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1.0 Description of the Procedure, Product, or Service

1.1 Durable Medical Equipment and Supplies

The following requirements must be met before an item can be considered medical equipment:

a. can withstand repeated use;

b. is primarily and customarily used to serve a medical purpose;

c. is not useful to a beneficiary in the absence of an illness or injury;

d. is appropriate for use in the home (for the purpose of this policy home includes a private residence for both a Medicaid and NCHC beneficiary or an adult care home for only a Medicaid beneficiary);

e. is intended to be used by only one beneficiary; and

All requirements above must be met before an item can be considered medical equipment.

Medical supplies are non-durable supplies that:

a. are disposable, consumable, and non-reusable in nature;

b. cannot withstand repeated use by more than one beneficiary;

c. are primarily and customarily used to serve a medical purpose;

d. are not useful to a beneficiary in the absence of illness or injury; and

e. are ordered or prescribed by a physician, physician assistant, or nurse practitioner.

1.2 Categories of Durable Medical Equipment and Supplies

Durable Medical Equipment and Supplies refers to the following categories of equipment and related supplies for use in a beneficiary's home:

a. **Inexpensive or Routinely Purchased:**

These items are purchased for a beneficiary.

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

These items are rented or purchased as follows:

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

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

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

d. **Related Medical Supplies:**

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

e. **Service and Repair:**

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

f. **Individually Priced Items:**

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

Refer to the **Durable Medical Equipment Fee Schedule** for a list of equipment, supplies, and services covered by Medicaid and NCHC. The fee schedules are available on the Division of Medical Assistance's Web site at http://dma.ncdhhs.gov/.
For a list of equipment, supplies, and services covered by Medicaid and NCHC, refer to the *Durable Medical Equipment Fee Schedule:* at http://dma.ncdhhs.gov/.

2.0 Eligibility Requirements

2.1 Provisions

2.1.1 General

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

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

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

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

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

2.1.2 Specific

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

a. Medicaid
None Apply.

b. NCHC
None Apply.

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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 medical equipment and related supplies listed on the *Durable Medical Equipment Fee Schedule* when the item is medically necessary and appropriate for use in a beneficiary's home where the beneficiary resides. The fee schedule is available on DMA's Web site at http://dma.ncdhhs.gov/.

Refer to **Subsection 1.1** for description of Durable Medical Equipment and Supplies. Medicaid and NCHC cover an item when medically necessary to maintain or improve a beneficiary's medical, physical or functional level within the beneficiary's home. This medical need must be verified by the beneficiary's physician, physician assistant, or nurse practitioner.

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

3.2.2 Medicaid Additional Criteria Covered

None Apply.

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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."

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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

Refer to Attachment A: Claims Related Information, Section C, Procedure Codes for a list of the HCPCS codes covered by Medicaid and NCHC, and for the life expectancy and quantity limitations for each code.

Medical necessity must be documented by the 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.

Note: the CMN/PA still must be completed and signed by the physician, physician assistant, or nurse practitioner.

5.3.1 Hospital Beds, Pediatric Beds and Related Supplies

All Hospital Beds require prior approval. They are covered by when they are medically necessary for the beneficiary:

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a. A **Fixed Height Hospital Bed** is medically necessary when one of the following is documented:
   1. The beneficiary's condition requires positioning of the body (e.g., to alleviate pain, promote good body alignment, prevent contractures, and avoid respiratory infections) in ways not feasible in an ordinary bed; or
   2. The beneficiary's condition requires special attachments that cannot be attached to and used on an ordinary bed.

b. A **Variable Height Hi-Lo Hospital Bed** is medically necessary when one of the following is documented:
   1. The beneficiary's condition requires positioning of the body to alleviate pain, promote good body alignment, prevent contractures, and avoid respiratory infections, etc, in ways not feasible in an ordinary bed; or
   2. The variable height feature is necessary for the beneficiary to ambulate and transfer in and out of bed.

c. A **Semi-Electric Hospital Bed** with electric-powered adjustments to lower and raise head and foot is medically necessary when the following is documented:
   1. The beneficiary's condition requires frequent change in body position; and
   2. There is an immediate need for a change in position and the beneficiary can operate the controls independently and make the adjustments.

d. A **Total Electric Hospital Bed** with electric-powered adjustments to lower and raise head and foot is medically necessary when the following is documented:
   1. The beneficiary's condition requires frequent change in body position; or
   2. There may be an immediate need for a change in position; and
   3. The beneficiary can operate the controls and make the adjustments; and
   4. The variable height feature must be medically justified.

e. An **Oversized Hospital Bed and Replacement Innerspring Mattress** are medically necessary when all of the following criteria are met:
   1. Documentation submitted shows the beneficiary meets the medical necessity requirements for the comparable standard size equipment and the medical need for the oversized equipment;
   2. The beneficiary's height, weight, and body measurements are included on the CMN/PA form and meet the weight requirements specified in the HCPCS code requested. The body measurements must be taken in the appropriate position for the requested equipment (i.e. supine for hospital beds); and
   3. The dimensions of the requested equipment and the manufacturer's specified weight capacity for the equipment are included on the CMN/PA form.

For a list of the specific HCPCS codes covered, refer to **Attachment A**, **Section C: Codes** Lifetime Expectancies and Quantity Limitations for Durable Medical Equipment and Supplies, *Hospital Beds and Related Supplies*.

Pediatric Beds

Pediatric Cribs, Pediatric Hospital Beds, and Safety Enclosures require prior approval and are covered when the beneficiary's diagnosis and medical condition deem it medically necessary. For prior approval one of the following criteria must be met:

a. Documentation from the physician, physician assistant, or nurse practitioner includes an order for the hospital grade crib, safety enclosure, or related supplies and documents that this is the most appropriate, medically necessary bed for the beneficiary;

b. The beneficiary's condition requires positioning of the body (e.g., to alleviate pain, promote good body alignment, prevent contractures, avoid respiratory infections) in ways not feasible in an ordinary bed or crib; or

c. The beneficiary's condition requires a bed or crib with special attachments that cannot be attached to and used on an ordinary bed.

Pediatric Specialty Beds are beds, such as the *Sleep Safe* or *Pedi craft* beds, that have special safety features that prevent entrapment or falls. These beds are designed for children with physical and cognitive disabilities who require a safe enclosed padded interior that allows quick and easy access for frequent or sudden medical attention.

These beds and accessories are covered when the beneficiary's diagnosis and medical condition deem it medically necessary. Prior approval is required. For prior approval all of the following criteria must be met:

a. Pediatric beds are deemed to be medically necessary when all the following criteria are met:

    1. Documentation from the physician, physician assistant, or nurse practitioner includes an order for the hospital grade crib, safety enclosure, pediatric specialty bed or related supplies and documents that this is the most appropriate, medically necessary bed for the beneficiary;

    2. The diagnosis and medical condition of the beneficiary must support the need for the additional features these beds offer, for example severe spasticity, thrashing or uncontrolled movements, cognitive impairment, unsafe activities or behaviors which place the beneficiary at risk for injury and make the use of a specialty bed necessary;

    3. A letter of medical necessity or clinical evaluation from a physical therapist or occupational therapist involved in the care of the beneficiary that includes:

        A. The specific detail to show how the requested equipment is medically necessary for the beneficiary; and

        B. An explanation of why a regular bed or a hospital bed with rails and rail pads does not meet the beneficiary's needs. This includes a

description of other less expensive specialty beds that were considered and ruled out and why they were ruled out.

Note: The physical therapist or occupational therapist completing the letter of medical necessity and evaluation cannot be employed by or have a financial relationship with the medical equipment provider.

4. The home environment supports the use of a hospital grade crib, safety enclosure, or pediatric specialty bed and related supplies. Documentation must be included to demonstrate suitability in the home and utilization for the beneficiary; and
5. Documentation that the family or caregiver is willing and able to safely and appropriately use the equipment.

b. Hospital grade cribs, safety enclosures, and pediatric specialty beds are not considered medically necessary when used for:

1. caregiver convenience,
2. behavior therapy,
3. physical restraint,
4. substitute for appropriate parental; or caregiver supervision; or
5. regular bed meets the needs of the beneficiary.

For a list of the specific HCPCS codes covered, refer to **Attachment A**, **Section C: Codes** Lifetime Expectancies and Quantity Limitations for Durable Medical Equipment and Supplies, *Pediatric Beds and Cribs*.

Hospital Bed Related Supplies

The following items **do not** require prior approval:

a. A **Replacement Mattress or Side Rails** for a hospital bed is covered when both of the following criteria are met:
   1. There is evidence that the mattress or side rails is worn out or broken and must be replaced; and
   2. Continued use of an approved beneficiary-owned hospital bed is medically necessary.
b. A **Trapeze Bar** is covered when the beneficiary requires the accessory to reposition himself or herself in an approved hospital bed.
c. A **Traction Frame** is covered when the beneficiary requires traction for a specific orthopedic diagnosis and the equipment is ordered by a physician for use with an approved hospital bed.
d. A **Bed Pan or Urinal** is covered when the beneficiary is unable to move from the bed to the bathroom or bedside commode for elimination.
e. A **Bed Cradle** is covered if the beneficiary requires protection of a body part from topical pressure.

The following items **do** require prior approval

A **Heavy Duty Trapeze Bar** is covered when the beneficiary requires the accessory to reposition the beneficiary in an approved hospital bed and meets the

weight requirement specified for the heavy duty trapeze bar. The beneficiary's weight must be stated on the CMN/PA form. Prior approval is required.

For a list of the specific HCPCS codes covered, refer to **Attachment A**, **Section C: Codes** Lifetime Expectancies and Quantity Limitations for Durable Medical Equipment and Supplies, *Hospital Beds and Related Supplies.*

5.3.2 Pressure-Reducing Support Surfaces—Group 1

Group I Pressure-Reducing Support Surfaces including an alternating pressure pad, pressure reducing mattress overlay, or air or gel pressure pad are covered when they are medically necessary for the beneficiary.

These pressure-reducing support surfaces do not require prior approval, but documentation of medical necessity must be completed and maintained in the provider's records according to the guidelines listed in **Subsection 7.2, Record Keeping**.

Group I **Overlays or Mattresses** are covered when the beneficiary meets one of the following criteria:

a. The beneficiary is completely immobile, i.e. cannot make changes in body position without assistance, or
b. The beneficiary has limited mobility, i.e. cannot independently make changes in body position significant enough to alleviate pressure, and has one of the following:
    1. impaired nutritional status;
    2. incontinent of feces or urine;
    3. altered sensory perception;
    4. compromised circulatory status; or
    5. inability to respond to pain.
c. The beneficiary has any stage pressure ulcer on the trunk or pelvis and has one of the following conditions:
    1. impaired nutritional status;
    2. altered mental status;
    3. incontinent of feces or urine;
    4. altered sensory perception; or
    5. compromised circulatory status.

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

Stage I	nonblanchable 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

Note: A foam overlay or mattress that does not have a waterproof cover is not considered durable and therefore non-covered.

All Group 1 Support Surfaces must be rented when the anticipated need for the item is six months or less, except for the **Replacement Pad for use with medically necessary alternating pressure pad owned by beneficiary** and the **Dry Pressure Pad for Mattress, standard mattress length and width**; which are purchase-only items. The Group I Support Surfaces may be rented or purchased when the physician, physician assistant, or nurse practitioner documents that the anticipated need exceeds six months.

For a list of the specific HCPCS codes covered, refer to **Attachment A, Section C: Codes** Lifetime Expectancies and Quantity Limitations for Durable Medical Equipment and Supplies, *Pressure Reducing Support Surfaces – Group I.*

5.3.3 Pressure-Reducing Support Surfaces—Group 2

Group 2 Pressure-Reducing Support Surfaces, including a powered air flotation bed, powered pressure-reducing air mattress, or pressure reducing overlay, are covered when they are medically necessary for the beneficiary**:**

Prior approval is required for all Group 2 support surfaces. Initial approval is given for a maximum of three months.

For initial approval, the beneficiary shall meet one of the conditions listed below:

a. The beneficiary has the following:
    1. multiple Stage II pressure ulcers (ulcers with partial-thickness skin loss involving epidermis and/or dermis) located on the trunk or pelvis; and
    2. the ulcers have worsened or remained the same over the past month; and
    3. the beneficiary has been on a comprehensive ulcer treatment program for at least the past month, which has included the use of an appropriate Group 1 support surface. Comprehensive ulcer treatment includes the following:
        A. education of the beneficiary and caregiver on the prevention and management of pressure ulcers;
        B. regular assessment by a physician, physician assistant, or nurse practitioner, or other licensed healthcare practitioner (usually at least weekly for a beneficiary with a Stage III or IV ulcer);
        C. appropriate turning and positioning;
        D. appropriate wound care (for a Stage II, III, or IV ulcer);
        E. appropriate management of moisture or incontinence; and
        F. a nutritional assessment and intervention consistent with the overall plan of care.

b. The beneficiary has large or multiple Stage III or IV pressure ulcer(s) on the trunk or pelvis; and

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

    Stage I nonblanchable erythema of intact skin

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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

c. The beneficiary has a recent myocutaneous flap or skin graft for a pressure ulcer on the trunk or pelvis (surgery within the past 60 calendar days) and has been on a Group 2 or 3 support surface immediately prior to a recent discharge from a hospital or nursing facility (discharge within the past 30 calendar days).

Prior approval renewals are given for a maximum of three months. The documentation requirements for continued renewal of prior approval are the same as those stated above for initial approval. Continued use of a Group 2 support surface is covered until the ulcer(s) is healed. If healing does not continue, there must be additional documentation in the health record to show:

a. Other aspects of the care plan are being revised at least every four weeks to promote healing; and
b. Use of the Group 2 support surface is medically necessary for wound management.

All items are rented and only become the property of the beneficiary when the monthly rental payments reach the purchase price.

For a list of the specific HCPCS codes covered, refer to **Attachment A, Section C: Codes** Lifetime Expectancies and Quantity Limitations for Durable Medical Equipment and Supplies, *Pressure Reducing Support Surfaces – Group 2*.

5.3.4 Pressure-Reducing Support Surfaces—Group 3

An air fluidized bed combines air fluidized therapy and low air-loss therapy on an articulating frame providing beneficiary with maximum relief from bed pressure. An air fluidized bed is covered when it is medically necessary for the beneficiary.
Prior approval is required. For initial approval, the beneficiary shall meet all the following criteria:

a. The beneficiary has a Stage III (full thickness tissue loss) or Stage IV (deep tissue destruction) pressure sore, or is status post-op muscle/skin flap repair of a stage III or IV pressure sore;

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

Stage I nonblanchable 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

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Stage IV full-thickness skin loss with extensive destruction, tissue necrosis, or damage to muscle, bone, or supporting structures

b. The beneficiary is bedridden or chair bound as a result of severely limited mobility;

c. The air-fluidized bed is prescribed in writing by the beneficiary's attending physician based upon a comprehensive assessment of the beneficiary after conservative treatment has been tried without success. Conservative treatment includes all of the following:

1. education of the beneficiary and caregiver on the prevention and management of pressure ulcers;
2. assessment by a physician, physician assistant, or nurse practitioner, or other licensed healthcare practitioner done at least weekly
3. turning and positioning;
4. use of a Group II support surface, if appropriate;
5. topical wound care;
6. management of moisture or incontinence; and
7. nutritional assessment and intervention consistent with the overall plan of care;

d. The beneficiary shall have been on the conservative treatment program for at least one month prior to use of the air-fluidized bed with no improvement or worsening of the ulcer. The evaluation must be performed within a week of initiating treatment with the air-fluidized bed;

e. A trained adult caregiver is available to assist the beneficiary with activities of daily living, fluid balance, dry skin care, repositioning, recognition, management of altered mental status, dietary needs, prescribed treatments, and management and support of the air-fluidized bed system;

f. A physician, physician assistant, or nurse practitioner directs the home treatment regimen, and re-evaluates and recertifies the need for the air-fluidized bed on a monthly basis; and

g. All other alternative equipment has been considered and ruled out.

An air-fluidized bed is denied as not medically necessary under any of the following circumstances.

a. The beneficiary has coexisting pulmonary disease (the lack of firm back support makes coughing ineffective and dry air inhalation thickens secretions).

b. The beneficiary requires treatment with wet soaks or moist wound dressings that are not protected with an impervious covering such as plastic wrap or other occlusive material.

c. The caregiver is unwilling or unable to provide the type of care required by the beneficiary on an air-fluidized bed.

d. Structural support is inadequate to support the weight of the air-fluidized bed system (it weighs around 1,600 pounds).

e. The home electrical system is insufficient for the anticipated increase in energy consumption.

f. There are other known contraindications to the use of this bed.

Note: Initial prior approval for an air-fluidized bed is given for a maximum of one month. Renewals are given for a maximum of one month. The documentation requirements are the same for requests to renew approval. An air fluidized bed is typically needed only 6-12 weeks post-operatively.

Continued use of an air-fluidized bed is covered until the ulcer is healed. If healing does not continue, there must be additional documentation in the clinical health care record to show:

a. Other aspects of the care plan are being modified to promote healing; and
b. The use of the air-fluidized bed is medically necessary for wound management.

For a list of the specific HCPCS codes covered, refer to **Attachment A, Section C: Codes** Lifetime Expectancies and Quantity Limitations for Durable Medical Equipment and Supplies, *Pressure Reducing Support Surfaces – Group 3.*

5.3.5 Negative Pressure Wound Therapy Electrical Pump, Stationary or Portable, and Related Supplies

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 three 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	nonblanchable 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

For a list of the specific HCPCS codes covered, refer to **Attachment A, Section C: Codes** Lifetime Expectancies and Quantity Limitations for Durable Medical Equipment and Supplies, *Negative Pressure Wound Therapy*.

5.3.6 Wheelchairs and Accessories

The following wheelchairs and wheelchair accessories are covered, for use in a beneficiary's home, when they are medically necessary for the beneficiary. Prior approval is required for all wheelchairs.

Manual Wheelchairs

A **Manual Wheelchair** is covered when all of the following **basic criteria** are met:

a. The beneficiary has a mobility limitation that significantly impairs the beneficiary's ability to participate in one or more mobility-related activities of daily living (MRADLs) in the home;

   Note: For this policy MRADLs are defined as toileting, feeding, dressing, grooming, and bathing. To be considered significantly impaired means the mobility limitation prevents performance of the activity entirely, prevents the activity from being completed in a reasonable time frame, or places the beneficiary at high risk for injury when performing the activity, or at a heightened risk of morbidity secondary to attempts to perform the MRADL.

b. The beneficiary's mobility limitation cannot be sufficiently resolved by the use of an appropriately fitted cane or walker;

c. The beneficiary's home is accessible for a wheelchair and provides adequate access between rooms, maneuvering space, and surfaces for use of the manual wheelchair that is provided;

d. Use of a manual wheelchair is reasonably expected to significantly improve the beneficiary's ability to participate in MRADLs; and

e. The beneficiary has sufficient upper extremity function and the physical and mental capabilities needed to safely self propel the manual wheelchair in the home throughout the course of a normal day **or** has a caregiver who is available, willing, and able to provide assistance with the wheelchair.

   Note: A wheelchair based solely for use outside the home is not covered.
   Note: Payment is made for only one wheelchair at a time. Backup wheelchairs are not covered as they are not medically necessary.

A **Standard Hemi (low seat) Wheelchair** is covered when all of the basic criteria are met plus the following:

a. The beneficiary requires a lower seat height (17 to 18 inches) because of short stature or to enables the beneficiary to place his or her feet on the ground for propulsion.

A **Lightweight Wheelchair** is covered when all of the basic manual wheelchair coverage criteria are met plus the following:

a. The beneficiary cannot self propel in a standard wheelchair in the home using his or her arms or legs;
b. The beneficiary can and does self propel safely and functionally in a lightweight wheelchair;
c. The provider shall submit supporting documentation with the request that demonstrates the beneficiary has limitations in upper extremity strength or function that prevents propulsion of a standard wheelchair; and
d. The beneficiary can safely propel the lightweight wheelchair.

A **High-Strength Lightweight Wheelchair** is covered when all of the basic manual wheelchair coverage criteria are met plus the following:

1. The beneficiary cannot safely and functionally self propel in a standard or lightweight wheelchair using his or her arms or legs while engaging in frequent activities in the home,
2. The beneficiary spends a minimum of six hours each day in the wheelchair,
3. The beneficiary can safely and functionally self propel in a high-strength lightweight wheelchair; and
4. The provider shall submit supporting documentation with the request that states the beneficiary has limitations in upper extremity strength or function that prevents propulsion of a standard wheelchair.

An **Ultra Lightweight Wheelchair** is covered when all of the basic manual wheelchair coverage criteria are met plus the following:

a. The routine activities the beneficiary engages in at home cannot be performed in a lightweight wheelchair;
b. The features of the ultra lightweight wheelchair are required for the beneficiary to be functional;
c. The beneficiary spends a minimum of six hours each day in the wheelchair; and
d. The beneficiary can safely propel the ultra lightweight wheelchair.

The following documentation must be submitted for prior approval:

a. A clinical wheelchair evaluation must be performed by a physical or occupational therapist with specific training and experience in rehabilitation wheelchair evaluations, and describe the beneficiary's medical condition, mobility limitations, and other physical and functional limitations. The physical or occupational therapist performing the evaluation shall not have a financial relationship with the wheelchair supplier.

   Note: An ultra lightweight wheelchair based solely on use outside the home is not covered.

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b. A Manufacturer's Suggested Retail Price (MSRP) quote for the requested wheelchair and accessories from the manufacturer.

A **Heavy-duty wheelchair** is covered when all of the basic manual wheelchair coverage criteria are met plus either of the following:
a. The beneficiary weights more than 250 pounds; or
b. The beneficiary has severe spasticity.

An **Extra Heavy-duty wheelchair** is covered when all of the basic manual wheelchair coverage criteria are met and the beneficiary weighs more than 300 pounds.

A **Manual Adult Size Wheelchair, which includes tilt in space,** is covered when all of the basic manual wheelchair coverage criteria are met plus coverage criteria for the tilt in space option.

The following is required for prior approval:
a. A clinical wheelchair evaluation must be performed by a physical or occupational therapist with specific training and experience in rehabilitation wheelchair evaluations, and describe the beneficiary's medical condition, mobility limitations, and other physical and functional limitations. The physical or occupational therapist performing the evaluation shall not have a financial relationship with the wheelchair supplier;
b. A letter of medical necessity from the physical or occupational therapist that documents the medical need for the manual adult size wheelchair and all additional accessories requested; and
c. A MSRP quote for the requested wheelchair and accessories from the manufacturer.

For prior approval of the **tilt in space** feature, the following criteria must be met:
a. The beneficiary requires the tilt in space feature for proper positioning during daily activities, such as eating;
b. The beneficiary has significant trunk or hip musculoskeletal deformity or abnormal tone in the trunk musculature and must be tilted to maintain postural control or spinal alignment;
c. The beneficiary is unable to actively change his or her upright seating position and is at risk for loss of skin integrity;
d. The beneficiary has a respiratory, digestive or cardiac dysfunction that is functionally improved with the tilt/recline feature; and
e. The beneficiary must spend a minimum of six hours per day in the wheelchair to qualify for the tilt in space feature.

For a list of the specific HCPCS codes covered, refer to **Attachment A, Section C: Codes** Lifetime Expectancies and Quantity Limitations for Durable Medical Equipment and Supplies, *Manual Wheelchairs*.

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Rental Wheelchairs

Prior approval for rental of a manual wheelchair may be granted for a maximum of nine months when the beneficiary meets all of the basic manual wheelchair coverage criteria.

Transport Chairs/Rollabout Chairs

Adult and pediatric transport chairs, and a rollabout chair are covered Medicaid and NCHC when they are medically necessary for the beneficiary. Prior approval is required for transport chairs rollabout chair does not require prior approval. .

For a list of the specific HCPCS codes covered, refer to **Attachment A, Section C: Codes** Lifetime Expectancies and Quantity Limitations for Durable Medical Equipment and Supplies, *Transport Chairs*.

Pediatric Manual Wheelchairs

Pediatric Manual Wheelchairs and accessories are covered when they are medically necessary for the beneficiary. Prior approval is required for all pediatric wheelchairs.

Note: Pediatric wheelchairs are covered only for a child or an adult of very small stature. The wheelchair width or depth must be 14 inches or less to be coded as pediatric.

The following is required for prior approval:

a. A clinical wheelchair evaluation must be performed by a physical or occupational therapist with specific training and experience in rehabilitation wheelchair evaluations, and describe the beneficiary's medical condition, mobility limitations, and other physical and functional limitations. The physical or occupational therapist performing the evaluation shall not have a financial relationship with the wheelchair supplier;
b. A letter of medical necessity from the physical or occupational therapist that documents:
    1. The medical need for mobility in the beneficiary's home
    2. And the medical need for the pediatric manual wheelchair selected and all the additional accessories requested.
    3. This letter must also document the home's accessibility; and
    4. A MSRP quote for the requested wheelchair and accessories from the manufacturer.

For a list of the specific HCPCS codes covered, refer to **Attachment A, Section C: Codes** Lifetime Expectancies and Quantity Limitations for Durable Medical Equipment and Supplies, *Pediatric Manual Wheelchairs*.

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Oversized Manual Wheelchairs

Oversized Manual Wheelchairs for weights greater than 451 pounds are covered when they are medically necessary for the beneficiary. Prior approval is required**.**

For prior approval all of the basic manual wheelchair coverage criteria must be met plus the following:

a. The beneficiary shall meet the weight requirements for the specific wheelchair requested. The beneficiary's height, weight, and body measurements must be included with the request for prior approval; and
b. The dimensions of the requested equipment and the manufacturer's specified weight capacity for the equipment must be submitted.

For a list of the specific HCPCS codes covered, refer to **Attachment A, Section C: Codes** Lifetime Expectancies and Quantity Limitations for Durable Medical Equipment and Supplies, *Oversized Manual Wheelchairs.*

Power Wheelchairs

All power wheelchairs require prior approval. The following information must be submitted with the prior approval request:

a. A face-to-face examination which consists of an in-person visit to the beneficiary's treating physician for the purpose of requesting a power wheelchair and a comprehensive medical examination. The face-to-face examination must be documented in a detailed narrative note in the physician's chart in the same format used for other entries. The physician's note must clearly indicate the major reason for the visit was a mobility examination. The physician's note must document the beneficiary's strength, mobility and functional deficits, and support the need for a power wheelchair to perform MRADLs in the beneficiary's home.

   The face-to-face evaluation must be completed prior to the physician's order for the power chair and must support the medical necessity for the power wheelchair. This evaluation must provide subjective and objective information about the beneficiary's condition and progression of the beneficiary's disease over time. It must clearly indicate the beneficiary's ambulatory status, explain why a power wheelchair is needed as compared to a cane, walker, or manual wheelchair and address the medical justification for each accessory billed. Other clinical health care records (physician office records, hospital records, home health agency records, or physical and occupation therapy notes) can be submitted to supplement the information in the face-to-face evaluation.
b. An onsite written assessment of the beneficiary's home that verifies and documents the beneficiary's environment that supports the use of a power wheelchair. The home assessment can be performed by the wheelchair supplier and must include measurements of the physical layout of the home, doorway widths, doorway thresholds, and surfaces the chair moves over.
c. A MSRP quote for the requested wheelchair and accessories from the manufacturer that gives a detailed description of the items requested.

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Note: A wheelchair supplier generated form must not be used to document the physician's examination since a supplier generated form is not considered to be part of the clinical health care record.

Payment is made for only one wheelchair at a time. A backup wheelchair is not covered as it is not medically necessary.

A power wheelchair is not medically necessary when the underlying condition is reversible and the length of need is less than three months.

Standard Power Wheelchairs

Standard Power Wheelchairs, including Group 1 chairs and some Group 2 chairs without power options, are covered when they are medically necessary for the beneficiary.

All of the following coverage criteria must be met:

a. The beneficiary has a mobility limitation that significantly impairs his or her ability to participate in one or more MRADLs in the home;

Note: For this policy MRADL's are defined as toileting, feeding, dressing, grooming, and bathing in customary locations in the home. To be considered **significantly impaired** means the mobility limitation prevents performance of the activity entirely, prevents the activity from being completed in a reasonable time frame, or places the beneficiary at high risk for injury when performing the activity, or at a heightened risk of morbidity secondary to attempts to perform the MRADL.

b. The beneficiary's mobility limitation cannot be sufficiently resolved by the use of an appropriately fitted cane or walker;
c. The beneficiary does not have sufficient upper extremity function to self-propel an optimally-configured manual wheelchair in the home to perform MRADL's throughout the course of a normal day. Limitations of strength, endurance, range of motion, coordination, presence of pain, deformities, or the absence of one or both upper extremities must be noted in the assessment of upper extremity function;
d. The beneficiary has the mental and physical capabilities to safely operate the power wheelchair and to assure it is cared for;
e. Use of the power wheelchair is reasonably expected to significantly improve the beneficiary's ability to participate in MRADL's and is for use in the home; and
f. The beneficiary's home is accessible to the wheelchair and provides adequate access between rooms, maneuvering space, and surfaces for use of the power wheelchair that is provided.

For a list of the specific HCPCS codes covered, refer to **Attachment A, Section C: Codes** Lifetime Expectancies and Quantity Limitations for Durable Medical Equipment and Supplies, *Power Wheelchairs – Standard*.

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Complex Rehab Power Wheelchairs

Complex rehab power wheelchairs, including power chairs with single or multiple power options, require prior approval. In addition to the face-to-face assessment with the physician, the onsite written assessment of the beneficiary's home, and the manufacturer's quote required for all power wheelchairs, the following are required:

a. A clinical wheelchair evaluation must be performed by a physical or occupational therapist with specific training and experience in rehabilitation wheelchair evaluations, and describe the beneficiary's medical condition, mobility limitations, and other physical and functional limitations. The physical or occupational therapist performing the evaluation shall not have a financial relationship with the wheelchair supplier; and
b. A letter of medical necessity from the physical or occupational therapist that documents the medical need for the complex rehab power wheelchair and all additional accessories requested.

Complex rehab power wheelchairs are covered if all of the criteria for a Standard Power Wheelchair are met plus the following:

a. The beneficiary requires a drive control interface other than a hand or chin-operated standard proportional joystick;
b. The beneficiary meets coverage criteria for a power tilt or a power recline seating system and the system is being used on the wheelchair. (Refer to *Wheelchair Accessories, Power Seating Systems*, for prior approval requirements for power tilt and recline);
c. The wheelchair clinic evaluation must document the medical necessity for the wheelchair and its special features;
d. A Group 3 power wheelchair is covered when the beneficiary's mobility limitation is due to a neurological condition, myopathy, or congenital skeletal deformity; and
e. Group 4 power wheelchairs have added capabilities that are not usually needed for use in the home. Options or features not for use in the home are not covered.

For a list of the specific HCPCS codes covered, refer to **Attachment A, Section C: Codes** Lifetime Expectancies and Quantity Limitations for Durable Medical Equipment and Supplies, *Power Wheelchairs – Complex Rehab.*

Heavy Duty Wheelchairs

Heavy duty power wheelchairs for beneficiaries who weigh more than 300 pounds are covered when they are medically necessary for the beneficiary. Prior approval is required.

For prior approval of heavy duty wheelchair all of the following must be submitted:

a. Documentation shall substantiate the following two requirements:

1. Beneficiary shall meet the weight requirements for the heavy duty power wheelchair requested; and
2. Medical necessity for a comparable standard size wheelchair.

b. The beneficiary's height, weight, and body measurements must be included.
c. The dimensions of the requested equipment and the manufacturer's specified weight capacity for the equipment must be submitted.

For a list of the specific HCPCS codes covered, refer to **Attachment A, Section C: Codes** Lifetime Expectancies and Quantity Limitations for Durable Medical Equipment and Supplies, *Power Wheelchairs – Heavy Duty.*

Wheelchair Accessories

Wheelchair Accessories are covered when they are medically necessary. The medical need must be documented and maintained in the provider's records, regardless of the need for prior approval.

Batteries

Batteries are covered when they are necessary to operate the power wheelchair that has been approved for the beneficiary. Prior approval is required only for Group 27 batteries.

Prior approval is required for Battery Chargers. Battery Chargers are covered when the criteria for a power wheelchair are met. An initial charger must be included in the allowance for a power wheelchair. The charger must be billed separately only when it is a replacement.

For a list of the specific HCPCS codes covered, refer to **Attachment A, Section C: Codes** Lifetime Expectancies and Quantity Limitations for Durable Medical Equipment and Supplies, *Wheelchair Accessories – Batteries.*

Armrests

Adjustable Height Armrests are covered when the beneficiary requires an arm height that is different from those available using non-adjustable armrests, and the beneficiary spends more than four hours per day in the wheelchair. Prior approval is required for adjustable height armrests.

Arm troughs are covered when the beneficiary requires additional support for the upper extremity not provided by the wheelchair armrest. Prior approval is not required.

For a list of the specific HCPCS codes covered, refer to **Attachment A, Section C: Codes** Lifetime Expectancies and Quantity Limitations for Durable Medical Equipment and Supplies, *Wheelchair Accessories – Armrests.*

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Cushions

General use wheelchair cushions are covered when the beneficiary has a diagnosis that causes deformities of the musculoskeletal system, has contractures such that the normal body alignment is significantly altered, and spends more than two hours per day in the wheelchair. Prior approval is not required.

Positioning wheelchair cushions are covered when the beneficiary has the potential for development of a musculoskeletal deformity of the trunk, or has already begun to develop such a deformity, and it can be ameliorated or retarded by the addition of a positioning cushion.

Skin protection and positioning wheelchair cushions may be covered if the beneficiary has a diagnosis or condition that causes skin breakdown due to immobility in a wheelchair for long periods of time. The beneficiary shall be wheelchair bound. Prior approval is required for some wheelchair cushions. Refer to the *Durable Medical Equipment and Supplies* fee schedule at: http://dma.ncdhhs.gov/ to determine if prior approval is required. Items on the fee schedule requiring prior approval are identified by an asterisk.

