ROCKY MOUNTAIN HEALTH PLANS®

Rocky Mountain Health Plans
Legend for Durable Medicare Equipment Preauthoirzation Schedule

Submit Requests to RMHP

Participating Providers access|RMHP Provider Portal

This list applies when RMHP is the primary payer.

ABBREVIATIONS:

PLAN TYPES		COVERED PLAN TYPES		PREAUTH REQUIRED	
MC =	Medicare	**Y =**	Yes, based on Coverage Guidelines	**Y =**	Yes
CM =	Commercial	**N =**	Not a benefit	**N =**	No
MD =	Medicaid			**N/A =**	NAB of any plan
CHP+	Children's Health Plans Plus				

STANDARD ABBREVIATION	
ICU =	Intensive Care Unit
LMN =	Letter of Medical Necessity
NAB =	Not a Benefit
CMN =	Certificate of Medical Necessity
PCP =	Primary Care Physician
RX =	Prescription
MRADL =	Mobility Related Activities of Daily Living

Benefit Key	
DISP	Disposable Benefit
DME	Durable Medical Equipment Benefit
ORHTO	Orthotic/Prosthetic/Bracing Benefit
OX	Oxygen Benefit
NAB	Not a Benefit

Use this schedule for basic information on what is needed to obtain prior authorization. Use your current year HCPCS book for codes and modifiers to use for billing.

Prior Authorization is required for ALL codes having a descriptor meaning "unlisted, unspecified product and/or miscellaneous", done alone or in conjunction with other services/procedures.

Although associated secondary supplies do not require prior authorization, they are only payable with an active authorization for the associated Primary product(s) (such as wound vacs, enteral nutrition, parenteral nutrition, etc). Depending on supplies requested, there may be an associated allowable limit. Anything over the allowable limit will require prior authorization.

All benefits listed are subject to the Member's Evidence of Coverage. All requests are subject to Medical review.

Please refer to your RMHP contract for items specific to your contract and payment information.

WE RESERVE THE RIGHT TO CHANGE THIS SCHEDULE AT ANY TIME.

Effective September 16, 2020

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The Rx, LMN, appropriate CNM, or appropriate MD Questionaire and Proof of Delivery are required to be on file in the vendor's office.

*The codes listed above are subject to change and may not be all inclusive.

Rocky Mountain Health Plans DME Preauthorization Schedule

Effective September 16, 2020

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Items	Covered Plan Types				Auth Needed	HCPCS Code		Coverage Guidelines	Benefit	Rental vs Purchase
	MC	CM	MD	CHP+		From	To	Colorado State Medicaid guidelines apply to Medicaid Members		
Additional Oxygen Related Equipment	Y	Y	N	Y	Y	E0447		Portable oxygen contents, liquid, 1 month's supply = 1 unit, prescribed amount at rest or nighttime exceeds 4 liters per minute (lpm)	OX	Purchase
Additional Oxygen Related Equipment A-V Impulse System Foot Pump	Y	Y	Y	Y	Y	E1399		Rx, LMN and an invoice of the cost of equipment is required. MD Review	DME	2 months rental then convert to Purchase
Additional Oxygen Related Equipment Heat/Cold Therapy Game-Ready Device	N	N	N	N	N/A	E1399		A water circulating cold pad with pump (E0218) will be denied as not medically necessary. Considered convenience items. Not a benefit of any plan.	NAB	N/A
Additional Oxygen Related Equipment Interferential Device	N	N	N	N	N/A	E1399		Considered experimental and investigational.	NAB	N/A
Additional Oxygen Related Equipment Nebulizer Supplies: Mask Tubing Reservoir Bottle Water Collection Device Filter Dome Peak Flow Meter Immersion External Heater	Y	Y	Y	Y	N	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	Purchase
Additional Oxygen Related Equipment Oxygen Supplies: Oxygen Tent Tubing Mask Cannula Face Tent Breathing Circuits Regulator Stand	Y	Y	Y	Y	N	E1352	to E1358	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 (E1352, E1353), wheeled carts (E1354, battery packs/cartridges and chargers (E1356 and E1357, DC power adapter (1358), and stand/rack (E1355) are included in the allowance for rented systems.	OX	Purchase

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Additional Oxygen Related Equipment Oxygen: Concentrator Gaseous Portable Stationary Liquid Portable Vapor Enriching System Contents	Y	Y	Y	Y	Y	E1390	to E1392	Coverage Guideline Applies. Emergency or stand-by oxygen systems will be denied as not medically necessary since they are precautionary and not therapeutic in nature. RMHP covers rental of oxygen equipment. Purchase of equipment is not covered.	OX	12 or 24 month rental only
Additional Oxygen Related Equipment Oxygen: Concentrator Gaseous Portable Stationary Liquid Portable Vapor Enriching System Contents	Y	Y	Y	Y	Y	E1405	to E1406	Coverage Guideline Applies. Emergency or stand-by oxygen systems will be denied as not medically necessary since they are precautionary and not therapeutic in nature. RMHP covers rental of oxygen equipment. Purchase of equipment is not covered.	OX	12 or 24 month rental only
Additional Oxygen Related Equipment Protime/Coagucheck/ INR Monitors	Y	Y	N	Y	Y	E1399		Coverage Guidelines apply. Clinical review. Protime Monitor/Coagucheck Monitor/International Normalized Ratio (INR) Monitor. G0248, G0249, and G0250 are not a benefit for Medicaid. Purchase of the monitor using E1399 is covered for Commercial Members only. An invoice of the cost of equipment is required	DME	Purchase applies to E1399 only
Additional Oxygen Related Equipment Shipping/Freight	Y	Y	Y	Y	Y	E1399		An invoice of the cost of freight will be required.		N/A
Additional Oxygen Related Equipment Spirometers P-Flex Incentive	Y	Y	N	Y	N	E1399		Covered when used for neuromuscular or chest wall diseases. Incentive spirometers are considered experimental and investigational for all other indications. An invoice of the cost of equipment is required	DME	Purchase
Additional Oxygen Related Equipment Stroller (Snug Seat, Pogon)	N	N	Y	N	Y	E1399		Rx , LMN and an invoice of the cost of equipment is required.	DME	Purchase - MD only

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Additional Oxygen Related Equipment Vasopneumatic Compression Device	N	N	N	N	N/A	E1399		Not a benefit of any plan.	NAB	N/A
Additional Oxygen Related Equipment Weighted Blanket Weighted Vest	N	N	N	N	Y	E1399		Rx , LMN and an invoice of the cost of equipment is required.	DME	Purchase - MD only
Artificial Kidney Machines and Accessories Dialysis Equipment ESRD Supplies Water Purifier Softener	Y	Y	N	Y	Y	E1500	to E1699	RMHP Coverage Guideline “Dialysis Equipment” Applies. Clinical Review 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	Purchase
Attachments Walker/Crutch Attachments	Y	Y	Y	Y	N	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	Purchase
Bath and Toilet Aids Bath Bench (shower chair, shower seat, shower bench, or tub stool)	N	N	Y	N	N	E0245		Considered a convenience item.	DME	Purchase - MD only
Bath and Toilet Aids Bath Bench (shower chair, shower seat, shower bench, or tub stool)	N	N	Y	N	N	E0247	to E0248	Considered a convenience item.	DME	Purchase - MD only
Bath and Toilet Aids Grab Bars/Rails for Bath/Shower/Stool/Toilet	N	N	Y	N	N	E0241	to E0243	Considered convenience items. Installation charges are not a benefit.	DME	Purchase - MD only

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Bath and Toilet Aids Grab Bars/Rails for Bath/Shower/Stool/Toilet	N	N	Y	N	N	E0246		Considered convenience items. Installation charges are not a benefit.	DME	Purchase - MD only
Bath and Toilet Aids Heat/Cold Therapy Game-Ready Device	N	N	N	N	N/A	E0249		A water circulating cold pad with pump (E0218) will be denied as not medically necessary. Considered convenience items. Not a benefit of any plan.	NAB	N/A
Bath and Toilet Aids Raised Toilet Seat	N	N	Y	N	N	E0244		Considered a convenience item.	DME	Purchase - MD only
Bath and Toilet Aids Shower Chair w/wo wheels	N	N	Y	N	N	E0240		Considered a convenience item. A standard non-mechanical, non-lift chair will be covered for Medicaid only.	DME	Purchase - MD only
Canes Cane/QuadCane/Straight(Adjustable)	Y	Y	Y	Y	N	E0100		Canes (E0100, E0105) are covered if 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 (A9270) for the blind are NAB since it is a self-help item.	DME	Purchase
Canes Cane/QuadCane/Straight(Adjustable)	Y	Y	Y	Y	N	E0105		Canes (E0100, E0105) are covered if 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 (A9270) for the blind are NAB since it is a self-help item.	DME	Purchase

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Commodes Commode Chair with Seat Lift Mechanism	Y	Y	Y	Y	Y	E0170	to 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	Purchase
Commodes Commodes: Assist Drop Arm Heavy Duty/Extra Wide Pail/Pan	Y	Y	Y	Y	N	E0163		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. A commode chair with detachable arms (E0165) is covered if the detachable arms feature is necessary to facilitate transferring the patient or if the patient has a body configuration that requires extra width. An extra wide/heavy duty commode chair (E0168) is covered for a member who weighs 300 pounds or more. A pan or pail (E0167) is only covered when Member has a commode chair	DME	2 months rental then convert to purchase - or may purchase without renting
Commodes Commodes: Assist Drop Arm Heavy Duty/Extra Wide Pail/Pan	Y	Y	Y	Y	N	E0165		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. A commode chair with detachable arms (E0165) is covered if the detachable arms feature is necessary to facilitate transferring the patient or if the patient has a body configuration that requires extra width. An extra wide/heavy duty commode chair (E0168) is covered for a member who weighs 300 pounds or more. A pan or pail (E0167) is only covered when Member has a commode chair	DME	2 months rental then convert to purchase - or may purchase without renting

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	MC	CM	MD	CHP+		From	To	Colorado State Medicaid guidelines apply to Medicaid Members		
Commodes Commodes: Assist Drop Arm Heavy Duty/Extra Wide Pail/Pan	Y	Y	Y	Y	N	E0167	to 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. A commode chair with detachable arms (E0165) is covered if the detachable arms feature is necessary to facilitate transferring the patient or if the patient has a body configuration that requires extra width. An extra wide/heavy duty commode chair (E0168) is covered for a member who weighs 300 pounds or more. A pan or pail (E0167) is only covered when Member has a commode chair	DME	2 months rental then convert to purchase - or may purchase without renting
Commodes Footrest for use with commode	N	N	N	N	N/A	E0175		A footrest is not covered.	NAB	N/A
Commodes Seat Lift Mechanism	N	N	N	N	N/A	E0172		A seat lift mechanism placed over or on top of a toilet is not covered.	NAB	N/A
Commodes Sitz Bath	Y	Y	Y	Y	N	E0160	to 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	Rental only
Compression Devices Pneumatic Appliances: Segmental Non-segmental	Y	Y	Y	Y	Y	E0655	to E0657	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	2 months rental then convert to Purchase

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	MC	CM	MD	CHP+		From	To	Colorado State Medicaid guidelines apply to Medicaid Members		
Compression Devices Pneumatic Appliances: Segmental Non-segmental	Y	Y	Y	Y	Y	E0660		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	2 months rental then convert to Purchase
Compression Devices Pneumatic Appliances: Segmental Non-segmental	Y	Y	Y	Y	Y	E0665	to E0669	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	2 months rental then convert to purchase. E0667 may be a purchase or rental
Compression Devices Pneumatic Appliances: Segmental Non-segmental	Y	Y	Y	Y	Y	E0671	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	2 months rental then convert to Purchase
Compression Devices Pneumatic Compressors: Segmental Non-segmental Intermittent Limb	Y	Y	Y	Y	Y	E0650	to E0652	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 (CVI) with venous stasis ulcers. Pneumatic compression devices are covered in the home setting for the treatment of lymphedema if the member has undergone a four-week trial of conservative therapy (compression bandage system or compression garment, exercise and elevation of the limb) and the treating physician determines that there has been no significant improvement or significant symptoms remain. Pneumatic compression devices are covered in the home setting for the treatment of CVI of the lower extremities only if the member has one or more venous stasis ulcer(s) which have failed to heal after a six month trial of conservative therapy (compression bandage system or compression garment, dressings for the wound, exercise and elevation of the limb) directed by the treating physician.	DME	2 months rental then convert to Purchase

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	MC	CM	MD	CHP+		From	To	Colorado State Medicaid guidelines apply to Medicaid Members		
Compression Devices Pneumatic Compressors: Segmental Non-segmental Intermittent Limb	Y	Y	Y	Y	Y	E0656	to E0657	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 (CVI) with venous stasis ulcers. Pneumatic compression devices are covered in the home setting for the treatment of lymphedema if the member has undergone a four-week trial of conservative therapy (compression bandage system or compression garment, exercise and elevation of the limb) and the treating physician determines that there has been no significant improvement or significant symptoms remain. Pneumatic compression devices are covered in the home setting for the treatment of CVI of the lower extremities only if the member has one or more venous stasis ulcer(s) which have failed to heal after a six month trial of conservative therapy (compression bandage system or compression garment, dressings for the wound, exercise and elevation of the limb) directed by the treating physician.	DME	2 months rental then convert to Purchase
Compression Devices Pneumatic Compressors: Segmental Non-segmental Intermittent Limb	N	N	Y	Y	Y	E0675	to E0676	Rx will be required from MD. Only covered for the treatment of lymphedema or for the treatment of chronic venous insufficiency (CVI) with venous stasis ulcers. Pneumatic compression devices are covered in the home setting for the treatment of lymphedema if the member has undergone a four-week trial of conservative therapy (compression bandage system or compression garment, exercise and elevation of the limb) and the treating physician determines that there has been no significant improvement or significant symptoms remain. Pneumatic compression devices are covered in the home setting for the treatment of CVI of the lower extremities only if the member has one or more venous stasis ulcer(s) which have failed to heal after a six month trial of conservative therapy (compression bandage system or compression garment, dressings for the wound, exercise and elevation of the limb) directed by the treating physician.	DME	2 months rental then convert to Purchase
Crutches Crutch Substitute	N	Y	Y	Y	Y	E0118		Covered when the individual's condition is such that he/she is unable to use crutches, standard walkers or other standard ambulatory assist devices. Rx and LMN will be required. Not a benefit of Medicare	DME	2 months rental then convert to Purchase

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Crutches Crutches:UnderarmForearm, F/A Handgrip replacementTip replacementUnderarm padreplacementPlatform attachment; forearm crutch, each	Y	Y	Y	Y	N	E0110	to E0117	Crutches (E0110 – E0116) are covered if 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	Rent up to 4 months then convert to purchase or may purchase without renting
Decubitus Care Equipment 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	Y	E0181	to E0182	Coverage Guideline Applies. RMHP Coverage Guideline: “Pressure Reducing Support Surfaces”	DME	2 to 6 months rental then convert to purchase or may purchase without renting
Decubitus Care Equipment 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	Y	E0184	to E0189	Coverage Guideline Applies. RMHP Coverage Guideline: “Pressure Reducing Support Surfaces”	DME	2 to 6 months rental then convert to purchase or may purchase without renting
Decubitus Care Equipment 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	Y	E0193	to E0199	Coverage Guideline Applies. RMHP Coverage Guideline: “Pressure Reducing Support Surfaces”	DME	2 to 6 months rental then convert to purchase or may purchase without renting

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Decubitus Care Equipment Mattress: Geomat Sheepskin Inner Spring Foam Rubber Synthetic Sheepskin Dry Pressure Mattress Overlay	Y	Y	Y	Y	Y	E0184	to E0189	Rx, LMN and Medical Records will be required. Covered when the patient meets: 1.Criterion A, or 2.Criteria B or C and at least one of criteria D to G. A.Completely immobile - i.e., patient cannot make changes in body position without assistance. B.Limited mobility - i.e., patient cannot independently make changes in body position significant enough to alleviate pressure. C.Any stage pressure ulcer on the trunk or pelvis. D.Impaired nutritional status. E.Fecal or urinary incontinence. F.Altered sensory perception. G.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	2 months rental then convert to purchase - or may purchase without renting
Decubitus Care Equipment Mattress: Geomat Sheepskin Inner Spring Foam Rubber Synthetic Sheepskin Dry Pressure Mattress Overlay	Y	Y	Y	Y	Y	E0196	to E0199	Rx, LMN and Medical Records will be required. Covered when the patient meets: 1.Criterion A, or 2.Criteria B or C and at least one of criteria D to G. A.Completely immobile - i.e., patient cannot make changes in body position without assistance. B.Limited mobility - i.e., patient cannot independently make changes in body position significant enough to alleviate pressure. C.Any stage pressure ulcer on the trunk or pelvis. D.Impaired nutritional status. E.Fecal or urinary incontinence. F.Altered sensory perception. G.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	2 months rental then convert to purchase - or may purchase without renting
Decubitus Care Equipment Positioning Cushion, Wedge, Pillow Heel or Elbow Protector	Y	Y	Y	Y	N	E0190	to E0191	Covered when medically indicated by the requesting physician.	DME	Purchase
DME Wheelchair Accessory Wheelchair Accessories	Y	Y	Y	Y	Y	E2201	to E2228	Coverage Guideline Applies. Wheelchair Accessories (E2331) is not a covered benefit of Medicaid.	DME	2 months rental then convert to purchase - or may purchase without renting

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DME Wheelchair Accessory Wheelchair Accessories	Y	Y	Y	Y	Y	E2230	to E2231	Coverage Guideline Applies. Wheelchair Accessories (E2331) is not a covered benefit of Medicaid.	DME	2 months rental then convert to purchase - or may purchase without renting
DME Wheelchair Accessory Wheelchair Accessories	Y	Y	Y	Y	Y	E2295		Coverage Guideline Applies. Wheelchair Accessories (E2331) is not a covered benefit of Medicaid.	DME	2 months rental then convert to purchase - or may purchase without renting
DME Wheelchair Accessory Wheelchair Accessories	Y	Y	Y	Y	Y	E2310	to E2398	Coverage Guideline Applies. Wheelchair Accessories (E2331) is not a covered benefit of Medicaid.	DME	2 months rental then convert to purchase - or may purchase without renting
DME Wheelchair Accessory Wheelchair Accessories	N	N	Y	N	Y	E2291	to E2294	A power seat elevation feature (E2300) and power standing feature (E2301) are not covered by Medicare because they are not primarily medical in nature. The following features of a power wheelchair are non-covered: stair climbing (A9270); electronic balance (A9270); ability to elevate the seat by balancing on two wheels (A9270); remote operation (A9270); E2300 is covered for MD only. E2301 and A9270 are not covered for all lines of business.	DME	Purchase
DME Wheelchair Accessory Wheelchair Accessories	N	N	Y	N	Y	E2300	to E2301	A power seat elevation feature (E2300) and power standing feature (E2301) are not covered by Medicare because they are not primarily medical in nature. The following features of a power wheelchair are non-covered: stair climbing (A9270); electronic balance (A9270); ability to elevate the seat by balancing on two wheels (A9270); remote operation (A9270); E2300 is covered for MD only. E2301 and A9270 are not covered for all lines of business.	DME	Purchase

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Flexion Extension Device Orthopedic Devices: Dynamic Splinting Devices	Y	Y	Y	Y	Y	E1800	to E1840	Coverage Guideline Applies. RMHP Policy Dynamic Splinting Devices (E1841 Does not require preauthorization)	ORTHO	Purchase
Gait Trainer Gait Trainer, Pediatric Size	N	N	Y	N	Y	E8000	to E8002	Rx , LMN and an invoice of the cost of equipment is required.	DME	Purchase - MD only
Heat/Cold Application Heat/Cold Equipment	N	N	N	N	N/A	E0200		Considered a convenience item.	NAB	N/A
Heat/Cold Application Heat/Cold Equipment	N	N	N	N	N/A	E0205		Considered a convenience item.	NAB	N/A
Heat/Cold Application Heat/Cold Equipment	N	N	N	N	N/A	E0225		Considered a convenience item.	NAB	N/A
Heat/Cold Application Heat/Cold Equipment	N	N	N	N	N/A	E0231	to E0232	Considered a convenience item.	NAB	N/A
Heat/Cold Application Heat/Cold Equipment	N	N	N	N	N/A	E0239		Considered a convenience item.	NAB	N/A

