Modification

6.1.10.5.1 Modification or replacement of AC devices will be covered by Medicaid subject to the following limitations:

6.1.10.5.1.1 All modification or replacement requests will require prior approval;

6.1.10.5.1.2 Prior approval request for replacement AAC devices may be submitted for identical or different devices;

6.1.10.5.1.3 Requests for prior approval for replacement of identical AAC devices must explain how replacement is more cost-effective than repair of current device(s). Data must be provided about age, repair history (frequency, duration and cost), and repair projections (estimated durability of repairs).

6.1.10.5.1.4 Requests for prior approval for modification or replacement of AAC devices with different devices due to changed circumstances may be submitted at any time and must include the following additional information:

6.1.10.5.1.4.1 A significant change has occurred in the beneficiary's expressive communication impairments and/or receptive communication limitations. Modification or replacement requests due to changed individual circumstance must be supported y a new assessment of communication limitations; or

6.1.10.5.1.4.2 Although there has been no significant change in the beneficiary's communication limitations, there has been a significant change in the characteristics, features or abilities of available AAC devices (i.e., a technological change) that will overcome or permit a significant further amelioration of the beneficiary's communication limitations as compared to the current AAC device. A detailed description of all AAC device changes and the purpose of the changes must be provided. In assessing such requests, Medicaid will place particular emphasis on whether the existing device reasonably achieves its purpose.

6.1.10.5.2 Requests for prior approval for replacement of AAC devices due to loss or damage (either for identical devices or different devices) must include additional information including a complete explanation of the cause of the loss or damage, and a plan to prevent the recurrence of the loss or damage.

## 6.2 Assessment, Data Reporting and Procedural Requirements

6.2.1 Role of the Speech-Language Pathologist

An assessment of individual functioning and communication limitations that preclude or interfere with meaningful participation in current and projected daily activities is required for Medicaid funding for AAC devices and AAC services. The assessment must provide the information detailed in the Required Assessment & Data Reporting section of this chapter. It must be completed by a speech-language pathologist (with input from other health professionals, e.g., occupational therapists and rehabilitation engineers).

6.2.2 Prior Approval

6.2.2.1 All requests for AAC device(s):

6.2.2.1.1 Require prior approval;

6.2.2.1.2 Require physician endorsement consistent with the definition of AAC as discussed in S A, Scope of Coverage;

6.2.2.1.3 Must include a sign-off by the beneficiary, guardian or similar representative as well as the vendor; and

6.2.2.1.4 Repairs that are greater than $300.00, and requests for modification or replacement of AAC devices require prior approval.

6.2.3 **Required Assessment & Data Reporting**

The following data are required to be submitted in support of a prior approval request for AAC devices:

6.2.3.1 Speech-Language Pathologist Identifying Information

6.2.3.1.1 Description of the speech-language pathologist's qualifications that satisfy the requirements of this policy.

6.2.3.1.2 Description of the speech-language pathologist's AAC services training and experience (and the AAC services experience of all other professionals, as appropriate) involved in the assessments of the beneficiary's functioning and communication limitations.

6.2.3.2 Beneficiary Information

6.2.3.2.1 Identifying Information:

6.2.3.2.1.1 Name

6.2.3.2.1.2 Medical Assistance ID number

6.2.3.2.1.3 Date of the Assessment

6.2.3.2.1.4 Medical diagnosis (primary, secondary, tertiary)

6.2.3.2.1.5 Significant medical history

6.2.3.2.2 Sensory Status:

6.2.3.2.2.1 Vision

6.2.3.2.2.2 Hearing

6.2.3.2.2.3 Description of how vision, hearing, tactile and/or receptive communication impairments or disabilities affect expressive communication

6.2.3.2.3 Postural, Mobility & Motor Status:

6.2.3.2.3.1 Motor status

6.2.3.2.3.2 Optimal positioning

6.2.3.2.3.3 Integration of mobility with AAC devices

6.2.3.2.3.4 Beneficiary's access methods (and options) for AAC devices

6.2.3.2.4 Current Speech, Language & Expressive Communication Status

6.2.3.2.4.1 Identification and description of the beneficiary's expressive or receptive (language comprehension) communication impairment diagnosis

6.2.3.2.4.2 Speech skills and prognosis

6.2.3.2.4.3 Language skills and prognosis

6.2.3.2.4.4 Communication behaviors and interaction skills (i.e., styples and patterns)

6.2.3.2.4.5 Indication of past treatment, if any

6.2.3.2.4.6 Description of current communication strategies, including use of an AAC device, if any

6.2.3.2.5 Communication Needs Inventory

6.2.3.2.5.1 Description of beneficiary's current and projected (e.g., within 2 years) communication needs

6.2.3.2.5.2 Communication partners and tasks, including partners' communication abilities limitations, if any

6.2.3.2.5.3 Communication environments and constraints which affect AAC device selection and/or features (e.g., verbal and/or visual output and/or feedback; distance communication needs)

6.2.3.2.6 Summary of Communication Limitations

6.2.3.2.6.1 Description of the communication limitations that preclude or interfere with meaningful participation in current and projected daily activities (i.e., why the beneficiary's current communication skills and behaviors prevent meaningful participation in the beneficiary's current and projected daily activities)

6.2.3.2.7 AAC Devices Assessment Components

6.2.3.2.7.1 Vocabulary requirements

6.2.3.2.7.2 Representational system(s)

6.2.3.2.7.3 Display organization and features

6.2.3.2.7.4 Rate enhancement techniques

6.2.3.2.7.5 Message characteristics, speech synthesis, printed output, display characteristics, feedback, auditory and visual output

6.2.3.2.7.6 Access techniques and strategies

6.2.3.2.7.7 Portability and durability concerns, if any

6.2.3.2.8 Identification of AAC Devices Considered for Beneficiary

6.2.3.2.8.1 Identification of the significant characteristics and features of the AAC devices considered for the beneficiary

6.2.3.2.8.2 Identification of the cost of the AAC devices considered for the beneficiary (including all required components, accessories, peripherals, and supplies, as appropriate)

6.2.3.2.9 AAC Device Recommendation

6.2.3.2.9.1 Identification of the requested AAC devices including all required components, accessories, peripheral devices, supplies, and the device vendor

6.2.3.2.9.2 Identification of the beneficiary's and communication partner's AAC devices preference, if any

6.2.3.2.9.3 Justification stating why the recommended AAC device (including description of the significant characteristics and features) is better able to overcome or ameliorate the communication limitations that preclude or interfere with the beneficiary's meaningful participation in current and projected daily activities, as compared to the other AAC devices considered

6.2.3.2.9.4 Justification stating why the recommended AAC device (including description of the significant characteristics and features) is the least costly, equally effective alternative form of treatment to overcome or ameliorate the communication limitations that preclude or interfere with the beneficiary's meaningful participation in current and projected daily activities

6.2.3.2.10 Treatment Plan & Follow Up

6.2.3.2.10.1 Description of short term communication goals

6.2.3.2.10.2 Description of long term communication goals

6.2.3.2.10.3 Assessment criteria to measure beneficiary's progress toward achieving short and long term communication goals

6.2.3.2.10.4 Description of amount, duration and scope of the AAC services required for the beneficiary to achieve short and long term communication goals

6.2.3.2.10.5 Schedule of data collection

6.2.3.2.10.6 Identification and experience of AAC services provider responsible for training (these services providers may include, e.g.: occupational therapists, rehabilitation engineers, the beneficiary's parents, teachers and other services providers).

## 6.3 Review Criteria

Medicaid funding for AAC devices will be approved when the devices are established to be medically necessary and the least costly, equally effective, alternative form of treatment to overcome or ameliorate the communication limitations that preclude or interfere with the beneficiary's meaningful participation in current and projected daily activities.

6.3.1 **Medical Necessity**

6.3.1.1 The medical need for AAC devices and services must be established by a speech-language pathologist (and other health professionals, as appropriate) according to the evaluation and data reporting criteria stated in the Required Assessment and Data Reporting section and be supported by a physician's completion of a DSS-approved form or letter of medical necessity.

6.3.1.2 In general, medical necessity is established when the requested device or service meets the criteria of the DSS-approved medical necessity standard. See Appendix H in the General Policy for the DSS-approved medical necessity standard.

6.3.1.3 Subject to these criteria, assessment of "medical necessity" for AAC devices and services will be guided by the following specific standards:

6.3.1.4 Medical Need Criteria for AAC Devices

6.3.1.4.1 Medical need will be established for beneficiaries:

6.3.1.4.1.1 Who have a diagnosis of a significant expressive or receptive (language comprehension) communication impairment or disability;

6.3.1.4.1.2 Whose impairment or disability either temporarily or permanently causes communication limitations that preclude or interfere with the beneficiary's meaningful participation in current and projected daily activities;

6.3.1.4.1.3 Who have had a speech-language pathologist (and other health professionals, as appropriate) who:

6.3.1.4.1.3.1 Perform an assessment and submit a report pursuant to the criteria set forth in section the Required Assessment and Data Reporting section;

6.3.1.4.1.3.2 Recommend speech-language pathology treatment in the form of AAC devices and AAC services; and

6.3.1.4.1.3.3 Prepare a speech-language pathology treatment plan that describes the specific components of the AAC devices and the required amount, duration and scope of the AAC services that will overcome or ameliorate communication limitations that preclude or interfere with the beneficiary's meaningful participation in current and projected daily activities.

6.3.1.4.1.4 Whose requested AAC devices and AAC services constitute the least costly, equally effective form of treatment that will overcome or ameliorate communication limitations that preclude or interfere with the beneficiary's meaningful participation in current and projected daily activities.

6.3.1.5 General Principles Governing Medical Need Determination

6.3.1.5.1 The cause of the beneficiary's impairment or disability (e.g., congenital, developmental, or acquired) or the beneficiary's age at the onset of the impairment or disability may be relevant considerations I the determination of medical need.

6.3.1.5.2 Whether a beneficiary's daily activities, communication partners and communication environments are related to or intersect with other benefits and/or services programs (e.g., school, early intervention services, adult services programs, employment) does not preclude a determination that the beneficiary has a medical need for AAC devices and AAC services.

6.3.1.5.3 No cognitive, language, literacy, prior treatment, or other similar pre-requisites must be satisfied by a beneficiary in advance of a request for AAC devices and AAC services.

6.3.1.5.4 The unavailability of an AAC devices, component or accessory for rental will not serve as the basis for denying a prior approval request for that device, component or accessory. The prior approval request must document the manner in which a comparable device may be substituted for assessment purposes in the event that a trial period is required.

6.3.1.5.5 The unavailability of a warranty for an AAC device or other component or accessory will not serve as the basis for denying a prior approval request for that device, component or accessory, although Medicaid encourages providers to consider the availability of a reasonable warranty as a factor within the device selection process.

6.3.1.6 Additional Information Needed - Request for Peer Review

6.3.1.6.1 When the medical need for an AAC device cannot be established pursuant to the criteria stated in the Medical Need Criteria for AAC Devices in this section, based on the information submitted in support of a prior approval request, Medicaid will determine and take the following steps:

6.3.1.6.1.1 If information required by the Medical Need Criteria for AAC Devices in this section is not included in the prior approval request, then Medicaid will make contact directly with the speech-language pathologist who conducted the assessment for the beneficiary, identify the specific additional information that is needed, and request that the additional information be submitted; and/or

6.3.1.6.1.2 If an interpretation is required of information in the prior approval request, then Medicaid will seek the advice of speech-language pathologist(s) with extensive AAC experience recommend to Medicaid by the American Speech-Language & Hearing Association (ASHA), the United States Society for Augmentative & Alternative Communication (USSAAC) and/or RESNA, who will provide the required information

6.3.1.6.2 Requested additional information and/or interpretations must be produced as soon as practicable but in no event more than 21 working days from the date of the request.

6.3.1.6.3 Requests for additional information and/or requests for interpretations of information submitted will be made prior to issuance of any denial of a prior approval request.

6.3.1.7 Time Limits and Notice for Decision Making

6.3.1.7.1 Review of prior approval request required by the Medical Need Criteria for AAC Devices in this section will be completed within a reasonable amount of time (in most cases no longer than 60 days). If review has not been completed within 45 days, the beneficiary, guardian, or similar representative will be notified of the status of the pending application.

6.3.1.7.2 Requests for additional information and/or request for interpretations will be made as soon as the need is identified.

6.3.1.7.3 Decisions on prior approval requests that are not timely issued may entitle the beneficiary to pursue an appeal.

6.3.1.7.4 Written notice of decisions to deny prior approval or to approve a funding request with or without modifications will be provided directly to the beneficiary and vendor. Written notice will be provided to other persons, as appropriate.

## 6.4 Glossary

6.4.1 Augmentative and Alternative Communication (AAC)

AAC approaches support, enhance, or augment the communication of individuals who are not independent communicators in all situations. An individual's AAC system should not be a single technique, device, or strategy, but rather an array of techniques, devices and strategies from which the individual chooses in order to effectively address the demands of a given communication opportunity.

6.4.2 AAC Devices

Electronic or non-electronic aids, devices or systems that assist a beneficiary to overcome or ameliorate (to the maximum degree possible) the communication limitations that preclude or interfere with meaningful participation in current and projected daily activities. Examples of AAC devices include communication boards or books, electrolarynxes, speech amplifiers, and electronic devices that produce speech and/or written output. AAC devices include devices that are constructed for use as communication devices as well as systems that may include a computer, when an important use of the computer will be as the beneficiary's communication device. AAC devices also include related components and accessories, including software programs, symbol sets, overlays, mounting devices, switches, cables and connectors, auditory, visual, and tactile output devices, and necessary supplies, such as rechargeable batteries.

6.4.3 AAC Services

Treatment to assist beneficiaries in meeting the full range of their communication needs. The scope of AAC services includes diagnostic, screening, preventive, and corrective services provided by or under the direction of a speech-language pathologist. Specific activities include evaluation for, recommendation of, design, sup-up, customization, programming, and training related to the use of AAC devices.

6.4.4 Beneficiary's Preferences

The means and mode of message transmission a beneficiary prefers to use in a given communication interaction.

6.4.5 Current and Projected Daily Activities

The activities of daily living in which the individual now participates and in which it is anticipated the individual will participate when the individual's communication limitations have been overcome or ameliorated via the application of AAC approaches.

6.4.6 Expressive Communication Limitations

Difficulties in language production via any expressive communication modality (speech, writing, sign language, gesture, facial expression, graphic symbol selection).

6.4.7 Meaningful Participation

Effective and efficient communication of messages, taking into account the beneficiary's preferences regarding means and mode of transmission.

6.4.8 Receptive Communication Limitations

Difficulties in language understanding via any communication modality (speech, writing, sign language, gesture, facial expression, graphic symbol selection).

# 7.0 Medicare Medical Review Policies

## 7.1 DME Review Policy Items

Medicare has developed review policies for the following DME items:

- Ankle-Foot/Knee-Ankle-Foot Orthosis
- Canes and Crutches
- Cold Therapy
- **Continuous Positive Airway Pressure Systems (CPAP)**
- **Enteral Nutrition**
- External Breast Prosthesis
- **External Infusion Pumps**
- Eye Prosthesis
- Facial Prosthesis
- Footwear
- Home Blood Glucose Monitor
- **Hospital Beds**
- Lower Limb Prosthesis
- **Manual Wheelchair Base**
- **Motorized/Power Wheelchair Base**
- Negative Pressure Wound Therapy Pumps
- Orthopedic Footwear
- **Osteogenesis Stimulators**
- Ostomy Supplies
- **Oxygen**
- Parenteral Nutrition
- Patient Lifts
- **Pneumatic Compression Devices (Used for Lymphedema)**
- **Power Operated Vehicle**

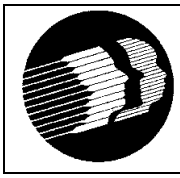
- **Pressure Reducing Support Surfaces – Group 1**
- **Pressure Reducing Support Surfaces – Group 2**
- **Pressure Reducing Support Surfaces – Group 3**
- Recumbent Ankle Positioning Splints
- Respiratory Assist Devices
- **Seat Lift Mechanisms**
- Spinal Orthotics: TLSO and LSO
- Suction Pumps
- Surgical Dressings
- Therapeutic Shoes
- Tracheostomy Care Supplies
- **Transcutaneous Electrical Nerve Stimulators (TENS)**
- Trapeze Bars and Other Bed Accessories
- Urological Supplies
- Wheelchair Options/Accessories

7.1.1 Medicaid refers to Medicare's Review Policies for coverage criteria in these cases for authorization of services. Medicaid requires the Medicaid CMN in addition to a Letter of Medical Necessity from the physician that describes how criteria are met. Where Medicare has developed a separate CMN, it is permissible for the physician to submit a completed form as medical documentation (see bolded items above and Appendix E).