For a list of the specific HCPCS codes covered, refer to **Attachment A, Section C: Codes** Lifetime Expectancies and Quantity Limitations for Durable Medical Equipment and Supplies, *Wheelchair Accessories – Cushions***.**

Headrest

Head and neck supports require prior approval. The beneficiary shall have all of the following for prior approval:

a. Weakness or abnormal muscle tone in cervical musculature such that function in those muscles is significantly impaired and the headrest is needed to support the head; and

b. The beneficiary is not able to actively maintain proper cervical positioning.

A head and neck support is approved when the beneficiary has a reclining back on the approved wheelchair.

For a list of the specific HCPCS codes covered, refer to **Attachment A, Section C: Codes** Lifetime Expectancies and Quantity Limitations for Durable Medical Equipment and Supplies, *Wheelchair Accessories – Headrests.*

Reclining Back

A reclining back is covered when the beneficiary has any of the following:

a. Severe trunk or hip bony deformity;
b. Trunk or lower extremity casting or bracing the requires reclined positioning;
c. Severe extensor tone of the trunk muscles;
d. The need to rest in a recumbent position two or more times during the day and transfers between the wheelchair and bed are very difficult;
e. Cannot tolerate upright positioning due to blood pressure instability; or
f. Spends more than four hours per day in the wheelchair.

Prior approval is required.

For a list of the specific HCPCS codes covered, refer to **Attachment A, Section C: Codes** Lifetime Expectancies and Quantity Limitations for Durable Medical Equipment and Supplies, *Wheelchair Accessories – Reclining Back.*

Leg rest

Elevating leg rests are covered when the beneficiary has any of the following:
a. A musculoskeletal condition which prevents 90 degree flexion at the knee;
b. The presence of a cast or brace which prevents 90 degree flexion at the knee;
c. Circulation issues that require lower extremity elevation; or
d. Meets the criteria for and has a reclining back on the wheelchair.

A residual limb support is covered when the beneficiary has had an amputation and the residual limb cannot be supported on a standard leg rest.

For a list of the specific HCPCS codes covered, refer to **Attachment A, Section C: Codes** Lifetime Expectancies and Quantity Limitations for Durable Medical Equipment and Supplies, *Wheelchair Accessories – Leg Rest.*

Foot Rest/Shoe Holder

Footrests, footplates, shoe holders, and straps are covered when the beneficiary requires lower extremity support due to muscular weakness, neuromuscular dysfunction or orthopedic deformity.

Prior approval is required for some of these items. Refer to the *Durable Medical Equipment and Supply* fee schedule at http://dma.ncdhhs.gov/ to determine when prior approval is required. Items on the fee schedule requiring prior approval are identified by an asterisk.

For a list of the specific HCPCS codes covered, refer to **Attachment A, Section C: Codes** Lifetime Expectancies and Quantity Limitations for Durable Medical Equipment and Supplies, *Wheelchair Accessories – Foot Rest/Shoe Holder.*

Seat/Back

A non standard seat height for a high-strength lightweight or ultra lightweight wheelchair is covered when:
a. The required seat height is at least two inches greater than or less than a standard option; and
b. The beneficiary's body dimensions justify the need.

Non standard seat frames are covered when all of the following criteria are met:
a. The beneficiary's dimensions justify the need for wheelchair seat width, depth, or height changes; and
b. The seat width, depth, or height changes are needed to maintain or improve the beneficiary's medical, physical, or functional level.

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A solid seat insert is covered when it is needed to provide a flat surface in a wheelchair with a sling seat so the beneficiary will be properly positioned.

A solid seat support base is covered when it replaces a sling seat and is needed to properly position the beneficiary in the wheelchair. A solid seat support base requires prior approval.

A planar or contoured back is covered when the beneficiary meets all of the following criteria:

a. Has a diagnosis that may result in deformities of the musculoskeletal system such that the normal body alignment could be significantly altered; and
b. Spends more than two hours per day in the wheelchair.

A Growth Kit is covered when the addition of this feature significantly increases the lifetime of the beneficiary's currently appropriate wheelchair.

These items all require prior approval.

Replacement upholstery is covered when the upholstery is damaged or worn beyond repair and replacing the upholstery will increase the lifetime of the wheelchair. Prior approval is not required for replacement upholstery.

For a list of the specific HCPCS codes covered, refer to **Attachment A, Section C: Codes** Lifetime Expectancies and Quantity Limitations for Durable Medical Equipment and Supplies, *Wheelchair Accessories – Seat/Back.*

Trunk/Extremity Alignment Support

Trunk/Extremity Alignment Supports, including lateral truck or hip supports, abductor or adductor pads, harnesses, straps, or positioning belts, are covered when:

a. The beneficiary has weakness or abnormal muscle tone in the trunk, body, or extremity musculature resulting in significantly impaired function in those muscles; or
b. The beneficiary is unable to actively maintain proper trunk or extremity positioning.

All of these items require prior approval except for the positioning belts and safety vest.

For a list of the specific HCPCS codes covered, refer to **Attachment A, Section C: Codes** Lifetime Expectancies and Quantity Limitations for Durable Medical Equipment and Supplies, *Wheelchair Accessories – Trunk/Extremity Support.*

Oversized Accessories

All oversized accessories require prior approval. For prior approval all of the following information must be included with the request:

a. Beneficiary's height, weight, and body measurements; and

b. The dimension of the requested equipment and the manufacturer's specified weight capacity for the equipment.

For a list of the specific HCPCS codes covered, by refer to **Attachment A, Section C: Codes** Lifetime Expectancies and Quantity Limitations for Durable Medical Equipment and Supplies, *Wheelchair Accessories – Oversized.*

Power Seating Systems

Power seating systems, including tilt, recline, and combination tilt and recline, require prior approval and are covered when the beneficiary meets all of the following:

a. The beneficiary requires the tilt in space feature for proper positioning during daily activities, such as eating;
b. The beneficiary has significant trunk or hip musculoskeletal deformity or abnormal tone in the trunk musculature and must be tilted to maintain postural control or spinal alignment;
c. The beneficiary is unable to actively change his or her upright seating position and is at risk for loss of skin integrity;
d. The beneficiary has respiratory, digestive or cardiac dysfunction that is functionally improved with the tilt/recline feature;
e. The beneficiary shall spend a minimum of six hours per day in the wheelchair; and
f. The beneficiary does not have a caregiver available to perform this function manually.

Power seat elevation is covered for beneficiary's ages 0 through 20 years only, when the beneficiary is not able to transfer from the wheelchair to bed or toilet without height adjustment or requires seat elevation to perform MRADL's in the home. Prior approval is required.

For a list of the specific HCPCS codes covered, refer to **Attachment A, Section C: Codes** Lifetime Expectancies and Quantity Limitations for Durable Medical Equipment and Supplies, *Wheelchair Accessories – Power Seating Systems.*

Electronics

Electronic components for power wheelchairs are covered when they are medically necessary for the beneficiary to function in the power wheelchair that has been provided.

Replacement electronics require prior approval and are covered when:

a. the part replaced cannot be repaired
b. the warranty has expired
c. replacing the part significantly extends the life of the wheelchair, and
d. the cost of replacing the part is less than the cost of a new comparable wheelchair.

Prior approval is required for most electronics. Refer to the *Durable Medical Equipment and Supply* fee schedule at http://dma.ncdhhs.gov/ to determine when prior approval is required. Items on the fee schedule requiring prior approval are identified by an asterisk.

For a list of the specific HCPCS codes covered, by Medicaid and NCHC refer to **Attachment A, Section C: Codes** Lifetime Expectancies and Quantity Limitations for Durable Medical Equipment and Supplies, *Wheelchair Accessories – Electronics.*

Wheels, Tires, Casters

Propulsion tires, drive wheel tires, caster tires, tubes, valves, inserts, wheel locks, and replacement parts are covered when they are medically necessary for the beneficiary to function in the power wheelchair that has been provided.

These items do not require prior approval. Wheelchair replacement parts are covered when the part being replaced is no longer functional due to normal wear and tear and the approved wheelchair remains appropriate for the beneficiary's function.

For a list of the specific HCPCS codes covered, refer to **Attachment A, Section C: Codes** Lifetime Expectancies and Quantity Limitations for Durable Medical Equipment and Supplies, *Wheelchair Accessories – Wheels, Tires, Casters.*

Other Accessories

Swing away retractable or removable hardware is covered when specialized mounting hardware is needed to improve the beneficiary's positioning or ability to use a joystick. Prior approval is not required.

A ventilator tray is covered when the beneficiary is dependent on mechanical ventilator support. Prior approval is not required.

Wheelchair trays are covered when the beneficiary's performance of daily function such as eating or fine motor activities requires this feature. A multi-adjustable tray requires prior approval.

Hand rims are covered when the beneficiary is unable to propel independently and functionally without special hand rims and is able to propel with special hand rims. Prior approval is not required

Anti-rollback devices, gear reduction drive wheels, wheel braking systems and other accessories are covered when they allow the beneficiary to be mobile safely and independently in an approved wheelchair. A gear reduction drive wheel, wheel braking system, and lock require prior approval.

Motor and gear box replacements require prior approval and are covered when
a. the part replaced cannot be repaired;
b. the warranty has expired;
c. replacing the part significantly extends the life of the wheelchair; and

d. the cost of replacing the part is less than the cost of a new comparable wheelchair.

For a list of the specific HCPCS codes covered, refer to **Attachment A, Section C: Codes** Lifetime Expectancies and Quantity Limitations for Durable Medical Equipment and Supplies, *Wheelchair Accessories – Other.*

5.3.7 Activity/Positioning Chairs

Activity/Positioning Chairs are designed to provide stability and support, maintain body alignment, decrease likelihood of postural deformities, and enhance upper extremity function for beneficiaries with physical disabilities. Activity/Positioning Chairs, Hi Lo Activity/Positioning Chairs, chair accessories, and Hi Lo Indoor Bases/Frames are covered for beneficiary's ages 0 through 20. Prior approval is required.

Activity Chair

Activity Chairs and accessories are covered for a beneficiary who has mild to moderate physical disabilities and needs positioning support to sit and perform activities.
An Activity Chair is considered medically necessary when a beneficiary meets any one of the following criteria:

a. Cannot safely sit in a regular chair, commercially available high chair, or other conventional seating option;
b. Needs additional support and stability for fine motor activities;
c. Has decreased trunk strength and motor control;
d. Must use arms to maintain sitting balance;
e. Requires external support to maintain upright position and good body alignment;
f. Has no functional protective or righting reaction; or
g. Must be in an upright supported position for safe and effective feeding and without this chair would have to be held by the caregiver for feeding.

All accessories must be medically justified.

a. A tilt/recline option is covered when the beneficiary:
    1. cannot maintain head control in the upright position
    2. requires pressure relief
    3. requires a tilted position to compensate for tonal changes, or
    4. must be tilted for proper digestion and to avoid reflux.
b. A mobile base is covered when it is medically necessary to move the beneficiary to different parts of the home with the rest of the family for safety or for medically necessary activities.
c. A Hi Lo feature is covered when height adjustments are needed for medically necessary activities or to allow the beneficiary to get into or out of the chair independently.

Hi Lo Positioning Activity Chair

Hi Lo Positioning Chairs and accessories are covered for a beneficiary who has more severe physical disabilities and needs optimum positioning support.

A Hi Lo Positioning Chair is considered medically necessary when a beneficiary meets any one of the following criteria:

a. Has non functional head or trunk control requiring customized postural support to maintain a sitting position;
b. Cannot sit unsupported due to poor static and dynamic sitting balance;
c. Requires maximum support for upright positioning;
d. Cannot interact with the environment without this level of support; or
e. Requires varying sitting heights to participate in medically necessary activities.

Hi Lo Indoor Base/Frame

A Hi Lo Indoor Base is covered for beneficiary who has a wheelchair seating system that can be transferred from a mobility base to an indoor base and is used as an activity/positioning chair in the home. A Hi Lo Indoor Base is considered medically necessary when a beneficiary meets any one of the following criteria:

a. A variety of heights are needed for the beneficiary to perform medically necessary activities in the home; or
b. At the low height the beneficiary is able to get into and out of the chair independently.

A letter of medical necessity from a physical or occupational therapist involved in the care of the beneficiary is required for prior approval of all **Activity/Positioning Chairs and Frames**. The physical or occupational therapist completing the evaluation shall not be employed by or have a financial relationship with the medical equipment provider.

For prior approval, the medical equipment provider shall submit a completed CMN/PA form and supporting documentation from the physical or occupational therapist that:

a. Demonstrates that the activity/positioning chair requested, and each of its components, are medically necessary and are the least expensive device that is appropriate for the beneficiary's medical condition.; and
b. Describes other less expensive devices that were considered and provides rationale as to why they were not appropriate for the beneficiary.

For a list of the specific HCPCS codes covered, refer to **Attachment A, Section C: Codes** Lifetime Expectancies and Quantity Limitations for Durable Medical Equipment and Supplies, *Activity/Positioning Chairs.*

5.3.8 Patient Lift, Hydraulic or Mechanical

Hydraulic lifts are covered when both of the following criteria are met:

a. The beneficiary's condition is such that periodic movement is necessary to effect improvement or to arrest or retard deterioration in the beneficiary's condition; and
b. The beneficiary or family is not able to transfer the beneficiary safely.

Prior approval is required for a hydraulic or mechanical lift.

Note: Powered lifts are not covered as they are considered to be for caregiver convenience and not medically necessary.

For a list of the specific HCPCS codes covered, refer to **Attachment A, Section C: Codes** Lifetime Expectancies and Quantity Limitations for Durable Medical Equipment and Supplies, *Patient Lift.*

5.3.9 Oxygen, Oxygen Supplies, and Equipment

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

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

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

c. Age 21 and older: there is a documented diagnosis from the treating physician that contains ALL of the following:

   1. severe lung disease or hypoxia-related symptoms that might be expected to improve with oxygen therapy,
   2. alternative treatments have been tried and considered, or deemed clinically ineffective, and
   3. The beneficiary has a qualifying blood gas study (either arterial blood gas (ABG), or pulse oximetry for SaO_2) that meets the criteria for ONE of the following groups:
      A. Group I
         i. An arterial oxygen blood level (PO_2) at or below 55 millimeters of mercury (mm Hg), or an arterial oxygen saturation at or below 88%, taken at rest, breathing room air;
         ii. An arterial PO2 at or below 55 mm Hg, or an arterial oxygen saturation at or below 88%, taken during sleep for a beneficiary who demonstrates an arterial PO2 at or above 56 mm Hg, or an arterial oxygen saturation at or above 89%, while awake; or a greater-than-normal fall in oxygen level during sleep (a decrease in arterial PO2 more than 10 mm Hg, or decrease in arterial oxygen saturation more than 5%) associated with symptoms or signs reasonably attributable to hypoxemia, (such as, impairment of cognitive processes and nocturnal restlessness or insomnia. Note: In either of these cases, coverage is provided only for use of oxygen during sleep, and then only one type of unit is covered. Portable oxygen, therefore, is not covered in this situation, or.
         iii. An arterial PO_2 at or below 55 mm Hg, or an arterial oxygen saturation at or below 88%, taken during exercise for a beneficiary who demonstrates an arterial PO_2 at or above 56 mm Hg, or an arterial oxygen saturation at or above 89%, during the day, while at rest. In this case, supplemental oxygen is provided during exercise, if there is evidence the use of oxygen improves

the hypoxemia that was demonstrated during exercise when the beneficiary was breathing room air.

B. Group II

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

i. Dependent edema suggesting congestive heart failure;

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

iii. Erythrocythemia with a hematocrit greater than 56%.

Requirements for Qualifying Oxygen Analysis and Coverage

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

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

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

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

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

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

Prior Approval Requirements

For initial approval on oxygen services, the following must be in block 25 of the CMN/PA form or on attached documentation:

a. Health record documentation from the beneficiary's prescriber ~~physician, physician assistant, or nurse practitioner~~ stating why the use of oxygen is indicated.

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

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

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

d. Initial prior approval is given for 12 calendar months for a **beneficiary under age 21 years of age, or who qualifies for oxygen under Group I criteria.**

e. Continuation prior approval for this beneficiary is required at the end of the 12 calendar months.

~~Another CMN/PA request must be submitted that includes medical documentation from the physician, physician assistant, or nurse practitioner, as to the need for the continuation of oxygen therapy as well as the date of the original oxygen testing and the results. If approved, continuation is granted for an additional 24 months.~~

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

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

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

i. When the prescribed maximum flow rate changes from one of the following categories to another, a repeat blood gas study with the beneficiary on 4liters per minute (LPM) must be performed and this must be the most recent study obtained within 30 calendar days prior to the Initial Certification Date:
    1. Less than 1 LPM,
    2. 1-4 LPM,
    3. Greater than 4 LPM

j. When the length of need expires – if the prescriber specified less than lifetime length of need on the most recent CMN/PA, then the blood gas study must be the most recent study obtained within 30 calendar days prior to the Initial Date.

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

~~Another CMN/PA request must be submitted that includes medical documentation~~ from ~~the physician, physician assistant, or nurse practitioner as to the need for the continuation of oxygen therapy as well as another oxygen analysis as stated in the **Requirements for Qualifying Oxygen Analysis and Coverage.** If the beneficiary continues to meet the qualifications for oxygen therapy, then a continuation prior approval will be granted for an additional nine months. At the end of the 12 months (the initial three months plus the continuation nine months), continuation prior approval is required. Documentation for continuation prior approval must include a written statement from the physician, physician assistant, or nurse practitioner as to the need for the continuation of oxygen therapy. This prior approval does not require an additional oxygen analysis, but the prior approval documentation must include the original date and results of the qualifying test.~~ If the beneficiary meets the criteria, the second continuation prior approval is given for an additional 24 months.

At the end of 36 months, **all** beneficiaries shall be recertified. The provider shall submit a new prior approval request for the continuation of oxygen therapy. This request must include a qualifying oxygen analysis that was obtained and reviewed by the treating prescriber ~~physician~~ within six (6) months of the renewal date. Approval given at the 36-month renewal period is considered to be lifetime approval.

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

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

Coverage is described as follows:

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

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

c. Portable oxygen systems—A beneficiaries who meets the clinical coverage criteria for medical necessity may qualify for coverage of a portable oxygen system either by itself or to use in addition to a stationary system. The qualifying health record documentation must indicate that the beneficiary is mobile in the home and would benefit from the use of the portable oxygen system in the home. Portable oxygen systems that are used on a standby basis are not covered except in instances of a fragile infant with a tracheostomy.

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

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

For a list of the specific HCPCS codes covered, refer to **Attachment A, Section C: Codes** Lifetime Expectancies and Quantity Limitations for Durable Medical Equipment and Supplies, *Oxygen Equipment and Supplies.*

5.3.10 Segmental and Non-Segmental Pneumatic Compressors and Appliances

A pneumatic compression device is covered only for the treatment of refractory lymphedema involving one or more limbs. This condition is a relatively uncommon medical problem. Causes of lymphedema include:

a. Radical surgical procedures with removal of regional groups of lymph nodes (e.g., after radical mastectomy);

b. Post-radiation fibrosis;

c. Spread of malignant tumors to regional lymph nodes with lymphatic obstruction;

d. Scarring of lymphatic channel;,

e. Onset of puberty (specifically Milroy's Disease); and

f. Congenital anomalies.

Pneumatic compression devices are only covered as a treatment of last resort. Other less intensive treatment must have been tried first and found to be inadequate. Such treatments would include leg or arm elevation and custom-fabricated pressure stockings or sleeves.

Pneumatic compression devices are covered only when prescribed by a physician and when they are used with appropriate physician oversight. This oversight must include physician evaluation of the beneficiary's condition to determine medical necessity of the device, suitable instruction in the operation of the machine, a treatment plan defining the pressure to be used and the frequency and duration of use, and ongoing monitoring of use and response to treatment.

Block 24 of the CMN/PA form must be checked.

When the cause of the lymphedema is scarring of the lymphatic channels (generalized, refractory edema from venous insufficiency which is complicated by recurrent cellulitis), a pneumatic compression device may be covered only if all of the following criteria have been met:

a. There is significant ulceration of the lower extremity(ies);
b. The beneficiary has received repeated, standard treatment from a physician using such methods as a compression bandage system or its equivalent; and
c. The ulcer(s) have failed to heal after six months of continuous treatment.

All pneumatic compressors and appliances require prior approval.

For a list of the specific HCPCS codes covered, refer to **Attachment A, Section C: Codes** Lifetime Expectancies and Quantity Limitations for Durable Medical Equipment and Supplies, *Pneumatic Compressors.*

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

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

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

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

a. Restrictive thoracic disorders:

   The beneficiary shall meet any one of the following criteria:

   1. Documentation of the beneficiary's progressive neuromuscular disease or severe thoracic cage abnormality and an arterial blood gas $PaCO_2$

[done while awake and breathing the beneficiary's usual fraction of inspired oxygen (FIO_2)] that is greater than or equal to 45 mmHg;

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

b. Severe chronic obstructive pulmonary disease (COPD):

All of the following criteria must be met:

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

Prior approval is required for a RAD.

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

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

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

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c. Central sleep apnea:

The beneficiary shall meet all of the following criteria:

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

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

Requirements for Coverage

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

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

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

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

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

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Initial Approval: For a RAD to be covered, the treating physician, physician assistant, or nurse practitioner, shall fully document in the beneficiary's clinical health record those symptoms characteristic of sleep-associated hypoventilation, such as daytime hypersomnolence, excessive fatigue, morning headache, cognitive dysfunction, dyspnea, etc.

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

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

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

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

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

Respiratory Devices for the Treatment of Obstructive Sleep Apnea

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

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

The CPAP and Bi-level require prior approval.

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

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

2. The AHI is from 5 to 14 events per hour with documented symptoms of:
   A. Excessive daytime sleepiness, impaired cognition, mood disorders, or insomnia; **or**
   B. Hypertension, ischemic heart disease, or history of stroke.

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

a. has had an unsuccessful six-month trial on a CPAP device;
b. is unable to tolerate CPAP;
c. has special needs that have been documented on the physician's letterhead stationery by a physician who is a sleep specialist.

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

Requirements for Coverage:

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

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

b. Polysomnograms must be provided according to requirements listed in Medicaid's Clinical Coverage Policy 1A-20, *Sleep Studies and Polysomnography Services*, on DMA's website: http://dma.ncdhhs.gov/.
c. The polysomnogram must be based on a minimum of two hours of recorded sleep time without the use of the CPAP device or bi-level device, reported by the polysomnogram. The polysomnogram must include sleep staging and other sleep parameters such as airflow, respiratory effort, and oxygen saturation by oximetry.
d. If the polysomnogram criteria listed above are not met, claims submitted for reimbursement of the CPAP device or bi-level device and related accessories are not medically necessary, and therefore not covered.
e. For an item to be covered by Medicaid and NCHC a written signed and dated order from the "treating physician" must be received by the supplier before the CMN/PA is submitted for prior approval. If the supplier submits a CMN/PA without first receiving the completed order, the prior approval request is denied as not medically necessary.
f. If there is discontinuation of the CPAP device or bi-level device at any time, the provider is expected to determine this, and stop billing for the equipment and related accessories.
g. Auto-titrating CPAP devices are billed the same as a CPAP device.
h. A non-heated or heated humidifier is covered by Medicaid/NCHC with the use of a CPAP/bi-level. The treating physician shall specify which type of humidifier the beneficiary is to use.

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Initial Approval:

For initial approval:

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

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

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

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

Renewal Approval:

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

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

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

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

For a list of the specific HCPCS codes covered, refer to **Attachment A, Section C: Codes** Lifetime Expectancies and Quantity Limitations for Durable Medical Equipment and Supplies, *Respiratory Devices.*

Other Respiratory Devices

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

For a list of the specific HCPCS codes covered, refer to **Attachment A, Section C: Codes** Lifetime Expectancies and Quantity Limitations for Durable Medical Equipment and Supplies, *Respiratory Devices – Other*.

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

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

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

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

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

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

For a list of the specific HCPCS codes covered, refer to **Attachment A, Section C: Codes** Lifetime Expectancies and Quantity Limitations for Durable Medical Equipment and Supplies, *Respiratory Devices – Other*.

Nebulizers

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

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

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

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

Prior approval is required for an ultrasonic nebulizer.

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

For a list of the specific HCPCS codes covered, refer to **Attachment A, Section C: Codes** Lifetime Expectancies and Quantity Limitations for Durable Medical Equipment and Supplies, *Respiratory Devices – Nebulizers.*

Apnea Monitor and Supplies

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

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

b. The beneficiary is a sibling of a sudden infant death syndrome (SIDS) child. If the sibling was three months of age or less at the time of death, the beneficiary is covered up to six months of age. If the sibling was four months of age or older at the time of death, the beneficiary is covered up to three months beyond the sibling's age at death;
c. The beneficiary has had an event or events requiring vigorous stimulation or resuscitation within the past three months;
d. The beneficiary is an infant with bronchopulmonary dysplasia who requires oxygen and displays medical instability; or
e. The beneficiary is less than two years of age and has a tracheostomy. After two years of age, additional documentation from the prescribing physician, physician assistant, or nurse practitioner justifying extended medical necessity for the apnea monitor must be attached.

Prior approval is required.

For a list of the specific HCPCS codes covered, refer to **Attachment A, Section C: Codes** Lifetime Expectancies and Quantity Limitations for Durable Medical Equipment and Supplies, *Respiratory Devices – Apnea Monitor*.

Percussor

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

Prior approval is required.

For a list of the specific HCPCS codes covered, refer to **Attachment A, Section C: Codes** Lifetime Expectancies and Quantity Limitations for Durable Medical Equipment and Supplies, *Respiratory Devices – Percussor*.

Oximeter

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

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

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

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

a. the beneficiary's condition meets one of the coverage criteria for a non-recording oximeter, and

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

Prior approval is required.

For a list of the specific HCPCS codes covered, refer to **Attachment A, Section C: Codes** Lifetime Expectancies and Quantity Limitations for Durable Medical Equipment and Supplies, *Respiratory Devices – Oximeter*.

5.3.12 Transcutaneous Electrical Nerve Stimulation Devices

For initial and renewal approval attach documentation that the main application is to control or suppress chronic painful states that are not amenable to control through elimination of the cause. The following information is also required:

a. The specific diagnosis related to the need for the unit;

b. Date of onset and duration of pain;

c. Specific area(s) of pain;

d. Prognosis; and

e. The physician, physician assistant, or nurse practitioner's statement that other appropriate treatments to ameliorate the pain have been tried without success. The specific treatments, including pain medications, must be included in the statement.

f. A statement from the physician, physician assistant, or nurse practitioner that the beneficiary has improved tolerance for activities of daily living with use of the TENS unit.

g. A pain scale and body map that shows the severity of the pain and the specific locations of the pain.

Prior approval is required for a TENS unit.

Note: The TENS must be rented for 30 to 60 calendar days prior to requesting purchase.

For a list of the specific HCPCS codes covered, refer to **Attachment A, Section C: Codes** Lifetime Expectancies and Quantity Limitations for Durable Medical Equipment and Supplies, *Transcutaneous Electric Nerve Stimulation.*

5.3.13 Osteogenesis Stimulators

An electrical non-invasive osteogenesis stimulator for non-spinal applications is covered for the following conditions:

a. Non-union of a long bone (clavicle, humerus, radius, ulna, femur, tibia, fibula, metacarpal, or metatarsal) fracture defined as radiographic evidence that fracture healing has ceased for three or more months prior to starting treatment with the osteogenesis stimulator;

b. Failed fusion of a joint other than in the spine where a minimum of nine months has elapsed since the last surgery; and
c. Congenital pseudoarthrosis

Non-union of a long bone fracture must be documented by a minimum of two sets of radiographs obtained prior to starting treatment with the osteogenesis stimulator, separated by a minimum of 90 calendar days, each including multiple views of the fracture site, and with a written interpretation by a physician, physician assistant, or nurse practitioner stating that there has been no evidence of fracture healing between the two sets of radiographs. An osteogenesis stimulator for a non-healed long bone fracture of less than six months duration or a lack of fusion of less than 12 months duration is not medically necessary and claims will be denied.

A non-invasive electrical osteogenesis stimulator for spinal applications is covered when medical necessity is documented and the beneficiary has one of the following:

a. a failed spinal fusion where a minimum of nine months has elapsed since the last surgery;
b. a multilevel spinal fusion surgery. A multilevel spinal fusion is one that involves three or more vertebrae (e.g., L3-L5, L4-S1, etc.); or
c. following spinal fusion surgery where there is a history of a previously failed spinal fusion at the same site.

A non-invasive, low-intensity ultrasonic osteogenesis stimulator is covered if all of the following criteria are met:

a. Non-union of a fracture documented by a minimum of two sets of radiographs obtained prior to starting treatment with the osteogenesis stimulator, separated by a minimum of 90 calendar days, each including multiple views of the fracture site, and with a written interpretation by a physician stating that there has been no clinically significant evidence of fracture healing between the two sets of radiographs;
b. Fracture is not of the skull or vertebrae; and
c. Fracture is not tumor related.

All osteogenesis stimulators require prior approval.

Note: For specific diagnosis requirements related to the coverage of osteogenesis stimulators refer to **Attachment A: B: ICD-10 Codes**.

For a list of the specific HCPCS codes covered, refer to **Attachment A, Section C: Codes** Lifetime Expectancies and Quantity Limitations for Durable Medical Equipment and Supplies, *Osteogenesis Stimulators.*

5.3.14 External Insulin Infusion Pump

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 age 0 through 20 who meet one of the following criteria:

a. The beneficiary has a diagnosis of diabetes mellitus, is insulin dependent, and has a 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: ICD-10 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.**

For a list of the specific HCPCS codes covered, refer to **Attachment A, Section C: Codes** Lifetime Expectancies and Quantity Limitations for Durable Medical Equipment and Supplies, *External Insulin Infusion Pump.*

5.3.15 Blood Glucose Monitors and Continuous Glucose Monitors and Related Supplies

Blood Glucose Monitors

Blood glucose monitors, syringes, strips, lancets, and other related supplies are covered when all of 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; and
5. The device is for home use.

A blood glucose monitor with an **integrated voice synthesizer** requires prior approval. All of 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

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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: ICD-10 Codes**.

For a list of the specific HCPCS codes covered, refer to **Attachment A, Section C: Code(s)** Lifetime Expectancies and Quantity Limitations for Durable Medical Equipment and Supplies, *Glucose Monitors and Supplies.*

5.3.16 Phototherapy

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** of 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.

For a list of the specific HCPCS codes covered, refer to **Attachment A, Section C: Code(s)** Lifetime Expectancies and Quantity Limitations for Durable Medical Equipment and Supplies, *Phototherapy*.

5.3.17 Continuous Passive Motion Exercise Device for Use on Knee Only

A continuous passive motion exercise device is covered for beneficiaries who have received a total knee replacement.

To qualify for coverage, use of the device must commence within two days following surgery. In addition, coverage is limited to that portion of the three-week period following surgery during which the device is used in the

beneficiary's home. There is insufficient evidence to justify coverage of these devices for longer periods of time or for other applications.

Block 24 on the CMN/PA form must be checked, indicating that the beneficiary's status will be monitored by the physician while this equipment is provided.
For a list of the specific HCPCS codes covered, refer to **Attachment A, Section C: Code(s)** Lifetime Expectancies and Quantity Limitations for Durable Medical Equipment and Supplies, *Continuous Passive Motion Exercise Device.*

5.3.18 High-Frequency Chest Wall Oscillation Device

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

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

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

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

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

For a list of the specific HCPCS codes covered, refer to **Attachment A, Section C: Codes** Lifetime Expectancies and Quantity Limitations for Durable Medical Equipment and Supplies, *High Frequency Chest Wall Oscillation.*

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

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

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bacterial filter, and either a facemask, a mouthpiece, or an adapter to a tracheostomy or endotracheal tube.

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

a. A diagnosis of a neuromuscular disease or high-level spinal cord injury (Refer to **Attachment A, Section B: ICD-10 Codes**, for the specific diagnosis codes required for this device;
b. Has a significant impairment of chest wall or diaphragmatic movement, resulting in an inability to effectively cough and clear retained secretions;
c. Lack of success with other standard respiratory treatments such as chest percussion and postural drainage, IPPB, incentive spirometry, inhalers, PEP therapy, or flutter devices; and
d. Has physician-documented evidence that the beneficiary or caregiver is willing and able to use the device as prescribed.

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

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

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

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

Cough-stimulating devices are not covered for beneficiaries with:

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

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

For a list of the specific HCPCS codes covered, refer to **Attachment A, Section C: Codes** Lifetime Expectancies and Quantity Limitations for Durable Medical Equipment and Supplies, *Cough Stimulating Device.*

5.3.20 Farrell Valve Enteral Gastric Pressure Relief System

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 of 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.

For a list of the specific HCPCS codes covered, refer to **Attachment A, Section C: Codes** Lifetime Expectancies and Quantity Limitations for Durable Medical Equipment and Supplies, *Farrell Valve.*

5.3.21 Canes, Crutches, Walkers, Gait Trainers, and Accessories Canes and Crutches

Canes and crutches are covered when **all** of the following criteria are met:

a. The beneficiary has a mobility limitation that significantly impairs his or her ability to participate in one or more mobility-related activities of daily living (MRADLs) in the home;

The MRADLs to be considered in this and all other statements in this policy are toileting, feeding, dressing, grooming, and bathing performed in customary locations in the home.

A mobility limitation is one that:

1. prevents the beneficiary from accomplishing the MRADL entirely;
2. places the beneficiary at reasonably determined heightened risk of morbidity or mortality secondary to the attempts to perform an MRADL; or
3. prevents the beneficiary from completing the MRADL within a reasonable time frame.

b. The beneficiary is able to safely use the cane or crutch; and

c. The functional mobility deficit can be sufficiently resolved by use of a cane or crutch.

If all of the criteria are not met, the cane or crutch will be denied as not medically necessary.

A crutch substitute, lower leg platform, requires prior approval and is covered if the beneficiary meets the above criteria and is not able to safely use crutches or a walker.

For a list of the specific HCPCS codes covered, refer to **Attachment A, Section C: Codes** Lifetime Expectancies and Quantity Limitations for Durable Medical Equipment and Supplies, *Canes and Crutches.*

Heavy Duty Canes and Crutches

Heavy duty canes and crutches are covered for beneficiaries who weigh more than 250 pounds. Prior approval is required. The beneficiary's height, weight, and body measurements must be included on the CMN/PA form as well as the dimensions of the requested equipment and the manufacturer's specified weight capacity for the equipment.

