

STATE OF MISSOURI



DURABLE MEDICAL
EQUIPMENT MANUAL



SECTION 1-PARTICIPANT CONDITIONS OF PARTICIPATION	16
1.1 INDIVIDUALS ELIGIBLE FOR MO HEALTHNET, MANAGED CARE OR STATE FUNDED BENEFITS	16
1.1.A DESCRIPTION OF ELIGIBILITY CATEGORIES	16
1.1.A(1) MO HealthNet	16
1.1.A(2) MO HealthNet for Kids	17
1.1.A(3) Temporary MO HealthNet During Pregnancy (TEMP).....	19
1.1.A(4) Voluntary Placement Agreement for Children	19
1.1.A(5) State Funded MO HealthNet	19
1.1.A(6) MO Rx.....	20
1.1.A(7) Women’s Health Services	20
1.1.A(8) ME Codes Not in Use	21
1.2 MO HEALTHNET AND MO HEALTHNET MANAGED CARE ID CARD.....	21
1.2.A FORMAT OF MO HEALTHNET ID CARD	22
1.2.B ACCESS TO ELIGIBILITY INFORMATION.....	23
1.2.C IDENTIFICATION OF PARTICIPANTS BY ELIGIBILITY CODES	23
1.2.C(1) MO HealthNet Participants	23
1.2.C(2) MO HealthNet Managed Care Participants.....	23
1.2.C(3) TEMP	23
1.2.C(4) Temporary Medical Eligibility for Reinstated TANF Individuals	24
1.2.C(5) Presumptive Eligibility for Children	24
1.2.C(6) Breast or Cervical Cancer Treatment Presumptive Eligibility	24
1.2.C(7) Voluntary Placement Agreement	24
1.2.D THIRD PARTY INSURANCE COVERAGE	25
1.2.D(1) Medicare Part A, Part B and Part C	25
1.3 MO HEALTHNET, STATE FUNDED MEDICAL ASSISTANCE AND MO HEALTHNET MANAGED CARE APPLICATION PROCESS	25
1.4 AUTOMATIC MO HEALTHNET ELIGIBILITY FOR NEWBORN CHILDREN	26
1.4.A NEWBORN INELIGIBILITY	27
1.4.B NEWBORN ADOPTION	27
1.4.C MO HEALTHNET MANAGED CARE HEALTH PLAN NEWBORN ENROLLMENT	27
1.5 PARTICIPANTS WITH RESTRICTED/LIMITED BENEFITS	28
1.5.A LIMITED BENEFIT PACKAGE FOR ADULT CATEGORIES OF ASSISTANCE	28
1.5.B ADMINISTRATIVE PARTICIPANT LOCK-IN	30
1.5.C MO HEALTHNET MANAGED CARE PARTICIPANTS	30
1.5.C(1) Home Birth Services for the MO HealthNet Managed Care Program	32
1.5.D HOSPICE BENEFICIARIES	32
1.5.E QUALIFIED MEDICARE BENEFICIARIES (QMB)	33
1.5.F WOMEN’S HEALTH SERVICES PROGRAM (ME CODES 80 and 89).....	34
1.5.G TEMP PARTICIPANTS.....	34



1.5.G(1) TEMP ID Card	35
1.5.G(2) TEMP Service Restrictions	36
1.5.G(3) Full MO HealthNet Eligibility After TEMP	36
1.5.H PROGRAM FOR ALL-INCLUSIVE CARE FOR THE ELDERLY (PACE)	36
1.5.I MISSOURI'S BREAST AND CERVICAL CANCER TREATMENT (BCCT) ACT	37
1.5.I(1) Eligibility Criteria	37
1.5.I(2) Presumptive Eligibility	38
1.5.I(3) Regular BCCT MO HealthNet	38
1.5.I(4) Termination of Coverage	39
1.5.J TICKET TO WORK HEALTH ASSURANCE PROGRAM	39
1.5.J(1) Disability	39
1.5.J(2) Employment	39
1.5.J(3) Premium Payment and Collection Process	39
1.5.J(4) Termination of Coverage	40
1.5.K PRESUMPTIVE ELIGIBILITY FOR CHILDREN	40
1.5.K(1) Eligibility Determination	41
1.5.K(2) MO HealthNet for Kids Coverage	41
1.5.L MO HEALTHNET COVERAGE FOR INMATES OF A PUBLIC INSTITUTION	42
1.5.L(1) MO HealthNet Coverage Not Available	43
1.5.L(2) MO HealthNet Benefits	43
1.5.M VOLUNTARY PLACEMENT AGREEMENT, OUT-OF- HOME CHILDREN'S SERVICES	44
1.5.M(1) Duration of Voluntary Placement Agreement	44
1.5.M(2) Covered Treatment and Medical Services	44
1.5.M(3) Medical Planning for Out-of-Home Care	44
1.6 ELIGIBILITY PERIODS FOR MO HEALTHNET PARTICIPANTS	45
1.6.A DAY SPECIFIC ELIGIBILITY	46
1.6.B SPENDDOWN	47
1.6.B(1) Notification of Spenddown Amount	48
1.6.B(2) Notification of Spenddown on New Approvals	48
1.6.B(3) Meeting Spenddown with Incurred and/or Paid Expenses	48
1.6.B(4) Meeting Spenddown with a Combination of Incurred Expenses and Paying the Balance	49
1.6.B(5) Preventing MO HealthNet Payment of Expenses Used to Meet Spenddown	49
1.6.B(6) Spenddown Pay-In Option	50
1.6.B(7) Prior Quarter Coverage	50
1.6.B(8) MO HealthNet Coverage End Dates	51
1.6.C PRIOR QUARTER COVERAGE	51
1.6.D EMERGENCY MEDICAL CARE FOR INELIGIBLE ALIENS	51
1.7 PARTICIPANT ELIGIBILITY LETTERS AND CLAIMS CORRESPONDENCE	52
1.7.A NEW APPROVAL LETTER	53
1.7.A(1) Eligibility Letter for Reinstated TANF (ME 81) Individuals	53



1.7.A(2) BCCT Temporary MO HealthNet Authorization Letter	53
1.7.A(3) Presumptive Eligibility for Children Authorization PC-2 Notice	53
1.7.B REPLACEMENT LETTER	54
1.7.C NOTICE OF CASE ACTION	54
1.7.D PARTICIPANT EXPLANATION OF MO HEALTHNET BENEFITS	54
1.7.E PRIOR AUTHORIZATION REQUEST DENIAL	55
1.7.F PARTICIPANT SERVICES UNIT ADDRESS AND TELEPHONE NUMBER	55
1.8 TRANSPLANT PROGRAM	55
1.8.A COVERED ORGAN AND BONE MARROW/STEM CELL TRANSPLANTS	56
1.8.B PATIENT SELECTION CRITERIA	56
1.8.C CORNEAL TRANSPLANTS	56
1.8.D ELIGIBILITY REQUIREMENTS	56
1.8.E MANAGED CARE PARTICIPANTS	57
1.8.F MEDICARE COVERED TRANSPLANTS	57
SECTION 2-PROVIDER CONDITIONS OF PARTICIPATION	59
2.1 PROVIDER ELIGIBILITY	59
2.1.A QMB-ONLY PROVIDERS	59
2.1.B NON-BILLING MO HEALTHNET PROVIDER	59
2.1.C PROVIDER ENROLLMENT ADDRESS	59
2.1.D ELECTRONIC CLAIM/ATTACHMENTS SUBMISSION AND INTERNET AUTHORIZATION	60
2.1.E PROHIBITION ON PAYMENT TO INSTITUTIONS OR ENTITIES LOCATED OUTSIDE OF THE UNITED STATES	60
2.2 NOTIFICATION OF CHANGES	60
2.3 RETENTION OF RECORDS	61
2.3.A ADEQUATE DOCUMENTATION	61
2.4 NONDISCRIMINATION POLICY STATEMENT	61
2.5 STATE’S RIGHT TO TERMINATE RELATIONSHIP WITH A PROVIDER	62
2.6 FRAUD AND ABUSE	62
2.6.A CLAIM INTEGRITY FOR MO HEALTHNET PROVIDERS	63
2.7 OVERPAYMENTS	63
2.8 POSTPAYMENT REVIEW	64
2.9 PREPAYMENT REVIEW	64
2.10 DIRECT DEPOSIT AND REMITTANCE ADVICE	65
SECTION 3 - STAKEHOLDER SERVICES	67
3.1 PROVIDER SERVICES	67
3.1.A MHD TECHNICAL HELP DESK	67
3.2 Missouri Medicaid Audit & Compliance (MMAC)	67
3.2.A PROVIDER ENROLLMENT UNIT	68
3.3 PROVIDER COMMUNICATIONS UNIT	68
3.3.A INTERACTIVE VOICE RESPONSE (IVR) SYSTEM	68
3.3.A(1) Using the Telephone Key Pad	75



3.3.B MO HEALTHNET SPECIALIST	75
3.3.C INTERNET	76
3.3.D WRITTEN INQUIRIES	77
3.4 PROVIDER EDUCATION UNIT.....	78
3.5 PARTICIPANT SERVICES.....	78
3.6 PENDING CLAIMS	79
3.7 FORMS	79
3.8 CLAIM FILING METHODS	79
3.9 CLAIM ATTACHMENT SUBMISSION VIA THE INTERNET.....	79
3.10 Pharmacy & Clinical Services Unit.....	79
3.11 Pharmacy and Medical Pre-certification Help Desk.....	80
3.12 Third Party Liability (TPL).....	80
SECTION 4 - TIMELY FILING.....	81
4.1 TIME LIMIT FOR ORIGINAL CLAIM FILING	81
4.1.A MO HEALTHNET CLAIMS	81
4.1.B MEDICARE/MO HEALTHNET CLAIMS	81
4.1.C MO HEALTHNET CLAIMS WITH THIRD PARTY LIABILITY	81
4.2 TIME LIMIT FOR RESUBMISSION OF A CLAIM	82
4.2.A CLAIMS FILED AND DENIED	82
4.2.B CLAIMS FILED AND RETURNED TO PROVIDER	82
4.3 CLAIMS NOT FILED WITHIN THE TIME LIMIT	83
4.4 TIME LIMIT FOR FILING AN INDIVIDUAL ADJUSTMENT	83
4.5 DEFINITIONS.....	83
SECTION 5-THIRD PARTY LIABILITY	85
5.1 GENERAL INFORMATION.....	85
5.1.A MO HEALTHNET IS PAYER OF LAST RESORT	85
5.1.B THIRD PARTY LIABILITY FOR MANAGED HEALTH CARE ENROLLEES	86
5.1.C PARTICIPANTS LIABILITY WHEN THERE IS A TPR	87
5.1.D PROVIDERS MAY NOT REFUSE SERVICE DUE TO TPL	88
5.2 HEALTH INSURANCE IDENTIFICATION	88
5.2.A TPL INFORMATION	89
5.2.B SOLICITATION OF TPR INFORMATION	89
5.3 INSURANCE COVERAGE CODES.....	90
5.4 COMMERCIAL MANAGED HEALTH CARE PLANS.....	91
5.5 MEDICAL SUPPORT	91
5.6 PROVIDER CLAIM DOCUMENTATION REQUIREMENTS	92
5.6.A EXCEPTION TO TIMELY FILING LIMIT.....	92
5.6.B TPR CLAIM PAYMENT DENIAL	93
5.7 THIRD PARTY LIABILITY BYPASS	93
5.8 MO HEALTHNET INSURANCE RESOURCE REPORT (TPL-4).....	94
5.9 LIABILITY AND CASUALTY INSURANCE.....	94
5.9.A TPL RECOVERY ACTION.....	95



5.9.B LIENS95

5.9.C TIMELY FILING LIMITS95

5.9.D ACCIDENTS WITHOUT TPL96

5.10 RELEASE OF BILLING OR MEDICAL RECORDS INFORMATION96

5.11 OVERPAYMENT DUE TO RECEIPT OF A THIRD PARTY RESOURCE96

5.12 THE HEALTH INSURANCE PREMIUM PAYMENT (HIPP) PROGRAM97

5.13 DEFINITIONS OF COMMON HEALTH INSURANCE TERMINOLOGY97

SECTION 6-ADJUSTMENTS100

6.1 GENERAL REQUIREMENTS.....100

6.2 INSTRUCTIONS FOR ADJUSTING CLAIMS WITHIN 24 MONTHS OF DATE OF SERVICE.....100

6.2.A NOTE: PROVIDERS MUST BE ENROLLED AS AN ELECTRONIC BILLING PROVIDER BEFORE USING THE ONLINE CLAIM ADJUSTMENT TOOL100

