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1.0 Description of the Procedure, Product, or Service

1.1 Definitions

1.1.1 Durable Medical Equipment

Durable Medical Equipment is primarily and customarily used to serve a medical purpose, is generally not useful to an individual in the absence of a disability, illness or injury, can withstand repeated use, and can be reusable or removable.

1.1.2 Medical Supplies

Medical Supplies are health care related items that are consumable or disposable, or cannot withstand repeated use by more than one individual, that are required to address an individual medical disability, illness or injury.

1.2 Categories of Durable Medical Equipment and Medical Supplies

Durable Medical Equipment and Medical Supplies refers to the following categories of equipment and related supplies:

a. **Inexpensive or Routinely Purchased:**

These items are purchased for a beneficiary.

b. **Capped Rental or Purchased Equipment:**

These items are rented or purchased as follows:

1. The item is **rented** if the physician, physician assistant, or nurse practitioner documents that the anticipated need is six months or less.
2. The item may be **rented** or **purchased** if the physician, physician assistant, or nurse practitioner documents that the anticipated need exceeds six months. Once rental is initiated on an item, a subsequent request for prior approval of purchase of that item will be denied. The item becomes the property of the beneficiary when the accrued rental payments reach NC Medicaid (Medicaid) or NC Health Choice's (NCHC) allowable purchase price.

c. **Equipment Requiring Frequent and Substantial Servicing:**

These items are rented; oxygen and items dealing with oxygen delivery are in this category.

d. **Related Medical Supplies:**

Supplies are covered when they are provided for use with medical equipment owned by the beneficiary.

e. **Service and Repair:**

The service and repair of medical equipment owned by a beneficiary is covered over the useful life of the item. Refer to **Subsection 5.8, Servicing and Repairing Medical Equipment**, for additional information.

f. **Individually Priced Items:**

These items are reviewed on an individual basis and manually priced.

Refer to **Attachment A, Section C: Procedure Code(s)** for a list of HCPCS codes, established lifetime expectancies and quantity limitations for Durable Medical Equipment and Medical Supplies.

For the rates associated with the list of equipment, supplies, and services found in **Attachment A, Section C,** refer to the Durable Medical Equipment fee schedule at http://dma.ncdhhs.gov/.

In compliance with the CMS Home Health Final Rule Title 42, §440.70, items not listed in **Attachment A, Section C** or in the Durable Medical Equipment fee schedule will be considered for coverage if requested by a provider, or a beneficiary through a provider, and submitted for prior authorization (PA) review of medical necessity. For beneficiaries under age 21, please request an "EPSDT review" using NCTracks. Refer to section **2.2 Special Provisions** for more information about EPSDT. For beneficiaries aged 21 and older, please submit the request directly to the Division of Medical Assistance (DMA) per the procedure detailed in **Attachment D**.

2.0 Eligibility Requirements

2.1 Provisions

2.1.1 General

(*The term "General" found throughout this policy applies to all Medicaid and NCHC policies*)

a. An eligible beneficiary shall be enrolled in either:
   1. the NC Medicaid Program *(Medicaid is NC Medicaid program, unless context clearly indicates otherwise*); or
   2. the NC Health Choice (*NCHC is NC Health Choice program, unless context clearly indicates otherwise)* Program on the date of service and shall meet the criteria in **Section 3.0 of this policy**.

b. Provider(s) shall verify each Medicaid or NCHC beneficiary's eligibility each time a service is rendered.

c. The Medicaid beneficiary may have service restrictions due to their eligibility category that would make them ineligible for this service.

d. Following is only one of the eligibility and other requirements for participation in the NCHC Program under GS 108A-70.21(a): Children must be between the ages of 6 through 18.

2.1.2 Specific

(***The term "Specific" found throughout this policy only applies to this policy***)

a. Medicaid
None Apply.

b. NCHC
None Apply.

2.2 Special Provisions

2.2.1 EPSDT Special Provision: Exception to Policy Limitations for a Medicaid Beneficiary under 21 Years of Age

a. **42 U.S.C. § 1396d(r) [1905(r) of the Social Security Act]**

Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) is a federal Medicaid requirement that requires the state Medicaid agency to cover services, products, or procedures for Medicaid beneficiary under 21 years of age **if** the service is **medically necessary health care** to correct or ameliorate a defect, physical or mental illness, or a condition [health problem] identified through a screening examination (includes any evaluation by a physician or other licensed practitioner).

This means EPSDT covers most of the medical or remedial care a child needs to improve or maintain his or her health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems.

Medically necessary services will be provided in the most economic mode, as long as the treatment made available is similarly efficacious to the service requested by the beneficiary's physician, therapist, or other licensed practitioner; the determination process does not delay the delivery of the needed service; and the determination does not limit the beneficiary's right to a free choice of providers.

EPSDT does not require the state Medicaid agency to provide any service, product or procedure:

1. that is unsafe, ineffective, or experimental or investigational.
2. that is not medical in nature or not generally recognized as an accepted method of medical practice or treatment.

Service limitations on scope, amount, duration, frequency, location of service, and other specific criteria described in clinical coverage policies may be exceeded or may not apply as long as the provider's documentation shows that the requested service is medically necessary "to correct or ameliorate a defect, physical or mental illness, or a condition" [health problem]; that is, provider documentation shows how the service, product, or procedure meets all EPSDT criteria, including to correct or improve or maintain the beneficiary's health in the best condition possible, compensate for a health

problem, prevent it from worsening, or prevent the development of additional health problems.

b. **EPSDT and Prior Approval Requirements**

1. If the service, product, or procedure requires prior approval, the fact that the beneficiary is under 21 years of age does **NOT** eliminate the requirement for prior approval.
2. **IMPORTANT ADDITIONAL INFORMATION** about EPSDT and prior approval is found in the *NCTracks Provider Claims and Billing Assistance Guide*, and on the EPSDT provider page. The Web addresses are specified below.

NCTracks Provider Claims and Billing Assistance Guide: https://www.nctracks.nc.gov/content/public/providers/provider-manuals.html

EPSDT provider page: http://dma.ncdhhs.gov/

2.2.2 EPSDT does not apply to NCHC beneficiaries

2.2.3 Health Choice Special Provision for a Health Choice Beneficiary age 6 through 18 years of age

The Division of Medical Assistance (DMA) shall deny the claim for coverage for an NCHC beneficiary who does not meet the criteria within **Section 3.0** of this policy. Only services included under the NCHC State Plan and the DMA clinical coverage policies, service definitions, or billing codes are covered for an NCHC beneficiary.

3.0 When the Procedure, Product, or Service Is Covered

Note: Refer to Subsection 2.2.1 regarding EPSDT Exception to Policy Limitations for a Medicaid Beneficiary under 21 Years of Age.

3.1 General Criteria Covered

Medicaid and NCHC shall cover the procedure, product, or service related to this policy when medically necessary, and:

a. the procedure, product, or service is individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the beneficiary's needs;
b. the procedure, product, or service can be safely furnished, and no equally effective and more conservative or less costly treatment is available statewide; and
c. the procedure, product, or service is furnished in a manner not primarily intended for the convenience of the beneficiary, the beneficiary's caretaker, or the provider.

3.2 Specific Criteria Covered

3.2.1 Specific criteria covered by both Medicaid and NCHC

Medicaid and NCHC cover durable medical equipment and related medical supplies when ALL the following requirements are met:

a. the item is ordered by a physician, physician assistant, or nurse practitioner;

b. the item is medically necessary to maintain or improve a beneficiary's medical, physical or functional level, and appropriate for use in any non-institutional setting in which normal life activities take place;

c. a documented face-to-face encounter with the beneficiary and the ordering physician, physician assistant, or nurse practitioner related to the primary reason the beneficiary requires durable medical equipment and medical supplies has occurred no more than six (6) months prior to the initiation of durable medical equipment and medical supplies; and

d. the beneficiary's need for durable medical equipment and medical supplies is reviewed by the ordering physician, physician assistant, or nurse practitioner at least annually.

Refer to **Subsection 1.1** for definitions of Durable Medical Equipment and Medical Supplies.

Refer to **Subsection 5.3, Documenting Medical Necessity**, for specific coverage requirements.

3.2.2 Medicaid Additional Criteria Covered

None Apply.

3.2.3 NCHC Additional Criteria Covered

None Apply.

4.0 When the Procedure, Product, or Service Is Not Covered

Note: Refer to Subsection 2.2.1 regarding EPSDT Exception to Policy Limitations for a Medicaid Beneficiary under 21 Years of Age.

4.1 General Criteria Not Covered

Medicaid and NCHC shall not cover the procedure, product, or service related to this policy when:

a. the beneficiary does not meet the eligibility requirements listed in **Section 2.0;**
b. the beneficiary does not meet the criteria listed in **Section 3.0;**
c. the procedure, product, or service duplicates another provider's procedure, product, or service; or
d. the procedure, product, or service is experimental, investigational, or part of a clinical trial.

4.2 Specific Criteria Not Covered

4.2.1 Specific Criteria Not Covered by both Medicaid and NCHC

Medicaid and NCHC shall not cover convenience items or features.

4.2.2 Medicaid Additional Criteria Not Covered

None Apply.

4.2.3 NCHC Additional Criteria Not Covered

a. NCHC beneficiaries are excluded from preconception care, pregnancy, and gestational diabetes services. If eligible, NCHC beneficiaries who become pregnant shall be enrolled in a Medicaid eligibility category that includes pregnancy coverage
b. NCGS § 108A-70.21(b) "Except as otherwise provided for eligibility, fees, deductibles, copayments, and other cost sharing charges, health benefits coverage provided to children eligible under the Program shall be equivalent to coverage provided for dependents under North Carolina Medicaid Program except for the following:
    1. No services for long-term care.
    2. No nonemergency medical transportation.
    3. No EPSDT.
    4. Dental services shall be provided on a restricted basis in accordance with criteria adopted by the Department to implement this subsection."

5.0 Requirements for and Limitations on Coverage

Note: Refer to Subsection 2.2.1 regarding EPSDT Exception to Policy Limitations for Medicaid Beneficiaries under 21 Years of Age.

5.1 Prior Approval

Some medical equipment and supplies require prior approval. Items that require prior approval are identified for the item identified on the *Durable Medical Equipment Fee Schedule* by an asterisk (*).The fee schedule is available on DMA's website: at: http://dma.ncdhhs.gov/.

Prior approval is valid for the time period approved on the Certificate of Medical Necessity/Prior Approval (CMN/PA) form. If a physician, physician assistant, or nurse practitioner decides that an item is needed for a longer period of time, a new CMN/PA form must be submitted.

Capped rental items have restrictions on the length of rental. Refer to **Subsection 1.2,** for information on capped rental items.

5.2 Prior Approval Requirements

5.2.1 The General

The provider(s) shall submit to the Department of Health and Human Services (DHHS) Utilization Review Contractor the following:

a. the prior approval request; and
b. all health records and any other records that support the beneficiary has met the specific criteria in **Subsection 3.2** of this policy.

Refer to **Subsection 5.3, Documenting Medical Necessity,** for information on documenting medical necessity requirements for specific Durable Medical Equipment and Supplies.

5.3 Documenting Medical Necessity

Medical necessity must be documented by the prescriber (physician, physician assistant, or nurse practitioner), for every item provided/billed regardless of any requirements for approval. A letter of medical necessity written and signed by the physician, physician assistant, or nurse practitioner, or other licensed professional permitted to perform those tasks and responsibilities by their NC state licensing board, may be submitted along with the CMN/PA.

5.3.1 Oxygen, Oxygen Supplies, and Equipment

Refer to **Attachment A, Section C: Procedure Code(s)** for a list of HCPCS codes, established lifetime expectancies and quantity limitations for Durable Medical Equipment and Supplies. To request a medical necessity review for an item not listed, see **sections 1.2**, **2.2 and Attachment D** for instructions.

Oxygen therapy and related supplies and equipment are covered for a beneficiary who meets the following criteria:

a. Age 0 through 3 years: arterial oxyhemoglobin saturation (SaO_2) equal to or less than 94% and have a documented supporting diagnosis.

b. Ages 4 through 20 years: SaO_2 equal to or less than 90% and a documented supporting diagnosis.

c. Ages 21 and older: there is a documented diagnosis from the treating physician that includes all the following:

   1. severe lung disease or hypoxia-related symptoms that might be expected to improve with oxygen therapy,
   2. alternative treatments have been tried and considered or deemed clinically ineffective,
   3. The beneficiary has a qualifying blood gas study (either arterial blood gas (ABG), or pulse oximetry for SaO_2) that meets the criteria for one of the following groups:
      A. Group I
         i. An arterial PO_2 at or below 55 mm Hg, or an arterial oxygen saturation at or below 88%, taken at rest, breathing room air.
         ii. An arterial PO_2 at or below 55 mm Hg, or an arterial oxygen saturation at or below 88%, taken during sleep for a patient who demonstrates an arterial PO_2 at or above 56 mm Hg, or an arterial oxygen saturation at or above 89%, while awake; or a greater-than-normal fall in oxygen level during sleep (a decrease in arterial PO_2 more than 10 mm Hg, or decrease in arterial oxygen saturation more than 5%) associated with symptoms or signs reasonably attributable to hypoxemia (for example, impairment of cognitive processes and nocturnal restlessness or insomnia). In either of these cases, coverage is provided only for use of oxygen during sleep, and then only one type of unit will be covered. Portable oxygen, therefore, would not be covered in this situation.

iii. An arterial PO_2 at or below 55 mm Hg or an arterial oxygen saturation at or below 88%, taken during exercise for a patient who demonstrates an arterial PO_2 at or above 56 mm Hg, or an arterial oxygen saturation at or above 89%, during the day while at rest. In this case, supplemental oxygen is provided during exercise if there is evidence the use of oxygen improves the hypoxemia that was demonstrated during exercise when the patient was breathing room air.

