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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.

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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 E**.

# 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. <u>Medicaid</u>**
None Apply.

**b. <u>NCHC</u>**
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 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 Negative Pressure Wound Therapy Electrical Pump, Stationary or Portable, and Related 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 E** for instructions.

Negative pressure wound therapy (NPWT) is the use of an electrical pump to convey sub-atmospheric pressure to a specialized wound dressing and thereby promote wound healing.

The NPWT pump and wound care set are covered when they are medically necessary for the beneficiary. These items require prior approval. Initial authorization is given for a maximum of six months.

For initial approval, the following criteria must be met:

The beneficiary has a chronic Stage III or Stage IV pressure ulcer, neuropathic ulcer, venous or arterial insufficiency ulcer, or chronic (present for at least 30 calendar days) ulcer of mixed etiology.

A complete wound therapy program, as described below, must have been considered and ruled out, or tried, prior to application of NPWT:

a. For all ulcers or wounds:
    1. Documentation in the beneficiary's clinical health care record of evaluation, care, and wound measurement by a licensed medical professional permitted to perform those tasks and responsibilities by their NC state licensing board;
    2. Application of dressings to maintain a moist wound environment;
    3. Debridement of necrotic tissue if present; and
    4. Evaluation of and provision for adequate nutritional status.
b. For Stage III or Stage IV ulcers:
    1. The beneficiary has been appropriately turned and positioned.
    2. A group 2 or 3 support surface has been used for pressure ulcers on the posterior trunk or pelvis (Note: A Group 2 or 3 support surface is not required if the ulcer is not on the trunk or pelvis).
    3. Moisture and incontinence have been appropriately managed.
c. For neuropathic (for example, diabetic) ulcers:
    1. The beneficiary has been on a comprehensive diabetic management program, and
    2. Reduction in pressure on a foot ulcer has been accomplished with appropriate modalities.
d. For venous insufficiency ulcers:
    1. Compression bandages and/or garments have been consistently applied; or if contraindicated to Peripheral Artery Disease (PAD);
    2. Lower extremity elevation and ambulation have been encouraged.

NPWT pumps must be capable of accommodating more than one wound dressing set when a beneficiary has multiple wounds. Therefore, more than one NPWT pump billing per beneficiary for the same time period is not covered.

An NPWT pump and supplies is not medically necessary when any of the following are present:

a. The presence in the wound of necrotic tissue with eschar, if debridement is not attempted;
b. Untreated osteomyelitis within the vicinity of the wound;
c. Cancer present in the wound; or

d. The presence of a fistula to an organ or body cavity within the vicinity of the wound.

For coverage to continue beyond the initial prior approval period, a licensed medical professional shall:

a. Directly assess the wound(s) treated with the NPWT pump;

b. Supervise or directly perform the NPWT dressing changes; and

c. On a **monthly** basis, document changes in the ulcer's dimension and characteristics.

**Note:** For the purposes of this policy, a licensed medical professional may be a physician, physician's assistant, registered nurse, licensed practical nurse or physical therapist. The practitioner shall be licensed to assess wounds and administer wound care within the state where the beneficiary is receiving NPWT.

Re-authorizations for continued coverage are given for a maximum of one month. If the criteria are not fulfilled, continued coverage of the NPWT pump and supplies are not medically necessary and therefore not covered.

Lack of improvement of a wound, as used within this policy, is defined as a lack of progress in quantitative measurements of wound characteristics, including wound length and width (surface area) or depth measured serially and documented over a specified time interval. Wound healing is defined as improvement occurring in either surface area or depth of the wound.

**Note:** The staging of pressure ulcers used in this policy is as follows:

| | |
|---|---|
| **Stage I** | non-blanchable erythema of intact skin |
| **Stage II** | partial-thickness skin loss involving epidermis, dermis, or both |
| **Stage III** | full-thickness skin loss involving damage or necrosis of subcutaneous tissue that may extend down to, but not through, underlying fascia |
| **Stage IV** | full-thickness skin loss with extensive destruction, tissue necrosis, or damage to muscle, bone, or supporting structures |

### 5.3.2 External Insulin Infusion Pump

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 E** for instructions.

An external insulin infusion pump is used in a beneficiary with diabetes to provide continuous subcutaneous insulin infusion to implement intensive diabetes management with the goal of achieving near-normal levels of blood glucose. Prior approval is required for the infusion pump, gray adapter, and piston rod. An external insulin infusion pump and related supplies are covered for a beneficiary who demonstrates medical necessity by meeting one of the following criteria:

**Adult Beneficiary (21 years of age or older)**

An adult beneficiary shall have a diagnosis of diabetes mellitus and be insulin dependent. Additionally, a beneficiary shall fulfill the requirements in a, or b, **and** c or d, below.

a. C-peptide testing requirement

The beneficiary shall meet criterion 1 **or** 2, **and** criterion 3:

1. The C-peptide level is less than or equal to 110% of the lower limit of normal of the laboratory's measurement method.
2. For a beneficiary with renal insufficiency and creatinine clearance (actual or calculated from age, weight, and serum creatinine) less than or equal to 50 ml/minute, the **fasting** C-peptide level is less than or equal to 200% of the lower limit of normal of the laboratory's measurement method.
3. A fasting blood sugar obtained at the same time as the C-peptide level is less than or equal to 225 mg/dl.

**Or**

b. The beneficiary's beta cell autoantibody test shall be positive.

**And**

The beneficiary shall also fulfill either criterion c **or** d below.

c. The beneficiary must have completed a comprehensive diabetes education program; been on a program of multiple daily injections of insulin (at least three injections per day), with frequent self-adjustments of insulin dose, for at least six months prior to initiation of the insulin pump; documented his or her frequency of glucose self-testing (an average of at least four times per day during the two months prior to initiation of the insulin pump); and experienced one or more of the following events or conditions while on the multiple injection regimen:
   1. Glycosylated hemoglobin level (HbA1C) greater than 7%
   2. History of recurring hypoglycemia
   3. Wide fluctuations in blood glucose before mealtime
   4. Dawn phenomenon (fasting blood sugar frequently exceeding 200 mg/dl)
   5. History of severe glycemic excursions

**or**

d. The beneficiary has been on an external insulin infusion pump prior to enrollment in Medicaid, and that pump is no longer functional, there is documentation from the manufacturer that the pump cannot be repaired, and the warranty has expired. These beneficiaries shall document their frequency of glucose self-testing (an average of at least four times per day during the month prior to enrollment). (Refer to **Subsections 5.8, Servicing and Repairing Durable Medical Equipment,** and **5.9, Replacing Durable Medical Equipment.**)

**Beneficiaries age 0 through 20**

External insulin infusion pumps are covered for beneficiaries aged 0 through 20 who meet one of the following criteria:

a. The beneficiary has a diagnosis of diabetes mellitus, is insulin dependent, and has an HbA1C greater than 6.5%, with medical record documentation that justifies the medical necessity for the insulin pump. Except for neonatal diabetes, a diagnosis of diabetes for six weeks is required before the pump is approved; or
b. The beneficiary has been on an external insulin infusion pump prior to enrollment in Medicaid or NCHC, when health care record documentation justifies the medical necessity for the insulin pump and that pump is no longer functional, there is documentation from the manufacturer that the pump cannot be repaired, and the warranty has expired.

(Refer to **Subsections 5.8, Servicing and Repairing Durable Medical Equipment,** and **5.9, Replacing Durable Medical Equipment.**)

**Beneficiaries with Gestational Diabetes**

External insulin infusion pumps are covered for beneficiaries who have a diagnosis of gestational diabetes and are insulin dependent when there is either a health record documentation of erratic blood glucose readings, despite maximum compliance, or other documented evidence that adequate control is not being achieved. Refer to **Attachment A: B, Diagnosis Codes**, for the specific diagnosis requirements for coverage for an external insulin infusion pump.

