CHAPTER 506 – COVERED SERVICES, LIMITATIONS, AND EXCLUSIONS FOR DME MEDICAL SUPPLIES

CHANGE LOG

Replace	Title	Change Date	Effective Date
Attachment I	HCPCS Codes for Durable Medical Equipment & Supplies	01/16/08	01/01/08
Attachment II	Non-Covered DME/Medical Supplies for Unlisted Codes	01/16/08	01/01/08
Section 506.2.1	Prescribing Practitioner	10/01/07	11/01/07
Section 506.2.2	Durable Medical Equipment/Medical Supply Provider	10/01/07	11/01/07
Section 506.5	Prior Authorization	10/01/07	11/01/07
Attachment I	HCPCS Codes for Durable Medical Equipment & Supplies	10/01/07	11/01/07
Section 506.5	Prior Authorization	06/01/06	07/01/06
Attachment I	HCPCS Codes for Durable Medical Equipment & Supplies	06/01/06	07/01/06
	Table of Contents	04/01/06	05/01/06
Introduction	Introduction	04/01/06	05/01/06
Section 506.1	Definitions	04/01/06	05/01/06
Section 506.2.1	Prescribing Practitioner	04/01/06	05/01/06
Section 506.2.2	DME/Medical Supply Provider	04/01/06	05/01/06
Section 506.2.3	Home IV Infusion Therapy	04/01/06	05/01/06

DISCLAIMER: This manual does not address all the complexities of Medicaid policies and procedures, and must be supplemented with all State and Federal Laws and Regulations.

Replace	Title	Change Date	Effective Date
Section 506.3.1.b	Repair	04/01/06	05/01/06
Section 506.4	Documentation Requirements	04/01/06	05/01/06
Section 506.5	Prior Authorization	04/01/06	05/01/06
Section 506.8	Non-Covered Durable Medical Equipment and Medical Supplies	04/01/06	05/01/06
Section 506.9	Billing and Reimbursement	04/01/06	05/01/06
Attachment III	Certificates of Medical Necessity	04/01/06	05/01/06
Add	Table of Contents	01/01/06	02/16/06
Introduction	Introduction	01/01/06	02/16/06
Section 506.1	Definitions	01/01/06	02/16/06
Section 506.2	Provider Participation Requirements	01/01/06	02/16/06
Section 506.3	Covered Durable Medical Equipment and Medical Supplies	01/01/06	02/16/06
Section 506.4	Documentation Requirements	01/01/06	02/16/06
Section 506.5	Prior Authorization	01/01/06	02/16/06
Section 506.7	Out-of State Service	01/01/06	2/16/06
Section 506.8	Non-Covered Durable Medical Equipment and Medical Supplies	01/01/06	02/16/06
Section 506.9	Billing and Reimbursement	01/01/06	02/16/06
Section 506.10	Managed Care	01/01/06	02/16/06

DISCLAIMER: This manual does not address all the complexities of Medicaid policies and procedures, and must be supplemented with all State and Federal Laws and Regulations.

Replace	Title	Change Date	Effective Date
Attachment I	HCPCS Codes for Durable Medical Equipment & Supplies	01/01/06	02/16/06
Attachment II	Non-Covered DME/Medical Supplies for Unlisted HCPCS Codes	01/01/06	02/16/06
Attachment III	WV Medicaid DME/Medical Supplies Authorization Request Form	01/01/06	03/15/06
Introduction	Introduction		05/01/05
Section 506.3	Covered Durable Medical Equipment & Medical Supplies		05/01/05
Section 506.4	Documentation Requirements		05/01/05
Section 506.5	Prior Authorization		05/01/05
Section 506.12	Miscellaneous		05/01/05
Attachment I	HCPCS Codes for Durable Medical Equipment		05/01/05
Attachment I	HCPCS Codes for Durable Medical Equipment		07/01/05
Attachment II	Non-Covered DME/Medical Supplies for Unlisted HCPCS Codes		05/01/05
Attachment III	DME CMN with Instructions		07/01/05
Attachment IV	Apnea Monitor Initial & Request for Extension CMN's		07/01/05

DISCLAIMER: This manual does not address all the complexities of Medicaid policies and procedures, and must be supplemented with all State and Federal Laws and Regulations.

CHAPTER 500 – COVERED SERVICES, LIMITATIONS, AND EXCLUSIONS FOR DME MEDICAL SUPPLIES

JANUARY 1, 2008

Attachment I

Introduction: Covered/Non-Covered DME/Medical Supply Services with Assigned HCPCS Codes
New Policy: Updated HCPCS Codes
Directions: Replace Attachment I

Attachment II

Introduction: Non-Covered DME/Medical Supply for Unlisted HCPCS Codes
New Policy: Updated Unlisted Codes
Directions: Replace Attachment

NOVEMBER 1, 2007

SECTION 506.2.1

Introduction: Section 506.2.1, 2nd paragraph, 1st sentence
Old Policy: The Bureau's website @ www.wvdhhr.org is the most efficient means of keeping current on updates and information regarding the Bureau for Medical Services.
New Policy: The Bureau's website @ www.wvdhhr.org is the most efficient means of keeping current on updates and information regarding BMS.
Directions: Replace page

Introduction: Section 506.2.1, 1st paragraph (17)
Old Policy: (17) provide any changes to original enrollment application (i.e., personnel, licensure, certification, registration, demographics) to Unisys, Provider Services, PO Box 2002, Charleston, WV, 25327-2002 within fifteen (15) days of change.
New Policy:(17) provide any changes to original enrollment application (i.e., personnel, licensure, certification, registration, demographics) to Unisys, Provider Services, PO Box 2002, Charleston, WV, 25327-2002 within fifteen (15) days. Copies of updated license, certification and/or registration must be submitted to Unisys annually.
Directions: Replace page

SECTION 506.5

Introduction: Section 506.5, 3rd paragraph, 6th bullet
Old Policy: Home Oxygen Therapy (E0424, E0431, E0434, E0439).
Effective March 15, 2006, any new oxygen system requested for medical necessity must follow InterQual criteria to include documentation of initial lab results. PA recertification review is required at the end of the prescription period specified or within one (1) year whichever comes first. Date of lab results must be

DISCLAIMER: This manual does not address all the complexities of Medicaid policies and procedures, and must be supplemented with all State and Federal Laws and Regulations.

within 6 months of the oxygen request. Note: The number of unused months of oxygen systems placed in the home for individual Medicaid members prior to March 15, 2006 is to be submitted to WVMI before June 1, 2006. However, if information is not received by WVMI within the specified time frame, DME providers are not eligible for reimbursement by WV Medicaid.
New Policy: Home Oxygen Therapy (E0424, E0431, E0434, E0439).
Effective March 15, 2006, any new oxygen system requested for medical necessity must follow InterQual criteria to include documentation of initial lab results. PA recertification review is required at the end of the prescription period specified or within one (1) year whichever comes first. Date of lab results must be within 6 months of the oxygen request.
Directions: Replace page

Introduction: Section 506.5, 3rd paragraph, 11th bullet
Old Policy: Manual Wheelchairs, Recliner/Tilt (K0001 + E1226, E1161, E1231, E1232, E1233, E1234)
New Policy: Manual Wheelchairs, Recliner/Tilt (K0001 + E1226, E1161)
Directions: Replace page

Introduction: Section 506.5, 3rd paragraph, 12th bullet
Old Policy: Manual Wheelchairs, Specialized (E1231, E1233, E1234, E1235, E1237, E1238, K0005, K0009)
New Policy: Delete
Directions: Replace page

Introduction: Section 506.5, 3rd paragraph, 15th bullet
Old Policy: N/A
New Policy: Pediatric Mobility Equipment (E1231, E1232, E1233, E1234, E1235, E1237, E1238, K0890, K0891)
Directions: Replace page

Introduction: Section 506.5, 3rd paragraph, 16th bullet
Old Policy: Power Operated Vehicles (POV) (E1230)
New Policy: Power Operated Vehicles (POV) (K0800, K0801, K0802, K0806, K0807, K0808, K0812)
Directions: Replace page

Introduction: Section 506.5, 3rd paragraph, 17th bullet
Old Policy: Power Wheelchairs (K0010, K0011, K0012, K0014)
New Policy: Power Wheelchairs (K0813, K0814, K0815, K0826, K0820, K0821, K0822, K0823, K0824, K0825, K0826, K0827, K0828, K0829, K0830, K0831, K0835, K0836, K0837, K0838, K0839, K0840, K0841, K0842, K0843, K0848, K0849, K0850, K0851, K0852, K0853, K0854, K0855, K0856, K0857, K0858, K0859, K0860, K0861, K0862, K0863, K0864, K0868, K0869, K0870, K0871, K0877, K0878, K0879, K0880, K0884, K0885, K0886)
Directions Replace page

Introduction: Section 506.5, 3rd paragraph, 19th bullet
Old Policy: Support Surfaces (E0180, E0181 E0182, E0184, E0185, E0186, E0187, E0196, E0197 – E0199, E0277, E0371)
New Policy: Support Surfaces (E0181 E0182, E0184, E0185, E0186, E0187, E0196, E0197 – E0199, E0277, E0371)

DISCLAIMER: This manual does not address all the complexities of Medicaid policies and procedures, and must be supplemented with all State and Federal Laws and Regulations.

Directions: Replace page

Attachment I

Introduction: Covered/Non-Covered DM/Medical Supply Services with Assigned HCPCS Codes
New Policy: Updated HCPCS Codes
Directions: Replace Attachment I

JULY 1, 2006

SECTION 506.5

Introduction: Section 506.5, 5th paragraph, 3rd bullet
Old Policy: (3) within 7 days post hospital discharge for apnea monitors and oxygen systems
New Policy: (3) within 7 days post hospital discharge for apnea monitors, oxygen systems, nebulizers
Directions: Replace page

Attachment I

Introduction: HCPCS Codes for DME & Supplies Changes: Special Instructions
Old Policy: N/A
New Policy: New HCPCS Codes K0733, K0734, K0735, K0736, and K0737 effective July 1, 2006 are non-covered
Directions: Replace page

MAY 1, 2006

Introduction: 4th paragraph, 3rd sentence
Old Policy: This review may include recouping of reimbursement based on inadequate documentation to support medical necessity.
New Policy: Delete
Direction: Replace page.

SECTION 506.1

Introduction: Section 506.1, 2nd paragraph.
Old Policy: Certificate of Medical Necessity: A two-fold document completed by a prescribing practitioner and the DME provider. The CMN is utilized to document the member's medical necessity for DME/medical supplies requiring prior authorization. **Discontinued 03/14/2006.**
New Policy: Delete
Directions: Replace page.

Introduction: Section 506.1, 6th paragraph, add to last sentence
Old Policy: power operated vehicles and scooters.
New Policy: "power operated vehicles and strollers.
Directions: Replace page.

Introduction: Section 506.1, 7th paragraph

DISCLAIMER: This manual does not address all the complexities of Medicaid policies and procedures, and must be supplemented with all State and Federal Laws and Regulations.

Old Policy: Identified as an M.D., D.O., DPM, Nurse Practitioner, or Physician Assistant.
New Policy: Identified as an M.D., D.O., DPM, Nurse Practitioner (NP), or Physician Assistant (PA) under the supervision of a participating physician. WV Medicaid does not recognize hospital residents as prescribing practitioners.
Directions: Replace page.

Introduction: Section 506.1, 8th paragraph
Old Policy: **WVMI Medicaid DME/Medical Supplies Authorization Request Form – Effective 03/15/2006 – Replaces DME/Medical Supplies CMN.** This form is used by the prescribing practitioner to document the medical necessity utilizing InterQual or DMERC criteria for DME/Medical Supply items requiring prior authorization (PA). Refer to Section 506.2.1.
New Policy: Delete.
Directions: Replace page.

SECTION 506.2.1

Introduction: Section 506.2.1, 1st & 2nd paragraph
Old Policy: The current DME/Medical Supplies CMN will no longer be valid after March 15, 2006. The current CMN will be replaced by the West Virginia Medical Institute (WVMI) Medicaid DME/Medical Supplies Authorization Request Form **(Attachment III)**. The prescribing practitioner is responsible for providing WVMI with medical necessity documentation via fax to 1-304-346-8185, telephonically at 1-800-296-9849 or 1-304-346-9167, option 5, or via mail to WVMI Medical Review Department, 3001 Chesterfield Place, Charleston, WV 25304. The WVMI Medicaid DME/Medical Supplies Authorization Request Form will be available at www.wvmi.org and www.wvdhhr.org websites. The Internet is the most efficient means of keeping current on updates and information regarding the Bureau for Medical Services. If you do not have the Internet, you may request a CD or paper copy of manuals or manual updates by calling Unisys Provider Enrollment at 1-888-483-0793.
New Policy: In addition to Chapter 300 Provider Participation Requirements, MDs, DOs, DPMs, NPs, and PAs under the supervision of a participating physician, prescribing DME/medical supplies and related items must:

(1) be actively enrolled in Medicaid;
(2) inquire if the member has a DME provider of choice;
(3) provide a written prescription to the member;
(4) provide clinical documentation for medical necessity to include diagnosis code, frequency of use, duration, quantity, and any relevant information to WVMI. Documentation may be submitted to WVMI in writing (with legal signature of prescribing practitioner), fax or telephonically;
(5) maintain all appropriate medical documentation in the Medicaid member's individual file; and,
(6) participate in on-site reviews and/or submission of medical documentation to BMS upon request.

The Bureau's website @ www.wvdhhr.org is the most efficient means of keeping current on updates and information regarding the Bureau for Medical Services. If you do not have the Internet, you may request a CD or paper copy of manuals or manual updates by calling Unisys Provider Enrollment at 1-888-483-0793.
Directions: Replace page

DISCLAIMER: This manual does not address all the complexities of Medicaid policies and procedures, and must be supplemented with all State and Federal Laws and Regulations.

SECTION 506.2.2

Introduction: 506.2.2, 2nd paragraph
Old Policy: (13) contact WVMI to obtain PA number before services are rendered;
New Policy: Delete #13 and re-number the remaining requirements
Directions: Replace page

SECTION 506.2.3

Introduction: 506.2.3, 1st paragraph, 2nd sentence
Old Policy: This change includes HCPCS codes A4221, A4222, A4223, B9004, B9006, and E0781.
New Policy: This change includes HCPCS codes A4221, A4222, A4223, B4164-B4224, B5000, B5100, and B5200
Directions: Replace page.

Introduction: 506.2.3, 2nd paragraph, 2nd sentence
Old Policy: Refer to Chapter 518, Pharmacy Manual, for additional information.
New Policy: Delete sentence
Directions: Replace page.

SECTION 506.3.1.b

Introduction: 506.3.1.b, 1st paragraph, 1st sentence
Old Policy: WV Medicaid's coverage for repair of equipment is limited to items that have been fully purchased by WV Medicaid including items in which the cap-rental timeframe has been exhausted, the medical need is expected to continue, and the repair is more economical than replacement.
New Policy: WV Medicaid's coverage for repair of equipment is limited to:

(1) items that have been fully purchased by WV Medicaid or by the Children with Special Healthcare Needs Program (CSHCN);
(2) equipment provided by CSHCN is covered by Medicaid;
(3) items in which the cap-rental time frame has been exhausted;
(4) the medical need is expected to continue; and
(5) repair is more economical than replacement.

Directions: Replace page.

SECTION 506.4

Introduction: 506.4, 2nd paragraph (1)
Old Policy: Effective March 15, 2006, WVMI Medicaid DME Authorization Request Form is required to provide WVMI medical necessity documentation for items or services prescribed by the treating practitioner.
New Policy: (1) Effective May 1, 2006, formal certificate of medical necessity forms (i.e, the WVMI Medicaid DME Authorization Request Form, the DME/Medical Supply Certificate of Medical Necessity, the Apnea Monitor Initial and Recertification Certificates of Medical Necessity) are not required to document medical necessity of items requiring prior authorization. However, as an enrolled participant of WV Medicaid, practitioners and DME providers are required to maintain individual Medicaid member files with documentation to assure that all services provided to Medicaid members are medically necessary and that billing of such services are accurate. **Attachment III** provides forms that may be submitted via fax to 1-

DISCLAIMER: This manual does not address all the complexities of Medicaid policies and procedures, and must be supplemented with all State and Federal Laws and Regulations.

304-346-8185 or 1-877-762-4338 or in writing to WVMI Medical Review Department, 3001 Chesterfield Place, Charleston, WV 25304. Telephonic reviews for urgent or emergency requests are available at 1-304-414-2551 or 1-800-296-9849.

Introduction: 506.4, 2nd paragraph (2)
Old Policy: (2) Effective March 15, 2006, a written prescription which includes the member's name, date of prescription, appropriate HCPCS code for item requested, description of code, estimated length of need in months, quantity of item(s), frequency of use and prescribing practitioner's signature, is to be given to the member by the prescribing practitioner. A copy of the hospital discharge plan and/or progress notes do not constitute a written prescription for DME/Medical Supplies.
New Policy: Effective May 1, 2006, delete "appropriate HCPCS code for item requested".
Directions: Replace page.

Introduction: 506.4, 2nd paragraph (3)
Old Policy: (3) Effective March 15, 2006, a signed delivery document by the member or caregiver and documentation of education for the DME item provided must be maintained in the individual member's record.
New Policy: The DME provider must maintain a delivery document signed …"
Direction: Replace page.

Introduction: 506.4, 2nd paragraph (5)
Old Policy: (5) Medical documentation submitted for review must not be more than six (6) months old at the time the prescription is written.
New Policy: "The prescriber's medical …"
Direction: Replace page.

SECTION 506.5

Introduction: 506.5, 1st paragraph, 1st, 2nd, and 3rd
Old Policy: For DME services and items requiring review for medical necessity by WVMI, it is the responsibility of the prescribing practitioner to submit the appropriate form to WVMI. The Authorization Form must be renewed at the end of the prescription period specified or within one (1) year whichever comes first.
New Policy: For DME services and items requiring prior authorization review for medical necessity by WVMI, it is the responsibility of the prescribing practitioner to submit the appropriate clinical documentation i.e., ICD-9 code(s), all information required on the written prescription (see Section 504, 2nd paragraph, (2) for clarification) and any other relevant information. Additionally, a licensed physical therapist or licensed occupational therapist who is fiscally, administratively and contractually independent from the DME provider may also submit clinical documentation for review when requested by the prescribing practitioner. PA recertification review is required at the end of the prescription period specified or within one (1) year whichever comes first.

Introduction: 506.5, 1st paragraph - Insert as 4th sentence
Old Policy: N/A
New Policy: It is strongly recommended that DME providers, in partnership with prescribing practitioners, assist in obtaining prior authorizations. Prescribing practitioners must provide clinical information and a written prescription while DME providers submit the appropriate HCPCS code and billing information.
Directions: Replace page.

DISCLAIMER: This manual does not address all the complexities of Medicaid policies and procedures, and must be supplemented with all State and Federal Laws and Regulations.

Introduction: 506.5, 2nd paragraph, Insert as 4th sentence.
Old Policy: N/A
New Policy: The explanation of benefit (EOB) must accompany the claim. An EOB documenting reasons for the denial of TPL for services requested must be provided to WVMI when requesting prior authorization review.

Introduction: 506.5, 3rd paragraph, 6th bullet
Old Policy: Home Oxygen Therapy (E0424, E0431, E0434, E0439)
New Policy: Add – Effective March 15, 2006, any new oxygen system requested for medical necessity must follow InterQual criteria to include documentation of initial lab results. PA recertification review is required at the end of the prescription period specified or within one (1) year whichever comes first. Date of lab results must be within 6 months of the oxygen request. Note: The number of unused months of oxygen systems placed in the home for individual Medicaid members prior to March 15, 2006 is to be submitted to WVMI before June 1, 2006. However, if information is not received by WVMI within the specified time frame, DME providers are not eligible for reimbursement by WV Medicaid.

Introduction: 506.5, 4th paragraph, 1st & 2nd sentences.
Old Policy: Practitioners are required to provide medical necessity documentation via mail, fax or telephonically to WVMI prior to items/services provided. Documentation form for DME PA will be available at www.wvmi.org and www.wvdhhr.org/bms.
New Policy: Delete

Introduction: 506.5, 4th paragraph, 3rd sentence
Old Policy: Items not listed above
New Policy: Items requiring PA not listed above will follow Palmetto, Region C, medical necessity criteria for covered services.
Directions: Replace page

Introduction: 506.5, 5th paragraph, 1st sentence
Old Policy: Retrospective authorization is only available under the following certain circumstances: (1) services covered by private insurance; (2) termination of Medicaid coverage; (3) Medicaid retro eligibility; and (4) an apnea monitor seven (7) days post hospital discharge.
New Policy: Retrospective authorization is available (1) for items denied due to TPL; (2) retrospective Medicaid eligibility; (3) within 7 days post hospital discharge for apnea monitors and oxygen systems; and, (4) for items other than referenced here on a case-by-case basis.
Directions: Replace page.

Introduction: 506.8, 1st paragraph, #6
Old Policy: by BMS
New Policy: Insert "or CSCHN" after BMS
Direction: Replace page.

Introduction: 506.8 1st paragraph, #8
Old Policy: through DME
New Policy: Insert "suppliers" after DME
Direction: Replace page.

Introduction: 506.8 1st paragraph, #9

DISCLAIMER: This manual does not address all the complexities of Medicaid policies and procedures, and must be supplemented with all State and Federal Laws and Regulations.

Old Policy: through DME
New Policy: Insert "suppliers" after DME
Direction: Replace page.

Introduction: 506.8 1st paragraph, #10
Old Policy: through DME
New Policy: Insert "suppliers" after DME
Direction: Replace page.

Introduction: 506.9, 5th paragraph, 7th sentence
Old Policy: In those instances where liability cannot be currently established; i.e., accident or injury, Medicaid benefits will not be withheld.
New Policy: Delete sentence.
Direction: Replace page.

Introduction: 506.9, 5th paragraph, 8th sentence
Old Policy: "on-setting adjustment"
New Policy: Delete "on-setting"
Direction: Replace page.

Attachment III

Introduction: Attachment III
Old Policy: N/A
New Policy: Add BMS Durable Medical Equipment/Medical Supplies Certificate of Medical Necessity

•BMS Certificate of Medical Necessity, Initial Infant Apnea Monitor

•BMS Certificate of Medical Necessity, Infant Apnea Monitor Request for Extension

FEBRUARY 16, 2006

TABLE OF CONTENTS
Introduction: Page 1
Old Policy: Not Applicable
New Policy: Add Table of Contents
Directions: Insert page

Introduction: delete 5th paragraph with bullets; change 6th paragraph to 5th paragraph and change wording
Old Policy: "This chapter describes WV Medicaid's major coverage policies for DME/Medical Supplies as below:"
New Policy: "This chapter describes WV Medicaid's major coverage policies for DME/Medical Supplies as noted in the following Sections:"
Directions: Replace page

SECTION 506.1

DISCLAIMER: This manual does not address all the complexities of Medicaid policies and procedures, and must be supplemented with all State and Federal Laws and Regulations.

Introduction: Section 506.1**,** 2nd paragraph
Old Policy: "**Certificate of Medical Necessity (CMN)** - A two-fold document completed by a prescribing practitioner and the DME provider. The CMN is utilized to document the member's medical necessity for DME/medical supplies requiring prior authorization."
New Policy: "Certificate of Medical Necessity (CMN) – A two-fold document completed by a prescribing practitioner and the DME provider. The CMN is utilized to document the member's medical necessity for DME/medical supplies requiring prior authorization. **Discontinued 03/14/2006."**
Directions: Replace page.

Introduction: Section 506.1, insert 6th paragraph
Old Policy: Not Applicable
New Policy: Mobility Assistive Equipment (MAE) – Items that offer assistance to members who have a physical impairment that results in a mobility deficit. MAE includes, but is not limited to, canes, crutches, walkers, manual wheelchairs, power wheelchairs, power operated vehicles and scooters.
Directions: Replace page.

Introduction: Section 506.1, insert 8th paragraph
Old Policy: Not Applicable
New Policy: "**WVMI Medicaid DME/Medical Supplies Authorization Request Form – Effective 03/15/2006 – Replaces DME/Medical Supplies CMN.** This form is used by the prescribing practitioner to document the medical necessity utilizing InterQual or DMERC criteria for DME/Medical Supply items requiring prior authorization (PA). Refer to Section 502.1."
Directions: Replace page.

SECTION 506.2

Introduction: Section 506.2, change heading
Old Policy: "Provider Participation Requirements" In addition to Chapter 300, Provider Participation Requirement, DME/medical supply providers must:

- maintain a physical facility. (PO Box, commercial mailbox, residence or homestead is prohibited) located within WV or within thirty (30) miles of WV's border. This requirement does not apply to Medicare crossover providers.

- maintain a retail store open to the public at least forty (40) hours per week. A notarized letter must be attached to the enrollment form indicating that the physical facility is a retail store.

- post a visible sign indicating hours of operation. Hours of operation and availability of emergency coverage must be stated on the WV Medicaid enrollment form.

- employ a WV licensed respiratory therapist that provides twenty-four (24) hour emergency coverage, if respiratory/oxygen equipment and/or supplies are to be provided to the Medicaid members.

- maintain inventory of equipment/supplies and display at least one of each item listed on an inventory and made readily available for delivery.

- maintain a business telephone that is listed locally under the name of the business. A toll-free

DISCLAIMER: This manual does not address all the complexities of Medicaid policies and procedures, and must be supplemented with all State and Federal Laws and Regulations.

number must be provided for Medicaid members. Exclusive use of a beeper number, answering service, pager, facsimile machine, car phone or an answering machine does not constitute a primary business telephone.

- maintain adequate space to store inventory, business and member records.
  have at least one public handicapped-accessible door from the street and/or parking lot.

- have handicapped-accessible parking.

- obtain individual WV Medicaid provider numbers for each physical facility under the same ownership. Satellite businesses affiliated with a provider are not covered under the provider=s contract; therefore, no reimbursement will be made to a provider doing business at a satellite location, unless the satellite enrolls as a separate entity and receives a separate provider number.

- employ or have the appropriate licensed or credentialed individuals on staff, depending on type of service provided (e.g., mastectomy fitter and/or orthotic fitter must be accredited by a nationally accrediting body that is certified by National Commission for Certifying Agencies (NCCA); e.g., American Board for Certification in Orthotics and Prosthetics, Board for Orthotist/Prosthetist Certification.)

- include the names of certified/licensed personnel on the enrollment form and attach copies of certification or license that demonstrates type, number and expiration date to the enrollment form.

- if any circumstances change that were part of the original application, including personnel, licensure, certification, or demographics, those changes must be provided in writing within 15 days and sent to Unisys, Provider Services, PO Box 2002, Charleston, WV 25327-2002 .

New Policy: "Section 506.2 Prescribing Practitioner and Provider Participation Requirements"

SECTION 506.2.1

New Policy:506.2.1 Prescribing Practitioner
The current DME/Medical Supplies CMN will no longer be valid after March 15, 2006. The current CMN will be replaced by the West Virginia Medical Institute (WVMI) Medicaid DME/Medical Supplies Authorization Request Form **(Attachment III)**. The prescribing practitioner is responsible for providing WVMI with medical necessity documentation via fax to 1-304-346-8185, telephonically at 1-800- 296-9849 or 1-304- 346-9167, option 5, or via mail to WVMI Medical Review Department, 3001 Chesterfield Place, Charleston, WV 25304. The WVMI Medicaid DME/Medical Supplies Authorization Request Form will be available at www.wvmi.org and www.wvdhhr.org websites. The Internet is the most efficient means of keeping current on updates and information regarding the Bureau for Medical Services. If you do not have the Internet, you may request a CD or paper copy of manuals or manual updates by calling Unisys Provider Enrollment at 1-888-483-0793.

Related to DME/Medical Supplies the Prescribing Practitioner must:

(1) be actively enrolled in Medicaid;
(2) ask member where they wish to obtain prescribed DME
(3) provide a written prescription to the member and instruct the member to present the prescription to the DME provider of choice;
(4) provide WVMI with the medical necessity documentation for items/services prescribed and

DISCLAIMER: This manual does not address all the complexities of Medicaid policies and procedures, and must be supplemented with all State and Federal Laws and Regulations.

obtain an assigned PA number, if approved;

(5) inform WVMI of the member's choice for DME provider;

(6) maintain all appropriate medical documentation in the Medicaid member's individual file; and,

(7) participate in on-site reviews and/or submission of medical documentation to BMS upon request.

SECTION 506.2.2

New Policy: 506.2.2 Durable Medical Equipment/Medical Supply Provider (Includes respective Pharmacies, Home IV Infusion Therapy and Home Health Agencies with DME and/or medical supply provider specialty)

The DME/Medical Supply Provider must:

(1) be actively enrolled in Medicaid;

(2) maintain a retail store open to the public at least forty (40) hours per week with a toll free telephone number and handicapped accessibilities. The store must be located within thirty (30) miles of the WV border;

(3) post a visible sign indicating hours of operation. Hours of operation and availability of emergency coverage must be stated on the WV Medicaid enrollment form;

(5) maintain inventory of equipment/supplies and display at least one of each item listed on an inventory and made readily available for delivery;

(5) maintain adequate space to store inventory, business and member records;

(6) obtain individual WV Medicaid provider numbers for each physical facility under the same ownership;

(7) provide DME/Medical Supplies per treating practitioner's prescription;

(8) assure the item/service provided is appropriate to the member's needs;

(9) assure the item/service can be used by the member;

(10) provide an appropriate replacement at no extra cost if the member is unable to use the equipment provided;

(11) agree to accept Medicaid's reimbursement as payment in full for all covered items/services;

(12) provide most economical items/services that meet the member's basic health care needs. Expensive items are not covered when less costly items/services are available;

(13) contact WVMI to obtain PA number before services are rendered;

(14) maintain all medical documentation and proof of delivery of all DME/medical supplies in the member's individual file;

(15) participate in on-site reviews and/or provide medical documentation upon request by BMS;

(16) employ current WV licensed respiratory therapist, registered professional nurse OR physician to provide 24 hour coverage if respiratory/related accessory services/items are offered. A maximum call response time is within thirty (30) minutes. Refer to West Virginia Board of Respiratory Care online at www.wvborc.org for additional information;

(17) employ current licensed or credentialed mastectomy, pedorthotist and/or orthotic fitter certified by National Commission for Certifying Agencies (NCCA), if providing orthotic and/or prosthetic services. Certifying Agencies e.g., American Board for Certification in Orthotics and Prosthetics (ABC), or Board for Orthotist/Prosthetist Certification (BOC), or Board for Certification in Pedorthotics; and,

(18) provide any changes to original enrollment application (i.e., personnel, licensure, certification, demographics) to Unisys, Provider Services, and PO Box 2002, Charleston,

DISCLAIMER: This manual does not address all the complexities of Medicaid policies and procedures, and must be supplemented with all State and Federal Laws and Regulations.

WV, 25327-2002 within fifteen (15) days of change.

SECTION 506.2.3

Introduction: Section 506.5, 3rd paragraph
Old Policy: **"NOTE:** Prior authorization is required from Rational Drug Therapy Program (RDTP) for home IV services. However, if equipment and supplies are required, a completed CMN and a copy of the final determination (RDTP) must be submitted to the UMC for assignment of a PA number. This number may be assigned before or after the IV therapy services are provided. Information from RDTP must contain language which clearly states that the member requires such services or supplies. RDTP may be contacted at 1-800-847-3859 or by fax to 1-800-531-7787."
New Policy: 506.2.3 Home Intravenous Infusion Therapy Suppliers
"Effective February 16, 2006, Home IV Infusion Therapy equipment and medical supplies provided through DME will not require prior authorization by WVMI. This change includes HCPCS codes A4221, A4222, A4223, B9004, B9006, and E0781. Services limits for medical supplies are based on Rational Drug Therapy Program's (RDTP) prior authorization of number(s) of bags or cassettes approved within a specified time frame. For example; if RDTP approves 63 bags or cassettes, the maximum medical supply units is 63; if 10 bags or cassettes are approved, the maximum medical supply units is 10, etc. Service limits for equipment is unchanged. PA from RDTP for medications is also unchanged. RDTP may be contacted at 1-800-847-3859 or fax to 1-800-531-7787. Refer to Chapter 518, Pharmacy Manual, for additional information."

SECTION 506.2.4

New Policy: 506.2.4 Home Health Agencies
"Refer to Chapter 508, Home Health Manual, Section 508.5, Medical Supplies, for additional information."
Directions: Replace/insert pages for Section 506.2

SECTION 506.3

Introduction: Section 506.3, delete 4th paragraph and replace with:
Old Policy: "Unless otherwise specified, WV Medicaid follows Medicare DMERC, Region B criteria for review of medical necessity for covered services/items. BMS Utilization Management Contractor (UMC) is available for information regarding medical necessity."
New Policy: "The most economical items/services will be provided. Expensive items are not covered when less costly items/services are available."
Directions: Replace page.

SECTION 506.3.1

Introduction: Section 506.3.1, 1st paragraph, insert 2nd sentence, change second sentence to 3rd sentence
Old Policy: N/A
New Policy: "All DME repairs and replacement require PA through WVMI."

Introduction: Section 506.3.1.b, Ist paragraph, delete 2nd, 3rd, & 4th sentences
Old Policy: "Charges should include the materials necessary to complete the repair, including HCPCS codes for any parts with the RP modifier and a period of necessary repair. Labor services are to be billed separately with the units equal to the number of hours of labor. DME providers are not reimbursed for

DISCLAIMER: This manual does not address all the complexities of Medicaid policies and procedures, and must be supplemented with all State and Federal Laws and Regulations.

setup or delivery following repair or for service calls that do not involve actual labor time for repairs."

New Policy: "DME providers may be reimbursed for materials necessary to complete the repair; however, providers are not eligible for reimbursement of setup or delivery following repair or service calls that do not involve actual labor time for repairs. Labor services are to be billed separately with the units equal to the number of labor hours.
Directions: Replace page.

SECTION 506.4

Introduction: Section 506.4, 1st paragraph
Old Policy: "In addition to the documentation requirements identified in Common Chapter 300, Provider Participation Requirements 320.5, DOCUMENT AND RETAIN RECORDS, providers submitting claims for Medicaid reimbursement must maintain complete, accurate and legible records documenting medical necessity for equipment and/or supplies provided to meet the basic health care needs of the individual Medicaid member."

New Policy: "In addition to the documentation requirements identified in Common Chapter 300, Provider Participation Requirements 320.5, DOCUMENT AND RETAIN RECORDS, providers submitting claims for Medicaid reimbursement must maintain complete individual, accurate and legible records. Records must include documentation of medical necessity for equipment and/or supplies provided to meet the basic health care needs of the member."

Introduction: Section 506.4, 2nd paragraph, number 1
Old Policy: "CMN must be completed in its entirety for DME /medical supplies and other related services/items requiring prior authorization. For BMS purposes, the CMN is considered a prescription once signed by the practitioner; therefore, a separate written prescription is not required. The prescribing practitioner must have examined **the** patient within the last six months. A copy of the manufacturer's cost invoice must be attached to the CMN for unlisted HCPCS codes and for items/services noted in Attachment I. The CMN must be renewed at the end of the prescription period specified or within one (1) year whichever comes first. (See Attachment III for the DME CMN with Instructions.)
New Policy: **"**Effective March 15. 2006, WVMI Medicaid DME Authorization Request Form is required to provide WVMI medical necessity documentation for items or services prescribed by the treating practitioner. The Authorization Form must be renewed at the end of the prescription period specified or within one (1) year whichever comes first.

Introduction: Section 506.4, 2nd paragraph, number 2
Old Policy: "A written prescription signed by the prescribing practitioner for DME/medical supplies that do not require prior authorization must be maintained in the individual member's records. Diagnosis, signature and date are required. Rubber stamp is prohibited. The written prescription must be renewed at the end of the prescriptive period specified or within one (1) year whichever comes first. A copy of the hospital discharge plan and/or progress notes do not constitute a written prescription for DME/medical supplies."
New Policy: "Effective March 15, 2006, a written prescription which includes the member's name, date of prescription, appropriate HCPCS code for item requested, description of code, estimated length of need in months, quantity of item(s), frequency of use and prescribing practitioner's signature, is to be given to the member by the prescribing practitioner. A copy of the hospital discharge plan and/or progress notes do not constitute a written prescription for DME/Medical Supplies.

DISCLAIMER: This manual does not address all the complexities of Medicaid policies and procedures, and must be supplemented with all State and Federal Laws and Regulations.

Introduction: Section 506.4, 2nd paragraph, number 3
Old Policy: "Proof of delivery (date and mode) and education to the member and/or caregiver must be documented in the individual member's record".
New Policy: "Effective March 15, 2006, a signed delivery document by the member or caregiver and documentation of education for the DME item provided must be maintained in the individual member's record."
Directions: Replace pages.

SECTION 506.5

Introduction: Section 506.5, delete
Old Policy: "Codes requiring PA must be reviewed and approved by the UMC before service is rendered. These specific services are identified in Attachment I of this manual. The exception to this rule is HCPCS Code E0619, Infant Apnea Monitor with recording feature. The "Initial Infant Apnea Monitor" CMN must be submitted to WVMI seven (7) calendar days post hospital discharge. If the monitor is medically necessary beyond the initial approval, the "Request for Extension" CMN must be submitted to WVMI prior to the end of the initial authorization. These CMN's are included in Attachment IV. Unless otherwise, specified, WV Medicaid follows Medicare DMERC, Region B, medical necessity criteria for covered services. All required documentation noted in Section 504 must be attached to a completed CMN and mailed or faxed to:

West Virginia Medical Institute (WVMI)
3001 Chesterfield Place
Charleston, WV 25304
Fax Number: 304-346-8185
Attn: DME/Medical Supply Review

When documentation submitted fails to justify medical necessity for DME or medical supplies, the UMC may request additional information, and/or deny the request for lack of medical necessity. Information must be member specific and not copied from the DMERC Medicare Manual. Retroactive or verbal authorization is not accepted. The issuance of an authorization from the UMC does not guarantee payment.

NOTE: Prior authorization is required from Rational Drug Therapy Program (RDTP) for home IV services. However, if equipment and supplies are required, a completed CMN and a copy of the final determination (RDTP) must be submitted to the UMC for assignment of a PA number. This number may be assigned before or after the IV therapy services are provided. Information from RDTP must contain language which clearly states that the member requires such services or supplies. RDTP may be contacted at 1-800-847-3859 or by fax to 1-800-531-7787.
New Policy: "For DME services and items requiring review for medical necessity by WVMI, it is the responsibility of the prescribing practitioner to submit the appropriate form to WVMI. If items and/or services provided before the PA is confirmed, the DME will not be reimbursed. PA does not guarantee payment. Refer to Attachment I for specific DME/medical supplies requiring PA and service limits for covered services.

Effective, January 1, 2006, Medicaid covered services which currently require a PA will no longer require a PA if the primary insurance approves the service. The EOB must accompany the claim. If the service is not allowed by the primary insurance, but is a covered service for Medicaid and the service requires a PA from the WVMI, Medicaid policy will be enforced. Please refer to Chapter 600 – Payment Methodologies

DISCLAIMER: This manual does not address all the complexities of Medicaid policies and procedures, and must be supplemented with all State and Federal Laws and Regulations.

for additional information.

Effective March 15, 2006, InterQual General Durable Medical Equipment Criteria, will be utilized by WVMI for determining medical necessity for DME items. These items include the following:

- Adaptive Strollers (E1232, E1236, E0950, E0966, E0978, E1029, E1030)
- Aerosol Delivery Devices (E0565, E0570)
- Augmentative and Alternative Communication Devices (E2508, E2510) - Refer to Speech/Audiology Manual for additional information
- Bone Growth Stimulators, Noninvasive (E0747, E0748, E0760)
- Continuous Passive Motion Device (CPM), Knee (E0935)
- Home Oxygen Therapy (E0424, E0431, E0434, E0439)
- Hospital Beds (E0250, E0255, E0260, E0303, E0304, E0910, E0911,E0912)
- Insulin Pump, Ambulatory (E0784)
- Lymphedema Compression Devices (E0650, E0651, E0652)
- Manual Wheelchairs (K0001, K0002, K0003, K0004, K0006, K0007)
- Manual Wheelchairs, Recliner/Tilt (K0001 + E1226, E1161, E1231, E1232, E1233, E1234)
- Manual Wheelchairs, Specialized (E1231, E1233, E1234, E1235, E1237, E1238, K0005, K0009)
- Negative Pressure Wound Therapy (NPWT) Pump (E2404, A6550)
- Noninvasive Airway Assist Devices (E0470, E0471, E0472, E0601)
- Power Operated Vehicles (POV) (E1230)
- Power Wheelchairs (K0010, K0011, K0012, K0014)
- Secretion Clearance Devices (E0480, E0483, E0484)
- Support Surfaces (E0180 – E0182, E0184, E0185, E0186, E0187, E0196, E0197 – E0199, E0277, E0371)
- Transcutaneous Electrical Nerve Stimulation (TENS) (E0720, E0730)
- Wheelchair Cushions/Seating System (E2603, E2604, E2605, E2606, E2607, E2608, E2609, E2611, E2612, E2617).

Practitioners are required to provide medical necessity documentation via mail, fax or telephonically to WVMI prior to items/services provided. Documentation form for DME PA will be available at www.wvmi.org and www.wvdhhr.org/bms . Items not listed above, will follow DMERC, Region B, medical necessity criteria for covered services. When documentation fails to meet criteria, WVMI may request additional information to be submitted within seven (7) days. If information is not received by WVMI within seven (7) days, the request will be denied for lack of documentation to support medical necessity.

Retrospective authorization is only available under the following certain circumstances: (1) services covered by private insurance; (2) termination of Medicaid coverage; (3) Medicaid retro eligibility; and (4) an apnea monitor seven (7) days post hospital discharge. A request for consideration of retrospective authorization does not guarantee approval or payment.

Directions: Replace Pages

SECTION 506.6

Introduction: Sections erroneously numbered in previous manual.
Old Policy: Not Applicable
New Policy: Section 506.6 – Nursing Facilities
Directions: Replace Page

DISCLAIMER: This manual does not address all the complexities of Medicaid policies and procedures, and must be supplemented with all State and Federal Laws and Regulations.

SECTION 506.7

Introduction: Sections erroneously numbered in previous manual.
Old Policy: Not Applicable
New Policy: Section 506.7 – Out-Of-State Services
Directions: Replace page.

Introduction: Section 506.7, 1st paragraph, last sentence
Old Policy: "All DME policies apply."
New Policy: Delete last sentence
Directions: Replace page

SECTION 506.8

Introduction: Sections erroneously numbered in previous manual
Old Policy: Not Applicable
New Policy: Section 506.8 – Non-Covered Durable Medical Equipment and Supplies
Directions: Replace page

Introduction: Section 506.8, 1st paragraph
Old Policy: "Attachment II describes unlisted HCPCS codes for items/services not covered by WV Medicaid. In addition, WV Medicaid does not cover DME/medical supplies and other related services/items provided through DME as stated below. Non-covered service/items cannot be prior authorized nor an exception made for reimbursement."
New Policy: "In addition to non-covered services listed on Attachments I and II, the following items are not covered by WV Medicaid."

Introduction: Section 506.8, 1st paragraph, insert 5th bullet
Old Policy: N/A
New Policy: "DME travel, setup or delivery following repairs.

Introduction: Section 506.8, 1st paragraph, change 6th bullet
Old Policy: "Repairs or replacement for equipment not purchased or rented by BMS (i.e., "loan closet", Muscular Dystrophy, Easter Seals, family, friend, yard/rummage sales, etc.)
New Policy: "Maintenance, repair"

Introduction: Section 506.8, 1st paragraph, 7th bullet
Old Policy: N/A
New Policy: "Service calls that do not involve actual labor time for repairs."

SECTION 506.9

Introduction: Sections erroneously numbered in previous manual
Old Policy: Not Applicable
New Policy: Section 506.9 – Billing and Reimbursement
Directions: Replace page

DISCLAIMER: This manual does not address all the complexities of Medicaid policies and procedures, and must be supplemented with all State and Federal Laws and Regulations.

Introduction: Section 506.9; delete paragraphs 1, 2, 3, and 4
Old Policy: "Medicaid payment is made on a rental or purchase basis. The total payment for rental equipment may not exceed the cost of purchasing the equipment and is reimbursed on a cap rental basis depending on the item requested.

Medicaid payment is based, where possible, on a percentage of Medicare fee schedule and is equal to the lesser of the billed charge or the fee schedule amount less any third party payment. This same rule applies to payments for repairs and maintenance.

The general requirements and procedures for billing are identified in Chapter 600. The professional claim form CMS-1500, or ASCX12N837P (004010X098A1) must be used to bill for DME/Medical supplies. Required attachments to the CMS 1500 are: (1) a manufacturer's cost invoice for unlisted or miscellaneous HCPCS codes, (2) a copy of the Medicare EOB for Medicare cross-over, and (3) medical documentation as previously stated in this chapter. The assigned PA number must be documented on the CMS-1500 for consideration of payment.

Repair and replacement of DME requires an RP modifier. Options or accessories that are included in the code for the base item may not be billed separately.
New Policy: "WV Medicaid requires practitioners, DME/medical supply providers and other appropriate individuals/groups to be enrolled as a Medicaid provider to be eligible for reimbursement of services rendered with exception of an emergent/medically necessary circumstance. Billing prior to rendering services/items is prohibited.

Medicaid payment for DME/Medical Supplies is made on a rental or purchase basis. The total payment for rental equipment may not exceed the cost of purchasing the equipment and is reimbursed on a cap-rental basis depending on the item requested. The billing period for rental equipment begins the day equipment is placed in the home to the next month. When submitting the claim for payment consideration the dates should be spanned; e.g. if DME is placed on 1/3/06, the billing period begins on 1/3/06 to 2/2/06; 2/3/06 to 3/2/06; 3/3/06 to 4/2/06, etc. Only dates that the equipment is in use may be billed. If the member becomes ineligible, the billing span is the begin date of the billing period to the last date of eligibility.

When billing for unlisted and/or unpriced HCPCS DME/Medical Supply codes (A4335, A4649, A6215, A6261, A6262, A6450, A6501 – A6513, A6538, A6540-A6543, A7523, A7524, B9998, B9999, E0240, E0247 – E0248, E1239, E1399, E2216-E2218, E2372, E2399, K0009, K0014, K0108, K0669) the description of the item provided must be entered on the claim form. An unaltered cost invoice is to be submitted to WVMI for pricing of unlisted/unpriced codes. Refer to Attachment I for specific codes and special instructions.

The professional claim form, CMS 1500 or ASCX12N837P (004010X098A1 must be used to bill DME/medical supplies. Repair and replacement of DME requires an RP modifier. Options or accessories included in the base item code will not be reimbursed.

Medicaid is payer of last resort. Third-party Liability (TPL) is a method of ensuring that Medicaid is the last payer to reimburse for covered Medicaid services. In particular, Medicaid participating providers must always seek reimbursement from other liable resources, including private or public insurance entities. Federal regulations require that state Medicaid administration identify any third-party resource available to meet the medical expenses of a member. The third-party may be an individual, institution, corporation or a public/private agency liable for all or part of the member's medical costs; e.g., private health insurance,

DISCLAIMER: This manual does not address all the complexities of Medicaid policies and procedures, and must be supplemented with all State and Federal Laws and Regulations.

UMWA benefits, Veterans Administration benefits, CHAMPUS, Medicare, Hospice, etc. No Medicaid reimbursement may be made if the service is the responsibility of a public or private Workers Compensation Plan. In those instances where liability cannot be currently established; i.e., accident or injury, Medicaid benefits will not be withheld. Subsequent establishment of liability which provides compensation and payment for the costs of such medical care requires that an on-setting adjustment be made by the provider to the Medicaid agency for benefits paid. Prior authorization is not required for services reimbursed by third-party payers. All claims must be submitted to Unisys at PO Box 3767, Charleston, WV 25337 for reimbursement consideration.

Medicaid payment is based, where possible, on a percentage of the Medicare fee schedule and is equal to the lesser of the billed charge or the fee schedule amount less any third party payment. This same rule applies to payments for repairs and maintenance.

SECTION 506.10

Introduction: Sections erroneously numbered in previous manual
Old Policy: Not Applicable
New Policy: Section 506.10 – Managed Care
Directions: Replace page

Introduction: Section 506.10
Old Policy: “Unless otherwise noted in this manual or appendices, services detailed in this manual are the responsibility of the Managed Care Organization (MCO), if the Medicaid member is enrolled in a WV MCO, MCO requirements must be met for reimbursement and those requirements may be different than BMS’. If a Medicaid member is a member of the PAAS Program, the member’s PAAS Primary Care Provider (PCP) must provide a referral for the DME ordered prior to rendering the services. Medicaid will not reimburse for services provided when MCO or PAAS requirements are not met.
New Policy: “Unless otherwise noted in this manual or appendices, services detailed in this manual are the responsibility of the Managed Care Organization (MCO). If the Medicaid member is enrolled in a WV MCO, MCO requirements must be met for reimbursement.”
Direction: Replace page

Attachment I

Introduction: HCPCS Codes for DME & Supplies Changes: Special Instructions
New Policy: A4217 – Change in ICD-9 Codes

A4221, A4222, A4223, A4349 see Special Instructions

A4223- remove PA, see Special Instructions

A4402, A7003-A7006, A7013, A7015, E0470-E0472, E0480, E0483, E0601, E0650-E0652, E0655-E0673, E2609, E0747, E0748 E0760, E0784, E0935, E0955-E0957 – Remove ICD-9 Codes

A4619, E0570, E1372, E2603-E2609, E2613-E2616, E2620-E2621 – Add PA and Remove ICD-9 Codes

A7000 – opened effective 01/01/2006

DISCLAIMER: This manual does not address all the complexities of Medicaid policies and procedures, and must be supplemented with all State and Federal Laws and Regulations.

A7030, A7031, A7032, A7033, A7034, A7035, A7036, A7037, A7038, A7039, A7045, A7046, E0424, E0431, E0434, E0439, E0441, E0443, E0445, E0450, E0460RR, E0463RR, E0464RR, E0470RR, E0471RR, E0472RR, E0561, E0562, E0565 and E0601 – added "Must have West Virginia certified respiratory therapist or professional registered nurse or physician on staff"

B4034, B4035, B4036, B4164-B4180, B4185-B5200 – Remove PA and add Service Limits

B9000, B9002, B9004, B9006, E0781 – Remove PA

E0180, E0181, E0184-E0187, E0196-E0199, E0424, E0431, E0434, E0439, E0484, E0910, E2601-E2602, E2611-E2612, E2619RP, K001-K0003 – Add PA

E1014 - Removed cost invoice

E1340 – added "travel not covered"

E2500, E2502, E2504, E2506, E2508, E2510, E2511, E2512, E2599, L8500, L8501, L8505, L8510, V5336 - Refer to Speech/Audiology Manual
Directions: Replace pages

ATTACHMENT II

Introduction: **Non**-Covered DME/Medical Supplies for Unlisted HCPCS Codes
New Policy: Delete Remote Control (remote pilot/remote box) for power wheelchair – Included in HCPCS codes E2310 and E2311

Add Male Vacuum Erection System

Add Canopy for Stroller

Add Hip Protector
Directions: Replace pages

ATTACHMENT III

Introduction: DME CMN with instructions
Old Policy: Delete DME CMN with instructions
New Policy: WVMI Medicaid DME/Medical Supply Authorization Request Form
Directions: Replace pages

ATTACHMENT IV

Introduction: Apnea Monitor – Initial and Request for Extension CMN's
New Policy: Delete Attachment IV

JULY 1, 2005

Introduction: 5th paragraph, 4th bullet, 1st sentence

DISCLAIMER: This manual does not address all the complexities of Medicaid policies and procedures, and must be supplemented with all State and Federal Laws and Regulations.

Old Policy: "physician's order and/or a certificate of medical (CMN)"
Change: "practitioner's order and/or a certificate of medical necessity (CMN)". "Services requiring a PA must have a CMN".
Directions: Replace page

Introduction: 5th paragraph, 14th bullet
Old Policy: "A respiratory therapist"
Change: "A WV licensed respiratory therapist"
Directions: Replace page

Introduction: Section 506.3, 2nd paragraph, 1st sentence
Old Policy: "DME are seen in Attachment I"
Change: "**DME are seen in Attachments I and II"**
Directions: Replace page

Introduction: Section 506.3, 2nd paragraph, 2nd sentence
Old Policy: "This document describes"
Change: "Attachment I describes"
Directions: Replace page

Introduction: Section 506.3, 2nd paragraph, 4th sentence
Old Policy: "Note: If a DME/medical supply HCPCS code is not included in Attachment I or II, it is considered non-covered by WV Medicaid".
Change: "Attachment II describes DME/medical supply items, without HCPCS codes, that are non-covered by WV Medicaid".
Directions: Replace page

Introduction: Section 506.3, 3rd paragraph, 2nd sentence
Old Policy: "retains ownership of the"
Change: "maintains responsibility for the"
Directions: Replace page

Introduction: Section 506.4, 2nd paragraph, 1st bullet, 1st sentence
Old Policy: "services/items provide through DME requiring prior authorization."
Change: "services/items requiring prior authorization".
Directions: Replace page

Introduction: Section 506.4, 2nd paragraph, 1st bullet, 4th sentence
Old Policy: "for items/services noted in Attachment III"
Change: "for items/services noted in Attachment I"
Directions: Replace page

Introduction: Section 506.5, 1st paragraph, 3rd, 4th, 5th and 6th sentence
Old Policy: Non-applicable
Change: Addition of new sentence to state "The exception to this rule is HCPCS Code E0619, Infant Apnea Monitor with recording feature. The "Initial Infant Apnea Monitor" CMN must be submitted to WVMI seven (7) calendar days post hospital discharge. If the monitor is medically necessary beyond the initial approval, the "Request for Extension" CMN must be submitted to WVMI prior to the end of the initial

DISCLAIMER: This manual does not address all the complexities of Medicaid policies and procedures, and must be supplemented with all State and Federal Laws and Regulations.

authorization. These CMN's are included in Attachment IV".
Directions: Replace page

Introduction: Section 506.12
Old Policy: Miscellaneous
Change: Delete section. Information documented in Section 505
Directions: Replace page

Attachment I

Introduction: ICD 9 Codes and Modifier Changes in Special Instructions
Change: A4362-A4369, A4371-A4373, A4375-A4378, A4384,-A4390, A4394-A4427, A4455 - added ICD-9 V44.6 and V55.6

A4619 -removed ICD-9 codes 591.1 and added code range 519.0 - 519.9

E0424, E0431, E0434, E0439, E1390 added "Arterial Oxygen Saturation"

A4619, A7030, A7031, A7032, A7033, A7034, A7035, A7036, A7037, A7038 A7039, A7045, A7046E0424, E0431. E0434, E0439, E0445, E0450, E0460, E0463, E0464, E0470 E471, E0472, E0561, E0562, E0565, E0601, and E1390 – added "Must have West Virginia Certified Respiratory Therapist on Staff".

E0450 and E0601 – removed "RR" modifier

E0470 – removed "non- reimbursable with A7030, A7031, A7032, A7033, A7034, A7035, A7036, A7037, A7038, A7039, A7046, E0561, E0562"

E0471 and E0472 - removed ICD 9 codes 780.51, 780.53, 780.57 and added ICD- 9 code 518.81

E0565 - removed ICD-9 codes 591.1 and added ICD9 code range 519.0 – 519.1

E0618 closed code effective 4/30/05

E0619, E1020 re-opened with Special Instruction effective 5/1/05

E0650, E0651, E0652, E0655, E0660, E0665, E0666, E0667, E0668, E0669, E0671, E0672, E0673 - Removed ICD-9 codes 547.0 and 547.1 and added ICD-9 codes 457.0 and 457.1

E0747 - removed ICD-9 code 815-55-815.19 and added ICD-9 code 815.00 - 815.19

E0760 - removed ICD-9 codes 809.9 and added ICD9 code 809.1

E0955, E0956, E0957, E0960 – added ICD-9 range 343.0 – 343.9

E1009, E1010 – added ICD-9 range 344.0 – 344.04

E1028 re-opened and added PA and Special Instruction effective 5/1/05
Directions: Replace pages

DISCLAIMER: This manual does not address all the complexities of Medicaid policies and procedures, and must be supplemented with all State and Federal Laws and Regulations.

Attachment I

Introduction: ICD 9 Codes and Modifier Changes in Special Instructions effective 7/01/05
Change: E1015 and E1016 codes opened effective 7/01/05
Directions: Replace pages

Attachment II

Introduction: Removed items from Non-Covered List
Change: Removed "Snug Seat
Directions: Replace page 116

Introduction: Add items to Non-Covered List
Change: Bacterial Filter, Glucowatch, Medical Identification Bracelet, Uplift Seat Assist
Directions: Replace Attachment II

Attachment III
Introduction: DME CMN with Instructions
Change: CMN Form – Section I added Member Medicaid ID # and Servicing Provider ID #
CMN Instructions - Section I added "Completed by Servicing Provider"
CMN Instructions – Section II added "Completed by Practitioner"
CMN Instructions – Section III, 1st, 3rd, 4th, and 5th bullets, added "Completed by Practitioner"
CMN Instructions – Section III, 2nd bullet added "Completed by Servicing Provider"
CMN Instructions – Section IV added "Completed by Practitioner"
Directions: Replace Attachment III

Attachment IV

Introduction: Apnea Monitor – Initial and Request for Extension CMN's
Change: Initial Infant Apnea Monitor CMN added DME Provider Medicaid ID # and Telephone # areas

Initial Infant Apnea Monitor CMN added "Request for prior authorization must be submitted to West Virginia Medical Institute seven (7) calendar days post hospital discharge" at the bottom of the page.

Request for Extension CMN added DME Provider Medicaid ID
Directions: Replace Attachment IV

DISCLAIMER: This manual does not address all the complexities of Medicaid policies and procedures, and must be supplemented with all State and Federal Laws and Regulations.

CHAPTER 506 COVERED SERVICES, LIMITATIONS, AND EXCLUSIONS FOR DME/MEDICAL SUPPLIES

TABLE OF CONTENTS

TOPIC **PAGE NO.**

Introduction 2

506.1 Definitions 2

506.2 Prescribing Practitioner and Provider Participation Requirements 3

506.2.1 Prescribing Practitioner 3
506.2.2 Durable Medical Equipment/Medical Supply Provider 3
506.2.3 Home Intravenous Infusion Therapy Suppliers 4
506.2.4 Home Health Agencies 4

506.3 Covered Durable Medical Equipment and Medical Supplies 5

506.3.1 Warranty, Repair, and Replacement 5

506.3.1.a Warranty 5

506.3.1.b Repair 5

506.3.1.c Replacement 6

506.4 Documentation Requirements 6

506.5 Prior Authorization 7

506.6 Nursing Facilities 9

506.7 Out-of-State Services 9

506.8 Non-Covered Durable Medical Equipment and Medical Supplies 9

506.9 Billing and Reimbursement 10

506.10 Managed Care 11

- Attachment I Covered/Non-Covered DME/Medical Supply Services With Assigned HCPCS Codes
- Attachment II Non-Covered DME/Medical Supplies for Unlisted HCPCS Codes
- Attachment III WVMI Medicaid DME/Medical Supply Authorization Request Form
- BMS Certificate of Medical Necessity Durable Medical Equipment/Medical Supplies
- BMS Certificate of Medical Necessity Initial Infant Apnea Monitor
- BMS Certificate of Medical Necessity Infant Apnea Monitor Request for Extension

DISCLAIMER: This manual does not address all the complexities of Medicaid policies and procedures, and must be supplemented with all State and Federal Laws and Regulations.

CHAPTER 506-COVERED SERVICES, LIMITATIONS, AND EXCLUSIONS FOR DME/MEDICAL SUPPLIES

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).

WV Medicaid Program offers a comprehensive scope of Durable Medical Equipment (DME)/Medical Supply services to Medicaid members, subject to medical necessity, appropriateness criteria and prior authorization requirements. DME/Medical Supply covered services are provided by approved DME providers, home IV infusion therapy suppliers, pharmacies and home health agencies in accordance with State and Federal regulations.

The WV Medicaid Program is administered pursuant to Title XIX of the Social Security Act and Chapter 9 of the WV Code. BMS in the WV Department of Health and Human Resources (DHHR) is the single State agency responsible for administering the WV Medicaid Program. This program, therefore, must also function within federally defined parameters.

Durable Medical Equipment/medical supply approved providers are subject to review of individual Medicaid member records by BMS, whether the service/item requires prior authorization (PA) or not. Providers must maintain current and accurate documentation and make available to BMS upon request.

This chapter describes WV Medicaid's major coverage policies for DME/Medical Supplies as noted in the following Sections:

506.1 DEFINITIONS

Definitions governing the provision of all WV Medicaid services will apply pursuant to Chapter 200. In addition, the following definitions also apply to the requirements for payment of the services described in this chapter.