B. Group II

An arterial PO_2 of 56–59 mm Hg or arterial blood oxygen saturation of 89%, if there is evidence of one of the following:

i. Dependent edema suggesting congestive heart failure

ii. Pulmonary hypertension or cor pulmonale, determined by measurement of pulmonary artery pressure, gated blood pool scan, echocardiogram, or "P" pulmonale on EKG (P wave greater than 3 mm in standard leads II, III, or AVF)

iii. Erythrocythemia with a hematocrit greater than 56%

Requirements for Qualifying Oxygen Analysis and Coverage

A qualifying oxygen analysis (either arterial blood gas (ABG) or pulse oximetry for SaO_2) must meet the following criteria.

a. If the oxygen analysis is performed during an inpatient hospital stay, the reported test must be the one obtained closest to, but no earlier than 2 calendar days prior to, the hospital discharge date; or

b. If the qualifying oxygen analysis is not performed during an inpatient hospital stay, the reported test must be performed while the patient is in a chronic stable state—that is, not during a period of acute illness or exacerbation of their underlying disease.

c. The oxygen analysis used to determine medical necessity must not be performed by a medical equipment supplier or a related corporation. In addition, the oxygen analysis must not be performed by a physician with a significant ownership interest in the medical equipment supplier or the laboratory performing such tests. These provisions include relationships through blood or marriage. A referring physician may perform the test in his office as part of routine care.

d. The oxygen analysis must be performed by a clinician that does not have a vested interest in the company that supplies the oxygen, equipment and supplies.

e. The initial oxygen analysis must be performed within the 30-calendar day period before the approved start date of treatment. Otherwise, the approved start date of treatment will be the date of the initial qualifying analysis.

Prior Approval Requirements

For initial approval on oxygen services, the following must be on the CMN/PA form or on attached documentation:

a. Health record documentation from the beneficiary's prescriber stating why the use of oxygen is indicated.

b. Health record documentation from the beneficiary's prescriber showing that the beneficiary has had an examination within 30 calendar days of the start of oxygen therapy. The documentation must list ALL of the following:

   1. The diagnosis of the disease requiring use of oxygen;
   2. The oxygen flow rate needed; and
   3. An estimate of the frequency, duration of use, and length of need for the oxygen.

c. Results of an oxygen analysis (either ABG or pulse oximetry for SaO_2) as noted in the **Requirements for Qualifying Oxygen Analysis and Coverage.**

d. Initial prior approval is given for 12 calendar months for a **beneficiary under age 21 years of age, or who qualifies for oxygen under Group I criteria.** Continuation prior approval for this beneficiary is required at the end of the 12 calendar months. If approved, continuation is granted for an additional 24 months. For a beneficiary under 21 years of age, repeat testing is not required for continuation prior approval.

e. Initial prior approval is given for three (3) calendar months for a **beneficiary who qualifies for oxygen therapy under Group II criteria.** Continuation prior approval for this beneficiary is required at the end of the three (3) months. If approved, continuation is granted for an additional nine (9) months. For a beneficiary initially meeting Group II criteria, the most recent blood gas study that was performed between the 61st and 90th day following initial Certification must be reported on the Recertification CMN/PA. If a qualifying test is not obtained between the 61st and 90th day of oxygen therapy, but the beneficiary continues to use oxygen and a test is obtained at a later date, if that test meets Group I or II criteria, coverage would resume beginning with the date of that test. For a beneficiary initially meeting Group I or II criteria, the beneficiary must be seen and re-evaluated by the treating prescriber within 90 calendar days prior to the date of any Recertification. If the prescriber's visit is not obtained within the 90-day window, but the beneficiary continues to use oxygen, and the visit is obtained at a later date, coverage would resume beginning with the date of that visit. If the beneficiary meets the Group II criteria, the second continuation prior approval is given for an additional 24 months.

f. Repeat testing is not required in cases where equipment is replaced. Enter the most recent qualifying value and test date. This test does not have to be within 30 calendar days prior to the Initial Date, but could be the test result reported on the most recent prior CMN/PA.

g. There is no requirement for a prescriber's visit that is specifically related to the completion of the CMN/PA for replacement equipment.

h. When the prescribed maximum flow rate changes from one of the following categories to another, a repeat blood gas study with the beneficiary on 4liters per minute (LPM) must be performed and this must be the most recent study obtained within 30 calendar days prior to the Initial Certification Date:

1. Less than 1 LPM,
2. 1-4 LPM,
3. Greater than 4 LPM

i. For beneficiaries 21 years of age and older who initially qualified under Group I criteria, when the length of need expires – if the prescriber specified less than lifetime length of need on the most recent CMN/PA, then the blood gas study can be the most recent study obtained within 30 calendar days prior to the Initial Date.

j. When a portable system is added subsequent to Initial Certification of a stationary system, there is not a requirement for a repeat blood gas study unless the initial qualifying study was performed during sleep, in which case a repeat blood gas study must be performed while the beneficiary is at rest (awake) or during exercise within 30 calendar days prior to the Revised Date.

At the end of 36 months, **all** beneficiaries shall be recertified. The provider shall submit a new prior approval request for the continuation of oxygen therapy. This request must include documentation of continued medical need reported by the treating prescriber within six (6) months of the renewal date. Approval given at the 36-month renewal period is considered to be lifetime approval.

Note: Continuation prior approval for oxygen therapy is not required if oxygen therapy for use with a continuous positive airway pressure (CPAP) device or respiratory assist device (RAD) for obstructive sleep apnea (OSA) has been diagnosed and initially approved, or ventilator dependency for respiratory failure.

Special Reimbursement Explanation: Oxygen contents are approved only for beneficiary-owned equipment. This includes portable tanks, liquid oxygen, and oxygen tanks that are used on an ongoing basis based on prior approval and medical necessity.

Coverage is described as follows:

a. For a beneficiary receiving oxygen therapy delivered by an oxygen concentrator and also prescribed a portable oxygen system, reimbursement is for rental on the oxygen concentrator and portable oxygen tank. There is no separate coverage for contents that are used by the portable system, regardless of the amount of portable oxygen contents used in that month, as rental for the oxygen systems include contents.

b. For a beneficiary who is on a stationary liquid oxygen system and portable liquid oxygen system, coverage is for rental at the published rate for both a stationary liquid oxygen system and a portable system. Contents are covered in the published rate, and no additional contents are separately approved for a monthly rental.

c. Portable oxygen systems—A beneficiary who meets the clinical coverage criteria for medical necessity may qualify for coverage of a portable oxygen system either by itself or to use in addition to a stationary system. The qualifying health record documentation must indicate that the beneficiary is mobile and would benefit from the use of the portable oxygen system.

Portable oxygen systems that are used on a standby basis are not covered except in instances of a fragile infant with a tracheostomy.

d. If basic oxygen coverage criteria have been met, a higher allowance for a stationary system for a flow of greater than 4 (LPM) will be paid only if a blood gas study performed while the beneficiary is on 4 LPM meets Group I or II criteria. If a flow rate greater than 4 LPM is billed and the coverage criterion for the higher allowance is not met, payment will be limited to the standard fee schedule allowance. The higher oxygen allowable will be paid to the supplier at 1.5 times the rate. A modifier must be added to the oxygen code being used. If a modifier is used, then only the 1.5 times the rate will be reimbursed and there will be no payment for the portable oxygen system. Refer to **Attachment A, Section D**, for a list of the modifiers that must be used.

A Carbon Dioxide (CO_2) **Saturation Monitor with Accessories and Probes** is considered medically necessary when it is required to monitor carbon dioxide (CO_2) levels in beneficiary's requiring oxygen therapy so that appropriate blood gas levels are achieved and maintained.

5.3.2 Respiratory Devices for the Treatment of Respiratory Disorders other than Obstructive Sleep Apnea (OSA)

Refer to **Attachment A, Section C: Procedure Code(s)** for a list of HCPCS codes, established lifetime expectancies and quantity limitations for Durable Medical Equipment and Supplies. To request a medical necessity review for an item not listed, see **sections 1.2**, **2.2 and Attachment D** for instructions.

A respiratory assist device (RAD)-bi-level (RAD) without back-up rate delivers adjustable, variable levels (within a single respiratory cycle) of positive air pressure by way of tubing and a noninvasive interface to assist spontaneous respiratory efforts and supplement the volume of inspired air into the lungs (i.e., noninvasive positive pressure respiratory assistance: NIPPRA).

A respiratory assist device-RAD bi-level with back-up rate delivers adjustable, variable levels (within a single respiratory cycle) of positive air pressure by way of tubing and a noninvasive interface to assist spontaneous respiratory efforts and supplement the volume of inspired air into the lungs. In addition, it has a timed back-up feature to deliver this air pressure whenever sufficient spontaneous inspiratory efforts fail to occur.

A RAD and related accessories are covered for beneficiaries with any of the following respiratory disorders who demonstrate medical necessity for each disorder:

a. Restrictive thoracic disorders:

   The beneficiary shall meet any one of the following criteria:

   1. Documentation of the beneficiary's progressive neuromuscular disease or severe thoracic cage abnormality and an arterial blood gas $PaCO_2$, done while awake and breathing the beneficiary's usual fraction of inspired oxygen (FIO_2), that is greater than or equal to 45 mmHg;

2. Sleep oximetry demonstrating oxygen saturation less than or equal to 88% for at least five continuous minutes, done while breathing the beneficiary's FIO_2; or
3. For a progressive neuromuscular disease (only), maximal inspiratory pressure is less than 60cm H_20 or forced vital capacity is less than 50% predicted; and chronic obstructive pulmonary disease does not contribute significantly to the beneficiary's pulmonary limitation.

b. Severe chronic obstructive pulmonary disease (COPD):

All the following criteria must be met:

1. An arterial blood gas $PaCO_2$, done while awake and breathing the beneficiary's usual FIO_2, that is greater than or equal to 52 mmHg;
2. Sleep oximetry demonstrates oxygen saturation less than or equal to 88% for at least five continuous minutes, done while breathing oxygen at 2 LPM or the beneficiary's usual FIO_2 (whichever is higher); or
3. Prior to initiating therapy, OSA (treatment with CPAP) has been considered and ruled-out.

Prior approval is required for a RAD.

Note: A RAD device **with a back-up rate** is not covered for a beneficiary with COPD during the first two months, because therapy with a RAD device **without a back-up rate** with proper adjustments of the device's settings and beneficiary's accommodation to its use will usually result in sufficient improvement without the need of a back-up rate.

For those COPD beneficiaries who qualify for a RAD device without a back-up rate, if at a time no sooner that the 61 calendar days after initial issue and compliant use of the device, the treating physician believes the beneficiary requires a RAD device with a back-up rate, the device may be covered if all the following criteria are met:

A. An arterial blood gas $PaCO_2$, repeated no sooner than 61 calendar days after initiation of compliant use of the RAD device without a back-up rate, done while awake and breathing the beneficiary's usual FIO_2, remains greater than or equal to 52 mm Hg;
B. A sleep oximetry, repeated no sooner than 61 calendar days after initiation of compliant use of a RAD device without a back-up rate, and while breathing with the device, demonstrates oxygen saturation less than or equal to 88% for at least five continuous minutes, done while breathing oxygen at 2 LPM or the beneficiary's usual FIO2 (whichever is higher);
C. A signed and dated statement from the treating physician, completed no sooner than 61 calendar days after initiation of the RAD device without a back-up rate-declaring that the beneficiary has been compliantly using the device (an average of four hours per 24-hour period) but that the patient is NOT benefiting from its use.

c. Central sleep apnea:

The beneficiary shall meet all the following criteria:

1. A polysomnogram documenting the Central Sleep Apnea (CSA);
2. Exclusion of Obstructive Sleep Apnea (OSA) as the predominant cause of sleep-associated hypoventilation;
3. Ruling out of CPAP as effective therapy of OSA is a component of the sleep-associated hypoventilation;
4. ~~4.~~ Oxygen saturation less than or equal to 88% for at least five continuous minutes, done while breathing the beneficiary's usual FIO_2; and
5. Significant improvement of the sleep-associated hypoventilation with the use of a RAD device without a back-up rate on the settings that will be prescribed for initial use, while breathing the beneficiary's usual FIO_2.

Note: For beneficiary's age 0 through 18 with CSA, an apnea-hypopnea index (AHI) of 5 to 10 is acceptable if the physician who is a sleep specialist provides appropriate documentation on the physician's letterhead stationary of medical necessity for the RAD in each individual case.

Requirements for Coverage

a. A polysomnogram must be submitted with the initial request for RAD with those diagnoses that have a polysomnogram requirement in the criteria.
   1. **Medicaid and NCHC shall not accept polysomnograms that are performed by a medical equipment provider**. Polysomnograms must be provided according to requirements listed in Clinical Coverage Policy 1A-20, *Sleep Studies and Polysomnography Services*, on DMA's website: http://dma.ncdhhs.gov/.
   2. The polysomnogram must be based on a minimum of two hours of recorded sleep time without the use of a CPAP or RAD device, reported by the polysomnogram. The polysomnogram must include sleep staging and other sleep parameters such as airflow, respiratory effort, and oxygen saturation by oximetry.

b. If the polysomnogram criteria listed above are **not** met, claims submitted for reimbursement of a RAD and related accessories are denied as not medically necessary.

c. For an item to be covered by Medicaid and NCHC a written signed and dated order from the "treating physician" must be received by the supplier before the CMN/PA is submitted for prior approval. The treating physician is one who is qualified by virtue of experience and training in non-invasive respiratory assistance, to order and monitor the use of the respiratory assist devices.

d. If there is a discontinuation of the RAD at any time, the provider is expected to determine that the RAD has been discontinued and stop billing for the equipment and related accessories.

e. A RAD device with a back-up rate is not medically necessary if the primary diagnosis is OSA.

Initial Approval: For a RAD to be covered, the treating physician, physician assistant, or nurse practitioner, shall fully document in the beneficiary's clinical health record those symptoms characteristic of sleep-associated hypoventilation,

such as daytime hypersomnolence, excessive fatigue, morning headache, cognitive dysfunction, dyspnea, etc.