For a list of the specific HCPCS codes covered, refer to **Attachment A, Section C: Codes** Lifetime Expectancies and Quantity Limitations for Durable Medical Equipment and Supplies, *Canes and Crutches – Heavy Duty*.

Walkers

A standard walker and related accessories are covered if **all** of the following criteria are met:

a. The beneficiary has a mobility limitation that significantly impairs his or her ability to participate in one or more MRADLs in the home. A mobility limitation is one that:

1. Prevents the beneficiary from accomplishing the MRADL entirely, or
2. Places the beneficiary at reasonably determined heightened risk of morbidity or mortality secondary to the attempts to perform the MRADL; or
3. Prevents the beneficiary from completing the MRADL within a reasonable time frame.

b. The beneficiary is able to safely use the walker.

c. The functional mobility deficit can be sufficiently resolved with use of a walker.

Prior approval is not required for walkers. All of the criteria must be met for the walker to be considered medically necessary.

Glides/skis for use with a walker require prior approval and are covered when the beneficiary requires them to mobilize an approved walker.

To substantiate medical necessity for heavy duty walkers, the beneficiary's height, weight, and body measurements must be included on the CMN/PA form as well as the manufacturer's specified weight capacity for the equipment.

For a list of the specific HCPCS codes covered, refer to **Attachment A, Section C: Codes** Lifetime Expectancies and Quantity Limitations for Durable Medical Equipment and Supplies, *Walkers.*

A gait trainer is a device similar to a walker and consists of a wide-based steel frame with four casters or wheels. It provides considerable postural support for beneficiaries who have severe motor and balance dysfunction and who require moderate to maximum support for ambulation. Additional components, called positioners or stabilizers, are added to offer additional support and control.

A gait trainer with accessories requires prior approval and may be covered for **beneficiaries ages 0 through 20**, if an evaluation by a physical or occupational therapist documents that the following criteria are met:

a. The beneficiary needs moderate to maximal support for walking due to impaired balance reactions or pelvic or trunk instability, or has a Gross Motor Function Classification System (GMFCS) score of 3 or greater.

b. The beneficiary is able to initiate movement without caregiver assistance, and there is a purposeful need for the movement.

The physical or occupational therapist shall document medical necessity for all components included with the gait trainer. The physical or occupational therapist completing the evaluation cannot be employed by the medical equipment provider.

For a list of the specific HCPCS codes covered, refer to **Attachment A, Section C: Codes** Lifetime Expectancies and Quantity Limitations for Durable Medical Equipment and Supplies, *Gait Trainers.*

5.3.22 Miscellaneous Durable Medical Equipment and Supplies

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

Cervical traction equipment is covered for use in a beneficiary's home if it is ordered by a physician for treatment of a specified orthopedic diagnosis.

Transfer boards or other transfer devices are covered when a beneficiary requires the device in order to complete transition from one position to another, e.g., from bed to wheelchair or wheelchair to bathtub seat.

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

A paraffin bath is covered when a beneficiary has a documented diagnosis for which paraffin treatment is deemed beneficial by the beneficiary's physician.

An over tub portable whirlpool bath unit is covered when a beneficiary has a documented diagnosis for which whirlpool treatment is deemed beneficial by the beneficiary's physician.

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

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

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 to be administered in the home.

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

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

For a list of the specific HCPCS codes covered, refer to **Attachment A, Section C: Codes** Lifetime Expectancies and Quantity Limitations for Durable Medical Equipment and Supplies, *Miscellaneous Durable Medical Equipment and Supplies.*

5.3.23 Nutrition

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 ages 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.

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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** of 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 a beneficiary's home.

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.

b. Refer to **Attachment A: C Procedure Code(s)** Lifetime Expectancies and Quantity Limitations for Durable Medical Equipment and Supplies, *Nutrition – Formula and Supplies* for covered formulae or solutions.

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** of 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 home;

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 a home 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 at home 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 in the home.

For a list of the specific HCPCS codes covered, refer to **Attachment A, Section C: Codes** Lifetime Expectancies and Quantity Limitations for Durable Medical Equipment and Supplies, *Nutrition – Formula and Supplies.*

5.3.24 Augmentative and Alternative Communication Devices

Augmentative and alternative communication (AAC) devices help beneficiaries with severe communication impairments to meet their functional communication needs. AAC devices, software, and related accessories are covered when **all** of the following conditions are met:

a. the device is determined to be medically necessary;
b. the device is a dedicated communication device;
c. it is used solely by the beneficiary; and
d. the beneficiary has a long-term severe communication impairment.

Note: A dedicated device is defined as a device used only for communication purposes.

The ACC device may be one of the following:

a. A manual device that uses orthographic or picture symbols;
b. A device that produces digitized speech output, using pre-recorded messages (these are typically classified by how much recording time they offer); or

c. A device that produces synthesized speech output, with messages formulated either by direct selection techniques or by any of multiple methods.

Note: A laptop computer, desktop computer, personal digital assistant, or other device that has not been modified to run AAC software and is not a device used only for communication purposes (that is, a dedicated device) is not covered. Laptop computers, personal computers, and personal digital assistants used for purposes other than communication are not primarily medical in nature and do not meet the definition of medical equipment.

AAC software is covered when a beneficiary has a laptop computer, desktop computer, or personal digital device in which software can be added to adapt the device for communication purposes.

Prior Approval and Medical Necessity

Speech-generating devices that produce synthesized speech, software, accessories, and AAC repairs require prior approval. To document medical necessity for prior approval, submit the CMN/PA form with the following documentation:

a. A physician's report with a description of the beneficiary's current medical status and history
b. A physician's order for the AAC device, including an itemization of the components (switches, special mounting devices, etc.) required by the beneficiary
c. An AAC device evaluation performed by a licensed speech–language pathologist who fulfills either requirements 1 and 3, or requirements 2 and 3, below:
    1. Has a valid license issued by the North Carolina Speech and Language Pathologists and Audiologists Board of Examiners, *and* has a Certificate of Clinical Competence (CCC) from the American Speech–Language–Hearing Association (ASHA);
    2. Has either completed the equivalent educational requirements and work experience necessary for the CCC, *or* has completed the academic program and is acquiring supervised work experience to qualify for the CCC;
    3. Has the education and experience in augmentative communication necessary to assess an individual and prescribe an AAC aid, system, or device that will maximize that individual's effective and functional communication.

(These education and experience requirements are listed in *Augmentative and Alternative Communication: Knowledge and Skills for Service Delivery,* ASHA Supplement 22 (2002), 97-106.)

Note: The AAC device evaluation must include **all** of the following information:

a. The language skills, oral and motor speech status, and type and severity of current communication impairment(s) that affect the beneficiary's abilities to communicate with and without the AAC device;

b. A detailed description of the therapeutic history in the areas of speech-language pathology, occupational therapy, and physical therapy, including the nature, frequency, and duration of treatment and the specific speech-language therapy approaches that have been tried in relation to the need for and use of an AAC device;
c. A detailed description of related impairments, including audiovisual, perceptual, cognitive level, and memory deficits, that would limit the beneficiary's ability to use a device, or that would require the use of a particular AAC device;
d. A detailed description of each communication device or method of communication tried by the beneficiary in the past and information on the effectiveness of each;
e. Specific information about the requested device, including the manufacturer's name, catalog number, product description, and list of accessories requested; justification for and use to be made of the device and accessories; and documentation of the manufacturer's price quote;
f. An explanation of the medical necessity of the AAC device, including how the device will be used in the home or in other settings and a statement that the device will be required for12 months or longer;
g. Demonstration that the beneficiary possesses a treatment plan that includes a training schedule for the selected device (technical assistance from the AAC vendor must include training on the use of the AAC device); and
h. A statement that the speech-language pathologist performing the AAC device evaluation is neither an employee of nor has a financial relationship with the vendor of the AAC device.

Note: Medical necessity must be supported even if prior approval is not required. Therefore, the above-listed requirements also apply to devices that do not require prior approval. In this instance, the information necessary to establish medical necessity must be kept in the beneficiary's confidential file by the speech–language pathologist responsible for ordering the device.

Rental Period

Any AAC device requiring prior approval must be rented for a one-month period before Medicaid or NCHC purchases the device. All components necessary for the use of the device—such as software, accessories, and mounting devices must be evaluated during this rental period. The rental fees for the one month period apply to the total purchase price. If during the one-month rental the initially approved device is effective for the beneficiary's communication needs, the provider submits a request for prior approval of purchase of the device. The request must document the effectiveness of the rented device.

When an AAC system is not available for rental, prior approval for purchase may be granted with supporting documentation that the beneficiary has had recent experience and achieved effective communication with the requested AAC.

A rental period is not required when replacing an existing AAC system unless the beneficiary's needs have changed and another AAC system is being considered.

Costs, Repairs, and Replacements

The cost of the AAC device, software (including software upgrades necessary to expand or improve the function of the AAC device), mounting system, accessories, and repairs for one beneficiary shall not exceed $9,500 for a two-year period. Technical assistance from a qualified augmentative communication technology professional also includes training on use of the AAC equipment and is included in the total purchase price for the AAC device. Technical assistance may not duplicate evaluation and services provided by licensed speech, occupational, or physical therapists.

Repairs of AAC devices must not exceed $500 annually. Requests for repairs in excess of the capped amount must be approved in advance. Refer to **Subsection 5.8** for details.

The lifetime expectancy for all AAC devices is three years. An AAC device may be modified or replaced in **one** of the following situations:

a. The beneficiary's medical, cognitive, or physical status changes in such a way as to significantly alter the effectiveness of the device.
b. The AAC device is no longer functional and cannot be repaired.
c. The manufacturer's warranty or other applicable warranty has expired and repairs to the AAC device are no longer cost effective. An identical or comparable component(s) will be provided if there is documentation from a licensed speech-language pathologist that the AAC device is still effective and appropriate for the beneficiary's needs.
d. The device is under manufacturer's warranty, but the repair is not covered by the warranty. Submit documentation from the manufacturer explaining the reason that the repair is not covered.
e. The AAC device has been damaged or stolen. A copy of the police or fire report must be submitted, if appropriate, and detail the measures to be taken to prevent reoccurrence. Refer to **Subsection 5.9** for details.

Note: All documentation of the history of service, maintenance, and repair of the device must accompany such a request. Medicaid or NCHC will not purchase an extended manufacturer's warranty for any AAC device.

For a list of the specific HCPCS codes covered, refer to **Attachment A, Section C: Codes** Lifetime Expectancies and Quantity Limitations for Durable Medical Equipment and Supplies, *Augmentative and Alternative Communication.*

5.3.25 Standers

A sit-to-stand stander is medical equipment that transitions a beneficiary who cannot stand on his or her own from a sitting to an upright standing position, with the ability to stop at any point in between and be supported during incremental weight bearing. This stander may include additional accessories for support.

A multi-position stander is medical equipment that transitions a beneficiary from the horizontal prone or supine position to an upright standing position. It is angle adjustable to provide graduated weight bearing and pressure. It is designed for either prone or supine standing. This stander may include additional accessories for support.

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A stander and stander accessories require prior approval and are covered for a beneficiary, age 0 through 20 years, if an evaluation by a physical or occupational therapist documents that the following criteria are met:

a. The beneficiary requires moderate to maximal support for standing in the home environment;
b. The beneficiary is unable to stand or ambulate due to long term medical conditions and ambulation will most likely not occur;
c. Effective weight bearing cannot be achieved by any other means;
d. The stander has been tried and used safely by the beneficiary;
e. The beneficiary's home can accommodate the stander;
f. The beneficiary has demonstrated motivation to stand and the beneficiary's caregiver is willing and able to carry out a prescribed home standing program.

Note: The physical or occupational therapist completing the evaluation cannot be employed by or have a financial relationship with the medical equipment provider.

Prior approval is required for the stander. The medical equipment provider shall submit a completed CMN/PA form and supporting documentation from the physical or occupational therapist demonstrating that the type of stander selected, and each of its components, is medically necessary and is the least expensive device that is appropriate for the beneficiary's medical condition. Documentation must include a description of other less expensive devices that were considered and provide a rationale as to why the less expensive devices were not appropriate for the beneficiary. The provider shall list all accessories included with the stander and document medical necessity for all accessories except the following:

a. Knee supports
b. Hip supports
c. Chest support
d. Footplate or sandals
e. Lateral supports
f. Straps
g. Tray

Note: A mobile option, power lift option, or glider option are not covered accessories.

For a list of the specific HCPCS codes covered, refer to **Attachment A, Section C: Codes** Lifetime Expectancies and Quantity Limitations for Durable Medical Equipment and Supplies, *Standers.*

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

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 tachyarrhthymia's 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's 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.

For a list of the specific HCPCS codes covered, refer to **Attachment A, Section C: Codes** Lifetime Expectancies and Quantity Limitations for Durable Medical Equipment and Supplies, *External Defibrillator.*

5.3.27 Bath and Toilet Aids

Bath/Shower Chair or Bench

A bath/shower chair sits in the bathtub or shower for bathing in the seated position. A tub transfer bench goes across the side of the tub and allows a beneficiary to safely slide into the tub and sit for bathing. Prior approval is not required.

A Bath /Shower Chair is considered medically necessary when a beneficiary cannot stand for bathing. A Tub Transfer Bench is considered medically necessary when a beneficiary cannot safely get into or out of a bath tub. A heavy duty transfer bench is allowed for a beneficiary who weighs 250 pounds or more.

For a list of the specific HCPCS codes covered, refer to **Attachment A, Section C: Codes** Lifetime Expectancies and Quantity Limitations for Durable Medical Equipment and Supplies, *Bath/Shower Chair.*

Toilet Seat and Commode Chair

A raised toilet seat clamps on to a standard toilet and elevates the toilet seat five inches above the existing toilet. It may include a frame and arm rests. A commode chair may be used as a bedside commode when a pan is added or as a toilet safety frame and elevated toilet seat over the existing toilet.

A raised toilet seat is considered medically necessary when a beneficiary cannot get up from or down to a standard commode. A commode chair is considered medically necessary for a beneficiary who is physically incapable of using a standard toilet or who cannot access the bathroom. A commode chair, extra wide or heavy duty is covered for a beneficiary who weighs 250 pounds or more.

For a list of the specific HCPCS codes covered, refer to **Attachment A, Section C: Codes** Lifetime Expectancies and Quantity Limitations for Durable Medical Equipment and Supplies, *Toilet Seat/Commode Chair*.

Pediatric: Bath Chairs, Shower Chairs and Bath Lifts

Pediatric: bath chairs, shower chairs, bath lifts, and bath transfer systems are covered for beneficiaries, ages 0 through 20 years, when this equipment is medically necessary as noted below

A pediatric bath chair provides postural support and stability for a child while bathing. The frame is adjustable to provide tilt and recline to meet various

positioning needs. Prior approval is required. The pediatric bath chair is considered medically necessary when a beneficiary meets **any one** of the following criteria:

a. Cannot maintain a sitting position independently;
b. Needs to be positioned in a reclining or tilted position for bathing;
c. Has poor or limited head control in supported sitting;
d. Cannot be safely lifted out of a bath tub due to size or weight; or
e. Requires proper positioning and additional support for safe bathing.

The following safety equipment is used in conjunction with a pediatric bath chair. This equipment does not require prior approval and includes the following:

Bath chair lateral supports, chest or pelvic straps, or wedge and pommel cushions are medically necessary when a beneficiary requires additional support to maintain the head or trunk in proper alignment or to maintain the beneficiary safely on the bath chair while bathing.

A tub stand or shower stand is medically necessary when the beneficiary cannot be safely transferred out of the tub from the pediatric bath chair and additional height is needed for safety or when the bath chair is to be used in a shower.

A shower trolley is medically necessary when a beneficiary cannot be safely lifted and placed onto the bath chair and must be transferred from bed to bath chair and transported into the shower on the shower trolley.

A hand held shower is medically necessary when the shower water must be redirected or diverted for safe and effective bathing.

Bath Support

A bath support consists of a low or hi back wrap around support used to maintain an upright seated position in the bath tub. Prior approval is required. A bath support is considered medically necessary when a Medicaid or NCHC beneficiary meets **any one** of the following criteria:

a. Requires minimal to moderate assistance to maintain an upright seated position;
b. Exhibits extensor thrusting; or
c. Has abnormal muscle tone.

Bath Lift

A bath lift consists of a seat and a battery powered lift that lowers to the bottom of the tub and then rises back to the top. A reclining model allows for positioning in a semi reclined position or for washing hair safely. Prior approval is required. A bath lift is considered medically necessary when a beneficiary meets **any one** of the following criteria:

a. Needs moderate to maximal assistance to get down into the tub and to get back up and cannot be safely lifted into and out of the tub when wet by caregivers due to size or medical condition;
b. Has a balance deficit or poor head and trunk control and cannot safely sit on a tub bench or other less supportive equipment; or
c. Is independent with bathing and positioning and is able to manage the bath lift controls, but cannot transfer into and out of the tub safely.

Shower/Commode Chair

A shower / commode chair is a shower chair with a commode cut out so the chair can be used in the shower for bathing or over the commode for toileting. Prior approval is required. A shower/commode chair is considered medically necessary when a beneficiary meets **any one** of the following criteria:

a. Is not able to stand for bathing in the shower;
b. Cannot be safely assisted into or out of a bath tub for bathing;
c. Does not have adequate balance or trunk support to sit on a tub bench for bathing; or
d. Does not have access to a bath tub and cannot stand for bathing in a shower.

All accessories for this chair require medical justification which must be included in the medical information provided.

Tilt/Recline Shower/ Commode Chair

A tilt / recline shower/ commode chair is a shower chair that can be tilted or reclined to various angles, provides extensive support, and can be rolled into a shower for bathing. This chair can also be rolled over a commode or a commode pan can be added for toileting. Prior approval is required. A tilt / recline shower /commode chair is considered medically necessary when a beneficiary meets **any one** of the following criteria:

a. Has extensive weakness, contractures, or abnormal tone requiring full body support;
b. Requires total assistance for transfers and bathing;
c. Cannot sit upright and must be tilted or reclined for safe positioning while bathing;
d. Has a medical need that requires the tilted or reclined position when upright; or
e. Requires pressure relief at all times when sitting.

All accessories for this chair require medical justification and must be included in the medical information provided.

Pediatric Bath Shower Transfer System

A bath shower transfer system is used for positioning and transfers into the bath. It consists of a multi-functional transfer system that includes a roll in shower chair and a bath slider. Prior approval is required. A bath shower transfer system is considered medically necessary when a beneficiary meets **any one** of the following criteria:

a. Requires maximal assistance to sit;
b. Has extensive weakness, contractures, or abnormal tone requiring full body support;
c. Requires total assistance for transfers and bathing; or
d. Must use a bath tub for bathing.

A letter of medical necessity from a physical or occupational therapist involved in the care of the beneficiary is required for prior approval of all pediatric bath

chairs, shower/commode chairs, bath lifts, and bath transfer systems. The physical or occupational therapist completing the evaluation shall not be employed by or have a financial relationship with the medical equipment provider.

For prior approval, the medical equipment provider shall submit a completed CMN/PA form and supporting documentation from the physical or occupational therapist that:

a. Demonstrates that the bathing device requested, and each of its components, is medically necessary and is the least expensive device that is appropriate for the beneficiary's medical condition.
b. Describes other less expensive devices that were considered and provides rationale as to why they were not appropriate for the beneficiary.

For a list of the specific HCPCS codes covered, refer to **Attachment A, Section C: Codes** Lifetime Expectancies and Quantity Limitations for Durable Medical Equipment and Supplies, *Pediatric Bath/Shower Chair/Lift.*

Pediatric Toilet Supports and Systems

Pediatric toilet supports and toileting systems require prior approval and are covered for beneficiaries ages 0 through 20 years, when they are medically necessary and:

a. the beneficiary shall be toilet trained; or
b. capable of being toilet trained within six months and able to participate in a toileting program.

Toilet Seat Reducer Ring

A Toilet Seat Reducer Ring is medical equipment that reduces the size of a commode opening. A Toilet Seat Reducer Ring is considered medically necessary when a beneficiary, age 0 through 20 years, is too small to sit safely on a regular commode because the opening is too large, but can safely sit on the commode for toileting with the reducer ring added.

Lo-Back Toilet Support

A Lo-Back Toilet Support is medical equipment that provides a posterior lower trunk support and reduced seat depth for a commode. A Lo-Back Toilet Support is considered medically necessary when a beneficiary, age 0 through 20 years, meets **any one** of the following criteria:

a. Cannot maintain balance while sitting on a commode and requires pelvic or trunk support to avoid loss of balance;
b. Has trunk weakness or tonal abnormalities;
c. Has poor protective reactions resulting in loss of balance and needs support for safety; or
d. Is unable to sit on a regular toilet seat without assistance of a caregiver to maintain balance.

Potty Trainer

A potty trainer is medical equipment that provides postural support and stability for a child while toileting. It has adjustable components and accessories to allow

a customized seating solution for children who cannot use a standard commode or potty chair. A potty trainer is considered medically necessary when a beneficiary, age 0 through 20 years, meets **any one** of the following criteria is met:

a. Toileting or toilet training needs to take place in locations other than a bathroom;
b. Cannot be maintained in a stable position while sitting on a commode and requires additional support for beneficiary to feel secure; or
c. Has deficits in balance, coordination, or function.

All accessories require prior approval and must be medically necessary to safely support the beneficiary while toileting.

Toileting System

A toileting system is medical equipment that can be mounted on the commode or used as a free standing system to provide moderate to maximal support for toileting. This system allows for the use of a variety of accessories to provide customized support where needed. A toileting system is considered medically necessary when a beneficiary, age 0 through 20 years, meets **any one** of the following criteria:

a. Cannot sit on a commode without the complete support of a caregiver;
b. Has significant deficits in balance, coordination, or abnormalities in tone;
c. Has poor head or trunk control; or
d. Will be independent in toileting with the use of this system.

All accessories require prior approval and must be medically necessary to safely support the beneficiary while toileting.

A letter of medical necessity from a physical or occupational therapist involved in the care of the beneficiary is required for prior approval of all Pediatric Toilet Supports and Systems. The physical or occupational therapist completing the evaluation shall not be employed by or have a financial relationship with the medical equipment provider.

For prior approval, the medical equipment provider shall submit a completed CMN/PA form and supporting documentation from the physical or occupational therapist that:

a. Demonstrates that the toileting device requested, and each of its components, is medically necessary and is the least expensive device that is appropriate for the beneficiary's medical condition.
b. Describes other less expensive devices that were considered and provides rationale as to why they were not appropriate for the beneficiary.

For a list of the specific HCPCS codes covered, refer to **Attachment A, Section C: Codes** Lifetime Expectancies and Quantity Limitations for Durable Medical Equipment and Supplies, *Pediatric Toilet Supports/Systems.*

5.3.28 Incontinence, Ostomy, and Urinary Catheter Supplies

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.

For a list of the specific HCPCS codes covered, refer to **Attachment A, Section C: Codes** Lifetime Expectancies and Quantity Limitations for Durable Medical Equipment and Supplies, *Incontinence, Ostomy, and Urinary Catheter Supplie.*

5.3.29 Provision of DMES on the Date of Discharge from a Hospital

a. Items listed in **Attachment B** must be provided to a beneficiary on the **date of Discharge** from a hospital only.
b. Delivery of DMES on the date of discharge from a hospital shall be consistent with Section 5.6 Delivery of Service.
c. For items that require PA, the DMES provider shall submit a physician's order and a discharge summary (D/C) electronically via the provider portal on the NC Tracks website.
d. For items that do not require PA, the DMES provider shall keep the physician's order and the discharge summary (D/C) 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 list of the lifetime expectancies and quantity limitations allowed for all equipment and supplies covered by Medicaid and NCHC.

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 from the DMA.

The medical equipment provider shall send a written 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, C: Codes** for a listing of the established lifetime expectancies and quantity limitations for Durable Medical Equipment and Supplies covered.

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 in the home.

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.

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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 sending a completed CMN/PA form with a repair estimate to the address listed on the form. 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 of 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.

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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).**

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

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

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

5.10 Changing Suppliers

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

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

5.10.1 Changing Suppliers for 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.

5.10.2 Changing Suppliers for Oxygen and Oxygen Equipment

The steps for transferring responsibility are as follows:

a. The new provider asks the previous provider for a copy of the current CMN/PA form.
b. The previous provider corrects the "TO" date on the form to the last date that it is responsible for service.

c. The previous provider sends a copy of the corrected CMN/PA to the new provider.

d. The new provider obtains a new CMN/PA form signed by the physician, physician assistant, or nurse practitioner, and forwards it to the address listed on the form along with a copy of the old CMN/PA form.

5.11 Terminating Rentals

The beneficiary, physician, physician assistant, or nurse practitioner, the supplier, Medicaid, or NCHC may terminate the rental of an item during the rental period. If the rental is terminated, providers may reclaim the equipment from the beneficiary within 30 calendar days.

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

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

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

a. meet Medicaid or NCHC qualifications for participation;

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

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

6.1 Provider Qualifications

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

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

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

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

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

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

f. Providers shall be either:

1. a business entity authorized to conduct business in the state or in the locality where the business site is located. Proof of authorization shall include a certificate of assumed name, certificate of authority, certificate of good standing, license, permit or privilege license; or
2. a Medicaid-enrolled home health agency, a state agency, a local health department, a local lead agency for the CAP for Disabled Adults, a local lead agency for the CAP for Individuals with Intellectual/ Developmental Disabilities, or an agency that provides case management for the Community Alternatives Program for Children.

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

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

6.2 Federal Laws

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

a. **Title VI of the Civil Rights Act of 1964,** which states that "no person in the United States shall, on the grounds of race, color, or national origin, be excluded from participation under any program or activity receiving federal financial assistance."

b. **Section 504 of the Rehabilitation Act of 1973,** as amended, which states that "no otherwise qualified handicapped individual in the United States shall, solely by reason of his handicap, be excluded from the participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving federal financial assistance."

c. **The Americans with Disabilities Act of 1990,** which prohibits exclusion from participation in or denial of services because the agency's facilities are not accessible to individuals with a disability.

6.3 Seeking Other Sources of Payment

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

Refer to the *Basic Medicaid and NC Health Choice Billing Guide* on DMA's website: http://dma.ncdhhs.gov/ for additional information.

6.4 Accepting Payment

Providers shall accept payment in full.

Refer to the *Basic Medicaid and NC Health Choice Billing Guide* on DMA's website: http://dma.ncdhhs.gov/ 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 home for service or repair, record the date of removal and the date of return.

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

7.3 Coordinating Care

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

8.0 Policy Implementation/Revision Information

Original Effective Date: March 1, 2003

Revision Information:

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

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Date	Section Revised	Change
10/01/2003	Section 5.3.12	This section was renumbered to 5.3.11. Codes W4011 and W4121 were deleted and replaced with E0445.
10/01/2003	Attachment A, block 24	Code E0608 was deleted and replaced with E0619.
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.

Date	Section Revised	Change
08/01/2004	Section 5.3.10	Criteria for segmental and non-segmental pneumatic compressors and appliances were clarified.
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.

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Date	Section Revised	Change
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.
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 covered 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.

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Date	Section Revised	Change
01/01/2007	All sections and attachment(s)	HCPCS codes E0164, E0166, E0180, E2320, K0090 through K0098, W4704 through W4706, K0010, and K0011 were end-dated and removed.
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 covered 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).

Date	Section Revised	Change
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
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/month to 4/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 with 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

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Date	Section Revised	Change
02/16/2011	Attachment E	Quantity for code A7000 changed from 1/Month to 10/Month
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.
	Subsection 5.3.9	Mirror Medicare oxygen recertification policy

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Date	Section Revised	Change
	Subsection 5.3.11	Simplify recertification on ventilators
	Subsection 5.6.2	Mirror Medicare policy when using shipping or delivery service
	Attachment A	**C: Codes**: Annual HCPCS code update; end date code E0450 and E0463 replace and add HCPCS code E0465 – Effective 01/01/2016

Attachment A: Claims-Related Information

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

A. Claim Type

Professional (CMS-1500/837P transaction)

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

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

ICD-10-CM Code(s)			
Osteogenesis Stimulators			
M80.00xK	S72.413M	S52.92xC	S72.001E
M80.011K	S72.413N	S52.92xE	S72.001F
M80.012K	S72.414K	S52.92xF	S72.001H
M80.019K	S72.414M	S52.92xH	S72.001J
M80.021K	S72.414N	S52.92xJ	S72.001M
M80.022K	S72.415K	S52.92xM	S72.001N
M80.029K	S72.415M	S52.92xN	S72.001Q
M80.031K	S72.415N	S52.92xQ	S72.001R
M80.032K	S72.416K	S52.92xR	S72.001S
M80.039K	S72.416M	S52.92xS	S72.002B
M80.041K	S72.416N	S42.302B	S72.002C
M80.042K	S72.421K	S42.309B	S72.002E
M80.049K	S72.421M	S52.021B	S72.002F
M80.051K	S72.421N	S52.021C	S72.002J
M80.052K	S72.422K	S52.022B	S72.002M
M80.059K	S72.422M	S52.022C	S72.002N
M80.061K	S72.422N	S52.023B	S72.002Q
M80.062K	S72.423K	S52.023C	S72.002R
M80.069K	S72.423M	S52.024B	S72.002S
M80.071K	S72.423N	S52.024C	S72.009B
M80.072K	S72.424K	S52.025B	S72.009C
M80.079K	S72.424M	S52.025C	S72.009E
M80.08xK	S72.424N	S52.026B	S72.009F
M80.80xK	S72.425K	S52.026C	S72.009S
M80.811K	S72.425M	S52.031B	S72.051B
M80.812K	S72.425N	S52.031C	S72.051C
M80.819K	S72.426K	S52.032B	S72.052B
M80.821K	S72.426M	S52.032C	S72.052C
M80.822K	S72.426N	S52.033B	S72.059B
M80.829K	S72.431K	S52.033C	S72.059C
M80.831K	S72.431M	S52.034B	S72.061B
M80.832K	S72.431N	S52.034C	S72.061C

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M80.839K	S72.432K	S52.035B	S72.062B
M80.841K	S72.432M	S52.035C	S72.062C
M80.842K	S72.432N	S52.036B	S72.063B
M80.849K	S72.433K	S52.036C	S72.063C
M80.851K	S72.433M	S52.041B	S72.064B
M80.852K	S72.433N	S52.041C	S72.064C
M80.859K	S72.434K	S52.041S	S72.065B
M80.861K	S72.434M	S52.042B	S72.065C
M80.862K	S72.434N	S52.042C	S72.066B
M80.869K	S72.435K	S52.042S	S72.066C
M80.871K	S72.435M	S52.043B	S72.091B
M80.872K	S72.435N	S52.043C	S72.091C
M80.879K	S72.436K	S52.043S	S72.092B
M80.88xK	S72.436M	S52.044B	S72.092C
M84.30xK	S72.436N	S52.044C	S72.099B
M84.311K	S72.441K	S52.044S	S72.099C
M84.312K	S72.441M	S52.045B	S72.001A
M84.319K	S72.441N	S52.045C	S72.002A
M84.321K	S72.442K	S52.045S	S72.009A
M84.322K	S72.442M	S52.046B	S72.101A
M84.329K	S72.442N	S52.046C	S72.102A
M84.331K	S72.443K	S52.046S	S72.109A
M84.332K	S72.443M	S52.271B	S72.111A
M84.333K	S72.443N	S52.271C	S72.112A
M84.334K	S72.444K	S52.271E	S72.113A
M84.339K	S72.444M	S52.271F	S72.114A
M84.341K	S72.444N	S52.271H	S72.115A
M84.342K	S72.445K	S52.271J	S72.116A
M84.343K	S72.445M	S52.271M	S72.121A
M84.344K	S72.445N	S52.271N	S72.122A
M84.345K	S72.446K	S52.271Q	S72.123A
M84.346K	S72.446M	S52.271R	S72.124A
M84.350K	S72.446N	S52.271S	S72.125A
M84.351K	S72.451K	S52.272B	S72.126A
M84.352K	S72.451M	S52.272C	S72.131A
M84.353K	S72.451N	S52.272E	S72.132A
M84.359K	S72.452K	S52.272F	S72.133A
M84.361K	S72.452M	S52.272H	S72.134A
M84.362K	S72.452N	S52.272J	S72.135A
M84.363K	S72.453K	S52.272M	S72.136A
M84.364K	S72.453M	S52.272N	S72.001A
M84.369K	S72.453N	S52.272Q	S72.002A
M84.371K	S72.454K	S52.272R	S72.009A
M84.372K	S72.454M	S52.272S	S72.141A
M84.373K	S72.454N	S52.279B	S72.142A
M84.374K	S72.455K	S52.279C	S72.143A
M84.375K	S72.455M	S52.279E	S72.144A
M84.376K	S72.455N	S52.279F	S72.145A
M84.377K	S72.456K	S52.279H	S72.146A
M84.378K	S72.456M	S52.279J	S72.001A
M84.379K	S72.456N	S52.279M	S72.002A
M84.38xK	S72.461K	S52.279N	S72.009A