Customized Equipment - Uniquely constructed for a specific member according to the description and order of the member's treating physician. Specific to wheelchairs and wheelchair accessories: A wheelchair which has been (1) measured, fitted or adapted in consideration of the patient's body size, disability, period of need or intended use; (2) ordered from a manufacturer who make available customized features or components for wheelchairs; and (3) is intended for an individual member's use in accordance with instructions from the member's physician would be considered Acustomized@.

DME Provider - An individual or entity approved by WV Medicaid to provide DME /medical supplies, repair and replacement of equipment to Medicaid members. (See Section 506.2 for specifics).

DISCLAIMER: This manual does not address all the complexities of Medicaid policies and procedures, and must be supplemented with all State and Federal Laws and Regulations.

Medical Supplies - Medically necessary non-durable medical or surgical items prescribed by a practitioner that are consumable, expendable and appropriate for use in a member's home.

Mobility Assistive Equipment (MAE) – Items that offer assistance to members who have a physical impairment that results in a mobility deficit. MAE includes, but is not limited to, canes, crutches, walkers, manual wheelchairs, power wheelchairs, power operated vehicles and strollers.

Prescribing Practitioner: Identified as an MD, DO, DPM, Nurse Practitioner (NP), or Physician Assistant (PA) under the supervision of a participating physician. WV Medicaid does not recognize hospital residents as prescribing practitioners.

506.2 PRESCRIBING PRACTITIONER AND PROVIDER PARTICIPATION REQUIREMENTS

506.2.1 Prescribing Practitioner

In addition to Chapter 300 Provider Participation Requirements, MDs, DOs, DPMs, NPs, and PAs under the supervision of a participating physician, prescribing DME/medical supplies and related items must:

(1) be actively enrolled in Medicaid;
(2) inquire if the member has a DME provider of choice;
(3) provide a written prescription to the member;
(4) provide clinical documentation for medical necessity to include diagnosis code, frequency of use, duration, quantity, and any relevant information to WVMI. Documentation may be submitted to WVMI in writing (with legal signature of prescribing practitioner), fax or telephonically;
(5) maintain all appropriate medical documentation in the Medicaid member's individual file; and,
(6) participate in on-site reviews and/or submission of medical documentation to BMS upon request.

The Bureau's website @ www.wvdhhr.org is the most efficient means of keeping current on updates and information regarding BMS. If you do not have the Internet, you may request a CD or paper copy of manuals or manual updates by calling Unisys Provider Enrollment at 1-888-483-0793.

506.2.2 Durable Medical Equipment/Medical Supply Provider (Includes respective Pharmacies, Home IV Infusion Therapy and Home Health Agencies with DME and/or medical supply provider specialty)

The DME/Medical Supply Provider must:

(1) be actively enrolled in Medicaid;
(2) maintain a retail store open to the public at least forty (40) hours per week with a toll free telephone number and handicapped accessibilities. The store must be located within thirty (30) miles of the WV border;
(3) post a visible sign indicating hours of operation. Hours of operation and availability of

DISCLAIMER: This manual does not address all the complexities of Medicaid policies and procedures, and must be supplemented with all State and Federal Laws and Regulations.

emergency coverage must be stated on the WV Medicaid enrollment form;

(4) maintain inventory of equipment/supplies and display at least one of each item listed on an inventory and made readily available for delivery;
(5) maintain adequate space to store inventory, business and member records;
(6) obtain individual WV Medicaid provider numbers for each physical facility under the same ownership;
(7) provide DME/Medical Supplies per treating practitioner's prescription;
(8) assure the item/service provided is appropriate to the member's needs;
(9) assure the item/service can be used by the member;
(10) provide an appropriate replacement at no extra cost if the member is unable to use the equipment provided;
(11) agree to accept Medicaid's reimbursement as payment in full for all covered items/services;
(12) provide most economical items/services that meets the member's basic health care needs. Expensive items are not covered when less costly items/services are available;
(13) maintain all medical documentation and proof of delivery of all DME/medical supplies in the member's individual file;
(14) participate in on-site reviews and/or provide medical documentation upon request by BMS;
(15) employ current WV licensed respiratory therapist, registered professional nurse OR physician to provide 24 hour coverage if respiratory/related accessory services/items are offered. A maximum call response time is within thirty (30) minutes. Refer to West Virginia Board of Respiratory Care online at www.wvborc.org for additional information;
(16) employ current licensed or credentialed mastectomy, pedorthotist and/or orthotic fitter certified by National Commission for Certifying Agencies (NCCA), if providing orthotic and/or prosthetic services. Certifying Agencies e.g., American Board for Certification in Orthotics and Prosthetics (ABC), or Board for Orthotist/Prosthetist Certification (BOC), or Board for Certification in Pedorthotics; and
(17) provide any changes to original enrollment application (i.e., personnel, licensure, certification, registration, demographics) to Unisys, Provider Services, PO Box 2002, Charleston, WV, 25327-2002 within fifteen (15) days. Copies of updated license, certification and/or registration must be submitted to Unisys annually.

506.2.3 Home Intravenous Infusion Therapy Suppliers

Effective February 16, 2006, Home IV Infusion Therapy equipment and medical supplies provided through DME will not require prior authorization by WVMI. This change includes HCPCS codes A4221, A4222, A4223, B4164-B4224, B5000, B5100, B5200, B9004, B9006, and E0781. Services limits for medical supplies are based on Rational Drug Therapy Program's (RDTP) prior authorization of number(s) of bags or cassettes approved within a specified time frame. For example; if RDTP approves 63 bags or cassettes, the maximum medical supply units is 63; if 10 bags or cassettes are approved, the maximum medical supply units is 10, etc. Service limits for equipment is unchanged. Prior Authorization from RDTP for medications is also unchanged.

RDTP may be contacted at 1-800-847-3859 or fax to 1-800-531-7787.

506.2.4 Home Health Agencies

DISCLAIMER: This manual does not address all the complexities of Medicaid policies and procedures, and must be supplemented with all State and Federal Laws and Regulations.

Refer to Chapter 508, Home Health Manual, Section 508.5, Medical Supplies, for additional information.

506.3 COVERED DURABLE MEDICAL EQUIPMENT AND MEDICAL SUPPLIES

Durable Medical Equipment/medical supplies and other related services/items provided through DME are considered for reimbursement by WV Medicaid when requested by a prescribing practitioner and determined medically necessary to meet the basic health care needs of the member.

A complete list of covered and non-covered DME/medical supplies and other related services/items provided through DME are seen in **Attachments I and II. Attachment I** describes the DME/medical supplies through current HCPCS codes, description of each code, replacement code for closed codes (as appropriate), service limits, prior authorization requirements and special coverage instructions. Dispensing of medical supplies for more than a one (1) month time frame or shipping supplies on an unsolicited or automatic basis is prohibited. **Attachment II** describes DME/medical supply items, without HCPCS codes, that are non-covered by WV Medicaid

Durable Medical Equipment/medical supply coverage is based on product category not specific item, brand or manufacturer. Medical supplies are purchased items, while equipment may be initially purchased or reimbursed on a cap-rental basis. Following the established cap-rental timeframe, DME items are determined purchased and the provider that received the last cap-rental reimbursement maintains responsibility for the item and must provide repairs and/or modification as needed.

The most economical items/services will be provided. Expensive items are not covered when less costly items/services are available.

506.3.1 WARRANTY, REPAIR, AND REPLACEMENT

Durable Medical Equipment and/or accessory repairs and replacements are limited to medically necessary items purchased by BMS or Children with Special Healthcare Needs Program (CSHCN). All DME repairs and replacement require PA through WVMI. Only one (1) MAE of the same category will be maintained or repaired by BMS at any time. Manufacturer's warranty for DME is required for not less than one (1) year.

Medicaid's initial payment for DME includes all adjustments and/or modifications needed to make the item functional for delivery to the member. The supplier must provide training and instruction to the member and/or caregiver on the safe, effective and appropriate use of the appliance.

506.3.1. a Warranty

All standard durable medical equipment must have a manufacturer's warranty of at least one year. If the provider supplies equipment that is not covered under a warranty, the provider is responsible for repairs and replacements for the first year. The warranty begins on the date of the delivery (date of service) to the member. The original warranty must be given to the member and a copy is maintained in the member's individual medical record. A copy of the warranty is provided to WV Medicaid or WVMI

DISCLAIMER: This manual does not address all the complexities of Medicaid policies and procedures, and must be supplemented with all State and Federal Laws and Regulations.

upon request.

506.3.1. b Repair

WV Medicaid's coverage for repair of equipment is limited to:

(1) items that have been fully purchased by WV Medicaid or by the Children with Special Healthcare Needs Program (CSHCN);
(2) equipment provided by CSHCN is covered by Medicaid;
(3) items in which the cap-rental timeframe has been exhausted;
(4) the medical need is expected to continue; and
(5) repair is more economical than replacement.

Durable Medical Equipment providers may be reimbursed for materials necessary to complete the repair; however, providers are not eligible for reimbursement of setup or delivery following repair or service calls that do not involve actual labor time for repairs. Labor services are to be billed separately with the units equal to the number of labor hours.

DME repairs are covered when all of the following conditions are met:

(1) Prior authorization is received before repairs are initiated B appropriate HCPCS Code and RP modifier must be included on the request.

(2) Substitute comparable or like equipment at no additional cost when broken or damaged equipment is being repaired.

(3) No other party is financially liable for the needed repair.

(4) Equipment remains medically necessary.

(5) Damage to the item is not due to the member's abuse or misuse.

506.3.1. c Replacement

Replacement of DME equipment may be covered by WV Medicaid on an as-needed basis due to acute rapid changes in the member's physical condition, wear, theft, irreparable damage, or loss by disasters. For consideration of equipment replacement, the provider must obtain prior authorization. The request must be submitted to WVMI **prior to rendering services.** Documentation to medically justify replacement must accompany all requests. A police or insurance report is required with all requests for replacement of stolen equipment. A report of insurance liability is required with requests for replacement of equipment lost or destroyed. In cases of neglect and/or wrongful misuse of DME, requests for replacement will be denied if such circumstances are confirmed.

506.4 DOCUMENTATION REQUIREMENTS

In addition to the documentation requirements identified in Common Chapter 300, Provider Participation Requirements 320.5, DOCUMENT AND RETAIN RECORDS, providers submitting claims for Medicaid reimbursement must maintain complete, individual, accurate and legible records. Records must include documentation of medical necessity for equipment and/or supplies provided to meet the basic health

DISCLAIMER: This manual does not address all the complexities of Medicaid policies and procedures, and must be supplemented with all State and Federal Laws and Regulations.

care needs of the member.
Documentation must include, but is not limited to:

(1) Effective May 1, 2006, formal certificate of medical necessity forms (i.e., the WVMI Medicaid DME Authorization Request Form, the DME/Medical Supply Certificate of Medical Necessity, the Apnea Initial and Recertification Certificates of Medical Necessity) are not required to document medical necessity of items requiring prior authorization. However, as an enrolled participant of WV Medicaid, practitioners and DME providers are required to maintain individual Medicaid member files with documentation to assure that all services provided to Medicaid members are medically necessary and that billing of such services are accurate. **Attachment III** provides forms that may be submitted via fax to 1-304-346-8185 or 1-877-762-4338 or in writing to WVMI Medical Review Department, 3001 Chesterfield Place, Charleston, WV 25304. Telephonic reviews for urgent or emergency requests are available at 1-304-414-2551 or 1-800-296-9849.

(2) Effective May 1, 2006, a written prescription which must include the member's name, date of prescription, description of code, estimated length of need in months, quantity of item(s), frequency of use and prescribing practitioner's signature and given to the member by the prescribing practitioner. A copy of the hospital discharge plan and/or progress notes do not constitute a written prescription for DME/Medical Supplies.

(3) The DME provider must maintain a delivery document signed by the member or caregiver and documentation of education for the DME item provided must be maintained in the individual member's record.

(4) DME Provider must be able to track serial, lot, and product numbers for purposes of recall.

(6) The prescriber's medical documentation submitted for review must not be more than six (6) months old at the time the prescription is written.

506.5 PRIOR AUTHORIZATION

For DME services and items requiring prior authorization review for medical necessity by WVMI, it is the responsibility of the prescribing practitioner to submit the appropriate clinical documentation i.e., ICD-9 code(s), all information required on the written prescription (see 506.4, 2nd paragraph, (2) for clarification) and any other relevant information. Additionally, a licensed physical therapist or licensed occupational therapist who is fiscally, administratively and contractually independent from the DME provider may also submit clinical documentation for review when requested by the prescribing practitioner. PA recertification review is required at the end of the prescription period specified or within one (1) year whichever comes first. It is strongly recommended that DME providers, in partnership with prescribing practitioners, assist in obtaining prior authorizations. Prescribing practitioners must provide clinical information and a written prescription while DME providers may submit the appropriate HCPCS code and billing information. If items and/or services provided before the PA is confirmed, the DME will not be reimbursed. PA does not guarantee payment. Refer to Attachment I for specific DME/medical supplies requiring PA and service limits for covered services.

DISCLAIMER: This manual does not address all the complexities of Medicaid policies and procedures, and must be supplemented with all State and Federal Laws and Regulations.

Effective, January 1, 2006, Medicaid covered services which currently require a PA will no longer require a PA if the primary insurance approves the service. The explanation of benefits (EOB) must accompany the claim. An EOB documenting the reasons for the denial of TPL for services requested must be provided to WVMI when requesting prior authorization review. If the service is not allowed or covered by the primary insurance, but is a covered service for Medicaid and the service requires a PA from WVMI, Medicaid policy will be enforced. If administrative denials are given by the primary payer, Medicaid will not reimburse for services. Please refer to Chapter 600 – Payment Methodologies for additional information.

Effective March 15, 2006, InterQual General Durable Medical Equipment Criteria, will be utilized by WVMI for determining medical necessity for DME items. These items include the following:

- Adaptive Strollers (E1232, E1236, E0950, E0966, E0978, E1029, E1030)
- Aerosol Delivery Devices (E0565, E0570)
- Augmentative and Alternative Communication Devices (E2508, E2510) - Refer to Speech/Audiology Manual for additional information
- Bone Growth Stimulators, Noninvasive (E0747, E0748, E0760)
- Continuous Passive Motion Device (CPM), Knee (E0935)
- Home Oxygen Therapy (E0424, E0431, E0434, E0439).
  Effective March 15, 2006, any new oxygen system requested for medical necessity must follow InterQual criteria to include documentation of initial lab results. PA recertification review is required at the end of the prescription period specified or within one (1) year whichever comes first. Date of lab results must be within 6 months of the oxygen request.
- Hospital Beds (E0250, E0255, E0260, E0303, E0304, E0910, E0911, E0912)
- Insulin Pump, Ambulatory (E0784)
- Lymphedema Compression Devices (E0650, E0651, E0652)
- Manual Wheelchairs (K0001, K0002, K0003, K0004, K0005 K0006, K0007)
- Manual Wheelchairs, Recliner/Tilt (K0001 + E1226, E1161)
- Negative Pressure Wound Therapy (NPWT) Pump (E2404, A6550)
- Noninvasive Airway Assist Devices (E0470, E0471, E0472, E0601)
- Pediatric Mobility Equipment (E1231, E1232, E1233, E1234, E1235, E1237, E1238, K0890, K0891)
- Power Operated Vehicles (POV) (K0800, K0801, K0802, K0806, K0807, K0808, K0812)
- Power Wheelchairs (K0813, K0814, K0815, K0826, K0820, K0821, K0822,
- K0823, K0824, K0825, K0826, K0827, K0828, K0829, K0830, K0831, K0835, K0836, K0837, K0838, K0839, K0840, K0841, K0842, K0843, K0848, K0849, K0850, K0851, K0852, K0853, K0854, K0855, K0856, K0857, K0858, K0859, K0860, K0861, K0862, K0863, K0864, K0868, K0869, K0870, K0871, K0877, K0878, K0879, K0880, K0884, K0885, K0886)
- Secretion Clearance Devices (E0480, E0483, E0484)
- Support Surfaces (E0181 E0182, E0184, E0185, E0186, E0187, E0196, E0197 – E0199, E0277, E0371)

DISCLAIMER: This manual does not address all the complexities of Medicaid policies and procedures, and must be supplemented with all State and Federal Laws and Regulations.

- Transcutaneous Electrical Nerve Stimulation (TENS) (E0720, E0730)
- Wheelchair Cushions/Seating System (E2603, E2604, E2605, E2606, E2607, E2608, E2609, E2611, E2612, E2617, K0734, K0735, K0736, K0737)

Items requiring PA not listed above will follow Palmetto, Region C, medical necessity criteria for covered services. When documentation fails to meet criteria, WVMI may request additional information to be submitted within seven (7) days. If information is not received by WVMI within seven (7) days, the request will be denied for lack of documentation to support medical necessity.

Retrospective authorization is available (1) for items denied due to TPL; (2) retrospective Medicaid eligibility; (3) within 7 days post hospital discharge for apnea monitors, oxygen systems, nebulizers; (4) for items other than those referenced here on a case-by-case basis; and (5) the **next** business day following DME placement occurring on weekends and holidays, or at times when the utilization management agency review process is unavailable. A request for consideration of retrospective authorization does not guarantee approval or payment.

506.6 NURSING FACILITIES

Reimbursement to nursing and intermediate care facilities (ICF/MR) is intended to cover the total cost of care provided in the nursing home, including durable medical equipment and supplies.

Durable Medical Equipment and medical supplies may be reported in the nursing home cost report and are subsequently reflected in their per diem rate. Therefore, none of these items will be reimbursed to a DME company/medical supplier as a direct billing to Medicaid if the Medicaid member is a resident of the nursing facility at the time the DME is issued.

506.7 OUT-OF-STATE SERVICES

For WV Medicaid members receiving covered services from an out-of–state facility and requiring DME/medical supplies and other related services/items that are medically necessary at discharge, a written prescription by the respective out-of-state attending physician must be presented to a WV provider for provision of services requested. West Virginia DME policies apply. This process is required for warranty validity and to ensure that repairs and maintenance are provided in the most efficient and cost-effective means for WV Medicaid members.

506.8 NON-COVERED DURABLE MEDICAL EQUIPMENT AND MEDICAL SUPPLIES

In addition to non-covered services listed on Attachments I and II, the following items are not covered by WV Medicaid:

(1) Use of an unlisted code when a national HCPCS code is available

(2) Unbundled HCPCS codes

(3) Services rendered prior to obtaining prior authorization

DISCLAIMER: This manual does not address all the complexities of Medicaid policies and procedures, and must be supplemented with all State and Federal Laws and Regulations.

(4) Routine or periodic maintenance (i.e., testing, cleaning, regulating)

(5) DME travel, set-up or delivery following repairs.

(6) Maintenance, repairs or replacement for equipment not purchased or rented by BMS or CSHCN (i.e., “loan closet”, Muscular Dystrophy, Easter Seals, family, friend, yard/rummage sales, etc.)

(7) Service calls that do not involve actual labor time for repairs.

(8) DME/medical supplies and other related services/items provided through DME suppliers to Nursing Facilities (ICF/MR), Hospice

(9) DME/medical supplies and other related services/items provided through DME suppliers to participants enrolled in the Division of Rehabilitative Services and/or Workers Compensation

(10) DME/medical supplies and other related service/items provided through DME suppliers to members enrolled in a Medicaid MCO.

(11) DME/medical supplies and other related service/items provided through DME to members enrolled in the PAAS Program without a referral from the PCP.

506.9 BILLING AND REIMBURSEMENT

WV Medicaid requires practitioners, DME/medical supply providers and other appropriate individuals/groups to be enrolled as a Medicaid provider to be eligible for reimbursement of services rendered with exception of an emergent/medically necessary circumstance. Billing prior to rendering services/items is prohibited.

Medicaid payment for DME/Medical Supplies is made on a rental or purchase basis. The total payment for rental equipment may not exceed the cost of purchasing the equipment and is reimbursed on a cap-rental basis depending on the item requested. The billing period for rental equipment begins the day equipment is placed in the home to the next month. When submitting the claim for payment consideration the dates should be spanned; e.g. if DME is placed on 1/3/06, the billing period begins on 1/3/06 to 2/2/06; 2/3/06 to 3/2/06; 3/3/06 to 4/2/06, etc. Only dates that the equipment is in use may be billed. If the member becomes ineligible, the billing span is the begin date of the billing period to the last date of eligibility.

When billing for unlisted and/or unpriced HCPCS DME/Medical Supply codes (A4335, A4649, A6215, A6261, A6262, A6450, A6501 – A6513, A6538, A6540-A6543, A7523, A7524, B9998, B9999, E0240, E0247 – E0248, E1239, E1399, E2216-E2218, E2372, E2399, K0009, K0108, K0669, K0898, K0899) the description of the item provided must be entered on the claim form. An unaltered cost invoice is to be submitted to WVMI for pricing of unlisted/unpriced codes. Refer to Attachment I for specific codes and special instructions.

The professional claim form, CMS 1500 or ASCX12N837P (004010X098A1 must be used to bill

DISCLAIMER: This manual does not address all the complexities of Medicaid policies and procedures, and must be supplemented with all State and Federal Laws and Regulations.

DME/medical supplies. Repair and replacement of DME requires an RP modifier. Options or accessories included in the base item code will not be reimbursed.

Medicaid is payer of last resort. Third-party Liability (TPL) is a method of ensuring that Medicaid is the last payer to reimburse for covered Medicaid services. In particular, Medicaid participating providers must always seek reimbursement from other liable resources, including private or public insurance entities. Federal regulations require that state Medicaid administration identify any third-party resource available to meet the medical expenses of a member. The third-party may be an individual, institution, corporation or a public/private agency liable for all or part of the member's medical costs; e.g., private health insurance, UMWA benefits, Veterans Administration benefits, CHAMPUS, Medicare, Hospice, etc. No Medicaid reimbursement may be made if the service is the responsibility of a public or private Workers Compensation Plan. Subsequent establishment of liability which provides compensation and payment for the costs of such medical care requires that an adjustment be made by the provider to the Medicaid agency for benefits paid. Prior authorization is not required for services reimbursed by third-party payers. All claims must be submitted to Unisys at PO Box 3767, Charleston, WV 25337 for reimbursement consideration.

Medicaid payment is based, where possible, on a percentage of the Medicare fee schedule and is equal to the lesser of the billed charge or the fee schedule amount less any third party payment. This same rule applies to payments for repairs and maintenance.

Certain supplies used by eligible diabetic Medicaid members (ICD-9-CM codes 250.00 B 250.93 or 648.8X**)** are covered through the outpatient pharmacy program. A prescription issued from a qualified practitioner within the scope of his/her practice is required for coverage of these items. Verbal prescriptions which meet federal and state regulations are permitted. Prescriptions must define the number of tests to be performed per day. Co-payments are not required on prescriptions for these items. Needles and syringes dispensed in this program are to be used only for the administration of insulin. Insulin syringe and needle combinations and pen needles are not covered for non-insulin dependent diabetic patients or those patients with other diagnoses through the pharmacy program.

Diabetic testing supplies and syringes/needles are not covered for members residing in skilled nursing or ICF/MR facilities. Blood glucose testing monitors, other types of diabetic testing supplies, insulin pumps and supplies, and/or syringes and needles for other purposes must be submitted as medical claims.

Covered supplies through the pharmacy program include: (See Pharmacy Manual)

- Blood glucose testing strips
- Urine testing tablets and strips
- Lancets
- Insulin syringe and needle combinations for the administration of insulin
- Needles for insulin pen systems

Diabetic medical supplies that include lancets, glucose strips and insulin syringes are covered by Medicaid through a retail pharmacy or through a DME company even if the member is enrolled in an MCO. All other equipment necessary for diabetic members who are members of the MCO is the

DISCLAIMER: This manual does not address all the complexities of Medicaid policies and procedures, and must be supplemented with all State and Federal Laws and Regulations.

responsibility of the MCO and the MCO's requirements must be met for reimbursement. If the MCO's requirements are not met, Medicaid will not reimburse for services provided.

506.10 MANAGED CARE

Unless otherwise noted in this manual or appendices, services detailed in this manual are the responsibility of the Managed Care Organization (MCO). If the Medicaid member is enrolled in a WV MCO, MCO requirements must be met for reimbursement. If a Medicaid member is enrolled in the PAAS Program, the member's PAAS Primary Care Provider (PCP) must provide a referral for the DME ordered prior to rendering the services. Medicaid will not reimburse for services provided when MCO or PAAS requirements are not met.

DISCLAIMER: This manual does not address all the complexities of Medicaid policies and procedures, and must be supplemented with all State and Federal Laws and Regulations.

Chapter 506

DME/Medical Supplies

May 1, 2005

Attachment I

Covered/Non-Covered DME/Medical Supply Services with Assigned HCPCS Codes

Revised January 1, 2008

WEST VIRGINIA DEPARTMENT OF HEALTH & HUMAN RESOURCES

BUREAU FOR MEDICAL SERVICES

HCPCS CODES FOR DURABLE MEDICAL EQUIPMENT AND SUPPLIES

***PRIOR AUTHORIZATION MUST BE OBTAINED IF SERVICE LIMITS ARE EXCEEDED**

HCPCS CODES	DESCRIPTION	REPLACES	SERVICE LIMIT	SPECIAL INSTRUCTIONS
A4206	SYRINGE WITH NEEDLE, STERILE 1CC **OR LESS**, EACH		100 PER ROLLING MONTH	
A4207	SYRINGE WITH NEEDLE, STERILE 2CC, EACH		100 PER ROLLING MONTH	
A4208	SYRINGE WITH NEEDLE, STERILE 3CC, EACH		100 PER ROLLING MONTH	
A4209	SYRINGE WITH NEEDLE, STERILE 5CC OR GREATER, EACH		100 PER ROLLING MONTH	
A4210	NEEDLE-FREE INJECTION DEVICE, EACH		NON-COVERED	
A4211	SUPPLIES FOR SELF-ADMINISTERED INJECTIONS		NON-COVERED	
A4212	NON-CORING NEEDLE OR STYLET WITH OR WITHOUT CATHETER		NON-COVERED	
A4213	SYRINGE, STERILE, 20 CC OR GREATER, EACH		60 PER ROLLING MONTH	
A4215	NEEDLE, STERILE, ANY SIZE EACH	A4656	100 PER ROLLING MONTH	
A4216	STERILE WATER, SALINE AND/OR DEXTROSE DILUENT/FLUSH, 10 ML			
A4217	STERILE WATER/SALINE, 500 ML			COVERAGE LIMITED TO TRACHEAL SUCTIONING ONLY. REQUIRES ICD-9-CM DIAGNOSIS CODE: 011.50-011.56, 277.02, 494.0, 494.1, 519.1, 748.61, V44.0 OR V55.0
A4218	STERILE SALINE OR WATER, METERED DOSE DISPENSER 10 ML		NON-COVERED	NEW CODE 01/01/2006
A4220	REFILL KIT FOR IMPLANTABLE INFUSION PUMP		NON-COVERED	
A4221	SUPPLIES FOR MAINTENANCE OF DRUG INFUSION CATHETER, PER WEEK (LIST DRUG SEPARATELY)	A4230 A4231	4 PER ROLLING MONTH	SUPPLIES INCLUDE: HEPLOCK START KITS, CENTRAL LINE KITS, INSYTES, ETOH SWABS, HUBER NEEDLES, SUB-Q- NEEDLE, SUB-Q KIT NON-REIMBURSABLE WITH A4230 OR A4231
A4222	INFUSION SUPPLIES FOR EXTERNAL DRUG INFUSION PUMP, PER CASSETTE OR BAG (LIST DRUGS SEPARATELY)	A4230 A4231		SUPPLIES INCLUDE: TUBING, BATTERIES, CLAVE VALVE, CLAVE, VIAL ACCESS, SYRINGES (3CC, 5CC, 10CC) 7” EXTENSION SETS SERVICE LIMIT BASED ON RATIONAL DRUG THERAPY PROGRAM AUTHORIZATION FOR NUMBER OF BAGS OR CASSETTES RDTP AUTHORIZATION FORM MUST BE ATTACHED TO CMS 1500 CLAIM FORM NON-REIMBURSABLE WITH A4230 OR A4231

HCPCS CODES	DESCRIPTION	REPLACES	SERVICE LIMIT	SPECIAL INSTRUCTIONS
A4223	INFUSION SUPPLIES NOT USED WITH EXTERNAL INFUSION PUMP, PER CASSETTE OR BAG (LIST DRUGS SEPARATELY)			SUPPLIES INCLUDE: TUBING, CENTRAL LINE KIT, INSYTES PERIPHERAL LINE, HUBER NEEDLES, CLAVE CONNECTOR, CLAVE VALVE, CLAVE VIAL ACCESS, LUMENS (TRIPLE, SINGLE, DOUBLE) SYRINGES (3CC, 5CC, 10CC) 7" EXTENSION SETS, HEPLOCK KITS, IV HOOK/POLE SERVICE LIMIT BASED ON RATIONAL DRUG THERAPY PROGRAM AUTHORIZATION FOR NUMBER OF BAGS OR CASSETTES RDTP AUTHORIZATION FORM MUST BE ATTACHED TO CMS 1500 CLAIM FORM NON-REIMBURSABLE WITH A4230 OR A4231
A4230	INFUSION SET FOR EXTERNAL INSULIN PUMP, NON NEEDLE CANNULA TYPE		12 PER ROLLING MONTH	REQUIRES ICD-9-CM DIAGNOSIS CODES: 250.00 - 250.93
A4231	INFUSION SET FOR EXTERNAL INSULIN PUMP, NEEDLE TYPE		12 PER ROLLING MONTH	REQUIRES ICD-9-CM DIAGNOSIS CODES: 250.00 - 250.93
A4232	SYRINGE WITH NEEDLE FOR EXTERNAL INSULIN PUMP, STERILE, 3CC		12 PER ROLLING MONTH	REQUIRES ICD-9-CM DIAGNOSIS CODES: 250.00 - 250.93
A4233	REPLACEMENT BATTERY, ALKALINE 9 (OTHER THAN T CELL) FOR USE WITH MEDICALLY NCESSARY HOME BLOOD GLUCOSE MONITOR OWNED BY THE PATIENT, EACH	A4254	1 PER 2 ROLLING YEARS	NEW CODE 01/01/2006
A4234	REPLACEMENT BATTERY, ALKALINE, J CELL, FOR USE WITH MEDICALLY NECESSARY HOME BLOOD GLUCOSE MONITOR OWNED BY PATIENT, EACH	A4254	1 PER 2 ROLLING YEARS	NEW CODE 01/01/2006
A4235	REPLACEMENT BATTERY, LITHIUM, FOR USE WITH MEDICALLY NECESSARY HOME BLOOD GLUCOSE MONITOR OWNED BY PATIENT, EACH	A4254	1 PER 2 ROLLING YEARS	NEW CODE 01/01/2006
A4236	REPLACEMENT BATTERY, SILVER OXIDE, FOR USE WITH MEDICALLY NECESSARY HOME BLOOD GLUCOSE MONITOR OWNED BY PATIENT, EACH	A4254	1 PER 2 ROLLING YEARS	NEW CODE 01/01/2006
A4244	ALCOHOL OR PEROXIDE, PER PINT		7 PER ROLLING MONTH	NON-REIMBURSABLE WITH A4245
A4245	ALCOHOL WIPES, PER BOX		4 PER ROLLING MONTH	NON-REIMBURSABLE WITH A4244
A4246	BETADINE OR PHISOHEX SOLUTION, PER PINT		6 PER ROLLING MONTH	NON-REIMBURSABLE WITH A4247
A4247	BETADINE OR IODINE SWABS/WIPES, PER BOX		4 PER ROLLING MONTH	NON-REIMBURSABLE WITH A4246
A4248	CHLOREHXIDINE CONTAINING ANTISEPTIC, 1 ML		NON-COVERED	

HCPCS CODES	DESCRIPTION	REPLACES	SERVICE LIMIT	SPECIAL INSTRUCTIONS
A4250	URINE TEST OR REAGENT STRIPS OR TABLETS (100 TABLETS OR STRIPS)		1 EVERY 3 ROLLING MONTHS	
A4252	BLOOD KETONE TEST OR REAGENT STRIP, EACH		NON-COVERED	NEW CODE 01/01/2008
A4253 KX	BLOOD GLUCOSE TEST OR REAGENT STRIPS FOR HOME BLOOD GLUCOSE MONITOR, PER 50 STRIPS		3 BOXES PER ROLLING MONTH	REQUIRES ICD-9-CM DIAGNOSIS CODES: 250.00 THRU 250.93 OR 648.8X INSULIN DEPENDENT NON-REIMBURSABLE WITH A4253KS
A4253 KS	BLOOD GLUCOSE TEST OR REAGENT STRIPS FOR HOME BLOOD GLUCOSE MONITOR, PER 50 STRIPS		2 BOXES PER ROLLING MONTH	REQUIRES ICD-9-CM DIAGNOSIS CODES: 250.00 THRU 250.93 OR 648.8X NON-INSULIN DEPENDENT NON-REIMBURSABLE WITH A4253KX
A4254	REPLACEMENT BATTERY, ANY TYPE, FOR USE WITH MEDICALLY NECESSARY HOME BLOOD GLUCOSE MONITOR OWNED BY PATIENT, EACH		NON-COVERED	DISCONTINUED BY CMS 12/31/2005
A4255	PLATFORMS FOR HOME BLOOD GLUCOSE MONITOR, 50 PER BOX		NON-COVERED	
A4256	NORMAL, LOW AND HIGH CALIBRATOR SOLUTION / CHIPS		1 PER 3 ROLLING MONTHS	REQUIRES ICD-9-CM DIAGNOSIS CODES: 250.00 THRU 250.93 OR 648.8X
A4257	REPLACEMENT LENS SHIELD CARTRIDGE FOR USE WITH LASER SKIN PIERCING DEVICE, EACH		NON-COVERED	
A4258	SPRING-POWERED DEVICE FOR LANCET, EACH		1 PER 2 ROLLING YEARS	REQUIRES ICD-9-CM DIAGNOSIS CODES: 250.00 THRU 250.93 OR 648.8X
A4259 KX	LANCETS, PER BOX OF 100		2 BOX PER ROLLING MONTH	REQUIRES ICD-9-CM DIAGNOSIS CODES: 250.00 THRU 250.93 OR 648.8X INSULIN DEPENDENT NON-REIMBURSABLE WITH A4259KS
A4259 KS	LANCETS, PER BOX OF 100		1 BOX PER ROLLING MONTH	REQUIRES ICD-9-CM DIAGNOSIS CODES: 250.00 THRU 250.93 OR 648.8X NON-INSULIN DEPENDENT NON-REIMBURSABLE WITH A4259KX
A4265	PARAFFIN, PER POUND		NON-COVERED	
A4280	ADHESIVE SKIN SUPPORT ATTACHMENT FOR USE WITH EXTERNAL BREAST PROSTHESIS, EACH		NON-COVERED	
A4281	TUBING FOR BREAST PUMP, REPLACEMENT		NON-COVERED	
A4282	ADAPTER FOR BREAST PUMP, REPLACEMENT		NON-COVERED	

WEST VIRGINIA DEPARTMENT OF HEALTH & HUMAN RESOURCES

BUREAU FOR MEDICAL SERVICES

HCPCS CODES FOR DURABLE MEDICAL EQUIPMENT AND SUPPLIES

***PRIOR AUTHORIZATION MUST BE OBTAINED IF SERVICE LIMITS ARE EXCEEDED**

HCPCS CODES	DESCRIPTION	REPLACES	SERVICE LIMIT	SPECIAL INSTRUCTIONS
A4283	CAP FOR BREAST PUMP BOTTLE, REPLACEMENT		NON-COVERED	
A4284	BREAST SHIELD AND SPLASH PROTECTOR FOR USE WITH BREAST PUMP, REPLACEMENT		NON-COVERED	
A4285	POLYCARBONATE BOTTLE FOR USE WITH BREAST PUMP, REPLACEMENT		NON-COVERED	
A4286	LOCKING RING FOR BREAST PUMP, REPLACEMENT		NON-COVERED	
A4310	INSERTION TRAY WITHOUT DRAINAGE BAG AND WITHOUT CATHETER (ACCESSORIES ONLY)		2 PER ROLLING MONTH	NON-REIMBURSABLE WITH A4332
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 ROLLING MONTH	NON-REIMBURSABLE WITH A4310, A4332, A4338
A4312	INSERTION TRAY WITHOUT DRAINAGE BAG WITH INDWELLING CATHETER, FOLEY TYPE, TWO-WAY, ALL SILICONE		2 PER ROLLING MONTH	NON-REIMBURSABLE WITH A4310, A4332, A4344
A4313	INSERTION TRAY WITHOUT DRAINAGE BAG WITH INDWELLING CATHETER, FOLEY TYPE,THREE-WAY, FOR CONTINUOUS IRRIGATION LATEX WITH COATING (TEFLON, SILICONE, SILICONE ELASTOMER OR HYDROPHILIC, ETC.)		1 PER DAY X 14 DAYS	NON-REIMBURSABLE WITH A4310, A4332, A4346
A4314	INSERTION TRAY WITH DRAINAGE BAG WITH INDWELLING CATHETER, FOLEY TYPE, TWO-WAY		2 PER ROLLING MONTH	NON-REIMBURSABLE WITH A4310, A4311, A4331, A4332, A4338, A4354, A4357
A4315	INSERTION TRAY WITH DRAINAGE BAG WITH INDWELLING CATHETER, FOLEY TYPE, TWO-WAY,ALL SILICONE		2 PER ROLLING MONTH	NON-REIMBURSABLE WITH A4310, A4312, A4331, A4332, A4344, A4354, A4357
A4316	INSERTION TRAY WITH DRAINAGE BAG WITH INDWELLING CATHETER, FOLEY TYPE, THREE-WAY, FOR CONTINUOUS IRRIGATION		1 PER DAY X 14 DAYS	NON-REIMBURSABLE WITH A4310, A4313, A4331, A4332, A4346, A4354, A4357
A4320	IRRIGATION TRAY WITH BULB OR PISTON SYRINGE, ANY PURPOSE		2 PER ROLLING MONTH	NON-REIMBURSABLE WITH A4322
A4321	THERAPEUTIC AGENT FOR URINARY CATHETER IRRIGATION		NON-COVERED	
A4322	IRRIGATION SYRINGE, BULB OR PISTON, EACH		2 PER ROLLING MONTH	NON-REIMBURSABLE WITH A4320
A4326	MALE EXTERNAL CATHETER WITH INTEGRAL COLLECTION CHAMBER, ANY TYPE, EACH		2 PER ROLLING MONTH	FOR MALE USE ONLY

HCPCS CODES	DESCRIPTION	REPLACES	SERVICE LIMIT	SPECIAL INSTRUCTIONS
A4327	FEMALE EXTERNAL URINARY COLLECTION DEVICE; MEATAL CUP, EACH		1 PER WEEK	FOR FEMALE USE ONLY
A4328	FEMALE EXTERNAL URINARY COLLECTION DEVICE; POUCH, EACH		1 PER DAY	FOR FEMALE USE ONLY
A4330	PERIANAL FECAL COLLECTION POUCH WITH ADHESIVE, EACH		31 PER ROLLING MONTH	
A4331	EXTENSION DRAINAGE TUBING, ANY TYPE, ANY LENGTH, WITH CONNECTOR/ADAPTOR, FOR USE WITH URINARY LEG BAG OR UROSTOMY POUCH, EACH		5 PER ROLLING MONTH	NON-REIMBURSABLE WITH A4314, A4315, A4316, A4354, A4357, A4358, A5105; CAN ONLY BE BILLED WITH A5112
A4332	LUBRICANT, INDIVIDUAL STERILE PACKET, EACH		31 PER ROLLING MONTH	NON-REIMBURSABLE FOR CLEAN, NONSTERILE INTERMITTENT CATHETERIZATION
A4333	URINARY CATHETER ANCHORING DEVICE, ADHESIVE SKIN ATTACHMENT, EACH		12 PER ROLLING MONTH	
A4334	URINARY CATHETER ANCHORING DEVICE, LEG STRAP, EACH		1 PER ROLLING MONTH	
A4335	INCONTINENCE SUPPLY; MISCELLANEOUS			PRIOR AUTHORIZATION COST INVOICE REQUIRED
A4338	INDWELLING CATHETER; FOLEY TYPE, TWO-WAY LATEX WITH COATING (TEFLON, SILICONE, ELASTOMER, OR HYDROPHILIC, ETC.), EACH		2 PER ROLLING MONTH	
A4340	INDWELLING CATHETER; SPECIALTY TYPE, EG; COUDE, MUSHROOM, WING, ETC.), EACH		2 PER ROLLING MONTH	
A4344	INDWELLING CATHETER, FOLEY TYPE, TWO-WAY, ALL SILICONE, EACH		2 PER ROLLING MONTH	
A4346	INDWELLING CATHETER; FOLEY TYPE, THREE WAY FOR CONTINUOUS IRRIGATION, EACH		1 PER DAY X 14 DAYS	
A4348	MALE EXTERNAL CATHETER WITH INTEGRAL COLLECTION COMPARTMENT, EXTENDED WEAR, EACH (E.G., 2 PER ROLLING MONTH)		NON-COVERED	
A4349	MALE EXTERNAL CATHETER, WITH OR WITHOUT ADHESIVE, DISPOSABLE, EACH	A4324 A4325 A4347	31 PER ROLLING MONTH	FOR MALE USE ONLY NON-REIMBURSABLE WITH ADHESIVE STRIPS OR TAPE
A4351	INTERMITTENT URINARY CATHETER; STRAIGHT TIP, WITH OR WITHOUT COATING (TEFLON, SILICONE ELASTOMER, OR HYDROPHILIC, ETC.), EACH		31 PER ROLLING MONTH	NON-REIMBURSABLE WITH A4353

WEST VIRGINIA DEPARTMENT OF HEALTH & HUMAN RESOURCES

BUREAU FOR MEDICAL SERVICES

HCPCS CODES FOR DURABLE MEDICAL EQUIPMENT AND SUPPLIES

***PRIOR AUTHORIZATION MUST BE OBTAINED IF SERVICE LIMITS ARE EXCEEDED**

HCPCS CODES	DESCRIPTION	REPLACES	SERVICE LIMIT	SPECIAL INSTRUCTIONS
A4352	INTERMITTENT URINARY CATHETER; COUDE (CURVED) TIP, WITH OR WITHOUT COATING (TEFLON, SILICONE, SILICONE ELASTOMERIC, OR HYDROPHILIC, ETC.), EACH		8 PER ROLLING MONTH	NON-REIMBURSABLE WITH A4353
A4353	INTERMITTENT URINARY CATHETER, WITH INSERTION SUPPLIES		31 PER ROLLING MONTH	NON-REIMBURSABLE WITH A4310, A4332, A4351, A4352; COVERAGE LIMITED TO STERILE TECHNIQUE ONLY WHEN SPECIFICALLY PRESCRIBED IN WRITING BY PRESCRIBING PRACTITIONER SUPPLIES INCLUDE: TRAY/BAG IN STERILE PACKAGE INCLUDES SINGLE USE CATHETER, LUBICANT, GLOVES, ANTISEPTIC SOLUTION, APPLICATOR AND DRAPE
A4354	INSERTION TRAY WITH DRAINAGE BAG BUT WITHOUT CATHETER		2 PER ROLLING MONTH	NON-REIMBURSABLE WITH A4310, A4331, A4332, A4357
A4355	IRRIGATION TUBING SET FOR CONTINUOUS BLADDER IRRIGATION THROUGH A THREE-WAY INDWELLING FOLEY CATHETER, EACH		1 PER DAY X 14 DAYS	REIMBURSED FOR CONTINUOUS BLADDER IRRIGATION OR HISTORY OF CATHETER OBSTRUCTION
A4356	EXTERNAL URETHRAL CLAMP OR COMPRESSION DEVICE (NOT TO BE USED FOR CATHETER CLAMP), EACH		1 PER 3 ROLLING MONTHS	
A4357	BEDSIDE DRAINAGE BAG, DAY OR NIGHT, WITH OR WITHOUT ANTI-REFLUX DEVICE, WITH OR WITHOUT TUBE, EACH		2 PER ROLLING MONTH	NON-REIMBURSABLE WITH A4331, A5102
A4358	URINARY DRAINAGE BAG, LEG OR ABDOMEN, VINYL, WITH OR WITHOUT TUBE, WITH STRAPS, EACH		2 PER ROLLING MONTH	FOR MEMBERS WHO ARE AMBULATORY OR ARE CHAIR OR WHEELCHAIR BOUND ONLY NON-REIMBURSABLE WITH A5112, A4331, A5113, A5114
A4359	URINARY SUSPENSORY WITHOUT LEG BAG, EACH		1 PER ROLLING MONTH	CLOSED BY CMS 12/31/2006
A4361	OSTOMY FACEPLATE, EACH		3 PER 6 ROLLING MONTHS	REQUIRES ICD-9-CM DIAGNOSIS CODES OF V44.2 V55.2 , V44.3, V55.3, V44.6 OR V55.6 NON-REIMBURSABLE WITH: A4375, A4376, A4377, A4378, A4379, A4380, A4381, A4382, A4383
A4362	SKIN BARRIER; SOLID, 4 X 4 OR EQUIVALENT; EACH		20 PER ROLLING MONTH	REQUIRES ICD-9-CM DIAGNOSIS CODES OF V44.2, V44.3, V44.6, V55.2, V55.3, OR V55.6
A4363	OSTOMY CLAMP, ANY TYPE, REPLACEMENT ONLY, EACH		NON-COVERED	NEW CODE 01/01/2006
A4364	ADHESIVE, LIQUID OR EQUAL, ANY TYPE, PER OZ		4 OZ. PER ROLLING MONTH	REQUIRES ICD-9-CM DIAGNOSIS CODES OF V44.2, V44.3, V44.6, V55.2, V55.3, OR V55.6
A4365	ADHESIVE REMOVER WIPES, ANY TYPE, PER 50		1 BOX PER ROLLING MONTH	REQUIRES ICD-9-CM DIAGNOSIS CODES OF V44.2, V44.3, V44.6, V55.2, V55.3, OR V55.6

WEST VIRGINIA DEPARTMENT OF HEALTH & HUMAN RESOURCES

BUREAU FOR MEDICAL SERVICES

HCPCS CODES FOR DURABLE MEDICAL EQUIPMENT AND SUPPLIES

***PRIOR AUTHORIZATION MUST BE OBTAINED IF SERVICE LIMITS ARE EXCEEDED**

HCPCS CODES	DESCRIPTION	REPLACES	SERVICE LIMIT	SPECIAL INSTRUCTIONS
A4366	OSTOMY VENT, ANY TYPE, EACH		15 PER ROLLING MONTH	REQUIRES ICD-9-CM DIAGNOSIS CODES OF V44.2, V44.3, V44.6, V55.2, V55.3, OR V55.6 NON-REIMBURSABLE WITH: A4416, A4417, A4418, A4419, A4423, A4424, A4425, and A4427;
A4367	OSTOMY BELT, EACH		2 PER 6 ROLLING MONTHS	REQUIRES ICD-9-CM DIAGNOSIS CODES OF V44.2, V44.3, V44.6, V55.2, V55.3, OR V55.6
A4368	OSTOMY FILTER, ANY TYPE, EACH		1 PER DAY	REQUIRES ICD-9-CM DIAGNOSIS CODES OF V44.2, V44.3, V44.6, V55.2, V55.3, OR V55.6
A4369	OSTOMY SKIN BARRIER, LIQUID (SPRAY, BRUSH, ETC), PER OZ		2 OZ PER ROLLING MONTH	REQUIRES ICD-9-CM DIAGNOSIS CODES OF V44.2, V44.3, V44.6, V55.2, V55.3, OR V55.6 NON-REIMBURSABLE WITH A 5119
A4371	OSTOMY SKIN BARRIER, POWDER, PER OZ		10 OZ. PER 6 ROLLING MONTHS	REQUIRES ICD-9-CM DIAGNOSIS CODES OF V44.2, V44.3, V44.6, V55.2, V55.3, OR V55.6
A4372	OSTOMY SKIN BARRIER, SOLID 4 X 4 OR EQUIVALENT, STANDARD WEAR, WITH BUILT-IN CONVEXITY, EACH		15 PER ROLLING MONTH	REQUIRES ICD-9-CM DIAGNOSIS CODES OF V44.2, V44.3, V44.6, V55.2, V55.3, OR V55.6
A4373	OSTOMY SKIN BARRIER, WITH FLANGE (SOLID, FLEXIBLE OR ACCORDIAN), WITH BUILT-IN CONVEXITY, ANY SIZE, EACH		15 PER ROLLING MONTH	REQUIRES ICD-9-CM DIAGNOSIS CODES OF V44.2, V44.3, V44.6, V55.2, V55.3, OR V55.6
A4375	OSTOMY POUCH, DRAINABLE, WITH FACEPLATE ATTACHED, PLASTIC, EACH		15 PER ROLLING MONTH	REQUIRES ICD-9-CM DIAGNOSIS CODES OF V44.2, V44.3, V44.6, V55.2, V55.3, OR V55.6 NON-REIMBURSABLE WITH: A4361, A4377
A4376	OSTOMY POUCH, DRAINABLE, WITH FACEPLATE ATTACHED, RUBBER, EACH		15 PER ROLLING MONTH	REQUIRES ICD-9-CM DIAGNOSIS CODES OF V44.2, V44.3, V44.6, V55.2, V55.3, OR V55.6 NON-REIMBURSABLE WITH: A4361, A4378;
A4377	OSTOMY POUCH, DRAINABLE, FOR USE ON FACEPLATE, PLASTIC, EACH		10 PER ROLLING MONTH	REQUIRES ICD-9-CM DIAGNOSIS CODES OF V44.2, V44.3, V44.6, V55.2, V55.3, OR V55.6 NON-REIMBURSABLE WITH: A4361, A4375;
A4378	OSTOMY POUCH, DRAINABLE, FOR USE ON FACEPLATE, RUBBER, EACH		10 PER ROLLING MONTH	REQUIRES ICD-9-CM DIAGNOSIS CODES OF V44.2, V44.3, V44.6, V55.2, OR V55.3, V55.6 NON-REIMBURSABLE WITH: A4361, A4376;
A4379	OSTOMY POUCH, URINARY, WITH FACEPLATE ATTACHED, PLASTIC, EACH		10 PER ROLLING MONTH	REQUIRES ICD-9-CM DIAGNOSIS CODES: V44.6 OR V55.6 NON-REIMBURSABLE WITH: A4361, A4381, and A4382
A4380	OSTOMY POUCH, URINARY, WITH FACEPLATE ATTACHED, RUBBER, EACH		10 PER ROLLING MONTH	REQUIRES ICD-9-CM DIAGNOSIS CODES: V44.6 OR V55.6 NON-REIMBURSABLE WITH: A4361, A4383
A4381	OSTOMY POUCH, URINARY, FOR USE ON FACEPLATE, PLASTIC, EACH		10 PER ROLLING MONTH	REQUIRES ICD-9-CM DIAGNOSIS CODES: V44.6 OR V55.6 NON-REIMBURSABLE WITH: A4361, A4379, A4382

HCPCS CODES	DESCRIPTION	REPLACES	SERVICE LIMIT	SPECIAL INSTRUCTIONS
A4382	OSTOMY POUCH, URINARY, FOR USE ON FACEPLATE, HEAVY PLASTIC, EACH		10 PER ROLLING MONTH	REQUIRES ICD-9-CM DIAGNOSIS CODES: V44.6 OR V55.6 NON-REIMBURSABLE WITH: A4361, A4379, A4381
A4383	OSTOMY POUCH, URINARY, FOR USE ON FACEPLATE, RUBBER, EACH		10 PER ROLLING MONTH	REQUIRES ICD-9-CM DIAGNOSIS CODES: V44.6 OR V55.6 NON-REIMBURSABLE WITH: A4361, A4380
A4384	OSTOMY FACEPLATE EQUIVALENT, SILICONE RING, EACH		2 PER 6 ROLLING MONTHS	REQUIRES ICD-9-CM DIAGNOSIS CODES OF V44.2, V44.3, V44.6, V55.2, V55.3, OR V55.6
A4385	OSTOMY SKIN BARRIER, SOLID 4X4 OR EQUIVALENT, EXTENDED WEAR, WITHOUT BUILT-IN CONVEXITY, EACH		15 PER ROLLING MONTH	REQUIRES ICD-9-CM DIAGNOSIS CODES OF V44.2, V44.3, V44.6, V55.2, V55.3, OR V55.6
A4387	OSTOMY POUCH, CLOSED, WITH BARRIER ATTACHED, WITH BUILT-IN CONVEXITY (1 PIECE), EACH		60 PER ROLLING MONTH	REQUIRES ICD-9-CM DIAGNOSIS CODES OF V44.2, V44.3, V44.6, V55.2, V55.3, OR V55.6
A4388	OSTOMY POUCH, DRAINABLE, WITH EXTENDED WEAR BARRIER ATTACHED, (1 PIECE), EACH		60 PER ROLLING MONTH	REQUIRES ICD-9-CM DIAGNOSIS CODES OF V44.2, V44.3, V44.6, V55.2, V55.3, OR V55.6
A4389	OSTOMY POUCH, DRAINABLE, WITH BARRIER ATTACHED, WITH BUILT-IN CONVEXITY (1 PIECE), EACH		60 PER ROLLING MONTH	REQUIRES ICD-9-CM DIAGNOSIS CODES OF V44.2, V44.3, V44.6, V55.2, V55.3, OR V55.6
A4390	OSTOMY POUCH, DRAINABLE, WITH EXTENDED WEAR BARRIER ATTACHED, WITH BUILT-IN CONVEXITY (1 PIECE), EACH		60 PER ROLLING MONTH	REQUIRES ICD-9-CM DIAGNOSIS CODES OF V44.2, V44.3, V44.6, V55.2, V55.3, OR V55.6
A4391	OSTOMY POUCH, URINARY, WITH EXTENDED WEAR BARRIER ATTACHED (1 PIECE), EACH		30 PER ROLLING MONTH	REQUIRES ICD-9-CM DIAGNOSIS CODES: V44.6 OR V55.6
A4392	OSTOMY POUCH, URINARY, WITH STANDARD WEAR BARRIER ATTACHED, WITH BUILT-IN CONVEXITY (1 PIECE), EACH		30 PER ROLLING MONTH	REQUIRES ICD-9-CM DIAGNOSIS CODES: V44.6 OR V55.6
A4393	OSTOMY POUCH, URINARY, WITH EXTENDED WEAR BARRIER ATTACHED, WITH BUILT-IN CONVEXITY (1 PIECE), EACH		30 PER ROLLING MONTH	REQUIRES ICD-9-CM DIAGNOSIS CODES: V44.6 OR V55.6
A4394	OSTOMY DEODORANT FOR USE IN OSTOMY POUCH, LIQUID, PER FLUID OUNCE		16 OZ. PER ROLLING MONTH	REQUIRES ICD-9-CM DIAGNOSIS CODES OF V44.2, V44.3, V44.6, V55.2, V55.3, OR V55.6
A4395	OSTOMY DEODORANT FOR USE IN OSTOMY POUCH, SOLID, PER TABLET		30 PER ROLLING MONTH	REQUIRES ICD-9-CM DIAGNOSIS CODES OF V44.2, V44.3, V44.6, V55.2, V55.3, OR V55.6
A4396	OSTOMY BELT WITH PERISTOMAL HERNIA SUPPORT		2 PER ROLLING YEAR	REQUIRES ICD-9-CM DIAGNOSIS CODES OF V44.2, V44.3, V44.6, V55.2, V55.3, OR V55.6
A4397	IRRIGATION SUPPLY; SLEEVE, EACH		4 PER ROLLING MONTH	REQUIRES ICD-9-CM DIAGNOSIS CODES OF V44.2, V44.3, V44.6, V55.2, V55.3, OR V55.6
A4398	OSTOMY IRRIGATION SUPPLY; BAG, EACH		2 PER 6 ROLLING MONTHS	REQUIRES ICD-9-CM DIAGNOSIS CODES OF V44.2, V44.3, V44.6, V55.2, V55.3, OR V55.6
A4399	OSTOMY IRRIGATION SUPPLY; CONE/CATHETER, INCLUDING BRUSH		2 PER 6 ROLLING MONTHS	REQUIRES ICD-9-CM DIAGNOSIS CODES OF V44.2, V44.3, V44.6, V55.2, V55.3, OR V55.6
A4400	OSTOMY IRRIGATION SET		1 PER ROLLING YEAR	REQUIRES ICD-9-CM DIAGNOSIS CODES OF V44.2, V44.3, V44.6, V55.2, V55.3, OR V55.6

HCPCS CODES	DESCRIPTION	REPLACES	SERVICE LIMIT	SPECIAL INSTRUCTIONS
A4402	LUBRICANT, PER OUNCE		4 OZ. PER ROLLING MONTH	
A4404	OSTOMY RING, EACH		10 PER ROLLING MONTH	REQUIRES ICD-9-CM DIAGNOSIS CODES OF V44.2, V44.3, V44.6, V55.2, V55.3, OR V55.6
A4405	OSTOMY SKIN BARRIER, NON-PECTIN BASED, PASTE, PER OUNCE	K0561	4 OZ. PER ROLLING MONTH	REQUIRES ICD-9-CM DIAGNOSIS CODES OF V44.2, V44.3, V44.6, V55.2, V55.3, OR V55.6
A4406	OSTOMY SKIN BARRIER, PECTIN-BASED, PASTE, PER OUNCE	K0562	4 OZ. PER ROLLING MONTH	REQUIRES ICD-9-CM DIAGNOSIS CODES OF V44.2, V44.3, V44.6, V55.2, V55.3, OR V55.6
A4407	OSTOMY SKIN BARRIER, WITH FLANGE (SOLID, FLEXIBLE, OR ACCORDION), EXTENDED WEAR, WITH BUILT-IN CONVEXITY, 4 X 4 INCHES OR SMALLER, EACH	K0563	20 PER ROLLING MONTH	REQUIRES ICD-9-CM DIAGNOSIS CODES OF V44.2, V44.3, V44.6, V55.2, V55.3, OR V55.6
A4408	OSTOMY SKIN BARRIER, WTIH FLANGE (SOLID, FLEXIBLE OR ACCORDION), EXTENDED WEAR, WITH BUILT-IN CONVEXITY, LARGER THAN 4 X 4 INCHES, EACH	K0564	20 PER ROLLING MONTH	REQUIRES ICD-9-CM DIAGNOSIS CODES OF V44.2, V44.3, V44.6, V55.2, V55.3, OR V55.6
A4409	OSTOMY SKIN BARRIER, WITH FLANGE (SOLID, FLEXIBLE OR ACCORDION), EXTENDED WEAR, WITHOUT BUILT-IN CONVEXITY, 4 X 4 INCHES OR SMALLER, EACH	K0565	20 PER ROLLING MONTH	REQUIRES ICD-9-CM DIAGNOSIS CODES OF V44.2, V44.3, V44.6, V55.2, V55.3, OR V55.6
A4410	OSTOMY SKIN BARRIER, WITH FLANGE (SOLID, FLEXIBLE OR ACCORDION), EXTENDED WEAR, ITHOUT BUILT-IN CONVEXITY, LARGER THAN 4 X 4 INCHES, EACH	K0566	20 PER ROLLING MONTH	REQUIRES ICD-9-CM DIAGNOSIS CODES OF V44.2, V44.3, V44.6, V55.2, V55.3, OR V55.6
A4411	OSTOMY SKIN BARRIER, SOLID 4 X 4 OR EQUIVALENT, EXTENDED WEAR, WITH BUILT-IN CONVEXITY, EACH		20 PER ROLLING MONTH	NEW CODE 01/01/2006
A4412	OSTOMY POUCH, DRAINABLE, HIGH OUTPUT, FOR USE ON A BARRIER WITH FLANGE (2 PIECE SYSTEM), WITHOUT FILTER, EACH		20 PER ROLLING MONTH	NEW CODE 01/012006
A4413	OSTOMY POUCH, DRAINABLE, HIGH OUTPUT, FOR USE ON A BARRIER WITH FLANGE (2 PIECE SYSTEM), WITH FILTER, EACH	K0569	20 PER ROLLING MONTH	REQUIRES ICD-9-CM DIAGNOSIS CODES OF V44.2, V44.3, V44.6, V55.2, V55.3, OR V55.6
A4414	OSTOMY SKIN BARRIER, WITH FLANGE (SOLID, FLEXIBLE OR ACCORDION), WITHOUT BUILT-IN CONVEXITY, 4 X 4 INCHES OR SMALLER, EACH	K0570	20 PER ROLLING MONTH	REQUIRES ICD-9-CM DIAGNOSIS CODES OF V44.2, V44.3, V44.6, V55.2, V55.3, OR V55.6
A4415	OSTOMY SKIN BARRIER, WITH FLANGE (SOLID, FLEXIBLE OR ACCORDION), WITHOUT BUILT-IN CONVEXITY, LARGER THAN 4X4 INCHES, EACH	K0571	20 PER ROLLING MONTH	REQUIRES ICD-9-CM DIAGNOSIS CODES OF V44.2, V44.3, V44.6, V55.2, V55.3, OR V55.6

