First Health Services Corporation
A Coventry Health Care Company

Billing Guidelines for Provider Type 33

Durable Medical Equipment, Prosthetics, Orthotics and Disposable Medical Supplies (DMEPOS)

DME Policy

The DME program covers medically necessary durable medical equipment, prosthetics, orthotics, and disposable medical supplies (DMEPOS); which includes oxygen and related supplies, parenteral and enteral nutrition and medical foods. Medicaid Services Manual (MSM) Chapter 1300 contains Nevada Medicaid DME policy, including but not limited to: documentation requirements, dispensing and delivery of items, recipient qualifications, coverage and limitations.

Durable Medical Equipment (DME) is medical equipment that:

- Can withstand repeated use;
- Is primarily and customarily used to serve a medical purpose;
- Is generally not useful to a person in the absence of illness or injury; and
- Is appropriate for use in the home.

Products and services must be medically necessary, safe and appropriate for the course and severity of the condition using the least costly and equally effective alternative to meet the recipient's needs.

Remember to check http://nevada.fhsc.com at least weekly for updates, policy changes, and Web Announcements!

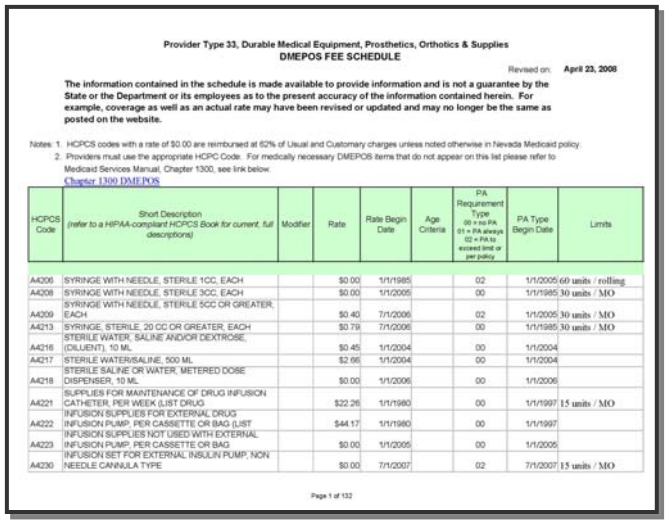
DMEPOS Fee Schedule

The Provider Type 33 DMEPOS Fee Schedule is online at http://dhcfp.state.nv.us/rates. Services/Products are listed according to their Healthcare Common Procedure Coding System (HCPCS), Level II alpha/numeric code.

The DMEPOS fee schedule provides coverage information and more.

- Non-covered codes show "999" in the "Flag Code" column; all other listed codes are covered.
- Service limits (if applicable) are shown in the "Limits" column.
- Prior authorization requirements are shown in the "PA Type" column on the fee schedule. In the "PA Type" column:
- "00" means that PA is not required.
- "01" means that PA is always required.
- "02" means that PA is required to exceed the service limitations.

For questions related to rates in the fee schedule, refer to MSM Chapter 700, "Rates."



Provider Type 33, Durable Medical Equipment, Prosthetics, Orthotics & Supplies
DMEPOS FEE SCHEDULE

Revised on: April 23, 2008

The information contained in the schedule is made available to provide information and is not a guarantee by the State or the Department or its employees as to the present accuracy of the information contained herein. For example, coverage as well as an actual rate may have been revised or updated and may no longer be the same as posted on the website.

