CHAPTER 508 – COVERED SERVICES, LIMITATIONS, AND EXCLUSIONS FOR HOME HEALTH
CHANGE LOG

Replace	Title	Change Date	Effective Date
Section 508.4	Covered Services	May 1, 2010	July 1, 2010
Section 508.4.1	Skilled Nursing Visit	May 1, 2010	July 1, 2010
Section 508.4.2	Medical Social Work Services	May 1, 2010	July 1, 2010
Section 508.4.2 (formerly Section 508.4.3)	Home Health Aide Services	May 1, 2010	July 1, 2010
Section 508.4.3 (formerly Section 508.4.4)	Speech-Language Pathology	May 1, 2010	July 1, 2010
Section 508.4.4 (formerly Section 508.4.5)	Physical Therapy	May 1, 2010	July 1, 2010
Section 508.4.5 (formerly Section 508.4.6)	Occupational Therapy	May 1, 2010	July 1, 2010
Section 508.4.7	All Inclusive Visit	May 1, 2010	July 1, 2010
Section 508.4.6 (formerly Section 508.8)	Venipuncture Performed in the Home	May 1, 2010	July 1, 2010
Section 508.4.7 (new section)	Reimbursement Methodology	May 1, 2010	July 1, 2010
Section 508.8	Authorization	May 1, 2010	July 1, 2010
Section 508.9	Billing Procedure	May 1, 2010	July 1,2010
Section 508.8	Authorization	08/11/05	08/15/05
Section 508.8.1	Services Requiring Authorization	08/11/05	08/15/05
Section 508.8.2	Authorization Procedures	08/11/05	08/15/05

JULY 1, 2010

SECTION 508.4

Introduction: Section 508.4, Covered Services
Old Policy: Home health agencies must obtain authorization when the services are in excess of 124 visits in a calendar year. The total 124 visits includes any combination of the following home health services: skilled nurse visits (SNV), physical therapy (PT), occupational therapy (OT), speech-language pathology (ST), home health aide (HHA), medical social worker (MSW), and the procedures for all-inclusive services.
New Policy: Home health agencies must obtain authorization when the services are in excess of 60 visits in a calendar year. The total 60 visits include any combination of the following home health services: skilled nurse visits (SNV), physical therapy (PT), occupational therapy (OT), speech-language pathology (ST), and home health aide (HHA).

SECTION 508.4.1

Introduction: Section 508.4.1, Skilled Nursing Visit
Old Policy: REVENUE CODE: 0551(W2100)
New Policy: REVENUE CODE: 0551

SECTION 508.4.2

Introduction: Section 508.4.2, Medical Social Work Services
Old Policy: REVENUE CODE: 0561(W2105)SERVICE UNIT: Visit
DEFINITION: Service definitions and limitation are delineated in Attachment 1
New Policy: Delete Section

SECTION 508.4.2 (FORMERLY SECTION 508.4.3)

Introduction: Section 508.4.2, Home Health Aide Services
Old Policy: REVENUE CODE: 0571(W2110)
New Policy: REVENUE CODE: 0571

SECTION 508.4.3 (FORMERLY SECTION 508.4.4)

Introduction: Section 508.4.3, Speech-Language Pathology
Old Policy: REVENUE CODE: 0441(W2115)
New Policy: REVENUE CODE: 0441

SECTION 508.4.4 (FORMERLY SECTION 508.4.5)

Introduction: Section 508.4.4, Physical Therapy
Old Policy: REVENUE CODE: 0421(W2135)

New Policy: REVENUE CODE: 0421

SECTION 508.4.5 (FORMERLY SECTION 508.4.6)

Introduction: Section 508.4.5, Occupational Therapy
Old Policy: REVENUE CODE: 0431(W2140)
New Policy: REVENUE CODE: 0431

SECTION 508.4.6 (FORMERLY SECTION 508.4.8)

Introduction: Renumbering Section Venipuncture Performed in the Home

SECTION 508.4.7 (OLD)

Introduction: Section 508.4.7, All Inclusive Visit
Old Policy: Medicare has identified that certain home health agencies must bill an all inclusive code for any home health service visit. The actual visit may be done by any one of the home health disciplines approved for providing home health services for the specific agency. The disciplines are skilled nurse visit (SNV), physical therapy (PT), speech-language pathology (ST), occupational therapy (OT), and home health aide (HHA). The agencies using this code are usually county health departments and are known as The Family of Home Health Agencies. Service definitions and limitations for each home health discipline are delineated in **Attachment 1.**
New Policy: Delete section.

SECTION 508.4.7 (NEW)

Introduction: Section 508.4.9, Reimbursement Methodology
Old Policy: N/A
New Policy: Medicaid reimbursement of Medicare certified home health services shall be based on 90% of the Medicare established low-utilization payment adjustment (LUPA) per visit rate by discipline or the provider's charge, whichever is less. The calculated LUPA rates will include an applicable Core-Base Statistical Area (CBSA) wage index adjustment for the county in which the provider has its initially assigned physical location. If services are rendered to beneficiaries outside that initially assigned county, payments will be limited to the provider's LUPA rates with no payment recognition for any difference between county wage indexes. The LUPA rate will be adjusted in accordance with Medicare's scheduled adjustments. LUPA per visit payment amounts are considered payment-in-full.

SECTION 508.8

Introduction: Section 508.8, Authorization

Old Policy: Authorizations for Home Health Services in excess of 124 visits per calendar year are no longer required; however, it is the responsibility of the provider to maintain the CMS-485, CMS-486, and OASIS assessments on file. Home Health visits are subject to post-payment audit.
New Policy: Authorizations for Home Health Services in excess of 60 visits per calendar year are no longer required; however, it is the responsibility of the provider to maintain the CMS-485, CMS-486, and OASIS assessments on file. Home Health visits are subject to post-payment audit.

SECTION 508.9

Introduction: Section 508.9, Billing Procedure
Old Policy: Home health claims may be billed using either the HCFA 1500 or the UB 92 until the date of change in the Bureau's fiscal agent. Following the implementation of the new fiscal agent for Medicaid, all claims must be billed using the UB 92 or the 837I electronic format. If the services were provided prior to the implementation date for the new fiscal agent, both the local W codes as well as the revenue codes must be noted on the claim. For services provided after implementation, only the revenue codes are required.
New Policy: All claims must be billed using the UB 04 or the 837I electronic format. If the services were provided prior to the implementation date for the new fiscal agent, only the revenue codes must be noted on the claim. For services provided after implementation, only the revenue codes are required.

AUGUST 15, 2005
SECTION 508.8

Introduction: Removal of Authorization Requirements for Home Health Services over 124 visits
Change: Removal of entire paragraph under "Authorization". Replace paragraph with statement "Authorizations for Home Health Services in excess of 124 visits per calendar year are no longer required; however, it is the responsibility of the provider to maintain the CMS-485, CMS-486, and the OASIS assessments on file. Home Health visits are subject to post-payment audit."
Directions: Replace this section

SECTION 508.8.1

Introduction: Removal of Authorization Requirements for Home Health Services over 124 visits
Change: Removal of entire paragraph under "Services Requiring Authorization".
Directions: Remove this section

SECTION 508.8.2

Introduction: Removal of Authorization Requirements for Home Health Services over 124 visits
Change: Removal of all paragraphs under “Authorization Procedures”.
Directions: Remove this section

CHAPTER 508—COVERED SERVICES, LIMITATIONS AND EXCLUSIONS FOR HOME HEALTH
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Attachment 2: Covered Medical Supplies

CHAPTER 508–COVERED SERVICES, LIMITATIONS, AND EXCLUSIONS, FOR HOME HEALTH

INTRODUCTION

The West Virginia (WV) Medicaid Program offers a comprehensive scope of medically necessary medical and mental health services to diagnose and treat eligible members. Covered and authorized services must be rendered by enrolled providers within the scope of their license and in accordance with all State and Federal requirements. Any service, procedure, item, or situation not discussed in the manual must be presumed non-covered unless informed otherwise in writing by the Bureau for Medical Services (BMS).

