

Rocky Mountain Health Plans Preauthorization Schedule



Effective October 1, 2008

Revision November 17, 2009

Coverage of all items is based on Medical Necessity.

| ITEMS | COVERED PLAN TYPES | | | PRIOR AUTH REQUIRED | HCPCS CODES* | COVERAGE GUIDELINES | BENEFIT |
|---|--------------------|---|----|---------------------|---|---|---------|
| | MC | C | MD | | | | |
| Ambulating Devices | | | | | | | |
| Cane/Quad Cane/Straight (Adjustable) | Y | Y | Y | N | E0100 E0105 | Covered when all of the following criteria are met: 1) The patient has a mobility limitation that significantly impairs his/her ability to participate in one or more mobility-related activities of daily living (MRADL) in the home. 2) The patient is able to safely use the cane; and 3) The functional mobility deficit can be sufficiently resolved by use of a cane. White canes for the blind are NAB since it is a self-help item. | DME |
| Crutches: Underarm Forearm, F/A Handgrip replacement Tip replacement Underarm pad replacement Platform attachment; forearm crutch, each | Y | Y | Y | N | E0110 to E0117 A4635 A4636 A4637 | Covered when all of the following criteria are met: 1) The patient has a mobility limitation that significantly impairs his/her ability to participate in one or more mobility-related activities of daily living (MRADL) in the home. 2) The patient is able to safely use the crutch; and 3) The functional mobility deficit can be sufficiently resolved by use of a crutch. The medical necessity for an underarm, articulating, spring assisted crutch (E0117) has not been established. These are for short term rental unless the patient has a diagnosis that requires them longer. | DME |
| Crutch Substitute | Y | Y | Y | Y | E0118 | Rx and LMN will be required. | DME |
| Walkers: Folding/Pickup Standard Heavy Duty Four Sided Frame Trunk Support | Y | Y | Y | N | E0130 E0135 E0140 E0141 E0143 E0144 E0147 E0148 E0149 | A standard walker is covered when the patient has a mobility limitation that significantly impairs his/her ability to participate in one or more mobility-related activities of daily living (MRADL) in the home and the functional mobility deficit can be sufficiently resolved with use of a walker. A walker with trunk support is covered for patients who have documentation in the medical record justifying the medical necessity for the special features. The medical necessity for a walker with an enclosed frame has not been established. A heavy duty, multiple braking system, variable wheel resistance walker is | DME |

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| | | | | | | covered for patients who are unable to use a standard walker due to a severe neurologic disorder or other condition causing the restricted use of one hand. A heavy duty walker is covered for patients who weigh more than 300 pounds. | |
| Walker (Seat/Hand Brakes) 4 - Wheeled Walker | N | N | N | | | Please refer to walker folding/pickup - standard and attachments for coding. This will need be broken down by code and no longer valid under E1399. | DME |
| Walker/Crutch Attachments | Y | Y | Y | N | A4636 A4637 E0153 to E0159 | Leg extensions are covered only for patients 6 feet tall or more. An enhancement accessory is one which does not contribute significantly to the therapeutic function of the walker. It may include, but is not limited to style, color, hand operated brakes or basket (or equivalent). | DME |
| <i>Bath and Toilet Aides</i> | | | | | | | |
| Bath Bench (shower chair, shower seat, shower bench, or tub stool) | N | N | Y | N | E0245 E0247 E0248 | Considered convenience items. | DME |
| Bath Tub /Toilet Lift | N | N | Y | N | E0625 | Considered convenience items. | DME |
| Bidet Toilet Seats | N | N | N | N | A9270 | Not primarily medical in nature. | DME |
| Commodes: Assist Drop Arm Heavy Duty/Extra Wide Pail/Pan | Y | Y | Y | N | E0163 E0165 E0167 E0168 | Covered when the patient is physically incapable of utilizing regular toilet facilities. This would occur in the following situations: 1) The patient is confined to a single room, or 2) The patient is confined to one level of the home environment and there is no toilet on that level, or 3) The patient is confined to the home and there are no toilet facilities in the home. E0165 is covered when the detachable arms feature is necessary to facilitate transferring the patient or if the patient has a body configuration that requires extra width. A pan or pail (E0167) is only covered when Member has commode. | DME |
| Commodes: Footrest Seat Lift Mechanism placed on or over a toilet | N | N | N | N | E0172 E0175 | A footrest is not covered. A seat lift mechanism placed over or on top of a toilet is not covered. | DME |

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| Commode Chair with Seat Lift Mechanism | N | N | Y | Y | E0170 E0171 | Rx and LMN will be required. Covered if the patient has medical necessity for a commode and meets the coverage criteria for a seat lift mechanism. However, a commode with seat lift mechanism is intended to allow the patient to walk after standing. If the patient can ambulate, he/she would rarely meet the coverage criterion for a commode. | DME |
| Grab Bars/Rails for Bath/Shower/Stool/Toilet | N | N | Y | N | E0241 E0242 E0243 E0246 | Considered convenience items. Installation charges are not a benefit. | DME |
| Paraffin Bath Unit (Portable) Paraffin/Pound | Y | Y | Y | Y | E0235 A4265 | Covered when the patient has undergone a successful trial period of Paraffin therapy ordered by a physician and the patient's condition is expected to be relieved by long term use of this modality. | DME |
| Paraffin Bath Units (standard) non-portable | N | N | N | N | A9270 | Not a benefit of any plan. | DME |
| Sitz Bath | Y | Y | Y | N | E0160 E0161 E0162 | Covered when the medical record indicates that the patient has an infection or injury of the perineal area and is prescribed by the physician. | DME |
| Shower Chair w/wo wheels | N | N | Y | N | E0240 | Considered a convenience item. | DME |
| Raised Toilet Seat | N | N | Y | N | E0244 | Considered a convenience item. | DME |
| <i>Beds and Bedroom Equipment</i> | | | | | | | |
| Mattress: Air Fluidized Alternating Pressure - Pump/Pad Gel Mattress Air Pressure Mattress Water Pressure Air Power Pressure - Reducing Powered Overlay Non-Powered Overlay Replacement Pad | Y | Y | Y | Y | A4640 E0180 to E0182 E0185 to E0187 E0193 to E0197 E0277 E0370 to E0373 | Medical Policy Applies. | DME |

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| Hospital Bed Accessory: Bed Board Over-Bed Table Board, Table or Support Device | N | N | Y | N | E0273 E0274 E0315 | Considered convenience items. | DME |
| Hospital Beds: Fixed Height Variable Height Semi-Electric Total Electric Heavy Duty Extra Heavy Duty | Y | Y | Y | Y | E0250 to E0270 E0290 to E0297 E0300 to E0304 E0328 to E0329 | Medical Policy Applies. | DME |
| Hospital Bed & Mattress Accessories: Bed Pan Bed Cradle Bedside Rails Canopy - Safety Enclosed Frame Trapeze Heavy Duty Trapeze Urinal | Y | Y | Y | N | E0275 E0276 E0280 E0305 E0310 E0316 E0325 E0326 E0350 E0352 E0910- E0912 E0940 | A bed cradle is covered when it is necessary to prevent contact with the bed coverings. Side Rails and Safety enclosures are covered when they are required by the patient's condition. Trapeze equipment is covered when the patient needs this device to sit up because of a respiratory condition, to change body position for other medical reasons, or to get in or out of bed. Heavy-duty trapeze equipment is covered when the patient's weight is more than 250 pounds. Urinals are covered when the patient is bed confined. | DME |