Notes: 1. HCPCS codes with a rate of $0.00 are reimbursed at 62% of Usual and Customary charges unless noted otherwise in Nevada Medicaid policy.
2. Providers must use the appropriate HCPC Code. For medically necessary DMEPOS items that do not appear on this list please refer to Medicaid Services Manual, Chapter 1300, see link below:
Chapter 1300 DMEPOS

HCPCS Code	Short Description (refer to a HIPAA-compliant HCPCS Book for current, full descriptions)	Modifier	Rate	Rate Begin Date	Age Criteria	PA Requirement Type (00 = no PA, 01 = PA always, 02 = PA to exceed limit or per policy	PA Type Begin Date	Limits
A4206	SYRINGE WITH NEEDLE, STERILE 1CC, EACH		$0.00	1/1/1985		02	1/1/2005	60 units / rolling
A4208	SYRINGE WITH NEEDLE, STERILE 3CC, EACH		$0.00	1/1/2005		00	1/1/1985	30 units / MO
A4209	SYRINGE WITH NEEDLE, STERILE 5CC OR GREATER, EACH		$0.40	7/1/2006		02	1/1/2005	30 units / MO
A4213	SYRINGE, STERILE, 20 CC OR GREATER, EACH		$0.79	7/1/2006		00	1/1/1985	30 units / MO
A4216	STERILE WATER, SALINE AND/OR DEXTROSE, (DILUENT), 10 ML		$0.45	1/1/2004		00	1/1/2004	
A4217	STERILE WATER/SALINE, 500 ML		$2.66	1/1/2004		00	1/1/2004	
A4218	STERILE SALINE OR WATER, METERED DOSE DISPENSER, 10 ML		$0.00	1/1/2006		00	1/1/2006	
A4221	SUPPLIES FOR MAINTENANCE OF DRUG INFUSION CATHETER, PER WEEK (LIST DRUG		$22.26	1/1/1980		00	1/1/1997	15 units / MO
A4222	INFUSION SUPPLIES FOR EXTERNAL DRUG INFUSION PUMP, PER CASSETTE OR BAG (LIST		$44.17	1/1/1980		00	1/1/1997	
A4223	INFUSION SUPPLIES NOT USED WITH EXTERNAL INFUSION PUMP, PER CASSETTE OR BAG		$0.00	1/1/2005		00	1/1/2005	
A4230	INFUSION SET FOR EXTERNAL INSULIN PUMP, NON NEEDLE CANNULA TYPE		$0.00	7/1/2007		02	7/1/2007	15 units / MO

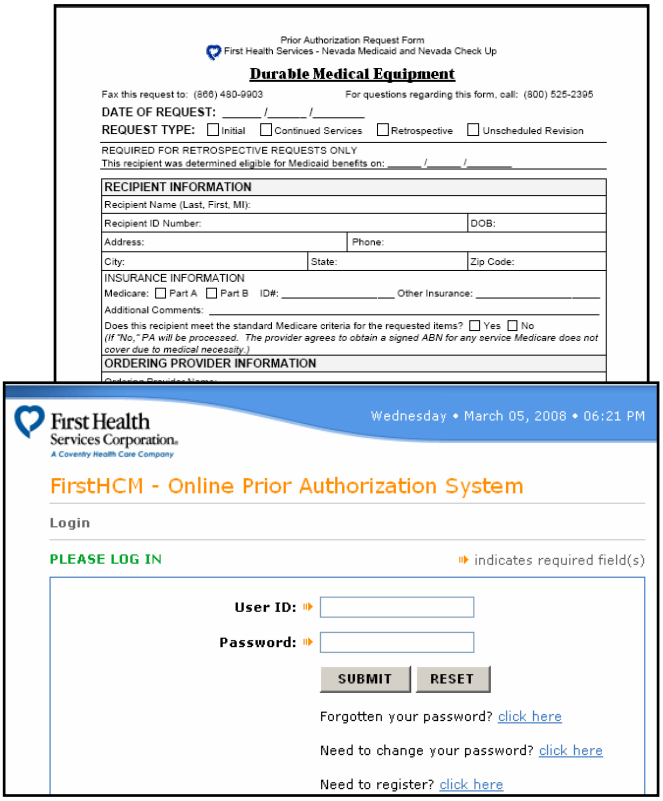
Page 1 of 132

Prior Authorization

Some DMEPOS services/items require prior authorization. Requests maybe submitted through the Online Prior Authorization System (OPAS) or by fax using form FH-1 (use form FH-1A for continuing usage of BIPAP and CPAP devices).