This chapter sets forth the BMS requirements for payment of services provided by certified home health agencies to eligible WV Medicaid members.

The policies and procedures set forth herein are regulations governing the provision of home health agency services in the Medicaid Program administered by the WV Department of Health and Human Resources under the provisions of Title XIX of the Social Security Act and Chapter 9 of the West Virginia Code.

508.1 DEFINITIONS

Definitions governing the provision of all WV Medicaid services will apply pursuant to Chapter 200, Definitions, of the Provider Manual.

508.2 PROVIDER PARTICIPATION

In order to participate in the WV Medicaid Program and receive payment from the Bureau, home health agencies must meet the following conditions in addition to requirements set forth in Chapter 300:

- Certification for participation in Title XVIII, Medicare, by the appropriate certifying agency in the State where the agency is located. (In West Virginia, the Office of Health Facility Licensure and Certification in the Department of Health and Human Resources is the certifying agency.)
- A home health agency must be approved for Medicare participation before requesting an application from Medicaid for enrollment as a provider. The home health agency must send a copy of approval as a Medicare provider along with the rate of reimbursement set by Medicare for each service which has been approved by Medicare. A change in the Medicare rate and/or services provided must be submitted on the Medicare letterhead to the Medicaid agency.

508.3 MEMBER ELIGIBILITY

Payment for medically necessary and appropriate home health agency services is available on behalf of all WV eligible Medicaid members subject to the conditions and limitations that apply to

these services. The qualifying criteria are described in Attachment 1 and may be found at the CMS web site www.cms.hhs.gov/manuals.

- The member must meet the qualifying criteria for Medicare coverage as currently published or modified in the future. These criteria include having a need for skilled nursing care on an intermittent basis, physical therapy, speech-language pathology services, or a need for occupational therapy subsequent to the initiation of physical therapy.

- The member may receive skilled nursing visits (SNV) if only a registered nurse or licensed practical nurse can provide the service as certified by a physician thus allowing the individual to be in the community rather than institutionalized.

- Home health services may be provided to a child who would be homebound if the services were not provided as certified by a physician. The home health services must not duplicate services received from other sources.

508.4 COVERED SERVICES

Except for the limitations and exclusions listed below and in attachment 1, the Bureau will pay for medically necessary and appropriate home health agency services provided to eligible Medicaid members by a Medicaid enrolled home health agency.

Home health agencies must obtain authorization when the services are in excess of 60 visits in a calendar year. The total 60 visits include any combination of the following home health services: skilled nurse visits (SNV), physical therapy (PT), occupational therapy (OT), speech-language pathology (ST), and home health aide (HHA).

508.4.1 SKILLED NURSING VISIT

REVENUE CODE: **0551**
SERVICE UNIT: **Visit**
DEFINITION: Service definitions and limitations are delineated in **Attachment 1**

508.4.2 HOME HEALTH AIDE SERVICES

REVENUE CODE: **0571**
SERVICE UNIT: **Visit**
DEFINITION: Service definitions and limitations are delineated in **Attachment 1**

508.4.3 SPEECH-LANGUAGE PATHOLOGY

REVENUE CODE: **0441**
SERVICE UNIT: **Visit**
DEFINITION: Service definitions and limitations are delineated in **Attachment 1**

508.4.4 PHYSICAL THERAPY

REVENUE CODE: **0421**
SERVICE UNIT: **Visit**

DEFINITION: Service definitions and limitations are delineated in **Attachment 1**

508.4.5 OCCUPATIONAL THERAPY

REVENUE CODE: **0431**
SERVICE UNIT: **Visit**
DEFINITION: Service definitions and limitations are delineated in **Attachment 1**

508.4.6 VENIPUNCTURE PERFORMED IN THE HOME

PROCEDURE CODE: **S9529**
SERVICE UNIT: **Visit**
SERVICE LIMIT: **None**
AUTHORIZATION: **None**
DEFINITION: Venipuncture performed in a member's home is a covered service. The member must meet the Medicare definition of home bound and have a physician's order for home based venipuncture. The member can not be receiving Home Health Services. This service includes transportation to the member's home and can not be provided at any other location.

508.4.7 REIMBURSEMENT METHODOLOGY

Medicaid reimbursement of Medicare certified home health services shall be based on 90% of the Medicare established low-utilization payment adjustment (LUPA) per visit rate by discipline or the provider's charge, whichever is less. The calculated LUPA rates will include an applicable Core-Base Statistical Area (CBSA) wage index adjustment for the county in which the provider has its initially assigned physical location. If services are rendered to beneficiaries outside that initially assigned county, payments will be limited to the provider's LUPA rates with no payment recognition for any difference between county wage indexes. The LUPA rate will be adjusted in accordance with Medicare's scheduled adjustments. LUPA per visit payment amounts are considered payment-in-full.

508.5 MEDICAL SUPPLIES

A comprehensive list of covered medical supplies can be found in **Attachment 2**. Unless specified otherwise, Medicaid follows Medicare's guidelines for medical necessity review for medical supplies. Items not listed in **Attachment 2** are presumed non-covered.

Medicare guidelines for medical necessity can be found at www.ngs.medicare.com and/or palmettogba.com web sites. Questions regarding product classification should be directed to Palmetto GBA-SADMERC.

Physician orders and documentation supporting medical necessity for supplies must be present. Home health agencies must use reasonable quantities of the least costly product which will adequately meet the needs of the member. Limited amounts of medical supplies may be left in the home between visits where repeated applications are required and rendered by the member or other caregivers.

Medical supplies are separated into three categories:

- Routine (non-billable): Supplies that are customarily used in small quantities during the usual course of most home visits. They are usually included in the staff's supplies and not designated for a specific member. These supplies are included in the cost per visit of home health care services.
- Non-Routine (billable): Supplies that are needed to treat a member's specific illness or injury in accordance with the physician's plan of care. The item must be directly identifiable to an individual, the cost of the item can be identified and accumulated in a separate cost center, and the item is furnished at the direction of the member's physician and is specifically identified in the plan of care, i.e., the item is needed to treat a member's specific illness. The home health agency must also follow a consistent charging practice for Medicaid and non-Medicaid members receiving the item.
- Non-Covered: Supplies that are not covered under the Medicare home health benefit. Home health agencies can not bill for these supplies and the cost of the supplies can not be included as a part of the "cost of doing business". Comfort and convenience items are non-covered as well as program exclusions such as prescription drugs and biologicals.

508.6 SERVICE LIMITATIONS

Service limitations governing the provision of all WV Medicaid services will apply pursuant to Chapter 100, General Information, of the Provider Manual. In addition, the following limitations also apply to the requirements for payment of home health agency services described in this chapter.

- Home health agency services are covered when provided by Medicare certified/Medicaid enrolled home health agencies only for those services for which they have been approved by Medicare to provide.
- Services and supplies must be provided pursuant to a physician's written order which details the member-specific plan of care.
- Home health aide services will not be covered unless the member requires skilled nursing services, physical therapy services, speech-language pathology services, or occupational therapy services provided subsequent to physical therapy services.
- Newborn home health care will not be covered unless there is a diagnosis and/or condition that require intermittent skilled nursing services.
- Pre-filling of insulin syringes is a covered home health skilled service if there is no pharmacy or person in the home to provide the service.