6.2.B ADJUSTING CLAIMS ONLINE.....100

6.2.B(1) Options for Adjusting a Paid Claim100

6.2.B(1)(i) Void101

6.2.B(1)(ii) Replacement101

6.2.B(2) Options for Adjusting a Denied Claim.....101

6.2.B(2)(i) Timely Filing101

6.2.B(2)(ii) Copy Claim – Original102

6.2.B(2)(iii) Copy Claim – Advanced102

6.2.C CLAIM STATUS CODES.....102

6.3 INSTRUCTIONS FOR ADJUSTING CLAIMS OLDER THAN 24 MONTHS OF DOS .102

6.4 EXPLANATION OF THE ADJUSTMENT TRANSACTIONS103

SECTION 7-MEDICAL NECESSITY104

7.1 CERTIFICATE OF MEDICAL NECESSITY104

7.1.A CERTIFICATE OF MEDICAL NECESSITY FOR DURABLE MEDICAL EQUIPMENT PROVIDERS105

7.2 INSTRUCTIONS FOR COMPLETING THE CERTIFICATE OF MEDICAL NECESSITY105

SECTION 8-PRIOR AUTHORIZATION107

8.1 BASIS.....107

8.2 PRIOR AUTHORIZATION GUIDELINES107

8.3 PROCEDURE FOR OBTAINING PRIOR AUTHORIZATION108

8.4 EXCEPTIONS TO THE PRIOR AUTHORIZATION REQUIREMENT109

8.5 INSTRUCTIONS FOR COMPLETING THE PRIOR AUTHORIZATION (PA) REQUEST FORM110

8.5.A WHEN TO SUBMIT A PRIOR AUTHORIZATION (PA) REQUEST111

8.6 MO HEALTHNET AUTHORIZATION DETERMINATION112

8.6.A A DENIAL OF PRIOR AUTHORIZATION (PA) REQUESTS113

8.6.B MO HEALTHNET AUTHORIZATION DETERMINATION EXPLANATION113

8.7 REQUEST FOR CHANGE (RFC) OF PRIOR AUTHORIZATION (PA) REQUEST114



8.7.A WHEN TO SUBMIT A REQUEST FOR CHANGE.....114

8.8 DEPARTMENT OF HEALTH AND SENIOR SERVICES (DHSS)115

8.9 OUT-OF-STATE, NON-EMERGENCY SERVICES.....115

8.9.A EXCEPTIONS TO OUT-OF-STATE PRIOR AUTHORIZATION REQUESTS116

SECTION 9-HEALTHY CHILDREN AND YOUTH PROGRAM117

9.1 GENERAL INFORMATION117

9.2 PLACE OF SERVICE (POS)117

9.3 DIAGNOSIS CODE118

9.4 INTERPERIODIC SCREENS118

9.5 FULL HCY/EPSDT SCREEN.....118

9.5.A QUALIFIED PROVIDERS120

9.6 PARTIAL HCY/EPSDT SCREENS120

9.6.A DEVELOPMENTAL ASSESSMENT121

9.6.A(1) Qualified Providers121

9.6.B UNCLOTHED PHYSICAL, ANTICIPATORY GUIDANCE, AND INTERVAL HISTORY, LAB/IMMUNIZATIONS AND LEAD SCREEN.....121

9.6.B(1) Qualified Providers.....122

9.6.C VISION SCREENING.....122

9.6.C(1) Qualified Providers.....122

9.6.D HEARING SCREEN123

9.6.D(1) Qualified Providers123

9.6.E DENTAL SCREEN.....123

9.6.E(1) Qualified Providers.....124

9.6.F ALL PARTIAL SCREENERS124

9.7 LEAD RISK ASSESSMENT AND TREATMENT—HEALTHY CHILDREN AND YOUTH (HCY)124

9.7.A SIGNS, SYMPTOMS AND EXPOSURE PATHWAYS125

9.7.B LEAD RISK ASSESSMENT126

9.7.C MANDATORY RISK ASSESSMENT FOR LEAD POISONING127

9.7.C(1) Risk Assessment.....127

9.7.C(2) Determining Risk127

9.7.C(3) Screening Blood Tests.....127

9.7.C(4) MO HealthNet Managed Care Health Plans128

9.7.D LABORATORY REQUIREMENTS FOR BLOOD LEAD LEVEL TESTING.....129

9.7.E BLOOD LEAD LEVEL—RECOMMENDED INTERVENTIONS.....129

9.7.E(1) Blood Lead Level <10 µg/dL129

9.7.E(2) Blood Lead Level 10-19 µg/dL129

9.7.E(3) Blood Lead Level 20-44 µg/dL130

9.7.E(4) Blood Lead Level 45-69 µg/dL130

9.7.E(5) Blood Lead Level 70 µg/dL or Greater131

9.7.F COORDINATION WITH OTHER AGENCIES131

9.7.G ENVIRONMENTAL LEAD INVESTIGATION132



9.7.G(1) Environmental Lead Investigation 132

9.7.H ABATEMENT 133

9.7.I LEAD CASE MANAGEMENT 133

9.7.J POISON CONTROL HOTLINE TELEPHONE NUMBER 133

9.7.K MO HEALTHNET ENROLLED LABORATORIES THAT PERFORM BLOOD LEAD TESTING 133

9.7.L OUT-OF-STATE LABS CURRENTLY REPORTING LEAD TEST RESULTS TO THE MISSOURI DEPARTMENT OF HEALTH AND SENIOR SERVICES 134

9.8 HCY CASE MANAGEMENT.....135

9.9 IMMUNIZATIONS135

9.9.A VACCINE FOR CHILDREN (VFC) 135

9.10 ASSIGNMENT OF SCREENING TIMES135

9.11 PERIODICITY SCHEDULE FOR HCY (EPSDT) SCREENING SERVICES.....135

9.11.A DENTAL SCREENING SCHEDULE 136

9.11.B VISION SCREENING SCHEDULE 136

9.11.C HEARING SCREENING SCHEDULE 136

9.12 REFERRALS RESULTING FROM A FULL, INTERPERIODIC OR PARTIAL SCREENING.....136

9.12.A PRIOR AUTHORIZATION FOR NON-STATE PLAN SERVICES (EXPANDED HCY SERVICES) 137

9.13 PARTICIPANT NONLIABILITY.....137

9.14 EXEMPTION FROM COST SHARING AND COPAY REQUIREMENTS137

9.15 STATE-ONLY FUNDED PARTICIPANTS.....137

9.16 MO HEALTHNET MANAGED CARE.....137

9.17 ORDERING HEALTHY CHILDREN AND YOUTH SCREENING AND HCY LEAD SCREENING GUIDE139

SECTION 10 - FAMILY PLANNING140

SECTION 11 - MO HEALTHNET MANAGED CARE PROGRAM DELIVERY SYSTEM141

11.1 MO HEALTHNET'S MANAGED CARE PROGRAM141

11.1.A EASTERN MISSOURI PARTICIPATING MO HEALTHNET MANAGED CARE HEALTH PLANS 141

11.1.B CENTRAL MISSOURI PARTICIPATING MO HEALTHNET MANAGED CARE HEALTH PLANS 141

11.1.D SOUTHWESTERN MISSOURI PARTICIPATING MO HEALTHNET MANAGED CARE HEALTH PLANS 142

11.1.E WESTERN MISSOURI PARTICIPATING MO HEALTHNET MANAGED CARE HEALTH PLANS 142

11.2 MO HEALTHNET MANAGED CARE HEALTH PLAN ENROLLMENT142

11.3 MO HEALTHNET MANAGED CARE HEALTH PLAN INCLUDED INDIVIDUALS143

11.4 MO HEALTHNET MANAGED CARE HEALTH PLAN EXCLUDED INDIVIDUALS143

11.5 MO HEALTHNET MANAGED CARE MEMBER BENEFITS145



11.6 STANDARD BENEFITS UNDER THE MO HEALTHNET MANAGED CARE PROGRAM	145
11.6.A BENEFITS FOR CHILDREN AND WOMEN IN A MO HEALTHNET CATEGORY OF ASSISTANCE FOR PREGNANT WOMEN	148
11.7 SERVICES PROVIDED OUTSIDE THE MO HEALTHNET MANAGED CARE PROGRAM	148
11.8 QUALITY OF CARE	150
11.9 IDENTIFICATION OF MO HEALTHNET MANAGED CARE PARTICIPANTS	150
11.9.A NON-BILLING MO HEALTHNET PROVIDER	151
11.10 EMERGENCY SERVICES	151
11.11 PROGRAM OF ALL-INCLUSIVE CARE FOR THE ELDERLY (PACE)	151
11.11.A ELIGIBILITY FOR PACE	152
11.11.B INDIVIDUALS NOT ELIGIBLE FOR PACE	152
11.11.C LOCK-IN IDENTIFICATION OF PACE INDIVIDUALS	153
11.11.D PACE COVERED SERVICES	153
SECTION 12—REIMBURSEMENT METHODOLOGY	155
12.1 THE BASIS FOR ESTABLISHING A RATE OF PAYMENT	155
12.2 DURABLE MEDICAL EQUIPMENT (DME) SERVICES	156
12.3 ON-LINE FEE SCHEDULE	156
12.4 MEDICARE/MO HEALTHNET REIMBURSEMENT (CROSSOVER CLAIMS)	156
12.5 PARTICIPANT COPAY	156
12.6 A MO HEALTHNET MANAGED HEALTH CARE DELIVERY SYSTEM METHOD OF REIMBURSEMENT	156
12.6.A MANAGED HEALTH CARE	157
SECTION 13-BENEFITS AND LIMITATIONS	158
13.1 CONDITIONS OF PARTICIPATION	158
13.1.A PROVIDER PARTICIPATION	158
13.1.D NONDISCRIMINATION	160
13.1.E RETENTION OF RECORDS	160
13.2 ADEQUATE DOCUMENTATION	160
13.3 PARTICIPANT NONLIABILITY	161
13.4 EMERGENCY SERVICES	161
13.5 OUT-OF-STATE, NON-EMERGENCY SERVICES	161
13.5.A EXCEPTIONS TO OUT-OF-STATE PRIOR AUTHORIZATION (PA) REQUESTS	162
13.6 PARTICIPANT COPAY	163
13.7 GENERAL INFORMATION	163
13.8 DEFINITIONS	163
13.8.A DURABLE MEDICAL EQUIPMENT (DME)	163
13.9 PURCHASE OF DURABLE MEDICAL EQUIPMENT (DME)	164
13.9.A PURCHASE OF USED DURABLE MEDICAL EQUIPMENT (DME)	164
13.9.B DELIVERY OF ITEMS COVERED UNDER THE DURABLE MEDICAL EQUIPMENT (DME) PROGRAM	164



13.9.C REPLACEMENT OF PURCHASED ITEMS.....	164
13.10 RENTAL OF DURABLE MEDICAL EQUIPMENT (DME).....	165
13.10.A ELIGIBILITY DURING DURABLE MEDICAL EQUIPMENT (DME) RENTAL....	165
13.10.B REACHING THE PURCHASE PRICE OF A DURABLE MEDICAL EQUIPMENT (DME) ITEM.....	165
13.10.C REPLACEMENT OF RENTED DURABLE MEDICAL EQUIPMENT (DME) ITEMS.....	166
13.10.D BILLING GUIDELINES FOR DURABLE MEDICAL EQUIPMENT (DME) RENTAL.....	166
13.11 REPAIR OF DURABLE MEDICAL EQUIPMENT (DME).....	166
13.11.A BILLING GUIDELINES FOR DURABLE MEDICAL EQUIPMENT (DME) REPAIR.....	167
13.12 WARRANTIES.....	168
13.13 TRADE-IN OF DURABLE MEDICAL EQUIPMENT (DME)	168
13.14 REIMBURSEMENT GUIDELINES	168
13.14.A MANUALLY PRICED ITEMS	168
13.14.B ADDITIONAL REIMBURSEMENT GUIDELINES.....	168
13.15 DELIVERY REQUIREMENTS	169
13.15.A PROOF OF DELIVERY	169
13.15.B DIRECT DELIVERY	170
13.15.C MAIL ORDER/SHIPPING SERVICE DELIVERY	170
13.15.D SUPPLY REFILLS - NO AUTO REFILLS.....	170
13.15.E EXCEPTIONS TO THE DATE OF SERVICE.....	171
13.16 PAYMENT FOR CUSTOM-MADE ITEMS WHEN DELIVERY OR PLACEMENT CANNOT BE MADE PRIOR TO PARTICIPANT’S LOSS OF ELIGIBILITY OR DEATH.....	171
13.16.A PREREQUISITE FOR PAYMENT OF CUSTOM-MADE ITEMS	172
13.16.B PAYMENT OF CUSTOM-MADE ITEMS AND DEVICES	172
13.17 MANAGED CARE HEALTH PLAN.....	173
13.18 COVERAGE OF DURABLE MEDICAL EQUIPMENT (DME) FOR PARTICIPANTS IN A NURSING HOME.....	174
13.18.A PRIOR AUTHORIZATION (PA) REQUESTS/LETTERS OF MEDICAL NECESSITY (LMN) FOR CUSTOM OR POWER WHEELCHAIRS	175
13.18.B ASSISTIVE TECHNOLOGY PROFESSIONAL.....	176
13.18.C PHYSICIAN FACE-TO-FACE EVALUATION.....	176
13.18.D PHYSICIAN ORDER.....	177
13.18.E POWER WHEELCHAIRS (PWC) AND ACCESSORIES FOR NURSING HOME PARTICIPANTS	178
13.18.F COVERAGE OF CUSTOM WHEELCHAIRS FOR NURSING HOME PARTICIPANTS	180
13.18.G WHEELCHAIRS AND OPTIONS/ACCESSORIES FOR NURSING HOME PARTICIPANTS	184