It is critical to submit complete and accurate clinical documentation on prior authorization requests. Documentation must include the prescription and fully support medical necessity of the item. When submitting supporting medical documentation online, the name and credentials of the provider who supplied the information are required. Failure to provide this information may result in a denied request and/or may delay the determination.

MSM Chapter 1300, including Appendix B lists specific prior authorization and documentation requirements. If you have any questions, please contact the Prior Authorization Department at (800) 525-2395.



Prior Authorization Request Form
First Health Services - Nevada Medicaid and Nevada Check Up

Durable Medical Equipment

Fax this request to: (866) 480-9903 For questions regarding this form, call: (800) 525-2395

DATE OF REQUEST: _____/_____/_____

REQUEST TYPE: ☐ Initial ☐ Continued Services ☐ Retrospective ☐ Unscheduled Revision

REQUIRED FOR RETROSPECTIVE REQUESTS ONLY
This recipient was determined eligible for Medicaid benefits on: _____/_____/_____

RECIPIENT INFORMATION		
Recipient Name (Last, First, MI):		
Recipient ID Number:		DOB:
Address:	Phone:	
City:	State:	Zip Code:

INSURANCE INFORMATION
Medicare: ☐ Part A ☐ Part B ID#: _____ Other Insurance: _____
Additional Comments: _____
Does this recipient meet the standard Medicare criteria for the requested items? ☐ Yes ☐ No
(If "No," PA will be processed. The provider agrees to obtain a signed ABN for any service Medicare does not cover due to medical necessity.)

ORDERING PROVIDER INFORMATION

First Health Services Corporation
A Coventry Health Care Company

Wednesday • March 05, 2008 • 06:21 PM

FirstHCM - Online Prior Authorization System

Login

PLEASE LOG IN indicates required field(s)

User ID:

Password:

SUBMIT RESET

Forgotten your password? click here

Need to change your password? click here

Need to register? click here

All items dispensed to recipients in an institutional setting (e.g., Nursing Facility (NF) or Intermediate Care Facility for the Mentally Retarded (ICF/MR)), require prior authorization for exception to inclusive facility rates.

Place of Service: Institutional Setting

Durable Medical Equipment, Prosthetics, Orthotics and Disposable Medical Supplies (DMEPOS) provided or supplied to recipients in an institutional setting (Nursing Facility and Intermediate Care Facility for the Mentally Retarded) are included in the facility's per diem rate and are not separately payable by Medicaid. The facility's per diem rate is all-inclusive to cover all items needed during the stay. The exceptions to this are as follows:

- Items provided in preparation for discharge to the community; or
- Custom fitted devices that are not suitable for use by any other individual; or
- Total Parenteral Nutrition (TPN); or
- Enteral formulas administered via a feeding tube.

Claims/Billing

- Provider must submit claims in accordance with the Healthcare Common Procedure Coding System (HCPCS) and national industry standards.
- Providers can only bill for the actual number of medically necessary units dispensed/delivered to a recipient, regardless of the number of units allowed by policy and/or prior authorization.
- Providers must bill their usual and customary charges.

Rental Items

Rates identified in the DMEPOS Fee Schedule for rental items (modifier code RR) are calculated as a monthly rate and are to be billed at monthly intervals beginning with the date item was dispensed/delivered to recipient. The exceptions to this are for codes E0202 and E0935, which are daily rates.

Special Instructions for Common Products and Services

For all DME items, refer to Nevada Medicaid DME policy in MSM Chapter 1300. Claims must include the appropriate physician's diagnosis code in accordance with policy.

Bundled Services

For any HCPCS code description in which various components are identified, the components may not be billed separately. The Nevada Medicaid rate includes all items in the description.