508.7 SERVICE EXCLUSIONS

In addition to the exclusions listed in Chapter 100, General Information, of the Provider Manual, the Bureau will not pay for the following services as a home health benefit:

- For a dually eligible member (Medicare/Medicaid), any services denied by the Medicare Program

- Services in excess of those deemed medically necessary by the Bureau to treat the member's condition
- Services not directly related to the member's diagnosis, symptoms, or medical history
- Duplicative services provided to members receiving benefits through the Home and Community-Based Aged/Disabled Waiver Program (ADW).
- Duplicative services provided to members receiving benefits through the Home and Community-Based Mental Retardation/Developmental Disability Waiver Program (MR/DDW)
- Services provided to members receiving benefits of the Hospice program
- Services provided to members receiving similar services from a behavioral health or community provider
- Homemaker services
- Respite care
- Custodial care
- Telephone consultations
- Failed appointments, including but not limited to, canceled appointments and appointments not kept
- Time spent in preparation of reports
- Experimental services or drugs

508.8 AUTHORIZATION

Prior authorizations for Home Health Services in excess of 60 visits per calendar year are required; it is the responsibility of the provider to maintain the CMS-485, CMS-486, and OASIS assessments on file. Home Health visits are subject to post-payment audit.

508.9 BILLING PROCEDURE

All claims must be billed using the UB 04 or the 837I electronic format; only revenue codes are required to be submitted on claim form.

508.10 COORDINATION OF CARE REQUIREMENTS AND PAYMENT LIMITS

Home health agency providers must determine whether Medicaid eligible member referred for home health agency services are authorized to receive similar services under other Medicaid programs or benefits. Home health agency providers must coordinate the provision of home health agency services with other Medicaid service providers in order to avoid duplication of similar services and subsequent disallowance of payments.

Requirements for coordination of care and payment limits for specific services are described in this section for the following benefits:

- Hospice
- Home and Community-Based Waiver Program for the Mentally Retarded/Developmentally Disabled
- Home and Community-Based Waiver Program for the Aged and Disabled

- Personal Care Services
- Children's Special Care

508.11 HOSPICE

Members who have elected to receive services through a hospice agency are not eligible to receive services through a home health agency. Medical care and case management of members receiving hospice services are the responsibility of the hospice agency.

508.12 MENTALLY RETARDED/ DEVELOPMENTALLY DISABLED (MR/DD) WAIVER

Members who have been determined eligible for and are enrolled in the Home and Community-Based Waiver Program for the MR/DD may receive services from a home health agency that do not duplicate MR/DD Waiver services. An agreement between the MR/DD Waiver coordination agency and the home health agency must be on record. The need for home health agency services must be documented in the member's Individual Program Plan (IPP). Documentation of the referral must be maintained in the member's records of both the MR/DD Waiver Program coordination agency and the home health agency.

508.13 AGED AND DISABLED WAIVER (ADW)

Members who have been determined eligible for and are enrolled in the Home and Community Based Aged/Disabled Waiver Program may receive services from a home health agency that do not duplicate AD Waiver services. Home health agency services provided to ADW member must be coordinated by the ADW case management agency, and in general may only include skilled nursing care or therapy services for post-hospitalization stays or acute episodes of chronic conditions. The need for home health services must be documented in the member's Plan of Care (POC). Documentation of the referral must be maintained in the member's records of both the AD Waiver agency and the home health agency

508.14 PERSONAL CARE SERVICES

Members who are receiving personal care services provided through behavioral health or community care programs may also receive home health agency services. These services are limited to services which can only be performed by a licensed nurse and/or a licensed therapist. The home health agency must maintain documentation regarding the need for services as well as the plan of care for the member. No payment shall be made to home health agencies for home health aide services provided to members who are also receiving personal care services.

508.15 CHILREN'S SPECIALTY CARE

Staff of the Children's Specialty Care (CSC) program shall authorize all care, including home health services, for children receiving specialized medical services under the auspices of the CSC program. The CSC program evaluates requests for prior authorization of home health

services based on Medicaid policy requirements for such services, regardless of the child's eligibility for the Medicaid program.

Requests for prior authorization of home health services for CSC enrollees should be forwarded to the CSC program as follows:

Children Specialty Care Program
350 Capitol Street
Charleston, West Virginia 25301

508.16 MANAGED CARE

If the Medicaid member is enrolled in an MCO, coverage and prior authorization requirements of the health plan must be followed. If the member is enrolled in the PAAS Program, authorization or a referral must be given by the member's PCP. Medicaid will not reimburse for services if the HMO denies payment because their requirements were not followed.

CHAPTER 508
HOME HEALTH SERVICES
JULY 1, 2004

ATTACHMENT 1
GUIDELINES FOR COVERED SERVICES
PAGE 1 OF 3
REVISED JULY 1, 2010

GUIDELINES FOR COVERED SERVICES

The Medicaid Program uses the Medicare guidelines for covered Home Health services as currently published or amended in the future. These guidelines and future updates may be found at www.cms.gov/manuals.

Since the West Virginia Medicaid population does not always fit the picture of the elderly or disabled Medicare members, exceptions to the Medicare guidelines have been implemented for Medicaid members. These exceptions include, but are not limited to the definition of homebound status when certain skilled medical procedures are necessary and when skilled services for infants and children are necessary.

Skilled nursing visits (SNV) may be provided for Medicaid eligible individuals who do not meet the Medicare defined criteria for homebound if only a registered nurse or licensed practical nurse can provide the service, thus allowing the individual to be deinstitutionalized. Documentation must clearly indicate the need for the service, such as why the individual cannot go to a health care provider for the treatment. Examples of this type of SNV include but are not limited to IV infusions, central line dressing changes, and sterile dressing changes for wounds with the application of a prescribed medication.

Skilled nursing, physical therapy, occupational therapy, and speech-language pathology home health services must be reasonable and necessary for the diagnosis and treatment of the illness or injury within the context of the member's unique medical condition. To determine if the services are reasonable and necessary, the following items will be considered:

- The diagnosis is never to be the sole factor in determining medical necessity.
- The determination of medical necessity of the services should be based upon the member's unique condition, whether it is acute, chronic, terminal, or expected to continue over a long period of time, and in some cases if the condition is stable.
- The services are intermittent.
- Documentation must support the establishment of medical necessity and should clearly define the member's unique circumstance that justifies provision of these services.

Skilled nursing visits for observation are medically necessary when the likelihood of change in a member's condition requires the skills of a registered nurse to identify and evaluate the need for possible modification of treatment or initiation of additional medical procedures. When documentation indicates a reasonable potential for a complication or further acute episode, skilled registered nurse visits for observation and assessment will be covered for a maximum of three weeks from the start of care. Visits may be covered longer if there remains a reasonable potential for such a complication or acute episode. Documentation in the medical record must clearly indicate a change in the health status such as fluctuation of vital signs for observation and assessment to continue as a skilled service.

Teaching and training activities by a skilled nurse are covered when it is necessary to teach a member, family member or care giver how to manage the treatment regimen and the skill being taught is reasonable and necessary to the treatment of the illness, injury or functional loss. There is no requirement that the member, family member or other care giver be taught to provide a service if the member, family member or care giver cannot or chooses not to provide the care.

In all cases, documentation of the member's mental status must clearly indicate why the individual cannot be educated to provide the skilled care. Additionally, if there are others in the household who might be able to provide care, documentation must indicate why these individuals cannot provide the care or are unwilling.

Infants and toddlers are not automatically considered homebound. Infants discharged from a neonatal intensive care unit may receive skilled nurse visits for observation and education as appropriate. Documentation must clearly indicate the need for these visits. This documentation would include the mental status of the care giver as well as the reason the infant is homebound. Other conditions may warrant skilled nurse visits for infants include, but are not limited to, home IVs and infants identified as failure to thrive.