NOTE: Medicaid waives the requirement of a physician's live signature on the Medicare CMN. However, the physician is required to sign the CMN and adhere to the face-to-face encounter requirements as provided in 3.1.5.

7.1.2 Medicaid will review any revised or new Medicare Review Policy for appropriateness and inclusion in this manual.

7.1.3 Information on Medicare's Medical Review Policies can be found in the Supplier Manual or at the Region A Durable Medical Equipment Regional Carrier (DMERC) website.



# DME Provider Policy Manual

## 8.0 Appendix A – Medical and Surgical Supplies

The 3-month limits established below for supply codes represent maximum usage for very ill patients and must not be billed routinely for all patients. The DME provider must limit billing to those items prescribed and dispensed as medically necessary.

*Items marked with an * do not require prior authorization

**Note: The list of supplies provided below may not represent an exhaustive list of billable codes. Providers must submit a prior authorization request for any supply that is not listed.**

### 8.1 Miscellaneous Supplies

| Code | 3-Mo. Limit | Item |
|---|---|---|
| A4206* | 270 | Syringe with needle, sterile, 1 cc or less, each |
| A4207* | 270 | Syringe with needle, sterile, 2 cc |
| A4208* | 270 | Syringe with needle, sterile 3 cc |
| A4209* | 180 | Syringe with needle, sterile, 5 cc or greater |
| A4210* | 100 | Needle-free injection device, each |
| A4212* | 33 | Non-coring needle or stylet with or without catheter.-Indicate manufacturer's name and product number on claim |
| A4213* | 100 | Syringe, sterile, 20 cc or greater, each |
| A4214* | 900 | Sterile saline or water, 30cc vial |
| A4215* | 1440 | Needles only, sterile, any size, each.-Indicate size, manufacturer's name and product number on claim |
| A4216* | 100 | Sterile water, saline and/or dextrose, diluent/flush, 10 ml |
| A4217* | 100 | Sterile water/saline 500 ml |
| A4218* | 100 | Sterile saline or water, metered dose dispenser, 10 ml |
| A4221* | 24 | Supplies for maintenance of drug infusion catheter per week, (list drug separately) |
| A4222* | 24 | Infusion supplies for external drug infusion pump, per cassette or bag (list drugs separately) |
| A4223 | Requires prior authorization | Infusion supplies not used with external fusion pump, per cassette or bag (list drugs separately) |
| A4224* | 12 | Supplies for maintenance of insulin Infusion catheter, per week |
| A4226 | Requires prior authorization | Supplies for maintenance of insulin infusion pump with dosage rate adjustment using therapeutic continuous glucose sensing, per week. |
| A4425* | 24 | Supplies for external insulin Infusion pump, syringe type cartridge, sterile, each |

| Code | 3-Mo. Limit | Item |
|---|---|---|
| A4230* | 90 | Infusion set for external insulin pump, (non-needle cannula type) |
| A4231* | 90 | Infusion set for external insulin pump, (needle type) |
| A4232* | 90 | Syringe with needle for external insulin pump, sterile, 3cc |
| A4233* | 1/12 mo. | Replacement battery, alkaline (other than J cell), for use with medically necessary home blood glucose monitor owned by patient, each |
| A4234* | 1/12 mo. | Replacement battery, alkaline, J cell, for use with medically necessary home blood glucose monitor owned by patient, each |
| A4235* | 1/12 mo. | Replacement battery, lithium, for use with medically necessary home blood glucose monitor owned by patient, each |
| A4236* | 1/12 mo. | Replacement battery, silver oxide, for use with medically necessary home blood glucose monitor owned by patient, each |
| A4244* | 180 | Alcohol or Peroxide, per pint |
| A4245* | 12 | Alcohol wipes, per box |
| A4246* | 180 | Betadine or Phisohex solution, per pint |
| A4247* | 4 | Betadine or Iodine swabs/wipes, per box |
| A4248* | 100 | Chlorhexidine containing antiseptic 1 ml |
| A4250 | 6 | Urine test or reagent strips or tablets (100 tablets or strips)- Requires prior authorization |
| A4252 | Requires prior authorization | Blood ketone test or reagent strip, each |
| A4280* | 45 | Adhesive skin support attachment for use with external breast prosthesis, each |
| A4290* | 4 | Sacral nerve stimulation test lead, each |

## 8.2 Vascular Catheters

| Code | 3-Mo. Limit | Item |
|---|---|---|
| A4305* | 90 | Disposable drug delivery system, flow rate of 50 ml or greater per hour-Indicate manufacturer's name and product number on claim |
| A4306* | 90 | Disposable drug delivery system, flow rate of less than 50 ml per hour |

## 8.3 Incontinence Appliances and Care Supplies

| Code | 3-Mo. Limit | Item |
|---|---|---|
| A4310* | 280 | Insertion tray without drainage bag and without catheter (accessories only) |
| A4311* | 15 | Insertion tray without drainage bag with indwelling catheter, foley type, two-way latex with coating (Teflon, Silicone, Silicone Elastomer or Hydrophilic, etc.) |

| Code | 3-Mo. Limit | Item |
|---|---|---|
| A4312* | 15 | Insertion tray without drainage bag with indwelling catheter, foley type, two-way, all silicone |
| A4313* | 15 | Insertion tray without drainage bag with indwelling catheter, foley type, three-way, for continuous irrigation |
| A4314* | 15 | Insertion tray with drainage bag with indwelling catheter, foley type, two-way latex with coating (Teflon, Silicone, Silicone Elastomer or Hydrophilic, etc.) |
| A4315* | 15 | Insertion tray with drainage bag with indwelling catheter, foley type, two-way, all silicone |
| A4316* | 15 | Insertion tray with drainage bag with indwelling catheter, foley type, three-way, for continuous irrigation |
| A4319* | 100 | Sterile water irrigation solution, 1000 ml |
| A4320* | 375 | Irrigation tray with bulb orpiston syringe, any purpose |
| A4322* | 375 | Irrigation syringe, bulb or piston |
| A4323* | 375 | Sterile saline irrigation solution, 1000 ml. |
| A4326* | 465 | Male external catheter with integral collection chamber, any type, each |
| A4327* | 1 | Female external urinary collection device; metal cup, each |
| A4328* | 1 | Female external urinary collection device; pouch, each |
| A4330* | 18 | Perianal fecal collection pouch with adhesive |
| A4331* | 15 | Extension drainage tubing, any type, any length, with connector/adaptor, for use with urinary leg bag or urostomy pouch, each |
| A4332* | 12 | Lubricant, individual sterile packet, each |
| A4333* | 6 | Urinary catheter anchoring device, adhesive skin attachment, each |
| A4334* | 6 | Urinary catheter anchoring device, leg strap, each |
| A4338* | 15 | Indwelling catheter, foley type, two-way latex with coating (Teflon, Silicone, Silicone Elastomer or Hydrophilic, etc.) |
| A4340* | 15 | Indwelling catheter, specialty type (e.g., Coude, Mushroom, Wing, etc.) |
| A4344* | 15 | Indwelling catheter, foley type, two-way, all silicone |
| A4346* | 15 | Indwelling catheter, foley type, three-way for continuous irrigation |
| A4348* | 6 | Male external catheter with integral collection compartment, extended wear, each (e.g., 2 per month) |
| A4349* | 100 | Male external catheter, with or without adhesive, disposable, each |
| A4351* | 375 | Intermittent urinary catheter, straight tip, with or without coating (teflon, silicone, silicone elastomer, or hydrophilic, etc.), each |
| A4352* | 375 | Intermittent urinary catheter, coude (curved) tip, with or without coating (teflon, silicone, silicone elastomer, or hydrophilic, etc.), each |
| A4353* | 280 | Intermittent urinary catheter, with insertion supplies |
| A4354* | 280 | Insertion tray with drainage bag but without catheter |

| Code | 3-Mo. Limit | Item |
|---|---|---|
| A4355* | 15 | Irrigation tubing set for continuous bladder irrigation through a three-way indwelling foley catheter |

## 8.4 External Urinary Supplies

| Code | 3-Mo. Limit | Item |
|---|---|---|
| A4356* | 6 | External urethral clamp or compression device (not to be used for catheter clamp) |
| A4357* | 15 | Bedside drainage bag, day or night, with or without anti-reflux device, with or without tube |
| A4358* | 15 | Urinary leg bag, leg or abdomen, vinyl, with or without tube, with straps, each |
| A4360* | 2 | Disposable external urethral clamp or compression device, with pad and/or pouch, each |

## 8.5 Ostomy Supplies

| Code | 3-Mo. Limit | Item |
|---|---|---|
| A4361* | 280 | Ostomy faceplate |
| A4362* | 280 | Skin barrier, solid, 4 X 4 or equivalent, each |
| A4363 | 1/12 mo. | Ostomy clamp, any type, replacement only, each |
| A4364* | 26 | Adhesive liquid, any type |
| A4365* | 3 | Adhesive remover wipes, any type, per 50 |
| A4366* | 270 | Ostomy vent, any type, each |
| A4367* | 4 | Ostomy belt |
| A4369* | 26 | Ostomy skin barrier, liquid (spray, brush, etc.), per oz. |
| A4371* | 26 | Ostomy skin barrier, powder, per oz. |
| A4372* | 3 | Ostomy skin barrier, solid 4x4 or equivalent, with built-in convexity, each |
| A4373* | 270 | Ostomy skin barrier, with flange (solid, flexible or accordion), with built-in convexity, any size, each |
| A4375* | 100 | Ostomy pouch, drainable, with faceplate attached, plastic, each |
| A4376* | 33 | Ostomy pouch, drainable, with faceplate attached, rubber, each |
| A4377* | 100 | Ostomy pouch, drainable, for use on faceplate, plastic, each |
| A4378* | 33 | Ostomy pouch, drainable, for use on faceplate, rubber, each |
| A4379* | 200 | Ostomy pouch, urinary, with faceplate attached, plastic, each |
| A4380* | 100 | Ostomy pouch, urinary, with faceplate attached, rubber, each |
| A4381* | 200 | Ostomy pouch, urinary, for use on faceplate, plastic, each |
| A4382* | 100 | Ostomy pouch, urinary, for use on faceplate, heavy plastic, each |

| Code | 3-Mo. Limit | Item |
|---|---|---|
| A4383* | 100 | Ostomy pouch, urinary, for use on faceplate, rubber, each |
| A4384* | 200 | Ostomy faceplate equivalent, silicone ring, each |
| A4385* | 3 | Ostomy skin barrier, solid 4x4 or equivalent, extended wear, without built-in convexity, each |
| A4387* | 270 | Ostomy pouch closed, with barrier attached, with built-in convexity (1 piece), each |
| A4388* | 45 | Ostomy pouch, drainable, with extended wear barrier attached, (1 piece) each |
| A4389* | 100 | Ostomy pouch, drainable, with barrier attached, with built-in convexity (1 piece), each |
| A4390* | 45 | Ostomy pouch, drainable, with extended wear barrier attached, with built-in convexity (1 piece), each |
| A4391* | 100 | Ostomy pouch, urinary, with extended wear barrier attached, (1 piece), each |
| A4392* | 200 | Ostomy pouch, urinary, with standard wear barrier attached, with built-in convexity (1 piece), each |
| A4393* | 100 | Ostomy pouch, urinary, with extended wear barrier attached, with built-in convexity (1 piece), each |
| A4394* | 26 | Ostomy deodorant, with or without lubricant, for use in ostomy pouch, per fluid ounce |
| A4395* | 270 | Ostomy deodorant for use in ostomy pouch, solid, per tablet |
| A4396* | 4 | Ostomy belt with peristomal hernia support |
| A4397* | 2 | Irrigation supply; sleeve |
| A4398* | 2 | Ostomy irrigation supply; bag, each |
| A4399* | 2 | Ostomy irrigation supply; cone/catheter, with or without brush |
| A4400* | 2 | Ostomy irrigation set |
| A4402* | 12 | Lubricant |
| A4404* | 280 | Ostomy rings |
| A4405* | 26 | Ostomy skin barrier, non-pectin based, paste, per ounce |
| A4406* | 26 | Ostomy skin barrier, pectin-based, paste, per ounce |
| A4407* | 180 | Ostomy skin barrier, with flange (solid, flexible, or accordion), extended wear, with built-in convexity, 4x4 inches or smaller, each |
| A4408* | 180 | Ostomy skin barrier, with flange (solid, flexible, or accordion), extended wear, with built-in convexity, larger than 4x4 inches, each |
| A4409* | 180 | Ostomy skin barrier, with flange (solid, flexible, or accordion), extended wear, without built-in convexity, 4x4 inches or smaller, each |
| A4410* | 180 | Ostomy skin barrier, with flange (solid, flexible, or accordion), extended wear, without built-in convexity, larger than 4x4 inches, each |
| A4411 | 180 | Ostomy skin barrier, solid 4x4 or equivalent, extended wear, with built-in convexity, each |

| Code | 3-Mo. Limit | Item |
|---|---|---|
| A4412 | 180 | Ostomy pouch, drainable, high output, for use on a barrier with flange (2 piece system) without filter, each |
| A4413* | 45 | Ostomy pouch, drainable, high output, for use on a barrier with flange (2 piece system), with filter, each |
| A4414* | 270 | Ostomy skin barrier, with flange (solid, flexible or accordion), without built-in convexity, 4x4 inches or smaller, each |
| A4415* | 270 | Ostomy skin barrier, with flange (solid, flexible or accordion), without built-in convexity, larger than 4x4 inches, each |
| A4416* | 270 | Ostomy pouch, closed; with barrier attached, with filter (one piece), each |
| A4417* | 270 | Ostomy pouch closed; with barrier attached, with built-in convexity, with filter (one piece), each |
| A4418* | 270 | Ostomy pouch, closed; without barrier attached, with filter (one piece) each |
| A4419* | 270 | Ostomy pouch, closed; for use on barrier with non-locking flange, with filter (two piece), each |
| A4420* | 270 | Ostomy pouch, closed; for use on barrier with locking flange (two piece), each |
| A4422* | 270 | Ostomy absorbent material (sheet/pad/crystal packet) for use in ostomy pouch to thicken liquid stomal output, each |
| A4423* | 270 | Ostomy pouch, closed; for use on barrier with locking flange, with filter (two piece), each |
| A4424* | 270 | Ostomy pouch, drainable; with barrier attached, with filter (one piece), each |
| A4425* | 270 | Ostomy pouch, drainable; for use on barrier with non-locking flange (two piece system), each |
| A4426* | 270 | Ostomy pouch, drainable; for use on barrier with locking flange (two piece system), each |
| A4427* | 270 | Ostomy pouch, drainable; for use on barrier with locking flange, with filter (two piece system), each |
| A4428* | 270 | Ostomy pouch, urinary; with extended wear barrier attached, with faucet-type tap with valve (one piece), each |
| A4429* | 270 | Ostomy pouch, urinary; with barrier attached, with built-in convexity, with faucet-type tap with valve (one piece), each |
| A4430* | 270 | Ostomy pouch, urinary; with extended wear barrier attached, with built-in convexity, with faucet-type tap with valve (one piece), each |
| A4431* | 270 | Ostomy pouch, urinary; with barrier with barrier attached, with faucet-type tap with valve (one piece), each |
| A4432* | 270 | Ostomy pouch, urinary; for use on barrier with non-locking flange, with faucet-type tap with valve (two piece), each |

| Code | 3-Mo. Limit | Item |
|---|---|---|
| A4433* | 270 | Ostomy pouch, urinary; for use on barrier with locking flange (two piece), each |
| A4434* | 270 | Ostomy pouch, urinary; for use on barrier with locking flange, with faucet-type with valve (two piece), each |
| A4435* | 100 | Ostomy pouch, drainable, high output, with extended wear barrier (one-piece system), with or without filter, each |