BIPAP Devices

Use OPAS or submit form FH-1A to request continued services for BIPAP devices **no sooner than 61 days and no later than 120 days** after initiation of therapy. Form FH-1A or an attached physician's note must contain a signed and dated statement declaring that the recipient is:

- Compliantly using the device an average of 4 hours per 24 hour period; and
- Benefiting from its use

CPAP Devices

Use OPAS or submit form FH-1A to request continued services for CPAP devices no sooner than 61 days and no later than 120 days after initiation of therapy. The request must include all of the following:

- The number of hours a day the machine is used;
- The number of months the recipient has used the machine;
- Whether the recipient will continue to use the machine; and
- The name of the person who answered these questions (it can not be the DME supplier).

Diabetic Supplies

Diabetic supplies are billed through the pharmacy program (provider type 28), not DME provider type 33.

The exceptions to this are as follows: insulin pumps (E0784) and insulin pump-related supplies (A4223, A4230, A4231 and K0552) or diabetic shoes/fittings/modifications (A5500 – A5513) which need to be billed through DME.

Enteral / Gastrostomy

The **Enteral Feeding Supply Kit**, **Pump fed** (code B4035) is limited to 31 units per month (1 unit equals 1 day). The Enteral Feeding Supply Kit, **Gravity fed** (code B4036) is limited to 30 units per month.

To **bill a partial month** for an Enteral Feeding Supply Kit, enter the first date of the billing cycle in the "from" date (Field 24A). Enter the same date for the "To" date (Field 24A also). Enter one unit for each day Field 24G. For example, to bill for March 12–31, enter a "From" date of March 12, a "To" date of March 12, and a "20" in Field 24G.

The following scenario shows how to **bill continued services (rolling months)** for code B4035 (a 31-day billing frequency). The same instructions would apply to code B4036, except a 30-day billing frequency would be used.

a) You begin your billing cycle on February 3. February has 28 days in it, and 31 days from February 3 is March 5. Therefore, March 5 will be the last day of your billing cycle. On the claim form, enter "February 3" (the first day of the billing cycle) as the From date and as the To date (Field 24A). Enter "31" in Field 24G.

b) The next 31-day billing cycle would start on March 6. March has 31 days in it, and 31 days from March 6 is April 5. Therefore, April 5 will be the last day of your billing cycle. On the claim form, enter "March 6" as the From date and as the To date (Field 24A). Enter "31" in Field 24G.

c) The next 31-day billing cycle would start on April 6. April has 30 days in it, and 31 days from April 6 is May 6. Therefore, May 6 will be the last day of your billing cycle. On the claim form, enter "April 6" as the From date and as the To date (Field 24A). Enter "31" in Field 24G.

Enteral Nutrition/Formula does not require prior authorization when the recipient has a feeding tube through which enteral feeding is administered.

If the recipient's diagnosis is gastrostomy or other artificial opening of gastrointestinal tract, such as jejunostomy or attention to one of these sites **(ICD-9 code V44.1, V44.4 V55.1 or V55.4), prior authorization is not required**. Enter the appropriate ICD-9 code in Field 21 on the CMS-1500 claim form. Leave blank Field 23. **This bypass of the prior authorization requirement does not pertain to recipients in an institutional setting (e.g., acute care, NF or ICF/MR).**

Refer to MSM Chapter 1300 for covered and non-covered services.

Bill enteral formulas monthly as prior authorized. On the claim form, enter the begin date of the billing cycle in both the "From" and "To" date fields (Field 24A). If the recipient has Medicare coverage and you billed Medicare more than one month on a claim line, bill Medicaid the same way. In all other instances (e.g., private insurance), you may need to bill Medicaid differently than the primary insurance.

For the following Enteral Formula codes**, 100 calories equals 1 unit**. Enter the units in Field 24G on the CMS-1500 claim form.

- B4149
- B4150
- B4152
- B4153
- B4154
- B4155
- B4157
- B4158
- B4159
- B4160
- B4161
- B4162

For **Feeding Tubes**, use code B4087 to bill for standard gastrostomy/jejunostomy tubes and code B4088 without a modifier to bill for a low-profile gastrostomy/jejunostomy feeding tube. For the **Low Profile Gastrostomy** Feeding Tube, MIC-KEY® Button only, use B4088 with modifier BA. Use B9998 to bill for Extension Sets. Prior authorization is required to exceed 1 unit every 3 months.