For children, the focus is to main stream the physically challenged individuals as much as possible. Home health services may be provided to a child who would be homebound if the services were not provided or the normal care giver is unavailable to provide the care for a short period of time. The home health visits must not duplicate services received from other sources.

A member with a psychiatric disorder is considered homebound if his/her illness is manifested in part by a refusal to leave the home, or is of such a nature that it would not be considered safe for him/her to leave home unattended, even if he/she has no physical limitations. The diagnosis and rationale for homebound status must be made by a psychiatrist. The following conditions support the homebound determination:

- Agoraphobia, paranoia, or panic disorder;
- Disorders of thought processes wherein the severity of delusions, hallucinations, agitation and/or impairment of thoughts/cognition grossly affect the member's judgment and decision making and therefore the member's safety;
- Acute depression with severe vegetative symptoms; and
- Psychiatric problems associated with medical problems that render the member homebound.

The services of a skilled psychiatric nurse must be required to provide the necessary care. Many members, who require the services of a skilled psychiatric nurse also require skilled nursing care related to a physical illness. Therefore, the psychiatric nurse must also have medical and surgical nursing experience to ensure that all the member's home care needs are met. Counseling services may be provided by either a trained psychiatric nurse. These services should not be duplicative, and concurrent counseling or psychotherapy services by multiple providers are not medically necessary.

For all home health services provided to Medicaid members, the documentation must clearly indicate that the services are reasonable and necessary. The documentation must be clear, specific and measurable. For homebound status, the medical record must indicate exactly why it is a considerable and taxing effort for the individual to leave the home. The lack of transportation is not evidence the individual is homebound. An individual who is physically and mentally capable of driving a car is not considered homebound.

CHAPTER 508
HOME HEALTH SERVICES
JULY 1, 2004

ATTACHMENT 2
COVERED MEDICAL SUPPLIES
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HCPCS CODE	DESCRIPTION	REPLACES	SERVICE LIMIT	SPECIALTY	NOT COVERED BY MEDICARE	SPECIAL INSTRUCTIONS
A4206	Syringe with needle; sterile 1 cc, each		100 per month	G3, T5, 58	X	
A4207	sterile 2 cc, each		100 per month	G3, T5, 58	X	
A4208	sterile, 3 cc, each		100 per month	G3, T5, 58	X	
A4209	sterile, 5cc or greater, each		100 per month	G3, T5, 58	X	
A4213	Syringe, sterile, 20cc or greater, each		60 per month	G3, T5, 58	X	
A4215	Needles only, sterile, any size, each		100 per month	G3, T5, 58	X	
A4216	Sterile water/saline, 10 ml		Cost Invoice	G3, T5, 58		
A4217	Sterile water/saline, 500 ml		Cost Invoice	G3, T5, 58		
A4244	Alcohol or peroxide, per pint		15 per month	G3, T5, 58	X	
A4245	Alcohol wipes, per box		2 boxes/month	G3, T5, 58	X	
A4246	Betadine or phisohex solution, per pint		12 per month	G3, T5, 58	X	
A4247	Betadine or iodine swabs/wipes, per box		2 boxes/month	G3, T5, 58	X	
A4253	Blood glucose test or reagent strips for home blood glucose monitor, per 50 strips		3 boxes/month	G3, T5, 58		Requires diagnosis of 250.00 thru 250.93
A4253 KS	Blood glucose test or reagent strips for home blood glucose monitor, per 50 strips (1 box)	W0708	2 boxes per month	G3, T5, 58		Requires diagnosis of 250.00 thru 250.93
A4256	Normal, low and high calibrator solution/chips		1 per 3 months	G3, T5, 58		
A4258	Spring-powered device for lancet, each		1 per 2 years	G3, T5, 58		
A4259	Lancets, per box of 100		2 boxes/month	G3, T5, 58		Requires diagnosis of 250.00 thru 250.93
A4259 KS	Lancets, per box of 100	W0709	1 box per month	G3, T5, 58		Requires diagnosis of 250.00 thru 250.93
A4265	Paraffin, per pound		12 per 3 months	G3, T5, 58		
A4310	Insertion tray without drainage bag; and without catheter (accessories only)		2 per month	G3, T5, 58		
A4311	Insertion tray without drainage bag; with indwelling catheter, foley type, two-way latex with coating (teflon, silicone, silicone elastomer or hydrophilic, etc.)		2 per month	G3, T5, 58		
A4312	with indwelling catheter, foley type, two-way, all silicone		2 per month	G3, T5, 58		

A4313	with indwelling catheter, foley type, three-way, for continuous irrigation	2 per month	G3, T5, 58		
A4314	Insertion tray with drainage bag; with indwelling catheter, foley type, two-way latex with coating (teflon, silicone, silicone elastomer or hydrophilic, etc.)	2 per month	G3, T5, 58		
A4315	with indwelling catheter, foley type, two-way, all silicone	2 per month	G3, T5, 58		
A4316	with indwelling catheter, foley type, three-way, for continuous irrigation	2 per month	G3, T5, 58		
A4320	Irrigation tray with bulb or piston syringe, any purpose	2 per month	G3, T5, 58		
A4322	Irrigation syringe, bulb or piston, each	2 per month	G3, T5, 58		
A4324	Male external catheter, with adhesive coating, each	31 per month	G3, T5, 58		
A4325	Male external catheter, with adhesive strip, each	31 per month	G3, T5, 58		
A4326	Male external catheter specialty type with integral collection chamber, each	31 per month	G3, T5, 58		
A4327	Female external urinary collection device, meatal cup, each	2 per month	G3, T5, 58		
A4328	pouch, each	2 per month	G3, T5, 58		
A4330	Perianal fecal collection pouch with adhesive, each	31 per month	G3, T5, 58		
A4331	Extension drainage tubing, any type, any length, with connector/adaptor, for use with urinary leg bag or urostomy pouch, each	5 per month	G3, T5, 58		
A4332	Lubricant, individual sterile packet, for insertion of urinary catheter, each	31 per month	G3, T5, 58		
A4333	Urinary catheter anchoring device, adhesive skin attached, each	12 per month	G3, T5, 58		
A4334	Urinary catheter anchoring device, leg strap, each	1 per month	G3, T5, 58		
A4335	Incontinence supply; miscellaneous	Prior Authorization	G3, T5, 58		
A4338	Indwelling catheter; foley type, two-way latex with coating (teflon, silicone, silicone elastomer, or hydrophilic, etc.), each	2 per month	G3, T5, 58		
A4340	Indwelling catheter; specialty type, (e.g.; coude, mushroom, wing, etc.), each	2 per month	G3, T5, 58		