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	MC	CM	MD	CHP+		From	To	Colorado State Medicaid guidelines apply to Medicaid Members		
Heat/Cold Application Heat/Cold Therapy Game-Ready Device	N	N	N	N	N/A	E0210	to E0218	A water circulating cold pad with pump (E0218) will be denied as not medically necessary. Considered convenience items. Not a benefit of any plan.	NAB	N/A
Heat/Cold Application Heat/Cold Therapy Game-Ready Device	N	N	N	N	N/A	E0236		A water circulating cold pad with pump (E0218) will be denied as not medically necessary. Considered convenience items. Not a benefit of any plan.	NAB	N/A
Heat/Cold Application Infrared Heating Pad System Replacement	N	N	N	N	N/A	E0221		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.	NAB	N/A
Heat/Cold Application Paraffin Bath Unit (Portable) Paraffin/Pound	Y	Y	Y	Y	Y	E0235		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	2 months rental then convert to Purchase
Heat/Cold Application Phototherapy: Bilirubin	Y	Y	Y	Y	N	E0202		Covered when it is used for the treatment of jaundice in infants.	DME	Rental only
Heat/Cold Application Therapeutic Lightbox	N	N	N	N	N/A	E0203		Non-covered for all indications.	NAB	N/A
Heat/Cold Application Wound warming device (non to contact) and accessories	N	N	N	N	N/A	E0231	to E0232	Not covered items.	NAB	N/A

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	MC	CM	MD	CHP+		From	To	Colorado State Medicaid guidelines apply to Medicaid Members		
Hospital Beds and Accessories Hospital Bed & Mattress Accessories: Bed Pan Bed Cradle Bedside Rails Canopy – Safety Enclosed Frame Trapeze Heavy Duty Trapeze Urinal	Y	Y	Y	Y	N	E0275	to E0276	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 and they are an integral part of, or an accessory to, a covered hospital bed. Trapeze equipment (E0910, E0940) is covered if 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 E0911, E0912) is covered when the patient's weight is more than 250 pounds. Urinals (E0325, E0326) are covered when the patient is bed confined.	DME	2 months rental then convert to purchase - or may purchase without renting
Hospital Beds and Accessories Hospital Bed & Mattress Accessories: Bed Pan Bed Cradle Bedside Rails Canopy – Safety Enclosed Frame Trapeze Heavy Duty Trapeze Urinal	Y	Y	Y	Y	N	E0280		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 and they are an integral part of, or an accessory to, a covered hospital bed. Trapeze equipment (E0910, E0940) is covered if 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 E0911, E0912) is covered when the patient's weight is more than 250 pounds. Urinals (E0325, E0326) are covered when the patient is bed confined.	DME	2 months rental then convert to purchase - or may purchase without renting
Hospital Beds and Accessories Hospital Bed & Mattress Accessories: Bed Pan Bed Cradle Bedside Rails Canopy – Safety Enclosed Frame Trapeze Heavy Duty Trapeze Urinal	Y	Y	Y	Y	N	E0305		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 and they are an integral part of, or an accessory to, a covered hospital bed. Trapeze equipment (E0910, E0940) is covered if 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 E0911, E0912) is covered when the patient's weight is more than 250 pounds. Urinals (E0325, E0326) are covered when the patient is bed confined.	DME	2 months rental then convert to purchase - or may purchase without renting

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Hospital Beds and Accessories Hospital Bed & Mattress Accessories: Bed Pan Bed Cradle Bedside Rails Canopy – Safety Enclosed Frame Trapeze Heavy Duty Trapeze Urinal	Y	Y	Y	Y	N	E0310		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 and they are an integral part of, or an accessory to, a covered hospital bed. Trapeze equipment (E0910, E0940) is covered if 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 E0911, E0912) is covered when the patient's weight is more than 250 pounds. Urinals (E0325, E0326) are covered when the patient is bed confined.	DME	2 months rental then convert to purchase - or may purchase without renting
Hospital Beds and Accessories Hospital Bed & Mattress Accessories: Bed Pan Bed Cradle Bedside Rails Canopy – Safety Enclosed Frame Trapeze Heavy Duty Trapeze Urinal	Y	Y	Y	Y	N	E0316		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 and they are an integral part of, or an accessory to, a covered hospital bed. Trapeze equipment (E0910, E0940) is covered if 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 E0911, E0912) is covered when the patient's weight is more than 250 pounds. Urinals (E0325, E0326) are covered when the patient is bed confined.	DME	2 months rental then convert to purchase - or may purchase without renting
Hospital Beds and Accessories Hospital Bed & Mattress Accessories: Bed Pan Bed Cradle Bedside Rails Canopy – Safety Enclosed Frame Trapeze Heavy Duty Trapeze Urinal	Y	Y	Y	Y	N	E0325	to E0326	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 and they are an integral part of, or an accessory to, a covered hospital bed. Trapeze equipment (E0910, E0940) is covered if 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 E0911, E0912) is covered when the patient's weight is more than 250 pounds. Urinals (E0325, E0326) are covered when the patient is bed confined.	DME	2 months rental then convert to purchase - or may purchase without renting

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	MC	CM	MD	CHP+		From	To	Colorado State Medicaid guidelines apply to Medicaid Members		
Hospital Beds and Accessories Hospital Bed & Mattress Accessories: Bed Pan Bed Cradle Bedside Rails Canopy – Safety Enclosed Frame Trapeze Heavy Duty Trapeze Urinal	Y	Y	Y	Y	N	E0350		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 and they are an integral part of, or an accessory to, a covered hospital bed. Trapeze equipment (E0910, E0940) is covered if 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 E0911, E0912) is covered when the patient's weight is more than 250 pounds. Urinals (E0325, E0326) are covered when the patient is bed confined.	DME	2 months rental then convert to purchase - or may purchase without renting
Hospital Beds and Accessories Hospital Bed & Mattress Accessories: Bed Pan Bed Cradle Bedside Rails Canopy – Safety Enclosed Frame Trapeze Heavy Duty Trapeze Urinal	Y	Y	Y	Y	N	E0352		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 and they are an integral part of, or an accessory to, a covered hospital bed. Trapeze equipment (E0910, E0940) is covered if 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 E0911, E0912) is covered when the patient's weight is more than 250 pounds. Urinals (E0325, E0326) are covered when the patient is bed confined.	DME	2 months rental then convert to purchase - or may purchase without renting
Hospital Beds and Accessories Hospital Bed Accessory: Bed Board Over-Bed Table Board, Table or Support Device	N	N	Y	N	N	E0273	to E0274	Not covered by Medicare - considered convenience items. Medicaid guidelines: Do not use bed cane (E0316) for over bed table.	DME	2 months rental then convert to purchase - or may purchase without renting
Hospital Beds and Accessories Hospital Bed Accessory: Bed Board Over-Bed Table Board, Table or Support Device	N	N	Y	N	N	E0315		Not covered by Medicare - considered convenience items. Medicaid guidelines: Do not use bed cane (E0316) for over bed table.	DME	2 months rental then convert to purchase - or may purchase without renting
Hospital Beds and Accessories Hospital Beds: Fixed Height Variable Height Semi-Electric Heavy Duty Extra Heavy Duty	Y	Y	Y	Y	Y	E0250	to E0251	Coverage Guideline Applies. RMHP Coverage Guideline: “Hospital Beds” Medicaid requires questionnaire #1	DME	2 to 6 months rental then convert to purchase or may purchase without renting

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	MC	CM	MD	CHP+		From	To	Colorado State Medicaid guidelines apply to Medicaid Members		
Hospital Beds and Accessories Hospital Beds: Fixed Height Variable Height Semi-Electric Heavy Duty Extra Heavy Duty	Y	Y	Y	Y	Y	E0255	to E0256	Coverage Guideline Applies. RMHP Coverage Guideline: “Hospital Beds” Medicaid requires questionnaire #1	DME	2 to 6 months rental then convert to purchase or may purchase without renting
Hospital Beds and Accessories Hospital Beds: Fixed Height Variable Height Semi-Electric Heavy Duty Extra Heavy Duty	Y	Y	Y	Y	Y	E0260	to E0261	Coverage Guideline Applies. RMHP Coverage Guideline: “Hospital Beds” Medicaid requires questionnaire #1	DME	2 to 6 months rental then convert to purchase or may purchase without renting
Hospital Beds and Accessories Hospital Beds: Fixed Height Variable Height Semi-Electric Heavy Duty Extra Heavy Duty	Y	Y	Y	Y	Y	E0290	to E0297	Coverage Guideline Applies. RMHP Coverage Guideline: “Hospital Beds” Medicaid requires questionnaire #1	DME	2 to 6 months rental then convert to purchase or may purchase without renting
Hospital Beds and Accessories Hospital Beds: Fixed Height Variable Height Semi-Electric Heavy Duty Extra Heavy Duty	Y	Y	Y	Y	Y	E0300	to E0304	Coverage Guideline Applies. RMHP Coverage Guideline: “Hospital Beds” Medicaid requires questionnaire #1	DME	2 to 6 months rental then convert to purchase or may purchase without renting
Hospital Beds and Accessories Hospital Beds: Fixed Height Variable Height Semi-Electric Heavy Duty Extra Heavy Duty	Y	Y	Y	Y	Y	E0328	to E0329	Coverage Guideline Applies. RMHP Coverage Guideline: “Hospital Beds” Medicaid requires questionnaire #1	DME	2 to 6 months rental then convert to purchase or may purchase without renting
Hospital Beds and Accessories Hospital Beds: Fully Electric	N	N	Y	N	Y	E0265	to E0266	Fully Electric Hospital beds are covered by Medicaid Only. Coverage Guideline Applies. RMHP Coverage Guideline: “Hospital Beds” Medicaid required questionnaire #1	DME	2 to 6 months rental then convert to purchase or may purchase without renting

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	MC	CM	MD	CHP+		From	To	Colorado State Medicaid guidelines apply to Medicaid Members		
Hospital Beds and Accessories 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	Y	E0277		Coverage Guideline Applies. RMHP Coverage Guideline: “Pressure Reducing Support Surfaces”	DME	2 to 6 months rental then convert to purchase or may purchase without renting
Hospital Beds and Accessories 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	Y	E0370	to E0373	Coverage Guideline Applies. RMHP Coverage Guideline: “Pressure Reducing Support Surfaces”	DME	2 to 6 months rental then convert to purchase or may purchase without renting
Hospital Beds and Accessories Mattress: Geomat Sheepskin Inner Spring Foam Rubber Synthetic Sheepskin Dry Pressure Mattress Overlay	Y	Y	Y	Y	Y	E0271	to E0272	Rx, LMN and Medical Records will be required. Covered when the patient meets: 1.Criterion A, or 2.Criteria B or C and at least one of criteria D to G. A.Completely immobile - i.e., patient cannot make changes in body position without assistance. B.Limited mobility - i.e., patient cannot independently make changes in body position significant enough to alleviate pressure. C.Any stage pressure ulcer on the trunk or pelvis. D.Impaired nutritional status. E.Fecal or urinary incontinence. F.Altered sensory perception. G.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	2 months rental then convert to purchase - or may purchase without renting

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	MC	CM	MD	CHP+		From	To	Colorado State Medicaid guidelines apply to Medicaid Members		
Hospital Beds and Accessories Mattress: Geomat Sheepskin Inner Spring Foam Rubber Synthetic Sheepskin Dry Pressure Mattress Overlay	Y	Y	Y	Y	Y	E0371	to E0373	Rx, LMN and Medical Records will be required. Covered when the patient meets: 1.Criterion A, or 2.Criteria B or C and at least one of criteria D to G. A.Completely immobile - i.e., patient cannot make changes in body position without assistance. B.Limited mobility - i.e., patient cannot independently make changes in body position significant enough to alleviate pressure. C.Any stage pressure ulcer on the trunk or pelvis. D.Impaired nutritional status. E.Fecal or urinary incontinence. F.Altered sensory perception. G.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	2 months rental then convert to purchase - or may purchase without renting
Humidifiers, Compressors, Nebulizers CPAP/BiPAP Humidifier	Y	Y	Y	Y	N	E0561	to E0562	A non-heated or heated humidifier is covered when ordered by the treating physician for use with a covered CPAP or BiPAP device and includes a detailed written order.	DME	2 months rental then convert to purchase - or may purchase without renting
Humidifiers, Compressors, Nebulizers IPPB Machine IPPB Humidifier	Y	Y	Y	Y	Y	E0550		Covered when used for the treatment of respiratory diseases. This is a rental only item.	DME	Rental only
Humidifiers, Compressors, Nebulizers IPPB Machine IPPB Humidifier	Y	Y	Y	Y	Y	E0560		Covered when used for the treatment of respiratory diseases. This is a rental only item.	DME	Rental only

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	MC	CM	MD	CHP+		From	To	Colorado State Medicaid guidelines apply to Medicaid Members		
Humidifiers, Compressors, Nebulizers Nebulizer: Compressor (Only one nebulizer will be covered)	Y	Y	Y	Y	N	E0570		Covered when: 1. It is medically necessary to administer albuterol, budesonide, cromolyn, ipratropium, levalbuterol or metaproterenol for the management of obstructive pulmonary disease, or 2. It is medically necessary to administer formoterol (J7606) or arformoterol (J7605) for the management of chronic obstructive pulmonary disease and the patient has a documented history of routine use of at least four doses per day of an FDA- approved albuterol or metaproterenol inhalation solution or at least three doses per day of an FDA-approvedlevalbuterol inhalation solution; or 3. It is medically necessary to administer dornase alpha to a patient with cystic fibrosis, or c) It is medically necessary to administer tobramycin to a patient with cystic fibrosis or bronchiectasis, or 4. It is medically necessary to administer pentamidine to patients with HIV, pneumocystosis or complications of organ transplants; or 5. It is medically necessary to administer acetylcysteine for persistent thick or tenacious pulmonary secretions. Purchase for patients with chronic conditions. Rent 60 days, then re-evaluate for patients with acute conditions.	DME	2 months rental then convert to purchase - or may purchase without renting
Humidifiers, Compressors, Nebulizers Nebulizer: Large Volume Bottle Type with Compressed Heater Compressor	Y	Y	Y	Y	N	E0565		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	2 months rental then convert to purchase - or may purchase without renting
Humidifiers, Compressors, Nebulizers Nebulizer: Large Volume Bottle Type with Compressed Heater Compressor	Y	Y	Y	Y	N	E0572		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	2 months rental then convert to purchase - or may purchase without renting
Humidifiers, Compressors, Nebulizers Nebulizer: Large Volume Bottle Type with Compressed Heater Compressor	Y	Y	Y	Y	N	E0580		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	2 months rental then convert to purchase - or may purchase without renting
Humidifiers, Compressors, Nebulizers Nebulizer: Large Volume Bottle Type with Compressed Heater Compressor	Y	Y	Y	Y	N	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	2 months rental then convert to purchase - or may purchase without renting

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Humidifiers, Compressors, Nebulizers Nebulizer: Portable Ultrasonic	N	N	Y	N	N	E0574	to E0575	A battery-powered compressor (E0571) is rarely medically necessary. Considered a convenience item A small volume ultrasonic nebulizer (E0574) 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; therefore, it is not covered.	DME	Purchase - MD only
Humidifiers, Compressors, Nebulizers Oxygen Supplies: Oxygen Tent Tubing Mask Cannula Face Tent Breathing Circuits Regulator Stand	Y	Y	Y	Y	N	E0555		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 (E1352, E1353), wheeled carts (E1354, battery packs/cartridges and chargers (E1356 and E1357, DC power adapter (1358), and stand/rack (E1355) are included in the allowance for rented systems.	OX	Purchase
Infusion Supplies Infusion Pumps	Y	Y	Y	Y	N	E0779	to E0783	Covered when Member meets Medicare guidelines. http://www.cgsmedicare.com/jc/coverage/lcdinfo.html	DME	Rental or Purchase depending on the pump
Infusion Supplies Infusion Pumps	Y	Y	Y	Y	N	E0785	to E0786	Covered when Member meets Medicare guidelines. http://www.cgsmedicare.com/jc/coverage/lcdinfo.html	DME	Rental or Purchase depending on the pump
Infusion Supplies Infusion Pumps	Y	Y	Y	Y	N	E0791		Covered when Member meets Medicare guidelines. http://www.cgsmedicare.com/jc/coverage/lcdinfo.html	DME	Rental or Purchase depending on the pump
Infusion Supplies Insulin Pump	Y	Y	Y	Y	Y	E0784		Coverage Guideline Applies. Fully implantable insulin pump is non-covered. Clinical Review. RMHP Coverage Guideline “Insulin Pump”. A9274 is non-covered by Medicare Part B. (Members with Medicare Part D plans should inquire with the plan carrier. RMHP does not provide any Part D plans)	DME	Rental or Purchase

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Infusion Supplies IV Pole	Y	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	Purchase
IPPB Machines IPPB Machine IPPB Humidifier	Y	Y	Y	Y	Y	E0500		Covered when used for the treatment of respiratory diseases. This is a rental only item.	DME	Rental only
Monitoring Devices Apnea Monitor (with or w/o kit)	Y	Y	Y	Y	N	E0618	to 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	Rental only
Monitoring Devices Glucometers: Standard Voice Activated	Y	Y	Y	Y	N	E0607		Covered when all of the following basic criteria is met: 1. The patient has diabetes 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 appropriate glycemic control; and 5. The devise is designed for home use. Home blood glucose monitors with special features (E2100, E2101) 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 20/20 or worse in both eyes) requiring use of this special monitoring system. Devices with special features are covered when the above criteria are met AND: 1. E2100, E2101 - 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 2. E2101 – The treating physician certifies that the patient has an impairment of manual dexterity severe enough to require the use of this special monitoring system.	DME	Purchase

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Nerve Stimulators and Devices Biofeedback Electromyography Device	N	N	N	N	Y	E0746	to E0746	Biofeedback is medically necessary for the following conditions: Urinary stress incontinence - Not covered for all other indications E0746 is covered for Medicaid Members only.	DME	Purchase
Nerve Stimulators and Devices Bone Growth Stimulator/ Osteogenesis Stimulator Non-spinal Electrical Spinal Electrical Ultrasonic	Y	Y	Y	Y	Y	E0747	to E0749	Coverage Guideline Applies.	DME	Purchase
Nerve Stimulators and Devices Bone Growth Stimulator/ Osteogenesis Stimulator Non-spinal Electrical Spinal Electrical Ultrasonic	Y	Y	Y	Y	Y	E0760		Coverage Guideline Applies.	DME	Purchase
Nerve Stimulators and Devices Electrical stimulation device used for cancer treatment	Y	Y	N	Y	N/A	E0766			DME	Rental only
Nerve Stimulators and Devices Electrical Stimulation/ Electromagnetic Wound	N	N	N	N	N/A	E0769		Electrical stimulation for the treatment of chronic ulcers or cancer in the home setting is not medically appropriate.	NAB	N/A
Nerve Stimulators and Devices Electronic Salivary Reflex Stimulator	N	N	N	N	N/A	E0755		Considered experimental and investigational for the treatment of xerostomia (dry mouth) or for any other indication because its effectiveness has not been established.	NAB	N/A
Nerve Stimulators and Devices Functional Electrical Stimulators (FES)	Y	Y	Y	Y	Y	E0764		Coverage Guideline Applies. RMHP Coverage Guideline Neuromuscular electrical stimulation (E0770, E0745, E0764)	DME	2 months rental then convert to Purchase