13.19 COVERAGE OF DURABLE MEDICAL EQUIPMENT (DME) FOR PARTICIPANTS IN A HOSPITAL	184
13.20 AUGMENTATIVE COMMUNICATION DEVICES (ACDs)	184
13.20.A AUGMENTATIVE COMMUNICATION DEVICE (ACD) DEFINITION	184
13.20.B ELIGIBILITY FOR AUGMENTATIVE COMMUNICATION EQUIPMENT	185
13.20.C AUGMENTATIVE COMMUNICATION DEVICE (ACD) EVALUATION TEAM/SITE	185
13.20.D AUGMENTATIVE COMMUNICATION EVALUATION FOR AUGMENTATIVE COMMUNICATION DEVICES (ACDs)	186
13.20.E MODIFICATION/REPLACEMENT/REPAIR OF AN AUGMENTATIVE COMMUNICATION DEVICE (ACD).....	187
13.20.F RENTAL OF AN AUGMENTATIVE COMMUNICATION DEVICE (ACD).....	187
13.21 EQUIPMENT	188
13.21.A MANUAL HOSPITAL BEDS	188
13.21.B SEMI-ELECTRIC HOSPITAL BED	188
13.21.C TRAPEZE BAR.....	188
13.21.D MATTRESS AND SIDE RAILS	188
13.21.E CANES AND CRUTCHES	188
13.21.F COMMODES	189
13.21.G PATIENT LIFT (HYDRAULIC)	189
13.21.H PRESSURE REDUCING SUPPORT SURFACES	189
13.21.I COVERAGE CRITERIA FOR OSTEOGENESIS STIMULATOR, LOW INTENSITY ULTRASOUND, NON-INVASIVE (E0760NU)	189
13.22 HEALTHY CHILDREN AND YOUTH (HCY) EARLY AND PERIODIC SCREENING, DIAGNOSTIC AND TREATMENT (EPSDT) PROGRAM (FOR PARTICIPANTS 20 AND UNDER).....	190
13.22.A UNDER PADS, DIAPERS, BRIEFS AND PROTECTIVE UNDERWEAR/PULL-ONS	190
13.22.B RENT-TO-PURCHASE FOR CHEST WALL OSCILLATION DEVICES (E0483EPRR)	190
13.22.C PULSE OXIMETER.....	191
13.22.C(1) Pulse Oximeter Reimbursement.....	191
13.22.C(2) Pulse Oximeter Supplies	191
13.22.D COUGH STIMULATING DEVICE	191
13.22.E CRANIAL REMOLDING ORTHOSIS.....	192
13.23 TOTAL PARENTERAL NUTRITION (TPN)	192
13.24 ENTERAL NUTRITION	193
13.24.A ENTERAL NUTRITION FORMULA	193
13.24.B. SPECIAL ENTERAL FORMULA.....	194
13.24.C ENTERAL NUTRITION SUPPLIES.....	195
13.25 ORTHOTIC DEVICES.....	195
13.25.A ORTHOPEDIC SHOES	195
13.25.B SHOES FOR DIABETIC PARTICIPANTS	195

13.25.C SERVICES INCLUDED IN REIMBURSEMENT OF ORTHOTIC DEVICES	196
13.25.D BILLING REQUIREMENTS FOR ORTHOTIC DEVICES	196
13.26 OSTOMY SUPPLIES	196
13.26.A NONCOVERED OSTOMY SUPPLIES	197
13.26.B BILLING AND REIMBURSEMENT OF OSTOMY SUPPLIES	197
13.27 OXYGEN AND RESPIRATORY EQUIPMENT	197
13.27.A OXYGEN.....	197
13.27.A(1) Certification Requirements	198
13.27.A(2) Testing Specifications	199
13.27.A(3) Modifier.....	199
13.27.A(4) Oxygen Contents	200
13.27.A(5) Oxygen Therapy <i>Not</i> Covered	200
13.27.B OXYGEN SUPPLIES, MAINTENANCE AND REPAIR.....	200
13.27.C PORTABLE OXYGEN SYSTEMS	200
13.27.D VENTILATOR	200
13.27.E BACK-UP VENTILATOR	201
13.27.F NEBULIZER, COMPRESSOR, SUCTION PUMP AND IPPB	202
13.27.G APNEA MONITOR	202
13.27.H(1) Apnea Monitor Reimbursement.....	203
13.28 RESPIRATORY ASSIST DEVICES (RAD) AND CONTINUOUS POSITIVE AIRWAY PRESSURE (CPAP) DEVICES	203
13.28.A COVERAGE FOR A CONTINUOUS POSITIVE AIRWAY PRESSURE (CPAP) DEVICE (E0601RR)	204
13.28.B CONTINUED COVERAGE FOR A CONTINUOUS POSITIVE AIRWAY PRESSURE (CPAP) DEVICE BEYOND THE FIRST THREE (3) MONTHS (E0601KJRR)	204
13.28.C COVERAGE FOR A RESPIRATORY ASSIST DEVICE (RAD) (E0470 AND E0471) FOR THE FIRST THREE (3) MONTHS OF THERAPY	204
13.28.D CONTINUED COVERAGE CRITERIA FOR A RESPIRATORY ASSIST DEVICE (RAD) BEYOND THE FIRST THREE (3) MONTHS OF THERAPY	205
13.28.E SUPPLIES FOR RESPIRATORY ASSIST DEVICES (RADs) AND CONTINUOUS POSITIVE AIRWAY PRESSURE (CPAP) DEVICES.....	205
13.29 PROSTHETIC DEVICES	206
13.29.A PROSTHETIC SOCKS AND SHEATHS.....	206
13.29.B MASTECTOMY BRAS AND BREAST PROSTHESIS.....	206
13.29.C SERVICES INCLUDED IN REIMBURSEMENT	206
13.30 WHEELCHAIRS.....	207
13.30.A STANDARD WHEELCHAIRS	207
13.30.A(1) Manual Wheelchair Basic Equipment Package	207
13.30.A(2) MANUAL WHEELCHAIR (MWC) RENTAL OF 3 MONTHS	208
13.30.B POWER WHEELCHAIRS	209
13.30.B(1) Power Wheelchair Basic Equipment Package.....	209
13.30.C POWER WHEELCHAIR ACCESSORIES.....	211
13.30.C(1) Power-Operated Vehicle (Scooters) Basic Equipment Package	211



13.30.D WHEELCHAIR BATTERIES	212
13.30.E CUSTOM WHEELCHAIRS.....	212
13.30.F WHEELCHAIR ACCESSORIES <i>NOT</i> OTHERWISE LISTED	212
13.30.F(1) Wheelchair Option/Accessory Replacement And Repair.....	212
13.30.G WHEELCHAIR SEAT AND BACK CUSHIONS	213
13.30.H CUSTOM MOLDED SEAT AND BACK CUSHION REIMBURSEMENT	215
13.30.I DOCUMENTATION FOR WHEELCHAIR PRIOR AUTHORIZATION (PA) REQUESTS	215
13.31 PRIOR AUTHORIZATION (PA).....	216
13.31.A SUBMISSION OF DURABLE MEDICAL EQUIPMENT (DME) PRIOR AUTHORIZATION (PA) REQUEST.....	216
13.31.B CLARIFICATION OF PRIOR AUTHORIZATION (PA) REQUEST FOR CHANGE (RFC)	217
13.32 PRE-CERTIFICATION PROCESS FOR DURABLE MEDICAL EQUIPMENT (DME)	217
13.33 DURABLE MEDICAL EQUIPMENT (DME) PROGRAM BILLING REMINDERS .	218
13.34 NONCOVERED SERVICES UNDER THE DURABLE MEDICAL EQUIPMENT (DME) PROGRAM	219
13.34.A NONCOVERED ITEMS	219
13.34.B DUAL ELIGIBLES IN MEDICARE COMPETITIVE BIDDING AREA (CBA)	220
SECTION 14—SPECIAL DOCUMENTATION REQUIREMENTS	221
14.1 CERTIFICATE OF MEDICAL NECESSITY	221
14.2 PRIOR AUTHORIZATION.....	221
14.2.A REQUESTING PRIOR AUTHORIZATION.....	222
14.2.B RETURN OF PRIOR AUTHORIZATION REQUEST FORMS	222
14.2.C RETURNED/DENIED PRIOR AUTHORIZATION REQUEST FORMS	222
14.3 OXYGEN AND RESPIRATORY EQUIPMENT MEDICAL JUSTIFICATION (OREMJ) FORM	222
14.4 PRE-CERTIFICATION PROCESS FOR DURABLE MEDICAL EQUIPMENT	223
SECTION 15-BILLING INSTRUCTIONS	224
15.1 CMS-1500 CLAIM FORM	224
15.2 PROVIDER COMMUNICATIONS UNIT	224
15.3 RESUBMISSION OF CLAIMS	224
15.4 BILLING PROCEDURES FOR MEDICARE/MO HEALTHNET	224
15.5 CMS-1500 CLAIM FILING INSTRUCTIONS.....	225
15.6 PLACE OF SERVICE CODES.....	231
15.7 INSURANCE COVERAGE CODES.....	233
SECTION 16—MEDICARE/MEDICAID CROSSOVER CLAIMS	234
16.1 GENERAL INFORMATION.....	234
16.2 BILLING PROCEDURES FOR MEDICARE/MO HEALTHNET CLAIMS (CROSSOVERS).....	235
16.3 BILLING OF SERVICES NOT COVERED BY MEDICARE	236
16.4 MEDICARE PART C CROSSOVER CLAIMS FOR QMB PARTICIPANTS	237



16.4.A MEDICARE PART C COORDINATION OF BENEFITS FOR NON-QMB PARTICIPANTS	238
16.5 TIMELY FILING.....	238
16.6 REIMBURSEMENT	238
16.6.A REIMBURSEMENT OF MEDICARE PART A AND MEDICARE ADVANTAGE/PART C INPATIENT HOSPITAL CROSSOVER CLAIMS	238
16.6.B REIMBURSEMENT OF OUTPATIENT HOSPITAL MEDICARE CROSSOVER CLAIMS	239
SECTION 17-CLAIMS DISPOSITION	240
17.1 ACCESS TO REMITTANCE ADVICES	240
17.2 INTERNET AUTHORIZATION.....	241
17.3 ON-LINE HELP	241
17.4 REMITTANCE ADVICE	241
17.5 CLAIM STATUS MESSAGE CODES.....	245
17.5.A FREQUENTLY REPORTED REDUCTIONS OR CUTBACKS	245
17.6 SPLIT CLAIM	246
17.7 ADJUSTED CLAIMS	246
17.8 SUSPENDED CLAIMS (CLAIMS STILL BEING PROCESSED)	247
17.9 CLAIM ATTACHMENT STATUS.....	247
17.10 PRIOR AUTHORIZATION STATUS	248
SECTION 18—DIAGNOSIS CODES	249
18.1 GENERAL INFORMATION.....	249
SECTION 19 - PROCEDURE CODES.....	250
19.1 HEALTHY CHILDRED AND YOUTH (HCY) COVERED ONLY FOR PARTICIPANTS AGE 0-20	251
19.2 DURABLE MEDICAL EQUIPMENT (DME), INCLUDES ALL AGE PARTICIPANTS	273
SECTION 20-EXCEPTION PROCESS.....	376
20.1 EXCEPTION PRINCIPLE.....	376
20.2 REQUIREMENTS	376
20.3 RESTRICTIONS	378
20.4 REQUESTING AN EXCEPTION	379
20.4.A LIFE-THREATENING EMERGENCY EXCEPTION REQUESTS	380
20.4.B NON-EMERGENCY EXCEPTION REQUESTS	380
SECTION 21- ADVANCE HEALTH CARE DIRECTIVES.....	381
SECTION 22-NON-EMERGENCY MEDICAL TRANSPORTATION (NEMT).....	382
22.1 INTRODUCTION	382
22.2 DEFINITIONS.....	382
22.3 COVERED SERVICES	387
22.4 PARTICIPANT ELIGIBILITY	388
22.5 NON-COVERED PARTICIPANTS	388
22.6 TRAVEL STANDARDS	388



22.7 COPAYMENTS.....392
22.8 MODES OF TRANSPORTATION393
22.9 LEVEL OF SERVICE394
22.10 ARRANGING TRANSPORTATION394
22.11 NON-COVERED SERVICES394
22.12 PUBLIC ENTITY REQUIREMENTS395
22.13 PROVIDER REQUIREMENTS396
22.14 PROVIDER INQUIRY, COMPLAINT, GRIEVANCE AND APPEAL PROCESS.....397
22.15 PARTICIPANT RIGHTS397
22.16 DENIALS.....398
22.17 PARTICIPANT GRIEVANCE PROCESS.....398
22.18 STANDING ORDERS.....398
22.19 ANCILLARY SERVICES399
 22.19.A ANCILLARY SERVICES REQUEST PROCEDURE400
22.20 WHERE'S MY RIDE? (WMR).....401
22.21 QUALITY ASSURANCE (QA) PROCEDURE401
22.22 FREQUENTLY ASKED QUESTIONS402
SECTION 23 - CLAIM ATTACHMENT SUBMISSION AND PROCESSING404
23.1 CLAIM ATTACHMENT SUBMISSIONS404
**23.2 CERTIFICATE OF MEDICAL NECESSITY FOR DURABLE MEDICAL
EQUIPMENT PROVIDERS ONLY.....405**



SECTION 1-PARTICIPANT CONDITIONS OF PARTICIPATION

1.1 INDIVIDUALS ELIGIBLE FOR MO HEALTHNET, MANAGED CARE OR STATE FUNDED BENEFITS

MO HealthNet benefits are available to individuals who are determined eligible by the local Family Support Division (FSD) office. Each eligibility group or category of assistance has its own eligibility determination criteria that *must* be met. Some eligibility groups or categories of assistance are subject to Day Specific Eligibility and some are *not* (refer to Section 1.6.A).

1.1.A DESCRIPTION OF ELIGIBILITY CATEGORIES

The following list includes a simple description and applicable ME codes for all categories of assistance:

1.1.A(1) MO HealthNet

ME CODE	DESCRIPTION
01, 04, 11, 12, 13, 14, 15, 16	Elderly, blind and disabled individuals who meet the MO HealthNet eligibility criteria in the community or a vendor facility; or receive a Missouri State Supplemental Conversion or Supplemental Nursing Care check.
03	Individuals who receive a Supplemental Aid to the Blind check or a Missouri State Supplemental check based on blindness.
55	Individuals who qualify to have their Medicare Part B Premiums paid by the state. These individuals are eligible for reimbursement of their Medicare deductible coinsurance and copay amounts only for Medicare covered services.
18, 43, 44, 45, 61	Pregnant women who meet eligibility factors for the MO HealthNet for Pregnant Women Program.
10, 19, 21, 24, 26	Individuals eligible for MO HealthNet under the Refugee Act of 1980 or the Refugee Education Assistance Act of 1980.