## 8.6 Additional Miscellaneous Supplies

| Code | 3-Mo. Limit | Item |
|---|---|---|
| A4450 | 560 | Tape, non-waterproof, per 18 square inches |
| A4452* | 560 | Tape, waterproof, per 18 square inches |
| A4455* | 186 | Adhesive remover or solvent (for tape, cement or other adhesive) |
| A4456* | 180 | Adhesive remover, wipes, any type, each |
| A4458 | Must be prior authorized | Enema bag with tubing, reusable |
| A4461 | Must be prior authorized | Surgical dressing holder, nonreusable, each |
| A4463 | Must be prior authorized | Surgical dressing holder, reusable, each |
| A4466 | Must be prior authorized | Garment, belt, sleeve or other covering, elastic or similar stretchable material, any type, each |
| A4467 | Must be prior authorized | Belt, strap, sleeve, garment, or covering, any type |
| A4470* | 3 | Gravlee jet washer |
| A4480* | 6 | Vabra aspirator |
| A4483* | 465 | Moisture exchanger, disposable for use with invasive mechanical ventilation |
| A4490* | 4 | Surgical stockings, above knee length, each |
| A4495* | 4 | Surgical stockings, thigh length, each |
| A4500* | 4 | Surgical stockings. Below knee length, each |
| A4510* | 4 | Surgical stockings, full length, each |
| A4553 | Must be prior authorized | Non-disposable underpads, all sizes |
| A4554 | Must be prior authorized | Disposable underpads, all sizes (e.g., Chux's) |
| A4555 | Must be prior authorized | Electrode/transducer for use with electrical stimulation device used for cancer treatment, replacement only |
| A4556 | Must be prior authorized | Electrodes, (e.g., apnea monitor), per pair |
| A4557 | Must be prior authorized | Lead wires, (e.g., apnea monitor), per pair |
| A4558* | 12 | Conductive gel or paste, for use with electrical device (e.g., TENS, NMES), per oz. |

| Code | 3-Mo. Limit | Item |
|---|---|---|
| A4561* | 12 | Pessary, rubber, any type |
| A4562* | 12 | Pessary, non rubber, any type |
| A4563 | Must be prior authorized | Rectal control system for vaginal insertion, for long term use, includes pump and all supplies and accessories, any type each |
| A4565* | 2/350 days | Slings |
| A4566* | 2/350 days | Shoulder sling or vest design, abduction restrainer with or without swathe control, prefabricated, includes fitting and adjustment |
| A4570* | 12 | Splint |
| A4600 | Must be prior authorized | Sleeve for intermittent limb compression device, replacement only, each |
| A4601 | Must be prior authorized | Lithium ion battery for nonprosthetic use, replacement |
| A4604* | 1 | Tubing with integrated heating element for use with positive airway pressure device |
| A4605 | Must be prior authorized | Tracheal suction catheter, closed system, each |
| A4606 | Must be prior authorized | Oxygen probe for use with oximeter device, replacement |
| T4521* | 720 – total combined incontinence prod(s) | Adult sized disposable incontinence product, brief/diaper, small, each |
| T4522* | 720 – total combined incontinence prod(s) | Adult sized disposable incontinence product, brief/diaper, medium, each |
| T4523* | 720 – total combined incontinence prod(s) | Adult sized disposable incontinence product, brief/diaper, large, each |
| T4524* | 720 – total combined incontinence prod(s) | Adult sized disposable incontinence product, brief/diaper, extra large, each |
| T4525* | 720 – total combined incontinence prod(s) | Adult sized disposable incontinence product, protective underwear/pull-on, small size, each |
| T4526* | 720 – total combined incontinence prod(s) | Adult sized disposable incontinence product, protective underwear/pull-on, medium size, each |
| T4527* | 720 – total combined incontinence prod(s) | Adult sized disposable incontinence product, protective underwear/pull-on, large size, each |

| Code | 3-Mo. Limit | Item |
|---|---|---|
| T4528* | 720 – total combined incontinence prod(s) | Adult sized disposable incontinence product, protective underwear/pull-on, extra large size, each |
| T4529* | 720 – total combined incontinence prod(s) | Pediatric sized disposable incontinence product, brief/diaper, small/medium size, each |
| T4530* | 720 – total combined incontinence prod(s) | Pediatric sized disposable incontinence product, brief/diaper, large size, each |
| T4531* | 720 – total combined incontinence prod(s) | Pediatric sized disposable incontinence product, protective underwear/pull-on, small/medium size, each |
| T4532* | 720 – total combined incontinence prod(s) | Pediatric sized disposable incontinence product, protective underwear/pull-on, large size, each |
| T4533* | 720 – total combined incontinence prod(s) | Youth sized disposable incontinence product, brief/diaper, each |
| T4534* | 720 – total combined incontinence prod(s) | Youth sized disposable incontinence product, protective underwear/pull-on, each |
| T4535* | 720 – total combined incontinence prod(s) | Disposable liner/shield/guard/pad/undergarment, for incontinence, each |
| T4541 | Requires prior authorization | Incontinence product, disposable underpad, large size, each |
| T4542* | 720 – total combined incontinence prod(s) | Incontinence product, disposable underpad, small size, each |
| T4543* | 720 – total combined incontinence prod(s) | Adult sized disposable incontinence product, protective brief/diaper, above extra large, each |
| T4544* | 720- total combined incontinence prod (s) | Adult sized disposable incontinence product, protective underwear/pull-on, above extra large, each |

| Code | 3-Mo. Limit | Item |
|---|---|---|
| E0570* | 1 every 5 years | Purchased nebulizer (Rental or replacement of nebulizer within the 5 year timeframe requires a PA) |

## 8.7 Supplies for Oxygen and Related Respiratory Equipment

| Code | 3-Mo. Limit | Item |
|---|---|---|
| A4608* | 2160 | Transtracheal oxygen catheter, each |
| A4611* | 2 | Battery, heavy duty, replacement for patient-owned ventilator |
| A4612* | 1 | Battery cables, replacement for patient-owned ventilator |
| A4613* | 1 | Battery charger, replacement for patient-owned ventilator |
| A4614* | 1/lifetime | Peak expiratory flow rate meter, hand held |
| A4615* | 45 | Cannula, nasal |
| A4616* | 100 | Tubing (oxygen), per foot |
| A4617* | 15 | Mouth piece |
| A4618* | 15 | Breathing circuits |
| A4619* | 15 | Face tent |
| A4620* | 15 | Variable concentration mask |
| A4621* | 15 | Tracheostomy mask or collar |
| A4622* | 12 | Tracheostomy or laryngectomy tube |
| A4623* | 12 | Tracheostomy, inner cannula (replacement only) |
| A4624* | 2160 | Tracheal suction catheter, any type other than closed system, each |
| A4625* | 1260 | Tracheostomy care or cleaning starter kit |
| A4626* | 1260 | Tracheostomy cleaning brush, each |
| A4628* | 280 | Oropharyngeal suction catheter, each |
| A4629* | 90 | Tracheostomy care kit for established tracheostomy |
| S8181* Temporary code | 15 | Trach tube holder |

## 8.8 Supplies for Other DME

| Code | 3-Mo. Limit | Item |
|---|---|---|
| A4630* | 24 | Replacement batteries, medically necessary T.E.N.S. owned by patient |
| A4631* | 2 | Replacement, batteries for medically necessary electronic wheelchair owned by patient |
| A4632 | Must be prior authorized | Replacement battery for external infusion pump, any type, each |
| A4633 | Must be prior authorized | Replacement bulb/lamp for ultraviolet light therapy system, each |
| A4634 | Must be prior authorized | Replacement bulb for therapeutic light box, tabletop model |

| Code | 3-Mo. Limit | Item |
|---|---|---|
| A4635 | Must be prior authorized | Underarm pad, crutch, replacement, each |
| A4636* | 2 | Replacement, hand grip, cane, crutch, or walker, each |
| A4637* | 2 | Replacement, tip, cane, crutch, walker, each |
| A4638 | Must be prior authorized | Replacement battery for patient-owned ear pulse generator, each |
| A4639 | Must be prior authorized | Replacement pad for infrared heating pad system, each |
| A4640* | 3 | Replacement pad for use with medically necessary alternating pressure pad owned by patient |

## 8.9 Dialysis Supplies

| Code | 3-Mo. Limit | Item |
|---|---|---|
| A4653 | Must be prior authorized | Peritoneal dialysis catheter anchoring device, belt, each |
| A4660* | 1 Per Lifetime | Sphygmomanometer/blood pressure apparatus with cuff and stethoscope |
| A4663* | 1 Per Lifetime | Blood pressure cuff only |
| A4670 | 1 Per Lifetime | Automatic Blood Pressure Monitor |
| A4671 | Must be prior authorized | Disposable cycler set used with cycler dialysis machine, each |
| A4672* | 45 | Drainage extension line, sterile, for dialysis, each |
| A4673* | 45 | Extension line with easy lock connectors, used with dialysis |
| A4674* | 360 | Chemicals/antiseptics solution used to clean/sterilize dialysis equipment, per 8 oz |
| A4927* | 6 | Gloves, non-sterile, per 100 |
| A4728* | 45 | Dialysate solution, non-dextrose containing, 500 ml |
| A4930* | 560 | Gloves, sterile, per pair |

## 8.10 Additional Ostomy Supplies

| Code | 3-Mo. Limit | Item |
|---|---|---|
| A5051* | 270 | Ostomy pouch, closed; with barrier attached (1 piece) each |
| A5052* | 270 | Ostomy pouch, closed, without barrier attached (1 piece) each |
| A5053* | 270 | Ostomy pouch, closed; for use on faceplate, each |
| A5054* | 270 | Ostomy pouch, closed, for use on barrier with flange (2 piece), each |
| A5055* | 180 | Stoma cap |
| A5056* | 100 | Ostomy pouch, drainable, with extended wear barrier attached, with filter, (1 piece) each |

| Code | 3-Mo. Limit | Item |
|---|---|---|
| A5057* | 100 | Ostomy pouch, drainable with extended wear barrier attached, with built in convexity, with filter, (1 piece), each |
| A5061* | 100 | Ostomy pouch, drainable; with barrier attached (1 piece), each |
| A5062* | 100 | Ostomy pouch, drainable; without barrier attached (1 piece), each |
| A5063* | 100 | Ostomy pouch, drainable; for use on barrier with flange (2 piece system), each |
| A5071* | 200 | Ostomy pouch, urinary; with barrier attached (1 piece), each |
| A5072* | 200 | Ostomy pouch, urinary; without barrier attached (1 piece), each |
| A5073* | 200 | Ostomy pouch, urinary; for use on barrier with flange (2 piece), each |
| A5081* | 3 | Stoma plug or seal, any type |
| A5082* | 6 | Continent device; catheter for continent stoma |
| A5083* | 100 | Continent device, stoma absorptive cover for continent stoma |
| A5093* | 100 | Ostomy accessory; convex insert |

## 8.11 Additional Incontinence Appliances/Supplies

| Code | 3-Mo. Limit | Item |
|---|---|---|
| A5102* | 1 | Bedside drainage bottle with or without tubing, rigid or expandable, each |
| A5105* | 3 | Urinary suspensory with leg bag, with or without tube, each |
| A5112* | 3 | Urinary drainage bag, leg or abdomen, latex, with or without tube, with straps, each |
| A5113* | 6 | Leg strap, latex, replacement only, per set |
| A5114* | 6 | Leg strap; foam or fabric, replacement only, per set |

## 8.12 Supplies for Either Incontinence or Ostomy Appliances

| Code | 3-Mo. Limit | Item |
|---|---|---|
| A5120 | 180 | Skin barrier, wipes or swabs, each |
| A5121* | 3 | Skin barrier; solid, 6 X 6 or equivalent, each |
| A5122* | 3 | Skin barrier; solid, 8 X 8 or equivalent, each |
| A5126* | 100 | Adhesive or non-adhesive; disc or foam pad |
| A5131* | 13 | Appliance cleaner, incontinence and ostomy appliances, per 16 oz. |
| A5200* | 100 | Percutaneous catheter/tube anchoring device, adhesive skin attachment |

## 8.13 Diabetic Shoes, Fitting, and Modifications

| Code | 3-Mo. Limit | Item |
|---|---|---|
| A5508 | Must be prior authorized | For diabetics only, deluxe feature of off-the-shelf depth-inlay shoe or custom-molded shoe, per shoe |
| A5510 | Must be prior authorized | For diabetics only, direct formed, compression molded to patient's foot without external heat source, multiple-density insert(s) prefabricated, per shoe |
| A5512 | Must be prior authorized | For diabetics only, multiple density insert, direct formed, molded to foot after external heat source of 230 degrees Fahrenheit or higher, total contact with patient's foot, including arch, base layer minimum of ¼ inch material of shore a 35 durometer of 3/16 inch material of shore a 40 durometer (or higher), prefabricated, each |
| A5513 | Must be prior authorized | For diabetics only, multiple density insert, custom molded from model of patient's foot, total contact with patient's foot, including arch, base layer minimum of ¼ inch material of shore a 35 durometer or 3/16 inch material of a 40 durometer (or higher), includes arch filler and other shaping material , custom fabricated, each |
| A5514 | Must be prior authorized | For diabetics only, multiple density insert, made by direct carving with cam technology from a rectified cad model created from a digitized scan of the patient, total contact with patient's foot, including arch, base layer minimum of 3/16 inch material of shore a 35 durometer (or higher), includes arch filler and other shaping material, custom fabricated, each |

## 8.14 Dressings

| Code | 3-Mo. Limit | Item |
|---|---|---|
| A6000 | Must be prior authorized | Non-contact wound warming wound cover for use with the non-contact wound warming device and warming card |
| A6010* | 180 | Collagen based wound filler, dry form, per gram of collagen |
| A6011 | Must be prior authorized | Collagen based wound filler, gel/paste, per gram of collagen |
| A6021* | 180 | Collagen dressing, sterile, size 16 sq. in. or less, each |
| A6022* | 180 | Collagen dressing, sterile, size more than 16 sq. in. but less than or equal to 48 sq. in., each |
| A6023* | 180 | Collagen dressing, sterile, size more than 48 sq. in., each |
| A6024* | 180 | Collagen dressing wound filler, per 6 inches |
| A6196* | 180 | Alginate or other fiber gelling dressing, wound cover, pad size 16 sq. in. or less, each dressing |
| A6197* | 180 | Alginate or other fiber gelling dressing, wound cover, pad size more than 16 sq. in. but less than or equal to 48 sq. |

| Code | 3-Mo. Limit | Item |
|---|---|---|
| | | in., each dressing |
| A6198* | 180 | Alginate or other fiber gelling dressing, wound cover, pad size more than 48 sq. in., each dressing |
| A6199* | 180 | Alginate or other fiber gelling dressing, wound filler, per 6 inches |
| A6200* | 360 | Composite dressing, pad size 16 sq. in. or less, without adhesive border, each dressing |
| A6201* | 360 | Composite dressing, pad size more than 16 sq. in. but less than or equal to 48 sq. in., without adhesive border, each dressing |
| A6202* | 360 | Composite dressing, pad size more than 48 sq. in., without adhesive border, each dressing |
| A6203* | 360 | Composite dressing, pad size 16 sq. in. or less, with any size adhesive border, each dressing |
| A6204* | 360 | Composite dressing, pad size more than 16 sq. in. but less than or equal to 48 sq. in., with any size adhesive border, each dressing |
| A6205* | 360 | Composite dressing, pad size more than 48 sq. in., with any size adhesive border, each dressing |
| A6206* | 360 | Contact layer, 16 sq. in. or less, each dressing |
| A6207* | 360 | Contact layer, more than 16 sq. in. but less than or equal to 48 sq. in., each dressing |
| A6208* | 360 | Contact layer, more than 48 sq. in., each dressing |
| A6209* | 180 | Foam dressing, wound cover, pad size 16 sq. in. or less, without adhesive border, each dressing |
| A6210* | 180 | Foam dressing, wound cover, pad size more than 16 sq. in. but less than or equal to 48 sq. in., without adhesive border, each dressing |
| A6211* | 180 | Foam dressing, wound cover, pad size more than 48 sq. in., without adhesive border, each dressing |
| A6212* | 180 | Foam dressing, wound cover, pad size 16 sq. in. or less, with any size adhesive border, each dressing |
| A6213* | 180 | Foam dressing, wound cover, pad size more than 16 sq. in. but less than or equal to 48 sq. in., with any size adhesive border, each dressing |
| A6214* | 180 | Foam dressing, wound cover, pad size more than 48 sq. in., with any size adhesive border, each dressing |
| A6215* | 180 | Foam dressing, wound filler, per gram |
| A6216* | 1800 | Gauze, non-impregnated, non-sterile, pad size 16 sq. in. or less, without adhesive border, each dressing |
| A6217* | 1800 | Gauze, non-impregnated, non-sterile, pad size more than 16 sq. in. but less than or equal to 48 sq. in., without adhesive border, each dressing |
| A6218* | 1800 | Gauze, non-impregnated, non-sterile, pad size more than 48 sq. in., without adhesive border, each dressing |
| A6219* | 1800 | Gauze, non-impregnated, pad size 16 sq. in. or less, with any size adhesive border, each dressing |