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Nerve Stimulators and Devices Functional Electrical Stimulators (FES)	Y	Y	Y	Y	Y	E0770		Coverage Guideline Applies. RMHP Coverage Guideline Neuromuscular electrical stimulation (E0770, E0745, E0764)	DME	2 months rental then convert to Purchase
Nerve Stimulators and Devices Nerve Stimulator for treatment of nausea or vomiting	Y	Y	Y	Y	Y	E0765		Coverage Guideline Applies. Clinical review. RMHP Coverage Guideline Vagus Nerve Stimulation	DME	Purchase
Nerve Stimulators and Devices Neuromuscular Stimulator	Y	Y	Y	Y	Y	E0744	to E0745	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: 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).	DME	2 months rental then convert to Purchase
Nerve Stimulators and Devices Non-thermal Pulsed High Frequency Radiowaves/High Peak Power Electromagnetic Energy Treatment Device	N	N	N	N	N/A	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.	NAB	N/A
Nerve Stimulators and Devices Pelvic Floor Stimulator	N	N	N	N	N	E0740		This item is non-covered for all lines of business.	DME	

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	MC	CM	MD	CHP+		From	To	Colorado State Medicaid guidelines apply to Medicaid Members		
Nerve Stimulators and Devices TENS Unit	Y	Y	Y	Y	Y	E0720		A transcutaneous electrical nerve stimulator (TENS) is covered with a detailed written order for the treatment of members 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 reasonable and 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. Conditions for which a TENS unit are not considered to be medically necessary include headache, visceral abdominal pain, pelvic pain, and temporomandibular joint (TMJ) pain. When used for treatment of chronic pain, the TENS unit must be used by the member on a trial basis for a minimum of one month (30 days), but not to exceed two months.	DME	2 months rental then convert to Purchase
Nerve Stimulators and Devices TENS Unit	Y	Y	Y	Y	Y	E0730		A transcutaneous electrical nerve stimulator (TENS) is covered with a detailed written order for the treatment of members 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 reasonable and 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. Conditions for which a TENS unit are not considered to be medically necessary include headache, visceral abdominal pain, pelvic pain, and temporomandibular joint (TMJ) pain. When used for treatment of chronic pain, the TENS unit must be used by the member on a trial basis for a minimum of one month (30 days), but not to exceed two months.	DME	2 months rental then convert to Purchase

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	MC	CM	MD	CHP+		From	To	Colorado State Medicaid guidelines apply to Medicaid Members		
Nerve Stimulators and Devices TENS Unit Supplies Batteries Electrodes Conductive Garment Conductive Paste or Gel	Y	Y	Y	Y	N	E0731		Member must have TENS unit (Must include a detailed written order) A conductive garment (E0731) used with a TENS unit is rarely medically necessary, but may be covered if all of the following conditions are met. 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: 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. A4555 is covered by Medicare, Commercial, and CHP+ A4556 is not covered by Medicare.	DISP	Purchase
Nerve Stimulators and Devices Transcutaneous Electrical Joint Stimulation Device System (BioniCare)	N	N	Y	N	Y	E0762		Considered experimental and investigational for the treatment of osteoarthritis because its effectiveness has not been established. MD Review	DME	Purchase
Orthopedic Devices Continuous Passive Motion Machine (CPM)	Y	Y	Y	Y	Y	E0935	to E0936	Coverage Guideline Applies Continuous Passive Motion (CPM) Device. E0935 for Medicaid is only covered for 14 days rental post op	DME	21 day rental (day 1 starts on rental request day) 14 day rental for E0935 MD, no purchase option
Orthopedic Devices Gravity Assisted Traction	N	N	Y	N	N	E0941		Considered experimental and investigational for the treatment of low back pain or other indications because their effectiveness has not been established.	DME	2 months rental then convert to purchase – MD only

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	MC	CM	MD	CHP+		From	To	Colorado State Medicaid guidelines apply to Medicaid Members		
Orthopedic Devices Hospital Bed & Mattress Accessories: Bed Pan Bed Cradle Bedside Rails Canopy – Safety Enclosed Frame Trapeze Heavy Duty Trapeze Urinal	Y	Y	Y	Y	N	E0910	to E0912	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 and they are an integral part of, or an accessory to, a covered hospital bed. Trapeze equipment (E0910, E0940) is covered if 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 E0911, E0912) is covered when the patient's weight is more than 250 pounds. Urinals (E0325, E0326) are covered when the patient is bed confined.	DME	2 months rental then convert to purchase - or may purchase without renting
Orthopedic Devices Hospital Bed & Mattress Accessories: Bed Pan Bed Cradle Bedside Rails Canopy – Safety Enclosed Frame Trapeze Heavy Duty Trapeze Urinal	Y	Y	Y	Y	N	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 and they are an integral part of, or an accessory to, a covered hospital bed. Trapeze equipment (E0910, E0940) is covered if 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 E0911, E0912) is covered when the patient's weight is more than 250 pounds. Urinals (E0325, E0326) are covered when the patient is bed confined.	DME	2 months rental then convert to purchase - or may purchase without renting
Orthopedic Devices Traction Accessories: Cervical Head Harness Pelvic Belt/Harness/Boot Extremity Belt/Harness	Y	Y	Y	Y	N	E0942		Covered only when Member meets the criteria for coverage for a traction unit.	DME	Purchase
Orthopedic Devices Traction Accessories: Cervical Head Harness Pelvic Belt/Harness/Boot Extremity Belt/Harness	Y	Y	Y	Y	N	E0944	to E0945	Covered only when Member meets the criteria for coverage for a traction unit.	DME	Purchase

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	MC	CM	MD	CHP+		From	To	Colorado State Medicaid guidelines apply to Medicaid Members		
Orthopedic Devices Traction: Cervical, Extremity, Fracture Frame, Pelvic	Y	Y	Y	Y	Y	E0920		Cervical traction devices (E0840 to E0860) 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 to standing frame (E0850) has no proven clinical advantage compared to cervical traction applied via an over-the-door mechanism (E0860). Cervical traction devices (E0849 or E0855) are covered only when criteria 1 and 2 above and following criteria are met: 1. The patient has a diagnosis and has received treatment for temporomandibular joint (TMJ) dysfunction; or, 2. The patient has distortion of lower jaw or neck anatomy where a chin halter cannot be utilized; or, 3. The treating physician orders and/or documents medical necessity for greater than 20 pounds of cervical traction in the home setting. 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	2 months rental then convert to Purchase
Orthopedic Devices Traction: Cervical, Extremity, Fracture Frame, Pelvic	Y	Y	Y	Y	Y	E0930		Cervical traction devices (E0840 to E0860) 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 to standing frame (E0850) has no proven clinical advantage compared to cervical traction applied via an over-the-door mechanism (E0860). Cervical traction devices (E0849 or E0855) are covered only when criteria 1 and 2 above and following criteria are met: 1. The patient has a diagnosis and has received treatment for temporomandibular joint (TMJ) dysfunction; or, 2. The patient has distortion of lower jaw or neck anatomy where a chin halter cannot be utilized; or, 3. The treating physician orders and/or documents medical necessity for greater than 20 pounds of cervical traction in the home setting. 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	2 months rental then convert to Purchase

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	MC	CM	MD	CHP+		From	To	Colorado State Medicaid guidelines apply to Medicaid Members		
Orthopedic Devices Traction: Cervical, Extremity, Fracture Frame, Pelvic	Y	Y	Y	Y	Y	E0946	to E0948	Cervical traction devices (E0840 to E0860) 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 to standing frame (E0850) has no proven clinical advantage compared to cervical traction applied via an over-the-door mechanism (E0860). Cervical traction devices (E0849 or E0855) are covered only when criteria 1 and 2 above and following criteria are met: 1. The patient has a diagnosis and has received treatment for temporomandibular joint (TMJ) dysfunction; or, 2. The patient has distortion of lower jaw or neck anatomy where a chin halter cannot be utilized; or, 3. The treating physician orders and/or documents medical necessity for greater than 20 pounds of cervical traction in the home setting. 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	2 months rental then convert to Purchase
Other Devices Glucometers: Standard Voice Activated	Y	Y	Y	Y	N	E2100	to E2101	Covered when all of the following basic criteria is met: 1. The patient has diabetes 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 appropriate glycemic control; and 5. The devise is designed for home use. Home blood glucose monitors with special features (E2100, E2101) 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 20/20 or worse in both eyes) requiring use of this special monitoring system. Devices with special features are covered when the above criteria are met AND: 1. E2100, E2101 - 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 2. E2101 – The treating physician certifies that the patient has an impairment of manual dexterity severe enough to require the use of this special monitoring system.	DME	Purchase

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	MC	CM	MD	CHP+		From	To	Colorado State Medicaid guidelines apply to Medicaid Members		
Other Devices Pulse Generator System	N	N	Y	N	Y	E2120		The pulse generator system is considered experimental.	DME	
Other Devices Speech Generating Device (SGD) (synthesized speech augmentive device with display)	Y	Y	Y	Y	Y	E1902		An SGD (E2500 – E2511) is covered when all of the following criteria (1 to 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; and, 7. The SLP performing the patient evaluation may not be an employee of or have a financial relationship with the supplier of the SGD. Claims for more than one SGD will be denied as not medically necessary. Questionnaire #13 - Augmentative Communication Device is required and should be completed and submitted for Medicaid plans.	DME	2 months rental then convert to Purchase

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	MC	CM	MD	CHP+		From	To	Colorado State Medicaid guidelines apply to Medicaid Members		
Other Devices Suction Pump Canister Tubing	Y	Y	Y	Y	N	E2000		A respiratory suction pump (E0600) is covered with a detailed written order 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.	DME	2 months rental then convert to Purchase
Other Supplies and Devices Bidet Toilet Seats	N	N	N	N	N/A	A9270		Not primarily medical in nature.	NAB	N/A
Other Supplies and Devices Paraffin Bath Units (standard) non-portable	N	N	N	N	N/A	A9270		Not a benefit of any plan.	NAB	N/A
Oxygen And Related Respiratory Equipment BiPAP (Bi-Level Positive Pressure Ventilator) for treatment of conditions other than obstructive sleep apnea	Y	Y	Y	Y	Y	E0470	to E0472	Coverage Guideline applies: Respiratory Assist Devices	DME	2 months rental then convert to Purchase
Oxygen And Related Respiratory Equipment Cough Stimulating Device	Y	Y	Y	Y	Y	E0482		Mechanical in/exsufflation devices (E0482) or cough stimulating devices are reasonable and necessary when the guidelines listed below are met. 1. Member has a neuromuscular disease as defined by the following diagnosis: a. Late effects of acute poliomyelitis b. Werding-Hoffmann Disease – Anterior Horn Cell Disease, unspecified c. Multiple Sclerosis d. Quadriplegia, unspecified – other quadriplegia e. Congenital hereditary muscular dystrophy f. Hereditary progressive muscular dystrophy g. Amyotrophic lateral sclerosis h. Myotonic Muscular Dystrophy i. Inclusion Body Myositis 2. The condition is causing significant impairment of chest wall and/or diaphragmatic movement, which results in an inability to clear retained secretions.		Rental or Purchase

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	MC	CM	MD	CHP+		From	To	Colorado State Medicaid guidelines apply to Medicaid Members		
Oxygen And Related Respiratory Equipment CPAP/BIPAP (continuous or bi-level positive airway pressure) for treatment of Obstructive Sleep Apnea See also: BiPAP (Bi-Level Positive Pressure Ventilator)	Y	Y	Y	Y	Y	E0470		Polysomnograph results and a detailed written order are required for rental. The BiPAP/CPAP Questionnaire is required for purchase. A single level continuous positive airway pressure (CPAP) device is covered for the treatment of obstructive sleep apnea (OSA) if the following criteria are met and includes a detailed written order: 1. The patient has a face-to-face clinical evaluation by the treating physician prior to the sleep test to assess the patient for OSA. 2. The patient has a Medicare covered sleep test that meets either of the following criteria: a. The apnea to hypopnea index (AHI) or Respiratory Disturbance Index (RHI) is greater than or equal to 15 events per hour; or, b. The AHI or RDI is from 5 to 14 events per hour with documented symptoms of excessive daytime sleepiness, impaired cognition, mood disorders, or insomnia; or Hypertension, ischemic heart disease or history of stroke. 3. The patient and/or caregiver have received instructions in proper use and care of the CPAP device and accessories. An E0470 bi-level respiratory assist device (BiPAP) is covered when the patient with OSA has met the above criteria AND a CPAP device (E0601) has been tried and proven ineffective based on a therapeutic trial conducted in either a facility or in the home. Ineffective is defined as documented failure to meet therapeutic goals using an E0601 during the titration portion of a facility-based study or during home use despite optimal therapy (i.e., proper mask selection and fitting and appropriate pressure settings). Coverage criteria for E0470 for diagnoses other than OSA are addressed under BiPAP in the next section.	DME	2 months rental then convert to purchase; if purchased without trial period, may not be returned
Oxygen And Related Respiratory Equipment High Frequency Chest Wall Oscillation Devices (HFCWO) Air-Pulse Generator System/ Vest Clearance Airway System	Y	Y	Y	Y	Y	E0483		High frequency chest wall oscillation devices (E0483) are covered for patients who meet either criteria 1, or 2, or 3, and criterion 4: 1. There is a diagnosis of cystic fibrosis 2. There is a diagnosis of bronchiectasis, , (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. The member has one of the following neuromuscular disease diagnoses: Post-polio (138), Acid maltase deficiency, Anterior horn cell diseases, Multiple sclerosis, Quadriplegia, Hereditary muscular dystrophy, Myotonic disorders, Other myopathies, and Paralysis of the diaphragm. 4. There must be well documented failure of standard treatments to adequately mobilize retained secretions. It is not medically necessary for a member to use both an HFCWO device and a mechanical in/exsufflation device (E0482).	DME	2 months rental then convert to Purchase

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Oxygen And Related Respiratory Equipment Home Ventilator, multi-function respiratory device	Y	Y	Y	Y	Y	E0467		Home ventilator, multi-function respiratory device, also performs any or all of the additional functions of oxygen concentration, drug nebulization, aspiration, and cough stimulation, includes all accessories, components and supplies for all functions Ventilator coverage guidelines applies. All requests go to medical review.	OX	12 month rental only
Oxygen And Related Respiratory Equipment Home ventilator, used with invasive interface (i.e. tracheostomy tube)	Y	Y	Y	Y	Y	E0465		Ventilator Coverage Guideline Applies. Alll requests go to medical review.	DME	12 month rental only
Oxygen And Related Respiratory Equipment Home Ventilator, used with non invasive interface (i.e. mask, chest shell)	Y	Y	Y	Y	Y	E0466		Policy does apply with multiple limitations for all other health plans and will go to medical review	OX	12 month rental only
Oxygen And Related Respiratory Equipment Intrapulmonary Percussive Vent System and accessories	N	N	N	N	N/A	E0481		An intrapulmonary percussive ventilator (IPV) has not been demonstrated to be reasonable and necessary in the home setting; therefore, it is non-covered.	NAB	N/A
Oxygen And Related Respiratory Equipment IPPB Machine IPPB Humidifier	Y	Y	Y	Y	Y	E0555		Covered when used for the treatment of respiratory diseases. This is a rental only item.	DME	Rental only
Oxygen And Related Respiratory Equipment Oscillatory Positive Expiratory Pressure Device	Y	Y	Y	Y	N	E0484		Considered medically necessary for cystic fibrosis, chronic bronchitis, asthma, and chronic obstructive pulmonary disease.	DME	Purchase
Oxygen And Related Respiratory Equipment Oxygen Contents	N	N	Y	N	Y	E0441	to E0444	Coverage Guideline Applies - covered when Member meets guidelines for oxygen. Oxygen contents are not separately payable when included in payment for equipment rental.	OX	Purchase

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Oxygen And Related Respiratory Equipment Oxygen Supplies: Oxygen Tent Tubing Mask Cannula Face Tent Breathing Circuits Regulator Stand	Y	Y	Y	Y	N	E0455		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 (E1352, E1353), wheeled carts (E1354, battery packs/cartridges and chargers (E1356 and E1357, DC power adapter (1358), and stand/rack (E1355) are included in the allowance for rented systems.	OX	Purchase
Oxygen And Related Respiratory Equipment Oxygen: Concentrator Gaseous Portable Stationary Liquid Portable Vapor Enriching System Contents	Y	Y	Y	Y	Y	E0424	to E0425	Coverage Guideline Applies. Emergency or stand-by oxygen systems will be denied as not medically necessary since they are precautionary and not therapeutic in nature. RMHP covers rental of oxygen equipment. Purchase of equipment is not covered.	OX	12 or 24 month rental only
Oxygen And Related Respiratory Equipment Oxygen: Concentrator Gaseous Portable Stationary Liquid Portable Vapor Enriching System Contents	Y	Y	Y	Y	Y	E0431		Coverage Guideline Applies. Emergency or stand-by oxygen systems will be denied as not medically necessary since they are precautionary and not therapeutic in nature. RMHP covers rental of oxygen equipment. Purchase of equipment is not covered.	OX	12 or 24 month rental only
Oxygen And Related Respiratory Equipment Oxygen: Concentrator Gaseous Portable Stationary Liquid Portable Vapor Enriching System Contents	Y	Y	Y	Y	Y	E0433	to E0435	Coverage Guideline Applies. Emergency or stand-by oxygen systems will be denied as not medically necessary since they are precautionary and not therapeutic in nature. RMHP covers rental of oxygen equipment. Purchase of equipment is not covered.	OX	12 or 24 month rental only
Oxygen And Related Respiratory Equipment Oxygen: Concentrator Gaseous Portable Stationary Liquid Portable Vapor Enriching System Contents	Y	Y	Y	Y	Y	E0439	to E0440	Coverage Guideline Applies. Emergency or stand-by oxygen systems will be denied as not medically necessary since they are precautionary and not therapeutic in nature. RMHP covers rental of oxygen equipment. Purchase of equipment is not covered.	OX	12 or 24 month rental only
Oxygen And Related Respiratory Equipment Oxygen: Concentrator Gaseous Portable Stationary Liquid Portable Vapor Enriching System Contents	Y	Y	Y	Y	Y	E0446		Coverage Guideline Applies. Emergency or stand-by oxygen systems will be denied as not medically necessary since they are precautionary and not therapeutic in nature. RMHP covers rental of oxygen equipment. Purchase of equipment is not covered.	OX	12 or 24 month rental only

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Oxygen And Related Respiratory Equipment Percussor/Phlegm Fighter Electronic	Y	Y	Y	Y	N	E0480		Mechanical percussors are considered medically necessary for treatment of cystic fibrosis, chronic bronchitis, bronchiectasis, immotile cilia syndrome, and asthma.	DME	Purchase
Oxygen And Related Respiratory Equipment Pulse Oximeter Pulse Oximeter Probes	N	N	Y	N	Y	E0445		Coverage Guideline Applies. E0445KR is a valid code for an overnight oximetry for Medicaid members and does not require preauthorization.	DME	2 months rental then convert to Purchase
Oxygen And Related Respiratory Equipment Spirometers P-Flex Incentive	Y	Y	N	Y	N	E0487		Covered when used for neuromuscular or chest wall diseases. Incentive spirometers are considered experimental and investigational for all other indications. An invoice of the cost of equipment is required	DME	Purchase
Oxygen And Related Respiratory Equipment Ventilator: Volume Control Negative Pressure Pressure Support Chest Shell Chest Wrap	Y	Y	Y	Y	Y	E0457		Ventilator Coverage Guideline Applies. Alll requests go to medical review.	DME	2 months rental then convert to Purchase
Oxygen And Related Respiratory Equipment Ventilator: Volume Control Negative Pressure Pressure Support Chest Shell Chest Wrap	Y	Y	Y	Y	Y	E0459		Ventilator Coverage Guideline Applies. Alll requests go to medical review.	DME	2 months rental then convert to Purchase
Oxygen And Related Respiratory Equipment, for Sleep Apnea Oral Appliance for Sleep Apnea	Y	Y	Y	Y	Y	E0485	to E0486	Coverage Guideline Applies. Oral Appliance for Obstructive Sleep Apnea (OSA)	DME	Purchase
Patient Lifts Bath Tub/Toilet Lift	N	N	Y	N	N	E0625		Considered a convenience item.	DME	Purchase - MD only