Initial approval for a RAD is given for a period of **six months**.

Note: The RAD device without a back-up rate is reimbursed as rental only and not to exceed a total of monthly rental payments equal to the purchase price. The RAD device with a back-up rate is reimbursed as a rental only item.

Renewal Approval: For renewal approval and continued coverage of the RAD beyond the first six months of therapy, no sooner than the fifth month after initiating therapy:

a. The provider shall obtain a statement of compliance from the treating physician declaring that the beneficiary is using the device an average of four hours per 24-hour period this must be submitted along with the CMN/PA request for renewal. Failure of the beneficiary to be consistently using the RAD for an average of four hours per the 24-hour period by the time of the reevaluation would represent non-compliant use and constitute reason for Medicaid and NCHC to deny continued coverage as not medically necessary; and
b. A statement must be submitted by the physician, physician assistant, or nurse practitioner indicating the progress of relevant symptoms and that the RAD is still medically necessary.

Note: A non-heated or heated humidifier is covered by Medicaid and NCHC with the use of a RAD. The treating physician shall specify which type of humidifier the beneficiary is to use.

Respiratory Devices for the Treatment of Obstructive Sleep Apnea

A bi-level device without back-up rate delivers adjustable, variable levels (within a single respiratory cycle) of positive air pressure by way of tubing and a noninvasive interface to assist spontaneous respiratory efforts and supplement the volume of inspired air into the lungs. This is also called noninvasive positive pressure respiratory assistance (NPPRA).

CPAP therapy is the use of a CPAP device and related equipment to deliver a constant level of positive air pressure into the throat to prevent the collapse of the airway during inhalation. This is done by way of tubing and noninvasive interface such as nasal, oral or face mask.

The CPAP and Bi-level require prior approval.

The CPAP device or bi-level device and related accessories are covered for beneficiaries who demonstrate medical necessity by meeting all the following criteria:

a. Has a diagnosis of OSA
b. Has a documented, attended by qualified personnel, facility-based polysomnogram that meets the following criteria:
    1. The AHI is greater than or equal to 15 events per hour; **or**
    2. The AHI is from 5 to 14 events per hour with documented symptoms of:

A. Excessive daytime sleepiness, impaired cognition, mood disorders, or insomnia; **or**

B. Hypertension, ischemic heart disease, or history of stroke.

The bi-level device is covered for beneficiaries who meet the criteria listed above and the prescribing physician, physician assistant, or nurse practitioner documents that the beneficiary meets one of the following conditions:

a. has had an unsuccessful six-month trial on a CPAP device;

b. is unable to tolerate CPAP;

c. has special needs that have been documented on the physician's letterhead stationery by a physician who is a sleep specialist.

Note: An AHI of 5 to 10 is acceptable if the physician who is a sleep specialist provides appropriate documentation on the physician's letterhead stationery of medical necessity for the CPAP device or bi-level device in each individual case.

Requirements for Coverage:

a. A polysomnogram must be submitted with the initial request for prior approval of a CPAP device or bi-level device.

Note: Medicaid and NCHC shall not accept polysomnograms that are performed by a medical equipment provider.

b. Polysomnograms must be provided according to requirements listed in Medicaid's Clinical Coverage Policy 1A-20, *Sleep Studies and Polysomnography Services*, on DMA's website: http://dma.ncdhhs.gov/.

c. The polysomnogram must be based on a minimum of two hours of recorded sleep time without the use of the CPAP device or bi-level device, reported by the polysomnogram. The polysomnogram must include sleep staging and other sleep parameters such as airflow, respiratory effort, and oxygen saturation by oximetry.

d. If the polysomnogram criteria listed above are not met, claims submitted for reimbursement of the CPAP device or bi-level device and related accessories are not medically necessary, and therefore not covered.

e. For an item to be covered by Medicaid and NCHC a written signed and dated order from the "treating physician" must be received by the supplier before the CMN/PA is submitted for prior approval. If the supplier submits a CMN/PA without first receiving the completed order, the prior approval request is denied as not medically necessary.

f. If there is discontinuation of the CPAP device or bi-level device at any time, the provider is expected to determine this, and stop billing for the equipment and related accessories.

g. Auto-titrating CPAP devices are billed the same as a CPAP device.

h. A non-heated or heated humidifier is covered by Medicaid/NCHC with the use of a CPAP/bi-level. The treating physician shall specify which type of humidifier the beneficiary is to use.

Initial Approval:

For initial approval:

a. Document that the beneficiary has OSA and meets the medical necessity requirements for CPAP therapy.

b. Submit results of the non-titrated polysomnogram summary (preferably in the non-narrative form).

The initial approval and coverage for a CPAP device or bi-level device is for a period of six months.

Note: A CPAP device or bi-level device is reimbursed as rental only. Reimbursement is not to exceed a total of monthly rental payments equal to the purchase price.

Renewal Approval:

Renewal approval and continued coverage of the CPAP device or bi-level device beyond the first six months of therapy, requires that, no sooner than the fifth month after initiating therapy the provider shall:

a. Determine from the treating physician that the beneficiary is continuing to use the CPAP device or bi-level device; **and**

b. Submit a statement from the physician, physician assistant, or nurse practitioner indicating that the CPAP device or bi-level device is still medically necessary. This information is acceptable in lieu of a polysomnogram for prior approval renewal only.

If the criteria listed above are not met, continued coverage of a CPAP device or bi-level device and related equipment and accessories is not medically necessary.

Other Respiratory Devices

A ventilator is covered for treatment of neuromuscular diseases, thoracic restrictive diseases, and chronic respiratory failure consequent to chronic obstructive pulmonary disease. Coverage is provided for both positive and negative pressure ventilators. Prior approval is required for a ventilator. Recertification is at 12 months. A lifetime PA may be considered at recertification if medical necessity is demonstrated.

An Intermittent Positive Pressure Breathing (IPPB) machine and humidifier are covered if the beneficiary's ability to breathe is severely impaired because of any of the following:

a. the beneficiary has unstable hyperventilation with CO_2 retention that can be reduced or prevented from rising with frequent mechanical assistance; or

b. the beneficiary requires intermittent or constant use of assisted or controlled ventilation to maintain adequate respiration because of chronic hypoventilation.

Note: The beneficiary shall have pulmonary function test evidence of difficulty removing bronchial secretions or reversible bronchial constriction that is better after IPPB. In the absence of medical indication, reimbursement is limited to compressor-driven nebulization.

Prior approval is required for an IPPB machine. To renew prior approval, a statement is needed from the physician, physician assistant, or nurse practitioner, indicating the beneficiary's overall condition has not changed and the IPPB remains medically indicated. This information is acceptable in lieu of a repeat pulmonary function test for renewal of prior approval only.

An air power source requires prior approval and is covered if it is required for use with medically necessary medical equipment for purposes of operating equipment that is not self-contained or cylinder driven.

Nebulizers

A nebulizer with compressor and related supplies is considered medically necessary when the beneficiary's ability to breathe is severely impaired.

Self-contained, ultrasonic nebulizer and related supplies are considered to be medically necessary when:

a. the beneficiary's ability to breathe is severely impaired; and

b. the prescribing physician, physician assistant, or nurse practitioner states that the ultrasonic nebulizer is medically necessary for the beneficiary to receive a smaller particle size than an ordinary nebulizer will provide.

Prior approval is required for an ultrasonic nebulizer.

Sterile saline is deemed medically necessary when used with the above equipment and accessories.

Apnea Monitor and Supplies

For initial and renewal approval of an apnea monitor, attach documentation showing that any one of the following applies to the beneficiary:

a. There has been an observed or recorded episode of prolonged apnea (greater than 10 seconds) within the last three months that is documented by medical personnel and associated with bradycardia, reflux, cyanosis or pallor;

b. The beneficiary is a sibling of a sudden infant death syndrome (SIDS) child. If the sibling was three months of age or less at the time of death, the beneficiary is covered up to six months of age. If the sibling was four months of age or older at the time of death, the beneficiary is covered up to three months beyond the sibling's age at death;

c. The beneficiary has had an event or events requiring vigorous stimulation or resuscitation within the past three months;

d. The beneficiary is an infant with bronchopulmonary dysplasia who requires oxygen and displays medical instability; or

e. The beneficiary is less than two years of age and has a tracheostomy. After two years of age, additional documentation from the prescribing physician, physician assistant, or nurse practitioner justifying extended medical necessity for the apnea monitor must be attached.

Prior approval is required.

Percussor

Percussors are covered for mobilizing respiratory secretions when the beneficiary or operator of the powered percussor has received appropriate training by a physician, physician assistant, or nurse practitioner or a therapist, and no one competent or able to administer manual therapy is available. Block 25 on CMN/PA must be checked.

Prior approval is required.

Oximeter

For initial and renewal approval of a **non-recording oximeter** attach documentation that the equipment is for continuous or intermittent use and at least one of the following applies to the beneficiary:

a. The beneficiary is dependent on both a ventilator and supplemental oxygen;
b. The beneficiary has a tracheostomy and is dependent on supplemental oxygen;
c. The beneficiary requires supplemental oxygen and has unstable saturations;
d. The beneficiary is on supplemental oxygen and weaning is in process; or
e. The beneficiary has an appropriately documented respiratory diagnosis and requires short-term oximetry to rule out hypoxemia. In this case coverage is allowed for a maximum of seven days.

Prior approval is required. The documentation requirements are the same for requests to renew approval.

For initial and renewal approval of a **recording oximeter**, attach documentation that:

a. the beneficiary's condition meets one of the coverage criteria for a non-recording oximeter, and
b. the recording oximeter is required to monitor the beneficiary during a specific event such as a weaning attempt from oxygen or ventilator, feeding times for an infant, or other times for which documentation of the beneficiary's oxygen saturation rate is needed.

Prior approval is required.

5.3.3 High-Frequency Chest Wall Oscillation Device

Refer to **Attachment A, Section C: Procedure Code(s)** for a list of HCPCS codes, established lifetime expectancies and quantity limitations for Durable Medical Equipment and Supplies. To request a medical necessity review for an item not listed, see **sections 1.2**, **2.2 and Attachment D** for instructions.

A high-frequency chest wall oscillation (HFCWO) device is an airway clearance device consisting of an inflatable vest connected by tubes to an air-pulse generator. This device is covered for beneficiaries with a diagnosis of cystic fibrosis, bronchiectasis, and some neurological and neuromuscular conditions that compromise the ability to actively clear secretions from the respiratory tract.

This device is covered when the beneficiary's disease is characterized by daily productive cough for at least six continuous months or frequent exacerbations (more than two per year) requiring antibiotic therapy. In addition, there must be well-documented failure of standard treatments (e.g. chest percussion, positional drainage, deep breathing exercises) to adequately mobilize mucus.

Prior approval is required. The initial approval is for a trial period of three months' rental. A request for subsequent purchase of the device may be considered based on the following documented results of the initial trial period:

1. Beneficiary compliance with device use and established plan of care;
2. Significant improvement of symptoms with use of the HWFCO device; and
3. Decreased hospitalizations for the qualifying diagnosis during the initial trial period

The oscillatory positive expiratory pressure (PEP) device and the Flutter device facilitate secretion removal. The PEP uses a counterweighted plug and magnet to create air flow oscillation. The Flutter uses a steel ball which vibrates inside a cone, causing air flow vibration. These devices are considered medically necessary when needed to mobilize secretions and assist with airway clearance. They do not require prior approval.

5.3.4 Cough-Stimulating Device, Alternating Positive and Negative Airway Pressure

Refer to **Attachment A, Section C: Procedure Code(s)** for a list of HCPCS codes, established lifetime expectancies and quantity limitations for Durable Medical Equipment and Supplies. To request a medical necessity review for an item not listed, see **sections 1.2**, **2.2 and Attachment D** for instructions.

A mechanical insufflator–exsufflator is an electric cough-stimulating device that utilizes a blower and a valve to alternately apply positive and then negative pressure to the beneficiary's airway. The shift in pressure produces a high expiratory flow from the lungs, stimulating a cough. This device assists a beneficiary to clear retained bronchopulmonary secretions. Air is delivered to

and from the beneficiary via a breathing circuit incorporating a flexible tube, a bacterial filter, and either a facemask, a mouthpiece, or an adapter to a tracheostomy or endotracheal tube.

A mechanical insufflator–exsufflator or a cough-stimulating device is covered for a beneficiary who is unable to cough and clear secretions effectively and who meets all the following criteria:

a. A diagnosis of a neuromuscular disease or high-level spinal cord injury (Refer to **Attachment A, Section B, Diagnosis Codes**, for the specific diagnosis codes required for this device;
b. Has a significant impairment of chest wall or diaphragmatic movement, resulting in an inability to effectively cough and clear retained secretions;
c. Lack of success with other standard respiratory treatments such as chest percussion and postural drainage, IPPB, incentive spirometry, inhalers, PEP therapy, or flutter devices; and
d. Has physician-documented evidence that the beneficiary or caregiver is willing and able to use the device as prescribed.

Prior approval is required. Initial approval may be granted for six months if the beneficiary meets all the following criteria:

a. Has a supporting medical diagnosis;
b. There is evidence that the beneficiary has tried other methods to control secretions, such as chest percussion and postural drainage, IPPB, incentive spirometry, inhalers, PEP mask therapy, or flutter devices, without significant response (methods should be described);
c. Has intolerance to, contraindication of, or unavailability of, chest physiotherapy; and
d. Has had incidents in the past year of respiratory illnesses requiring either physician office visits, emergency room visits, hospitalizations, or antibiotics.

For subsequent approvals, continued medical necessity must be reestablished for each successive six months by:

a. evidence of beneficiary compliance, caregiver compliance, or both; and
b. improved disease management since beginning the use of the cough-stimulating device (as indicated by fewer infections requiring antibiotics and fewer hospitalizations).