23, 41	Children in a Nursing Facility/ICF/MR.
28, 49, 67	Children placed in foster homes or residential care by DMH.
33, 34	Missouri Children with Developmental Disabilities (Sarah Jean Lopez) Waiver.
81	Temporary medical eligibility code. Used for individuals reinstated to MHF for 3 months (January-March, 2001), due to loss of MO HealthNet coverage when their TANF cases closed between December 1, 1996 and February 29, 2000. Used for White v. Martin participants and used for BCCT.
83	Women under age 65 determined eligible for MO HealthNet based on Breast or Cervical Cancer Treatment (BCCT) Presumptive Eligibility.
84	Women under age 65 determined eligible for MO HealthNet based on Breast or Cervical Cancer Treatment (BCCT).
85	Ticket to Work Health Assurance Program (TWHAP) participants--premium
86	Ticket to Work Health Assurance Program (TWHAP) participants--non-premium

1.1.A(2) MO HealthNet for Kids

ME CODE	DESCRIPTION
05, 06	Eligible children under the age of 19 in MO HealthNet for Families (based on 7/96 AFDC criteria) and the eligible relative caring for the children including families eligible for Transitional MO HealthNet.
60	Newborns (infants under age 1 born to a MO HealthNet or managed care participant).



- 40, 62 Coverage for non-CHIP children up to age 19 in families with income under the applicable poverty standard.
- 07, 29, 30, 37, 38, 50, 63, 66, 68, 69, 70 Children in custody of the Department of Social Services (DSS) Children's Division who meet Federal Poverty Level (FPL) requirements and children in residential care or foster care under custody of the Division of Youth Services (DYS) or Juvenile Court who meet MO HealthNet for Kids non-CHIP criteria.
- 36, 56 Children who receive a federal adoption subsidy payment.
- 71, 72 Children's Health Insurance Program covers uninsured children under the age of 19 in families with gross income above the non-CHIP limits up to 150% of the FPL. (Also known as MO HealthNet for Kids.)
- 73 Covers uninsured children under the age of 19 in families with gross income above 150% but less than 185% of the FPL. (Also known as MO HealthNet for Kids.) There is a premium.
- 74 Covers uninsured children under the age of 19 in families with gross income above 185% but less than 225% of the FPL. (Also known as MO HealthNet for Kids.) There is a premium.
- 75 Covers uninsured children under the age of 19 in families with gross income above 225% of the FPL up to 300% of the FPL. (Also known as MO HealthNet for Kids.) Families *must* pay a monthly premium. There is a premium.



87 Children under the age of 19 determined to be presumptively eligible for benefits prior to having a formal eligibility determination completed.

1.1.A(3) Temporary MO HealthNet During Pregnancy (TEMP)

ME CODE DESCRIPTION

58 Pregnant women who qualify under the Presumptive Eligibility (TEMP) Program receive limited coverage for ambulatory prenatal care while they await the formal determination of MO HealthNet eligibility.

59 Pregnant women who received benefits under the Presumptive Eligibility (TEMP) Program but did *not* qualify for regular MO HealthNet benefits after the formal determination. The eligibility period is from the date of the formal determination until the last day of the month of the TEMP card or shown on the TEMP letter.

NOTE: Providers should encourage women with a TEMP card to apply for regular MO HealthNet.

1.1.A(4) Voluntary Placement Agreement for Children

ME CODE DESCRIPTION

88 Children seventeen (17) years of age or younger in need of mental health treatment whose parent, legal guardian or custodian has signed an out-of-home care Voluntary Placement Agreement (VPA) with the Department of Social Services (DSS) Children's Division.

1.1.A(5) State Funded MO HealthNet

ME CODE DESCRIPTION



02	Individuals who receive a Blind Pension check.
08	Children and youth under age 21 in DSS Children's Division foster homes or who are receiving state funded foster care.
52	Children who are in the custody of the Division of Youth Services (DYS-GR) who do <i>not</i> meet MO HealthNet for Kids non-CHIP criteria. (NOTE: GR in this instance means general revenue as services are provided by all state funds. Services are <i>not</i> restricted.)
57	Children who receive a state only adoption subsidy payment.
64	Children who are in the custody of Juvenile Court who do <i>not</i> qualify for federally matched MO HealthNet under ME codes 30, 69 or 70.
65	Children placed in residential care by their parents, if eligible for MO HealthNet on the date of placement.

1.1.A(6) MO Rx

ME CODE	DESCRIPTION
82	Participants only have pharmacy Medicare Part D wrap-around benefits through the MoRx.

1.1.A(7) Women's Health Services

ME CODE	DESCRIPTION
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- 80 Uninsured women, ages 18 through 55, who do *not* qualify for other benefits, and lose their MO HealthNet for Pregnant Women eligibility 60 days after the birth of their child, will continue to be eligible for family planning and limited testing and treatment of Sexually Transmitted Diseases for up to one (1) year if the family income is at or below 196% of the Federal poverty level (FPL), and who are not otherwise eligible for MO HealthNet, the Children’s Health Insurance Program (CHIP), Medicare, or health insurance coverage that provides family planning services.
- 89 Women’s Health Services Program provides family planning and limited testing and treatment of Sexually Transmitted Diseases to women, ages 18 through 55, who have family income at or below 201% of the Federal poverty level (FPL), and who are not otherwise eligible for MO HealthNet, the Children’s Health Insurance Program (CHIP), Medicare, or health insurance coverage that provides family planning services.

1.1.A(8) ME Codes Not in Use

The following ME codes are *not* currently in use:

09, 17, 20, 22, 25, 27, 31, 32, 35, 39, 42, 46, 47, 48, 51, 53, 54, 76, 77, 78, 79

1.2 MO HEALTHNET AND MO HEALTHNET MANAGED CARE ID CARD

The Department of Social Services issues a MO HealthNet ID card for each MO HealthNet or managed care eligible participant. For example, the eligible caretaker and each eligible child receives his/her own ID card. Providers *must* use the card that corresponds to each individual/child to verify eligibility and determine any other pertinent information applicable to the participant. Participants enrolled in a MO HealthNet managed health care plan also receive an ID card from the



managed health care plan. (Refer to Section 1.2.C for a listing of MO HealthNet/MO HealthNet Managed Care Eligibility (ME) codes identifying which individuals are to receive services on a fee-for-service basis and which individuals are eligible to enroll in a managed health care plan.

*An ID card does **not** show eligibility dates or any other information regarding restrictions of benefits or Third Party Resource (TPR) information. Providers must verify the participant's eligibility status before rendering services as the ID card only contains the participant's identifying information (ID number, name and date of birth). As stated on the card, *holding the card does not certify eligibility or guarantee benefits.**

The local Family Support Division (FSD) office issues an approval letter for each individual or family at the time of approval to be used in lieu of the ID card until the permanent ID card can be mailed and received by the participant. The card should normally be received within a few days of the Eligibility Specialist's action. Replacement letters are also furnished when a card has been lost, destroyed or stolen until an ID card is received in the mail. Providers may accept these letters to verify the participant's ID number.

The card carrier mailer notifies participants *not* to throw the card away as they will *not* receive a new ID card each month. The participant *must* keep the ID card for as long as the individual named on the card qualifies for MO HealthNet or managed care. Participants who are eligible as spenddown participants are encouraged to keep the ID card to use for subsequent spenddown periods. Replacement cards are issued whenever necessary as long as the participant remains eligible.

Participants receive a new ID card within a few days of the Eligibility Specialist's action under the following circumstances:

- The participant is determined eligible or regains eligibility;
- The participant has a name change;
- A file correction is made to a date of birth which was invalid at time of card issue; or
- The participant reports a card as lost, stolen or destroyed.

1.2.A FORMAT OF MO HEALTHNET ID CARD

The plastic MO HealthNet ID card will be red if issued prior to January 1, 2008 or white if issued on or after January 1, 2008. Each card contains the participant's name, date of birth and MO HealthNet ID number. The reverse side of the card contains basic information and the Participant Services Hotline number.

An ID card does not guarantee benefits. It is important that the provider always check eligibility and the MO HealthNet/Managed Care Eligibility (ME) code on file for the date of service. The ME code helps the provider know program benefits and limitations including copay requirements.



1.2.B ACCESS TO ELIGIBILITY INFORMATION

Providers *must* verify eligibility via the Internet or by using the interactive voice response (IVR) system by calling (576) 751-2896 and keying in the participant ID number shown on the face of the card. Refer to Section 3 for information regarding the Internet and the IVR inquiry process.

Participants may be subject to Day Specific Eligibility. Refer to Section 1.6.A for more information.

1.2.C IDENTIFICATION OF PARTICIPANTS BY ELIGIBILITY CODES

1.2.C(1) MO HealthNet Participants

The following ME codes identify people who get a MO HealthNet approval letter and MO HealthNet ID card:

01, 02, 03, 04, 11, 12, 13, 14, 15, 16, 23, 28, 33, 34, 41, 49, 55, 67, 83, 84, 89

1.2.C(2) MO HealthNet Managed Care Participants

MO HealthNet Managed Care refers to:

- some adults and children who used to get a MO HealthNet ID card
- people eligible under the MO HealthNet for Kids (SCHIP) and the uninsured parent's program
- people enrolled in a MO HealthNet managed care health plan*

The following ME codes identify people who get a MO HealthNet Managed Care health insurance approval letter and MO HealthNet Managed Care ID Card

05, 06, 07, 08, 10, 18, 19, 21, 24, 26, 29, 30, 36, 37, 40, 43, 44, 45, 50, 52, 56, 57, 60, 61, 62, 63, 64, 65, 66, 68, 69, 70, 71, 72, 73, 74, 75

*An individual may be eligible for managed care and *not* be in a MO HealthNet managed care health plan because they do *not* live in a managed care health plan area. Individuals enrolled in MO HealthNet Managed Care also get a MO HealthNet Managed Care health plan card issued by the managed care health plan. Refer to Section 11 for more information regarding Missouri's managed care program.

1.2.C(3) TEMP

A pregnant woman who has *not* applied for MO HealthNet can get a white temporary MO HealthNet ID card. The TEMP card provides limited benefits during pregnancy. The following ME codes identify people who have TEMP eligibility:



58, 59

1.2.C(4) Temporary Medical Eligibility for Reinstated TANF Individuals

Individuals who stopped getting a Temporary Assistance for Needy Families (TANF) cash grant between December 1, 1996 and February 29, 2000 and lost their MO HealthNet/MO HealthNet Managed Care benefits had their medical benefits reinstated for three months from January 1, 2001 to March 31, 2001.

ME code 81 identifies individuals who received an eligibility letter from the Family Support Division. These individuals are *not* enrolled in a MO HealthNet managed care health plan.

1.2.C(5) Presumptive Eligibility for Children

Children in families with income below 150% of the Federal Poverty Level (FPL) determined eligible for MO HealthNet benefits prior to having a formal eligibility determination completed by the Family Support Division (FSD) office. The families receive a MO HealthNet for Kids Presumptive Eligibility Authorization (PC-2) notice which includes the MO HealthNet for Kids number(s) and effective date of coverage.

ME code 87 identifies children determined eligible for Presumptive Eligibility for Children.

1.2.C(6) Breast or Cervical Cancer Treatment Presumptive Eligibility

Women determined eligible by the Department of Health and Senior Services' Breast and Cervical Cancer Control Project (BCCCCP) or the Breast or Cervical Cancer Treatment (BCCT) Presumptive Eligibility (PE) Program receive a BCCT Temporary MO HealthNet Authorization letter which provides for limited MO HealthNet benefits while they wait for a formal eligibility determination by the FSD.

ME code 83 identifies women receiving benefits through BCCT PE.

1.2.C(7) Voluntary Placement Agreement

Children determined eligible for out-of-home care, per a signed Voluntary Placement Agreement (VPA), require medical planning and are eligible for a variety of children's treatment services, medical and psychiatric services. The Children's Division (CD) worker makes appropriate referrals to CD approved contractual treatment providers. Payment is made at the MO HealthNet or state contracted rates.



ME code 88 identifies children receiving coverage under a VPA.

1.2.D THIRD PARTY INSURANCE COVERAGE

When the MO HealthNet Division (MHD) has information that the participant has third party insurance coverage, the relationship code and the full name of the third party coverage are identified. The address information can be obtained through emomed. A provider *must* always bill the other insurance before billing MO HealthNet unless the service qualifies as an exception as specified in Section 5. For additional information, contact Provider Communications at (573) 751-2896 or the TPL Unit at (573) 751-2005.

NOTE: The provider *must* always ask the participant if they have third party insurance regardless of information on the participant file. *It is the provider's responsibility to obtain from the participant the name and address of the insurance company, the policy number, policy holder and the type of coverage.* See Section 5, Third Party Liability.

1.2.D(1) Medicare Part A, Part B and Part C

The eligibility file (IVR/Internet) provides an indicator if the MO HealthNet Division has information that the participant is eligible for Medicare Part A, Part B and/or Medicare Part C.

NOTE: The provider *must* always ask the participant if they have Medicare coverage, regardless of information on the participant file. It is also important to identify the participant's type of Medicare coverage. Part A provides for nursing home, inpatient hospital and certain home health benefits; Part B provides for medical insurance benefits; and Part C provides the services covered under Part A and Part B through a Medicare Advantage Plan (private companies approved by Medicare). When MO HealthNet is secondary to Medicare Part C, a crossover claim for coinsurance, deductible and copay may be reimbursed for participants who have MO HealthNet QMB (reference Section 1.5.E). For non-QMB participants enrolled in a Medicare Advantage/Part C Plan, MO HealthNet secondary claims will process in accordance with the established MHD coordination of benefits policy (reference Section 5.1.A).

1.3 MO HEALTHNET, STATE FUNDED MEDICAL ASSISTANCE AND MO HEALTHNET MANAGED CARE APPLICATION PROCESS

If a patient who has *not* applied for MO HealthNet, state funded Medical Assistance or MO HealthNet Managed Care benefits is unable to pay for services rendered and appears to meet eligibility requirements, the provider should encourage the patient or the patient's representative (related or unrelated) to apply for benefits through the Family Support Division in the patient's



county of residence. Information can also be obtained by calling the FSD Call Center at (855) 373-4636. Applications for MO HealthNet Managed Care may be requested by phone by calling (888) 275-5908. The county office accepts and processes the application and notifies the patient of the resulting determination.