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M84.40xK	S72.461M	S52.279Q	S72.21xA
M84.411K	S72.461N	S52.279R	S72.22xA
M84.412K	S72.462K	S52.279S	S72.23xA
M84.419K	S72.462M	S52.001B	S72.24xA
M84.421K	S72.462N	S52.001C	S72.25xA
M84.422K	S72.463K	S52.001E	S72.26xA
M84.429K	S72.463M	S52.001F	S72.141B
M84.431K	S72.463N	S52.001H	S72.141C
M84.432K	S72.464K	S52.001J	S72.142B
M84.433K	S72.464M	S52.001M	S72.142C
M84.434K	S72.464N	S52.001N	S72.143B
M84.439K	S72.465K	S52.001Q	S72.143C
M84.441K	S72.465M	S52.001R	S72.144B
M84.442K	S72.465N	S52.001S	S72.144C
M84.443K	S72.466K	S52.002B	S72.145B
M84.444K	S72.466M	S52.002C	S72.145C
M84.445K	S72.466N	S52.002E	S72.146B
M84.446K	S72.471K	S52.002F	S72.146C
M84.451K	S72.472K	S52.002H	S72.21xB
M84.452K	S72.479K	S52.002J	S72.21xC
M84.453K	S72.491K	S52.002M	S72.22xB
M84.454K	S72.491M	S52.002N	S72.22xC
M84.459K	S72.491N	S52.002Q	S72.23xB
M84.461K	S72.492K	S52.002R	S72.23xC
M84.462K	S72.492M	S52.002S	S72.24xB
M84.463K	S72.492N	S52.009B	S72.24xC
M84.464K	S72.499K	S52.009C	S72.25xB
M84.469K	S72.499M	S52.009E	S72.25xC
M84.471K	S72.499N	S52.009F	S72.26xB
M84.472K	S72.8X1K	S52.009H	S72.26xC
M84.473K	S72.8X1M	S52.009J	S72.001A
M84.474K	S72.8X1N	S52.009M	S72.002A
M84.475K	S72.8X2K	S52.009N	S72.009A
M84.476K	S72.8X2M	S52.009Q	S72.001B
M84.477K	S72.8X2N	S52.009R	S72.001C
M84.478K	S72.8X9K	S52.009S	S72.001E
M84.479K	S72.8X9M	S52.091B	S72.001F
M84.48xK	S72.8X9N	S52.091C	S72.001H
M84.50xK	S72.90xK	S52.091E	S72.001J
M84.511K	S72.90xM	S52.091F	S72.001M
M84.512K	S72.90xN	S52.091H	S72.001N
M84.519K	S72.91xK	S52.091J	S72.001Q
M84.521K	S72.91xM	S52.091M	S72.001R
M84.522K	S72.91xN	S52.091N	S72.001S
M84.529K	S72.92xK	S52.091Q	S72.002B
M84.531K	S72.92xM	S52.091R	S72.002C
M84.532K	S72.92xN	S52.091S	S72.002E
M84.533K	S79.001K	S52.092B	S72.002F
M84.534K	S79.002K	S52.092C	S72.002J
M84.539K	S79.009K	S52.092S	S72.002M
M84.541K	S79.011K	S52.099B	S72.002N
M84.542K	S79.012K	S52.099C	S72.002Q

M84.549K	S79.019K	S52.099S	S72.002R
M84.550K	S79.091K	S52.121B	S72.002S
M84.551K	S79.092K	S52.121C	S72.009B
M84.552K	S79.099K	S52.122B	S72.009C
M84.553K	S79.101K	S52.122C	S72.009E
M84.559K	S79.102K	S52.123B	S72.009F
M84.561K	S79.109K	S52.123C	S72.009H
M84.562K	S79.111K	S52.124B	S72.009J
M84.563K	S79.112K	S52.124C	S72.009M
M84.564K	S79.119K	S52.125B	S72.009N
M84.569K	S79.121K	S52.125C	S72.009Q
M84.571K	S79.122K	S52.126B	S72.009R
M84.572K	S79.129K	S52.126C	S72.009S
M84.573K	S79.131K	S52.181B	S72.091M
M84.574K	S79.132K	S52.181C	S72.091S
M84.575K	S79.139K	S52.181E	S72.092S
M84.576K	S79.141K	S52.181F	S72.099S
M84.58xK	S79.142K	S52.181H	S72.8X1A
M84.60xK	S79.149K	S52.181J	S72.8X2A
M84.611K	S79.191K	S52.181M	S72.8X9A
M84.612K	S79.192K	S52.181N	S72.90xA
M84.619K	S79.199K	S52.181Q	S72.91xA
M84.621K	S82.001K	S52.181R	S72.92xA
M84.622K	S82.001M	S52.182B	S72.301A
M84.629K	S82.001N	S52.182C	S72.302A
M84.631K	S82.002K	S52.182E	S72.309A
M84.632K	S82.002M	S52.189B	S72.321A
M84.633K	S82.002N	S52.189C	S72.322A
M84.634K	S82.009K	S52.131B	S72.323A
M84.639K	S82.009M	S52.131C	S72.324A
M84.641K	S82.009N	S52.131E	S72.325A
M84.642K	S82.011K	S52.131F	S72.326A
M84.649K	S82.011M	S52.131H	S72.331A
M84.650K	S82.011N	S52.131J	S72.332A
M84.651K	S82.012K	S52.131M	S72.333A
M84.652K	S82.012M	S52.131N	S72.334A
M84.653K	S82.012N	S52.131Q	S72.335A
M84.659K	S82.013K	S52.131R	S72.336A
M84.661K	S82.013M	S52.131S	S72.341A
M84.662K	S82.013N	S52.132B	S72.342A
M84.663K	S82.014K	S52.132C	S72.343A
M84.664K	S82.014M	S52.132E	S72.344A
M84.669K	S82.014N	S52.132F	S72.345A
M84.671K	S82.015K	S52.132H	S72.346A
M84.672K	S82.015M	S52.132J	S72.351A
M84.673K	S82.015N	S52.132M	S72.352A
M84.674K	S82.016K	S52.132N	S72.353A
M84.675K	S82.016M	S52.132Q	S72.354A
M84.676K	S82.016N	S52.132R	S72.355A
M84.68xK	S82.021K	S52.132S	S72.356A
S02.0xxK	S82.021M	S52.133B	S72.361A
S02.10xK	S82.021N	S52.133C	S72.362A

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S02.110K	S82.022K	S52.133E	S72.363A
S02.111K	S82.022M	S52.133F	S72.364A
S02.112K	S82.022N	S52.133H	S72.365A
S02.113K	S82.023K	S52.133J	S72.366A
S02.118K	S82.023M	S52.133M	S72.391A
S02.119K	S82.023N	S52.133N	S72.392A
S02.19xK	S82.024K	S52.133Q	S72.399A
S02.2xxK	S82.024M	S52.133R	S72.8X1B
S02.3xxK	S82.024N	S52.133S	S72.8X1C
S02.400K	S82.025K	S52.134B	S72.8X1S
S02.401K	S82.025M	S52.134C	S72.8X2B
S02.402K	S82.025N	S52.134E	S72.8X2C
S02.411K	S82.026K	S52.134F	S72.8X2M
S02.412K	S82.026M	S52.134H	S72.8X2N
S02.413K	S82.026N	S52.134J	S72.8X2S
S02.42xK	S82.031K	S52.134M	S72.8X9B
S02.5xxK	S82.031M	S52.134N	S72.8X9C
S02.600K	S82.031N	S52.134Q	S72.8X9M
S02.609K	S82.032K	S52.134R	S72.8X9N
S02.61xK	S82.032M	S52.134S	S72.8X9S
S02.62xK	S82.032N	S52.135B	S72.90xB
S02.63xK	S82.033K	S52.135C	S72.90xC
S02.64xK	S82.033M	S52.135S	S72.90xS
S02.65xK	S82.033N	S52.136B	S72.91xB
S02.66xK	S82.034K	S52.136C	S72.91xC
S02.67xK	S82.034M	S52.136S	S72.91xS
S02.69xK	S82.034N	S52.101B	S72.92xB
S02.8xxK	S82.035K	S52.101C	S72.92xC
S02.91xK	S82.035M	S52.101E	S72.92xS
S02.92xK	S82.035N	S52.101F	S72.301B
S12.000K	S82.036K	S52.101H	S72.301C
S12.001K	S82.036M	S52.101J	S72.301S
S12.01xK	S82.036N	S52.101M	S72.302B
S12.02xK	S82.041K	S52.101N	S72.302C
S12.030K	S82.041M	S52.101Q	S72.302S
S12.031K	S82.041N	S52.101R	S72.309B
S12.040K	S82.042K	S52.101S	S72.309C
S12.041K	S82.042M	S52.102B	S72.309S
S12.090K	S82.042N	S52.102C	S72.321B
S12.091K	S82.043K	S52.102E	S72.321C
S12.100K	S82.043M	S52.102F	S72.322B
S12.101K	S82.043N	S52.102H	S72.322C
S12.110K	S82.044K	S52.102S	S72.323B
S12.111K	S82.044M	S52.109B	S72.323C
S12.112K	S82.044N	S52.109C	S72.324B
S12.120K	S82.045K	S52.109H	S72.324C
S12.121K	S82.045M	S52.109J	S72.325B
S12.130K	S82.045N	S52.109M	S72.325C
S12.131K	S82.046K	S52.109N	S72.326B
S12.14xK	S82.046M	S52.109Q	S72.326C
S12.150K	S82.046N	S52.109R	S72.331B
S12.151K	S82.091K	S52.109S	S72.331C

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S12.190K	S82.091M	S52.181B	S72.332B
S12.191K	S82.091N	S52.181C	S72.332C
S12.200K	S82.092K	S52.181S	S72.333B
S12.201K	S82.092M	S52.182B	S72.333C
S12.230K	S82.092N	S52.182C	S72.334B
S12.231K	S82.099K	S52.182F	S72.334C
S12.24xK	S82.099M	S52.182H	S72.335B
S12.250K	S82.099N	S52.182J	S72.335C
S12.251K	S82.101K	S52.182M	S72.336B
S12.290K	S82.101M	S52.182N	S72.336C
S12.291K	S82.101N	S52.182Q	S72.341B
S12.300K	S82.102K	S52.182R	S72.341C
S12.301K	S82.102M	S52.182S	S72.342B
S12.330K	S82.102N	S52.189B	S72.342C
S12.331K	S82.109K	S52.189C	S72.343B
S12.34xK	S82.109M	S52.189E	S72.343C
S12.350K	S82.109N	S52.189F	S72.344B
S12.351K	S82.111K	S52.189H	S72.344C
S12.390K	S82.111M	S52.189J	S72.345B
S12.391K	S82.111N	S52.189M	S72.345C
S12.400K	S82.112K	S52.189N	S72.346B
S12.401K	S82.112M	S52.189Q	S72.346C
S12.430K	S82.112N	S52.189R	S72.351B
S12.431K	S82.113K	S52.189S	S72.351C
S12.44xK	S82.113M	S52.009B	S72.352B
S12.450K	S82.113N	S52.109C	S72.352C
S12.451K	S82.114K	S52.009B	S72.353B
S12.490K	S82.114M	S52.109B	S72.353C
S12.491K	S82.114N	S52.009C	S72.354B
S12.500K	S82.115K	S52.109B	S72.354C
S12.501K	S82.115M	S52.009C	S72.355B
S12.530K	S82.115N	S52.90xA	S72.355C
S12.531K	S82.116K	S52.91xA	S72.356B
S12.54xK	S82.116M	S52.92xA	S72.356C
S12.550K	S82.116N	S52.301A	S72.361B
S12.551K	S82.121K	S52.302A	S72.361C
S12.590K	S82.121M	S52.309A	S72.362B
S12.591K	S82.121N	S52.311A	S72.362C
S12.600K	S82.122K	S52.312A	S72.363B
S12.601K	S82.122M	S52.319A	S72.363C
S12.630K	S82.122N	S52.321A	S72.364B
S12.631K	S82.123K	S52.322A	S72.364C
S12.64xK	S82.123M	S52.323A	S72.365B
S12.650K	S82.123N	S52.324A	S72.365C
S12.651K	S82.124K	S52.325A	S72.366B
S12.690K	S82.124M	S52.326A	S72.366C
S12.691K	S82.124N	S52.331A	S72.391B
S22.000K	S82.125K	S52.332A	S72.391C
S22.001K	S82.125M	S52.333A	S72.391S
S22.002K	S82.125N	S52.334A	S72.392B
S22.008K	S82.126K	S52.335A	S72.392C
S22.009K	S82.126M	S52.336A	S72.392S

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S22.010K	S82.126N	S52.341A	S72.399B
S22.011K	S82.131K	S52.342A	S72.399C
S22.012K	S82.131M	S52.343A	S72.399S
S22.018K	S82.131N	S52.344A	S72.401A
S22.019K	S82.132K	S52.345A	S72.402A
S22.020K	S82.132M	S52.346A	S72.409A
S22.021K	S82.132N	S52.351A	S72.411A
S22.022K	S82.133K	S52.352A	S72.412A
S22.028K	S82.133M	S52.353A	S72.413A
S22.029K	S82.133N	S52.354A	S72.414A
S22.030K	S82.134K	S52.355A	S72.415A
S22.031K	S82.134M	S52.356A	S72.416A
S22.032K	S82.134N	S52.361A	S72.421A
S22.038K	S82.135K	S52.362A	S72.422A
S22.039K	S82.135M	S52.363A	S72.423A
S22.040K	S82.135N	S52.364A	S72.424A
S22.041K	S82.136K	S52.365A	S72.425A
S22.042K	S82.136M	S52.366A	S72.426A
S22.048K	S82.136N	S52.371A	S72.431A
S22.049K	S82.141K	S52.372A	S72.432A
S22.050K	S82.141M	S52.379A	S72.433A
S22.051K	S82.141N	S52.381A	S72.434A
S22.052K	S82.142K	S52.382A	S72.435A
S22.058K	S82.142M	S52.389A	S72.436A
S22.059K	S82.142N	S52.391A	S72.441A
S22.060K	S82.143K	S52.392A	S72.442A
S22.061K	S82.143M	S52.399A	S72.443A
S22.062K	S82.143N	S52.201A	S72.444A
S22.068K	S82.144K	S52.202A	S72.445A
S22.069K	S82.144M	S52.209A	S72.446A
S22.070K	S82.144N	S52.211A	S79.101A
S22.071K	S82.145K	S52.212A	S79.102A
S22.072K	S82.145M	S52.219A	S79.109A
S22.078K	S82.145N	S52.221A	S79.111A
S22.079K	S82.146K	S52.222A	S79.112A
S22.080K	S82.146M	S52.223A	S79.119A
S22.081K	S82.146N	S52.224A	S79.121A
S22.082K	S82.151K	S52.225A	S79.122A
S22.088K	S82.151M	S52.226A	S79.129A
S22.089K	S82.151N	S52.231A	S79.131A
S22.20xK	S82.152K	S52.232A	S79.132A
S22.21xK	S82.152M	S52.233A	S79.139A
S22.22xK	S82.152N	S52.234A	S79.141A
S22.23xK	S82.153K	S52.235A	S79.142A
S22.24xK	S82.153M	S52.236A	S79.149A
S22.31xK	S82.153N	S52.241A	S79.191A
S22.32xK	S82.154K	S52.242A	S79.192A
S22.39xK	S82.154M	S52.243A	S79.199A
S22.41xK	S82.154N	S52.244A	S72.451A
S22.42xK	S82.155K	S52.245A	S72.452A
S22.43xK	S82.155M	S52.246A	S72.453A
S22.49xK	S82.155N	S52.251A	S72.454A

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S22.5xxK	S82.156K	S52.252A	S72.455A
S22.9xxK	S82.156M	S52.253A	S72.456A
S32.000K	S82.156N	S52.254A	S72.461A
S32.001K	S82.161K	S52.255A	S72.462A
S32.002K	S82.162K	S52.256A	S72.463A
S32.008K	S82.169K	S52.261A	S72.464A
S32.009K	S82.191K	S52.262A	S72.465A
S32.010K	S82.191M	S52.263A	S72.466A
S32.011K	S82.191N	S52.264A	S72.471A
S32.012K	S82.192K	S52.265A	S72.472A
S32.018K	S82.192M	S52.266A	S72.479A
S32.019K	S82.192N	S52.281A	S72.491A
S32.020K	S82.199K	S52.282A	S72.492A
S32.021K	S82.199M	S52.283A	S72.499A
S32.022K	S82.199N	S52.291A	S72.401B
S32.028K	S82.201K	S52.292A	S72.401C
S32.029K	S82.201M	S52.299A	S72.401E
S32.030K	S82.201N	S52.209A	S72.401F
S32.031K	S82.202K	S52.309A	S72.401H
S32.032K	S82.202M	S52.391B	S72.401J
S32.038K	S82.202N	S52.391C	S72.401M
S32.039K	S82.209M	S52.391E	S72.401N
S32.040K	S82.209N	S52.391F	S72.401R
S32.041K	S82.221K	S52.391H	S72.401S
S32.042K	S82.221M	S52.391J	S72.402B
S32.048K	S82.221N	S52.391M	S72.402C
S32.049K	S82.222K	S52.391N	S72.402E
S32.050K	S82.222M	S52.391Q	S72.402F
S32.051K	S82.222N	S52.391R	S72.402H
S32.052K	S82.223K	S52.391S	S72.402S
S32.058K	S82.223M	S52.392B	S72.409B
S32.059K	S82.223N	S52.392C	S72.409C
S32.10xK	S82.224K	S52.392S	S72.409S
S32.110K	S82.224M	S52.399B	S72.491B
S32.111K	S82.224N	S52.399C	S72.491C
S32.112K	S82.225K	S52.399S	S72.492B
S32.119K	S82.225M	S52.90xB	S72.492C
S32.120K	S82.225N	S52.90xC	S72.499B
S32.121K	S82.226K	S52.90xS	S72.499C
S32.122K	S82.226M	S52.91xB	S72.411B
S32.129K	S82.226N	S52.91xC	S72.411C
S32.130K	S82.231K	S52.91xS	S72.412B
S32.131K	S82.231M	S52.92xB	S72.412C
S32.132K	S82.231N	S52.92xC	S72.413B
S32.139K	S82.232K	S52.92xE	S72.413C
S32.14xK	S82.232M	S52.92xF	S72.414B
S32.15xK	S82.232N	S52.92xH	S72.414C
S32.16xK	S82.233K	S52.92xS	S72.415B
S32.17xK	S82.233M	S52.301B	S72.415C
S32.19xK	S82.233N	S52.301C	S72.416B
S32.2xxK	S82.234K	S52.301S	S72.416C
S32.301K	S82.234M	S52.302B	S72.416S

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S32.302K	S82.234N	S52.302C	S72.421B
S32.309K	S82.235K	S52.302S	S72.421C
S32.311K	S82.235M	S52.309B	S72.421S
S32.312K	S82.235N	S52.309C	S72.422B
S32.313K	S82.236K	S52.309S	S72.422C
S32.314K	S82.236M	S52.321B	S72.422S
S32.315K	S82.236N	S52.321C	S72.423B
S32.316K	S82.241K	S52.322B	S72.423C
S32.391K	S82.241M	S52.322C	S72.423S
S32.392K	S82.241N	S52.323B	S72.424B
S32.399K	S82.242K	S52.323C	S72.424C
S32.401K	S82.242M	S52.324B	S72.424S
S32.402K	S82.242N	S52.324C	S72.425B
S32.409K	S82.243K	S52.325B	S72.425C
S32.411K	S82.243M	S52.325C	S72.425S
S32.412K	S82.243N	S52.326B	S72.426B
S32.413K	S82.244K	S52.326C	S72.426C
S32.414K	S82.244M	S52.331B	S72.426S
S32.415K	S82.244N	S52.331C	S72.431B
S32.416K	S82.245K	S52.332B	S72.431C
S32.421K	S82.245M	S52.332C	S72.431S
S32.422K	S82.245N	S52.333B	S72.432B
S32.423K	S82.246K	S52.333C	S72.432C
S32.424K	S82.246M	S52.334B	S72.432S
S32.425K	S82.246N	S52.334C	S72.433B
S32.426K	S82.251K	S52.335B	S72.433C
S32.431K	S82.251M	S52.335C	S72.434B
S32.432K	S82.251N	S52.336B	S72.434C
S32.433K	S82.252K	S52.336C	S72.435B
S32.434K	S82.252M	S52.341B	S72.435C
S32.435K	S82.252N	S52.341C	S72.436B
S32.436K	S82.253K	S52.342B	S72.436C
S32.441K	S82.253M	S52.342C	S72.441B
S32.442K	S82.253N	S52.343B	S72.441C
S32.443K	S82.254K	S52.343C	S72.441M
S32.444K	S82.254M	S52.344B	S72.441N
S32.445K	S82.254N	S52.344C	S72.441S
S32.446K	S82.255K	S52.345B	S72.442B
S32.451K	S82.255M	S52.345C	S72.442C
S32.452K	S82.255N	S52.346B	S72.442S
S32.453K	S82.256K	S52.346C	S72.443B
S32.454K	S82.256M	S52.351B	S72.443C
S32.455K	S82.256N	S52.351C	S72.443S
S32.456K	S82.261K	S52.352B	S72.444B
S32.461K	S82.261M	S52.352C	S72.444C
S32.462K	S82.261N	S52.353B	S72.444S
S32.463K	S82.262K	S52.353C	S72.445B
S32.464K	S82.262M	S52.354B	S72.445C
S32.465K	S82.262N	S52.354C	S72.445S
S32.466K	S82.263K	S52.355B	S72.446B
S32.471K	S82.263M	S52.355C	S72.446C
S32.472K	S82.263N	S52.356B	S72.446S

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S32.473K	S82.264K	S52.356C	S72.451B
S32.474K	S82.264M	S52.361B	S72.451C
S32.475K	S82.264N	S52.361C	S72.451S
S32.476K	S82.265K	S52.362B	S72.452B
S32.481K	S82.265M	S52.362C	S72.452C
S32.482K	S82.265N	S52.363B	S72.452S
S32.483K	S82.266K	S52.363C	S72.453B
S32.484K	S82.266M	S52.364B	S72.453C
S32.485K	S82.266N	S52.364C	S72.453S
S32.486K	S82.291K	S52.365B	S72.454B
S32.491K	S82.291M	S52.365C	S72.454C
S32.492K	S82.291N	S52.366B	S72.454S
S32.499K	S82.292K	S52.366C	S72.455B
S32.501K	S82.292M	S52.371B	S72.455C
S32.502K	S82.292N	S52.371C	S72.455S
S32.509K	S82.299K	S52.372B	S72.456B
S32.511K	S82.299M	S52.372C	S72.456C
S32.512K	S82.299N	S52.379B	S72.456S
S32.519K	S82.301K	S52.379C	S72.461B
S32.591K	S82.301M	S52.381B	S72.461C
S32.592K	S82.301N	S52.381C	S72.462B
S32.599K	S82.302K	S52.382B	S72.462C
S32.601K	S82.302M	S52.382C	S72.463B
S32.602K	S82.302N	S52.389B	S72.463C
S32.609K	S82.309K	S52.389C	S72.464B
S32.611K	S82.309M	S52.391B	S72.464C
S32.612K	S82.309N	S52.391C	S72.465B
S32.613K	S82.311K	S52.391S	S72.465C
S32.614K	S82.312K	S52.392B	S72.466B
S32.615K	S82.319K	S52.392C	S72.466C
S32.616K	S82.391K	S52.392S	S72.401B
S32.691K	S82.391M	S52.399B	S72.401C
S32.692K	S82.391N	S52.399C	S72.402B
S32.699K	S82.392K	S52.399S	S72.402C
S32.810K	S82.392M	S52.201B	S72.491B
S32.811K	S82.392N	S52.201C	S72.491C
S32.82xK	S82.399K	S52.201E	S72.491S
S32.89xK	S82.399M	S52.201F	S72.492B
S32.9xxK	S82.399N	S52.201H	S72.492C
S42.001K	S82.401K	S52.201J	S72.492S
S42.002K	S82.401M	S52.201M	S72.499B
S42.009K	S82.401N	S52.201N	S72.499C
S42.011K	S82.402K	S52.201S	S72.499S
S42.012K	S82.402M	S52.202B	S82.001A
S42.013K	S82.402N	S52.202C	S82.002A
S42.014K	S82.409K	S52.202S	S82.009A
S42.015K	S82.409M	S52.209B	S82.011A
S42.016K	S82.409N	S52.209C	S82.012A
S42.017K	S82.421K	S52.209S	S82.013A
S42.018K	S82.421M	S52.221B	S82.014A
S42.019K	S82.421N	S52.221C	S82.015A
S42.021K	S82.422K	S52.222B	S82.016A

S42.022K	S82.422M	S52.222C	S82.021A
S42.023K	S82.422N	S52.223B	S82.022A
S42.024K	S82.423K	S52.223C	S82.023A
S42.025K	S82.423M	S52.224B	S82.024A
S42.026K	S82.423N	S52.224C	S82.025A
S42.031K	S82.424K	S52.225B	S82.026A
S42.032K	S82.424M	S52.225C	S82.031A
S42.033K	S82.424N	S52.226B	S82.032A
S42.034K	S82.425K	S52.226C	S82.033A
S42.035K	S82.425M	S52.231B	S82.034A
S42.036K	S82.425N	S52.231C	S82.035A
S42.101K	S82.426K	S52.232B	S82.036A
S42.102K	S82.426M	S52.232C	S82.041A
S42.109K	S82.426N	S52.233B	S82.042A
S42.111K	S82.431K	S52.233C	S82.043A
S42.112K	S82.431M	S52.234B	S82.044A
S42.113K	S82.431N	S52.234C	S82.045A
S42.114K	S82.432K	S52.235B	S82.046A
S42.115K	S82.432M	S52.235C	S82.091A
S42.116K	S82.432N	S52.236B	S82.092A
S42.121K	S82.433K	S52.236C	S82.099A
S42.122K	S82.433M	S52.241B	S82.001B
S42.123K	S82.433N	S52.241C	S82.001C
S42.124K	S82.434K	S52.242B	S82.002B
S42.125K	S82.434M	S52.242C	S82.002C
S42.126K	S82.434N	S52.243B	S82.009B
S42.131K	S82.435K	S52.243C	S82.009C
S42.132K	S82.435M	S52.244B	S82.011B
S42.133K	S82.435N	S52.244C	S82.011C
S42.134K	S82.436K	S52.245B	S82.012B
S42.135K	S82.436M	S52.245C	S82.012C
S42.136K	S82.436N	S52.246B	S82.013B
S42.141K	S82.441K	S52.246C	S82.013C
S42.142K	S82.441M	S52.251B	S82.014B
S42.143K	S82.441N	S52.251C	S82.014C
S42.144K	S82.442K	S52.252B	S82.015B
S42.145K	S82.442M	S52.252C	S82.015C
S42.146K	S82.442N	S52.253B	S82.016B
S42.151K	S82.443K	S52.253C	S82.016C
S42.152K	S82.443M	S52.254B	S82.021B
S42.153K	S82.443N	S52.254C	S82.021C
S42.154K	S82.444K	S52.255B	S82.022B
S42.155K	S82.444M	S52.255C	S82.022C
S42.156K	S82.444N	S52.256B	S82.023B
S42.191K	S82.445K	S52.256C	S82.023C
S42.192K	S82.445M	S52.261B	S82.024B
S42.199K	S82.445N	S52.261C	S82.024C
S42.201K	S82.446K	S52.262B	S82.025B
S42.202K	S82.446M	S52.262C	S82.025C
S42.209K	S82.446N	S52.263B	S82.026B
S42.211K	S82.451K	S52.263C	S82.026C
S42.212K	S82.451M	S52.264B	S82.031B

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S42.213K	S82.451N	S52.264C	S82.031C
S42.214K	S82.452K	S52.265B	S82.032B
S42.215K	S82.452M	S52.265C	S82.032C
S42.216K	S82.452N	S52.266B	S82.033B
S42.221K	S82.453K	S52.266C	S82.033C
S42.222K	S82.453M	S52.281B	S82.034B
S42.223K	S82.453N	S52.281C	S82.034C
S42.224K	S82.454K	S52.282B	S82.035B
S42.225K	S82.454M	S52.282C	S82.035C
S42.226K	S82.454N	S52.283B	S82.036B
S42.231K	S82.455K	S52.283C	S82.036C
S42.232K	S82.455M	S52.291B	S82.041B
S42.239K	S82.455N	S52.291C	S82.041C
S42.241K	S82.456K	S52.292B	S82.042B
S42.242K	S82.456M	S52.292C	S82.042C
S42.249K	S82.456N	S52.292S	S82.043B
S42.251K	S82.461K	S52.299B	S82.043C
S42.252K	S82.461M	S52.299C	S82.044B
S42.253K	S82.461N	S52.299S	S82.044C
S42.254K	S82.462K	S52.90xC	S82.045B
S42.255K	S82.462M	S52.90xS	S82.045C
S42.256K	S82.462N	S52.91xB	S82.046B
S42.261K	S82.463K	S52.91xC	S82.046C
S42.262K	S82.463M	S52.92xB	S82.091B
S42.263K	S82.463N	S52.92xC	S82.091C
S42.264K	S82.464K	S52.209B	S82.092B
S42.265K	S82.464M	S52.309C	S82.092C
S42.266K	S82.464N	S52.209B	S82.099B
S42.271K	S82.465K	S52.309B	S82.099C
S42.272K	S82.465M	S52.209C	S82.101A
S42.279K	S82.465N	S52.309B	S82.102A
S42.291K	S82.466K	S52.209C	S82.109A
S42.292K	S82.466M	S52.309C	S82.111A
S42.293K	S82.466N	S52.90xA	S82.112A
S42.294K	S82.491K	S52.91xA	S82.113A
S42.295K	S82.491M	S52.92xA	S82.114A
S42.296K	S82.491N	S52.531A	S82.115A
S42.301K	S82.492K	S52.532A	S82.116A
S42.302K	S82.492M	S52.539A	S82.121A
S42.309K	S82.492N	S52.501A	S82.122A
S42.311K	S82.499K	S52.502A	S82.123A
S42.312K	S82.499M	S52.509A	S82.124A
S42.319K	S82.499N	S52.511A	S82.125A
S42.321K	S82.51xK	S52.512A	S82.126A
S42.322K	S82.51xM	S52.513A	S82.131A
S42.323K	S82.51xN	S52.514A	S82.132A
S42.324K	S82.52xK	S52.515C	S82.133A
S42.325K	S82.52xM	S52.516B	S82.134A
S42.326K	S82.52xN	S52.516C	S82.135A
S42.331K	S82.53xK	S52.541B	S82.136A
S42.332K	S82.53xM	S52.541C	S82.141A
S42.333K	S82.53xN	S52.542B	S82.142A

S42.334K	S82.54xK	S52.542C	S82.143A
S42.335K	S82.54xM	S52.549B	S82.144A
S42.336K	S82.54xN	S52.549C	S82.145A
S42.341K	S82.55xK	S52.551B	S82.146A
S42.342K	S82.55xM	S52.551C	S82.151A
S42.343K	S82.55xN	S52.552B	S82.152A
S42.344K	S82.56xK	S52.552C	S82.153A
S42.345K	S82.56xM	S52.559B	S82.154A
S42.346K	S82.56xN	S52.559C	S82.155A
S42.351K	S82.61xK	S52.561B	S82.156A
S42.352K	S82.61xM	S52.561C	S82.191A
S42.353K	S82.61xN	S52.562B	S82.192A
S42.354K	S82.62xK	S52.562C	S82.199A
S42.355K	S82.62xM	S52.569B	S89.001A
S42.356K	S82.62xN	S52.569C	S89.002A
S42.361K	S82.63xK	S52.571B	S89.009A
S42.362K	S82.63xM	S52.571C	S89.011A
S42.363K	S82.63xN	S52.572B	S89.012A
S42.364K	S82.64xK	S52.572C	S89.019A
S42.365K	S82.64xM	S52.579B	S89.021A
S42.366K	S82.64xN	S52.579C	S89.022A
S42.391K	S82.65xK	S52.591B	S89.029A
S42.392K	S82.65xM	S52.591C	S89.031A
S42.399K	S82.65xN	S52.592B	S89.032A
S42.401K	S82.66xK	S52.592C	S89.039A
S42.402K	S82.66xM	S52.599B	S89.041A
S42.409K	S82.66xN	S52.599C	S89.042A
S42.411K	S82.811K	S52.601B	S89.049A
S42.412K	S82.812K	S52.601C	S89.091A
S42.413K	S82.819K	S52.515A	S89.092A
S42.414K	S82.821K	S52.516A	S89.099A
S42.415K	S82.822K	S52.541A	S82.831A
S42.416K	S82.829K	S52.542A	S82.832A
S42.421K	S82.831K	S52.549A	S82.839A
S42.422K	S82.831M	S52.551A	S89.201A
S42.423K	S82.831N	S52.552A	S89.202A
S42.424K	S82.832K	S52.559A	S89.209A
S42.425K	S82.832M	S52.561A	S89.211A
S42.426K	S82.832N	S52.562A	S89.212A
S42.431K	S82.839K	S52.569A	S89.219A
S42.432K	S82.839M	S52.571A	S89.221A
S42.433K	S82.839N	S52.572A	S89.222A
S42.434K	S82.841K	S52.579A	S89.229A
S42.435K	S82.841M	S52.591A	S89.291A
S42.436K	S82.841N	S52.592A	S89.292A
S42.441K	S82.842K	S52.599A	S89.299A
S42.442K	S82.842M	S59.201A	S82.101A
S42.443K	S82.842N	S59.202A	S82.831A
S42.444K	S82.843K	S59.209A	S82.102A
S42.445K	S82.843M	S59.211A	S82.832A
S42.446K	S82.843N	S59.212A	S82.101B
S42.447K	S82.844K	S59.219A	S82.101C