A4344	Indwelling catheter, foley type; two-way all silicone; each		2 per month	G3, T5, 58		
A4346	three-way for continuous irrigation, each		2 per month	G3, T5, 58		
A4347	Male external catheter, with or without adhesive, with or without anti-reflux device; per dozen		3 units per month	G3, T5, 58		
A4351	Intermittent urinary catheter; straight tip, with or without coating (teflon, silicone, silicone elastomer, or hydrophilic, etc.), each		31 per month	G3, T5, 58		
A4352	Intermittent urinary catheter; coude (curved) tip, with or without coating (teflon, silicone, silicone elastomer, or hydrophilic, etc.), each		Prior Authorization	G3, T5, 58		
A4353	Intermittent urinary catheter, with insertion supplies		180 per month Sterile Technique **Only**	G3, T5, 58		Coverage limited to Sterile Technique **Only** when specifically prescribed in writing by physician
A4354	Insertion tray with drainage bag, but without catheter		2 per month	G3, T5, 58		
A4355	Irrigation tubing set for continuous bladder irrigation through a three-way indwelling foley catheter, each		10 per month	G3, T5, 58		
A4356	External urethral clamp or compression device (not to be used for catheter clamp), each		Prior Authorization	G3, T5, 58		
A4357	Bedside drainage bag, day or night with or without anti-reflux device, with or without tube, each		2 per month	G3, T5, 58		
A4358	Urinary drainage bag, leg or abdomen, vinyl, with or without tube, with straps, each		4 per month	G3, T5, 58		
A4359	Urinary suspensory without leg bag, each		1 per month	G3, T5, 58		
A4361	Ostomy faceplate, each		3 per 6 months	G3, T5, 58		Not reimbursable when billed with: A4375, A4376, A4377, A4378, A4379, A4380, A4381, A4382, A4383
A4364	Adhesive, liquid or equal, any type, per ounce		6 oz. per month	G3, T5, 58		
A4365	Adhesive remover wipes, any type, per 50		1 box per month	G3, T5, 58		
A4366	Ostomy vent, any type, each		15 per month	G3, T5, 58		Not reimbursable when billed with: A4416, A4417, A4418, A4419, A4423, A4424, A4425, and A4427

A4367	Ostomy belt, each		2 per 6 months	G3, T5, 58		
A4368	Ostomy filter, any type, each		1 per day	G3, T5, 58		
A4371	Ostomy skin barrier, powder, per oz		10 per 6 months	G3, T5, 58		
A4372	Ostomy skin barrier, solid 4 x 4 or equivalent, with built-in convexity, each		15 per month	G3, T5, 58		
A4375	Ostomy pouch, drainable, with faceplate attached, plastic, each		15 per month	G3, T5, 58		Not reimbursable with: A4361, A4377
A4376	Ostomy pouch, drainable, with faceplate attached, rubber, each		15 per month	G3, T5, 58		Not reimbursable with: A4361, A4378
A4377	Ostomy pouch, drainable, for use on faceplate, plastic, each		20 per month	G3, T5, 58		Not reimbursable with: A4361, A4375
A4378	Ostomy pouch, drainable, for use on faceplate, rubber, each		20 per month	G3, T5, 58		Not reimbursable with: A4361, A4376
A4379	Ostomy pouch, urinary, with faceplate attached, plastic, each		20 per month	G3, T5, 58		Not reimbursable with: A4361, A4381, and A4382
A4380	Ostomy pouch, urinary, with faceplate attached, rubber, each		20 per month	G3, T5, 58		Not reimbursable with: A4361, A4383
A4381	Ostomy pouch, urinary, for use on faceplate, plastic, each		30 per month	G3, T5, 58		Not reimbursable with: A4361, A4379, A4382
A4382	Ostomy pouch, urinary, for use on faceplate, heavy plastic, each		30 per month	G3, T5, 58		Not reimbursable with: A4361, A4379, A4381
A4383	Ostomy pouch, urinary, for use on faceplate, rubber, each		30 per month	G3, T5, 58		Not reimbursable with: A4361, A4380
A4384	Ostomy faceplate equivalent, silicone ring, each		2 per month	G3, T5, 58		
A4385	Ostomy skin barrier, solid 4x4 or equivalent, extended wear, without built-in convexity, each		15 per month	G3, T5, 58		
A4387	Ostomy pouch, closed with barrier attached, with built-in convexity (1 piece), each		60 per month	G3, T5, 58		
A4388	Ostomy pouch, drainable, with extended wear barrier attached, (1 piece), each		60 per month	G3, T5, 58		
A4389	Ostomy pouch, drainable, with barrier attached, with built-in convexity (1 piece), each		60 per month	G3, T5, 58		
A4390	Ostomy pouch, drainable, with extended wear barrier attached, with built-in convexity (1 piece), each		60 per month	G3, T5, 58		
A4391	Ostomy pouch, urinary, with extended, wear barrier attached (1 piece), each		30 per month	G3, T5, 58		

A4392	Ostomy pouch, urinary, with standard wear barrier attached, with built-in convexity (1 piece), each		30 per month	G3, T5, 58		
A4393	Ostomy pouch, urinary, with extended wear barrier attached, with built-in convexity (1 piece), each		30 per month	G3, T5, 58		
A4394	Ostomy deodorant for use in ostomy pouch, liquid, per fluid ounce		16 oz. per month	G3, T5, 58		
A4395	Ostomy deodorant for use in ostomy pouch, solid, per tablet		30 per month	G3, T5, 58		
A4397	Irrigation supply; sleeve, each		4 per month	G3, T5, 58		
A4398	Ostomy irrigation supply; bag, each		1 per 6 months	G3, T5, 58		
A4399	cone/catheter, including brush		1 per 6 months	G3, T5, 58		
A4400	Ostomy irrigation set		1 per year	G3, T5, 58		
A4402	Lubricant, per ounce		4 oz per month	G3, T5, 58		
A4404	Ostomy ring, each		2 per month	G3, T5, 58		
A4405	Ostomy skin barrier, non-pectin based, paste, per ounce		4 oz per month	G3, T5, 58		
A4406	Ostomy skin barrier; pectin-based, paste, per ounce		4 oz per month	G3, T5, 58		
A4407	Ostomy skin barrier; with flange (solid, flexible, or accordion), extended wear, with built-in convexity, 4x4 inches or smaller, each		20 per month	G3, T5, 58		
A4408	Ostomy skin barrier; with flange (solid, flexible, or accordion), extended wear, with built-in convexity, larger than 4x4 inches, each		20 per month	G3, T5, 58		
A4409	Ostomy skin barrier; with flange (solid, flexible or accordion), extended wear, without built-in convexity, 4x4 inches or smaller, each		20 per month	G3, T5, 58		
A4410	Ostomy skin barrier; with flange (solid, flexible or accordion), extended wear, without built-in convexity, larger than 4x4 inches, each		20 per month	G3, T5, 58		
A4413	Ostomy pouch, drainable, high output, for use on a barrier with flange (2 piece system), with filter; each		20 per month	G3, T5, 58		
A4414	Ostomy skin barrier, with flange (solid, flexible or accordion), without built-in convexity, 4x4 inches or smaller, each		20 per month	G3, T5, 58		

A4415	Ostomy skin barrier, with flange (solid, flexible or accordion), without built-in convexity, larger than 4x4 inches, each		20 per month	G3, T5, 58		
A4416	Ostomy pouch, closed; with barrier attached, with filter (1 piece), each	K0581	30 per month	G3, T5, 58		Not reimbursable with: A4366
A4417	Ostomy pouch, closed; with barrier attached, with built-in convexity, with filter (1 piece)	K0582	15 per month	G3, T5, 58		Not reimbursable with: A4366
A4418	Ostomy pouch, closed; without barrier attached, with filter (1 piece), each	K0583	60 per month	G3, T5, 58		Not reimbursable with: A4366
A4419	Ostomy pouch, closed; for use on barrier with non-locking flange, with filter (2 piece), each	K0584	15 per month	G3, T5, 58		
A4420	Ostomy pouch, closed; for use on barrier with locking flange (2 piece), each	K0585	15 per month	G3, T5, 58		
A4421	Ostomy supply; miscellaneous		Prior Authorization	G3, T5, 58		
A4422	Ostomy absorbent material (sheet/pad/cyrstal packet) for use in ostomy pouch to thicken liquid stomal output, each		1 per day	G3, T5, 58		
A4423	Ostomy pouch, closed; for use on barrier with locking flange, with filter (2 piece), each	K0586	15 per month	G3, T5, 58		
A4424	Ostomy pouch, drainable; with barrier attached, with filter (1 piece) , each	K0587	15 per month	G3, T5, 58		
A4425	Ostomy pouch, drainable; for use n barrier with non-locking flange, with filter (2 piece system), each	K0588	15 per month	G3, T5, 58		
A4427	Ostomy pouch, drainable; for use on barrier with locking flange, with filter (2 piece system), each	K0590	15 per month	G3, T5, 58		
A4428	Ostomy pouch, urinary; with extended wear barrier, with faucet-type tap with valve (1 piece), each	K0591	15 per month	G3, T5, 58		
A4429	Ostomy pouch, urinary; with barrier attached, with built-in convexity, with faucet-type tap with valve (1 piece), each	K0592	15 per month	G3, T5, 58		
A4430	Ostomy pouch, urinary; with extended wear barrier attached, with built-in convexity, with faucet-type tap with valve (1 piece), each	K0593	15 per month	G3, T5, 58		
A4431	Ostomy pouch, urinary; with barrier attached, with faucet-type tap with valve (1 piece), each	K0594	15 per month	G3, T5, 58		