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| Mattress: Geomat Sheepskin Inner Spring Foam Rubber Synthetic Sheepskin Dry Pressure | Y | Y | Y | Y | E0184 E0188 E0189 E0199 E0271 E0272 | Rx, LMN and Medical Records will be required. Covered when the patient meets: a) Criterion 1, or b) Criteria 2 or 3 and at least one of criteria 4-7. 1) Completely immobile - i.e., patient cannot make changes in body position without assistance. 2) Limited mobility - i.e., patient cannot independently make changes in body position significant enough to alleviate pressure. 3) Any stage pressure ulcer on the trunk or pelvis. 4) Impaired nutritional status. 5) Fecal or urinary incontinence. 6) Altered sensory perception. 7) Compromised circulatory status. An Inner Spring Mattress or Foam Rubber Mattress is covered when a patient's condition requires a replacement innerspring mattress or foam rubber mattress for a patient owned hospital bed. | DME |
| Transfer Board | Y | Y | Y | N | E0705 | Covered when the patient needs assistance transferring from bed to chair or from chair to bed. | DME |
| Diabetic Monitors and Supplies | | | | | | | |
| Airjet Injector (Needle free injection device) | N | N | Y | N | A4210 | Considered a convenience item. | DME |
| Batteries for Glucometers | Y | Y | Y | N | A4233 A4234 A4235 A4236 | Covered when the Member has a glucometer. | DME |
| Diabetic Disposable Supplies | Y | Y | Y | N | | Limited to a 90 day supply every 90 days. Must have diagnosis of diabetes. | DISP |

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| <p>Diabetic Shoes Diabetic Inserts</p> | <p style="text-align: center;">Y</p> | <p style="text-align: center;">Y</p> | <p style="text-align: center;">Y</p> | <p style="text-align: center;">N</p> | <p>A5500 A5501 A5503 A5504 A5505 A5506 A5507 A5508 A5510 A5512 A5513</p> | <p>Refer to section "Orthopedic Footwear" on page 19 of this document for information on codes L3000 – L3649.</p> <p>Preauthorization is NOT required when devices billed with codes A5500 – A5513 are used to treat manifestations of diabetes. A diagnosis of diabetes must be the primary diagnosis code. Claims with any other diagnosis will be denied as not a benefit.</p> <p>Therapeutic shoes, inserts and/or modifications are covered if the following criteria are met:</p> <ol style="list-style-type: none"> 1) The patient has diabetes mellitus (ICD-9 diagnosis codes 250.00-250.93); and 2) The patient has one or more of the following conditions: <ol style="list-style-type: none"> a) Previous amputation of the other foot, or part of either foot, or b) History of previous foot ulceration of either foot, or c) History of pre-ulcerative calluses of either foot, or d) Peripheral neuropathy with evidence of callus formation of either foot, or e) Foot deformity of either foot, or f) Poor circulation in either foot; and 3) The certifying physician who is managing the patient's systemic diabetes condition has certified that indications (1) and (2) are met and that he/she is treating the patient under a comprehensive plan of care for his/her diabetes and that the patient needs diabetic shoes. <p>Coverage is limited to one of the following within one calendar year (January – December):</p> <ol style="list-style-type: none"> 1) One pair of custom molded shoes and 2 additional pairs of inserts; or 2) One pair of depth shoes and 3 pairs of inserts. <p>Quantities of shoes and/or inserts greater than those listed above will be denied as non-covered.</p> | <p style="text-align: center;">ORTHO</p> |
| <p>Glucometers: Standard Voice Activated</p> | <p style="text-align: center;">Y</p> | <p style="text-align: center;">Y</p> | <p style="text-align: center;">Y</p> | <p style="text-align: center;">N</p> | <p>E0607 E2100 E2101</p> | <p>Covered when all of the following basic criteria is met:</p> <ol style="list-style-type: none"> 1) The patient has diabetes (ICD-9 codes 250.00-250.93) which is being treated by a physician; and 2) The treating physician maintains records reflecting the care provided including, but not limited to, evidence of medical necessity for the prescribed frequency of testing; and 3) The patient has successfully completed training or is scheduled to begin training in the use of the monitor, test strips, and lancing devices; and 4) The patient is capable of using the test results to assure the patient's | <p style="text-align: center;">DME</p> |

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| | | | | | | appropriate glycemic control; and 5) The devise is designed for home use. Home blood glucose monitors with special features are covered when the basic coverage criteria are met and the treating physician certifies that the patient has a severe visual impairment (i.e., best corrected visual acuity of 20/200 or worse in both eyes) requiring use of this special monitoring system. A9276 to A9278 are non-covered. | |
| Insulin Pump | Y | Y | Y | Y | E0784 | Medical Policy Applies. A9274 is non-covered. | DME |
| Insulin Pump Supplies | Y | Y | Y | N | A4230 A4231 A4232 | Limited to a 90 day supply per purchase every 90 days. Must have diagnosis of diabetes and have an insulin pump. | DISP |
| <i>Dialysis/ESRD Equipment</i> | | | | | | | |
| Blood Pressure Monitor | Y | Y | Y | Y | A4660 A4663 A4670 | Rx, LMN and Medical Records will be required. Covered when approved for home dialysis. Please refer to home dialysis. | DME |
| Dialysis Equipment ESRD Supplies Water Purifier Softener | Y | Y | N | Y | A4671 to A4690 A4706 to A4932 E1500 to E1699 | Medical Policy Applies. A4927 and A4930 require modifier AX to be appended when the gloves are used by the member or the member's caregiver in conjunction with home dialysis. | DME |
| Gloves – non-sterile | N | N | Y | The first two boxes of non-sterile gloves per month do not require preauthorization | A4927 | For Medicaid only, non-sterile gloves are covered when used by the member or the member's care-giver in conjunction with a covered service, e.g. ostomy care, urinary catheter care, enteral feedings, and incontinence when incontinence supplies are covered. | DISP |

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| Gloves - sterile | Y | Y | Y | Sterile gloves require preauthorization | A4930 | For all lines of business, sterile gloves are covered only when used by the member or the member's care-giver for procedures that need to avoid contamination of the area (sterile technique). Medicaid Limit – 5 pair per day. | DISP |
| Disposable Supplies (Not Including Wound Care/Surgical Supplies) | | | | | | | |
| Disposable Supplies: Ostomy Supplies Urinary Supplies | Y | Y | Y | N | A4310 to A4434 A4561 to A4562 A5051 to A5200 A7040 to A7043 | Limited to a 90 day supply per purchase every 90 days. | DISP |
| Incontinence Supplies: Incontinence Garment Youth Briefs/Diapers Adult Briefs/Diapers Disposable Underpads Protective Underwear Disposable Liners | N | N | Y | When units exceed the Medicaid limits, authorization is required. | A4534 A4554 T4521 to T4543 | <p>Medicaid only. COMBINATION LIMIT: Diapers or briefs are not a covered benefit for Members under the age of 4 years. Products are limited to 240 per calendar month in any combination of diapers, liners and undergarments. Medically necessary usage above that amount requires preauthorization.</p> <p>Disposable Underpads (Chux, A4554) are limited to 150 per calendar month. Above 150 requires prior authorization.</p> <p>Incontinence wipes are not a benefit.</p> | DISP |