Prior Approval Requirements for All Beneficiaries

For prior approval, the physician, physician assistant, or nurse practitioner experienced in pump therapy who orders the pump shall document all of the following:

a. The beneficiary's status shall be monitored during the time he or she uses the pump
b. The beneficiary (or caregiver, if applicable) has demonstrated the ability and commitment to comply with:
    1. the regimen of pump care,
    2. frequent self-monitoring of blood glucose,
    3. careful attention to diet and exercise; and
    4. has completed a comprehensive diabetes education program.

The external insulin infusion pump is covered as a purchase item for all beneficiaries meeting coverage criteria except for those with gestational diabetes. For gestational diabetes, Medicaid beneficiaries meeting coverage criteria, the external insulin infusion pump is provided only as a rental through the end of the delivery month. If the Medicaid beneficiary requires continued use of the external insulin infusion pump post-partum, prior approval is required. If approved, payments will continue until the combined payments for gestational and post-partum use cap at the purchase price.

**Replacement Pumps**

Medicaid and NCHC may cover a replacement external insulin infusion pump if the pump is no longer functional, and there is documentation from the manufacturer that:

a. the pump cannot be repaired, and

b. the warranty has expired.

A replacement pump is *not* medically necessary simply because the pump is out of warranty or is no longer being manufactured. Replacement of a functioning external insulin infusion pump with a newer advanced model is *not* covered

Refer to **Subsections 5.8, Servicing and Repairing Durable Medical Equipment,** and **5.9, Replacing Durable Medical Equipment.**

### 5.3.3 Blood Glucose Monitors and Continuous Glucose Monitors and Related 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 E** for instructions.

Blood glucose monitors, syringes, strips, lancets, and other related supplies are covered when all the following coverage criteria are met:

1. The beneficiary has a diagnosis of insulin dependent diabetes, non-insulin dependent diabetes, gestational diabetes, or glycogen storage disease which is being treated by a physician;
2. The glucose monitor and related accessories and supplies have been ordered by the physician who is treating the beneficiary's diabetes;
3. The beneficiary or the beneficiary's caregiver has successfully completed training or is scheduled to begin training in the use of the monitor, test strips, and lancets;
4. The beneficiary or the beneficiary's caregiver is capable of using the test results to assure the beneficiary's appropriate glycemic control.

A blood glucose monitor with an **integrated voice synthesizer** requires prior approval. All the coverage criteria for a Blood Glucose Monitor must be met for prior approval plus the following additional criteria:

The beneficiary's physician certifies that:

1. the beneficiary has a severe visual impairment (defined as a best corrected visual acuity of 20/200 or worse); and
2. documents the beneficiary's best corrected visual acuity is 20/200 or worse.

**Continuous Glucose Monitoring System and Related Supplies for ages 0 through 20 years**

A Continuous Glucose Monitoring System (CGMS) is a U.S, Food and Drug Administration (FDA) approved device that measures the glucose in the interstitial fluid throughout the day and night. CGMS should be used in **conjunction** with self-monitoring blood glucose testing.

A CGMS and related supplies are covered when the following criteria are met:

1. the beneficiary has a diagnosis of insulin-dependent diabetes and;
2. the beneficiary has documentation of recurrent unexplained severe hypoglycemic episodes or fasting hyperglycemia, nocturnal hypoglycemic episodes, hypoglycemic unawareness **or**
3. the beneficiary has an external insulin pump which communicates with a CGMS

Prior Approval is required for CGMS.

**Note:** For the specific diagnosis requirements for coverage of a blood glucose monitor refer to **Attachment A: B, Diagnosis Codes**.

### 5.3.4 Phototherapy

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 E** for instructions.

**Medicaid (only)** covers Phototherapy (bilirubin) light therapy. Bilirubin light therapy is covered for the treatment of hyperbilirubinemia within the first 30 calendar days of life for a maximum of seven consecutive days. The family members or caregivers must be trained in the use of the equipment.

Block 24 on the CMN/PA form must be checked, indicating that the beneficiary's status will be monitored by the physician, physician assistant, or nurse practitioner, while the equipment is provided.

**Medicaid and NCHC cover** Ultraviolet light therapy. Ultraviolet light therapy requires prior approval and is covered when **all** the following criteria are met:

1. the severity of the beneficiary's condition is such that it has **not** been significantly improved by conventional treatment;
2. the beneficiary has involvement over more than 20 percent of his or her body; and
3. a trial period of light treatment in a clinical setting has been successful.

### 5.3.5 Farrell Valve Enteral Gastric Pressure Relief System

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 E** for instructions.

The Farrell valve is a vented, closed, disposable system used for gastric pressure relief with some enterally fed beneficiaries. It is used to eliminate the buildup of gastric reflux and gas in the stomach and around the outside of a feeding tube.

The Farrell valve is not indicated or required for all enterally fed beneficiaries. Medicaid and NCHC shall cover the Farrell valve when all the following criteria are met:

a. the beneficiary is receiving continuous enteral feedings via gravity or pump;
b. there is documented evidence of disorders or complications with enteral feedings, including gastric dysmotility, abdominal distention, aspiration pneumonia, anti-reflux surgery, gastric pseudo-obstruction, tracheoesophageal fistula, or atresia repair; and
c. other attempted gastric decompression measures have failed.

The Farrell valve is not covered when clinical documentation demonstrates that the beneficiary is tolerating continuous enteral feedings without difficulty or complications.

Prior approval is required for the Farrell valve. Initial prior approval is for a maximum of one valve per day per beneficiary for a maximum period of six months. For additional approvals, medical necessity must be re-established for each successive six months.

The health record must contain documentation by the physician, physician assistant, or nurse practitioner substantiating the medical necessity requirement. A starting date and expected duration for the use of the Farrell valve must also be included. The medical necessity must specifically address the beneficiary's complicating factors, such as gastric dysmotility, distention, reflux, aspiration risk, excessive gastric residuals, pain, neurological impairments, and dates of any anti-reflux procedures. The inability of the beneficiary to tolerate enteral feedings without the Farrell valve must be documented.

**Note:** Only one Farrell valve per day is allowed. The valve is not provided and billed under routine enteral feeding supply kits.

### 5.3.6 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 E** for instructions.

An IV pole is covered when a beneficiary receives either parenteral or enteral fluids.

Sterile and non-sterile gloves are covered for use with medically necessary Durable Medical Equipment and Supplies for the protection of the beneficiary. Gloves must be required to maintain or improve a beneficiary's medical, physical or functional level.

An ambulatory infusion pump is covered when a beneficiary requires covered IV medications.

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 (*).

### 5.3.7 Nutrition

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 E** for instructions.

**Oral Nutrition Products/Metabolic Formulas**

Oral Nutrition products are covered for beneficiaries' ages 0 through 20 when required to ameliorate a medical condition, prevent severe health complications, prevent worsening health outcomes, or improve clinical and functional benefits. Refer to **Subsection 2.1** for specific age eligibility for NCHC.

Metabolic Formulas are covered for beneficiaries aged 0 through 115 for in-born errors of metabolism diagnosed at birth and before the age of 10 years. Refer to **Subsection 2.1** for specific age eligibility for NCHC.

Oral nutrition products and metabolic formulas include formulas, such as Peptamen, Peptamen Jr., and PhenylAde; modular components, such as thickening agents and single nutrients (used in treatment of inborn errors of metabolism); and feeding systems, such as Pigeon feeding systems.