A4432	Ostomy pouch, urinary; for use on barrier with non-locking flange, with faucet-type tap with valve (2 piece), each	K0595	15 per month	G3, T5, 58		
A4433	Ostomy pouch, urinary; for use on barrier with locking flange (2 piece), each	K0596	15 per month	G3, T5, 58		
A4434	Ostomy pouch, urinary; for use on barrier with locking flange, with faucet-type tap with valve (2 piece), each	K0597	15 per month	G3, T5, 58		
A4450	Tape, non-waterproof, per 18 square inches		60 units per month	G3, T5, 58		
A4452	Tape, waterproof, per 18 square inches		30 units per month	G3, T5, 58		
A4455	Adhesive remover or solvent (for tape, cement or other adhesive), per ounce		4 oz per month	G3, T5, 58		
A4521	Adult-sized incontinence product, diaper, small size; each	W0560	200 per month	G3, T5, 58	X	Available only for members 3 years or older. When billing incontinent supplies (diapers, briefs, underpads, etc.) in combination, the total maximum is 250 items per month
A4522	Adult-sized incontinence product, diaper, medium size, each	W0560	200 per month	G3, T5, 58	X	Available only for members 3 years or older. When billing incontinent supplies (diapers, briefs, underpads, etc.) in combination, the total maximum is 250 items per month
A4523	Adult-sized incontinence product, diaper, large size, each	W0560	200 per month	G3, T5, 58	X	Available only for members 3 years or older. When billing incontinent supplies (diapers, briefs, underpads, etc.) in combination, the total maximum is 250 items per month
A4524	Adult-sized incontinence product, diaper, extra large size, each	W0560	200 per month	G3, T5, 58	X	Available only for members 3 years or older. When billing incontinent supplies (diapers, briefs, underpads, etc.) in combination, the total maximum is 250 items per month

A4525	Adult-sized incontinence product, brief, small size, each	W0560	200 per month	G3, T5, 58	X	Available only for members 3 years or older. When billing incontinent supplies (diapers, briefs, underpads, etc.) in combination, the total maximum is 250 items per month
A4526	Adult-sized incontinence product, brief, medium size, each	W0560	200 per month	G3, T5, 58	X	Available only for members 3 years or older. When billing incontinent supplies (diapers, briefs, underpads, etc.) in combination, the total maximum is 250 items per month
A4527	Adult-sized incontinence product, brief, large size, each	W0560	200 per month	G3, T5, 58	X	Available only for members 3 years or older. When billing incontinent supplies (diapers, briefs, underpads, etc.) in combination, the total maximum is 250 items per month
A4528	Adult-sized incontinence product, brief, extra large size, each	W0560	200 per month	G3, T5, 58	X	Available only for members 3 years or older. When billing incontinent supplies (diapers, briefs, underpads, etc.) in combination, the total maximum is 250 items per month
A4529	Child-sized incontinence product, diaper, small/medium size, each	W0560	200 per month	G3, T5, 58	X	Available only for members 3 years or older. When billing incontinent supplies (diapers, briefs, underpads, etc.) in combination, the total maximum is 250 items per month

A4530	Child-sized incontinence product, large size, each	W0560	200 per month	G3, T5, 58	X	Available only for members 3 years or older. When billing incontinent supplies (diapers, briefs, underpads, etc.) in combination, the total maximum is 250 items per month
A4531	Child-sized incontinence product, brief, small/medium size, each	W0560	200 per month	G3, T5, 58	X	Available only for members 3 years or older. When billing incontinent supplies (diapers, briefs, underpads, etc.) in combination, the total maximum is 250 items per month
A4532	Child-sized incontinence product, brief, large size, each	W0560	200 per month	G3, T5, 58	X	Available only for members 3 years or older. When billing incontinent supplies (diapers, briefs, underpads, etc.) in combination, the total maximum is 250 items per month
A4533	Youth-sized incontinence product, diaper, each	W0560	200 per month	G3, T5, 58	X	Available only for members 3 years or older. When billing incontinent supplies (diapers, briefs, underpads, etc.) in combination, the total maximum is 250 items per month
A4534	Youth-sized incontinence product, brief, each	W0560	200 per month	G3, T5, 58	X	
A4535	Disposable liner/shield for incontinence, each	W0564	150 per month	G3, T5, 58	X	
A4536	Protective underwear, washable, any size, each	W0562	8 per year	G3, T5, 58	X	
A4537	Under pad, reusable/washable, any size, each		2 per year	G3, T5, 58	X	Available only for members 3 years or older. When billing incontinent supplies (diapers, briefs, underpads, etc.) in combination, the total maximum is 250 items per month

A4550	Surgical supply, miscellaneous		15 per month	G3, T5, 58	X	
A4554	Disposable underpads, all sizes, (e.g., chux's)		150 per month	G3, T5, 58		
A4561	Pessary, rubber, any type		1 per lifetime	G3, T5, 58		
A4562	Pessary, non-rubber, any type		1 per lifetime	G3, T5, 58		
A4623	Tracheostomy, inner cannula		1 per month	G3, T5, 58		
A4625	Tracheostomy care kit for new tracheostomy		14 per lifetime	G3, T5, 58		
A4626	Tracheostomy cleaning brush, each		1 per 6 months	G3, T5, 58		
A4629	Tracheostomy care kit for established tracheostomy		1 daily	G3, T5, 58		
A4649	Surgical supply, miscellaneous		Prior Authorization Cost Invoice	G3, T5, 58		
A4927	Gloves, non-sterile, per 100		1 box monthly	G3, T5, 58	X	
A5102	Bedside drainage bottle with or without tubing, rigid or expandable,each		2 per month	G3, T5, 58		
A5105	Urinary suspensory; with leg bag, with or without tube		1 per month	G3, T5, 58		
A5112	Urinary leg bag; latex		1 per month	G3, T5, 58		
A5113	Leg strap; latex, replacement only, per set		2 per month	G3, T5, 58		
A5114	foam or fabric, replacement only, per set		2 per month	G3, T5, 58		
A4561	Pessary, rubber, any type		1 per lifetime	G3, T5, 58		
A4562	Pessary, non-rubber, any type		1 per lifetime	G3, T5, 58		
A5051	Ostomy pouch, closed; with barrier attached (1 piece), each		60 per month	G3, T5, 58		
A5052	Ostomy pouch, closed;without barrier attached (1 piece), each		60 per month	G3, T5, 58		
A5053	for use on faceplate, each		60 per month	G3, T5, 58		
A5054	for use on barrier with flange (2 piece), each		90 per month	G3, T5, 58		
A5055	Stoma cap		30 per month	G3, T5, 58		
A5061	Ostomy pouch, drainable; with barrier attached (1 piece), each		60 per month	G3, T5, 58		
A5062	without barrier attached (1 piece), each		20 per month	G3, T5, 58		
A5071	Ostomy pouch, urinary; with barrier attached (1 piece), each		20 per month	G3, T5, 58		
A5072	without barrier attached (1 piece), each		30 per month	G3, T5, 58		
A5073	for use on barrier with flange (2 piece), each		30 per month	G3, T5, 58		
A5082	catheter for continent stoma		2 per month	G3, T5, 58		

