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Rocky Mountain Health Plans
Legend for Durable Medical Equipment Preauthorization Schedule

Submit requests to RMHP

Participating Providers access|RMHP Provider Portal

fax 877-201-7302 or 970-254-5738

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		
CHP+ = Children's Health Plan Plus		

STANDARD ABBREVIATIONS

ICU	=	Intensive Care Unit
LMN	=	Letter of Medical Necessity
NAB	=	Not a Benefit
CMN	=	Certificate of Medical Necessity
PCP	=	Primary Care Physician
RX	=	Prescription

BENEFIT KEY

DISP	Disposable Benefit
DME	Durable Medical Equipment Benefit
ORTHO	Orthotic/Prosthetic/Bracing Benefit
OX	Oxygen 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.**

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.

Rocky Mountain Health Plans
DME Preauthorization Schedule

Effective October 1, 2015 w code revision 1/1/2016

Coverage of all items is based on Benefits and Medical Necessity.

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Items	Covered Plan Types				AUTH Needed	HCPCS Codes	COVERAGE GUIDELINES Colorado State Medicaid guidelines apply to Medicaid Members	Benefit	Rental vs Purchase
	MC	*CM*	*MD*	*CHP+*					
• Cane/Quad • Cane/Straight (Adjustable)	Y	Y	Y	Y	N	E0100 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
Crutches: • Underarm • Forearm, F/A • Handgrip replacement • Tip replacement • Underarm pad replacement • Platform attachment; forearm crutch, each	Y	Y	Y	Y	N	E0110 to E0117 A4635 A4636 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
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	Purchase
Walker/Crutch Attachments	Y	Y	Y	Y	N	A4635 to A4637 E0153 to E0159	Leg extensions are covered only for patients 6 feet tall or more. An enhancement accessory is one which does not contribute significantly to the therapeutic function of the walker. It may include, but is not limited to style, color, hand operated brakes or basket (or equivalent).	DME	Purchase

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	MC	*CM*	*MD*	*CHP+*					
Walkers: • Folding/Pickup • Standard • Heavy Duty • Four Sided Frame • Trunk Support	Y	Y	Y	Y	N	E0130 E0135 E0140 E0141 E0143 E0144 E0147 E0148 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
Bath Bench (shower chair, shower seat, shower bench, or tub stool)	N	N	Y	N	N	E0245 E0247 E0248	Considered convenience items.	DME	Purchase (MD only)
Bath Tub /Toilet Lift	N	N	Y	N	N	E0625	Considered convenience items.	DME	Purchase MD only
Bidet Toilet Seats	N	N	N	N	N	A9270	Not primarily medical in nature.	NAB	N/A
Commodes: • Assist • Drop Arm • Heavy Duty/Extra Wide Pail/Pan	Y	Y	Y	Y	N	E0163, E0165 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

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Commodes: • Footrest • Seat Lift Mechanism placed on or over a toilet	N	N	N	N	N	E0172 E0175	A footrest is not covered. A seat lift mechanism placed over or on top of a toilet is not covered.	NAB	N/A
Commode Chair with Seat Lift Mechanism	N	N	Y	N	Y	E0170 E0171	Rx and LMN will be required. Covered if the patient has medical necessity for a commode and meets the coverage criteria for a seat lift mechanism. However, a commode with seat lift mechanism is intended to allow the patient to walk after standing. If the patient can ambulate, he/she would rarely meet the coverage criterion for a commode.	DME	Purchase
Grab Bars/Rails for Bath/Shower/Stool/ Toilet	N	N	Y	N	N	E0241 E0242 E0243 E0246	Considered convenience items. Installation charges are not a benefit.	DME	Purchase MD only
Paraffin Bath Unit (Portable) Paraffin/Pound	Y	Y	Y	Y	Y	E0235 A4265	Covered when the patient has undergone a successful trial period of Paraffin therapy ordered by a physician and the patient's condition is expected to be relieved by long term use of this modality.	DME	2 months rental then convert to purchase
Paraffin Bath Units (standard) non-portable	N	N	N	N	N	A9270	Not a benefit of any plan.	NAB	N/A
Sitz Bath	Y	Y	Y	Y	N	E0160 E0161 E0162	Covered when the medical record indicates that the patient has an infection or injury of the perineal area and is prescribed by the physician.	DME	Rental only
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