***PRIOR AUTHORIZATION MUST BE OBTAINED IF SERVICE LIMITS ARE EXCEEDED**

HCPCS CODES	DESCRIPTION	REPLACES	SERVICE LIMIT	SPECIAL INSTRUCTIONS
A4416	OSTOMY POUCH, CLOSED, WITH BARRIER ATTACHED, WITH FILTER (1 PIECE), EACH	K0581	60 PER ROLLING MONTH	REQUIRES ICD-9-CM DIAGNOSIS CODES OF V44.2, V44.3, V44.6, V55.2, V55.3, OR V55.6 NON-REIMBURSABLE WITH A4366
A4417	OSTOMY POUCH, CLOSED, WITH BARRIER ATTACHED, WITH BUILT-IN CONVEXITY, WITH FILTER (1 PIECE), EACH	K0582	60 PER ROLLING MONTH	REQUIRES ICD-9-CM DIAGNOSIS CODES OF V44.2, V44.3, V44.6, V55.2, V55.3, OR V55.6 NON-REIMBURSABLE WITH A4366
A4418	OSTOMY POUCH, CLOSED; WITHOUT BARRIER ATTACHED, WITH FILTER (1 PIECE), EACH	K0583	60 PER ROLLING MONTH	REQUIRES ICD-9-CM DIAGNOSIS CODES OF V44.2, V44.3, V44.6, V55.2, V55.3, OR V55.6 NON-REIMBURSABLE WITH A4366
A4419	OSTOMY POUCH, CLOSED; FOR USE ON BARRIER WITH NON-LOCKING FLANGE, WITH FILTER (2 PIECE), EACH	K0584	60 PER ROLLING MONTH	REQUIRES ICD-9-CM DIAGNOSIS CODES OF V44.2, V44.3, V44.6, V55.2, V55.3, OR V55.6 NON-REIMBURSABLE WITH A4366
A4420	OSTOMY POUCH, CLOSED; FOR USE ON BARRIER WITH LOCKING FLANGE (2 PIECE), EACH	K0585	60 PER ROLLING MONTH	COST INVOICE REQUIRED REQUIRES ICD-9-CM DIAGNOSIS CODES OF V44.2, V44.3, V44.6, V55.2, OR V55.3, V55.6
A4421	OSTOMY SUPPLY; MISCELLANEOUS			PRIOR AUTHORIZATION COST INVOICE REQUIRED REQUIRES ICD-9-CM DIAGNOSIS CODES OF V44.2, V44.3, V44.6, V55.2, V55.3, OR V55.6
A4422	OSTOMY ABSORBENT MATERIAL (SHEET/PAD/CRYSTAL PACKET) FOR USE IN OSTOMY POUCH TO THICKEN LIQUID STOMAL OUTPUT, EACH		1 PER DAY	REQUIRES ICD-9-CM DIAGNOSIS CODES OF V44.2, V44.3, V44.6, V55.2, V55.3, OR V55.6
A4423	OSTOMY POUCH, CLOSED; FOR USE ON BARRIER WITH LOCKING FLANGE, WITH FILTER (2 PIECE), EACH	K0586	60 PER ROLLING MONTH	REQUIRES ICD-9-CM DIAGNOSIS CODES OF V44.2, V44.3, V44.6, V55.2, V55.3, OR V55.6 NON-REIMBURSABLE WITH A4366
A4424	OSTOMY POUCH, DRAINABLE, WITH BARRIER ATTACHED, WITH FILTER (1 PIECE), EACH	K0587	20 PER ROLLING MONTH	REQUIRES ICD-9-CM DIAGNOSIS CODES OF V44.2, V44.3, V44.6, V55.2, V55.3, OR V55.6 NON-REIMBURSABLE WITH A4366
A4425	OSTOMY POUCH, DRAINABLE; FOR USE ON BARRIER WITH NON-LOCKING FLANGE, WITH FILTER (2 PIECE SYSTEM), EACH	K0588	20 PER ROLLING MONTH	REQUIRES ICD-9-CM DIAGNOSIS CODES OF V44.2, V44.3, V44.6, V55.2, V55.3, OR V55.6 NON-REIMBURSABLE WITH A4366
A4426	OSTOMY POUCH, DRAINABLE; FOR USE ON BARRIER WITH LOCKING FLANGE (2 PIECE SYSTEM), EACH	K0589	20 PER ROLLING MONTH	REQUIRES ICD-9-CM DIAGNOSIS CODES OF V44.2, V44.3, V44.6, V55.2, V55.3, OR V55.6
A4427	OSTOMY POUCH, DRAINABLE; FOR USE ON BARRIER WITH LOCKING FLANGE, WITH FILTER (2 PIECE SYSTEM), EACH	K0590	20 PER ROLLING MONTH	REQUIRES ICD-9-CM DIAGNOSIS CODES OF V44.2, V44.3, V44.6, V55.2, V55.3, OR V55.6 NON-REIMBURSABLE WITH A4366;

HCPCS CODES	DESCRIPTION	REPLACES	SERVICE LIMIT	SPECIAL INSTRUCTIONS
A4428	OSTOMY POUCH, URINARY, WITH EXTENDED WEAR BARRIER ATTACHED, WITH FAUCET-TYPE TAP WITH VALVE (1 PIECE), EACH	K0591	15 PER ROLLING MONTH	REQUIRES ICD-9-CM DIAGNOSIS CODES: V44.6 OR V55.6
A4429	OSTOMY POUCH, URINARY, WITH BARRIER ATTACHED, WITH BUILT-IN CONVEXITY, WITH FAUCET-TYPE TAP WITH VALVE (1 PIECE), EACH	K0592	20 PER ROLLING MONTH	REQUIRES ICD-9-CM DIAGNOSIS CODES: V44.6 OR V55.6
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 ROLLING MONTH	REQUIRES ICD-9-CM DIAGNOSIS CODES: V44.6 OR V55.6
A4431	OSTOMY POUCH, URINARY; WITH BARRIER ATTACHED, WITH FAUCET-TYPE TAP WITH VALVE (1 PIECE), EACH	K0594	20 PER ROLLING MONTH	REQUIRES ICD-9-CM DIAGNOSIS CODES: V44.6 OR V55.6
A4432	OSTOMY POUCH, URINARY; FOR USE ON BARRIER WITH NON-LOCKING FLANGE, WITH FAUCET-TYPE TAP WITH VALVE (2 PIECE), EACH	K0595	20 PER ROLLING MONTH	REQUIRES ICD-9-CM DIAGNOSIS CODES: V44.6 OR V55.6
A4433	OSTOMY POUCH, URINARY; FOR USE ON BARRIER WITH LOCKING FLANGE (2 PIECE), EACH	K0596	20 PER ROLLING MONTH	REQUIRES ICD-9-CM DIAGNOSIS CODES: V44.6 OR V55.6
A4434	OSTOMY POUCH, URINARY; FOR USE ON BARRIER WITH LOCKING FLANGE, WITH FAUCET-TYPE TAP WITH VALVE (2 PIECE), EACH	K0597	20 PER ROLLING MONTH	REQUIRES ICD-9-CM DIAGNOSIS CODES: V44.6 OR V55.6
A4450	TAPE, NON-WATERPROOF, PER 18 SQUARE INCHES		40 UNITS PER ROLLING MONTH	
A4452	TAPE, WATERPROOF, PER 18 SQUARE INCHES		40 UNITS PER ROLLING MONTH	
A4455	ADHESIVE REMOVER OR SOLVENT (FOR TAPE, CEMENT OR OTHER ADHESIVE), PER OUNCE		16 OZ. PER ROLLING MONTH	REQUIRES ICD-9-CM DIAGNOSIS CODES OF V44.2, V44.3, V44.6, V55.2, V55.3, OR V55.6
A4458	ENEMA BAG WITH TUBING, REUSABLE		NON-COVERED	
A4461	SURGICAL DRESSING HOLDER, NON-REUSABLE, EACH	A4462	1 PER ROLLING YEARS	NEW CODE 01/01/2007
A4462	ABDOMINAL DRESSING HOLDER, EACH		1 PER ROLLING YEAR	CLOSED BY CMS 12/31/2006
A4463	SURGICAL DRESSING HOLDER, REUSABLE, EACH	A4462	1 PER ROLLING YEAR	NEW CODE 01/01/2007
A4465	NON-ELASTIC BINDER FOR EXTREMITY		NON-COVERED	
A4470	GRAVLEE JET WASHER		NON-COVERED	
A4480	VABRA ASPIRATOR		NON-COVERED	

HCPCS CODES	DESCRIPTION	REPLACES	SERVICE LIMIT	SPECIAL INSTRUCTIONS
A4481	TRACHEOSTOMA FILTER, ANY TYPE, ANY SIZE, EACH		31 PER ROLLING MONTH	
A4483	MOISTURE EXCHANGER, DISPOSABLE, FOR USE WITH INVASIVE MECHANICAL VENTILATION		NON-COVERED	
A4490	SURGICAL STOCKINGS ABOVE KNEE LENGTH, EACH		4 PER 6 ROLLING MONTHS	REQUIRES FITTER'S CERTIFICATION BY THE AMERICAN BOARD FOR CERTIFICATION OF ORTHOTICS & PROSTHETICS OR BOARD FOR CERTIFICATION OF ORTHOTICS & PROSTHETICS
A4495	SURGICAL STOCKINGS THIGH LENGTH, EACH		4 PER 6 ROLLING MONTHS	REQUIRES FITTER'S CERTIFICATION BY THE AMERICAN BOARD FOR CERTIFICATION OF ORTHOTICS & PROSTHETICS OR BOARD FOR CERTIFICATION OF ORTHOTICS & PROSTHETICS
A4500	SURGICAL STOCKINGS BELOW KNEE LENGTH, EACH		4 PER 6 ROLLING MONTHS	REQUIRES FITTER'S CERTIFICATION BY THE AMERICAN BOARD FOR CERTIFICATION OF ORTHOTICS & PROSTHETICS OR BOARD FOR CERTIFICATION OF ORTHOTICS & PROSTHETICS
A4510	SURGICAL STOCKINGS FULL LENGTH, EACH		2 PER 6 ROLLING MONTHS	REQUIRES FITTER'S CERTIFICATION BY THE AMERICAN BOARD FOR CERTIFICATION OF ORTHOTICS & PROSTHETICS OR BOARD FOR CERTIFICATION OF ORTHOTICS & PROSTHETICS
A4520	INCONTINENCE GARMENT, ANY TYPE, (E.G. BRIEF, DIAPER), EACH	A4521 THRU A4535	250 PER ROLLING MONTH	PRIOR AUTHORIZATION REQUIRED AVAILABLE ONLY FOR MEMBERS 3 YEARS OR OLDER. WHEN BILLING SINGLE INCONTINENT SUPPLIES (A4520 OR A4554) OR A COMBINATION OF THE TWO, THE TOTAL MAXIMUM IS 250 ITEMS PER MONTH. NO AUTHORIZATION WILL BE GIVEN OVER THIS MONTHLY ALLOWABLE.
A4550	SURGICAL TRAYS		NON-COVERED	
A4554	DISPOSABLE UNDERPADS, ALL SIZES, (E.G., CHUX'S)		250 PER ROLLING MONTH	PRIOR AUTHORIZATION REQUIRED AVAILABLE ONLY FOR MEMBERS 3 YEARS OR OLDER. WHEN BILLING SINGLE INCONTINENT SUPPLIES (A4520 OR A4554) OR A COMBINATION OF THE TWO, THE TOTAL MAXIMUM IS 250 ITEMS PER MONTH. NO AUTHORIZATION WILL BE GIVEN OVER THIS MONTHLY ALLOWABLE.
A4556	ELECTRODES, (E.G., APNEA MONITOR), PER PAIR		15 PER ROLLING MONTH	COVERAGE LIMITED TO MAXIMUM AGE OF 12 MONTHS. NON-REIMBURSABLE WITH: E0720, E0730 SUPPLIES BUNDLED INTO A4595
A4557	LEAD WIRES, (E.G., APNEA MONITOR), PER PAIR		2 PER ROLLING MONTH	COVERAGE LIMITED TO MAXIMUM AGE OF 12 MONTHS. NON-REIMBURSABLE WITH: E0720, E0730 SUPPLIES BUNDLED INTO A4595
A4558	CONDUCTIVE GEL OR PASTE, FOR USE WITH ELECTRICAL DEVICE (E.G.,TENS, NMES), PER OZ.		NON-COVERED	
A4561	PESSARY, RUBBER, ANY TYPE		1 PER LIFETIME	

HCPCS CODES	DESCRIPTION	REPLACES	SERVICE LIMIT	SPECIAL INSTRUCTIONS
A4562	PESSARY, NON RUBBER, ANY TYPE		1 PER LIFETIME	
A4565	SLINGS		1 PER LIFETIME	
A4570	SPLINT		2 PER 6 ROLLING MONTHS	
A4595	ELECTRICAL STIMULATOR SUPPLIES, 2 LEAD, PER MONTH, (E.G. TENS, NMES)		1 PER ROLLING MONTH FOR E0720 2 PER ROLLING MONTH FOR E0730	NON-REIMBURSABLE WITH: A4556, A4558 and A4630
A4601	LITHIUM ION BATTERY FOR NON-PROSTHETIC USE, REPLACEMENT	A4632	4 PER ROLLING YEAR	NEW CODE EFFECTIVE 0101/2007
A4604	TUBING WITH INTEGRATED HEARING ELEMENT FOR USE WITH POSITIVE AIRWAY PRESSURE DEVICE		1 PER ROLLING MONTH	NEW CODE 01/01/2006 NON-REIMBURSABLE WITH A7037, E0471 OR E0472
A4605	TRACHEAL SUCTION CATHETER, CLOSED SYSTEM, EACH	A4609 A4610	31 PER ROLLING MONTH	
A4606	OXYGEN PROBE FOR USE WITH OXIMETER DEVICE, REPLACEMENT		2 PER ROLLING MONTH	PRIOR AUTHORIZATION NON-REIMBURSABLE WITH E0445 WHEN UNIT IS UNDER CAP RENTAL
A4608	TRANSTRACHEAL OXYGEN CATHETER, EACH		NON-COVERED	
A4610	TRACHEAL SUCTION CATHETER, CLOSED SYSTEM, FOR 72 OR MORE HOURS OF USE, EACH		NON-COVERED	
A4611	BATTERY, HEAVY DUTY; REPLACEMENT FOR PATIENT OWNED VENTILATOR		NON-COVERED	
A4612	BATTERY CABLES; REPLACEMENT FOR PATIENT-OWNED VENTILATOR		NON-COVERED	
A4613	BATTERY CHARGER; REPLACEMENT FOR PATIENT-OWNED VENTILATOR		NON-COVERED	
A4614	PEAK EXPIRATORY FLOW RATE METER, HAND HELD		1 PER LIFETIME	
A4615	CANNULA, NASAL		NON-COVERED	
A4616	TUBING (OXYGEN), PER FOOT		NON-COVERED	
A4617	MOUTH PIECE		NON-COVERED	
A4618	BREATHING CIRCUITS		NON-COVERED	
A4619	FACE TENT		1 PER ROLLING MONTH	PRIOR AUTHORIZATION REQUIRED REIMBURSABLE ONLY WITH: E0570

HCPCS CODES	DESCRIPTION	REPLACES	SERVICE LIMIT	SPECIAL INSTRUCTIONS
A4620	VARIABLE CONCENTRATION MASK		NON-COVERED	
A4623	TRACHEOSTOMY, INNER CANNULA		1 PER ROLLING MONTH	
A4624	TRACHEAL SUCTION CATHETER, ANY TYPE OTHER THAN CLOSED SYSTEM, EACH		90 PER ROLLING MONTH	NON-REIMBURSABLE WITH A 4628
A4625	TRACHEOSTOMY CARE KIT FOR NEW TRACHEOSTOMY		14 UNITS PER LIFETIME	NON-REIMBURSABLE WITH A4626 OR A4629
A4626	TRACHEOSTOMY CLEANING BRUSH, EACH		NON-COVERED	DISCONTINUED 04/01/2005
A4627	SPACER, BAG OR RESERVOIR, WITH OR WITHOUT MASK, FOR USE WITH METERED DOSE INHALER		1 PER LIFETIME	
A4628	OROPHARYNGEAL SUCTION CATHETER, EACH		90 PER ROLLING MONTH	
A4629	TRACHEOSTOMY CARE KIT FOR ESTABLISHED TRACHEOSTOMY		1 PER DAY	SERVICE REIMBURSABLE TWO WEEK POST SURGERY. NON-REIMBURSABLE WITH A4625 AND A4626
A4630	REPLACEMENT BATTERIES. MEDICALLY NECESSARY TRANSCUTANEOUS ELECTRICAL STIMULATOR, OWNED BY PATIENT		NON-COVERED	
A4632	REPLACEMENT BATTERY FOR EXTERNAL INFUSION PUMP, ANY TYPE, EACH		4 PER ROLLING YEAR	CLOSED BY CMS 12/31/2006
A4633	REPLACEMENT BULB/LAMP FOR ULTRAVIOLET LIGHT THERAPY SYSTEM, EACH		NON-COVERED	
A4634	REPLACEMENT BULB FOR THERAPEUTIC LIGHT BOX, TABLETOP MODEL		NON-COVERED	
A4635	UNDERARM PAD, CRUTCH, REPLACEMENT, EACH		2 PER 2 ROLLING YEARS	NON-REIMBURSABLE WITH E0110, E0111, E0112, E0113, E0114, OR E0116,
A4636	REPLACEMENT, HANDGRIP, CANE, CRUTCH, OR WALKER, EACH		2 PER 2 ROLLING YEARS	NON-REIMBURSABLE WITH E0100, E0105, E0110, E0111, E0112, E0113, E0114, E0114, E0130, E0135, E0140, E0141, E0143, E0147, E0148, OR E0149
A4637	REPLACEMENT, TIP, CANE, CRUTCH, WALKER, EACH.		4 PER ROLLING YEAR	NON-REIMBURSABLE WITH E0100, E0105, E0110, E0111, E0112, E0113, E0114, E0114, E0130, E0135, E0140, E0141, E0143, E0147, E0148, OR E0149
A4638	REPLACEMENT BATTERY FOR PATIENT-OWNED EAR PULSE GENERATOR, EACH		NON-COVERED	
A4639	REPLACEMENT PAD FOR INFRARED HEATING PAD SYSTEM, EACH		NON-COVERED	
A4640	REPLACEMENT PAD FOR USE WITH MEDICALLY NECESSARY ALTERNATING PRESSURE PAD OWNED BY PATIENT			PRIOR AUTHORIZATION ITEM IS PURCHASED NON-REIMBURSABLE WITH: E0180, E0181, OR E0182

HCPCS CODES	DESCRIPTION	REPLACES	SERVICE LIMIT	SPECIAL INSTRUCTIONS
A4649	SURGICAL SUPPLY; MISCELLANEOUS			PRIOR AUTHORIZATION COST INVOICE REQUIRED
A4656	NEEDLE, ANY SIZE, EACH		NON-COVERED	
A4657	SYRINGE, WITH OR WITHOUT NEEDLE, EACH		NON-COVERED	
A4660	SPHYGMOMANOMETER/BLOOD PRESSURE APPARATUS WITH CUFF AND STETHOSCOPE		NON-COVERED	
A4663	BLOOD PRESSURE CUFF ONLY		NON-COVERED	
A4670	AUTOMATIC BLOOD PRESSURE MONITOR		NON-COVERED	
A4927	GLOVES, NON-STERILE, PER 100		1 PER ROLLING MONTH	REQUIRES ICD-9-CM DIAGNOSIS CODES: 042 OR 585
A4928	SURGICAL MASK, PER 20		NON-COVERED	
A4930	GLOVES, STERILE, PER PAIR		NON-COVERED	
A4931	ORAL THERMOMETER, REUSABLE, ANY TYPE, EACH		NON-COVERED	
A4932	RECTAL THERMOMETER, REUSABLE, ANY TYPE, EACH		NON-COVERED	
A5051	OSTOMY POUCH, CLOSED; WITH BARRIER ATTACHED (1 PIECE), EACH		60 PER ROLLING MONTH	REQUIRES ICD-9-CM DIAGNOSIS CODES: V44.2, V55.2 V44.3 OR V55.3
A5052	OSTOMY POUCH, CLOSED; WITHOUT BARRIER ATTACHED (1 PIECE), EACH		60 PER ROLLING MONTH	REQUIRES ICD-9-CM DIAGNOSIS CODES: V44.2, V55.2 V44.3 OR V55.3
A5053	OSTOMY POUCH, CLOSED; FOR USE ON FACEPLATE, EACH		60 PER ROLLING MONTH	REQUIRES ICD-9-CM DIAGNOSIS CODES: V44.2, V55.2 V44.3 OR V55.3
A5054	OSTOMY POUCH, CLOSED; FOR USE ON BARRIER WITH FLANGE (2 PIECE), EACH		60 PER ROLLING MONTH	REQUIRES ICD-9-CM DIAGNOSIS CODES: V44.2, V55.2 V44.3 OR V55.3
A5055	STOMA CAP		31 PER ROLLING MONTH	REQUIRES ICD-9-CM DIAGNOSIS CODES: V44.2, V55.2 V44.3 OR V55.3
A5061	OSTOMY POUCH, DRAINABLE; WITH BARRIER ATTACHED, (1 PIECE), EACH		20 PER ROLLING MONTH	REQUIRES ICD-9-CM DIAGNOSIS CODES: V44.2, V55.2 V44.3 OR V55.3 NON-REIMBURSABLE WITH A5081, A6246
A5062	OSTOMY POUCH, DRAINABLE; WITHOUT BARRIER ATTACHED (1 PIECE), EACH		20 PER ROLLING MONTH	REQUIRES ICD-9-CM DIAGNOSIS CODES: V44.2, V55.2, V44.3, OR V55.3
A5063	OSTOMY POUCH, DRAINABLE; FOR USE ON BARRIER WITH FLANGE (2 PIECE SYSTEM), EACH		20 PER ROLLING MONTH	REQUIRES ICD-9-CM DIAGNOSIS CODES: V44.2, V55.2 V44.3 OR V55.3

HCPCS CODES	DESCRIPTION	REPLACES	SERVICE LIMIT	SPECIAL INSTRUCTIONS
A5071	OSTOMY POUCH, URINARY; WITH BARRIER ATTACHED (1 PIECE), EACH		20 PER ROLLING MONTH	REQUIRES ICD-9-CM DIAGNOSIS CODES: V44.6 OR V55.6
A5072	OSTOMY POUCH, URINARY; WITHOUT BARRIER ATTACHED (1 PIECE), EACH		20 PER ROLLING MONTH	REQUIRES ICD-9-CM DIAGNOSIS CODES: V44.6 OR V55.6
A5073	OSTOMY POUCH, URINARY; FOR USE ON BARRIER WITH FLANGE (2 PIECE), EACH		20 PER ROLLING MONTH	REQUIRES ICD-9-CM DIAGNOSIS CODES: V44.6 OR V55.6
A5081	CONTINENT DEVICE; PLUG FOR CONTINENT STOMA		31 PER ROLLING MONTH	REQUIRES ICD-9-CM DIAGNOSIS CODES: V44.2, V55.2, V44.3, V55.3, V44.6 OR V55.6 NON-REIMBURSABLE WITH A5055, A6216
A5082	CONTINENT DEVICE; CATHETER FOR CONTINENT STOMA		1 PER ROLLING MONTH	REQUIRES ICD-9-CM DIAGNOSIS CODES: V44.2, V55.2, V44.3, V55.3, V44.6 OR V55.6
A5083	CONTINENT DEVICE, STOMA ABSORPTIVE COVER FOR CONTINENT STOMA		31 PER ROLLING MONTH	COST INVOICE REQUIRED NEW CODE 01/01/2008
A5093	OSTOMY ACCESSORY; CONVEX INSERT		10 PER ROLLING MONTH	REQUIRES ICD-9-CM DIAGNOSIS CODES: V44.2, V55.2, V44.3, V55.3, V44.6 OR V55.6
A5102	BEDSIDE DRAINAGE BOTTLE WITH OR WITHOUT TUBING, RIGID OR EXPANDABLE, EACH		2 PER 6 ROLLING MONTHS	NON-REIMBURSABLE WITH A4357
A5105	URINARY SUSPENSORY **WITH LEG BAG**, WITH OR WITHOUT TUBE, **EACH**		1 PER ROLLING MONTH	NON-REIMBURSABLE WITH A4331, A4358, A4359, A5112, A5113, A5114
A5112	URINARY LEG BAG; LATEX		1 PER ROLLING MONTH	FOR MEMBERS WHO ARE AMBULATORY OR CHAIR OR WHEELCHAIR BOUND ONLY NONREIMBURSABLE WITH A4358, A5113, A5114
A5113	LEG STRAP; LATEX, REPLACEMENT ONLY, PER SET		2 PER ROLLING MONTH	NON-REIMBURSABLE WITH A5112, A5114
A5114	LEG STRAP; FOAM OR FABRIC, REPLACEMENT ONLY, PER SET		2 PER ROLLING MONTH	NON-REIMBURSABLE WITH A5112, A5113
A5119	SKIN BARRIER, WIPES OR SWABS, PER BOX 50		31 PER ROLLING MONTH	DISCONTINUED BY CMS 12/31/2005
A5120	SKIN BARRIER, WIPES OR SWABS, EACH	A5119	150 PER ROLLING MONTH	NEW CODE 01/01/2006
A5121	SKIN BARRIER; SOLID, 6 X 6 OR EQUIVALENT, EACH		20 PER ROLLING MONTH	REQUIRES ICD-9-CM DIAGNOSIS CODES: V44.2, V55.2, V44.3 OR V55.3
A5122	SKIN BARRIER; SOLID, 8 X 8 OR EQUIVALENT, EACH		20 PER ROLLING MONTH	REQUIRES ICD-9-CM DIAGNOSIS CODES: V44.2, V55.2, V44.3 OR V55.3
A5126	ADHESIVE OR NON-ADHESIVE; DISK OR FOAM PAD		20 PER ROLLING MONTH	REQUIRES ICD-9-CM DIAGNOSIS CODES: V44.2, V55.2, V44.3 OR V55.3
A5131	APPLIANCE CLEANER, INCONTINENCE AND OSTOMY APPLIANCES, PER 16 OZ.		1 PER ROLLING MONTH	REQUIRES ICD-9-CM DIAGNOSIS CODES: V44.2, V55.2, V44.3, V55.3, V44.6 OR V55.6 ONLY USED WITH A5102 AND A5112

HCPCS CODES	DESCRIPTION	REPLACES	SERVICE LIMIT	SPECIAL INSTRUCTIONS
A5200	PERCUTANEOUS CATHETER/TUBE ANCHORING DEVICE, ADHESIVE SKIN ATTACHMENT		NON-COVERED	
A5500 - A5513	SHOES SUPPLIES FOR DIABETICS			REFER TO ORTHOTIC/PROSTHETIC MANUAL
A6000	NON-CONTACT WOUND WARMING WOUND COVER FOR USE WITH THE NON-CONTACT WOUND WARMING DEVICE AND WARMING CARD		NON-COVERED	
A6010	COLLAGEN BASED WOUND FILLER, DRY FORM, PER GRAM OF COLLAGEN		NON-COVERED	
A6011	COLLAGEN BASED WOUND FILLER, GEL/PASTE, PER GRAM OF COLLAGEN		NON-COVERED	
A6021	COLLAGEN DRESSING, PAD SIZE 16 SQ. IN. OR LESS, EACH		NON-COVERED	
A6022	COLLAGEN DRESSING, PAD SIZE MORE THAN 16 SQ. IN. BUT LESS THAN OR EQUAL TO 48 SQ. IN., EACH		NON-COVERED	
A6023	COLLAGEN DRESSING, PAD SIZE MORE THAN 48 SQ. IN., EACH		NON-COVERED	
A6024	COLLAGEN DRESSING WOUND FILLER, PER 6 INCHES		NON-COVERED	
A6025	GEL SHEET FOR DERMAL OR EPIDERMAL APPLICATION, (E.G., SILICONE, HYDROGEL, OTHER), EACH		NON-COVERED	
A6154	WOUND POUCH, EACH		31 PER ROLLING MONTH	WEST VIRGINIA MEDICAID FOLLOWS PALMETTO, REGION C, MEDICAL CRITERIA FOR COVERAGE.
A6196	ALGINATE OR OTHER FIBER GELLING DRESSING, WOUND COVER, PAD SIZE 16 SQ. IN. OR LESS, EACH DRESSING		31 PER ROLLING MONTH	REIMBURSED FOR STAGE III AND IV PRESSURE ULCERS ONLY WEST VIRGINIA MEDICAID FOLLOWS PALMETTO, REGION C, MEDICAL CRITERIA FOR COVERAGE.
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 ROLLING MONTH	REIMBURSED FOR STAGE III AND IV PRESSURE ULCERS ONLY WEST VIRGINIA MEDICAID FOLLOWS PALMETTO, REGION C, MEDICAL CRITERIA FOR COVERAGE.
A6198	ALGINATE OR OTHER FIBER GELLING DRESSING, WOUND COVER, PAD SIZE MORE THAN 48 SQ. IN., EACH DRESSING		31 PER ROLLING MONTH	REIMBURSED FOR STAGE III AND IV PRESSURE ULCERS ONLY WEST VIRGINIA MEDICAID FOLLOWS PALMETTO, REGION C, MEDICAL CRITERIA FOR COVERAGE.
A6199	ALGINATE OR OTHER FIBER GELLING DRESSING, WOUND FILLER, PER 6 INCHES		31 PER ROLLING MONTH	REIMBURSED FOR STAGE III AND IV PRESSURE ULCERS ONLY WEST VIRGINIA MEDICAID FOLLOWS PALMETTO, REGION C, MEDICAL CRITERIA FOR COVERAGE.
A6200	COMPOSITE DRESSING, PAD SIZE 16 SQ. IN. OR LESS, WITHOUT ADHESIVE BORDER, EACH DRESSING		15 PER ROLLING MONTH	WEST VIRGINIA MEDICAID FOLLOWS PALMETTO, REGION C, MEDICAL CRITERIA FOR COVERAGE.

WEST VIRGINIA DEPARTMENT OF HEALTH & HUMAN RESOURCES

BUREAU FOR MEDICAL SERVICES

HCPCS CODES FOR DURABLE MEDICAL EQUIPMENT AND SUPPLIES

***PRIOR AUTHORIZATION MUST BE OBTAINED IF SERVICE LIMITS ARE EXCEEDED**

HCPCS CODES	DESCRIPTION	REPLACES	SERVICE LIMIT	SPECIAL INSTRUCTIONS
A6201	COMPOSITE DRESSING, PAD SIZE MORE THAN 16 SQ. IN. BUT LESS THAN OR EQUAL TO 48 SQ. IN., WITHOUT ADHESIVE BORDER, EACH DRESSING		15 PER ROLLING MONTH	WEST VIRGINIA MEDICAID FOLLOWS PALMETTO, REGION C, MEDICAL CRITERIA FOR COVERAGE.
A6202	COMPOSITE DRESSING, PAD SIZE MORE THAN 48 SQ. IN., WITHOUT ADHESIVE BORDER, EACH DRESSING		15 PER ROLLING MONTH	WEST VIRGINIA MEDICAID FOLLOWS PALMETTO, REGION C, MEDICAL CRITERIA FOR COVERAGE.
A6203	COMPOSITE DRESSING, PAD SIZE 16 SQ. IN. OR LESS, WITH ANY SIZE ADHESIVE BORDER, EACH DRESSING		15 PER ROLLING MONTH	WEST VIRGINIA MEDICAID FOLLOWS PALMETTO, REGION C, MEDICAL CRITERIA FOR COVERAGE.
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 ROLLING MONTH	WEST VIRGINIA MEDICAID FOLLOWS PALMETTO, REGION C, MEDICAL CRITERIA FOR COVERAGE.
A6205	COMPOSITE DRESSING, PAD SIZE MORE THAN 48 SQ. IN., WITH ANY SIZE ADHESIVE BORDER, EACH DRESSING		15 PER ROLLING MONTH	WEST VIRGINIA MEDICAID FOLLOWS PALMETTO, REGION C, MEDICAL CRITERIA FOR COVERAGE.
A6206	CONTACT LAYER, 16 SQ. IN. OR LESS, EACH DRESSING		5 PER ROLLING MONTH	WEST VIRGINIA MEDICAID FOLLOWS PALMETTO, REGION C, MEDICAL CRITERIA FOR COVERAGE.
A6207	CONTACT LAYER, MORE THAN 16 SQ. IN. BUT LESS THAN OR EQUAL TO 48 SQ. IN., EACH DRESSING		5 PER ROLLING MONTH	WEST VIRGINIA MEDICAID FOLLOWS PALMETTO, REGION C, MEDICAL CRITERIA FOR COVERAGE.
A6208	CONTACT LAYER, MORE THAN 48 SQ. IN., EACH DRESSING		5 PER ROLLING MONTH	WEST VIRGINIA MEDICAID FOLLOWS PALMETTO, REGION C, MEDICAL CRITERIA FOR COVERAGE.
A6209	FOAM DRESSING, WOUND COVER, PAD SIZE 16 SQ. IN. OR LESS, WITHOUT ADHESIVE BORDER, EACH DRESSING		15 PER ROLLING MONTH	REIMBURSED FOR STAGE III AND IV PRESSURE ULCERS ONLY WEST VIRGINIA MEDICAID FOLLOWS PALMETTO, REGION C, MEDICAL CRITERIA FOR COVERAGE.
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 ROLLING MONTH	REIMBURSED FOR STAGE III AND IV PRESSURE ULCERS ONLY WEST VIRGINIA MEDICAID FOLLOWS PALMETTO, REGION C, MEDICAL CRITERIA FOR COVERAGE.
A6211	FOAM DRESSING, WOUND COVER, PAD SIZE MORE THAN 48 SQ. IN., WITHOUT ADHESIVE BORDER, EACH DRESSING		15 PER ROLLING MONTH	REIMBURSED FOR STAGE III AND IV PRESSURE ULCERS ONLY WEST VIRGINIA MEDICAID FOLLOWS PALMETTO, REGION C, MEDICAL CRITERIA FOR COVERAGE.
A6212	FOAM DRESSING, WOUND COVER, PAD SIZE 16 SQ. IN. OR LESS, WITH ANY SIZE ADHESIVE BORDER, EACH DRESSING		15 PER ROLLING MONTH	REIMBURSED FOR STAGE III AND IV PRESSURE ULCERS ONLY WEST VIRGINIA MEDICAID FOLLOWS PALMETTO, REGION C, MEDICAL CRITERIA FOR COVERAGE.
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 ROLLING MONTH	REIMBURSED FOR STAGE III AND IV PRESSURE ULCERS ONLY WEST VIRGINIA MEDICAID FOLLOWS PALMETTO, REGION C, MEDICAL CRITERIA FOR COVERAGE.
A6214	FOAM DRESSING, WOUND COVER, PAD SIZE MORE THAN 48 SQ. IN., WITH ANY SIZE ADHESIVE BORDER, EACH DRESSING		15 PER ROLLING MONTH	REIMBURSED FOR STAGE III AND IV PRESSURE ULCERS ONLY WEST VIRGINIA MEDICAID FOLLOWS PALMETTO, REGION C, MEDICAL CRITERIA FOR COVERAGE.

HCPCS CODES	DESCRIPTION	REPLACES	SERVICE LIMIT	SPECIAL INSTRUCTIONS
A6215	FOAM DRESSING, WOUND FILLER, PER GRAM		31 PER ROLLING MONTH	PRIOR AUTHORIZATION COST INVOICE REQUIRED REIMBURSED FOR STAGE III AND IV PRESSURE ULCERS ONLY WEST VIRGINIA MEDICAID FOLLOWS PALMETTO, REGION C, MEDICAL CRITERIA FOR COVERAGE.
A6216	GAUZE, NON-IMPREGNATED, NON-STERILE, PAD SIZE 16 SQ. IN. OR LESS, WITHOUT ADHESIVE BORDER, EACH DRESSING		90 PER ROLLING MONTH	NON-REIMBURSABLE WITH: A5055, A5081
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		90 PER ROLLING MONTH	WEST VIRGINIA MEDICAID FOLLOWS PALMETTO, REGION C, MEDICAL CRITERIA FOR COVERAGE.
A6218	GAUZE, NON-IMPREGNATED, NON-STERILE, PAD SIZE MORE THAN 48 SQ. IN., WITHOUT ADHESIVE BORDER, EACH DRESSING		90 PER ROLLING MONTH	WEST VIRGINIA MEDICAID FOLLOWS PALMETTO, REGION C, MEDICAL CRITERIA FOR COVERAGE.
A6219	GAUZE, NON-IMPREGNATED, PAD SIZE 16 SQ. IN. OR LESS, WITH ANY SIZE ADHESIVE BORDER, EACH DRESSING		60 PER ROLLING MONTH	WEST VIRGINIA MEDICAID FOLLOWS PALMETTO, REGION C, MEDICAL CRITERIA FOR COVERAGE.
A6220	GAUZE, NON-IMPREGNATED, PAD SIZE MORE THAN 16 SQ. IN. BUT LESS THAN OR EQUAL TO 48 SQ. IN., WITH ANY SIZE ADHESIVE BORDER, EACH DRESSING		60 PER ROLLING MONTH	WEST VIRGINIA MEDICAID FOLLOWS PALMETTO, REGION C, MEDICAL CRITERIA FOR COVERAGE.
A6221	GAUZE, NON-IMPREGNATED, PAD SIZE MORE THAN 48 SQ. IN., WITH ANY SIZE ADHESIVE BORDER, EACH DRESSING		60 PER ROLLING MONTH	WEST VIRGINIA MEDICAID FOLLOWS PALMETTO, REGION C, MEDICAL CRITERIA FOR COVERAGE.
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 ROLLING MONTH	WEST VIRGINIA MEDICAID FOLLOWS PALMETTO, REGION C, MEDICAL CRITERIA FOR COVERAGE.
A6223	GAUZE, IMPREGNATED WITH OTHER THAN WATER, NORMAL SALINE, OR HYDROGEL, PAD SIZE MORE THAN 16 SQUARE INCHES, BUT LESS THAN OR EQUAL TO 48 SQUARE INCHES, WITHOUT ADHESIVE BORDER, EACH DRESSING		31 PER ROLLING MONTH	WEST VIRGINIA MEDICAID FOLLOWS PALMETTO, REGION C, MEDICAL CRITERIA FOR COVERAGE.
A6224	GAUZE, IMPREGNATED WITH OTHER THAN WATER, NORMAL SALINE, OR HYDROGEL, PAD SIZE MORE THAN 48 SQUARE INCHES, WITHOUT ADHESIVE BORDER, EACH DRESSING		31 PER ROLLING MONTH	WEST VIRGINIA MEDICAID FOLLOWS PALMETTO, REGION C, MEDICAL CRITERIA FOR COVERAGE.
A6228	GAUZE, IMPREGNATED, WATER OR NORMAL SALINE, PAD SIZE 16 SQ. IN. OR LESS, WITHOUT ADHESIVE BORDER, EACH DRESSING		NON-COVERED	

HCPCS CODES	DESCRIPTION	REPLACES	SERVICE LIMIT	SPECIAL INSTRUCTIONS
A6229	GAUZE, IMPREGNATED, WATER OR NORMAL SALINE, PAD SIZE MORE THAT 16 SQ. IN. BUT LESS THAN OR EQUAL TO 48 SQ. IN., WITHOUT ADHESIVE BORDER, EACH DRESSING		NON-COVERED	
A6230	GAUZE, IMPREGNATED, WATER OR NORMAL SALINE, PAD SIZE MORE THAN 48 SQ. IN., WITHOUT ADHESIVE BORDER, EACH DRESSING		NON-COVERED	
A6231	GAUZE, IMPREGNATED, HYDROGEL, FOR DIRECT WOUND CONTACT, PAD SIZE 16 SQ. IN. OR LESS, EACH DRESSING		12 PER ROLLING MONTH	REIMBURSED FOR STAGE III AND IV PRESSURE ULCERS ONLY WEST VIRGINIA MEDICAID FOLLOWS PALMETTO, REGION C, MEDICAL CRITERIA FOR COVERAGE.
A6232	GAUZE, IMPREGNATED, HYDROGEL, FOR DIRECT WOUND CONTACT, PAD SIZE GREATER THAN 16 SQ. IN., BUT LESS THAN OR EQUAL TO 48 SQ. IN., EACH DRESSING		12 PER ROLLING MONTH	REIMBURSED FOR STAGE III AND IV PRESSURE ULCERS ONLY WEST VIRGINIA MEDICAID FOLLOWS PALMETTO, REGION C, MEDICAL CRITERIA FOR COVERAGE.
A6233	GAUZE, IMPREGNATED, HYDROGEL FOR DIRECT WOUND CONTACT, PAD SIZE MORE THAN 48 SQ. IN., EACH DRESSING		12 PER ROLLING MONTH	REIMBURSED FOR STAGE III AND IV PRESSURE ULCERS ONLY WEST VIRGINIA MEDICAID FOLLOWS PALMETTO, REGION C, MEDICAL CRITERIA FOR COVERAGE.
A6234	HYDROCOLLOID DRESSING, WOUND COVER, PAD SIZE 16 SQ. IN. OR LESS, WITHOUT ADHESIVE BORDER, EACH DRESSING		15 PER ROLLING MONTH	REIMBURSED FOR STAGE III AND IV PRESSURE ULCERS ONLY WEST VIRGINIA MEDICAID FOLLOWS PALMETTO, REGION C, MEDICAL CRITERIA FOR COVERAGE.
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 ROLLING MONTH	REIMBURSED FOR STAGE III AND IV PRESSURE ULCERS ONLY WEST VIRGINIA MEDICAID FOLLOWS PALMETTO, REGION C, MEDICAL CRITERIA FOR COVERAGE.
A6236	HYDROCOLLOID DRESSING, WOUND COVER, PAD SIZE MORE THAN 48 SQ. IN., WITHOUT ADHESIVE BORDER, EACH DRESSING		15 PER ROLLING MONTH	REIMBURSED FOR STAGE III AND IV PRESSURE ULCERS ONLY WEST VIRGINIA MEDICAID FOLLOWS PALMETTO, REGION C, MEDICAL CRITERIA FOR COVERAGE.
A6237	HYDROCOLLOID DRESSING, WOUND COVER, PAD SIZE 16 SQ. IN. OR LESS, WITH ANY SIZE ADHESIVE BORDER, EACH DRESSING		15 PER ROLLING MONTH	REIMBURSED FOR STAGE III AND IV PRESSURE ULCERS ONLY WEST VIRGINIA MEDICAID FOLLOWS PALMETTO, REGION C, MEDICAL CRITERIA FOR COVERAGE.
A6238	HYDROCOLLOID 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 ROLLING MONTH	REIMBURSED FOR STAGE III AND IV PRESSURE ULCERS ONLY WEST VIRGINIA MEDICAID FOLLOWS PALMETTO, REGION C, MEDICAL CRITERIA FOR COVERAGE.
A6239	HYDROCOLLOID DRESSING, WOUND COVER, PAD SIZE MORE THAN 48 SQ. IN., WITH ANY SIZE ADHESIVE BORDER, EACH DRESSING		15 PER ROLLING MONTH	REIMBURSED FOR STAGE III AND IV PRESSURE ULCERS ONLY WEST VIRGINIA MEDICAID FOLLOWS PALMETTO, REGION C, MEDICAL CRITERIA FOR COVERAGE.
A6240	HYDROCOLLOID DRESSING, WOUND FILLER, PASTE, PER FLUID OUNCE		15 PER ROLLING MONTH	REIMBURSED FOR STAGE III AND IV PRESSURE ULCERS ONLY WEST VIRGINIA MEDICAID FOLLOWS PALMETTO, REGION C, MEDICAL CRITERIA FOR COVERAGE.

HCPCS CODES	DESCRIPTION	REPLACES	SERVICE LIMIT	SPECIAL INSTRUCTIONS
A6241	HYDROCOLLOID DRESSING, WOUND FILLER, DRY FORM, PER GRAM		15 PER ROLLING MONTH	REIMBURSED FOR STAGE III AND IV PRESSURE ULCERS ONLY WEST VIRGINIA MEDICAID FOLLOWS PALMETTO, REGION C, MEDICAL CRITERIA FOR COVERAGE.
A6242	HYDROGEL DRESSING, WOUND COVER, PAD SIZE 16 SQ. IN. OR LESS, WITHOUT ADHESIVE BORDER, EACH DRESSING		31 PER ROLLING MONTH	REIMBURSED FOR STAGE III AND IV PRESSURE ULCERS ONLY WEST VIRGINIA MEDICAID FOLLOWS PALMETTO, REGION C, MEDICAL CRITERIA FOR COVERAGE.
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 ROLLING MONTH	REIMBURSED FOR STAGE III AND IV PRESSURE ULCERS ONLY WEST VIRGINIA MEDICAID FOLLOWS PALMETTO, REGION C, MEDICAL CRITERIA FOR COVERAGE.
A6244	HYDROGEL DRESSING, WOUND COVER, PAD SIZE MORE THAN 48 SQ. IN., WITHOUT ADHESIVE BORDER, EACH DRESSING		31 PER ROLLING MONTH	REIMBURSED FOR STAGE III AND IV PRESSURE ULCERS ONLY WEST VIRGINIA MEDICAID FOLLOWS PALMETTO, REGION C, MEDICAL CRITERIA FOR COVERAGE.
A6245	HYDROGEL DRESSING, WOUND COVER, PAD SIZE 16 SQ. IN. OR LESS, WITH ANY SIZE ADHESIVE BORDER, EACH DRESSING		15 PER ROLLING MONTH	REIMBURSED FOR STAGE III AND IV PRESSURE ULCERS ONLY WEST VIRGINIA MEDICAID FOLLOWS PALMETTO, REGION C, MEDICAL CRITERIA FOR COVERAGE.
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 ROLLING MONTH	REIMBURSED FOR STAGE III AND IV PRESSURE ULCERS ONLY WEST VIRGINIA MEDICAID FOLLOWS PALMETTO, REGION C, MEDICAL CRITERIA FOR COVERAGE.
A6247	HYDROGEL DRESSING, WOUND COVER, PAD SIZE MORE THAN 48 SQ. IN., WITH ANY SIZE ADHESIVE BORDER, EACH DRESSING		15 PER ROLLING MONTH	REIMBURSED FOR STAGE III AND IV PRESSURE ULCERS ONLY WEST VIRGINIA MEDICAID FOLLOWS PALMETTO, REGION C, MEDICAL CRITERIA FOR COVERAGE.
A6248	HYDROGEL DRESSING, WOUND FILLER, GEL, PER FLUID OUNCE		15 PER ROLLING MONTH	REIMBURSED FOR STAGE III AND IV PRESSURE ULCERS ONLY WEST VIRGINIA MEDICAID FOLLOWS PALMETTO, REGION C, MEDICAL CRITERIA FOR COVERAGE.
A6250	SKIN SEALANTS, PROTECTANTS, MOISTURIZERS, OINTMENTS, ANY TYPE, ANY SIZE	Z7047	1 PER ROLLING MONTH	WEST VIRGINIA MEDICAID FOLLOWS PALMETTO, REGION C, MEDICAL CRITERIA FOR COVERAGE.
A6251	SPECIALTY ABSORPTIVE DRESSING, WOUND COVER, PAD SIZE 16 SQ. IN. OR LESS, WITHOUT ADHESIVE BORDER, EACH DRESSING		31 PER ROLLING MONTH	REIMBURSED FOR STAGE III AND IV PRESSURE ULCERS ONLY WEST VIRGINIA MEDICAID FOLLOWS PALMETTO, REGION C, MEDICAL CRITERIA FOR COVERAGE.
A6252	SPECIALTY ABSORPTIVE 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 ROLLING MONTH	REIMBURSED FOR STAGE III AND IV PRESSURE ULCERS ONLY WEST VIRGINIA MEDICAID FOLLOWS PALMETTO, REGION C, MEDICAL CRITERIA FOR COVERAGE.
A6253	SPECIALTY ABSORPTIVE DRESSING, WOUND COVER, PAD SIZE MORE THAN 48 SQ. IN., WITHOUT ADHESIVE BORDER, EACH DRESSING		31 PER ROLLING MONTH	REIMBURSED FOR STAGE III AND IV PRESSURE ULCERS ONLY WEST VIRGINIA MEDICAID FOLLOWS PALMETTO, REGION C, MEDICAL CRITERIA FOR COVERAGE.

HCPCS CODES	DESCRIPTION	REPLACES	SERVICE LIMIT	SPECIAL INSTRUCTIONS
A6254	SPECIALTY ABSORPTIVE DRESSING, WOUND COVER, PAD SIZE 16 SQ. IN. OR LESS, WITH ANY SIZE ADHESIVE BORDER, EACH DRESSING		31 PER ROLLING MONTH	REIMBURSED FOR STAGE III AND IV PRESSURE ULCERS ONLY WEST VIRGINIA MEDICAID FOLLOWS PALMETTO, REGION C, MEDICAL CRITERIA FOR COVERAGE.
A6255	SPECIALTY ABSORPTIVE 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		31 PER ROLLING MONTH	REIMBURSED FOR STAGE III AND IV PRESSURE ULCERS ONLY WEST VIRGINIA MEDICAID FOLLOWS PALMETTO, REGION C, MEDICAL CRITERIA FOR COVERAGE.
A6256	SPECIALTY ABSORPTIVE DRESSING, WOUND COVER, PAD SIZE MORE THAN 48 SQ. IN., WITH ANY SIZE ADHESIVE BORDER, EACH DRESSING		31 PER ROLLING MONTH	REIMBURSED FOR STAGE III AND IV PRESSURE ULCERS ONLY WEST VIRGINIA MEDICAID FOLLOWS PALMETTO, REGION C, MEDICAL CRITERIA FOR COVERAGE.
A6257	TRANSPARENT FILM, 16 SQ. IN. OR LESS, EACH DRESSING		15 PER ROLLING MONTH	WEST VIRGINIA MEDICAID FOLLOWS PALMETTO, REGION C, MEDICAL CRITERIA FOR COVERAGE.
A6258	TRANSPARENT FILM, MORE THAN 16 SQ. IN. BUT LESS THAN OR EQUAL TO 48 SQ. IN., EACH DRESSING		15 PER ROLLING MONTH	WEST VIRGINIA MEDICAID FOLLOWS PALMETTO, REGION C, MEDICAL CRITERIA FOR COVERAGE.
A6259	TRANSPARENT FILM, MORE THAN 48 SQ. IN., EACH DRESSING		15 PER ROLLING MONTH	WEST VIRGINIA MEDICAID FOLLOWS PALMETTO, REGION C, MEDICAL CRITERIA FOR COVERAGE.
A6260	WOUND CLEANSERS, ANY TYPE, ANY SIZE		1 PER ROLLING MONTH	WEST VIRGINIA MEDICAID FOLLOWS PALMETTO, REGION C, MEDICAL CRITERIA FOR COVERAGE.
A6261	WOUND FILLER, GEL/PASTE, PER FLUID OUNCE, NOT ELSEWHERE CLASSIFIED		31 PER ROLLING MONTH	PRIOR AUTHORIZATION COST INVOICE REQUIRED WEST VIRGINIA MEDICAID FOLLOWS PALMETTO, REGION C, MEDICAL CRITERIA FOR COVERAGE.
A6262	WOUND FILLER, DRY FORM, PER GRAM, NOT ELSEWHERE CLASSIFIED		31 PER ROLLING MONTH	PRIOR AUTHORIZATION COST INVOICE REQUIRED WEST VIRGINIA MEDICAID FOLLOWS PALMETTO, REGION C, MEDICAL CRITERIA FOR COVERAGE. .
A6266	GAUZE, IMPREGNATED, OTHER THAN WATER, NORMAL SALINE, OR ZINC PASTE, ANY WIDTH, PER LINEAR YARD		31 PER ROLLING MONTH	WEST VIRGINIA MEDICAID FOLLOWS PALMETTO, REGION C, MEDICAL CRITERIA FOR COVERAGE.
A6402	GAUZE, NON-IMPREGNATED, STERILE, PAD SIZE 16 SQ. IN. OR LESS, WITHOUT ADHESIVE BORDER, EACH DRESSING		90 PER ROLLING MONTH	WEST VIRGINIA MEDICAID FOLLOWS PALMETTO, REGION C, MEDICAL CRITERIA FOR COVERAGE
A6403	GAUZE, NON-IMPREGNATED, STERILE, PAD SIZE MORE THAN 16 SQ. IN. LESS THAN OR EQUAL TO 48 SQ. IN., WITHOUT ADHESIVE BORDER, EACH DRESSING		90 PER ROLLING MONTH	WEST VIRGINIA MEDICAID FOLLOWS PALMETTO, REGION C, MEDICAL CRITERIA FOR COVERAGE
A6404	GAUZE, NON-IMPREGNATED, STERILE, PAD SIZE MORE THAN 48 SQ. IN., WITHOUT ADHESIVE BORDER, EACH DRESSING		90 PER ROLLING MONTH	WEST VIRGINIA MEDICAID FOLLOWS PALMETTO, REGION C, MEDICAL CRITERIA FOR COVERAGE
A6407	PACKING STRIPS, NON-IMPREGNATED, UP TO 2 INCHES IN WIDTH, PER LINEAR YARD		90 PER ROLLING MONTH	WEST VIRGINIA MEDICAID FOLLOWS PALMETTO, REGION C, MEDICAL CRITERIA FOR COVERAGE

HCPCS CODES	DESCRIPTION	REPLACES	SERVICE LIMIT	SPECIAL INSTRUCTIONS
A6410	EYE PAD, STERILE, EACH		NON-COVERED	
A6411	EYE PAD, NON-STERILE, EACH		NON-COVERED	
A6412	EYE PATCH, OCCLUSIVE, EACH		NON-COVERED	
A6413	ADHESIVE BANDAGE, FIRST-AID TYPE, ANY SIZE, EACH		NON-COVERED	NEW CODE 01/01/2008
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 ROLLING MONTH	WEST VIRGINIA MEDICAID FOLLOWS PALMETTO, REGION C, MEDICAL CRITERIA FOR COVERAGE
A6442	CONFORMING BANDAGE, NON-ELASTIC, KNITTED/WOVEN, NON-STERILE, WIDTH LESS THAN THREE INCHES, PER YARD		4 PER ROLLING MONTH	WEST VIRGINIA MEDICAID FOLLOWS PALMETTO, REGION C, MEDICAL CRITERIA FOR COVERAGE
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 ROLLING MONTH	WEST VIRGINIA MEDICAID FOLLOWS PALMETTO, REGION C, MEDICAL CRITERIA FOR COVERAGE
A6444	CONFORMING BANDAGE, NON-ELASTIC, KNITTED/WOVEN, NON-STERILE, WIDTH GREATER THAN OR EQUAL TO 5 INCHES, PER YARD	A6424	4 PER ROLLING MONTH	WEST VIRGINIA MEDICAID FOLLOWS PALMETTO, REGION C, MEDICAL CRITERIA FOR COVERAGE
A6445	CONFORMING BANDAGE, NON-ELASTIC, KNITTED/WOVEN, STERILE, WIDTH LESS THAN THREE INCHES, PER YARD		4 PER ROLLING MONTH	WEST VIRGINIA MEDICAID FOLLOWS PALMETTO, REGION C, MEDICAL CRITERIA FOR COVERAGE
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 ROLLING MONTH	WEST VIRGINIA MEDICAID FOLLOWS PALMETTO, REGION C, MEDICAL CRITERIA FOR COVERAGE
A6447	CONFORMING BANDAGE, NON-ELASTIC, KNITTED/WOVEN, STERILE, WIDTH GREATER THAN OR EQUAL TO FIVE INCHES, PER YARD	A6428	4 PER ROLLING MONTH	WEST VIRGINIA MEDICAID FOLLOWS PALMETTO, REGION C, MEDICAL CRITERIA FOR COVERAGE
A6448	LIGHT COMPRESSION BANDAGE, ELASTIC, KNITTED/WOVEN, WIDTH LESS THAN THREE INCHES, PER YARD		4 PER ROLLING MONTH	WEST VIRGINIA MEDICAID FOLLOWS PALMETTO, REGION C, MEDICAL CRITERIA FOR COVERAGE
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 ROLLING MONTH	WEST VIRGINIA MEDICAID FOLLOWS PALMETTO, REGION C, MEDICAL CRITERIA FOR COVERAGE

HCPCS CODES	DESCRIPTION	REPLACES	SERVICE LIMIT	SPECIAL INSTRUCTIONS
A6450	LIGHT COMPRESSION BANDAGE, ELASTIC, KNITTED/WOVEN, WIDTH GREATER THAN OR EQUAL TO FIVE INCHES, PER YARD	A6432	4 PER ROLLING MONTH	COST INVOICE REQUIRED WEST VIRGINIA MEDICAID FOLLOWS PALMETTO, REGION C, MEDICAL CRITERIA FOR COVERAGE
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 FIVE INCHES, PER YARD	A6434	4 PER ROLLING MONTH	COST INVOICE REQUIRED WEST VIRGINIA MEDICAID FOLLOWS PALMETTO, REGION C, MEDICAL CRITERIA FOR COVERAGE
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 ROLLING MONTH	WEST VIRGINIA MEDICAID FOLLOWS PALMETTO, REGION C, MEDICAL CRITERIA FOR COVERAGE
A6453	SELF-ADHERENT BANDAGE, ELASTIC, NON-KNITTED/NON-WOVEN, WIDTH LESS THAN THREE INCHES, PER YARD		4 PER ROLLING MONTH	WEST VIRGINIA MEDICAID FOLLOWS PALMETTO, REGION C, MEDICAL CRITERIA FOR COVERAGE
A6454	SELF-ADHERENT BANDAGE, ELASTIC, NON-KNITTED/NON-WOVEN, WIDTH GREATER THAN OR EQUAL TO THREE INCHES AND LESS THAN FIVE INCHES, PER YARD	A6438	4 PER ROLLING MONTH	WEST VIRGINIA MEDICAID FOLLOWS PALMETTO, REGION C, MEDICAL CRITERIA FOR COVERAGE
A6455	SELF-ADHERENT BANDAGE, ELASTIC, NON-KNITTED/NON-WOVEN, WIDTH GREATER THAN OR EQUAL TO FIVE INCHES, PER YARD		4 PER ROLLING MONTH	WEST VIRGINIA MEDICAID FOLLOWS PALMETTO, REGION C, MEDICAL CRITERIA FOR COVERAGE
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 ROLLING MONTH	WEST VIRGINIA MEDICAID FOLLOWS PALMETTO, REGION C, MEDICAL CRITERIA FOR COVERAGE
A6457	TUBULAR DRESSING WITH OR WITHOUT ELASTIC, ANY WIDTH, PER LINEAR YARD	K0620	NON-COVERED	
A6501	COMPRESSION BURN GARMENT, BODYSUIT (HEAD TO FOOT), CUSTOM FABRICATED	L8210		COST INVOICE REQUIRED REQUIRES FITTER'S CERTIFICATION BY THE AMERICAN BOARD FOR CERTIFICATION OF ORTHOTICS & PROSTHETICS OR BOARD FOR CERTIFICATION OF ORTHOTICS & PROSTHETICS
A6502	COMPRESSION BURN GARMENT, CHIN STRAP, CUSTOM FABRICATED	L8210		COST INVOICE REQUIRED REQUIRES FITTER'S CERTIFICATION BY THE AMERICAN BOARD FOR CERTIFICATION OF ORTHOTICS & PROSTHETICS OR BOARD FOR CERTIFICATION OF ORTHOTICS & PROSTHETICS
A6503	COMPRESSION BURN GARMENT, FACIAL HOOD, CUSTOM FABRICATED	L8210		COST INVOICE REQUIRED REQUIRES FITTER'S CERTIFICATION BY THE AMERICAN BOARD FOR CERTIFICATION OF ORTHOTICS & PROSTHETICS OR BOARD FOR CERTIFICATION OF ORTHOTICS & PROSTHETICS