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Patient Lifts Patient Lift: Bathroom or Toilet Standing Frame System Combination sit to stand system Moveable Fixed System	N	N	Y	N	Y	E0625		Patient lift, bathroom or toilet (E0625), combination sit to stand system (E0637), standing frame (E0638)Patient lift, fixed system, includes all components/accessories multi-position standing frame or three-way stander (E0641), and mobile standing frame or dynamic stander (E0642) are considered self-help or convenience items and not medically necessary. These items are covered for Medicaid only.	DME	Purchase
Patient Lifts Patient Lift: Bathroom or Toilet Standing Frame System Combination sit to stand system Moveable Fixed System	N	N	Y	N	Y	E0637	to E0638	Patient lift, bathroom or toilet (E0625), combination sit to stand system (E0637), standing frame (E0638)Patient lift, fixed system, includes all components/accessories multi-position standing frame or three-way stander (E0641), and mobile standing frame or dynamic stander (E0642) are considered self-help or convenience items and not medically necessary. These items are covered for Medicaid only.	DME	Purchase
Patient Lifts Patient Lift: Bathroom or Toilet Standing Frame System Combination sit to stand system Moveable Fixed System	N	N	Y	N	Y	E0641	to E0642	Patient lift, bathroom or toilet (E0625), combination sit to stand system (E0637), standing frame (E0638)Patient lift, fixed system, includes all components/accessories multi-position standing frame or three-way stander (E0641), and mobile standing frame or dynamic stander (E0642) are considered self-help or convenience items and not medically necessary. These items are covered for Medicaid only.	DME	Purchase
Patient Lifts Patient Lift: Electrical Multi-positional Patient Support System Multi-positional transfer system	Y	Y	Y	Y	Y	E0636		A multi-positional patient transfer system (E0636, patient accessible controls and E1035 or E1036, operated by caregiver) is covered if both of the following criteria are met: 1. The criteria for a lift (E0630) are met; and, 2. The patient requires supine positioning for transfers. If coverage is provided for code E1035 or E1036, payment will be discontinued for any other mobility assistive equipment, including but not limited to: canes, crutches, walkers, roll-about chairs, transfer chairs, manual wheelchairs, power-operated vehicles, or power wheelchairs.	DME	2 months rental then convert to Purchase
Patient Lifts Patient Lift: Hydraulic (Hoyer) Sling or Seat	Y	Y	Y	Y	Y	E0621		A patient lift described by codes (E0630, E0635, E0639, or E0640 is covered if transfer between bed and a chair, wheelchair, or commode is required and, without the use of a lift, the patient would be bed confined. A sling or seat for patient lift (E0621) is covered as an accessory when ordered as a replacement for the original equipment item. When a device is only used in a bathroom, it is coded E0625.	DME	2 months rental then convert to Purchase
Patient Lifts Patient Lift: Hydraulic (Hoyer) Sling or Seat	Y	Y	Y	Y	Y	E0630		A patient lift described by codes (E0630, E0635, E0639, or E0640 is covered if transfer between bed and a chair, wheelchair, or commode is required and, without the use of a lift, the patient would be bed confined. A sling or seat for patient lift (E0621) is covered as an accessory when ordered as a replacement for the original equipment item. When a device is only used in a bathroom, it is coded E0625.	DME	2 months rental then convert to Purchase

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Patient Lifts Patient Lift: Hydraulic (Hoyer) Sling or Seat	Y	Y	Y	Y	Y	E0635		A patient lift described by codes (E0630, E0635, E0639, or E0640 is covered if transfer between bed and a chair, wheelchair, or commode is required and, without the use of a lift, the patient would be bed confined. A sling or seat for patient lift (E0621) is covered as an accessory when ordered as a replacement for the original equipment item. When a device is only used in a bathroom, it is coded E0625.	DME	2 months rental then convert to Purchase
Patient Lifts Patient Lift: Hydraulic (Hoyer) Sling or Seat	Y	Y	Y	Y	Y	E0639	to E0640	A patient lift described by codes (E0630, E0635, E0639, or E0640 is covered if transfer between bed and a chair, wheelchair, or commode is required and, without the use of a lift, the patient would be bed confined. A sling or seat for patient lift (E0621) is covered as an accessory when ordered as a replacement for the original equipment item. When a device is only used in a bathroom, it is coded E0625.	DME	2 months rental then convert to Purchase
Patient Lifts Seat Lift Mechanism	Y	Y	Y	Y	N	E0627	to E0629	Note: Coverage is limited to the seat-lift mechanism, even if it is incorporated into a chair (E0627). A seat lift mechanism is covered when all of the following criteria are met: 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	Purchase
Prosthetic Devices MyoPro Upper Body Mobile Assist Device	N	N	N	N	N/A	L8701	to L8702	Considered experimental and investigational.	NAB	
Pumps and Supplies Breast Pump Tubing Adapter Cap Breast Shield Olycarbonate Bottle Locking Ring	N	Y	Y	Y	N	E0602	to E0604	Medicaid and CHP+ Benefit only when newborn is in NICU. Clinical review. Commercial– effective 8/1/2012 RENTAL COVERED IN NETWORK ONLY - 100% up to the purchase price of our preferred pump (Madelia Symphony) OR PURCHASE COVERED IN or OUT OF NETWORK - Manual or Electric (AC and or DC) type pump up to the purchase price of our preferred pump (Madelia Symphony)	DME	MD - Rental Only; Commercial - Rental or Purchase

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Respiratory Supplies CPAP/BIPAP (continuous or bi-level positive airway pressure) for treatment of Obstructive Sleep Apnea See also: BiPAP (Bi-Level Positive Pressure Ventilator)	Y	Y	Y	Y	N	E0601		Polysomnograph results and a detailed written order are required for rental. The BiPAP/CPAP Questionnaire is required for purchase. A single level continuous positive airway pressure (CPAP) device is covered for the treatment of obstructive sleep apnea (OSA) if the following criteria are met and includes a detailed written order: 1. The patient has a face-to-face clinical evaluation by the treating physician prior to the sleep test to assess the patient for OSA. 2. The patient has a Medicare covered sleep test that meets either of the following criteria: a. The apnea to hypopnea index (AHI) or Respiratory Disturbance Index (RHI) is greater than or equal to 15 events per hour; or, b. The AHI or RDI is from 5 to 14 events per hour with documented symptoms of excessive daytime sleepiness, impaired cognition, mood disorders, or insomnia; or Hypertension, ischemic heart disease or history of stroke. 3. The patient and/or caregiver have received instructions in proper use and care of the CPAP device and accessories. An E0470 bi-level respiratory assist device (BiPAP) is covered when the patient with OSA has met the above criteria AND a CPAP device (E0601) has been tried and proven ineffective based on a therapeutic trial conducted in either a facility or in the home. Ineffective is defined as documented failure to meet therapeutic goals using an E0601 during the titration portion of a facility-based study or during home use despite optimal therapy (i.e., proper mask selection and fitting and appropriate pressure settings). Coverage criteria for E0470 for diagnoses other than OSA are addressed under BiPAP in the next section.	DME	2 months rental then convert to purchase; if purchased without trial period, may not be returned
Respiratory Supplies Suction Pump Canister Tubing	Y	Y	Y	Y	N	E0600		A respiratory suction pump (E0600) is covered with a detailed written order 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.	DME	2 months rental then convert to Purchase
Safety Equipment Safety Equipment (e.g. Belt, Harness, or Vest) Restraint	Y	Y	Y	Y	N	E0700		Covered when medically indicated by the requesting physician.	DME	Purchase

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Safety Equipment Safety Equipment (e.g. Belt, Harness, or Vest) Restraint	Y	Y	Y	Y	N	E0710		Covered when medically indicated by the requesting physician.	DME	Purchase
Safety Equipment Transfer Board	Y	Y	Y	Y	N	E0705		Covered when the patient needs assistance transferring from bed to chair or from chair to bed.		Purchase

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Speech Generating Device (SGD) Speech Generating Device (SGD) (synthesized speech augmentive device with display)	Y	Y	Y	Y	Y	E2500	to E2599	An SGD (E2500 – E2511) is covered when all of the following criteria (1 to 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; and, 7. The SLP performing the patient evaluation may not be an employee of or have a financial relationship with the supplier of the SGD. Claims for more than one SGD will be denied as not medically necessary. Questionnaire #13 - Augmentative Communication Device is required and should be completed and submitted for Medicaid plans.	DME	2 months rental then convert to Purchase

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Traction Equipment Traction: Cervical, Extremity, Fracture Frame, Pelvic	Y	Y	Y	Y	Y	E0830	to E0900	Cervical traction devices (E0840 to E0860) 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 to standing frame (E0850) has no proven clinical advantage compared to cervical traction applied via an over-the-door mechanism (E0860). Cervical traction devices (E0849 or E0855) are covered only when criteria 1 and 2 above and following criteria are met: 1. The patient has a diagnosis and has received treatment for temporomandibular joint (TMJ) dysfunction; or, 2. The patient has distortion of lower jaw or neck anatomy where a chin halter cannot be utilized; or, 3. The treating physician orders and/or documents medical necessity for greater than 20 pounds of cervical traction in the home setting. 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	2 months rental then convert to Purchase
Ultraviolet Light Ultraviolet Light Therapy System, replacmement bulb/lamp	Y	Y	Y	Y	Y	E0691	to E0694	Coverage Guideline Applies. “Phototherapy with PUVA (photochemotherapy), UVA and/or UVB	DME	2 months rental then convert to Purchase
Walkers Walkers: Folding/Pickup Standard Heavy Duty Four Sided Frame Trunk Support	Y	Y	Y	Y	N	E0130		A standard walker (E0130, E0135, E0141, E0143) 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. Hemi-walkers must be billed using codes E0130 or E0135, not E1399. (MRADL) in the home, the patient is able to safely use the walker and the functional mobility deficit can be sufficiently resolved with use of a walker. A walker with trunk support (E0140) 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 (E0144) compared to a standard folding wheeled walker has not been established. A heavy duty, multiple braking system, variable wheel resistance walker (E0147) is covered for patients who are unable to use a standard walker due to a severe neurological disorder or other condition causing the restricted use of one hand. A heavy duty walker (E0148, E0149) is covered for patients who weigh more than 300 lbs.	DME	2 months rental then convert to purchase - or may purchase without renting

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Walkers Walkers: Folding/Pickup Standard Heavy Duty Four Sided Frame Trunk Support	Y	Y	Y	Y	N	E0135		A standard walker (E0130, E0135, E0141, E0143) 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. Hemi-walkers must be billed using codes E0130 or E0135, not E1399. (MRADL) in the home, the patient is able to safely use the walker and the functional mobility deficit can be sufficiently resolved with use of a walker. A walker with trunk support (E0140) 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 (E0144) compared to a standard folding wheeled walker has not been established. A heavy duty, multiple braking system, variable wheel resistance walker (E0147) is covered for patients who are unable to use a standard walker due to a severe neurological disorder or other condition causing the restricted use of one hand. A heavy duty walker (E0148, E0149) is covered for patients who weigh more than 300 lbs.	DME	2 months rental then convert to purchase - or may purchase without renting
Walkers Walkers: Folding/Pickup Standard Heavy Duty Four Sided Frame Trunk Support	Y	Y	Y	Y	N	E0140	to E0141	A standard walker (E0130, E0135, E0141, E0143) 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. Hemi-walkers must be billed using codes E0130 or E0135, not E1399. (MRADL) in the home, the patient is able to safely use the walker and the functional mobility deficit can be sufficiently resolved with use of a walker. A walker with trunk support (E0140) 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 (E0144) compared to a standard folding wheeled walker has not been established. A heavy duty, multiple braking system, variable wheel resistance walker (E0147) is covered for patients who are unable to use a standard walker due to a severe neurological disorder or other condition causing the restricted use of one hand. A heavy duty walker (E0148, E0149) is covered for patients who weigh more than 300 lbs.	DME	2 months rental then convert to purchase - or may purchase without renting

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Walkers Walkers: Folding/Pickup Standard Heavy Duty Four Sided Frame Trunk Support	Y	Y	Y	Y	N	E0143	to E0144	A standard walker (E0130, E0135, E0141, E0143) 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. Hemi-walkers must be billed using codes E0130 or E0135, not E1399. (MRADL) in the home, the patient is able to safely use the walker and the functional mobility deficit can be sufficiently resolved with use of a walker. A walker with trunk support (E0140) 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 (E0144) compared to a standard folding wheeled walker has not been established. A heavy duty, multiple braking system, variable wheel resistance walker (E0147) is covered for patients who are unable to use a standard walker due to a severe neurological disorder or other condition causing the restricted use of one hand. A heavy duty walker (E0148, E0149) is covered for patients who weigh more than 300 lbs.	DME	2 months rental then convert to purchase - or may purchase without renting
Walkers Walkers: Folding/Pickup Standard Heavy Duty Four Sided Frame Trunk Support	Y	Y	Y	Y	N	E0147	to E0149	A standard walker (E0130, E0135, E0141, E0143) 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. Hemi-walkers must be billed using codes E0130 or E0135, not E1399. (MRADL) in the home, the patient is able to safely use the walker and the functional mobility deficit can be sufficiently resolved with use of a walker. A walker with trunk support (E0140) 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 (E0144) compared to a standard folding wheeled walker has not been established. A heavy duty, multiple braking system, variable wheel resistance walker (E0147) is covered for patients who are unable to use a standard walker due to a severe neurological disorder or other condition causing the restricted use of one hand. A heavy duty walker (E0148, E0149) is covered for patients who weigh more than 300 lbs.	DME	2 months rental then convert to purchase - or may purchase without renting

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Wheelchair Accessories Patient Lift: Electrical Multi-positional Patient Support System Multi-positional transfer system	Y	Y	Y	Y	Y	E1035	to E1036	A multi-positional patient transfer system (E0636, patient accessible controls and E1035 or E1036, operated by caregiver) is covered if both of the following criteria are met: 1. The criteria for a lift (E0630) are met; and, 2. The patient requires supine positioning for transfers. If coverage is provided for code E1035 or E1036, payment will be discontinued for any other mobility assistive equipment, including but not limited to: canes, crutches, walkers, roll-about chairs, transfer chairs, manual wheelchairs, power-operated vehicles, or power wheelchairs.	DME	2 months rental then convert to Purchase
Wheelchair Accessories Roll-about Wheelchair (Geri chair)	Y	Y	Y	Y	Y	E1031	to E1039	Coverage Guideline Applies. Manual Wheelchair	DME	2 months rental then convert to Purchase
Wheelchair Accessories Wheelchair Accessories	Y	Y	Y	Y	Y	E0950	to E0969	Coverage Guideline Applies. Wheelchair Accessories (E2331) is not a covered benefit of Medicaid.	DME	2 months rental then convert to purchase - or may purchase without renting
Wheelchair Accessories Wheelchair Accessories	Y	Y	Y	Y	Y	E0971	to E1030	Coverage Guideline Applies. Wheelchair Accessories (E2331) is not a covered benefit of Medicaid.	DME	2 months rental then convert to purchase - or may purchase without renting
Wheelchair Accessories Wheelchair Accessories	N	N	Y	N	Y	E0970		A power seat elevation feature (E2300) and power standing feature (E2301) are not covered by Medicare because they are not primarily medical in nature. The following features of a power wheelchair are non-covered: stair climbing (A9270); electronic balance (A9270); ability to elevate the seat by balancing on two wheels (A9270); remote operation (A9270); E2300 is covered for MD only. E2301 and A9270 are not covered for all lines of business.	DME	Purchase

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Wheelchair Cushion Wheelchair Accessories	Y	Y	Y	Y	Y	E2601	to E2625	Coverage Guideline Applies. Wheelchair Accessories (E2331) is not a covered benefit of Medicaid.	DME	2 months rental then convert to purchase - or may purchase without renting
Wheelchairs Manual Wheelchair Base: Standard Hemi Fully Reclining Extra Heavy Duty High Strength Lightweight Heavy Duty Lightweight Ultra-Lightweight Pediatric	Y	Y	Y	Y	Y	E1050	to E1093	Coverage Guideline Applies. Manual Wheelchair	DME	2 months rental then convert to Purchase
Wheelchairs Manual Wheelchair Base: Standard Hemi Fully Reclining Extra Heavy Duty High Strength Lightweight Heavy Duty Lightweight Ultra-Lightweight Pediatric	Y	Y	Y	Y	Y	E1100	to E1200	Coverage Guideline Applies. Manual Wheelchair	DME	2 months rental then convert to Purchase
Wheelchairs Manual Wheelchair Base: Standard Hemi Fully Reclining Extra Heavy Duty High Strength Lightweight Heavy Duty Lightweight Ultra-Lightweight Pediatric	Y	Y	Y	Y	Y	E1220	to E1224	Coverage Guideline Applies. Manual Wheelchair	DME	2 months rental then convert to Purchase
Wheelchairs Manual Wheelchair Base: Standard Hemi Fully Reclining Extra Heavy Duty High Strength Lightweight Heavy Duty Lightweight Ultra-Lightweight Pediatric	Y	Y	Y	Y	Y	E1229		Coverage Guideline Applies. Manual Wheelchair	DME	2 months rental then convert to Purchase
Wheelchairs Manual Wheelchair Base: Standard Hemi Fully Reclining Extra Heavy Duty High Strength Lightweight Heavy Duty Lightweight Ultra-Lightweight Pediatric	Y	Y	Y	Y	Y	E1231	to E1238	Coverage Guideline Applies. Manual Wheelchair	DME	2 months rental then convert to Purchase

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Wheelchairs Manual Wheelchair Base: Standard Hemi Fully Reclining Extra Heavy Duty High Strength Lightweight Heavy Duty Lightweight Ultra-Lightweight Pediatric	Y	Y	Y	Y	Y	E1240	to E1295	Coverage Guideline Applies. Manual Wheelchair	DME	2 months rental then convert to Purchase
Wheelchairs Power Operated Vehicles	Y	Y	Y	Y	Y	E1230		Coverage Guideline Applies. Power Operated Vehicle	DME	2 months rental then convert to Purchase
Wheelchairs Power Wheelchair Base	Y	Y	Y	Y	Y	E1239			DME	2 months rental then convert to Purchase
Wheelchairs Wheelchair Accessories	Y	Y	Y	Y	Y	E1225	to E1228	Coverage Guideline Applies. Wheelchair Accessories (E2331) is not a covered benefit of Medicaid.	DME	2 months rental then convert to purchase - or may purchase without renting
Wheelchairs Wheelchair Accessories	Y	Y	Y	Y	Y	E1296	to E1298	Coverage Guideline Applies. Wheelchair Accessories (E2331) is not a covered benefit of Medicaid.	DME	2 months rental then convert to purchase - or may purchase without renting
Whirlpool Equipment Whirlpool/Hot Tub Portable Non-portable	N	N	N	N	N/A	E1300		Not a benefit of any plan.	NAB	N/A
Whirlpool Equipment Whirlpool/Hot Tub Portable Non-portable	N	N	N	N	N/A	E1310		Not a benefit of any plan.	NAB	N/A