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Raised Toilet Seat	N	N	Y	N	N	E0244	Considered a convenience item.	DME	Purchase MD only
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
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 E0181 to E0182 E0184 to E0189 E0193 to E0199 E0277 E0370 to E0373	Coverage Guideline Applies. RMHP Coverage Guideline: “Pressure Reducing Support Surfaces”	DME	2 to 6 months rental then convert to purchase may purchase without renting
Hospital Bed Accessory: • Bed Board • Over-Bed Table • Board, Table or Support Device	N	N	Y	N	N	E0273 E0274 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

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	MC	*CM*	*MD*	*CHP+*					
Hospital Beds: • Fixed Height • Variable Height • Semi-Electric • Heavy Duty • Extra Heavy Duty	Y	Y	Y	Y	Y	E0250 to E0251 E0255 to E0256 E0260 to E0261 E0290 to E0297 E0300 to E0304 E0328 to E0329	Coverage Guideline Applies. RMHP Coverage Guideline: "Hospital Beds"	DME	2 to 6 months rental then convert to purchase or may purchase without renting
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"	DME	2 to 6 months rental then convert to purchase or may purchase without renting
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 E0280 E0305 E0310 E0316 E0325 E0326 E0350 E0352 E0910 to E0912 E0940	A bed cradle is covered when it is necessary to prevent contact with the bed coverings. Side Rails and Safety enclosures are covered when they are required by the patient's condition 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+*					
Mattress: • Geomat • Sheepskin • Inner Spring • Foam Rubber • Synthetic Sheepskin • Dry Pressure • Mattress Overlay	Y	Y	Y	Y	Y	E0184 to E0189 E0196 to E0199 E0271 to E0272 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
Airjet Injector (Needle free injection device)	N	N	N	N	N	A4210	Considered a convenience item.	NAB	N/A
Batteries for Glucometers	Y	Y	Y	Y	N	A4233 to A4236	Covered when the Member has a glucometer.	DME	Purchase
Diabetic Disposable Supplies	Y	Y	Y	Y	N	A4206 to A4213 A4215 to A4218 A4220 to A4223 A4230 to A4232 A4244 to A4248 A4250, A4252 A4253 A4255– 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

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	MC	*CM*	*MD*	*CHP+*					
Glucometers: • Standard • Voice Activated	Y	Y	Y	Y	N	E0607 E2100 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
Continuous Glucose Monitor – Sensors	N	Y	N	Y	Y	A9276 A9277-A9278	Coverage Guideline Applies. Clinical Review. RMHP Coverage Guideline "Continuous Glucose Monitor-Sensors (CGM)"	Disposal Supplies DME Purchase	Purchase Sensors
Continuous noninvasive glucose monitoring device	N	Y	N	Y	Y	S1030 S1031	Coverage Guideline Applies. Clinical Review RMHP Coverage Guideline "Continuous Glucose Monitor-Sensors (CGM)"		Purchase or Rental
Insulin Pump	Y	Y	Y	Y	Y	E0784 A9274	Coverage Guideline Applies. Fully implantable insulin pump is non-covered. A9270 is non-covered. A9274 is non-covered for MC. Clinical Review. RMHP Coverage Guideline "Insulin Pump"	DME	Rental or Purchase
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

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	MC	*CM*	*MD*	*CHP+*					
• Diabetic Shoes • Diabetic Inserts	Y	Y	Y	Y	N Modifier KX must be appended to indicate coverage criteria are met.	A5500 to A5501 A5503 to A5508 A5510 A5512 to A5513	Refer to section "Orthopedic Footwear" on page 21 of this document for information on codes 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
Blood Pressure Monitor	Y	Y	Y	Y	Y	A4660 A4663 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. Ambulatory monitors require clinical review (93784, 93786, 93788, 93790)	DME	Purchase