HCPCS CODES	DESCRIPTION	REPLACES	SERVICE LIMIT	SPECIAL INSTRUCTIONS
A6504	COMPRESSION BURN GARMENT, GLOVE TO WRIST, CUSTOM FABRICATED	L8210		COST INVOICE REQUIRED REQUIRES FITTER'S CERTIFICATION BY THE AMERICAN BOARD FOR CERTIFICATION OF ORTHOTICS & PROSTHETICS OR BOARD FOR CERTIFICATION OF ORTHOTICS & PROSTHETICS
A6505	COMPRESSION BURN GARMENT, GLOVE TO ELBOW, CUSTOM FABRICATED	L8210		COST INVOICE REQUIRED REQUIRES FITTER'S CERTIFICATION BY THE AMERICAN BOARD FOR CERTIFICATION OF ORTHOTICS & PROSTHETICS OR BOARD FOR CERTIFICATION OF ORTHOTICS & PROSTHETICS
A6506	COMPRESSION BURN GARMENT, GLOVE TO AXILLA, CUSTOM FABRICATED	L8210		COST INVOICE REQUIRED REQUIRES FITTER'S CERTIFICATION BY THE AMERICAN BOARD FOR CERTIFICATION OF ORTHOTICS & PROSTHETICS OR BOARD FOR CERTIFICATION OF ORTHOTICS & PROSTHETICS
A6507	COMPRESSION BURN GARMENT, FOOT TO KNEE LENGTH, CUSTOM FABRICATED	L8210		COST INVOICE REQUIRED REQUIRES FITTER'S CERTIFICATION BY THE AMERICAN BOARD FOR CERTIFICATION OF ORTHOTICS & PROSTHETICS OR BOARD FOR CERTIFICATION OF ORTHOTICS & PROSTHETICS
A6508	COMPRESSION BURN GARMENT, FOOT TO THIGH LENGTH, CUSTOM FABRICATED	L8210		COST INVOICE REQUIRED REQUIRES FITTER'S CERTIFICATION BY THE AMERICAN BOARD FOR CERTIFICATION OF ORTHOTICS & PROSTHETICS OR BOARD FOR CERTIFICATION OF ORTHOTICS & PROSTHETICS
A6509	COMPRESSION BURN GARMENT, UPPER TRUNK TO WAIST INCLUDING ARM OPENINGS (VEST), CUSTOM FABRICATED	L8210		COST INVOICE REQUIRED REQUIRES FITTER'S CERTIFICATION BY THE AMERICAN BOARD FOR CERTIFICATION OF ORTHOTICS & PROSTHETICS OR BOARD FOR CERTIFICATION OF ORTHOTICS & PROSTHETICS
A6510	COMPRESSION BURN GARMENT, TRUNK, INCLUDING ARMS DOWN TO LEG OPENINGS (LEOTARD), CUSTOM FABRICATED	L8210		COST INVOICE REQUIRED REQUIRES FITTER'S CERTIFICATION BY THE AMERICAN BOARD FOR CERTIFICATION OF ORTHOTICS & PROSTHETICS OR BOARD FOR CERTIFICATION OF ORTHOTICS & PROSTHETICS
A6511	COMPRESSION BURN GARMENT, LOWER TRUNK INCLUDING LEG OPENINGS (PANTY), CUSTOM FABRICATED	L8210		COST INVOICE REQUIRED REQUIRES FITTER'S CERTIFICATION BY THE AMERICAN BOARD FOR CERTIFICATION OF ORTHOTICS & PROSTHETICS OR BOARD FOR CERTIFICATION OF ORTHOTICS & PROSTHETICS
A6512	COMPRESSION BURN GARMENT, NOT OTHERWISE CLASSIFIED	L8210		COST INVOICE REQUIRED REQUIRES FITTER'S CERTIFICATION BY THE AMERICAN BOARD FOR CERTIFICATION OF ORTHOTICS & PROSTHETICS OR BOARD FOR CERTIFICATION OF ORTHOTICS & PROSTHETICS
A6513	COMPRESSION BURN MASK, FACE AND/OR NECK, PLASTIC OR EQUAL, CUSTOM FABRICATED	L8210		COST INVOICE REQUIRED REQUIRES FITTER'S CERTIFICATION BY THE AMERICAN BOARD FOR CERTIFICATION OF ORTHOTICS & PROSTHETICS OR BOARD FOR CERTIFICATION OF ORTHOTICS & PROSTHETICS

HCPCS CODES	DESCRIPTION	REPLACES	SERVICE LIMIT	SPECIAL INSTRUCTIONS
A6530	GRADIENT COMPRESSION STOCKING, BELOW KNEE, 18-30 MMHG, EACH	L8100	4 PER 6 ROLLING MONTHS	REQUIRES FITTER'S CERTIFICATION BY THE AMERICAN BOARD FOR CERTIFICATION OF ORTHOTICS & PROSTHETICS OR BOARD FOR CERTIFICATION OF ORTHOTICS & PROSTHETICS
A6531	GRADIENT COMPRESSIN STOCKING, BELOW KNEE, 30-40 MMHG, EACH	L8110	4 PER 6 ROLLING MONTHS	REQUIRES FITTER'S CERTIFICATION BY THE AMERICAN BOARD FOR CERTIFICATION OF ORTHOTICS & PROSTHETICS OR BOARD FOR CERTIFICATION OF ORTHOTICS & PROSTHETICS
A6532	GRADIEN COMPRESSION STOCKING, BELOW KNEE, 40-50 MMHG, EACH	L8120	4 PER 6 ROLLING MONTHS	REQUIRES FITTER'S CERTIFICATION BY THE AMERICAN BOARD FOR CERTIFICATION OF ORTHOTICS & PROSTHETICS OR BOARD FOR CERTIFICATION OF ORTHOTICS & PROSTHETICS
A6533	GRADIENT COMPRESSION STOCKING, THIGH LENGTH, 18-30 MMHG, EACH	L8130	4 PER 6 ROLLING MONTHS	REQUIRES FITTER'S CERTIFICATION BY THE AMERICAN BOARD FOR CERTIFICATION OF ORTHOTICS & PROSTHETICS OR BOARD FOR CERTIFICATION OF ORTHOTICS & PROSTHETICS
A6534	GRADIENT COMPRESSION STOCKING, THIGH LENGTH, 30-40 MMHG, EACH	L8140	4 PER 6 ROLLING MONTHS	REQUIRES FITTER'S CERTIFICATION BY THE AMERICAN BOARD FOR CERTIFICATION OF ORTHOTICS & PROSTHETICS OR BOARD FOR CERTIFICATION OF ORTHOTICS & PROSTHETICS
A6535	GRADIENT COMPRESSION STOCKING, THIGH LENGTH, 30-40 MMHG EACH	L8150	4 PER 6 ROLLING MONTHS	REQUIRES FITTER'S CERTIFICATION BY THE AMERICAN BOARD FOR CERTIFICATION OF ORTHOTICS & PROSTHETICS OR BOARD FOR CERTIFICATION OF ORTHOTICS & PROSTHETICS
A6536	GRADIENT COMPRESSION STOCKING, FULL LENGTH/CHAP STYLE, 18-30 MMHG, EACH	L8160	4 PER 6 ROLLING MONTHS	REQUIRES FITTER'S CERTIFICATION BY THE AMERICAN BOARD FOR CERTIFICATION OF ORTHOTICS & PROSTHETICS OR BOARD FOR CERTIFICATION OF ORTHOTICS & PROSTHETICS
A6537	GRADIENT COMPRESSION STOCKING, FULL LENGTH/CHAP STYLE, 30-40 MMHG, EACH	L8170	4 PER 6 ROLLING MONTHS	REQUIRES FITTER'S CERTIFICATION BY THE AMERICAN BOARD FOR CERTIFICATION OF ORTHOTICS & PROSTHETICS OR BOARD FOR CERTIFICATION OF ORTHOTICS & PROSTHETICS
A6538	GRADIENT COMPRESSION STOCKING, FULL LENGTH/CHAP STYLE, 40-50 MMHG, EACH	L8180	4 PER 6 ROLLING MONTHS	COST INVOICE REQUIRED REQUIRES FITTER'S CERTIFICATION BY THE AMERICAN BOARD FOR CERTIFICATION OF ORTHOTICS & PROSTHETICS OR BOARD FOR CERTIFICATION OF ORTHOTICS & PROSTHETICS
A6539	GRADIENT COMPRESSION STOCKING, WAIST LENGTH, 18-30 MMHG, EACH	L8190	2 PER 6 ROLLING MONTHS	REQUIRES FITTER'S CERTIFICATION BY THE AMERICAN BOARD FOR CERTIFICATION OF ORTHOTICS & PROSTHETICS OR BOARD FOR CERTIFICATION OF ORTHOTICS & PROSTHETICS

HCPCS CODES	DESCRIPTION	REPLACES	SERVICE LIMIT	SPECIAL INSTRUCTIONS
A6540	GRADIENT COMPRESSION STOCKING, WAIST LENGTH, 30-40 MMHG, EACH	L8195	2 PER 6 ROLLING MONTHS	COST INVOICE REQUIRED REQUIRES FITTER'S CERTIFICATION BY THE AMERICAN BOARD FOR CERTIFICATION OF ORTHOTICS & PROSTHETICS OR BOARD FOR CERTIFICATION OF ORTHOTICS & PROSTHETICS
A6541	GRADIENT COMPRESSION STOCKING, WAIST LENGTH, 40-50 MMHG, EACH	L8200	2 PER 6 ROLLING MONTHS	COST INVOICE REQUIRED REQUIRES FITTER'S CERTIFICATION BY THE AMERICAN BOARD FOR CERTIFICATION OF ORTHOTICS & PROSTHETICS OR BOARD FOR CERTIFICATION OF ORTHOTICS & PROSTHETICS
A6542	GRADIENT COMPRESSION STOCKING, CUSTOM MADE	L8210		COST INVOICE REQUIRED REQUIRES FITTER'S CERTIFICATION BY THE AMERICAN BOARD FOR CERTIFICATION OF ORTHOTICS & PROSTHETICS OR BOARD FOR CERTIFICATION OF ORTHOTICS & PROSTHETICS
A6543	GRADIENT COMPRESSION STOCKING, LYMPHEDEMA	L8220		COST INVOICE REQUIRED REQUIRES FITTER'S CERTIFICATION BY THE AMERICAN BOARD FOR CERTIFICATION OF ORTHOTICS & PROSTHETICS OR BOARD FOR CERTIFICATION OF ORTHOTICS & PROSTHETICS
A6544	GRADIENT COMPRESSION STOCKING, GARTER BELT	L8230	2 PER 2 ROLLING YEARS	REQUIRES FITTER'S CERTIFICATION BY THE AMERICAN BOARD FOR CERTIFICATION OF ORTHOTICS & PROSTHETICS OR BOARD FOR CERTIFICATION OF ORTHOTICS & PROSTHETICS
A6549	GRADIENT COMPRESSION STOCKING, NOT OTHERWISE SPECIFIED	L8239		COST INVOICE REQUIRED REQUIRES FITTER'S CERTIFICATION BY THE AMERICAN BOARD FOR CERTIFICATION OF ORTHOTICS & PROSTHETICS OR BOARD FOR CERTIFICATION OF ORTHOTICS & PROSTHETICS
A6550	WOUND CARE SET, FOR NEGATIVE PRESSURE WOUND THERAPY ELECTRICAL PUMP, INCLUDES ALL SUPPLIES AND ACCESSORIES	K0539	15 KITS PER ROLLING MONTH PER WOUND	PRIOR AUTHORIZATION
A6551	CANISTER SET FOR NEGATIVE PRESSURE WOUND THERAPY ELECTRICAL PUMP, STATIONARY OR PORTABLE, EACH	K0540	10 PER ROLLING MONTH	DISCONTINUED BY CMS 12/31/2005
A7000	CANISTER, DISPOSABLE, USED WITH SUCTION PUMP, EACH		1 PER ROLLING MONTH	
A7001	CANISTER, NON-DISPOSABLE, USED WITH SUCTION PUMP, EACH		NON-COVERED	
A7002	TUBING, USED WITH SUCTION PUMP, EACH	A4616	1 UNIT PER ROLLING MONTH	NON-REIMBURSABLE WITH: E0600 INCLUDED IN INITIAL DISPENSING OF EQUIPMENT
A7003	ADMINISTRATION SET, WITH SMALL VOLUME NONFILTERED PNEUMATIC NEBULIZER, DISPOSABLE	A4618	2 PER ROLLING MONTH	NON-REIMBURSABLE WITH: A7004, A7005, OR A7006

HCPCS CODES	DESCRIPTION	REPLACES	SERVICE LIMIT	SPECIAL INSTRUCTIONS
A7004	SMALL VOLUME NONFILTERED PNEUMATIC NEBULIZER, DISPOSABLE	A4618	2 PER ROLLING MONTH	NON-REIMBURSABLE WITH: A7003, A7005 OR A7006
A7005	ADMINISTRATION SET, WITH SMALL VOLUME NONFILTERED PNEUMATIC NEBULIZER, NON-DISPOSABLE	A4618	1 PER 6 ROLLING MONTHS	NON-REIMBURSABLE WITH: A7003, A7004 OR A7006
A7006	ADMINISTRATION SET, WITH SMALL VOLUME FILTERED PNEUMATIC NEBULIZER	A4618	1 PER ROLLING MONTH	NON- REIMBURSABLE WITH: A7003, A7004, OR A7005
A7007	LARGE VOLUME NEBULIZER, DISPOSABLE, UNFILLED, USED WITH AEROSOL COMPRESSOR		NON-COVERED	
A7008	LARGE VOLUME NEBULIZER, DISPOSABLE, PREFILLED, USED WITH AEROSOL COMPRESSOR		NON-COVERED	
A7009	RESERVOIR BOTTLE, NON-DISPOSABLE, USED WITH LARGE VOLUME ULTRASONIC NEBULIZER		NON-COVERED	
A7010	CORRUGATED TUBING, DISPOSABLE, USED WITH LARGE VOLUME NEBULIZER, 100 FEET		NON-COVERED	
A7011	CORRUGATED TUBING, NON-DISPOSABLE, USED WITH LARGE VOLUME NEBULIZER, 10 FEET		NON-COVERED	
A7012	WATER COLLECTION DEVICE, USED WITH LARGE VOLUME NEBULIZER		NON-COVERED	
A7013	FILTER, DISPOSABLE, USED WITH AEROSOL COMPRESSOR		1 PER ROLLING MONTH	
A7014	FILTER, NONDISPOSABLE, USED WITH AEROSOL COMPRESSOR OR ULTRASONIC GENERATOR		NON-COVERED	
A7015	AEROSOL MASK, USED WITH DME NEBULIZER		2 PER ROLLING MONTH	
A7016	DOME AND MOUTHPIECE, USED WITH SMALL VOLUME ULTRASONIC NEBULIZER		NON-COVERED	
A7017	NEBULIZER, DURABLE, GLASS OR AUTOCLAVABLE PLASTIC, BOTTLE TYPE, NOT USED WITH OXYGEN		NON-COVERED	
A7018	WATER, DISTILLED, USED WITH LARGE VOLUME NEBULIZER, 1000 ML		NON-COVERED	
A7025	HIGH FREQUENCY CHEST WALL OSCILLATION SYSTEM VEST, REPLACEMENT FOR USE WITH PATIENT OWNED EQUIPMENT, EACH		NON-COVERED	
A7026	HIGH FREQUENCY CHEST WALL OSCILLATION SYSTEM HOSE, REPLACEMENT FOR USE WITH PATIENT OWNED EQUIPMENT, EACH		NON-COVERED	

HCPCS CODES	DESCRIPTION	REPLACES	SERVICE LIMIT	SPECIAL INSTRUCTIONS
A7027	COMBINATION ORAL/NASAL MASK, USED WITH CONTINUOUS POSTIVE AIRWAY PRESSURE	K0553	NON-C0VERED	NEW CODE 01/01/2008
A7028	ORAL CUSHION FOR COMBINATION ORAL/NASAL MASK, REPLACEMENT ONLY, EACH	K0554	NON-COVERED	NEW CODE 01/01/2008
A7029	NASAL PILLOWS FOR COMBINATION ORAL/NASAL MASK,REPLACEMENT ONLY, PAIR	K0555	N0N-COVERED	NEW CODE 01/01/2008
A7030	FULL FACE MASK USED WITH POSITIVE AIRWAY PRESSURE DEVICE, EACH		1 PER 6 ROLLING MONTHS	NON-REIMBURSABLE WITH: E0471 OR E0472 MUST HAVE WEST VIRGINIA CERTIFIED RESPIRATORY THERAPIST OR PROFESSIONAL REGISTERED NURSE OR PHYSICIAN ON STAFF
A7031	FACE MASK INTERFACE, REPLACEMENT FOR FULL FACE MASK, EACH		1 PER 6 ROLLING MONTHS	NON-REIMBURSABLE WITH: E0471 OR E0472 MUST HAVE WEST VIRGINIA CERTIFIED RESPIRATORY THERAPIST OR PROFESSIONAL REGISTERED NURSE OR PHYSICIAN ON STAFF
A7032	CUSHION FOR USE ON NASAL MASK INTERFACE, REPLACEMENT ONLY, EACH		2 PER ROLLING MONTH	NON-REIMBURSABLE WITH: E0471 OR E0472 MUST HAVE WEST VIRIGNIA CERTIFIED RESPIRATORY THERAPIST OR PROFESSIONAL REGISTERED NURSE OR PHYSICIAN ON STAFF
A7033	PILLOW FOR USE ON NASAL CANNULA TYPE INTERFACE, REPLACEMENT ONLY, PAIR		2 PER ROLLING MONTH	NON-REIMBURSABLE WITH: E0471 OR E0472 MUST HAVE WEST VIRGINIA CERTIFIED RESPIRATORY THERAPIST OR PROFESSIONAL REGISTERED NURSE OR PHYSICIAN ON STAFF
A7034	NASAL INTERFACE (MASK OR CANNULA TYPE) USED WITH POSITIVE AIRWAY PRESSURE DEVICE, WITH OR WITHOUT HEAD STRAP		1 PER 3 ROLLING MONTHS	NON-REIMBURSABLE WITH: E0471 OR E0472 MUST HAVE WEST VIRGINIA CERTIFIED RESPIRATORY THERAPIST OR PROFESSIONAL REGISTERED NURSE OR PHYSICIAN ON STAFF
A7035	HEADGEAR USED WITH POSITIVE AIRWAY PRESSURE DEVICE		1 PER 6 ROLLING MONTHS	NON-REIMBURSABLE WITH: E0471 OR E0472 MUST HAVE WEST VIRGINIA CERTIFIED RESPIRATORY THERAPIST OR PROFESSIONAL REGISTERED NURSE OR PHYSICIAN ON STAFF
A7036	CHINSTRAP USED WITH POSITIVE AIRWAY PRESSURE DEVICE		1 PER 6 ROLLING MONTHS	NON-REIMBURSABLE WITH: E0471 OR E0472 MUST HAVE WEST VIRGINIA CERTIFIED RESPIRATORY THERAPIST OR PROFESSIONAL REGISTERED NURSE OR PHYSICIAN ON STAFF
A7037	TUBING USED WITH POSITIVE AIRWAY PRESSURE DEVICE		1 PER ROLLING MONTH	NON-REIMBURSABLE WITH: E0471 OR E0472 MUST HAVE WEST VIRGINIA CERTIFIED RESPIRATORY THERAPIST OR PROFESSIONAL REGISTERED NURSE OR PHYSICIAN ON STAFF
A7038	FILTER, DISPOSABLE, USED WITH POSITIVE AIRWAY PRESSURE DEVICE		2 PER ROLLING MONTH	NON-REIMBURSABLE WITH: E0471 OR E0472 MUST HAVE WEST VIRGINIA CERTIFIED RESPIRATORY THERAPIST OR PROFESSIONAL REGISTERED NURSE OR PHYSICIAN ON STAFF
A7039	FILTER, NON DISPOSABLE, USED WITH POSITIVE AIRWAY PRESSURE DEVICE		1 PER 6 ROLLING MONTHS	NON-REIMBURSABLE WITH: E0471 OR E0472 MUST HAVE WEST VIRGINIA CERTIFIED RESPIRATORY THERAPIST OR PROFESSIONAL REGISTERED NURSE OR PHYSICIAN ON STAFF

***PRIOR AUTHORIZATION MUST BE OBTAINED IF SERVICE LIMITS ARE EXCEEDED**

HCPCS CODES	DESCRIPTION	REPLACES	SERVICE LIMIT	SPECIAL INSTRUCTIONS
A7040	ONE WAY CHEST DRAIN VALVE		NON-COVERED	
A7041	WATER SEAL DRAINAGE CONTAINER AND TUBING FOR USE WITH IMPLANTED CHEST TUBE		NON-COVERED	
A7042	IMPLANTED PLEURAL CATHETER, EACH		NON-COVERED	
A7043	VACUUM DRAINAGE BOTTLE AND TUBING FOR USE WITH IMPLANTED CATHETER		NON-COVERED	
A7044	ORAL INTERFACE USED WITH POSITIVE AIRWAY PRESSURE DEVICE, EACH		NON-COVERED	
A7045	EXHALATION PORT WITH OR WITHOUT SWIVEL USED WITH ACCESSORIES FOR POSITIVE AIRWAY DEVICES, REPLACEMENT ONLY		2 PER 2 ROLLING YEARS	NON-REIMBURSABLE WITH: E0471 OR E0472 MUST HAVE WEST VIRGINIA CERTIFIED RESPIRATORY THERAPIST OR PROFESSIONAL REGISTERED NURSE OR PHYSICIAN ON STAFF
A7046	WATER CHAMBER FOR HUMIDIFIER, USED WITH POSITIVE AIRWAY PRESSURE DEVICE, REPLACEMENT, EACH		2 PER 2 ROLLING YEARS	NON-REIMBURSABLE WITH: E0471, E0472, E0561, OR E0562 MUST HAVE WEST VIRGINIA CERTIFIED RESPIRATORY THERAPIST OR PROFESSIONAL REGISTERED NURSE OR PHYSICIAN ON STAFF
A7501	TRACHEOSTOMA VALVE, INCLUDING DIAPHRAGM, EACH		NON-COVERED	
A7502	REPLACEMENT DIAPHRAGM/FACEPLATE FOR TRACHEOSTOMA VALVE, EACH		NON-COVERED	
A7503	FILTER HOLDER OR FILTER CAP, REUSABLE, FOR USE IN A TRACHEOSTOMA HEAT AND MOISTURE EXCHANGE SYSTEM, EACH		NON-COVERED	
A7504	FILTER FOR USE IN A TRACHEOSTOMA HEAT AND MOISTURE EXCHANGE SYSTEM, EACH		NON-COVERED	
A7505	HOUSING, REUSABLE WITHOUT ADHESIVE, FOR USE IN A HEAT AND MOISTURE EXCHANGE SYSTEM AND/OR WITH A TRACHEOSTOMA VALVE, EACH		NON-COVERED	
A7506	ADHESIVE DISC FOR USE IN A HEAT AND MOISTURE EXCHANGE SYSTEM AND/OR WITH TRACHEOSTOMA VALVE, ANY TYPE EACH		NON-COVERED	
A7507	FILTER HOLDER AND INTEGRATED FILTER WITHOUT ADHESIVE, FOR USE IN A TRACHEOSTOMA HEAT AND MOISTURE EXCHANGE SYSTEM, EACH		31 PER ROLLING MONTH	
A7508	HOUSING AND INTEGRATED ADHESIVE, FOR USE IN A TRACHEOSTOMA HEAT AND MOISTURE EXCHANGE SYSTEM AND/OR WITH A TRACHEOSTOMA VALVE, EACH		31 PER ROLLING MONTH	
A7509	FILTER HOLDER AND INTEGRATED FILTER HOUSING, AND ADHESIVE, FOR USE AS A TRACHEOSTOMA HEAT AND MOISTURE EXCHANGE SYSTEM, EACH		31 PER ROLLING MONTH	

HCPCS CODES	DESCRIPTION	REPLACES	SERVICE LIMIT	SPECIAL INSTRUCTIONS
A7520	TRACHEOSTOMY/LARYNGECTOMY TUBE, NON-CUFFED, POLYVINYLCHLORIDE (PVC), SILICONE OR EQUAL, EACH	A4622	4 PER ROLLING MONTH	
A7521	TRACHEOSTOMY/LARYNGECTOMY TUBE, CUFFED, POLYVINYLCHLORIDE (PVC), SILICONE OR EQUAL, EACH	A4622	4 PER ROLLING MONTH	
A7522	TRACHEOSTOMY/LARYNGECTOMY TUBE, STAINLESS STEEL OR EQUAL (STERILIZABLE AND REUSABLE), EACH	A4622	4 PER ROLLING MONTH	
A7523	TRACHEOSTOMY SHOWER PROTECTOR, EACH			PRIOR AUTHORIZATION COST INVOICE REQUIRED
A7524	TRACHEOSTOMA STENT/STUD/BUTTON, EACH			PRIOR AUTHORIZATION
A7525	TRACHEOSTOMY MASK, EACH	A4621	4 PER ROLLING MONTH	
A7526	TRACHEOSTOMY TUBE COLLAR/HOLDER, EACH	A4621 S8181	4 PER ROLLING MONTH	
A7527	TRACHEOSTOMY/LARYNGECTOMY TUBE PLUG/STOP, EACH		2 PER ROLLING MONTH	
A9282	WIG, ANY TYPE, EACH		NON-COVERED	
B4034	ENTERAL FEEDING SUPPLY KIT; SYRINGE **FED**, PER DAY		1 PER DAY	
B4035	ENTERAL FEEDING SUPPLY KIT; PUMP FED, PER DAY		1 PER DAY	
B4036	ENTERAL FEEDING SUPPLY KIT; GRAVITY FED, PER DAY		1 PER DAY	
B4081	NASOGASTRIC TUBING WITH STYLET		4 PER ROLLING MONTH	
B4082	NASOGASTRIC TUBING WITHOUT STYLET		4 PER ROLLING MONTH	
B4083	STOMACH TUBE - LEVINE TYPE		4 PER ROLLING MONTH	
B4086	GASTROSTOMY / JEJUNOSTOMY TUBE, ANY MATERIAL, ANY TYPE, (STANDARD OR LOW PROFILE), EACH		2 PER 6 ROLLING MONTHS	NON-REIMBURSABLE WITH B9998 DISCONTINUED BY CMS 12/31/2007
B4087	GASTROSTOMY/JEJUNOSTOMY TUBE, STANDARD, ANY MATERIAL ANY TYPE, EACH	B4086 B9998	2 PER 6 ROLLING MONTHS	NEW CODE 01/01/2008
B4088	GASTROSTOMY/JEJUNOSTOMY TUBE, LOW-PROFILE, ANY MATERIAL, ANY TYPE, EACH	B4086 B9998	2 PER 6 ROLLING MONTHS	NEW CODE 01/01/2008

HCPCS CODES	DESCRIPTION	REPLACES	SERVICE LIMIT	SPECIAL INSTRUCTIONS
B4100	FOOD THICKENER, ADMINISTERED ORALLY, PER OUNCE		NON-COVERED	
B4102	ENTERAL FORMULA, FOR ADULTS, USED TO REPLACE FLUIDS AND ELECTROLYTES (E.G. CLEAR LIQUIDS), 500 ML = 1 UNIT		NON-COVERED	
B4103	ENTERAL FORMULA, FOR PEDIATRICS, USED TO REPLACE FLUIDS AND ELECTROLYTES (E.G. CLEAR LIQUIDS), 500 ML = 1 UNIT		NON-COVERED	
B4104	ADDITIVE FOR ENTERAL FORMULA (E.G. FIBER)		NON-COVERED	
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		NON-COVERED	
B4150	ENTERAL FORMULA, 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		NON-COVERED	
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		NON-COVERED	
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		NON-COVERED	
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		NON-COVERED	

HCPCS CODES	DESCRIPTION	REPLACES	SERVICE LIMIT	SPECIAL INSTRUCTIONS
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 = 1 UNIT		NON-COVERED	
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		NON-COVERED	
B4158	ENTERAL FORMULA, FOR PEDIATRICS, 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 CALORIES = 1 UNIT		NON-COVERED	
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 CALORIES = 1 UNIT		NON-COVERED	
B4160	ENTERAL FORMULA, FOR PEDIATRICS, NUTRITIONALLY COMPLETE CALORICALLY DENSE (EQUAL TO OR GREATER THAN 0.7 KCAL/ML) WITH INTACT NUTRIENTS, INCLUDES (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 CALORIES = 1 UNIT		NON-COVERED	
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 CALORIES = 1 UNIT		NON-COVERED	

***PRIOR AUTHORIZATION MUST BE OBTAINED IF SERVICE LIMITS ARE EXCEEDED**

HCPCS CODES	DESCRIPTION	REPLACES	SERVICE LIMIT	SPECIAL INSTRUCTIONS
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 CALORIES = 1 UNIT		NON-COVERED	
B4164	PARENTERAL NUTRITION SOLUTION: CARBOHYDRATES (DEXTROSE), 50% OR LESS (500 ML = 1 UNIT) - HOMEMIX		1 PER DAY	WEST VIRGINIA MEDICAID FOLLOWS PALMETTO, REGION C, MEDICAL CRITERIA FOR COVERAGE
B4168	PARENTERAL NUTRITION SOLUTION; AMINO ACID, 3.5%, (500 ML = 1 UNIT) - HOMEMIX		1 PER DAY	WEST VIRGINIA MEDICAID FOLLOWS PALMETTO, REGION C, MEDICAL CRITERIA FOR COVERAGE
B4172	PARENTERAL NUTRITION SOLUTION; AMINO ACID, 5.5% THROUGH 7%, (500 ML = 1 UNIT) - HOMEMIX		1 PER DAY	WEST VIRGINIA MEDICAID FOLLOWS PALMETTO, REGION C, MEDICAL CRITERIA FOR COVERAGE
B4176	PARENTERAL NUTRITION SOLUTION; AMINO ACID, 7% THROUGH 8.5%, (500 ML = 1 UNIT) - HOMEMIX		1 PER DAY	WEST VIRGINIA MEDICAID FOLLOWS PALMETTO, REGION C, MEDICAL CRITERIA FOR COVERAGE
B4178	PARENTERAL NUTRITION SOLUTION: AMINO ACID, GREATER THAN 8.5% (500 ML = 1 UNIT) HOMEMIX		1 PER DAY	WEST VIRGINIA MEDICAID FOLLOWS PALMETTO, REGION C, MEDICAL CRITERIA FOR COVERAGE
B4180	PARENTERAL NUTRITION SOLUTION; CARBOHYDRATES (DEXTROSE), GREATER THAN 50% (500 ML=1 UNIT) - HOMEMIX		1 PER DAY	WEST VIRGINIA MEDICAID FOLLOWS PALMETTO, REGION C, MEDICAL CRITERIA FOR COVERAGE
B4184	PARENTERAL NUTRITION SOLUTION; LIPIDS, 10% WITH ADMINISTRATION SET (500 ML = 1UNIT)			DISCONTINUED BY CMS 12/31/2005
B4185	PARENTAL NUTRITION SOLUTION, PER 10 GRAMS LIPIDS	B4185 B4186	1 PER DAY	WEST VIRGINIA MEDICAID FOLLOWS PALMETTO, REGION C, MEDICAL CRITERIA FOR COVERAGE
B4186	PARENTERAL NUTRITION SOLUTION, LIPIDS, 20% WITH ADMINISTRATION SET (500 ML = 1UNIT)			DISCONTINUED BY CMS 12/31/2005
B4189	PARENTERAL NUTRITION SOLUTION; COMPOUNDED AMINO ACID AND CARBOHYDRATES WITH ELECTROLYTES, TRACE ELEMENTS, AND VITAMINS, INCLUDING PREPARATION, ANY STRENGTH, 10 TO 51 GRAMS OF PROTEIN - PREMIX		1 PER DAY	WEST VIRGINIA MEDICAID FOLLOWS PALMETTO, REGION C, MEDICAL CRITERIA FOR COVERAGE
B4193	PARENTERAL NUTRITION SOLUTION; COMPOUNDED AMINO ACID AND CARBOHYDRATES WITH ELECTROLYTES, TRACE ELEMENTS, AND VITAMINS, INCLUDING PREPARATION, ANY STRENGTH, 52 TO 73 GRAMS OF PROTEIN - PREMIX		1 PER DAY	WEST VIRGINIA MEDICAID FOLLOWS PALMETTO, REGION C, MEDICAL CRITERIA FOR COVERAGE

HCPCS CODES	DESCRIPTION	REPLACES	SERVICE LIMIT	SPECIAL INSTRUCTIONS
B4197	PARENTERAL NUTRITION SOLUTION; COMPOUNDED AMINO ACID AND CARBOHYDRATES WITH ELECTROLYTES, TRACE ELEMENTS AND VITAMINS, INCLUDING PREPARATION, ANY STRENGTH, 74 TO 100 GRAMS OF PROTEIN - PREMIX		1 PER DAY	WEST VIRGINIA MEDICAID FOLLOWS PALMETTO, REGION C, MEDICAL CRITERIA FOR COVERAGE
B4199	PARENTERAL NUTRITION SOLUTION; COMPOUNDED AMINO ACID AND CARBOHYDRATES WITH ELECTROLYTES, TRACE ELEMENTS AND VITAMINS, INCLUDING PREPARATION, ANY STRENGTH, OVER 100 GRAMS OF PROTEIN - PREMIX		1 PER DAY	WEST VIRGINIA MEDICAID FOLLOWS PALMETTO, REGION C, MEDICAL CRITERIA FOR COVERAGE
B4216	PARENTERAL NUTRITION; ADDITIVES (VITAMINS, TRACE ELEMENTS, HEPARIN, ELECTROLYTES) HOMEMIX PER DAY		1 PER DAY	WEST VIRGINIA MEDICAID FOLLOWS PALMETTO, REGION C, MEDICAL CRITERIA FOR COVERAGE
B4220	PARENTERAL NUTRITION SUPPLY KIT; PREMIX, PER DAY		1 PER DAY	WEST VIRGINIA MEDICAID FOLLOWS PALMETTO, REGION C, MEDICAL CRITERIA FOR COVERAGE
B4222	PARENTERAL NUTRITION SUPPLY KIT; HOME MIX, PER DAY		1 PER DAY	WEST VIRGINIA MEDICAID FOLLOWS PALMETTO, REGION C, MEDICAL CRITERIA FOR COVERAGE
B4224	PARENTERAL NUTRITION ADMINISTRATION KIT, PER DAY		1 PER DAY	WEST VIRGINIA MEDICAID FOLLOWS PALMETTO, REGION C, MEDICAL CRITERIA FOR COVERAGE
B5000	PARENTERAL NUTRITION SOLUTION: COMPOUNDED AMINO ACID AND CARBOHYDRATES WITH ELECTROLYTES, TRACE ELEMENTS, AND VITAMINS, INCLUDING PREPARATION, ANY STRENGTH, RENAL - AMIROSYN RF, NEPHRAMINE, RENAMINE - PREMIX			WEST VIRGINIA MEDICAID FOLLOWS PALMETTO, REGION C, MEDICAL CRITERIA FOR COVERAGE
B5100	PARENTERAL NUTRITION SOLUTION: COMPOUNDED AMINO ACID AND CARBOHYDRATES WITH ELECTROLYTES, TRACE ELEMENTS, AND VITAMINS, INCLUDING PREPARATION, ANY STRENGTH, HEPATIC - FREAMINE HBC, HEPATAMINE - PREMIX			WEST VIRGINIA MEDICAID FOLLOWS PALMETTO, REGION C, MEDICAL CRITERIA FOR COVERAGE.
B5200	PARENTERAL NUTRITION SOLUTION: COMPOUNDED AMINO ACID AND CARBOHYDRATES WITH ELECTROLYTES, TRACE ELEMENTS, AND VITAMINS, INCLUDING PREPARATION, ANY STRENGTH, STRESS - BRANCH CHAIN AMINO ACIDS - PREMIX			WEST VIRGINIA MEDICAID FOLLOWS PALMETTO, REGION C, MEDICAL CRITERIA FOR COVERAGE.
B9000	ENTERAL NUTRITION INFUSION PUMP - WITHOUT ALARM		1UNIT PER LIFETIME	ITEM IS 10 MONTH CAP RENTAL
B9002	ENTERAL NUTRITION INFUSION PUMP - WITH ALARM		1UNIT PER LIFETIME	ITEM IS 10 MONTH CAP RENTAL

HCPCS CODES	DESCRIPTION	REPLACES	SERVICE LIMIT	SPECIAL INSTRUCTIONS
B9004	PARENTERAL NUTRITION INFUSION PUMP, PORTABLE		1UNIT PER LIFETIME	ITEM IS 10 MONTH CAP RENTAL WEST VIRGINIA MEDICAID FOLLOWS PALMETTO, REGION C, MEDICAL CRITERIA FOR COVERAGE.
B9006	PARENTERAL NUTRITION INFUSION PUMP, STATIONARY		1UNIT PER LIFETIME	ITEM IS 10 MONTH CAP RENTAL WEST VIRGINIA MEDICAID FOLLOWS PALMETTO, REGION C, MEDICAL CRITERIA FOR COVERAGE.
B9998	NOC FOR ENTERAL SUPPLIES			PRIOR AUTHORIZATION COST INVOICE REQUIRED
B9999	NOC FOR PARENTERAL SUPPLIES			PRIOR AUTHORIZATION COST INVOICE REQUIRED
E0100	CANE, INCLUDES CANES OF ALL MATERIALS, ADJUSTABLE OR FIXED, WITH TIP		1 PER 2 ROLLING YEARS	ITEM IS PURCHASED WHEN PRESCRIBED BY A PRACTITIONER FOR A MEMBER WITH A CONDITION CAUSING IMPAIRED AMBULATION AND THERE IS A POTENTIAL FOR AMBULATION NON-REIMBURSABLE WITH A4636, A4637OR E0105
E0105	CANE, QUAD OR THREE PRONG, INCLUDES CANES OF ALL MATERIALS, ADJUSTABLE OR FIXED, WITH TIPS		1 PER 2 ROLLING YEARS	ITEM IS PURCHASED WHEN PRESCRIBED BY A PRACTITIONER FOR A MEMBER WITH A CONDITION CAUSING IMPAIRED AMBULATION AND THERE IS A POTENTIAL FOR AMBULATION NON-REIMBURSABLE WITH A4636, A4637 OR E0100
E0110	CRUTCHES, FOREARM, INCLUDES CRUTCHES OF VARIOUS MATERIALS, ADJUSTABLE OR FIXED, PAIR, COMPLETE WITH TIPS AND HANDGRIPS		1 PER 2 ROLLING YEARS	ITEM IS PURCHASED WHEN PRESCRIBED BY A PRACTITIONER FOR A MEMBER WITH A CONDITION CAUSING IMPAIRED AMBULATION AND THERE IS A POTENTIAL FOR AMBULATION NON-REIMBURSABLE WITH A4635, A4636, A4637 E0111, E112, E0113, E0114, 0R E0116
E0111	CRUTCH FOREARM, INCLUDES CRUTCHES OF VARIOUS MATERIALS, ADJUSTABLE OR FIXED, EACH, WITH TIP AND HANDGRIPS		2 PER 2 ROLLING YEARS	ITEM IS PURCHASED WHEN PRESCRIBED BY A PRACTITIONER FOR A MEMBER WITH A CONDITION CAUSING IMPAIRED AMBULATION AND THERE IS A POTENTIAL FOR AMBULATION NON-REIMBURSABLE WITH A4635, A4636, A4637 E0110, E112, E0113, E0114, 0R E0116
E0112	CRUTCHES UNDERARM, WOOD, ADJUSTABLE OR FIXED, PAIR, WITH PADS, TIPS AND HANDGRIPS		1 PER 2 ROLLING YEARS	ITEM IS PURCHASED WHEN PRESCRIBED BY A PRACTITIONER FOR A MEMBER WITH A CONDITION CAUSING IMPAIRED AMBULATION AND THERE IS A POTENTIAL FOR AMBULATION NON-REIMBURSABLE WITH A4635, A4636, A4637 E0110, E111, E0113, E0114, 0R E0116
E0113	CRUTCH UNDERARM, WOOD, ADJUSTABLE OR FIXED, EACH, WITH PAD, TIP AND HANDGRIP		2 PER 2 ROLLING YEARS	ITEM IS PURCHASED WHEN PRESCRIBED BY A PRACTITIONER FOR A MEMBER WITH A CONDITION CAUSING IMPAIRED AMBULATION AND THERE IS A POTENTIAL FOR AMBULATION NON-REIMBURSABLE WITH A4635, A4636, A4637 E0110, E111, E0112, E0114, 0R E0116

HCPCS CODES	DESCRIPTION	REPLACES	SERVICE LIMIT	SPECIAL INSTRUCTIONS
E0114	CRUTCHES UNDERARM, OTHER THAN WOOD, ADJUSTABLE OR FIXED, PAIR, WITH PADS, TIPS AND HANDGRIPS		1 PER 2 ROLLING YEARS	ITEM IS PURCHASED WHEN PRESCRIBED BY A PRACTITIONER FOR A MEMBER WITH A CONDITION CAUSING IMPAIRED AMBULATION AND THERE IS A POTENTIAL FOR AMBULATION NON-REIMBURSABLE WITH A4635, A4636, A4637 E0110, E111, E0112, E0113, 0R E0116
E0116	CRUTCH, UNDERARM, OTHER THAN WOOD, ADJUSTABLE OR FIXED, EACH, WITH PAD, TIP HANDGRIP, WITH OR WITHOUT SHOCK ABSORBER, EACH		2 PER 2 ROLLING YEARS	ITEM IS PURCHASED WHEN PRESCRIBED BY A PRACTITIONER FOR A MEMBER WITH A CONDITION CAUSING IMPAIRED AMBULATION AND THERE IS A POTENTIAL FOR AMBULATION NON-REIMBURSABLE WITH A4635, A4636, A4637 E0110, E111, E0112, E0113, 0R E0114
E0117	CRUTCH, UNDERARM, ARTICULATING, SPRING ASSISTED, EACH		NON-COVERED	
E0118	CRUTCH SUBSTITUTE, LOWER LEG PLATFORM, WITH OR WITHOUT WHEELS, EACH		NON-COVERED	
E0130	WALKER, RIGID (PICKUP), ADJUSTABLE OR FIXED HEIGHT		1 PER 3 ROLLING YEARS	PURCHASED ITEM WEST VIRGINIA MEDICAID FOLLOWS PALMETTO, REGION C, MEDICAL CRITERIA FOR COVERAGE. NON-REIMBURSABLE WITH: A4636 or A4637
E0135	WALKER, FOLDING (PICKUP), ADJUSTABLE OR FIXED HEIGHT		1 PER 3 ROLLING YEARS	PURCHASED ITEM WEST VIRGINIA MEDICAID FOLLOWS PALMETTO, REGION C MEDICAL CRITERIA FOR COVERAGE. NON-REIMBURSABLE WITH: A4636 or A4637
E0140	WALKER, WITH TRUNK SUPPORT, ADJUSTABLE OR FIXED HEIGHT, ANY TYPE		1 PER 3 ROLLING YEARS	PURCHASED ITEM NON-REIMBURSABLE WITH: A4636, A4637, E0155 or E0159
E0141	WALKER, RIGID, WHEELED, ADJUSTABLE OR FIXED HEIGHT		1 PER 3 ROLLING YEARS	PURCHASED ITEM NON-REIMBURSABLE WITH: A4636, A4637, E0155 or E0159
E0143	WALKER, FOLDING, WHEELED, ADJUSTABLE OR FIXED HEIGHT		1 PER 3 ROLLING YEARS	PURCHASED ITEM NON-REIMBURSABLE WITH: A4636, A4637, E0155 or E0159
E0144	WALKER, ENCLOSED, FOUR SIDED FRAMED, RIGID OR FOLDING, WHEELED WITH POSTERIOR SEAT		NON-COVERED	
E0147	WALKER, HEAVY DUTY, MULTIPLE BRAKING SYSTEM, VARIABLE WHEEL RESISTANCE		1 PER 3 ROLLING YEARS	PRIOR AUTHORIZATION PURCHASED ITEM WEST VIRGINIA MEDICAID FOLLOWS PALMETTO, REGION C, MEDICAL CRITERIA FOR COVERAGE. NON-REIMBURSABLE WITH: A4636, E0155 OR E0159
E0148	WALKER, HEAVY DUTY, WITHOUT WHEELS, RIGID OR FOLDING, ANY TYPE, EACH		1 PER 3 ROLLING YEARS	PURCHASED ITEM WEST VIRGINIA MEDICAID FOLLOWS PALMETTO, REGION C, MEDICAL CRITERIA FOR COVERAGE. NON-REIMBURSABLE WITH: A4636 OR A4637
E0149	WALKER, HEAVY DUTY, WHEELED, RIGID OR FOLDING, ANY TYPE		1 PER 3 ROLLING YEARS	PURCHASED ITEM WEST VIRGINIA MEDICAID FOLLOWS PALMETTO, REGION C, MEDICAL CRITERIA FOR COVERAGE. NON-REIMBURSABLE WITH: A4636, A4637, E0155 OR E0159

HCPCS CODES	DESCRIPTION	REPLACES	SERVICE LIMIT	SPECIAL INSTRUCTIONS
E0153	PLATFORM ATTACHMENT, FOREARM CRUTCH, EACH		2 PER 3 ROLLING YEARS	PURCHASE ITEM
E0154	PLATFORM ATTACHMENT, WALKER, EACH		2 PER 3 ROLLING YEARS	PURCHASED ITEM WEST VIRGINIA MEDICAID FOLLOWS PALMETTO, REGION C, MEDICAL CRITERIA FOR COVERAGE. NON-REIMBURSABLE WITH: E0141, E0143, E0147, or E0149
E0155	WHEEL ATTACHMENT, RIGID PICK-UP WALKER, PER PAIR		2 PER 3 ROLLING YEARS	PURCHASED ITEM WEST VIRGINIA MEDICAID FOLLOWS PALMETTO, REGION C, MEDICAL CRITERIA FOR COVERAGE.
E0156	SEAT ATTACHMENT, WALKER		1 PER 3 ROLLING YEARS	PURCHASED ITEM WEST VIRGINIA MEDICAID FOLLOWS PALMETTO, REGION C, MEDICAL CRITERIA FOR COVERAGE
E0157	CRUTCH ATTACHMENT, WALKER, EACH		2 PER 3 ROLLING YEARS	PURCHASED ITEM WEST VIRGINIA MEDICAID FOLLOWS PALMETTO, REGION C, MEDICAL CRITERIA FOR COVERAGE
E0158	LEG EXTENSIONS FOR WALKER, PER SET OF FOUR (4)		2 PER 3 ROLLING YEARS	PURCHASED ITEM WEST VIRGINIA MEDICAID FOLLOWS PALMETTO, REGION C MEDICAL CRITERIA FOR COVERAGE. NON-REIMBURSABLE WITH: E0141, E0143, E0147, or E0149
E0159	BRAKE ATTACHMENT FOR WHEELED WALKER, REPLACEMENT, EACH		1 PER ROLLING YEAR	PURCHASED ITEM WEST VIRGINIA MEDICAID FOLLOWS PALMETTO, REGION C, MEDICAL CRITERIA FOR COVERAGE
E0160	SITZ TYPE BATH OR EQUIPMENT, PORTABLE, USED WITH OR WITHOUT COMMODE		1 PER 2 ROLLING YEARS	PURCHASED ITEM WEST VIRGINIA MEDICAID FOLLOWS PALMETTO, REGION C, MEDICAL CRITERIA FOR COVERAGE
E0161	SITZ TYPE BATH OR EQUIPMENT, PORTABLE, USED WITH OR WITHOUT COMMODE, WITH FAUCET ATTACHMENT/S		1 PER 2 ROLLING YEARS	PURCHASED ITEM WEST VIRGINIA MEDICAID FOLLOWS PALMETTO, REGION C, MEDICAL CRITERIA FOR COVERAGE
E0162	SITZ BATH CHAIR		1 PER 2 ROLLING YEARS	PURCHASED ITEM NON-REIMBURSABLE WITH: E0167
E0163	COMMODE CHAIR, MOBILE OR STATIONARY, WITH FIXED ARMS		1 PER 5 ROLLING YEARS	ITEM PURCHASED FOR MEMBER WEIGHING 300 LBS OR LESS WHEN PHYSICALLY INCAPABLE OF UTILIZING TOILET FACILITIES; I.E., CONFINED TO A SINGLE ROOM, OR CONFINED TO ONE LEVEL OF THE HOME WITHOUT TOILET FACILITIES, OR CONFINED TO THE HOME WITHOUT TOILET FACILITIES. MEMBER'S FILE MUST CONTAIN THE ABOVE DOCUMENTATION INCLUDING WEIGHT. NON-REIMBURSABLE WITH: E0165, E0167 or E0168
E0164	COMMODE CHAIR, MOBILE, WITH FIXED ARMS		NON-COVERED	

HCPCS CODES	DESCRIPTION	REPLACES	SERVICE LIMIT	SPECIAL INSTRUCTIONS
E0165	COMMODE CHAIR, MOBILE OR STATIONARY, WITH DETACHABLE ARMS		1 PER 5 ROLLING YEARS	ITEM PURCHASED FOR MEMBER WEIGHING 300 LBS OR LESS WHEN PHYSICALLY INCAPABLE OF UTILIZING TOILET FACILITIES.; I.E., CONFINED TO A SINGLE ROOM, OR CONFINED TO ONE LEVEL OF THE HOME WITHOUT TOILET FACILITIES, OR CONFINED TO THE HOME WITHOUT TOILET FACILITIES AND IF THE DETACHABLE ARM FEATURE IS NECESSARY TO FACILITY TRANSFERRING THE MEMBER OR HAS A BODY CONFIGURATION THAT REQUIRES EXTRA WIDTH. MEMBER'S FILE MUST CONTAIN THE ABOVE DOCUMENTATION INCLUDING WEIGHT. NON-REIMBURSABLE WITH: E0163, E0164, E0167 or E0168
E0166	COMMODE CHAIR, MOBILE, WITH DETACHABLE ARMS		NON-COVERED	
E0167	PAIL OR PAN FOR USE WITH COMMODE CHAIR, REPLACEMENT ONLY		1 PER ROLLING YEAR	NON-REIMBURSABLE WITH: E0163, E0164, E0165 or E0168
E0168	COMMODE CHAIR, EXTRA WIDE AND/OR HEAVY DUTY, STATIONARY OR MOBILE, WITH OR WITHOUT ARMS, ANY TYPE, EACH		1 PER 5 ROLLING YEARS	ITEM PURCHASED FOR MEMBER WEIGHING 300 LBS OR MORE WHEN PHYSICALLY INCAPABLE OF UTILIZING TOILET FACILITIES; I.E., CONFINED TO A SINGLE ROOM, OR CONFINED TO ONE LEVEL OF THE HOME WITHOUT TOILET FACILITIES, OR CONFINED TO THE HOME WITHOUT TOILET FACILITIES. MEMBER'S FILE MUST CONTAIN THE ABOVE DOCUMENTATION INCLUDING WEIGHT. MEMBER'S FILE MUST CONTAIN THE ABOVE DOCUMENTATION INCLUDING WEIGHT. NON-REIMBURSABLE WITH: E0163, E0165 or E0167
E0169	COMMODE CHAIR WITH SEAT LIFT MECHANISM		NON-COVERED	
E0170	COMMODE CHAIR WITH INTEGRATED SEAT LIFT MECHANISM, ELECTRIC, ANY TYPE		NON-COVERED	
E0171	COMMODE CHAIR WITH INTEGRATED SEAT LIFT MECHANISM, NON-ELECTRIC, ANY TYPE	E0169	NON-COVERED	
E0172	SEAT LIFT MECHANISM PLACED OVER OR ON TOP OF TOILET, ANY TYPE	E0169	NON-COVERED	
E0175	FOOT REST, FOR USE WITH COMMODE CHAIR, EACH		NON-COVERED	
E0180	PRESSURE PAD, ALTERNATING WITH PUMP		1 PER 4 ROLLING YEARS	PRIOR AUTHORIZATION ITEM IS PURCHASED NON-REIMBURSABLE WITH: A4640 OR E0182 MEDICAL NECESSITY REVIEW WILL BE BASED ON INTERQUAL DME GENERAL CRITERIA CLOSED BY CMS 12/31/2006

HCPCS CODES	DESCRIPTION	REPLACES	SERVICE LIMIT	SPECIAL INSTRUCTIONS
E0181	POWERED PRESSURE REDUCING MATTRESS OVERLAY/PAD, ALTERNATING, WITH PUMP, INCLUDES HEAVY DUTY		1 PER 4 ROLLING YEARS	PRIOR AUTHORIZATION ITEM IS PURCHASED NON-REIMBURSABLE WITH: A4640 OR E0182 MEDICAL NECESSITY REVIEW WILL BE BASED ON INTERQUAL DME GENERAL CRITERIA
E0182	PUMP FOR ALTERNATING PRESSURE PAD, FOR REPLACEMENT ONLY		1 PER 4 ROLLING YEARS	PRIOR AUTHORIZATION ITEM IS PURCHASED NON-REIMBURSABLE WITH: A4640, E0180, OR E0181 MEDICAL NECESSITY REVIEW WILL BE BASED ON INTERQUAL DME GENERAL CRITERIA
E0184	DRY PRESSURE MATTRESS		1 PER ROLLING YEAR	PRIOR AUTHORIZATION PURCHASED ITEM MEDICAL NECESSITY REVIEW WILL BE BASED ON INTERQUAL DME GENERAL CRITERIA
E0185	GEL OR GEL-LIKE PRESSURE PAD FOR MATTRESS, STANDARD MATTRESS LENGTH AND WIDTH		1 PER 2 ROLLING YEARS	PRIOR AUTHORIZATION PURCHASED ITEM MEDICAL NECESSITY REVIEW WILL BE BASED ON INTERQUAL DME GENERAL CRITERIA
E0186	AIR PRESSURE MATTRESS		1 PER 2 ROLLING YEARS	PRIOR AUTHORIZATION PURCHASED ITEM MEDICAL NECESSITY REVIEW WILL BE BASED ON INTERQUAL DME GENERAL CRITERIA
E0187	WATER PRESSURE MATTRESS		1 PER 2 ROLLING YEARS	PRIOR AUTHORIZATION PURCHASED ITEM NON-REIMBURSABLE WITH: A4640, E0180, OR E0181 MEDICAL NECESSITY REVIEW WILL BE BASED ON INTERQUAL DME GENERAL CRITERIA
E0188	SYNTHETIC SHEEPSKIN PAD		2 PER 6 ROLLING MONTHS	PURCHASED ITEM WEST VIRGINIA MEDICAID FOLLOWS PALMETTO, REGION C, MEDICAL CRITERIA FOR COVERAGE.
E0189	LAMBSWOOL SHEEPSKIN PAD, ANY SIZE		2 PER 2 ROLLING YEARS	PURCHASED ITEM WEST VIRGINIA MEDICAID FOLLOWS PALMETTO, REGION C, MEDICAL CRITERIA FOR COVERAGE
E0190	POSITIONING CUSHION/PILLOW/WEDGE, ANY SHAPE OR SIZE, INCLUDES ALL COMPONENTS AND ACCESSORES	E0943	1 PER ROLLING YEAR	PURCHASED ITEM
E0191	HEEL OR ELBOW PROTECTOR, EACH		4 PER 6 ROLLING MONTHS	PURCHASED ITEM
E0192	LOW PRESSURE AND POSITIONING EQUALIZATION PAD, FOR WHEELCHAIR		NON-COVERED	
E0193	POWERED AIR FLOTATION BED (LOW AIR LOSS THERAPY)		NON-COVERED	
E0194	AIR FLUIDIZED BED		NON-COVERED	

HCPCS CODES	DESCRIPTION	REPLACES	SERVICE LIMIT	SPECIAL INSTRUCTIONS
E0196	GEL PRESSURE MATTRESS		1 PER 4 ROLLING YEARS	PRIOR AUTHORIZATION PURCHASED ITEM MEDICAL NECESSITY REVIEW WILL BE BASED ON INTERQUAL DME GENERAL CRITERIA
E0197	AIR PRESSURE PAD FOR MATTRESS, STANDARD MATTRESS LENGTH AND WIDTH		1 PER 4 ROLLING YEARS	PRIOR AUTHORIZATION PURCHASED ITEM MEDICAL NECESSITY REVIEW WILL BE BASED ON INTERQUAL DME GENERAL CRITERIA
E0198	WATER PRESSURE PAD FOR MATTRESS, STANDARD MATTRESS LENGTH AND WIDTH		1 PER 4 ROLLING YEARS	PRIOR AUTHORIZATION PURCHASED ITEM MEDICAL NECESSITY REVIEW WILL BE BASED ON INTERQUAL DME GENERAL CRITERIA
E0199	DRY PRESSURE PAD FOR MATTRESS, STANDARD MATTRESS LENGTH AND WIDTH		1 PER 4 ROLLING YEARS	PRIOR AUTHORIZATION PURCHASED ITEM MEDICAL NECESSITY REVIEW WILL BE BASED ON INTERQUAL DME GENERAL CRITERIA
E0200	HEAT LAMP, WITHOUT STAND (TABLE MODEL), INCLUDES BULB, OR INFRARED ELEMENT		NON-COVERED	
E0202	PHOTOTHERAPY (BILIRUBIN) LIGHT WITH PHOTOMETER		5 DAYS PER LIFETIME	REQUIRES ICD9-CM DIAGNOSIS CODES: 774.0-774.7 COVERAGE LIMITED FROM BIRTH TO 30 DAYS OF AGE
E0203	THERAPEUTIC LIGHTBOX, MINIMUM 10,000 LUX, TABLE TOP MODEL		NON-COVERED	
E0205	HEAT LAMP, WITH STAND, INCLUDES BULB, OR INFRARED ELEMENT		NON-COVERED	
E0210	ELECTRIC HEAT PAD, STANDARD		NON-COVERED	
E0215	ELECTRIC HEAT PAD, MOIST		NON-COVERED	
E0217	WATER CIRCULATING HEAT PAD WITH PUMP		NON-COVERED	
E0218	WATER CIRCULATING COLD PAD WITH PUMP		NON-COVERED	
E0220	HOT WATER BOTTLE		NON-COVERED	
E0221	INFRARED HEATING PAD SYSTEM		NON-COVERED	
E0225	HYDROCOLLATOR UNIT, INCLUDES PADS		NON-COVERED	
E0230	ICE CAP OR COLLAR		NON-COVERED	

HCPCS CODES	DESCRIPTION	REPLACES	SERVICE LIMIT	SPECIAL INSTRUCTIONS
E0231	NON-CONTACT WOUND WARMING DEVICE (TEMPERATURE CONTROL UNIT, AC ADAPTER AND POWER CORD) FOR USE WITH WARMING CARD AND WOUND COVER		NON-COVERED	
E0232	WARMING CARD FOR USE WITH THE NON CONTACT WOUND WARMING DEVICE AND NON CONTACT WOUND WARMING WOUND COVER		NON-COVERED	
E0235	PARAFFIN BATH UNIT, PORTABLE (SEE MEDICAL SUPPLY CODE A4265 FOR PARAFFIN)		NON-COVERED	
E0236	PUMP FOR WATER CIRCULATING PAD		NON-COVERED	
E0238	NON-ELECTRIC HEAT PAD, MOIST		NON-COVERED	
E0239	HYDROCOLLATOR UNIT, PORTABLE		NON-COVERED	
E0240	BATH/SHOWER CHAIR, WITH OR WITHOUT WHEELS, ANY SIZE	E1399		PRIOR AUTHORIZATION COST INVOICE REQUIRED
E0241	BATH TUB WALL RAIL, EACH		1 PER 2 ROLLING YEARS	
E0242	BATH TUB RAIL, FLOOR BASE		NON-COVERED	
E0243	TOILET RAIL, EACH		2 PER 2 ROLLING YEARS	
E0244	RAISED TOILET SEAT		1 PER 2 ROLLING YEARS	
E0245	TUB STOOL OR BENCH		1 PER 2 ROLLING YEARS	
E0246	TRANSFER TUB RAIL ATTACHMENT		NON-COVERED	
E0247	TRANSFER BENCH FOR TUB OR TOILET WITH OR WITHOUT COMMODE OPENING	E1399		PRIOR AUTHORIZATION COST INVOICE REQUIRED
E0248	TRANSFER BENCH, HEAVY DUTY, FOR TUB OR TOILET WITH OR WITHOUT COMMODE OPENING	E1399		PRIOR AUTHORIZATION COST INVOICE REQUIRED
E0249	PAD FOR WATER CIRCULATING HEAT UNIT		NON-COVERED	