Percutaneous Catheter/Tube Anchoring Devices (code A5200) and dressing holders (A4461 or A4463) used in conjunction with a gastrostomy or enterostomy tube are included in supply kit codes B4034-B4036 and may not be billed separately.

Gloves, Non-sterile, per 100 (Code A4927)

One box contains 100 gloves. Therefore, one box of 100 gloves equals one unit for billing.

Incontinent Products

Providers must use the appropriate HCPCS code for the size of the recipient.

- **Codes T4521 – T4528** small, medium, large, or extra large adult-sized products;
- **Codes T4529 – T4532** small/medium, or large pediatric-sized products;
- **Codes T4533 and T4534** youth-sized products;
- **Code T4543** is only to be used for bariatric-sized adult recipients with waist size 60" to 90".

Refer to a HCPCS book for exact sizing (small, med, large, etc.) for each code. If an alternate size product is medically necessary for a recipient, supportive medical documentation must be obtained and maintained by the provider for audit purposes. Example: a child who needs an adult-sized diaper.

The use of **codes A4520, A4335, and T4535** for incontinent products should only be used when there is not a more appropriate T code.

For **underpads**, use code T4542 for small-sized underpads and T4521 for large-sized underpads; or code A4554 for any size underpad.

Medicaid does not pay for products used for menses.

Intravenous Therapy Supplies

Intravenous therapy supplies including all HCPCS "S" codes listed on the DMEPOS Fee Schedule are billed through the DME program (provider type 33), not provider type 37.

Medications added to **TPN Solution** immediately prior to administration are billed through Point of Sale (POS) using provider type 37. See the Provider Type 37 Billing Guidelines and MSM Chapter 1200 for coverage and limitations.

Orthotic and Prosthetic Devices

With the exception of "repair" codes, DME providers (provider type 33) are not required to request prior authorization for "**L codes**" with a reimbursement rate of less than $250.00. This does not negate the provider or supplier's responsibility to practice within their scope and to follow DHCFP policy in MSM Chapter 1300.

Power Mobility Devices (PMD)

Prescribing physician/practitioners may bill an additional fee using HCPCS code G0372 on the claim for the office visit (CPT 99211) during which the Medicare-required face-to-face examination/evaluation was completed.

Power Operated Vehicle (POV), Basic Equipment Package

Upon initial issue, a POV must include all items below; separate billing/payment is not acceptable.

- Battery or batteries required for operation
- Battery charger, single mode
- Weight appropriate upholstery and seating system
- Tiller steering
- Non-expandable controller with proportional response to input
- Complete set of tires
- All accessories needed for safe operation

Power Wheelchair, Basic Equipment Package

Upon initial issue, a power wheelchair must include all items below unless otherwise noted; separate billing/payment is not acceptable.

Inclusion of a code below does not indicate coverage. See the DMEPOS Fee Schedule for coverage and limitations.

- Lap belt or safety belt (E0978)
- Battery charger, single mode (E2366)
- Complete set of tires and casters any type (K0090, K0091, K0092, K0093, K0094, K0095, K0096, K0097, K0099)
- Legrests. Separate billing is not allowed when swingaway, detachable, non-elevating legrests with/without calf pad (K0051, K0052, E0995) are provided. Elevating leg rests may be billed separately.
- Fixed/swing-away detachable footrests with/without angle adjustment footplate/platform (K0037, K0040, K0041, K0042, K0043, K0044, K0045, K0052)
- Armrests. Separate billing is not allowed when fixed/swingaway, detachable, non-adjustable armrests with arm pad (K0015, K0019, K0020) are provided. Adjustable height armrests may be billed separately.
- Upholstery for seat and back of proper strength and type for recipient weight capacity of the power wheelchair (E0981, E0982)
- Weight specific components per recipient weight capacity
- Controller and Input Device. Separate billing is not allowed when a non-expandable controller and proportional input device (integrated or remote) is provided. If a code specifies an expandable controller as an option (but not a requirement) at the time of initial issue, it may be billed separately.