Cough-stimulating devices are not covered for beneficiaries with:

a. chronic obstructive pulmonary disease (COPD),
b. bullous emphysema,
c. susceptibility to pneumothorax or pneumomediastinum, or
d. recent barotrauma (an injury occurring after exposure to sudden contractions or expansions of air).

A cough-stimulating device may not be covered if the beneficiary tolerates and demonstrates a response to other techniques for cough assistance and secretion removal.

5.3.5 Miscellaneous Durable Medical Equipment and Supplies

Refer to **Attachment A, Section C: Procedure Code(s)** for a list of HCPCS codes, established lifetime expectancies and quantity limitations for Durable Medical Equipment and Supplies. To request a medical necessity review for an item not listed, see **sections 1.2**, **2.2 and Attachment D** for instructions.

A manual ventilation bag requires prior approval and is covered when a beneficiary has a life-threatening diagnosis and requires ventilator support.

Peak flow meters are covered when a beneficiary's physician deems it medically necessary for the beneficiary to monitor his peak expiratory flow rate on a regular basis.

Supplies for use with metered dose inhalers are covered when ordered by the physician who has also ordered a medically necessary metered dose inhaler for the beneficiary.

A respiratory suction pump, catheters, canisters, and tubing are covered if a beneficiary is physically unable to independently expectorate respiratory secretions.

For prior approval requirements refer to the *Durable Medical Equipment and Supply* fee schedule on DMA's website: http://dma.ncdhhs.gov/. Items that require prior approval are identified on the *Durable Medical Equipment Fee Schedule* by an asterisk (*).

5.3.6 Provision of DMES on the Date of Discharge from Specified Facilities

a. Items listed in **Attachment B** must be provided to a beneficiary, discharged home on the **date of Discharge** from a skilled nursing facility, short term physical disability rehabilitation center or hospital only.
b. Delivery of DMES on the date of discharge from a skilled nursing facility, short term physical disability rehabilitation center or hospital shall be consistent with Section 5.6 Delivery of Service.
c. For items that require PA, the DMES provider shall submit a prescriber's order and an admission history and physical note and any supporting documentation electronically via the provider portal on the NC Tracks website.
d. For items that do not require PA, the DMES provider shall keep the prescriber's order, a history and physical note, and any supporting documentation on file.

5.4 Amount of Service

The amount of service is limited to that which is medically necessary as determined by DMA's clinical coverage policies. Refer to **Attachment A, Section C**: **Procedure Codes**, for a listing of the established lifetime expectancies and quantity limitations for

Durable Medical Equipment and Supplies. To request a medical necessity review for an item not listed, see **sections 1.2**, **2.2 and Attachment D** for instructions.

5.5 Durable Medical Equipment and Supplies Limitations

Medicaid and NCHC may place appropriate limits, based on medical necessity criteria, on Durable Medical Equipment and Supplies. When the prescribing physician, physician assistant, or nurse practitioner, orders equipment or supplies beyond these limits, the provider shall seek authorization for payment for these items through NCTracks.

The medical equipment provider shall submit an override request to DMA which contains the following information:

a. A statement requesting an override of the quantity or life expectancy limitation and an explanation of why an override is needed.

b. The item (including HCPCS code) an override is needed for.

c. A prescription for the additional quantity or item the override is needed for.

d. A letter of medical necessity stating the medical need for the additional quantity requested, written by the physician, physician's assistant, nurse practitioner, or therapist.

e. A copy of the remittance and status advice statement showing a denial by Medicaid or NCHC.

The override request is reviewed for appropriateness and medical necessity and a written decision, either an override letter or a denial letter, is returned to the medical equipment provider. Beneficiaries are notified in writing if the override request is denied.

Refer to **Attachment A, Section C: Procedure Code(s)** for a listing of the established lifetime expectancies and quantity limitations for Durable Medical Equipment and Supplies. To request a medical necessity review for an item not listed, see **sections 1.2**, **2.2 and Attachment D** for instructions.

5.6 Delivery of Service

Providers shall dispense Durable Medical Equipment and Supplies as quickly as possible due to the medical necessity identified for an item. However, providers shall not deliver an item requiring prior approval before approval has been received. Providers who deliver before receiving prior approval do so at their own risk.

5.6.1 Delivery directly to the beneficiary

When an item is delivered directly to a beneficiary, the delivery slip must be signed by the beneficiary or a designee. The provider shall assemble the equipment and provide teaching and training on the safe use of the equipment. The provider shall ensure the equipment or supply is appropriate for the beneficiary's needs, and the beneficiary will be educated on the lifetime expectancy and the warranty of the item.

5.6.2 Utilizing Delivery or Shipping Service

When a provider utilizes a shipping service or mail order, the provider shall report the shipping date as the date of service on the claim. Proof of delivery is required. The provider's records shall include the shipping service's package

identification number for the package sent to the beneficiary. The shipping service's tracking slip must reference each individual package, the delivery address, the corresponding package identification number given by the shipping service, and the delivery date. In case of lost, stolen, damaged or incomplete delivery of specified medical equipment or supplies; it is the provider's responsibility to replace the specified medical equipment or supplies without cost to the beneficiary or Medicaid and NCHC. It is expected that the replacement occurs within 48 hours.

5.7 Monitoring Care

5.7.1 Assuring Continuing Need for Rental Items and Supplies

Providers are expected to be alert to changes in the beneficiary's needs for rental items and supplies, and work with the physician, physician assistant, or nurse practitioner, to implement the changes. At a minimum, the continuing need to provide a rental item (one that is not subject to prior approval) or a supply must be verified with the attending physician, physician assistant, or nurse practitioner, at least every 12 months. If there is a need for one of these items beyond 12 months from the date of last signed CMN/PA, a new CMN/PA must be completed and signed by the physician, physician assistant, or nurse practitioner, for the continued coverage. The provider shall obtain the signed form before billing for any services beyond 12 months.

5.8 Servicing and Repairing Medical Equipment

Service and repair of medical equipment is handled in one of three ways:

Rental Equipment: Service and repairs are provided as part of the rental arrangement with no additional charge to Medicaid or NCHC.

Purchased Equipment Warranty: Service and repairs are handled under any warranty coverage an item may have. If there is no warranty, providers may request prior approval to perform the needed service and repairs by submitting a completed CMN/PA form with a repair estimate to NCTracks. The estimate must show a breakdown of charges for parts and the number of hours of labor. No charge is allowed for pick-up or delivery of the item or for the assembly of Medicaid or NCHC reimbursed parts.

Purchased Equipment Non-Warranty: Service or repair is covered if the equipment is owned by the beneficiary and if the repair is not covered under the warranty. A repair estimate must be provided. The estimate must show a breakdown of charges for parts and the number of hours of labor. No charge is allowed for pick-up or delivery, for the assembly of Medicaid or NCHC reimbursed parts or for freight or the provider's travel time or expenses. All the following information must be entered in block 25 of the CMN/PA form:

a. The description and HCPCS code of the item being serviced or repaired.
b. The age of the item.
c. The number of times the item has been previously repaired.
d. The current replacement cost.

Note: Providers shall have emergency repair service available 24-hours a day, seven days a week for any life-sustaining equipment they provide.

Note: Medicaid and NCHC shall not cover maintenance or service contracts.

5.9 Replacing Medical Equipment

Medicaid or NCHC may consider replacing the item, when repairing is no longer cost-effective and the item is out of warranty, Refer to **Attachment A, Section C: Procedure Codes(s).** To request a medical necessity review for an item not listed, see **sections 1.2**, **2.2 and Attachment D** for instructions.

Note: When requesting prior approval for the replacement of an item before its usual life expectancy has ended, explain on the CMN/PA form why the replacement is needed.

Specific documentation, in addition to the prescription and CMN/PA form, is required in the following situations:

a. In cases of equipment loss or damage beyond repair, a letter from the social worker, case manager or child service coordinator explaining the circumstances.
b. In cases of theft, a copy of the police report or a letter from the appropriate person with knowledge of the occurrence, such as the school principal, social worker, etc.
c. In cases of equipment destruction by fire, a copy of the fire report.

5.10 Changing Suppliers

A change in suppliers may occur for various reasons, including a beneficiary exercising his freedom of choice of suppliers. When the change involves a transfer of responsibility for providing a rental item or oxygen and oxygen equipment, the transfer must be coordinated with the new supplier and the prescribing physician, physician assistant, or nurse practitioner.

For the new provider to get prior approval to provide rental equipment that has been supplied by the previous provider, the new provider shall submit a pick-up slip from the first provider showing the equipment has been picked-up and new equipment is needed. The previous provider shall submit a pick-up slip that includes the provider's name, beneficiary's name, item picked up, and date item was picked up. Failure to submit a pick-up slip to the new provider within 30 calendar days will result in an investigation and possible recoupment of funds.

5.10.1 Changing Suppliers for Oxygen and Oxygen Equipment

The steps for transferring responsibility are as follows:

a. The new provider asks the previous provider for a copy of the current CMN/PA form.
b. The previous provider corrects the "TO" date on the form to the last date that it is responsible for service.
c. The previous provider sends a copy of the corrected CMN/PA to the new provider.
d. The new provider obtains a new CMN/PA form signed by the physician, physician assistant, or nurse practitioner, and forwards it to the address listed on the form along with a copy of the old CMN/PA form.

5.11 Terminating Rentals

The beneficiary, physician, physician assistant, or nurse practitioner, the supplier, Medicaid, or NCHC may terminate the rental of an item during the rental period. If the

rental is terminated, providers may reclaim the equipment from the beneficiary within 30 calendar days.

Note: Medical equipment rented under the "capped rental" rules becomes the beneficiary's property when the total rental payments reach the Medicaid or NCHC-allowable new purchase price for the item. Providers may not reclaim an item after it becomes the beneficiary's property.

6.0 Provider(s) Eligible to Bill for the Procedure, Product, or Service

To be eligible to bill for the procedure, product, or service related to this policy, the provider(s) shall:

a. meet Medicaid or NCHC qualifications for participation;

b. have a current and signed Department of Health and Human Services (DHHS) Provider Administrative Participation Agreement; and

c. bill only for procedures, products, and services that are within the scope of their clinical practice, as defined by the appropriate licensing entity.

6.1 Provider Qualifications

Providers shall be enrolled with Medicaid as a Durable Medical Equipment and Supplies provider and meet the following conditions to qualify for participation with Medicaid and NCHC as a provider.

a. Providers shall not accept prescriptions for Medicaid or NCHC covered equipment from any physician, physician assistant, or nurse practitioner, who has an ownership interest in their agency.

b. Providers shall be enrolled and participate in Medicare as a medical equipment supplier. When the beneficiary is insured under NC Health Choice, the NCHC provider is exempt from the requirement to be enrolled and participate in Medicare.

c. Service must be provided on an emergency basis, 24 hours per day, 7 days per week, for life-sustaining equipment.

d. The providing agency shall be located within 40 miles of the North Carolina border in a contiguous state from which North Carolina beneficiaries living on the border can use the agency as a general practice. Out-of-state providers more than 40 miles outside of the North Carolina border may enroll with DMA when the medically necessary product they supply or manufacture is not reasonably available through an enrolled provider located within 40 miles of the North Carolina border.

e. Refer to http://www.ncbop.org under the topic *DME Suppliers and Pharmacy Law/Rules* for other rules that may apply to Durable Medical Equipment and Supplies providers.

f. Providers shall be either:

   1. a business entity authorized to conduct business in the state or in the locality where the business site is located. Proof of authorization shall include a certificate of assumed name, certificate of authority, certificate of good standing, license, permit or privilege license; or

   2. a Medicaid-enrolled home health agency, a state agency, a local health department, a local lead agency for the CAP for Disabled Adults, a local lead agency for the CAP for Individuals with Intellectual/ Developmental Disabilities,

or an agency that provides case management for the Community Alternatives Program for Children.

Note: Providers shall be enrolled and meet the provider qualifications on the date that service is provided.

Note: An agency enrolled to provide Home Infusion Therapy (HIT) may also provide EN. (A HIT provider shall be a home care agency licensed by the Division of Health Service Regulation to provide infusion nursing services and shall have service available 24 hours a day, seven days a week.)

6.2 Federal Laws

Providers shall comply with the following requirements in addition to the laws specifically pertaining to Medicaid and NCHC:

a. **Title VI of the Civil Rights Act of 1964,** which states that "no person in the United States shall, on the grounds of race, color, or national origin, be excluded from participation under any program or activity receiving federal financial assistance."
b. **Section 504 of the Rehabilitation Act of 1973,** as amended, which states that "no otherwise qualified handicapped individual in the United States shall, solely by reason of his handicap, be excluded from the participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving federal financial assistance."
c. **The Americans with Disabilities Act of 1990,** which prohibits exclusion from participation in or denial of services because the agency's facilities are not accessible to individuals with a disability.

6.3 Seeking Other Sources of Payment

Medicaid providers shall take all reasonable measures to determine the legal liabilities of third parties, including Medicare and private insurance, to pay for services. If third party liability is established, providers shall bill the third party before billing Medicaid. NC Health Choice is the sole insurer and sole payer. NC Health Choice providers are exempt from identifying and billing third party payers.

Refer to the *NCTracks Provider Claims and Billing Assistance Guide*: https://www.nctracks.nc.gov/content/public/providers/provider-manuals.html for additional information.

6.4 Accepting Payment

Providers shall accept payment in full.

Refer to the *NCTracks Provider Claims and Billing Assistance Guide*: https://www.nctracks.nc.gov/content/public/providers/provider-manuals.html for additional information.

6.5 Disclosing Ownership Information

Providers shall disclose ownership and control information, and information about the provider's agency's owners or employees that have been convicted of criminal offenses against Medicare, Medicaid or NCHC, and the Title XX services program.

7.0 Additional Requirements

Note: Refer to Subsection 2.2.1 regarding EPSDT Exception to Policy Limitations for a Medicaid Beneficiary under 21 Years of Age.