A5102	Bedside drainage bottle with or without tubing, rigid or expandable,each		2 per month	G3, T5, 58		
A5105	Urinary suspensory; with leg bag, with or without tube		1 per month	G3, T5, 58		
A5112	Urinary leg bag; latex		1 per month	G3, T5, 58		
A5113	Leg strap; latex, replacement only, per set		2 per month	G3, T5, 58		
A5114	foam or fabric, replacement only, per set		2 per month	G3, T5, 58		
A5119	Skin barrier; wipes, box per 50		1 per month	G3, T5, 58		
A5121	solid, 6x6 or equivalent, each		15 per month	G3, T5, 58		
A5122	solid, 8x8 or equivalent, each		15 per month	G3, T5, 58		
A5126	Adhesive or non-adhesive; disk or foam pad		36 per month	G3, T5, 58		
A5131	Appliance cleaner, incontinence and ostomy appliances, per 16 oz.		1 per month	G3, T5, 58		
A6154	Wound pouch, each		10 per month	G3, T5, 58		
A6196	Alginate or other fiber gelling dressing, wound cover, pad size 16 sq. in. or less, each dressing		31 per month	G3, T5, 58		
A6197	Alginate or other fiber gelling dressing, wound cover, pad size more than 16 sq. in. but less than or equal to 48 sq. in., each dressing		31 per month	G3, T5, 58		
A6198	Alginate or other fiber gelling dressing, wound cover, pad size more than 48 sq. in., each dressing		31 per month	G3, T5, 58		
A6199	Alginate or other fiber gelling dressing, wound filler, per 6 inches		45 per month	G3, T5, 58		
A6200	Composite dressing, pad size 16 sq. in. or less, without adhesive border, each dressing		15 per month	G3, T5, 58		
A6201	Composite dressing, pad size more than 16 sq. in. but less than or equal to 48 sq. inc., without adhesive border, each dressing		15 per month	G3, T5, 58		
A6202	Composite dressing, pad size more than 48 sq. in., without adhesive border, each dressing		15 per month	G3, T5, 58		
A6203	Composite dressing, pad size 16 sq. in. or less, with any size adhesive border, each dressing		15 per month	G3, T5, 58		

A6204	Composite dressing, pad size more than 16 sq. in. but less than or equal to 48 sq. in., with any size adhesive border, each dressing		15 per month	G3, T5, 58		
A6205	Composite dressing, pad size more than 48 sq. in, with any size adhesive border, each dressing		15 per month	G3, T5, 58		
A6206	Contact layer, 16 sq. in. or less, each dressing		5 per month	G3, T5, 58		
A6207	Contact layer, more than 16 sq. in. but less than or equal to 48 sq. in., each dressing		5 per month	G3, T5, 58		
A6208	Contact layer, more than 48 sq. in., each dressing		5 per month	G3, T5, 58		
A6209	Foam dressing, wound cover, pad size 16 sq. in. or less, without adhesive border, each dressing		15 per month	G3, T5, 58		
A6210	Foam dressing, wound cover, pad size more than 16 sq. in. but less than or equal to 48 sq. in., without adhesive border, each dressing		15 per month	G3, T5, 58		
A6211	Foam dressing, wound cover, pad size more than 48 sq. in., without adhesive border, each dressing		15 per month	G3, T5, 58		
A6212	Foam dressing, wound cover, pad size 16 sq. in. or less, with any size adhesive border, each dressing		15 per month	G3, T5, 58		
A6213	Foam dressing, wound cover, pad size more than 16 sq. in. but less than or equal to 48 sq. in., with any size adhesive border, each dressing		15 per month	G3, T5, 58		
A6214	Foam dressing, wound cover, pad size more than 48 sq. in., with any size adhesive border, each dressing		15 per month	G3, T5, 58		
A6215	Foam dressing, wound filler, per gram		Prior Authorization Cost Invoice	G3, T5, 58		
A6216	Gauze, non-impregnated, non-sterile, pad size 16 sq. in. or less, without adhesive border, each dressing		95 per month	G3, T5, 58		

A6217	Gauze, non-impregnated, non-sterile, pad size more than 16 sq. in. but less than or equal to 48 sq. in., without adhesive border, each dressing	95 per month	G3, T5, 58		
A6218	Gauze, non-impregnated, non-sterile, pad size more than 48 sq. in., without adhesive border, each dressing	95 per month	G3, T5, 58		
A6219	Gauze, non-impregnated, pad size 16 sq. in. or less, with any size adhesive border, each dressing	95 per month	G3, T5, 58		
A6220	Gauze, non-impregnated, pad size more 16 sq. in. but less than or equal to 48 sq. in., with any size adhesive border, each dressing	95 per month	G3, T5, 58		
A6221	Gauze, non-impregnated, pad size more than 48 sq. in. ., with any size adhesive border, each dressing	95 per month	G3, T5, 58		
A6222	Gauze, impregnated with other than water, normal saline, or hydrogel, pad size 16 sq. in. or less, without adhesive border, each dressing	31 per month	G3, T5, 58		
A6223	Gauze, impregnated with other than water, normal saline, or hydrogel, pad size more than 16 sq. in. but less than or equal to 48 sq. in., without adhesive border, each dressing	31 per month	G3, T5, 58		
A6224	Gauze, impregnated with other than water, normal saline, or hydrogel, pad size more than 48 sq. in., without adhesive border, each dressing	31 per month	G3, T5, 58		
A6228	Gauze, impregnated, water or normal saline, pad size 16 sq. in. or less, without adhesive border, each dressing	250 per month	G3, T5, 58		
A6229	Gauze, impregnated, water or normal saline, pad size more than 16 sq. in. but less than or equal to 48 sq. in., without adhesive border, each dressing	150 per month	G3, T5, 58		
A6230	Gauze, impregnated, water or normal saline, pad size more than 48 sq. in., without adhesive border, each dressing	150 per month	G3, T5, 58		

A6231	Gauze, impregnated, hydrogel, for direct wound contact, pad size 16 sq. in. or less, each dressing	12 per month	G3, T5, 58		
A6232	Gauze, impregnated, hydrogel, for direct wound contact, pad size greater than 16 sq. in., but or less than or equal to 48 sq. in., each dressing	12 per month	G3, T5, 58		
A6233	Gauze, impregnated, hydrogel, for direct wound contact, pad size more than 48 sq. in., each dressing	12 per month	G3, T5, 58		
A6234	Hydrocolloid dressing, wound cover, pad size 16 sq. in. or less, without adhesive border, each dressing	15 per month	G3, T5, 58		
A6235	Hydrocolloid dressing, wound cover, pad size more than 16 sq. in. but less than or equal to 48 sq. in., without adhesive border, each dressing	15 per month	G3, T5, 58		
A6236	Hydrocolloid dressing, wound cover, pad size more than 48 sq. in., without adhesive border, each dressing	15 per month	G3, T5, 58		
A6237	Hydrocolloid dressing, wound cover, pad size 16 sq. in. or less, with any size adhesive border, each dressing	15 per month	G3, T5, 58		
A6238	Hydrocolloid dressing, wound cover, pad size ore than 16 sq. in. but less than or equal to 48 sq. in., with any size adhesive border, each dressing	15 per month	G3, T5, 58		
A6239	Hydrocolloid dressing, wound cover, pad size more than 48 sq. in, with any size adhesive border, each dressing	15 per month	G3, T5, 58		
A6240	Hydrocolloid dressing, wound filler, paste, per fluid ounce	15 per month	G3, T5, 58		
A6241	Hydrocolloid dressing, wound filler, dry form, per gram	15 per month	G3, T5, 58		
A6242	Hydrogel dressing, wound cover, pad size 16 sq. in. or less, without adhesive border, each dressing	31 per month	G3, T5, 58		
A6243	Hydrogel dressing, wound cover, pad size more than 16 sq. in. but less than or equal to 48 sq. in., without adhesive border, each dressing	31 per month	G3, T5, 58		