New, Deleted, Crosswalk/Replacement, and Changed Codes

The tables below identify 2008 HCPCS code changes effective **January 1, 2008**. For code descriptions or more information, see the most recent HCPCS coding book or the CMS website at www.cms.hhs.gov.

Inclusion of a code in this document is not an indication of coverage or non-coverage. Please refer to the Provider Type 33 DMEPOS Fee Schedule at http://dhcfp.nv.gov/RatesUnit.htm for Medicaid coverage.

New Codes Effective January 1, 2008		
A4252	A4648	A4650

Deleted Codes	Crosswalk/Replacement Codes
E2618	K0108 *(for manual wheelchairs and replacement on power wheelchairs), or* NONE *(for power wheelchairs at initial issue - not separately billable)*
K0553	A7027
K0554	A7029
K0555	NONE
L0960	NONE
L1855	L1846
L1858	L1846
L1870	L1846
L1880	L1846
L3800	L3808
L3805	L3808
L3810	NONE - *Included in allowance for the base code*
L3815	NONE - *Included in allowance for the base code*
L3820	NONE - *Included in allowance for the base code*
L3825	NONE - *Included in allowance for the base code*
L3830	NONE - *Included in allowance for the base code*
L3835	NONE - *Included in allowance for the base code*
L3840	NONE - *Included in allowance for the base code*
L3845	NONE - *Included in allowance for the base code*
L3850	NONE - *Included in allowance for the base code*
L3855	NONE - *Included in allowance for the base code*
L3860	NONE - *Included in allowance for the base code*
L3907	L3808
L3910	L3931
L3916	L3931
L3918	L3929
L3920	L3929
L3922	NONE
L3924	L3931
L3926	L3931
L3928	L3929
L3930	L3931
L3932	L3925

Deleted Codes	Crosswalk/Replacement Codes
L3934	L3925
L3936	L3931
L3938	L3931
L3940	L3931
L3942	L3929
L3944	L3929
L3946	NONE
L3948	L3929
L3950	L3925
L3952	L3931
L3954	L3923
L3985	L3764
L3986	L3763

Changed Codes/Narrative Descriptions	
A4206	Syringe with needle, sterile 1cc or less, each
A5105	Urinary suspensory with leg bag, with or without tube, each
B4034	Enteral feeding supply kit; syringe fed, per day
E0630	Patient lift, hydraulic or mechanical, includes any seat, sling, strap(s) or pad(s)
E0705	Transfer device, any type, each
E1801	Static progressive stretch elbow device, extension and/or flexion, with or without range of motion adjustment, includes all components and accessories
E1806	Static progressive stretch wrist device, flexion and/or extension, with or without range of motion adjustment, includes all components and accessories
E1811	Static progressive stretch knee device, extension and/or flexion, with or without range of motion adjustment, includes all components and accessories
E1816	Static progressive stretch ankle device, flexion and/or extension, with or without range of motion adjustment, includes all components and accessories
E1818	Static progressive stretch forearm pronation/supination device, with or without range of motion adjustment, includes all components and accessories
E1841	Static progressive stretch shoulder device, with or without range of motion adjustment, includes all components and accessories
E2205	Manual wheelchair accessory, handrim without projections (includes ergonomic or contoured), any type, replacement only, each
E2373	Power wheelchair accessory, hand or chin control interface, compact remote joystick, proportional, including fixed mounting hardware
L3806	Wrist hand finger orthosis, includes one or more nontorsion joint(s), turnbuckles, elastic bands/springs, may include soft interface material, straps, custom fabricated, includes fitting and adjustment
L7360	Six volt battery, each
L7362	Battery charger, six volt, each
L7364	Twelve volt battery, each
L7366	Battery charger, twelve volt, each