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| Tracheotomy Supplies: Cleaning Kit Collar/mask Trach/Laryngectomy Tubing Tracheal suction catheter | Y | Y | Y | N | A4481 A4605 A4608 A4623 to A4626 A4628 A4629 A7501 to A7527 | Limited to a 30 days supply per purchase per every 30 days. | DISP |
| Elastic Support/Circaids/Compression Garments/Lymphedema Pump and Accessories | | | | | | | |
| A-V Impulse System Foot Pump | Y | Y | Y | Y | E1399 | Rx and LMN will be required. | DME |
| Conforming Bandage Compression Bandage | Y | Y | Y | N | A6441 to A6457 | Most compression bandages are reusable. Usual frequency of replacement would be no more than one per week unless they are part of a multi-layer compression bandage system. Conforming bandage dressing change is determined by the frequency of change of the selected underlying dressing. | DISP |
| Compression Burn Garments | Y | Y | Y | N | A6501 to A6513 | Covered under the Surgical Dressings benefit when they are used to reduce hypertrophic scarring and joint contractures following a burn injury. | DME |
| Compression Garments (not used with pump. i.e. <i>Circaids, Ready-Fit</i>) | N | N | Y | N | A4465 | Noncovered for all indications because it does not meet the definition of a surgical dressing. | DME |
| Pneumatic Compressors: Segmental Non-segmental Intermittent Limb | Y | Y | Y | Y | E0650 E0651 E0652 E0675 E0676 | Rx will be required from MD. CMN Pneumatic Compression Devices will be required for Commercial and MC. Only covered for the treatment of lymphedema or for the treatment of chronic venous insufficiency with venous stasis ulcers. | DME |
| Pneumatic Appliances: Segmental Non-segmental | Y | Y | Y | Y | E0655 to E0673 | Rx will be required for MD. CMN Pneumatic Compression Devices will be required for Commercial and MC. Only covered for the treatment of lymphedema or for the treatment of chronic venous insufficiency with venous stasis ulcers. | DME |
| Vasopneumatic Compression Device Game Ready Compression Device | N | N | N | N | E1399 | Not a benefit of any plan. | DME |

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| Stockings: Elastic Support TED Hose Gradient Compression Jobst | N | N | Y | N | A4490 to A4510 A6530 A6533 to A6549 | Noncovered for all indications because it does not meet the definition of a surgical dressing. | ORTHO |
| Stockings: Gradient Compression | Y | Y | Y | N | A6531 A6532 | Only covered when used in the treatment of an open venous stasis ulcer. | DME |
| Heat and Cold Equipment | | | | | | | |
| Heat/Cold Therapy | N | N | N | N | E0210 to E0218 E0236 E0238 E0249 | Considered convenience items. | DME |
| Heat/Cold Equipment | N | N | N | N | E0200 E0205 E0220 E0225 E0230 E0239 E0231 E0232 | Considered convenience items. | DME |
| Infrared Heating Pad System Replacement Pad | N | N | N | N | E0221 A4639 | There are no indications for which these devices have been demonstrated to have any therapeutic effect. The device and any related accessories will be denied as not medically reasonable and necessary. | DME |
| Phototherapy: Bilirubin | Y | Y | Y | N | E0202 | Covered when it is used for the treatment of jaundice in infants. | DME |
| Ultraviolet Light Therapy System Replacement Bulb/Lamp | Y | Y | Y | Y | A4633 A4634 E0691 to E0694 | Medical Policy Applies. | DME |
| Therapeutic Lightbox | N | N | N | N | E0203 | Non-covered for all indications. | DME |

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| Apnea Monitor (with or w/o kit) | Y | Y | Y | N | E0618 E0619 | These are for rental only. Covered for infants less than 12 months of age with documented apnea or who have known risk factors for life threatening apnea. | DME |
| Protime/Coagucheck/INR Monitors | Y | Y | Y | Y | E1399 | Medical Policy Applies. | DME |
| Infusion Pumps | Y | Y | Y | N | E0779 to E0783 E0785 E0786 E0791 K0455 | Covered when Member meets Medicare guidelines. Please check www.cignagovernmentservices.com/jc/index.html | DME |
| IV Pole | Y | Y | Y | N | E0776 | An IV pole (E0776) is covered only when a stationary infusion pump (E0791) is covered. It is considered not medically necessary if it is billed with an ambulatory infusion pump (E0779, E0780, E0781, E0784, or K0455). | DME |
| Disposable Drug Delivery System | Y | Y | Y | N | A4305 A4306 | Covered when medically indicated by the requesting physician. | DME |
| Oxygen and Respiratory Care/Supplies/Compressors/Nebulizers | | | | | | | |
| BiPAP (Bi-Level Positive Pressure Ventilator) | Y | Y | Y | Y | E0470 E0471 E0472 | Polysomnograph results and Rx are required for rental. BiPAP/CPAP Questionnaire (see attachment) is required for purchase. Covered when patients with clinical disorder groups characterized as restrictive thoracic disorders (i.e., progressive neuromuscular diseases or severe thoracic cage abnormalities), severe chronic obstructive pulmonary disease (COPD), central sleep apnea (CSA), or (IV) obstructive sleep apnea (OSA) (E0470 only). For obstructive sleep apnea the following criteria (A) and (B) must be met: A) A complete facility-based, attended polysomnogram, has established the diagnosis of obstructive sleep apnea according to the following criteria: 1) The apnea-hypopnea index (AHI) is greater than or equal to 15 events per hour, or 2) The AHI is from 5 to 14 events per hour with documented symptoms of: a) Excessive daytime sleepiness, impaired cognition, mood disorders, or insomnia, or b) Hypertension, ischemic heart disease, or history of stroke, and B) A single level device (E0601,CPAP) has been tried and proven ineffective. | DME |

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| CPAP (continuous positive airway pressure) | Y | Y | Y | N | E0601 | CPAP is covered when the patient has a diagnosis of obstructive sleep apnea (OSA) documented by an attended, facility-based polysomnogram and meets either of the following criteria (1 or 2): 1) The AHI is greater than or equal to 15 events per hour; or, 2) The AHI is from 5 to 14 events per hour with documented symptoms of: a) Excessive daytime sleepiness, impaired cognition, mood disorders, or insomnia; or, b) Hypertension, ischemic heart disease, or history of stroke. The polysomnogram and BiPAP/CPAP Questionnaire (see attachment) will need to be on file in Vendor's office. | DME |
| CPAP/BiPAP Humidifier | Y | Y | Y | N | E0561 E0562 | A non-heated or heated humidifier is covered when ordered by the treating physician for use with a covered CPAP or BiPAP device. | DME |
| CPAP/BiPAP Supplies: Mask (Full or Regular) Headgear Tubing Filters Water Chambers Cannula Chin Strap Whisper Swivel | Y | Y | Y | N | A4604 A7027 to A7039 A7044 to A7046 | Covered when Member has CPAP or BiPAP. The following are allowed as stated below: A4604 – 1 per 3 months A7027 – 1 per 3 months A7028 – 2 per 1 month A7029 – 2 per 1 month A7030 – 1 per 3 months A7031 – 1 per 1 month A7032 – 2 per 1 month A7033 – 2 per 1 month A7034 – 1 per 3 months A7035 – 1 per 6 months A7036 – 1 per 6 months A7037 – 1 per 3 month A7038 – 2 per 1 month A7039 – 1 per 6 months A7046 – 1 per 6 months | DISP |
| Cough Stimulating Device | Y | Y | Y | Y | E0482 | Cough stimulating devices are medically necessary when a Member has a neuromuscular disease (e.g., amyotrophic lateral sclerosis, high spinal cord injury with quadriplegia) that is causing a significant impairment of chest wall and/or diaphragmatic movement and for whom standard treatments (e.g., chest percussion and postural drainage, etc.) have not been successful in adequately mobilizing retained secretions. | DME |