7.1 Compliance

Provider(s) shall comply with the following in effect at the time the service is rendered:

a. All applicable agreements, federal, state and local laws and regulations including the Health Insurance Portability and Accountability Act (HIPAA) and record retention requirements; and
b. All DMA's clinical (medical) coverage policies, guidelines, policies, provider manuals, implementation updates, and bulletins published by the Centers for Medicare and Medicaid Services (CMS), DHHS, DHHS division(s) or fiscal contractor(s).

7.2 Record Keeping

The provider shall furnish any information that the U.S. Department of Health and Human Services and its agents, DMA and its agents or the State Medicaid Fraud Investigation Unit regarding payments received for providing Medicaid or NCHC services.

Providers shall keep the following documentation of their services:

a. The prescription for the item signed by the physician, physician assistant, or nurse practitioner, specifying the order as much as possible (e.g., number being ordered, frequency to be used, duration of prescription, etc.).
b. The original CMN/PA form for Durable Medical Equipment and Supplies.
c. The original orders signed by the physician, physician assistant, or nurse practitioner, that were used to provide enteral nutrition.
d. A full description of all item(s) supplied to a beneficiary.
e. The dates the items were supplied—the delivery date for purchased items or the delivery and pickup dates for rental items, including signed pick-up and delivery slips. The delivery slip must be signed by the beneficiary or the beneficiary's designee when the delivery is direct to the beneficiary. When utilizing delivery or shipping services, all requirements as outlined under **Subsection 5.6.2** shall apply.
f. A full description of any service or repairs, including details of parts and labor, applicable warranty information, and the date of the service or repair. If the item is removed from the beneficiary's environment for service or repair, record the date of removal and the date of return.

Note: All beneficiary information, including the beneficiary's Medicaid or NCHC status, shall be kept confidential. Provide this information only to those who are authorized to receive it.

7.3 Coordinating Care

The Durable Medical Equipment and Supplies provider shall be responsible for determining what other services the beneficiary is receiving and for coordinating care to ensure there is no duplication of service.

8.0 Policy Implementation/Revision Information

Original Effective Date: March 1, 2003

Revision Information:

Date	Section Revised	Change
06/01/2003	Section 6.3, 6.4, 6.5	Text pertaining to provider responsibilities for payment and disclosure was added; effective with date of publication 03/01/03.
06/01/2003	Section 5.3.12, Respiratory Devices	Codes E0452 and E0453 were deleted and replaced with codes K0532 and K0533, respectively.
08/01/2003	Attachment B, block 26	The reminder for billing rentals was updated to reflect the implementation of modifiers.
08/01/2003	Attachment C, block 24c	The instruction for block 24c, Type of Service Code, was updated to read "leave blank."
08/01/2003	Attachment C, block 24d	The instruction for block 24d, Procedures, Services, was updated to state that providers must bill with modifiers NU, UE, and RR.
08/01/2003	Attachment C, claim form examples	Claim examples were updated to reflect the use of modifiers NU, UE, and RR.
09/01/2003	Section 5.3.16	Code W4006 was deleted and replaced with codes E0691 and E0692.
09/01/2003	Section 5.3.17	Code W4007, isolette, was deleted.
09/01/2003	Section 5.3.18 through 5.3.21	These sections were renumbered to 5.3.17 through 5.3.20
09/01/2003	Attachment A, block 24	Code W4006 was deleted and replaced with codes E0691 and E0692. The reference to code W4007 was deleted.
10/01/2003	Section 5.3.7	Code W4127 was deleted and replaced with E1037 and E1038.
10/01/2003	Section 5.3.8	Code W4029 was deleted. Subsequent sections were renumbered.
10/01/2003	Section 5.3.10	This section was renumbered to 5.3.9. The references to codes W4040 and W4041 on page 22 were replaced with codes S8120 and S8121. The reference to code W4042 was deleted.
10/01/2003	Section 5.3.12	This section was renumbered to 5.3.11. Codes W4011 and W4121 were deleted and replaced with E0445.
10/01/2003	Attachment A, block 24	Code E0608 was deleted and replaced with E0619.

Date	Section Revised	Change
11/01/2003	Section 5.3.1	Code W4684 was deleted; W4692 and W4693 were deleted and replaced with E0148; W4694 was deleted and replaced with E0149; W4724 and W4725 were deleted and replaced with K0549; W4727, W4728, and W4729 were deleted and replaced with K0549 and K0550; W4679, W4680, W4681, W4682, and W4683 were deleted and replaced by E0168.
01/01/2004	Section 5.3.1	Codes W4685 and W4686 were end-dated and replaced with E0248; W4687 was end-dated and replaced with E0247; K0459 was end-dated and replaced with E0303; K0550 was end-dated and replaced with E0304.
01/01/2004	Section 5.3.6	Codes K0538 was end-dated and replaced with E2042. Codes K0539 and K0540 were end-dated and replaced with A6550 and A6551; criteria for these items was deleted from the section because they do not require prior approval.
01/01/2004	Section 5.3.7	Code K0016 was end-dated and replaced with E0973. Codes K0022 and K0029 were end-dated and replaced with E0982. Code K0030 was end-dated and was not replaced. Code K0025 was end-dated and replaced with E0996. Code K0028 was end-dated and replaced E1226. Code K0048 was end-dated and replaced with E0990. Codes KL0054, K0055, K0057, and K0058 were end-dated and were not replaced. Codes K0062 and K0063 were end-dated and replaced with E0967. Codes K0088 was end-dated and replaced with E2366. Code K0089 was end-dated and replaced with E2367.
01/01/2004	Section 5.3.11	Code K0533 was end-dated and replaced with E0471. Code K0532 was end-dated and replaced with E0470.
01/01/2004	Section 5.7	Code W4005 was end-dated and replaced E1340.
02/01/2004	Section 5.3.13	Criteria for coverage of ultrasonic osteogenesis stimulators were added.
02/01/2004	Section 5.3.11	Code E0608 was deleted and replaced with E0619.
03/01/2004	Sections 5.3.1; 5.3.7; 5.3.11	National miscellaneous HCPCS codes were added to state-created codes.
03/01/2004	Section 5.3.13	Criteria were added for Non-Invasive Electrical Osteogenesis Stimulators for Spinal Applications.
03/01/2004	Attachment A, Block 26	Instructions were added on how to complete the CMN/PA form for approval of items with a national miscellaneous code and the CMN/PA example was revised.
03/01/2004	Attachment C, Block 23	Instructions were added on when to include the Service Request Number and the example of the claim form for DME was revised.
03/01/2004	Attachment D	Attachment D was re-numbered to Attachment E and the list of lifetime expectancies for DME items was added as Attachment D.
08/01/2004	Section 5.3.10	Criteria for segmental and non-segmental pneumatic compressors and appliances were clarified.

Date	Section Revised	Change
10/01/2004	Section 5.3.1	HCPCS codes W4698 through W4700 were end-dated and replaced with E2001 and E2202; W4701 through W4703 were end-dated and replaced with E2203 and E2204; W4707 through W4712 were end-dated and replaced with E2340, E2341, E2342, and E2343; K0651 was added.
10/01/2004	Section 5.3.7	HCPCS code E0192 was end-dated and replaced with K0652 through K0657; K0023 and K0024 were end-dated and replaced with K0660 and K0661; W4148 was end-dated and replaced with K0662 through K0665; E0964 was end-dated and replaced with K0650. The code descriptions for K0108/W4117 and K0108/W4118 were updated.
10/01/2004	Attachment A	The example of the CMN/PA form for DME was revised to reflect new codes.
10/01/2004	Attachment D	The list of Lifetime Expectancies and Quantity Limitations for DME was revised to include new codes.
02/01/2005	Sections 5.3.1, 5.3.7, and 5.3.11	HCPCS codes K0059-K0061, K0081, K0650-K0657, K0660-K0665, E0176-E0179, E1091, W4122-W4126, W4128, W4129, and W4134-W4137 were end-dated and replaced with new codes. Code descriptions were updated.
02/01/2005	Attachment D	The list of Lifetime Expectancies and Quantity Limitations for DME was revised to include new codes.
07/01/2005	Section 5.3.7	HCPCS codes E2294, K0108/W4138, K0108/W4151, and E2603-E2606 were end-dated and replaced with new codes. Code descriptions were updated.
07/01/2005	Section 5.3.17 and 5.3.18	These sections, related to orthotics and prosthetics, were deleted.
07/01/2005	Section 5.8	Information related to repairing and servicing orthotics and prosthetics was deleted.
07/01/2005	Attachment D	The list of Lifetime Expectancies and Quantity Limitations for DME was revised to include new codes.
08/01/2005	Attachment A	Instructions were updated to comply with revised CMN/PA form.
09/01/2005	Section 2.2	The special provision related to EPSDT was revised.
09/01/2005	Section 5.3.16	HCPCS code E0609 was end-dated and replaced with E2100
10/01/2005	Section 8.7	Information related to co-payments was added.
10/01/2005	Attachment D	Quantity limits were added for A7032 AND A7034 through A7039.
12/01/2005	Section 2.2	The website address for DMA's EDPST policy instructions was added to this section.
12/01/2005	Section 8.3	The information pertaining to crossover claims was updated.
01/01/2006	Section 5.3.1 and Attachment A	HCPCS code W4737 was end-dated and replaced with codes E2371 and E2372; W4721 was end-dated and replaced with codes E0911 and E0912.
01/01/2006	Section 5.3.7 and Attachment A	The description for HCPCS code E1038 was revised. HCPCS codes E1025, E1026, and E1027 were end-dated and deleted from the policy.

Date	Section Revised	Change
01/01/2006	Section 5.3.17 and Attachment A, block 24.	The description for HCPCS code E0935 was revised.
01/01/2006	Attachment D	HCPCS code A4254 was end-dated and replaced with A4233, A4234, A4235, and A4236; E0972 was end-dated and replaced with E0705; K0064 was end-dated and replaced with E2216; K0066 was end-dated and replaced with E2220; K0067 was end-dated and replaced with E2211; K0068 was end-dated and replaced with E2212; K0074 was end-dated and replaced with E2214; K0075 was end-dated and replaced with E2217; K0076 was end-dated and replaced with E2221; K0078 was end-dated and replaced with E2215; K0102 was end-dated and replaced with E2207; K0104 was end-dated and replaced with E2208; and K0106 was end-dated and replaced with E2209.
01/01/2006	Attachment D	The descriptions for HCPCS codes A4215, A6550, A7032, A7033, B4149, and E0971.
01/01/2006	Attachment D	The following HCPCS codes, descriptions and lifetime expectancies were added to the attachment: E1039, E2210, E2213, E2218, E2219, E2222, E2223, E2224, E2225, and E2226.
01/01/2006	Attachment D	HCPCS code A6551 was end-dated and deleted from the policy.
02/01/2006	Attachment B, Step #6	Information pertaining to denied prior approval requests was updated.
04/01/2006	Section 6.1	Information about when an out-of-state provider can enroll with N.C. Medicaid was added to item #4.
04/01/2006	Section 6.1	A permit or letter of exemption from the N.C. Board of Pharmacy was added as a requirement.
05/01/2006	Attachment D	HCPCS code L8501 was added to the table as a covered code.
07/01/2006	Section 5.3.7	Added HCPCS codes E1029 and E1030 as covered codes.
08/01/2006	Attachment D	Added HCPCS codes K0734 through K0737 as covered codes.
09/01/2006	Section 5.3.11	Coverage criteria and requirements for respiratory assist devices and continuous positive airway pressure devices were updated.
09/01/2006	Section 5.3.18	Coverage criteria for high-frequency chest wall oscillation device added to policy effective with date of service June 1, 2006.
09/01/2006	Attachment D	HCPCS codes E0483, A7025 and A7026 were added to the list of codes.
12/01/2006	Section 2.2	The special provision related to EPSDT was revised.
12/01/2006	Sections 3.0, 4.0, and 5.0	A note regarding EPSDT was added to these sections.
01/01/2007	All sections and attachment(s)	HCPCS codes E0164, E0166, E0180, E2320, and K0090 through K0098, W4704 through W4706, K0010, and K0011 were end-dated and removed.