Any individual authorized by the participant may make application for MO HealthNet Managed Care, MO HealthNet and other state funded Medical Assistance on behalf of the client. This includes staff members from hospital social service departments, employees of private organizations or companies, and any other individual designated by the client. Clients *must* authorize non-relative representatives to make application for them through the use of the IM Authorized Representative form. A supply of this form and instructions for completion may be obtained from the Family Support Division county office.

1.4 AUTOMATIC MO HEALTHNET ELIGIBILITY FOR NEWBORN CHILDREN

A child born to a woman who is eligible for and is receiving MO HealthNet or under a federally funded program on the date the child is born is automatically eligible for MO HealthNet. Federally funded MO HealthNet programs that automatically cover newborn children are MO HealthNet for Families, Pregnant Women, Supplemental Nursing Care, Refugee, Supplemental Aid to the Blind, Supplemental Payments, MO HealthNet for Children in Care, Children's Health Insurance Program, and Uninsured Parents.

Coverage begins on the date of birth and extends through the date the child becomes one year of age as long as the mother remains continuously eligible for MO HealthNet or who would remain eligible if she were still pregnant and the child continues to live with the mother.

Notification of the birth should be sent immediately by the mother, physician, nurse-midwife, hospital or managed care health plan to the Family Support Division office in the county in which the mother resides and should contain the following information:

- The mother's name and MO HealthNet or Managed Care ID number
- The child's name, birthdate, race, and sex
- Verification of birth.

If the mother notifies the Family Support Division office of the birth, that office verifies the birth by contacting the hospital, attending physician, or nurse-midwife.

The Family Support Division office assigns a MO HealthNet ID number to the child as quickly as possible and gives the ID number to the hospital, physician, or nurse-midwife. Family Support Division staff works out notification and verification procedures with local hospitals.



The Family Support Division office explores the child's eligibility for other types of assistance beyond the newborn policy. However, the eligibility determination for another type of assistance does *not* delay or prevent the newborn from being added to the mother's case when the Family Support Division staff is notified of the birth.

1.4.A NEWBORN INELIGIBILITY

The automatic eligibility for newborns is *not* available in the following situations:

- The mother is eligible under the Blind Pension (state-funded) category of assistance.
- The mother has a pending application for assistance but is *not* receiving MO HealthNet at the time of the child's birth.
- The mother has TEMP eligibility, which is *not* considered regular MO HealthNet eligibility. If the mother has applied for and has been approved for a federally funded type of assistance at the time of the birth, however, the child is automatically eligible.
- MO HealthNet spenddown: if the mother's spenddown amount has *not* been met on the day of the child's birth, the child is *not* automatically eligible for MO HealthNet. If the mother has met her spenddown amount prior to or on the date of birth, the child is automatically eligible. Once the child is determined automatically eligible, they remain eligible, regardless of the mother's spenddown eligibility.
- Emergency Medical Care for Ineligible Aliens: The delivery is covered for the mother, however the child is *not* automatically eligible. An application *must* be filed for the newborn for MO HealthNet coverage and *must* meet CHIP or non-CHIP eligibility requirements.
- Women covered by the Extended Women's Health Services Program.

1.4.B NEWBORN ADOPTION

MO HealthNet coverage for an infant whose birth mother intends to relinquish the child continues from birth until the time of relinquishment if the mother remains continuously eligible for MO HealthNet or would if still pregnant during the time that the child continues to live with the mother. This includes the time period in which the child is in the hospital, unless removed from mother's custody by court order.

1.4.C MO HEALTHNET MANAGED CARE HEALTH PLAN NEWBORN ENROLLMENT

The managed care health plan *must* have written policies and procedures for enrolling the newborn children of program members effective to the time of birth. Newborns of program eligible mothers who were enrolled at the time of the child's birth are automatically enrolled with the mother's managed care health plan. The managed care health plan should have a



procedure in place to refer newborns to an enrollment counselor or Family Support Division to initiate eligibility determinations or enrollment procedures as appropriate. A mother of a newborn may choose a different managed care health plan for her child; unless a different managed care health plan is requested, the child remains with the mother’s managed care health plan.

- Newborns are enrolled with the mother’s managed care health plan unless a different managed care health plan is specified.
- The mother’s managed care health plan shall be responsible for all medically necessary services provided under the standard benefit package to the newborn child of an enrolled mother. The child’s date of birth shall be counted as day one. When the newborn is assigned an ID number, the managed care health plan shall provide services to the child until the child is disenrolled from the managed care health plan. The managed care health plan shall receive capitation payment for the month of birth and for all subsequent months the child remains enrolled with the managed care health plan.
- If there is an administrative lag in enrolling the newborn and costs are incurred during that period, it is essential that the participant be held harmless for those costs. The managed care health plan is responsible for the cost of the newborn.

1.5 PARTICIPANTS WITH RESTRICTED/LIMITED BENEFITS

Participants may have restricted or limited benefits, be subject to administrative lock-in, be managed care enrollees, be hospice beneficiaries or have other restrictions associated with their category of assistance.

It is the provider’s responsibility to determine if the participant has restricted or limited coverage. Restrictions can be added, changed or deleted at any time during a month. The following information is furnished to assist providers to identify those participants who may have restricted/limited benefits.

1.5.A LIMITED BENEFIT PACKAGE FOR ADULT CATEGORIES OF ASSISTANCE

Senate Bill 539 was passed by the 93rd General Assembly and became effective August 28, 2005. Changes in MO HealthNet Program benefits were effective for dates of service on or after September 1, 2005. The bill eliminated certain optional MO HealthNet services for individuals age 21 and over that are eligible for MO HealthNet under one of the following categories of assistance:

ME CODE	DESCRIPTION
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01	MO HealthNet for the Aged
04	Permanently and Totally Disabled (APTD)
05	MO HealthNet for Families - Adult (ADC-AD)
10	Vietnamese or Other Refugees (VIET)
11	MO HealthNet - Old Age (MHD-OAA)
13	MO HealthNet - Permanently and Totally Disabled (MHD-PTD)
14	Supplemental Nursing Care - MO HealthNet for the Aged
16	Supplemental Nursing Care - PTD (NC-PTD)
19	Cuban Refugee
21	Haitian Refugee
24	Russian Jew
26	Ethiopian Refugee
83	Presumptive Eligibility - Breast or Cervical Cancer Treatment (BCCT)
84	Regular Benefit - Breast or Cervical Cancer Treatment (BCCT)
85	Ticket to Work Health Assurance Program (TWHAP) --premium
86	Ticket to Work Health Assurance Program (TWHAP) -- non-premium

MO HealthNet coverage for the following programs or services has been eliminated or reduced for adults with a limited benefit package. Providers should refer to Section 13 of the applicable provider manual for specific restrictions or guidelines.

- Comprehensive Day Rehabilitation
- Dental Services
- Diabetes Self-Management Training Services
- Hearing Aid Program
- Home Health Services
- Outpatient Therapy
- Physician Rehabilitation Services
- Podiatry Services

NOTE: MO HealthNet participants residing in nursing homes are able to use their surplus to pay for federally mandated medically necessary services. This may be done by adjudicating claims through the MO HealthNet claims processing system to ensure best price, quality, and program integrity. MO HealthNet participants receiving home health services receive all



federally mandated medically necessary services. MO HealthNet children and those in the assistance categories for pregnant women or blind participants are *not* affected by these changes.

1.5.B ADMINISTRATIVE PARTICIPANT LOCK-IN

Some MO HealthNet participants are restricted or locked-in to authorized MO HealthNet providers of certain services to help the participant use the MO HealthNet Program properly. When the participant has an administrative lock-in provider, the provider's name and telephone number are identified on the Internet or IVR when verifying eligibility.

Payment of services for a locked-in participant is *not* made to unauthorized providers for other than emergency services or authorized referral services. Emergency services are only considered for payment if the claim is supported by medical records documenting the emergency circumstances.

When a physician is the designated/authorized provider, they are responsible for the participant's primary care and for making necessary referrals to other providers as medically indicated. When a referral is necessary, the authorized physician *must* complete a Medical Referral Form of Restricted Participant (PI-118) and send it to the provider to whom the participant is referred. *This referral is good for 30 days only* from the date of service. This form *must* be mailed or submitted via the Internet (Refer to Section 23) by the unauthorized provider. The Referred Service field should be completed on the claim form. These referral forms are available on the Missouri Medicaid Audit and Compliance (MMAC) website at www.MMAC.MO.GOV or from MMAC, Provider Review & Lock-In Section, P.O. Box 6500, Jefferson City, Missouri 65102.

If a participant presents an ID card that has administrative lock-in restrictions to other than the authorized provider and the service is *not* an emergency, an authorized referral, or if a provider feels that a participant is improperly using benefits, the provider is requested to notify MMAC Provider Review, P.O. Box 6500, Jefferson City, Missouri 65102.

1.5.C MO HEALTHNET MANAGED CARE PARTICIPANTS

Participants who are enrolled in MO HealthNet's Managed Care programs are identified on the Internet or IVR when verifying eligibility. The response received identifies the name and phone number of the participant's selected managed care health plan. The response also includes the identity of the participant's primary care provider in the managed care program areas. Participants who are eligible for MO HealthNet and who are enrolled with a managed care health plan *must* have their basic benefit services provided by or prior authorized by the managed care health plan.

MO HealthNet Managed Care health plans may also issue their own individual health plan ID cards. The individual *must* be eligible for MO HealthNet and enrolled with the managed



care health plan on the date of service for the managed care health plan to be responsible for services. MO HealthNet eligibility dates are different from managed care health plan enrollment dates. Managed care enrollment can be effective on any date in a month. Sometimes a participant may change managed care health plans and be in one managed care health plan for part of the month and another managed care health plan for the remainder of the month. Managed care health plan enrollment can be verified by the IVR/Internet.

Providers *must* verify the eligibility status including the participant's ME code and managed care health plan enrollment status on all MO HealthNet participants before providing service.

The following information is provided to assist providers in determining those participants who are eligible for inclusion in MO HealthNet Managed Care Programs. The participants who are eligible for inclusion in the health plan are divided into five groups.* Refer to Section 11 for a listing of included counties and the managed care benefits package.

- Group 1 and 2 have been combined and are referred to as Group 1. Group 1 generally consists of the MO HealthNet for Families population (both the caretaker and child[ren]), the children up to age 19 of families with income under the applicable poverty standard, Refugee MO HealthNet participants and pregnant women. NOTE: Previous policy stated that participants over age 65 were exempt from inclusion in managed care. There are a few individuals age 65 and over who are caretakers or refugees and who do *not* receive Medicare benefits and are therefore included in managed care.

The following ME codes fall into Group 1: 05, 06, 10, 18, 19, 21, 24, 26, 40, 43, 44, 45, 60, 61 and 62.

- *Group 3 previously consisting of General Relief participants has been deleted from inclusion in the managed care program at this time.*
- Group 4 generally consists of those children in state care and custody. The following ME codes fall into this group: 07, 08, 29, 30, 36, 37, 38, 50, 52, 56, 57, 63, 64, 66, 68, 69, 70, and 88.
- Group 5 consists of uninsured children.

The following ME codes for uninsured children are included in Group 5: 71, 72, 73, 74 and 75.

* Participants who are identified as eligible for inclusion in the managed care program are *not* enrolled with a managed care health plan until 15 days after they actually select or are assigned to a managed care health plan. When the selection or assignment is in effect, the name of the managed care health plan appears on the IVR/Internet information. If a managed care health plan name does *not* appear for a particular date of service, the participant is in a fee-for-service status for each date of service that a managed care health plan is *not* listed for the participant.

"OPT" OUT POPULATIONS: The Department of Social Services is allowing participants, who are currently in the managed care program because they receive SSI disability payments, who meet the SSI disability definition as determined by the Department of Social Services, or who receive adoption subsidy benefits, the option of choosing to receive services on a fee-for-service basis or through the managed care program. The option is entirely up to the



participant, parent or guardian.

1.5.C(1) Home Birth Services for the MO HealthNet Managed Care Program

If a managed care health plan member elects a home birth, the member may be disenrolled from the managed care program at the request of the managed care health plan. The disenrolled member then receives all services through the fee-for-service program.

The member remains disenrolled from the managed care health plan if eligible under the MO HealthNet for Pregnant Women category of assistance. If the member is *not* in the MO HealthNet for Pregnant Women category and is disenrolled for the home birth, she is enrolled/re-enrolled in a managed care health plan six weeks post-partum or after a hospital discharge, whichever is later. The baby is enrolled in a managed care health plan once a managed care health plan number is assigned or after a hospital discharge, whichever is later.

1.5.D HOSPICE BENEFICIARIES

MO HealthNet participants *not* enrolled with a managed care health plan who elect hospice care are identified as such on the Internet or IVR. The name and telephone number of the hospice provider is identified on the Internet or IVR.

Hospice care is palliative *not* curative. It focuses on pain control, comfort, spiritual and emotional support for a terminally ill patient and his or her family. To receive MO HealthNet covered hospice services the participant *must*:

- be eligible for MO HealthNet on all dates of service;
- be certified by two physicians (M.D. or D.O.) as terminally ill and as having less than six months to live;
- elect hospice services and, if an adult, waive active treatment for the terminal illness; and
- obtain all services related to the terminal illness from a MO HealthNet-participating hospice provider, the attending physician, or through arrangements by the hospice.

When a participant elects the hospice benefit, the hospice assumes the responsibility for managing the participant's medical care related to the terminal illness. The hospice provides or arranges for services reasonable and necessary for the palliation or management of the terminal illness and related conditions. This includes all care, supplies, equipment and medicines.