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	MC	*CM*	*MD*	*CHP+*					
• Dialysis Equipment • ESRD Supplies • Water Purifier Softener	Y	Y	N	Y	Y	A4671 to A4690 A4706 to A4932 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
Gloves – non-sterile	N	N	Y	N	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 for MD only
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
Disposable Supplies: • Ostomy Supplies • Urinary Supplies	Y	Y	Y	Y	N	A4310 to A4435 A4561 to A4562 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
Incontinence Supplies: • Incontinence Garment • Youth Briefs/Diapers • Adult Briefs/Diapers Disposable Underpads • Protective Underwear • Disposable Liners	N	N	Y	N	Yes, when units exceed the Medicaid limits	A4520 A4554 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. Disposable Underpads (Chux, 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
Tracheotomy Supplies: • Cleaning Kit • Collar/mask Trach/Laryngectomy • Tubing • Tracheal suction catheter	Y	Y	Y	Y	N	A4481 A4605 A4608 A4623 to A4626 A4628 to A4629 A7501 to A7509 A7520 to A7527	Limited to a 30 days 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
A-V Impulse System Foot Pump	Y	Y	Y	Y	Y	E1399	Rx and LMN will be required. MD Review	DME	2 months rental then convert to purchase

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• 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
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
Compression Garments (not used with pump. *i.e. Circaids, Ready-Fit*)	N	N	Y	N	N Except for code L2999	A4465 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
Pneumatic Compressors: • Segmental • Non-segmental • Intermittent Limb	Y	Y	Y	Y	Y	E0650 to E0652 E0656 to E0657 E0675 to E0676	Rx will be required from MD. CMN Pneumatic Compression Devices will be required for Commercial and MC. Only covered for the treatment of lymphedema or for the treatment of chronic venous insufficiency (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
Pneumatic Appliances: • Segmental • Non-segmental	Y	Y	Y	Y	Y	E0655 to E0657 E0660 E0665 to E0669, 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
• Vasopneumatic Compression Device	N	N	N	N	N	E1399	Not a benefit of any plan.	NAB	N/A

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Stockings: • Elastic • Support • TED Hose • Gradiant Compression • Jobst	N	N	Y	N	N	A4490 to A4510 A6530 A6533 to A6541 A6544 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 for MD only
Stockings: • Gradiant Compression • Non-elastic Gradient • Compression Wrap	Y	Y	Y	Y	N	A6531 A6532 A6545	Covered only when used in the treatment of an open venous stasis ulcer.	DME	Purchase
Heat/Cold Therapy Game Ready Device	N	N	N	N	N	E0210 to E0218 E0236 E0249 E1399	A water circulating cold pad with pump (E0218) will be denied as not medically necessary. Considered convenience items. Not a benefit of any pan.	NAB	N/A
Heat/Cold Equipment	N	N	N	N	N	A9273 E0200 E0205 E0225 E0231 to E0232 E0239	Considered convenience items.	NAB	N/A
• Infrared Heating Pad System • Replacement Pad	N	N	N	N	N	E0221 A4639	There are no indications for which these devices have been demonstrated to have any therapeutic effect. The device and any related accessories will be denied as not medically reasonable and necessary.	NAB	N/A
Phototherapy: • Bilirubin	Y	Y	Y	Y	N	E0202	Covered when it is used for the treatment of jaundice in infants.	DME	Rental only
• Ultraviolet Light Therapy System • Replacement Bulb/Lamp	Y	Y	Y	Y	Y	A4633 to A4634 E0691 to E0694	Coverage Guideline Applies. “Phototherapy with PUVA (photochemotherapy), UVA and/or UVB”	DME	2 months rental then convert to purchase
Therapeutic Lightbox	N	N	N	N	N	E0203	Non-covered for all indications.	NAB	N/A
Apnea Monitor (with or w/o kit)	Y	Y	Y	Y	N	E0618 E0619	These are for rental only. Covered for infants less than 12 months of age with documented apnea or who have known risk factors for life threatening apnea.	DME	Rental only

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	MC	*CM*	*MD*	*CHP+*					
Protime/Coagucheck/ INR Monitors	Y	Y	N	Y	Y	E1399 G0248, G0249, 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.	DME	Purchase applies to E1399 only
Infusion Pumps	Y	Y	Y	Y	N	E0779 to E0783 E0785 to E0786 E0791 K0455	Covered when Member meets Medicare guidelines. http://www.cgsmedicare.com/jc/coverage/lcdinfo.html	DME	Rental or purchase dependin g upon the pump
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
Disposable Drug Delivery System	Y	Y	Y	Y	N	A4305 to A4306	Covered when medically indicated by the requesting physician.	DME	Purchase
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
CPAP/BiPAP Supplies: • Mask (Full or Regular) • Headgear • Tubing • Filters • Water Chambers • Cannula • Chin Strap • Whisper Swivel	Y	Y	Y	Y	N	A4604 A7027 to A7039 A7044 to 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 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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	MC	*CM*	*MD*	*CHP+*					
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	E0601 – N E0470 - Y	E0601 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: 1. The apnea to hypopnea index (AHI) or Respiratory Disturbance Index (RHI) is greater than or equal to 15 events per hour; or, 2. 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
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