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S42.448K	S82.844M	S59.221A	S82.102B
S42.449K	S82.844N	S59.222A	S82.102C
S42.451K	S82.845K	S59.229A	S82.109B
S42.452K	S82.845M	S59.231A	S82.109C
S42.453K	S82.845N	S59.232A	S82.111B
S42.454K	S82.846K	S59.239A	S82.111C
S42.455K	S82.846M	S59.241A	S82.112B
S42.456K	S82.846N	S59.242A	S82.112C
S42.461K	S82.851K	S59.249A	S82.113B
S42.462K	S82.851M	S59.291A	S82.113C
S42.463K	S82.851N	S59.292A	S82.114B
S42.464K	S82.852K	S59.299A	S82.114C
S42.465K	S82.852M	S52.601A	S82.115B
S42.466K	S82.852N	S52.602A	S82.115C
S42.471K	S82.853K	S52.609A	S82.116B
S42.472K	S82.853M	S52.611A	S82.116C
S42.473K	S82.853N	S52.612A	S82.121B
S42.474K	S82.854K	S52.613A	S82.121C
S42.475K	S82.854M	S52.614A	S82.122B
S42.476K	S82.854N	S52.615A	S82.122C
S42.481K	S82.855K	S52.616A	S82.123B
S42.482K	S82.855M	S52.691A	S82.123C
S42.489K	S82.855N	S52.692A	S82.124B
S42.491K	S82.856K	S52.699A	S82.124C
S42.492K	S82.856M	S59.001A	S82.125B
S42.493K	S82.856N	S59.002A	S82.125C
S42.494K	S82.861K	S59.009A	S82.126B
S42.495K	S82.861M	S59.011A	S82.126C
S42.496K	S82.861N	S59.012A	S82.131B
S42.90xK	S82.862K	S59.019A	S82.131C
S42.91xK	S82.862M	S59.021A	S82.132B
S42.92xK	S82.862N	S59.022A	S82.132C
S49.001K	S82.863K	S59.029A	S82.133B
S49.002K	S82.863M	S59.031A	S82.133C
S49.009K	S82.863N	S59.032A	S82.134B
S49.011K	S82.864K	S59.039A	S82.134C
S49.012K	S82.864M	S59.041A	S82.135B
S49.019K	S82.864N	S59.042A	S82.135C
S49.021K	S82.865K	S59.049A	S82.136B
S49.022K	S82.865M	S59.091A	S82.136C
S49.029K	S82.865N	S59.092A	S82.141B
S49.031K	S82.866K	S59.099A	S82.141C
S49.032K	S82.866M	S52.609A	S82.142B
S49.039K	S82.866N	S52.509A	S82.142C
S49.041K	S82.871K	S52.111A	S82.143B
S49.042K	S82.871M	S52.112A	S82.143C
S49.049K	S82.871N	S52.119A	S82.144B
S49.091K	S82.872K	S52.521A	S82.144C
S49.092K	S82.872M	S52.522A	S82.145B
S49.099K	S82.872N	S52.529A	S82.145C
S49.101K	S82.873K	S52.011A	S82.146B
S49.102K	S82.873M	S52.012A	S82.146C

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S49.109K	S82.873N	S52.019A	S82.151B
S49.111K	S82.874K	S52.621A	S82.151C
S49.112K	S82.874M	S52.622A	S82.152B
S49.119K	S82.874N	S52.629A	S82.152C
S49.121K	S82.875K	S52.011A	S82.153B
S49.122K	S82.875M	S52.111A	S82.153C
S49.129K	S82.875N	S52.012A	S82.154B
S49.131K	S82.876K	S52.112A	S82.154C
S49.132K	S82.876M	S52.621A	S82.155B
S49.139K	S82.876N	S52.521A	S82.155C
S49.141K	S82.891K	S52.622A	S82.156B
S49.142K	S82.891M	S52.522A	S82.156C
S49.149K	S82.891N	S52.501B	S82.191B
S49.191K	S82.892K	S52.501C	S82.191C
S49.192K	S82.892M	S52.502B	S82.192B
S49.199K	S82.892N	S52.502C	S82.192C
S52.001K	S82.899K	S52.509B	S82.199B
S52.001M	S82.899M	S52.90xB	S82.199C
S52.001N	S82.899N	S52.90xC	S82.831B
S52.002K	S82.90xK	S52.90xN	S82.831C
S52.002M	S82.90xM	S52.90xQ	S82.832B
S52.002N	S82.90xN	S52.90xR	S82.832C
S52.009K	S82.91xK	S52.90xS	S82.839B
S52.009M	S82.91xM	S52.91xB	S82.839C
S52.009N	S82.91xN	S52.91xC	S82.101B
S52.011K	S82.92xK	S52.91xE	S82.832B
S52.012K	S82.92xM	S52.91xF	S82.101B
S52.019K	S82.92xN	S52.91xH	S82.102B
S52.021K	S89.001K	S52.91xJ	S82.102B
S52.021M	S89.002K	S52.91xM	S82.831B
S52.021N	S89.009K	S52.91xN	S82.831B
S52.022K	S89.011K	S52.91xQ	S82.832B
S52.022M	S89.012K	S52.91xS	S82.201A
S52.022N	S89.019K	S52.92xB	S82.202A
S52.023K	S89.021K	S52.92xC	S82.209A
S52.023M	S89.022K	S52.92xS	S82.221A
S52.023N	S89.029K	S52.531B	S82.222A
S52.024K	S89.031K	S52.531C	S82.223A
S52.024M	S89.032K	S52.531E	S82.224A
S52.024N	S89.039K	S52.531F	S82.225A
S52.025K	S89.041K	S52.531H	S82.226A
S52.025M	S89.042K	S52.531J	S82.231A
S52.025N	S89.049K	S52.531M	S82.232A
S52.026K	S89.091K	S52.531N	S82.233A
S52.026M	S89.092K	S52.531Q	S82.234A
S52.026N	S89.099K	S52.531R	S82.235A
S52.031K	S89.101K	S52.532B	S82.236A
S52.031M	S89.102K	S52.532C	S82.241A
S52.031N	S89.109K	S52.532E	S82.242A
S52.032K	S89.111K	S52.532F	S82.243A
S52.032M	S89.112K	S52.532H	S82.244A
S52.032N	S89.119K	S52.532J	S82.245A

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S52.033K	S89.121K	S52.532M	S82.246A
S52.033M	S89.122K	S52.532N	S82.251A
S52.033N	S89.129K	S52.532Q	S82.252A
S52.034K	S89.131K	S52.532R	S82.253A
S52.034M	S89.132K	S52.539B	S82.254A
S52.034N	S89.139K	S52.539C	S82.255A
S52.035K	S89.141K	S52.539E	S82.256A
S52.035M	S89.142K	S52.539F	S82.261A
S52.035N	S89.149K	S52.539H	S82.262A
S52.036K	S89.191K	S52.539J	S82.263A
S52.036M	S89.192K	S52.539M	S82.264A
S52.036N	S89.199K	S52.539N	S82.265A
S52.041K	S89.201K	S52.539Q	S82.266A
S52.041M	S89.202K	S52.539R	S82.291A
S52.041N	S89.209K	S52.501B	S82.292A
S52.042K	S89.211K	S52.501C	S82.299A
S52.042M	S89.212K	S52.502B	S82.401A
S52.042N	S89.219K	S52.502C	S82.402A
S52.043K	S89.221K	S52.509B	S82.409A
S52.043M	S89.222K	S52.509C	S82.421A
S52.043N	S89.229K	S52.511B	S82.422A
S52.044K	S89.291K	S52.511C	S82.423A
S52.044M	S89.292K	S52.512B	S82.424A
S52.044N	S89.299K	S52.512C	S82.425A
S52.045K	S89.301K	S52.513B	S82.426A
S52.045M	S89.302K	S52.513C	S82.431A
S52.045N	S89.309K	S52.514B	S82.432A
S52.046K	S89.311K	S52.514C	S82.433A
S52.046M	S89.312K	S52.515B	S82.434A
S52.046N	S89.319K	S52.601M	S82.435A
S52.091K	S89.321K	S52.601N	S82.436A
S52.091M	S89.322K	S52.601S	S82.441A
S52.091N	S89.329K	S52.602B	S82.442A
S52.092K	S89.391K	S52.602C	S82.443A
S52.092M	S89.392K	S52.602M	S82.444A
S52.092N	S89.399K	S52.602N	S82.445A
S52.099K	S92.001K	S52.602S	S82.446A
S52.099M	S92.002K	S52.609B	S82.451A
S52.099N	S92.009K	S52.609C	S82.452A
S52.101K	S92.011K	S52.609M	S82.453A
S52.101M	S92.012K	S52.609N	S82.454A
S52.101N	S92.013K	S52.609S	S82.455A
S52.102K	S92.014K	S52.611B	S82.456A
S52.102M	S92.015K	S52.611C	S82.461A
S52.102N	S92.016K	S52.612B	S82.462A
S52.109K	S92.021K	S52.612C	S82.463A
S52.109M	S92.022K	S52.613B	S82.464A
S52.109N	S92.023K	S52.613C	S82.465A
S52.111K	S92.024K	S52.614B	S82.466A
S52.112K	S92.025K	S52.614C	S82.491A
S52.119K	S92.026K	S52.615B	S82.492A
S52.121K	S92.031K	S52.615C	S82.499A

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S52.121M	S92.032K	S52.616B	S82.861A
S52.121N	S92.033K	S52.616C	S82.862A
S52.122K	S92.034K	S52.691B	S82.863A
S52.122M	S92.035K	S52.691C	S82.864A
S52.122N	S92.036K	S52.691S	S82.865A
S52.123K	S92.041K	S52.692B	S82.866A
S52.123M	S92.042K	S52.692C	S82.201A
S52.123N	S92.043K	S52.692S	S82.401A
S52.124K	S92.044K	S52.699B	S82.202A
S52.124M	S92.045K	S52.699C	S82.402A
S52.124N	S92.046K	S52.699S	S82.201B
S52.125K	S92.051K	S52.509B	S82.201C
S52.125M	S92.052K	S52.609C	S82.202B
S52.125N	S92.053K	S52.509B	S82.202C
S52.126K	S92.054K	S52.609B	S82.209B
S52.126M	S92.055K	S52.509C	S82.209C
S52.126N	S92.056K	S52.609C	S82.221B
S52.131K	S92.061K	S52.509C	S82.221C
S52.131M	S92.062K	S52.609B	S82.222B
S52.131N	S92.063K	S52.92xA	S82.222C
S52.132K	S92.064K	S52.90xA	S82.223B
S52.132M	S92.065K	S52.001A	S82.223C
S52.132N	S92.066K	S52.002A	S82.224B
S52.133K	S92.101K	S52.009A	S82.224C
S52.133M	S92.102K	S52.90xA	S82.225B
S52.133N	S92.109K	S52.90xA	S82.225C
S52.134K	S92.111K	S52.91xA	S82.226B
S52.134M	S92.112K	S52.92xA	S82.226C
S52.134N	S92.113K	S52.501B	S82.231B
S52.135K	S92.114K	S52.501C	S82.231C
S52.135M	S92.115K	S52.501E	S82.232B
S52.135N	S92.116K	S52.501F	S82.232C
S52.136K	S92.121K	S52.501H	S82.233B
S52.136M	S92.122K	S52.501J	S82.233C
S52.136N	S92.123K	S52.501M	S82.234B
S52.181K	S92.124K	S52.501N	S82.234C
S52.181M	S92.125K	S52.501Q	S82.235B
S52.181N	S92.126K	S52.501R	S82.235C
S52.182K	S92.131K	S52.502B	S82.236B
S52.182M	S92.132K	S52.502C	S82.236C
S52.182N	S92.133K	S52.502E	S82.241B
S52.189K	S92.134K	S52.502F	S82.241C
S52.189M	S92.135K	S52.502H	S82.242B
S52.189N	S92.136K	S52.502J	S82.242C
S52.201K	S92.141K	S52.502M	S82.243B
S52.201M	S92.142K	S52.502N	S82.243C
S52.201N	S92.143K	S52.502Q	S82.244B
S52.202K	S92.144K	S52.502R	S82.244C
S52.202M	S92.145K	S52.509B	S82.245B
S52.202N	S92.146K	S52.509C	S82.245C
S52.209K	S92.151K	S52.509E	S82.246B
S52.209M	S92.152K	S52.509F	S82.246C

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S52.209N	S92.153K	S52.509H	S82.251B
S52.211K	S92.154K	S52.509J	S82.251C
S52.212K	S92.155K	S52.509M	S82.252B
S52.219K	S92.156K	S52.509N	S82.252C
S52.221K	S92.191K	S52.509Q	S82.253B
S52.221M	S92.192K	S52.509R	S82.253C
S52.221N	S92.199K	S52.90xB	S82.254B
S52.222K	S92.201K	S52.90xC	S82.254C
S52.222M	S92.202K	S52.91xB	S82.255B
S52.222N	S92.209K	S52.91xC	S82.255C
S52.223K	S92.211K	S52.92xB	S82.256B
S52.223M	S92.212K	S52.92xC	S82.256C
S52.223N	S92.213K	S52.181B	S82.261B
S52.224K	S92.214K	S52.181C	S82.261C
S52.224M	S92.215K	S52.181E	S82.262B
S52.224N	S92.216K	S52.181F	S82.262C
S52.225K	S92.221K	S52.181H	S82.263B
S52.225M	S92.222K	S52.181J	S82.263C
S52.225N	S92.223K	S52.181M	S82.264B
S52.226K	S92.224K	S52.181N	S82.264C
S52.226M	S92.225K	S42.325A	S82.265B
S52.226N	S92.226K	S52.181Q	S82.265C
S52.231K	S92.231K	S52.181R	S82.266B
S52.231M	S92.232K	S52.182B	S82.266C
S52.231N	S92.233K	S52.182C	S82.291B
S52.232K	S92.234K	S52.182E	S82.291C
S52.232M	S92.235K	S52.189B	S82.292B
S52.232N	S92.236K	S52.189C	S82.292C
S52.233K	S92.241K	S52.501B	S82.299B
S52.233M	S92.242K	S52.501C	S82.299C
S52.233N	S92.243K	S52.501E	S82.401B
S52.234K	S92.244K	S52.501F	S82.401C
S52.234M	S92.245K	S52.501H	S82.402B
S52.234N	S92.246K	S52.501J	S82.402C
S52.235K	S92.251K	S52.501M	S82.409B
S52.235M	S92.252K	S52.501N	S82.409C
S52.235N	S92.253K	S52.501Q	S82.421B
S52.236K	S92.254K	S52.501R	S82.421C
S52.236M	S92.255K	S52.502B	S82.422B
S52.236N	S92.256K	S52.502C	S82.422C
S52.241K	S92.301K	S52.502E	S82.423B
S52.241M	S92.302K	S52.502F	S82.423C
S52.241N	S92.309K	S52.502H	S82.424B
S52.242K	S92.311K	S52.502J	S82.424C
S52.242M	S92.312K	S52.502M	S82.425B
S52.242N	S92.313K	S52.502N	S82.425C
S52.243K	S92.314K	S52.502Q	S82.426B
S52.243M	S92.315K	S52.502R	S82.426C
S52.243N	S92.316K	S52.509B	S82.431B
S52.244K	S92.321K	S52.90xB	S82.431C
S52.244M	S92.322K	S52.90xC	S82.432B
S52.244N	S92.323K	S52.001B	S82.432C

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S52.245K	S92.324K	S52.001C	S82.433B
S52.245M	S92.325K	S52.001S	S82.433C
S52.245N	S92.326K	S52.002B	S82.434B
S52.246K	S92.331K	S52.002C	S82.434C
S52.246M	S92.332K	S52.002S	S82.435B
S52.246N	S92.333K	S52.009B	S82.435C
S52.251K	S92.334K	S52.009C	S82.436B
S52.251M	S92.335K	S52.009S	S82.436C
S52.251N	S92.336K	S52.091B	S82.441B
S52.252K	S92.341K	S52.091C	S82.441C
S52.252M	S92.342K	S52.092B	S82.442B
S52.252N	S92.343K	S52.092C	S82.442C
S52.253K	S92.344K	S52.099B	S82.443B
S52.253M	S92.345K	S52.099C	S82.443C
S52.253N	S92.346K	S52.271B	S82.444B
S52.254K	S92.351K	S52.271C	S82.444C
S52.254M	S92.352K	S52.271J	S82.445B
S52.254N	S92.353K	S52.272B	S82.445C
S52.255K	S92.354K	S52.272C	S82.446B
S52.255M	S92.355K	S52.279B	S82.446C
S52.255N	S92.356K	S52.279C	S82.451B
S52.256K	S92.401K	S52.601B	S82.451C
S52.256M	S92.402K	S52.601C	S82.452B
S52.256N	S92.403K	S52.601S	S82.452C
S52.261K	S92.404K	S52.602B	S82.453B
S52.261M	S92.405K	S52.602C	S82.453C
S52.261N	S92.406K	S52.602S	S82.454B
S52.262K	S92.411K	S52.609B	S82.454C
S52.262M	S92.412K	S52.609C	S82.455B
S52.262N	S92.413K	S52.609S	S82.455C
S52.263K	S92.414K	S52.691B	S82.456B
S52.263M	S92.415K	S52.691C	S82.456C
S52.263N	S92.416K	S52.691S	S82.461B
S52.264K	S92.421K	S52.692B	S82.461C
S52.264M	S92.422K	S52.692C	S82.462B
S52.264N	S92.423K	S52.699B	S82.462C
S52.265K	S92.424K	S52.699C	S82.463B
S52.265M	S92.425K	S52.90xB	S82.463C
S52.265N	S92.426K	S52.90xC	S82.464B
S52.266K	S92.491K	S52.391C	S82.464C
S52.266M	S92.492K	S52.392B	S82.465B
S52.266N	S92.499K	S52.392C	S82.465C
S52.271K	S92.501K	S52.399B	S82.466B
S52.271M	S92.502K	S52.399C	S82.466C
S52.271N	S92.503K	S52.90xB	S82.491B
S52.272K	S92.504K	S52.90xC	S82.491C
S52.272M	S92.505K	S52.90xE	S82.492B
S52.272N	S92.506K	S52.90xF	S82.492C
S52.279K	S92.511K	S52.90xH	S82.499B
S52.279M	S92.512K	S52.90xJ	S82.499C
S52.279N	S92.513K	S52.90xM	S82.861B
S52.281K	S92.514K	S52.90xN	S82.861C

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S52.281M	S92.515K	S52.90xQ	S82.862B
S52.281N	S92.516K	S52.90xR	S82.862C
S52.282K	S92.521K	S52.90xS	S82.863B
S52.282M	S92.522K	S52.91xB	S82.863C
S52.282N	S92.523K	S52.91xC	S82.864B
S52.283K	S92.524K	S52.91xE	S82.864C
S52.283M	S92.525K	S52.91xF	S82.865B
S52.283N	S92.526K	S52.91xH	S82.865C
S52.291K	S92.531K	S52.91xJ	S82.866B
S52.291M	S92.532K	S52.91xM	S82.866C
S52.291N	S92.533K	S52.91xN	S82.201B
S52.292K	S92.534K	S52.91xQ	S82.402B
S52.292M	S92.535K	S52.91xR	S82.201B
S52.292N	S92.536K	S52.91xS	S82.202B
S52.299K	S92.591K	S52.92xB	S82.202B
S52.299M	S92.592K	S52.92xC	S82.401B
S52.299N	S92.599K	S52.92xE	S82.401B
S52.301K	S92.901K	S52.92xF	S82.402B
S52.301M	S92.902K	S52.92xH	S82.161A
S52.301N	S92.909K	S52.92xJ	S82.162A
S52.302K	S92.911K	S52.92xM	S82.169A
S52.302M	S92.912K	S52.92xN	S82.311A
S52.302N	S92.919K	S52.92xQ	S82.312A
S52.309K	S22.39xA	S52.92xR	S82.319A
S52.309M	S22.31xA	S52.92xS	S82.811A
S52.309N	S22.32xA	S62.101A	S82.812A
S52.311K	S22.39xA	S62.102A	S82.819A
S52.312K	S22.41xA	S62.109A	S82.821A
S52.319K	S22.42xA	S62.001A	S82.822A
S52.321K	S22.43xA	S62.002A	S82.829A
S52.321M	S22.49xA	S62.009A	S82.161A
S52.321N	S22.41xA	S62.011A	S82.811A
S52.322K	S22.42xA	S62.012A	S82.162A
S52.322M	S22.43xA	S62.013A	S82.812A
S52.322N	S22.49xA	S62.014A	S82.311A
S52.323K	S32.401A	S62.015A	S82.821A
S52.323M	S32.402A	S62.016A	S82.312A
S52.323N	S32.409A	S62.021A	S82.822A
S52.324K	S32.411A	S62.022A	S82.101A
S52.324M	S32.412A	S62.023A	S82.109A
S52.324N	S32.413A	S62.024A	S82.191A
S52.325K	S32.414A	S62.025A	S82.192A
S52.325M	S32.415A	S62.026A	S82.201A
S52.325N	S32.416A	S62.031A	S82.202A
S52.326K	S32.421A	S62.032A	S82.209A
S52.326M	S32.422A	S62.033A	S82.401A
S52.326N	S32.423A	S62.034A	S82.402A
S52.331K	S32.424A	S62.035A	S82.409A
S52.331M	S32.425A	S62.036A	S82.201A
S52.331N	S32.426A	S62.121A	S82.401A
S52.332K	S32.431A	S62.122A	S82.202A
S52.332M	S32.432A	S62.123A	S82.402A

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S52.332N	S32.433A	S62.124A	S82.101B
S52.333K	S32.434A	S62.125A	S82.101C
S52.333M	S32.435A	S62.126A	S82.109B
S52.333N	S32.436A	S62.111A	S82.109C
S52.334K	S32.441A	S62.112A	S82.191B
S52.334M	S32.442A	S62.113A	S82.191C
S52.334N	S32.443A	S62.114A	S82.192B
S52.335K	S32.444A	S62.115A	S82.192C
S52.335M	S32.445A	S62.116A	S82.192M
S52.335N	S32.446A	S62.161A	S82.192N
S52.336K	S32.451A	S62.162A	S82.192S
S52.336M	S32.452A	S62.163A	S82.199B
S52.336N	S32.453A	S62.164A	S82.199C
S52.341K	S32.454A	S62.165A	S82.199M
S52.341M	S32.455A	S62.166A	S82.199N
S52.341N	S32.456A	S62.171A	S82.199S
S52.342K	S32.461A	S62.172A	S82.201B
S52.342M	S32.462A	S62.173A	S82.201C
S52.342N	S32.463A	S62.174A	S82.202B
S52.343K	S32.464A	S62.175A	S82.202C
S52.343M	S32.465A	S62.176A	S82.209B
S52.343N	S32.466A	S62.181A	S82.209C
S52.344K	S32.471A	S62.182A	S82.301B
S52.344M	S32.472A	S62.183A	S82.301C
S52.344N	S32.473A	S62.184A	S82.302B
S52.345K	S32.474A	S62.185A	S82.302C
S52.345M	S32.475A	S62.186A	S82.309B
S52.345N	S32.476A	S62.131A	S82.309C
S52.346K	S32.481A	S62.132A	S82.391B
S52.346M	S32.482A	S62.133A	S82.391C
S52.346N	S32.483A	S62.134A	S82.391E
S52.351K	S32.484A	S62.135A	S82.391F
S52.351M	S32.485A	S62.136A	S82.391H
S52.351N	S32.486A	S62.141A	S82.391J
S52.352K	S32.491A	S62.142A	S82.391M
S52.352M	S32.492A	S62.143A	S82.391N
S52.352N	S32.499A	S62.144A	S82.391Q
S52.353K	S32.401B	S62.145A	S82.391R
S52.353M	S32.402B	S62.146A	S82.391S
S52.353N	S32.409B	S62.151A	S82.392B
S52.354K	S32.411B	S62.152A	S82.392C
S52.354M	S32.412B	S62.153A	S82.392E
S52.354N	S32.413B	S62.154A	S82.392J
S52.355K	S32.414B	S62.155A	S82.392M
S52.355M	S32.415B	S62.156A	S82.392S
S52.355N	S32.416B	S62.101B	S82.399S
S52.356K	S32.421B	S62.101K	S82.401B
S52.356M	S32.422B	S62.102B	S82.401C
S52.356N	S32.423B	S62.102K	S82.402B
S52.361K	S32.424B	S62.102S	S82.402C
S52.361M	S32.425B	S62.109B	S82.409B
S52.361N	S32.426B	S62.109K	S82.409C

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S52.362K	S32.431B	S62.001B	S82.831B
S52.362M	S32.432B	S62.001S	S82.831C
S52.362N	S32.433B	S62.002B	S82.832B
S52.363K	S32.434B	S62.002D	S82.832C
S52.363M	S32.435B	S62.002G	S82.839B
S52.363N	S32.436B	S62.002S	S82.839C
S52.364K	S32.441B	S62.009B	S82.201B
S52.364M	S32.442B	S62.009S	S82.401B
S52.364N	S32.443B	S62.011B	S82.202B
S52.365K	S32.444B	S62.011S	S82.402B
S52.365M	S32.445B	S62.012B	S82.51xA
S52.365N	S32.446B	S62.012S	S82.52xA
S52.366K	S32.451B	S62.013B	S82.53xA
S52.366M	S32.452B	S62.013S	S82.54xA
S52.366N	S32.453B	S62.014B	S82.55xA
S52.371K	S32.454B	S62.014S	S82.56xA
S52.371M	S32.455B	S62.015B	S82.871A
S52.371N	S32.456B	S62.016B	S82.872A
S52.372K	S32.461B	S62.016S	S82.873A
S52.372M	S32.462B	S62.021B	S82.874A
S52.372N	S32.463B	S62.021S	S82.875A
S52.379K	S32.464B	S62.022B	S82.876A
S52.379M	S32.465B	S62.022S	S82.51xB
S52.379N	S32.466B	S62.023B	S82.51xC
S52.381K	S32.471B	S62.023S	S82.52xB
S52.381M	S32.472B	S62.024B	S82.52xC
S52.381N	S32.473B	S62.024S	S82.52xE
S52.382K	S32.474B	S62.025B	S82.52xF
S52.382M	S32.475B	S62.025S	S82.52xH
S52.382N	S32.476B	S62.026B	S82.52xJ
S52.389K	S32.481B	S62.026S	S82.52xM
S52.389M	S32.482B	S62.031B	S82.52xN
S52.389N	S32.483B	S62.031S	S82.52xQ
S52.391K	S32.484B	S62.032B	S82.52xR
S52.391M	S32.485B	S62.032S	S82.52xS
S52.391N	S32.486B	S62.033B	S82.53xB
S52.392K	S32.491B	S62.033S	S82.53xC
S52.392M	S32.492B	S62.034B	S82.53xE
S52.392N	S32.499B	S62.034S	S82.53xF
S52.399K	S32.501A	S62.035B	S82.53xH
S52.399M	S32.502A	S62.035S	S82.53xM
S52.399N	S32.509A	S62.036B	S82.53xN
S52.501K	S32.511A	S62.036S	S82.53xQ
S52.501M	S32.512A	S62.121B	S82.53xS
S52.501N	S32.519A	S62.121S	S82.54xB
S52.502K	S32.591A	S62.122B	S82.54xC
S52.502M	S32.592A	S62.122S	S82.54xS
S52.502N	S32.599A	S62.123B	S82.55xB
S52.509K	S32.501B	S62.123S	S82.55xC
S52.509M	S32.501S	S62.124B	S82.55xS
S52.509N	S32.502B	S62.124S	S82.56xB
S52.511K	S32.502S	S62.125B	S82.56xC

S52.511M	S32.509B	S62.125S	S82.56xS
S52.511N	S32.509S	S62.126B	S82.871B
S52.512K	S32.511B	S62.111B	S82.871C
S52.512M	S32.511S	S62.112B	S82.872B
S52.512N	S32.512B	S62.113B	S82.872C
S52.513K	S32.519B	S62.114B	S82.873B
S52.513M	S32.519S	S62.115B	S82.873C
S52.513N	S32.591B	S62.116B	S82.874B
S52.514K	S32.592B	S62.142B	S82.874C
S52.514M	S32.599B	S62.143B	S82.875B
S52.514N	S32.301A	S62.161B	S82.875C
S52.515K	S32.302A	S62.162B	S82.876B
S52.515M	S32.309A	S62.162S	S82.876C
S52.515N	S32.311A	S62.163B	S82.61xA
S52.516K	S32.312A	S62.163S	S82.62xA
S52.516N	S32.313A	S62.164B	S82.63xA
S52.521K	S32.314A	S62.164S	S82.64xA
S52.522K	S32.315A	S62.165B	S82.65xA
S52.529K	S32.316A	S62.165S	S82.66xA
S52.531K	S32.391A	S62.166B	S82.61xB
S52.531M	S32.392A	S62.166S	S82.61xC
S52.531N	S32.399A	S62.171B	S82.61xE
S52.532K	S32.601A	S62.172B	S82.61xF
S52.532M	S32.602A	S62.172S	S82.61xH
S52.532N	S32.609A	S62.173B	S82.61xJ
S52.539K	S32.611A	S62.173S	S82.61xM
S52.539M	S32.612A	S62.174B	S82.61xN
S52.539N	S32.613A	S62.174S	S82.61xQ
S52.541K	S32.614A	S62.175B	S82.61xR
S52.541M	S32.615A	S62.175S	S82.61xS
S52.541N	S32.616A	S62.176B	S82.62xB
S52.542K	S32.691A	S62.181B	S82.62xC
S52.542M	S32.692A	S62.182B	S82.62xE
S52.542N	S32.699A	S62.182S	S82.62xF
S52.549K	S32.810A	S62.183B	S82.62xH
S52.549M	S32.811A	S62.183S	S82.62xJ
S52.549N	S32.82xA	S62.184B	S82.62xM
S52.551K	S32.89xA	S62.184S	S82.62xN
S52.551M	S32.9xxA	S62.185B	S82.62xQ
S52.551N	S32.301B	S62.185S	S82.62xR
S52.552K	S32.301S	S62.186B	S82.62xS
S52.552M	S32.302B	S62.186S	S82.63xB
S52.552N	S32.302S	S62.131B	S82.63xC
S52.559K	S32.309B	S62.131S	S82.63xE
S52.559M	S32.309S	S62.132B	S82.63xF
S52.559N	S32.311B	S62.132S	S82.63xH
S52.561K	S32.312B	S62.133B	S82.63xJ
S52.561M	S32.313B	S62.133S	S82.63xM
S52.561N	S32.314B	S62.134B	S82.63xN
S52.562K	S32.315B	S62.134S	S82.63xQ
S52.562M	S32.316B	S62.135B	S82.63xR
S52.562N	S32.391B	S62.135S	S82.63xS

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S52.569K	S32.391S	S62.136B	S82.64xB
S52.569M	S32.392B	S62.136S	S82.64xC
S52.569N	S32.392S	S62.141B	S82.64xE
S52.571K	S32.399B	S62.142B	S82.64xF
S52.571M	S32.399S	S62.142S	S82.64xN
S52.571N	S32.601B	S62.143B	S82.64xS
S52.572K	S32.601S	S62.143S	S82.65xB
S52.572M	S32.602B	S62.144B	S82.65xC
S52.572N	S32.602S	S62.144S	S82.65xE
S52.579K	S32.609B	S62.145B	S82.65xF
S52.579M	S32.609S	S62.145S	S82.65xH
S52.579N	S32.611B	S62.146B	S82.65xJ
S52.591K	S32.612B	S62.146S	S82.65xS
S52.591M	S32.613B	S62.001B	S82.66xB
S52.591N	S32.614B	S62.002B	S82.66xC
S52.592K	S32.615B	S62.009B	S82.841A
S52.592M	S32.616B	S62.011B	S82.842A
S52.592N	S32.691B	S62.012B	S82.843A
S52.599K	S32.692B	S62.013B	S82.844A
S52.599M	S32.699B	S62.014B	S82.845A
S52.599N	S32.810B	S62.015B	S82.846A
S52.601K	S32.810S	S62.016B	S82.841B
S52.601M	S32.811B	S62.021B	S82.841C
S52.601N	S32.811S	S62.022B	S82.841J
S52.602K	S32.82xB	S62.023B	S82.841M
S52.602M	S32.82xB	S62.024B	S82.841N
S52.602N	S32.89xB	S62.032B	S82.841Q
S52.609K	S32.89xS	S62.033B	S82.841R
S52.609M	S32.9xxB	S62.034B	S82.841S
S52.609N	S32.9xxA	S62.035B	S82.842B
S52.611K	S32.10xB	S62.036B	S82.842C
S52.611M	S32.89xB	S62.101B	S82.842E
S52.611N	S32.89xS	S62.102B	S82.842F
S52.612K	S32.9xxB	S62.109B	S82.842H
S52.612M	S42.001A	S62.142B	S82.842J
S52.612N	S42.002A	S62.143B	S82.842M
S52.613K	S42.009A	S62.144B	S82.842N
S52.613M	S42.011A	S62.145B	S82.842Q
S52.613N	S42.012A	S62.146B	S82.842R
S52.614K	S42.013A	S62.151B	S82.842S
S52.614M	S42.014A	S62.151D	S82.843B
S52.614N	S42.015A	S62.151G	S82.843C
S52.615K	S42.016A	S62.151K	S82.843H
S52.615M	S42.017A	S62.151S	S82.843J
S52.615N	S42.018A	S62.152B	S82.843M
S52.616K	S42.019A	S62.152D	S82.843N
S52.616M	S42.021A	S62.152G	S82.843Q
S52.616N	S42.022A	S62.152K	S82.843R
S52.621K	S42.023A	S62.152S	S82.843S
S52.622K	S42.024A	S62.153B	S82.844B
S52.629K	S42.025A	S62.153S	S82.844C
S52.691K	S42.026A	S62.154B	S82.844E

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S52.691M	S82.209K	S62.154S	S82.844F
S52.691N	S42.031A	S62.155B	S82.844H
S52.692K	S42.032A	S62.155S	S82.844J
S52.692M	S42.033A	S62.156B	S82.844M
S52.692N	S42.034A	S62.156S	S82.844N
S52.699K	S42.035A	S62.305B	S82.844S
S52.699M	S42.036A	S62.306B	S82.845B
S52.699N	S42.011B	S62.307B	S82.845C
S52.90xK	S42.012B	S62.309A	S82.845S
S52.90xM	S42.013B	S62.319A	S82.846B
S52.90xN	S42.014B	S62.329A	S82.846C
S52.91xK	S42.015B	S62.339A	S82.846S
S52.91xM	S42.016B	S62.349A	S82.851A
S52.91xN	S42.017B	S62.359A	S82.852A
S52.92xK	S42.018B	S62.369A	S82.853A
S52.92xM	S42.019B	S62.398A	S82.854A
S52.92xN	S42.002B	S62.399A	S82.855A
S59.001K	S42.009B	S62.201A	S82.856A
S59.002K	S42.021B	S62.202A	S82.851B
S59.009K	S42.022B	S62.209A	S82.851C
S59.011K	S42.023B	S62.211A	S82.851E
S59.012K	S42.024B	S62.212A	S82.851F
S59.019K	S42.025B	S62.213A	S82.851H
S59.021K	S42.026B	S62.221A	S82.851J
S59.022K	S42.001B	S62.222A	S82.851M
S59.029K	S42.002B	S62.223A	S82.851N
S59.031K	S42.009B	S62.224A	S82.851Q
S59.032K	S42.031B	S62.225A	S82.851R
S59.039K	S42.032B	S62.226A	S82.851S
S59.041K	S42.033B	S62.231A	S82.852B
S59.042K	S42.034B	S62.232A	S82.852C
S59.049K	S42.035B	S62.233A	S82.852E
S59.091K	S42.036B	S62.234A	S82.852F
S59.092K	S42.101A	S62.235A	S82.852H
S59.099K	S42.102A	S62.236A	S82.852J
S59.101K	S42.109A	S62.291A	S82.852M
S59.102K	S42.121A	S62.292A	S82.852N
S59.109K	S42.122A	S62.299A	S82.852Q
S59.111K	S42.123A	S62.241A	S82.852S
S59.112K	S42.124A	S62.309A	S82.853B
S59.119K	S42.125A	S62.310A	S82.853C
S59.121K	S42.126A	S62.311A	S82.853H
S59.122K	S42.131A	S62.312A	S82.853J
S59.129K	S42.132A	S62.313A	S82.853M
S59.131K	S42.133A	S62.314A	S82.853N
S59.132K	S42.134A	S62.315A	S82.853Q
S59.139K	S42.135A	S62.316A	S82.853R
S59.141K	S42.136A	S62.317A	S82.853S
S59.142K	S42.141A	S62.318A	S82.854B
S59.149K	S42.142A	S62.319A	S82.854C
S59.191K	S42.143A	S62.340A	S82.854E
S59.192K	S42.144A	S62.341A	S82.854F