HCPCS CODES	DESCRIPTION	REPLACES	SERVICE LIMIT	SPECIAL INSTRUCTIONS
E0250	HOSPITAL BED, FIXED HEIGHT, WITH ANY TYPE SIDE RAILS, WITH MATTRESS		1 UNIT PER LIFETIME	PRIOR AUTHORIZATION ITEM IS 10 MONTH CAP RENTAL NON-REIMBURSABLE WITH: E0255, E0260, E0271, E0272, E0277 E0303, E0304, E0305, OR E0310 MEDICAL NECESSITY REVIEW WILL BE BASED ON INTERQUAL DME GENERAL CRITERIA
E0251	HOSPITAL BED, FIXED HEIGHT, WITH ANY TYPE SIDE RAILS, WITHOUT MATTRESS		NON-COVERED	
E0255	HOSPITAL BED, VARIABLE HEIGHT, HI-LO, WITH ANY TYPE SIDE RAILS, WITH MATTRESS		1 UNIT PER LIFETIME	PRIOR AUTHORIZATION ITEM IS 10 MONTH CAP RENTAL NON-REIMBURSABLE WITH: E0250, E0260, E0271, E0272, E0277 E0303, E0304, E0305, OR E0310 MEDICAL NECESSITY REVIEW WILL BE BASED ON INTERQUAL DME GENERAL CRITERIA
E0256	HOSPITAL BED, VARIABLE HEIGHT, HI-LO, WITH ANY TYPE SIDE RAILS, WITHOUT MATTRESS		NON-COVERED	
E0260	HOSPITAL BED, SEMI-ELECTRIC (HEAD AND FOOT ADJUSTMENT), WITH ANY TYPE SIDE RAILS, WITH MATTRESS		1 UNIT PER LIFETIME	PRIOR AUTHORIZATION ITEM IS 10 MONTH CAP RENTAL NON-REIMBURSABLE WITH: E0250, E0255, E0271, E0272, E0277 E0303, E0304, E0305, OR E0310 MEDICAL NECESSITY REVIEW WILL BE BASED ON INTERQUAL DME GENERAL CRITERIA
E0261	HOSPITAL BED, SEMI-ELECTRIC (HEAD AND FOOT ADJUSTMENT), WITH ANY TYPE SIDE RAILS, WITHOUT MATTRESS		NON-COVERED	
E0265	HOSPITAL BED, TOTAL ELECTRIC (HEAD, FOOT AND HEIGHT ADJUSTMENTS), WITH ANY TYPE SIDE RAILS, WITH MATTRESS		NON-COVERED	
E0266	HOSPITAL BED, TOTAL ELECTRIC (HEAD, FOOT AND HEIGHT ADJUSTMENTS), WITH ANY TYPE SIDE RAILS, WITHOUT MATTRESS		NON-COVERED	
E0270	HOSPITAL BED, INSTITUTIONAL TYPE INCLUDES: OSCILLATING, CIRCULATING AND STRYKER FRAME, WITH MATTRESS		NON-COVERED	
E0271	MATTRESS, INNERSPRING			PRIOR AUTHORIZATION PURCHASED ITEM NON-REIMBURSABLE WITH E0250, E0255, E0260, E0277, E0300, E0303, OR E0304
E0272	MATTRESS, FOAM RUBBER			PRIOR AUTHORIZATION PURCHASED ITEM NON-REIMBURSABLE WITH E0250, E0255, E0260, E0300, E0303, OR E0304
E0273	BED BOARD		NON-COVERED	

HCPCS CODES	DESCRIPTION	REPLACES	SERVICE LIMIT	SPECIAL INSTRUCTIONS
E0274	OVER-BED TABLE		NON-COVERED	
E0275	BED PAN, STANDARD, METAL OR PLASTIC		1 PER 2 ROLLING YEARS	PURCHASED ITEM
E0276	BED PAN, FRACTURE, METAL OR PLASTIC		1 PER 2 ROLLING YEARS	PURCHASED ITEM
E0277	POWERED PRESSURE-REDUCING AIR MATTRESS		1UNIT PER LIFETIME	PRIOR AUTHORIZATION ITEM IS 10 MONTH CAP RENTAL MEDICAL NECESSITY REVIEW WILL BE BASED ON INTERQUAL DME GENERAL CRITERIA
E0280	BED CRADLE, ANY TYPE		NON-COVERED	
E0290	HOSPITAL BED, FIXED HEIGHT, WITHOUT SIDE RAILS, WITH MATTRESS		NON-COVERED	
E0291	HOSPITAL BED, FIXED HEIGHT, WITHOUT SIDE RAILS, WITHOUT MATTRESS		NON-COVERED	
E0292	HOSPITAL BED, VARIABLE HEIGHT, HI-LO, WITHOUT SIDE RAILS, WITH MATTRESS		NON-COVERED	
E0293	HOSPITAL BED, VARIABLE HEIGHT, HI-LO, WITHOUT SIDE RAILS, WITHOUT MATTRESS		NON-COVERED	
E0294	HOSPITAL BED, SEMI-ELECTRIC (HEAD AND FOOT ADJUSTMENT), WITHOUT SIDE RAILS, WITH MATTRESS		NON-COVERED	
E0295	HOSPITAL BED, SEMI-ELECTRIC (HEAD AND FOOT ADJUSTMENT), WITHOUT SIDE RAILS, WITHOUT MATTRESS		NON-COVERED	
E0296	HOSPITAL BED, TOTAL ELECTRIC (HEAD, FOOT AND HEIGHT ADJUSTMENTS). WITHOUT SIDE RAILS, WITH MATTRESS		NON-COVERED	
E0297	HOSPITAL BED, TOTAL ELECTRIC (HEAD, FOOT AND HEIGHT ADJUSTMENTS), WITHOUT SIDE RAILS, WITHOUT MATTRESS		NON-COVERED	
E0300	PEDIATRIC CRIB, HOSPITAL GRADE, FULLY ENCLOSED	E1399	1 UNIT PER LIFETIME	PRIOR AUTHORIZATION ITEM IS 10 MONTH CAP RENTAL COVERED FOR MEMBERS FROM BIRTH TO AGE 21 YEARS NON-REIMBURSABLE WITH: E0250, E0255, E0260
E0301	HOSPITAL BED, HEAVY DUTY, EXTRA WIDE, WITH WEIGHT CAPACITY GREATER THAN 350 POUNDS, BUT LESS THAN OR EQUAL TO 600 POUNDS, WITH ANY TYPE SIDE RAILS, WITHOUT MATTRESS		NON-COVERED	

***PRIOR AUTHORIZATION MUST BE OBTAINED IF SERVICE LIMITS ARE EXCEEDED**

HCPCS CODES	DESCRIPTION	REPLACES	SERVICE LIMIT	SPECIAL INSTRUCTIONS
E0302	HOSPITAL BED, EXTRA HEAVY DUTY, EXTRA WIDE, WITH WEIGHT CAPACITY GREATER THAN 600 POUNDS, WITH ANY TYPE SIDE RAILS, WITHOUT MATTRESS		NON-COVERED	
E0303	HOSPITAL BED, HEAVY DUTY, EXTRA WIDE, WITH WEIGHT CAPACITY GREATER THAN 350 POUNDS, BUT LESS THAN OR EQUAL TO 600 POUNDS, WITH ANY TYPE SIDE RAILS, WITH MATTRESS	K0549	1 UNIT PER LIFETIME	PRIOR AUTHORIZATION ITEM IS 10 MONTH CAP RENTAL NON-REIMBURSABLE WITH: E0271, E0272, E0277, E0305 or E0310 MEDICAL NECESSITY REVIEW WILL BE BASED ON INTERQUAL DME GENERAL CRITERIA
E0304	HOSPITAL BED, EXTRA HEAVY DUTY, EXTRA WIDE, WITH WEIGHT CAPACITY GREATER THAN 600 POUNDS, WITH ANY TYPE SIDE RAILS, WITH MATTRESS	K0550	1 UNIT PER LIFETIME	PRIOR AUTHRIZATION ITEM IS 10 MONTH CAP RENTAL NON-REIMBURSABLE WITH: E0250, E0255, E0260, E0271, E0272, E0303, E0304, E0305 OR E0310 MEDICAL NECESSITY REVIEW WILL BE BASED ON INTERQUAL DME GENERAL CRITERIA
E0305	BED SIDE RAILS, HALF LENGTH		2 PER LIFETIME	NON-REIMBURSABLE WITH E0250, E0255, E0260, E0277, E0300, E0303, or E0304
E0310	BED SIDE RAILS, FULL LENGTH		2 PER LIFETIME	NON-REIMBURSABLE WITH E0250, E0255, E0260, E0277, E0300, E0303, or E0304
E0315	BED ACCESSORY: BOARD, TABLE, OR SUPPORT DEVICE, ANY TYPE		NON-COVERED	
E0316	SAFETY ENCLOSURE FRAME/CANOPY FOR USE WITH HOSPITAL BED, ANY TYPE		NON-COVERED	
E0325	URINAL; MALE, JUG-TYPE, ANY MATERIAL		2 PER 6 ROLLING MONTHS	FOR MALES ONLY
E0326	URINAL; FEMALE, JUG-TYPE, ANY MATERIAL		2 PER 6 ROLLING MONTHS	FOR FEMALES ONLY
E0328	HOSPITAL BED, PEDIATRIC, MANUAL, 360 DEGREE SIDE ENCLOSURES, TOP OF HEADBOARD, FOOTBOARD, AND SIDE RAILS UP TO 24 IN. ABOVE THE SPRING, INCLUDES MATTRESS		NON-COVERED	NEW CODE 01/01/2008
E0329	HOSPITAL BED, PEDIATRIC, ELECTRIC OR SEMI-ELECTRIC, 360 DEGREE SIDE ENCLOSURES, TOP OF HEADBOARD, FOOTBOARD, AND SIDE REAILS UP TO 24 IN. ABOVE THE SRPING, INCLUDES MATTRESS		NON-COVERED	NEW CODE 01/01/2008
E0350	CONTROL UNIT FOR ELECTRONIC BOWEL IRRIGATION/EVACUATION SYSTEM		NON-COVERED	
E0352	DISPOSABLE PACK (WATER RESERVOIR BAG, SPECULUM, VALVING MECHANISM AND COLLECTION BAG/BOX) FOR USE WITH THE ELECTRONIC BOWEL IRRIGATION/EVACUATION SYSTEM		NON-COVERED	

HCPCS CODES	DESCRIPTION	REPLACES	SERVICE LIMIT	SPECIAL INSTRUCTIONS
E0370	AIR PRESSURE ELEVATOR FOR HEEL		NON-COVERED	
E0371	NONPOWERED ADVANCED PRESSURE REDUCING OVERLAY FOR MATTRESS, STANDARD MATTRESS LENGTH AND WIDTH		1 UNIT PER LIFETIME	PRIOR AUTHORIZATION ITEM IS 10 MONTH CAP RENTAL NON-REIMBURSABLE WITH: E0250, E0255, E0260, E0303, OR E0304 MEDICAL NECESSITY REVIEW WILL BE BASED ON INTERQUAL DME GENERAL CRITERIA
E0372	POWERED AIR OVERLAY FOR MATTRESS, STANDARD MATTRESS LENGTH AND WIDTH		NON-COVERED	
E0373	NONPOWERED ADVANCED PRESSURE REDUCING MATTRESS		NON-COVERED	
E0424	STATIONARY COMPRESSED GASEOUS OXYGEN SYSTEM, RENTAL; INCLUDES CONTAINER, CONTENTS, REGULATOR, FLOWMETER, HUMIDIFIER, NEBULIZER, CANNULA OR MASK, AND TUBING		1 UNIT PER ROLLING MONTH	PRIOR AUTHORIZATION MUST HAVE WEST VIRGINIA CERTIFIED RESPIRATORY THERAPIST OR PROFESSIONAL REGISTERED NURSE OR PHYSICIAN ON STAFF MEDICAL NECESSITY REVIEW WILL BE BASED ON INTERQUAL DME GENERAL CRITERIA
E0425	STATIONARY COMPRESSED GAS SYSTEM, PURCHASE; INCLUDES REGULATOR, FLOWMETER, HUMIDIFIER, NEBULIZER, CANNULA OR MASK, AND TUBING		NON-COVERED	
E0430	PORTABLE GASEOUS OXYGEN SYSTEM, PURCHASE; INCLUDES REGULATOR, FLOWMETER, HUMIDIFIER, CANNULA OR MASK, AND TUBING		NON-COVERED	
E0431	PORTABLE GASEOUS OXYGEN SYSTEM, RENTAL; INCLUDES PORTABLE CONTAINER, REGULATOR, FLOWMETER, HUMIDIFIER, CANNULA OR MASK, AND TUBING		1 UNIT PER ROLLING MONTH	PRIOR AUTHORIZATION MUST HAVE WEST VIRGINIA CERTIFIED RESPIRATORY THERAPIST OR PROFESSIONAL REGISTERED NURSE OR PHYSICIAN ON STAFF MEDICAL NECESSITY REVIEW WILL BE BASED ON INTERQUAL DME GENERAL CRITERIA
E0434	PORTABLE LIQUID OXYGEN SYSTEM, RENTAL; INCLUDES PORTABLE CONTAINER, SUPPLY RESERVOIR, HUMIDIFIER, FLOWMETER, REFILL ADAPTOR, CONTENTS GAUGE, CANNULA OR MASK, AND TUBING		1 UNIT PER ROLLING MONTH	PRIOR AUTHORIZATION MUST HAVE WEST VIRGINIA CERTIFIED RESPIRATORY THERAPIST OR PROFESSIONAL REGISTERED NURSE OR PHYSICIAN ON STAFF MEDICAL NECESSITY REVIEW WILL BE BASED ON INTERQUAL DME GENERAL CRITERIA
E0435	PORTABLE LIQUID OXYGEN SYSTEM, PURCHASE; INCLUDES PORTABLE CONTAINER, SUPPLY RESERVOIR, FLOWMETER, HUMIDIFIER, CONTENTS GAUGE, CANNULA OR MASK, TUBING AND REFILL ADAPTOR		NON-COVERED	

HCPCS CODES	DESCRIPTION	REPLACES	SERVICE LIMIT	SPECIAL INSTRUCTIONS
E0439	STATIONARY LIQUID OXYGEN SYSTEM, RENTAL; INCLUDES CONTAINER, CONTENTS, REGULATOR, FLOWMETER, HUMIDIFIER, NEBULIZER, CANNULA OR MASK, & TUBING		1 UNIT PER ROLLING MONTH	PRIOR AUTHORIZATION MUST HAVE WEST VIRGINIA CERTIFIED RESPIRATORY THERAPIST OR PROFESSIONAL REGISTERED NURSE OR PHYSICIAN ON STAFF MEDICAL NECESSITY REVIEW WILL BE BASED ON INTERQUAL DME GENERAL CRITERIA
E0440	STATIONARY LIQUID OXYGEN SYSTEM, PURCHASE; INCLUDES USE OF RESERVOIR, CONTENTS INDICATOR, REGULATOR, FLOWMETER, HUMIDIFIER, NEBULIZER, CANNULA OR MASK, AND TUBING		NON-COVERED	
E0441	OXYGEN CONTENTS, GASEOUS (FOR USE WITH OWNED GASEOUS STATIONARY SYSTEMS OR WHEN BOTH A STATIONARY AND PORTABLE GASEOUS SYSTEM ARE OWNED), 1 MONTH'S SUPPLY = 1 UNIT		1 UNIT PER ROLLING MONTH	PRIOR AUTHORIZATION MUST HAVE WEST VIRGINIA CERTIFIED RESPIRATORY THERAPIST OR PROFESSIONAL REGISTERED NURSE OR PHYSICIAN ON STAFF MEDICAL NECESSITY REVIEW WILL BE BASED ON INTERQUAL DME GENERAL CRITERIA
E0442	OXYGEN CONTENTS, LIQUID (FOR USE WITH OWNED LIQUID STATIONARY SYSTEMS OR WHEN BOTH A STATIONARY AND PORTABLE LIQUID SYSTEM ARE OWNED), 1 MONTH'S SUPPLY = 1 UNIT		NON-COVERED	
E0443	PORTABLE OXYGEN CONTENTS, GASEOUS (FOR USE ONLY WITH PORTABLE GASEOUS SYSTEMS WHEN NO STATIONARY GAS OR LIQUID SYSTEM IS USED), 1 MONTH'S SUPPLY = 1 UNIT		1 UNIT PER ROLLING MONTH	PRIOR AUTHORIZATION MUST HAVE WEST VIRGINIA CERTIFIED RESPIRATORY THERAPIST OR PROFESSIONAL REGISTERED NURSE OR PHYSICIAN ON STAFF MEDICAL NECESSITY REVIEW WILL BE BASED ON INTERQUAL DME GENERAL CRITERIA
E0444	PORTABLE OXYGEN CONTENTS, LIQUID (FOR USE ONLY WITH PORTABLE LIQUID SYSTEMS WHEN NO STATIONARY GAS OR LIQUID SYSTEM IS USED), 1 MONTH'S SUPPLY = 1 UNIT		NON-COVERED	
E0445	OXIMETER DEVICE FOR MEASURING BLOOD OXYGEN LEVELS NON-INVASIVELY		1 UNIT PER LIFETIME	PRIOR AUTHORIZATION ITEM IS 10 MONTH CAP RENTAL NON-REIMBURSABLE WITH A4606 DURING THE CAP RENTAL PERIOD (10 MONTHS) MUST HAVE WEST VIRGINIA CERTIFIED RESPIRATORY THERAPIST OR PROFESSIONAL REGISTERED NURSE OR PHYSICIAN ON STAFF
E0450	VOLUME CONTROL VENTILATOR, WITHOUT PRESSURE SUPPORT MODE, MAY INCLUDE PRESSURE CONTROL MODE, USED WITH INVASIVE INTERFACE (E.G., TRACHEOSTOMY TUBE)		1 UNIT PER ROLLING MONTH	PRIOR AUTHORIZATION ITEM IS MONTHLY RENTAL MUST HAVE WEST VIRGINIA CERTIFIED RESPIRATORY THERAPIST OR PROFESSIONAL REGISTERED NURSE OR PHYSICIAN ON STAFF
E0455	OXYGEN TENT, EXCLUDING CROUP OR PEDIATRIC TENTS		NON-COVERED	

HCPCS CODES	DESCRIPTION	REPLACES	SERVICE LIMIT	SPECIAL INSTRUCTIONS
E0457	CHEST SHELL (CUIRASS)		NON-COVERED	
E0459	CHEST WRAP		NON-COVERED	
E0460RR	NEGATIVE PRESSURE VENTILATOR; PORTABLE OR STATIONARY		1 UNIT PER ROLLING MONTH	PRIOR AUTHORIZATION ITEM IS MONTHLY RENTAL MUST HAVE WEST VIRGINIA CERTIFIED RESPIRATORY THERAPIST OR PROFESSIONAL REGISTERED NURSE OR PHYSICIAN ON STAFF
E0461	VOLUME CONTROL VENTILATOR, WITHOUT PRESSURE SUPPORT MODE, MAY INCLUDE PRESSURE CONTROL MODE, USED WITH NON-INVASIVE INTERFACE (E.G. MASK)		NON-COVERED	
E0462	ROCKING BED WITH OR WITHOUT SIDE RAILS		NON-COVERED	
E0463RR	PRESSURE SUPPORT VENTILATOR WITH VOLUME CONTROL MODE, MAY INCLUDE PRESSURE CONTROL MODE, USED WITH INVASIVE INTERFACE (E.G. TRACHEOSTOMY TUBE)	E0454	1 UNIT PER ROLLING MONTH	PRIOR AUTHORIZATION ITEM IS MONTHLY RENTAL MUST HAVE WEST VIRGINIA CERTIFIED RESPIRATORY THERAPIST OR PROFESSIONAL REGISTERED NURSE OR PHYSICIAN ON STAFF
E0464RR	PRESSURE SUPPORT VENTILATOR WITH VOLUME CONTROL MODE, MAY INCLUDE PRESSURE CONTROL MODE, USED WITH NON-INVASIVE INTERFACE (E.G. MASK)	E0454	1 UNIT PER ROLLING MONTH	PRIOR AUTHORIZATION ITEM IS MONTHLY RENTAL MUST HAVE WEST VIRGINIA CERTIFIED RESPIRATORY THERAPIST OR PROFESSIONAL REGISTERED NURSE OR PHYSICIAN ON STAFF
E0470RR	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)	K0532	10 UNITS PER LIFETIME	PRIOR AUTHORIZATION MUST HAVE WEST VIRGINIA CERTIFIED RESPIRATORY THERAPIST OR PROFESSIONAL REGISTERED NURSE OR PHYSICIAN ON STAFF MEDICAL NECESSITY REVIEW WILL BE BASED ON INTERQUAL DME GENERAL CRITERIA
E0471RR	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)	K0533	1 UNIT PER ROLLING MONTH	PRIOR AUTHORIZATION MUST HAVE WEST VIRGINIA CERTIFIED RESPIRATORY THERAPIST OR PROFESSIONAL REGISTERED NURSE OR PHYSICIAN ON STAFF MEDICAL NECESSITY REVIEW WILL BE BASED ON INTERQUAL DME GENERAL CRITERIA

HCPCS CODES	DESCRIPTION	REPLACES	SERVICE LIMIT	SPECIAL INSTRUCTIONS
E0472RR	RESPIRATORY ASSIST DEVICE, BI-LEVEL PRESSURE CAPABILITY, WITH BACKUP RATE FEATURE, USED WITH INVASIVE INTERFACE, E.G., TRACHEOSTOMY TUBE (INTERMITTENT ASSIST DEVICE WITH CONTINUOUS POSITIVE AIRWAY PRESSURE DEVICE)	K0534	1 UNIT PER ROLLING MONTH	PRIOR AUTHORIZATION MUST HAVE WEST VIRGINIA CERTIFIED RESPIRATORY THERAPIST OR PROFESSIONAL REGISTERED NURSE OR PHYSICIAN ON STAFF MEDICAL NECESSITY REVIEW WILL BE BASED ON INTERQUAL DME GENERAL CRITERIA
E0480	PERCUSSOR, ELECTRIC OR PNEUMATIC, HOME MODEL		1 UNIT PER 5 ROLLING YEARS	PRIOR AUTHORIZATION 10 MONTH CAP RENTAL ITEM MEDICAL NECESSITY REVIEW WILL BE BASED ON INTERQUAL DME GENERAL CRITERIA
E0481	INTRAPULMONARY PERCUSSIVE VENTILATION SYSTEM AND RELATED ACCESSORIES		NON-COVERED	
E0482	COUGH STIMULATING DEVICE, ALTERNATING POSITIVE AND NEGATIVE AIRWAY PRESSURE		1 PER LIFETIME	PRIOR AUTHORIZATION 10 MONTH CAP RENTAL ITEM MEDICAL NECESSITY REVIEW WILL BE BASED ON INTERQUAL DME GENERAL CRITERIA EFFECTIVE 12/01/2007
E0483	HIGH FREQUENCY CHEST WALL OSCILLATION AIR-PULSE GENERATOR SYSTEM, (INCLUDES HOSES AND VEST), EACH		1 PER LIFETIME	PRIOR AUTHORIZATION 10 MONTH CAP RENTAL ITEM MEDICAL NECESSITY REVIEW WILL BE BASED ON INTERQUAL DME GENERAL CRITERIA
E0484	OSCILLATORY POSITIVE EXPIRATORY PRESSURE DEVICE, NON-ELECTRIC, ANY TYPE, EACH		1 PER ROLLING YEAR	PRIOR AUTHORIZATION MEDICAL NECESSITY REVIEW WILL BE BASED ON INTERQUAL DME GENERAL CRITERIA
E0485	ORAL DEVICE/APPLIANCE USED TO REDUCE UPPER AIRWAY COLLAPSIBILITY, ADJUSTABLE OR NON-ADJUSTABLE, PREFABRICATED, INCLUDES FITTING AND ADJUSTMENT		NON-COVERED	
E0486	ORAL DEVICE/APPLIANCE USED TO REDUCE UPPER AIRWAY COLLAPSIBILITY, ADJUSTABLE OR ON-ADJUSTABLE, CUSTOM FABRICATED, INCLUDES FITTING AND ADJUSTMENT		NON-COVERED	
E0500	IPPB MACHINE, ALL TYPES, WITH BUILT-IN NEBULIZATION; MANUAL OR AUTOMATIC VALVES; INTERNAL OR EXTERNAL POWER SOURCE		NON-COVERED	
E0550	HUMIDIFIER, DURABLE FOR EXTENSIVE SUPPLEMENTAL HUMIDIFICATION DURING IPPB TREATMENTS OR OXYGEN DELIVERY		NON-COVERED	
E0555	HUMIDIFIER, DURABLE, GLASS OR AUTOCLAVABLE PLASTIC BOTTLE TYPE, FOR USE WITH REGULATOR OR FLOWMETER		NON-COVERED	
E0560	HUMIDIFIER, DURABLE FOR SUPPLEMENTAL HUMIDIFICATION DURING IPPB TREATMENT OR OXYGEN DELIVERY		NON-COVERED	

HCPCS CODES	DESCRIPTION	REPLACES	SERVICE LIMIT	SPECIAL INSTRUCTIONS
E0561	HUMIDIFIER, NON-HEATED, USED WITH POSITIVE AIRWAY PRESSURE DEVICE	K0268		PRIOR AUTHORIZATION PURCHASED ITEM NON-REIMBURSABLE WITH: A7046, E0471 OR E0472 MUST HAVE WEST VIRGINIA CERTIFIED RESPIRATORY THERAPIST OR REGISTERED PROFESSIONAL NURSE OR PHYSICIAN ON STAFF
E0562	HUMIDIFIER, HEATED, USED WITH POSITIVE AIRWAY PRESSURE DEVICE	K0531		PRIOR AUTHORIZATION PURCHASED ITEM NON-REIMBURSABLE WITH: A7046, E0471 OR E0472 MUST HAVE WEST VIRGINIA CERTIFIED RESPIRATORY THERAPIST OR REGISTERED PROFESSIONAL NURSE OR PHYSICIAN ON STAFF
E0565	COMPRESSOR, AIR POWER SOURCE FOR EQUIPMENT WHICH IS NOT SELF- CONTAINED OR CYLINDER DRIVEN		1 UNIT PER 3 ROLLING YEARS	PRIOR AUTHORIZATION ITEM 10 MONTH CAP RENTAL MUST HAVE WEST VIRGINIA CERTIFIED RESPIRATORY THERAPIST OR REGISTERED PROFESSIONAL NURSE OR PHYSICIAN ON STAFF MEDICAL NECESSITY REVIEW WILL BE BASED ON INTERQUAL DME GENERAL CRITERIA
E0570	NEBULIZER, WITH COMPRESSOR		1 PER 3 ROLLING YEARS	PRIOR AUTHORIZATION PURCHASE ITEM MEDICAL NECESSITY REVIEW WILL BE BASED ON INTERQUAL DME GENERAL CRITERIA
E0571	AEROSOL COMPRESSOR, BATTERY POWERED, FOR USE WITH SMALL VOLUME NEBULIZER		NON-COVERED	
E0572	AEROSOL COMPRESSOR, ADJUSTABLE PRESSURE, LIGHT DUTY FOR INTERMITTENT USE		NON-COVERED	
E0574	ULTRASONIC/ELECTRONIC AEROSOL GENERATOR WITH SMALL VOLUME NEBULIZER		NON-COVERED	
E0575	NEBULIZER, ULTRASONIC, LARGE VOLUME		NON-COVERED	
E0580	NEBULIZER, DURABLE, GLASS OR AUTOCLAVABLE PLASTIC, BOTTLE TYPE, FOR USE WITH REGULATOR OR FLOWMETER		NON-COVERED	
E0585	NEBULIZER, WITH COMPRESSOR AND HEATER		NON-COVERED	
E0590	DISPENSING FEE COVERED DRUG ADMINISTERED THROUGH DME NEBULIZER		NON-COVERED	
E0600	RESPIRATORY SUCTION PUMP, HOME MODEL, PORTABLE OR STATIONARY, ELECTRIC		1 PER 4 ROLLING YEARS	PURCHASED ITEM NON-REIMBURSABLE WITH A7002

HCPCS CODES	DESCRIPTION	REPLACES	SERVICE LIMIT	SPECIAL INSTRUCTIONS
E0601	CONTINUOUS AIRWAY PRESSURE (CPAP) DEVICE		10 UNITS PER LIFETIME	PRIOR AUTHORIZATION ITEM IS 10 MONTH CAP RENTAL MUST HAVE WEST VIRGINIA CERTIFIED RESPIRATORY THERAPIST OR PROFESSIONAL REGISTERED NURSE OR PHYSICIAN ON STAFF MEDICAL NECESSITY REVIEW WILL BE BASED ON INTERQUAL DME GENERAL CRITERIA
E0602	BREAST PUMP, MANUAL, ANY TYPE		1 UNIT PER 5 ROLLING YEARS	PURCHASED ITEM
E0603	BREAST PUMP, ELECTRIC (AC AND/OR DC), ANY TYPE		1 UNIT PER ROLLING YEAR	PURCHASE ITEM INCLUDES ALL REQUIRED ACCESSORIES
E0604	BREAST PUMP, HOSPITAL GRADE, ELECTRIC (AC AND / OR DC)		NON-COVERED	
E0605	VAPORIZER, ROOM TYPE		1 PER 2 ROLLING YEARS	PURCHASED ITEM
E0606	POSTURAL DRAINAGE BOARD		1 PER LIFETIME	PURCHASE ITEM
E0607	HOME BLOOD GLUCOSE MONITOR		1 PER 3 ROLLING YEARS	REQUIRES DIAGNOSIS OF 250.00 THRU 250.93 OR 648.8X
E0610	PACEMAKER MONITOR, SELF-CONTAINED, (CHECKS BATTERY DEPLETION, INCLUDES AUDIBLE AND VISIBLE CHECK SYSTEMS)		NON-COVERED	
E0615	PACEMAKER MONITOR, SELF CONTAINED, CHECKS BATTERY DEPLETION AND OTHER PACEMAKER COMPONENTS, INCLUDES DIGITAL/VISIBLE CHECK SYSTEMS		NON-COVERED	
E0616	IMPLANTABLE CARDIAC EVENT RECORDER WITH MEMORY, ACTIVATOR AND PROGRAMMER		NON-COVERED	
E0617	EXTERNAL DEFIBRILLATOR WITH INTEGRATED ELECTROCARDIOGRAM ANALYSIS		NON-COVERED	
E0618	APNEA MONITOR, WITHOUT RECORDING FEATURE	E0608	NON-COVERED	
E0619	APNEA MONITOR, WITH RECORDING FEATURE	E0608	1 PER LIFETIME	PRIOR AUTHORIZATION (REQUEST FOR PA MUST BE SUBMITTED TO WVMI 7 CALENDAR DAYS POST HOSPITAL DISCHARGE) ITEM IS 10 MONTH CAP RENTAL AVAILABLE FOR MEMBERS 1 YEAR OF AGE OR YOUNGER. INCLUDES PNEUMOGRAM

HCPCS CODES	DESCRIPTION	REPLACES	SERVICE LIMIT	SPECIAL INSTRUCTIONS
E0620	SKIN PIERCING DEVICE FOR COLLECTION OF CAPILLARY BLOOD, LASER, EACH		NON-COVERED	
E0621	SLING OR SEAT, PATIENT LIFT, CANVAS OR NYLON		1 PER 2 ROLLING YEARS	NON-REIMBURSABLE WITH: E0630
E0625	PATIENT LIFT, BATHROOM OR TOILET, NOT OTHERWISE CLASSIFIED		NON-COVERED	
E0627	SEAT LIFT MECHANISM INCORPORATED INTO A COMBINATION LIFT-CHAIR MECHANISM		NON-COVERED	
E0628	SEPARATE SEAT LIFT MECHANISM FOR USE WITH PATIENT OWNED FURNITURE-ELECTRIC		NON-COVERED	
E0629	SEPARATE SEAT LIFT MECHANISM FOR USE WITH PATIENT OWNED FURNITURE-NON-ELECTRIC		NON-COVERED	
E0630	PATIENT LIFT, HYDRAULIC **OR MECHANICAL, INCLUDES ANY SEAT, SLING, STRAPS(S), OR PADS**		1 UNIT PER LIFETIME	PRIOR AUTHORIZATION ITEM IS 10 MONTH CAP RENTAL NON-REIMBURSABLE WITH: E0621 WEST VIRGINIA MEDICAID FOLLOWS PALMETTO, REGION C, MEDICAL CRITERIA FOR COVERAGE.
E0635	PATIENT LIFT, ELECTRIC WITH SEAT OR SLING		NON-COVERED	
E0636	MULTIPOSITIONAL PATIENT SUPPORT SYSTEM, WITH INTEGRATED LIFT, PATIENTACCESSIBLE CONTROLS		NON-COVERED	
E0637	COMBINATION SIT TO STAND SYSTEM, ANY SIZE INCLUDING PEDIATRIC, WITH SEATLIFT FEATURE, WITH OR WITHOUT WHEELS		NON-COVERED	
E0638	STANDING FRAME SYSTEM, ONE POSITION (E.G. UPRIGHT, SUPINE OR PRONE STANDER), ANY SIZE INCLUDING PEDIATRIC, WITH OR WITHOUT WHEELS		NON-COVERED	
E0639	PATIENT LIFT, MOVEABLE FROM ROOM TO ROOM WITH DISASSEMBLY AND REASSEMBLY, INCLUDES ALL COMPONENTS/ACCESSORIES		NON-COVERED	
E0640	PATIENT LIFT, FIXED SYSTEM, INCLUDES ALL COMPONENTS/ACCESSORIES		NON-COVERED	
E0641	STANDING FRAME SYSTEM, MULTI-POSITION (E.G. THREE-WAY STANDER), ANY SIZE INCLUDING PEDIATRIC, WITH OR WITHOUT WHEELS		NON-COVERED	
E0642	STANDING FRAME SYSTEM, MOBILE (DYNAMIC STANDER), ANY SIZE INCLUDING PEDIATRIC		NON-COVERED	
E0650	PNEUMATIC COMPRESSOR, NON-SEGMENTAL HOME MODEL		1 PER LIFETIME	PRIOR AUTHORIZATION 10 MONTH CAP RENTAL ITEM MEDICAL NECESSITY REVIEW WILL BE BASED ON INTERQUAL DME GENERAL CRITERIA

HCPCS CODES	DESCRIPTION	REPLACES	SERVICE LIMIT	SPECIAL INSTRUCTIONS
E0651	PNEUMATIC COMPRESSOR, SEGMENTAL HOME MODEL WITHOUT CALIBRATED GRADIENT PRESSURE		1 PER LIFETIME	PRIOR AUTHORIZATION 10 MONTH CAP RENTAL ITEM MEDICAL NECESSITY REVIEW WILL BE BASED ON INTERQUAL DME GENERAL CRITERIA
E0652	PNEUMATIC COMPRESSOR, SEGMENTAL HOME MODEL WITH CALIBRATED GRADIENT PRESSURE		1 PER LIFETIME	PRIOR AUTHORIZATION 10 MONTH CAP RENTAL ITEM MEDICAL NECESSITY REVIEW WILL BE BASED ON INTERQUAL DME GENERAL CRITERIA
E0655	NON-SEGMENTAL PNEUMATIC APPLIANCE FOR USE WITH PNEUMATIC COMPRESSOR, HALF ARM			PRIOR AUTHORIZATION PURCHASE ITEM
E0660	NON-SEGMENTAL PNEUMATIC APPLIANCE FOR USE WITH PNEUMATIC COMPRESSOR, FULL LEG			PRIOR AUTHORIZATION PURCHASE ITEM
E0665	NON-SEGMENTAL PNEUMATIC APPLIANCE FOR USE WITH PNEUMATIC COMPRESSOR, FULL ARM			PRIOR AUTHORIZATION PURCHASE ITEM
E0666	NON-SEGMENTAL PNEUMATIC APPLIANCE FOR USE WITH PNEUMATIC COMPRESSOR, HALF LEG			PRIOR AUTHORIZATION PURCHASE ITEM
E0667	SEGMENTAL PNEUMATIC APPLIANCE FOR USE WITH PNEUMATIC COMPRESSOR, FULL LEG			PRIOR AUTHORIZATION PURCHASE ITEM
E0668	SEGMENTAL PNEUMATIC APPLIANCE FOR USE WITH PNEUMATIC COMPRESSOR, FULL ARM			PRIOR AUTHORIZATION PURCHASE ITEM

HCPCS CODES	DESCRIPTION	REPLACES	SERVICE LIMIT	SPECIAL INSTRUCTIONS
E0669	SEGMENTAL PNEUMATIC APPLIANCE FOR USE WITH PNEUMATIC COMPRESSOR, HALF LEG			PRIOR AUTHORIZATION PURCHASE ITEM
E0671	SEGMENTAL GRADIENT PRESSURE PNEUMATIC APPLIANCE, FULL LEG			PRIOR AUTHORIZATION PURCHASE ITEM
E0672	SEGMENTAL GRADIENT PRESSURE PNEUMATIC APPLIANCE, FULL ARM			PRIOR AUTHORIZATION PURCHASE
E0673	SEGMENTAL GRADIENT PRESSURE PNEUMATIC APPLIANCE, HALF LEG			PRIOR AUTHORIZATION PURCHASE ITEM
E0675	PNEUMATIC COMPRESSION DEVICE, HIGH PRESSURE, RAPID INFLATION/DEFLATION CYCLE, OR ARTERIAL INSUFFICIENCY (UNILATERAL OR BILATERAL SYSTEM)		NON-COVERED	
E0676	INTERMITTENT LIMB COMPRESSION DEVICE (INCLUDES ALL ACCESSORIES), NOT OTHERWISE		NON-COVERED	
E0691	ULTRAVIOLET LIGHT THERAPY SYSTEM PANEL, INCLUDES BULBS/LAMPS, TIMER AND EYE PROTECTION; TREATMENT AREA 2 SQUARE FEET OR LESS		NON-COVERED	
E0692	ULTRAVIOLET LIGHT THERAPY SYSTEM PANEL, INCLUDES BULBS/LAMPS, TIMER AND EYE PROTECTION, 4 FOOT PANEL		NON-COVERED	
E0693	ULTRAVIOLET LIGHT THERAPY SYSTEM PANEL, INCLUDES BULBS/LAMPS, TIMER AND EYE PROTECTION, 6 FOOT PANEL		NON-COVERED	
E0694	ULTRAVIOLET MULTIDIRECTIONAL LIGHT THERAPY SYSTEM IN 6 FOOT CABINET, INCLUDES BULBS/LAMPS, TIMER AND EYE PROTECTION		NON-COVERED	

*PRIOR AUTHORIZATION MUST BE OBTAINED IF SERVICE LIMITS ARE EXCEEDED

HCPCS CODES	DESCRIPTION	REPLACES	SERVICE LIMIT	SPECIAL INSTRUCTIONS
E0700	SAFETY EQUIPMENT (E.G., BELT, HARNESS OR VEST)		NON-COVERED	
E0701	HELMET WITH FACE GUARD AND SOFT INTERFACE MATERIAL, PREFABRICATED		NON-COVERED	
E0705	TRANSFER DEVICE, ANY TYPE, EACH	E0972		PRIOR AUTHORIZATION PURCHASED ITEM
E0710	RESTRAINTS, ANY TYPE (BODY, CHEST, WRIST OR ANKLE)		NON-COVERED	
E0720	TRANSCUTANTEOUS ELECTRICAL NERVE STIMULATION (TENS) DEVICE, TWO LEAD, LOCALIZED STIMULATION		1 PER 4 ROLLING YEARS	PRIOR AUTHORIZATION PURCHASED ITEM NON-REIMBURSABLE WITH: A4556, A4557 OR E0730 MEDICAL NECESSITY REVIEW WILL BE BASED ON INTERQUAL DME GENERAL CRITERIA
E0730	TRANSCUTANEOUS ELECTRICAL NERVE STIMULATION (TENS) DEVICE, FOUR OR MORE LEADS, FOR MULTIPLE NERVE STIMULATION		1 PER 4 ROLLING YEARS	PRIOR AUTHORIZATION PURCHASED ITEM NON-REIMBURSABLE WITH: A4556, A4557 OR E0730 MEDICAL NECESSITY REVIEW WILL BE BASED ON INTERQUAL DME GENERAL CRITERIA
E0731	FORM FITTING CONDUCTIVE GARMENT FOR DELIVERY OF TENS OR NMES (WITH CONDUCTIVE IBERS SEPARATED FROM THE PATIENT'S SKIN BY LAYERS OF FABRIC)		NON-COVERED	
E0740	INCONTINENCE TREATMENT SYSTEM, PELVIC FLOOR STIMULATOR, MONITOR, SENSOR AND/OR TRAINER		NON-COVERED	
E0744	NEUROMUSCULAR STIMULATOR FOR SCOLIOSIS		NON-COVERED	
E0745	NEUROMUSCULAR STIMULATOR, ELECTRONIC SHOCK UNIT		NON-COVERED	
E0746	ELECTROMYOGRAPHY (EMG), BIOFEEDBACK DEVICE		NON-COVERED	
E0747	OSTEOGENESIS STIMULATOR, ELECTRICAL, NON-INVASIVE, OTHER THAN SPINAL APPLICATIONS			PRIOR AUTHORIZATION PURCHASED ITEM MEDICAL NECESSITY REVIEW WILL BE BASED ON INTERQUAL DME GENERAL CRITERIA
E0748	OSTEOGENESIS STIMULATOR, ELECTRICAL, NON-INVASIVE, SPINAL APPLICATIONS			PRIOR AUTHORIZATION PURCHASED ITEM MEDICAL NECESSITY REVIEW WILL BE BASED ON INTERQUAL DME GENERAL CRITERIA
E0749	OSTEOGENESIS STIMULATOR, ELECTRICAL, SURGICALLY IMPLANTED		NON-COVERED	
E0752	IMPLANTABLE NEUROSTIMULATOR ELECTRODE, EACH		NON-COVERED	

HCPCS CODES	DESCRIPTION	REPLACES	SERVICE LIMIT	SPECIAL INSTRUCTIONS
E0754	PATIENT PROGRAMMER (EXTERNAL) FOR USE WITH IMPLANTABLE PROGRAMMABLE NEUROSTIMULATOR PULSE GENERATOR		NON-COVERED	
E0755	ELECTRONIC SALIVARY REFLEX STIMULATOR (INTRA-ORAL/NON-INVASIVE)		NON-COVERED	
E0756	IMPLANTABLE NEUROSTIMULATOR PULSE GENERATOR		NON-COVERED	
E0757	IMPLANTABLE NEUROSTIMULATOR RADIOFREQUENCY RECEIVER		NON-COVERED	
E0758	RADIOFREQUENCY TRANSMITTER (EXTERNAL) FOR USE WITH IMPLANTABLE NEUROSTIMULATOR RADIOFREQUENCY RECEIVER		NON-COVERED	
E0759	RADIOFREQUENCY TRANSMITTER (EXTERNAL) FOR USE WITH IMPLANTABLE SACRAL ROOT NEUROSTIMULATOR RECEIVER FOR BOWEL AND BLADDER MANAGEMENT, REPLACEMENT		NON-COVERED	
E0760	OSTEOGENESIS STIMULATOR, LOW INTENSITY ULTRASOUND, NON-INVASIVE			PRIOR AUTHORIZATION PURCHASED ITEM MEDICAL NECESSITY REVIEW WILL BE BASED ON INTERQUAL DME GENERAL CRITERIA
E0761	NON-THERMAL PULSED HIGH FREQUENCY RADIOWAVES, HIGH PEAK POWER ELECTROMAGNETIC ENERGY TREATMENT DEVICE		NON-COVERED	
E0762	TRANSCUTANEOUS ELECTRICAL JOINT STIMULATION DEVICE SYSTEM, INCLUDES ALL ACCESSORIES		NON-COVERED	
E0764	FUNCTIONAL NEUROMUSCULAR STIMULATOR, TRANSCUTANEOUS STIMULATION OF MUSCLES OF AMBULATION WITH COMPUTER CONTROL, USED FOR WALKING BY SPINAL CORD INJURED, ENTIRE SYSTEM, AFTER COMPLETION OF TRAINING PROGRAM	K0600	NON-COVERED	
E0765	FDA APPROVED NERVE STIMULATOR, WITH REPLACEABLE BATTERIES, FOR TREATMENT OF NAUSEA AND VOMITING		NON-COVERED	
E0769	ELECTRICAL STIMULATION OR ELECTROMAGNETIC WOUND TREATMENT DEVICE, NOT OTHERWISE CLASSIFIED		NON-COVERED	
E0776	IV POLE		NON-COVERED	
E0779	AMBULATORY INFUSION PUMP, MECHANICAL, REUSABLE, FOR INFUSION 8 HOURS OR GREATER		NON-COVERED	

HCPCS CODES	DESCRIPTION	REPLACES	SERVICE LIMIT	SPECIAL INSTRUCTIONS
E0780	AMBULATORY INFUSION PUMP, MECHANICAL, REUSABLE, FOR INFUSION LESS THAN 8 HOURS		NON-COVERED	
E0781	AMBULATORY INFUSION PUMP, SINGLE OR MULTIPLE CHANNELS, ELECTRIC OR BATTERY OPERATED, WITH ADMINISTRATIVE EQUIPMENT, WORN BY PATIENT		1 UNIT PER LIFETIME	10 MONTH CAP RENTAL ITEM
E0782	INFUSION PUMP, IMPLANTABLE, NON-PROGRAMMABLE (INCLUDES ALL COMPONENTS, E.G., PUMP, CATHETER, CONNECTORS, ETC.)		NON-COVERED	
E0783	INFUSION PUMP SYSTEM, IMPLANTABLE, PROGRAMMABLE (INCLUDES ALL COMPONENTS, E.G., PUMP, CATHETER, CONNECTORS, ETC.)		NON-COVERED	
E0784	EXTERNAL AMBULATORY INFUSION PUMP, INSULIN		1 PER 4 ROLLING YEARS	PRIOR AUTHORIZATION ITEM IS 10 MONTH CAP RENTAL. MEDICAL NECESSITY REVIEW WILL BE BASED ON INTERQUAL DME GENERAL CRITERIA
E0785	IMPLANTABLE INTRASPINAL (EPIDURAL/INTRATHECAL) CATHETER USED WITH IMPLANTABLE INFUSION PUMP, REPLACEMENT		NON-COVERED	
E0786	IMPLANTABLE PROGRAMMABLE INFUSION PUMP, REPLACEMENT (EXCLUDES IMPLANTABLE INTRASPINAL CATHETER)		NON-COVERED	
E0791	PARENTERAL INFUSION PUMP, STATIONARY, SINGLE OR MULTI-CHANNEL		NON-COVERED	
E0830	AMBULATORY TRACTION DEVICE, ALL TYPES, EACH		NON-COVERED	
E0840	TRACTION FRAME, ATTACHED TO HEADBOARD, CERVICAL TRACTION		NON-COVERED	
E0849	TRACTION EQUIPMENT, CERVICAL, FREE-STANDING STAND/FRAME, PNEUMATIC, APPLYING TRACTION FORCE TO OTHER THAN MANDIBLE	K0627	NON-COVERED	
E0850	TRACTION STAND, FREE STANDING, CERVICAL TRACTION		NON-COVERED	
E0855	CERVICAL TRACTION EQUIPMENT NOT REQUIRING ADDITIONAL STAND OR FRAME		NON-COVERED	
E0856	CERVICAL TRACTION DEVICE, CERVICAL COLLAR WITH INFLATABLE AIR BLADDER		NON-COVERED	NEW CODE 01/01/2008

HCPCS CODES	DESCRIPTION	REPLACES	SERVICE LIMIT	SPECIAL INSTRUCTIONS
E0860	TRACTION EQUIPMENT, OVERDOOR, CERVICAL		1 PER LIFETIME	ITEM PURCHASED WHEN THE FOLLOWING CRITERIA ARE MET: 1) THE PATIENT HAS A MUSCULOSKETAL OR NEUROLOGIC IMPAIRMENT REQUIRING TRACTION EQUIPMENT; AND 2) THE APPROPRIATE USE OF A HOME CERVICAL TRACTION DEVICE HAS BEEN DEMONSTRATED TO THE PATIENT AND THE PATIENT TOLERATED THE SELECTED DEVICE. ABOVE DOCUMENTATION MUST BE CONTAINED IN MEMBER'S FILE.
E0870	TRACTION FRAME, ATTACHED TO FOOTBOARD, EXTREMITY TRACTION, (E.G. BUCK'S)		NON-COVERED	
E0880	TRACTION STAND, FREE STANDING, EXTREMITY TRACTION, (E.G., BUCK'S)		NON-COVERED	
E0890	TRACTION FRAME, ATTACHED TO FOOTBOARD, PELVIC TRACTION		NON-COVERED	
E0900	TRACTION STAND, FREE STANDING, PELVIC TRACTION, (E.G., BUCK'S)		NON-COVERED	
E0910	TRAPEZE BARS, A/K/A PATIENT HELPER, ATTACHED TO BED, WITH GRAB BAR		1 PER LIFETIME	PRIOR AUTHORIZATION PURCHASED ITEM FOR USE WITH HOSPITAL BED ONLY MEDICAL NECESSITY REVIEW WILL BE BASED ON INTERQUAL DME GENERAL CRITERIA NON-REIMBURSABLE WITH: E0940
E0911	TRAPEZE BAR, HEAVY DUTY, FOR PATIENT WEIGHT CAPACITY GREATER THAN 250 POUNDS, ATTACHED TO BED, WITH GRAB BAR		1 PER LIFETIME	PRIOR AUTHORIZATION PURCHASED ITEM MEDICAL NECESSITY REVIEW WILL BE BASED ON INTERQUAL DME GENERAL CRITERIA NON-REIMBURSABLE WITH E0910, E0912 OR E0940
E0912	TRAPEZE BAR, HEAVY DUTY, FOR PATIENT WEIGHT CAPACITY GREATER THAN 250 POUNDS, FREE STANDING, COMPLETE WITH GRAB BAR		1 PER LIFETIME	PRIOR AUTHORIZATION PURCHASED ITEM MEDICAL NECESSITY REVIEW WILL BE BASED ON INTERQUAL DME GENERAL CRITERIA NON-REIMBURSABLE WITH E0910, E0911 OR E0940
E0920	FRACTURE FRAME, ATTACHED TO BED, INCLUDES WEIGHTS		NON-COVERED	DISCONTINUED BY BMS 04/01/2005
E0930	FRACTURE FRAME, FREE STANDING, INCLUDES WEIGHTS		NON-COVERED	DISCONTINUED BY BMS 04/01/2005
E0935	CONTINUOUS PASSIVE MOTION EXERCISE DEVICE FOR USE ON KNEE ONLY		1 PER DAY NOT TO EXCEED 30 DAYS	PRIOR AUTHORIZATION RENTAL ITEM MEDICAL NECESSITY REVIEW WILL BE BASED ON INTERQUAL DME GENERAL CRITERIA
E0936	CONTINUOUS PASSIVE MOTION EXERCISE DEVICE FOR USE OTHER THAN KNEE		NON-COVERED	

HCPCS CODES	DESCRIPTION	REPLACES	SERVICE LIMIT	SPECIAL INSTRUCTIONS
E0940	TRAPEZE BAR, FREE STANDING, COMPLETE WITH GRAB BAR		1 PER LIFETIME	PURCHASED ITEM NOT FOR USE WITH HOSPITAL BED NON-REIMBURSABLE WITH: E0250, E0255, E0260, E0277, E0300, E0303, E0304 OR E0910 WEST VIRGINIA MEDICAID FOLLOWS PALMETTO, REGION C, MEDICAL CRITERIA FOR COVERAGE.
E0941	GRAVITY ASSISTED TRACTION DEVICE, ANY TYPE		NON-COVERED	
E0942	CERVICAL HEAD HARNESS/HALTER		1 PER ROLLING YEAR	PURCHASED ITEM NON-REIMBURSABLE WITH: E0860
E0950	WHEELCHAIR ACCESSORY, TRAY, EACH	K0107		PRIOR AUTHORIZATION PURCHASED ITEM
E0951	HEEL LOOP/HOLDER, ANY TYPE, WITH OR WITHOUT ANKLE STRAP, EACH	K0035		PRIOR AUTHORIZATION PURCHASED ITEM
E0952	TOE LOOP/HOLDER, ANY TYPE, EACH	K0036		PRIOR AUTHORIZATION PURCHASED ITEM
E0953	PNEUMATIC TIRE, EACH		NON-COVERED	
E0954	SEMI-PNEUMATIC CASTER, EACH		NON-COVERED	
E0955	WHEELCHAIR ACCESSORY, HEADREST, CUSHIONED, ANY TYPE, INCLUDING FIXED MOUNTING HARDWARE, EACH	K0108		PRIOR AUTHORIZATION PURCHASE ITEM
E0956	WHEELCHAIR ACCESSORY, LATERAL TRUNK OR HIP SUPPORT, ANY TYPE, INCLUDING FIXED MOUNTING HARDWARE, EACH	K0108		PRIOR AUTHORIZATION PURCHASED ITEM
E0957	WHEELCHAIR ACCESSORY, MEDIAL THIGH SUPPORT, ANY TYPE, INCLUDING FIXED MOUNTING HARDWARE, EACH	K0108		PRIOR AUTHORIZATION PURCHASED ITEM
E0958	MANUAL WHEELCHAIR ACCESSORY, ONE-ARM DRIVE ATTACHMENT, EACH	K0101		PRIOR AUTHORIZATION PURCHASED ITEM
E0959	MANUAL WHEELCHAIR ACCESSORY, ADAPTER FOR AMPUTEE, EACH	K0100		PRIOR AUTHORIZATION PURCHASED ITEM
E0960	WHEELCHAIR ACCESSORY, SHOULDER HARNESS/STRAPS OR CHEST STRAP, INCLUDING ANY TYPE MOUNTING HARDWARE	K0108		PRIOR AUTHORIZATION PURCHASED ITEM
E0961	MANUAL WHEELCHAIR ACCESSORY, WHEEL LOCK BRAKE EXTENSION (HANDLE), EACH	K0079		PRIOR AUTHORIZATION PURCHASED ITEM
E0966	MANUAL WHEELCHAIR ACCESSORY, HEADREST EXTENSION, EACH	K0025		PRIOR AUTHORIZATION PURCHASED ITEM

HCPCS CODES	DESCRIPTION	REPLACES	SERVICE LIMIT	SPECIAL INSTRUCTIONS
E0967	MANUAL WHEELCHAIR ACCESSORY, HAND RIM WITH PROJECTIONS, ANY TYPE, EACH	K0062 and K0063		PRIOR AUTHORIZATION PURCHASED ITEM
E0968	COMMODE SEAT, WHEELCHAIR			PRIOR AUTHORIZATION PURCHASED ITEM
E0969	NARROWING DEVICE, WHEELCHAIR			PRIOR AUTHORIZATION PURCHASED ITEM
E0970	NO.2 FOOTPLATES, EXCEPT FOR ELEVATING LEG REST			PRIOR AUTHORIZATION COST INVOICE REQUIRED PURCHASED ITEM
E0971	MANUAL WHEELCHAIR ACCESSORY, ANTI-TIPPING DEVICE EACH	K0021		PRIOR AUTHORIZATION PURCHASED ITEM NON-REIMBURSABLE WITH: K0813THRU K0843 OR K0848 THRU K0891
E0972	WHEELCHAIR ACCESSORY, TRANSFER BOARD OR DEVICE, EACH	K0103		DISCONTINUED BY CMS 12/31/2005
E0973	WHEELCHAIR ACCESSORY, ADJUSTABLE HEIGHT, DETACHABLE ARMREST, COMPLETE ASSEMBLY, EACH	K0016		PRIOR AUTHORIZATION PURCHASED ITEM NON-REIMBURSABLE WITH: E1002, E1003, E1004, E1005, E1006, E1007, E1008, K0017, K0018 OR K0019
E0974	MANUAL WHEELCHAIR ACCESSORY, ANTI-ROLLBACK DEVICE, EACH	K0080		PRIOR AUTHORIZATION PURCHASED ITEM
E0977	WEDGE CUSHION, WHEELCHAIR		NON-COVERED	
E0978	WHEELCHAIR ACCESSORY, POSITIONING BELT/SAFETY BELT/PELVIC STRAP, EACH	K0030		PRIOR AUTHORIZATION PURCHASED ITEM
E0980	SAFETY VEST, WHEELCHAIR			PRIOR AUTHORIZATION PURCHASED ITEM
E0981	WHEELCHAIR ACCESSORY, SEAT UPHOLSTERY, REPLACEMENT ONLY, EACH	K0032 and K0033		PRIOR AUTHORIZATION PURCHASED ITEM NON-REIMBURSABLE WITH: E1161, E1231, E1233, E1234, E1235, E1236, E1237, E1238, K0001, K0002, K0003, K0004, K0005, K0006, K0007, K0009, K0010, K0011, K0012 OR K0014
E0982	WHEELCHAIR ACCESSORY, BACK UPHOLSTERY, REPLACEMENT ONLY, EACH	K0022 K0026 K0027		PRIOR AUTHORIZATION PURCHASED ITEM NON-REIMBURSABLE WITH: E1161, E1231, E1233, E1234, E1235, E1236, E1237, E1238, K0001, K0002, K0003, K0004, K0005, K0006, K0007, K0009, K0010, K0011, K0012 OR K0014
E0983	MANUAL WHEELCHAIR ACCESSORY, POWER ADD-ON TO CONVERT MANUAL WHEELCHAIR TO MOTORIZED WHEELCHAIR, JOYSTICK CONTROL	K0460		PRIOR AUTHORIZATION PURCHASED ITEM

HCPCS CODES	DESCRIPTION	REPLACES	SERVICE LIMIT	SPECIAL INSTRUCTIONS
E0984	MANUAL WHEELCHAIR ACCESSORY, POWER ADD-ON TO CONVERT MANUAL WHEELCHAIR TO MOTORIZED WHEELCHAIR, TILLER CONTROL	K0461		PRIOR AUTHORIZATION PURCHASED ITEM
E0985	WHEELCHAIR ACCESSORY, SEAT LIFT MECHANISM		NON-COVERED	
E0986	MANUAL WHEELCHAIR ACCESSORY, PUSH ACTIVATED POWER ASSIST, EACH		NON-COVERED	
E0990	WHEELCHAIR ACCESSORY, ELEVATING LEG REST, COMPLETE ASSEMBLY, EACH	K0048		PRIOR AUTHORIZATION PURCHASED ITEM NON-REIMBURSABLE WITH: E0995, E1009, E1010, K0042, K0043, K0044, K0045, K0046, K0047, OR K0053
E0992	MANUAL WHEELCHAIR ACCESSORY, SOLID SEAT INSERT	K0030		PRIOR AUTHORIZATION PURCHASED ITEM
E0994	ARM REST, EACH		NON-COVERED	
E0995	WHEELCHAIR ACCESSORY, CALF REST/PAD, EACH		NON-COVERED	
E0996	TIRE, SOLID, EACH		NON-COVERED	
E0997	CASTER WITH A FORK	K0108		PRIOR AUTHORIZATION PURCHASED ITEM CLOSED BY CMS 12/31/2006
E0998	CASTER WITHOUT FORK	K0108		PRIOR AUTHORIZATION PURCHASED ITEM CLOSED BY CMS 12/31/2006
E0999	PNEUMATIC TIRE WITH WHEEL		NON-COVERED	
E1000	TIRE, PNEUMATIC CASTER		NON-COVERED	
E1001	WHEEL, SINGLE		NON-COVERED	
E1002	WHEELCHAIR ACCESSORY, POWER SEATING SYSTEM, TILT ONLY			PRIOR AUTHORIZATION PURCHASED ITEM NON-REIMBURSABLE WITH: E0973, K0015, K00017, K0018, K0019, K0020, K0042, K0043, K0044, K0045, K0046, K0047, K0050, K0051, K0052
E1003	WHEELCHAIR ACCESSORY, POWER SEATING SYSTEM, RECLINE ONLY, WITHOUT SHEAR REDUCTION			PRIOR AUTHORIZATION PURCHASED ITEM NON-REIMBURSABLE WITH: E0973, K0015, K00017, K0018, K0019, K0020, K0042, K0043, K0044, K0045, K0046, K0047, K0050, K0051, K0052

HCPCS CODES	DESCRIPTION	REPLACES	SERVICE LIMIT	SPECIAL INSTRUCTIONS
E1004	WHEELCHAIR ACCESSORY, POWER SEATING SYSTEM, RECLINE ONLY, WITH MECHANICAL SHEAR REDUCTION			PRIOR AUTHORIZATION PURCHASED ITEM NON-REIMBURSABLE WITH: E0973, K0015, K00017, K0018, K0019, K0020, K0042, K0043, K0044, K0045, K0046, K0047, K0050, K0051, K0052
E1005	WHEELCHAIR ACCESSORY, POWER SEATNG SYSTEM, RECLINE ONLY, WITH POWER SHEAR REDUCTION			PRIOR AUTHORIZATION PURCHASED ITEM NON-REIMBURSABLE WITH: E0973, K0015, K00017, K0018, K0019, K0020,K0042, K0043, K0044, K0045, K0046, K0047, K0050, K0051, K0052
E1006	WHEELCHAIR ACCESSORY, POWER SEATING SYSTEM, COMBINATION TILT AND RECLINE, WITHOUT SHEAR REDUCTION			PRIOR AUTHORIZATION PURCHASED ITEM NON-REIMBURSABLE WITH: E0973, K0015, K00017, K0018, K0019, K0020, K0042, K0043, K0044, K0045, K0046, K0047, K0050, K0051, K0052
E1007	WHEELCHAIR ACCESSORY, POWER SEATING SYSTEM, COMBINATION TILT AND RECLINE, WITH MECHANICAL SHEAR REDUCTION			PRIOR AUTHORIZATION PURCHASED ITEM NON-REIMBURSABLE WITH: E0973, K0015, K00017, K0018, K0019, K0020, K0042, K0043, K0044, K0045, K0046, K0047, K0050, K0051, K0052
E1008	WHEELCHAIR ACCESSORY, POWER SEATING SYSTEM, COMBINATION TILT AND RECLINE, WITH POWER SHEAR REDUCTION			PRIOR AUTHORIZATION PURCHASED ITEM NON-REIMBURSABLE WITH: E0973, K0015, K00017, K0018, K0019, K0020, K0042, K0043, K0044, K0045, K0046, K0047, K0050, K0051
E1009	WHEELCHAIR ACCESSORY, ADDITION TO POWER SEATING SYSTEM, MECHANICALLY LINKED LEG ELEVATION SYSTEM, INCLUDING PUSHROD AND LEG REST, EACH			PRIOR AUTHORIZATION PURCHASED ITEM COST INVOICE NONREIMBURSABLE WITH: E0990, E0995, K0042, K0043, K0044, K0045, K0046, K0047, K0052, K0053, K0195
E1010	WHEELCHAIR ACCESSORY, ADDITION TO POWER SEATING SYSTEM, POWER LEG ELEVATION SYSTEM, INCLUDING LEG REST, PAIR			PRIOR AUTHORIZATION PURCHASED ITEM NON-REIMBURSABLE WITH: E0990, E0995, K0042, K0043, K0044, K0045, K0046, K0047, K0052, K0053, K0195
E1011	MODIFICATION TO PEDIATRIC SIZE WHEELCHAIR, WIDTH ADJUSTMENT PACKAGE (NOT TO BE DISPENSED WITH INITIAL CHAIR)	K0108		PRIOR AUTHORIZATION PURCHASED ITEM COST INVOICE
E1014	RECLINING BACK, ADDITION TO PEDIATRIC SIZE WHEELCHAIR	K0108		PRIOR AUTHORIZATION PURCHASED ITEM COVERAGE LIMTED UP TO 21 YEARS OF AGE
E1015	SHOCK ABSORBER FOR MANUAL WHEELCHAIR, EACH			PRIOR AUTHORIZATION PURCHASED ITEM