| Code | 3-Mo. Limit | Item |
|---|---|---|
| A6220* | 1800 | Gauze, non-impregnated, pad size more than 16 sq. in. but less than or equal to 48 sq. in., with any size adhesive border, each dressing |
| A6221* | 1800 | Gauze, non-impregnated, pad size more than 48 sq. in., with any size adhesive border, each dressing |
| A6222* | 1800 | Gauze, impregnated with other than water, normal saline, or hydrogel, pad size 16 sq. in. or less, without adhesive border, each dressing |
| A6223* | 1800 | Gauze, impregnated with other than water, normal saline, or hydrogel, pad size more than 16 sq. in. but less than or equal to 48 sq. in., without adhesive border, each dressing |
| A6224* | 1800 | Gauze, impregnated with other than water, normal saline, or hydrogel, pad size more than 48 sq. in., without adhesive border, each dressing |
| A6228* | 1800 | Gauze, impregnated, water or normal saline, pad size 16 sq. in. or less, without adhesive border, each |
| A6229* | 1800 | Gauze, impregnated, water or normal saline, pad size more than 16 sq. in. but less than or equal to 48 sq. in. without adhesive border, each |
| A6230* | 1800 | Gauze, impregnated, water or normal saline, pad size more than 48 sq. in., without adhesive border, each dressing |
| A6231* | 1800 | Gauze, impregnated, hydrogel, for direct wound contact, pad size 16 sq. in. or less, each dressing |
| A6232* | 1800 | Gauze, impregnated, hydrogel, for direct wound contact, pad size greater than 16 sq. in., but less than or equal to 48 sq. in., each dressing |
| A6233* | 1800 | Gauze, impregnated, hydrogel, for direct wound contact, pad size more than 48 sq. in., each dressing |
| A6234* | 180 | Hydrocolloid dressing, wound cover, pad size 16 sq. in. or less, without adhesive border, each |
| A6235* | 180 | Hydrocolloid dressing, wound cover, pad size more than 16 sq. in. but less than or equal to 48 sq. in., without adhesive border, each |
| A6236* | 180 | Hydrocolloid dressing, wound cover, pad size more than 48 sq. in., without adhesive border, each dressing |
| A6237* | 180 | Hydrocolloid dressing, wound cover, pad size 16 sq. in. or less, with any size adhesive border, each dressing |
| A6238* | 180 | Hydrocolloid dressing, wound cover, pad size more than 16 sq. in. but less than or equal to 48 sq. in., with any adhesive border, each |
| A6239* | 180 | Hydrocolloid dressing, wound cover, pad size more than 48 sq. in., with any size adhesive border, each |
| A6240* | 180 | Hydrocolloid dressing, wound filler, paste, per fluid ounce |
| A6241* | 180 | Hydrocolloid dressing, wound filler, dry form, per gram |
| A6242* | 360 | Hydrogel dressing, wound cover, pad size 16 sq. in. or |

| Code | 3-Mo. Limit | Item |
|---|---|---|
| | | less, without adhesive border, each |
| A6243* | 360 | Hydrogel dressing, wound cover, pad size more than 16 sq. in. but less than or equal to 48 sq. in., without adhesive border, each |
| A6244* | 360 | Hydrogel dressing, wound cover, pad size more than 48 sq. in., without adhesive border, each |
| A6245* | 360 | Hydrogel dressing, wound cover, pad size 16 sq. in. or less, with any size adhesive border, each |
| A6246* | 360 | Hydrogel dressing, wound cover, pad size more than 16 sq. in. but less than or equal to 48 sq. in., with any size adhesive border, each |
| A6247* | 360 | Hydrogel dressing, wound cover, pad size more than 48 sq. in., with any size adhesive border, each |
| A6248* | 180 | Hydrogel dressing, wound filler, gel, per fluid ounce |
| A6251* | 180 | Specialty absorptive dressing, wound cover, pad size 16 sq. in. or less, without adhesive border, each |
| A6252* | 180 | Specialty absorptive dressing, wound cover, pad size more than 16 sq. in. but less than or equal to 48 sq. in., without adhesive border, each |
| A6253* | 180 | Specialty absorptive dressing, wound cover, pad size more than 48 sq. in., without adhesive border, each dressing |
| A6254* | 180 | Specialty absorptive dressing, wound cover, pad size 16 sq. in. or less, with any size adhesive border, each dressing |
| A6255* | 180 | Specialty absorptive dressing, wound cover, pad size more than 16 sq. in. but less than or equal to 48 sq. in., with any size adhesive border, each |
| A6256* | 180 | Specialty absorptive dressing, wound cover, pad size more than 48 sq. in., with any size adhesive border, each dressing |
| A6257* | 360 | Transparent film, 16 sq. in. or less, each dressing |
| A6258* | 360 | Transparent film, more than 16 sq. in but less than or equal to 48 sq. in., each dressing |
| A6259* | 360 | Transparent film, more than 48 sq. in., each dressing |
| A6261* | 180 | Wound filler, gel/paste, per fluid ounce, not otherwise specified |
| A6262* | 180 | Wound filler, dry form, per gram, not otherwise specified |
| A6266* | 180 | Gauze, impregnated other than water, normal saline, or zinc paste, any width, per linear yard |
| A6402* | 1800 | Gauze, non-impregnated, sterile, pad size 16 sq. in. or less, without adhesive border, each dressing |
| A6403* | 1800 | Gauze, non-impregnated, sterile, pad size more than 16 sq. in. less than or equal to 48 sq. in., without adhesive border, each dressing |
| A6404* | 1800 | Gauze, non-impregnated, sterile, pad size more than 48 sq. in., without adhesive border, each dressing |

| Code | 3-Mo. Limit | Item |
|---|---|---|
| A6405* | 180 | Gauze, elastic, sterile, all types, per linear yard |
| A6406* | 180 | Gauze, non-elastic, sterile, all types, per linear yard |
| A6407* | 360 | Packing strips, non-impregnated, up to two inches in width, per linear yard |
| A6410* | 180 | Eye pad, sterile, each |
| A6411* | 180 | Eye pad, non-sterile, each |
| A6412* | 180 | Eye patch, occlusive, each |
| A6421 | Must be prior authorized | Padding bandage, non-elastic, non-woven/non-knitted, width greater than or equal to three inches and less than five inches, per roll (at least three yards, unstretched) |
| A6422 | Must be prior authorized | Conforming bandage, non-elastic, knitted/woven, non-sterile, width greater than or equal to three inches and less than five inches per roll (at least three yards, unstretched) |
| A6424 | Must be prior authorized | Conforming bandage, non-elastic, knitted/woven, non-sterile, width greater than or equal to five inches, per roll (at least three yards, unstretched) |
| A6426 | Must be prior authorized | Conforming bandage, non-elastic, knitted/woven, sterile, width greater than or equal to three inches and less than five inches, per roll (at least three yards, unstretched) |
| A6428 | Must be prior authorized | Conforming bandage, non-elastic, knitted/woven, sterile, width greater than or equal to five inches, per roll (at least three yards, unstretched) |
| A6430 | Must be prior authorized | Light compression bandage, elastic, knitted/woven, load resistance less than 1.25 foot pounds at 50% maximum stretch, width greater than or equal to three inches and less than five inches, per roll (at least three yards, unstretched) |
| A6432 | Must be prior authorized | Light compression bandage, elastic, knitted/woven, load resistance less than 1.25 foot pounds at 50% maximum stretch, width greater than or equal to five inches, per roll (at least three yards, unstretched) |
| A6434 | Must be prior authorized | Moderate compression bandage, elastic, knitted/woven, load resistance of 1.25 to 1.34 foot pounds at 50% maximum stretch, width greater than or equal to three inches or less than five inches, per roll (at least three yards, unstretched) |
| A6436 | Must be prior authorized | 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 roll (at least three yards, unstretched) |
| A6438 | Must be prior authorized | Self-adherent bandage, elastic, non-knitted/non-woven, load resistance greater than or equal to 0.55 foot pounds at 50% maximum stretch, width greater than or equal to three inches and less than five inches, per roll (at least five yards, unstretched) |

| Code | 3-Mo. Limit | Item |
|---|---|---|
| A6440 | Must be prior authorized | Zinc paste impregnated bandage, non-elastic, knitted/woven, width greater than or equal to three inches and less than five inches, per roll (at least 10 yards, unstretched) |
| A6441* | 360 | Padding bandage, non-elastic, non-woven/non-knitted, width greater than or equal to three inches and less than five inches, per yard |
| A6442* | 360 | Conforming bandage, non-elastic, knitted/woven, non-sterile, width less than three inches, per yard |
| A6443* | 360 | Conforming bandage, non-elastic, knitted/woven, non-sterile, width greater than or equal to three inches and less than five inches, per yard |
| A6444* | 360 | Conforming bandage, non-elastic, knitted/woven, non-sterile, width greater than or equal to five inches, per yard |
| A6445* | 360 | Conforming bandage, non-elastic, knitted/woven, sterile, width less than three inches, per yard |
| A6446* | 360 | Conforming bandage, non –elastic, knitted/woven, sterile, width greater than or equal to three inches and less than five inches, per yard |
| A6447* | 360 | Conforming bandage, non-elastic, knitted/woven, sterile, width greater than or equal to five inches, per yard |
| A6448* | 360 | Light compression bandage, elastic, knitted/woven, width less than three inches, per yard |
| A6449* | 360 | Light compression bandage, elastic, knitted/woven, width greater than or equal to three inches and less than five inches, per yard |
| A6450* | 360 | Light compression bandage, elastic, knitted/woven, width greater than or equal to five inches, per yard |
| A6451* | 360 | 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 |
| A6452* | 360 | High compression bandage, elastic, knitted/woven, load resistance greater than or equal to 1.35 foot pounds at 50 percent maximum stretch, width greater than or equal to three inches and less than five inches, per yard |
| A6453* | 360 | Self-adherent bandage, elastic, non-knitted/non –woven, width less than three inches, per yard |
| A6454* | 360 | Self-adherent bandage, elastic, non-knitted/non-woven, width greater than or equal to three inches and less than five inches, per yard |
| A6455* | 360 | Self-adherent bandage, elastic, non-knitted/non-woven, width greater than or equal to five inches, per yard |
| A6456* | 360 | Zinc paste impregnated bandage, non-elastic, knitted/woven, width greater than or equal to three inches and less than five inches, per yard |
| A6457* | 360 | Tubular dressing with or without elastic, any width, per |

| Code | 3-Mo. Limit | Item |
|---|---|---|
| | | linear yard |
| A6460* | 360 | Synthetic resorbable wound dressing, sterile, pad size 16 sq. in. or less, without adhesive border, each dressing |
| A6461* | 360 | Synthetic resorbable wound dressing, sterile, pad size more than 16 sq. in. but less than or equal to 48 sq. in., without adhesive border, each dressing |
| A6501 | Must be prior authorized | Compression burn garment, bodysuit (head to foot), custom fabricated |
| A6502 | Must be prior authorized | Compression burn garment, chin strap, custom fabricated |
| A6503 | Must be prior authorized | Compression burn garment, facial hood, custom fabricated |
| A6504 | Must be prior authorized | Compression burn garment, glove to wrist, custom fabricated |
| A6505 | Must be prior authorized | Compression burn garment, glove to elbow, custom fabricated |
| A6506 | Must be prior authorized | Compression burn garment, glove to axilla, custom fabricated |
| A6507 | Must be prior authorized | Compression burn garment, foot to knee length, custom fabricated |
| A6508 | Must be prior authorized | Compression burn garment, foot to thigh length, custom fabricated |
| A6509 | Must be prior authorized | Compression burn garment, upper trunk to waist including arm openings (vest), custom fabricated |
| A6510 | Must be prior authorized | Compression burn garment, trunk, including arms down to leg openings (leotard), custom fabricated |
| A6511 | Must be prior authorized | Compression burn garment, lower trunk including leg openings (panty), custom fabricated |
| A6512 | Must be prior authorized | Compression burn garment, not otherwise classified |
| A6513 | Must be prior authorized | Compression burn mask, face and/or neck, plastic or equal, custom fabricated |
| A6530 | Must be prior | Gradient compression stocking, below knee, 18-30 mm Hg, each |

| Code | 3-Mo. Limit | Item |
|---|---|---|
| | authorized | |
| A6531 | Must be prior authorized | Gradient compression stocking, below knee, 30-40 mm Hg, each |
| A6532 | Must be prior authorized | Gradient compression stocking, below knee, 40-50 mm Hg, each |
| A6533 | Must be prior authorized | Gradient compression stocking, thigh length, 18-30 mm Hg, each |
| A6534 | Must be prior authorized | Gradient compression stocking, thigh length, 30-40 mm Hg, each |
| A6535 | Must be prior authorized | Gradient compression stocking, thigh length, 40-50 mm Hg, each |
| A6536 | Must be prior authorized | Gradient compression stocking, full length/chap style, 18-30 mm Hg, each |
| A6537 | Must be prior authorized | Gradient compression stocking, full length/chap style, 30-40 mm Hg, each |
| A6538 | Must be prior authorized | Gradient compression stocking, full length/chap style, 40-50 mm Hg, each |
| A6539 | Must be prior authorized | Gradient compression stocking, waist length, 18-30 mm Hg, each |
| A6540 | Must be prior authorized | Gradient compression stocking, waist length, 30-40 mm Hg, each |
| A6541 | Must be prior authorized | Gradient compression stocking, waist length, 40-50 mm Hg, each |
| A6542 | Must be prior authorized | Gradient compression stocking, custom made |
| A6543 | Must be prior authorized | Gradient compression stocking, lymphedema |
| A6544 | Must be prior authorized | Gradient compression stocking, garter belt |
| A6545 | Must be prior authorized | Gradient compression wrap, non-elastic, below knee, 30-50 mm Hg, each |

| Code | 3-Mo. Limit | Item |
|---|---|---|
| A6549 | Must be prior authorized | Gradient compression stocking/sleeve, not otherwise specified |
| A6550 | Must be prior authorized | Dressing set for negative pressure wound therapy electrical pump, stationary or portable, each |

## 8.15 Miscellaneous Supply

| | | |
|---|---|---|
| A7000* | 6 | Canister, disposable, used with suction pump, each |
| A7001 | Must be prior authorized | Canister, non-disposable, used with suction pump, each |
| A7002* | 6 | Tubing, used with suction pump, each |
| A7003* | 6 | Administration set, with small volume nonfiltered pneumatic nebulizer, disposable |
| A7004* | 6 | Small volume nonfiltered pneumatic nebulizer, disposable |
| A7005* | 1 | Administration set, with small volume nonfiltered pneumatic nebulizer, non-disposable |
| A7006 | Must be prior authorized | Administration set, with small volume filtered pneumatic nebulizer |
| A7007 | Must be prior authorized | Large volume nebulizer, disposable, unfilled, used with aerosol compressor |
| A7008 | Must be prior authorized | Large volume nebulizer, disposable, prefilled, used with aerosol compressor |
| A7009 | Must be prior authorized | Reservoir bottle, non-disposable, used with large volume ultrasonic nebulizer |
| A7010 | Must be prior authorized | Corrugated tubing, disposable, used with large volume nebulizer, 100 feet |
| A7011 | Must be prior authorized | Corrugated tubing, non-disposable, used with large volume nebulizer, 10 feet |
| A7012 | Must be prior authorized | Water collection device, used with large volume nebulizer |
| A7013* | 6 | Filter, disposable, used with aerosol compressor or ultrasonic generator |
| A7014* | 1 | Filter, non-disposable, used with aerosol compressor or ultrasonic generator |
| A7015* | 3 | Aerosol mask, used with DME nebulizer |

| | | |
|---|---|---|
| A7016* | 2/350 days | Dome and mouthpiece, used with small volume ultrasonic nebulizer |
| A7017 | Must be prior authorized | Nebulizer, durable, glass or autoclavabe plastic, bottle type, not use with oxygen |
| A7018* | 100 | Water, distilled, used with large volume nebulizer, 1000 ml |
| A7019* | 100 | Saline solution, per 10 ml, metered dose dispenser, for use with inhalation drugs |
| A7020* | Must be prior authorized | Interface for cough stimulating device, includes all components, replacement only |
| A7025 | Must be prior authorized | High frequency chest wall oscillation system vest, replacement for use with patient owned equipment, each |
| A7026 | Must be prior authorized | High frequency chest wall oscillation system hose, replacement for use with patient owned equipment, each |
| A7027 | Must be prior authorized | Combination oral/nasal mask, used with continuous positive airway pressure device, each |
| A7028 | Must be prior authorized | Oral cushion for combination oral/nasal mask, replacement only, each |
| A7029 | Must be prior authorized | Nasal pillows for combination oral/nasal mask, replacement only, pair |
| A7030* | 2/350 days | Full face mask used with positive airway pressure device, each |
| A7031* | 2/350 days | Face mask interface, replacement for full face mask, each |
| A7032* | 6 | Replacement cushion for nasal application device, each |
| A7033* | 6 | Replacement pillows for nasal application device, pair |
| A7034* | 1 | Nasal interface (mask or cannula type) used with positive airway pressure device, with or without head strap |
| A7035* | 2/350 days | Headgear used with positive airway pressure device |
| A7036* | 2/350 days | Chinstrap used with positive airway pressure device |
| A7037* | 1 | Tubing used with positive airway pressure device |
| A7038* | 3 | Filter, disposable, used with positive airway pressure device |
| A7039 | Must be prior authorized | Filter, non disposable, used with positive airway pressure device |
| A7040 | Must be prior authorized | One way chest drain valve |
| A7041 | Must be prior authorized | Water seal drainage container and tubing for use with implanted chest tube |
| A7043 | Must be prior | Vacuum drainage bottle and tubing for use with implanted catheter |