Date	Section Revised	Change
01/01/2007	All sections and attachment(s)	HCPCS code descriptions for E0163, E0165, E0167, 30181, E0182, E0720, E0730, E0967, and E2209 were revised.
01/01/2007	Appendix D, Capped Rental/Purchase tables	Multiple HCPCS codes in the ranges of E2373 through E2396 and K0733 through K0898 were added.
03/01/2007	Section 2.2	EPSDT statement was updated.
03/01/2007	Attachment D	HCPCS procedure codes E2601 through E2608 and K0734 through K0737 were removed from Inexpensive or Routinely Purchased Items and placed in Capped Rental/Purchase. HCPCS procedure codes K0552 and L8501 were removed from Inexpensive or Routinely Purchased Items and placed in DME-Related Supplies. HCPCS procedure codes A4614, A7006, E0424, E0431, E0434, and E0439 were removed from Frequently Serviced Items and placed in Oxygen and Oxygen-Related Items. HCPCS procedure codes A7030 and A7031 were added to DME-Related Supplies.
03/01/2007	Section 5.3.19 and Attachment D	Coverage added for cough-stimulating device, alternating positive and negative airway pressure (E0482).
04/01/2007	Section 5.3.20	Coverage added for Farrell valve enteral gastric pressure relief system.
04/01/2007	Section 5.8	Removed requirement for hourly labor rate to be included in repair estimates.
04/01/2007	Sections 2.2, 3.0, 4.0, and 5.0	EPSDT information was revised to clarify exceptions to policy limitations for beneficiaries under 21 years of age.
05/01/2007	Section 5.3.1	Transferred some power wheelchairs previously designated as “oversize equipment” into the standard wheelchair category (Section 5.3.7).
05/01/2007	Section 5.3.7	Restored the requirements for power wheelchairs, which were inadvertently deleted in the January 1, 2007, version. Reordered the items so that all manual wheelchairs are together, followed by manual wheelchair accessories. The same organization applies to power wheelchairs and their accessories.
06/01/2007	All sections and attachment(s)	Reformatted lists and styles to be consistent with other DMA documents.
06/01/2007	Section 5.3.7, Attachment D	Removed end-dated codes K0108/W4146 and K0108/W4147; added replacement codes E1002 through E1008.
06/01/2007	Section 7.2	Reformatted the section to set off headings more clearly; moved statement about restrictions on HIT and Hospice service to those subsections; moved a general statement to the beginning of the section.
08/01/2007	Section 6.1	Changed the name of Division of Facility Services (DFS) to Division of Health Service Regulation (DHSR).
01/01/2008	Section 5.3.7	HCPCS code update: deleted E2618; changed the description of E2373; added E2312 and E2313
01/01/2008	Section 5.3.8	HCPCS code update: changed the description of E0630

Date	Section Revised	Change
01/01/2008	Section 5.3.9	Updated the oxygen policy to reflect current standards of practice and Medicare's coverage criteria. Added HCPCS codes E1392 and K0738 to fee schedule. Added modifiers to code E1390 for special reimbursement rates.
01/01/2008	Section 5.10	Deleted requirement to perform a new study to change suppliers.
01/01/2008	Section 5.11	Deleted section on changing the type of oxygen equipment.
01/01/2008	old Section 8.0	Billing Guidelines was renamed Claims-Related Information, moved to **Attachment A**, and reorganized according to a standard outline. The previous Section 9.0 became Section 8.0, and existing attachments were renumbered in sequence.
01/01/2008	Attachment E	HCPCS code update: deleted B4086, E2618, and W4210; changed the description of B4034, E0630, E2205, and E2373; added A7027, A7028, A7029, B4087, B4088, E2227, E2228, E2312, and E2313.
01/01/2008	All sections and attachment(s)	Removed boldface as a designation for Medicare coverage and asterisks as indicators of prior approval requirements.
04/01/2008	Sections 5.2 and 5.3.7, Attachments C and F	EDS took over the prior approval of pediatric mobility devices from Children's Special Health Services. Deleted references to CSHS and instructions for contacting them.
08/11/2008 (eff. 01/01/2008)	Attachment E	Corrected quantity limitation in HCPCS code B4088 from 2 per month to 4 per year. This is a correction to a typographical error, not a change in actual coverage.
01/01/2009	Section 5.3.21	Added this section on canes, crutches, walkers, and gait trainers.
01/01/2009	Attachment E	Revised lifetime expectancies for HCPCS codes A4637, E0100, E0105, E0110, E0111, E0112, E0114, E0130, E0135, E0141, E0143, E0154; added HCPCS codes A4635, A4636, E0113, E0118, E0155, E0156, E0158, E8000, E8001, and E8002; added miscellaneous HCPCS code E1399.
02/01/2009 (eff. 07/01/2008)	Section 5.3.22, Attachment E	Added section and codes on oral nutrition.
02/01/2009	Section 5.3.23	Added section and codes on augmentative and alternative communication devices.
02/01/2009 (eff. 01/01/2009)	Attachment E	HCPCS code update: changed descriptions of A6257 and A6258; added A9284, E1354, E1355, E1356, E1357, E1358, E2231, and E2295. Corrected descriptions of A7520, A7521, and A7522.
05/01/2009	Section 5.3.22	Added URL for Oral Nutrition Request Form.
05/01/2009	All sections and attachment(s)	Corrected URLs to conform to new DMA website organization.
06/01/2009	5.3.14	Revised coverage criteria for external insulin pumps.
11/01/2009	5.3.24	Added section and codes on Standers
02/16/2011	Attachment E	Quantity for code A7000 changed from 1/Month to 10/Month

Date	Section Revised	Change
04/20/2011	Subsection 5.3.11	Added "Pressure support ventilator, with volume control mode, may include pressure control mode, used with invasive interface (e.g., tracheostomy tube) (E0463)"
07/01/2011	Subsection 5.5.1	Added Subsection 5.5.1 Override Process
10/01/2011	Throughout	Updated policy template language and formatting
07/01/2012	Subsection 5.3.6	Added Prior approval criteria on Rental wheelchairs
07/01/2012	Subsection 5.6.1	Added Subsection 5.6.1 Delivery directly to the recipient
07/01/2012	Subsection 5.6.2	Added Subsection 5.6.2 utilizing delivery or Shipping Service.
07/01/2012	Subsection 7.2	Added and referenced Subsection 5.6.1 and 5.6.2 to Subsection 7.2.e Record Keeping
02/01/2013	Attachment A©	Attachment E relocated information to Attachment A©
02/01/2013	All sections and attachment(s)	Merge Medicaid and NCHC current coverage into one policy.
02/01/2013	All sections and attachment(s)	Replaced "recipient" with "beneficiary."
03/01/2013	Subsection 5.3.1	Item "d." Total Electric Hospital Bed – Wording revised to clarify requirements
07/01/2013	Subsection 5.3.9	Replaced "written statement" with "medical documentation" to reflect process changes.
07/01/2013	Subsection 5.3.11	Deleted "The physician, physician assistant, or nurse practitioner shall document in block 11 and 25 of the CMN/PA form and attach the required documentation that the beneficiary meets the medical necessity requirement for RAD therapy along with the results of the polysomnogram (if required based on the diagnosis)."
07/01/2013	Subsection 5.3.11	Deleted "in block 11 and 25 of the CMN/PA form, or on attached documentation,"
07/01/2013	Subsection 5.3.11	Deleted "the physician, physician assistant, or nurse practitioner shall indicate in block 25 of the CMN/PA form or"
07/01/2013	Subsection 5.3.12	Deleted "the physician, physician assistant, or nurse practitioner shall indicate in block 25 of the CMN/PA form or"
07/01/2013	Attachment B	Deleted Attachment B due to those instructions becoming obsolete with new fiscal agent.
07/01/2013	Attachment C&D	Renumbered to now become Attachment B and Attachment C after the deletion of Attachment B. Updated references throughout the policy to reflect this change.
10/01/2015	All Sections and Attachments	Updated policy template language and added ICD-10 codes to comply with federally mandated 10/1/2015 implementation where applicable.
11/01/2015	Subsection 5.3.29	Added process change for the provision of DMES on the Date of Discharge from a Hospital.
11/01/2015	Attachment B	Specific codes to be provided on the date of Discharge from a Hospital.
02/15/2016	Subsection 5.3.29	Policy/Section name updated to Provision of DMES on the Date of Discharge from Specified Facilities.

Date	Section Revised	Change
02/15/2016	Subsection 5.3	Guidance for Electronic Signatures added
02/15/2016	Attachment B	Specific codes to be provided on the date of Discharge from Specified Facilities was updated.
11/01/2016	Subsection 5.3.9	Mirror Medicare oxygen recertification policy (Effective 04/25/2016 per the April 2016 Medicaid Special Bulletin)
11/01/2016	Subsection 5.3.11	Simplify recertification on ventilators (Effective 04/25/2016 per the April 2016 Medicaid Special Bulletin)
11/01/2016	Subsection 5.6.2	Mirror Medicare policy when using shipping or delivery service (Effective 04/25/2016 per the April 2016 Medicaid Special Bulletin)
11/01/2016	Attachment A	C: Codes: Annual HCPCS code update; end date code E0450 and E0463 replace and add HCPCS code E0465 – (Effective 01/01/2016)
11/01/2016	Subsection 5.3.9	Added clarifying language to items “d.” and “i.” and returned wording that had inadvertently been dropped during revision process. (Effective 04/25/2016 per the April 2016 Medicaid Special Bulletin)
11/01/2016	Subsection 5.3.9	Added clarifying language to items “i.” and “j.” (Effective 04/25/2016 per the April 2016 Medicaid Special Bulletin)
11/01/2016	Attachment D	Eliminated Carolina Access requirement from box 19 of example claim in Attachment D. (per September 2016 Special Medicaid Bulletin)
11/01/2016	Subsection 5.3.3, 5.3.5	Initial authorization extended from 3 to 6 months (Effective 10/1/16 per the October 2016 Medicaid Bulletin)
11/01/2016	Subsection 5.6.1	Added beneficiary education on useful life and warranty (Effective 10/1/16 per the October 2016 Medicaid Bulletin)
11/01/2016	Attachment B	Specific codes to be provided on the date of Discharge from Specified Facilities was updated. (Effective 10/1/16)
07/01/2017	All Sections and Attachments	Clinical coverage policy 5A, Durable Medical Equipment and Supplies, separated into three categorical policies: 5A-1, Physical Rehabilitation Equipment and Supplies, 5A-2, Respiratory Equipment and Supplies, and 5A-3, Nursing Equipment and Supplies. The technical change resulted in no substantive changes to the existing 5A clinical coverage policy language.
07/01/2017	Subsections 1.1, 1.2, 3.2.1, 5.3.1, 5.3.2, 5.3.4, 5.6.1 & 7.2	Language amended to comply with CMS 42 CFR Part 440.70, Home Health Services, Final Rule.
08/01/2017	All Sections and Attachments	Amended policy posted on this date, with an **EFFECTIVE Date** of 07/01/2017.
12/01/2017	All Sections	Policy language was amended to clarify compliance with the CMS Home Health Final Rule, 42CFR, Part 440.70. References to requesting items not listed in policy or the corresponding fee schedule were added in multiple locations throughout the policy.

Date	Section Revised	Change
12/01/2017	Attachment D	Added Attachment D: Requesting Unlisted DME and Supplies for Adults.

Attachment A: Claims-Related Information

Provider(s) shall comply with the, *NCTracks Provider Claims and Billing Assistance Guide*, Medicaid bulletins, fee schedules, DMA's clinical coverage policies and any other relevant documents for specific coverage and reimbursement for Medicaid and NCHC:

A. Claim Type

Professional (CMS-1500/837P transaction)

B. International Classification of Diseases, Tenth Revisions, Clinical Modification (ICD-10-CM) and Procedural Coding System (PCS)

Provider(s) shall report the ICD-10-CM and Procedural Coding System (PCS) to the highest level of specificity that supports medical necessity. Provider(s) shall use the current ICD-10 edition and any subsequent editions in effect at the time of service. Provider(s) shall refer to the applicable edition for code description, as it is no longer documented in the policy.

ICD-10-CM Code(s)			
Cough Stimulating Device			
B91	G12.22	G82.54	G73.1
G14	G12.29	G61.0	G70.81
G12.0	G12.20	G65.0	G70.2
G12.9	G35	G70.00	G70.89
G12.1	G82.50	G73.3	G70.9
G12.8	G82.51	G70.01	G71.2
G12.21	G82.52	G70.1	G71.0
	G82.53	G70.80	G71.11

ICD-10-CM Code(s)			
S22.20xA	S22.24xA	S22.41xB	S22.43xB
S22.20xB	S22.24xB	S22.41xD	S22.43xD
S22.21xA	S22.31xB	S22.41xG	S22.43xG
S22.21xB	S22.31xS	S22.41xS	S22.43xS
S22.22xA	S22.32xB	S22.42xB	S22.49xB
S22.22xB	S22.32xS	S22.42xD	S22.49xD
S22.23xA	S22.39xB	S22.42xG	S22.49xG
S22.23xB	S22.39xS	S22.42xS	S22.49xS

C. Procedure Code(s)

Provider(s) shall report the most specific billing code that accurately and completely describes the procedure, product or service provided. Provider(s) shall use the Current Procedural Terminology (CPT), Health Care Procedure Coding System (HCPCS), and UB-04 Data Specifications Manual (for a complete listing of valid revenue codes) and any subsequent editions in effect at the time of service. Provider(s) shall refer to the applicable edition for the code description, as it is no longer documented in the policy.

If no such specific CPT or HCPCS code exists, then the provider(s) shall report the procedure, product or service using the appropriate unlisted procedure or service code.

Refer to the **Durable Medical Equipment Fee Schedule** for the rates associated with the equipment, supplies, and services listed in the table below. The fee schedules are available on DMA's website: http://dma.ncdhhs.gov/. To request a medical necessity review for an item not listed, see **sections 1.2**, **2.2 and Attachment D** for instructions.