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S59.199K	S42.145A	S62.342A	S82.854H
S59.201K	S42.146A	S62.343A	S82.854J
S59.202K	S42.151A	S62.344A	S82.854M
S59.209K	S42.152A	S62.345A	S82.854N
S59.211K	S42.153A	S62.346A	S82.854Q
S59.212K	S42.154A	S62.347A	S82.854S
S59.219K	S42.155A	S62.348A	S82.855B
S59.221K	S42.156A	S62.349A	S82.855C
S59.222K	S42.111A	S62.398A	S82.855S
S59.229K	S42.112A	S62.399A	S82.856B
S59.231K	S42.113A	S62.242A	S82.856C
S59.232K	S42.114A	S62.243A	S82.856S
S59.239K	S42.115A	S62.244A	S82.301A
S59.241K	S42.116A	S62.245A	S82.302A
S59.242K	S42.191A	S62.246A	S82.309A
S59.249K	S42.192A	S62.320A	S82.391A
S59.291K	S42.199A	S62.321A	S82.392A
S59.292K	S42.101B	S62.322A	S82.399A
S59.299K	S42.101K	S62.323A	S82.891A
S62.001K	S42.101P	S62.324A	S82.892A
S62.002K	S42.102B	S62.325A	S82.899A
S62.009K	S42.102K	S62.326A	S89.101A
S62.011K	S42.102P	S62.327A	S89.102A
S62.012K	S42.102S	S62.328A	S89.109A
S62.013K	S42.109B	S62.329A	S89.111A
S62.014K	S42.109K	S62.338A	S89.112A
S62.015K	S42.109S	S62.350A	S89.119A
S62.016K	S42.111B	S62.351A	S89.121A
S62.021K	S42.111S	S62.352A	S89.122A
S62.022K	S42.112B	S62.353A	S89.129A
S62.023K	S42.112S	S62.354A	S89.131A
S62.024K	S42.113B	S62.355A	S89.132A
S62.025K	S42.113S	S62.356A	S89.139A
S62.026K	S42.114B	S62.357A	S89.141A
S62.031K	S42.114S	S62.358A	S89.142A
S62.032K	S42.115B	S62.359A	S89.149A
S62.033K	S42.115S	S62.251A	S89.191A
S62.034K	S42.116B	S62.252A	S89.192A
S62.035K	S42.116S	S62.253A	S89.199A
S62.036K	S42.191B	S62.254A	S89.301A
S62.101K	S42.191P	S62.255A	S89.302A
S62.102K	S42.191S	S62.256A	S89.309A
S62.109K	S42.192B	S62.291A	S89.311A
S62.111K	S42.192P	S62.330A	S89.312A
S62.112K	S42.192S	S62.331A	S89.319A
S62.113K	S42.199B	S62.332A	S89.321A
S62.114K	S42.199P	S62.333A	S89.322A
S62.115K	S42.199S	S62.334A	S89.329A
S62.116K	S42.101B	S62.335A	S89.391A
S62.121K	S42.102B	S62.336A	S89.392A
S62.122K	S42.109B	S62.337A	S89.399A
S62.123K	S42.121B	S62.339A	S82.301B

S62.124K	S42.122B	S62.360A	S82.301C
S62.125K	S42.123B	S62.361A	S82.301S
S62.126K	S42.124B	S62.362A	S82.302B
S62.131K	S42.125B	S62.363A	S82.302C
S62.132K	S42.126B	S62.364A	S82.302S
S62.133K	S42.101B	S62.365A	S82.309B
S62.134K	S42.102B	S62.366A	S82.309C
S62.135K	S42.109B	S62.367A	S82.309S
S62.136K	S42.131B	S62.368A	S82.391B
S62.141K	S42.132B	S62.369A	S82.391C
S62.142K	S42.133B	S62.291A	S82.392B
S62.143K	S42.134B	S62.292A	S82.392C
S62.144K	S42.135B	S62.292A	S82.399B
S62.145K	S42.136B	S62.299A	S82.399C
S62.146K	S42.191B	S62.299A	S82.891B
S62.151K	S42.191S	S62.300A	S82.891C
S62.152K	S42.192B	S62.300A	S82.892B
S62.153K	S42.192S	S62.301A	S82.892C
S62.154K	S42.199B	S62.301A	S82.899B
S62.155K	S42.199S	S62.302A	S82.899C
S62.156K	S42.141B	S62.302A	S82.90xB
S62.161K	S42.142B	S62.303A	S82.90xS
S62.162K	S42.143B	S62.303A	S82.91xS
S62.163K	S42.144B	S62.304A	S82.92xS
S62.164K	S42.145B	S62.304A	S92.001A
S62.165K	S42.146B	S62.305A	S92.002A
S62.166K	S42.151B	S62.305A	S92.009A
S62.171K	S42.152B	S62.306A	S92.011A
S62.172K	S42.153B	S62.306A	S92.012A
S62.173K	S42.154B	S62.307A	S92.013A
S62.174K	S42.155B	S62.307A	S92.014A
S62.175K	S42.156B	S62.308A	S92.015A
S62.176K	S42.101B	S62.308A	S92.016A
S62.181K	S42.102B	S62.309A	S92.021A
S62.182K	S42.109B	S62.309A	S92.022A
S62.183K	S42.111B	S62.390A	S92.023A
S62.184K	S42.112B	S62.390A	S92.024A
S62.185K	S42.113B	S62.391A	S92.025A
S62.186K	S42.114B	S62.391A	S92.026A
S62.201K	S42.115B	S62.392A	S92.031A
S62.202K	S42.116B	S62.392A	S92.032A
S62.209K	S42.191B	S62.393A	S92.033A
S62.211K	S42.191S	S62.393A	S92.034A
S62.212K	S42.192B	S62.394A	S92.035A
S62.213K	S42.192S	S62.394A	S92.036A
S62.221K	S42.199B	S62.395A	S92.041A
S62.222K	S42.199S	S62.395A	S92.042A
S62.223K	S42.201A	S62.396A	S92.043A
S62.224K	S42.202A	S62.396A	S92.044A
S62.225K	S42.209A	S62.397A	S92.045A
S62.226K	S42.211A	S62.397A	S92.046A
S62.231K	S42.212A	S62.398A	S92.051A

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S62.232K	S42.213A	S62.398A	S92.052A
S62.233K	S42.214A	S62.399A	S92.053A
S62.234K	S42.215A	S62.399A	S92.054A
S62.235K	S42.216A	S62.308B	S92.055A
S62.236K	S42.221A	S62.308S	S92.056A
S62.241K	S42.222A	S62.309B	S92.061A
S62.242K	S42.223A	S62.309D	S92.062A
S62.243K	S42.224A	S62.309G	S92.063A
S62.244K	S42.225A	S62.309K	S92.064A
S62.245K	S42.226A	S62.309P	S92.065A
S62.246K	S42.231A	S62.309S	S92.066A
S62.251K	S42.232A	S62.318B	S92.001B
S62.252K	S42.239A	S62.319B	S92.001S
S62.253K	S42.241A	S62.328B	S92.002B
S62.254K	S42.242A	S62.328S	S92.002S
S62.255K	S42.249A	S62.329B	S92.009B
S62.256K	S42.291A	S62.329S	S92.009S
S62.291K	S42.292A	S62.338B	S92.011B
S62.292K	S42.293A	S62.338D	S92.012B
S62.299K	S42.294A	S62.338S	S92.013B
S62.300K	S42.295A	S62.339B	S92.014B
S62.301K	S42.296A	S62.339S	S92.015B
S62.302K	S42.251A	S62.348B	S92.016B
S62.303K	S42.252A	S62.349B	S92.021B
S62.304K	S42.253A	S62.358B	S92.022B
S62.305K	S42.254A	S62.358S	S92.023B
S62.306K	S42.255A	S62.359B	S92.024B
S62.307K	S42.256A	S62.359S	S92.025B
S62.308K	S42.261A	S62.368B	S92.026B
S62.309K	S42.262A	S62.368S	S92.031B
S62.310K	S42.263A	S62.369B	S92.032B
S62.311K	S42.264A	S62.369S	S92.033B
S62.312K	S42.265A	S62.398B	S92.034B
S62.313K	S42.266A	S62.398D	S92.035B
S62.314K	S42.271A	S62.398G	S92.036B
S62.315K	S42.272A	S62.398K	S92.041B
S62.316K	S42.279A	S62.398P	S92.042B
S62.317K	S42.291A	S62.398S	S92.043B
S62.318K	S42.292A	S62.399B	S92.044B
S62.319K	S42.293A	S62.399D	S92.045B
S62.320K	S42.294A	S62.399G	S92.046B
S62.321K	S42.295A	S62.399K	S92.051B
S62.322K	S42.296A	S62.399P	S92.052B
S62.323K	S49.001A	S62.399S	S92.053B
S62.324K	S49.002A	S62.201B	S92.054B
S62.325K	S49.009A	S62.202B	S92.055B
S62.326K	S49.011A	S62.209B	S92.056B
S62.327K	S49.012A	S62.211B	S92.061B
S62.328K	S49.019A	S62.212B	S92.062B
S62.329K	S49.021A	S62.213B	S92.063B
S62.330K	S49.022A	S62.221B	S92.064B
S62.331K	S49.029A	S62.222B	S92.065B

S62.332K	S49.031A	S62.223B	S92.066B
S62.333K	S49.032A	S62.224B	S92.101A
S62.334K	S49.039A	S62.225B	S92.102A
S62.335K	S49.041A	S62.226B	S92.109A
S62.336K	S49.042A	S62.231B	S92.111A
S62.337K	S49.049A	S62.232B	S92.112A
S62.338K	S49.091A	S62.233B	S92.113A
S62.339K	S49.092A	S62.234B	S92.114A
S62.340K	S49.099A	S62.235B	S92.115A
S62.341K	S42.201B	S62.236B	S92.116A
S62.342K	S42.201S	S62.291B	S92.121A
S62.343K	S42.202B	S62.309B	S92.122A
S62.344K	S42.202S	S62.310B	S92.123A
S62.345K	S42.209B	S62.311B	S92.124A
S62.346K	S42.209S	S62.312B	S92.125A
S62.347K	S42.211B	S62.313B	S92.126A
S62.348K	S42.212B	S62.314B	S92.131A
S62.349K	S42.213B	S62.315B	S92.132A
S62.350K	S42.214B	S62.316B	S92.133A
S62.351K	S42.215B	S62.317B	S92.134A
S62.352K	S42.216B	S62.318B	S92.135A
S62.353K	S42.301B	S62.319B	S92.136A
S62.354K	S42.211B	S62.340B	S92.141A
S62.355K	S42.212B	S62.341B	S92.142A
S62.356K	S42.213B	S62.342B	S92.143A
S62.357K	S42.214B	S62.343B	S92.144A
S62.358K	S42.215B	S62.344B	S92.145A
S62.359K	S42.216B	S62.345B	S92.146A
S62.360K	S42.221B	S62.346B	S92.151A
S62.361K	S42.222B	S62.347B	S92.152A
S62.362K	S42.223B	S62.348B	S92.153A
S62.363K	S42.224B	S62.349B	S92.154A
S62.364K	S42.225B	S62.399B	S92.155A
S62.365K	S42.226B	S62.399S	S92.156A
S62.366K	S42.231B	S62.241B	S92.191A
S62.367K	S42.232B	S62.242B	S92.192A
S62.368K	S42.239B	S62.243B	S92.199A
S62.369K	S42.241B	S62.244B	S92.101A
S62.390K	S42.242B	S62.245B	S92.102A
S62.391K	S42.249B	S62.246B	S92.109A
S62.392K	S42.201B	S62.309B	S92.111A
S62.393K	S42.202B	S62.320B	S92.112A
S62.394K	S42.209B	S62.321B	S92.113A
S62.395K	S42.291B	S62.322B	S92.114A
S62.396K	S42.292B	S62.323B	S92.115A
S62.397K	S42.293B	S62.324B	S92.116A
S62.398K	S42.294B	S62.325B	S92.121A
S62.399K	S42.295B	S62.326B	S92.122A
S62.501K	S42.296B	S62.327B	S92.123A
S62.502K	S49.002S	S62.328B	S92.124A
S62.509K	S42.251B	S62.329B	S92.125A
S62.511K	S42.251S	S62.350B	S92.126A

S62.512K	S42.252B	S62.351B	S92.131A
S62.513K	S42.252S	S62.352B	S92.132A
S62.514K	S42.253B	S62.353B	S92.133A
S62.515K	S42.253S	S62.354B	S92.134A
S62.516K	S42.254B	S62.355B	S92.135A
S62.521K	S42.255B	S62.356B	S92.136A
S62.522K	S42.256B	S62.357B	S92.141A
S62.523K	S42.201B	S62.358B	S92.142A
S62.524K	S42.202B	S62.358S	S92.143A
S62.525K	S42.209B	S62.359B	S92.144A
S62.526K	S42.261B	S62.359S	S92.145A
S62.600K	S42.262B	S62.399B	S92.146A
S62.601K	S42.263B	S62.251B	S92.151A
S62.602K	S42.264B	S62.252B	S92.152A
S62.603K	S42.265B	S62.253B	S92.153A
S62.604K	S42.266B	S62.254B	S92.154A
S62.605K	S42.291B	S62.255B	S92.155A
S62.606K	S42.292B	S62.256B	S92.156A
S62.607K	S42.293B	S62.330B	S92.191A
S62.608K	S42.294B	S62.331B	S92.192A
S62.609K	S42.295B	S62.332B	S92.199A
S62.610K	S42.296B	S62.333B	S92.251A
S62.611K	S49.002S	S62.334B	S92.252A
S62.612K	S42.301A	S62.335B	S92.253A
S62.613K	S42.302A	S62.336B	S92.254A
S62.614K	S42.309A	S62.337B	S92.255A
S62.615K	S42.90xA	S62.338B	S92.256A
S62.616K	S42.91xA	S62.338D	S92.211A
S62.617K	S42.92xA	S62.338G	S92.212A
S62.618K	S42.311A	S62.338K	S92.213A
S62.619K	S42.312A	S62.338P	S92.214A
S62.620K	S42.319A	S62.338S	S92.215A
S62.621K	S42.321A	S62.339B	S92.216A
S62.622K	S42.322A	S62.339D	S92.221A
S62.623K	S42.323A	S62.339G	S92.222A
S62.624K	S42.324A	S62.339K	S92.223A
S62.625K	S42.326A	S62.339P	S92.224A
S62.626K	S42.331A	S62.339S	S92.225A
S62.627K	S42.332A	S62.360B	S92.226A
S62.628K	S42.333A	S62.361B	S92.231A
S62.629K	S42.334A	S62.362B	S92.232A
S62.630K	S42.335A	S62.363B	S92.233A
S62.631K	S42.336A	S62.364B	S92.234A
S62.632K	S42.341A	S62.365B	S92.235A
S62.633K	S42.342A	S62.366B	S92.236A
S62.634K	S42.343A	S62.367B	S92.241A
S62.635K	S42.344A	S62.368B	S92.242A
S62.636K	S42.345A	S62.368K	S92.243A
S62.637K	S42.346A	S62.368P	S92.244A
S62.638K	S42.351A	S62.368S	S92.245A
S62.639K	S42.352A	S62.369B	S92.246A
S62.640K	S42.353A	S62.369D	S92.301A

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S62.641K	S42.354A	S62.369S	S92.302A
S62.642K	S42.355A	S62.291B	S92.309A
S62.643K	S42.356A	S62.292B	S92.311A
S62.644K	S42.361A	S62.299B	S92.312A
S62.645K	S42.362A	S62.299S	S92.313A
S62.646K	S42.363A	S62.300B	S92.314A
S62.647K	S42.364A	S62.301B	S92.315A
S62.648K	S42.365A	S62.302B	S92.316A
S62.649K	S42.366A	S62.303B	S92.321A
S62.650K	S42.391A	S62.304B	S92.322A
S62.651K	S42.392A	S62.305B	S92.323A
S62.652K	S42.399A	S62.306B	S92.324A
S62.653K	S42.301B	S62.307B	S92.325A
S62.654K	S42.302B	S62.308B	S92.326A
S62.655K	S42.309B	S62.309B	S92.331A
S62.656K	S42.321B	S62.309S	S92.332A
S62.657K	S42.322B	S62.338B	S92.333A
S62.658K	S42.323B	S62.390B	S92.334A
S62.659K	S42.324B	S62.391B	S92.335A
S62.660K	S42.325B	S62.392B	S92.336A
S62.661K	S42.326B	S62.393B	S92.341A
S62.662K	S42.331B	S62.394B	S92.342A
S62.663K	S42.332B	S62.395B	S92.343A
S62.664K	S42.333B	S62.396B	S92.344A
S62.665K	S42.334B	S62.397B	S92.345A
S62.666K	S42.335B	S62.398B	S92.346A
S62.667K	S42.336B	S62.398D	S92.351A
S62.668K	S42.341B	S62.399B	S92.352A
S62.669K	S42.342B	S62.501A	S92.353A
S62.90xK	S42.343B	S62.502A	S92.354A
S62.91xK	S42.344B	S62.509A	S92.355A
S62.92xK	S42.345B	S62.600A	S92.356A
S72.001K	S42.346B	S62.601A	S92.201A
S72.001M	S42.351B	S62.602A	S92.202A
S72.001N	S42.352B	S62.603A	S92.209A
S72.002K	S42.353B	S62.604A	S92.301A
S72.002M	S42.354B	S62.605A	S92.302A
S72.002N	S42.355B	S62.606A	S92.309A
S72.009K	S42.356B	S62.607A	S92.311A
S72.009M	S42.361B	S62.608A	S92.312A
S72.009N	S42.362B	S62.609A	S92.313A
S72.011K	S42.363B	S62.511A	S92.314A
S72.011M	S42.364B	S62.512A	S92.315A
S72.011N	S42.365B	S62.513A	S92.316A
S72.012K	S42.366B	S62.514A	S92.321A
S72.012M	S42.391B	S62.515A	S92.322A
S72.012N	S42.392B	S62.516A	S92.323A
S72.019K	S42.399B	S62.610A	S92.324A
S72.019M	S42.90xB	S62.611A	S92.325A
S72.019N	S42.91xB	S62.612A	S92.326A
S72.021K	S42.91xS	S62.613A	S92.331A
S72.021M	S42.92xB	S62.614A	S92.332A

S72.021N	S42.301B	S62.615A	S92.333A
S72.022K	S42.301S	S62.616A	S92.334A
S72.022M	S42.302B	S62.617A	S92.335A
S72.022N	S42.302S	S62.618A	S92.336A
S72.023K	S42.309B	S62.619A	S92.341A
S72.023M	S42.309S	S62.620A	S92.342A
S72.023N	S42.321B	S62.621A	S92.343A
S72.024K	S42.322B	S62.622A	S92.344A
S72.024M	S42.323B	S62.623A	S92.345A
S72.024N	S42.324B	S62.624A	S92.346A
S72.025K	S42.325B	S62.625A	S92.351A
S72.025M	S42.326B	S62.626A	S92.352A
S72.025N	S42.331B	S62.627A	S92.353A
S72.026K	S42.332B	S62.628A	S92.354A
S72.026M	S42.333B	S62.629A	S92.355A
S72.026N	S42.334B	S62.640A	S92.356A
S72.031K	S42.335B	S62.641A	S92.202B
S72.031M	S42.336B	S62.642A	S92.302B
S72.031N	S42.341B	S62.643A	S92.901B
S72.032K	S42.342B	S62.644A	S92.901S
S72.032M	S42.343B	S62.645A	S92.902B
S72.032N	S42.344B	S62.646A	S92.902S
S72.033K	S42.345B	S62.647A	S92.909B
S72.033M	S42.346B	S62.648A	S92.909S
S72.033N	S42.351B	S62.649A	S92.101B
S72.034K	S42.352B	S62.650A	S92.101S
S72.034M	S42.353B	S62.651A	S92.102B
S72.034N	S42.354B	S62.652A	S92.102S
S72.035K	S42.355B	S62.653A	S92.109B
S72.035M	S42.356B	S62.654A	S92.111B
S72.035N	S42.361B	S62.655A	S92.111S
S72.036K	S42.362B	S62.656A	S92.112B
S72.036M	S42.363B	S62.657A	S92.113B
S72.036N	S42.364B	S62.658A	S92.114B
S72.041K	S42.365B	S62.659A	S92.115B
S72.041M	S42.366B	S62.521A	S92.116B
S72.041N	S42.391B	S62.522A	S92.121B
S72.042K	S42.392B	S62.523A	S92.122B
S72.042M	S42.399B	S62.524A	S92.123B
S72.042N	S42.401A	S62.525A	S92.124B
S72.043K	S42.402A	S62.526A	S92.125B
S72.043M	S42.409A	S62.630A	S92.126B
S72.043N	S42.411A	S62.631A	S92.131B
S72.044K	S42.412A	S62.632A	S92.132B
S72.044M	S42.413A	S62.633A	S92.133B
S72.044N	S42.414A	S62.634A	S92.134B
S72.045K	S42.415A	S62.635A	S92.135B
S72.045M	S42.416A	S62.636A	S92.136B
S72.045N	S42.421A	S62.637A	S92.141B
S72.046K	S42.422A	S62.638A	S92.142B
S72.046M	S42.423A	S62.639A	S92.143B
S72.046N	S42.424A	S62.660A	S92.144B

S72.051K	S42.425A	S62.661A	S92.145B
S72.051M	S42.426A	S62.662A	S92.146B
S72.051N	S42.431A	S62.663A	S92.151B
S72.052K	S42.432A	S62.664A	S92.152B
S72.052M	S42.433A	S62.665A	S92.153B
S72.052N	S42.434A	S62.666A	S92.154B
S72.059K	S42.435A	S62.667A	S92.155B
S72.059M	S42.436A	S62.668A	S92.156B
S72.059N	S42.451A	S62.669A	S92.191B
S72.061K	S42.452A	S62.90xA	S92.192B
S72.061M	S42.453A	S62.91xA	S92.199B
S72.061N	S42.454A	S62.92xA	S92.901B
S72.062K	S42.455A	S62.305B	S92.251B
S72.062M	S42.456A	S62.306B	S92.251D
S72.062N	S42.441A	S62.307B	S92.251G
S72.063K	S42.442A	S62.501B	S92.251K
S72.063M	S42.443A	S62.502B	S92.251P
S72.063N	S42.444A	S62.509B	S92.251S
S72.064K	S42.445A	S62.600B	S92.252B
S72.064M	S42.446A	S62.601B	S92.252D
S72.064N	S42.447A	S62.602B	S92.252G
S72.065K	S42.448A	S62.603B	S92.252K
S72.065M	S42.449A	S62.604B	S92.252P
S72.065N	S42.461A	S62.605B	S92.252S
S72.066K	S42.462A	S62.606B	S92.253B
S72.066M	S42.463A	S62.607B	S92.253K
S72.066N	S42.464A	S62.608B	S92.253S
S72.091K	S42.465A	S62.609B	S92.254B
S72.091M	S42.466A	S62.511B	S92.254S
S72.091N	S42.471A	S62.512B	S92.255B
S72.092K	S42.472A	S62.513B	S92.255S
S72.092M	S42.473A	S62.514B	S92.256B
S72.092N	S42.474A	S62.515B	S92.256S
S72.099K	S42.475A	S62.516B	S92.211B
S72.099M	S42.476A	S62.607B	S92.211D
S72.099N	S49.101A	S62.610B	S92.211G
S72.101K	S49.102A	S62.611B	S92.211P
S72.101M	S49.109A	S62.612B	S92.211S
S72.101N	S49.111A	S62.613B	S92.212B
S72.102K	S49.112A	S62.614B	S92.212D
S72.102M	S49.119A	S62.615B	S92.212G
S72.102N	S49.121A	S62.616B	S92.212P
S72.109K	S49.122A	S62.617B	S92.212S
S72.109M	S49.129A	S62.618B	S92.213B
S72.109N	S49.131A	S62.619B	S92.213K
S72.111K	S49.132A	S62.620B	S92.213S
S72.111M	S49.139A	S62.621B	S92.214B
S72.111N	S49.141A	S62.622B	S92.214D
S72.112K	S49.142A	S62.623B	S92.214G
S72.112M	S49.149A	S62.624B	S92.214P
S72.112N	S49.191A	S62.625B	S92.214S
S72.113K	S49.192A	S62.626B	S92.215B

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S72.113M	S49.199A	S62.627B	S92.215D
S72.113N	S42.481A	S62.628B	S92.215G
S72.114K	S42.482A	S62.629B	S92.215P
S72.114M	S42.489A	S62.640B	S92.215S
S72.114N	S42.491A	S62.641B	S92.216B
S72.115K	S42.492A	S62.642B	S92.216K
S72.115M	S42.493A	S62.643B	S92.216S
S72.115N	S42.494A	S62.644B	S92.221B
S72.116K	S42.495A	S62.645B	S92.221D
S72.116M	S42.496A	S62.646B	S92.221G
S72.116N	S42.401B	S62.647B	S92.221K
S72.121K	S42.402B	S62.648B	S92.221S
S72.121M	S42.402S	S62.649B	S92.222B
S72.121N	S42.409B	S62.650B	S92.222S
S72.122K	S42.409S	S62.651B	S92.223B
S72.122M	S42.491B	S62.652B	S92.223S
S72.122N	S42.492B	S62.653B	S92.224B
S72.123K	S42.493B	S62.654B	S92.224S
S72.123M	S42.494B	S62.655B	S92.225B
S72.123N	S42.495B	S62.656B	S92.225S
S72.124K	S42.496B	S62.657B	S92.226B
S72.124M	S42.411B	S62.658B	S92.226S
S72.124N	S42.412B	S62.659B	S92.231B
S72.125K	S42.413B	S62.501B	S92.231S
S72.125M	S42.414B	S62.502B	S92.232B
S72.125N	S42.415B	S62.509B	S92.232S
S72.126K	S42.416B	S62.521B	S92.233B
S72.126M	S42.421B	S62.522B	S92.233S
S72.126N	S42.422B	S62.523B	S92.234B
S72.131K	S42.423B	S62.524B	S92.234S
S72.131M	S42.424B	S62.525B	S92.235B
S72.131N	S42.425B	S62.526B	S92.235S
S72.132K	S42.426B	S62.600B	S92.236B
S72.132M	S42.431B	S62.603B	S92.236S
S72.132N	S42.432B	S62.604B	S92.241B
S72.133K	S42.433B	S62.605B	S92.241S
S72.133M	S42.434B	S62.606B	S92.242B
S72.133N	S42.435B	S62.607B	S92.242S
S72.134K	S42.436B	S62.608B	S92.243B
S72.134M	S42.451B	S62.609B	S92.243S
S72.134N	S42.451S	S62.630B	S92.244B
S72.135K	S42.452B	S62.631B	S92.244S
S72.135M	S42.452S	S62.632B	S92.245B
S72.135N	S42.453B	S62.633B	S92.245S
S72.136K	S42.453S	S62.634B	S92.246B
S72.136M	S42.454B	S62.635B	S92.246S
S72.136N	S42.455B	S62.636B	S92.301B
S72.141K	S42.456B	S62.637B	S92.302B
S72.141M	S42.441B	S62.638B	S92.309B
S72.141N	S42.442B	S62.639B	S92.309S
S72.142K	S42.442S	S62.660B	S92.311B
S72.142M	S42.443B	S62.661B	S92.311S

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S72.142N	S42.443S	S62.662B	S92.312B
S72.143K	S42.444B	S62.663B	S92.312S
S72.143M	S42.444S	S62.664B	S92.313B
S72.143N	S42.445B	S62.665B	S92.313S
S72.144K	S42.445S	S62.666B	S92.314B
S72.144M	S42.446B	S62.667B	S92.314S
S72.144N	S42.446S	S62.668B	S92.315B
S72.145K	S42.447B	S62.669B	S92.315S
S72.145M	S42.448B	S62.501B	S92.316B
S72.145N	S42.449B	S62.502B	S92.321B
S72.146K	S42.461B	S62.509B	S92.322B
S72.146M	S42.461S	S62.600B	S92.323B
S72.146N	S42.462B	S62.601B	S92.324B
S72.21xK	S42.462S	S62.602B	S92.325B
S72.21xM	S42.463B	S62.603B	S92.326B
S72.21xN	S42.463S	S62.604B	S92.331B
S72.22xK	S42.464B	S62.605B	S92.332B
S72.22xM	S42.464S	S62.606B	S92.333B
S72.22xN	S42.465B	S62.608B	S92.334B
S72.23xK	S42.465S	S62.609B	S92.335B
S72.23xM	S42.466B	S62.90xB	S92.336B
S72.23xN	S42.466S	S62.91xB	S92.341B
S72.24xK	S42.401B	S62.92xB	S92.342B
S72.24xM	S42.402B	S72.001A	S92.343B
S72.24xN	S42.409B	S72.002A	S92.344B
S72.25xK	S42.471B	S72.009A	S92.345B
S72.25xM	S42.471S	S72.011A	S92.346B
S72.25xN	S42.472B	S72.012A	S92.351B
S72.26xK	S42.472S	S72.019A	S92.352B
S72.26xM	S42.473B	S72.001A	S92.353B
S72.26xN	S42.473S	S72.002A	S92.354B
S72.301K	S42.474B	S72.009A	S92.355B
S72.301M	S42.474S	S72.021A	S92.356B
S72.301N	S42.475B	S72.022A	S92.201B
S72.302K	S42.475S	S72.023A	S92.202B
S72.302M	S42.476B	S72.024A	S92.209B
S72.302N	S42.491B	S72.025A	S92.301B
S72.309K	S42.492B	S72.026A	S92.301D
S72.309M	S42.493B	S79.001A	S92.301G
S72.309N	S42.494B	S79.002A	S92.301K
S72.321K	S42.495B	S79.009A	S92.301P
S72.321M	S42.496B	S79.011A	S92.301S
S72.321N	S49.191S	S79.012A	S92.302B
S72.322K	S42.401B	S79.019A	S92.302S
S72.322M	S42.402B	S79.091A	S92.309B
S72.322N	S42.409B	S79.092A	S92.309D
S52.516M	S42.491B	S79.099A	S92.309G
S72.323K	S42.492B	S72.001A	S92.311B
S72.323M	S42.492S	S72.002A	S92.312B
S72.323N	S42.493B	S72.009A	S92.313B
S72.324K	S42.493S	S72.031A	S92.314B
S72.324M	S42.494B	S72.032A	S92.315B

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S72.324N	S42.494S	S72.033A	S92.316B
S72.325K	S42.495B	S72.034A	S92.321B
S72.325M	S42.495S	S72.035A	S92.322B
S72.325N	S42.496B	S72.036A	S92.323B
S72.326K	S42.496S	S72.041A	S92.324B
S72.326M	S52.90xA	S72.042A	S92.325B
S72.326N	S52.021A	S72.043A	S92.326B
S72.331K	S52.022A	S72.044A	S92.331B
S72.331M	S52.023A	S72.045A	S92.332B
S72.331N	S52.024A	S72.046A	S92.333B
S72.332K	S52.025A	S72.001A	S92.334B
S72.332M	S52.026A	S72.002A	S92.335B
S72.332N	S52.031A	S72.009A	S92.336B
S72.333K	S52.032A	S72.051A	S92.341B
S72.333M	S52.033A	S72.052A	S92.342B
S72.333N	S52.034A	S72.059A	S92.343B
S72.334K	S52.035A	S72.061A	S92.344B
S72.334M	S52.036A	S72.062A	S92.345B
S72.334N	S52.001A	S72.063A	S92.346B
S72.335K	S52.002A	S72.064A	S92.351B
S72.335M	S52.009A	S72.065A	S92.352B
S72.335N	S52.011A	S72.066A	S92.353B
S72.336K	S52.012A	S72.091A	S92.354B
S72.336M	S52.019A	S72.092A	S92.355B
S72.336N	S52.041A	S72.099A	S92.356B
S72.341K	S52.042A	S72.011B	S92.401A
S72.341M	S52.043A	S72.011C	S92.402A
S72.341N	S52.044A	S72.012B	S92.403A
S72.342K	S52.045A	S72.012C	S92.404A
S72.342M	S52.046A	S72.019B	S92.405A
S72.342N	S52.091A	S72.019C	S92.406A
S72.343K	S52.092A	S72.021B	S92.411A
S72.343M	S52.099A	S72.021C	S92.412A
S72.343N	S52.271A	S72.022B	S92.413A
S72.344K	S52.272A	S72.022C	S92.414A
S72.344M	S52.279A	S72.023B	S92.415A
S72.344N	S52.001A	S72.023C	S92.416A
S72.345K	S52.002A	S72.024B	S92.421A
S72.345M	S52.009A	S72.024C	S92.422A
S72.345N	S52.091A	S72.025B	S92.423A
S72.346K	S52.092A	S72.025C	S92.424A
S72.346M	S52.099A	S72.026B	S92.425A
S72.346N	S52.121A	S72.026C	S92.426A
S72.351K	S52.122A	S72.031B	S92.491A
S72.351M	S52.123A	S72.031C	S92.492A
S72.351N	S52.124A	S72.032B	S92.499A
S72.352K	S52.125A	S72.032C	S92.501A
S72.352M	S52.126A	S72.033B	S92.502A
S72.352N	S52.181A	S72.033C	S92.503A
S72.353K	S52.131A	S72.034B	S92.504A
S72.353M	S52.132A	S72.034C	S92.505A
S72.353N	S52.133A	S72.035B	S92.506A