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	MC	*CM*	*MD*	*CHP+*					
Cough Stimulating Device	Y	Y	Y	Y	Y	E0482 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
• High Frequency Chest Wall Oscillation Devices (HFCWO) • Air-Pulse Generator System/ Vest Clearance Airway System	Y	Y	Y	Y	Y	A7025 to A7026 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
Intrapulmonary Percussive Vent System and accessories	N	N	N	N	N	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
IPPB Machine IPPB Humidifier	Y	Y	Y	Y	Y	E0500 E0550 E0555 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+*					
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
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
Nebulizer: • Large Volume Bottle Type with Compressed Heater Compressor	Y	Y	Y	Y	N	A7008 E0565 E0572 E0580 E0585	A large volume nebulizer and related compressor are covered when it is medically necessary to deliver humidity to a patient with thick, tenacious secretions, who has cystic fibrosis, bronchiectasis, a tracheostomy, a tracheobronchial stent. They are also covered when it is medically necessary to administer pentamidine to patients with HIV, pneumocystosis, and complications of organ transplants.	DME	2 months rental then convert to purchase or may purchase without renting

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	MC	*CM*	*MD*	*CHP+*					
Nebulizer Supplies: • Mask • Tubing • Reservoir Bottle • Water Collection Device • Filter • Dome • Peak Flow Meter • Immersion External Heater	Y	Y	Y	Y	N	A4614 A7003 to A7018 E1372	Covered when Member has nebulizer. The following are allowed as stated below: A7003 Two per month A7004 Two per month in addition to A7003 A7005 One every 6 months A7005 One every 3 months only with K0730 A7006 One per month A7007 Two per month A7010 One unit (100 ft.) every 2 months A7011 One per year A7012 Two per month A7013 Two per month A7014 One every 3 months A7015 One per month A7016 Two per year A7017 One every 3 years	DME	Purchase
Oral Appliance for Sleep Apnea	Y	Y	Y	Y	Y	E0485 E0486	Coverage Guideline Applies. Oral Appliance for Obstructive Sleep Apnea (OSA)	DME	Purchase
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: • Concentrator • Gaseous Portable • Stationary • Liquid Portable • Vapor Enriching System • Contents	Y	Y	Y	Y	Y	E0424 E0425 E0431 E0433 E0434 E0435 E0439 E0440 E0446 E1390 E1391 E1392 E1405 E1406 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
Oxygen Contents	N	N	Y	N	Y	E0441 to E0444 K0742	Covered when Member meets guidelines for oxygen listed above. Oxygen contents are not separately payable when included in payment for equipment rental.	OX	Purchase

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	MC	*CM*	*MD*	*CHP+*					
Oxygen Supplies: • Oxygen Tent • Tubing • Mask • Cannula • Face Tent • Breathing Circuits • Regulator • Stand	Y	Y	Y	Y	N	A4608 A4615 to A4620 A9900 E0455 E0555 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
• Spirometers • P-Flex Incentive	Y	Y	N	Y	N	E1399 E0487 A9284	Covered when used for neuromuscular or chest wall diseases. Incentive spirometers are considered experimental and investigational for all other indications.	DME	Purchase
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
• Pulse Oximeter • Pulse Oximeter Probes	N	N	Y	N	Y	A4606 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
Ventilator: • Volume Control • Negative Pressure • Pressure Support • Chest Shell • Chest Wrap	Y	Y	Y	Y	Y	E0457 E0459 E0465 E0466	Coverage Guideline Applies. Ventilator	DME	
Ventilator Supplies: • Moisture Exchange Battery	Y	Y	Y	Y	N	A4483 A4611 A4612 A4613	Covered when the Member has a ventilator.	DISP	Purchase
Patient Lift: • Hydraulic (Hoyer) Sling or Seat	Y	Y	Y	Y	Y	E0621 E0630 E0635 E0639 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 month rental convert to purchase