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| High Frequency Chest Wall Oscillation Air-Pulse Generator System/ Vest Clearance Airway System | Y | Y | Y | Y | A7025 A7026 E0483 | High frequency chest wall oscillation devices are covered for patients who meet either criteria 1 or 2 and criterion 3: 1. There is a diagnosis of cystic fibrosis (ICD-9 277.00, 277.02). 2. There is a diagnosis of bronchiectasis, (ICD-9 011.50-011.56, 494.0, 494.1, 748.61), (a) characterized by daily productive cough for at least 6 continuous months or, frequent (i.e. more than 2/year) exacerbations requiring antibiotic therapy, and (b) confirmed by high resolution, spiral, or standard CT scan. 3. There must be well-documented failure of standard treatments to adequately mobilize retained secretions. | DME |
| Intrapulmonary Percussive Vent System and accessories | N | N | N | N | E0481 | An intrapulmonary percussive ventilator (IPV) has not been demonstrated to be reasonable and necessary in the home setting, thus it is non-covered. | DME |
| IPPB Machine IPPB Humidifier | Y | Y | Y | Y | E0500 E0550 E0555 E0560 | Covered when used for the treatment of respiratory diseases. This is a rental only item. | DME |
| Nebulizer: Compressor (Only one nebulizer will be covered) | Y | Y | Y | N | E0570 | Covered when: a) It is medically necessary to administer beta-adrenergics, anticholinergics, corticosteroids, and cromolyn for the management of obstructive pulmonary disease (ICD-9 491.0 - 508.9), or b) It is medically necessary to administer gentamicin, tobramycin, amikacin, or dornase alpha to a patient with cystic fibrosis (ICD-9 277.02), or c) It is medically necessary to administer tobramycin to a patient with bronchiectasis (ICD-9 494.0, 494.1, 748.61, 011.50-011.56), or d) It is medically necessary to administer pentamidine to patients with HIV (ICD-9 diagnosis code 042), pneumocystosis (ICD-9 136.3), and complications of organ transplants (ICD-9 diagnosis codes 996.80-996.89), or e) It is medically necessary to administer mucolytics for persistent thick or tenacious pulmonary secretions (ICD-9 480.0-508.9, 786.4). Purchase for patients with chronic conditions. Rent 60 days, then re-evaluate for patients with acute conditions. | DME |
| Nebulizer: Portable Ultrasonic | N | N | Y | N | E0571 E0574 E0575 | Considered a convenience item. A small volume ultrasonic nebulizer is not covered, there is no proven medical benefit to nebulizing particles to diameters smaller than achievable with a pneumatic model. A large volume ultrasonic nebulizer (E0575) offers no proven clinical advantage over a pneumatic compressor, thus it is not covered. | DME |

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| Nebulizer: Large Volume Bottle Type with Compressed Heater Compressor | Y | Y | Y | N | A7008 E0565 E0572 E0580 E0585 | A large volume nebulizer and related compressor are covered when it is medically necessary to deliver humidity to a patient with thick, tenacious secretions, who has cystic fibrosis, bronchiectasis, a tracheostomy, a tracheobronchial stent. They are also covered when it is medically necessary to administer pentamidine to patients with HIV, pneumocystosis, and complications of organ transplants. | DME |
| Nebulizer Supplies: Mask Tubing Reservoir Bottle Water Collection Device Filter Dome Peak Flow Meter Immersion External Heater | Y | Y | Y | N | A4614 A7003 to A7007 A7009 to A7018 E1372 | Covered when Member has nebulizer. The following are allowed as stated below: A7003 Two per month A7004 Two per month in addition to A7003 A7005 One every 6 months A7005 One every 3 months only with K0730 A7006 One per month A7007 Two per month A7010 One unit (100 ft.) every 2 months A7011 One per year A7012 Two per month A7013 Two per month A7014 One every 3 months A7015 One per month A7016 Two per year A7017 One every 3 years | DME |
| Oral Appliance for Sleep Apnea | Y | Y | Y | Y | E0485 E0486 D7880 | Medical Policy Applies. | DME |
| Oscillatory Positive Expiratory Pressure Device | Y | Y | Y | N | E0484 | Considered medically necessary for cystic fibrosis, chronic bronchitis, asthma, and chronic obstructive pulmonary disease. | DME |

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| Oxygen: Concentrator Gaseous Portable Stationary Liquid Portable Vapor Enriching System Contents | Y | Y | Y | Y | E0424 E0425 E0431 E0434 E0435 E0439 E0440 E1390 E1391 E1392 E1405 E1406 K0738 | <p>Medical Policy Applies.</p> <p>Initial approval for oxygen will follow CMS guidelines, including oxygen saturation requirements. Annual oxygen saturation with the current testing date is required for renewal.</p> <p>All requests must be submitted on the Certificate of Medical Necessity (CMN) form.</p> <p>Rocky Mountain Health Plans (Rocky Mountain) will require an annual renewal except for the following diagnoses:</p> <ul style="list-style-type: none"> COPD CHF interstitial lung disease pulmonary hypertension <p>Oxygen prescribed for COPD, CHF, interstitial lung disease and pulmonary hypertension will require authorization. The initial approval will be for one year. Renewals for these diagnoses will be for two (2) years. Requests must include current oxygen saturation with the current testing date.</p> <p>Oxygen provided to newborns within the first 30 days of life do not require preauthorization. Services after day 30 must be authorized.</p> <p>Emergency or stand-by oxygen systems will be denied as not medically necessary since they are precautionary and not therapeutic in nature.</p> | OX |
| Oxygen Contents | Y | Y | Y | Y | E0441 to E0444 | <p>Covered when Member meets guidelines for oxygen listed above. Payment for contents is generally included in the equipment rental.</p> | |
| Oxygen Supplies: Oxygen Tent Tubing Mask Cannula Face Tent Breathing Circuits Regulator Stand | Y | Y | Y | N | A4608 A4615 to A4620 A9900 E0455 E1353 E1355 | <p>Accessories, including but not limited to, transtracheal catheters (A4608), cannulas (A4615), tubing (A4616), mouthpieces (A4617), face tent (A4619), masks (A4620, A7525), oxygen conserving devices (A9900), oxygen tent (E0455), humidifiers (E0555), nebulizer for humidification (E0580), regulators (E1353), and stand/rack (E1355) are included in the allowance for rented systems.</p> | OX |
| P-Flex Incentive Spirometer | Y | Y | Y | N | E1399 | <p>Covered when used for neuromuscular or chest wall diseases. Incentive spirometers are considered experimental and investigational for all other indications.</p> | DME |