Lifetime Expectancies and Quantity Limitations for Durable Medical Equipment and Supplies

HCPCS Code	Item Description	Lifetime Expectancy or Quantity Limitation
	Oxygen Equipment and Supplies	
A4615	Cannula, nasal	N/A
A4616	Tubing (oxygen), per foot	N/A
A4617	Mouth piece	N/A
A4618	Breathing circuits	N/A
A7027	Combination oral/nasal mask, used with continuous positive airway pressure device, each	2 per year
A7028	Oral cushion for combination oral/nasal mask, replacement only, each	2 per year
A7029	Nasal pillows for combination oral/nasal mask, replacement only, pair	2 per year
A9284	Spirometer, non-electronic, includes all accessories	2 per year
E0424	Stationary compressed gaseous oxygen system, rental; includes container, contents, regulator, flowmeter, humidifier, nebulizer, cannula or mask and tubing.	N/A
E0431	Portable gaseous oxygen system, rental; includes portable container, regulator, flowmeter, humidifier, cannula or mask and tubing	N/A
E0433	Portable liquid oxygen system, rental; home liquefier used to fill portable liquid oxygen containers, includes portable containers, regulator, flowmeter, humidifier, cannula or mask and tubing, with or without supply reservoir and contents gauge	N/A
E0434	Portable liquid oxygen system, rental; includes portable container, supply reservoir, humidifier, flowmeter, refill adaptor, contents gauge, cannula or mask, and tubing	N/A
E0439	Stationary liquid oxygen system, rental; includes container, contents, regulator, flowmeter, humidifier, nebulizer, cannula or mask & tubing.	N/A
E0441	Stationary oxygen contents, gaseous, 1 month's supply = 1 unit	N/A
E0442	Stationary oxygen contents, liquid, 1 month's supply = 1 unit	N/A
E0443	Portable oxygen contents, gaseous, 1 month's supply = 1 unit	N/A
E0444	Portable oxygen contents, liquid, 1 month's supply = 1 unit	N/A
E0550	Humidifier, durable for extensive supplemental humidification during IPPB treatments or oxygen delivery	2 years
E0555	Humidifier, durable, glass or auto-clavable plastic bottle type, for use with regulator or flowmeter	2 years
E1354	Oxygen accessory, wheeled cart for portable cylinder or portable concentrator, any type, replacement only, each	5 years
E1355	Stand/rack	5 years
E1356	Oxygen accessory, battery pack/cartridge for portable concentrator, any type, replacement only, each	1 year
E1357	Oxygen accessory, battery charger for portable concentrator, any type, replacement only, each	1 year
E1358	Oxygen accessory, DC power adapter for portable concentrator, any type, replacement only, each	1 year
E1390	Oxygen concentrator, single delivery port, capable of delivering 85 percent or greater oxygen concentration at the prescribed flow rate	N/A
E1392	Portable oxygen concentrator, rental	N/A

HCPCS Code	Item Description	Lifetime Expectancy or Quantity Limitation
K0738	Portable gaseous oxygen system, rental; home compressor used to fill portable oxygen cylinders; includes portable containers, regulator, flowmeter, humidifier, cannula or mask, and tubing	N/A
S8120	Oxygen contents, gaseous, 1 unit equals 1 cubic foot	N/A
S8121	Oxygen contents, liquid, 1 unit equals 1 pound	N/A
W4001	CO_2 saturation monitor with accessories, probes	N/A
	Respiratory Devices	
E0470	Respiratory assist device, bi-level pressure capability, without backup rate feature, used with noninvasive interface, e.g., nasal or facial mask (intermittent assist device with continuous positive airway pressure device)	5 years
E0471	Respiratory assist device, bi-level pressure capability, with back-up rate feature, used with noninvasive interface, e.g., nasal or facial mask (intermittent assist device with continuous positive airway pressure device)	N/A
E0561	Humidifier, non-heated, used with positive airway pressure device	2 years
E0562	Humidifier, heated, used with positive airway pressure device	2 years
E0601	Continuous airway pressure (CPAP) device	5 years
A7030	Full face mask used with positive airway pressure device, each	2 per year
A7031	Face mask interface, replacement for full face mask, each	2 per year
A7032	Cushion for use on nasal mask interface, replacement only, each	2 per year
A7033	Pillow for use on nasal cannula type interface, replacement only, pair	2 per year
A7034	Nasal interface (mask or cannula type) used with positive airway pressure device with or without head strap	2 per year
A7035	Headgear used with positive airway pressure device	2 per year
A7036	Chinstrap used with positive airway pressure device	1 per year
A7037	Tubing used with positive airway pressure device	2 per year
A7038	Filter, disposable, used with positive airway pressure device	1 per month
A7039	Filter, non-disposable, used with positive airway pressure device	6 per year
	Respiratory Devices - Other	
E0465	Home ventilator, any type, used with invasive interface, (e.g., tracheostomy tube)	N/A
E0500	IPPB machine, all types, with built-in nebulization; manual or automatic valves; internal or external power source	N/A
E0550	Humidifier, durable for extensive supplemental humidification during IPPB treatments or oxygen delivery	2 years
E0565	Compressor, air power source for equipment which is not self- contained or cylinder driven	2 years
E0600	Respiratory suction pump, home model, portable or stationary, electric	5 years
A4483	Moisture exchanger, disposable, for use with invasive mechanical ventilation	60 per month
A4611	Battery, heavy duty; replacement for patient owned ventilator	N/A
A4612	Battery cables; replacement for patient-owned ventilator	N/A
A4613	Battery charger; replacement for patient-owned ventilator	N/A
	Respiratory Devices - Nebulizers	
E0570	Nebulizer, with compressor	3 years
E0575	Nebulizer, ultrasonic, large volume	1 year ages 0-20 2 years ages 21 and over
A7003	Administration set, with small volume nonfiltered pneumatic nebulizer, disposable	1 per month
A7004	Small volume nonfiltered pneumatic nebulizer, disposable	4 per month

HCPCS Code	Item Description	Lifetime Expectancy or Quantity Limitation
A7005	Administration set, with small volume nonfiltered pneumatic nebulizer, non-disposable	2 per year
A7006	Administration set, with small volume filtered pneumatic nebulizer	1 per month
A7007	Large volume nebulizer, disposable, unfilled, used with aerosol compressor	3 per month
A7010	Corrugated tubing, disposable, used with large volume nebulizer, 100 feet	1 per month
A7012	Water collection device, used with large volume nebulizer	3 per month
A7013	Filter, disposable, used with aerosol compressor or ultrasonic generator	1 per month
A7015	Aerosol mask, used with DME nebulizer	4 per month
	Respiratory Devices – Apnea Monitor	
E0619	Apnea monitor, with recording feature	N/A
A4556	Electrodes (e.g., apnea monitor), per pair	2 per month
A4557	Lead wires (e.g., apnea monitor), per pair	2 per month
	Respiratory Devices – Percussor	
E0480	Percussor, electric or pneumatic, home model	2 years
	Respiratory Devices – Oximeter	
E0445	Oximeter device for measuring blood oxygen levels non-invasively	N/A
	High Frequency Chest Wall Oscillation	
E0483	High frequency chest wall oscillation air-pulse generator system, (includes hoses and vest), each	Lifetime
E0484	Oscillatory positive expiratory pressure device, non-electric, any type, each	2 per lifetime
A7025	High frequency chest wall oscillation system vest, replacement for use with patient owned equipment, each	Lifetime
A7026	High frequency chest wall oscillation system hose, replacement for use with patient owned equipment, each	Lifetime
S8185	Flutter device	2 per lifetime
	Cough Stimulating Device	
E0482	Cough stimulating device, alternating positive and negative airway pressure	5 years
A7020	Interface for cough stimulating device, includes all components, replacement only	2 per year
	Miscellaneous Durable Medical Equipment and Supplies	
W4002	Manual ventilation bag (e.g. Ambu bag)	2 per year
A4614	Peak expiratory flow rate meter, hand held	2 per year
A4627	Spacer, bag or reservoir, with or without mask, for use with metered dose inhaler	3 per year
W4120	Disposable bags for Inspirease inhaler system, set of 3	4 per year
A4628	Oropharyngeal suction catheter, each	4 per month
A7000	Canister, disposable, used with suction pump, each	10 per month
A7001	Canister, non-disposable, used with suction pump, each	2 per year
A7002	Tubing, used with suction pump, each	2 per month
W4678	Replacement battery for portable suction pump	2 years
A4623	Tracheostomy, inner cannula	N/A
A4624	Tracheal suction catheter, any type, other than closed system, each	720 per month
A4625	Tracheostomy care kit for new tracheostomy	90 per month ages 0-20; 30 per month ages 21 and over
A4626	Tracheostomy cleaning brush, each	N/A

HCPCS Code	Item Description	Lifetime Expectancy or Quantity Limitation
A4629	Tracheostomy care kit for established tracheostomy	90 per month ages 0-20; 30 per month ages 21 and over
A7520	Tracheostomy/laryngectomy tube, non-cuffed, polyvinylchloride (PVC), silicone or equal, each	N/A
A7521	Tracheostomy/laryngectomy tube, cuffed, polyvinylchloride (PVC), silicone or equal, each	N/A
A7522	Tracheostomy/laryngectomy tube, stainless steel or equal (sterilizable and reusable), each	N/A
A7525	Tracheostomy mask, each	N/A
A7526	Tracheostomy tube collar/holder, each	12 per month
L8501	Tracheostomy speaking valve	7 per month
W4153	Tracheostomy ties, twill	2 per day

Unlisted Procedure or Service
CPT: The provider(s) shall refer to and comply with the Instructions for Use of the CPT Codebook, Unlisted Procedure or Service, and Special Report as documented in the current CPT in effect at the time of service.

HCPCS: The provider(s) shall refer to and comply with the Instructions for Use of HCPCS National Level II codes, Unlisted Procedure or Service and Special Report as documented in the current HCPCS edition in effect at the time of service.

D. Modifiers

Provider(s) shall follow applicable modifier guidelines.

Oxygen:
If a flow of greater than 4 liters per minute (LPM) is documented as medically necessary, the higher oxygen allowable will be paid to the supplier at 1.5 times the rate. The modifiers listed below are to be added to the oxygen code being used. If either of these modifiers is used, then only the 1.5 times the rate will be reimbursed and there will be no payment for the portable oxygen system.

QF: Prescribed amount of oxygen is greater than 4 LPM and portable oxygen is also prescribed

QG: Prescribed amount of oxygen is greater than 4 LPM and portable oxygen is not prescribed

E. Billing Units

Provider(s) shall report the appropriate code(s) used which determines the billing unit(s).

F. Place of Service

Home

G. Co-payments

For Medicaid refer to Medicaid State Plan, Attachment 4.18-A, page 1, located at http://dma.ncdhhs.gov/.
For NCHC refer to G.S. 108A-70.21(d), located at http://www.ncleg.net/EnactedLegislation/Statutes/HTML/BySection/Chapter_108A/GS_108A-70.21.html

Medicaid and NCHC eligible beneficiaries are exempt from co-payments.

H. Reimbursement

Providers shall bill their usual and customary charges.
For a schedule of rates, see: http://dma.ncdhhs.gov/

Attachment B: Provision of DMES on the Date of Discharge from Specified Facilities

Note: * indicates that item requires prior approval
BOLD indicates Medicare is primary payer for this item

Oxygen Equipment and Supplies **For Clinical Coverage and Prior Approval Criteria, refer to Subsection 5.3.1**	
E0431*	Portable gaseous oxygen system, rental; includes portable container, regulator, flowmeter, humidifier, cannula or mask and tubing
E0433*	Portable liquid oxygen system, rental; home liquefier used to fill portable liquid oxygen containers, includes portable containers, regulator, flowmeter, humidifier, cannula or mask and tubing, with or without supply reservoir and contents gauge
E0434*	Portable liquid oxygen system, rental; includes portable container, supply reservoir, humidifier, flowmeter, refill adaptor, contents gauge, cannula or mask, and tubing
E0439*	Stationary liquid oxygen system, rental; includes container, contents, regulator, flowmeter, humidifier, nebulizer, cannula or mask & tubing.
E1390*	Oxygen concentrator, single delivery port, capable of delivering 85 percent or greater oxygen concentration at the prescribed flow rate
E1392*	Portable oxygen concentrator, rental
K0738*	Portable gaseous oxygen system, rental; home compressor used to fill portable oxygen cylinders; includes portable containers, regulator, flowmeter, humidifier, cannula or mask, and tubing
W4001*	CO2 saturation monitor with accessories, probes
	Respiratory Devices - Nebulizers
E0570	Nebulizer, with compressor
A7003	Administration set, with small volume nonfiltered pneumatic nebulizer, disposable
A7005	Administration set, with small volume nonfiltered pneumatic nebulizer, non-disposable
A7013	Filter, disposable, used with aerosol compressor or ultrasonic generator
A7015	Aerosol mask, used with DME nebulizer

HCPCS Code	**Item Description**
Respiratory Devices – Apnea Monitor **For Clinical Coverage and Prior Approval Criteria, refer to Subsection 5.3.2**	
E0619*	Apnea monitor, with recording feature

HCPCS Code	Item Description
Respiratory Devices – Percussor **For Clinical Coverage and Prior Approval Criteria, refer to Subsection 5.3.2**	
E0480*	Percussor, electric or pneumatic, home model
Respiratory Devices – Oximeter **For Clinical Coverage and Prior Approval Criteria, refer to Subsection 5.3.2**	
E0445*	Oximeter device for measuring blood oxygen levels non-invasively
Cough Stimulating Device **For Clinical Coverage and Prior Approval Criteria, refer to Subsection 5.3.4**	
E0482*	Cough stimulating device, alternating positive and negative airway pressure
Miscellaneous Durable Medical Equipment and Supplies **For Clinical Coverage and Prior Approval Criteria, refer to Subsection 5.3.5**	
W4002*	Manual ventilation bag (e.g. Ambu bag)
A4627	Spacer, bag or reservoir, with or without mask, for use with metered dose inhaler

Attachment C: Completing a Claim for DME or EN Services

Refer to the following information for completing a CMS-1500 claim form for DME services.

Block #/Description	Instruction
1.	Place an **X** in the MEDICAID or NCHC block.
1a. Insured's ID Number	Enter the beneficiary's Medicaid or NCHC ID number (nine digits and the alpha suffix) from the beneficiary's Medicaid or NCHC ID card.
2. Beneficiary's Name	Enter the beneficiary's last name, first name and middle initial from the Medicaid or NCHC ID card.
3. Beneficiary's Birth Date/Sex	Enter eight numbers to show the beneficiary's date of birth - MMDDYYYY. The birth date is on the Medicaid or NCHC ID card. ***EXAMPLE:*** *November 14, 1949 is* **11141949**. Place an **X** in the appropriate block to show the beneficiary's sex.
4. Insured's Name.	Leave blank
5. Beneficiary's Address	Enter the beneficiary's street address, including the city, state and zip code. The information is on the Medicaid or NCHC ID card. Entering the telephone number is optional.
6.—8.	Leave blank.
9. Other Insurer's Name	Enter applicable private insurer's name or the appropriate Medicare override statement if you know that Medicare will not cover the billed item, using the EXACT wording shown below: *This is a Medicare non-covered service.* *Service does not meet Medicare criteria.* *Medicare benefits are exhausted.* ***REMEMBER:*** *You must have documentation to support the use of any of these statements.*
9a.—9d.	Enter applicable insurance information.
10. Is Beneficiary's Condition…?	Place an **X** in the appropriate block for each question.
11.—14.	Optional.
15.—16.	Leave blank.
17., 17a. and 18.	Optional.
19. Reserved for Local Use	Leave blank.
20. Outside Lab…	Leave blank.
21. Diagnosis or Nature of Illness	Enter the ICD-9-CM code(s) to describe the primary diagnosis related to the service. You may also enter related secondary diagnoses. Entering written descriptions is optional.
22. Medicaid Resubmission Code	Leave blank.
23. Prior Authorization Number	When billing a national miscellaneous code, enter the 11-digit Service Request Number (SRN) from block 26 (Prior Approval No.) on the CMN/PA form. For all other codes, leave this block blank.