Examples of conditions that may indicate a need for oral nutrition products include, inborn errors of metabolism, such as phenylketonuria (PKU) or galactosemia; history of prematurity, very low birth weight (VLBW), or low birth weight (LBW); cystic fibrosis; human immunodeficiency virus (HIV); necrotizing enterocolitis (NEC); short bowel syndrome; cleft lip or cleft palate; central nervous system disorders resulting in dysphagia; and Crohn's disease.

Oral nutrition products are considered medically necessary when **all** the following conditions are met:

a. There is a documented diagnosis in which caloric or dietary nutrients cannot be safely or adequately consumed, absorbed, or metabolized; and
b. The oral nutrition product is an integral component of a documented medical treatment plan and is ordered in writing by the treating physician, physician's assistant, or nurse practitioner.

Medical necessity of the oral nutrition product is substantiated by documented physical findings, and laboratory data if available, that demonstrate malnutrition or risk of nutritional depletion.

**Requirements for coverage**

a. A beneficiary shall be under the care of the ordering physician, physician's assistant, or nurse practitioner who develops a medical treatment plan that incorporates oral nutrition products.
b. The prescriber may order a nutritional assessment to aid if it aids in the development of a comprehensive oral nutrition therapy plan.
c. If a nutritional assessment is ordered, it must be conducted by a licensed dietitian/nutritionist (LDN) or registered dietitian (RD).

d. The prescriber may also order a feeding or swallowing evaluation by a licensed therapist (SLP-CCC or OTR/L).

The above-mentioned assessments must be maintained within the health record as supporting documentation to substantiate medical necessity.

An Oral Nutrition Product Request Form (refer to **Attachment B** for a sample), is available online at http://dma.ncdhhs.gov/ under Durable Medical Equipment and Supplies, and a CMN/PA must be submitted by the provider along with any supporting documentation (for example, a growth chart or a nutrition assessment).

Medical necessity of oral nutrition product use must be re-established at specific intervals:

a. For beneficiaries with a diagnosed inborn error of metabolism, the provider shall submit a new Oral Nutrition Product Request Form and CMN/PA every 12 months.
b. For beneficiaries with other medical conditions necessitating oral nutrition supplementation, the provider shall submit a new Oral Nutrition Product Request Form and CMN/PA every six months with documentation supporting the effectiveness of the oral nutrition supplementation.
c. For beneficiaries receiving modular components and feeding devices the provider shall submit a new Oral Nutrition Product Request Form and a CMN/PA at either the 6-month or 12-month interval, depending on the approved certification period.

**Note:** Oral nutrition products are not covered when medical necessity is not established, or when they are used as convenient food substitutes.

**Note:** Oral nutrition products must be billed using a second modifier. Refer to **Attachment A: D, Modifiers** for information about the correct modifier to use.

**Enteral Nutrition**

Enteral nutrition (EN) refers to the medical equipment, supplies, formulae or solutions ordered by a physician, physician assistant, or nurse practitioner, and provided according to standards of practice. The allowance for all items includes delivery to the beneficiary.

Enteral nutrition includes the following equipment, supplies, formulae or solutions:

a. Medical equipment includes the pump used for EN and the IV pole. The equipment is rented if the physician, physician assistant, or nurse practitioner documents that the anticipated need is six months or less. The equipment 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 purchase of that item is denied. The item becomes the property of the beneficiary when the accrued rental payments reach the Medicaid or NCHC allowable purchase price.

For home infusion therapy nutrition, refer to Clinical Coverage Policy 3H-1, *Home Infusion Therapy,* on DMA's website: http://dma.ncdhhs.gov/.

For EN to be covered the beneficiary shall be under the care of the referring physician, physician assistant, or nurse practitioner, who prescribes EN therapy, establishes a plan of care for EN, and monitors the therapy's progress.

A beneficiary shall meet **all** the following criteria:

a. Require infusion therapy on an ongoing basis that is medically indicated for the treatment of his or her condition;
b. Have a clinical status that allows EN to be safely administered in his or her environment;
c. Be unable to tolerate nutrients orally sufficient to maintain life. The beneficiary is either unable to take oral nutrition or unable to tolerate oral intake. EN is considered reasonable and necessary for a beneficiary with a functioning gastrointestinal tract who, due to non-function of the structures that normally permit food to reach the digestive tract, cannot maintain weight and strength commensurate with his or her general condition. Examples of conditions that usually indicate the need for EN include dysphagia or aphagia due to a cardiovascular accident, a comatose condition, myasthenia gravis causing inability to swallow due to paralysis of the structure that permits swallowing, or a brain tumor with neurological deficit resulting in the lack of a gag reflex;
d. Understand the purpose and need for the therapy, accepts the associated requirements, and wants to pursue the treatment. When the beneficiary is unable to comprehend all that is involved, there must be a primary caregiver responsible for the beneficiary and acting in the beneficiary's behalf to meet this requirement;
e. Be in an environment conducive to the provision of EN—that is, a clean environment with electricity, water, telephone access, refrigeration, and enough space to support EN;
f. Be capable of self-administering EN or have a primary caregiver who is adequately trained, capable, and willing to administer EN safely and effectively; and
g. Be psychologically stable—the prospect of adhering to a disciplined medical regimen and coping with infusion therapy is realistic.

**Infusion Pumps**
Enteral and parenteral nutrition infusion pumps are covered by Medicaid and NCHC when a beneficiary requires medically necessary covered enteral and parenteral nutrition.

### 5.3.8 Automatic External Defibrillator, With Integrated Electrocardiogram Analysis, Garment Type (also known as wearable cardioverter defibrillator)

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 E** for instructions.

A wearable cardioverter defibrillator (WCD) is an external device (vest-like garment) that contains the following components:

a. cardiac monitor;
b. electrodes;
c. alarm system; and
d. cardioverter-defibrillator.

The WCD monitors cardiac (heart) rhythm and delivers an electrical shock if a life threatening ventricular arrhythmia is detected. The WCD is worn continuously, 24 hours per day.

A WCD requires prior approval and is considered medically necessary and covered for a beneficiary who is at risk for sudden cardiac death, is not a suitable candidate for immediate internal cardiac defibrillator (ICD); and meets **any one** of the following criteria:

a. A documented episode of ventricular fibrillation or sustained run of ventricular tachycardia lasting 30 seconds or longer. These dysrhythmias may either be spontaneous or induced during an electrophysiologic (EP) study, but may not be due to a transient or reversible cause and not occurring during the first 48 hours of an acute myocardial infarction;
b. Familial or inherited conditions with a high risk of life-threatening ventricular tachyarrhthymias such as long QT syndrome, hypertrophic cardiomyopathy;
c. Either a documented prior myocardial infarction or a dilated cardiomyopathy and measured left ventricular ejection fraction less than or equal to 35%;
d. Documentation of a previously implanted defibrillator that due to infection, injury or illness requires a waiting period before ICD reinsertion;
e. Documentation of an infection or other temporary medical condition that prevents the initial implantation of an ICD.

The FDA has **not** approved use of the WCD for the indications listed below. Therefore, the WCD is **not medically necessary and not covered** for a beneficiary who meets **any one** of the following:

a. Meets the criteria for an ICD or already has an ICD implanted and operating;
b. **Is under 18 years of age**;
c. Has a vision or hearing problem that may interfere with reading or hearing the WCD messages;
d. Is taking medication that would interfere with pushing the response buttons on the WCD alarm module;
e. Is unwilling or unable to wear the device continuously, except when bathing or showering;
f. Is pregnant or breast feeding;
g. Is of childbearing age and not attempting to prevent pregnancy; or
h. Is exposed to excessive electromagnetic interference (EMI) from machinery, such as powerful electric motors, radio transmitters, power lines or

electronic security scanners, EMI can prevent the WCD from detecting an abnormal heart rhythm.