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| Percussor/Phlegm Fighter Electronic | Y | Y | Y | N | E0480 | Mechanical percussors are considered medically necessary for cystic fibrosis, chronic bronchitis, bronchiectasis, immotile cilia syndrome, and asthma. | DME |
| Pulse Oximeter Pulse Oximeter Probes | N | N | Y | Y | A4606 E0445 | Medical Policy Applies. | DME |
| Ventilator: Volume Control Negative Pressure Pressure Support Chest Shell Chest Wrap | Y | Y | Y | Y | E0450 E0457 E0459 E0460 E0461 E0463 E0464 | Medical Policy Applies. | DME |
| Ventilator Supplies: Moisture Exchange Battery | Y | Y | Y | N | A4483 A4611 A4612 A4613 | Covered when the Member has a ventilator. | DISP |
| Patient Lifts | | | | | | | |
| Patient Lift: Hydraulic (Hoyer) Sling or Seat | Y | Y | Y | Y | E0621 E0630 | Covered if transfer between bed and a chair, wheelchair, or commode requires the assistance of more than one person and, without the use of a lift, the patient would be bed confined. A sling or seat for patient lift is covered as an accessory when ordered as a replacement for the original equipment item. | DME |
| Patient Lift: Electrical Multi-positional Patient Support System Bathroom or Toilet Standing Frame System | N | N | Y | Y | E0625 E0635 E0636 E0638 E0641 E0642 | Considered convenience items. | DME |
| Patient Lift: Combination sit to stand system Moveable Fixed System | N | N | N | N | E0637 E0639 E0640 | Noncovered items. E0639 and E0640 are non-covered. These items do not meet the statutory definition of durable medical equipment. | DME |

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| Seat Lift Mechanism | Y | Y | Y | N | E0627 E0628 E0629 | <p>Note: Coverage is limited to the seat-lift mechanism, even if it is incorporated into a chair. A seat lift mechanism is covered when all of the following criteria are met:</p> <ol style="list-style-type: none"> 1) The patient must have severe arthritis of the hip or knee or have a severe neuromuscular disease. 2) The seat lift mechanism must be a part of the physician's course of treatment and be prescribed to effect improvement, or arrest or retard deterioration in the patient's condition. 3) The patient must be completely incapable of standing up from a regular armchair or any chair in their home. (The fact that a patient has difficulty or is even incapable of getting up from a chair, particularly a low chair, is not sufficient justification for a seat lift mechanism. Almost all patients who are capable of ambulating can get out of an ordinary chair if the seat height is appropriate and the chair has arms.) 4) Once standing, the patient must have the ability to ambulate. | DME |
| Orthotics, Prosthetics and Braces | | | | | | | |
| Orthosis: Static Ankle Foot Orthosis Soft Interface Material | Y | Y | Y | N | L4392 L4396 | <p>A static AFO (L4396) is covered if either all of criteria 1 - 4 or criterion 5 is met:</p> <ol style="list-style-type: none"> 1) Plantar flexion contracture of the ankle (ICD-9 diagnosis code 718.47) with dorsiflexion on passive range of motion testing of at least 10 degrees (i.e., a nonfixed contracture); and, 2) Reasonable expectation of the ability to correct the contracture; and, 3) Contracture is interfering or expected to interfere significantly with the patient's functional abilities; and, 4) Used as a component of a therapy program which includes active stretching of the involved muscles and/or tendons. 5) The patient has plantar fasciitis (ICD-9 diagnosis code 728.71) <p>If code L4396 is covered, a replacement interface (L4392) is covered as long as the patient continues to meet indications and other coverage rules for the splint. Coverage of a replacement interface is limited to a maximum of one (1) per 6 months. Additional interfaces will be denied as not medically necessary.</p> | ORTHO |
| Orthosis: Foot Drop Splint/ Recumbent | N | N | Y | N | L4394 L4398 | <p>A foot drop splint/recumbent positioning device (L4398) or replacement interface (L4394) is not covered.</p> | ORTHO |

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| Orthosis: AFO KAFO Ankle Control Walking Boot Pneumatic Leg Splint Pneumatic Knee Splint | Y | Y | Y | N | L1900 to L2038 L2106 to L2116 L2126 to L2136 L4350 L4360 L4370 L4380 L4386 | <p>AFOs are covered for ambulatory patients with weakness or deformity of the foot and ankle, who require stabilization for medical reasons, and have the potential to benefit functionally.</p> <p>KAFOs are covered for ambulatory patients for whom an ankle-foot orthosis is covered and for whom additional knee stability is required.</p> <p>AFOs and KAFOs that are molded-to-patient-model, or custom-fabricated, are covered for ambulatory patients when the basic coverage criteria listed above and one of the following criteria are met:</p> <ol style="list-style-type: none"> 1) The patient could not be fit with a prefabricated AFO, or 2) The condition necessitating the orthosis is expected to be permanent or of longstanding duration (more than 6 months), or 3) There is a need to control the knee, ankle or foot in more than one plane, or 4) The patient has a documented neurological, circulatory, or orthopedic status that requires custom fabricating over a model to prevent tissue injury, or 5) The patient has a healing fracture which lacks normal anatomical integrity or anthropometric proportions. | ORTHO |
| Orthosis: Additions to Lower Extremity Orthosis | Y | Y | Y | N | L2180 to L2999 | <p>Additions to AFOs and KAFOs (L2180-L2550, L2750-L2830) will be denied as not medically necessary if either the base orthosis is not medically necessary or the specific addition is not medically necessary.</p> | ORTHO |
| Orthosis: Additions to Upper Extremity Orthosis | Y | Y | Y | N | L3890 L3970 to L3974 | <p>Covered when medically indicated by the requesting physician.</p> | ORTHO |

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| Orthosis: CTLSO TLSO LO LSO | Y | Y | Y | N | L0430 to L0492 L0625 to L0710 L0970 to L1290 | <p>A thoracic-lumbar-sacral orthosis (L0450-L0492), lumbar orthosis (L0625-L0627) or lumbar-sacral orthosis (L0628-L0640) is covered when it is ordered for one of the following indications:</p> <ol style="list-style-type: none"> 1) To reduce pain by restricting mobility of the trunk; or 2) To facilitate healing following an injury to the spine or related soft tissues; or 3) To facilitate healing following a surgical procedure on the spine or related soft tissue; or 4) To otherwise support weak spinal muscles and/or a deformed spine. <p>A supportive back brace is medically necessary for any of the following indications:</p> <p>To reduce pain by restricting mobility of the trunk; or To facilitate healing following an injury to the spine or related soft tissues; or To facilitate healing following a surgical procedure on the spine or related soft tissue (see section on Postoperative Back Braces below); or To otherwise support weak spinal muscles and/or a deformed spine.</p> | ORTHO |
| Orthosis: Thoracic Rib Belt | N | N | Y | N | L0210 L0220 | Non-covered items. | ORTHO |
| Orthosis: HO | Y | Y | Y | N | L1600 to L1755 | <p>Other post-operative and post-injury braces are considered medically necessary when applied within six weeks of surgery or injury.</p> <p>Specialized hip braces are considered medically necessary for children with hip disorders to stabilize the hip and/or to correct and maintain hip abduction.</p> | ORTHO |
| Orthosis: KO | Y | Y | Y | N | L1800 to L1880 | Covered when medically indicated by the requesting physician. | ORTHO |
| Orthosis: Halo Procedures | Y | Y | Y | N | L0810 to L0960 | Covered when medically indicated by the requesting physician. | ORTHO |
| Orthosis: Other Scoliosis Procedures | Y | Y | Y | N | L1300 to L1499 | <p>Considered medically necessary in the treatment of congenital defects.</p> <p>Replacement braces are medically necessary when the Member has outgrown the previous brace or because his/her condition has changed such as to make the previous brace unusable. This includes scoliosis braces.</p> | ORTHO |
| Orthosis: Cranial Orthosis | Y | Y | Y | N | L0112 | <p>Covered for moderate to severe positional head deformities associated with premature birth, restrictive intrauterine positioning, cervical abnormalities, birth trauma, torticollis (shortening of the sternocleidomastoid muscle) and sleeping positions in children when banding is initiated at 4 to 12 months of age.</p> | ORTHO |