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	MC	*CM*	*MD*	*CHP+*					
Patient Lift: • Electrical Multi-positional Patient Support System • Multi-positional transfer system	Y	Y	Y	Y	Y	E0636 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, rollabout chairs, transfer chairs, manual wheelchairs, power-operated vehicles, or power wheelchairs.	DME	2 months rental convert to purchase
Patient Lift: • Bathroom or Toilet Standing Frame System • Combination sit to stand system • Moveable Fixed System	N	N	Y	N	N	E0625, E0637 to E0638 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	
Seat Lift Mechanism	Y	Y	Y	Y	N	E0627 E0628 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

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	MC	*CM*	*MD*	*CHP+*					
Orthosis: • Static Ankle Foot • Orthosis Soft Interface Material	Y	Y	Y	Y	N	L4392 L4396 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 which 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
Orthosis: • Foot Drop Splint/ Recumbent	N	N	Y	N	N	L4394 L4398	A foot drop splint/recumbent positioning device (L4398) or replacement interface (L4394) is not covered.	ORTHO	Purchase MD only
Orthosis: • Additions to Lower Extremity Orthosis	Y	Y	Y	Y	N Except for code 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
Orthosis: • Additions to Upper Extremity Orthosis	Y	Y	Y	Y	N	L3971 L3973 L3975 to L3978	Covered when medically indicated by the requesting physician.	ORTHO	Purchase

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	MC	*CM*	*MD*	*CHP+*					
Orthosis: • AFO • KAFO • Ankle Control Walking Boot • Pneumatic Leg Splint • Pneumatic Knee Splint	Y	Y	Y	Y	N	L1900, L1902 L1904 L1906 to L1907 L1910 L1920,L1930, L1932, L1940, L1945, L1950, L1951, L1960, L1970, L1971, L1980, L1990, L2000, L2005, L2010, L2020, L2030 L2034 to L2038 L2040 to L2116 L2126 to L2136 L4350 L4360 to L4361 L4370 L4386 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
Orthosis: • CTLSO • TLSO • LO • LSO	Y	Y	Y	Y	N L0628 requires authorization for Medicaid only	L0430 to L0492 L0621 to L0710 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
Orthosis: • Thoracic Rib Belt	N	N	Y	N	N	L0220		ORTHO	Purchase for MD only

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	MC	*CM*	*MD*	*CHP+*					
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
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
Orthosis: • Halo Procedures	Y	Y	Y	Y	N	L0810 to L0861	Covered when medically indicated by the requesting physician.	ORTHO	Purchase
Orthosis: • Other Scoliosis Procedures	Y	Y	Y	Y	N Except for "not otherwise specified" code L1499	L1300 to 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
Orthosis: • Cranial Cervical Orthosis	Y	Y	Y	Y	N	L0112 L0113 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
Orthosis: • THKAO • HKFAO	Y	Y	Y	Y	N	L2040 to L2090	Covered when medically indicated by the requesting physician.	ORTHO	Purchase
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
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

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	MC	*CM*	*MD*	*CHP+*					
Orthopedic Footwear Do not report L3000 – L3649 as devices used to treat diabetes. Refer to section "Diabetes Shoes and Inserts" on page 8.	Y	Y	Y	Y	Append KX modifier to indicate these criteria are met. No PA is needed if criteria are met. Items are not covered if these criteria are not met.	L3000 to L3170 L3215 to L3649	Medicare, Commerical & 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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	MC	*CM*	*MD*	*CHP+*					
Orthopedic Footwear (Surgical Boot/Benesch Boot)	N	Y	Y	Y	N	L3201 to L3214	Covered when medically indicated by the requesting physician.	ORTHO	Purchase
Orthopedic Devices: • Dynamic Splinting Devices	Y	Y	Y	Y	Y	E1800 to E1841	Coverage Guideline Applies. RMHP Policy Dynamic Splinting Devices	ORTHO	Purchase
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
Prosthesis: • Breast (External) Mastectomy Bras	Y	Y	Y	Y	N	L8000 to L8002 L8010 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
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