| | | |
|---|---|---|
| | authorized | |
| A7044 | Must be prior authorized | Oral interface used with positive airway pressure device, each |
| A7045 | Must be prior authorized | Exhalation port with or without swivel used with accessories for positive airway devices, replacement only |
| A7046 | Must be prior authorized | Water chamber for humidifier, used with positive airway pressure device, replacement, each |
| A7047 | Must be prior authorized | Oral interface used with respiratory suction pump, each |
| A7501 | Must be prior authorized | Tracheostoma value, including diaphragm, each |
| A7502 | Must be prior authorized | Replacement diaphragm/faceplate for tracheostoma value, each |
| A7503* | 12 | Filter holder or filter cap, reusable, for use in a tracheostoma heat and moisture exchange system, each |
| A7504* | 12 | Filter for use in a trecheostoma heat and moisture exchange system, each |
| A7505* | 12 | Housing, reusable without adhesive, for use in a heat and moisture exchange system and/or with a tracheostoma value, each |
| A7506* | 12 | Adhesive disc for use in a heat and moisture exchange system and/or with treacheostoma value, any type, each |
| A7507* | 12 | Filter holder and integrated filter without adhesive, for use in a tracheostoma heat and moisture exchange system, each |
| A7508* | 12 | Housing and integrated adhesive, for use in a tracheostoma heat and moisture exchange system and/or with a tracheostoma value, each |
| A7509* | 12 | Filter holder and integrated filter housing, and adhesive, for use as a tracheostoma heat and moisture exchange system, each |
| A7520 | Must be prior authorized | Tracheostomy/laryngectomy tube, non-cuffed, polyvinylchloride (PVC), silicone or equal, each |
| A7521 | Must be prior authorized | Tracheostomy/laryngectomy tube, cuffed, polyvinylchloride (PVC), silicone or equal, each |
| A7522 | Must be prior authorized | Tracheostomy/laryngectomy tube, stainless steel or equal (sterilizable and reusable), each |
| A7523 | Must be prior authorized | Tracheostomy shower protector, each |

| | | |
|---|---|---|
| A7524 | Must be prior authorized | Tracheostoma stent/stud/button, each |
| A7525* | 1 | Tracheostomy mask, each |
| A7526 | Must be prior authorized | Tracheostomy tube collar/holder, each |
| A7527 | Must be prior authorized | Tracheostomy/Laryngectomy tube plug/stop, each |
| A8000 | Must be prior authorized | Helmet, protective, soft, prefabricated, includes all components and accessories |
| A8001 | Must be prior authorized | Helmet, protective, hard, prefabricated, includes all components and accessories |
| A8002 | Must be prior authorized | Helmet, protective, soft, custom fabricated, includes all components and accessories |
| A8003 | Must be prior authorized | Helmet, protective, hard, custom fabricated, includes all components and accessories |
| A8004 | Must be prior authorized | Soft interface for helmet, replacement only |

## 8.16 Administrative, Miscellaneous & Investigational

| Code | 3-Mo. Limit | Item |
|---|---|---|
| A9155 | Must be prior authorized | Artificial saliva, 30 ml |
| A9272 | Must be prior authorized | Wound suction, disposable, includes dressing, all accessories and components, any type, each |
| A9274 | Must be prior authorized | External ambulatory insulin delivery system, disposable, each, includes all supplies and accessories |
| A9280 | Must be prior authorized | Alert or alarm device, not otherwise classified |
| A9283 | Must be prior authorized | Foot pressure off loading/supportive device, any type, each |
| A9900 | Must be prior authorized | Miscellaneous DME supply, accessory, and/or service component of another HCPCS code |

| | | |
|---|---|---|
| A9999 | Must be prior authorized | Miscellaneous DME supply or accessory, not otherwise specified |

## 8.17 Prosthetics

| Code | 3-Mo. Limit | Item |
|---|---|---|
| L8000* | 2 | Breast prosthesis, mastectomy bra |
| L8020* | 2/350 days | Breast prosthesis, mastectomy form |

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# 9.0 Appendix B – Medicaid Certificate of Medical Necessity

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DELAWARE HEALTH AND SOCIAL SERVICES

# Appendix B – Medicaid Certificate of Medical Necessity

## General Instructions

- Incomplete or illegible forms will be returned and may delay the authorization process.
- Review the Delaware Medical Assistance Program manuals for instructions and form downloads at https://medicaid.dhss.delaware.gov

- Date Received: _____
- Date Eligible: _____
- Supporting Documentation ☐ YES ☐ NO
- TPL: ☐ YES-Type:_____ ☐ NO

| | | |
|---|---|---|
| **FAX completed forms to: 302-255-4481**<br>**Telephone: 302-255-9500** | DMMA<br>Prior Authorization/Lewis Bldg<br>1901 N. DuPont Hwy. P.O. Box 906<br>New Castle, DE 19720 | **Comments:** |

## A. PROVIDER INFORMATION

| | |
|---|---|
| **Name:** | **FAX Number:** |
| **Address:** | |
| **Contact Name:** | **Telephone Number:** |
| **NPI (Provider ID#):** | **Taxonomy:** |

## B. Member / PATIENT INFORMATION

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| **Name:** | | | | | | **Medicaid ID#:** | |
| **Service Dates:** **FROM:** | | **TO:** | | | | **Continuation of Service** ☐ **Yes** ☐ **No** | |
| **DOB:** | **Diagnosis(es):** | | | | | | |

## C. EQUIPMENT / SUPPLY(IES) (List additional items on "Continuation Form.")

| HCPCS CODE | MOD | DESCRIPTION | TOTAL # OF UNITS | TOTAL U&C CHARGE |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |

MOD(Modifier): Use "NU" for Purchase New, "UE" for Purchase Used, or "RR" for Rental;
Include Brand Name and Serial/Product Number as part of the description

**EST. LENGTH OF NEED (# OF MONTHS):_____ 1-99 (99=LIFETIME)**

## D. PRACTITIONER AUTHORIZATION **IMPORTANT:** This section must be completed by the attending physician/practitioner.

| | |
|---|---|
| **Name** (print)**:** | **Telephone Number:** |
| **Address:** | |
| **Contact Name:** | **FAX Number:** |
| **NPI (Provider ID#):** | |
| **Signature:** | **Date:** |

**I certify that the services described above are medically necessary for the identified patient/member.**

**DO NOT WRITE BELOW THIS LINE**

| | | |
|---|---|---|
| Date Reviewed: | ☐ **Approved** ☐ **Denied** ☐ **Incomplete** | **Authorization #:** |
| Signature: | Comments: | |




# Appendix B – Continuation Form

**Member / PATIENT INFORMATION**

| | |
|---|---|
| **Name:** | **Medicaid ID#:** |
| **Service Dates:** **FROM:** **TO:** | |

**E. EQUIPMENT / SUPPLY(IES)**

| HCPCS CODE | MOD | DESCRIPTION | TOTAL # OF UNITS | TOTAL U&C CHARGE |
|---|---|---|---|---|
| | | | | |
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**PRACTITIONER AUTHORIZATION** **IMPORTANT:** This section must be completed by the attending physician/practitioner.

| | |
|---|---|
| **Name** (print)**:** | **Telephone Number:** |
| **Contact Name:** | **FAX Number:** |
| **Signature:** | **Date:** |
| I certify that the services described above are medically necessary for the identified patient/member. | |

# 10.0 Appendix C – Renal Supplement Form

**10.1**

**Department of Health and Social Services**
**Division of Medicaid and Medical Assistance**

# RENAL SUPPLEMENT

**Certificate of Medical Necessity Form**

_____ Application/Renewal

_____ Cancellation/Change

Member's Name _____ Phone _____

Address _____

Birth Date _____ End State Renal Yes ☐ No ☐

Dialysis/Transplant Unit _____

Nephrologist _____ Phone Number _____

MCI # _____ Effective Date _____

## NUTRITIONAL INFORMATION

IBW _____ % of WT loss in past 3-6 months _____

Please document date and lab value for the past 3 months:

| | | | |
|---|---|---|---|
| **Date** | | | |
| **Weight** | | | |
| **Albumin** | | | |
| **PCR** | | | |
| **Supplement Calories/Day** | | | |

Supplement requested _____

Daily amount requested _____

Explanation of need _____

_____ _____
Signature (MD/NP/RD) Date

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| | |
|---|---|
| | **Practitioner's Medical Necessity Letter** |

## 11.0 Appendix D – Practitioner's Medical Necessity Letter

Practitioner's Medical Necessity Letter
STATE OF DELAWARE

Member's Name:_____Date of Birth:_____

Item Requested (separate letter required for each item requested):

_____

_____

1. Diagnosis and prognosis: Include present physical condition and functional limitations.

2. Treatment Plan. (Medications, therapies, nursing services, etc.)

3. Reason for use of requested item.

Estimated duration of use.

4. Expected Therapeutic effect of requested item.

5. Please attach pertinent laboratory/pulmonary function test results and/or summaries from other professionals involved in the care of this member.

Please note: Medicaid policy requires coverage of the least costly appropriate alternative available that can be safely and effectively provided to the member and not duplicate other services. The Medical Review Team may require additional information to process your request.

Physician's Name (Signature):_____Date:_____
Physician's Name (Printed):_____
Physician's Address:_____
_____
Physician's Phone Number:_____

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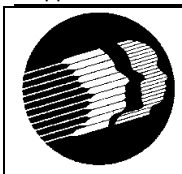

# Medicare Certificates of Medical Necessity

## 12.0 Appendix E - Medicare Certificates of Medical Necessity

The appropriate Medicare Certificate of Medical Necessity (CMN) in this Section must be completed and signed by the physician.

U.S. DEPARTMENT OF HEALTH & HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO.0938-0679
**DMERC 09.02**

**CERTIFICATE OF MEDICAL NECESSITY**

**EXTERNAL INFUSION PUMP)**

**SECTION A** **Certification Type/Date: INITIAL_____/_____/_____ REVISED_____/_____/_____**

| PATIENT NAME, ADDRESS, TELEPHONE and HIC NUMBER | | SUPPLIER NAME, ADDRESS, TELEPHONE and NSC NUMBER |
|---|---|---|
| (_____)_____-_____ HICN_____ | | (___)_____-_____ NSC#_____ |
| PLACE OF SERVICE_____<br>NAME and ADDRESS of FACILITY if applicable (See Reverse) | HCPCS CODE<br>_____<br>_____<br>_____<br>_____ | PT DOB___/___/____ SEX____(M/F) HT____(IN.) WT_____(lbs.)<br>PHYSICIAN NAME, ADDRESS **(Printed or Type)**<br>PHYSICIAN'S UPIN:_____<br>PHYSICIAN'S TELEPHONE # (_____)_____-_____ |

**SECTION B** **Information in this Section May Not Be Completed by the Supplier of the Items/Supplies**

EST. LENGTH OF NEED (# OF MONTHS) _____1-99 (99=LIFETIME) DIAGNOSIS CODES (ICD-10) _____ _____ _____ _____

| ANSWERS | ANSWER QUESTIONS 1-7 FOR EXTERNAL INFUSION PUMP<br>(Circle **Y** for Yes, **N** for No, or **D** for Does Not Apply, Unless Otherwise Noted) |
|---|---|
| 1 3 4 | 1. Circle number of pump which has been prescribed:<br>1. – External infusion pump (non-disposable) 2. – Reserved for other or future use;<br>3 – Implantable infusion pump; 4. – Disposable infusion pump (e.g., elastomeric) |
| HCPCS CODE;<br>_____ | 2. Provide the HCPCS code for the drug that requires the use of the pump. |
| _____ | 3. If non-specific code was used to answer questions, print name of drug. |
| 1 3 4 | 4. Circle number for route of administration:<br>1. – Intravenous; 2. – Reserved for other or future use; 3. – Epidural; 4. - Subcutaneous |
| 1 2 3 | 5. Circle number for method of administration: 1. – Continuous; 2. – Intermittent; 3. - Bolus |
| _____ | 6. What is the total duration of drug infusion per 24 hours? (1-24) |
| Y N D | 7. Does the patient have intractable cancer pain which has failed to respond to an adequate oral/transdermal narcotic analgesic regimen or is the patient unable to tolerate oral/transdermal narcotics? |

NAME OF PERSON ANSWERING SECTION B QUESTIONS, IF OTHER THAN PHYSICIAN (Please Print)
NAME:_____TITLE:_____EMPLOYER:_____:

**SECTION C** **Narrative Description Of Equipment And Cost**

**(1)** Narrative description of all items, accessories and options ordered; (**2**) Supplier's charge; and (**3**) Medicare Fee Schedule Allowance for each item, accessory, and option. *(See Instructions On Back)*

**SECTION D** **Physician Attestation and Signature/Date**

I certify that I am the physician identified in Section A of this form. I have received Sections A, B and C of the Certificate of Medical Necessity (including charges for items ordered). Any statement on my letterhead attached hereto, has been reviewed and signed by me. I certify that the medical necessity information in Section B is true, accurate and complete, to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fat in that section may subject me to civil or criminal liability.

PHYSICIAN'S SIGNATURE_____DATE____/____/____ (SIGNATURE AND DATE STAMPS NOT ACCEPTABLE)

FORM HCFA-851 (4/96)

| | |
|---|---|
| **SECTION A:** | **(May be completed by the supplier)** |
| CERTIFICATION TYPE/DATE: | If this is an initial certification for this patient, indicate this by placing date (MM/DD/YY) needed initially in the space marked "INITIAL." If this is a revised certification (to be completed when the physician changes the order, based on the patient's changing clinical needs), indicate the initial date needed in the space marked "INITIAL", and also indicate the recertification date in the space marked "REVISED." If this is a recertification, indicate the initial date needed in the space marked "INITIAL" and also indicate the recertification date in the space marked "RECERTIFICATION." Whether submitting a REVISED or a RECERTIFIED CMN, be sure to always furnish the INITIAL date as well as the REVISED **or** RECERTIFICATION date. |
| PATIENT INFORMATION | Indicate the patient's name, permanent legal address, telephone number and his/her health insurance claim number (HICN) as it appears on this/her Medicare card an on the claim form. |
| SUPPLIER INFORMATION: | Indicate the name of our company (supplier name), address and telephone number along with the Medicare Supplier Number assigned to you by the National Supplier Clearinghouse (NSC) |
| PLACE OF SERVICE: | Indicate the place in which the item is being used, i.e., patient's home is 12, skilled nursing facility (SNF) is 31, End Stage Renal Disease (ESRD) facility is 65, etc. Refer to the DMERC supplier manual for a complete list. |
| FACILITY NAME | If the place of service is a facility, indicate the name and complete address of the facility |
| HCPCS CODES | List all HCPCS procedure codes for items ordered that require a CMN. Procedure codes that do not require certification should not be listed on the CMN. |
| PATIENT DOB, HEIGHT, WEIGHT AND SEX: | Indicate patient's date of birth (MM/DD/YY) and sex (male or female); height in inches and weight in pounds, if requested. |
| PHYSICIAN NAME, ADDRESS: | Indicate the physician's name and complete mailing address |
| UPIN: | Accurately indicate the ordering physician's Unique Physician Identification Number (UPIN). |
| PHYSICIAN'S TELEPHONE NO: | Indicate the telephone number where the physician can be contacted (preferably where records would be accessible pertaining to this patient) if more information is needed. |
| **SECTION B** | **(May not be completed by the supplier. While this section may be completed by a non-physician clinician, or a physician employee, it must be reviewed, and the CMN signed (in Section D) by the ordering physician.)** |
| EST. LENGTH OF NEED | Indicate the estimated length of need (the length of time the physician expects the patient to require use of the ordered item) by filling in the appropriate number of months. If the physician expects that the patient will require the item for the duration of his/her life, then enter 99. |
| DIAGNOSIS CODES: | In the first space, list the ICD10 code that represents the primary reason for ordering this item. List any additional ICD10 codes that would further describe the medical need for the item (up to 3 codes). |
| QUESTION SECTION: | This section is used to gather clinical information to determine medical necessity. Answer each question which applies to the items ordered, circling "Y" for yes, "N" for no, "D" for does not apply, a number if this is offered as an answer option, or fill in the blank if other information is requested. |
| NAME OF PERSON ANSWERING SECTION B QUESTIONS | If a clinical professional other than the ordering physician (e.g., home health nurse, physical therapist, dietician) or a physician employee answers the questions of Section B, he/she must print his/her name, give his/her professional title and the name of his/her employer where indicate. If the physician is answering the questions, this space may be left blank. |
| **SECTION C:** | **(To be completed by the supplier)** |
| NARRATIVE DESCRIPTION OF EQUIPMENT & COST | Supplier gives (1) a narrative description of the item(s) ordered, as well as all options, accessories, supplies and drug; (2) the supplier's charge for each item, option, accessory, supply and drug; and (3) the Medicare fee schedule allowance for each item/option/accessory/supply/drug, if applicable. |
| **SECTION D** | **(To be completed by the physician)** |
| PHYSICIAN ATTESTATION: | The physician's signature certifies (1) the CMN which he/she is reviewing includes Sections A, B, C and D; (2) the answers in Section B are correct; and (3) the self-identifying information in Section A is correct. |
| PHYSICIAN SIGNATURE AND DATE: | After completion and/or review by the physician of Sections A, B and C, the physician must sign and date the CMN in Section D, verifying the Attestation appearing in this Section. The physician's signature also certifies the items ordered are medically necessary for this patient. Signature and date stamps are not acceptable. |