A6244	Hydrogel dressing, wound cover, pad size more than 48 sq. in., without adhesive border, each dressing		31 per month	G3, T5, 58		
A6245	Hydrogel dressing, wound cover, pad size 16 sq. in. or less, with any size adhesive border, each dressing		15 per month	G3, T5, 58		
A6246	Hydrogel dressing, wound cover, pad size more than 16 sq. in. but less than or equal to 48 sq. in., with any size adhesive border, each dressing		15 per month	G3, T5, 58		
A6247	Hydrogel dressing, wound cover, pad size more than 48 sq. in., with any size adhesive border, each dressing		15 per month	G3, T5, 58		
A6248	Hydrogel dressing, wound filler, gel, per fluid ounce		15 per month	G3, T5, 58		
A6250	Skin sealants, protectants, moisturizers, ointments, any type,any size	Z7047	1 per month	G3, T5, 58		
A6251	Specialty absorptive dressing; wound cover, pad size 16 sq. in. or less, without adhesive border, each dressing		31 per month	G3, T5, 58		
A6252	Specialty absorptive dressing; wound cover, pad size more than 16 sq. in. but less that or equal to 48 sq. in., without adhesive border, each dressing		31 per month	G3, T5, 58		
A6253	Specialty absorptive dressing, wound cover, pad size more than 48 sq. in., without adhesive border, each dressing		31 per month	G3, T5, 58		
A6254	Specialty absorptive dressing, wound cover, pad size 16 sq. in. or less, with any size adhesive border, each dressing		31 per month	G3, T5, 58		
A6255	Specialty absorptive dressing, wound cover, pad size more than 16sq. In. but less than or equal to 48 sq. in., with any size adhesive border, each dressing.		31 per month	G3, T5, 58		
A6256	Specialty absorptive dressing, wound cover, pad size more than 48 sq. in., with any size adhesive border, each dressing		31 per month	G3, T5, 58		
A6257	Transparent film, 16 sq. in. or less, each dressing		15 per month	G3, T5, 58		

A6258	Transparent film, more than 16 sq. in. but less than or equal to 48 sq. in., each dressing		15 per month	G3, T5, 58		
A6259	Transparent film, more than 48 sq. in., each dressing		15 per month	G3, T5, 58		
A6260	Wound cleansers, any type, any size		1 per month	G3, T5, 58		
A6261	Wound filler, gel/paste, per fluid ounce, not elsewhere classified		Prior Authorization Cost Invoice.	G3, T5, 58		
A6262	Wound filler, dry form, per gram, not elsewhere classified		Prior Authorization Cost Invoice	G3, T5, 58		
A6266	Gauze, impregnated, other than water, normal saline or zinc paste, any width, per linear yard		60 per month	G3, T5, 58		
A6402	Gauze, non-impregnated, sterile, pad size 16 sq. in. or less, without adhesive border, each dressing		60 per month	G3, T5, 58		
A6403	Gauze, non-impregnated, sterile, pad size more than 16 sq. in. but less than or equal to 48 sq. in., without adhesive border, each dressing		60 per month	G3, T5, 58		
A6404	Gauze, non-impregnated, sterile, pad size more than 48 sq. in., without adhesive border, each dressing		31 per month	G3, T5, 58		
A6407	Packing strips, non-impregnated, up to 2 inches in width, per linear yard		31 per month	G3, T5, 58		
A6441	Padding bandage, non-elastic; non-woven/non-knitted, width greater than or equal to three inches and less than five inches, per yard	A6421	4 per month	G3, T5, 58		
A6442	Conforming bandage, non-elastic, knitted/woven, non-sterile, width less than three inches, per yard		4 per month	G3, T5, 58		
A6443	Conforming bandage, non-elastic, knitted/woven, non-sterile, width greater than or equal to three inches and less than five inches, per yard	A6422	4 per month	G3, T5, 58		
A6444	Conforming bandage, non-elastic, knitted/woven, non-sterile, width greater than or equal to 5 inches, per yard	A6424	4 per month	G3, T5, 58		

A6445	Conforming bandage, non-elastic, knitted/woven, sterile, width less than three inches, per yard		4 per month	G3, T5, 58		
A6446	Conforming bandage, non-elastic, knitted/woven, sterile, width greater than or equal to three inches and less than five inches, per yard	A6426	4 per month	G3, T5, 58		
A6447	Conforming bandage, non-elastic, knitted/woven, sterile, width greater than or equal to five inches per yard	A6428	4 per month	G3, T5, 58		
A6448	Light compression bandage, elastic, knitted/woven, width less than three inches, per yard		4 per month	G3, T5, 58		
A6449	Light compression bandage, elastic, knitted/woven, width greater than or equal to three inches and less than five inches, per yard.	A6430	4 per month	G3, T5, 58		
A6450	Light compression bandage, elastic, knitted/woven, width greater than or equal to five inches, per yard	A6432	4 per month Cost Invoice	G3, T5, 58		
A6451	Moderate compression bandage, elastic, knitted/woven, load resistance of 1.25 to 1.34 foot pounds at 50% maximum stretch, width greater than or equal to three inches and less than fives inches, per yard	A6434	4 per month	G3, T5, 58		
A6452	High compression bandage, elastic, knitted/woven, load resistance greater than or equal to 1.35 foot pounds at 50% maximum stretch, width greater than or equal to three inches and less than five inches, per yard	A6436	4 per month	G3, T5, 58		
A6453	Self-adherent bandage, elastic, non-knitted/non-woven, width less than three inches, per yard		4 per month	G3, T5, 58		
A6454	Self-adherent bandage, elastic, non-knitted/non-woven, width greater than or equal to three inches and less than 5 inches, per yard	A6438	4 per month	G3, T5, 58		
A6455	Self-adherent band, elastic, non-knitted/non-woven, width greater than or equal to five inches, per yard		4 per month	G3, T5, 58		

A6456	Zinc paste impregnated bandage, non-elastic, knitted/woven, width greater than or equal to three inches and less than five inches, per yard	A6440	4 per month	G3, T5, 58		
A7524	Tracheostoma stent/stud/button, each		Prior Authorization	G3, T5, 58		
A7525	Tracheostomy mask, each	A4621	4 per month	G3, T5, 58		
A7526	Tracheostomy tube collar/holder, each	A4621 S8181	4 per month	G3, T5, 58		
B4034	Enteral feeding supply kit; syringe, per day -		1 per day Prior Authorization	G3, T5, 58		
B4035	pump fed, per day		1 per day Prior Authorization	G3, T5, 58		
B4081	Nasogastric tubing; with stylet		4 per month	G3, T5, 58		
B4082	without stylet		4 per month	G3, T5, 58		
B4083	Stomach tube - levine type		4 per month	G3, T5, 58		
B4086	Gastrostomy/jejunostomy tube, any material, any type, (standard or low profile), each		2 per 6 months	G3, T5, 58		
B9999	NOC for Parenteral supplies		Prior Authorization Cost Invoice	G3, T5, 58		
	****SPECIALTY**					
	G3 - Durable Medical Provider					
	T5 - Pharmacy					
	58 - Home Health Agency					