The WCD must be ordered by a cardiologist who is experienced in management of a beneficiary at risk for sudden cardiac death, agrees to closely monitor the beneficiary during the coverage period, and is willing to obtain documentation of beneficiary's compliance with the WCD.

WCD is for rental only and prior approval is given for a maximum time period of three months when the beneficiary meets all medical necessity and coverage criteria.

### 5.3.9 Incontinence, Ostomy, and Urinary Catheter 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 E** for instructions.

Medicaid and NCHC shall reimburse medical equipment providers for the provision of incontinence, ostomy and urinary catheter supplies to beneficiaries only when they are medically necessary due to a disease, illness or injury. The supplies must be prescribed by a physician, physician assistant, or nurse practitioner, and the amount delivered must be supported by the beneficiary's actual medical needs. Medical equipment providers shall obtain the written, signed, and dated prescription for the supplies prior to submitting their claim for reimbursement. If the provider submits a claim for reimbursement before obtaining the completed prescription, the supplies are considered not medically necessary. Claims paid for supplies issued before the date of the prescription are subject to recoupment.

The prescription must include the type(s) of supplies ordered and the quantity to be used for a specified time (for example per month). All requests for specialty supplies (for example silicone catheter instead of regular latex catheters) must include medical necessity documentation from the physician, physician assistant, or nurse practitioner stating the medical necessity for the specialty supply.

Incontinence supplies (for example diapers) are only covered for beneficiaries three years of age and older who are incontinent due to disease, illness or injury.

Incontinence supplies must be in compliance with industry-wide quality standards for rate acquisition, rewet and capacity.

Prior approval is not required for incontinence, ostomy and urinary catheter supplies; however, the medical equipment provider shall have on file a CMN/PA (completed and signed by the provider as well as the physician, physician assistant, or nurse practitioner,) which is valid for no more than 12 consecutive months. If the need for the supplies continues beyond 12 consecutive months from the date of the last signed CMN/PA, a new completed and signed CMN/PA

must be obtained and kept on file. The DME provider shall obtain the signed CMN/PA before billing for the supplies.

These quantity limitations do not reflect minimum quantities to which the beneficiary is entitled. These limitations are the maximum quantities allowed for the beneficiary. The quantities billed must be the quantities that are documented as medically necessary to meet the beneficiary's needs and the quantity prescribed by the physician, physician assistant, or nurse practitioner. The medical equipment provider shall make every effort, in coordination with the beneficiary or their caregiver (such as the Adult Care Home staff), to ensure the quantity of supplies ordered each month remains medically necessary, prior to providing them. This is necessary to eliminate stockpiling of excessive supplies, waste, abuse and the excess cost of unused supplies. Claims that have been paid for supplies that have been stockpiled, wasted or abused are subject to recoupment by Medicaid or NCHC.

Home health agencies shall provide supplies to beneficiaries receiving other home health services. Please refer to Clinical Coverage Policy 3A, *Home Health Services* (linked from DMA's website: http://dma.ncdhhs.gov/).

All requests or orders that exceed the quantity limitations allowed by Medicaid or NCHC must be requested through a Medicare-certified home health agency enrolled as a Medicaid or NCHC provider.

### 5.3.10 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 E** 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 E** for instructions.

### 5.5.1 Diabetic Supply Override Process

An override process is available for beneficiaries who are not able to obtain reliable results with diabetic supplies from the designated preferred manufacturer's product(s). The provider furnishing the product for this beneficiary shall be a medical equipment provider.

The provider shall comply with **Subsection 5.5** above. A request for an override may be considered if the beneficiary meets **one** of the following:

a. The designated preferred manufacturer's glucose meter is incompatible with the beneficiary's current insulin pump; or
b. The beneficiary has diabetes mellitus and is now being referred by his or her healthcare provider because of the ongoing inability to obtain reliable results that cannot be resolved with user education.

## 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.

### 5.7.2 Monitoring Enteral Nutrition (EN)

The provider and the physician, physician assistant, or nurse practitioner, shall ensure sufficient monitoring to protect a beneficiary's health and well-being. The Physician, physician assistant, or nurse practitioner, orders any other service, such as Home Health skilled nursing visits, that are needed for the beneficiary.

The provider's responsibilities for monitoring EN include the following:

a. Supplies, equipment, and formulae must be provided according to orders from the physician, physician assistant, or nurse practitioner. Problems must be resolved immediately without delay. Defective equipment must be repaired or replaced so that there is no lapse in treatment.
b. The beneficiary's physician, physician assistant, or nurse practitioner, shall be notified when the ordered services do not appear appropriate, there are problems with their provision, or there are concerns about administration.

**Note:** Medicaid and NCHC do not cover infusion nursing services for EN. When RN monitoring is needed, refer the beneficiary to Home Health Services. The provider may not bill Medicaid or NCHC for RN monitoring.

## 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 E** 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 ticket from the first provider showing the equipment has been picked-up and new equipment is needed.

The previous provider shall submit a pick-up ticket that includes the provider's name, beneficiary's name, item picked up, and date item was picked up. Failure to submit a pick-up ticket to the new provider within 30 calendar days will result in an investigation and possible recoupment of funds.

#### 5.10.1 Changing Suppliers for Rental Items Other than Oxygen Equipment

The new provider shall obtain a new completed and signed CMN/PA form and a pick-up slip from the former provider. Failure to provide a pick-up ticket to the new provider within 30 calendar days may result in investigation and possible recoupment of funds from the previous provider. If the item needs prior approval, the new provider sends the CMN/PA to the address listed on the form. A new prior approval number is issued for the item and assigned to the new supplier.

**Note:** The allowable rental period on capped rental items carries over from the old to new supplier. The new supplier is able to get rental payments for only the balance of the rental period before the item becomes the property of the beneficiary.

### 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.<br>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.<br>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 per month to 10 per 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, 5.3.3, 5.3.6, 5.3.7, 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 E | Added Attachment E: Requesting Unlisted DME and Supplies for Adults. |
| 12/01/2017 | Attachment A, Section C: Procedure Code(s) | HCPCS code T4544 added to code list as it was inadvertently left out during a previous update. |
| 06/15/2018 | Attachment A, Section C: Procedure Code(s) | HCPCS code K0606 added to code list as it was inadvertently during a previous update. Policy posted on 06/15/2018, but no change to Amended Date. |

# 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 and Related Health Problems, 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) | | | | |
|---|---|---|---|---|
| **Blood Glucose Monitor and Related Supplies and External Insulin Pump** | | | | |
| E10.10 | E10.618 | E11.359 | E13.01 | E13.610 |
| E10.11 | E10.620 | E11.36 | E13.10 | E13.618 |
| E10.21 | E10.621 | E11.39 | E13.11 | E13.620 |
| E10.22 | E10.622 | E11.40 | E13.21 | E13.621 |
| E10.29 | E10.628 | E11.41 | E13.22 | E13.622 |
| E10.311 | E10.630 | E11.42 | E13.29 | E13.628 |
| E10.319 | E10.638 | E11.43 | E13.311 | E13.630 |
| E10.321 | E10.641 | E11.44 | E13.319 | E13.638 |
| E10.329 | E10.649 | E11.49 | E13.321 | E13.641 |
| E10.331 | E10.65 | E11.51 | E13.329 | E13.649 |
| E10.339 | E10.69 | E11.52 | E13.331 | E13.65 |
| E10.341 | E10.8 | E11.59 | E13.339 | E13.69 |
| E10.349 | E10.9 | E11.610 | E13.341 | E13.8 |
| E10.351 | E11.00 | E11.618 | E13.349 | E13.9 |
| E10.359 | E11.01 | E11.620 | E13.351 | E74.00 |
| E10.36 | E11.21 | E11.621 | E13.359 | E74.01 |
| E10.39 | E11.22 | E11.622 | E13.36 | E74.02 |
| E10.40 | E11.29 | E11.628 | E13.39 | E74.03 |
| E10.41 | E11.311 | E11.630 | E13.40 | E74.04 |
| E10.42 | E11.319 | E11.638 | E13.41 | E74.09 |
| E10.43 | E11.321 | E11.641 | E13.42 | O24.410 |
| E10.44 | E11.329 | E11.649 | E13.43 | O24.414 |
| E10.49 | E11.331 | E11.65 | E13.44 | O24.419 |
| E10.51 | E11.339 | E11.69 | E13.49 | O24.911 |
| E10.52 | E11.341 | E11.8 | E13.51 | O24.912 |
| E10.59 | E11.349 | E11.9 | E13.52 | O24.913 |
| E10.610 | E11.351 | E13.00 | E13.59 | O24.919 |
| | | | | O99.810 |