HCPCS CODES	DESCRIPTION	REPLACES	SERVICE LIMIT	SPECIAL INSTRUCTIONS
E1016	SHOCK ABSORBER FOR POWER WHEELCHAIR, EACH			PRIOR AUTHORIZATION PURCHASED ITEM
E1017	HEAVY DUTY SHOCK ABSORBER FOR HEAVY DUTY OR EXTRA HEAVY DUTY MANUAL WHEELCHAIR, EACH		NON-COVERED	
E1018	HEAVY DUTY SHOCK ABSORBER FOR HEAVY DUTY OR EXTRA HEAVY DUTY POWER WHEELCHAIR, EACH		NON-COVERED	
E1019	WHEELCHAIR ACCESSORY, POWER SEATING SYSTEM, HEAVY DUTY FEATURE, PATIENT WEIGHT CAPACITY GREATER THAN 250 POUNDS AND LESS THAN OR EQUAL TO 400 POUNDS		NON-COVERED	
E1020	RESIDUAL LIMB SUPPORT SYSTEM FOR WHEELCHAIR	K0108		PRIOR AUTHORIZATION PURCHASED ITEM STUMP SUPPORT FOR A LOWER LIMB AMPUTEE THAT IS ATTACHED TO A WHEELCHAIR BASE. IT CONTAINS A MECHANISM TO ALLOW THE SUPPORT TO SWING AWAY, FOLD DOWN, OR RETRACT.
E1021	WHEELCHAIR ACCESSORY, POWER SEATING SYSTEM, EXTRA HEAVY DUTY FEATURE, WEIGHT CAPACITY GREATER THAN 400 POUNDS		NON-COVERED	
E1025	LATERAL THORACIC SUPPORT, NON-CONTOURED, FOR PEDIATRIC WHEELCHAIR, EACH (INCLUDES HARDWARE)	K0108		DISCONTINUED BY CMS 12/31/2005
E1026	LATERAL THORACIC SUPPORT, CONTOURED, FOR PEDIATRIC WHEELCHAIR, EACH (INCLUDES HARDWARE)	K0108		DISCONTINUED BY CMS 12/31/2005
E1027	LATERAL/ANTERIOR SUPPORT, FOR PEDIATRIC WHEELCHAIR, EACH (INCLUDES HARDWARE)	K0108		DISCONTINUED BY CMS 12/31/2005
E1028	WHEELCHAIR ACCESSORY, MANUAL SWINGAWAY, RETRACTABLE OR REMOVABLE MOUNTING HARDWARE FOR JOYSTICK, OTHER CONTROL INTERFACE OR POSITIONING ACCESSORY	K0108		PRIOR AUTHORIZATION PURCHASED ITEM
E1029	WHEELCHAIR ACCESSORY, VENTILATOR TRAY, FIXED	K0108		PRIOR AUTHORIZATION PURCHASED ITEM
E1030	WHEELCHAIR ACCESSORY, VENTILATOR TRAY, GIMBALED	K0108		PRIOR AUTHORIZATION PURCHASED ITEM
E1031	ROLLABOUT CHAIR, ANY AND ALL TYPES WITH CASTORS 5" OR GREATER		1 PER 5 ROLLING YEARS	PRIOR AUTHORIZATION ITEM IS 10 MONTH CAP RENTAL INCLUDES ALL OPTIONS AND ACCESSORIES NON-REIMBURSABLE WITH: K0001, K0002, K0003, K0004, K0005, K0006, K0007, K0009, K0813THRU K0843 OR K0848 THRU K0891

HCPCS CODES	DESCRIPTION	REPLACES	SERVICE LIMIT	SPECIAL INSTRUCTIONS
E1035	MULTI-POSITIONAL PATIENT TRANSFER SYSTEM, WITH INTEGRATED SEAT, OPERATED BY CARE GIVER		NON-COVERED	
E1037	TRANSPORT CHAIR, PEDIATRIC SIZE		NON-COVERED	
E1038	TRANSPORT CHAIR, ADULT SIZE, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS		NON-COVERED	
E1039	TRANSPORT CHAIR, ADULT SIZE, HEAVY DUTY, PATIENT WEIGHT CAPACITY GREATER THAN 300 POUNDS		NON-COVERED	
E1050	FULLY-RECLINING WHEELCHAIR, FIXED FULL LENGTH ARMS, SWING AWAY DETACHABLE ELEVATING LEG RESTS		NON-COVERED	
E1060	FULLY-RECLINING WHEELCHAIR, DETACHABLE ARMS, DESK OR FULL LENGTH, SWING AWAY DETACHABLE ELEVATING LEGRESTS		NON-COVERED	
E1070	FULLY-RECLINING WHEELCHAIR, DETACHABLE ARMS (DESK OR FULL LENGTH) SWING AWAY DETACHABLE FOOTREST		NON-COVERED	
E1083	HEMI-WHEELCHAIR, FIXED FULL LENGTH ARMS, SWING AWAY DETACHABLE ELEVATING LEG REST		NON-COVERED	
E1084	HEMI-WHEELCHAIR, DETACHABLE ARMS DESK OR FULL LENGTH ARMS, SWING AWAY DETACHABLE ELEVATING LEG RESTS		NON-COVERED	
E1085	HEMI-WHEELCHAIR, FIXED FULL LENGTH ARMS, SWING AWAY DETACHABLE FOOT RESTS		NON-COVERED	
E1086	HEMI-WHEELCHAIR DETACHABLE ARMS DESK OR FULL LENGTH, SWING AWAY DETACHABLE FOOTRESTS		NON-COVERED	
E1087	HIGH STRENGTH LIGHTWEIGHT WHEELCHAIR, FIXED FULL LENGTH ARMS, SWING AWAY DETACHABLE ELEVATING LEG RESTS		NON-COVERED	
E1088	HIGH STRENGTH LIGHTWEIGHT WHEELCHAIR, DETACHABLE ARMS DESK OR FULL LENGTH, SWING AWAY DETACHABLE ELEVATING LEG RESTS		NON-COVERED	
E1089	HIGH STRENGTH LIGHTWEIGHT WHEELCHAIR, FIXED LENGTH ARMS, SWING AWAY DETACHABLE FOOTREST		NON-COVERED	
E1090	HIGH STRENGTH LIGHTWEIGHT WHEELCHAIR, DETACHABLE ARMS DESK OR FULL LENGTH, SWING AWAY DETACHABLE FOOT RESTS		NON-COVERED	
E1092	WIDE HEAVY DUTY WHEEL CHAIR, DETACHABLE ARMS (DESK OR FULL LENGTH), SWING AWAY DETACHABLE ELEVATING LEG RESTS		NON-COVERED	

HCPCS CODES	DESCRIPTION	REPLACES	SERVICE LIMIT	SPECIAL INSTRUCTIONS
E1093	WIDE HEAVY DUTY WHEELCHAIR, DETACHABLE ARMS DESK OR FULL LENGTH ARMS, SWING AWAY DETACHABLE FOOTRESTS		NON-COVERED	
E1100	SEMI-RECLINING WHEELCHAIR, FIXED FULL LENGTH ARMS, SWING AWAY DETACHABLE ELEVATING LEG RESTS		NON-COVERED	
E1110	SEMI-RECLINING WHEELCHAIR, DETACHABLE ARMS (DESK OR FULL LENGTH) ELEVATING LEGREST		NON-COVERED	
E1130	STANDARD WHEELCHAIR, FIXED FULL LENGTH ARMS, FIXED OR SWING AWAY DETACHABLE FOOTRESTS		NON-COVERED	
E1140	WHEELCHAIR, DETACHABLE ARMS, DESK OR FULL LENGTH, SWING AWAY DETACHABLE FOOTRESTS		NON-COVERED	
E1150	WHEELCHAIR, DETACHABLE ARMS, DESK OR FULL LENGTH SWING AWAY DETACHABLE ELEVATING LEGRESTS		NON-COVERED	
E1160	WHEELCHAIR, FIXED FULL LENGTH ARMS, SWING AWAY DETACHABLE ELEVATING LEGRESTS		NON-COVERED	
E1161	MANUAL ADULT SIZE WHEELCHAIR, INCLUDES TILT IN SPACE		1 PER 5 ROLLING YEARS	PRIOR AUTHORIZATION PURCHASED ITEM NON-REIMBURSABLE WITH: E0967, E0981, E0982, E0995, E2205, E2206, E2210, E2220, E2221, E2222, E2223, E2224, E2225, E2226,K0015, K0017, K0018, K0019, K0042, K0043, K0044, K0045, K0046, K0047, K0050, K0052, K0069, K0070, K0071, K0072- OR WHEELCHAIR BASES: E1229,E1231, E1232, E1233, E1234, E1235, E1236, E1237, E1238, K0001, K0002, K0003, K0004, K0005, K0006, K0007, K0009,K0813 THRU K0843 OR K0848 THRU K0891 MEDICAL NECESSITY REVIEW WILL BE BASED ON INTERQUAL DME GENERAL CRITERIA
E1170	AMPUTEE WHEELCHAIR, FIXED FULL LENGTH ARMS, SWING AWAY DETACHABLE ELEVATING LEGRESTS		NON-COVERED	
E1171	AMPUTEE WHEELCHAIR, FIXED FULL LENGTH ARMS, WITHOUT FOOTRESTS OR LEGREST		NON-COVERED	
E1172	AMPUTEE WHEELCHAIR, DETACHABLE ARMS (DESK OR FULL LENGTH) WITHOUT FOOTRESTS OR LEGREST		NON-COVERED	
E1180	AMPUTEE WHEELCHAIR, DETACHABLE ARMS (DESK OR FULL LENGTH) SWING AWAY DETACHABLE FOOTRESTS		NON-COVERED	
E1190	AMPUTEE WHEELCHAIR, DETACHABLE ARMS (DESK OR FULL LENGTH) SWING AWAY DETACHABLE ELEVATING LEGRESTS		NON-COVERED	
E1195	HEAVY DUTY WHEELCHAIR, FIXED FULL LENGTH ARMS, SWING AWAY DETACHABLE ELEVATING LEGRESTS		NON-COVERED	

HCPCS CODES	DESCRIPTION	REPLACES	SERVICE LIMIT	SPECIAL INSTRUCTIONS
E1200	AMPUTEE WHEELCHAIR, FIXED FULL LENGTH ARMS, SWING AWAY DETACHABLE FOOTREST		NON-COVERED	
E1210	MOTORIZED WHEELCHAIR, FIXED FULL LENGTH ARMS, SWING AWAY DETACHABLE ELEVATING LEGRESTS		NON-COVERED	
E1211	MOTORIZED WHEELCHAIR, DETACHABLE ARMS DESK OR FULL LENGTH SWING AWAY, DETACHABLE ELEVATING LEG REST		NON-COVERED	
E1212	MOTORIZED WHEELCHAIR, FIXED FULL LENGTH ARMS, SWING AWAY DETACHABLE FOOT RESTS		NON-COVERED	
E1213	MOTORIZED WHEELCHAIR, DETACHABLE ARMS DESK OR FULL LENGTH, SWING AWAY DETACHABLE FOOT RESTS		NON-COVERED	
E1220	WHEELCHAIR; SPECIALLY SIZED OR CONSTRUCTED, (INDICATE BRAND NAME, MODEL NUMBER, IF ANY) AND JUSTIFICATION		NON-COVERED	
E1221	WHEELCHAIR WITH FIXED ARM, FOOTRESTS		NON-COVERED	
E1222	WHEELCHAIR WITH FIXED ARM, ELEVATING LEGRESTS		NON-COVERED	
E1223	WHEELCHAIR WITH DETACHABLE ARMS, FOOTRESTS		NON-COVERED	
E1224	WHEELCHAIR WITH DETACHABLE ARMS, ELEVATING LEGRESTS		NON-COVERED	
E1225	WHEELCHAIR ACCESSORY, MANUAL SEMI-RECLINING BACK, (RECLINE GREATER THAN 15 DEGREES, BUT LESS THAN 80 DEGREES), EACH			PRIOR AUTHORIZATION PURCHASED ITEM
E1226	WHEELCHAIR ACCESSORY, MANUAL FULLY RECLINING BACK, (RECLINE GREATER THAN 80 DEGREES), EACH	K0028		PRIOR AUTHORIZATION PURCHASED ITEM
E1227	SPECIAL HEIGHT ARMS FOR WHEELCHAIR		NON-COVERED	
E1228	SPECIAL BACK HEIGHT FOR WHEELCHAIR		NON-COVERED	
E1229	WHEELCHAIR, PEDIATRIC SIZE, NOT OTHERWISE SPECIFIED	K0009		PRIOR AUTHORIZATION COST INVOICE REQUIRED PURCHASE ITEM COVERED FOR MEMBERS UP TO 21 YEARS OF AGE

HCPCS CODES	DESCRIPTION	REPLACES	SERVICE LIMIT	SPECIAL INSTRUCTIONS
E1230	POWER OPERATED VEHICLE (THREE OR FOUR WHEEL NONHIGHWAY) SPECIFY BRAND NAME AND MODEL NUMBER		1 PER 5 ROLLING YEARS	PRIOR AUTHORIZATION ITEM IS 10 MONTH CAP RENTAL INCLUDES ALL OPTIONS AND ACCESSORIES MEDICAL NECESSITY REVIEW WILL BE BASED ON INTERQUAL DME GENERAL CRITERIA CLOSED BY BMS EFFECTIVE 6/30/2007
E1231	WHEELCHAIR, PEDIATRIC SIZE, TILT-IN-SPACE, RIGID, ADJUSTABLE, WITH SEATING SYSTEM	K0009	1 PER 5 ROLLING YEARS	PRIOR AUTHORIZATION PURCHASED ITEM NON-REIMBURSABLE WITH: E0967, E0981, E0982, E0995, E2205, E2206, E2210, E2220, E2221, E2222, E2223, E2224, E2225, E2226,K0015, K0017, K0018, K0019, K0042, K0043, K0044, K0045, K0046, K0047, K0050, K0052, K0069, K0070, K0071, K0072-OR WHEELCHAIR BASES: E1229, E1232, E1233, E1234, E1235, E1236, E1237, E1238, K0001, K0002, K0003, K0004, K0005, K0006, K0007, K0009, K0813 THRU K0843 OR K0848 THRU K0891 MEDICAL NECESSITY REVIEW WILL BE BASED ON INTERQUAL DME GENERAL CRITERIA
E1232	WHEELCHAIR, PEDIATRIC SIZE, TILT-IN-SPACE, FOLDING, ADJUSTABLE, WITH SEATING SYSTEM	K0009	1 PER 5 ROLLING YEARS	PRIOR AUTHORIZATION PURCHASED ITEM NON-REIMBURSABLE WITH: E0967, E0981, E0982, E0995, E2205, E2206, E2210, E2220, E2221, E2222, E2223, E2224, E2225, E2226,K0015, K0017, K0018, K0019, K0042, K0043, K0044, K0045, K0046, K0047, K0050, K0052, K0069, K0070, K0071, K0072 OR WHEELCHAIR BASES: E1229,E1231,E1233, E1234, E1235, E1236, E1237, E1238, K0001, K0002, K0003, K0004, K0005, K0006, K0007, K0009, K0813 THRU K0843 OR K0848 THRU K0891 MEDICAL NECESSITY REVIEW WILL BE BASED ON INTERQUAL DME GENERAL CRITERIA
E1233	WHEELCHAIR, PEDIATRIC SIZE, TILT-IN-SPACE, RIGID, ADJUSTABLE, WITHOUT SEATING SYSTEN	K0009	1 PER 5 ROLLING YEARS	PRIOR AUTHORIZATION PURCHASED ITEM NON-REIMBURSABLE WITH: E0967, E0981, E0982, E0995, E2205, E2206, E2210, E2220, E2221, E2222, E2223, E2224, E2225, E2226,K0015, K0017, K0018, K0019, K0042, K0043, K0044, K0045, K0046, K0047, K0050, K0052, K0069, K0070, K0071, K0072 OR WHEELCHAIR BASES: E1229,E1231, E1232,E1234, E1235, E1236, E1237, E1238, K0001, K0002, K0003, K0004, K0005, K0006, K0007, K0009,K0813 THRU K0843 OR K0848 THRU K0891 MEDICAL NECESSITY REVIEW WILL BE BASED ON INTERQUAL DME GENERAL CRITERIA

HCPCS CODES	DESCRIPTION	REPLACES	SERVICE LIMIT	SPECIAL INSTRUCTIONS
E1234	WHEELCHAIR, PEDIATRIC SIZE, TILT-IN-SPACE, FOLDING, ADJUSTABLE, WITHOUT SEATING SYSTEM	K0009	1 PER 5 ROLLING YEARS	PRIOR AUTHORIZATION PURCHASED ITEM NON-REIMBURSABLE WITH: E0967, E0981, E0982, E0995, E2205, E2206, E2210, E2220, E2221, E2222, E2223, E2224, E2225, E2226,K0015, K0017, K0018, K0019, K0042, K0043, K0044, K0045, K0046, K0047, K0050, K0052, K0069, K0070, K0071, K0072 OR WHEELCHAIR BASES: E1229,E1231, E1232, E1233,E1235, E1236, E1237, E1238, K0001, K0002, K0003, K0004, K0005, K0006, K0007, K0009, K0813 THRU K0843 OR K0848 THRU K0891 MEDICAL NECESSITY REVIEW WILL BE BASED ON INTERQUAL DME GENERAL CRITERIA
E1235	WHEELCHAIR, PEDIATRIC SIZE, RIGID, ADJUSTABLE, WITH SEATING SYSTEM	K0009	1 PER 5 ROLLING YEARS	PRIOR AUTHORIZATION PURCHASED ITEM NON-REIMBURSABLE WITH: E0967, E0981, E0982, E0995, E2205, E2206, E2210, E2220, E2221, E2222, E2223, E2224, E2225, E2226,K0015, K0017, K0018, K0019, K0042, K0043, K0044, K0045, K0046, K0047, K0050, K0052, K0069, K0070, K0071, K0072-OR WHEELCHAIR BASES: E1229,E1231, E1232, E1233, E1234, E1236, E1237, E1238, K0001, K0002, K0003, K0004, K0005, K0006, K0007, K0009, K0813 THRU K0843 OR K0848 THRU K0891 MEDICAL NECESSITY REVIEW WILL BE BASED ON INTERQUAL DME GENERAL CRITERIA
E1236	WHEELCHAIR, PEDIATRIC SIZE, FOLDING, ADJUSTABLE, WITH SEATING SYSTEM	K0009	1 PER 5 ROLLING YEARS	PRIOR AUTHORIZATION PURCHASED ITEM NON-REIMBURSABLE WITH: E0967, E0981, E0982, E0995, E2205, E2206, E2210, E2220, E2221, E2222, E2223, E2224, E2225, E2226,K0015, K0017, K0018, K0019, K0042, K0043, K0044, K0045, K0046, K0047, K0050, K0052, K0069, K0070, K0071, K0072 OR WHEELCHAIR BASES: E1229,E1231, E1232, E1233, E1234, E1235, E1237, E1238, K0001, K0002, K0003, K0004, K0005, K0006, K0007, K0009,K0813 THRU K0843 OR K0848 THRU K0891 MEDICAL NECESSITY REVIEW WILL BE BASED ON INTERQUAL DME GENERAL CRITERIA
E1237	WHEELCHAIR, PEDIATRIC SIZE, RIGID, ADJUSTABLE, WITHOUT SEATING SYSTEM	K0009	1 PER 5 ROLLING YEARS	PRIOR AUTHORIZATION PURCHASED ITEM NON-REIMBURSABLE WITH: E0967, E0981, E0982, E0995, E2205, E2206, E2210, E2220, E2221, E2222, E2223, E2224, E2225, E2226,K0015, K0017, K0018, K0019, K0042, K0043, K0044, K0045, K0046, K0047, K0050, K0052, K0069, K0070, K0071, K0072 OR WHEELCHAIR BASES: E1229,E1231, E1232, E1233, E1234, E1235, E1236, E1238, K0001, K0002, K0003, K0004, K0005, K0006, K0007, K0009,K0813 THRU K0843 OR K0848 THRU K0891 MEDICAL NECESSITY REVIEW WILL BE BASED ON INTERQUAL DME GENERAL CRITERIA

HCPCS CODES	DESCRIPTION	REPLACES	SERVICE LIMIT	SPECIAL INSTRUCTIONS
E1238	WHEELCHAIR, PEDIATRIC SIZE, FOLDING, ADJUSTABLE, WITHOUT SEATING SYSTEM	K0009	1 PER 5 ROLLING YEARS	PRIOR AUTHORIZATION PURCHASED ITEM NON-REIMBURSABLE WITH: E0967, E0981, E0982, E0995, E2205, E2206, E2210, E2220, E2221, E2222, E2223, E2224, E2225, E2226,K0015, K0017, K0018, K0019, K0042, K0043, K0044, K0045, K0046, K0047, K0050, K0052, K0069, K0070, K0071, K0072-OR WHEELCHAIR BASES: E1229,E1231, E1232, E1233, E1234, E1235, E1236, E1237, K0001, K0002, K0003, K0004, K0005, K0006, K0007, K0009, K0813 THRU K0843 OR K0848 THRU K0891 MEDICAL NECESSITY REVIEW WILL BE BASED ON INTERQUAL DME GENERAL CRITERIA
E1239	POWER WHEELCHAIR, PEDIATRIC SIZE, NOT OTHERWISE SPECIFIED	K0014		PRIOR AUTHORIZATION PURCHASE ITEM COVERED FOR MEMBERS UP TO 21 YEARS OF AGE
E1240	LIGHTWEIGHT WHEELCHAIR, DETACHABLE ARMS, (DESK OR FULL LENGTH) SWING AWAY DETACHABLE, ELEVATING LEGREST		NON-COVERED	
E1250	LIGHTWEIGHT WHEELCHAIR, FIXED FULL LENGTH ARMS, SWING AWAY DETACHABLE FOOTREST		NON-COVERED	
E1260	LIGHTWEIGHT WHEELCHAIR, DETACHABLE ARMS (DESK OR FULL LENGTH) SWING AWAY DETACHABLE FOOTREST		NON-COVERED	
E1270	LIGHTWEIGHT WHEELCHAIR, FIXED FULL LENGTH ARMS, SWING AWAY DETACHABLE ELEVATING LEGRESTS		NON-COVERED	
E1280	HEAVY DUTY WHEELCHAIR, DETACHABLE ARMS (DESK OR FULL LENGTH) ELEVATING LEGRESTS		NON-COVERED	
E1285	HEAVY DUTY WHEELCHAIR, FIXED FULL LENGTH ARMS, SWING AWAY DETACHABLE FOOTREST		NON-COVERED	
E1290	HEAVY DUTY WHEELCHAIR, DETACHABLE ARMS (DESK OR FULL LENGTH) SWING AWAY DETACHABLE FOOTREST		NON-COVERED	
E1295	HEAVY DUTY WHEELCHAIR, FIXED FULL LENGTH ARMS, ELEVATING LEGREST		NON-COVERED	
E1296	SPECIAL WHEELCHAIR SEAT HEIGHT FROM FLOOR		NON-COVERED	
E1297	SPECIAL WHEELCHAIR SEAT DEPTH, BY UPHOLSTERY		NON-COVERED	
E1298	SPECIAL WHEELCHAIR SEAT DEPTH AND/OR WIDTH, BY CONSTRUCTION		NON-COVERED	
E1300	WHIRLPOOL, PORTABLE (OVERTUB TYPE)		NON-COVERED	

HCPCS CODES	DESCRIPTION	REPLACES	SERVICE LIMIT	SPECIAL INSTRUCTIONS
E1310	WHIRLPOOL, NON-PORTABLE (BUILT-IN TYPE)		NON-COVERED	
E1340	REPAIR OR NONROUTINE SERVICE FOR DURABLE MEDICAL EQUIPMENT REQUIRING THE SKILL OF A TECHNICIAN, LABOR COMPONENT, PER 15 MINUTES		16 UNITS PER ROLLING YEAR	PRIOR AUTHORIZATION TRAVEL NOT COVERED
E1353	REGULATOR		NON-COVERED	
E1355	STAND/RACK		NON-COVERED	
E1372	IMMERSION EXTERNAL HEATER FOR NEBULIZER		1 PER 5 ROLLING YEARS	PRIOR AUTHORIZATION PURCHASED ITEM
E1390	OXYGEN CONCENTRATOR, SINGLE DELIVERY PORT, CAPABLE OF DELIVERING 85 PERCENT OR GREATER OXYGEN CONCENTRATION AT THE PRESCRIBED FLOW RATE		1 UNIT PER ROLLING MONTH	PROVIDER MUST MAINTAIN A PERSONALLY SIGNED AND DATED PRACTITIONER'S ORDER WITH DIAGNOSIS, DIRECTION FOR USE ALONG WITH ABG'S OR ARTERIAL OXYGEN SATURATION IN THE MEMBER'S FILE. WEST VIRGINIA MEDICAID FOLLOWS PALMETTO, REGION C MEDICAL CRITERIA FOR COVERAGE. MUST HAVE WEST VIRGINIA CERTIFIED RESPIRATORY THERAPIST OR PROFESSIONAL REGISTERED NURSE OR PHYSICIAN ON STAFF
E1391	OXYGEN CONCENTRATOR, DUAL DELIVERY PORT, CAPABLE OF DELIVERING 85 PERCENT OR GREATER OXYGEN CONCENTRATION AT THE PRESCRIBED FLOW RATE, EACH		NON-COVERED	
E1392	PORTABLE OXYGEN CONCENTRATOR, RENTAL	K0671	NON-COVERED	
E1399	DURABLE MEDICAL EQUIPMENT, MISCELLANEOUS			PRIOR AUTHORIZATION COST INVOICE REQUIRED
E1405	OXYGEN AND WATER VAPOR ENRICHING SYSTEM WITH HEATED DELIVERY		NON-COVERED	
E1406	OXYGEN AND WATER VAPOR ENRICHING SYSTEM WITHOUT HEATED DELIVERY		NON-COVERED	
E1902	COMMUNICATION BOARD, NON-ELECTRONIC AUGMENTATIVE OR ALTERNATIVE COMMUNICATION DEVICE		NON-COVERED	
E2000	GASTRIC SUCTION PUMP, HOME MODEL, PORTABLE OR STATIONARY, ELECTRIC		NON-COVERED	

HCPCS CODES	DESCRIPTION	REPLACES	SERVICE LIMIT	SPECIAL INSTRUCTIONS
E2100	BLOOD GLUCOSE MONITOR WITH INTEGRATED VOICE SYNTHESIZER		1 PER 3 ROLLING YEARS	PRIOR AUTHORIZATION PURCHASED ITEM REQUIRES ICD-9-CM DIAGNOSIS CODES: 250.00 - 250.93 OR 648.8X. WEST VIRGINIA MEDICAID FOLLOWS PALMETTO, REGION C, MEDICAL CRITERIA FOR COVERAGE.
E2101	BLOOD GLUCOSE MONITOR WITH INTEGRATED LANCING/BLOOD SAMPLE		NON-COVERED	
E2120	PULSE GENERATOR SYSTEM FOR TYMPANIC TREATMENT OF INNER EAR ENDOLYMPHATIC FLUID		NON-COVERED	
E2201	MANUAL WHEELCHAIR ACCESSORY, NONSTANDARD SEAT FRAME, WIDTH GREATER THAN OR EQUAL TO 20 INCHES AND LESS THAN 24 INCHES	K0108		PRIOR AUTHORIZATION PURCHASED ITEM COVERED ONLY IF MEMBER'S DIMENSIONS JUSTIFY THE NEED
E2202	MANUAL WHEELCHAIR ACCESSORY, NONSTANDARD SEAT FRAME WIDTH, 24-27 INCHES	K0108		PRIOR AUTHORIZATION PURCHASED ITEM COVERED ONLY IF MEMBER'S DIMENSIONS JUSTIFY THE NEED
E2203	MANUAL WHEELCHAIR ACCESSORY, NONSTANDARD SEAT FRAME DEPTH, 20 TO LESS THAN 22 INCHES	K0108		PRIOR AUTHORIZATION PURCHASED ITEM COVERED ONLY IF MEMBER'S DIMENSIONS JUSTIFY THE NEED
E2204	MANUAL WHEELCHAIR ACCESSORY, NONSTANDARD SEAT FRAME DEPTH, 22 TO 25 INCHES	K0108		PRIOR AUTHORIZATION PURCHASED ITEM COVERED ONLY IF MEMBER'S DIMENSIONS JUSTIFY THE NEED
E2205	MANUAL WHEELCHAIR ACCESSORY, HANDRIM WITHOUT PROJECTIONS **(INCLUDES ERGONOMIC OR CONTOURED**), ANY TYPE, REPLACEMENT ONLY, EACH	K0108		PRIOR AUTHORIZATION PURCHASED ITEM
E2206	MANUAL WHEELCHAIR ACCESSORY, WHEEL LOCK ASSEMBLY, COMPLETE, EACH	K0081		PRIOR AUTHORIZATION PURCHASED ITEM
E2207	WHEELCHAIR ACCESSORY, CRUTCH AND CANE HOLDER, EACH	K0102		PRIOR AUTHORIZATION PURCHASED ITEM
E2208	WHEELCHAIR ACCESSORY, CYLINDER TANK CARRIER, EACH	K0104		PRIOR AUTHORIZATION PURCHASED ITEM
E2209	ACCESSORY, ARM TOUGH, WITH OR WITHOUT HANDSUPPORT, EACH	K0106		PRIOR AUTHORIZATION PURCHASED ITEM
E2210	WHEELCHAIR ACCESSORY, BEARNGS, ANY TYPE, REPLACEMENT ONLY, EACH	K0452		PRIOR AUTHORIZATION PURCHASED ITEM
E2211	MANUAL WHEELCHAIR ACCESSORY, PNEUMATIC PROPULSION TIRE, ANY SIZE, EACH	K0067		PRIOR AUTHORIZATION PURCHASED ITEM

HCPCS CODES	DESCRIPTION	REPLACES	SERVICE LIMIT	SPECIAL INSTRUCTIONS
E2212	MANUAL WHEELCHAIR ACCESSORY, TUBE FOR PNEUMATIC PROPULSION TIRE, ANY SIZE, EACH	K0068		PRIOR AUTHORIZATION PURCHASED ITEM NON-REIMBURSABLE WITH: E2223
E2213	MANUAL WHEELCHAIR ACCESSORY, INSERT FOR PNEUMATIC PROPULSION TIRE (REMOVABLE), ANY TYPE, ANY SIZE, EACH	K0064		PRIOR AUTHORIZATION PURCHASED ITEM
E2214	MANUAL WHEELCHAIR ACCESSORY, PNEUMATIC CASTER TIRE, ANY SIZE, EACH	K0074		PRIOR AUTHORIZATION PURCHASED ITEM
E2215	MANUAL WHEELCHAIR ACCESSORY, TUBE FOR PNEUMATIC CASTER TIRE, ANY SIZE EACH	K0078		PRIOR AUTHORIZATION PURCHASED ITEM NON-REIMBURSABLE WITH: E2223
E2216	MANUAL WHEELCHAIR ACCESSORY, FOAM FILLED PROPULSION TIRE, ANY SIZE, EACH			PRIOR AUTHORIZATION COST INVOICE REQUIRED PURCHASED ITEM
E2217	MANUAL WHEELCHAIR ACCESSORY, FOAM FILLED CASTER TIRE, ANY SIZE, EACH			PRIOR AUTHORIZATION COST INVOICE REQUIRED PURCHASED ITEM
E2218	MANUAL WHEELCHAIR ACCESORY, FOAM PROPULSION TIRE, ANY SIZE, EACH			PRIOR AUTHORIZATION COST INVOICE REQUIRED PURCHASED ITEM
E2219	MANUAL WHEELCHAIR ACCESSORY, FOAM CASTER TIRE, ANY SIZE, EACH	K0075		PRIOR AUTHORIZATION PURCHASED ITEM
E2220	MANUAL WHEELCHAIR ACCESORY, SOLID (RUBBER/PLASTIC) PROPULSION TIRE, ANY SIZE, EACH			PRIOR AUTHORIZATION PURCHASED ITEM
E2221	MANUAL WHEELCHAIR ACESSORY, SOLID (RUBBER/PLASTIC) CASTER TIRE WITH INTEGRATED WHEEL, ANY SIZE, EACH	K0076		PRIOR AUTHORIZATION PURCHASED ITEM
E2222	MANUAL WHEELCHAIR ACCESSORY, SOLID (RUBBER/PLASTIC) CASTER TIRE WITH INTEGRATED WHEEL, ANY SIZE, EACH	K0076		PRIOR AUTHORIZATION PURCHASED ITEM
E2223	WHEELCHAIR ACCESSORY, VALVE, ANY TYPE, REPLACEMENT ONLY, EACH			PRIOR AUTHORIZATION PURCHASED ITEM
E2224	MANUAL WHEELCHAIR ACCESSORY, PROPULSION WHEEL EXCLUDES TIRE, ANY SIZE, EACH			PRIOR AUTHORIZATION PURCHASED ITEM
E2225	MANUAL WHEELCHAIR ACCESSORY, CASTER WHEEL EXCLUDES TIRE, ANY SIZE, REPLACEMENT ONLY, EACH			PRIOR AUTHORIZATION PURCHASED ITEM

HCPCS CODES	DESCRIPTION	REPLACES	SERVICE LIMIT	SPECIAL INSTRUCTIONS
E2226	MANUAL WHEELCHAIR ACCESSORY, CASTER FORK, ANY SIZE, REPLACEMENT ONLY, EACH			PRIOR AUTHORIZATION PURCHASED ITEM
E2227	MANUAL WHEELCHAIR ACCESSORY, GEAR REDUCTION DRIVE WHEEL, EACH			PRIOR AUTHORIZATION PURCHASE ITEM COST INVOICE REQUIRED NEW CODE 01/01/2008
E2228	MANUAL WHEELCHAIR ACCESSORY, WHEEL BRAKING SYSTEM AND LOCK,COMPLETE EACH			PRIOR AUTHORIZATION PURCHASE ITEM COST INVOICE REQUIRED NEW CODE 01/01/2008
E2291	BACK, PLANAR, FOR PEDIATRIC SIZE WHEELCHAIR INCLUDING FIXED ATTACHING HARDWARE			PRIOR AUTHORIZATION COST INVOICE REQUIRED COVERED FOR MEMBERS UP TO 21 YEARS OF AGE
E2292	SEAT, PLANAR, FOR PEDIATRIC SIZE WHEELCHAIR INCLUDING FIXED ATTACHING HARDWARE			PRIOR AUTHORIZATION COST INVOICE REQUIRED COVERED FOR MEMBERS UP TO 21 YEARS OF AGE
E2293	BACK, CONTOURED, FOR PEDIATRIC SIZE WHEELCHAIR INCLUDING FIXED ATTACHING HARDWARE			PRIOR AUTHORIZATION COST INVOICE REQUIRED COVERED FOR MEMBERS UP TO 21 YEARS OF AGE
E2294	SEAT, CONTOURED, FOR PEDIATRIC SIZE WHEELCHAIR INCLUDING FIXED ATTACHING HARDWARE			PRIOR AUTHORIZATION COST INVOICE REQUIRED COVERED FOR MEMBERS UP TO 21 YEARS OF AGE
E2300	POWER WHEELCHAIR ACCESSORY, POWER SEAT ELEVATION SYSTEM		NON-COVERED	
E2301	POWER WHEELCHAIR ACCESSORY, POWER STANDING SYSTEM		NON-COVERED	
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	K0108		PRIOR AUTHORIZATION PURCHASED ITEM
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	K0108		PRIOR AUTHORIZATION PURCHASED ITEM

HCPCS CODES	DESCRIPTION	REPLACES	SERVICE LIMIT	SPECIAL INSTRUCTIONS
E2312	POWER WHEELCHAIR ACCESSORY, HAND OR CHIN CONTROL INTERFACE, MINI-PROPORTIONAL REMOTE JOYSTICK, PROPORTIONAL, INCLUDING FIXED MOUNTING HARDWARE			PRIOR AUTHORIZATION PURCHASE ITEM NEW CODE 01/01/2008
E2313	POWER WHEELCHAIR ACCESSORY, HARNESS FOR UPGRADE TO EXPANDABLE CONTROLLER, INCLUDING ALL FASTENERS, CONNECTORS AND MOUNTING HARDWARE, EACH			PRIOR AUTHORIZATION PURCHASE ITEM NEW CODE 01/01/2008
E2320	POWER WHEELCHAIR ACCESSORY, HAND OR CHIN CONTROL INTERFACE, REMOTE JOYSTICK OR TOUCHPAD, PROPORTIONAL, INCLUDING ALL RELATED ELECTRONICS, AND FIXED MOUNTING HARDWARE	K0108		PRIOR AUTHORIZATION PURCHASED ITEM CLOSED BY CMS 12/31/2006
E2321	POWER WHEELCHAIR ACCESSORY, HAND CONTROL INTERFACE, REMOTE JOYSTICK, NONPROPORTIONAL, INCLUDING ALL RELATED ELECTRONICS, MECHANICAL STOP SWITCH, AND FIXED MOUNTING HARDWARE	K0108		PRIOR AUTHORIZATION PURCHASED ITEM
E2322	POWER WHEELCHAIR ACCESSORY, HAND CONTROL INTERFACE, MULTIPLE MECHANICAL SWITCHES, NONPROPORTIONAL, INCLUDING ALL RELATED ELECTRONICS, MECHANICAL STOP SWITCHES, NONPROPORTIONAL, INCLUDING ALL RELATED ELECTRONICS, MECHANICAL STOP	K0108		PRIOR AUTHORIZATION PURCHASED ITEM
E2323	POWER WHEELCHAIR ACCESSORY, SPECIALTY JOYSTICK HANDLE FOR HAND CONTROL INTERFACE, PREFABRICATED	K0108		PRIOR AUTHORIZATION PURCHASED ITEM
E2324	POWER WHEELCHAIR ACCESSORY, CHIN CUP FOR CHIN CONTROL INTERFACE	K0108		PRIOR AUTHORIZATION PURCHASED ITEM
E2325	POWER WHEELCHAIR ACCESSORY, SIP AND PUFF INTERFACE, NONPROPORTIONAL, INCLUDING ALL RELATED ELECTRONICS, MECHANICAL STOP SWITCH, AND MANUAL SWINGAWAY MOUNTING HARDWARE	K0108		PRIOR AUTHORIZATION PURCHASED ITEM NON-REIMBURSABLE WITH: E1028
E2326	POWER WHEELCHAIR ACCESSORY, BREATH TUBE KIT FOR SIP AND PUFF INTERFACE	K0108		PRIOR AUTHORIZATION PURCHASED ITEM
E2327	POWER WHEELCHAIR ACCESSORY, HEAD CONTROL INTERFACE, MECHANICAL, PROPORTIONAL, INCLUDING ALL RELATED ELECTRONICS, MECHANICAL DIRECTION CHANGE SWITCH, AND FIXED MOUNTING HARDWARE	K0108		PRIOR AUTHORIZATION PURCHASED ITEM

HCPCS CODES	DESCRIPTION	REPLACES	SERVICE LIMIT	SPECIAL INSTRUCTIONS
E2328	POWER WHEELCHAIR ACCESSORY, HEAD CONTROL OR EXTREMITY CONTROL INTERFACE, ELECTRONIC, PROPORTIONAL, INCLUDING ALL RELATED ELECTRONICS AND FIXED MOUNTING HARDWARE	K0108		PRIOR AUTHORIZATION PURCHASED ITEM
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	K0108		PRIOR AUTHORIZATION PURCHASED ITEM
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	K0108		PRIOR AUTHORIZATION PURCHASED ITEM
E2331	POWER WHEELCHAIR ACCESSORY, ATTENDANT CONTROL, PROPORTIONAL, INCLUDING ALL RELATED ELECTRONICS AND FIXED MOUNTING HARDWARE		NON-COVERED	
E2340	POWER WHEELCHAIR ACCESSORY, NONSTANDARD SEAT FRAME WIDTH, 20-23 INCHES	K0108		PRIOR AUTHORIZATION PURCHASED ITEM COVERED ONLY IF MEMBER'S DIMENSIONS JUSTIFY THE NEED
E2341	POWER WHEELCHAIR ACCESSORY, NONSTANDARD SEAT FRAME WIDTH, 24-27 INCHES	K0108		PRIOR AUTHORIZATION PURCHASED ITEM COVERED ONLY IF MEMBER'S DIMENSIONS JUSTIFY THE NEED
E2342	POWER WHEELCHAIR ACCESSORY, NONSTANDARD SEAT FRAME DEPTH, 20 OR 21 INCHES	K0108		PRIOR AUTHORIZATION PURCHASED ITEM COVERED ONLY IF MEMBER'S DIMENSIONS JUSTIFY THE NEED
E2343	POWER WHEELCHAIR ACCESSORY, NONSTANDARD SEAT FRAME DEPTH, 22-25 INCHES	K0108		PRIOR AUTHORIZATION PURCHASED ITEM COVERED ONLY IF MEMBER'S DIMENSIONS JUSTIFY THE NEED
E2351	POWER WHEELCHAIR ACCESSORY, ELECTRONIC INTERFACE TO OPERATE SPEECH GENERATING DEVICE USING POWER WHEELCHAIR CONTROL INTERFACE	K0108		PRIOR AUTHORIZATION PURCHASED ITEM COVERED IF MEMBER HAS A MEDICAID APPROVED SPEECH GENERATING DEVICE ONLY
E2360	POWER WHEELCHAIR ACCESSORY, 22 NF NON-SEALED LEAD ACID BATTERY, EACH	K0082	2 PER 2 ROLLING YEARS	PRIOR AUTHORIZATION PURCHASED ITEM
E2361	POWER WHEELCHAIR ACCESSORY, 22NF SEALED LEAD ACID BATTERY, EACH, (E.G. GEL CELL, ABSORBED GLASSMAT)	K0083	2 PER 2 ROLLING YEARS	PRIOR AUTHORIZATION PURCHASED ITEM
E2362	POWER WHEELCHAIR ACCESSORY, GROUP 24 NON-SEALED LEAD ACID BATTERY, EACH	K0084	2 PER 2 ROLLING YEARS	PRIOR AUTHORIZATION PURCHASED ITEM

HCPCS CODES	DESCRIPTION	REPLACES	SERVICE LIMIT	SPECIAL INSTRUCTIONS
E2363	POWER WHEELCHAIR ACCESSORY, GROUP 24 SEALED LEAD ACID BATTERY, EACH (E.G. GEL CELL, ABSORBED GLASSMAT)	K0085	2 PER 2 ROLLING YEARS	PRIOR AUTHORIZATION PURCHASED ITEM
E2364	POWER WHEELCHAIR ACCESSORY, U-1 NON-SEALED LEAD ACID BATTERY, EACH	K0086	2 PER 2 ROLLING YEARS	PRIOR AUTHORIZATION PURCHASED ITEM
E2365	POWER WHEELCHAIR ACCESSORY, U-1 SEALED LEAD ACID BATTERY, EACH (E.G. GEL CELL, ABSORBED GLASSMAT)	K0087	2 PER 2 ROLLING YEARS	PRIOR AUTHORIZATION PURCHASED ITEM
E2366	POWER WHEELCHAIR ACCESSORY, BATTERY CHARGER, SINGLE MODE, FOR USE WITH ONLY ONE BATTERY TYPE, SEALED OR NON-SEALED, EACH	K0088		PRIOR AUTHORIZATION PURCHASED ITEM NON-REIMBURSABLE WITH: K0813 THRU K0843 OR K0848 THRU K0891
E2367	POWER WHEELCHAIR ACCESSORY, BATTERY CHARGER, DUAL MODE, FOR USE WITH EITHER BATTERY TYPE, SEALED OR NON-SEALED, EACH	K0089	NON-COVERED	
E2368	POWER WHEELCHAIR COMPONENT, MOTOR, REPLACEMENT ONLY	K0108		PRIOR AUTHORIZATION PURCHASED ITEM
E2369	POWER WHEELCHAIR COMPONENT, GEAR BOX, REPLACEMENT ONLY	K0108		PRIOR AUTHORIZATION PURCHASED ITEM
E2370	POWER WHEELCHAIR COMPONENT, MOTOR AND GEAR BOX COMBINATION, REPLACEMENT ONLY	K0108		PRIOR AUTHORIZATION PURCHASED ITEM
E2371	POWER WHEELCHAIR ACCESSORY, GROUP 27 SEALED LEAD ACID BATTERY, (E.G. GEL CELL, ABSORBED GLASSMAT), EACH			PRIOR AUTHORIZATION PURCHASED ITEM
E2372	POWER WHEELCHAIR ACCESSORY, GROUP 27 NON-SEALED LEAD ACID BATTERY, EACH			PRIOR AUTHORIZATION COST INVOICE REQUIRED PURCHASED ITEM
E2373	POWER WHEELCHAIR ACCESSORY, HAND OR CHIN CONTROL INTERFACE, **COMPACT REMOTE JOYSTICK, PROPORTIONAL, INCLUDING FIXED MOUNTING HARDWARE**			PRIOR AUTHORIZATION NEW CODE 01/01/2007
E2374	POWER WHEELCHAIR ACCESSORY, HAND OR CHIN CONTROL INTERFACE, STANDARD REMOTE JOYSTICK (NOT INCLUDING CONTROLLER), PROPROTIONAL, INCLUDING ALL RELATED ELECTRONICS AND FXED MOUNTING HARDWARE, REPLACEMENT ONLY	E2320		PRIOR AUTHORIZATION PURCHASE ITEM NEW CODE 01/01/2007
E2375	POWER WHEELCHAIR ACCESSORY, NON-EXPANDABLE CONTROLLER, INCLUDING ALL RELATED ELECTRONICS AND MOUNTING HARDWARE, REPLACEMENT ONLY			PRIOR AUTHORIZATION PURCHASE ITEM NEW CODE 01/01/2007
E2376	POWER WHEELCHAIR ACCESSORY, EXPANDABLE CONTROLLER, INCLUDING ALL RELATEDELECTRONICS AND MOUNTING HARDWARE, REPLACEMENT ONLY			PRIOR AUTHORIZATION PURCHASE ITEM NEW CODE 01/01/2007

HCPCS CODES	DESCRIPTION	REPLACES	SERVICE LIMIT	SPECIAL INSTRUCTIONS
E2377	POWER WHEELCHAIR ACCESSORY, EXPANDABLE CONTROLLER, INLUDING ALL RELATED ELECTRONICS AND MOUNTING HARDWARE, UPGRADE PROVIDED AT INITIAL ISSUE			PRIOR AUTHORIZATION PURCHASE ITEM NEW CODE 01/01/2007
E2381	POWER WHEELCHAIR ACCESSORY, PNEUMATIC DRIVE WHEEL TIRE, ANY SIZE, REPLACEMENT	K0090		PRIOR AUTHORIZATION PURCHASE ITEM NEW CODE 01/01/2007
E2382	POWER WHEELCHAIR ACCESSORY, TUBE FOR PNEUMATIC DRIVE WHEEL TIRE, ANY SIZE, REPLACEMENT ONLY, EACH	K0091		PRIOR AUTHORIZATION PURCHASE ITEM NEW CODE 01/01/2007
E2383	POWER WHEELCHAIR ACCESSSORY, INSERT FOR PNEUMATIC DRIVE WHEEL TIRE (REMOVABLE), ANY TYPE, ANY SIZE, REPLACEMENT ONLY, EACH			PRIOR AUTHORIZATION PURCHASE ITEM NEW CODE 01/01/2007
E2384	POWER WHEELCHAIR ACCESSORY, PNEUMATIC CASTER TIRE, ANY SIZE, REPLACEMENT ONLY	K0094		PRIOR AUTHORIZATION PURCHASE ITEM NEW CODE 01/01/2007
E2385	POWER WHEELCHAIR ACCESSORY, TUBE FOR PNEUMATIC CASTER TIRE, ANY SIZE, REPLACEMENT ONLY, EACH	K0095		PRIOR AUTHORIZATION PURCHASE ITEM NEW CODE 01/01/2007
E2386	POWER WHEELCHAIR ACCESSORY, FOAM FILLED DRIVE WHEEL TIRE, ANY SIZE REPLACEMENT ONLY, EACH	K0090		PRIOR AUTHORIZATION PURCHASE ITEM NEW CODE 01/01/2007
E2387	POWER WHEELCHAIR ACCESSORY, FOAM FILLED CASTER TIRE, ANY SIZE, REPLACEMENT ONLY, EACH	K0094		PRIOR AUTHORIZATION PURCHASE ITEM NEW CODE 01/01/2007
E2388	POWER WHEELCHAIR ACCESSORY, FOAM DRIVE WHEEL TIRE, ANY SIZE, REPLACMENT ONLY, EACH			PRIOR AUTHORIZATION PURCHASE ITEM NEW CODE 01/01/2007
E2389	POWER WHEELCHAIR ACCESSORY, FOAM CASTER TIRE, ANY SIZE, REPLACEMENT ONLY, EACH			PRIOR AUTHORIZATION PURCHASE ITEM NEW CODE 01/01/2007
E2390	POWER WHEELCHAIR ACCESSORY, SOLID (RUBBER/PLASTIC) DRIVE WHEEL TIRE, ANY SIZE, REPLACEMENT ONLY, EACH	K0090		PRIOR AUTHORIZATION PURCHASE ITEM NEW CODE 01/01/2007
E2391	POWER WHEELCHAIR ACCESSORY, SOLID (RUBBER/PLASTIC) CASTER TIRE (REMOVABLE), ANY SIZE, REPLACEMENT ONLY, EACH	K0094		PRIOR AUTHORIZATION PURCHASE ITEM NEW CODE 01/01/2007
E2392	POWER WHEELCHAIR ACCESSORY, SOLID (RUBBER/PLASTIC) CASTER TIRE WITH INTEGRATEDWHEEL, ANY SIZE, REPLACEMENT ONLY, EACH			PRIOR AUTHORIZATION PURCHASE ITEM NEW CODE 01/01/2007
E2393	POWER WHEELCHAIR ACCESSORY, VALVE FOR PNEUMATIC TIRE TUBE, ANY TYPE, REPLACEMENT ONLY, EACH			PRIOR AUTHORIZATION PURCHASE ITEM NEW CODE 01/01/2007

HCPCS CODES	DESCRIPTION	REPLACES	SERVICE LIMIT	SPECIAL INSTRUCTIONS
E2394	POWER WHEELCHAIR ACCESSORY, DRIVE WHEEL EXCLUDES TIRE, ANY SIZE, REPLACEMENT			PRIOR AUTHORIZATION PURCHASE ITEM NEW CODE 01/01/2007
E2395	POWER WHEELCHAIR ACCESSORY, CASTER WHEEL EXCLUDES TIRE, ANY SIZE, REPLACEMENT			PRIOR AUTHORIZATION PURCHASE ITEM NEW CODE 01/01/2007
E2396	POWER WHEELCHAIR ACCESSORY, CASTER FORK, ANY SIZE, REPLACEMENT ONLY, EACH			PRIOR AUTHORIZATION PURCHASE ITEM NEW CODE 01/01/2007
E2397	POWER WHEELCHAIR ACCESSORY, LITHIUM-BASED BATTERY, EACH			PRIOR AUTHORIZATION PURCHASE ITEM COST INVOICE REQUIRED NEW CODE 01/01/2008
E2399	POWER WHEELCHAIR ACCESSORY, NOT OTHERWISE CLASSIFIED INTERFACE, INCLUDING ALL RELATED ELECTRONICS AND ANY TYPE MOUNTING HARDWARE	K0108		PRIOR AUTHORIZATION COST INVOICE REQUIRED THIS CODE IS APPROPRIATELY USED IN THE FOLLOWING SITUATIONS: 1) AN INTEGRATED PROPORTIONAL JOYSTICK AND CONTROLLER BOX ARE BEING REPLACED DUE TO DAMAGE. 2) THE ITEM BEING REPLACE IS A REMOTE JOYSTICK BOX ONLY (WITHOUT THE CONTROLLER). 3) THE ITEM BEING REPLACED IS ANOTHER TYPE OF INTERFACE, E.G., SIP AND PUFF, HEAD CONTROL (WITHOUT THE CONTROLLER). 4) THE ITEM BEING REPLACED IS THE CONTOLLER BOX ONLY (WITHOUT THE REMOTE JOYSTICK OR OTHER TYPE OF INTERFACE). 5) THERE IS NOT SPECIFIC E CODE WHICH DESCRIBES THE TYPE OF DRIVE CONTROL INTERFACE SYSTEM WHICH IS PROVIDED. IN THIS SITUATION, E2399 WOULD BE USED AT THE TIME OF INITIAL ISSUE OR IF THE ITEM WAS BEING PROVIDED AS A REPLACEMENT. REQUEST FOR AUTHORIZATION MUST CONTAIN THE FOLLOWING DOCUMENTATION: 1) A CLEAR NARRATIVE DESCRIPTION OF THE ITEM THAT IS BEING REQUESTED. 2) IF REQUESTING REPLACEMENT, THE DOCUMENTATION MUST DESCRIBE THE ITEM THAT IS BEING REPLACED AND THE REASON FOR REPLACEMENT.
E2402	NEGATIVE PRESSURE WOUND THERAPY ELECTRICAL PUMP, STATIONARY OR PORTABLE	K0538	1 UNIT PER LIFETIME	PRIOR AUTHORIZATION. ITEM IS 10 MONTH CAP RENTAL MEDICAL NECESSITY REVIEW WILL BE BASED ON INTERQUAL DME GENERAL CRITERIA
E2500 – E2599	SPEECH GENERATING DEVICES			**REFER TO SPEECH/AUDIOLOGY MANUAL**
E2601	GENERAL USE WHEELCHAIR SEAT CUSHION, WIDTH LESS THAN 22 INCHES, ANY DEPTH	K0650 K0651	1 PER 2 ROLLING YEARS	PRIOR AUTHORIZATION PURCHASE ITEM MEDICAL NECESSITY REVIEW WILL BE BASED ON INTERQUAL DME GENERAL CRITERIA
E2602	GENERAL USE WHEELCHAIR SEAT CUSHION, WIDTH 22 INCHES OR GREATER, ANY DEPTH	K0650 K0651	1 PER 2 ROLLING YEARS	PRIOR AUTHORIZATION PURCHASE ITEM MEDICAL NECESSITY REVIEW WILL BE BASED ON INTERQUAL DME GENERAL CRITERIA

HCPCS CODES	DESCRIPTION	REPLACES	SERVICE LIMIT	SPECIAL INSTRUCTIONS
E2603	SKIN PROTECTION WHEELCHAIR SEAT CUSHION, WIDTH LESS THAN 22 INCHES, ANY DEPTH	K0652 K0653	1 PER 2 ROLLING YEARS	PRIOR AUTHORIZATION PURCHASE ITEM MEDICAL NECESSITY REVIEW WILL BE BASED ON INTERQUAL DME GENERAL CRITERIA
E2604	SKIN PROTECTION WHEELCHAIR SEAT CUSHION, WIDTH 22 INCHES OR GREATER, ANY DEPTH	K0652 K0653	1 PER 2 ROLLING YEARS	PRIOR AUTHORIZATION PURCHASE ITEM MEDICAL NECESSITY REVIEW WILL BE BASED ON INTERQUAL DME GENERAL CRITERIA
E2605	POSITIONING WHEELCHAIR SEAT CUSHION, WIDTH LESS THAN 22 INCHES, ANY DEPTH	K0654 K0655	1 PER 2 ROLLING YEARS	PRIOR AUTHORIZATION PURCHASE ITEM MEDICAL NECESSITY REVIEW WILL BE BASED ON INTERQUAL DME GENERAL CRITERIA
E2606	POSITIONING WHEELCHAIR SEAT CUSHION, WIDTH 22 INCHES OR GREATER, ANY DEPTH	K0654 K0655	1 PER 2 ROLLING YEARS	PRIOR AUTHORIZATION PURCHASE ITEM MEDICAL NECESSITY REVIEW WILL BE BASED ON INTERQUAL DME GENERAL CRITERIA
E2607	SKIN PROTECTION AND POSITIONING WHEELCHAIR SEAT CUSHION, WIDTH LESS THAN 22 INCHES, ANY DEPTH	K0656 K0657	1 PER 2 ROLLING YEARS	PRIOR AUTHORIZATION PURCHASE ITEM MEDICAL NECESSITY REVIEW WILL BE BASED ON INTERQUAL DME GENERAL CRITERIA
E2608	SKIN PROTECTION AND POSITIONING WHEELCHAIR SEAT CUSHION, WIDTH 22 INCHES OR GREATER, ANY DEPTH	K0656 K0657	1 PER 2 ROLLING YEARS	PRIOR AUTHORIZATION PURCHASE ITEM MEDICAL NECESSITY REVIEW WILL BE BASED ON INTERQUAL DME GENERAL CRITERIA
E2609	CUSTOM FABRICATED WHEELCHAIR SEAT CUSHION, ANY SIZE	K0658+K0666		PRIOR AUTHORIZATION PURCHASED ITEM COST INVOICE REQUIRED MEDICAL NECESSITY REVIEW WILL BE BASED ON INTERQUAL DME GENERAL CRITERIA
E2610	WHEELCHAIR SEAT CUSHION, POWERED		NON-COVERED	
E2611	GENERAL USE WHEELCHAIR BACK CUSHION, WIDTH LESS THAN 22 INCHES, ANY HEIGHT, INCLUDING ANY TYPE MOUNTING HARDWARE	K0660 K0661	1 PER 2 ROLLING YEARS	PRIOR AUTHORIZATION PURCHASED ITEM MEDICAL NECESSITY REVIEW WILL BE BASED ON INTERQUAL DME GENERAL CRITERIA
E2612	GENERAL USE WHEELCHAIR BACK CUSHION, WIDTH 22 INCHES OR GREATER, ANY HEIGHT, INCLUDING ANY TYPE MOUNTING HARDWARE	K0660 K0661	1 PER 2 ROLLING YEARS	PRIOR AUTHORIZATION PURCHASED ITEM MEDICAL NECESSITY REVIEW WILL BE BASED ON INTERQUAL DME GENERAL CRITERIA
E2613	POSITIONING WHEELCHAIR BACK CUSHION, POSTERIOR, WIDTH LESS THAN 22 INCHES, ANY HEIGHT, INCLUDING ANY TYPE MOUNTING HARDWARE	K0662 K0663	1 PER 2 ROLLING YEARS	PRIOR AUTHORIZATION PURCHASED ITEM MEDICAL NECESSITY REVIEW WILL BE BASED ON INTERQUAL DME GENERAL CRITERIA