U.S. DEPARTMENT OF HEALTH & HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO.0938-0679
**DMERC 04.03B**

## CERTIFICATE OF MEDICAL NECESSITY

**LYMPHEDEMA PUMPS**

**SECTION A** **Certification Type/Date:** **INITIAL**_____/_____/_____ **REVISED**_____/_____/_____

| PATIENT NAME, ADDRESS, TELEPHONE and HIC NUMBER | SUPPLIER NAME, ADDRESS, TELEPHONE and NSC NUMBER |
|---|---|
| (_____)_____-_____ HICN_____ | (____)_____-_____ NSC#_____ |
| PLACE OF SERVICE_____<br>NAME and ADDRESS of FACILITY if applicable<br>(See Reverse) | HCPCS CODE<br>_____<br>_____<br>_____<br>_____ | PT DOB____/____/____ SEX____(M/F) HT____(IN.) WT_____(lbs.)<br>_____<br>**PHYSICIAN NAME, ADDRESS, TELEPHONE and UPIN NUMBER**<br>(_____)_____-_____ UPIN #_____ |

**SECTION B** **Information in this Section May Not Be Completed by the Supplier of the Items/Supplies.**

EST. LENGTH OF NEED (# OF MONTHS) _____1-99 (99=LIFETIME)

DIAGNOSIS CODES (ICD-10) _____ _____ _____ _____

| ANSWERS | ANSWER QUESTIONS 1-5 FOR LYMPHEDEMA PUMP<br>(Circle **Y** for Yes, **N** for No, or **D** for Does Not Apply) |
|---|---|
| Y N D | 1. Does the patient malignant tumor with obstruction of the lymphatic drainage of an extremity:? |
| Y N D | 2. Has the patient had radical cancer surgery or radiation for cancer that interrupted normal lymphatic drainage of the extremity: |
| Y N D | 3. Does the patient have chronic venous insufficiency with venous stasis ulcer(s): (If :YES, additional documentation must accompany the claim)? |
| Y N D | 4. Is there a congenital abnormality of lymphatic drainage? (If YES, additional documentation must accompany the claim) |
| Y N D | 5. Are you the treating physician and have you prescribed the pressures to be used and the frequency and duration of use of this device? |

NAME OF PERSON ANSWERING SECTION B QUESTIONS, IF OTHER THAN PHYSICIAN (Please Print)
NAME:_____ TITLE:_____ EMPLOYER:_____:

**SECTION C** **Narrative Description Of Equipment And Cost**

**(1)** Narrative description of all items, accessories and options ordered; (**2**) Supplier's charge; and (**3**) Medicare Fee Schedule Allowance for each item, accessory, and option. *(See Instructions On Back)*

**SECTION D** **Physician Attestation and Signature/Date**

I certify that I am the physician identified in Section A of this form. I have received Sections A, B and C of the Certificate of Medical Necessity (including charges for items ordered). Any statement on my letterhead attached hereto, has been reviewed and signed by me. I certify that the medical necessity information in Section B is true, accurate and complete, to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fat in that section may subject me to civil or criminal liability.

PHYSICIAN'S SIGNATURE_____DATE____/____/____ (SIGNATURE AND DATE STAMPS NOT ACCEPTABLE)

FORM HCFA-846 (5/97)

| | |
|---|---|
| **SECTION A:** | **(May be completed by the supplier)** |
| CERTIFICATION TYPE/DATE: | If this is an initial certification for this patient, indicate this by placing date (MM/DD/YY) needed initially in the space marked "INITIAL." If this is a revised certification (to be completed when the physician changes the order, based on the patient's changing clinical needs), indicate the initial date needed in the space marked "INITIAL", and also indicate the recertification date in the space marked "REVISED." If this is a recertification, indicate the initial date needed in the space marked "INITIAL" and also indicate the recertification date in the space marked "RECERTIFICATION." Whether submitting a REVISED or a RECERTIFIED CMN, be sure to always furnish the INITIAL date as well as the REVISED **or** RECERTIFICATION date. |
| PATIENT INFORMATION | Indicate the patient's name, permanent legal address, telephone number and his/her health insurance claim number (HICN) as it appears on this/her Medicare card an on the claim form. |
| SUPPLIER INFORMATION: | Indicate the name of our company (supplier name), address and telephone number along with the Medicare Supplier Number assigned to you by the National Supplier Clearinghouse (NSC) |
| PLACE OF SERVICE: | Indicate the place in which the item is being used, i.e., patient's home is 12, skilled nursing facility (SNF) is 31, End Stage Renal Disease (ESRD) facility is 65, etc. Refer to the DMERC supplier manual for a complete list. |
| FACILITY NAME | If the place of service is a facility, indicate the name and complete address of the facility |
| HCPCS CODES | List all HCPCS procedure codes for items ordered that require a CMN. Procedure codes that do not require certification should not be listed on the CMN. |
| PATIENT DOB, HEIGHT, WEIGHT AND SEX: | Indicate patient's date of birth (MM/DD/YY) and sex (male or female); height in inches and weight in pounds, if requested. |
| PHYSICIAN NAME, ADDRESS: | Indicate the physician's name and complete mailing address |
| UPIN: | Accurately indicate the ordering physician's Unique Physician Identification Number (UPIN). |
| PHYSICIAN'S TELEPHONE NO: | Indicate the telephone number where the physician can be contacted (preferably where records would be accessible pertaining to this patient) if more information is needed. |
| **SECTION B** | **(May not be completed by the supplier. While this section may be completed by a non-physician clinician, or a physician employee, it must be reviewed, and the CMN signed (in Section D) by the ordering physician.)** |
| EST. LENGTH OF NEED | Indicate the estimated length of need (the length of time the physician expects the patient to require use of the ordered item) by filling in the appropriate number of months. If the physician expects that the patient will require the item for the duration of his/her life, then enter 99. |
| DIAGNOSIS CODES: | In the first space, list the ICD10 code that represents the primary reason for ordering this item. List any additional ICD10 codes that would further describe the medical need for the item (up to 3 codes). |
| QUESTION SECTION: | This section is used to gather clinical information to determine medical necessity. Answer each question which applies to the items ordered, circling "Y" for yes, "N" for no, "D" for does not apply, a number if this is offered as an answer option, or fill in the blank if other information is requested. |
| NAME OF PERSON ANSWERING SECTION B QUESTIONS | If a clinical professional other than the ordering physician (e.g., home health nurse, physical therapist, dietician) or a physician employee answers the questions of Section B, he/she must print his/her name, give his/her professional title and the name of his/her employer where indicate. If the physician is answering the questions, this space may be left blank. |
| **SECTION C:** | **(To be completed by the supplier)** |
| NARRATIVE DESCRIPTION OF EQUIPMENT & COST | Supplier gives (1) a narrative description of the item(s) ordered, as well as all options, accessories, supplies and drug; (2) the supplier's charge for each item, option, accessory, supply and drug; and (3) the Medicare fee schedule allowance for each item/option/accessory/supply/drug, if applicable. |
| **SECTION D** | **(To be completed by the physician)** |
| PHYSICIAN ATTESTATION: | The physician's signature certifies (1) the CMN which he/she is reviewing includes Sections A, B, C and D; (2) the answers in Section B are correct; and (3) the self-identifying information in Section A is correct. |
| PHYSICIAN SIGNATURE AND DATE: | After completion and/or review by the physician of Sections A, B and C, the physician must sign and date the CMN in Section D, verifying the Attestation appearing in this Section. The physician's signature also certifies the items ordered are medically necessary for this patient. Signature and date stamps are not acceptable. |

U.S. DEPARTMENT OF HEALTH & HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO.0938-0679
**DMERC 04.03C**

## CERTIFICATE OF MEDICAL NECESSITY

### OSTEOGENESIS STIMULATORS

**SECTION A** **Certification Type/Date: INITIAL_____/_____/_____ REVISED_____/_____/_____**

| PATIENT NAME, ADDRESS, TELEPHONE and HIC NUMBER | SUPPLIER NAME, ADDRESS, TELEPHONE and NSC NUMBER |
|---|---|
| (____)_____-_____ HICN_____ | (____)_____-_____ NSC#_____ |
| PLACE OF SERVICE_____<br>NAME and ADDRESS of FACILITY if applicable (See Reverse) | HCPCS CODE<br>_____<br>_____<br>_____<br>_____ |
| | PT DOB____/____/____ SEX____(M/F) HT____(IN.) WT_____(lbs.)<br>_____<br>**PHYSICIAN NAME, ADDRESS, TELEPHONE and UPIN NUMBER**<br>(_____)_____-_____ UPIN #_____ |

**SECTION B** **Information in this Section May Not Be Completed by the Supplier of the Items/Supplies.**

| **EST. LENGTH OF NEED (# OF MONTHS)** _____**1-99 (99=LIFETIME**) | DIAGNOSIS CODES (ICD-10) _____ _____ _____ _____ |
|---|---|

| ANSWERS | ANSWER QUESTIONS 6-8 FOR NONSPINAL OSTEOGENESIS STIMULATOR<br>ANSWER QUESTIONS 9-11 FOR SPINAL OSTEOGENESIS STIMULATOR<br>(Circle **Y** for Yes, **N** for No, or **D** for Does Not Apply. For questions about months, enter 1-99 or D. If less than one month, enter 1.) |
|---|---|
| a) Y N D<br>b) _____ | 6. (a) Does the patient have a nonunion of a long-bone fracture><br>(b) How many months prior to ordering the device did the patient sustain the fracture? |
| a) Y N D<br>b) _____ | 7. (a) Does the patient have a failed fusion of a joint other than the spine?<br>(b) How many months prior to ordering the device did the patient have the fusion? |
| Y N D | 8. Does the patient have a congenital pseudoarthrosis? |
| a) Y N D<br>b) _____ | 9. (a) Is the device being ordered as a treatment of a failed spinal fusion in a patient who has not had a recent repeat fusion?<br>(b) How many months prior to ordering the device did the patient have the fusion? |
| a) Y N D<br>b)_____<br>c)_____ | 10. (a) Is the device being ordered as an adjunct to repeat spinal fusion surgery in a patient with a previously failed spinal fusion at the same level(s)?<br>(b) How many months prior t ordering the device did the patient have the repeat fusion?<br>(c) How many months prior to ordering the device did the patient have the previously failed fusion: |
| a) Y N D<br>b) _____ | 11. (a) Is the device being ordered as an adjunct to recent spinal fusion surgery in a patient who has had a multi-level fusion?<br>(b) How many months prior to ordering the device did the patient have the multi-level fusion? |

NAME OF PERSON ANSWERING SECTION B QUESTIONS, IF OTHER THAN PHYSICIAN (Please Print)
NAME:_____TITLE:_____EMPLOYER:_____:

**SECTION C** **Narrative Description Of Equipment And Cost**

**(1)** Narrative description of all items, accessories and options ordered; (**2**) Supplier's charge; and (**3**) Medicare Fee Schedule Allowance for each item, accessory, and option. *(See Instructions On Back)*

**SECTION D** **Physician Attestation and Signature/Date**

I certify that I am the physician identified in Section A of this form. I have received Sections A, B and C of the Certificate of Medical Necessity (including charges for items ordered). Any statement on my letterhead attached hereto, has been reviewed and signed by me. I certify that the medical necessity information in Section B is true, accurate and complete, to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fat in that section may subject me to civil or criminal liability.

PHYSICIAN'S SIGNATURE_____DATE____/____/____ (SIGNATURE AND DATE STAMPS NOT ACCEPTABLE)

FORM HCFA-847 (5/97)

| | |
|---|---|
| **SECTION A:** | **(May be completed by the supplier)** |
| CERTIFICATION TYPE/DATE: | If this is an initial certification for this patient, indicate this by placing date (MM/DD/YY) needed initially in the space marked "INITIAL." If this is a revised certification (to be completed when the physician changes the order, based on the patient's changing clinical needs), indicate the initial date needed in the space marked "INITIAL", and also indicate the recertification date in the space marked "REVISED." If this is a recertification, indicate the initial date needed in the space marked "INITIAL" and also indicate the recertification date in the space marked "RECERTIFICATION." Whether submitting a REVISED or a RECERTIFIED CMN, be sure to always furnish the INITIAL date as well as the REVISED **or** RECERTIFICATION date. |
| PATIENT INFORMATION | Indicate the patient's name, permanent legal address, telephone number and his/her health insurance claim number (HICN) as it appears on this/her Medicare card an on the claim form. |
| SUPPLIER INFORMATION: | Indicate the name of our company (supplier name), address and telephone number along with the Medicare Supplier Number assigned to you by the National Supplier Clearinghouse (NSC) |
| PLACE OF SERVICE: | Indicate the place in which the item is being used, i.e., patient's home is 12, skilled nursing facility (SNF) is 31, End Stage Renal Disease (ESRD) facility is 65, etc. Refer to the DMERC supplier manual for a complete list. |
| FACILITY NAME | If the place of service is a facility, indicate the name and complete address of the facility |
| HCPCS CODES | List all HCPCS procedure codes for items ordered that require a CMN. Procedure codes that do not require certification should not be listed on the CMN. |
| PATIENT DOB, HEIGHT, WEIGHT AND SEX: | Indicate patient's date of birth (MM/DD/YY) and sex (male or female); height in inches and weight in pounds, if requested. |
| PHYSICIAN NAME, ADDRESS: | Indicate the physician's name and complete mailing address |
| UPIN: | Accurately indicate the ordering physician's Unique Physician Identification Number (UPIN). |
| PHYSICIAN'S TELEPHONE NO: | Indicate the telephone number where the physician can be contacted (preferably where records would be accessible pertaining to this patient) if more information is needed. |
| **SECTION B** | **(May not be completed by the supplier. While this section may be completed by a non-physician clinician, or a physician employee, it must be reviewed, and the CMN signed (in Section D) by the ordering physician.)** |
| EST. LENGTH OF NEED | Indicate the estimated length of need (the length of time the physician expects the patient to require use of the ordered item) by filling in the appropriate number of months. If the physician expects that the patient will require the item for the duration of his/her life, then enter 99. |
| DIAGNOSIS CODES: | In the first space, list the ICD10 code that represents the primary reason for ordering this item. List any additional ICD10 codes that would further describe the medical need for the item (up to 3 codes). |
| QUESTION SECTION: | This section is used to gather clinical information to determine medical necessity. Answer each question which applies to the items ordered, circling "Y" for yes, "N" for no, "D" for does not apply, a number if this is offered as an answer option, or fill in the blank if other information is requested. |
| NAME OF PERSON ANSWERING SECTION B QUESTIONS | If a clinical professional other than the ordering physician (e.g., home health nurse, physical therapist, dietician) or a physician employee answers the questions of Section B, he/she must print his/her name, give his/her professional title and the name of his/her employer where indicate. If the physician is answering the questions, this space may be left blank. |
| **SECTION C:** | **(To be completed by the supplier)** |
| NARRATIVE DESCRIPTION OF EQUIPMENT & COST | Supplier gives (1) a narrative description of the item(s) ordered, as well as all options, accessories, supplies and drug; (2) the supplier's charge for each item, option, accessory, supply and drug; and (3) the Medicare fee schedule allowance for each item/option/accessory/supply/drug, if applicable. |
| **SECTION D** | **(To be completed by the physician)** |
| PHYSICIAN ATTESTATION: | The physician's signature certifies (1) the CMN which he/she is reviewing includes Sections A, B, C and D; (2) the answers in Section B are correct; and (3) the self-identifying information in Section A is correct. |
| PHYSICIAN SIGNATURE AND DATE: | After completion and/or review by the physician of Sections A, B and C, the physician must sign and date the CMN in Section D, verifying the Attestation appearing in this Section. The physician's signature also certifies the items ordered are medically necessary for this patient. Signature and date stamps are not acceptable. |

U.S. DEPARTMENT OF HEALTH & HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO.0938-0679
**DMERC 06.02B**