## 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 E** for instructions.

**Lifetime Expectancies and Quantity Limitations for Durable Medical Equipment and Supplies**

| HCPCS Code | Item Description | Lifetime Expectancy or Quantity Limitation |
|---|---|---|
| | **Negative Pressure Wound Therapy** | |
| E2402 | Negative pressure wound therapy electrical pump, stationary or portable | N/A (Rental only) |
| A6550 | Wound care set, for negative pressure wound therapy electrical pump, includes all supplies and accessories | 15 per month |

| HCPCS Code | Item Description | Lifetime Expectancy or Quantity Limitation |
|---|---|---|
| | **External Insulin Infusion Pump** | |
| E0784 | External ambulatory infusion pump, insulin | 5 years |
| A4230 | Infusion set for external insulin pump, non-needle cannula type | 16 per month |
| A4231 | Infusion set for external insulin pump, needle type | 16 per month |
| A6257 | Transparent film, sterile, 16 sq. in. or less, each dressing | 16 per month |
| A6258 | Transparent film, sterile, more than 16 sq. in. but less than or equal to 48 sq. in., each dressing | 16 per month |
| A9274 | External ambulatory insulin delivery system, disposable, each, includes all supplies and accessories | 16 per month |
| K0552 | Supplies for external drug infusion pump, syringe type cartridge, sterile, each | 16 per month |
| K0601 | Replacement battery for external infusion pump owned by patient, silver oxide, 1.5 volt, each | 18 per year |
| K0602 | Replacement battery for external infusion pump owned by patient, silver oxide, 3 volt, each | 18 per year |
| K0603 | Replacement battery for external infusion pump owned by patient, alkaline, 1.5 volt, each | 18 per year |
| K0604 | Replacement battery for external infusion pump owned by patient, lithium, 3.6 volt, each | 18 per year |

| HCPCS Code | Item Description | Lifetime Expectancy or Quantity Limitation |
|---|---|---|
| K0605 | Replacement battery for external infusion pump owned by patient, lithium, 4.5 volt, each | 18 per year |
| | **External Defibrillator** | |
| K0606 | Automatic external defibrillator, with integrated electrocardiogram analysis, garment type | 18 years of age and older only |
| | **Glucose Monitors and Supplies** | |
| E0607 | Home blood glucose monitor | 2 years |
| E2100 | Blood glucose monitor with integrated voice synthesizer | 3 years |
| A4215 | Needle, sterile, any size, each | 200 per month |
| A4233 | Replacement battery, alkaline (other than J cell), for use with medically necessary home blood glucose monitor owned by patient, each | 8 per year |
| A4234 | Replacement battery, alkaline, J cell, for use with medically necessary home blood glucose monitor owned by patient, each | 8 per year |
| A4235 | Replacement battery, lithium, for use with medically necessary home blood glucose monitor owned by patient, each | 8 per year |
| A4236 | Replacement battery, silver oxide, for use with medically necessary home blood glucose monitor owned by patient, each | 8 per year |
| A4244 | Alcohol or peroxide, per pint | 100 per month |
| A4250 | Urine test or reagent strips or tablets (100 tablets or strips) | 1 per month |
| A4252 | Blood Ketone test or reagent strip, each | 100 per calendar month |
| A4253 | Blood glucose test or reagent strips for home blood glucose monitor, per 50 strips | 6 per month ages 0-20<br>4 per month age 21 and over |
| A4256 | Normal, low and high calibrator solution/chips | 4 per year |
| A4258 | Spring-powered device for lancet, each | 2 per year |
| A4259 | Lancets, per box of 100 | 2 per month |
| A9276 | Sensor; invasive (e.g. subcutaneous), disposable, for use with interstitial continuous glucose monitoring system, one unit = 1 day supply | Allow 30-day supply per calendar month |
| A9277 | Transmitter; external, for use with interstitial continuous glucose monitoring system | 2 years |
| A9278 | Receiver (monitor); external, for use with interstitial continuous glucose monitoring system | 2 years |
| S5560 | Insulin delivery device, reusable pen; 1.5 ml size | 3 years |
| S5561 | Insulin delivery device, reusable pen; 3 ml size | 3 years |
| S8490 | Insulin syringes (100 syringes, any size) | 2 per month |
| | **Phototherapy** | |
| E0202 | Phototherapy (bilirubin) light with photometer | 7 days max.<br>Ages birth to 1 month only |
| E0691 | Ultraviolet light therapy system, includes bulbs/lamps, timer, and eye protection; treatment area 2 square feet or less | N/A |
| E0692 | Ultraviolet light therapy system panel, includes bulbs/lamps, timer and eye protection, 4 foot panel | N/A |
| | **Farrell Valve** | |
| A9999 | Miscellaneous DME supply or accessory, not otherwise specified (For use with Farrell Valve only) | 1 per day |
| | **Miscellaneous Durable Medical Equipment and Supplies** | |
| A4927 | Gloves, non-sterile, per 100 | N/A |
| A4930 | Gloves, sterile, per pair | N/A |

| HCPCS Code | Item Description | Lifetime Expectancy or Quantity Limitation |
|---|---|---|
| E0781 | Ambulatory infusion pump, single or multiple channels electric or battery operated with administrative equipment, worn by patient | N/A |
| A4213 | Syringe, sterile, 20cc or greater, each | 50 per month |
| A4217 | Sterile water/saline, 500 ml | 300 per month |
| A4246 | Betadine or pHisoHex solution, per pint | 10 per month |
| A4456 | Adhesive remover, wipes, any type, each | 1 box of 50 per month |
| | **Nutrition – Formula and Supplies** | |
| B4034 | Enteral feeding supply kit; syringe fed, per day, includes but not limited to feeding/flushing syringe, administration set tubing, dressings, tape | 1 per day, no more than 31 per month. |
| B4035 | Enteral feeding supply kit; pump fed, per day, includes but not limited to feeding/flushing syringe, administration set tubing, dressings, tape | 1 per day, no more than 31 per month. |
| B4036 | Enteral feeding supply kit; gravity fed, per day, includes but not limited to feeding/flushing syringe, administration set tubing, dressings, tape | 1 per day, no more than 31 per month |
| B4081 | Nasogastric tubing with stylet | 3 every 3 months, not to exceed 12 per year. |
| B4082 | Nasogastric tubing without stylet | 3 every 3 months, not to exceed 12 per year. |
| B4083 | Stomach tube—Levine type | 3 every 3 months, not to exceed 12 per year. |
| B4087 | Gastrostomy/jejunostomy tube, standard, any material, any type, each | 1 every 3 months, not to exceed 4 per year |
| B4088 | Gastrostomy/jejunostomy tube, low-profile, any material, any type, each | 1 every 3 months, not to exceed 4 per year |
| B4100 | Food thickener, administered orally, per ounce | N/A |
| B4103 | Enteral formula, for pediatrics, used to replace fluids and electrolytes (e.g., clear liquids), 500 ml = 1 unit | Maximum allowed per calendar month is 100 units. |
| B4104 | Additive for enteral formula (e.g., fiber) | N/A |
| B4149 | Enteral formula, manufactured blenderized natural foods with intact nutrients, includes proteins, fats, carbohydrates, vitamins and minerals, may include fiber, administered through an enteral feeding tube, 100 calories=1 unit | Monthly limits depend on the individual beneficiary's medical/nutritional needs and physician's orders not to exceed 775 units per calendar month. |
| B4150 | Enteral formulae, nutritionally complete with intact nutrients, includes proteins, fats, carbohydrates, vitamins, and minerals, may include fiber, administered through an enteral feeding tube, 100 calories= 1 unit | Monthly limits depend on the individual beneficiary's medical/nutritional needs and physician's orders not to exceed 775 units per calendar month. |
| B4152 | Enteral formula, nutritionally complete, calorically dense (equal to or greater than 1.5 kcal/ml) with intact nutrients, includes proteins, fats, carbohydrates, vitamins and minerals, may include fiber, administered through an enteral feeding tube, 100 calories=1 unit | Monthly limits depend on the individual beneficiary's medical/nutritional needs and physician's orders not to exceed 775 units per calendar month. |
| B4153 | Enteral formula, nutritionally complete, hydrolyzed proteins (amino acids and peptide chain), includes fats, carbohydrates, vitamins and minerals, may include fiber, administered through an enteral feeding tube, 100 calories=1 unit | Monthly limits depend on the individual beneficiary's medical/nutritional needs and physician's orders not to exceed 775 units per calendar month. |