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S72.354K	S52.134A	S72.035C	S92.511A
S72.354M	S52.135A	S72.036B	S92.512A
S72.354N	S52.136A	S72.036C	S92.513A
S72.355K	S52.101A	S72.041B	S92.514A
S72.355M	S52.102A	S72.041C	S92.515A
S72.355N	S52.109A	S72.041E	S92.516A
S72.356K	S52.181A	S72.041F	S92.521A
S72.356M	S52.182A	S72.041H	S92.522A
S72.356N	S52.189A	S72.041J	S92.523A
S72.361K	S59.101A	S72.041M	S92.524A
S72.361M	S59.102A	S72.041N	S92.525A
S72.361N	S59.109A	S72.041Q	S92.526A
S72.362K	S59.111A	S72.041R	S92.531A
S72.362M	S59.112A	S72.041S	S92.532A
S72.362N	S59.119A	S72.042B	S92.533A
S72.363K	S59.121A	S72.042C	S92.534A
S72.363M	S59.122A	S72.042E	S92.535A
S72.363N	S59.129A	S72.042F	S92.536A
S72.364K	S59.131A	S72.042H	S92.591A
S72.364M	S59.132A	S72.042J	S92.592A
S72.364N	S59.139A	S72.042M	S92.599A
S72.365K	S59.141A	S72.042N	S92.911A
S72.365M	S59.142A	S72.042Q	S92.912A
S72.365N	S59.149A	S72.042R	S92.919A
S72.366K	S59.191A	S72.042S	S92.401B
S72.366M	S59.192A	S72.043B	S92.402B
S72.366N	S59.199A	S72.043C	S92.403B
S72.391K	S52.109A	S72.043E	S92.404B
S72.391M	S52.009A	S72.043F	S92.405B
S72.391N	S52.90xB	S72.043H	S92.406B
S72.392K	S52.90xC	S72.043J	S92.411B
S72.392M	S52.90xE	S72.043M	S92.412B
S72.392N	S52.90xF	S72.043N	S92.413B
S72.399K	S52.90xH	S72.043Q	S92.414B
S72.399M	S52.90xJ	S72.043S	S92.415B
S72.399N	S52.90xM	S72.044B	S92.416B
S72.401K	S52.90xN	S72.044C	S92.421B
S72.401M	S52.90xQ	S72.044M	S92.422B
S72.401N	S52.90xR	S72.044N	S92.423B
S72.402K	S52.90xS	S72.044S	S92.424B
S72.402M	S52.91xB	S72.045B	S92.425B
S72.402N	S52.91xC	S72.045C	S92.426B
S72.409K	S52.91xE	S72.045M	S92.491B
S72.409M	S52.91xF	S72.045N	S92.492B
S72.409N	S52.91xH	S72.045S	S92.499B
S72.411K	S52.91xJ	S72.046B	S92.501B
S72.411M	S52.91xM	S72.046C	S92.502B
S72.411N	S52.91xN	S72.046M	S92.503B
S72.412K	S52.91xQ	S72.046N	S92.504B
S72.412M	S52.91xR	S72.046S	S92.505B
S72.412N	S52.91xS	S72.001B	S92.506B
S72.413K	S52.92xB	S72.001C	S92.511B

			S92.512B S92.513B S92.514B S92.515B S92.516B S92.521B S92.522B S92.523B S92.524B S92.525B S92.526B S92.531B S92.532B S92.533B S92.534B S92.535B S92.536B S92.591B S92.592B S92.599B S92.911B S92.912B S92.919B

ICD-10-CM Code(s)			
Blood Glucose Monitor and Related Supplies and External Insulin Pump			
E10.10	E11.00	E13.00	E13.8
E10.11	E11.01	E13.01	E13.9
E10.21	E11.21	E13.10	E74.00
E10.22	E11.22	E13.11	E74.01
E10.29	E11.29	E13.21	E74.02
E10.311	E11.311	E13.22	E74.03
E10.319	E11.319	E13.29	E74.04
E10.321	E11.321	E13.311	E74.09
E10.329	E11.329	E13.319	O24.410
E10.331	E11.331	E13.321	O24.414
E10.339	E11.339	E13.329	O24.419
E10.341	E11.341	E13.331	O24.911
E10.349	E11.349	E13.339	O24.912
E10.351	E11.351	E13.341	O24.913
E10.359	E11.359	E13.349	O24.919
E10.36	E11.36	E13.351	O99.810
E10.39	E11.39	E13.359	
E10.40	E11.40	E13.36	
E10.41	E11.41	E13.39	
E10.42	E11.42	E13.40	
E10.43	E11.43	E13.41	
E10.44	E11.44	E13.42	
E10.49	E11.49	E13.43	
E10.51	E11.51	E13.44	
E10.52	E11.52	E13.49	

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E10.59	E11.59	E13.51	
E10.610	E11.610	E13.52	
E10.618	E11.618	E13.59	
E10.620	E11.620	E13.610	
E10.621	E11.621	E13.618	
E10.622	E11.622	E13.620	
E10.628	E11.628	E13.621	
E10.630	E11.630	E13.622	
E10.638	E11.638	E13.628	
E10.641	E11.641	E13.630	
E10.649	E11.649	E13.638	
E10.65	E11.65	E13.641	
E10.69	E11.69	E13.649	
E10.8	E11.8	E13.65	
E10.9	E11.9	E13.69	

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

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

C. 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.

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Refer to the **Durable Medical Equipment Fee Schedule** and the **Orthotic and Prosthetic Devices Fee Schedule** for a list of equipment, supplies, and services covered by Medicaid and NCHC. The fee schedules are available on DMA's website: http://dma.ncdhhs.gov/.

Lifetime Expectancies and Quantity Limitations for Durable Medical Equipment and Supplies

HCPCS Code	Item Description	Lifetime Expectancy or Quantity Limitation
	Hospital Beds and Related Supplies	
E0250	Hospital bed, fixed height, with any type side rails, with mattress	5 years
E0255	Hospital bed, variable height, hi-lo, with any type side rails, with mattress	5 years
E0260	Hospital bed, semi-electric (head and foot adjustment), with any type side rails, with mattress	5 years
E0265	Hospital bed, total electric (head, foot and height adjustments), with any type side rails, with mattress	5 years
E0303	Hospital bed, heavy duty, extra wide, with weight capacity greater than 350 lbs, but less than or equal to 600 lbs, with any type side rails, with mattress	5 years
E0304	Hospital bed, extra heavy duty, extra wide, with weight capacity greater than 600 lbs, with any type side rails, with mattress	5 years
E0271	Mattress, innerspring	3 years
E0272	Mattress, foam rubber	3 years
E0305	Bed side rails, half length	3 years
E0310	Bed side rails, full length	3 years
E0840	Traction frame, attached to headboard, cervical traction	3 years
E0890	Traction frame, attached to footboard, pelvic traction	3 years
E0910	Trapeze bars, A/K/A patient helper, attached to bed, with grab bar	3 years
E0911	Trapeze bar, heavy duty, for patient weight capacity greater than 250 pounds, attached to bed, complete with grab bar	3 years
E0912	Trapeze bar, heavy duty, for patient weight capacity greater than 250 pounds, free standing, complete with grab bar	3 years
E0940	Trapeze bar, free standing, complete with grab bar	3 years
E0276	Bed pan, fracture, metal or plastic	3 years
E0280	Bed cradle, any type	3 years
E0325	Urinal; male, jug-type, any material	6 per year
E0326	Urinal; female, jug-type, any material	6 per year
	Pediatric Beds and Cribs	
E0300	Pediatric crib, hospital grade, fully enclosed	0-20 years only: 5 years
E0316	Safety enclosure frame/canopy for use with hospital bed, any type	0-20 years only: 5 years
E0328	Hospital bed, pediatric, manual, 360 degree side enclosures, top of headboard, footboard and side rails up to 24 inches above spring, includes mattress	0-20 years only: 5 years
E0329	Hospital bed, pediatric, electric or semi-electric, 360 degree side enclosures, top of headboard, footboard and side rails up to 24 inches above spring, includes mattress	0-20 years only: 5 years
W4047	Miscellaneous for pediatric DME	0-20 years only

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HCPCS Code	Item Description	Lifetime Expectancy or Quantity Limitation
	Pressure Reducing Support Surfaces – Group I	
A4640	Replacement pad for use with medically necessary alternating pressure pad owned by patient	2 Years
E0181	Powered pressure reducing mattress overlay/pad, alternating, with pump, includes heavy duty	3 years
E0182	Pump for alternating pressure pad, for replacement only	3 years
E0184	Dry pressure mattress	3 years
E0185	Gel or gel-like pressure pad for mattress, standard mattress length and width	3 years
E0186	Air pressure mattress	3 years
E0187	Water pressure mattress	3 years
E0196	Gel pressure mattress	3 years
E0197	Air pressure pad for mattress, standard mattress length and width	3 years
E0198	Water pressure pad for mattress, standard mattress length and width	3 years
E0199	Dry pressure pad for mattress, standard mattress length and width	3 years
	Pressure Reducing Support Surfaces – Group 2	
E0193	Powered air flotation bed (low air loss therapy)	5 years
E0277	Powered pressure-reducing air mattress	5 years
E0371	Non powered advanced pressure reducing overlay for mattress, standard mattress length and width	5 years
E0372	Powered air overlay for mattress, standard mattress length and width	5 years
E0373	Non powered advanced pressure reducing mattress	5 years
	Pressure Reducing Support Surfaces – Group 3	
E0194	Air fluidized bed	N/A (Rental only)
	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
	Manual Wheelchairs	
K0001	Standard wheelchair	3 years
K0002	Standard hemi (low seat) wheelchair	3 years
K0003	Lightweight wheelchair	3 years
K0004	High strength, lightweight wheelchair	3 years
K0005	Ultra lightweight wheelchair	3 years
K0006	Heavy duty wheelchair	3 years
K0007	Extra heavy duty wheelchair	3 years
E1161	Manual adult size wheelchair, includes tilt in space	3 years
	Transport Chairs	
E1031	Rollabout chair, any and all types with castors 5” or greater	2 years
E1037	Transport chair, pediatric size	4 years
E1038	Transport chair, adult size, patient weight capacity up to and including 300 pounds	4 years

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HCPCS Code	Item Description	Lifetime Expectancy or Quantity Limitation
E1039	Transport chair, adult size, heavy duty, patient weight capacity greater than 300 pounds	4 years

HCPCS Code	Item Description	Lifetime Expectancy or Quantity Limitation
	Pediatric Manual Wheelchairs	
E1229	Wheelchair, pediatric size, not otherwise specified	3 years
E1231	Wheelchair, pediatric size, tilt-in-space, rigid, adjustable, with seating system	3 years
E1232	Wheelchair, pediatric size, tilt-in-space, folding, adjustable, with seating system	3 years
E1233	Wheelchair, pediatric size, tilt-in-space, rigid, adjustable, without seating system	3 years
E1234	Wheelchair, pediatric size, tilt-in-space, folding, adjustable, without seating system	3 years
E1235	Wheelchair, pediatric size, rigid, adjustable, with seating system	3 years
E1236	Wheelchair, pediatric size, folding, adjustable, with seating system	3 years
E1237	Wheelchair, pediatric size, rigid, adjustable, without seating system	3 years
E1238	Wheelchair, pediatric size, folding, adjustable, without seating system	3 years
	Power Wheelchairs - Standard	
K0813	Power wheelchair, group 1 standard, portable, sling/solid seat and back, patient weight capacity up to and including 300 pounds	4 years
K0814	Power wheelchair, group 1 standard, portable, captains chair, patient weight capacity up to and including 300 pounds	4 years
K0815	Power wheelchair, group 1 standard, sling/solid seat and back, patient weight capacity up to and including 300 pounds	4 years
K0816	Power wheelchair, group 1 standard, captains chair, patient weight capacity up to and including 300 pounds	4 years
K0820	Power wheelchair, group 2 standard, portable, sling/solid seat/back, patient weight capacity up to and including 300 pounds	4 years
K0821	Power wheelchair, group 2 standard, portable, captains chair, patient weight capacity up to and including 300 pounds	4 years
K0822	Power wheelchair, group 2 standard, sling/solid seat/back, patient weight capacity up to and including 300 pounds	4 years
K0823	Power wheelchair, group 2 standard, captains chair, patient weight capacity up to and including 300 pounds	4 years
K0830	Power wheelchair, group 2 standard, seat elevator, sling/solid seat/back, patient weight capacity up to and including 300 pounds	4 years
K0831	Power wheelchair, group 2 standard, seat elevator, captains chair, patient weight capacity up to and including 300 pounds	4 years
	Power Wheelchairs – Complex Rehab	
E1239	Power wheelchair, pediatric size, not otherwise specified	4 years
K0835	Power wheelchair, group 2 standard, single power option, sling/solid seat back, patient weight capacity up to and including 300 pounds	4 years
K0836	Power wheelchair, group 2 standard, single power option, captains chair, patient weight capacity up to and including 300 pounds	4 years
K0841	Power wheelchair, group 2 standard, multiple power option, sling/solid seat/back, patient weight capacity up to and including 300 pounds	4 years

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HCPCS Code	Item Description	Lifetime Expectancy or Quantity Limitation
K0842	Power wheelchair, group 2 standard, multiple power option, captains chair, patient weight capacity up to and including 300 pounds	4 years
K0848	Power wheelchair, group 3 standard, sling/solid seat/back, patient weight capacity up to and including 300 pounds	4 years
K0849	Power wheelchair, group 3 standard, captains chair, patient weight capacity up to and including 300 pounds	4 years
K0856	Power wheelchair, group 3 standard, single power option, sling/solid seat/back, patient weight capacity up to and including 300 pounds	4 years
K0857	Power wheelchair, group 3 standard, single power option, captains chair, patient weight capacity up to and including 300 pounds	4 years
K0861	Power wheelchair, group 3 standard, multiple power option, sling/solid seat/back, patient weight capacity up to and including 300 pounds	4 years
K0868	Power wheelchair, group 4 standard, sling/solid seat/back, patient weight capacity up to and including 300 pounds	4 years
K0869	Power wheelchair, group 4 standard, captains chair, patient weight capacity up to and including 300 pounds	4 years
K0877	Power wheelchair, group 4 standard, single power option, sling/solid seat back, patient weight capacity up to and including 300 pounds	4 years
K0878	Power wheelchair, group 4 standard, single power option, captains chair, patient weight capacity up to and including 300 pounds	4 years
K0884	Power wheelchair, group 4 standard, multiple power option, sling/solid seat/back, patient weight capacity up to and including 300 pounds	4 years
K0885	Power wheelchair, group 4 standard, multiple power option, captains chair, patient weight capacity up to and including 300 pounds	4 years
K0890	Power wheelchair, group 5 pediatric, single power option, sling/solid seat/back, patient weight capacity up to and including 125 pounds	4 years
K0891	Power wheelchair, group 5 pediatric, multiple power option, sling/solid seat/back, patient weight capacity up to and including 125 pounds	4 years
	Power Wheelchairs – Heavy Duty	
K0824	Power wheelchair, group 2 heavy duty, sling/solid seat/back, patient weight capacity 301 to 450 pounds	4 years
K0825	Power wheelchair, group 2 heavy duty, captains chair, patient weight capacity 301 to 450 pounds	4 years
K0826	Power wheelchair, group 2 very heavy duty, sling/solid seat/back, patient weight capacity 451 to 600 pounds	4 years
K0827	Power wheelchair, group 2 very heavy duty, captains chair, patient weight capacity 451 to 600 pounds	4 years
K0828	Power wheelchair, group 2 extra heavy duty, sling/solid seat/back, patient weight capacity 601 pounds or more	4 years
K0829	Power wheelchair, group 2 extra heavy duty, captains chair, patient weight 601 pounds or more	4 years
K0837	Power wheelchair, group 2 heavy duty, single power option, sling/solid seat/back, patient weight capacity 301 to 450 pounds	4 years
K0838	Power wheelchair, group 2 heavy duty, single power option, captains chair, patient weight capacity 301 to 450 pounds	4 years
K0839	Power wheelchair, group 2 very heavy duty, single power option, sling/solid seat/back, patient weight capacity 451 to 600 pounds	4 years
K0840	Power wheelchair, group 2 extra heavy duty, single power option, sling/solid seat/back, patient weight capacity 601 pounds or more	4 years
K0843	Power wheelchair, group 2 heavy duty, multiple power options, sling/solid seat/back, patient weight capacity 301 to 450 pounds	4 years

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HCPCS Code	Item Description	Lifetime Expectancy or Quantity Limitation
K0850	Power wheelchair, group 3 heavy duty, sling/solid seat/back, patient weight capacity 301 to 450 pounds	4 years
K0851	Power wheelchair, group 3 heavy duty, captains chair, patient weight capacity 301 to 450 pounds	4 years
K0852	Power wheelchair, group 3 very heavy duty, sling/solid seat/back, patient weight capacity 451 to 600 pounds	4 years
K0853	Power wheelchair, group 3 very heavy duty, captains chair, patient weight capacity 451 to 600 pounds	4 years
K0854	Power wheelchair, group 3 extra heavy duty, sling/solid seat/back, patient weight capacity 601 pounds or more	4 years
K0855	Power wheelchair, group 3 extra heavy duty, captains chair, patient weight capacity 601 pounds or more	4 years
K0858	Power wheelchair, group 3 heavy duty, single power option, sling/solid seat/back, patient weight 301 to 450 pounds	4 years
K0859	Power wheelchair, group 3 heavy duty, single power option, captains chair, patient weight capacity 301 to 450 pounds	4 years
K0860	Power wheelchair, group 3 very heavy duty, single power option, sling/solid seat/back, patient weight capacity 451 to 600 pounds	4 years
K0862	Power wheelchair, group 3 heavy duty, multiple power option, sling/solid seat/back, patient weight capacity 301 to 450 pounds	4 years
K0863	Power wheelchair, group 3 very heavy duty, multiple power option, sling/solid seat/back, patient weight capacity 451 to 600 pounds	4 years
K0864	Power wheelchair, group 3 extra heavy duty, multiple power option, sling/solid seat/back, patient weight capacity 601 pounds or more	4 years
K0870	Power wheelchair, group 4 heavy duty, sling/solid seat/back, patient weight capacity 301 to 450 pounds	4 years
K0871	Power wheelchair, group 4 very heavy duty, sling/solid seat/back, patient weight capacity 451 to 600 pounds	4 years
K0879	Power wheelchair, group 4 heavy duty, single power option, sling/solid seat/back, patient weight capacity 301 to 450 pounds	4 years
K0880	Power wheelchair, group 4 very heavy duty, single power option, sling/solid seat/back, patient weight 451 to 600 pounds	4 years
K0886	Power wheelchair, group 4 heavy duty, multiple power option, sling/solid seat/back, patient weight capacity 301 to 450 pounds	4 years
	Wheelchair Accessories - Batteries	
E2358	Power wheelchair accessory, group 34, non-sealed lead acid battery, each	2 per year
E2359	Power wheelchair accessory, group 34, sealed lead acid battery each, e.g. gel-cell, absorbed glass mat	2 per year
E2360	Power wheelchair accessory, 22 NF non-sealed lead acid battery, each	2 per year
E2361	Power wheelchair accessory, 22 NF sealed lead acid battery, each, (e.g. gel cell, absorbed glass mat)	2 per year
E2362	Power wheelchair accessory, group 24 non-sealed lead acid battery, each	2 per year
E2363	Power wheelchair accessory, group 24 sealed lead acid battery, each (e.g. gel cell, absorbed glass mat)	2 per year
E2364	Power wheelchair accessory, U-1 non-sealed lead acid battery, each	2 per year
E2365	Power wheelchair accessory, U-1 sealed lead acid battery, each (e.g. gel cell, absorbed glass mat)	2 per year
E2366	Power wheelchair accessory, battery charger, single mode, for use with only one battery type, sealed or non-sealed, each	1 year ages 0-20; 2 years 21 and over
E2367	Power wheelchair accessory, battery charger, dual mode, for use with either battery type, sealed or non-sealed, each	1 year ages 0-20; 2 years 21 and over
E2371	Power wheelchair accessory, group 27 sealed lead acid battery, (e.g., gel cell, absorbed glass mat), each	2/yr

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HCPCS Code	Item Description	Lifetime Expectancy or Quantity Limitation
E2372	Power wheelchair accessory, group 27 non-sealed lead acid battery, each	2/yr
K0733	Power wheelchair accessory, 12 to 24 amp hour sealed lead acid battery, each (e.g., gel cell, absorbed glass mat)	2/yr
	Wheelchair Accessories – Armrests	
E0973	Wheelchair accessory, adjustable height, detachable armrest, complete assembly, each	2/year ages 0-20; 2/3 yrs 21 and over
E2209	Accessory arm trough, with or without hand support, each	2/year ages 0-20; 2/3 yrs 21 and over
K0015	Detachable, non-adjustable height armrest, each	2/year ages 0-20; 2/3 yrs 21 and over
K0017	Detachable, adjustable height armrest, base, each	2/year ages 0-20; 2/3 yrs 21 and over
K0018	Detachable, adjustable height armrest, upper portion, each	2/year ages 0-20; 2/3 yrs 21 and over
K0019	Arm pad, each	2 per/2 years
K0020	Fixed, adjustable height armrest, pair	2 per/1 yr 0-20 1 per/3yrs 21-115
	Wheelchair Accessories – Cushions	
E2601	General use wheelchair seat cushion, width less than 22 inches, any depth	2 years ages 0-20; 3 years 21 and over
E2602	General use wheelchair seat cushion, width 22 inches or greater, any depth	2 years ages 0-20; 3 years 21 and over
E2603	Skin protection wheelchair seat cushion, width less than 22 inches, any depth	3 years
E2604	Skin protection wheelchair seat cushion, width 22 inches or greater, any depth	3 years
E2605	Positioning wheelchair seat cushion, width less than 22 inches, any depth	3 years
E2606	Positioning wheelchair seat cushion, width 22 inches or greater, any depth	3 years
E2607	Skin protection and positioning wheelchair seat cushion, width less than 22 inches, any depth	3 years
E2608	Skin protection and positioning wheelchair seat cushion, width 22 inches or greater, any depth	3 years
E2609	Custom fabricated wheelchair seat cushion, any size	3 years
E2611	General use wheelchair back cushion, width less than 22 inches, any height, including any type mounting hardware	3 years
E2612	General use wheelchair back cushion, width 22 inches or greater, any height, including any type mounting hardware	3 years
E2613	Positioning wheelchair back cushion, posterior, width less than 22 inches, any height, including any type mounting hardware	3 years
E2614	Positioning wheelchair back cushion, posterior, width 22 inches or greater, any height, including any type mounting hardware	3 years
E2615	Positioning wheelchair back cushion, posterior-lateral, width less than 22 inches, any height, including any type mounting hardware	3 years
E2616	Positioning wheelchair back cushion, posterior-lateral, width 22 inches or greater, any height, including any type mounting hardware	3 years
E2617	Custom fabricated wheelchair back cushion, any size, including any type mounting hardware	3 years
E2620	Positioning wheelchair back cushion, planar back with lateral supports, width less than 22 inches, any height, including any type mounting hardware	2 years ages 0-20; 3 years 21 and over

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HCPCS Code	Item Description	Lifetime Expectancy or Quantity Limitation
E2621	Positioning wheelchair back cushion, planar back with lateral supports, width 22 inches or greater, any height, including any type mounting hardware	2 years ages 0-20; 3 years 21 and over
E2622	Skin protection wheelchair seat cushion, adjustable width less than 22 inches, any depth	3 years
E2623	Skin protection wheelchair seat cushion, adjustable, width 22 inches or greater, any depth	3 years
E2624	Skin protection and positioning wheelchair seat cushion, adjustable, width less than 22 inches, any depth	3 years
E2625	Skin protection and positioning wheelchair seat cushion, adjustable, width 22 inches or greater, any depth	3 years
E2626	Wheelchair accessory, shoulder elbow, mobile arm support attached to wheelchair, balanced, adjustable	1 every 6mo ages 0-20 1 per 3 yrs 21-115
E2627	Wheelchair accessory, shoulder elbow, mobile arm support attached to wheelchair, balanced, adjustable Rancho type	1 every 6mo ages 0-20 1 per 3 yrs 21-115
E2628	Wheelchair accessory, shoulder elbow, mobile arm support attached to wheelchair, balanced, reclining	1 every 6mo ages 0-20 1 per 3 yrs 21-115
E2629	Wheelchair accessory, shoulder elbow, mobile arm support attached to wheelchair, balanced, friction arm support (friction dampening to proximal and distal joints)	1 every 6mo ages 0-20 1 per 3 yrs 21-115
E2630	Wheelchair accessory, shoulder elbow, mobile arm support, monosuspension arm and hand support, overhead elbow forearm hand sling support, yoke type suspension support	1 every 6mo ages 0-20 1 per 3 yrs 21-115
E2631	Wheelchair accessory, addition to mobile arm support, elevating proximal arm	1 every 6mo ages 0-20 1 per 3 yrs 21-115
E2632	Wheelchair accessory, addition to mobile arm support, offset or lateral rocker arm with elastic balance control	1 every 6mo ages 0-20 1 per 3 yrs 21-115
E2633	Wheelchair accessory, addition to mobile arm support, supinator	1 every 6mo ages 0-20 1 per 3 yrs 21-115
	Wheelchair Accessories – Headrests	
E0966	Manual wheelchair accessory, headrest extension, each	1 year ages 0-20; 2 years 21 and over
W4130	Contoured or 3-piece head/neck supports with hardware	1 years ages 0-20; 3 years 21 and over
W4131	Basic head/neck support with hardware	1 years ages 0-20; 3 years 21 and over
W4132	Contoured or 3-piece head/neck support with multi-adjustable hardware	1 years ages 0-20; 3 years 21 and over
W4133	Basic head/neck support with multi-adjustable hardware	1 years ages 0-20; 3 years 21 and over
	Wheelchair Accessories – Reclining Back	
E1226	Wheelchair accessory, manual fully reclining back, (recline greater than 80 degrees), each	1 year ages 0-20; 3 years 21 and over
	Wheelchair Accessories – Leg Rest	
E0990	Wheelchair accessory, elevating leg rest, complete assembly, each	1 year ages 0-20; 3 years 21 and over
K0046	Elevating legrest, lower extension tube, each	1 yr ages 0-20 3 yrs ages 21-115
K0047	Elevating legrest, upper hanger bracket, each	1 yr ages 0-20 3 yrs ages 21-115

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HCPCS Code	Item Description	Lifetime Expectancy or Quantity Limitation
K0195	Elevating leg rests, pair (for use with capped rental wheelchair base)	1 yr ages 0-20 3 yrs ages 21-115
	Wheelchair Accessories – Foot Rest/Shoe Holder	
E0951	Heel loop/holder, any type, with or without ankle strap, each	1/ yr ages 0-20 2 years ages 21-115
E0952	Toe loop/holder, any type, each	2 years
E0995	Wheelchair accessory, calf rest/pad, each	2 years
K0037	High mount flip-up footrest, each	1/yr ages 0-20 3 years ages 21-115
K0038	Leg strap, each	1/yr ages 0-20 2 years ages 21-115
K0039	Leg strap, H style, each	1/yr ages 0-20 2 years ages 21-115
K0040	Adjustable angle footplate, each	2 years ages 00-20; 3 years 21 and over
K0041	Large size footplate, each	3 years
K0042	Standard size footplate, each	3 years
K0043	Footrest, lower extension tube, each	3 years
K0044	Footrest, upper hanger bracket, each	3 years
K0045	Footrest, complete assembly	1/ year ages 0-20; 3 years 21 and over
K0050	Ratchet assembly	1/yr ages 0-20 3 years ages 21-115
K0051	Cam release assembly, footrest or legrest, each	1/yr ages 0-20 3 years ages 21-115
K0052	Swing-away, detachable footrests, each	1/yr ages 0-20 3 years ages 21-115
K0053	Elevating footrests, articulating (telescoping), each	1/yr ages 0-20 3 years ages 21-115
W4143	Shoe holders with hardware	1 /yr ages 0-20 2 years ages 21-115
W4144	Foot/legrest cradle	1 /yr ages 0-20 2 years ages 21-115
	Wheelchair Accessories – Seat/Back	
K0056	Seat height less than 17" or equal to or greater than 21" for a high strength, lightweight or ultralightweight wheelchair	1/yr ages 0-20 3 years ages 21-115
E0981	Wheelchair accessory, seat upholstery, replacement only, each	2 years
E0982	Wheelchair accessory, back upholstery, replacement only, each	2 years
E0992	Manual wheelchair accessory, solid seat insert	1 year ages 0-20; 3 years 21 and over
E2201	Manual wheelchair accessory, nonstandard seat frame, width greater than or equal to 20 inches and less than 24 inches	3 years
E2202	Manual wheelchair accessory, nonstandard seat frame width, 24-27 inches	3 years
E2203	Manual wheelchair accessory, nonstandard seat frame depth, 20 to less than 22 inches	3 years
E2204	Manual wheelchair accessory, nonstandard seat frame depth, 22 to 25 inches	3 years
E2231	Manual wheelchair accessory, solid seat support base (replaces sling seat), includes any type mounting hardware	2 year ages 0-20, 3 years 21 and over
E2291	Back, planar, for pediatric size wheelchair including fixed attaching hardware	0-20 years only; 2 years

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HCPCS Code	Item Description	Lifetime Expectancy or Quantity Limitation
E2292	Seat, planar, for pediatric size wheelchair including fixed attaching hardware	0-20 years only; 2 years
E2293	Back, contoured, for pediatric size wheelchair including fixed attaching hardware	0-20 years only; 2 years
E2294	Seat, contoured, for pediatric size wheelchair including fixed attaching hardware	0-20 years only; 2 years
E2295	Manual wheelchair accessory, for pediatric size wheelchair, dynamic seating frame, allows coordinated movement of multiple positioning features	0-20 years only; 2 years
E2340	Power wheelchair accessory, non standard seat frame width, 20-23 inches	4 years
E2341	Power wheelchair accessory, nonstandard seat frame width, 24-27 inches	4 years
E2342	Power wheelchair accessory, nonstandard seat frame depth, 20 or 21 inches	4 years
E2343	Power wheelchair accessory, nonstandard seat frame depth, 22-25 inches	4 years
W4119	Wheelchair seat height, optional	3 years
W4152	Growth kit	1 yr ages 0-20 2 years ages 21-115
	W/C Accessories – Trunk/Extremity Support	
E0956	Wheelchair accessory, lateral trunk or hip support, any type, including fixed mounting hardware, each	2 years ages 0-20; 3 years 21 and over
E0957	Wheelchair accessory, medial thigh support, any type, including fixed mounting hardware, each	2 years ages 0-20; 3 years 21 and over
E0960	Wheelchair accessory, shoulder harness/straps or chest strap, including any type mounting hardware	2 years ages 00-2; 3 years 21 and over
E0978	Wheelchair accessory, positioning belts/safety belt/pelvic strap, each	1 year ages 0-20; 3 years 21 and over
E0980	Safety vest, wheelchair	3 years
W4139	Sub-asis bars with hardware	1 years ages 0-20; 3 years 21 and over
W4140	Abductor pads with hardware, pair	1 years ages 0-20; 3 years 21 and over
W4141	Knee blocks with hardware	1 years ages 0-20; 3 years 21 and over
W4155	Adductor pads with hardware, pair	1 years ages 0-20; 3 years 21 and over
	Wheelchair Accessories – Oversized	
W4713	Oversized footplates for weights 301# and greater	3 years
W4714	Swingaway special construction footrests for weights 401# and greater	3 years
W4715	Swingaway reinforced legrest elevating, for weights 301# to 400#	3 years
W4716	Swingaway special construction legrest, elevation for weights 401# and greater	3 years
W4717	Oversized calf pads	2 years
W4718	Oversized solid seat	3 years
W4719	Oversized solid back	3 years
W4722	Oversized full support footboard	3 years
W4723	Oversized full support calfboard	3 years
	Wheelchair Accessories – Power Seating Systems	
E1002	Wheelchair accessory, power seating system, tilt only	5 years
E1003	Wheelchair accessory, power seating system, recline only, without shear reduction	5 years
E1004	Wheelchair accessory, power seating system, recline only, with mechanical shear reduction	5 years