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Wound Therapy Wound Vac	Y	Y	Y	Y	Y	E2402		Coverage Guideline Applies. Clinical review. Wound Vac/ Negative Pressure Wound Therapy Pumps (NPWT) and Supplies Medicaid: For claims payment, modifier KR must be appended to E2402. Includes all equipment and supplies.	DME	Rent up to 4 months
Hearing Aids, Services, and Accessories Hearing Aids Fitting Ear molds Batteries Repairs	N	Y	N	Y	Y	V5221	to V5267	Commercial and CHP+ Plans: hearing aids or repairs of hearing aids for children less than 18 years of age. V5240 is dispensing fee, contralateral routing system, binaural	CM and CHP+ Only	N/A
Hearing Aids, Services, and Accessories Hearing Aids Fitting Ear Molds Batteries Repairs	N	Y	N	Y	Y	V5120	to V5160	Commercial and CHP+ Plans: hearing aids or repairs of hearing aids for children less than 18 years of age.	CM and CHP+ Only	N/A
Hearing Aids, Services, and Accessories Hearing Aids Fitting Ear Molds Batteries Repairs	N	Y	N	Y	Y	V5171	to V5172	Commercial and CHP+ Plans: hearing aids or repairs of hearing aids for children less than 18 years of age.	CM and CHP+ Only	N/A
Hearing Aids, Services, and Accessories Hearing Aids Fitting Ear Molds Batteries Repairs	N	Y	N	Y	Y	V5181	to V5200	Commercial and CHP+ Plans: hearing aids or repairs of hearing aids for children less than 18 years of age. V5200 is dispensing fee, contralateral, monaural	CM and CHP+ Only	N/A
Hearing Aids, Services, and Accessories Hearing Aids Fitting Ear Molds Batteries Repairs	Y	N	Y	N	Y	V5211	to V5215	Commercial and CHP+ Plans: hearing aids or repairs of hearing aids for children less than 18 years of age.	CM and CHP+ Only	N/A
Hearing Aids, Services, and Accessories Prosthetic: •Cochlear Device Recharging Sytsem	Y	Y	N	Y	Y	L8625		Coverage Guideline Applies. RMHP Coverage Guideline – Prosthetic External recharging system for battery for use with cochlear implant or auditory osseointegrated device, replacement only, each	DME	Purchase

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Monaural Hearing Aids Hearing Aids Fitting Ear molds Batteries Repairs	N	Y	N	Y	Y	V5030	to V5080	Commercial and CHP+ Plans: hearing aids or repairs of hearing aids for children less than 18 years of age.	CM and CHP+ Only	N/A
Other Hearing Services Hearing Aids Fitting Ear molds Batteries Repairs	N	Y	N	Y	Y	V5090		Commercial and CHP+ Plans: hearing aids or repairs of hearing aids for children less than 18 years of age.	CM and CHP+ Only	N/A
Other Hearing Services Hearing Aids Fitting Ear molds Batteries Repairs	N	Y	N	Y	Y	V5100		Commercial and CHP+ Plans: hearing aids or repairs of hearing aids for children less than 18 years of age.	CM and CHP+ Only	N/A
Repair Hearing Aid Hearing Aids Fitting Ear molds Batteries Repairs	N	Y	N	Y	Y	V5014		Commercial and CHP+ Plans: hearing aids or repairs of hearing aids for children less than 18 years of age.	CM and CHP+ Only	N/A
Speech-Lanquage Pathology Services Hearing Aids Fitting Ear molds Batteries Repairs	N	Y	N	Y	Y	V5336		Commercial and CHP+ Plans: hearing aids or repairs of hearing aids for children less than 18 years of age.	CM and CHP+ Only	N/A
Batteries Batteries for Glucometers	Y	Y	Y	Y	N	A4233	to A4236	Covered when the Member has a glucometer.	DME	Purchase
Compression Garments Compression Burn Garments	Y	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	Purchase

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Compression Garments Stockings: Elastic Support, TED Hose, Gradiant Compression, Jobst	N	N	Y	N	N	A6530		A4490 – A4510, A6530, A6533 – A6544 and A6549 are non-covered by Medicare because they do not meet the definition of a surgical dressing. Coverage of a non-elastic gradient compression wrap (A6545) is limited to one per 6 months per leg. A9270 is a non-covered item for all lines of business.	ORTHO	Purchase - MD only
Compression Garments Stockings: Elastic Support, TED Hose, Gradiant Compression, Jobst	N	N	Y	N	N	A6533	to A6541	A4490 – A4510, A6530, A6533 – A6544 and A6549 are non-covered by Medicare because they do not meet the definition of a surgical dressing. Coverage of a non-elastic gradient compression wrap (A6545) is limited to one per 6 months per leg. A9270 is a non-covered item for all lines of business.	ORTHO	Purchase - MD only
Compression Garments Stockings: Elastic Support, TED Hose, Gradiant Compression, Jobst	N	N	Y	N	N	A6544		A4490 – A4510, A6530, A6533 – A6544 and A6549 are non-covered by Medicare because they do not meet the definition of a surgical dressing. Coverage of a non-elastic gradient compression wrap (A6545) is limited to one per 6 months per leg. A9270 is a non-covered item for all lines of business.	ORTHO	Purchase - MD only
Compression Garments Stockings: Elastic Support, TED Hose, Gradiant Compression, Jobst	N	N	Y	N	N	A6549		A4490 – A4510, A6530, A6533 – A6544 and A6549 are non-covered by Medicare because they do not meet the definition of a surgical dressing. Coverage of a non-elastic gradient compression wrap (A6545) is limited to one per 6 months per leg. A9270 is a non-covered item for all lines of business.	ORTHO	Purchase - MD only
Compression Garments Stockings: Gradiant, Compression, Non-elastic Gradiant, Compression Wrap	Y	Y	Y	Y	N	A6531	to A6532	Covered only when used in the treatment of an open venous stasis ulcer.	DME	Purchase
Compression Garments Stockings: Gradiant, Compression, Non-elastic Gradiant, Compression Wrap	Y	Y	Y	Y	N	A6545		Covered only when used in the treatment of an open venous stasis ulcer.	DME	Purchase
Compression Garments Wound Care Kit	Y	Y	Y	Y	N	A6550		Coverage Guideline Applies. Clinical review. Wound Vac/ Negative Pressure Wound Therapy Pumps (NPWT) and Supplies Medicaid: For claims payment, modifier KR must be appended to E2402. Includes all equipment and supplies.		Rent up to 4 months

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Diabetic Shoes, Fitting and Modifications Diabetic Shoes Diabetic Inserts	Y	Y	Y	Y	N	A5500	to A5501	For "Orthopedic Footwear", refer to L3000 – L3649. A5508 – A5510 are non-covered Preauthorization is NOT required when devices billed with codes A5500 – A5507, A5512, or 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. Therapeutic shoes, inserts and/or modifications are covered if the following criteria are met: 1. The patient has diabetes mellitus; and 2. The patient has one or more of the following conditions: 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. Coverage is limited to one of the following within one calendar year (January – December): a. One pair of custom molded shoes and 2 additional pairs of inserts; or b. One pair of depth shoes and 3 pairs of inserts. Quantities of shoes and/or inserts greater than those listed above will be denied as non-covered.	ORTHO	Purchase

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Diabetic Shoes, Fitting and Modifications Diabetic Shoes Diabetic Inserts	Y	Y	Y	Y	N	A5512	to A5513	For "Orthopedic Footwear", refer to L3000 – L3649. A5508 – A5510 are non-covered Preauthorization is NOT required when devices billed with codes A5500 – A5507, A5512, or 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. Therapeutic shoes, inserts and/or modifications are covered if the following criteria are met: 1. The patient has diabetes mellitus; and 2. The patient has one or more of the following conditions: 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. Coverage is limited to one of the following within one calendar year (January – December): a. One pair of custom molded shoes and 2 additional pairs of inserts; or b. One pair of depth shoes and 3 pairs of inserts. Quantities of shoes and/or inserts greater than those listed above will be denied as non-covered.	ORTHO	Purchase
Dialysis Supplies Blood Pressure Cuff Only	Y	Y	Y	Y	Y	A4663		Rx, LMN and Medical Records will be required. Medicaid requires Questionnaire #18. Blood pressure monitors are covered only for members receiving hemodialysis or peritoneal dialysis in the home. Please refer to home dialysis.	DME	Purchase
Dialysis Supplies Blood Pressure Monitor	Y	Y	Y	Y	Y	A4660		Rx, LMN and Medical Records will be required. Medicaid requires Questionnaire #18. Blood pressure monitors are covered only for members receiving hemodialysis or peritoneal dialysis in the home. Please refer to home dialysis.	DME	Purchase

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Dialysis Supplies Blood Pressure Monitor	Y	Y	Y	Y	Y	A4670		Rx, LMN and Medical Records will be required. Medicaid requires Questionnaire #18. Blood pressure monitors are covered only for members receiving hemodialysis or peritoneal dialysis in the home. Please refer to home dialysis.	DME	Purchase
Dialysis Supplies Dialysis Equipment ESRD Supplies Water Purifier Softener	Y	Y	N	Y	Y	A4671	to A4690	RMHP Coverage Guideline “Dialysis Equipment” Applies. Clinical Review 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	Purchase
Dialysis Supplies Dialysis Equipment ESRD Supplies Water Purifier Softener	Y	Y	N	Y	Y	A4706	to A4932	RMHP Coverage Guideline “Dialysis Equipment” Applies. Clinical Review 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	Purchase
Dialysis Supplies Gloves – non-sterile	N	N	Y	N	Y Yes, after the first 2 boxes per month	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. A letter of medical necessity is required for amounts over the limit.	DISP	Purchase - MD only
Dialysis Supplies Gloves – sterile	Y	Y	Y	Y	Y	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	Purchase
Dressings Conforming Bandage Compression Bandage	Y	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	Purchase
Dressings Eye Pad	Y	Y	Y	Y	N	A6410	to A6411	Covered when medically indicated by the requesting physician.	DISP	Purchase

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Dressings Eye Patch	N	N	N	N	N/A	A6412		Eye Patch is not covered.	NAB	N/A
Dressings Synthetic resorbable wound dressing	Y	Y	N	Y	N	A6460	to A6461	Synthetic resorbable wound dressing , sterile, pad size 48 sq in or less, without adhesive border The product will fully absorb and does not have to be removed	DISP	Purchase
Dressings Wound Care Supplies: 4x4 or 2x2 Kerlix Alginate Dressings Betadine/Iodine/ Peroxide Gauze/Wraps/Bandages Hibiclens Saline/Sodium Chloride/Sterile Water Syringes Tape (i.e. Zonas, Micropore, Hupafix) Telfapads Unnaboot	Y	Y	Y	Y	N	A6010	to A6024	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 to 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 non-covered. Silver coated wound dressing (eg, Actisorb, ActicoatTM, Silversorb®) are covered where there is critical concern over colonization of the wound.	DISP	Purchase

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Dressings Wound Care Supplies: 4x4 or 2x2 Kerlix Alginate Dressings Betadine/Iodine/ Peroxide Gauze/Wraps/Bandages Hibiclens Saline/Sodium Chloride/Sterile Water Syringes Tape (i.e. Zonas, Micropore, Hupafix) Telfapads Unnaboot	Y	Y	Y	Y	N	A6154	to A6248	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 to 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 non-covered. Silver coated wound dressing (eg, Actisorb, ActicoatTM, Silversorb®) are covered where there is critical concern over colonization of the wound.	DISP	Purchase
Dressings Wound Care Supplies: 4x4 or 2x2 Kerlix Alginate Dressings Betadine/Iodine/ Peroxide Gauze/Wraps/Bandages Hibiclens Saline/Sodium Chloride/Sterile Water Syringes Tape (i.e. Zonas, Micropore, Hupafix) Telfapads Unnaboot	Y	Y	Y	Y	N	A6251	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 to 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 non-covered. Silver coated wound dressing (eg, Actisorb, ActicoatTM, Silversorb®) are covered where there is critical concern over colonization of the wound.	DISP	Purchase

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Dressings Wound Care: Gel Sheet for Dermal, Wound Cleansers, Skin Sealants	N	N	Y	N	N	A6025		Surgical dressings applied by a physician are included as part of the professional service. Surgical dressings obtained by the Member to perform homecare as prescribed by the physician are covered. Also, any item listed in the latest edition of the Orange Book (e.g., an antibiotic to impregnated dressing which requires a prescription) is considered a drug and is non-covered under the Surgical Dressings benefit.	DISP	Purchase - MD only
Dressings Wound Care: Gel Sheet for Dermal, Wound Cleansers, Skin Sealants	N	N	Y	N	N	A6250		Surgical dressings applied by a physician are included as part of the professional service. Surgical dressings obtained by the Member to perform homecare as prescribed by the physician are covered. Also, any item listed in the latest edition of the Orange Book (e.g., an antibiotic to impregnated dressing which requires a prescription) is considered a drug and is non-covered under the Surgical Dressings benefit.	DISP	Purchase - MD only
Dressings Wound Care: Gel Sheet for Dermal, Wound Cleansers, Skin Sealants	N	N	Y	N	N	A6260		Surgical dressings applied by a physician are included as part of the professional service. Surgical dressings obtained by the Member to perform homecare as prescribed by the physician are covered. Also, any item listed in the latest edition of the Orange Book (e.g., an antibiotic to impregnated dressing which requires a prescription) is considered a drug and is non-covered under the Surgical Dressings benefit.	DISP	Purchase - MD only
Dressings Wound warming device (non to contact) and accessories	N	N	N	N	N/A	A6000		Not covered items.	NAB	N/A
Incontinennce Appliances and Care Supplies Disposable Supplies: Ostomy Supplies Urinary Supplies	Y	Y	Y	Y	N	A4310	to A4435	Limited to a 90 day supply per purchase every 90 days. Must include a detailed written order. A4336 and A4360 are covered for Medicaid Only.	DISP	Purchase
Injection Supplies - i.e., Airjet Injector Airjet Injector (Needle free injection device)	N	N	N	N	N/A	A4210		Considered a convenience item.	NAB	N/A

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Injection Supplies Diabetic Disposable Supplies	Y	Y	Y	Y	N	A4206	to A4213	Syringes and needles; Miscellaneous supplies. Limited to a 90 day supply every 90 days. Must have diagnosis of diabetes. A4250 and A4252 are non-covered by Medicare	DISP	Purchase
Injection Supplies Diabetic Disposable Supplies	Y	Y	Y	Y	N	A4215	to A4218	Syringes and needles; Miscellaneous supplies. Limited to a 90 day supply every 90 days. Must have diagnosis of diabetes. A4250 and A4252 are non-covered by Medicare	DISP	Purchase
Injection Supplies Diabetic Disposable Supplies	Y	Y	Y	Y	N	A4220	to A4223	Syringes and needles; Miscellaneous supplies. Limited to a 90 day supply every 90 days. Must have diagnosis of diabetes. A4250 and A4252 are non-covered by Medicare	DISP	Purchase
Injection Supplies Diabetic Disposable Supplies	Y	Y	Y	Y	N	A4230	to A4232	Syringes and needles; Miscellaneous supplies. Limited to a 90 day supply every 90 days. Must have diagnosis of diabetes. A4250 and A4252 are non-covered by Medicare	DISP	Purchase
Injection Supplies Insulin Pump Supplies	Y	Y	Y	Y	N	A4230	to A4232	Limited to a 90 day supply per purchase every 90 days. Must have diagnosis of diabetes and have an insulin pump. Clinical Review.	DISP	Purchase
Miscellaneous Oxygen Supplies: Oxygen Tent Tubing Mask Cannula Face Tent Breathing Circuits Regulator Stand	Y	Y	Y	Y	N	A9900		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 (E1352, E1353), wheeled carts (E1354, battery packs/cartridges and chargers (E1356 and E1357, DC power adapter (1358), and stand/rack (E1355) are included in the allowance for rented systems.	OX	Purchase

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Miscellaneous Supplies Compression Garments (not used with pump. i.e. Circaids, Ready-Fit)	N	N	Y	N	N Except forcode L2999	A4465		Non-covered for all indications because it does not meet the definition of a surgical dressing. Code L2999 should only be used if a more specific code is not available. Preauthorization is required when L2999 is used.	DME	Purchase
Miscellaneous Supplies CPAP/BiPAP Supplies: Mask (Full or Regular) Headgear Tubing Filters Water Chambers Cannula Chin Strap Whisper Swivel	Y	Y	Y	Y	N	A4604		Covered when Member has CPAP or BiPAP and includes a detailed written order. The following are allowed as stated below: A4604 – 1 per 3 months A4606 -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	Purchase
Miscellaneous Supplies Disposable Supplies: Ostomy Supplies Urinary Supplies	Y	Y	Y	Y	N	A4561	to A4562	Limited to a 90 day supply per purchase every 90 days. Must include a detailed written order. A4336 and A4360 are covered for Medicaid Only.	DISP	Purchase
Miscellaneous Supplies Incontinence Supplies: Incontinence Garment Youth Briefs/Diapers Adult Briefs/Diapers Disposable Under-pads Protective Underwear Disposable Liners	N	N	Y	N	Y Yes, whenunits exceedthe Medicaidlimits	A4520		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 prior authorization. Under-pads (Chux, A4553, A4554) are limited to 150 per calendar month. Above 150 requires prior authorization. Letter of Medical Necessity is required for amounts over the limit. A4520, T4536, T4537, T4538, T4539, T4540, T4541, T4542 are not a benefit.	DISP	Purchase - MD only

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Miscellaneous Supplies Incontinence Supplies: Incontinence Garment Youth Briefs/Diapers Adult Briefs/Diapers Disposable Under-pads Protective Underwear Disposable Liners	N	N	Y	N	Y Yes, whenunits exceedthe Medicaidlimits	A4553	to A4554	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 prior authorization. Under-pads (Chux, A4553, A4554) are limited to 150 per calendar month. Above 150 requires prior authorization. Letter of Medical Necessity is required for amounts over the limit. A4520, T4536, T4537, T4538, T4539, T4540, T4541, T4542 are not a benefit.	DISP	Purchase - MD only
Miscellaneous Supplies Oxygen Supplies: Oxygen Tent Tubing Mask Cannula Face Tent Breathing Circuits Regulator Stand	Y	Y	Y	Y	N	A4608		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 (E1352, E1353), wheeled carts (E1354, battery packs/cartridges and chargers (E1356 and E1357, DC power adapter (1358), and stand/rack (E1355) are included in the allowance for rented systems.	OX	Purchase
Miscellaneous Supplies Pulse Oximeter Pulse Oximeter Probes	N	N	Y	N	Y	A4606		Coverage Guideline Applies. E0445KR is a valid code for an overnight oximetry for Medicaid members and does not require preauthorization.	DME	2 months rental then convert to Purchase
Miscellaneous Supplies Stockings: Elastic Support, TED Hose, Gradiant Compression, Jobst	N	N	Y	N	N	A4490	to A4510	A4490 – A4510, A6530, A6533 – A6544 and A6549 are non-covered by Medicare because they do not meet the definition of a surgical dressing. Coverage of a non-elastic gradient compression wrap (A6545) is limited to one per 6 months per leg. A9270 is a non-covered item for all lines of business.	ORTHO	Purchase - MD only

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Miscellaneous Supplies TENS Unit Supplies Batteries Electrodes Conductive Garment Conductive Paste or Gel	Y	Y	Y	Y	Y	A4555	to A4558	Member must have TENS unit (Must include a detailed written order) A conductive garment (E0731) used with a TENS unit is rarely medically necessary, but may be covered if all of the following conditions are met. 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: 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. A4555 is covered by Medicare, Commercial, and CHP+ A4556 is not covered by Medicare.	DISP	Purchase
Miscellaneous Supplies TENS Unit Supplies Batteries Electrodes Conductive Garment Conductive Paste or Gel	Y	Y	Y	Y	Y	A4595		Member must have TENS unit (Must include a detailed written order) A conductive garment (E0731) used with a TENS unit is rarely medically necessary, but may be covered if all of the following conditions are met. 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: 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. A4555 is covered by Medicare, Commercial, and CHP+ A4556 is not covered by Medicare.	DISP	Purchase