HCPCS CODES	DESCRIPTION	REPLACES	SERVICE LIMIT	SPECIAL INSTRUCTIONS
E2614	POSITIONING WHEELCHAIR BACK CUSHION, POSTERIOR, WIDTH 22 INCHES OR GREATER, ANY HEIGHT, INCLUDING ANY TYPE MOUNTING HARDWARE	K0662 K0663	1 PER 2 ROLLING YEARS	PRIOR AUTHORIZATION PURCHASED ITEM MEDICAL NECESSITY REVIEW WILL BE BASED ON INTERQUAL DME GENERAL CRITERIA
E2615	POSITIONING WHEELCHAIR BACK CUSHION, POSTERIOR-LATERAL, WIDTH LESS THAN 22 NCHES, ANY HEIGHT, INCLUDING ANY TYPE MOUNTING HARDWARE	K0664 K0665	1 PER 2 ROLLING YEARS	PRIOR AUTHORIZATION PURCHASED ITEM MEDICAL NECESSITY REVIEW WILL BE BASED ON INTERQUAL DME GENERAL CRITERIA
E2616	POSITIONING WHEELCHAIR BACK CUSHION, POSTERIOR-LATERAL, WIDTH 22 INCHES OR GREATER, ANY HEIGHT, INCLUDING ANY TYPE MOUNTING HARDWARE	K0664 K0665	1 PER 2 ROLLING YEARS	PRIOR AUTHORIZATION PURCHASED ITEM MEDICAL NECESSITY REVIEW WILL BE BASED ON INTERQUAL DME GENERAL CRITERIA
E2617	CUSTOM FABRICATED WHEELCHAIR BACK CUSHION, ANY SIZE, INCLUDING ANY TYPE MOUNTING HARDWARE	K0658+K0666	1 PER 2 ROLLING YEARS	PRIOR AUTHORIZATION PURCHASED ITEM COST INVOICE REQUIRED MEDICAL NECESSITY REVIEW WILL BE BASED ON INTERQUAL DME GENERAL CRITERIA
E2618	WHEELCHAIR ACCESSORY, SOLID SEAT SUPPORT BASE (REPLACES SLING SEAT), FOR USE WITH MANUAL WHEELCHAIR OR LIGHTWEIGHT POWER WHEELCHAIR, INCLUDES ANY TYPE MOUNTING HARDWARE	K0667		PRIOR AUTHORIZATION PURCHASED ITEM COST INVOICE REQUIRED DISCONTINUED BY CMS 12/31/2007
E2619RP	REPLACEMENT COVER FOR WHEELCHAIR SEAT CUSHION OR BACK CUSHION, EACH	K0668	4 PER ROLLING YEAR	PRIOR AUTHORIZATION PURCHASED ITEM
E2620	POSITIONING WHEELCHAIR BACK CUSHION, PLANAR BACK WITH LATERAL SUPPORTS, WIDTH LESS THAN 22 INCHES, ANY HEIGHT, INCLUDING ANY TYPE MOUNTING HARDWARE	K0108		PRIOR AUTHORIZATION PURCHASED ITEM
E2621	POSITIONING WHEELCHAIR BACK CUSHION, PLANAR BACK WITH LATERAL SUPPORTS, WIDTH 22 INCHES OR GREATER, ANY HEIGHT, INCLUDING ANY TYPE MOUNTING HARDWARE			PRIOR AUTHORIZATION PURCHASED ITEM
E8000	GAIT TRAINER, PEDIATRIC SIZE, POSTERIOR SUPPORT, INCLUDES ALL ACCESSORIES AND COMPONENTS		NON-COVERED	
E8001	GAIT TRAINER, PEDIATRIC SIZE, UPRIGHT SUPPORT, INCLUDES ALL ACCESSORIES AND COMPONENTS		NON-COVERED	
E8002	GAIT TRAINER, PEDIATRIC SIZE, ANTERIOR SUPPORT, INCLUDES ALL ACCESSORIES AND COMPONENTS		NON-COVERED	

HCPCS CODES	DESCRIPTION	REPLACES	SERVICE LIMIT	SPECIAL INSTRUCTIONS
K0001	STANDARD WHEELCHAIR		1 UNIT PER 5 ROLLING YEARS	PRIOR AUTHORIZATION ITEM IS 10 MONTHCAP RENTAL COVERAGE FOR MEMBERS WEIGHING 250 LBS OR LESS NON- REIMBURSABLE WITH: E0967, E0981, E0982, E0995, E2205, E2206, E2210, E2220, E2221, E2222, E2223, E2224, E2225, E2226, , E2367, K0015, K0017, K0018, K0019, K0042, K0043, K0044, K0045, K0046, K0047, K0050, K0051, K0052,K0069, K0070, K0071, K0072 OR WHEELCHAIR BASES: E1161, E1229, E1231, E1232, E1233, E1234, E1235, E1236, E1237, E1238, K0002, K0003, K0004, K0005, K0006, K0007, K0009, K0800, K0801,K0802,K0806,K0807,K0808, OR K0812 THRU K0891 MEDICAL NECESSITY REVIEW WILL BE BASED ON INTERQUAL DME GENERAL CRITERIA
K0002	STANDARD HEMI (LOW SEAT) WHEELCHAIR		1 UNIT PER 5 ROLLING YEARS	PRIOR AUTHORIZATION ITEM IS 10 MONTHCAP RENTAL COVERAGE FOR MEMBERS WEIGHING 250 LBS OR LESS NON- REIMBURSABLE WITH: E0967, E0981, E0982, E0995, E2205, E2206, E2210, E2220, E2221, E2222, E2223, E2224, E2225, E2226, , E2367, K0015, K0017, K0018, K0019, K0042, K0043, K0044, K0045, K0046, K0047, K0050, K0051, K0052,K0069, K0070, K0071, K0072 OR WHEELCHAIR BASES: E1161, E1229, E1231, E1232, E1233, E1234, E1235, E1236, E1237, E1238, K0001, K0003, K0004, K0005, K0006, K0007, K0009, K0800, K0801,K0802,K0806,K0807,K0808, OR K0812 THRU K0891 MEDICAL NECESSITY REVIEW WILL BE BASED ON INTERQUAL DME GENERAL CRITERIA
K0003	LIGHTWEIGHT WHEELCHAIR		1 UNIT PER 5 ROLLING YEARS	PRIOR AUTHORIZATION ITEM IS 10 MONTHCAP RENTAL COVERAGE FOR MEMBERS WEIGHING 250 LBS OR LESS NON- REIMBURSABLE WITH: E0967, E0981, E0982, E0995, E2205, E2206, E2210, E2220, E2221, E2222, E2223, E2224, E2225, E2226, , E2367, K0015, K0017, K0018, K0019, K0042, K0043, K0044, K0045, K0046, K0047, K0050, K0051, K0052,K0069, K0070, K0071, K0072 OR WHEELCHAIR BASES: E1161, E1229, E1231, E1232, E1233, E1234, E1235, E1236, E1237, E1238, K0001,K0002, K0004, K0005, K0006, K0007, K0009, K0800, K0801,K0802,K0806,K0807,K0808, OR K0812 THRU K0891 MEDICAL NECESSITY REVIEW WILL BE BASED ON INTERQUAL DME GENERAL CRITERIA

HCPCS CODES	DESCRIPTION	REPLACES	SERVICE LIMIT	SPECIAL INSTRUCTIONS
K0004	HIGH STRENGTH, LIGHTWEIGHT WHEELCHAIR		1 UNIT PER 5 ROLLING YEARS	PRIOR AUTHORIZATION ITEM IS 10 MONTHCAP RENTAL COVERAGE FOR MEMBERS WEIGHING 250 LBS OR LESS NON- REIMBURSABLE WITH: E0967, E0981, E0982, E0995, E2205, E2206, E2210, E2220, E2221, E2222, E2223, E2224, E2225, E2226, , E2367, K0015, K0017, K0018, K0019, K0042, K0043, K0044, K0045, K0046, K0047, K0050, K0051, K0052,K0069, K0070, K0071, K0072 OR WHEELCHAIR BASES: E1161, E1229, E1231, E1232, E1233, E1234, E1235, E1236, E1237, E1238, K0001, K0002, K0003, K0005, K0006, K0007, K0009, K0800, K0801,K0802,K0806,K0807,K0808, OR K0812 THRU K0891 MEDICAL NECESSITY REVIEW WILL BE BASED ON INTERQUAL DME GENERAL CRITERIA
K0005	ULTRALIGHTWEIGHT WHEELCHAIR		1 UNIT PER 5 ROLLING YEARS	PRIOR AUTHORIZATION ITEM IS 10 MONTHCAP RENTAL COVERAGE FOR MEMBERS WEIGHING 250 LBS OR LESS NON- REIMBURSABLE WITH: E0967, E0981, E0982, E0995, E2205, E2206, E2210, E2220, E2221, E2222, E2223, E2224, E2225, E2226, , E2367, K0015, K0017, K0018, K0019, K0042, K0043, K0044, K0045, K0046, K0047, K0050, K0051, K0052,K0069, K0070, K0071, K0072 OR WHEELCHAIR BASES: E1161, E1229, E1231, E1232, E1233, E1234, E1235, E1236, E1237, E1238, K0001, K0002, K0003, K0004, K0006, K0007, K0009, K0800, K0801,K0802,K0806,K0807,K0808, OR K0812 THRU K0891 MEDICAL NECESSITY REVIEW WILL BE BASED ON INTERQUAL DME GENERAL CRITERIA
K0006	HEAVY DUTY WHEELCHAIR		1 UNIT PER 5 ROLLING YEARS	PRIOR AUTHORIZATION ITEM IS 10 MONTHCAP RENTAL COVERAGE FOR MEMBERS WEIGHING 250 LBS OR LESS NON- REIMBURSABLE WITH: E0967, E0981, E0982, E0995, E2205, E2206, E2210, E2220, E2221, E2222, E2223, E2224, E2225, E2226, , E2367, K0015, K0017, K0018, K0019, K0042, K0043, K0044, K0045, K0046, K0047, K0050, K0051, K0052,K0069, K0070, K0071, K0072 OR WHEELCHAIR BASES: E1161, E1229, E1231, E1232, E1233, E1234, E1235, E1236, E1237, E1238, K0001, K0002, K0003, K0004, K0005, K0007, K0009, K0800, K0801,K0802,K0806,K0807,K0808, OR K0812 THRU K0891 MEDICAL NECESSITY REVIEW WILL BE BASED ON INTERQUAL DME GENERAL CRITERIA

HCPCS CODES	DESCRIPTION	REPLACES	SERVICE LIMIT	SPECIAL INSTRUCTIONS
K0007	EXTRA HEAVY DUTY WHEELCHAIR		1 UNIT PER 5 ROLLING YEARS	PRIOR AUTHORIZATION ITEM IS 10 MONTHCAP RENTAL COVERAGE FOR MEMBERS WEIGHING 250 LBS OR LESS NON- REIMBURSABLE WITH: E0967, E0981, E0982, E0995, E2205, E2206, E2210, E2220, E2221, E2222, E2223, E2224, E2225, E2226, , E2367, K0015, K0017, K0018, K0019, K0042, K0043, K0044, K0045, K0046, K0047, K0050, K0051, K0052,K0069, K0070, K0071, K0072 OR WHEELCHAIR BASES: E1161, E1229, E1231, E1232, E1233, E1234, E1235, E1236, E1237, E1238, K0001, K0002, K0003, K0004, K0005, K0006, K0009, K0800, K0801,K0802,K0806,K0807,K0808, OR K0812 THRU K0891 MEDICAL NECESSITY REVIEW WILL BE BASED ON INTERQUAL DME GENERAL CRITERIA
K0009	OTHER MANUAL WHEELCHAIR/BASE		1 UNIT PER 5 ROLLING YEARS	PRIOR AUTHORIZATION ITEM IS 10 MONTHCAP RENTAL COVERAGE FOR MEMBERS WEIGHING 250 LBS OR LESS NON- REIMBURSABLE WITH: E0967, E0981, E0982, E0995, E2205, E2206, E2210, E2220, E2221, E2222, E2223, E2224, E2225, E2226, , E2367, K0015, K0017, K0018, K0019, K0042, K0043, K0044, K0045, K0046, K0047, K0050, K0051, K0052,K0069, K0070, K0071, K0072 OR WHEELCHAIR BASES: E1161, E1229, E1231, E1232, E1233, E1234, E1235, E1236, E1237, E1238, K0001, K0002, K0003, K0004, K0005, K0006, K0007, K0800, K0801,K0802,K0806,K0807,K0808, OR K0812 THRU K0891 MEDICAL NECESSITY REVIEW WILL BE BASED ON INTERQUAL DME GENERAL CRITERIA
K0010	STANDARD - WEIGHT FRAME MOTORIZED/POWER WHEELCHAIR		1 UNIT PER 5 ROLLING YEARS	PRIOR AUTHORIZATION. ITEM IS 10 MONTH CAP RENTAL. NON-REIMBURSABLE WITH: E0971, E0981, E0982, E0995, E2366, E2367, K0015, K0017, K0018, K0019, K0042, K0043, K0044, K0045, K0046, K0047, K0050, K0051, K0052, K0081, K0090, K0092, K0094, K0096, K0098, K0099, K0452 OR WHEELCHAIR BASES E1161, E1231,E1232, E1233, E1234, E1235, E1236, E1237, E1238, K0001, K0002, K0003, K0004, K0005, K0006, K0007, K0009, K0011, K0012, K0014 MEDICAL NECESSITY REVIEW WILL BE BASED ON INTERQUAL DME GENERAL CRITERIA CLOSED BY BMS EFFECTIVE 6/30/2007

HCPCS CODES	DESCRIPTION	REPLACES	SERVICE LIMIT	SPECIAL INSTRUCTIONS
K0011	STANDARD - WEIGHT FRAME MOTORIZED/POWER WHEELCHAIR WITH PROGRAMMABLE CONTROL PARAMETERS FOR SPEED ADJUSTMENT, TREMOR DAMPENING, ACCELERATION CONTROL AND BRAKING		1 UNIT PER 5 ROLLING YEARS	PRIOR AUTHORIZATION. ITEM IS 10 MONTH CAP RENTAL. NON-REIMBURSABLE WITH: E0971, E0981, E0982, E0995, E2366, E2367, K0015, K0017, K0018, K0019, K0042, K0043, K0044, K0045, K0046, K0047, K0050, K0051, K0052, K0081, K0090, K0092, K0094, K0096, K0098, K0099, K0452 OR WHEELCHAIR BASES E1161, E1231,E1232, E1233, E1234, E1235, E1236, E1237, E1238, K0001, K0002, K0003, K0004, K0005, K0006, K0007, K0009, K0010, K0012, K0014 MEDICAL NECESSITY REVIEW WILL BE BASED ON INTERQUAL DME GENERAL CRITERIA CLOSED BY BMS EFFECTIVE 6/30/2007
K0012	LIGHTWEIGHT PORTABLE MOTORIZED/POWER WHEELCHAIR		1 UNIT PER 5 ROLLING YEARS	PRIOR AUTHORIZATION. ITEM IS 10 MONTH CAP RENTAL. NON-REIMBURSABLE WITH: E0971, E0981, E0982, E0995, E2366, E2367, K0015, K0017, K0018, K0019, K0042, K0043, K0044, K0045, K0046, K0047, K0050, K0051, K0052, K0081, K0090, K0092, K0094, K0096, K0098, K0099, K0452 OR WHEELCHAIR BASES E1161, E1231,E1232, E1233, E1234, E1235, E1236, E1237, E1238, K0001, K0002, K0003, K0004, K0005, K0006, K0007, K0009, K0010, K0011, K0014 MEDICAL NECESSITY REVIEW WILL BE BASED ON INTERQUAL DME GENERAL CRITERIA CLOSED BY BMS EFFECTIVE 6/30/2007
K0014	OTHER MOTORIZED/POWER WHEELCHAIR BASE		1 UNIT PER 5 ROLLING YEARS	PRIOR AUTHORIZATION PURCHASED ITEM COST INVOICE REQUIRED . NON-REIMBURSABLE WITH: E0971, E0981, E0982, E0995, E2366, E2367, K0015, K0017, K0018, K0019, K0042, K0043, K0044, K0045, K0046, K0047, K0050, K0051, K0052, K0081, K0090, K0092, K0094, K0096, K0098, K0099, K0452 OR WHEELCHAIR BASES E1161, E1231,E1232, E1233, E1234, E1235, E1236, E1237, E1238, K0001, K0002, K0003, K0004, K0005, K0006, K0007, K0009, K0 MEDICAL NECESSITY REVIEW WILL BE BASED ON INTERQUAL DME GENERAL CRITERIA CLOSED BY BMS EFFECTIVE 6/30/2007
K0015	DETACHABLE, NON-ADJUSTABLE HEIGHT ARMREST, EACH			PRIOR AUTHORIZATION PURCHASED ITEM NON-REIMBURSABLE WITH: E1002, E1003, E1004, E1005, E1006, E1007, E1008, E1161, E1231, E1233, E1234, E1235, E1236, E1237, E1238, K0001, K0002, K0003, K0004, K0005, K0006, K0007, K0009, K0813 THRU K0843 OR K0848 THRU K0891

HCPCS CODES	DESCRIPTION	REPLACES	SERVICE LIMIT	SPECIAL INSTRUCTIONS
K0017	DETACHABLE, ADJUSTABLE HEIGHT ARMREST, BASE, EACH			PRIOR AUTHORIZATION PURCHASED ITEM NON-REIMBURSABLE WITH: E1002, E1003, E1004, E1005, E1006, E1007, E1008, E1161, E1231, E1233, E1234, E1235, E1236, E1237, E1238, K0001, K0002, K0003, K0004, K0005, K0006, K0007, K0009, K0813 THRU K0843 OR K0848 THRU K0891
K0018	DETACHABLE, ADJUSTABLE HEIGHT ARMREST, UPPER PORTION, EACH			PRIOR AUTHORIZATION PURCHASED ITEM NON-REIMBURSABLE WITH: E1002, E1003, E1004, E1005, E1006, E1007, E1008, E1161, E1231, E1233, E1234, E1235, E1236, E1237, E1238, K0001, K0002, K0003, K0004, K0005, K0006, K0007, K0009, K0813 THRU K0843 OR K0848 THRU
K0019	ARM PAD, EACH			PRIOR AUTHORIZATION PURCHASED ITEM NON-REIMBURSABLE WITH: E1002, E1003, E1004, E1005, E1006, E1007, E1008, E1161, E1231, E1233, E1234, E1235, E1236, E1237, E1238, K0001, K0002, K0003, K0004, K0005, K0006, K0007, K0009, K0813 THRU K0843 OR K0848 THRU K0891
K0020	FIXED, ADJUSTABLE HEIGHT ARMREST, PAIR			PRIOR AUTHORIZATION PURCHASED ITEM NON-REIMBURSABLE WITH: E1002, E1003, E1004, E1005, E1006, E1007, E1008, K0813 THRU K0843 OR K0848 THRU K0891
K0037	HIGH MOUNT FLIP-UP FOOTREST, EACH			PRIOR AUTHORIZATION PURCHASED ITEM NON-REIMBURSABLE WITH: K0813 THRU K0843 OR K0848 THRU K0891
K0038	LEG STRAP, EACH			PRIOR AUTHORIZATION PURCHASED ITEM NON-REIMBURSABLE WITH: K0039
K0039	LEG STRAP, H STYLE, EACH			PRIOR AUTHORIZATION PURCHASED ITEM NON-REIMBURSABLE WITH: K0038
K0040	ADJUSTABLE ANGLE FOOTPLATE, EACH			PRIOR AUTHORIZATION PURCHASED ITEM NON-REIMBURSABLE WITH: K0813 OR K0843
K0041	LARGE SIZE FOOTPLATE, EACH			PRIOR AUTHORIZATION PURCHASED ITEM NON-REIMBURSABLE WITH: K0813 THRU K0843 OR K0848 THRU K0891
K0042	STANDARD SIZE FOOTPLATE, EACH			PRIOR AUTHORIZATION PURCHASED ITEM NON-REIMBURSABLE WITH: E0990, E1002, E1003, E1004, E1005, E1006, E1007, E1008,, E1009, E1010, E1161, E1231, E1233, E1234, E1235, E1236, E1237, E1238, K001, K002, K0003, K0004, K0005, K0006, K0007, K0009, K0043, K0044, K0045, K0046, K0047, K0053, K0195, K0813 THRU K0843 OR K0848 THRU K0891

HCPCS CODES	DESCRIPTION	REPLACES	SERVICE LIMIT	SPECIAL INSTRUCTIONS
K0043	FOOTREST, LOWER EXTENSION TUBE, EACH			PRIOR AUTHORIZATION PURCHASED ITEM NON-REIMBURSABLE WITH: E0990,E1002, E1003, E1004, E1005, E1006, E1007, E1008,, E1009, E1010, E1161, E1231, E1233, E1234, E1235, E1236, E1237, E1238, K001, K002, K0003, K0004, K0005, K0006, K0007, K0009, K0042, K0043, K0044,K0045,K0046, K0047,K0053, K0195, K0813 THRU K0843 OR K0848 THRU K0891
K0044	FOOTREST, UPPER HANGER BRACKET, EACH			PRIOR AUTHORIZATION PURCHASED ITEM NON-REIMBURSABLE WITH: E0990, E1161, E1231, E1233, E1234, E1235, E1236, E1237, E1238, K0001, K0002, K0003, K0004, K0005, K0006, K0007, K0009, K0042, K0043, K0045, K0046, K0047 OR K0053
K0045	FOOTREST, COMPLETE ASSEMBLY			PRIOR AUTHORIZATION PURCHASED ITEM NON-REIMBURSABLE WITH: E0990,E1161, E1231, E1233, E1234, E1235, E1236, E1237, E1238, K0001, K0002, K0003, K0004, K0005, K0006, K0007, K0009, K0042, K0043, K0044, K0046, K0047, K0053, K0195, K0813 THRU K0843 OR K0848 THRU K0891
K0046	ELEVATING LEGREST, LOWER EXTENSION TUBE, EACH			PRIOR AUTHORIZATION PURCHASED ITEM NON-REIMBURSABLE WITH: E0990,E1002, E1003, E1004, E1005, E1006, E1007, E1008,, E1009, E1010, E1161, E1231, E1233, E1234, E1235, E1236, E1237, E1238, K0001, K0002, K0003, K0004, K0005, K0006, K0007, K0009, K0042, K0043, K0044, K0045, K0047, K0053,K0195, K0813 THRU K0843 OR K0848 THRU K0891
K0047	ELEVATING LEGREST, UPPER HANGER BRACKET, EACH			PRIOR AUTHORIZATION PURCHASED ITEM NON-REIMBURSABLE WITH: E0990,E1002, E1003, E1004, E1005, E1006, E1007, E1008,, E1009, E1010, E1161, E1231, E1233, E1234, E1235, E1236, E1237, E1238, K0001, K0002, K0003, K0004, K0005, K0006, K0007, K0009, K0042, K0043, K0044, K0045, K0046, K0053, K0195, K0813 THRU K0843 OR K0848 THRU K0891
K0050	RATCHET ASSEMBLY			PRIOR AUTHORIZATION PURCHASED ITEM NON-REIMBURSABLE WITH: E1161, E1231, E1233, E1234, E1235, E1236, E1237, E1238, K0001, K0002, K0003, K0004, K0005, K0006, K0007 OR K0009
K0051	CAM RELEASE ASSEMBLY, FOOTREST OR LEGREST, EACH			PRIOR AUTHORIZATION PURCHASED ITEM NON-REIMBURSABLE WITH: E1002, E1003, E1004, E1005, E1006, E1007, E1008, K0813 THRU K0843 OR K0848 THRU K0891

HCPCS CODES	DESCRIPTION	REPLACES	SERVICE LIMIT	SPECIAL INSTRUCTIONS
K0052	SWINGAWAY, DETACHABLE FOOTRESTS, EACH			PRIOR AUTHORIZATION PURCHASED ITEM NON-REIMBURSABLE WITH: E1002, E1003, E1004, E1005, E1006, E1007, E1008,, E1009, E1010, E1161, E1231, E1233, E1234, E1235, E1236, E1237, E1238, K0001, K0002, K0003, K0004, K0005, K0006, K0007, K0009, K0813 THRU K0843 OR K0848 THRU K0891
K0053	ELEVATING FOOTRESTS, ARTICULATING (TELESCOPING), EACH			PRIOR AUTHORIZATION PURCHASED ITEM NON-REIMBURSABLE WITH: E0990, E0995,E1009,E1010, K0042, K0043, K0044, K0045, K0046, OR K0047
K0056	SEAT HEIGHT LESS THAN 17" OR EQUAL TO OR GREATER THAN 21" FOR A HIGH STRENGTH, LIGHTWEIGHT, OR ULTRALIGHTWEIGHT WHEELCHAIR			PRIOR AUTHORIZATION PURCHASED ITEM
K0060	STEEL HANDRIM, EACH		NON-COVERED	
K0064	ZERO PRESSURE TUBE (FLAT FREE INSERTS), ANY SIZE, EACH			DISCONTINUED BY CMS 12/31/2005
K0065	SPOKE PROTECTORS, EACH			PRIOR AUTHORIZATION PURCHASED ITEM
K0066	SOLID TIRE, ANY SIZE, EACH			DISCONTINUED BY CMS 12/31/2005
K0067	PNEUMATIC TIRE, ANY SIZE, EACH	E0953		DISCONTINUED BY CMS 12/31/2005
K0068	PNEUMATIC TIRE TUBE, EACH			DISCONTINUED BY CMS 12/31/2005
K0069	REAR WHEEL ASSEMBLY, COMPLETE, WITH SOLID TIRE, SPOKES OR MOLDED, EACH			PRIOR AUTHORIZATION PURCHASED ITEM NON-REIMBURSABLE WITH: E1161, E1231, E1233, E1234, E1235, E1236, E1237, E1238,E2220, E2224, K0001, K0002, K0003, K0004, K0005, K0006, K0007 OR K0009
K0070	REAR WHEEL ASSEMBLY, COMPLETE, WITH PNEUMATIC TIRE, SPOKES OR MOLDED, EACH			PRIOR AUTHORIZATION PURCHASED ITEM NON-REIMBURSABLE WITH: E1161, E1231, E1233, E1234, E1235, E1236, E1237, E1238,E2211, E2212, E2223, E2224, K0001, K0002, K0003, K0004, K0005, K0006, K0007 OR K0009
K0071	FRONT CASTER ASSEMBLY, COMPLETE, WITH PNEUMATIC TIRE, EACH			PRIOR AUTHORIZATION PURCHASED ITEM NON-REIMBURSABLE WITH: E1161, E1231, E1233, E1234, E1235, E1236, E1237, E1238, E2214, E2215, E2223, E2224, K0001, K0002, K0003, K0004, K0005, K0006, K0007 OR K0009

HCPCS CODES	DESCRIPTION	REPLACES	SERVICE LIMIT	SPECIAL INSTRUCTIONS
K0072	FRONT CASTER ASSEMBLY, COMPLETE, WITH SEMI-PNEUMATIC TIRE, EACH			PRIOR AUTHORIZATION PURCHASED ITEM NON-REIMBURSABLE WITH: E1161, E1231, E1233, E1234, E1235, E1236, E1237, E1238, E2219, E2225, E2226, K0001, K0002, K0003, K0004, K0005, K0006, K0007 OR K0009
K0073	CASTER PIN LOCK,EACH			PRIOR AUTHORIZATION PURCHASED ITEM
K0074	PNEUMATIC CASTER TIRE, ANY SIZE, EACH			DISCONTINUED BY CMS 12/31/2005
K0075	SEMI-PNEUMATIC CASTER TIRE, ANY SIZE, EACH	E0954		DISCONTINUED BY CMS 12/31/2005
K0076	SOLID CASTER TIRE, ANY SIZE, EACH			DISCONTINUED BY CMS 12/31/2005
K0077	FRONT CASTER ASSEMBLY, COMPLETE, WITH SOLID TIRE, EACH			PRIOR AUTHORIZATION PURCHASED ITEM NON-REIMBURSABLE WITH: E2221, E2222, 32225 OR E2226
K0078	PNEUMATIC CASTER TIRE TUBE, EACH			DISCONTINUED BY CMS 12/31/2005
K0090	REAR WHEEL TIRE FOR POWER WHEELCHAIR, ANY SIZE, EACH			PRIOR AUTHORIZATION PURCHASED ITEM NON-REIMBURSABLE WITH: K0010, K0011, K0012, K0014, K0091 OR K0092 CLOSED BY CMS 12/31/2006
K0091	REAR WHEEL TIRE TUBE OTHER THAN ZERO PRESSURE FOR POWER WHEELCHAIR, ANY SIZE, EACH			PRIOR AUTHORIZATION PURCHASED ITEM NON-REIMBURSABLE WITH: K0090 OR K0092 CLOSED BY CMS 12/31/2006
K0092	REAR WHEEL ASSEMBLY FOR POWER WHEELCHAIR, COMPLETE, EACH			PRIOR AUTHORIZATION PURCHASED ITEM NON-REIMBURSABLE WITH: K0010, K0011, K0012,K0014, K0090 OR K0091 CLOSED BY CMS 12/31/2006
K0093	REAR WHEEL, ZERO PRESSURE TIRE TUBE (FLAT FREE INSERT) FOR POWER WHEELCHAIR, ANY SIZE, EACH			PRIOR AUTHORIZATION PURCHASED ITEM CLOSED BY CMS 12/31/2006
K0094	WHEEL TIRE FOR POWER BASE, ANY SIZE, EACH			PRIOR AUTHORIZATION PURCHASED ITEM NON-REIMBURSABLE WITH: K0010, K0011, K0012,K0014, K0095 OR K0096 CLOSED BY CMS 12/31/2006
K0095	WHEEL TIRE TUBE OTHER THAN ZERO PRESSURE FOR EACH BASE, ANY SIZE, EACH			PRIOR AUTHORIZATION PURCHASED ITEM NON-REIMBURSABLE WITH: K0094 OR K0095 CLOSED BY CMS 12/31/2006

HCPCS CODES	DESCRIPTION	REPLACES	SERVICE LIMIT	SPECIAL INSTRUCTIONS
K0096	WHEEL ASSEMBLY FOR POWER BASE, COMPLETE, EACH			PRIOR AUTHORIZATION PURCHASED ITEM NON-REIMBURSABLE WITH: K0010, K0011, K0012, K0014, K0094 OR K0095 CLOSED BY CMS 12/31/2006
K0097	WHEEL ZERO PRESSURE TIRE TUBE (FLAT FREE INSERT) FOR POWER BASE, ANY SIZE, EACH			PRIOR AUTHORIZATION PURCHASED ITEM CLOSED BY CMS 12/31/2006
K0098	DRIVE BELT FOR POWER WHEELCHAIR			PRIOR AUTHORIZATION PURCHASED ITEM NON-REIMBURSABLE WITH: K0813 THRU K0843 OR K0848 THRU K0891
K0099	FRONT CASTER FOR POWER WHEELCHAIR, EACH			PRIOR AUTHORIZATION PURCHASED ITEM NON-REIMBURSABLE WITH: K0010, K0011, K0012 OR K0014 DISCONTINUED BY CMS 12/31/2006
K0102	CRUTCH AND CANE HOLDER, EACH			DISCONTINUED BY CMS 12/31/2005
K0104	CYLINDER TANK CARRIER, EACH			DISCONTINUED BY CMS 12/31/2005
K0105	IV HANGER, EACH			PRIOR AUTHORIZATION PURCHASED ITEM
K0106	ARM TROUGH, EACH			DISCONTINUED BY CMS 12/31/2005
K0108	WHEELCHAIR COMPONENT OR ACCESSORY, NOT OTHERWISE SPECIFIED			PRIOR AUTHORIZATION COST INVOICE REQUIRED
K0195	ELEVATING LEG RESTS, PAIR (FOR USE WITH CAPPED RENTAL WHEELCHAIR BASE)			PRIOR AUTHORIZATION PURCHASED ITEM NON REIMBURSABLE WITH: E0995, E1009,E1010, K0042, K0043, K0044, K0045, K0046 OR K0047
K0415	PRESCRIPTION ANTIEMETIC DRUG, ORAL, PER 1 MG, FOR USE IN CONJUNCTION WITH ORAL ANTI-CANCER DRUG, NOT OTHERWISE SPECIFIED		NON-COVERED	
K0416	PRESCRIPTION ANTIEMETIC DRUG, RECTAL, PER 1 MG, FOR USE IN CONJUCTION WITH ORAL ANTI-CANCER DRUG, NOT OTHERWISE SPECIFIED		NON-COVERED	
K0452	WHEELCHAIR BEARINGS, ANY TYPE			DISCONTINUED BY CMS 12/31/2005
K0455	INFUSION PUMP USED FOR UNINTERRUPTED PARENTERAL ADMINISTRATION OF MEDICATION, (E.G., EPOPROSTENOL OR TREPROSTINOL)		NON-COVERED	
K0462	TEMPORARY REPLACEMENT FOR PATIENT OWNED EQUIPMENT BEING REPAIRED, ANY TYPE		NON-COVERED	

HCPCS CODES	DESCRIPTION	REPLACES	SERVICE LIMIT	SPECIAL INSTRUCTIONS
K0553	COMBINATION ORAL/NASAL MASK, USED WITH CONTINUOUS POSTIVE AIRWAY PRESSURE DEVICE, EACH		NON-COVERED	DISCONTINUED BY CMS 12/31/2007
K0554	ORAL CUSHION FOR COMBINATION ORAL/NASAL MASK, REPLACEMENT ONLY, EACH		NON-COVERED	DISCONTINUED BY CMS 12/31/2007
K0555	NASAL PILLOWS FOR COMBINATION ORAL/NASAL MASK, REPLACEMENT ONLY, PAIR		NON-COVERED	DISCONTINUED BY CMS 12/31/2007
K0600	FUNCTIONAL NEUROMUSCULAR STIMULATOR, TRANSCUTANEOUS STIMULATION OF MUSCLES OF AMBULATION WITH COMPUTER CONTROL, USED FOR WALKING BY SPINAL CORD INJURED, ENTIRE SYSTEM, AFTER COMPLETION OF TRAINING PROGRAM		NON-COVERED	
K0601	REPLACEMENT BATTERY FOR EXTERNAL INFUSION PUMP OWNED BY PATIENT, SILVER OXIDE, 1.5 VOLT, EACH		NON-COVERED	
K0602	REPLACEMENT BATTERY FOR EXTERNAL INFUSION PUMP OWNED BY PATIENT, SILVER OXIDE, 3 VOLT, EACH		NON-COVERED	
K0603	REPLACEMENT BATTERY FOR EXTERNAL INFUSION PUMP OWNED BY PATIENT, ALKALINE, 1.5 VOLT, EACH		NON-COVERED	
K0604	REPLACEMENT BATTERY FOR EXTERNAL INFUSION PUMP OWNED BY PATIENT, LITHIUM, 3.6 VOLT, EACH		NON-COVERED	
K0605	REPLACEMENT BATTERY FOR EXTERNAL INFUSION PUMP OWNED BY PATIENT, LITHIUM, 4.5 VOLT, EACH		NON-COVERED	
K0606	AUTOMATIC EXTERNAL DEFIBRILLATOR, WITH INTEGRATED ELECTROCARDIOGRAM ANALYSIS, GARMENT TYPE			PRIOR AUTHORIZATION 10 MONTH CAP RENTAL NON-REIMBURSABLE WITH K0607, K0608 AND K0609MEDICAL NECESSITY REVIEW WILL BE BASED ON INTERQUAL DME GENERAL CRITERIA EFFECTIVE 01/01/2008
K0607	REPLACEMENT BATTERY FOR AUTOMATED EXTERNAL DEFIBRILLATOR, GARMENT TYPE ONLY, EACH		NON-COVERED	
K0608	REPLACEMENT GARMENT FOR USE WITH AUTOMATED EXTERNAL DEFIBRILLATOR, EACH		NON-COVERED	
K0609	REPLACEMENT ELECTRODES FOR USE WITH AUTOMATED EXTERNAL DEFIBRILLATOR, GARMENT TYPE ONLY, EACH		NON-COVERED	
K0620	TUBULAR ELASTIC DRESSING, ANY WIDTH, PER LINEAR YARD		NON-COVERED	

HCPCS CODES	DESCRIPTION	REPLACES	SERVICE LIMIT	SPECIAL INSTRUCTIONS
K0669	WHEELCHAIR ACCESSORY, SEAT OR BACK CUSHION, DOES NOT MEET SPECIFIC CODE CRITERIA OR NO WRITTEN CODING VERIFICATION FROM SADMERC			PRIOR AUTHORIZATION COST INVOICE REQUIRED
K0730	CONTROLLED DOSE INHALATION DRUG DELIVERY SYSTEM		1 PER 5 ROLLING YEARS	RDTP AUTHORIZATION FORM FOR THE DRUG IIOPROST/VENTAVIS MUST BE ATTACHED TO CMS 1500 CLAIM FORM REQUIRES ICD-9 DIAGNOSIS CODE: 416.0 EFFECTIVE 01/01/2007
K0733	POWER WHEELCHAIR ACCESSORY, 12 TO 24 AMP HOUR SEALED LEAD ACID BATTERY EACH (E.G. GEL CELL, ABSORBED GLASSMAT)		NON COVERED	
K0734	SKIN PROTECTION WHEELCHAIR SEAT CUSHION, ADJUSTABLE, WITH LESS THAN 22 INCHES, ANY DEPTH		1 PER 2 ROLLING YEARS	PRIOR AUTHORIZATION PURCHASE ITEM MEDICAL NECESSITY REVIEW WILL BE BASED ON INTERQUAL DME GENERAL CRITERIA
K0735	SKIN PROTECTION WHEELCHAIR SEAT CUSHION, ADJUSTABLE, WIDTH 22 INCHES OR GREATER, ANY DEPTH		1 PER 2 ROLLING YEARS	PRIOR AUTHORIZATION PURCHASE ITEM MEDICAL NECESSITY REVIEW WILL BE BASED ON INTERQUAL DME GENERAL CRITERIA
K0736	SKIN PROTECTION AND POSITIONING WHEELCHAIR SEAT CUSHION, ADJUSTABLE, WIDTH LESS THAN 22 INCDES, ANY DEPTH		1 PER 2 ROLLING YEARS	PRIOR AUTHORIZATION PURCHASE ITEM MEDICAL NECESSITY REVIEW WILL BE BASED ON INTERQUAL DME GENERAL CRITERIA
K0737	SKIN PROTECTION AND POSITIONING WHEELCHAIR SEAT CUSHION, ADJUSTABLE, WIDTH 22 INCHES OR GREATER, ANY DEPTH		1 PER 2 ROLLING YEARS	PRIOR AUTHORIZATION PURCHASE ITEM MEDICAL NECESSITY REVIEW WILL BE BASED ON INTERQUAL DME GENERAL CRITERIA
K0800	POWER OPERATED VEHICLE, GROUP 1 STANDARD, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS	E1230	1 UNIT PER 5 ROLLING YEARS	PRIOR AUTHORIZATION ITEM IS 10 MONTH CAP RENTAL. INCLUDES ALL OPTIONS AND ACCESSORIES NON REIMBURSABLE WITH: E1031, K0001, K0002, K0003, K0004, K0005, K0006, K0007, OR K0009 MEDICAL NECESSITY REVIEW BASED ON INTERQUAL DME GENERAL CRITERIA NEW CODE 01/01/2007
K0801	POWER OPERATED VEHICLE, GROUP 1 HEAVY DUTY, PATIENT WEIGHT CAPACITY, 301 TO 450 POUNDS	E1230	1 UNIT PER 5 ROLLING YEARS	PRIOR AUTHORIZATION ITEM IS 10 MONTH CAP RENTAL. INCLUDES ALL OPTIONS AND ACCESSORIES NON REIMBURSABLE WITH: E1031, K0001, K0002, K0003, K0004, K0005, K0006, K0007, OR K0009 MEDICAL NECESSITY REVIEW BASED ON INTERQUAL DME GENERAL CRITERIA NEW CODE 01/01/2007

HCPCS CODES	DESCRIPTION	REPLACES	SERVICE LIMIT	SPECIAL INSTRUCTIONS
K0802	POWER OPERATED VEHICLE, GROUP 1 VERY HEAVY DUTY, PATIENT WEIGHT CAPACITY 451 TO 600 POUNDS	E1230	1 UNIT PER 5 ROLLING YEARS	PRIOR AUTHORIZATION ITEM IS 10 MONTH CAP RENTAL. INCLUDES ALL OPTIONS AND ACCESSORIES NON REIMBURSABLE WITH: E1031,K0001, K0002, K0003, K0004, K0005, K0006, K0007, OR K0009 MEDICAL NECESSITY REVIEW BASED ON INTERQUAL DME GENERAL CRITERIA NEW CODE 01/01/2007
K0806	POWER OPERATED VEHICLE, GROUP 2 STANDARD, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS	E1230	1 UNIT PER 5 ROLLING YEARS	PRIOR AUTHORIZATION ITEM IS 10 MONTH CAP RENTAL. INCLUDES ALL OPTIONS AND ACCESSORIES. NON REIMBURSABLE WITH: E1031, K0001, K0002, K0003, K0004, K0005, K0006, K0007, OR K0009 MEDICAL NECESSITY REVIEW BASED ON INTERQUAL DME GENERAL CRITERIA NEW CODE 01/01/2007
K0807	POWER OPERATED VEHICLE, GROUP 2 HEAVY DUTY, PATIENT WEIGHT CAPACITY 301 TO 450 POUNDS	E1230	1 UNIT PER 5 ROLLING YEARS	PRIOR AUTHORIZATION ITEM IS 10 MONTH CAP RENTAL. INCLUDES ALL OPTIONS AND ACCESSORIES NON REIMBURSABLE WITH: E1031, K0001, K0002, K0003, K0004, K0005, K0006, K0007, OR K0009 MEDICAL NECESSITY REVIEW BASED ON INTERQUAL DME GENERAL CRITERIA NEW CODE 01/01/2007
K0808	POWER OPERATED VEHICLE, GROUP 2 VERY HEAVY DUTY, PATIENT WEIGHT CAPACITY 451 TO 600 POUNDS	E1230	1 UNIT PER 5 ROLLING YEARS	PRIOR AUTHORIZATION ITEM IS 10 MONTH CAP RENTAL. INCLUDES ALL OPTIONS AND ACCESSORIES NON REIMBURSABLE WITH: E1031, K0001, K0002, K0003, K0004, K0005, K0006, K0007, OR K0009 MEDICAL NECESSITY REVIEW BASED ON INTERQUAL DME GENERAL CRITERIA NEW CODE 01/01/2007
K0812	POWER OPERATED VEHICLE, NOT OTHERWISE CLASSIFIED	E1230	1 UNIT PER 5 ROLLING YEARS	PRIOR AUTHORIZATION ITEM IS 10 MONTH CAP RENTAL. INCLUDES ALL OPTIONS AND ACCESSORIES COST INVOICE REQUIRED MEDICAL NECESSITY REVIEW BASED ON INTERQUAL DME GENERAL CRITERIA NEW CODE 01/01/2007

HCPCS CODES	DESCRIPTION	REPLACES	SERVICE LIMIT	SPECIAL INSTRUCTIONS
K0813	POWER WHEELCHAIR, GROUP 1 STANDARD, PORTABLE, SLING/SOLID SEAT AND BACK, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS		1 UNIT PER 5 ROLLING YEARS	PRIOR AUTHORIZATION ITEM IS 10 MONTH CAP RENTAL. NON REIMBURSABLE WITH: E0971, E0978,E0981,E0982,E0995, E1225,E2366,E2367,E2368,E2369, 2370,E2374,E2375,E2376,E2381, E2382,E2383,E2384,E2385,E2386, E2387,E2388,E2389,E2390,E2391, E2392,E2393,E2394,E2395,E2396, K0015,K0017,K0018,K0019,K0020, K0037,K0040,K0041,K0042,K0043, K0044,K0045,K0046,K0047,K0051, K0052, K0098 OR WHEELCHAIR BASES: E1031, E1161, E1231, E1232, E1233, E1234, E1235, E1236, E1237, E1238, K0001, K0002, K0003, K0004, K0005, K0007, K0009, K0800THRU K0812, K0813 THRU K0843, OR K0848 THRU K0891 MEDICAL NECESSITY REVIEW BASED ON INTERQUAL DME GENERAL CRITERIA NEW CODE 01/01/2007
K0814	POWER WHEELCHAIR, GROUP 1 STANDARD, PORTABLE, CAPTAINS CHAIR, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS		1 UNIT PER 5 ROLLING YEARS	PRIOR AUTHORIZATION ITEM IS 10 MONTH CAP RENTAL. NON REIMBURSABLE WITH: E0971, E0978,E0981,E0982,E0995, E1225,E2366,E2367,E2368,E2369, 2370,E2374,E2375,E2376,E2381, E2382,E2383,E2384,E2385,E2386, E2387,E2388,E2389,E2390,E2391, E2392,E2393,E2394,E2395,E2396, K0015,K0017,K0018,K0019,K0020, K0037,K0040,K0041,K0042,K0043, K0044,K0045,K0046,K0047,K0051, K0052, K0098 OR WHEELCHAIR BASES: E1031, E1161, E1231, E1232, E1233, E1234, E1235, E1236, E1237, E1238, K0001, K0002, K0003, K0004, K0005, K0007, K0009, K0800THRU K0812, K0813 THRU K0843, OR K0848 THRU K0891 MEDICAL NECESSITY REVIEW BASED ON INTERQUAL DME GENERAL CRITERIA NEW CODE 01/01/2007
K0815	POWER WHEELCHAIR, GROUP 1 STANDARD, SLING/SOLID SEAT AND BACK, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS		1 UNIT PER 5 ROLLING YEARS	PRIOR AUTHORIZATION ITEM IS 10 MONTH CAP RENTAL. NON REIMBURSABLE WITH: E0971, E0978,E0981,E0982,E0995, E1225,E2366,E2367,E2368,E2369, 2370,E2374,E2375,E2376,E2381, E2382,E2383,E2384,E2385,E2386, E2387,E2388,E2389,E2390,E2391, E2392,E2393,E2394,E2395,E2396, K0015,K0017,K0018,K0019,K0020, K0037,K0040,K0041,K0042,K0043, K0044,K0045,K0046,K0047,K0051, K0052, K0098 OR WHEELCHAIR BASES: E1031, E1161, E1231, E1232, E1233, E1234, E1235, E1236, E1237, E1238, K0001, K0002, K0003, K0004, K0005, K0007, K0009, K0800THRU K0812, K0813 THRU K0843, OR K0848 THRU K0891 MEDICAL NECESSITY REVIEW BASED ON INTERQUAL DME GENERAL CRITERIA NEW CODE 01/01/2007

HCPCS CODES	DESCRIPTION	REPLACES	SERVICE LIMIT	SPECIAL INSTRUCTIONS
K0816	POWER WHEELCHAIR, GROUP 1 STANDARD, CAPTAINS CHAIR, PATIENT WEIGHT CAPACTIY UP TO AND INCLUDING 300 POUNDS		1 UNIT PER 5 ROLLING YEARS	PRIOR AUTHORIZATION ITEM IS 10 MONTH CAP RENTAL. NON REIMBURSABLE WITH: E0971, E0978,E0981,E0982,E0995, E1225,E2366,E2367,E2368,E2369, 2370,E2374,E2375,E2376,E2381, E2382,E2383,E2384,E2385,E2386, E2387,E2388,E2389,E2390,E2391, E2392,E2393,E2394,E2395,E2396, K0015,K0017,K0018,K0019,K0020, K0037,K0040,K0041,K0042,K0043, K0044,K0045,K0046,K0047,K0051, K0052, K0098 OR WHEELCHAIR BASES: E1031, E1161, E1231, E1232, E1233, E1234, E1235, E1236, E1237, E1238, K0001, K0002, K0003, K0004, K0005, K0007, K0009, K0800THRU K0812, K0813 THRU K0843, OR K0848 THRU K0891 MEDICAL NECESSITY REVIEW BASED ON INTERQUAL DME GENERAL CRITERIA NEW CODE 01/01/2007
K0820	POWER WHEELCHAIR, GROUP 2 STANDARD, PORTABLE, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS		1 UNIT PER 5 ROLLING YEARS	PRIOR AUTHORIZATION ITEM IS 10 MONTH CAP RENTAL. NON REIMBURSABLE WITH: E0971, E0978,E0981,E0982,E0995, E1225,E2366,E2367,E2368,E2369, 2370,E2374,E2375,E2376,E2381, E2382,E2383,E2384,E2385,E2386, E2387,E2388,E2389,E2390,E2391, E2392,E2393,E2394,E2395,E2396, K0015,K0017,K0018,K0019,K0020, K0037,K0040,K0041,K0042,K0043, K0044,K0045,K0046,K0047,K0051, K0052, K0098 OR WHEELCHAIR BASES: E1031, E1161, E1231, E1232, E1233, E1234, E1235, E1236, E1237, E1238, K0001, K0002, K0003, K0004, K0005, K0007, K0009, K0800THRU K0812, K0813 THRU K0843, OR K0848 THRU K0891 MEDICAL NECESSITY REVIEW BASED ON INTERQUAL DME GENERAL CRITERIA NEW CODE 01/01/2007
K0821	POWER WHEELCHAIR, GROUP 2 STANDARD, PORTABLE, CAPTAINS CHAIR, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS		1 UNIT PER 5 ROLLING YEARS	PRIOR AUTHORIZATION ITEM IS 10 MONTH CAP RENTAL. NON REIMBURSABLE WITH: E0971, E0978,E0981,E0982,E0995, E1225,E2366,E2367,E2368,E2369, 2370,E2374,E2375,E2376,E2381, E2382,E2383,E2384,E2385,E2386, E2387,E2388,E2389,E2390,E2391, E2392,E2393,E2394,E2395,E2396, K0015,K0017,K0018,K0019,K0020, K0037,K0040,K0041,K0042,K0043, K0044,K0045,K0046,K0047,K0051, K0052, K0098 OR WHEELCHAIR BASES: E1031, E1161, E1231, E1232, E1233, E1234, E1235, E1236, E1237, E1238, K0001, K0002, K0003, K0004, K0005, K0007, K0009, K0800THRU K0812, K0813 THRU K0843, OR K0848 THRU K0891 MEDICAL NECESSITY REVIEW BASED ON INTERQUAL DME GENERAL CRITERIA NEW CODE 01/01/2007

HCPCS CODES	DESCRIPTION	REPLACES	SERVICE LIMIT	SPECIAL INSTRUCTIONS
K0822	POWER WHEELCHAIR, GROUP 2 STANDARD, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS		1 UNIT PER 5 ROLLING YEARS	PRIOR AUTHORIZATION ITEM IS 10 MONTH CAP RENTAL. NON REIMBURSABLE WITH: E0971, E0978,E0981,E0982,E0995, E1225,E2366,E2367,E2368,E2369, 2370,E2374,E2375,E2376,E2381, E2382,E2383,E2384,E2385,E2386, E2387,E2388,E2389,E2390,E2391, E2392,E2393,E2394,E2395,E2396, K0015,K0017,K0018,K0019,K0020, K0037,K0040,K0041,K0042,K0043, K0044,K0045,K0046,K0047,K0051, K0052, K0098 OR WHEELCHAIR BASES: E1031, E1161, E1231, E1232, E1233, E1234, E1235, E1236, E1237, E1238, K0001, K0002, K0003, K0004, K0005, K0007, K0009, K0800THRU K0812, K0813 THRU K0843, OR K0848 THRU K0891 MEDICAL NECESSITY REVIEW BASED ON INTERQUAL DME GENERAL CRITERIA NEW CODE 01/01/2007
K0823	POWER WHEELCHAIR, GROUP 2 STANDARD, CAPTAINS CHAIR, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS		1 UNIT PER 5 ROLLING YEARS	PRIOR AUTHORIZATION ITEM IS 10 MONTH CAP RENTAL. NON REIMBURSABLE WITH: E0971, E0978,E0981,E0982,E0995, E1225,E2366,E2367,E2368,E2369, 2370,E2374,E2375,E2376,E2381, E2382,E2383,E2384,E2385,E2386, E2387,E2388,E2389,E2390,E2391, E2392,E2393,E2394,E2395,E2396, K0015,K0017,K0018,K0019,K0020, K0037,K0040,K0041,K0042,K0043, K0044,K0045,K0046,K0047,K0051, K0052, K0098 OR WHEELCHAIR BASES: E1031, E1161, E1231, E1232, E1233, E1234, E1235, E1236, E1237, E1238, K0001, K0002, K0003, K0004, K0005, K0007, K0009, K0800THRU K0812, K0813 THRU K0843, OR K0848 THRU K0891 MEDICAL NECESSITY REVIEW BASED ON INTERQUAL DME GENERAL CRITERIA NEW CODE 01/01/2007
K0824	POWER WHEELCHAIR, GROUP 2 HEAVY DUTY, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY 301 TO 450 POUNDS		1 UNIT PER 5 ROLLING YEARS	PRIOR AUTHORIZATION ITEM IS 10 MONTH CAP RENTAL. NON REIMBURSABLE WITH: E0971, E0978,E0981,E0982,E0995, E1225,E2366,E2367,E2368,E2369, 2370,E2374,E2375,E2376,E2381, E2382,E2383,E2384,E2385,E2386, E2387,E2388,E2389,E2390,E2391, E2392,E2393,E2394,E2395,E2396, K0015,K0017,K0018,K0019,K0020, K0037,K0040,K0041,K0042,K0043, K0044,K0045,K0046,K0047,K0051, K0052, K0098 OR WHEELCHAIR BASES: E1031, E1161, E1231, E1232, E1233, E1234, E1235, E1236, E1237, E1238, K0001, K0002, K0003, K0004, K0005, K0007, K0009, K0800THRU K0812, K0813 THRU K0843, OR K0848 THRU K0891 MEDICAL NECESSITY REVIEW BASED ON INTERQUAL DME GENERAL CRITERIA NEW CODE 01/01/2007

HCPCS CODES	DESCRIPTION	REPLACES	SERVICE LIMIT	SPECIAL INSTRUCTIONS
K0825	POWER WHEELCHAIR, GROUP 2 HEAVY DUTY, CAPTAINS CHAIR, PATIENT WEIGHT CAPACITY 301 TO 450 POUNDS		1 UNIT PER 5 ROLLING YEARS	PRIOR AUTHORIZATION ITEM IS 10 MONTH CAP RENTAL. NON REIMBURSABLE WITH: E0971, E0978,E0981,E0982,E0995, E1225,E2366,E2367,E2368,E2369, 2370,E2374,E2375,E2376,E2381, E2382,E2383,E2384,E2385,E2386, E2387,E2388,E2389,E2390,E2391, E2392,E2393,E2394,E2395,E2396, K0015,K0017,K0018,K0019,K0020, K0037,K0040,K0041,K0042,K0043, K0044,K0045,K0046,K0047,K0051, K0052, K0098 OR WHEELCHAIR BASES: E1031, E1161, E1231, E1232, E1233, E1234, E1235, E1236, E1237, E1238, K0001, K0002, K0003, K0004, K0005, K0007, K0009, K0800THRU K0812, K0813 THRU K0843, OR K0848 THRU K0891 MEDICAL NECESSITY REVIEW BASED ON INTERQUAL DME GENERAL CRITERIA NEW CODE 01/01/2007
K0826	POWER WHEELCHAIR, GROUP 2 VERY HEAVY DUTY, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY 451 TO 600 POUNDS		1 UNIT PER 5 ROLLING YEARS	PRIOR AUTHORIZATION ITEM IS 10 MONTH CAP RENTAL. NON REIMBURSABLE WITH: E0971, E0978,E0981,E0982,E0995, E1225,E2366,E2367,E2368,E2369, 2370,E2374,E2375,E2376,E2381, E2382,E2383,E2384,E2385,E2386, E2387,E2388,E2389,E2390,E2391, E2392,E2393,E2394,E2395,E2396, K0015,K0017,K0018,K0019,K0020, K0037,K0040,K0041,K0042,K0043, K0044,K0045,K0046,K0047,K0051, K0052, K0098 OR WHEELCHAIR BASES: E1031, E1161, E1231, E1232, E1233, E1234, E1235, E1236, E1237, E1238, K0001, K0002, K0003, K0004, K0005, K0007, K0009, K0800THRU K0812, K0813 THRU K0843, OR K0848 THRU K0891 MEDICAL NECESSITY REVIEW BASED ON INTERQUAL DME GENERAL CRITERIA NEW CODE 01/01/2007
K0827	POWER WHEELCHAIR, GROUP 2 VERY HEAVY DUTY, CAPTAINS CHAIR, PATIENT WEIGHT CAPACITY 451 TO 600 POUNDS		1 UNIT PER 5 ROLLING YEARS	PRIOR AUTHORIZATION ITEM IS 10 MONTH CAP RENTAL. NON REIMBURSABLE WITH: E0971, E0978,E0981,E0982,E0995, E1225,E2366,E2367,E2368,E2369, 2370,E2374,E2375,E2376,E2381, E2382,E2383,E2384,E2385,E2386, E2387,E2388,E2389,E2390,E2391, E2392,E2393,E2394,E2395,E2396, K0015,K0017,K0018,K0019,K0020, K0037,K0040,K0041,K0042,K0043, K0044,K0045,K0046,K0047,K0051, K0052, K0098 OR WHEELCHAIR BASES: E1031, E1161, E1231, E1232, E1233, E1234, E1235, E1236, E1237, E1238, K0001, K0002, K0003, K0004, K0005, K0007, K0009, K0800THRU K0812, K0813 THRU K0843, OR K0848 THRU K0891 MEDICAL NECESSITY REVIEW BASED ON INTERQUAL DME GENERAL CRITERIA NEW CODE 01/01/2007

HCPCS CODES	DESCRIPTION	REPLACES	SERVICE LIMIT	SPECIAL INSTRUCTIONS
K0828	POWER WHEELCHAIR, GROUP 2 EXTRA HEAVY DUTY, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY 601 POUNDS OR MORE		1 UNIT PER 5 ROLLING YEARS	PRIOR AUTHORIZATION ITEM IS 10 MONTH CAP RENTAL. NON REIMBURSABLE WITH: E0971, E0978,E0981,E0982,E0995, E1225,E2366,E2367,E2368,E2369, 2370,E2374,E2375,E2376,E2381, E2382,E2383,E2384,E2385,E2386, E2387,E2388,E2389,E2390,E2391, E2392,E2393,E2394,E2395,E2396, K0015,K0017,K0018,K0019,K0020, K0037,K0040,K0041,K0042,K0043, K0044,K0045,K0046,K0047,K0051, K0052, K0098 OR WHEELCHAIR BASES: E1031, E1161, E1231, E1232, E1233, E1234, E1235, E1236, E1237, E1238, K0001, K0002, K0003, K0004, K0005, K0007, K0009, K0800THRU K0812, K0813 THRU K0843, OR K0848 THRU K0891 MEDICAL NECESSITY REVIEW BASED ON INTERQUAL DME GENERAL CRITERIA NEW CODE 01/01/2007
K0829	POWER WHEELCHAIR, GROUP 2 EXTRA HEAVY DUTY, CAPTAINS CHAIR, PATIENT WEIGHT CAPACITY 601 POUNDS OR MORE		1 UNIT PER 5 ROLLING YEARS	PRIOR AUTHORIZATION ITEM IS 10 MONTH CAP RENTAL. NON REIMBURSABLE WITH: E0971, E0978,E0981,E0982,E0995, E1225,E2366,E2367,E2368,E2369, 2370,E2374,E2375,E2376,E2381, E2382,E2383,E2384,E2385,E2386, E2387,E2388,E2389,E2390,E2391, E2392,E2393,E2394,E2395,E2396, K0015,K0017,K0018,K0019,K0020, K0037,K0040,K0041,K0042,K0043, K0044,K0045,K0046,K0047,K0051, K0052, K0098 OR WHEELCHAIR BASES: E1031, E1161, E1231, E1232, E1233, E1234, E1235, E1236, E1237, E1238, K0001, K0002, K0003, K0004, K0005, K0007, K0009, K0800THRU K0812, K0813 THRU K0843, OR K0848 THRU K0891 MEDICAL NECESSITY REVIEW BASED ON INTERQUAL DME GENERAL CRITERIA NEW CODE 01/01/2007
K0830	POWER WHEELCHAIR, GROUP 2 STANDARD, SEAT ELEVATOR, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS		1 UNIT PER 5 ROLLING YEARS	PRIOR AUTHORIZATION ITEM IS 10 MONTH CAP RENTAL. NON REIMBURSABLE WITH: E0971, E0978,E0981,E0982,E0995, E1225,E2366,E2367,E2368,E2369, 2370,E2374,E2375,E2376,E2381, E2382,E2383,E2384,E2385,E2386, E2387,E2388,E2389,E2390,E2391, E2392,E2393,E2394,E2395,E2396, K0015,K0017,K0018,K0019,K0020, K0037,K0040,K0041,K0042,K0043, K0044,K0045,K0046,K0047,K0051, K0052, K0098 OR WHEELCHAIR BASES: E1031, E1161, E1231, E1232, E1233, E1234, E1235, E1236, E1237, E1238, K0001, K0002, K0003, K0004, K0005, K0007, K0009, K0800THRU K0812, K0813 THRU K0843, OR K0848 THRU K0891 MEDICAL NECESSITY REVIEW BASED ON INTERQUAL DME GENERAL CRITERIA NEW CODE 01/01/2007