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	MC	*CM*	*MD*	*CHP+*					
Hearing Aids/Fitting/Earmolds Batteries	N	Y	N	Y	Y for CM and CHP+	V5014 V5030 to V5080 V5100 V5120 to V5150 V5170 to V5190 V5210 to V5230 V5242 to V5261	Commercial and CHP+ Plans: hearing aids or repairs of hearing aids for children less than 18 years of age.	NAB	N/A
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
Prosthesis: • Penile (External) Manual only	Y	Y	Y	Y	N	L7900	Medicare: covered when Member has diagnosis of impotence of organic origin. Clinical Review Commercial: coverage is limited based upon member's evidence of coverage.	DME	Purchase
Prosthetic: • Lower Limb	Y	Y	Y	Y	Y	L5000 to L5999	Coverage Guideline Applies. Clinical review. RMHP Coverage Guideline - Prosthetic	ORTHO	Purchase
Prosthetic: • Upper Limb	Y	Y	Y	Y	Y	L6000 to L6915	Coverage Guideline Applies. Clinical review. RMHP Coverage Guideline - Prosthetic	ORTHO	Purchase
Prosthetic: • External Power	Y	Y	Y	Y	Y	L6920 to L7499	Coverage Guideline Applies. Clinical review. RMHP Coverage Guideline - Prosthetic	ORTHO	Purchase
Prosthetic: • Truss	Y	Y	Y	Y	N	L8300 to L8330	Covered when medically indicated by the requesting physician.	ORTHO	Purchase
Prosthetics: • Socks Excluding "Fracture Socks"	Y	Y	Y	Y	N Except for code L8499	L8400 to L8499		ORTHO	Purchase
Prosthetic Implants: • Artificial Larynx • Tracheostomy Speaking Valve • Implantable neurostimulator, pulse generator, any type	Y	Y	Y	Y	Y	L8500 to L8515 L8679	Coverage Guideline Applies. RMHP Coverage Guideline – Prosthetic	ORTHO	Purchase
Prosthetic: • Cochlear Device Batteries	Y	Y	Y	Y	Y	L8614 to L8624	Coverage Guideline Applies. RMHP Coverage Guideline – Prosthetic	ORTHO	Purchase
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

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	MC	*CM*	*MD*	*CHP+*					
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
Biofeedback Therapy	Y	Y	Y	Y	Y	E0746	Biofeedback is medically necessary for the following conditions: Urinary stress incontinence Not covered for all other indications	DME	Purchase
• Bone Growth Stimulator/ Osteogenesis Stimulator • Nonspinal Electrical Spinal Electrical Ultrasonic	Y	Y	Y	Y	Y	E0747 E0748 E0749 E0760	Coverage Guideline Applies.	DME	Purchase
Electronic Salivary Reflex Stimulator	N	N	N	N	N	E0755	Considered experimental and investigational for the treatment of xerostomia (dry mouth) or for any other indication because its effectiveness has not been established.	NAB	N/A
Non-thermal Pulsed High Frequency Radiowaves/ High Peak Power Electromagnetic Energy Treatment Device	N	N	N	N	N	E0761	Considered experimental and investigational for all indications, including the treatment of wounds, soft tissue injuries, mechanical neck disorders, osteoarthritis, or acute postoperative pain and edema because its effectiveness has not been established.	NAB	N/A
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
Interferential Device	N	N	N	N	N	E1399	Considered experimental and investigational.	NAB	N/A
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
Electrical Stimulation/ Electromagnetic Wound or Cancer Treatment Devices	N	N	N	N	N	E0766 E0769	Electrical stimulation for the treatment of chronic ulcers or cancer in the home setting is not medically appropriate.	NAB	N/A

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	MC	*CM*	*MD*	*CHP+*					
TENS Unit	Y	Y	Y	Y	Y	E0720 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 convert to purchase
Pelvic Floor Stimulator	Y	Y	N	Y	Y	E0740	Electrical muscle stimulators are medically necessary durable medical equipment (DME) for the management of urinary incontinence when all of the following criteria are met: For the treatment of stress and/or urge urinary incontinence in cognitively intact patients who have failed a documented trial of pelvic muscle exercise (PME) training. A failed trial of PME training is defined as no clinically significant improvement in urinary continence after completing 4 weeks of an ordered plan of pelvic muscle exercises designed to increase periurethral muscle strength.	DME	Purchase
Neuromuscular Stimulator	Y	Y	Y	Y	Y	E0744 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 convert to purchase
Functional Electrical Stimulators (FES)	Y	Y	Y	Y	Y	E0764 E0770	Coverage Guideline Applies RMHP Coverage Guideline Neuromuscular electrical stimulation (E0770, E0745, E0764)	DME	2 months rental convert to purchase