| HCPCS Code | Item Description | Lifetime Expectancy or Quantity Limitation |
|---|---|---|
| B4154 | Enteral formula, nutritionally complete, for special metabolic needs, excludes inherited disease of metabolism, includes altered composition of proteins, fats, carbohydrates, vitamins and/or minerals, may include fiber, administered through an enteral feeding tube, 100 calories=1 unit | Monthly limits depend on the individual beneficiary's medical/nutritional needs and physician's orders not to exceed 775 units per calendar month. |
| B4155 | Enteral formula, nutritionally incomplete/modular nutrients, includes specific nutrients, carbohydrates (e.g. glucose polymers), proteins/amino acids (e.g. glutamine, arginine), fat (e.g. medium chain triglycerides) or combination, administered through an enteral feeding tube, 100 calories= 1unit | Monthly limits depend on the individual beneficiary's medical/nutritional needs and physician's orders not to exceed 775 units per calendar month. |
| B4157 | Enteral formula, nutritionally complete, for special metabolic needs for inherited disease of metabolism, includes proteins, fats, carbohydrates, vitamins and minerals, may include fiber, administered through an enteral feeding tube, 100 calories = 1 unit | Monthly limits depend on the individual beneficiary's medical/nutritional needs and physician's orders not to exceed 775 units per calendar month. |
| B4158 | Enteral formula, for pediatric nutritionally complete with intact nutrients, includes proteins, fats, carbohydrates, vitamins and minerals, may include fiber and/or iron, administered through an enteral feeding tube, 100 cal = 1 unit | Monthly limits depend on the individual beneficiary's medical/nutritional needs and physician's orders not to exceed 775 units per calendar month. |
| B4159 | Enteral formula, for pediatrics, nutritionally complete soy based with intact nutrients, includes proteins, fats, carbohydrates, vitamins and minerals, may include fiber and/or iron, administered through an enteral feeding tube, 100 Cal = 1 unit | Monthly limits depend on the individual beneficiary's medical/nutritional needs and physician's orders not to exceed 775 units per calendar month. |
| B4160 | Enteral formula, for pediatrics, nutritionally complete calorically dense (equal to or greater than 0.7 kcal/ml) with intact nutrients, includes proteins, fats, carbohydrates, vitamins and minerals, may include fiber, administered through an enteral feeding tube, 100 Cal = 1 unit | Monthly limits depend on the individual beneficiary's medical/nutritional needs and physician's orders not to exceed 775 units per calendar month. |
| B4161 | Enteral formula, for pediatrics, hydrolyzed/amino acids and peptide chain proteins, includes fats, carbohydrates, vitamins and minerals, may include fiber, administered through an enteral feeding tube, 100 Cal = 1 unit | Monthly limits depend on the individual beneficiary's medical/nutritional needs and physician's orders not to exceed 775 units per calendar month. |
| B4162 | Enteral formula, for pediatrics, special metabolic needs for inherited disease of metabolism, includes proteins, fats, carbohydrates, vitamins and minerals, may include fiber, administered through an enteral feeding tube, 100 Cal = 1 unit | Monthly limits depend on the individual beneficiary's medical/nutritional needs and physician's orders not to exceed 775 units per calendar month. |
| B9002 | Enteral nutrition infusion pump - with alarm | 2 years |
| B9004 | Parenteral nutrition infusion pump, portable | 2 years |
| B9006 | Parenteral nutrition infusion pump, stationary | 2 years |
| S8265 | Haberman Feeder for cleft lip/palate | N/A |
| W4211 | Low profile gastrostomy extension/replacement kit tubes for cont. feed. | 2 per month |
| W4212 | Low profile gastrostomy extension/replacement kit for bolus feeding | 2 per month |

| HCPCS Code | Item Description | Lifetime Expectancy or Quantity Limitation |
|---|---|---|
| | **Incontinence, Ostomy, and Urinary Catheter Supplies** | |
| A4310 | Insertion tray without drainage bag and without catheter (accessories only) | 2 per month |
| A4311 | Insertion tray without drainage bag with indwelling catheter, Foley type, two-way latex with coating (Teflon, silicone, silicone elastomer, or hydrophilic, etc.) | 1 per month |
| A4313 | Insertion tray without drainage bag with indwelling catheter, Foley type, three-way, for continuous irrigation | 1 per month |
| A4314 | Insertion tray with drainage bag with indwelling catheter, Foley type, two-way latex with coating (Teflon, silicone, silicone elastomer, or hydrophilic, etc.) | 1 per month |
| A4316 | Insertion tray with drainage bag with indwelling catheter, Foley type, three-way, for continuous irrigation | 1 per month |
| A4320 | Irrigation tray with bulb or piston syringe, any purpose | 3 per month |
| A4321 | Therapeutic agent for urinary catheter irrigation | 2 per month |
| A4322 | Irrigation syringe, bulb or piston, each | 2 per month |
| A4328 | Female external urinary collection device; pouch, each | 31 per month |
| A4331 | Extension drainage tubing, any type, any length, with connector/adapter, for use with urinary leg bag or urostomy pouch, each | 2 per month |
| A4334 | Urinary catheter anchoring device, leg strap, each | 2 per month |
| A4335 | Incontinence supply; miscellaneous | 2 per month |
| A4338 | Indwelling catheter; Foley type, two-way latex with coating (Teflon, silicone, silicone elastomer, or hydrophilic, etc.), each | 1 per month |
| A4340 | Indwelling catheter; specialty type (e.g., coude, mushroom, wing, etc.), each | 1 per month |
| A4344 | Indwelling catheter, Foley type, two-way, all silicone, each | 1 per month |
| A4349 | Male external catheter, with or without adhesive, disposable, each | 35 per month |
| A4351 | Intermittent urinary catheter; straight tip, with or without coating (Teflon, silicone, silicone elastomer, or hydrophilic, etc.), each | 200 per month |
| A4352 | Intermittent urinary catheter; coude (curved) tip, with or without coating (Teflon, silicone, silicone elastomer, or hydrophilic, etc.), each | 200 per month |
| A4353 | Intermittent urinary catheter, with insertion supplies | 200 per month |
| A4354 | Insertion tray with drainage bag but without catheter | 2 per month |
| A4357 | Bedside drainage bag, day or night, with or without anti-reflux device, with or without tube, each | 2 per month |
| A4358 | Urinary drainage bag, leg or abdomen, vinyl, with or without tube, with straps, each | 2 per month |
| A4361 | Ostomy faceplate, each | 3 per 6 months |
| A4362 | Skin barrier; solid, 4X4 or equivalent; each | 20 per month |
| A4364 | Adhesive, liquid or equal, any type, per oz. | 4 oz. per month |
| A4367 | Ostomy belt, each | 1 per month |
| A4368 | Ostomy filter, any type, each | 60 per month |
| A4369 | Ostomy skin barrier, liquid (spray, brush, etc.), per oz. | 2 oz. per month |
| A4371 | Ostomy skin barrier, powder, per oz. | 2 oz. per month |
| A4372 | Ostomy skin barrier, solid 4X4 or equivalent, standard wear, with built-in convexity, each | 20 per month |
| A4373 | Ostomy skin barrier, with flange (solid, flexible, or accordion), with built-in convexity, any size, each | 20 per month |
| A4375 | Ostomy pouch, drainable, with faceplate attached, plastic, each | 15 per month |
| A4376 | Ostomy pouch, drainable, with faceplate attached, rubber, each | 3 per month |
| A4377 | Ostomy pouch, drainable, for use on faceplate, plastic each | 10 per month |
| A4378 | Ostomy pouch, drainable, for use on faceplate, rubber, each | 3 per month |
| A4379 | Ostomy pouch, urinary, with faceplate attached, plastic, each | 15 per month |
| A4380 | Ostomy pouch, urinary, with faceplate attached, rubber, each | 3 per month |