Any provider, other than the attending physician, who provides care related to the terminal illness to a hospice participant, *must* contact the hospice to arrange for payment. MO



HealthNet reimburses the hospice provider for covered services and the hospice reimburses the provider of the service(s).

For adults age 21 and over, curative or active treatment of the terminal illness is *not* covered by the MO HealthNet Program while the patient is enrolled with a hospice. If the participant wishes to resume active treatment, they *must* revoke the hospice benefit for MO HealthNet to provide reimbursement of active treatment services. The hospice is reimbursed for the date of revocation. MO HealthNet does *not* provide reimbursement of active treatment until the day following the date of revocation. Children under the age of 21 may continue to receive curative treatment services while enrolled with a hospice.

Services *not* related to the terminal illness are available from any MO HealthNet-participating provider of the participant's choice. Claims for these services should be submitted directly to Wipro Infocrossing.

Refer to the Hospice Manual, Section 13 for a detailed discussion of hospice services.

1.5.E QUALIFIED MEDICARE BENEFICIARIES (QMB)

To be considered a QMB an individual *must*:

- be entitled to Medicare Part A
- have an income of less than 100% of the Federal Poverty Level
- have resources of less than \$4000 (or no more than \$6000 if married)

Participants who are eligible only as a Qualified Medicare Beneficiary (QMB) are eligible for reimbursement of their Medicare deductible, coinsurance and copay amounts only for Medicare covered services whether or not the services are covered by MO HealthNet. QMB-only participants are *not* eligible for MO HealthNet services that are *not* generally covered by Medicare. When verifying eligibility, QMB-only participants are identified with an ME code 55 when verifying eligibility.

Some participants who are eligible for MO HealthNet covered services under the MO HealthNet or MO HealthNet spenddown categories of assistance may also be eligible as a QMB participant and are identified on the IVR/Internet by a QMB indicator "Y." If the participant has a QMB indicator of "Y" and the ME code is *not* 55 the participant is also eligible for MO HealthNet services and *not* restricted to the QMB-only providers and services.

QMB coverage includes the services of providers who by choice do *not* participate in the MO HealthNet Program and providers whose services are *not* currently covered by MO HealthNet but who are covered by Medicare, such as chiropractors and independent therapists. Providers who do *not* wish to enroll in the MO HealthNet Program for MO HealthNet participants and providers of Medicare-only covered services may enroll as QMB-



only providers to be reimbursed for deductible, coinsurance, and copay amounts only for QMB eligibles. Providers who wish to be identified as QMB-only providers may contact the Provider Enrollment Unit via their e-mail address: mmac.providerenrollment@dss.mo.gov.

Providers who are enrolled with MO HealthNet as QMB-only providers need to ascertain a participant's QMB status in order to receive reimbursement of the deductible and coinsurance and copay amounts for QMB-only covered services.

1.5.F WOMEN'S HEALTH SERVICES PROGRAM (ME CODES 80 and 89)

The Women's Health Services Program provides family planning and family planning-related services to low income women, ages 18 through 55, who are not otherwise eligible for Medicaid, the Children's Health Insurance Program (CHIP), Medicare, or health insurance that provides family planning services.

Women who have been sterilized are not eligible for the Women's Health Services Program. Women who are sterilized while participating in the Women's Health Services Program become ineligible 90 days from the date of sterilization.

Services for ME codes 80 and 89 are limited to family planning and family planning-related services, and testing and treatment of Sexually Transmitted Diseases (STDs) which are provided in a family planning setting. Services include:

- approved methods of birth control including sterilization and x-ray services related to the sterilization
- family planning counseling and education on birth control options
- testing and treatment for Sexually Transmitted Diseases (STDs)
- pharmacy, including birth control devices & pills, and medication to treat STDs
- Pap Test and Pelvic Exams

All services under the Women's Health Services Program must be billed with a primary diagnosis code within the ranges of Z30.011-Z30.9.

1.5.G TEMP PARTICIPANTS

The purpose of the Temporary MO HealthNet During Pregnancy (TEMP) Program is to provide pregnant women with access to *ambulatory prenatal care* while they await the formal determination of MO HealthNet eligibility. Certain qualified providers, as determined by the Family Support Division, may issue TEMP cards. These providers have the responsibility for making limited eligibility determinations for their patients based on preliminary information that the patient's family income does *not* exceed the applicable MO HealthNet for Pregnant Women income standard for a family of the same size.



If the qualified provider makes an assessment that a pregnant woman is eligible for TEMP, the qualified provider issues her a white paper temporary ID card. The participant may then obtain ambulatory prenatal services from any MO HealthNet-enrolled provider. If the woman makes a formal application for MO HealthNet with the Family Support Division during the period of TEMP eligibility, her TEMP eligibility is extended while the application is pending. If application is *not* made, the TEMP eligibility ends in accordance with the date shown on the TEMP card.

Infants born to mothers who are eligible under the TEMP Program are *not* automatically eligible for MO HealthNet benefits. Information regarding automatic MO HealthNet Eligibility for Newborn Children is addressed in this manual.

Providers and participants can obtain the name of MO HealthNet enrolled Qualified Providers in their service area by contacting the local Family Support Division Call Center at (855) 373-4636. Providers may call Provider Relations at (573) 751-2896 and participants may call Participant Services at (800) 392-2161 for questions regarding TEMP.

1.5.G(1) TEMP ID Card

Pregnant women who have been determined presumptively eligible for Temporary MO HealthNet During Pregnancy (TEMP) do *not* receive a plastic MO HealthNet ID card but receive a white paper TEMP card. A valid TEMP number begins with the letter "P" followed by seven (7) numeric digits. The 8-character temporary number should be entered in the appropriate field of the claim form until a permanent number is issued to the participant. The temporary number appearing on the claim form is converted to the participant's permanent MO HealthNet identification number during claims processing and the permanent number appears on the provider's Remittance Advice. Providers should note the new number and file future claims using the permanent number.

A white paper TEMP card can be issued by qualified providers to *pregnant* women whom they presume to be eligible for MO HealthNet based on income guidelines. A TEMP card is issued for a limited period but presumptive eligibility may be extended if the pregnant woman applies for public assistance at the county Family Support Division office. The TEMP card may only be used for ambulatory prenatal services. Because TEMP services are limited, providers should verify that the service to be provided is covered by the TEMP card.

The start date (FROM) is the date the qualified provider issues the TEMP card, and coverage expires at midnight on the expiration date (THROUGH) shown. A TEMP replacement letter (IM-29 TEMP) may also be issued when the TEMP individual has formally applied for MO HealthNet and is awaiting eligibility determination.



Third party insurance information does *not* appear on a TEMP card.

1.5.G(2) TEMP Service Restrictions

TEMP services for pregnant women are limited to *ambulatory prenatal services* (physician, clinic, nurse midwife, diagnostic laboratory, x-ray, pharmacy, and outpatient hospital services). Risk Appraisals and Case Management Services are covered under the TEMP Program. Services other than those listed above (i.e. dental, ambulance, home health, durable medical equipment, CRNA, or psychiatric services) may be covered with a Certificate of Medical Necessity in the provider's file that testifies that the pregnancy would have been adversely affected without the service. Proof of medical necessity must be retained in the patient's file and be available upon request by the MO HealthNet Division. Inpatient services, including miscarriage or delivery, are *not* covered for TEMP participants.

Other noncovered services for TEMP participants include; global prenatal care, postpartum care, contraceptive management, dilation and curettage and treatment of spontaneous/missed abortions or other abortions.

1.5.G(3) Full MO HealthNet Eligibility After TEMP

A TEMP participant may apply for full MO HealthNet coverage and be determined eligible for the complete range of MO HealthNet-covered services. Regular MO HealthNet coverage may be backdated and may or may not overlap the entire TEMP eligibility period. Approved participants receive an approval letter that shows their eligibility and type of assistance coverage. These participants also receive an ID card within a few days of approval. The services that are *not* covered under the TEMP Program may be resubmitted under the new type of assistance using the participant's MO HealthNet identification number instead of the TEMP number. The resubmitted claims are then processed without TEMP restrictions for the dates of service that were *not* included under the TEMP period of eligibility.

1.5.H PROGRAM FOR ALL-INCLUSIVE CARE FOR THE ELDERLY (PACE)

Missouri and the Centers for Medicare & Medicaid (CMS) have entered into a three-way program agreement with Alexian Brothers Community Services (ABCS) of St. Louis. PACE is an integrated service system that includes primary care, restorative therapy, transportation, home health care, inpatient acute care, and even long-term care in a nursing facility when home and community-based services are no longer appropriate. Services are provided in the PACE center, the home, or the hospital, depending upon the needs of the individual. Refer to Section 11.11.E.



The target population for this program includes individuals age 55 and older, who are identified by the Missouri Department of Health and Senior Services, Division of Senior Services and Regulation through a health status assessment with specific types of eligibility categories and at least 21 points on the nursing home level of care assessment. These targeted individuals *must* reside in the St. Louis area within specific zip codes. Refer to Section 11.11.A.

Lock-in information is available to providers through the Internet or Interactive Voice Response (IVR). Enrollment in a PACE program is always voluntary and participants have the option to disenroll and return to the fee-for-service system at any time. Refer to Section 11.11.D.

1.5.I MISSOURI'S BREAST AND CERVICAL CANCER TREATMENT (BCCT) ACT

The Breast and Cervical Cancer Mortality Prevention Act of 1990 (Public Law: 101-354) established the National Breast and Cervical Cancer Early Detection Program (NBCCEDP), to reduce the morbidity and mortality rates of breast and cervical cancers. The NBCCEDP provides grants to states to carry out activities aimed at early screenings and detection of breast and/or cervical cancer, case management services, education and quality assurance. The Missouri Department of Health and Senior Services, Division of Chronic Disease Prevention and Health Promotion's grant application was approved by the Centers for Disease Control and Prevention (CDC) to provide funding to establish the Missouri Breast and Cervical Cancer Control Project (BCCCP), known as Show Me Healthy Women. Matching funds were approved by the Missouri legislation to support breast and cervical cancer screening and education for low-income Missouri women through the Show Me Healthy Women project. Additional federal legislation was signed allowing funded programs in the NBCCEDP to participate in a new program with the MO HealthNet Breast and Cervical Cancer Treatment (BCCT) Act. State legislation authorized matching funds for Missouri to participate.

Most women who are eligible for Show Me Healthy Women, receive a Show Me Healthy Women-paid screening and/or diagnostic service and are found to need treatment for either breast and/or cervical cancer, are eligible for MO HealthNet coverage. For more information, providers may reference the Show Me Healthy Women Provider Manual at <http://www.dhss.mo.gov/BreastCervCancer/providerlist.pdf>.

1.5.I(1) Eligibility Criteria

To qualify for MO HealthNet based on the need for BCCT, all of the following eligibility criteria *must* be met:

- Screened by a Missouri BCCCP Provider;



- Need for treatment for breast or cervical cancer including certain pre-cancerous conditions;
- Under the age of 65 years old;
- Have a Social Security Number;
- Citizenship or eligible non-citizen status;
- Uninsured (or have health coverage that does *not* cover breast or cervical cancer treatment);
- A Missouri Resident.

1.5.I(2) Presumptive Eligibility

Presumptive Eligibility (PE) determinations are made by BCCCP MO HealthNet providers. When a BCCCP provider determines a woman is eligible for PE coverage, a BCCT Temporary MO HealthNet Authorization letter is issued and provides for temporary, limited MO HealthNet benefits. A MO HealthNet ID Card is issued and should be received in approximately five days. MO HealthNet coverage under PE begins on the date the BCCCP provider determines the woman is in need of treatment. This allows for minimal delays for women in receiving the necessary treatment. Women receiving coverage under Presumptive Eligibility are assigned ME code 83. PE coverage continues until the last day of the month that the regular MO HealthNet application is approved or BCCT is no longer required, whichever is later.

1.5.I(3) Regular BCCT MO HealthNet

The BCCT MO HealthNet Application *must* be completed by the PE eligible client and forwarded as soon as possible to a managed care Service Center or the local Family Support Division office to determine eligibility for regular BCCT MO HealthNet benefits. The PE eligible client receives information from MO HealthNet for the specific services covered. Limited MO HealthNet benefits coverage under regular BCCT begins the first day of the month of application, if the woman meets all eligibility requirements. Prior quarter coverage can also be approved, if the woman was eligible. Coverage *cannot* begin prior to the month the BCCCP screening occurred. No coverage can begin prior to August 28, 2001 (although the qualifying screening may have occurred prior to August 28, 2001). MO HealthNet benefits are discontinued when the treating physician determines the client no longer needs treatment for the diagnosed condition or if MO HealthNet denies the BCCT application. Women approved for Regular BCCT MO HealthNet benefits are assigned ME code 84.



1.5.I(4) Termination of Coverage

MO HealthNet coverage is date-specific for BCCT cases. A date-specific termination can take effect in the future, up to the last day of the month following the month of the closing action.

1.5.J TICKET TO WORK HEALTH ASSURANCE PROGRAM

Implemented August 28, 2007, the Ticket to Work Health Assurance Program (TWHAP) eligibility groups were authorized by the federal Ticket to Work and Work Incentives Improvement Act of 1999 (Public Law 106-170) and Missouri Senate Bill 577 (2007). TWHAP is for individuals who have earnings and are determined to be permanently and totally disabled or would be except for earnings. They have the same MO HealthNet fee-for-service benefits package and cost sharing as the Medical Assistance for the Permanently and Totally Disabled (ME code 13). An age limitation, 16 through 64, applies. The gross income ceiling for this program is 300% of the Federal Poverty Level (FPL) for an individual or a Couple. Premiums are charged on a sliding scale based on gross income between 101% - 300% FPL. Additional income and asset disregards apply for MO HealthNet. Proof of employment/self-employment is required. Eligible individuals are enrolled with ME code 85 for premium and ME code 86 for non-premium. Eligibility for the Ticket to Work Health Assurance Program is determined by the Family Support Division.