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	MC	*CM*	*MD*	*CHP+*					
TENS Unit Supplies • Batteries • Electrodes • Conductive Garment • Conductive Paste or Gel	Y	Y	Y	Y	N	E0731 A4555 to A4558 A4595 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 not a benefit, as the device with which it is used is not a benefit.	DISP	Purchase
Traction Accessories: • Cervical Head Harness • Pelvic Belt/Harness/Boot • Extremity Belt/Harness	Y	Y	Y	Y	N	E0942 E0944 E0945	Covered only when Member meets the criteria for coverage for a traction unit.	DME	Purchase

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	MC	*CM*	*MD*	*CHP+*					
Traction: • Cervical • Extremity • Fracture Frame • Pelvic	Y	Y	Y	Y	Y	E0830 to E0900 E0920 E0930 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 month rental convert to purchase
Continuous Passive Motion Machine (CPM)	Y	Y	Y	Y	Y	E0935 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

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	MC	*CM*	*MD*	*CHP+*					
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
Rollabout Wheelchair (Geri chair)	Y	Y	Y	Y	Y	E1031 to E1039	Coverage Guideline Applies. Wheelchair Accessories	DME	2 months rental then convert to purchase
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 E1100 to E1200 E1220 to E1224 E1229 E1231 to E1238 E1240 to E1295 K0001 to K0009	Coverage Guideline Applies. Wheelchair Accessories	DME	2 months rental then convert to purchase
Power Wheelchair Base	Y	Y	Y	Y	Y	E1239 K0010 to K0014 K0813 to K0891 K0898	Coverage Guideline Applies. Wheelchair Accessories	DME	2 months rental then convert to purchase
Power Operated Vehicles	Y	Y	Y	Y	Y	E1230 K0800 to K0808 K0812 K0899	Coverage Guideline Applies. Power Operated Vehicle	DME	2 months rental then convert to purchase

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	MC	*CM*	*MD*	*CHP+*					
Wheelchair Accessories:	Y	Y	Y	Y	Y	E0950 to E0969 E0971 to E1030 E1225 to E1228 E1296 to E1298 E2201 to E2228 E2230 E2231 E2295 E2310 to E2397 E2601 to E2625 K0015 to K0108 K0195 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
Wheelchair Accessories	N	N	Y	N	Y	E0970 E2291 to E2294 E2300 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
Wound Care: • Gel Sheet for Dermal • Wound Cleansers • Skin Sealants	N	N	Y	N	N	A6025 A6250 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 for MD only
• Wound Vac • Wound Care Kit	Y	Y	Y	Y	Y	E2402 A6550	Coverage Guideline Applies. Clinical review. Wound Vac/ Negative Pressure Wound Therapy Pumps (NPWT) and Supplies Medicaid: Modifier KR must be appended to E2402. Includes all equipment and supplies.	DME	Rental Max 4 mo.
Wound warming device (non to contact) and accessories	N	N	N	N	N	E0231 E0232 A6000	Not covered items.	NAB	N/A

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	MC	*CM*	*MD*	*CHP+*					
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 A6154 to A6248 A6251 to A6260 A6261 to A6407	Covered when either of the following criteria are met: 1. Required for the treatment of a wound caused by, or treated by, a surgical procedure; Or 2. Required after debridement of a wound. Surgical dressings include both primary dressings (i.e., therapeutic or protective coverings applied directly to wounds or lesions either on the skin or caused by an opening to the skin) and secondary dressings (i.e., materials that serve a therapeutic or protective function and that are needed to secure a primary dressing). The surgical procedure or debridement must be performed by a physician or other healthcare professional to the extent permissible under State law. Debridement of a wound may be any type of debridement (examples given are not all 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, Acticoat™, Silversorb®) are covered where there is critical concern over colonization of the wound.	DISP	Purchase
• Breast Pump • Tubing • Adaper • Cap • Breast Shield • olycarbonate Bottle • Locking Ring	N	Y	Y	Y	N	A4281 to A4286 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
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
Eye Pad	Y	Y	Y	Y	N	A6410 A6411	Covered when medically indicated by the requesting physician.	DISP	Purchase
Eye Patch	N	N	N	N	N	A6412	Eye Patch is not covered.	NAB	N/A