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HCPCS Code	Item Description	Lifetime Expectancy or Quantity Limitation
E1005	Wheelchair accessory, power seating system, recline only, with power shear reduction	5 years
E1006	Wheelchair accessory, power seating system, combination tilt and recline, without shear reduction	5 years
E1007	Wheelchair accessory, power seating system, combination tilt and recline, with mechanical shear reduction	5 years
E1008	Wheelchair accessory, power seating system, combination tilt and recline, with power shear reduction	5 years
E2300	Power wheelchair accessory, power seat elevation system	0-20 years only; 3 years
	Wheelchair Accessories – Electronics	
E2310	Power wheelchair accessory, electronic connection between wheelchair controller and one power seating system motor, including all related electronics, indicator feature, mechanical function selection switch, and fixed mounting hardware	2 years ages 0-20; 4 years 21 and over
E2311	Power wheelchair accessory, electronic connection between wheelchair controller and two or more power seating system motors, including all related electronics, indicator feature, mechanical function selection switch, and fixed mounting hardware	2 years ages 0-20; 4 years 21 and over
E2312	Power wheelchair accessory, hand or chin control interface, mini-proportional remote joystick, proportional, including fixed mounting hardware	2 years ages 0-20; 4 years 21 and over
E2313	Power wheelchair accessory, harness for upgrade to expandable controller, including all fasteners, connectors and mounting hardware, each	2 years ages 0-20; 4 years 21 and over
E2321	Power wheelchair accessory, hand control interface, remote joystick, nonproportional, including all related electronics, mechanical stop switch, and fixed mounting hardware	2 years ages 0-20; 4 years 21 and over
E2322	Power wheelchair accessory, hand control interface, multiple mechanical switches, nonproportional, including all related electronics, mechanical stop switch, and fixed mounting hardware	2 years ages 0-20; 4 years 21 and over
E2323	Power wheelchair accessory, specialty joystick handle for hand control interface, prefabricated	2 years
E2324	Power wheelchair accessory, chin cup for chin control interface	2 years
E2325	Power wheelchair accessory, sip and puff interface, nonproportional, including all related electronics, mechanical stop switch, and manual swingaway mounting hardware	2 years ages 0-20; 4 years 21 and over
E2326	Power wheelchair accessory, breath tube kit for sip and puff interface	2 years
E2327	Power wheelchair accessory, head control interface, mechanical, proportional, including all related electronics, mechanical direction change switch, and fixed mounting hardware	2 years ages 0-20; 4 years 21 and over
E2328	Power wheelchair accessory, head control or extremity control interface, electronic, proportional, including all related electronics and fixed mounting hardware	2 years ages 0-20; 4 years 21 and over
E2329	Power wheelchair accessory, head control interface, contact switch mechanism, nonproportional, including all related electronics, mechanical stop switch, mechanical direction change switch, head array, and fixed mounting hardware	2 years ages 0-20; 4 years 21 and over
E2330	Power wheelchair accessory, head control interface, proximity switch mechanism, nonproportional, including all related electronics, mechanical stop switch, mechanical direction change switch, head array, and fixed mounting hardware	2 years ages 0-20; 4 years 21 and over
E2373	Power wheelchair accessory, hand or chin control interface, compact remote joystick, proportional, including fixed mounting hardware	2 years ages 0-20; 4 years 21 and over

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HCPCS Code	Item Description	Lifetime Expectancy or Quantity Limitation
E2374	Power wheelchair accessory, hand or chin control interface, standard remote joystick (not including controller), proportional, including all related electronics and fixed mounting hardware, replacement only	2 years ages 0-20; 4 years 21 and over
E2375	Power wheelchair accessory, non-expandable controller, including all related electronics and mounting hardware, replacement only	2 years ages 0-20; 4 years 21 and over
E2376	Power wheelchair accessory, expandable controller, including all related electronics and mounting hardware, replacement only	2 years ages 0-20; 4 years 21 and over
E2377	Power wheelchair accessory, expandable controller, including all related electronics and mounting hardware, upgrade provided at initial issue	2 years ages 0-20; 4 years 21 and over
	Wheelchair Accessories – Wheels, Tires, Casters	
E2205	Manual wheelchair accessory, handrim without projections (includes ergonomic or contoured), any type, replacement only, each	3 years
E2206	Manual wheelchair accessory, wheel lock assembly, complete, each	2 per 3 years
E2210	Wheelchair accessory, bearings, any type, replacement only, each	1 year
E2211	Manual wheelchair accessory, pneumatic propulsion tire, any size, each	1 year
E2212	Manual wheelchair accessory, tube for pneumatic propulsion tire, any size, each	1 year
E2213	Manual wheelchair accessory, insert for pneumatic propulsion tire (removable), any type, any size, each	1 year
E2214	Manual wheelchair accessory, pneumatic caster tire, any size, each	1 year
E2215	Manual wheelchair accessory, tube for pneumatic caster tire, any size, each	1 year
E2216	Manual wheelchair accessory, foam filled propulsion tire, any size, each	2 years
E2217	Manual wheelchair accessory, foam filled caster tire, any size, each	1 year
E2218	Manual wheelchair accessory, foam propulsion tire, any size, each	1 year
E2219	Manual wheelchair accessory, foam caster tire, any size, each	1 year
E2220	Manual wheelchair accessory, solid (rubber/plastic) propulsion tire, any size, each	1 year
E2221	Manual wheelchair accessory, solid (rubber/plastic) caster tire (removable), any size, each	1 year
E2222	Manual wheelchair accessory, solid (rubber/plastic) caster tire with integrated wheel, any size, each	1 year
E2224	Manual wheelchair accessory, propulsion wheel excludes tire, any size, each	1 year
E2225	Manual wheelchair accessory, caster wheel excludes tire, any size, replacement only, each	1 year
E2226	Manual wheelchair accessory, caster fork, any size, replacement only, each	1 year
E2228	Manual wheelchair accessory, wheel braking system and lock, complete, each	1 year
E2381	Power wheelchair accessory, pneumatic drive wheel tire, any size, replacement only, each	1 year
E2382	Power wheelchair accessory, tube for pneumatic drive wheel tire, any size, replacement only, each	1 year
E2383	Power wheelchair accessory, insert for pneumatic drive wheel tire (removable), any type, any size, replacement only, each	1 year
E2384	Power wheelchair accessory, pneumatic caster tire, any size, replacement only, each	1 year
E2385	Power wheelchair accessory, tube for pneumatic caster tire, any size, replacement only, each	1 year
E2386	Power wheelchair accessory, foam filled drive wheel tire, any size, replacement only, each	1 year
E2387	Power wheelchair accessory, foam filled caster tire, any size, replacement only, each	1 year

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HCPCS Code	Item Description	Lifetime Expectancy or Quantity Limitation
E2388	Power wheelchair accessory, foam drive wheel tire, any size, replacement only, each	1 year
E2389	Power wheelchair accessory, foam caster tire, any size, replacement only, each	1 year
E2390	Power wheelchair accessory, solid (rubber/plastic}drive wheel tire, any size, replacement only, each	1 year
E2391	Power wheelchair accessory, solid (rubber/plastic) caster tire (removable), any size, replacement only, each	1 year
E2392	Power wheelchair accessory, solid (rubber/plastic) caster tire with integrated wheel, any size, replacement only, each	1 year
E2394	Power wheelchair accessory, drive wheel excludes tire, any size, replacement only, each	1 year
E2395	Power wheelchair accessory, caster wheel excludes tire, any size, replacement only, each	1 year
E2396	Power wheelchair accessory, caster fork, any size, replacement only, each	1 year
K0065	Spoke protectors, each	0-20 years only; 2 years
K0069	Rear wheel assembly, complete, with solid tire, spokes or molded, each	1 yr ages 0-20 3 years ages 21-115
K0070	Rear wheel assembly, complete, with pneumatic tire, spokes or molded, each	1 yr ages 0-20 3 years ages 21-115
K0071	Front caster assembly, complete, with pneumatic tire, each	1 yr ages 0-20 3 years ages 21-115
K0072	Front caster assembly, complete, with semi-pneumatic tire, each	1 yr ages 0-20 3 years ages 21-115
K0073	Caster pin lock, each	1 yr ages 0-20 3 years ages 21-115
K0077	Front caster assembly, complete, with solid tire, each	1 yr ages 0-20 3 years ages 21-115
	Wheelchair Accessories – Other	
E0950	Wheelchair accessory, tray, each	1 year ages 0-20; 3 years 21 and over
E0958	Manual wheelchair accessory, one-arm drive attachment, each	1 year ages 0-20; 3 years 21 and over
E0959	Manual wheelchair accessory, adapter for amputee, each	1 year ages 0-20; 3 years 21 and over
E0961	Manual wheelchair accessory, wheel lock brake extension (handle), each	1 year ages 0-20; 3 years 21 and over
E0967	Manual wheelchair accessory, hand rim with projections, any type, each	1 year ages 0-20; 3 years 21 and over
E0971	Manual wheelchair accessory, anti-tipping device, each	2 years
E0974	Manual wheelchair accessory, anti-rollback device, each	1 year ages 0-20; 3 years 21 and over
E1029	Wheelchair accessory, ventilator tray, fixed	3 years
E1030	Wheelchair accessory, ventilator tray, gimbaled	3 years
E2207	Manual wheelchair accessory, crutch and cane holder, each	1 yr ages 0-20 3 years ages 21-115
E2208	Manual wheelchair accessory, cylinder tank carrier, each	1 yr ages 0-20 3 years ages 21-115
E2227	Manual wheelchair accessory, gear reduction drive wheel, each	1 year
E2368	Power wheelchair component, motor, replacement only	2 years
E2369	Power wheelchair component, gear box, replacement only	2 years

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HCPCS Code	Item Description	Lifetime Expectancy or Quantity Limitation
E2370	Power wheelchair component, motor and gear box combination, replacement only	2 years
K0105	IV hanger, each	1 yr ages 0-20 3 years ages 21-115
W4005	Unlisted replacement or repair parts	NA
W4145	Manual tilt-in-space option	1 yr ages 0-20 3 years ages 21-115
W4150	Multi-adjustable tray	1 yr ages 0-20 2 years ages 21-115
	Activity/Positioning Chairs	
W4047	Miscellaneous for pediatric DME	0-20 years only
	Patient Lift	
E0630	Patient lift, hydraulic or mechanical, includes any seat, sling, strap(s) or pad(s)	3 years
E0621	Sling or seat, patient lift, canvas or nylon	2 years
	Oxygen Equipment and Supplies	
A4615	Cannula, nasal	N/A
A4616	Tubing (oxygen), per foot	N/A
A4617	Mouth piece	N/A
A4618	Breathing circuits	N/A
A7027	Combination oral/nasal mask, used with continuous positive airway pressure device, each	2 per year
A7028	Oral cushion for combination oral/nasal mask, replacement only, each	2 per year
A7029	Nasal pillows for combination oral/nasal mask, replacement only, pair	2 per year
A9284	Spirometer, non-electronic, includes all accessories	2 per year
E0424	Stationary compressed gaseous oxygen system, rental; includes container, contents, regulator, flowmeter, humidifier, nebulizer, cannula or mask and tubing.	N/A
E0431	Portable gaseous oxygen system, rental; includes portable container, regulator, flowmeter, humidifier, cannula or mask and tubing	N/A
E0433	Portable liquid oxygen system, rental; home liquefier used to fill portable liquid oxygen containers, includes portable containers, regulator, flowmeter, humidifier, cannula or mask and tubing, with or without supply reservoir and contents gauge	N/A
E0434	Portable liquid oxygen system, rental; includes portable container, supply reservoir, humidifier, flowmeter, refill adaptor, contents gauge, cannula or mask, and tubing	N/A
E0439	Stationary liquid oxygen system, rental; includes container, contents, regulator, flowmeter, humidifier, nebulizer, cannula or mask & tubing.	N/A
E0441	Stationary oxygen contents, gaseous, 1 month's supply = 1 unit	N/A
E0442	Stationary oxygen contents, liquid, 1 month's supply = 1 unit	N/A
E0443	Portable oxygen contents, gaseous, 1 month's supply = 1 unit	N/A
E0444	Portable oxygen contents, liquid, 1 month's supply = 1 unit	N/A
E0550	Humidifier, durable for extensive supplemental humidification during IPPB treatments or oxygen delivery	2 years
E0555	Humidifier, durable, glass or autoclavable plastic bottle type, for use with regulator or flowmeter	2 years
E1354	Oxygen accessory, wheeled cart for portable cylinder or portable concentrator, any type, replacement only, each	5 years
E1355	Stand/rack	5 years

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HCPCS Code	Item Description	Lifetime Expectancy or Quantity Limitation
E1356	Oxygen accessory, battery pack/cartridge for portable concentrator, any type, replacement only, each	1 year
E1357	Oxygen accessory, battery charger for portable concentrator, any type, replacement only, each	1 year
E1358	Oxygen accessory, DC power adapter for portable concentrator, any type, replacement only, each	1 year
E1390	Oxygen concentrator, single delivery port, capable of delivering 85 percent or greater oxygen concentration at the prescribed flow rate	N/A
E1392	Portable oxygen concentrator, rental	N/A
K0738	Portable gaseous oxygen system, rental; home compressor used to fill portable oxygen cylinders; includes portable containers, regulator, flowmeter, humidifier, cannula or mask, and tubing	N/A
S8120	Oxygen contents, gaseous, 1 unit equals 1 cubic foot	N/A
S8121	Oxygen contents, liquid, 1 unit equals 1 pound	N/A
W4001	CO_2 saturation monitor with accessories, probes	N/A
	Pneumatic Compressors	
E0650	Pneumatic compressor, non-segmental home model	2 years
E0651	Pneumatic compressor, segmental home model without calibrated gradient pressure	3 years
E0652	Pneumatic compressor, segmental home model with calibrated gradient pressure	3 years
E0655	Non-segmental pneumatic appliance for use with pneumatic compressor, half arm	2 years
E0660	Non-segmental pneumatic appliance for use with pneumatic compressor, full leg	2 years
E0665	Non-segmental pneumatic appliance for use with pneumatic compressor, full arm	2 years
E0666	Non-segmental pneumatic appliance for use with pneumatic compressor, half leg	2 years
E0667	Segmental pneumatic appliance for use with pneumatic compressor, full leg	2 years
E0668	Segmental pneumatic appliance for use with pneumatic compressor, full arm	2 years
E0669	Segmental pneumatic appliance for use with pneumatic compressor, half leg	2 years
E0671	Segmental gradient pressure pneumatic appliance, full leg	2 years
E0672	Segmental gradient pressure pneumatic appliance, full arm	2 years
E0673	Segmental gradient pressure pneumatic appliance, half leg	2 years
	Respiratory Devices	
E0470	Respiratory assist device, bi-level pressure capability, without backup rate feature, used with noninvasive interface, e.g., nasal or facial mask (intermittent assist device with continuous positive airway pressure device)	5 years
E0471	Respiratory assist device, bi-level pressure capability, with back-up rate feature, used with noninvasive interface, e.g., nasal or facial mask (intermittent assist device with continuous positive airway pressure device)	N/A
E0561	Humidifier, non-heated, used with positive airway pressure device	2 years
E0562	Humidifier, heated, used with positive airway pressure device	2 years
E0601	Continuous airway pressure (CPAP) device	5 years
A7030	Full face mask used with positive airway pressure device, each	2 per year
A7031	Face mask interface, replacement for full face mask, each	2 per year
A7032	Cushion for use on nasal mask interface, replacement only, each	2 per year
A7033	Pillow for use on nasal cannula type interface, replacement only, pair	2 per year

HCPCS Code	Item Description	Lifetime Expectancy or Quantity Limitation
A7034	Nasal interface (mask or cannula type) used with positive airway pressure device with or without head strap	2 per year
A7035	Headgear used with positive airway pressure device	2 per year
A7036	Chinstrap used with positive airway pressure device	1 per year
A7037	Tubing used with positive airway pressure device	2 per year
A7038	Filter, disposable, used with positive airway pressure device	1 per month
A7039	Filter, non disposable, used with positive airway pressure device	6 per year
	Respiratory Devices - Other	
~~E0450~~	~~Volume control ventilator, without pressure support mode, may include pressure control mode used with invasive interface (e.g., tracheostomy tube)~~	~~N/A~~
~~E0463~~	~~Pressure support ventilator with volume control mode, may include pressure control mode, used with invasive interface (e.g., tracheostomy tube)~~	~~N/A~~
E0465	Home ventilator, any type, used with invasive interface, (e.g. , tracheostomy tube)	N/A
E0500	IPPB machine, all types, with built-in nebulization; manual or automatic valves; internal or external power source	N/A
E0550	Humidifier, durable for extensive supplemental humidification during IPPB treatments or oxygen delivery	2 years
E0565	Compressor, air power source for equipment which is not self- contained or cylinder driven	2 years
E0600	Respiratory suction pump, home model, portable or stationary, electric	5 years
A4483	Moisture exchanger, disposable, for use with invasive mechanical ventilation	60 per month
A4611	Battery, heavy duty; replacement for patient owned ventilator	N/A
A4612	Battery cables; replacement for patient-owned ventilator	N/A
A4613	Battery charger; replacement for patient-owned ventilator	N/A
	Respiratory Devices - Nebulizers	
E0570	Nebulizer, with compressor	3 years
E0575	Nebulizer, ultrasonic, large volume	1 yr ages 0-20 2 years ages 21-115
A7003	Administration set, with small volume nonfiltered pneumatic nebulizer, disposable	1 per month
A7004	Small volume nonfiltered pneumatic nebulizer, disposable	4 per month
A7005	Administration set, with small volume nonfiltered pneumatic nebulizer, non-disposable	2 per year
A7006	Administration set, with small volume filtered pneumatic nebulizer	1 per month
A7007	Large volume nebulizer, disposable, unfilled, used with aerosol compressor	3 per month
A7010	Corrugated tubing, disposable, used with large volume nebulizer, 100 feet	1per month
A7012	Water collection device, used with large volume nebulizer	3 per month
A7013	Filter, disposable, used with aerosol compressor or ultrasonic generator	1per month
A7015	Aerosol mask, used with DME nebulizer	4 per month
	Respiratory Devices – Apnea Monitor	
E0619	Apnea monitor, with recording feature	N/A
A4556	Electrodes (e.g., apnea monitor), per pair	2 per month
A4557	Lead wires (e.g., apnea monitor), per pair	2 per month
	Respiratory Devices – Percussor	
E0480	Percussor, electric or pneumatic, home model	2 years

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HCPCS Code	Item Description	Lifetime Expectancy or Quantity Limitation
	Respiratory Devices – Oximeter	
E0445	Oximeter device for measuring blood oxygen levels non-invasively	N/A
	Transcutaneous Electric Nerve Stimulation	
E0720	Transcutaneous electrical nerve stimulation (TENS) device, two lead, localized stimulation	2 years
E0730	Transcutaneous electrical nerve stimulation (TENS) device, four or more leads, for multiple nerve stimulation	2 years
A4595	Electrical stimulator supplies, 2 lead, per month (e.g., TENS, NMES)	2 per month
	Osteogenesis Stimulators	
E0747	Osteogenesis stimulator, electrical, non-invasive, other than spinal application	N/A
E0748	Osteogenesis stimulator, electrical, noninvasive, spinal applications	N/A
E0760	Osteogenesis stimulator, low intensity ultrasound, non-invasive	N/A
	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
K0605	Replacement battery for external infusion pump owned by patient, lithium, 4.5 volt, each	18 per year
	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

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HCPCS Code	Item Description	Lifetime Expectancy or Quantity Limitation
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 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. 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
	Continuous Passive Motion Exercise Device	
E0935	Continuous passive motion exercise device for use on knee only	N/A
	High Frequency Chest Wall Oscillation	
E0483	High frequency chest wall oscillation air-pulse generator system, (includes hoses and vest), each	Lifetime
E0484	Oscillatory positive expiratory pressure device, non-electric, any type, each	2 per Lifetime
A7025	High frequency chest wall oscillation system vest, replacement for use with patient owned equipment, each	Lifetime
A7026	High frequency chest wall oscillation system hose, replacement for use with patient owned equipment, each	Lifetime
S8185	Flutter device	2 per Lifetime
	Cough Stimulating Device	
E0482	Cough stimulating device, alternating positive and negative airway pressure	5 years
A7020	Interface for cough stimulating device, includes all components, replacement only	2 per year
	Farrell Valve	
A9999	Miscellaneous DME supply or accessory, not otherwise specified (For use with Farrell Valve only)	1 per day
	Canes and Crutches	
A4635	Underarm pad, crutch, replacement, each	6 months ages 0-20; 1 year 21 and over
A4636	Replacement, handgrip, cane, crutch, or walker, each	6 months ages 0-20; 1 year 21 and over

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HCPCS Code	Item Description	Lifetime Expectancy or Quantity Limitation
A4637	Replacement, tip, cane, crutch, walker, each	6 months ages 0-20; 1 year 21 and over
E0100	Cane, includes canes of all materials, adjustable or fixed, with tip	2 years ages 0-20; 3 years 21 and over
E0105	Cane, quad or three prong, includes canes of all materials, adjustable or fixed, with tips	2 years ages 0-20; 3 years 21 and over
E0110	Crutches, forearm, includes crutches of various materials, adjustable or fixed, pair, complete with tips and handgrips	2 years ages 0-20; 3 years 21 and over
E0111	Crutch forearm, includes crutches of various materials, adjustable or fixed, each, with tips and handgrips	2 years ages 0-20; 3 years 21 and over
E0112	Crutches, underarm, wood, adjustable or fixed, pair, with pads, tips and handgrips	2 years ages 0-20; 3 years 21 and over
E0113	Crutch underarm, wood, adjustable or fixed, each, with pad, tip and handgrip	2 years ages 0-20; 3 years 21 and over
E0114	Crutches, underarm, other than wood, adjustable or fixed, pair, with pads, tips and handgrips	2 years ages 0-20; 3 years 21 and over
E0118	Crutch substitute, lower leg platform, with or without wheels, each	3 years
	Canes and Crutches – Heavy Duty	
W4688	Single point cane for weights 251# to 500#	3 years
W4689	Quad cane for weights 251# to 500#	3 years
W4690	Crutches for weights 251# to 500#	3 years
W4691	Fixed-height forearm crutches for weights to 600#	3 years
	Walkers	
A4636	Replacement, handgrip, cane, crutch, or walker, each	6 months ages 0-20; year 21 and over
A4637	Replacement tip, cane, crutch, walker, each	6 months ages 0-20; 1 year 21 and over
E0130	Walker, rigid (pickup), adjustable or fixed height	2 years ages 0-20; 3 years 21 and over
E0135	Walker, folding (pickup), adjustable or fixed height	2 years ages 0-20; 3 years 21 and over
E0141	Walker, rigid, wheeled, adjustable or fixed height	2 years ages 0-20; 3 years 21 and over
E0143	Walker, folding, wheeled, adjustable or fixed height	2 years ages 0-20; 3 years 21 and over
E0148	Walker, heavy duty, without wheels, rigid or folding, any type, each	3 years
E0149	Walker, heavy duty, wheeled, rigid or folding, any type	3 years
E0154	Platform attachment, walker, each	2 years ages 0-20; 3 years 21 and over
E0155	Wheel attachment, rigid pick-up walker, per pair	3 years
E0156	Seat attachment, walker	3 years
E0158	Leg extensions for walker, per set of four (4)	3 years
W4695	Glides/skis for use with walker	2 years
	Gait Trainers	
E8000	Gait trainer, pediatric size, posterior support, includes all accessories and components	0-20 years only; 3 years
E8001	Gait trainer, pediatric size, upright support, includes all accessories and components	0-20 years only; 3 years
E8002	Gait trainer, pediatric size, anterior support, includes all accessories and components	0-20 years only; 3 years

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HCPCS Code	Item Description	Lifetime Expectancy or Quantity Limitation
	Miscellaneous Durable Medical Equipment and Supplies	
W4002	Manual ventilation bag (e.g. Ambu bag)	2 per year
E0860	Traction equipment, overdoor, cervical	3 years
E0705	Transfer device, any type, each	1 year ages 00-20; 3 years 21 and over
E0776	IV pole	3 years
E0235	Paraffin bath unit, portable	2 years
E1300	Whirlpool, portable (overtub type)	2 years
A4614	Peak expiratory flow rate meter, hand held	2 per year
A4627	Spacer, bag or reservoir, with or without mask, for use with metered dose inhaler	3 per year
W4120	Disposable bags for Inspirease inhaler system, set of 3	4 per year
A4927	Gloves, non-sterile, per 100	N/A
A4930	Gloves, sterile, per pair	N/A
E0781	Ambulatory infusion pump, single or multiple channels electric or battery operated with administrative equipment, worn by patient	N/A
A4628	Oropharyngeal suction catheter, each	4 per month
A7000	Canister, disposable, used with suction pump, each	10 per month
A7001	Canister, non-disposable, used with suction pump, each	2 per year
A7002	Tubing, used with suction pump, each	2 per month
W4678	Replacement battery for portable suction pump	2 years
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
A4623	Tracheostomy, inner cannula	N/A
A4624	Tracheal suction catheter, any type, other than closed system, each	720 per month
A4625	Tracheostomy care kit for new tracheostomy	90 per mth ages 0-20; 30 per mth ages 21 and over
A4626	Tracheostomy cleaning brush, each	N/A
A4629	Tracheostomy care kit for established tracheostomy	90 per mth ages 0-20; 30 per mth ages 21 and over
A7520	Tracheostomy/laryngectomy tube, non-cuffed, polyvinylchloride (PVC), silicone or equal, each	N/A
A7521	Tracheostomy/laryngectomy tube, cuffed, polyvinylchloride (PVC), silicone or equal, each	N/A
A7522	Tracheostomy/laryngectomy tube, stainless steel or equal (sterilizable and reusable), each	N/A
A7525	Tracheostomy mask, each	N/A
A7526	Tracheostomy tube collar/holder, each	12 per month
L8501	Tracheostomy speaking valve	7 per month
W4153	Tracheostomy ties, twill	2 per day
	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

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HCPCS Code	Item Description	Lifetime Expectancy or Quantity Limitation
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.
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.

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HCPCS Code	Item Description	Lifetime Expectancy or Quantity Limitation
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
	Augmentative and Alternative Communication	
E2500	Speech generating device, digitized speech, using pre-recorded messages, less than or equal to 8 minutes recording time	3 years
E2502	Speech generating device, digitized speech, using pre-recorded messages, greater than 8 minutes but less than or equal to 20 minutes recording time	3 years
E2504	Speech generating device, digitized speech, using pre-recorded messages, greater than 20 minutes but less than or equal to 40 minutes recording time	3 years
E2506	Speech generating device, digitized speech, using pre-recorded messages, greater than 40 minutes recording time	3 years
E2508	Speech generating device, synthesized speech, requiring message formulation by spelling and access by physical contact with the device	3 years

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HCPCS Code	Item Description	Lifetime Expectancy or Quantity Limitation
E2510	Speech generating device, synthesized speech, permitting multiple methods of message formulation and multiple methods of device access	3 years
E2511	Speech generating software program, for personal computer or personal digital assistant	3 years
E2512	Accessory for speech generating device, mounting system	3 years
E2599	Accessory for speech generating device, not otherwise specified	2 years
V5336	Repair/modification of augmentative communicative system or device (excludes adaptive hearing aid)	$500 per year
	Standers	
E0637	Combination sit to stand system, any size including pediatric, with seat lift feature, with or without wheels	0-20 years only; 3 years
E0638	Standing frame/table system, one position (e.g. upright, supine or prone stander), any size including pediatric, with or without wheels	0-20 years only; 3 years
E0641	Standing frame/table system, multi-position (e.g. three-way stander), any size including pediatric, with or without	0-20 years only; 3 years
E0642	Standing frame/table system, mobile (dynamic stander), any size including pediatric	0-20 years only; 3 years
	External Defibrillator	
K0606	Automatic external defibrillator, with integrated electrocardiogram analysis, garment type	18 years of age and older only
	Bath/Shower Chair	
E0240	Bath/shower chair, with or without wheels, any size	3 years
E0247	Transfer bench for tub or toilet with or without commode opening	3 years
E0248	Transfer bench, heavy duty, for tub or toilet with or without commode opening	3 years
	Pediatric Bath/Shower Chair/Lift	
W4016	Bath seat, pediatric (e.g., TLC)	3 years
E0700	Safety equipment, device or accessory, any type	3 years
W4047	Miscellaneous for pediatric DME	0-20 years only
	Toilet Seat/Commode Chair	
E0163	Commode chair, mobile or stationary, with fixed arms	3 years
E0165	Commode chair, mobile or stationary, with detachable arms	3 years
E0167	Pail or pan for use with commode chair, replacement only	1 year
E0168	Commode chair, extra wide and/or heavy duty, stationary or mobile, with or without arms, any type each	3 years
E0244	Raised toilet seat	3 years
	Pediatric Toilet Supports/Systems	
W4047	Miscellaneous for pediatric DME	0-20 years only
	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

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HCPCS Code	Item Description	Lifetime Expectancy or Quantity Limitation
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
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

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HCPCS Code	Item Description	Lifetime Expectancy or Quantity Limitation
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
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

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HCPCS Code	Item Description	Lifetime Expectancy or Quantity Limitation
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
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

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HCPCS Code	Item Description	Lifetime Expectancy or Quantity Limitation
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
	Equipment Service and Repair	
K0739	Repair or nonroutine 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.

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

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

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

E. Billing Units

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

F. Place of Service

Home

G. Co-payments

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

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

H. Reimbursement

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

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Attachment B: Provision of DMES on the Date of Discharge from a Hospital

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

Cushions:

E2601	**General use wheelchair seat cushion, width less than 22 inches, any depth**
E2602	**General use wheelchair seat cushion, width 22 inches or greater, any depth**
E2603*	**Skin protection wheelchair seat cushion, width less than 22 inches, any depth**
E2604*	**Skin protection wheelchair seat cushion, width 22 inches or greater, any depth**
E2611	**General use wheelchair back cushion, width less than 22 inches, any height, including any type mounting hardware**
E2612	**General use wheelchair back cushion, width 22 inches or greater, any height, including any type mounting hardware**

For Clinical Coverage and Prior Approval Criteria, refer to **Subsection 5.3.6** Wheelchairs and Accessories

Oxygen:

E1390*	**Oxygen concentrator, capable of delivering 85 percent or greater oxygen concentration at the the prescribed rate; *note 1 - modifiers qf & qg used with modifier rr will increase reimbursement to 150% of rate (used when prescribed amount of oxygen is greater than 4lpm)***
E1392*	**Portable oxygen concentrator**
E0431*	**Portable gaseous oxygen system, rental; includes regulator, flowmeter, humidifier, cannula or mask and tubing**
E0434*	**Portable liquid oxygen system, rental; includes portable container, supply reservoir, humidifier, flowmeter, refill adapter, contents gauge, cannula or mask & tubing**
E0439*	**Stationary liquid oxygen system, rental; includes use of reservoir, contents (per unit), regulator, flowmeter, humidifier, nebulizer, cannula or mask and tubing. 1 unit = 10lbs**
K0738*	**Portable gaseous oxygen system, rental; home compressor used to fill portable oxygen cylinders; includes portable containers, regulator, flowmeter, humidifier, cannula or mask, and tubing**
E0433*	**Portable liquid oxygen system, rental; home liquefier used to fill portable liquid oxygen containers; includes portable containers, includes regulator, flowmeter, humidifier, , cannula or mask & tubing, with or without supply reservoir and contents gauge**

For Clinical Coverage and Prior Approval Criteria, refer to **Subsection 5.3.9** Oxygen, Oxygen Supplies, and Equipment.

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Beds:

E0250*	**Hospital bed, fixed height, with any type side rails, with mattress**
E0255*	**Hospital bed, variable height, hi-lo, with any type side rails, with mattress**
E0260*	**Hospital bed, semi-electric (head and foot adjustment) with any type side rails, with mattress**
E0265*	Hospital bed, total electric (head, foot and height adjustments), with any type side rails, with mattress
E0303*	Hospital bed heavy duty , extra wide for weights 350 lbs but less than 600 lbs w/ mattress and any type side rails
E0304*	Hospital bed, extra heavy duty for weight capacity greater than 600 lbs w/ mattress and any type side rails

For Clinical Coverage and Prior Approval Criteria, refer to **Subsection 5.3.1** Hospital Beds, Pediatric Beds and Related Supplies.

Wheelchairs and Accessories:

K0001*	**Standard wheelchair**
K0002*	**Standard hemi (low seat) wheelchair**
K0003*	**Lightweight wheelchair**
K0004*	**High strength, lightweight wheelchair**
K0006*	**Heavy duty wheelchair**
K0007*	**Extra heavy duty wheelchair**
K0053*	**Elevating footrests, articulating (telescoping), each**
K0195*	**Elevated legrest, pair (for use with capped rental wheelchair base)**

For Clinical Coverage and Prior Approval Criteria, refer to **Subsection 5.3.6** Wheelchairs and Accessories.

Walkers:

E0141	Walker, rigid, wheeled, adjustable or fixed height
E0143	Walker, folding, wheeled, adjustable or fixed height

For Clinical Coverage and Prior Approval Criteria, refer to **Subsection 5.3.21** Canes, Crutches, Walkers, Gait Trainers, and Accessories Canes and Crutches.

Commode:

E0165	Commode chair, mobile or stationary, with detachable arms
E0168	Commode chair, extra wide and/or heavy duty, stationary or mobile with or without arms, any type each

For Clinical Coverage and Prior Approval Criteria, refer to **Subsection 5.3.27** Bath and Toilet Aides.

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

DMA-3125 Rev. 01.2013

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. ***EXAMPLE:*** *November 14, 1949 is* **11141949**. Place an **X** in the appropriate block to show the beneficiary's sex.
4. Insured's Name.	Leave blank
5. Beneficiary's Address	Enter the beneficiary's street address, including the city, state and zip code. The information is on the Medicaid or NCHC ID card. Entering the telephone number is optional.
6.—8.	Leave blank.
9. Other Insurer's Name	Enter applicable private insurer's name or the appropriate Medicare override statement if you know that Medicare will not cover the billed item, using the EXACT wording shown below: *This is a Medicare non-covered service.* *Service does not meet Medicare criteria.* *Medicare benefits are exhausted.* ***REMEMBER:*** *You must have documentation to support the use of any of these statements.*
9a.—9d.	Enter applicable insurance information.
10. Is Beneficiary's Condition…?	Place an **X** in the appropriate block for each question.
11.—14.	Optional.
15.—16.	Leave blank.
17., 17a., and 18.	Optional.
19. Reserved for Local Use	If the claim is for a Carolina ACCESS participant, enter the primary care provider's referring number—otherwise 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.

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

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

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

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

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

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Example of Claim Form for DME

PLEASE DO NOT STAPLE IN THIS AREA

[redacted]

HEALTH INSURANCE CLAIM FORM

PICA

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

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

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

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

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

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

6. PATIENT RELATIONSHIP TO INSURED: Self Spouse Child Other

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

CITY: Any Town STATE: NC

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

CITY STATE

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

ZIP CODE TELEPHONE (INCLUDE AREA CODE) ( )

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

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

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

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

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

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

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES X NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

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

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

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

SIGNED _____ DATE _____

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

SIGNED _____

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

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

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

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. 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)

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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? PLACE (State): YES ☐ NO X

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.*

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM. 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

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)