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Miscellaneous Supplies Tracheotomy Supplies: Cleaning Kit Collar/mask Trach/Laryngectomy Tubing Tracheal suction catheter	Y	Y	Y	Y	N	A4481		Limited to a 30 day supply per purchase per every 30 days. Must include a detailed written order. Sterile suction catheters (A4624) are medically necessary only for tracheostomy suctioning.	DISP	Purchase
Miscellaneous Supplies Tracheotomy Supplies: Cleaning Kit Collar/mask Trach/Laryngectomy Tubing Tracheal suction catheter	Y	Y	Y	Y	N	A4605		Limited to a 30 day supply per purchase per every 30 days. Must include a detailed written order. Sterile suction catheters (A4624) are medically necessary only for tracheostomy suctioning.	DISP	Purchase
Miscellaneous Supplies Tracheotomy Supplies: Cleaning Kit Collar/mask Trach/Laryngectomy Tubing Tracheal suction catheter	Y	Y	Y	Y	N	A4608		Limited to a 30 day supply per purchase per every 30 days. Must include a detailed written order. Sterile suction catheters (A4624) are medically necessary only for tracheostomy suctioning.	DISP	Purchase
Miscellaneous Supplies Ventilator Supplies: Moisture Exchange Battery	Y	Y	Y	Y	N	A4483		Covered when the Member has a ventilator.	DISP	Purchase
Ostomy Pouches and Supplies Disposable Supplies: Ostomy Supplies Urinary Supplies	Y	Y	Y	Y	N	A5051	to A5200	Limited to a 90 day supply per purchase every 90 days. Must include a detailed written order. A4336 and A4360 are covered for Medicaid Only.	DISP	Purchase
Other Supplies and Devices Air Cleaners/Purifiers (includes electrostatic machines)	N	N	N	N	N/A	A9270		Not a benefit of any plan.	NAB	N/A

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Coverage of all items is based on Benefits and Medical Necessity

Items	Covered Plan Types				Auth Needed	HCPCS Code		Coverage Guidelines	Benefit	Rental vs Purchase
	MC	CM	MD	CHP+		From	To	Colorado State Medicaid guidelines apply to Medicaid Members		
Other Supplies and Devices Air Conditioners	N	N	N	N	N/A	A9270		Not a benefit of any plan.	NAB	N/A
Other Supplies and Devices Exercise Equipment	N	N	N	N	N/A	A9300		Not a benefit of any plan.	NAB	N/A
Other Supplies and Devices Face Down Positioning Device	N	N	N	N	N/A	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.	NAB	N/A
Other Supplies and Devices Heat/Cold Equipment	N	N	N	N	N/A	A9273		Considered a convenience item.	NAB	N/A
Other Supplies and Devices Humidifiers/Vaporizers/Purifiers/Air Filters	N	N	N	N	N/A	A9270		Not a benefit of any plan.	NAB	N/A
Other Supplies and Devices Hydraulic Van Lift	N	N	N	N	N/A	A9270		Not a benefit of any plan.	NAB	N/A

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Other Supplies and Devices Insulin Pump	Y	Y	Y	Y	Y	A9274		Coverage Guideline Applies. Fully implantable insulin pump is non-covered. Clinical Review. RMHP Coverage Guideline "Insulin Pump". A9274 is non-covered by Medicare Part B. (Members with Medicare Part D plans should inquire with the plan carrier. RMHP does not provide any Part D plans)	DME	Rental or Purchase
Other Supplies and Devices Inversion Table	N	N	N	N	N/A	A9270		Not a benefit of any plan.	NAB	N/A
Other Supplies and Devices Massage Devices	N	N	N	N	N/A	A9270		Not a benefit of any plan.	NAB	N/A
Other Supplies and Devices Parallel Bars	N	N	N	N	N/A	A9300		Not a benefit of any plan.	NAB	N/A
Other Supplies and Devices Reacher	N	N	N	N	N/A	A9281		Not a benefit of any plan.	NAB	N/A
Other Supplies and Devices Scooter Lift Attachment for Vehicle Ramps (For Home Modifications)	N	N	N	N	N/A	A9270		Not a benefit of any plan.	NAB	N/A
Other Supplies and Devices Sock-Aid	N	N	N	N	N/A	A9270		Not a benefit of any plan.	NAB	N/A

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Other Supplies and Devices Spirometers P-Flex Incentive	Y	Y	N	Y	N	A9284		Covered when used for neuromuscular or chest wall diseases. Incentive spirometers are considered experimental and investigational for all other indications. An invoice of the cost of equipment is required	DME	Purchase
Other Supplies and Devices Standard Continuous Glucose Monitor – Sensors	N	Y	Y	Y	Y	A9276		Coverage Guideline Applies. Clinical Review. RMHP Coverage Guideline "Continuous Glucose Monitor-Sensors (CGM)" Standard CGM (A9276, A9277, A9278) is not a benefit for Medicare members or Medicaid (RAE / Prime) members over age 20	DISP	Purchase
Other Supplies and Devices Standard Continuous Glucose Monitor - Transmitter/Receiver	N	Y	Y	Y	Y	A9277	to A9278	Coverage Guideline Applies. Clinical Review. RMHP Coverage Guideline "Continuous Glucose Monitor-Sensors (CGM)" Standard CGM (A9276, A9277, A9278) is not a benefit for Medicare members or Medicaid (RAE / Prime) members over age 20	DME	Purchase
Other Supplies and Devices Telephone Alert Systems Life Line	N	N	N	N	N/A	A9280		Not a benefit of any plan.	NAB	N/A
Other Supplies and Devices Wigs/Artificial Hair Pieces	N	N	N	N	N/A	A9282		Not a benefit of any plan.	NAB	N/A
Other Supplies Breast Pump Tubing Adaper Cap Breast Shield Olycarbonate Bottle Locking Ring	N	Y	Y	Y	N	A4281	to A4286	Medicaid and CHP+ Benefit only when newborn is in NICU. Clinical review. Commercial– effective 8/1/2012 RENTAL COVERED IN NETWORK ONLY - 100% up to the purchase price of our preferred pump (Madelia Symphony) OR PURCHASE COVERED IN or OUT OF NETWORK - Manual or Electric (AC and or DC) type pump up to the purchase price of our preferred pump (Madelia Symphony)	DME	MD - Rental Only; Commercial - Rental or Purchase

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Other Supplies Diabetic Disposable Supplies	Y	Y	Y	Y	N	A4244	to A4248	Syringes and needles; Miscellaneous supplies. Limited to a 90 day supply every 90 days. Must have diagnosis of diabetes. A4250 and A4252 are non-covered by Medicare	DISP	Purchase
Other Supplies Diabetic Disposable Supplies	Y	Y	Y	Y	N	A4250		Syringes and needles; Miscellaneous supplies. Limited to a 90 day supply every 90 days. Must have diagnosis of diabetes. A4250 and A4252 are non-covered by Medicare	DISP	Purchase
Other Supplies Diabetic Disposable Supplies	Y	Y	Y	Y	N	A4252	to A4253	Syringes and needles; Miscellaneous supplies. Limited to a 90 day supply every 90 days. Must have diagnosis of diabetes. A4250 and A4252 are non-covered by Medicare	DISP	Purchase
Other Supplies Diabetic Disposable Supplies	Y	Y	Y	Y	N	A4255	to A4259	Syringes and needles; Miscellaneous supplies. Limited to a 90 day supply every 90 days. Must have diagnosis of diabetes. A4250 and A4252 are non-covered by Medicare	DISP	Purchase
Other Supplies Paraffin Bath Unit (Portable) Paraffin/Pound	Y	Y	Y	Y	Y	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	2 months rental then convert to Purchase
Protective Helmet Helmet	Y	Y	Y	Y	N	A8000	to A8004	Covered when medically indicated by the requesting physician.	ORTHO	Purchase

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Replacement Supplies for DME Crutches:UnderarmForearm, F/A Handgrip replacementTip replacementUnderarm padreplacementPlatform attachment; forearm crutch, each	Y	Y	Y	Y	N	A4635	to A4637	Crutches (E0110 – E0116) are covered if 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	Rent up to 4 months then convert to purchase or may purchase without renting
Replacement Supplies for DME Infrared Heating Pad System Replacement	N	N	N	N	N/A	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.	NAB	N/A
Replacement Supplies for DME 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	Y	A4640		Coverage Guideline Applies. RMHP Coverage Guideline: “Pressure Reducing Support Surfaces”	DME	2 to 6 months rental then convert to purchase or may purchase without renting
Replacement Supplies for DME TENS Unit Supplies Batteries Electrodes Conductive Garment Conductive Paste or Gel	Y	Y	Y	Y	N	A4630		Member must have TENS unit (Must include a detailed written order) A conductive garment (E0731) used with a TENS unit is rarely medically necessary, but may be covered if all of the following conditions are met. 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: 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. A4555 is covered by Medicare, Commercial, and CHP+ A4556 is not covered by Medicare.	DISP	Purchase

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Replacement Supplies for DME Ultraviolet Light Therapy System, replacmement bulb/lamp	Y	Y	Y	Y	Y	A4633	to A4634	Coverage Guideline Applies. “Phototherapy with PUVA (photochemotherapy), UVA and/or UVB	DME	2 months rental then convert to Purchase
Replacement Supplies for DME Walker/Crutch Attachments	Y	Y	Y	Y	N	A4635	to A4637	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	Purchase
Respiratory Supplies Cough Stimulating Device	Y	Y	Y	Y	Y	A7020		Mechanical in/exsufflation devices (E0482) or cough stimulating devices are reasonable and necessary when the guidelines listed below are met. 1. Member has a neuromuscular disease as defined by the following diagnosis: a. Late effects of acute poliomyelitis b. Werding-Hoffmann Disease – Anterior Horn Cell Disease, unspecified c. Multiple Sclerosis d. Quadriplegia, unspecified – other quadriplegia e. Congenital hereditary muscular dystrophy f. Hereditary progressive muscular dystrophy g. Amyotrophic lateral sclerosis h. Myotonic Muscular Dystrophy i. Inclusion Body Myositis 2. The condition is causing significant impairment of chest wall and/or diaphragmatic movement, which results in an inability to clear retained secretions.		Rental or Purchase
Respiratory Supplies CPAP/BiPAP Supplies: Mask (Full or Regular) Headgear Tubing Filters Water Chambers Cannula Chin Strap Whisper Swivel	Y	Y	Y	Y	N	A7027	to A7039	Covered when Member has CPAP or BiPAP and includes a detailed written order. The following are allowed as stated below: A4604 – 1 per 3 months A4606 -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	Purchase

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Respiratory Supplies CPAP/BiPAP Supplies: Mask (Full or Regular) Headgear Tubing Filters Water Chambers Cannula Chin Strap Whisper Swivel	Y	Y	Y	Y	N	A7046		Covered when Member has CPAP or BiPAP and includes a detailed written order. The following are allowed as stated below: A4604 – 1 per 3 months A4606 -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	Purchase
Respiratory Supplies High Frequency Chest Wall Oscillation Devices (HFCWO) Air-Pulse Generator System/ Vest Clearance Airway System	Y	Y	Y	Y	Y	A7025	to A7026	High frequency chest wall oscillation devices (E0483) are covered for patients who meet either criteria 1, or 2, or 3, and criterion 4: 1. There is a diagnosis of cystic fibrosis 2. There is a diagnosis of bronchiectasis, , (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. The member has one of the following neuromuscular disease diagnoses: Post-polio (138), Acid maltase deficiency, Anterior horn cell diseases, Multiple sclerosis, Quadriplegia, Hereditary muscular dystrophy, Myotonic disorders, Other myopathies, and Paralysis of the diaphragm. 4. There must be well documented failure of standard treatments to adequately mobilize retained secretions. It is not medically necessary for a member to use both an HFCWO device and a mechanical in/exsufflation device (E0482).	DME	2 months rental then convert to Purchase
Respiratory Supplies Nebulizer Supplies: Mask Tubing Reservoir Bottle Water Collection Device Filter Dome Peak Flow Meter Immersion External Heater	Y	Y	Y	Y	N	A7003	to A7018	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	Purchase
Respiratory Supplies Nebulizer: Large Volume Bottle Type with Compressed Heater Compressor	Y	Y	Y	Y	N	A7008		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	2 months rental then convert to purchase - or may purchase without renting

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Respiratory Supplies Suction Pump Canister Tubing	Y	Y	Y	Y	N	A7000	to A7002	A respiratory suction pump (E0600) is covered with a detailed written order 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.	DME	2 months rental then convert to Purchase
Supplies for Oxygen and Related Respiratory Equipment Nebulizer Supplies: Mask Tubing Reservoir Bottle Water Collection Device Filter Dome Peak Flow Meter Immersion External Heater	Y	Y	Y	Y	N	A4614		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	Purchase
Supplies for Oxygen and Related Respiratory Equipment Oxygen Supplies: Oxygen Tent Tubing Mask Cannula Face Tent Breathing Circuits	Y	Y	Y	Y	N	A4615	to A4620	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 (E1352, E1353), wheeled carts (E1354, battery packs/cartridges and chargers (E1356 and E1357, DC power adapter (1358), and stand/rack (E1355) are included in the allowance for rented systems.	OX	Purchase
Supplies for Oxygen and Related Respiratory Equipment Tracheotomy Supplies: Cleaning Kit Collar/mask Trach/Laryngectomy Tubing Tracheal suction catheter	Y	Y	Y	Y	N	A4623	to A4626	Limited to a 30 day supply per purchase per every 30 days. Must include a detailed written order. Sterile suction catheters (A4624) are medically necessary only for tracheostomy suctioning.	DISP	Purchase
Supplies for Oxygen and Related Respiratory Equipment Tracheotomy Supplies: Cleaning Kit Collar/mask Trach/Laryngectomy Tubing Tracheal suction catheter	Y	Y	Y	Y	N	A4628	to A4629	Limited to a 30 day supply per purchase per every 30 days. Must include a detailed written order. Sterile suction catheters (A4624) are medically necessary only for tracheostomy suctioning.	DISP	Purchase
Supplies for Oxygen and Related Respiratory Equipment Ventilator Supplies: Moisture Exchange Battery	Y	Y	Y	Y	N	A4611	to A4613	Covered when the Member has a ventilator.	DISP	Purchase

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Tracheostomy Supplies Tracheotomy Supplies: Cleaning Kit Collar/mask Trach/Laryngectomy Tubing Tracheal suction catheter	Y	Y	Y	Y	N	A7501	to A7509	Limited to a 30 day supply per purchase per every 30 days. Must include a detailed written order. Sterile suction catheters (A4624) are medically necessary only for tracheostomy suctioning.	DISP	Purchase
Tracheostomy Supplies Tracheotomy Supplies: Cleaning Kit Collar/mask Trach/Laryngectomy Tubing Tracheal suction catheter	Y	Y	Y	Y	N	A7520	to A7527	Limited to a 30 day supply per purchase per every 30 days. Must include a detailed written order. Sterile suction catheters (A4624) are medically necessary only for tracheostomy suctioning.	DISP	Purchase
Vascular Catheters and Drug Delivery Systems Disposable Drug Delivery System	Y	Y	Y	Y	N	A4305	to A4306	Covered when medically indicated by the requesting physician.	DME	Purchase
Disposable Incontinence Garments Incontinence Supplies	N	N	N	N	Y	T4545		Incontinence product, disposable penile wrap, each	NAB	
Disposable Incontinence Garments Incontinence Supplies: Incontinence Garment Youth Briefs/Diapers Adult Briefs/Diapers Disposable Under-pads Protective Underwear Disposable Liners	N	N	Y	N	Y Yes, whenunits exceedthe Medicaidlimits	T4521	to T4544	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 prior authorization. Under-pads (Chux, A4553, A4554) are limited to 150 per calendar month. Above 150 requires prior authorization. Letter of Medical Necessity is required for amounts over the limit. A4520, T4536, T4537, T4538, T4539, T4540, T4541, T4542 are not a benefit.	DISP	Purchase - MD only
Passenger Vehicle Restraint System Passenger Vehicle Restraint System	N	N	Y	N	Y	T5001		Rx and LMN will be required. Covered for Medicaid only. Coverage Guideline Applies. Passenger Vehicle Safety Device T5001 Positioning seat for persons with special orthopedic needs	DME	Purchase

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Additions to Fracture Orthotic Orthosis: Additions to Lower Extremity Orthosis	Y	Y	Y	Y	N Except forcode L2999	L2180	to L2999	Additions to AFOs and KAFOs (L2180 to L2550, L2750 to 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. L2861 is covered for MD only.	ORTHO	Purchase
Additions to Mobile Arm Supports Orthosis: Additions to Upper Extremity Orthosis	Y	Y	Y	Y	N	L3971		Covered when medically indicated by the requesting physician.	ORTHO	Purchase
Additions to Mobile Arm Supports Orthosis: Additions to Upper Extremity Orthosis	Y	Y	Y	Y	N	L3973		Covered when medically indicated by the requesting physician.	ORTHO	Purchase
Additions to Mobile Arm Supports Orthosis: Additions to Upper Extremity Orthosis	Y	Y	Y	Y	N	L3975	to L3978	Covered when medically indicated by the requesting physician.	ORTHO	Purchase
Additions to Spinal Orthotic Orthosis: CTLSO, TLSO, LO, LSO	Y	Y	Y	Y	N	L0970	to L1290	A spinal orthosis (L0450 to L0651) is covered when it is ordered with a detailed written order for one of the following indications: 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. L0628 is not covered for Medicaid members for OB or obesity. Elastic support garments (A4466) is covered for Medicaid only. Not covered: Protective body sock (L0984)	ORTHO	Purchase

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Ankle - Foot Orthotic Orthosis: AFO, KAFO, Ankle Control Walking Boot, Pneumatic Leg Split, Pneumatice Ankle Splint	Y	Y	Y	Y	N	L1900		AFOs are covered for ambulatory patients with weakness or deformity of the foot and ankle which requires stabilization for medical reasons, and have the potential to benefit functionally. Must include a detailed written order. KAFOs are covered for ambulatory patients for whom an ankle-foot orthosis is covered and for whom additional knee stability is required. 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: 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	Purchase
Ankle - Foot Orthotic Orthosis: AFO, KAFO, Ankle Control Walking Boot, Pneumatic Leg Split, Pneumatice Ankle Splint	Y	Y	Y	Y	N	L1902		AFOs are covered for ambulatory patients with weakness or deformity of the foot and ankle which requires stabilization for medical reasons, and have the potential to benefit functionally. Must include a detailed written order. KAFOs are covered for ambulatory patients for whom an ankle-foot orthosis is covered and for whom additional knee stability is required. 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: 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	Purchase

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Ankle - Foot Orthotic Orthosis: AFO, KAFO, Ankle Control Walking Boot, Pneumatic Leg Split, Pneumatice Ankle Splint	Y	Y	Y	Y	N	L1904		AFOs are covered for ambulatory patients with weakness or deformity of the foot and ankle which requires stabilization for medical reasons, and have the potential to benefit functionally. Must include a detailed written order. KAFOs are covered for ambulatory patients for whom an ankle-foot orthosis is covered and for whom additional knee stability is required. 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: 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	Purchase
Ankle - Foot Orthotic Orthosis: AFO, KAFO, Ankle Control Walking Boot, Pneumatic Leg Split, Pneumatice Ankle Splint	Y	Y	Y	Y	N	L1906	to L1907	AFOs are covered for ambulatory patients with weakness or deformity of the foot and ankle which requires stabilization for medical reasons, and have the potential to benefit functionally. Must include a detailed written order. KAFOs are covered for ambulatory patients for whom an ankle-foot orthosis is covered and for whom additional knee stability is required. 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: 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	Purchase