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	MC	*CM*	*MD*	*CHP+*					
Face Down Positioning Device	N	N	N	N	N	A9270	Following vitrectomy and certain other eye surgery procedures, patients are instructed to position themselves with their face down through most of the day. There are certain devices that facilitate this positioning. Examples (not all-inclusive) are a face cushion that is attached to a frame that can rest on a table or be positioned on a bed or a cushion pad that is attached to a chair-like device. CMS has confirmed that these devices are statutorily non-covered because they do not fall within a Medicare benefit category. The reasons are that they are considered "precautionary devices" and also the equipment can be used for purposes other than the treatment of an illness or injury. The denial is a non-coverage denial, not a medical necessity denial.	NAB	N/A
Gait Trainer, Pediatric Size	N	N	Y	N	Y	E8000 to E8002	Rx and LMN will be required. Covered for Medicaid only.	DME	Purchase MD only
Positioning Cushion, Wedge, Pillow Heel or Elbow Protector	Y	Y	Y	Y	N	E0190 E0191	Covered when medically indicated by the requesting physician.	DME	Purchase
Helmet	Y	Y	Y	Y	N	A8000 to A8004	Covered when medically indicated by the requesting physician.	ORTHO	Purchase
Safety Equipment (e.g. Belt, Harness, or Vest) Restraint	Y	Y	Y	Y	N	E0700 E0710	Covered when medically indicated by the requesting physician.	DME	Purchase
Stroller (Snug Seat, Pogon)	N	N	Y	N	Y	E1399	Rx and LMN will be required. Covered for Medicaid only.	DME	Purchase MD only
Suction Pump Canister Tubing	Y	Y	Y	Y	N	E0600 E2000 A7000 A7001 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
Weighted Blanket Weighted Vest	N	N	Y	N	Y	E1399	Rx and LMN will be required. Covered for Medicaid only.	DME	Purchase MD only
Whirlpool/Hot Tub Portable Non-portable	N	N	N	N	N	E1300 E1310	Not a benefit of any plan.	NAB	N/A

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	MC	*CM*	*MD*	*CHP+*					
Speech Generating Device (SGD) (Synthesized speech augmentive device with display)	Y	Y	Y	Y	Y	E1902 E2500 E2502 E2504 E2506 E2508 E2510 E2511 E2512 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.	DME	Purchase
Shipping/Freight	Y	Y	Y	Y	Y	E1399	An invoice of the cost of freight will be required.		N/A

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	MC	*CM*	*MD*	*CHP+*					
DME Labor (repair)	Y	Y	Y	Y	Y	K0739 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
Air Cleaners/ Purifiers (includes electrostatic machines)	N	N	N	N	N	A9270	Not a benefit of any plan.	NAB	N/A
Air Conditioners	N	N	N	N	N	A9270	Not a benefit of any plan.	NAB	N/A
Exercise Equipment	N	N	N	N	N	A9300	Not a benefit of any plan.	NAB	N/A
Humidifiers/Vaporizers / Purifiers / Air Filters	N	N	N	N	N	A9270	Not a benefit of any plan.	NAB	N/A
Massage Devices	N	N	N	N	N	A9270	Not a benefit of any plan.	NAB	N/A
Scooter Lift Attachment for Vehicle Ramps (For Home Modifications)	N	N	N	N	N	A9270	Not a benefit of any plan.	NAB	N/A
Hydraulic Van Lift	N	N	N	N	N	A9270	Not a benefit of any plan.	NAB	N/A
Inversion Table	N	N	N	N	N	A9270	Not a benefit of any plan.	NAB	N/A
Reacher	N	N	N	N	N	A9281	Not a benefit of any plan.	NAB	N/A
Sock-Aid	N	N	N	N	N	A9270	Not a benefit of any plan.	NAB	N/A
Telephone Alert Systems Life Line	N	N	N	N	N	A9280	Not a benefit of any plan.	NAB	N/A
Wigs/Artificial Hair Pieces	N	N	N	N	N	A9282	Not a benefit of any plan.	NAB	N/A
Parallel Bars	N	N	N	N	N	A9300	Not a benefit of any plan.	NAB	N/A