HCPCS CODES	DESCRIPTION	REPLACES	SERVICE LIMIT	SPECIAL INSTRUCTIONS
K0831	POWER WHEELCHAIR, GROUP 2 STANDARD, SEAT ELEVATOR, CAPTAINS CHAIR, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS		1 UNIT PER 5 ROLLING YEARS	PRIOR AUTHORIZATION ITEM IS 10 MONTH CAP RENTAL. NON REIMBURSABLE WITH: E0971, E0978,E0981,E0982,E0995, E1225,E2366,E2367,E2368,E2369, 2370,E2374,E2375,E2376,E2381, E2382,E2383,E2384,E2385,E2386, E2387,E2388,E2389,E2390,E2391, E2392,E2393,E2394,E2395,E2396, K0015,K0017,K0018,K0019,K0020, K0037,K0040,K0041,K0042,K0043, K0044,K0045,K0046,K0047,K0051, K0052, K0098 OR WHEELCHAIR BASES: E1031, E1161, E1231, E1232, E1233, E1234, E1235, E1236, E1237, E1238, K0001, K0002, K0003, K0004, K0005, K0007, K0009, K0800THRU K0812, K0813 THRU K0843, OR K0848 THRU K0891 MEDICAL NECESSITY REVIEW BASED ON INTERQUAL DME GENERAL CRITERIA NEW CODE 01/01/2007
K0835	POWER WHEELCHAIR, GROUP 2 STANDARD, SINGLE POWER OPTION, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS		1 UNIT PER 5 ROLLING YEARS	PRIOR AUTHORIZATION ITEM IS 10 MONTH CAP RENTAL. NON REIMBURSABLE WITH: E0971, E0978,E0981,E0982,E0995, E1225,E2366,E2367,E2368,E2369, 2370,E2374,E2375,E2376,E2381, E2382,E2383,E2384,E2385,E2386, E2387,E2388,E2389,E2390,E2391, E2392,E2393,E2394,E2395,E2396, K0015,K0017,K0018,K0019,K0020, K0037,K0040,K0041,K0042,K0043, K0044,K0045,K0046,K0047,K0051, K0052, K0098 OR WHEELCHAIR BASES: E1031, E1161, E1231, E1232, E1233, E1234, E1235, E1236, E1237, E1238, K0001, K0002, K0003, K0004, K0005, K0007, K0009, K0800THRU K0812, K0813 THRU K0843, OR K0848 THRU K0891 MEDICAL NECESSITY REVIEW BASED ON INTERQUAL DME GENERAL CRITERIA NEW CODE 01/01/2007
K0836	POWER WHEELCHAIR, GROUP 2 STANDARD, SINGLE POWER OPTION, CAPTAINS CHAIR, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS		1 UNIT PER 5 ROLLING YEARS	PRIOR AUTHORIZATION ITEM IS 10 MONTH CAP RENTAL. NON REIMBURSABLE WITH: E0971, E0978,E0981,E0982,E0995, E1225,E2366,E2367,E2368,E2369, 2370,E2374,E2375,E2376,E2381, E2382,E2383,E2384,E2385,E2386, E2387,E2388,E2389,E2390,E2391, E2392,E2393,E2394,E2395,E2396, K0015,K0017,K0018,K0019,K0020, K0037,K0040,K0041,K0042,K0043, K0044,K0045,K0046,K0047,K0051, K0052, K0098 OR WHEELCHAIR BASES: E1031, E1161, E1231, E1232, E1233, E1234, E1235, E1236, E1237, E1238, K0001, K0002, K0003, K0004, K0005, K0007, K0009, K0800THRU K0812, K0813 THRU K0843, OR K0848 THRU K0891 MEDICAL NECESSITY REVIEW BASED ON INTERQUAL DME GENERAL CRITERIA NEW CODE 01/01/2007

HCPCS CODES	DESCRIPTION	REPLACES	SERVICE LIMIT	SPECIAL INSTRUCTIONS
K0837	POWER WHEELCHAIR, GROUP 2 HEAVY DUTY, SINGLE POWER OPTION, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY 301 TO 450 POUNDS		1 UNIT PER 5 YEARS	PRIOR AUTHORIZATION ITEM IS 10 MONTH CAP RENTAL. NON REIMBURSABLE WITH: E0971, E0978,E0981,E0982,E0995, E1225,E2366,E2367,E2368,E2369, 2370,E2374,E2375,E2376,E2381, E2382,E2383,E2384,E2385,E2386, E2387,E2388,E2389,E2390,E2391, E2392,E2393,E2394,E2395,E2396, K0015,K0017,K0018,K0019,K0020, K0037,K0040,K0041,K0042,K0043, K0044,K0045,K0046,K0047,K0051, K0052, K0098 OR WHEELCHAIR BASES: E1031, E1161, E1231, E1232, E1233, E1234, E1235, E1236, E1237, E1238, K0001, K0002, K0003, K0004, K0005, K0007, K0009, K0800THRU K0812, K0813 THRU K0843, OR K0848 THRU K0891 MEDICAL NECESSITY REVIEW BASED ON INTERQUAL DME GENERAL CRITERIA NEW CODE 01/01/2007
K0838	POWER WHEELCHAIR, GROUP 2 HEAVY DUTY, SINGLE POWER OPTION, CAPTAINS CHAIR, PATIENT WEIGHT CAPACITY 301 TO 450 POUNDS		1 UNIT PER 5 ROLLING YEARS	PRIOR AUTHORIZATION ITEM IS 10 MONTH CAP RENTAL. NON REIMBURSABLE WITH: E0971, E0978,E0981,E0982,E0995, E1225,E2366,E2367,E2368,E2369, 2370,E2374,E2375,E2376,E2381, E2382,E2383,E2384,E2385,E2386, E2387,E2388,E2389,E2390,E2391, E2392,E2393,E2394,E2395,E2396, K0015,K0017,K0018,K0019,K0020, K0037,K0040,K0041,K0042,K0043, K0044,K0045,K0046,K0047,K0051, K0052, K0098 OR WHEELCHAIR BASES: E1031, E1161, E1231, E1232, E1233, E1234, E1235, E1236, E1237, E1238, K0001, K0002, K0003, K0004, K0005, K0007, K0009, K0800THRU K0812, K0813 THRU K0843, OR K0848 THRU K0891 MEDICAL NECESSITY REVIEW BASED ON INTERQUAL DME GENERAL CRITERIA NEW CODE 01/01/2007
K0839	POWER WHEELCHAIR, GROUP 2 VERY HEAVY DUTY, SINGLE POWER OPTION, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY 451 TO 600 POUNDS		1 UNIT PER 5 ROLLING YEARS	PRIOR AUTHORIZATION ITEM IS 10 MONTH CAP RENTAL. NON REIMBURSABLE WITH: E0971, E0978,E0981,E0982,E0995, E1225,E2366,E2367,E2368,E2369, 2370,E2374,E2375,E2376,E2381, E2382,E2383,E2384,E2385,E2386, E2387,E2388,E2389,E2390,E2391, E2392,E2393,E2394,E2395,E2396, K0015,K0017,K0018,K0019,K0020, K0037,K0040,K0041,K0042,K0043, K0044,K0045,K0046,K0047,K0051, K0052, K0098 OR WHEELCHAIR BASES: E1031, E1161, E1231, E1232, E1233, E1234, E1235, E1236, E1237, E1238, K0001, K0002, K0003, K0004, K0005, K0007, K0009, K0800THRU K0812 K0813 THRU K0843, OR K0848 THRU K0891 MEDICAL NECESSITY REVIEW BASED ON INTERQUAL DME GENERAL CRITERIA NEW CODE 01/01/2007

HCPCS CODES	DESCRIPTION	REPLACES	SERVICE LIMIT	SPECIAL INSTRUCTIONS
K0840	POWER WHEELCHAIR, GROUP 2 EXTRA HEAVY DUTY, SINGLE POWER OPTION, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY 601 POUNDS OR MORE		1 UNIT PER 5 ROLLING YEARS	PRIOR AUTHORIZATION ITEM IS 10 MONTH CAP RENTAL. NON REIMBURSABLE WITH: E0971, E0978,E0981,E0982,E0995, E1225,E2366,E2367,E2368,E2369, 2370,E2374,E2375,E2376,E2381, E2382,E2383,E2384,E2385,E2386, E2387,E2388,E2389,E2390,E2391, E2392,E2393,E2394,E2395,E2396, K0015,K0017,K0018,K0019,K0020, K0037,K0040,K0041,K0042,K0043, K0044,K0045,K0046,K0047,K0051, K0052, K0098 OR WHEELCHAIR BASES: E1031, E1161, E1231, E1232, E1233, E1234, E1235, E1236, E1237, E1238, K0001, K0002, K0003, K0004, K0005, K0007, K0009, K0800THRU K0812, K0813 THRU K0843, OR K0848 THRU K0891 MEDICAL NECESSITY REVIEW BASED ON INTERQUAL DME GENERAL CRITERIA NEW CODE 01/01/2007
K0841	POWER WHEELCHAIR, GROUP 2 STANDARD, MULTIPLE POWER OPTION, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS		1 UNIT PER 5 ROLLING YEARS	PRIOR AUTHORIZATION ITEM IS 10 MONTH CAP RENTAL. NON REIMBURSABLE WITH: E0971, E0978,E0981,E0982,E0995, E1225,E2366,E2367,E2368,E2369, 2370,E2374,E2375,E2376,E2381, E2382,E2383,E2384,E2385,E2386, E2387,E2388,E2389,E2390,E2391, E2392,E2393,E2394,E2395,E2396, K0015,K0017,K0018,K0019,K0020, K0037,K0040,K0041,K0042,K0043, K0044,K0045,K0046,K0047,K0051, K0052, K0098 OR WHEELCHAIR BASES: E1031, E1161, E1231, E1232, E1233, E1234, E1235, E1236, E1237, E1238, K0001, K0002, K0003, K0004, K0005, K0007, K0009, K0800THRU K0812, K0813 THRU K0843, OR K0848 THRU K0891 MEDICAL NECESSITY REVIEW BASED ON INTERQUAL DME GENERAL CRITERIA NEW CODE 01/01/2007
K0842	POWER WHEELCHAIR, GROUP 2 STANDARD, MULTIPLE POWER OPTION, CAPTAINS CHAIR, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS		1 UNIT PER 5 ROLLING YEARS	PRIOR AUTHORIZATION NON REIMBURSABLE WITH: E0971, E0978,E0981,E0982,E0995, E1225,E2366,E2367,E2368,E2369, 2370,E2374,E2375,E2376,E2381, E2382,E2383,E2384,E2385,E2386, E2387,E2388,E2389,E2390,E2391, E2392,E2393,E2394,E2395,E2396, K0015,K0017,K0018,K0019,K0020, K0037,K0040,K0041,K0042,K0043, K0044,K0045,K0046,K0047,K0051, K0052, K0098 OR WHEELCHAIR BASES: E1031, E1161, E1231, E1232, E1233, E1234, E1235, E1236, E1237, E1238, K0001, K0002, K0003, K0004, K0005, K0007, K0009, K0800THRU K0812, K0813 THRU K0843, OR K0848 THRU K0891 MEDICAL NECESSITY REVIEW BASED ON INTERQUAL DME GENERAL CRITERIA NEW CODE 01/01/2007

HCPCS CODES	DESCRIPTION	REPLACES	SERVICE LIMIT	SPECIAL INSTRUCTIONS
K0843	POWER WHEELCHAIR, GROUP 2 HEAVY DUTY, MULTIPLE POWER OPTION, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY 301 TO 450 POUNDS		1 UNIT PER 5 ROLLING YEARS	PRIOR AUTHORIZATION ITEM IS 10 MONTH CAP RENTAL. NON REIMBURSABLE WITH: E0971, E0978,E0981,E0982,E0995, E1225,E2366,E2367,E2368,E2369, 2370,E2374,E2375,E2376,E2381, E2382,E2383,E2384,E2385,E2386, E2387,E2388,E2389,E2390,E2391, E2392,E2393,E2394,E2395,E2396, K0015,K0017,K0018,K0019,K0020, K0037,K0040,K0041,K0042,K0043, K0044,K0045,K0046,K0047,K0051, K0052, K0098 OR WHEELCHAIR BASES: E1031, E1161, E1231, E1232, E1233, E1234, E1235, E1236, E1237, E1238, K0001, K0002, K0003, K0004, K0005, K0007, K0009, K0800THRU K0812, K0813 THRU K0843, OR K0848 THRU K0891 MEDICAL NECESSITY REVIEW BASED ON INTERQUAL DME GENERAL CRITERIA NEW CODE 01/01/2007
K0848	POWER WHEELCHAIR, GROUP 3 STANDARD, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS		1 UNIT PER 5 ROLLING YEARS	PRIOR AUTHORIZATION ITEM IS 10 MONTH CAP RENTAL. NON REIMBURSABLE WITH: E0971, E0978,E0981,E0982,E0995, E1225,E2366,E2367,E2368,E2369, 2370,E2374,E2375,E2376,E2381, E2382,E2383,E2384,E2385,E2386, E2387,E2388,E2389,E2390,E2391, E2392,E2393,E2394,E2395,E2396, K0015,K0017,K0018,K0019,K0020, K0037,K0041,K0042,K0043, K0044,K0045,K0046,K0047,K0051, K0052, K0098 OR WHEELCHAIR BASES: E1031, E1161, E1231, E1232, E1233, E1234, E1235, E1236, E1237, E1238, K0001, K0002, K0003, K0004, K0005, K0007, K0009, K0800 THRU K0812, K0813 THRU K0843 OR K0848 THRU K0891 MEDICAL NECESSITY REVIEW BASED ON INTERQUAL DME GENERAL CRITERIA NEW CODE 01/01/2007
K0849	POWER WHEELCHAIR, GROUP 3 STANDARD, CAPTAINS CHAIR, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS		1 UNIT PER 5 ROLLING YEARS	PRIOR AUTHORIZATION ITEM IS 10 MONTH CAP RENTAL. NON REIMBURSABLE WITH: E0971, E0978,E0981,E0982,E0995, E1225,E2366,E2367,E2368,E2369, 2370,E2374,E2375,E2376,E2381, E2382,E2383,E2384,E2385,E2386, E2387,E2388,E2389,E2390,E2391, E2392,E2393,E2394,E2395,E2396, K0015,K0017,K0018,K0019,K0020, K0037,K0041,K0042,K0043, K0044,K0045,K0046,K0047,K0051, K0052, K0098 OR WHEELCHAIR BASES: E1031, E1161, E1231, E1232, E1233, E1234, E1235, E1236, E1237, E1238, K0001, K0002, K0003, K0004, K0005, K0007, K0009, K0800 THRU K0812, K0813 THRU K0843 OR K0848 THRU K0891 MEDICAL NECESSITY REVIEW BASED ON INTERQUAL DME GENERAL CRITERIA NEW CODE 01/01/2007

HCPCS CODES	DESCRIPTION	REPLACES	SERVICE LIMIT	SPECIAL INSTRUCTIONS
K0850	POWER WHEELCHAIR, GROUP 3 HEAVY DUTY, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY 301 TO 450 POUNDS		1 UNIT PER 5 ROLLING YEARS	PRIOR AUTHORIZATION ITEM IS 10 MONTH CAP RENTAL. NON REIMBURSABLE WITH: E0971, E0978,E0981,E0982,E0995, E1225,E2366,E2367,E2368,E2369, 2370,E2374,E2375,E2376,E2381, E2382,E2383,E2384,E2385,E2386, E2387,E2388,E2389,E2390,E2391, E2392,E2393,E2394,E2395,E2396, K0015,K0017,K0018,K0019,K0020, K0037,K0041,K0042,K0043, K0044,K0045,K0046,K0047,K0051, K0052, K0098 OR WHEELCHAIR BASES: E1031, E1161, E1231, E1232, E1233, E1234, E1235, E1236, E1237, E1238, K0001, K0002, K0003, K0004, K0005, K0007, K0009, K0800 THRU K0812, K0813 THRU K0843 OR K0848 THRU K0891 MEDICAL NECESSITY REVIEW BASED ON INTERQUAL DME GENERAL CRITERIA NEW CODE 01/01/2007
K0851	POWER WHEELCHAIR, GROUP 3 HEAVY DUTY, CAPTAINS CHAIR, PATIENT WEIGHT CAPACITY 301 TO 450 POUNDS		1 UNIT PER 5 ROLLING YEARS	PRIOR AUTHORIZATION ITEM IS 10 MONTH CAP RENTAL. NON REIMBURSABLE WITH: E0971, E0978,E0981,E0982,E0995, E1225,E2366,E2367,E2368,E2369, 2370,E2374,E2375,E2376,E2381, E2382,E2383,E2384,E2385,E2386, E2387,E2388,E2389,E2390,E2391, E2392,E2393,E2394,E2395,E2396, K0015,K0017,K0018,K0019,K0020, K0037,K0041,K0042,K0043, K0044,K0045,K0046,K0047,K0051, K0052, K0098 OR WHEELCHAIR BASES: E1031, E1161, E1231, E1232, E1233, E1234, E1235, E1236, E1237, E1238, K0001, K0002, K0003, K0004, K0005, K0007, K0009, K0800 THRU K0812, K0813 THRU K0843 OR K0848 THRU K0891 MEDICAL NECESSITY REVIEW BASED ON INTERQUAL DME GENERAL CRITERIA NEW CODE 01/01/2007
K0852	POWER WHEELCHAIR, GROUP 3 VERY HEAVY DUTY, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY 451 TO 600 POUNDS		1 UNIT PER 5 ROLLING YEARS	PRIOR AUTHORIZATION ITEM IS 10 MONTH CAP RENTAL. NON REIMBURSABLE WITH: E0971, E0978,E0981,E0982,E0995, E1225,E2366,E2367,E2368,E2369, 2370,E2374,E2375,E2376,E2381, E2382,E2383,E2384,E2385,E2386, E2387,E2388,E2389,E2390,E2391, E2392,E2393,E2394,E2395,E2396, K0015,K0017,K0018,K0019,K0020, K0037,K0041,K0042,K0043, K0044,K0045,K0046,K0047,K0051, K0052, K0098 OR WHEELCHAIR BASES: E1031, E1161, E1231, E1232, E1233, E1234, E1235, E1236, E1237, E1238, K0001, K0002, K0003, K0004, K0005, K0007, K0009, K0800 THRU K0812, K0813 THRU K0843 OR K0848 THRU K0891 MEDICAL NECESSITY REVIEW BASED ON INTERQUAL DME GENERAL CRITERIA NEW CODE 01/01/2007

HCPCS CODES	DESCRIPTION	REPLACES	SERVICE LIMIT	SPECIAL INSTRUCTIONS
K0853	POWER WHEELCHAIR, GROUP 3 VERY HEAVY DUTY, CAPTAINS CHAIR, PATIENT WEIGHT CAPACITY, 451 TO 600 POUNDS		1 UNIT PER 5 ROLLING YEARS	PRIOR AUTHORIZATION ITEM IS 10 MONTH CAP RENTAL. NON REIMBURSABLE WITH: E0971, E0978,E0981,E0982,E0995, E1225,E2366,E2367,E2368,E2369, 2370,E2374,E2375,E2376,E2381, E2382,E2383,E2384,E2385,E2386, E2387,E2388,E2389,E2390,E2391, E2392,E2393,E2394,E2395,E2396, K0015,K0017,K0018,K0019,K0020, K0037,K0041,K0042,K0043, K0044,K0045,K0046,K0047,K0051, K0052, K0098 OR WHEELCHAIR BASES: E1031, E1161, E1231, E1232, E1233, E1234, E1235, E1236, E1237, E1238, K0001, K0002, K0003, K0004, K0005, K0007, K0009, K0800 THRU K0812, K0813 THRU K0843 OR K0848 THRU K0891 MEDICAL NECESSITY REVIEW BASED ON INTERQUAL DME GENERAL CRITERIA NEW CODE 01/01/2007
K0854	POWER WHEELCHAIR, GROUP 3 EXTRA HEAVY DUTY, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY 601 POUNDS OR MORE		1 UNIT PER 5 ROLLING YEARS	PRIOR AUTHORIZATION ITEM IS 10 MONTH CAP RENTAL. NON REIMBURSABLE WITH: E0971, E0978,E0981,E0982,E0995, E1225,E2366,E2367,E2368,E2369, 2370,E2374,E2375,E2376,E2381, E2382,E2383,E2384,E2385,E2386, E2387,E2388,E2389,E2390,E2391, E2392,E2393,E2394,E2395,E2396, K0015,K0017,K0018,K0019,K0020, K0037,K0041,K0042,K0043, K0044,K0045,K0046,K0047,K0051, K0052, K0098 OR WHEELCHAIR BASES: E1031, E1161, E1231, E1232, E1233, E1234, E1235, E1236, E1237, E1238, K0001, K0002, K0003, K0004, K0005, K0007, K0009, K0800 THRU K0812, K0813 THRU K0843 OR K0848 THRU K0891 MEDICAL NECESSITY REVIEW BASED ON INTERQUAL DME GENERAL CRITERIA NEW CODE 01/01/2007
K0855	POWER WHEELCHAIR, GROUP 3 EXTRA HEAVY DUTY, CAPTAINS CHAIR, PATIENT WEIGHT CAPACITY 601 POUNDS OR MORE		1 UNIT PER 5 ROLLING YEARS	PRIOR AUTHORIZATION ITEM IS 10 MONTH CAP RENTAL. NON REIMBURSABLE WITH: E0971, E0978,E0981,E0982,E0995, E1225,E2366,E2367,E2368,E2369, 2370,E2374,E2375,E2376,E2381, E2382,E2383,E2384,E2385,E2386, E2387,E2388,E2389,E2390,E2391, E2392,E2393,E2394,E2395,E2396, K0015,K0017,K0018,K0019,K0020, K0037,K0041,K0042,K0043, K0044,K0045,K0046,K0047,K0051, K0052, K0098 OR WHEELCHAIR BASES: E1031, E1161, E1231, E1232, E1233, E1234, E1235, E1236, E1237, E1238, K0001, K0002, K0003, K0004, K0005, K0007, K0009, K0800 THRU K0812, K0813 THRU K0843 OR K0848 THRU K0891 MEDICAL NECESSITY REVIEW BASED ON INTERQUAL DME GENERAL CRITERIA NEW CODE 01/01/2007

HCPCS CODES	DESCRIPTION	REPLACES	SERVICE LIMIT	SPECIAL INSTRUCTIONS
K0856	POWER WHEELCHAIR, GROUP 3 STANDARD, SINGLE POWER OPTION, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS		1 UNIT PER 5 ROLLING YEARS	PRIOR AUTHORIZATION ITEM IS 10 MONTH CAP RENTAL. NON REIMBURSABLE WITH: E0971, E0978,E0981,E0982,E0995, E1225,E2366,E2367,E2368,E2369, 2370,E2374,E2375,E2376,E2381, E2382,E2383,E2384,E2385,E2386, E2387,E2388,E2389,E2390,E2391, E2392,E2393,E2394,E2395,E2396, K0015,K0017,K0018,K0019,K0020, K0037,K0041,K0042,K0043, K0044,K0045,K0046,K0047,K0051, K0052, K0098 OR WHEELCHAIR BASES: E1031, E1161, E1231, E1232, E1233, E1234, E1235, E1236, E1237, E1238, K0001, K0002, K0003, K0004, K0005, K0007, K0009, K0800 THRU K0812, K0813 THRU K0843 OR K0848 THRU K0891 MEDICAL NECESSITY REVIEW BASED ON INTERQUAL DME GENERAL CRITERIA NEW CODE 01/01/2007
K0857	POWER WHEELCHAIR, GROUP 3 STANDARD, SINGLE POWER OPTION, CAPTAINS CHAIR, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS		1 UNIT PER 5 ROLLING YEARS	PRIOR AUTHORIZATION ITEM IS 10 MONTH CAP RENTAL. NON REIMBURSABLE WITH: E0971, E0978,E0981,E0982,E0995, E1225,E2366,E2367,E2368,E2369, 2370,E2374,E2375,E2376,E2381, E2382,E2383,E2384,E2385,E2386, E2387,E2388,E2389,E2390,E2391, E2392,E2393,E2394,E2395,E2396, K0015,K0017,K0018,K0019,K0020, K0037,K0041,K0042,K0043, K0044,K0045,K0046,K0047,K0051, K0052, K0098 OR WHEELCHAIR BASES: E1031, E1161, E1231, E1232, E1233, E1234, E1235, E1236, E1237, E1238, K0001, K0002, K0003, K0004, K0005, K0007, K0009, K0800 THRU K0812, K0813 THRU K0843 OR K0848 THRU K0891 MEDICAL NECESSITY REVIEW BASED ON INTERQUAL DME GENERAL CRITERIA NEW CODE 01/01/2007
K0858	POWER WHEELCHAIR, GROUP 3 HEAVY DUTY, SINGLE POWER OPTION, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY 301 TO 450 POUNDS		1 UNIT PER 5 ROLLING YEARS	PRIOR AUTHORIZATION ITEM IS 10 MONTH CAP RENTAL. NON REIMBURSABLE WITH: E0971, E0978,E0981,E0982,E0995, E1225,E2366,E2367,E2368,E2369, 2370,E2374,E2375,E2376,E2381, E2382,E2383,E2384,E2385,E2386, E2387,E2388,E2389,E2390,E2391, E2392,E2393,E2394,E2395,E2396, K0015,K0017,K0018,K0019,K0020, K0037,K0041,K0042,K0043, K0044,K0045,K0046,K0047,K0051, K0052, K0098 OR WHEELCHAIR BASES: E1031, E1161, E1231, E1232, E1233, E1234, E1235, E1236, E1237, E1238, K0001, K0002, K0003, K0004, K0005, K0007, K0009, K0800 THRU K0812, K0813 THRU K0843 OR K0848 THRU K0891 MEDICAL NECESSITY REVIEW BASED ON INTERQUAL DME GENERAL CRITERIA NEW CODE 01/01/2007

HCPCS CODES	DESCRIPTION	REPLACES	SERVICE LIMIT	SPECIAL INSTRUCTIONS
K0859	POWER WHEELCHAIR, GROUP 3 HEAVY DUTY, SINGLE POWER OPTION, CAPTAINS CHAIR, PATIENT WEIGHT CAPACITY 301 TO 450 POUNDS		1 UNIT PER 5 ROLLING YEARS	PRIOR AUTHORIZATION ITEM IS 10 MONTH CAP RENTAL. NON REIMBURSABLE WITH: E0971, E0978,E0981,E0982,E0995, E1225,E2366,E2367,E2368,E2369, 2370,E2374,E2375,E2376,E2381, E2382,E2383,E2384,E2385,E2386, E2387,E2388,E2389,E2390,E2391, E2392,E2393,E2394,E2395,E2396, K0015,K0017,K0018,K0019,K0020, K0037,K0041,K0042,K0043, K0044,K0045,K0046,K0047,K0051, K0052, K0098 OR WHEELCHAIR BASES: E1031, E1161, E1231, E1232, E1233, E1234, E1235, E1236, E1237, E1238, K0001, K0002, K0003, K0004, K0005, K0007, K0009, K0800 THRU K0812, K0813 THRU K0843 OR K0848 THRU K0891 MEDICAL NECESSITY REVIEW BASED ON INTERQUAL DME GENERAL CRITERIA NEW CODE 01/01/2007
K0860	POWER WHEELCHAIR, GROUP 3 VERY HEAVY DUTY, SINGLE POWER OPTION, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY 451 TO 600 POUNDS		1 UNIT PER 5 ROLLING YEARS	PRIOR AUTHORIZATION ITEM IS 10 MONTH CAP RENTAL. NON REIMBURSABLE WITH: E0971, E0978,E0981,E0982,E0995, E1225,E2366,E2367,E2368,E2369, 2370,E2374,E2375,E2376,E2381, E2382,E2383,E2384,E2385,E2386, E2387,E2388,E2389,E2390,E2391, E2392,E2393,E2394,E2395,E2396, K0015,K0017,K0018,K0019,K0020, K0037,K0041,K0042,K0043, K0044,K0045,K0046,K0047,K0051, K0052, K0098 OR WHEELCHAIR BASES: E1031, E1161, E1231, E1232, E1233, E1234, E1235, E1236, E1237, E1238, K0001, K0002, K0003, K0004, K0005, K0007, K0009, K0800 THRU K0812, K0813 THRU K0843 OR K0848 THRU K0891 MEDICAL NECESSITY REVIEW BASED ON INTERQUAL DME GENERAL CRITERIA NEW CODE 01/01/2007
K0861	POWER WHEELCHAIR, GROUP 3 STANDARD, MULTIPLE POWER OPTION, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS		1 UNIT PER 5 ROLLING YEARS	PRIOR AUTHORIZATION ITEM IS 10 MONTH CAP RENTAL. NON REIMBURSABLE WITH: E0971, E0978,E0981,E0982,E0995, E1225,E2366,E2367,E2368,E2369, 2370,E2374,E2375,E2376,E2381, E2382,E2383,E2384,E2385,E2386, E2387,E2388,E2389,E2390,E2391, E2392,E2393,E2394,E2395,E2396, K0015,K0017,K0018,K0019,K0020, K0037,K0041,K0042,K0043, K0044,K0045,K0046,K0047,K0051, K0052, K0098 OR WHEELCHAIR BASES: E1031, E1161, E1231, E1232, E1233, E1234, E1235, E1236, E1237, E1238, K0001, K0002, K0003, K0004, K0005, K0007, K0009, K0800 THRU K0812, K0813 THRU K0843 OR K0848 THRU K0891 MEDICAL NECESSITY REVIEW BASED ON INTERQUAL DME GENERAL CRITERIA NEW CODE 01/01/2007

HCPCS CODES	DESCRIPTION	REPLACES	SERVICE LIMIT	SPECIAL INSTRUCTIONS
K0862	POWER WHEELCHAIR, GROUP 3 HEAVY DUTY, MULTIPLE POWER OPTION, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY 301 TO 450 POUNDS		1 UNIT PER 5 ROLLING YEARS	PRIOR AUTHORIZATION ITEM IS 10 MONTH CAP RENTAL. NON REIMBURSABLE WITH: E0971, E0978,E0981,E0982,E0995, E1225,E2366,E2367,E2368,E2369, 2370,E2374,E2375,E2376,E2381, E2382,E2383,E2384,E2385,E2386, E2387,E2388,E2389,E2390,E2391, E2392,E2393,E2394,E2395,E2396, K0015,K0017,K0018,K0019,K0020, K0037,K0041,K0042,K0043, K0044,K0045,K0046,K0047,K0051, K0052, K0098 OR WHEELCHAIR BASES: E1031, E1161, E1231, E1232, E1233, E1234, E1235, E1236, E1237, E1238, K0001, K0002, K0003, K0004, K0005, K0007, K0009, K0800 THRU K0812, K0813 THRU K0843 OR K0848 THRU K0891 MEDICAL NECESSITY REVIEW BASED ON INTERQUAL DME GENERAL CRITERIA NEW CODE 01/01/2007
K0863	POWER WHEELCHAIR, GROUP 3 VERY HEAVY DUTY, MULTIPLE POWER OPTION, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY 451 TO 600 POUNDS		1 UNIT PER 5 ROLLING YEARS	PRIOR AUTHORIZATION ITEM IS 10 MONTH CAP RENTAL. NON REIMBURSABLE WITH: E0971, E0978,E0981,E0982,E0995, E1225,E2366,E2367,E2368,E2369, 2370,E2374,E2375,E2376,E2381, E2382,E2383,E2384,E2385,E2386, E2387,E2388,E2389,E2390,E2391, E2392,E2393,E2394,E2395,E2396, K0015,K0017,K0018,K0019,K0020, K0037,K0041,K0042,K0043, K0044,K0045,K0046,K0047,K0051, K0052, K0098 OR WHEELCHAIR BASES: E1031, E1161, E1231, E1232, E1233, E1234, E1235, E1236, E1237, E1238, K0001, K0002, K0003, K0004, K0005, K0007, K0009, K0800 THRU K0812, K0813 THRU K0843 OR K0848 THRU K0891 MEDICAL NECESSITY REVIEW BASED ON INTERQUAL DME GENERAL CRITERIA NEW CODE 01/01/2007
K0864	POWER WHEELCHAIR, GROUP 3 EXTRA HEAVY DUTY, MULTIPLE POWER OPTION, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY 601 POUNDS OR MORE		1 UNIT PER 5 ROLLING YEARS	PRIOR AUTHORIZATION ITEM IS 10 MONTH CAP RENTAL. NON REIMBURSABLE WITH: E0971, E0978,E0981,E0982,E0995, E1225,E2366,E2367,E2368,E2369, 2370,E2374,E2375,E2376,E2381, E2382,E2383,E2384,E2385,E2386, E2387,E2388,E2389,E2390,E2391, E2392,E2393,E2394,E2395,E2396, K0015,K0017,K0018,K0019,K0020, K0037,K0041,K0042,K0043, K0044,K0045,K0046,K0047,K0051, K0052, K0098 OR WHEELCHAIR BASES: E1031, E1161, E1231, E1232, E1233, E1234, E1235, E1236, E1237, E1238, K0001, K0002, K0003, K0004, K0005, K0007, K0009, K0800 THRU K0812, K0813 THRU K0843 OR K0848 THRU K0891 MEDICAL NECESSITY REVIEW BASED ON INTERQUAL DME GENERAL CRITERIA NEW CODE 01/01/2007

HCPCS CODES	DESCRIPTION	REPLACES	SERVICE LIMIT	SPECIAL INSTRUCTIONS
K0868	POWER WHEELCHAIR, GROUP 4 STANDARD, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS		1 UNIT PER 5 ROLLING YEARS	PRIOR AUTHORIZATION PURCHASED ITEM COST INVOICE REQUIRED NON REIMBURSABLE WITH: E0971, E0978,E0981,E0982,E0995, E1225,E2366,E2367,E2368,E2369, 2370,E2374,E2375,E2376,E2381, E2382,E2383,E2384,E2385,E2386, E2387,E2388,E2389,E2390,E2391, E2392,E2393,E2394,E2395,E2396, K0015,K0017,K0018,K0019,K0020, K0037,K0041,K0042,K0043, K0044,K0045,K0046,K0047,K0051, K0052, K0098 OR WHEELCHAIR BASES: E1031, E1161, E1231, E1232, E1233, E1234, E1235, E1236, E1237, E1238, K0001, K0002, K0003, K0004, K0005, K0007, K0009, K0800 THRU K0812, K0813 THRU K0843 OR K0848 THRU K0891 MEDICAL NECESSITY REVIEW BASED ON INTERQUAL DME GENERAL CRITERIA NEW CODE 01/01/2007
K0869	POWER WHEELCHAIR, GROUP 4 STANDARD, CAPTAINS CHAIR, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS		1 UNIT PER 5 ROLLING YEARS	PRIOR AUTHORIZATION PURCHASED ITEM COST INVOICE REQUIRED NON REIMBURSABLE WITH: E0971, E0978,E0981,E0982,E0995, E1225,E2366,E2367,E2368,E2369, 2370,E2374,E2375,E2376,E2381, E2382,E2383,E2384,E2385,E2386, E2387,E2388,E2389,E2390,E2391, E2392,E2393,E2394,E2395,E2396, K0015,K0017,K0018,K0019,K0020, K0037,K0041,K0042,K0043, K0044,K0045,K0046,K0047,K0051, K0052, K0098 OR WHEELCHAIR BASES: E1031, E1161, E1231, E1232, E1233, E1234, E1235, E1236, E1237, E1238, K0001, K0002, K0003, K0004, K0005, K0007, K0009, K0800 THRU K0812, K0813 THRU K0843 OR K0848 THRU K0891 MEDICAL NECESSITY REVIEW BASED ON INTERQUAL DME GENERAL CRITERIA NEW CODE 01/01/2007
K0870	POWER WHEELCHAIR, GROUP 4 HEAVY DUTY, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY 301 TO 450 POUNDS		1 UNIT PER 5 ROLLING YEARS	PRIOR AUTHORIZATION PURCHASED ITEM COST INVOICE REQUIRED NON REIMBURSABLE WITH: E0971, E0978,E0981,E0982,E0995, E1225,E2366,E2367,E2368,E2369, 2370,E2374,E2375,E2376,E2381, E2382,E2383,E2384,E2385,E2386, E2387,E2388,E2389,E2390,E2391, E2392,E2393,E2394,E2395,E2396, K0015,K0017,K0018,K0019,K0020, K0037,K0041,K0042,K0043, K0044,K0045,K0046,K0047,K0051, K0052, K0098 OR WHEELCHAIR BASES: E1031, E1161, E1231, E1232, E1233, E1234, E1235, E1236, E1237, E1238, K0001, K0002, K0003, K0004, K0005, K0007, K0009, K0800 THRU K0812, K0813 THRU K0843 OR K0848 THRU K0891 MEDICAL NECESSITY REVIEW BASED ON INTERQUAL DME GENERAL CRITERIA NEW CODE 01/01/2007

HCPCS CODES	DESCRIPTION	REPLACES	SERVICE LIMIT	SPECIAL INSTRUCTIONS
K0871	POWER WHEELCHAIR, GROUP 4 VERY HEAVY DUTY, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY 451 TO 600 POUNDS		1 UNIT PER 5 ROLLING YEARS	PRIOR AUTHORIZATION PURCHASED ITEM COST INVOICE REQUIRED NON REIMBURSABLE WITH: E0971, E0978,E0981,E0982,E0995, E1225,E2366,E2367,E2368,E2369, 2370,E2374,E2375,E2376,E2381, E2382,E2383,E2384,E2385,E2386, E2387,E2388,E2389,E2390,E2391, E2392,E2393,E2394,E2395,E2396, K0015,K0017,K0018,K0019,K0020, K0037,K0041,K0042,K0043, K0044,K0045,K0046,K0047,K0051, K0052, K0098 OR WHEELCHAIR BASES: E1031, E1161, E1231, E1232, E1233, E1234, E1235, E1236, E1237, E1238, K0001, K0002, K0003, K0004, K0005, K0007, K0009, K0800 THRU K0812, K0813 THRU K0843 OR K0848 THRU K0891 MEDICAL NECESSITY REVIEW BASED ON INTERQUAL DME GENERAL CRITERIA NEW CODE 01/01/2007
K0877	POWER WHEELCHAIR, GROUP 4 STANDARD, SINGLE POWER OPTION, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS		1 UNIT PER 5 ROLLING YEARS	PRIOR AUTHORIZATION PURCHASED ITEM COST INVOICE REQUIRED NON REIMBURSABLE WITH: E0971, E0978,E0981,E0982,E0995, E1225,E2366,E2367,E2368,E2369, 2370,E2374,E2375,E2376,E2381, E2382,E2383,E2384,E2385,E2386, E2387,E2388,E2389,E2390,E2391, E2392,E2393,E2394,E2395,E2396, K0015,K0017,K0018,K0019,K0020, K0037,K0041,K0042,K0043, K0044,K0045,K0046,K0047,K0051, K0052, K0098 OR WHEELCHAIR BASES: E1031, E1161, E1231, E1232, E1233, E1234, E1235, E1236, E1237, E1238, K0001, K0002, K0003, K0004, K0005, K0007, K0009, K0800 THRU K0812, K0813 THRU K0843 OR K0848 THRU K0891 MEDICAL NECESSITY REVIEW BASED ON INTERQUAL DME GENERAL CRITERIA NEW CODE 01/01/2007
K0878	POWER WHEELCHAIR, GROUP 4 STANDARD, SINGLE POWER OPTION, CAPTAINS CHAIR, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS		1 UNIT PER 5 ROLLING YEARS	PRIOR AUTHORIZATION PURCHASED ITEM COST INVOICE REQUIRED NON REIMBURSABLE WITH: E0971, E0978,E0981,E0982,E0995, E1225,E2366,E2367,E2368,E2369, 2370,E2374,E2375,E2376,E2381, E2382,E2383,E2384,E2385,E2386, E2387,E2388,E2389,E2390,E2391, E2392,E2393,E2394,E2395,E2396, K0015,K0017,K0018,K0019,K0020, K0037,K0041,K0042,K0043, K0044,K0045,K0046,K0047,K0051, K0052, K0098 OR WHEELCHAIR BASES: E1031, E1161, E1231, E1232, E1233, E1234, E1235, E1236, E1237, E1238, K0001, K0002, K0003, K0004, K0005, K0007, K0009, K0800 THRU K0812, K0813 THRU K0843 OR K0848 THRU K0891 MEDICAL NECESSITY REVIEW BASED ON INTERQUAL DME GENERAL CRITERIA NEW CODE 01/01/2007

HCPCS CODES	DESCRIPTION	REPLACES	SERVICE LIMIT	SPECIAL INSTRUCTIONS
K0879	POWER WHEELCHAIR, GROUP 4 HEAVY DUTY, SINGLE POWER OPTION, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY 301 TO 450 POUNDS		1 UNIT PER 5 ROLLING YEARS	PRIOR AUTHORIZATION PURCHASED ITEM COST INVOICE REQUIRED NON REIMBURSABLE WITH: E0971, E0978,E0981,E0982,E0995, E1225,E2366,E2367,E2368,E2369, 2370,E2374,E2375,E2376,E2381, E2382,E2383,E2384,E2385,E2386, E2387,E2388,E2389,E2390,E2391, E2392,E2393,E2394,E2395,E2396, K0015,K0017,K0018,K0019,K0020, K0037,K0041,K0042,K0043, K0044,K0045,K0046,K0047,K0051, K0052, K0098 OR WHEELCHAIR BASES: E1031, E1161, E1231, E1232, E1233, E1234, E1235, E1236, E1237, E1238, K0001, K0002, K0003, K0004, K0005, K0007, K0009, K0800 THRU K0812, K0813 THRU K0843 OR K0848 THRU K0891 MEDICAL NECESSITY REVIEW BASED ON INTERQUAL DME GENERAL CRITERIA NEW CODE 01/01/2007
K0880	POWER WHEELCHAIR, GROUP 4 VERY HEAVY DUTY, SINGLE POWER OPTION, SLING/SOLID SEAT/BACK, PATIENT WEIGHT 451 TO 600 POUNDS		1 UNIT PER 5 ROLLING YEARS	PRIOR AUTHORIZATION PURCHASED ITEM COST INVOICE REQUIRED NON REIMBURSABLE WITH: E0971, E0978,E0981,E0982,E0995, E1225,E2366,E2367,E2368,E2369, 2370,E2374,E2375,E2376,E2381, E2382,E2383,E2384,E2385,E2386, E2387,E2388,E2389,E2390,E2391, E2392,E2393,E2394,E2395,E2396, K0015,K0017,K0018,K0019,K0020, K0037,K0041,K0042,K0043, K0044,K0045,K0046,K0047,K0051, K0052, K0098 OR WHEELCHAIR BASES: E1031, E1161, E1231, E1232, E1233, E1234, E1235, E1236, E1237, E1238, K0001, K0002, K0003, K0004, K0005, K0007, K0009, K0800 THRU K0812, K0813 THRU K0843 OR K0848 THRU K0891 MEDICAL NECESSITY REVIEW BASED ON INTERQUAL DME GENERAL CRITERIA NEW CODE 01/01/2007
K0884	POWER WHEELCHAIR, GROUP 4 STANDARD, MULTIPLE POWER OPTION, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS		1 UNIT PER 5 ROLLING YEARS	PRIOR AUTHORIZATION PURCHASED ITEM COST INVOICE REQUIRED NON REIMBURSABLE WITH: E0971, E0978,E0981,E0982,E0995, E1225,E2366,E2367,E2368,E2369, 2370,E2374,E2375,E2376,E2381, E2382,E2383,E2384,E2385,E2386, E2387,E2388,E2389,E2390,E2391, E2392,E2393,E2394,E2395,E2396, K0015,K0017,K0018,K0019,K0020, K0037,K0041,K0042,K0043, K0044,K0045,K0046,K0047,K0051, K0052, K0098 OR WHEELCHAIR BASES: E1031, E1161, E1231, E1232, E1233, E1234, E1235, E1236, E1237, E1238, K0001, K0002, K0003, K0004, K0005, K0007, K0009, K0800 THRU K0812, K0813 THRU K0843 OR K0848 THRU K0891 MEDICAL NECESSITY REVIEW BASED ON INTERQUAL DME GENERAL CRITERIA NEW CODE 01/01/2007

HCPCS CODES	DESCRIPTION	REPLACES	SERVICE LIMIT	SPECIAL INSTRUCTIONS
K0885	POWER WHEELCHAIR, GROUP 4 STANDARD, MULTIPLE POWER OPTION, CAPTAINS CHAIR, WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS		1 UNIT PER 5 ROLLING YEARS	PRIOR AUTHORIZATION PURCHASED ITEM COST INVOICE REQUIRED NON REIMBURSABLE WITH: E0971, E0978,E0981,E0982,E0995, E1225,E2366,E2367,E2368,E2369, 2370,E2374,E2375,E2376,E2381, E2382,E2383,E2384,E2385,E2386, E2387,E2388,E2389,E2390,E2391, E2392,E2393,E2394,E2395,E2396, K0015,K0017,K0018,K0019,K0020, K0037,K0041,K0042,K0043, K0044,K0045,K0046,K0047,K0051, K0052, K0098 OR WHEELCHAIR BASES: E1031, E1161, E1231, E1232, E1233, E1234, E1235, E1236, E1237, E1238, K0001, K0002, K0003, K0004, K0005, K0007, K0009, K0800 THRU K0812, K0813 THRU K0843 OR K0848 THRU K0891 MEDICAL NECESSITY REVIEW BASED ON INTERQUAL DME GENERAL CRITERIA NEW CODE 01/01/2007
K0886	POWER WHEELCHAIR, GROUP 4 HEAVY DUTY, MULTIPLE POWER OPTION, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY 301 TO 450 POUNDS		1 UNIT PER 5 ROLLING YEARS	PRIOR AUTHORIZATION PURCHASED ITEM COST INVOICE REQUIRED NON REIMBURSABLE WITH: E0971, E0978,E0981,E0982,E0995, E1225,E2366,E2367,E2368,E2369, 2370,E2374,E2375,E2376,E2381, E2382,E2383,E2384,E2385,E2386, E2387,E2388,E2389,E2390,E2391, E2392,E2393,E2394,E2395,E2396, K0015,K0017,K0018,K0019,K0020, K0037,K0041,K0042,K0043, K0044,K0045,K0046,K0047,K0051, K0052, K0098 OR WHEELCHAIR BASES: E1031, E1161, E1231, E1232, E1233, E1234, E1235, E1236, E1237, E1238, K0001, K0002, K0003, K0004, K0005, K0007, K0009, K0800 THRU K0812, K0813 THRU K0843 OR K0848 THRU K0891 MEDICAL NECESSITY REVIEW BASED ON INTERQUAL DME GENERAL CRITERIA NEW CODE 01/01/2007
K0890	POWER WHEELCHAIR, GROUP 5 PEDIATRIC, SINGLE POWER OPTION, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 125 POUNDS		1 UNIT PER 5 ROLLING YEARS	PRIOR AUTHORIZATION PURCHASED ITEM COST INVOICE REQUIRED NON REIMBURSABLE WITH: E0971, E0978,E0981,E0982,E0995, E1225,E2366,E2367,E2368,E2369, 2370,E2374,E2375,E2376,E2381, E2382,E2383,E2384,E2385,E2386, E2387,E2388,E2389,E2390,E2391, E2392,E2393,E2394,E2395,E2396, K0015,K0017,K0018,K0019,K0020, K0037,K0041,K0042,K0043, K0044,K0045,K0046,K0047,K0051, K0052, K0098 OR WHEELCHAIR BASES: E1031, E1161, E1231, E1232, E1233, E1234, E1235, E1236, E1237, E1238, K0001, K0002, K0003, K0004, K0005, K0007, K0009, K0800 THRU K0812, K0813 THRU K0843 OR K0848 THRU K0891 MEDICAL NECESSITY REVIEW BASED ON INTERQUAL DME GENERAL CRITERIA NEW CODE 01/01/2007

HCPCS CODES	DESCRIPTION	REPLACES	SERVICE LIMIT	SPECIAL INSTRUCTIONS
K0891	POWER WHEELCHAIR, GROUP 5 PEDIATRIC, MULTIPLE POWER OPTION, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 125 POUNDS		1 UNIT PER 5 ROLLING YEARS	PRIOR AUTHORIZATION PURCHASED ITEM COST INVOICE REQUIRED NON REIMBURSABLE WITH: E0971, E0978,E0981,E0982,E0995, E1225,E2366,E2367,E2368,E2369, 2370,E2374,E2375,E2376,E2381, E2382,E2383,E2384,E2385,E2386, E2387,E2388,E2389,E2390,E2391, E2392,E2393,E2394,E2395,E2396, K0015,K0017,K0018,K0019,K0020, K0037,K0041,K0042,K0043, K0044,K0045,K0046,K0047,K0051, K0052, K0098 OR WHEELCHAIR BASES: E1031, E1161, E1231, E1232, E1233, E1234, E1235, E1236, E1237, E1238, K0001, K0002, K0003, K0004, K0005, K0007, K0009, K0800 THRU K0812, K0813 THRU K0843 OR K0848 THRU K0891 MEDICAL NECESSITY REVIEW BASED ON INTERQUAL DME GENERAL CRITERIA NEW CODE 01/01/2007
K0898	POWER WHEELCHAIR, NOT OTHERWISE CLASSIFIED			PRIOR AUTHORIZATION COST INVOICE REQUIRED NEW CODE 01/01/2007
K0899	POWER MOBILITY DEVICE, NOT CODED BY SADMERC OR DOES NOT MEET CRITERIA			PRIOR AUTHORIZATION COST INVOICE REQUIRED NEW CODE 01/01/2007
L8500 – L8510	PROSTHETIC IMPLANTS			REFER TO SPEECH/AUDIOLOGY MANUAL
S8490KX	INSULIN SYRINGES (100 SYRINGES, ANY SIZE)		1 UNIT OF 100 PER ROLLING MONTH	REQUIRES ICD-9-CM DIAGNOSIS CODE: 250.00 THRU 250.93 OR 648.8X NON-REIMBURSABLE WITH: A4206, A4207, A4208 OR A4209
S9435	MEDICAL FOODS FOR INBORN ERRORS OF METABOLISM		NON-COVERED	
V5336	REPAIR/MODIFICATION OF AUGMENTATIVE COMMUNICATIVE SYSTEM OR DEVICE (EXCLUDES ADAPTIVE HEARING AID)			REFER TO SPEECH/AUDIOLOGY MANUAL

CHAPTER 506

DME/MEDICAL SUPPLIES

MAY 1, 2005

ATTACHMENT II

NON-COVERED DME/MEDICAL SUPPLIES FOR UNLISTED HCPCS CODES

PAGE 1 OF 4

REVISED JANUARY 1, 2008

West Virginia Department of Health and Human Resources
Bureau for Medical Services

NON-COVERED DME/MEDICAL SUPPLIES FOR UNLISTED HCPCS CODES

DESCRIPTION/ITEM
Adaptive feeding tools
Armrest pouch
Backpack, medical necessity bag
Backpack clips
Bacterial Filter
Bath/Commode Transfer System
Bath Mat
Bathtub lift
Battery powered Nebulizer
Bed rail ---padded
Bed wetting monitors (enuresis alarm)
Bowel Management kit
Canopy for Stroller
Carrying case for enteral feeding pump
Ceiling track lift system
Combination standing seat (to stand patient in w/c)
Compression garments/pumps (Lymphedema) not otherwise categorized in E0650-E0673, e.g., Reid sleeves, Solaris etc.
Cotton tipped applicators
Customized power flip up foot plates
Craftmatic bed
Electric Crib Bed
Environmental Control Equipment & Supplies (Air Conditioners, Humidifiers, Dehumidifiers, Electrostatic Filters, Hepa filter, Air Purifier, etc.)
Equipment for nursing home, ICF/MR patients
Equipment for Hospice patients (should be covered by Hospice)
Exercise equipment (deluxe cycle, treadmill, etc.)
Extended warranties for any type of equipment
Fleet enemas
Floor sitters (feeding or positioning chair)
Gait belts
Gait trainers
Gloves-sterile
Glucowatch
Glycerin swabs
Hand held showers
Hip Protector
Hospital bed, institutional type, includes: Oscillating, circulating and stryker frames with mattress, e.g., Air fluidize, KenAir, Clinitron
Hospital gowns

DESCRIPTION/ITEM
Hot tubs
Hydraulic van and car lifts
Incline wedge/therapy wedge
Incontinent supplies for enuresis or toilet training or menses
Isolation masks
Male Vacuum Erection System
Medical Identification Bracelet
Medical necessities bag, backpack, etc.
Medical supplies for nursing home patients
Non-custom strollers
Orthopedic mattress
Padded bed rail
Pelvic support system
Personal Hygiene items (toothbrushes, mouthwash, deodorants, shampoo, etc)
Physical/occupational therapy equipment to be used @ home (e.g., physioball, table for therapy, etc)
Portable feeding pump
Portable room heaters
Positioning pillow/mattress with or without pump
Posture bench
Posture training system
Power adjustable seat kit
Power cord kit and rechargeable batteries for a suction machine
Pro-Time Microcoagulation Machine
Rain Cape for wheelchair
Reacher devices
Remote control (remote pilot/remote box) for power wheelchair
Reid Sleeve (See compression garments/pumps)
Repairs of equipment/accessories not purchased by Medicaid
Shampoo tray
Shower gurney
Sleepsafe Safety Bed
Soft Seat for Rehab Shower Chair
Spare Tires for wheelchairs
Stand and drive legrest assembly
Standers
Stairway elevators
Stools of any kind
Supine Board
Telephone alert systems
Therapeutic Light Box
Toileting System
Toothettes
Turny System
Uplift Seat Assist

DESCRIPTION/ITEM
Vehicle safety devices, e.g., EZ Vests, Transit systems, car seats and accessories, etc.
Vibrators
Water bed and/or mattress
Wheelchair bag (for back of wheelchair to carry items in)
Wheelchair gloves
Wheelchair headlight/light kit
Wheelchair ramp

CHAPTER 506

DME/MEDICAL SUPPLIES

MAY 1, 2005

ATTACHMENT III

WVMI MEDICAID DME/MEDICAL SUPPLY

AUTHORIZATION REQUEST FORM

PAGE 1 OF 5

REVISED JANUARY 1, 2008

Confidential

WVMI MEDICAID DME / MEDICAL SUPPLIES AUTHORIZATION REQUEST FORM

Fax: 304-346-8185 **or** 1-877-762-4338 **Phone:** 304-414-2551 or (Toll Free) 1-800-296-9849

Request Date: ____________ Member's Medicaid ID #:___________________ Date of Birth: _____________
(If Medicaid not primary, denial for requested items must be attached)

A. **Member** Name: ____ Phone #:________________
Member Address: ____

B. **Prescribing Practitioner** Name: ____
Mailing Address: ____

Contact Name: __________________________ Phone# (_____) __________________ Ext: ___________
Fax # (_____) ____________________ E-Mail Address:______________________________________

C. Name of **DME Vendor** Selected by Member: ____
Physical Address: ____
Provider #: ______________________ Phone #:______________________Fax #:_____________________

D.

ICD-9 Codes	Clinical Diagnosis	Date of Onset

E.

* Status	HCPCS Code	Item Description	Length of Need (# of Months)	Amt / Mo Requested	* Amt / Mo Approved

* WVMI Use Only. Key: P=Pending, D=Denied

F. **Clinical Indication(s) for Item(s) requested:** ____
____
____
____

G. **PRACTITIONER CERTIFICATION**

I certify that I have examined the member within the past 6 months and the equipment and/or supplies requested are part of the plan of care. They are reasonable, medically necessary, and cost effective, and are not a convenience item for the member or any individual involved with the member's care. I certify that the member or his representative have been offered a choice of vendors.

____________________________________ ________________ ________________
Prescribing Practitioner's Signature (***required***) Medicaid ID# Date

***** REMINDER: Preauthorization for medical necessity does not guarantee payment***

For WVMI Use Only:

Approved: ___ Authorization Number: ______________________ Date: _______________

Denied: ____ Detailed letter to follow

NOTICE OF CONFIDENTIALITY

The information contained in this facsimile is legally privileged and confidential and only for the use of the intended recipient. If you have received this in error you are Hereby notified that any dissemination, distribution, or copying of this information is strictly prohibited. Please immediately notify us by phone at 1-800-642-8686, ext. 3273 and confirm the original message has been destroyed. Thank you.

Bureau for Medical Services
Certificate of Medical Necessity
Durable Medical Equipment/Medical Supplies

SECTION I

MEMBER DATA
Medicaid ID#____________________
Name___________________________
D.O.B.__________________________
Phone # (___) ___________________

SERVICING PROVIDER
Provider ID#____________________
Provider Name__________________
Contact Person_________________
Phone # (____) _________________

CMN Status
____Initial
____Revised
____Renewed

Section II MEMBER INFORMATION

Answer all questions that are applicable to **DME/ Medical Supplies** services being requested. If answer is **Yes**. You must describe/ attach additional information to support medical justification..

DOES PATIENT:	YES	NO
1. Have impaired mobility?	___	___
2. Have impaired endurance?	___	___
3. Have restricted activity?	___	___
4. Have skin break down? (Attach description of site, size, depth, and drainage)	___	___
5. Have impaired respiration? (Results of recent PO2/ saturation levels must be on file)	___	___
6. Require assistance with ADL'S ?	___	___
7. Have impaired speech?	___	___
8. Is item suitable for use in home and does the member/caregiver demonstrate willingness and ability to use the equipment?	___	___

9. Height: _________________ Weight: _______________

DATE PATIENT LAST EXAMINED BY PRACTITIONER: _____/_______/_______

ICD 9- CODES	CLINICAL DIAGNOSIS	DATE OF ONSET

SECTION III

Begin Service Date	HCPCS Code	Item Description	Estimated Length of Need (# Months)	Quantity and Frequency Of Use	Dollar Amount

SECTION IV PRACTITIONER CERTIFICATION OF MEDICAL NECESSITY

I certify that this patient meets the program eligibility criteria and that this equipment is a part of my course of treatment and is "Reasonable, Medically Necessary, and is most cost effective", and is not a convenience item for the member, family, attending practitioner, other practitioner or supplier. To my knowledge, the above information is accurate. (Must be completed, signed and dated by the Practitioner.)

Prescribing Practitioner's Name	Practitioner's Signature	Date	ID #	Phone #

WVDHHR/BMS/CMU/CMN/Revised 04/2005

West Virginia Department of Health and Human Resources
Bureau for Medical Services
Certificate of Medical Necessity
Initial Infant Apnea Monitor

Member's Name____ Medicaid ID #_________________________

Member's Birthdate____________________ Birth Weight _________________ Gestational Age____________________

Address____

Parent/Guardian____ Telephone #__________________

Prescribing Practitioner____Telephone #__________________

Address____

Diagnosis relating to need of Apnea Monitor (Must be one of the conditions below):
[ ] Sibling of SIDS
[ ] Apparent life threatening event (ALTE)
[ ] Infant with narcotic addict mother
[ ] Infant with high risk cardiac disease
[ ] Infant with tracheostomy
[ ] Prematurity

Date of ALTE____________ Number of episodes________ How documented___________________________________

Hospital____

Admission date______________________________ Discharge date____

Estimated length of need/frequency of use:
[ ] Short term (e.g., weaning from theophylline 1-2 weeks)
[ ] One Month [ ] Two Months [ ] Three Months [ ] Six Months

Frequency of use ____ Apnea delay rate_____________________

Follow-up appointment scheduled for______________________ with____

DME Provider____Medicaid ID #_____________________

Address____Telephone #_______________________

Date of monitor placement____

I, the undersigned, certify the above prescribed equipment is medically necessary for the indications certified above, and at the termination of
the period of medical necessity, the monitor will be removed. If a renewal prescription is not issued, then the authorization for the monitor is
cancelled and it is reasonable for the DME provider to remove the equipment.

____ _________________________________
Practitioner's Signature Date Signed

I have read and understand that before the end of the estimated period of need, I must bring my infant to the prescribing practitioner's office or
clinic so that he/she can determine how my infant is progressing and if there is further need for the monitor. Should I not comply with this regulation, then the monitor will no longer be prescribed and may be removed by the DME provider.

____ _________________________________
Parent/Guardian's Signature Date Signed

Request for prior authorization must be submitted to West Virginia Medical Institute seven (7) calendar days post hospital discharge

West Virginia Department of Health and Human Resources
Bureau for Medical Services
Certificate of Medical Necessity
Infant Apnea Monitor
Request For Extension

Member's Name____ Medicaid ID #_______________________

Address____

Diagnosis relating to need of Apnea Monitor (Must be one of the conditions below):

[ ] Sibling of SIDS
[ ] Apparent life threatening event (ALTE)
[ ] Infant with narcotic addict mother
[ ] Infant with high risk cardiac disease
[ ] Infant with tracheostomy
[ ] Prematurity

DME Provider____ Medicaid ID #_________________

Date of initial monitor placement____

Frequency of monitor use ____

Date, frequency and type of alarms in past month____

Date of last appointment______________________________Practitioner____________________________________

Date of next appointment______________________________Practitioner____________________________________

Please describe the conditions requiring extension____

____

Period of Medical Necessity: [ ] One Month [ ] Two Months [ ] Three Months

Apnea delay rate________________________________ Bradycardia alarm limit______________________________

I, the undersigned, certify the above prescribed equipment is medically necessary for the indications certified above, and at the termination of the period of medical necessity, the monitor will be removed. If a renewal prescription is not issued, then the authorization for the monitor is cancelled and it is reasonable for the DME provider to remove the equipment.

____ ______________________________
Practitioner's Signature Date Signed

I have read and understand that before the end of the estimated period of need, I must bring my infant to the prescribing practitioner's office or clinic so that he/she can determine how my infant is progressing and if there is further need for the monitor. Should I not comply with this regulation, then the monitor will no longer be prescribed and may be removed by the DME provider.

____ ______________________________
Parent/Guardian's Signature Date Signed