| HCPCS Code | Item Description | Lifetime Expectancy or Quantity Limitation |
|---|---|---|
| A4381 | Ostomy pouch, urinary, for use on faceplate, plastic each | 10 per month |
| A4382 | Ostomy pouch, urinary, for use on faceplate, heavy plastic, each | 3 per month |
| A4383 | Ostomy pouch, urinary, for use on faceplate, rubber, each | 3 per month |
| A4384 | Ostomy faceplate equivalent, silicone ring, each | 3 per 6 months |
| A4385 | Ostomy skin barrier, solid 4X4 or equivalent, extended wear, without built-in convexity, each | 20 per month |
| A4388 | Ostomy pouch, drainable, with extended wear barrier attached (1 piece), each | 20 per month |
| A4389 | Ostomy pouch, drainable, with barrier attached, with built-in convexity (1 piece), each | 20 per month |
| A4390 | Ostomy pouch, drainable, with extended wear barrier attached, with built-in convexity (1 piece), each | 20 per month |
| A4391 | Ostomy pouch, urinary, with extended wear barrier attached (1 piece), each | 20 per month |
| A4392 | Ostomy pouch, urinary, with standard wear barrier attached, with built-in convexity (1 piece), each | 20 per month |
| A4393 | Ostomy pouch, urinary, with extended wear barrier attached, with built-in convexity (1 piece), each | 20 per month |
| A4394 | Ostomy deodorant, with or without lubricant, for use in ostomy pouch, per fluid ounce | 16 oz. per month |
| A4395 | Ostomy deodorant, for use in ostomy pouch, solid, per tablet | 100 per month |
| A4397 | Irrigation supply; sleeve, each | 4 per month |
| A4398 | Ostomy irrigation supply; bag, each | 2 per 6 months |
| A4399 | Ostomy irrigation supply; cone/catheter, with or without brush | 2 per 6 months |
| A4400 | Ostomy irrigation set | 2 per month |
| A4402 | Lubricant, per ounce | 4 oz. per month |
| A4404 | Ostomy ring, each | 10 per month |
| A4405 | Ostomy skin barrier, non-pectin based, paste, per ounce | 4 oz. per month |
| A4406 | Ostomy skin barrier, pectin-based, paste, per ounce | 4 oz. per month |
| A4407 | Ostomy skin barrier, with flange (solid, flexible, or accordion), extended wear, with built-in convexity, 4X4 inches or smaller, each | 20 per month |
| A4408 | Ostomy skin barrier, with flange (solid, flexible, or accordion), extended wear, with built-in convexity, larger than 4X4 inches, each | 20 per month |
| A4409 | Ostomy skin barrier, with flange (solid, flexible, or accordion), extended wear, without built-in convexity, 4X4 inches or smaller, each | 20 per month |
| A4410 | Ostomy skin barrier, with flange (solid, flexible, or accordion), extended wear, without built-in convexity, larger than 4X4 inches, each | 20 per month |
| A4411 | Ostomy skin barrier, solid 4X4 or equivalent, extended wear, with built-in convexity, each | 20 per month |
| A4414 | Ostomy skin barrier, with flange (solid, flexible, or accordion), without built-in convexity, 4X4 inches or smaller, each | 20 per month |
| A4415 | Ostomy skin barrier, with flange (solid, flexible, or accordion), without built-in convexity, larger than 4X4 inches, each | 20 per month |
| A4416 | Ostomy pouch, closed, with barrier attached, with filter (1 piece), each | 60 per month |
| A4417 | Ostomy pouch, closed, with barrier attached, with built-in convexity, with filter (1 piece), each | 60 per month |
| A4418 | Ostomy pouch, closed, without barrier attached, with filter (1 piece), each | 60 per month |
| A4419 | Ostomy pouch, closed; for use on barrier with non-locking flange, with filter (2 piece), each | 60 per month |
| A4423 | Ostomy pouch, closed; for use on barrier with locking flange, with filter (2 piece), each | 60 per month |
| A4424 | Ostomy pouch, drainable, with barrier attached, with filter (1 piece), each | 20 per month |
| A4425 | Ostomy pouch, drainable; for use on barrier with non-locking flange, with filter (2 piece system), each | 20 per month |