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Ankle - Foot Orthotic Orthosis: AFO, KAFO, Ankle Control Walking Boot, Pneumatic Leg Split, Pneumatice Ankle Splint	Y	Y	Y	Y	N	L1910		AFOs are covered for ambulatory patients with weakness or deformity of the foot and ankle which requires stabilization for medical reasons, and have the potential to benefit functionally. Must include a detailed written order. KAFOs are covered for ambulatory patients for whom an ankle-foot orthosis is covered and for whom additional knee stability is required. 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: 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	Purchase
Ankle - Foot Orthotic Orthosis: AFO, KAFO, Ankle Control Walking Boot, Pneumatic Leg Split, Pneumatice Ankle Splint	Y	Y	Y	Y	N	L1920		AFOs are covered for ambulatory patients with weakness or deformity of the foot and ankle which requires stabilization for medical reasons, and have the potential to benefit functionally. Must include a detailed written order. KAFOs are covered for ambulatory patients for whom an ankle-foot orthosis is covered and for whom additional knee stability is required. 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: 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	Purchase

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Ankle - Foot Orthotic Orthosis: AFO, KAFO, Ankle Control Walking Boot, Pneumatic Leg Split, Pneumatice Ankle Splint	Y	Y	Y	Y	N	L1930		AFOs are covered for ambulatory patients with weakness or deformity of the foot and ankle which requires stabilization for medical reasons, and have the potential to benefit functionally. Must include a detailed written order. KAFOs are covered for ambulatory patients for whom an ankle-foot orthosis is covered and for whom additional knee stability is required. 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: 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	Purchase
Ankle - Foot Orthotic Orthosis: AFO, KAFO, Ankle Control Walking Boot, Pneumatic Leg Split, Pneumatice Ankle Splint	Y	Y	Y	Y	N	L1932		AFOs are covered for ambulatory patients with weakness or deformity of the foot and ankle which requires stabilization for medical reasons, and have the potential to benefit functionally. Must include a detailed written order. KAFOs are covered for ambulatory patients for whom an ankle-foot orthosis is covered and for whom additional knee stability is required. 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: 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	Purchase

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Ankle - Foot Orthotic Orthosis: AFO, KAFO, Ankle Control Walking Boot, Pneumatic Leg Split, Pneumatice Ankle Splint	Y	Y	Y	Y	N	L1940		AFOs are covered for ambulatory patients with weakness or deformity of the foot and ankle which requires stabilization for medical reasons, and have the potential to benefit functionally. Must include a detailed written order. KAFOs are covered for ambulatory patients for whom an ankle-foot orthosis is covered and for whom additional knee stability is required. 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: 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	Purchase
Ankle - Foot Orthotic Orthosis: AFO, KAFO, Ankle Control Walking Boot, Pneumatic Leg Split, Pneumatice Ankle Splint	Y	Y	Y	Y	N	L1945		AFOs are covered for ambulatory patients with weakness or deformity of the foot and ankle which requires stabilization for medical reasons, and have the potential to benefit functionally. Must include a detailed written order. KAFOs are covered for ambulatory patients for whom an ankle-foot orthosis is covered and for whom additional knee stability is required. 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: 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	Purchase

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Ankle - Foot Orthotic Orthosis: AFO, KAFO, Ankle Control Walking Boot, Pneumatic Leg Split, Pneumatice Ankle Splint	Y	Y	Y	Y	N	L1950	to L1951	AFOs are covered for ambulatory patients with weakness or deformity of the foot and ankle which requires stabilization for medical reasons, and have the potential to benefit functionally. Must include a detailed written order. KAFOs are covered for ambulatory patients for whom an ankle-foot orthosis is covered and for whom additional knee stability is required. 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: 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	Purchase
Ankle - Foot Orthotic Orthosis: AFO, KAFO, Ankle Control Walking Boot, Pneumatic Leg Split, Pneumatice Ankle Splint	Y	Y	Y	Y	N	L1960		AFOs are covered for ambulatory patients with weakness or deformity of the foot and ankle which requires stabilization for medical reasons, and have the potential to benefit functionally. Must include a detailed written order. KAFOs are covered for ambulatory patients for whom an ankle-foot orthosis is covered and for whom additional knee stability is required. 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: 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	Purchase

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Ankle - Foot Orthotic Orthosis: AFO, KAFO, Ankle Control Walking Boot, Pneumatic Leg Split, Pneumatice Ankle Splint	Y	Y	Y	Y	N	L1970	to L1971	AFOs are covered for ambulatory patients with weakness or deformity of the foot and ankle which requires stabilization for medical reasons, and have the potential to benefit functionally. Must include a detailed written order. KAFOs are covered for ambulatory patients for whom an ankle-foot orthosis is covered and for whom additional knee stability is required. 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: 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	Purchase
Ankle - Foot Orthotic Orthosis: AFO, KAFO, Ankle Control Walking Boot, Pneumatic Leg Split, Pneumatice Ankle Splint	Y	Y	Y	Y	N	L1980		AFOs are covered for ambulatory patients with weakness or deformity of the foot and ankle which requires stabilization for medical reasons, and have the potential to benefit functionally. Must include a detailed written order. KAFOs are covered for ambulatory patients for whom an ankle-foot orthosis is covered and for whom additional knee stability is required. 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: 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	Purchase

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Ankle - Foot Orthotic Orthosis: AFO, KAFO, Ankle Control Walking Boot, Pneumatic Leg Split, Pneumatice Ankle Splint	Y	Y	Y	Y	N	L1990		AFOs are covered for ambulatory patients with weakness or deformity of the foot and ankle which requires stabilization for medical reasons, and have the potential to benefit functionally. Must include a detailed written order. KAFOs are covered for ambulatory patients for whom an ankle-foot orthosis is covered and for whom additional knee stability is required. 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: 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	Purchase
Cervical Orthosis: Cranial Cervical Orthosis	Y	Y	Y	Y	N	L0112	to L0113	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. S1040 is an invalid code for Medicare.	ORTHO	Purchase
Cervical Orthotics: Cervical Collar (plastic/foam)/Collar Liner	Y	Y	Y	Y	N	L0120	to L0200	1 collar/collar liner allowed. Covered for Members with neck injury and other appropriate indications.	ORTHO	Purchase
Cervical, Thoracic, Lumbar, Sacral Orthotic Orthosis: CTLSO, TLSO, LO, LSO	Y	Y	Y	Y	N	L0621	to L0627	A spinal orthosis (L0450 to L0651) is covered when it is ordered with a detailed written order for one of the following indications: 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. L0628 is not covered for Medicaid members for OB or obesity. Elastic support garments (A4466) is covered for Medicaid only. Not covered: Protective body sock (L0984)	ORTHO	Purchase

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Cervical, Thoracic, Lumbar, Sacral Orthotic Orthosis: CTLSO, TLSO, LO, LSO	Y	Y	Y	Y	N/Y L0628 requires authorization for Medicaid only	L0628		A spinal orthosis (L0450 to L0651) is covered when it is ordered with a detailed written order for one of the following indications: 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. L0628 is not covered for Medicaid members for OB or obesity. Elastic support garments (A4466) is covered for Medicaid only. Not covered: Protective body sock (L0984)	ORTHO	Purchase
Cervical, Thoracic, Lumbar, Sacral Orthotic Orthosis: CTLSO, TLSO, LO, LSO	Y	Y	Y	Y	N	L0629	to L0710	A spinal orthosis (L0450 to L0651) is covered when it is ordered with a detailed written order for one of the following indications: 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. L0628 is not covered for Medicaid members for OB or obesity. Elastic support garments (A4466) is covered for Medicaid only. Not covered: Protective body sock (L0984)	ORTHO	Purchase

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Diabetic Shoes, Fitting and Modifications Diabetic Shoes Diabetic Inserts	Y	Y	Y	Y	N	A5503	to A5508	For “Orthopedic Footwear”, refer to L3000 – L3649. A5508 – A5510 are non-covered Preauthorization is NOT required when devices billed with codes A5500 – A5507, A5512, or 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. Therapeutic shoes, inserts and/or modifications are covered if the following criteria are met: 1. The patient has diabetes mellitus; and 2. The patient has one or more of the following conditions: 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. Coverage is limited to one of the following within one calendar year (January – December): a. One pair of custom molded shoes and 2 additional pairs of inserts; or b. One pair of depth shoes and 3 pairs of inserts. Quantities of shoes and/or inserts greater than those listed above will be denied as non-covered.	ORTHO	Purchase

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Diabetic Shoes, Fitting and Modifications Diabetic Shoes Diabetic Inserts	Y	Y	Y	Y	N	A5510		For "Orthopedic Footwear", refer to L3000 – L3649. A5508 – A5510 are non-covered Preauthorization is NOT required when devices billed with codes A5500 – A5507, A5512, or 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. Therapeutic shoes, inserts and/or modifications are covered if the following criteria are met: 1. The patient has diabetes mellitus; and 2. The patient has one or more of the following conditions: 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. Coverage is limited to one of the following within one calendar year (January – December): a. One pair of custom molded shoes and 2 additional pairs of inserts; or b. One pair of depth shoes and 3 pairs of inserts. Quantities of shoes and/or inserts greater than those listed above will be denied as non-covered.	ORTHO	Purchase

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Diabetic Shoes, Fitting and Modifications Diabetic Shoes Diabetic Inserts	Y	Y	Y	Y	N	A5514		For "Orthopedic Footwear", refer to L3000 – L3649. A5508 – A5510 are non-covered Preauthorization is NOT required when devices billed with codes A5500 – A5507, A5512, or 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. Therapeutic shoes, inserts and/or modifications are covered if the following criteria are met: 1. The patient has diabetes mellitus; and 2. The patient has one or more of the following conditions: 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. Coverage is limited to one of the following within one calendar year (January – December): a. One pair of custom molded shoes and 2 additional pairs of inserts; or b. One pair of depth shoes and 3 pairs of inserts. Quantities of shoes and/or inserts greater than those listed above will be denied as non-covered.	ORTHO	Purchase
Halo Procedure Orthosis: Halo Procedures	Y	Y	Y	Y	N	L0810	to L0861	Covered when medically indicated by the requesting physician.	ORTHO	Purchase
Hip Orthotic (HO) Flexible Orthosis: HO	Y	Y	Y	Y	N	L1600	to L1755	Other post-operative and post-injury braces are considered medically necessary when applied within six weeks of surgery or injury. Specialized hip braces are considered medically necessary for children with hip disorders to stabilize the hip and/or to correct and maintain hip abduction.	ORTHO	Purchase

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Knee Orthotic Orthosis: KO	Y	Y	Y	Y	N	L1810	to L1860	Other items are covered when medically indicated by the requesting physician. Must include a detailed written order.	ORTHO	Purchase
Knee, Ankle, Foot Orthotic Orthosis: AFO, KAFO, Ankle Control Walking Boot, Pneumatic Leg Split, Pneumatice Ankle Splint	Y	Y	Y	Y	N	L2000		AFOs are covered for ambulatory patients with weakness or deformity of the foot and ankle which requires stabilization for medical reasons, and have the potential to benefit functionally. Must include a detailed written order. KAFOs are covered for ambulatory patients for whom an ankle-foot orthosis is covered and for whom additional knee stability is required. 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: 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	Purchase
Knee, Ankle, Foot Orthotic Orthosis: AFO, KAFO, Ankle Control Walking Boot, Pneumatic Leg Split, Pneumatice Ankle Splint	Y	Y	Y	Y	N	L2005		AFOs are covered for ambulatory patients with weakness or deformity of the foot and ankle which requires stabilization for medical reasons, and have the potential to benefit functionally. Must include a detailed written order. KAFOs are covered for ambulatory patients for whom an ankle-foot orthosis is covered and for whom additional knee stability is required. 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: 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	Purchase

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Knee, Ankle, Foot Orthotic Orthosis: AFO, KAFO, Ankle Control Walking Boot, Pneumatic Leg Split, Pneumatice Ankle Splint	Y	Y	Y	Y	N	L2034	to L2038	AFOs are covered for ambulatory patients with weakness or deformity of the foot and ankle which requires stabilization for medical reasons, and have the potential to benefit functionally. Must include a detailed written order. KAFOs are covered for ambulatory patients for whom an ankle-foot orthosis is covered and for whom additional knee stability is required. 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: 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	Purchase
Miscellaneous Lower Limb Supports Orthosis: Foot Drop Splint/Recumbent	N	N	Y	N	N	L4394		A foot drop splint/recumbent positioning device (L4398) or replacement interface (L4394) is not covered.	ORTHO	Purchase - MD only
Miscellaneous Lower Limb Supports Orthosis: Foot Drop Splint/Recumbent	N	N	Y	N	N	L4398		A foot drop splint/recumbent positioning device (L4398) or replacement interface (L4394) is not covered.	ORTHO	Purchase - MD only
Miscellaneous Lower Limb Supports Orthosis: Static Ankle Foot Orthosis Soft Interface Material	Y	Y	Y	Y	N	L4392		A static AFO (L4396, L4397) is covered if either all of criteria 1 to 4 or criterion 5 is met: 1. Plantar flexion contracture of the ankle with dorsiflexion on passive range of motion testing of at least 10 degrees (i.e., a non-fixed 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, this includes: active stretching of the involved muscles and/or tendons. 5. The patient has plantar fasciitis; 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.	ORTHO	Purchase

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Miscellaneous Lower Limb Supports Orthosis: Static Ankle Foot Orthosis Soft Interface Material	Y	Y	Y	Y	N	L4396	to L4397	A static AFO (L4396, L4397) is covered if either all of criteria 1 to 4 or criterion 5 is met: 1. Plantar flexion contracture of the ankle with dorsiflexion on passive range of motion testing of at least 10 degrees (i.e., a non-fixed 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, this includes: active stretching of the involved muscles and/or tendons. 5. The patient has plantar fasciitis; 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.	ORTHO	Purchase
Miscellaneous Lower Limb Supports Orthosis: AFO, KAFO, Ankle Control Walking Boot, Pneumatic Leg Split, Pneumatice Ankle Splint	Y	Y	Y	Y	N	L4350		AFOs are covered for ambulatory patients with weakness or deformity of the foot and ankle which requires stabilization for medical reasons, and have the potential to benefit functionally. Must include a detailed written order. KAFOs are covered for ambulatory patients for whom an ankle-foot orthosis is covered and for whom additional knee stability is required. 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: 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	Purchase

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Miscellaneous Lower Limb Supports Orthosis: AFO, KAFO, Ankle Control Walking Boot, Pneumatic Leg Split, Pneumatice Ankle Splint	Y	Y	Y	Y	N	L4360	to L4361	AFOs are covered for ambulatory patients with weakness or deformity of the foot and ankle which requires stabilization for medical reasons, and have the potential to benefit functionally. Must include a detailed written order. KAFOs are covered for ambulatory patients for whom an ankle-foot orthosis is covered and for whom additional knee stability is required. 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: 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	Purchase
Miscellaneous Lower Limb Supports Orthosis: AFO, KAFO, Ankle Control Walking Boot, Pneumatic Leg Split, Pneumatice Ankle Splint	Y	Y	Y	Y	N	L4370		AFOs are covered for ambulatory patients with weakness or deformity of the foot and ankle which requires stabilization for medical reasons, and have the potential to benefit functionally. Must include a detailed written order. KAFOs are covered for ambulatory patients for whom an ankle-foot orthosis is covered and for whom additional knee stability is required. 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: 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	Purchase

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Miscellaneous Lower Limb Supports Orthosis: AFO, KAFO, Ankle Control Walking Boot, Pneumatic Leg Split, Pneumatice Ankle Splint	Y	Y	Y	Y	N	L4386		AFOs are covered for ambulatory patients with weakness or deformity of the foot and ankle which requires stabilization for medical reasons, and have the potential to benefit functionally. Must include a detailed written order. KAFOs are covered for ambulatory patients for whom an ankle-foot orthosis is covered and for whom additional knee stability is required. 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: 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	Purchase
Miscellaneous Lower Limb Supports Orthosis: AFO, KAFO, Ankle Control Walking Boot, Pneumatic Leg Split, Pneumatice Ankle Splint	Y	Y	Y	Y	N	L4631		AFOs are covered for ambulatory patients with weakness or deformity of the foot and ankle which requires stabilization for medical reasons, and have the potential to benefit functionally. Must include a detailed written order. KAFOs are covered for ambulatory patients for whom an ankle-foot orthosis is covered and for whom additional knee stability is required. 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: 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	Purchase
Miscellaneous Supplies Compression Garments (not used with pump. i.e. Circaids, Ready-Fit)	N	N	Y	N	N Except forcode L2999	L2999		Non-covered for all indications because it does not meet the definition of a surgical dressing. Code L2999 should only be used if a more specific code is not available. Preauthorization is required when L2999 is used.	DME	Purchase

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Orthopedic Footwear - Inserts (Do not report as device to treat diabetes. Refer to section Diabetic Shoes & Inserts - A5500 through A5513) Orthopedic Footwear: Refer to section "Diabetes Shoes and Inserts" on page 8 for DIABETIC footwear HCPC codes.	Y	Y	Y	Y	Y	L3000	to L3170	Medicare, Commercial & CHP + members A9283, L3215 to L3222, L3251 to L3257, L3265, and L3649 are non-covered. L3250 is covered only for a diagnosis; Transverse Deficiency of Lower Limb, Longitudinal Deficiency, Tarsals Or Metatarsals, Complete Or Partial, Longitudinal Deficiency, Phalanges, Complete Or Partial, Traumatic Amputation of Toe(S) (Complete) (Partial), Traumatic Amputation of Foot (Complete) (Partial), Bilateral. Shoes, inserts and modifications are covered if they are an integral part of a covered leg brace described by codes L1900, L1920, L1980 to L2030, L2050, L2060, L2080 or L2090 and if they are medically necessary for the proper functioning of the brace. This includes: □ Oxford shoes (L3224, L3225) □ Other shoes, e.g. high top, depth inlay or custom for non to diabetics, etc. (L3649KX), □ Heel replacements (L3455, L3460), sole replacements (L3530, L3540), and shoe transfers (L3600 to L3640) involving shoes on a covered brace □ Inserts and other shoe modifications (L3000 to L3170, L3300 to L3450, L3465 to 3520, and L3550 to L3595) A matching shoe which is NOT attached to a brace and items related to that shoe MUST NOT be billed with modifier KX and will be denied as non-covered. Shoes are denied as not covered when they are put on over a partial foot prosthesis or other lower extremity prosthesis (L5010 to L5600) which is attached to the residual limb by other mechanisms. Except as described above, orthopedic footwear billed using codes L3000 to L3649 will be denied as not covered. Coverage is limited to one of the following within one calendar year (January – December): 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. Quantities of shoes and/or inserts greater than those listed above will be denied as not covered. Medicaid Members only: orthotic inserts/modifications are not denied on the basis of age or whether or not the client has a brace.	ORTHO	Purchase