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| Orthosis: THKAO HKFAO | Y | Y | Y | N | L1500 to L1520 L2040 to L2090 | Covered when medically indicated by the requesting physician. | ORTHO |
| Orthotics: Upper Limb Fracture Orthosis | Y | Y | Y | N | L3650 to L3999 | Covered when medically indicated by the requesting physician. | ORTHO |
| Orthotics: Cervical Collar (plastic/foam)/Collar Liner | Y | Y | Y | N | L0120 to L0200 | 1 collar/collar liner allowed. Covered for Members with neck injury and other appropriate indications. | ORTHO |
| Orthopedic Footwear | Y | Y | Y | See Note | L3000 to L3649 | <p>With a diagnosis of diabetes, NO preauthorization is required. Do not report L3000 – L3649 as devices used to treat diabetes. Refer to section “Diabetes Shoes and Inserts” on page 6 of this document.</p> <p>Preauthorization is required for any diagnosis other than diabetes for all plans except RMHP Medicaid.</p> <p>Shoes are covered if they are an integral part of a covered leg brace described by codes L1900, L1920, L1980-L2030, L2050, L2060, L2080 or L2090. Inserts and other shoe modifications (L3000-L3170, L3300-L3450, L3465-3520, and L3550-L3595) are covered if they are on a shoe that is an integral part of a covered brace and if they are medically necessary for the proper functioning of the brace. Shoes are denied as not covered when they are put on over a partial foot prosthesis or other lower extremity prosthesis (L5010-L5600) which is attached to the residual limb by other mechanisms because there is no Medicare benefit for these items.</p> <p>With the exception of the situations described above, orthopedic footwear billed using codes L3000-L3649 will be denied as not covered. Coverage is limited to one of the following within one calendar year (January – December):</p> <ol style="list-style-type: none"> 1) One pair of custom molded shoes and 2 additional pairs of inserts; or 2) One pair of depth shoes and 3 pairs of inserts. <p>Quantities of shoes and/or inserts greater than those listed above will be denied as not covered.</p> | ORTHO |

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| Orthopedic Devices: Dynamic Splinting Devices | Y | Y | Y | Y | E1800 to E1841 | Medical Policy Applies. | ORTHO |
| Orthotics: Repairs for Orthotic Devices | Y | Y | Y | Y | L4000- L4210 | An estimate of the cost and what is being repaired will be required. | ORTHO |
| Prosthesis: Breast (External) Mastectomy Bras | Y | Y | Y | N | L8000 to L8002 L8015 to L8039 | A breast prosthesis is covered for a patient who has had a mastectomy, ICD-9-CM diagnosis codes V45.71, 174.0-174.9, or 233.0. An external breast prosthesis garment, with mastectomy form (L8015) is covered for use in the postoperative period prior to a permanent breast prosthesis or as an alternative to a mastectomy bra and breast prosthesis. The additional features of a custom fabricated prosthesis (L8035), compared to a prefabricated silicone breast prosthesis, are not medically necessary. Only one breast prosthesis per side for the useful lifetime of the prosthesis is covered. Two prostheses, one per side, are allowed for those persons who have had bilateral mastectomies. More than one external breast prosthesis per side will be denied as not medically necessary. | ORTHO |
| Compression Glove Mastectomy Sleeve | N | N | N | N | L8010 S8420- S8428 | Non-covered | |
| Prosthesis: Ocular (Eyeball) | Y | Y | Y | N | V2623 to V2629 | An eye prosthesis is covered for a patient with absence or shrinkage of an eye due to birth defect, trauma or surgical removal. Polishing and resurfacing (V2624) is covered on a twice per year basis. One enlargement (V2625) or reduction (V2626) of the prosthesis is covered without documentation. Additional enlargements or reductions are rarely medically necessary and are therefore covered only when there is information in the medical record which supports medical necessity. | ORTHO |
| Prosthesis: Face | Y | Y | Y | N | L8040 to L8049 | A facial prosthesis is covered when there is loss or absence of facial tissue due to disease, trauma, surgery, or a congenital defect. | ORTHO |
| Prosthesis: Penile (External) Manual only | Y | Y | Y | N | L7900 | Covered when Member has diagnosis of impotence of organic origin (607.84). | ORTHO |

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| Prosthetic: Lower Limb | Y | Y | Y | Y | L5000 to L5999 | Medical Policy Applies. | ORTHO |
| Prosthetic: Upper Limb | Y | Y | Y | Y | L6000 to L6915 | Medical Policy Applies. | ORTHO |
| Prosthetic: External Power | Y | Y | Y | Y | L6920 to L7499 L7611 to L7622 | Medical Policy Applies. | ORTHO |
| Prosthetic: Truss | Y | Y | Y | N | L8300 to L8330 | Covered when medically indicated by the requesting physician. | ORTHO |
| Prosthetics: Socks Excluding "Fracture Socks" | Y | Y | Y | N | L8400 to L8499 | Allowed 6 per calendar year when Member has prosthetic. | ORTHO |
| Prosthetic Implants: Artificial Larynx Tracheostomy Speaking Valve | Y | Y | Y | Y | L8500 to L8515 | Medical Policy Applies. | ORTHO |
| Prosthetic: Cochlear Device Batteries | Y | Y | Y | Y | L8614 to L8624 | Medical Policy Applies. | ORTHO |
| Prosthesis: Repairs for Prosthetic Devices | Y | Y | Y | Y | L7500 to L7520 | An estimate of the cost and what is being repaired will be required. | ORTHO |
| <i>TENS, Neuromuscular Stimulators and Other Stimulators</i> | | | | | | | |
| Biofeedback Therapy | Y | Y | Y | Y | E0746 | Biofeedback is medically necessary for the following conditions: Urinary stress incontinence Not covered for all other indications | DME |
| Bone Growth Stimulator/ Osteogenesis Stimulator Nonspinal Electrical Spinal Electrical Ultrasonic | Y | Y | Y | Y | E0747 E0748 E0749 E0760 | Medical Policy Applies. | DME |

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| Electronic Salivary Reflex Stimulator | N | N | N | N | E0755 | Considered experimental and investigational for the treatment of xerostomia (dry mouth) or for any other indication because its effectiveness has not been established. | DME |
| Non-thermal Pulsed High Frequency Radiowaves/ High Peak Power Electromagnetic Energy Treatment Device | N | N | N | N | E0761 | Considered experimental and investigational for all indications, including the treatment of wounds, soft tissue injuries, mechanical neck disorders, osteoarthritis, or acute postoperative pain and edema because its effectiveness has not been established. | DME |
| Transcutaneous Electrical Joint Stimulation Device System (BioniCare) | N | N | Y | N | E0762 | Considered experimental and investigational for the treatment of osteoarthritis because its effectiveness has not been established. | DME |
| Interferential Device | N | N | N | N | E1399 | Considered experimental and investigational. | DME |
| Nerve Stimulator for treatment of nausea or vomiting | Y | Y | Y | Y | E0765 | Considered medically necessary for the treatment of post-operative nausea and chemotherapy-induced nausea that is unresponsive to antiemetics and other conservative therapies. Also covered for the treatment of hyperemesis gravidarum that is unresponsive to other conservative medical therapy (e.g., change in diet, ginger capsules, vitamin B6). Considered experimental and investigational for the prevention of motion sickness because its effectiveness for this indication has not been established. | DME |
| Electrical Stimulation/ Electromagnetic Wound Treatment Device | N | N | N | N | E0769 | Electrical stimulation for the treatment of chronic ulcers in the home setting is not medically appropriate. | DME |
| TENS Unit | Y | Y | Y | Y | E0720 E0730 | A transcutaneous electrical nerve stimulator (TENS) is covered for the treatment of patients with chronic, intractable pain or acute post-operative pain who meet the coverage rules listed below. When a TENS unit is used for acute post-operative pain, the medical necessity is usually limited to 30 days from the day of surgery. Payment for more than one month is determined by individual consideration based upon supportive documentation provided by the attending physician. Payment will be made only as a rental. A TENS unit will be denied as not medically necessary for acute pain (less than three months duration) other than post-operative pain. For chronic pain, the medical record must document the location of the pain, the duration of time the patient has had the pain, and the presumed etiology of the pain. The pain must have been present for at least three months. Other appropriate treatment modalities must have been tried and failed, and the medical record must document what treatment modalities have been used. | DME |