| HCPCS Code | Item Description | Lifetime Expectancy or Quantity Limitation |
|---|---|---|
| A4426 | Ostomy pouch, drainable; for use on barrier with locking flange (2 piece system), each | 20 per month |
| A4427 | Ostomy pouch, drainable; for use on barrier with locking flange, with filter (2 piece system), each | 20 per month |
| A4428 | Ostomy pouch, urinary, with extended wear barrier attached, with faucet-type tap with valve (1 piece), each | 20 per month |
| A4429 | Ostomy pouch, urinary, with barrier attached, with built-in convexity, with faucet-type tap with valve (1 piece), each | 20 per month |
| A4430 | Ostomy pouch, urinary, with extended wear barrier attached, with built-in convexity, with faucet-type tap with valve (1 piece), each | 15 per month |
| A4431 | Ostomy pouch, urinary; with barrier attached, with faucet-type tap with valve (1 piece), each | 20 per month |
| A4432 | Ostomy pouch, urinary; for use on barrier with non-locking flange, with faucet-type tap with valve (2 piece), each | 20 per month |
| A4433 | Ostomy pouch, urinary; for use on barrier with locking flange (2 piece), each | 20 per month |
| A4450 | Tape, non-waterproof, per 18 square inches | 80 units |
| A4452 | Tape, waterproof, per 18 square inches | 80 units |
| A4455 | Adhesive remover or solvent (for tape, cement or other adhesive), per ounce | 16 oz. per 6 months |
| A4554 | Disposable underpads, all sizes | 150 per month |
| A5051 | Ostomy pouch, closed; with barrier attached (1 piece), each | 60 per month |
| A5052 | Ostomy pouch, closed; without barrier attached (1 piece), each | 60 per month |
| A5053 | Ostomy pouch, closed; for use on faceplate, each | 60 per month |
| A5054 | Ostomy pouch, closed; for use on barrier with flange (2 piece), each | 60 per month |
| A5055 | Stoma cap | 31 per month |
| A5056 | Ostomy pouch, drainable, with extended wear barrier attached, with filter, (1 piece), each | 20 per month |
| A5057 | Ostomy pouch, drainable, with extended wear barrier attached, with built in convexity, with filter, (1 piece), each | 20 per month |
| A5061 | Ostomy pouch, drainable; with barrier attached, (1 piece), each | 20 per month |
| A5062 | Ostomy pouch, drainable; without barrier attached (1 piece), each | 20 per month |
| A5063 | Ostomy pouch, drainable; for use on barrier with flange (2 piece system), each | 20 per month |
| A5071 | Ostomy pouch, urinary; with barrier attached (1 piece), each | 20 per month |
| A5072 | Ostomy pouch, urinary; without barrier attached (1 piece), each | 20 per month |
| A5073 | Ostomy pouch, urinary; for use on barrier with flange (2 piece), each | 20 per month |
| A5093 | Ostomy accessory; convex insert | 10 per month |
| A5102 | Bedside drainage bottle with or without tubing, rigid or expandable, each | 2 per 6 months |
| A5120 | Skin barrier, wipes, or swabs, each | 150 per 6 months |
| A5121 | Skin barrier; solid, 6X6 or equivalent, each | 20 per month |
| A5122 | Skin barrier; solid, 8X8 or equivalent, each | 20 per month |
| A5126 | Adhesive or non-adhesive; disk or foam pad | 20 per month |
| A5131 | Appliance cleaner, incontinence and ostomy appliances, per 16 oz. | 1 per month |
| A6216 | Gauze, non-impregnated, non-sterile, pad size 16 sq. in or less, without adhesive boarder, each dressing | 60 per month |
| T4521 | Adult sized disposable incontinence product, brief/diaper, small, each | 192 per month |
| T4522 | Adult sized disposable incontinence product, brief/diaper, medium, each | 192 per month |
| T4523 | Adult sized disposable incontinence product, brief/diaper, large, each | 192 per month |
| T4524 | Adult sized disposable incontinence product, brief/diaper, extra-large, each | 192 per month |
| T4525 | Adult sized disposable incontinence product, protective underwear/pull on, small size, each | 200 per month |
| T4526 | Adult sized disposable incontinence product, protective underwear/pull on, medium size, each | 200 per month |

| HCPCS Code | Item Description | Lifetime Expectancy or Quantity Limitation |
|---|---|---|
| T4527 | Adult sized disposable incontinence product, protective underwear/pull on, large size, each | 200 per month |
| T4528 | Adult sized disposable incontinence product, protective underwear/pull on, extra-large size, each | 200 per month |
| T4529 | Pediatric sized disposable incontinence product, brief/diaper, small/ medium size, each | 192 per month |
| T4530 | Pediatric sized disposable incontinence product, brief/diaper, large size, each | 192 per month |
| T4531 | Pediatric sized disposable incontinence product, protective underwear/pull on, small/medium size, each | 200 per month |
| T4532 | Pediatric sized disposable incontinence product, protective underwear/pull on, large size, each | 200 per month |
| T4533 | Youth sized disposable incontinence product, brief/diaper, each | 192 per month |
| T4534 | Youth-sized disposable incontinence product, protective underwear/pull on, each | 200 per month |
| T4543 | Disposable incontinence product, brief/diaper, bariatric, each | 200 per month |
| T4544 | Adult sized disposable incontinence product, protective underwear/pull-on, above extra large, each | 192 per month |
| | **Equipment Service and Repair** | |
| K0739 | Repair or non-routine service for durable medical equipment other than oxygen equipment requiring the skill of a technician, labor component, per 15 minutes | N/A |

**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.

Oral Nutrition:
Oral nutrition products must be billed using a second modifier, the BO modifier.

## 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

| | |
|---|---|
| **Farrell Valve**<br>**For Clinical Coverage and Prior Approval Criteria, refer to Subsection 5.3.5** | |
| A9999* | Miscellaneous DME supply or accessory, not otherwise specified (For use with Farrell Valve only) |

# Attachment C: Oral Nutrition Product Request Form

As of July 1, 2008, use this form for medically necessary oral nutrition products.
Refer to **Subsection 5.3.23, Medically Necessary Oral Nutrition,** for requirements. Copies of this form are available on DMA's website: (http://dma.ncdhhs.gov/).

## Oral Nutrition Product Request Form

Prescriber: For medically necessary oral nutrition products, submit this form to the DME provider with a Certificate of Medical Necessity/Prior Approval (CMN/PA) and any supporting documentation (for example, a growth chart or a nutrition assessment).

See Clinical Coverage Policy 5A, *Durable Medical Equipment and Supplies* for details.

| **Beneficiary Information** | | | | | |
|---|---|---|---|---|---|
| Beneficiary name | | | | Date of birth | |
| Medicaid or NCHC ID # | | | | | |
| Is the beneficiary eligible for WIC? | Y | N | If yes, list the oral nutrition products supplied by WIC: | | |
| | | | | | |
| | | | | | |
| | | | | | |

| **Product Information** |
|---|
| Oral nutrition product requested |
| |
| |
| Amount of product needed per month |
| |
| |
| Expected duration of oral nutrition product |
| |
| |

| **Medical Diagnosis(es)** (list all that are relevant to this request) |
|---|
| |
| |
| |
| |

| **Supporting Data** | | | | | | | |
|---|---|---|---|---|---|---|---|
| Current height/length | | Percentile (children) | | BMI | | | |
| Current weight | | Percentile (children) | | | | | |
| Does the recipient have a history of growth failure or weight loss? | Y | N | (If Yes, provide copy of growth chart or weight history.) | | | | |
| Are there laboratory data indicating nutrition depletion? If Yes, please list. | | | | | | | |
| Have other nutrition interventions been attempted? If Yes, please list. | | | | | | | |

| **Provider Contact Information** | |
|---|---|
| Name | Telephone |

| **Parent/Guardian or Beneficiary Contact Information** | |
|---|---|
| Name | Telephone |

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# Attachment D: 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.<br>***EXAMPLE:*** *November 14, 1949 is* **11141949**.<br>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:<br>*This is a Medicare non-covered service.*<br>*Service does not meet Medicare criteria.*<br>*Medicare benefits are exhausted.*<br>***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:<br>**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.<br>**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.<br>**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.<br>***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.*<br>**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.<br>**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.<br>**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.<br>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.<br>See the ***EXAMPLE*** under **Rental Equipment** for guidance.<br>**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.<br>**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:<br>**NU** for new purchase<br>**UE** for used purchase<br>**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:<br>**Purchased Equipment (DME and EN):** Enter the number of units provided on the date of service.<br>**Rental Equipment (DME and EN)—Other than Oxygen:** Enter **1**.<br>**Oxygen and Oxygen Equipment:** Enter the units provided on the date of service.<br>**Service and Repair:** Enter **1 unit for each 15-minute increment** being billed.<br>**DME-Related Supplies:** Enter the number of units provided on the date of service.<br>**EN Supply Kits:** Enter the number of consecutive days shown in 24A.<br>**EN Individual Supply Items:** Enter the number of units provided on the dates of service.<br>**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 [ ] 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 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 #) | MEDICAID (Medicaid #) X | 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 ☐ — Employed ☐ Full-Time Student ☐ Part-Time Student ☐

CITY: — STATE:

ZIP CODE: 54321 — TELEPHONE (Include Area Code): (999)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 ☐ 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 — 3. L — 2. 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

(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)

CARRIER — PATIENT AND INSURED INFORMATION — PHYSICIAN OR SUPPLIER INFORMATION

# Attachment E: 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-3 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-3 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.