1.5.J(1) Disability

An individual must meet the definition of Permanent and Total Disability. The definition is the same as for Medical Assistance (MA), except earnings of the individual are not considered in the disability determination.

1.5.J(2) Employment

An individual and/or spouse must have earnings from employment or self-employment. There is no minimum level of employment or earnings required. The maximum gross income allowed is 250% of the federal poverty level, excluding any earned income of the worker with a disability between 250 and 300% of the federal poverty level. "Gross income" includes all income of the person and the person's spouse. Individuals with gross incomes in excess of 100% of the federal poverty level shall pay a premium for participation.

1.5.J(3) Premium Payment and Collection Process

An individual whose computed gross income exceeds 100%, but is not more than 300%, of the FPL must pay a monthly premium to participate in TWHAP. TWHAP premium amounts are based on a formula specified by State statute. On new approvals, individuals in the premium group must select the beginning date of



coverage, which may be as early as the first month of the prior quarter (if otherwise applicable) but no later than the month following approval. If an individual is not in the premium group, coverage begins on the first day of the first month the client is eligible.

Upon approval by Family Support Division, the MO HealthNet Division (MHD) sends an initial Invoice letter, billing the individual for the premium amount for any past coverage selected through the month following approval. Coverage does not begin until the premium payment is received. If the individual does not send in the complete amount, the individual is credited for any full month premium amount received starting with the month after approval and going back as far as the amount of paid premium allows.

Thereafter, MHD sends a Recurring Invoice on the second working day of each month for the next month's premium. If the premium is not received prior to the beginning of the new month, the individual's coverage ends on the day of the last paid month.

MHD sends a Final Recurring Invoice after the individual has not paid for three consecutive months. It is sent in place of the Recurring Invoice, on the second working day of the month for the next month's premium. The Final Recurring Invoice notifies the individual that the case will be closed if a payment is not received by the end of the month.

MHD collects the premiums as they do for the Medical Assistance (MA) Spenddown Program and the managed care program.

1.5.J(4) Termination of Coverage

MO HealthNet coverage end dates are the same as for the Medical Assistance Program. TWHAP non-premium case end dates are date-specific. TWHAP premium case end dates are not date-specific.

1.5.K PRESUMPTIVE ELIGIBILITY FOR CHILDREN

The Balanced Budget Act of 1997 (The Act) created Section 1920A of the Social Security Act which gives states the option of providing a period of presumptive eligibility to children when a qualified entity determines their family income is below the state's applicable MO HealthNet or SCHIP limit. This allows these children to receive medical care before they have formally applied for MO HealthNet for Kids. Missouri selected this option and effective March 10, 2003, children under the age of 19 may be determined eligible for benefits on a temporary basis prior to having a formal eligibility determination completed.



Presumptive eligible children are identified by ME code 87. These children receive the full range of MO HealthNet for Kids covered services subject to the benefits and limitations specified in each MO HealthNet provider manual. These children are *NOT* enrolled in managed care health plans but receive all services on a fee-for-service basis as long as they are eligible under ME code 87.

1.5.K(1) Eligibility Determination

The Act allows states to determine what type of Qualified Entities to use for Presumptive Eligibility determinations. Currently, Missouri is limiting qualified entities to children's hospitals. Designated staff of qualified entities makes Presumptive Eligibility determinations for children by determining the family meets the income guidelines and contacting the MO HealthNet for Kids Phone Centers to obtain a MO HealthNet number. The family is then provided with a MO HealthNet Presumptive Eligibility Authorization (PC-2) notice that includes the MO HealthNet number and effective date of coverage. This notice guarantees a minimum of five days of coverage with day one being the beginning date. After the five days, providers *must* check eligibility as for any client. Coverage for each child under ME code 87 continues until the last day of the second month of Presumptive Eligibility, unless the Family Support Division determines eligibility or ineligibility for MO HealthNet for Kids prior to that day. Presumptive Eligibility coverage ends on the date the child is approved or rejected for a regular MO HealthNet Program. Presumptive Eligibility is limited to one period during a rolling 12 month period.

Qualified entities making temporary eligibility determinations for children facilitate a formal application for MO HealthNet for Kids. Children who are then determined by the Family Support Division to be eligible for MO HealthNet for Kids are placed in the appropriate MO HealthNet eligibility category (ME code), and are subsequently enrolled with a MO HealthNet Managed Care health plan if residing in a managed care health plan area and under ME codes enrolled with managed care health plans.

1.5.K(2) MO HealthNet for Kids Coverage

Children determined presumptively eligible for MO HealthNet for Kids receive the same coverage during the presumptive period. The children active under Presumptive Eligibility for Children are *not* enrolled in managed care. While the children *must* obtain their presumptive determination from a Qualified Entity (QE), once eligible, they can obtain covered services from any enrolled MO HealthNet fee-for-service provider. Coverage begins on the date the QE makes the presumptive eligibility determination and coverage ends on the later of:



- the 5th day after the Presumptive Eligibility for Children determination date;
- the day a MO HealthNet for Kids application is approved or rejected; or
- if no MO HealthNet for Kids application is made, the last date of the month following the month of the presumptive eligibility determination.

A presumptive eligibility period has no effect on the beginning eligibility date of regular MO HealthNet for Kids coverage. Prior quarter coverage may be approved. In many cases the MO HealthNet for Kids begin dates may be prior to the begin date of the presumptive eligibility period.

1.5.L MO HEALTHNET COVERAGE FOR INMATES OF A PUBLIC INSTITUTION

Changes to eligibility requirements may allow incarcerated individuals (both juveniles and adults), who leave the public institution to enter a medical institution or individuals who are under house arrest, to be determined eligible for temporary MO HealthNet coverage. Admittance as an inpatient in a hospital, nursing facility, juvenile psychiatric facility or intermediate care facility interrupts or terminates the inmate status. Upon an inmate's admittance, the Family Support Division office in the county in which the penal institution is located may take the appropriate type of application for MO HealthNet benefits. The individual, a relative, an authorized representative, or penal institution designee may initiate the application.

When determining eligibility for these individuals, the county Family Support Division office considers all specific eligibility groups, including children, pregnant women, and elderly, blind or disabled, to determine if the individual meets all eligibility factors of the program for which they are qualifying. Although confined to a public institution, these individuals may have income and resources available to them. If an individual is ineligible for MO HealthNet, the application is rejected immediately and the appropriate rejection notice is sent to the individual.

MO HealthNet eligibility is limited to the days in which the individual was an inpatient in the medical institution. Once the individual returns to the penal institution, the county Family Support Division office verifies the actual inpatient dates in the medical institution and determines the period of MO HealthNet eligibility. Appropriate notification is sent to the individual. The approval notice includes the individual's specific eligibility dates and a statement that they are *not* currently eligible for MO HealthNet because of their status as an inmate in a public institution.

Some individuals may require admittance into a long term care facility. If determined eligible, the period of MO HealthNet eligibility is based on the length of inpatient stay in the



long term care facility. Appropriate MO HealthNet eligibility notification is sent to the individual.

1.5.L(1) MO HealthNet Coverage Not Available

Eligibility for MO HealthNet coverage does *not* exist when the individual is an inmate and when the facility in which the individual is residing is a public institution. An individual is an inmate when serving time for a criminal offense or confined involuntarily to a state or federal prison, jail, detention facility or other penal facility. An individual voluntarily residing in a public institution is *not* an inmate. A facility is a public institution when it is under the responsibility of a government unit, or a government unit exercises administrative control over the facility.

MO HealthNet coverage is *not* available for individuals in the following situations:

- Individuals (including juveniles) who are being held involuntarily in detention centers awaiting trial;
- Inmates involuntarily residing at a wilderness camp under governmental control;
- Inmates involuntarily residing in half-way houses under governmental control;
- Inmates receiving care on the premises of a prison, jail, detention center, or other penal setting; or
- Inmates treated as outpatients in medical institutions, clinics or physician offices.

1.5.L(2) MO HealthNet Benefits

If determined eligible by the county Family Support Division office, full or limited MO HealthNet benefits may be available to individuals residing in or under the control of a penal institution in any of the following circumstances:

- Infants living with the inmate in the public institution;
- Paroled individuals;
- Individuals on probation;
- Individuals on home release (except when reporting to a public institution for overnight stay); or
- Individuals living voluntarily in a detention center, jail or county penal facility after their case has been adjudicated and other living arrangements are being made for them (for example, transfer to a community residence).



All specific eligibility groups, including children, pregnant women, and elderly, blind or disabled are considered to determine if the individual meets all eligibility factors of the program for which they are applying.

1.5.M VOLUNTARY PLACEMENT AGREEMENT, OUT-OF- HOME CHILDREN'S SERVICES

With the 2004 passage of House Bill 1453, the Voluntary Placement Agreement (VPA) was introduced and established in statute. The VPA is predicated upon the belief that no parent should have to relinquish custody of a child solely in order to access clinically indicated mental health services. This is a written agreement between the Department of Social Services (DSS)/Children's Division (CD) and a parent, legal guardian, or custodian of a child under the age of eighteen (18) solely in need of mental health treatment. A VPA developed pursuant to a Department of Mental Health (DMH) assessment and certification of appropriateness authorizes the DSS/CD to administer the placement and out-of-home care for a child while the parent, legal guardian, or custodian of the child retains legal custody. The VPA requires the commitment of a parent to be an active participant in his/her child's treatment

1.5.M(1) Duration of Voluntary Placement Agreement

The duration of the VPA may be for as short a period as the parties agree is in the best interests of the child, but under no circumstances shall the total period of time that a child remains in care under a VPA exceed 180 days. Subsequent agreements may be entered into, but the total period of placement under a single VPA or series of VPAs shall *not* exceed 180 days without express authorization of the Director of the Children's Division or his/her designee.

1.5.M(2) Covered Treatment and Medical Services

Children determined eligible for out-of-home care, (ME88), per a signed VPA, are eligible for a variety of children's treatment services, medical and psychiatric services. The CD worker makes the appropriate referrals to CD approved contractual treatment providers. Payment is made at the MO HealthNet or state contracted rates. Providers should contact the local CD staff for payment information.

1.5.M(3) Medical Planning for Out-of-Home Care

Medical planning for children in out-of-home care is a necessary service to ensure that children receive the needed medical care. The following includes several medical service alternatives for which planning is necessary:

- Routine Medical/Dental Care;



- Human Immunodeficiency Virus (HIV) Screening;
- Emergency and Extraordinary Medical/Dental Care (over \$500.00);
- Children's Treatment Services;
- Medical/Dental Services Program;
- Bureau for Children with Special Health Care Needs;
- Department of Mental Health Services;
- Residential Care;
- Private Psychiatric Hospital Placement; or
- Medical Foster Care.

1.6 ELIGIBILITY PERIODS FOR MO HEALTHNET PARTICIPANTS

Most participants are eligible for coverage of their services on a fee-for-service basis for those retroactive periods of eligibility from the first of the month of application until approval, or until the effective date of their enrollment in a MO HealthNet managed care health plan. This is often referred to as the period of “backdated eligibility.”

Eligibility for MO HealthNet participants (except ME codes 71, 72, 73, 74, 75 and 89) is from the first day of the month of application through the last day of each subsequent month for which they are eligible unless the individual is subject to the provisions of Day Specific Eligibility. Some MO HealthNet participants may also request and be approved for prior quarter coverage.

Participants with ME codes 71, 72 and 89 are eligible for MO HealthNet benefits from the first day of the month of application and are subject to the provisions of Day Specific Eligibility. Codes 71 and 72 are eligible from date of application. ME Code 80 is Extended Women's Health Care and eligibility begins the beginning of the month following the 60 day post partum coverage period for MPW (if *not* insured).

MO HealthNet for Kids participants with ME codes 73, 74, and 75 who *must* pay a premium for coverage are eligible the later of 30 days after the date of application or the date the premium is paid. The 30 day waiting period does *not* apply to children with special health care needs. Codes 73 and 74 are eligible on the date of application or date premium is paid, whichever is later. Code 75 is eligible for coverage the later of 30 days after date of application or date premium is paid. All three codes are subject to day specific eligibility (coverage ends date case/eligibility is closed).

MO HealthNet participants with ME code 83 are eligible for coverage beginning on the day the BCCCP provider determines the woman is in need of treatment for breast or cervical cancer. Presumptive Eligibility coverage continues until the last day of the month that the regular MO HealthNet application is approved or BCCT is no longer required, whichever is last.



MO HealthNet participants with ME code 84 are eligible for coverage beginning the 1st day of the month of application. Prior quarter coverage may also be approved, if the woman is eligible. Coverage *cannot* begin prior to the month the BCCCP screening occurred. No coverage can begin prior to August 28, 2001.

MO HealthNet children with ME code 87 are eligible for coverage during the presumptive period (fee-for-service only). Coverage begins on the date of the presumptive eligibility determination and ends on the later of 5th day after the eligibility determination or the day a MO HealthNet for Kids application is approved or rejected or if no MO HealthNet for Kids application is made, the last day of the month following the month of the presumptive eligibility determination.

For those participants who reside in a MO HealthNet managed care county and are approved for a category of assistance included in MO HealthNet managed care, the reimbursement is fee-for-service or covered services for the period from the date of eligibility until enrollment in a managed care health plan. Once a participant has been notified they are eligible for assistance, they have 15 days to select a managed care health plan or have a managed care health plan assigned for them. After they have selected the managed care health plan, they are *not* actually enrolled in the managed care health plan for another 15 days.

The ID Card is mailed out within a few days of the caseworker's eligibility approval. Participants may begin to use the ID Card when it is received. Providers should honor the approval/replacement/case action letter until a new card is received. MO HealthNet and managed care participants should begin using their new ID Card when it is received.