## CERTIFICATE OF MEDICAL NECESSITY

### TRANSCUTANEOUS ELECTRICAL NERVE STIMULATOR (TENS)

**SECTION A** **Certification Type/Date: INITIAL_____/_____/_____ REVISED_____/_____/_____**

| PATIENT NAME, ADDRESS, TELEPHONE and HIC NUMBER | SUPPLIER NAME, ADDRESS, TELEPHONE and NSC NUMBER |
|---|---|
| (____)____-_____ HICN_____ | (____)____-_____ NSC#_____ |
| PLACE OF SERVICE_____<br>NAME and ADDRESS of FACILITY if applicable (See Reverse) | HCPCS CODE<br>_____<br>_____<br>_____<br>_____ |
| | PT DOB___/___/____ SEX____(M/F) HT____(IN.) WT_____(lbs.)<br>**PHYSICIAN NAME, ADDRESS (Printed or Type)**<br>**PHYSICIAN'S UPIN:_____**<br>**PHYSICIAN'S TELEPHONE # (_____)_____-_____** |

**SECTION B** **Information in this Section May Not Be Completed by the Supplier of the Items/Supplies**

| EST. LENGTH OF NEED (# OF MONTHS) _____1-99 (99=LIFETIME) | DIAGNOSIS CODES (ICD-10) _____ _____ _____ _____ |
|---|---|

| ANSWERS | ANSWER QUESTIONS 1-6 FOR RENTAL OF TENS, AND 3-12 FOR PURCHASE OF TENS<br>(Circle **Y** for Yes, **N** for No, or **D** for Does Not Apply, Unless Otherwise Noted) |
|---|---|
| Y N D | 1. Does the patient have acute post-operative pain? |
| ___/___/____ | 2. What is the date of surgery resulting in acute post-operative pain? |
| Y N D | 3. Does the patient have chronic, intractable pain? |
| [_____months] | 4. How long has the patient 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? (Circle appropriate number)<br>1 – Headache 2 – Visceral abdominal pain 3 – Pelvic pain<br>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 patient received a TENS trial? |
| Began/Ended<br>___/___/____<br>___/___/____ | 8. What are the dates that trial of TENS unit began and ended? |
| ___/___/____ | 9. What is the date that you reevaluated the patient at the end of the trial period? |
| 1 2 3 | 10. How often has the patient been using the TENS? (Circle appropriate number)<br>1 = Daily 2 = 3 to 6 days per week 3 = 2 or less days per week |
| Y N D | 11. Do you and the patient agree that there has been a significant improvement in the pain and that long term use of a TENS is warranted? |
| 2 4 | 12. Number of TENS leads (i.e., separate electrodes) routinely needed and used by the patient at any one time: (Circle appropriate number) 2 = 2 leads 4 = 4 leads |

NAME OF PERSON ANSWERING SECTION B QUESTIONS, IF OTHER THAN PHYSICIAN (Please Print)
NAME:_____TITLE:_____EMPLOYER:_____:

**SECTION C** **Narrative Description Of Equipment And Cost**

**(1)** Narrative description of all items, accessories and options ordered; (**2**) Supplier's charge; and (**3**) Medicare Fee Schedule Allowance for each item, accessory, and option. *(See Instructions On Back)*

**SECTION D** **Physician Attestation and Signature/Date**

I certify that I am the physician identified in Section A of this form. I have received Sections A, B and C of the Certificate of Medical Necessity (including charges for items ordered). Any statement on my letterhead attached hereto, has been reviewed and signed by me. I certify that the medical necessity information in Section B is true, accurate and complete, to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fat in that section may subject me to civil or criminal liability.

PHYSICIAN'S SIGNATURE_____DATE____/____/____ (SIGNATURE AND DATE STAMPS NOT ACCEPTABLE)

FORM HCFA-848 (4/96)

| | |
|---|---|
| **SECTION A:** | **(May be completed by the supplier)** |
| CERTIFICATION TYPE/DATE: | If this is an initial certification for this patient, indicate this by placing date (MM/DD/YY) needed initially in the space marked "INITIAL." If this is a revised certification (to be completed when the physician changes the order, based on the patient's changing clinical needs), indicate the initial date needed in the space marked "INITIAL", and also indicate the recertification date in the space marked "REVISED." If this is a recertification, indicate the initial date needed in the space marked "INITIAL" and also indicate the recertification date in the space marked "RECERTIFICATION." Whether submitting a REVISED or a RECERTIFIED CMN, be sure to always furnish the INITIAL date as well as the REVISED **or** RECERTIFICATION date. |
| PATIENT INFORMATION | Indicate the patient's name, permanent legal address, telephone number and his/her health insurance claim number (HICN) as it appears on this/her Medicare card an on the claim form. |
| SUPPLIER INFORMATION: | Indicate the name of our company (supplier name), address and telephone number along with the Medicare Supplier Number assigned to you by the National Supplier Clearinghouse (NSC) |
| PLACE OF SERVICE: | Indicate the place in which the item is being used, i.e., patient's home is 12, skilled nursing facility (SNF) is 31, End Stage Renal Disease (ESRD) facility is 65, etc. Refer to the DMERC supplier manual for a complete list. |
| FACILITY NAME | If the place of service is a facility, indicate the name and complete address of the facility |
| HCPCS CODES | List all HCPCS procedure codes for items ordered that require a CMN. Procedure codes that do not require certification should not be listed on the CMN. |
| PATIENT DOB, HEIGHT, WEIGHT AND SEX: | Indicate patient's date of birth (MM/DD/YY) and sex (male or female); height in inches and weight in pounds, if requested. |
| PHYSICIAN NAME, ADDRESS: | Indicate the physician's name and complete mailing address |
| UPIN: | Accurately indicate the ordering physician's Unique Physician Identification Number (UPIN). |
| PHYSICIAN'S TELEPHONE NO: | Indicate the telephone number where the physician can be contacted (preferably where records would be accessible pertaining to this patient) if more information is needed. |
| **SECTION B** | **(May not be completed by the supplier. While this section may be completed by a non-physician clinician, or a physician employee, it must be reviewed, and the CMN signed (in Section D) by the ordering physician.)** |
| EST. LENGTH OF NEED | Indicate the estimated length of need (the length of time the physician expects the patient to require use of the ordered item) by filling in the appropriate number of months. If the physician expects that the patient will require the item for the duration of his/her life, then enter 99. |
| DIAGNOSIS CODES: | In the first space, list the ICD10 code that represents the primary reason for ordering this item. List any additional ICD10 codes that would further describe the medical need for the item (up to 3 codes). |
| QUESTION SECTION: | This section is used to gather clinical information to determine medical necessity. Answer each question which applies to the items ordered, circling "Y" for yes, "N" for no, "D" for does not apply, a number if this is offered as an answer option, or fill in the blank if other information is requested. |
| NAME OF PERSON ANSWERING SECTION B QUESTIONS | If a clinical professional other than the ordering physician (e.g., home health nurse, physical therapist, dietician) or a physician employee answers the questions of Section B, he/she must print his/her name, give his/her professional title and the name of his/her employer where indicate. If the physician is answering the questions, this space may be left blank. |
| **SECTION C:** | **(To be completed by the supplier)** |
| NARRATIVE DESCRIPTION OF EQUIPMENT & COST | Supplier gives (1) a narrative description of the item(s) ordered, as well as all options, accessories, supplies and drug; (2) the supplier's charge for each item, option, accessory, supply and drug; and (3) the Medicare fee schedule allowance for each item/option/accessory/supply/drug, if applicable. |
| **SECTION D** | **(To be completed by the physician)** |
| PHYSICIAN ATTESTATION: | The physician's signature certifies (1) the CMN which he/she is reviewing includes Sections A, B, C and D; (2) the answers in Section B are correct; and (3) the self-identifying information in Section A is correct. |
| PHYSICIAN SIGNATURE AND DATE: | After completion and/or review by the physician of Sections A, B and C, the physician must sign and date the CMN in Section D, verifying the Attestation appearing in this Section. The physician's signature also certifies the items ordered are medically necessary for this patient. Signature and date stamps are not acceptable. |

## CERTIFICATE OF MEDICAL NECESSITY

### ENTERAL NUTRITION

**SECTION A** Certification Type/Date: INITIAL____/____/____ REVISED____/____/____ RECERTIFICATION____/____/____

| PATIENT NAME, ADDRESS, TELEPHONE and HIC NUMBER | SUPPLIER NAME, ADDRESS, TELEPHONE and NSC NUMBER |
|---|---|
| (____)____-_____ HICN_____ | (____)____-_____ NSC#_____ |
| PLACE OF SERVICE_____<br>NAME and ADDRESS of FACILITY if applicable (See Reverse) | HCPCS CODE<br>_____<br>_____<br>_____<br>_____ |
| | PT DOB___/___/____ SEX____(M/F) HT____(IN.) WT_____(lbs.)<br>PHYSICIAN NAME, ADDRESS **(Printed or Type)**<br>PHYSICIAN'S UPIN:_____<br>PHYSICIAN'S TELEPHONE # (_____)_____-_____ |

**SECTION B** **Information in this Section May Not Be Completed by the Supplier of the Items/Supplies**

| EST. LENGTH OF NEED (# OF MONTHS) _____1-99 (99=LIFETIME) | DIAGNOSIS CODES (ICD-10) _____ _____ _____ _____ |
|---|---|

| ANSWERS | ANSWER QUESTIONS 7, 8, AND 10 – 15 FOR ENTERAL NUTRITION<br>(Circle **Y** for Yes, **N** for No, or **D** for Does Not Apply, Unless Otherwise Noted) |
|---|---|
| | Questions 1 – 6, and 9, reserved for other or future use. |
| Y N | 7. Does the patient have permanent non-function or disease of the structures that normally permit food to reach or be absorbed from the small bowel? |
| Y N | 8. Does the patient require tube feedings to provide sufficient nutrients to maintain weigh and strength commensurate with the patient's overall health status? |
| A)_____<br>B)_____ | 10. Print product name(s) |
| A)_____<br>B)_____ | 11. Calories per day for each product? |
| _____ | 12. Days per week administered? (Enter 1 – 7) |
| 1 2 3 4 | 13. Circle the number for method of administration?<br>1. - Syringe 2. - Gravity 3. – Pump 4 – Does not apply |
| Y N D | 14. Does the patient have a documented allergy or intolerance to semi-synthetic nutrients? |
| | 15. Additional information when required by policy: |

NAME OF PERSON ANSWERING SECTION B QUESTIONS, IF OTHER THAN PHYSICIAN (Please Print)
NAME:_____TITLE:_____EMPLOYER:_____:

**SECTION C** **Narrative Description Of Equipment And Cost**

**(1)** Narrative description of all items, accessories and options ordered; (**2**) Supplier's charge; and (**3**) Medicare Fee Schedule Allowance for each item, accessory, and option. *(See Instructions On Back)*

**SECTION D** **Physician Attestation and Signature/Date**

I certify that I am the physician identified in Section A of this form. I have received Sections A, B and C of the Certificate of Medical Necessity (including charges for items ordered). Any statement on my letterhead attached hereto, has been reviewed and signed by me. I certify that the medical necessity information in Section B is true, accurate and complete, to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fat in that section may subject me to civil or criminal liability.

PHYSICIAN'S SIGNATURE_____DATE____/____/____ (SIGNATURE AND DATE STAMPS NOT ACCEPTABLE)

| | |
|---|---|
| **SECTION A:** | **(May be completed by the supplier)** |
| CERTIFICATION TYPE/DATE: | If this is an initial certification for this patient, indicate this by placing date (MM/DD/YY) needed initially in the space marked "INITIAL." If this is a revised certification (to be completed when the physician changes the order, based on the patient's changing clinical needs), indicate the initial date needed in the space marked "INITIAL", and also indicate the recertification date in the space marked "REVISED." If this is a recertification, indicate the initial date needed in the space marked "INITIAL" and also indicate the recertification date in the space marked "RECERTIFICATION." Whether submitting a REVISED or a RECERTIFIED CMN, be sure to always furnish the INITIAL date as well as the REVISED **or** RECERTIFICATION date. |
| PATIENT INFORMATION | Indicate the patient's name, permanent legal address, telephone number and his/her health insurance claim number (HICN) as it appears on this/her Medicare card an on the claim form. |
| SUPPLIER INFORMATION: | Indicate the name of our company (supplier name), address and telephone number along with the Medicare Supplier Number assigned to you by the National Supplier Clearinghouse (NSC) |
| PLACE OF SERVICE: | Indicate the place in which the item is being used, i.e., patient's home is 12, skilled nursing facility (SNF) is 31, End Stage Renal Disease (ESRD) facility is 65, etc. Refer to the DMERC supplier manual for a complete list. |
| FACILITY NAME | If the place of service is a facility, indicate the name and complete address of the facility |
| HCPCS CODES | List all HCPCS procedure codes for items ordered that require a CMN. Procedure codes that do not require certification should not be listed on the CMN. |
| PATIENT DOB, HEIGHT, WEIGHT AND SEX: | Indicate patient's date of birth (MM/DD/YY) and sex (male or female); height in inches and weight in pounds, if requested. |
| PHYSICIAN NAME, ADDRESS: | Indicate the physician's name and complete mailing address |
| UPIN: | Accurately indicate the ordering physician's Unique Physician Identification Number (UPIN). |
| PHYSICIAN'S TELEPHONE NO: | Indicate the telephone number where the physician can be contacted (preferably where records would be accessible pertaining to this patient) if more information is needed. |
| **SECTION B** | **(May not be completed by the supplier. While this section may be completed by a non-physician clinician, or a physician employee, it must be reviewed, and the CMN signed (in Section D) by the ordering physician.)** |
| EST. LENGTH OF NEED | Indicate the estimated length of need (the length of time the physician expects the patient to require use of the ordered item) by filling in the appropriate number of months. If the physician expects that the patient will require the item for the duration of his/her life, then enter 99. |
| DIAGNOSIS CODES: | In the first space, list the ICD10 code that represents the primary reason for ordering this item. List any additional ICD10 codes that would further describe the medical need for the item (up to 3 codes). |
| QUESTION SECTION: | This section is used to gather clinical information to determine medical necessity. Answer each question which applies to the items ordered, circling "Y" for yes, "N" for no, "D" for does not apply, a number if this is offered as an answer option, or fill in the blank if other information is requested. |
| NAME OF PERSON ANSWERING SECTION B QUESTIONS | If a clinical professional other than the ordering physician (e.g., home health nurse, physical therapist, dietician) or a physician employee answers the questions of Section B, he/she must print his/her name, give his/her professional title and the name of his/her employer where indicate. If the physician is answering the questions, this space may be left blank. |
| **SECTION C:** | **(To be completed by the supplier)** |
| NARRATIVE DESCRIPTION OF EQUIPMENT & COST | Supplier gives (1) a narrative description of the item(s) ordered, as well as all options, accessories, supplies and drug; (2) the supplier's charge for each item, option, accessory, supply and drug; and (3) the Medicare fee schedule allowance for each item/option/accessory/supply/drug, if applicable. |
| **SECTION D** | **(To be completed by the physician)** |
| PHYSICIAN ATTESTATION: | The physician's signature certifies (1) the CMN which he/she is reviewing includes Sections A, B, C and D; (2) the answers in Section B are correct; and (3) the self-identifying information in Section A is correct. |
| PHYSICIAN SIGNATURE AND DATE: | After completion and/or review by the physician of Sections A, B and C, the physician must sign and date the CMN in Section D, verifying the Attestation appearing in this Section. The physician's signature also certifies the items ordered are medically necessary for this patient. Signature and date stamps are not acceptable. |

U.S. DEPARTMENT OF HEALTH & HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO.0938-0679
**DMERC 07.02A**

## CERTIFICATE OF MEDICAL NECESSITY

### SEAT LIFT MECHANISM

**SECTION A** **Certification Type/Date: INITIAL_____/_____/_____ REVISED_____/_____/_____**

| PATIENT NAME, ADDRESS, TELEPHONE and HIC NUMBER | | SUPPLIER NAME, ADDRESS, TELEPHONE and NSC NUMBER |
|---|---|---|
| (____) ____-_____ HICN | | (___) ____-_____ NSC# |
| PLACE OF SERVICE_____<br>NAME and ADDRESS of FACILITY if applicable (See Reverse) | HCPCS CODE<br>_____<br>_____<br>_____<br>_____ | PT DOB___/___/____ SEX____(M/F) HT____(IN.) WT_____(lbs.)<br>PHYSICIAN NAME, ADDRESS (Printed or Type)<br>PHYSICIAN'S UPIN:_____<br>PHYSICIAN'S TELEPHONE # (_____)_____-_____ |

**SECTION B** **Information in this Section May Not Be Completed by the Supplier of the Items/Supplies**

EST. LENGTH OF NEED (# OF MONTHS) _____1-99 (99=LIFETIME)

DIAGNOSIS CODES (ICD-10) _____ _____ _____ _____

| ANSWERS | ANSWER QUESTIONS 1-5 FOR SEAT LIFT MECHANISM (Circle **Y** for Yes, **N** for No, or **D** for Does Not Apply) |
|---|---|
| Y N D | 1 Does the patient have severe arthritis of the hip or knee? |
| Y N D | 2. Does the patient have a severe neuromuscular disease? |
| Y N D | 3. Is the patient completely incapable of standing up from a regular armchair or any chair in his/her home? |
| Y N D | 4. Once standing, does the patient have the ability to ambulate? |
| Y N D | 5. Have all appropriate therapeutic modalities to enable the patient to transfer from a chair to a standing position (e.g., medication, physical therapy) been tried and failed: If YES, this is documented in the patient's medical records. |
| Y N D | 7. Does the patient require frequent changes in body position and/or have an immediate need for a change in body position? |

NAME OF PERSON ANSWERING SECTION B QUESTIONS, IF OTHER THAN PHYSICIAN (Please Print)
NAME:_____ TITLE:_____ EMPLOYER:_____:

**SECTION C** **Narrative Description Of Equipment And Cost**

**(1)** Narrative description of all items, accessories and options ordered; (**2**) Supplier's charge; and (**3**) Medicare Fee Schedule Allowance for each item, accessory, and option. *(See Instructions On Back)*

**SECTION D** **Physician Attestation and Signature/Date**

I certify that I am the physician identified in Section A of this form. I have received Sections A, B and C of the Certificate of Medical Necessity (including charges for items ordered). Any statement on my letterhead attached hereto, has been reviewed and signed by me. I certify that the medical necessity information in Section B is true, accurate and complete, to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fat in that section may subject me to civil or criminal liability.