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Orthopedic Shoes and Boots (Do not report as device to treat diabetes. Refer to section Diabetic Shoes & Inserts - A5500 through A5513) Orthopedic Footwear: Refer to section "Diabetes Shoes and Inserts" on page 8 for DIABETIC footwear HCPC codes.	Y	Y	Y	Y	Y	L3215	to L3649	Medicare, Commercial & CHP + members A9283, L3215 to L3222, L3251 to L3257, L3265, and L3649 are non-covered. L3250 is covered only for a diagnosis; Transverse Deficiency of Lower Limb, Longitudinal Deficiency, Tarsals Or Metatarsals, Complete Or Partial, Longitudinal Deficiency, Phalanges, Complete Or Partial, Traumatic Amputation of Toe(S) (Complete) (Partial), Traumatic Amputation of Foot (Complete) (Partial), Bilateral. Shoes, inserts and modifications are covered if they are an integral part of a covered leg brace described by codes L1900, L1920, L1980 to L2030, L2050, L2060, L2080 or L2090 and if they are medically necessary for the proper functioning of the brace. This includes: □ Oxford shoes (L3224, L3225) □ Other shoes, e.g. high top, depth inlay or custom for non to diabetics, etc. (L3649KX), □ Heel replacements (L3455, L3460), sole replacements (L3530, L3540), and shoe transfers (L3600 to L3640) involving shoes on a covered brace □ Inserts and other shoe modifications (L3000 to L3170, L3300 to L3450, L3465 to 3520, and L3550 to L3595) A matching shoe which is NOT attached to a brace and items related to that shoe MUST NOT be billed with modifier KX and will be denied as non-covered. Shoes are denied as not covered when they are put on over a partial foot prosthesis or other lower extremity prosthesis (L5010 to L5600) which is attached to the residual limb by other mechanisms. Except as described above, orthopedic footwear billed using codes L3000 to L3649 will be denied as not covered. Coverage is limited to one of the following within one calendar year (January – December): 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. Quantities of shoes and/or inserts greater than those listed above will be denied as not covered. Medicaid Members only: orthotic inserts/modifications are not denied on the basis of age or whether or not the client has a brace.	ORTHO	Purchase
Orthopedic Shoes and Boots Orthopedic Footwear (Surgical Boot/Benesch Boot)	N	Y	Y	Y	N	L3201	to L3214	Covered when medically indicated by the requesting physician.	ORTHO	Purchase

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Orthotic Repairs Orthotics: Repairs for Orthotic Devices	Y	Y	Y	Y	Y	L4000	to L4210	An estimate of the cost (supplies and labor) and what is being repaired will be required. Repairs will be approved only when the orthotic device meets the coverage guideline for the purchase of Orthotic Footwear.	ORTHO	Purchase
Other Scoliosis Procedures Orthosis: Other Scoliosis Procedures	Y	Y	Y	Y	N	L1300	to L1310	Considered medically necessary in the treatment of congenital defects. 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.	ORTHO	Purchase
Other Scoliosis Procedures Orthosis: Other Scoliosis Procedures	Y	Y	Y	Y	Y	L1499		Considered medically necessary in the treatment of congenital defects. 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.	ORTHO	Purchase
Shoulder Orthotic Orthotics: Upper Limb Fracture Orthosis	Y	Y	Y	Y	N	L3650	to L4398	Other items are covered when medically indicated by the requesting physician. L3891 is covered for MD only.	ORTHO	Purchase
Thoracic Orthosis: Thoracic Rib Belt	N	N	Y	N	N	L0220		Purchase for MD Only - Pre-Auth not required	ORTHO	Purchase - MD only
Thoracic Orthosis: CTLSO, TLSO, LO, LSO	Y	Y	Y	Y	N	L0430	to L0492	A spinal orthosis (L0450 to L0651) is covered when it is ordered with a detailed written order for one of the following indications: 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. L0628 is not covered for Medicaid members for OB or obesity. Elastic support garments (A4466) is covered for Medicaid only. Not covered: Protective body sock (L0984)	ORTHO	Purchase

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Torsion Control: Hip, Knee, Ankle, Foot Orthotic (HKAFO) Orthosis: THKAO HKFAO	Y	Y	Y	Y	N	L2040	to L2090	Covered when medically indicated by the requesting physician.	ORTHO	Purchase
Torsion Control: Hip, Knee, Ankle, Foot Orthotic (HKAFO) Orthosis: AFO, KAFO, Ankle Control Walking Boot, Pneumatic Leg Split, Pneumatice Ankle Splint	Y	Y	Y	Y	N	L2010		AFOs are covered for ambulatory patients with weakness or deformity of the foot and ankle which requires stabilization for medical reasons, and have the potential to benefit functionally. Must include a detailed written order. KAFOs are covered for ambulatory patients for whom an ankle-foot orthosis is covered and for whom additional knee stability is required. 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: 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	Purchase
Torsion Control: Hip, Knee, Ankle, Foot Orthotic (HKAFO) Orthosis: AFO, KAFO, Ankle Control Walking Boot, Pneumatic Leg Split, Pneumatice Ankle Splint	Y	Y	Y	Y	N	L2020		AFOs are covered for ambulatory patients with weakness or deformity of the foot and ankle which requires stabilization for medical reasons, and have the potential to benefit functionally. Must include a detailed written order. KAFOs are covered for ambulatory patients for whom an ankle-foot orthosis is covered and for whom additional knee stability is required. 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: 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	Purchase

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Torsion Control: Hip, Knee, Ankle, Foot Orthotic (HKAFO) Orthosis: AFO, KAFO, Ankle Control Walking Boot, Pneumatic Leg Split, Pneumatice Ankle Splint	Y	Y	Y	Y	N	L2030		AFOs are covered for ambulatory patients with weakness or deformity of the foot and ankle which requires stabilization for medical reasons, and have the potential to benefit functionally. Must include a detailed written order. KAFOs are covered for ambulatory patients for whom an ankle-foot orthosis is covered and for whom additional knee stability is required. 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: 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	Purchase
Torsion Control: Hip, Knee, Ankle, Foot Orthotic (HKAFO) Orthosis: AFO, KAFO, Ankle Control Walking Boot, Pneumatic Leg Split, Pneumatice Ankle Splint	Y	Y	Y	Y	N	L2040	to L2116	AFOs are covered for ambulatory patients with weakness or deformity of the foot and ankle which requires stabilization for medical reasons, and have the potential to benefit functionally. Must include a detailed written order. KAFOs are covered for ambulatory patients for whom an ankle-foot orthosis is covered and for whom additional knee stability is required. 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: 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	Purchase

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Torsion Control: Hip, Knee, Ankle, Foot Orthotic (HKAFO) Orthosis: AFO, KAFO, Ankle Control Walking Boot, Pneumatic Leg Split, Pneumatice Ankle Splint	Y	Y	Y	Y	N	L2126	to L2136	AFOs are covered for ambulatory patients with weakness or deformity of the foot and ankle which requires stabilization for medical reasons, and have the potential to benefit functionally. Must include a detailed written order. KAFOs are covered for ambulatory patients for whom an ankle-foot orthosis is covered and for whom additional knee stability is required. 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: 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	Purchase
Miscellaneous Services Protime/Coagucheck/ INR Monitors	Y	Y	N	Y	Y	G0248	to G2050	Coverage Guidelines apply. Clinical review. Protime Monitor/Coagucheck Monitor/International Normalized Ratio (INR) Monitor. G0248, G0249, and G0250 are not a benefit for Medicaid. Purchase of the monitor using E1399 is covered for Commercial Members only. An invoice of the cost of equipment is required	DME	Purchase applies to E1399 only

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Breast Prosthesis Prosthesis: Breast (External) Mastectomy Bras	Y	Y	Y	Y	N	L8000	to L8002	A breast prosthesis is covered for a patient who has had a mastectomy, diagnosis: Personal History of Malignant Neoplasm of Breast, Acquired absence of breast and nipple, Malignant Neoplasm of Nipple and Areola of Female Breast, Malignant Neoplasm of Breast (Female), Unspecified, Secondary Malignant Neoplasm of Breast, Carcinoma in Situ of Breast, Postmastectomy Lymphedema Syndrome. L8000 to L8002 are allowed 4 per calendar year. An external breast prosthesis garment, with mastectomy form (L8015) is covered for use in the postoperative period prior to permanent breast prosthesis or as an alternative to mastectomy bra and breast prosthesis. The additional features of a custom fabricated prosthesis (L8035), compared to prefabricated silicone breast prosthesis, are not medically necessary. An external breast prosthesis of the same type can be replaced at any time if it is lost or irreparably damaged (does not include normal wear and tear). External breast prosthesis of a different type can be covered at any time if there is a change in the member's medical condition. 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. S8420 - S8428 are non-covered.	ORTHO	Purchase

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Breast Prosthesis Prosthesis: Breast (External) Mastectomy Bras	Y	Y	Y	Y	N	L8010		A breast prosthesis is covered for a patient who has had a mastectomy, diagnosis: Personal History of Malignant Neoplasm of Breast, Acquired absence of breast and nipple, Malignant Neoplasm of Nipple and Areola of Female Breast, Malignant Neoplasm of Breast (Female), Unspecified, Secondary Malignant Neoplasm of Breast, Carcinoma in Situ of Breast, Postmastectomy Lymphedema Syndrome. L8000 to L8002 are allowed 4 per calendar year. An external breast prosthesis garment, with mastectomy form (L8015) is covered for use in the postoperative period prior to permanent breast prosthesis or as an alternative to mastectomy bra and breast prosthesis. The additional features of a custom fabricated prosthesis (L8035), compared to prefabricated silicone breast prosthesis, are not medically necessary. An external breast prosthesis of the same type can be replaced at any time if it is lost or irreparably damaged (does not include normal wear and tear). External breast prosthesis of a different type can be covered at any time if there is a change in the member's medical condition. 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. S8420 - S8428 are non-covered.	ORTHO	Purchase

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Breast Prosthesis Prosthesis: Breast (External) Mastectomy Bras	Y	Y	Y	Y	N	L8015	to L8039	A breast prosthesis is covered for a patient who has had a mastectomy, diagnosis: Personal History of Malignant Neoplasm of Breast, Acquired absence of breast and nipple, Malignant Neoplasm of Nipple and Areola of Female Breast, Malignant Neoplasm of Breast (Female), Unspecified, Secondary Malignant Neoplasm of Breast, Carcinoma in Situ of Breast, Postmastectomy Lymphedema Syndrome. L8000 to L8002 are allowed 4 per calendar year. An external breast prosthesis garment, with mastectomy form (L8015) is covered for use in the postoperative period prior to permanent breast prosthesis or as an alternative to mastectomy bra and breast prosthesis. The additional features of a custom fabricated prosthesis (L8035), compared to prefabricated silicone breast prosthesis, are not medically necessary. An external breast prosthesis of the same type can be replaced at any time if it is lost or irreparably damaged (does not include normal wear and tear). External breast prosthesis of a different type can be covered at any time if there is a change in the member's medical condition. 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. S8420 - S8428 are non-covered.	ORTHO	Purchase
External Power Prosthetic: External Power	Y	Y	Y	Y	Y	L6920	to L7499	Coverage Guideline Applies. Clinical review. RMHP Coverage Guideline - Prosthetic	ORTHO	Purchase
Eye and Ear Implants and Accessories Prosthetic: Cochlear Device Batteries	Y	Y	N	Y	Y	L8614	to L8629	Coverage Guideline Applies for Commercial, CHP+ and RMHP Medicare Members ONLY. Clinical review. RMHP Coverage Guideline - Prosthetic (Covered as a wrap around service. Submit to Colorado State Medicaid) Not a benefit of any Commercial Plan	ORTHO	Purchase
Face and Ear Prosthesis Prosthesis: Face	Y	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	Purchase

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Hearing Aids, Services, and Accessories Prosthetic: Auditory Osteointegrated device	Y	N	N	Y	Y	L8690	to L8694	Coverage Guideline Applies. RMHP Coverage Guideline – Prosthetic (Covered as a wrap around service. Submit to Colorado State Medicaid) Not a benefit of any Commercial Plan	DME	Purchase
Larynx and Trachea Prosthetics and Accessories Prosthetic Implants: Artificial Larynx Tracheostomy Speaking Valve Implantable neurostimulator, pulse generator, any type	Y	Y	Y	Y	Y	L8500	to L8515	Coverage Guideline Applies. Clinical review. RMHP Coverage Guideline - Prosthetic	ORTHO	Purchase
Neurostimulator and Accessories Prosthetic Implants: Artificial Larynx Tracheostomy Speaking Valve Implantable neurostimulator, pulse generator, any type	Y	Y	Y	Y	Y	L8679		Coverage Guideline Applies. Clinical review. RMHP Coverage Guideline - Prosthetic	ORTHO	Purchase
Partial Foot Prosthetic: Lower Limb	Y	Y	Y	Y	Y	L5000	to L5999	Coverage Guideline Applies. Clinical review. RMHP Coverage Guideline - Prosthetic	ORTHO	Purchase
Partial Hand Prosthetic: Upper Limb	Y	Y	Y	Y	Y	L6000	to L6915	Coverage Guideline Applies. Clinical review. RMHP Coverage Guideline - Prosthetic	ORTHO	Purchase
Prosthesis Penile Prosthesis: Penile (External) Manual only	N	N	N	N	N/A	L7900			NAB	N/A
Prosthesis Penile Prosthesis: •Penile (External) Manual only	N	N	N	N	N/A	L7900			NAB	N/A

Rocky Mountain Health Plans DME Preauthorization Schedule

Effective September 16, 2020

Coverage of all items is based on Benefits and Medical Necessity

Items	Covered Plan Types				Auth Needed	HCPCS Code		Coverage Guidelines	Benefit	Rental vs Purchase
	MC	CM	MD	CHP+		From	To	Colorado State Medicaid guidelines apply to Medicaid Members		
Prosthetic Eye Prosthesis: Lense, intraocular (telescopic)	Y	Y	N	Y	Y	C1840		NAB for Prime. Policy does apply with multiple limitations for all other health plans.	DME	Purchase
Prosthetic Socks - Excluding Fracture Socks Prosthetics: Socks Excluding "Fracture Socks"	Y	Y	Y	Y	N Yes for code L8499, Unlisted Procedure	L8400	to L8499	Rx, LMN and an invoice of the cost of equipment is required. MD Review	ORTHO	Purchase
Repairs Prosthesis: Repairs for Prosthetic Devices	Y	Y	Y	Y	Y	L7510	to L7520	An estimate of the cost (supplies and labor) and what is being repaired will be required.	ORTHO	Purchase
Trusses Prosthetic: Truss	Y	Y	Y	Y	N	L8300	to L8330	Covered when medically indicated by the requesting physician.	ORTHO	Purchase
Equipment, Replacement, Repair, Rental Automatic External Defibrillator and components	Y	Y	Y	Y	Y	K0606	to K0609	Coverage Guideline Applies. Clinical review. RMHP Coverage Guideline – Wearable Defibrillator Vest	DME	Rental or Purchase
Equipment, Replacement, Repair, Rental DME Labor (repair)	Y	Y	Y	Y	Y	K0739	to K0740	Repair or non-routine service for durable medical equipment other than oxygen (K0739) requiring the skill of a technician, labor component, per 15 minutes. Repair or non-routine service for oxygen equipment (K0740) requiring the skill of a technician, labor component, per 15 minutes. An Rx will be required along with a statement of what is being repaired. An estimate of the cost (supplies and labor) is required. Code E1340 is no longer valid for repairs for dates of services on or after April 1, 2009 for Medicare, August 1, 2009 for Medicaid. Routine periodic maintenance or servicing, such as testing, cleaning, regulating, and checking of the Member's equipment is not covered.		N/A

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	MC	CM	MD	CHP+		From	To	Colorado State Medicaid guidelines apply to Medicaid Members		
Equipment, Replacement, Repair, Rental Infusion Pumps	Y	Y	Y	Y	N	K0455		Covered when Member meets Medicare guidelines. http://www.cgsmedicare.com/jc/coverage/lcdinfo.html	DME	Rental or Purchase depending on the pump
Equipment, Replacement, Repair, Rental Oxygen Contents	N	N	Y	N	Y	K0742		Coverage Guideline Applies - covered when Member meets guidelines for oxygen. Oxygen contents are not separately payable when included in payment for equipment rental.	OX	Purchase
Equipment, Replacement, Repair, Rental Oxygen: Concentrator Gaseous Portable Stationary Liquid Portable Vapor Enriching System Contents	Y	Y	Y	Y	Y	K0738		Coverage Guideline Applies. Emergency or stand-by oxygen systems will be denied as not medically necessary since they are precautionary and not therapeutic in nature. RMHP covers rental of oxygen equipment. Purchase of equipment is not covered.	OX	12 or 24 month rental only
Equipment, Replacement, Repair, Rental Therapeutic Continuous Glucose Monitor (CGM)	Y	Y	Y	Y	Y	K0553	to K0554	Coverage Guideline Applies. Clinical Review. NOTE: Therapeutic CGM is differentiated from Standard CGM. For A9276, A9277, A9278 refer to section titled, Standard Continuous Glucose Monitor and Sensors. Requests will be reviewed for Medical Necessity.	DME	Purchase
Equipment, Replacement, Repair, Rental Wheelchair Accessories	Y	Y	Y	Y	Y	K0669		Coverage Guideline Applies. Wheelchair Accessories (E2331) is not a covered benefit of Medicaid.	DME	2 months rental then convert to purchase - or may purchase without renting
Power Operated Vehicle and Accessories Power Operated Vehicles	Y	Y	Y	Y	Y	K0800	to K0808	Coverage Guideline Applies. Power Operated Vehicle	DME	2 months rental then convert to Purchase
Power Operated Vehicle and Accessories Power Operated Vehicles	Y	Y	Y	Y	Y	K0812		Coverage Guideline Applies. Power Operated Vehicle	DME	2 months rental then convert to Purchase

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	MC	CM	MD	CHP+		From	To	Colorado State Medicaid guidelines apply to Medicaid Members		
Power Wheelchairs Power Operated Vehicles	Y	Y	Y	Y	Y	K0899		Coverage Guideline Applies. Power Operated Vehicle	DME	2 months rental then convert to Purchase
Power Wheelchairs Power Wheelchair Base	Y	Y	Y	Y	Y	K0813	to K0891	Coverage Guideline Applies. Wheelchair Accessories	DME	2 months rental then convert to Purchase
Power Wheelchairs Power Wheelchair Base	Y	Y	Y	Y	Y	K0898		Coverage Guideline Applies. Wheelchair Accessories	DME	2 months rental then convert to Purchase
Wheelchairs 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	Y	K0001	to K0009	Coverage Guideline Applies. Manual Wheelchair	DME	2 months rental then convert to Purchase
Wheelchairs And Accessories Power Wheelchair Base	Y	Y	Y	Y	Y	K0010	to K0014	Coverage Guideline Applies. Wheelchair Accessories	DME	2 months rental then convert to Purchase
Wheelchairs And Accessories Wheelchair Accessories	Y	Y	Y	Y	Y	K0015	to K0108	Coverage Guideline Applies. Wheelchair Accessories (E2331) is not a covered benefit of Medicaid.	DME	2 months rental then convert to purchase - or may purchase without renting

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Items	Covered Plan Types				Auth Needed	HCPCS Code		Coverage Guidelines	Benefit	Rental vs Purchase
	MC	CM	MD	CHP+		From	To	Colorado State Medicaid guidelines apply to Medicaid Members		
Wheelchairs And Accessories Wheelchair Accessories	Y	Y	Y	Y	Y	K0195		Coverage Guideline Applies. Wheelchair Accessories (E2331) is not a covered benefit of Medicaid.	DME	2 months rental then convert to purchase - or may purchase without renting
Cranial Remolding Orthotic (Not Valid for Medicare) Orthosis: Cranial Cervical Orthosis	Y	Y	Y	Y	N	S1040		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. S1040 is an invalid code for Medicare.	ORTHO	Purchase
Glucose Monitoring Device (Not Valid for Medicare) Continuous noninvasive glucose monitoring device	N	Y	N	Y	Y	S1030	to S1031	Coverage Guideline Applies. Clinical Review. RMHP Coverage Guideline "Continuous Glucose Monitor-Sensors (CGM)" Standard CGM (A9276, A9277, A9278) is not a benefit for Medicare members or Medicaid (RAE / Prime) members over age 20	DME	Rental or Purchase
Prosthetic Eye Prosthesis: Ocular (Eyeball)	Y	Y	Y	Y	N	V2623	to V2629	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. This information must be available upon request.	ORTHO	Purchase