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| Pelvic Floor Stimulator | Y | Y | Y | Y | E0740 | <p>Electrical muscle stimulators are medically necessary durable medical equipment (DME) for the management of urinary incontinence when all of the following criteria are met:</p> <p>Member is diagnosed with stress, urge, or mixed incontinence; and There is an average of 3 or more episodes of urinary incontinence per week; and There is no glycosuria or pyuria; and Member has tried and failed pelvic floor exercises (Kegel exercises).</p> | DME |
| Neuromuscular Stimulator | Y | Y | Y | Y | E0744 E0745 E0764 | <p>Covered for disuse atrophy where the nerve supply to the muscle is intact and the Member has any of the following non-neurological reasons for disuse atrophy:</p> <p>Previous casting or splinting of a limb, or Contractures due to burn scarring, or Recent hip replacement surgery (NMES is covered until physical therapy begins), or Previous major knee surgery (when there is failure to respond to physical therapy).</p> | DME |
| TENS Unit Supplies: Batteries Electrodes Conductive Garment Conductive Paste or Gel | Y | Y | Y | N | E0731 A4556 to A4558 A4595 A4630 | <p>Member must have TENS unit. A conductive garment used with a TENS unit is rarely medically necessary, but may be covered if all of the following conditions are met:</p> <p>1) It has been prescribed by a physician for use in delivering covered TENS treatment; and 2) One of the medical indications outlined below is met:</p> <p>a) the patient cannot manage without the conductive garment because there is such a large area or so many sites to be stimulated and the stimulation would have to be delivered so frequently that it is not feasible to use conventional electrodes, adhesive tapes, and lead wires; or b) the patient cannot manage without the conductive garment for the treatment of chronic intractable pain because the areas or sites to be stimulated are inaccessible with the use of conventional electrodes, adhesive tapes, and lead wires; or c) the patient has a documented medical condition, such as skin problems, that preclude the application of conventional electrodes, adhesive tapes, and lead wires; or d) the patient requires electrical stimulation beneath a cast to treat chronic intractable pain.</p> | DISP |

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| Traction, Trapeze and Fracture Frames | | | | | | | |
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| Traction: Cervical Extremity Fracture Frame Pelvic | Y | Y | Y | Y | E0830 to E0900 E0920 E0930 E0946 to E0948 | Cervical traction devices are covered only if both of the criteria below are met: 1. The patient has a musculoskeletal or neurologic impairment requiring traction equipment; and, 2. The appropriate use of a home cervical traction device has been demonstrated to the patient and the patient tolerated the selected device. Cervical traction applied via attachment to a headboard (E0840) or a free-standing frame (E0850) has no proven clinical advantage compared to cervical traction applied via an over-the-door mechanism (E0860). Pneumatic Lumbar Traction devices are not covered, they are considered experimental and investigational because they have not been demonstrated to be an effective treatment for low back pain or other indications. | DME |
| Traction Accessories: Cervical Head Harness Pelvic Belt/Harness/Boot Extremity Belt/Harness | Y | Y | Y | N | E0942 E0944 E0945 | Covered only when Member has traction unit. | DME |
| Continuous Passive Motion Machine (CPM) | Y | Y | Y | Y | E0935 E0936 | Medical Policy Applies | DME |
| Gravity Assisted Traction | N | N | Y | N | E0941 | Considered experimental and investigational for the treatment of low back pain or other indications because their effectiveness has not been established. | DME |

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| Wheelchairs, Power Operated Vehicles and Accessories | | | | | | | |
|---|---|---|---|---|---|-------------------------|-----|
| Manual Wheelchair Base: Standard Hemi Fully Reclining Extra Heavy Duty High Strength Lightweight Heavy Duty Lightweight Ultra-Lightweight Pediatric | Y | Y | Y | Y | E1050 to E1093 E1100 to E1200 E1220 to E1224 E1229 E1231 to E1238 E1240 to E1295 K0001 to K0009 | Medical Policy Applies. | DME |
| Power Wheelchair Base | Y | Y | Y | Y | E1239 K0010 to K0014 K0813 to K0891 K0898 | Medical Policy Applies. | DME |
| Power Operated Vehicles | Y | Y | Y | Y | E1230 K0800 to K0812 | Medical Policy Applies. | DME |

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| | | | | | | | |
|-------------------------------|---|---|---|---|--|---|------------|
| Rollabout Wheelchair | Y | Y | Y | Y | E1031 to E1039 | Medical Policy Applies. | DME |
| Wheelchair Accessories | Y | Y | Y | Y | E0950 to E0969 E0971 to E1030 E1225 to E1228 E1296 to E1298 E2201 to E2228 E2302 to E2399 E2601 to E2621 K0015 to K0108 K0195 K0669 | Medical Policy Applies. | DME |
| Wheelchair Accessories | N | N | Y | Y | E0970 E2291 to E2294 E2300 E2301 | Not covered items. A power seat elevation feature (E2300) and power standing feature (E2301) are not covered because they are not primarily medical in nature. The following features of a power wheelchair are noncovered: stair climbing (A9270), electronic balance (A9270), ability to elevate the seat by balancing on two wheels (A9270), remote operation (A9270). | DME |