PHYSICIAN'S SIGNATURE_____DATE____/____/____ (SIGNATURE AND DATE STAMPS NOT ACCEPTABLE)

FORM HCFA-849 (4/96)

| | |
|---|---|
| **SECTION A:** | **(May be completed by the supplier)** |
| CERTIFICATION TYPE/DATE: | If this is an initial certification for this patient, indicate this by placing date (MM/DD/YY) needed initially in the space marked "INITIAL." If this is a revised certification (to be completed when the physician changes the order, based on the patient's changing clinical needs), indicate the initial date needed in the space marked "INITIAL", and also indicate the recertification date in the space marked "REVISED." If this is a recertification, indicate the initial date needed in the space marked "INITIAL" and also indicate the recertification date inthe space marked "RECERTIFICATION." Whether submitting a REVISED or a RECERTIFIED CMN, be sure to always furnish the INITIAL date as well as the REVISED **or** RECERTIFICATION date. |
| PATIENT INFORMATION | Indicate the patient's name, permanent legal address, telephone number and his/her health insurance claim number (HICN) as it appears on this/her Medicare card an on the claim form. |
| SUPPLIER INFORMATION: | Indicate the name of our company (supplier name), address and telephone number along with the Medicare Supplier Number assigned to you by the National Supplier Clearinghouse (NSC) |
| PLACE OF SERVICE: | Indicate the place in which the item is being used, i.e., patient's home is 12, skilled nursing facility (SNF) is 31, End Stage Renal Disease (ESRD) facility is 65, etc. Refer to the DMERC supplier manual for a complete list. |
| FACILITY NAME | If the place of service is a facility, indicate the name and complete address of the facility |
| HCPCS CODES | List all HCPCS procedure codes for items ordered that require a CMN. Procedure codes that do not require certification should not be listed on the CMN. |
| PATIENT DOB, HEIGHT, WEIGHT AND SEX: | Indicate patient's date of birth (MM/DD/YY) and sex (male or female); height in inches and weight in pounds, if requested. |
| PHYSICIAN NAME, ADDRESS: | Indicate the physician's name and complete mailing address |
| UPIN: | Accurately indicate the ordering physician's Unique Physician Identification Number (UPIN). |
| PHYSICIAN'S TELEPHONE NO: | Indicate the telephone number where the physician can be contacted (preferably where records would be accessible pertaining to this patient) if more information is needed. |
| **SECTION B** | **(May not be completed by the supplier. While this section may be completed by a non-physician clinician, or a physician employee, it must be reviewed, and the CMN signed (in Section D) by the ordering physician.)** |
| EST. LENGTH OF NEED | Indicate the estimated length of need (the length of time the physician expects the patient to require use of the ordered item) by filling in the appropriate number of months. If the physician expects that the patient will require the item for the duration of his/her life, then enter 99. |
| DIAGNOSIS CODES: | In the first space, list the ICD10 code that represents the primary reason for ordering this item. List any additional ICD10 codes that would further describe the medical need for the item (up to 3 codes). |
| QUESTION SECTION: | This section is used to gather clinical information to determine medical necessity. Answer each question which applies to the items ordered, circling "Y" for yes, "N" for no, "D" for does not apply, a number if this is offered as an answer option, or fill in the blank if other information is requested. |
| NAME OF PERSON ANSWERING SECTION B QUESTIONS | If a clinical professional other than the ordering physician (e.g., home health nurse, physical therapist, dietician) or a physician employee answers the questions of Section B, he/she must print his/her name, give his/her professional title and the name of his/her employer where indicate. If the physician is answering the questions, this space may be left blank. |
| **SECTION C:** | **(To be completed by the supplier)** |
| NARRATIVE DESCRIPTION OF EQUIPMENT & COST | Supplier gives (1) a narrative description of the item(s) ordered, as well as all options, accessories, supplies and drug; (2) the supplier's charge for each item, option, accessory, supply and drug; and (3) the Medicare fee schedule allowance for each item/option/accessory/supply/drug, if applicable. |
| **SECTION D** | **(To be completed by the physician)** |
| PHYSICIAN ATTESTATION: | The physician's signature certifies (1) the CMN which he/she is reviewing includes Sections A, B, C and D; (2) the answers in Section B are correct; and (3) the self-identifying information in Section A is correct. |
| PHYSICIAN SIGNATURE AND DATE: | After completion and/or review by the physician of Sections A, B and C, the physician must sign and date the CMN in Section D, verifying the Attestation appearing in this Section. The physician's signature also certifies the items ordered are medically necessary for this patient. Signature and date stamps are not acceptable. |

U.S. DEPARTMENT OF HEALTH & HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO.0938-0679
**DMERC 11.01**

**CERTIFICATE OF MEDICAL NECESSITY**

**SECTION C CONTINUATION FORM**

**PATIENT'S NAME:**_____ **HICN**_____

**SECTION C (Continued)** **Narrative Description Of Equipment And Cost**

**(1)** Narrative description of all items, accessories and options ordered; (**2**) Supplier's charge; and (**3**) Medicare Fee Schedule Allowance for each item, accessory, and option. *(See Instructions On Back)*

**SECTION D** **Physician Attestation and Signature/Date**

I certify that I am the physician identified in Section A of this form. I have received Sections A, B and C of the Certificate of Medical Necessity (including charges for items ordered). Any statement on my letterhead attached hereto, has been reviewed and signed by me. I certify that the medical necessity information in Section B is true, accurate and complete, to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fat in that section may subject me to civil or criminal liability.

PHYSICIAN'S SIGNATURE_____DATE____/____/____ (SIGNATURE AND DATE STAMPS NOT ACCEPTABLE)

FORM HCFA-854(5/97)

| | |
|---|---|
| **SECTION C:** | **(To be completed by the supplier)** |
| NARRATIVE DESCRIPTION OF EQUIPMENT & COST | Supplier gives (1) a narrative description of the item(s) ordered, as well as all options, accessories, supplies and drug; (2) the supplier's charge for each item, option, accessory, supply and drug; and (3) the Medicare fee schedule allowance for each item/option/accessory/supply/drug, if applicable. |
| **SECTION D** | **(To be completed by the physician)** |
| PHYSICIAN ATTESTATION: | The physician's signature certifies (1) the CMN which he/she is reviewing includes Sections A, B, C and D; (2) the answers in Section B are correct; and (3) the self-identifying information in Section A is correct. |
| PHYSICIAN SIGNATURE AND DATE: | After completion and/or review by the physician of Sections A, B and C, the physician must sign and date the CMN in Section D, verifying the Attestation appearing in this Section. The physician's signature also certifies the items ordered are medically necessary for this patient. Signature and date stamps are not acceptable. |

FORM APPROVED

U.S. DEPARTMENT OF HEALTH & HUMAN SERVICS
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO.0938-0679
DMERC 484.2

CERTIFICATE OF MEDICAL NECESSITY

**OXYGEN**

SECTION A Certification Type/Date: INITIAL_____/_____/_____ REVISED_____/_____/_____ RECERTIFICATION_____/____/_____

| PATIENT NAME, ADDRESS, TELEPHONE and HIC NUMBER | SUPPLIER NAME, ADDRESS, TELEPHONE and NSC NUMBER |
|---|---|
| (____)____-_____ HICN_____ | (____)_____-_____ NSC#_____ |
| PLACE OF SERVICE_____<br>NAME and ADDRESS of FACILITY if applicable (See Reverse) | HCPCS CODE<br>_____<br>_____<br>_____<br>_____ |
| | PT DOB____/____/____ SEX____(M/F) HT____(IN.) WT_____(lbs.)<br>**PHYSICIAN NAME, ADDRESS, TELEPHONE and UPIN NUMBER**<br>(_____)_____-_____ **UPIN #**_____ |

**SECTION B** **Information in this Section May Not Be Completed by the Supplier of the Items/Supplies.**

**EST. LENGTH OF NEED (# OF MONTHS)** _____**1-99 (99=LIFETIME)** DIAGNOSIS CODES (ICD-10) _____ _____ _____ _____

| ANSWERS | ANSWER QUESTIONS 1 – 10. (Circle **Y** for Yes, **N** for No, or **D** for Does Not Apply, unless otherwise noted). |
|---|---|
| a)____mm Hg<br>b) _____%<br>c) __/__/___ | 1. Enter the result of most recent test taken on or before the certification date listed in Section A. Enter (a) arterial blood gas $PO^2$ and/or (b) oxygen saturation test. Enter date of test (c) |
| Y N | 2. Was the test in Question 1 performed EITHER with the patient in a chronic stable state as an outpatient OR within two days prior to discharge from an inpatient facility to home? |
| 1 2 3 | 3. Circle the one number for the condition of the test in Question 1: (1) At Test; (2) During Exercise; (3) During Sleep |
| XXXXXXXX<br>XXXXXXXX<br>XXXXXXXX | 4. Physician/provider performing test in Question 1 (and, if applicable, Question 7). Pint/type name and address below:<br>NAME:_____ ADDRESS: |
| Y N D | 5. If you are ordering portable oxygen, is the patient mobile within the home? If you are Not ordering portable oxygen, circle D. |
| _____ | 6. Enter the highest oxygen flow rate ordered for this patient in liters per minute. If less than 1 LPM, enter a "X" |
| a)____mm Hg<br>b) _____%<br>c) __/__/___ | 7. If greater than 4 LPM is prescribed, enter results of most recent test taken on 4 LPM. This may be an (a) arterial blood gas $PO^2$ and/or (b) oxygen saturation test with patient in a chronic stable state. Enter date of test (c). |
| **IF $PO^2$ =56-59 OR OXYGEN SATURATION =89%, AT LEAST ONE OF THE FOLLOWING CRITERIA MUST BE MET.** | |
| Y N D | 8. Does the patient have dependent edema due to congestive heart failure? |
| Y N D | 9. Does the patient have cor pulmonale or pulmonary hypertension documented by P pulmonale on an EKG or by an echocardiogram, gated blood pool scan or direct pulmonary artery pressure measurement? |
| Y N D | 10. Does the patient have a hematocrit greater than 56%? |

NAME OF PERSON ANSWERING SECTION B QUESTIONS, IF OTHER THAN PHYSICIAN (Please Print)
NAME:_____TITLE:_____EMPLOYER:_____:

**SECTION C** **Narrative Description Of Equipment And Cost**

(1) Narrative description of all items, accessories and options ordered; (2) Supplier's charge; and (3) Medicare Fee Schedule Allowance for each item, accessory, and option. (*See Instructions On Back*)

**SECTION D** **Physician Attestation and Signature/Date**

I certify that I am the physician identified in Section A of this form. I have received Sections A, B and C of the Certificate of Medical Necessity (including charges for items ordered). Any statement on my letterhead attached hereto, has been reviewed and signed by me. I certify that the medical necessity information in Section B is true, accurate and complete, to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fat in that section may subject me to civil or criminal liability.

PHYSICIAN'S SIGNATURE_____DATE____/____/____ (SIGNATURE AND DATE STAMPS NOT ACCEPTABLE)

FORM HCFA-484 (11/99)

**SECTION A:** **(May be completed by the supplier)**
CERTIFICATION If this is an initial certification for this patient, indicate this by placing date (MM/DD/YY) needed initially in the space marked

| | |
|---|---|
| TYPE/DATE: | "INITIAL." If this is a revised certification (to be completed when the physician changes the order, based on the patient's changing clinical needs), indicate the initial date needed in the space marked "INITIAL", and also indicate the recertification date in the space marked "REVISED." If this is a recertification, indicate the initial date needed in the space marked "INITIAL" and also indicate the recertification date I the space marked "RECERTIFICATION." Whether submitting a REVISED or a RECERTIFIED CMN, be sure to always furnish the INITIAL date as well as the REVISED or RECERTIFICATION date. |
| PATIENT INFORMATION | Indicate the patient's name, permanent legal address, telephone number and his/her health insurance claim number (HICN) as it appears on this/her Medicare card an on the claim form. |
| SUPPLIER INFORMATION: | Indicate the name of our company (supplier name), address and telephone number along with the Medicare Supplier Number assigned to you by the National Supplier Clearinghouse (NSC) |
| PLACE OF SERVICE: | Indicate the place in which the item is being used, i.e., patient's home is 12, skilled nursing facility (SNF) is 31, End Stage Renal Disease (ESRD) facility is 65, etc. Refer to the DMERC supplier manual for a complete list. |
| FACILITY NAME | If the place of service is a facility, indicate the name and complete address of the facility |
| HCPCS CODES | List all HCPCS procedure codes for items ordered that require a CMN. Procedure codes that do not require certification should not be listed on the CMN. |
| PATIENT DOB, HEIGHT, WEIGHT AND SEX: | Indicate patient's date of birth (MM/DD/YY) and sex (male or female); height in inches and weight in pounds, if requested. |
| PHYSICIAN NAME, ADDRESS: | Indicate the physician's name and complete mailing address |
| UPIN: | Accurately indicate the ordering physician's Unique Physician Identification Number (UPIN). |
| PHYSICIAN'S TELEPHONE NO: | Indicate the telephone number where the physician can be contacted (preferably where records would be accessible pertaining to this patient) if more information is needed. |
| **SECTION B** | **(May not be completed by the supplier. While this section may be completed by a non-physician clinician, or a physician employee, it must be reviewed, and the CMN signed (in Section D) by the ordering physician.)** |
| EST. LENGTH OF NEED | Indicate the estimated length of need (the length of time the physician expects the patient to require use of the ordered item) by filling in the appropriate number of months. If the physician expects that the patient will require the item for the duration of his/her life, then enter 99. |
| DIAGNOSIS CODES: | In the first space, list the ICD10 code that represents the primary reason for ordering this item. List any additional ICD10 codes that would further describe the medical need for the item (up to 3 codes). |
| QUESTION SECTION: | This section is used to gather clinical information to determine medical necessity. Answer each question which applies t the items ordered, circling "Y" for yes, "N" for no, "D" for does not apply, a number if this is offered as an answer option, or fill in the blank if other information is requested. |
| NAME OF PERSON ANSWERING SECTION B QUESTIONS | If a clinical professional other than the ordering physician (e.g., home health nurse, physical therapist, dietician) or a physician employee answers the questions of Section B, he/she must print his/her name, give his/her professional title and the name of his/her employer where indicate. If the physician is answering the questions, this space may be left blank. |
| **SECTION C:** | **(To be completed by the supplier)** |
| NARRATIVE DESCRIPTION OF EQUIPMENT & COST | Supplier gives (1) a narrative description of the item(s) ordered, as well as all options, accessories, supplies and drug; (2) the supplier's charge for each item, option, accessory, supply and drug; and (3) the Medicare fee schedule allowance for each item/option/accessory/supply/drug, if applicable. |
| SECTION D | (To be completed by the physician) |
| PHYSICIAN ATTESTATION: | The physician's signature certifies (1) the CMN which he/she is reviewing includes Sections A, B, C and D; (2) the answers in Section B are correct; and (3) the self-identifying information in Section A is correct. |
| PHYSICIAN SIGNATURE AND DATE: | After completion and/or review by the physician of Sections A, B and C, the physician must sign and date the CMN in Section D, verifying the Attestation appearing in this Section. The physician's signature also certifies the items ordered are medically necessary for this patient. Signature and date stamps are not acceptable. |