Note: Blocks 24A through 24K are where you provide the details about what you are billing. There are several lines for listing services. Each line is called a "detail." When completing these blocks:

- Use one line for each HCPCS code that you bill on a given date.
- If you provide more than one unit of the same item on one day, include all the items on the same line. For example, if you provide 100 blood glucose strips (A4253) on August 2, include all of the strips on one line. Enter 2 units in 24G for that date of service.
- Include only dates of service in the SAME calendar month.
- Include only dates of service for which the beneficiary is eligible for Medicaid or NCHC.

Block #/Description	Instruction
24a. Date(s) of Service, From/To	Your entry depends upon the services: **Customized Equipment:** You may enter either the date of the physician's prescription or the date of delivery to the beneficiary's home as the date of service. Place the date in the **FROM** block. Enter the same date in the **TO** block. **Other Purchased Equipment - DME and EN:** Enter the date the item is delivered to the beneficiary in the **FROM** block. Enter the same date in the **TO** block. **Rental Equipment - DME and EN:** For the month being billed, enter the first day in that month that the item is at the beneficiary's residence in the **FROM** block. Enter the last day in that month that the item is at the beneficiary's residence in the **TO** block. Do NOT span calendar months. ***EXAMPLE:*** *An enteral pump is provided from 3/25/02 through 5/15/02. Submit three claims. On March's claim, enter* 032502 *in the* FROM *block and* 033102 *in the* TO *block. On April's claim, enter* 040102 *in the* FROM *block and* 043002 *in the* TO *block. On May's claim, enter* 050102 *in the* FROM *block and* 051502 *in the* TO *block.* **Service and Repairs:** Enter the date that the item is serviced or repaired in the beneficiary's home as the date of service. If the item is removed from the beneficiary's home for service or repairs, enter the date that it is returned. Place the date in the **FROM** block. Enter the same date in the **TO** block. **DME-Related Supplies:** Enter the date that the item is delivered to the beneficiary's residence in the **FROM** block. Enter the same date in the **TO** block. **EN Supply Kits:** Enter the date in the month that the therapy begins in the **FROM** block. If the therapy is continued from the prior month, enter the first of the month in the **FROM** block. Enter the last day of therapy for the month in the **TO** block. If the therapy extends into the next month, enter the last day of the current month in the **TO** block. Do NOT span calendar months. See the ***EXAMPLE*** under **Rental Equipment** for guidance. **EN Individual Supply Items:** Enter the date that the item is delivered to the beneficiary in the **FROM** block. Enter the same date in the **TO** block. **EN Formulae:** Enter the service dates for the formula in the **FROM** and **TO** blocks.
24b. Place of Service	Enter **12** to show the items are provided at the beneficiary's residence.
24c. Type of Services	Leave blank.

Block #/Description	Instruction
24d. Procedures, Services…	Enter the appropriate HCPCS code and modifier: **NU** for new purchase **UE** for used purchase **RR** for rental
24e. Diagnosis Code	Leave blank.
24f. Charges	Enter the total charge for the items on the line. For rental items, enter the full month's rental charge—do not prorate the charge if the item is provided less than a full month.
24g. Days or Units	Enter the number of units as follows: **Purchased Equipment (DME and EN):** Enter the number of units provided on the date of service. **Rental Equipment (DME and EN)—Other than Oxygen:** Enter **1**. **Oxygen and Oxygen Equipment:** Enter the units provided on the date of service. **Service and Repair:** Enter **1 unit for each 15-minute increment** being billed. **DME-Related Supplies:** Enter the number of units provided on the date of service. **EN Supply Kits:** Enter the number of consecutive days shown in 24A. **EN Individual Supply Items:** Enter the number of units provided on the dates of service. **EN Formulae:** Enter the number of units provided for the dates of service.
24h.—24i.	Leave blank.
24j.—24k.	Optional.
25. Federal Tax ID Number	Optional
26. Beneficiary's Account No.	Optional. You may enter your agency's record or account number for the beneficiary. The entry may be any combination of numbers and letters up to a total of nine characters. If you enter a number, it will appear on your RA. This will assist in reconciling your accounts.
27. Accept Assignment	Leave blank.
28. Total Charge	Enter the sum of the charges listed in Item **24F**.
29. Amount Paid	Enter the total amount received from third party payment sources.
30. Balance Due	Subtract the amount in Item **29** from the amount in Item **28** and enter the result here.
31. Signature of Physician or Supplier...	Leave blank if there is a signature on file with Medicaid and NCHC. Otherwise, an authorized representative of your agency must sign and date the claim in this block. A written signature stamp is acceptable.
32. Name and Address of Facility...	Optional.
33. Physician's/ Supplier's Billing Name...	Enter your agency's name, address, including ZIP code, and phone number. The name and address must be EXACTLY as shown on your Medicaid and NCHC DME participation agreement.
PIN#	Leave blank.
GRP#	Enter your seven-digit Medicaid and NCHC DME provider number.

Remember: When submitting a claim for other manually priced items (e.g., for external insulin pumps), an invoice must also be attached to the claim.

PLEASE DO NOT STAPLE IN THIS AREA

[redacted]

Example of Claim Form for DME

HEALTH INSURANCE CLAIM FORM

PICA

1. MEDICARE (Medicare #) [X] MEDICAID (Medicaid #) CHAMPUS (Sponsor's SSN) CHAMPVA (VA File #) GROUP HEALTH PLAN (SSN or ID) FECA BLK LUNG (SSN) OTHER (ID)

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1): 999-99-9999B

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Recipient Joe A.

3. PATIENT'S BIRTH DATE MM DD YY: 12 18 43 SEX M [X] F

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street): 123 Any Street

6. PATIENT RELATIONSHIP TO INSURED: Self Spouse Child Other

7. INSURED'S ADDRESS (No., Street)

CITY: Any Town STATE: NC

8. PATIENT STATUS: Single Married Other; Employed Full-Time Student Part-Time Student

CITY STATE

ZIP CODE: 12345 TELEPHONE (Include Area Code): (919) 123-1234

ZIP CODE TELEPHONE (INCLUDE AREA CODE) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES [X] NO

a. INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. AUTO ACCIDENT? YES [X] NO PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES [X] NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO *If yes*, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED _____ DATE _____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED _____

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

17a. I.D. NUMBER OF REFERRING PHYSICIAN

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)

1. 768.09
2. 428.0
3. 790.6
4.

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER: 04257738906

24. A DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1 03 28 04	03 31 04	12		E1390	RR		265 51	1				
2 03 28 04	03 31 04	12		E0431	RR		37 76	1				
3 03 28 04	03 28 04	12		K0001	UE		415 23	1				
4 03 28 04	03 28 04	12		E0607	NU		58 71	1				
5 03 28 04	03 28 04	12		K0108	NU		100 07	1				
6 04 12 04	04 12 04	12		E1340	NU		33 75	3				

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.: IAF0009

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO

28. TOTAL CHARGE: $ 911 03

29. AMOUNT PAID: $

30. BALANCE DUE: $ 911 03

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

A Provider 4/5/04

SIGNED DATE

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE # 910-555-1212

Acme Medical Supply
123 Any Street
Anytown, NC 12345

PIN# 7700000 GRP#

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88) **PLEASE PRINT OR TYPE** APPROVED OMB-0938-0008 FORM CMS-1500 (12-90), FORM RRB-1500, APPROVED OMB-1215-0055 FORM OWCP-1500, APPROVED OMB-0720-0001 (CHAMPUS)

Example of Claim Form for EN

PLEASE DO NOT STAPLE IN THIS AREA

[redacted]

HEALTH INSURANCE CLAIM FORM

PICA

1. MEDICARE (Medicare #) [X] MEDICAID (Medicaid #) CHAMPUS (Sponsor's SSN) CHAMPVA (VA File #) GROUP HEALTH PLAN (SSN or ID) FECA BLK LUNG (SSN) OTHER (ID)

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1): 123-45-6789F

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Recipient, Jane A

3. PATIENT'S BIRTH DATE MM DD YY: 06 20 44 SEX: M [ ] F [X]

4. INSURED'S NAME (Last Name, First Name, Middle Initial):

5. PATIENT'S ADDRESS (No., Street): 456 Any Street

6. PATIENT RELATIONSHIP TO INSURED: Self [ ] Spouse [ ] Child [ ] Other [ ]

7. INSURED'S ADDRESS (No., Street):

CITY: Anywhere STATE: NC

8. PATIENT STATUS: Single [ ] Married [ ] Other [ ]

CITY: STATE:

ZIP CODE: 54321 TELEPHONE (Include Area Code): (999)123-1234

Employed [ ] Full-Time Student [ ] Part-Time Student [ ]

ZIP CODE: TELEPHONE (INCLUDE AREA CODE): ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial):

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER:

a. OTHER INSURED'S POLICY OR GROUP NUMBER:

a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES [ ] NO [X]

a. INSURED'S DATE OF BIRTH MM DD YY: SEX M [ ] F [ ]

b. OTHER INSURED'S DATE OF BIRTH MM DD YY: SEX M [ ] F [ ]

b. AUTO ACCIDENT? YES [ ] NO [X] PLACE (State):

b. EMPLOYER'S NAME OR SCHOOL NAME:

c. EMPLOYER'S NAME OR SCHOOL NAME:

c. OTHER ACCIDENT? YES [ ] NO [X]

c. INSURANCE PLAN NAME OR PROGRAM NAME:

d. INSURANCE PLAN NAME OR PROGRAM NAME:

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES [ ] NO [ ] If yes, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED: DATE:

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED:

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

17a. I.D. NUMBER OF REFERRING PHYSICIAN

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES [ ] NO [ ] $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)

1. L 212 1
2. L
3. L
4. L

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1 09 01 02	09 30 02	12		B4150	NU		85 40	140				
2 09 01 02	09 30 02	12		B9002	RR		114 89	1				
3 09 01 02	09 30 02	12		B4035	NU		320 10	30				
4												
5												
6												

25. FEDERAL TAX I.D. NUMBER SSN EIN [ ]

26. PATIENT'S ACCOUNT NO. 99AZ0098

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES [ ] NO [ ]

28. TOTAL CHARGE $ 520 39

29. AMOUNT PAID $ 00 00

30. BALANCE DUE $ 520 39

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

A. Provider 10/10/02

SIGNED DATE

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE # 919-999-9999

A Medical Supply Company
9 South Street
Anywhere, NC 12345

PIN# GRP# 7700000

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88) **PLEASE PRINT OR TYPE** APPROVED OMB-0938-0008 FORM CMS-1500 (12-90), FORM RRB-1500, APPROVED OMB-1215-0055 FORM OWCP-1500, APPROVED OMB-0720-0001 (CHAMPUS)

Attachment D: Requesting Unlisted DME and Medical Supplies for Adults

In compliance with the Centers for Medicare & Medicaid Services (CMS) Home Health Final Rule, 42 CFR Part 440.70, please follow these guidelines when requesting medical necessity reviews for DME and medical supplies for adults not listed in **Attachment A, Section C** or the DME fee schedule.

a. The general requirements and criteria set forth in clinical coverage policy 5A-2 must be met. This includes, but is not limited to:
   1. The item being requested must fit the definition of durable medical equipment or medical supplies;
   2. The beneficiary must be enrolled in the N.C. Medicaid program and be eligible for the item;
   3. The provider must be enrolled in the N.C. Medicaid program with an appropriate taxonomy;
   4. The requested item must be safe, effective, economical and not intended for the convenience of the beneficiary, the beneficiary's caregiver, or the provider;
   5. The item must be medical in nature, generally recognized as an accepted method of treatment, and must not be experimental or investigational;
   6. The item must be ordered by a physician, physician assistant, or nurse practitioner; and
   7. The item must be medically necessary to maintain or improve a beneficiary's medical, physical or functional level, and appropriate for use in any non-institutional setting in which normal life activities take place;
   8. A documented face-to-face encounter with the beneficiary and the ordering physician, physician assistant, or nurse practitioner related to the primary reason the beneficiary requires the item must have occurred no more than six months prior to the initiation of durable medical equipment or medical supplies; and
   9. The beneficiary's need for the item must be reviewed by the ordering physician, physician assistant, or nurse practitioner at least annually.

b. If the provider determines that the applicable requirements and criteria set forth in clinical coverage policy 5A-2 have been met, then the provider may submit a completed Certificate of Medical Necessity/Prior Approval (CMN/PA) and the usual supportive prior authorization documentation, to the N.C. Division of Medical Assistance (DMA) for a medical necessity review.

c. The documentation should be **faxed directly to DMA at 919-715-1255** with a cover sheet to the attention of the **DME unit**. **Do not** submit these requests through NCTracks.

d. Items approved by this procedure will be manually priced. Please include the appropriate manual pricing documentation with the prior authorization request (see May 2017 Medicaid Bulletin for details).

e. The same timelines for review used by CSRA may also apply to this medical necessity review process.

f. If approved, the provider will be notified and given instructions for submitting claims.

g. If denied, the provider and beneficiary will be notified, and normal beneficiary appeal rights will apply.

h. Providers will be notified if the device requested is covered by a different N.C. Medicaid policy area or waiver program.

Additional Resources

For additional information, link to the DMA Durable Medical Equipment and Supplies web page, or the CMS final rule at 42 CFR Part 440.70.