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| Wound Care and Surgical Supplies | | | | | | | |
|--|---|---|---|---|--|---|------|
| Wound Care Supplies: 4x4 or 2x2 Kerlix Betadine/Iodine/ Peroxide Gauze/Wraps/ Bandages Hibiclens Saline/Sodium Chloride/Sterile Water Syringes Tape (i.e. Zonas, Micropore, Hupafix) Telfapads Unnaboot | Y | Y | Y | N | A6010 to A6024 A6154 to A6248 A6251 to A6259 A6261 to A6407 | Covered when either of the following criteria are met: 1) Required for the treatment of a wound caused by, or treated by, a surgical procedure; or 2) Required after debridement of a wound. Surgical dressings include both primary dressings (i.e., therapeutic or protective coverings applied directly to wounds or lesions either on the skin or caused by an opening to the skin) and secondary dressings (i.e., materials that serve a therapeutic or protective function and that are needed to secure a primary dressing). The surgical procedure or debridement must be performed by a physician or other healthcare professional to the extent permissible under State law. Debridement of a wound may be any type of debridement (examples given are not all-inclusive): surgical (e.g., sharp instrument or laser), mechanical (e.g., irrigation or wet-to-dry dressings), chemical (e.g., topical application of enzymes), or autolytic (e.g., application of occlusive dressings to an open wound). Dressings used for mechanical debridement, to cover chemical debriding agents, or to cover wounds to allow for autolytic debridement are covered although the agents themselves are noncovered. A6413 is non-covered. | DISP |
| Wound Care: Gel Sheet for Dermal Wound Cleansers Skin Sealants | N | N | Y | N | A6025 A6250 A6260 | Skin sealants or barriers (A6250), wound cleansers (A6260) or irrigating solutions, solutions used to moisten gauze (e.g., saline), silicone gel sheets, topical antiseptics, topical antibiotics, enzymatic debriding agents, gauze or other dressings used to cleanse or debride a wound but not left on the wound. Also, any item listed in the latest edition of the Orange Book (e.g., an antibiotic-impregnated dressing which requires a prescription) is considered a drug and is noncovered under the Surgical Dressings benefit. | DISP |
| Wound Vac Wound Care Kit | Y | Y | Y | Y | E2402 A6550 | Medical Policy Applies. | DME |
| Wound warming device (non-contact) and accessories | N | N | N | N | E0231 E0232 A6000 | Not covered items. | DME |

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| Miscellaneous Equipment | | | | | | | |
|---|---|---|---|---|--|--|------|
| Breast Pump Tubing Adaper Cap Breast Shield Polycarbonate Bottle Locking Ring | N | N | Y | N | A4281 to A4286 E0602 to E0604 | Benefit only when newborn is in NICU. | DME |
| Car Seat (for children with special needs) | N | N | Y | Y | E1399 | Rx and LMN will be required. Covered for Medicaid only. | DME |
| Eye Pad | Y | Y | Y | N | A6410 A6411 | Covered when medically indicated by the requesting physician. | DISP |
| Eye Patch | N | N | N | N | A6412 | Eye Patch is not covered. | DISP |
| Face Down Positioning Device | N | N | N | N | A9270 | Following vitrectomy and certain other eye surgery procedures, patients are instructed to position themselves with their face down through most of the day. There are certain devices that facilitate this positioning. Examples (not all-inclusive) are a face cushion that is attached to a frame that can rest on a table or be positioned on a bed or a cushion pad that is attached to a chair-like device. CMS has confirmed that these devices are statutorily non-covered because they do not fall within a Medicare benefit category. The reasons are that they are considered "precautionary devices" and also the equipment can be used for purposes other than the treatment of an illness or injury. The denial is a non-coverage denial, not a medical necessity denial. | DME |
| Gait Trainer | N | N | Y | Y | E8000 to E8002 | Rx and LMN will be required. Covered for Medicaid only. | DME |
| Positioning Cushion, Wedge, Pillow Heel or Elbow Protector | Y | Y | Y | N | E0190 E0191 | Covered when medically indicated by the requesting physician. | DME |
| Helmet | Y | Y | Y | N | A8000 to A8004 | Covered when medically indicated by the requesting physician. | DME |
| Safety Equipment (e.g. Belt, Harness, or Vest) Restraint | Y | Y | Y | N | E0700 E0710 | Covered when medically indicated by the requesting physician. | DME |

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|---|---|---|---|---|--|---|------------|
| Speech Equipment (Synthesized speech augmentive device with display) | Y | Y | Y | Y | E1902 E2500 to E2599 | Covered when all of the following criteria (1-7) are met: 1) Prior to the delivery of the SGD, the patient has had a formal evaluation of their cognitive and communication abilities by a speech-language pathologist (SLP). The formal, written evaluation must include, at a minimum, the following elements: a) Current communication impairment, including the type, severity, language skills, cognitive ability, and anticipated course of the impairment; b) An assessment of whether the individual's daily communication needs could be met using other natural modes of communication; c) A description of the functional communication goals expected to be achieved and treatment options; d) Rationale for selection of a specific device and any accessories; e) Demonstration that the patient possesses a treatment plan that includes a training schedule for the device; f) The cognitive and physical abilities to effectively use the device and any accessories to communicate; g) For a subsequent upgrade to a previously issued SGD, information regarding the functional benefit to the patient of the upgrade compared to the initially provided SGD; and, 2) The patient's medical condition is one resulting in a severe expressive speech impairment; and, 3) The patient's speaking needs cannot be met using natural communication methods; and, 4) Other forms of treatment have been considered and ruled out; and, 5) The patient's speech impairment will benefit from the device ordered; and, 6) A copy of the SLP's written evaluation and recommendation have been forwarded to the treating physician | DME |
| Stroller (Snug Seat, Pogon) | N | N | Y | Y | E1399 | Rx and LMN will be required. Covered for Medicaid only. | DME |
| Suction Pump Canister Tubing | Y | Y | Y | N | A7000 A7001 A7002 E0600 E2000 | Medically necessary for Members who have difficulty raising and clearing secretions secondary to any of the following conditions: Cancer or surgery of the throat or mouth; or Dysfunction of the swallowing muscles; or Unconsciousness or obtunded state; or Tracheostomy. Suction pumps are considered experimental and investigational for all other indications. | DME |
| Weighted Blanket Weighted Vest | N | N | Y | Y | E1399 | Rx and LMN will be required. Covered for Medicaid only. | DME |

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| | | | | | | | |
|--|---|---|---|---|-------------------------|--|-----|
| Whirlpool/Hot Tub Portable Nonportable | N | N | N | N | E1300 E1310 | Not a benefit of any plan. | DME |
| <i>Delivery, Freight and Labor</i> | | | | | | | |
| DME Labor (repair) | Y | Y | Y | Y | E1340 | An Rx will be required along with a statement of what is being repaired. | |
| Shipping/Freight | Y | Y | Y | Y | E1399 | An invoice of the cost of freight will be required. | |
| <i>Non-Covered Equipment</i> | | | | | | | |
| Air Cleaners/ Purifiers (includes electrostatic machines) | N | N | N | N | A9270 | Not a benefit of any plan. | NAB |
| Air Conditioners | N | N | N | N | A9270 | Not a benefit of any plan. | NAB |
| Exercise Equipment | N | N | N | N | A9300 | Not a benefit of any plan. | NAB |
| Hearing Aids/Fitting/Ear Molds Batteries | N | N | N | N | V5170 V5180 V5266 | Not a benefit of any plan. | NAB |
| Humidifiers/Vaporizers / Purifiers / Air Filters | N | N | N | N | A9270 | Not a benefit of any plan. | NAB |
| Massage Devices | N | N | N | N | A9270 | Not a benefit of any plan. | NAB |
| Scooter Lift Attachment for Vehicle Ramps (For Home Modifications) | N | N | N | N | A9270 | Not a benefit of any plan. | NAB |
| Hydraulic Van Lift | N | N | N | N | A9270 | Not a benefit of any plan. | NAB |
| Inversion Table | N | N | N | N | A9270 | Not a benefit of any plan. | NAB |
| Reacher | N | N | N | N | A9281 | Not a benefit of any plan. | NAB |
| Sock-Aid | N | N | N | N | A9270 | Not a benefit of any plan. | NAB |
| Telephone Alert Systems Life Line | N | N | N | N | A9280 | Not a benefit of any plan. | NAB |
| Wigs/Artificial Hair Pieces | N | N | N | N | A9282 | Not a benefit of any plan. | NAB |
| Parallel Bars | N | N | N | N | A9300 | Not a benefit of any plan. | NAB |

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