1.6.A DAY SPECIFIC ELIGIBILITY

Certain MO HealthNet participants are subject to the provisions of Day Specific Eligibility. This means that some MO HealthNet participants lose eligibility at the time of case closure, which may occur anytime in the month. Prior to implementation of Day Specific Eligibility, participants in all categories of assistance retained eligibility through the last date of the month if they were eligible on the first of the month. As of January 1, 1997, this varies for certain MO HealthNet participants.

As with all MO HealthNet services, the participant *must* be eligible on the date of service. When the participant is in a Day Specific Eligibility category of assistance, the provider is *not* able to check eligibility on the Internet or IVR for a future date during the current month of eligibility.

In order to convey to a provider that a participant's eligibility is day specific, the MO HealthNet Division provides a verbal message on the IVR system. The Internet also advises of day specific eligibility.

Immediately following the current statement, "The participant is eligible for service on MONTH, DAY, YEAR through MONTH, DAY, YEAR with a medical eligibility code of



XX,” the IVR says, “This participant is subject to day specific eligibility.” The Internet gives this information in the same way as the IVR.

If neither the Internet nor IVR contains a message that the participant is subject to day specific eligibility, the participant’s eligibility continues through the last day of the current month. Providers are able to check eligibility for future dates for the participants who are *not* subject to day specific eligibility.

It is important to note that the message regarding day specific eligibility is only a reminder to providers that the participant’s type of assistance is such that should his/her eligibility end, it may be at any time during that month. The Internet and IVR will verify the participant’s eligibility in the usual manner.

Providers *must* also continue to check for managed care health plan enrollment for those participant’s whose ME codes and county are included in managed care health plan enrollment areas, because participant’s enrollment or end dates can occur any date within the month.

1.6.B SPENDDOWN

In the MO HealthNet for the Aged, Blind, and Disabled (MHABD) Program some individuals are eligible for MO HealthNet benefits only on the basis of meeting a periodic spenddown requirement. Effective October 1, 2002, eligibility for MHABD spenddown is computed on a monthly basis. If the individual is eligible for MHABD on a spenddown basis, MO HealthNet coverage for the month begins with the date on which the spenddown is met and ends on the last day of that month when using medical expenses to meet spenddown. MO HealthNet coverage begins and ends without the case closing at the end of the monthly spenddown period. The MO HealthNet system prevents payment of medical services used to meet an individual's spenddown amount.

The individual may choose to meet their spenddown by one of the following options:

- submitting incurred medical expenses to their Family Support Division (FSD) Eligibility Specialist; or
- paying the monthly spenddown amount to the MO HealthNet Division (MHD).

Effective July 1, 2012, a participant can meet spenddown by using a combination of incurred expenses and paying the balance to MHD.

Individuals have the option of changing the method in which their spenddown is met each month. A choice is made to either send the payment to MHD or to send bills to the FSD Eligibility Specialist. For those months that the individual does *not* pay-in or submit bills, no coverage is available.



1.6.B(1) Notification of Spenddown Amount

MHD mails a monthly invoice to active spenddown cases on the second working day of each month. The invoice is for the next month's spenddown amount. The invoice gives the participant the option of paying in the spenddown amount to MHD or submitting bills to FSD. The invoice instructs the participant to call the MHD Premium Collections Unit at 1 (877) 888-2811 for questions about a payment.

MHD stops mailing monthly invoices if the participant does *not* meet the spenddown for 6 consecutive months. MHD resumes mailing invoices the month following the month in which the participant meets spenddown by bills or pay-in for the current month or past months.

1.6.B(2) Notification of Spenddown on New Approvals

On new approvals, the FSD Eligibility Specialist *must* send an approval letter notifying the participant of approval for spenddown, but MO HealthNet coverage does *not* begin until the spenddown is met. The letter informs the participant of the spenddown amount and the months for which coverage may be available once spenddown is met. If the Eligibility Specialist has already received bills to meet spenddown for some of the months, the letter includes the dates of coverage for those months.

MHD sends separate invoices for the month of approval and the month following approval. These invoices are sent on the day after the approval decision. Notification of the spenddown amount for the months prior to approval is only sent by the FSD Eligibility Specialist.

1.6.B(3) Meeting Spenddown with Incurred and/or Paid Expenses

If the participant chooses to meet spenddown for the current month using incurred and/or medical expenses, MO HealthNet coverage begins on the date the incurred and/or expenses equal the spenddown amount. The bills do *not* have to have been paid. In order to determine whether or not the participant has met spenddown, the FSD Eligibility Specialist counts the full amount of the valid medical expenses the participant incurred and/or paid to establish eligibility for spenddown coverage. The Eligibility Specialist does *not* try to estimate amounts, or deduct estimated amounts, to be paid by the participant's insurance from the amount of incurred and/or paid expenses. The QMB Program provides MO HealthNet payment of the Medicare premium, and coinsurance, deductibles and copay for all Medicare covered services. Therefore, the cost of Medicare covered services *cannot* be used to meet spenddown for participants approved for QMB.



Upon receipt of verification that spenddown has been met with incurred and/or paid expenses for a month, FSD sends a Notification of Spenddown Coverage letter to inform the participant spenddown was met with the incurred and/or paid expenses. The letter informs the participant of the MO HealthNet start date and the amount of spenddown met on the start date.

1.6.B(4) Meeting Spenddown with a Combination of Incurred Expenses and Paying the Balance

If the participant chooses to meet spenddown for a month using incurred expenses and paying the balance of their spenddown amount, coverage begins on the date of the most recent incurred expense once the balance is paid and received by MHD. The participant must take the incurred expenses to their FSD Eligibility Specialist who will inform them of the balance they must pay to MHD.

1.6.B(5) Preventing MO HealthNet Payment of Expenses Used to Meet Spenddown

On spenddown cases, MO HealthNet only reimburses providers for covered medical expenses that exceed a participant's spenddown amount. MO HealthNet does *not* pay the portion of a bill used to meet the spenddown. To prevent MO HealthNet from paying for an expense used to meet spenddown, MHD withholds the participant liability amount of spenddown met on the first day of coverage for a month. The MHD system tracks the bills received for the first day of coverage until the bills equal the participant's remaining spenddown liability. For the first day of coverage, MHD denies or splits (partially pays) the claims until the participant's liability for that first day is reduced to zero. After MHD has reduced the liability to zero for the first day of coverage, other claims submitted for that day of spenddown coverage are paid up to the MO HealthNet rate. Claims for all other days of spenddown coverage process in the same manner as those of non-spenddown participants. MHD notifies both the provider and the participant of any claim amount *not* paid due to the bill having been used to meet spenddown.

When a participant has multiple expenses on the day spenddown is met and the total expenses exceed the remaining spenddown, the liability amount may be withheld from the wrong claim. This can occur if Provider A submits a claim to MHD and Provider B does *not* (either because the bill was paid or it was a non-MO HealthNet covered service). Since the MHD system can only withhold the participant liability from claims submitted, the liability amount is deducted from the bill of the Provider A. Provider B's bill may have been enough to reduce the liability to zero, which would have allowed MO HealthNet to pay for Provider A's claim. MHD Participants Services Unit authorizes payment of the submitted claim



upon receipt of verification of other expenses for the day which reduced the liability to zero. The Participant Services Unit may request documentation from the case record of bills FSD used to meet spenddown on the day it was met.

1.6.B(6) Spenddown Pay-In Option

The pay-in option allows participants to meet spenddown requirements by making a monthly payment of the spenddown amount to MHD. Participants who choose to pay-in may pay by sending a check (or money order) each month to MHD or having the spenddown amount automatically withdrawn from a bank account each month. When a participant pays in, MHD creates a coverage period that begins on the first day of the month for which the participant is paying. If the participant pays for the next month prior to the end of the current month, there is no end date on the coverage period. If a payment has been missed, the coverage period is *not* continuous.

Participants are given the option of having the spenddown amount withdrawn from an existing bank account. Withdrawals are made on the 10th of each month for the following month's coverage. The participant receives a monthly notification of withdrawal from MHD.

In some instances, other state agencies, such as Department of Mental Health, may choose to pay the spenddown amount for some of their clients. Agencies interested in this process work with MHD to identify clients the agency intends to pay for and establish payment options on behalf of the client.

1.6.B(7) Prior Quarter Coverage

The eligibility determination for prior quarter MO HealthNet coverage is separate from the eligibility determination for current MO HealthNet coverage. A participant does *not* have to be currently eligible for MO HealthNet coverage to be eligible for prior quarter coverage. Prior quarter coverage can begin no earlier than the first day of the third month prior to the month of the application and can extend up to but *not* including the first day of the month of application. The participant *must* meet all eligibility requirements including spenddown/non-spenddown during the prior quarter. If the participant becomes eligible for assistance sometime during the prior quarter, the date on which eligibility begins depends on whether the participant is eligible as a non-spenddown or spenddown case.

MO HealthNet coverage begins on the first day in which spenddown is met in each of the prior months. Each of the three prior quarter month's medical expenses are compared to that month's spenddown separately. Using this process, it may be that the individual is eligible for one, two or all three months, sometimes *not*



consecutively. As soon as the FSD Eligibility Specialist receives bills to meet spenddown for a prior quarter month, eligibility is met.

1.6.B(8) MO HealthNet Coverage End Dates

MO HealthNet coverage is date-specific for MO HealthNet for the Aged, Blind, and Disabled (MHABD) non-spenddown cases at the time of closing. A date-specific closing can take effect in the future, up to the last day of the month following the month of closing. For MHABD spenddown cases MO HealthNet eligibility and coverage is *not* date-specific at the time of the closing. When an MHABD spenddown case is closed, MO HealthNet eligibility continues through the last day of the month of the closing. If MO HealthNet coverage has been authorized by pay-in or due to incurred expenses, it continues through the last day of the month of the closing.

1.6.C PRIOR QUARTER COVERAGE

Eligibility determination for prior quarter Title XIX coverage is separate from the eligibility determination of current Title XIX coverage. An individual does *not* have to be currently eligible for Title XIX coverage to be eligible for prior quarter coverage and vice versa.

Eligible individuals may receive Title XIX coverage retroactively for up to 3 months prior to the month of application. This 3-month period is referred to as the prior quarter. The effective date of prior quarter coverage for participants can be no earlier than the first day of the third month prior to the month of the application and can extend up to, but *not* include, the first day of the month of application.

MO HealthNet for Kids (ME codes 71-75) who meet federal poverty limit guidelines and who qualify for coverage because of lack of medical insurance are *not* eligible to receive prior quarter coverage.

The individual *must* have met all eligibility factors during the prior quarter. If the individual becomes eligible for assistance sometime during the prior quarter, eligibility for Title XIX begins on the first day of the month in which the individual became eligible or, if a spenddown case, the *date* in the prior 3-month period on which the spenddown amount was equaled or exceeded.

Example of Prior Quarter Eligibility on a Non-Spenddown Case: An individual applies for assistance in June. The prior quarter is March through May. A review of the eligibility requirements during the prior quarter indicates the individual would have been eligible on March 1 because of depletion of resources. Title XIX coverage begins March 1 and extends through May 31 if an individual continues to be eligible during April and May.

1.6.D EMERGENCY MEDICAL CARE FOR INELIGIBLE ALIENS



The Social Security Act provides MO HealthNet coverage for emergency medical care for ineligible aliens, who meet all eligibility requirements for a federally funded MO HealthNet program except citizenship/alien status. *Coverage is for the specific emergency only.* Providers should contact the local Family Support Division office and identify the services and the nature of the emergency. State staff identify the emergency nature of the claim and add or deny coverage for the period of the emergency only. Claims are reimbursed only for the eligibility period identified on the participant's eligibility file. An emergency medical condition is defined as follows:

An emergency medical condition for a MO HealthNet participant means a medical or behavioral health condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in the following:

1. Placing the physical or behavioral health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; or
2. Serious impairment of bodily functions; or
3. Serious dysfunction of any bodily organ or part; or
4. Serious harm to self or others due to an alcohol or drug abuse emergency; or
5. Injury to self or bodily harm to others; or
6. With respect to a pregnant woman having contractions: (a) there is no adequate time to affect a safe transfer to another hospital before delivery; or (b) that transfer may pose a threat to the health or safety of the woman or the unborn child.

Post stabilization care services mean covered services, related to an emergency medical condition that are provided after a participant is stabilized in order to maintain the stabilized condition or to improve or resolve the participant's condition.

1.7 PARTICIPANT ELIGIBILITY LETTERS AND CLAIMS CORRESPONDENCE

It is common for MO HealthNet participants to be issued an eligibility letter from the Family Support Division or other authorizing entity that may be used in place of an ID card. Participants who are new approvals or who need a replacement card are given an authorization letter. These letters are valid proof of eligibility in lieu of an ID Card. Dates of eligibility and most restrictions are contained in these letters. Participants who are enrolled or who will be enrolled in a managed care health plan may *not* have this designation identified on the letter. It is important that the provider verify the managed care enrollment status for participants who reside in a managed care service area. If the participant does *not* have an ID Card or authorization letter, the provider may also verify



eligibility by contacting the IVR or the Internet if the participant's MO HealthNet number is known. Refer to Section 3.3.A

The MO HealthNet Division furnishes MO HealthNet participants with written correspondence regarding medical services submitted as claims to the division. Participants are also informed when a prior authorization request for services has been made on their behalf but denied.

1.7.A NEW APPROVAL LETTER

An Approval Notice (IM-32, IM-32 MAF, IM-32 MC, IM-32 MPW or IM-32 PRM, IM-32 QMB) is prepared when the application is approved. Coverage may be from the first day of the month of application or the date of eligibility in the prior quarter until the last day of the month in which the case was approved or the last day of the following month if approval occurs late in the month. Approval letters may be used to verify eligibility for services until the ID Card is received. The letter indicates whether an individual will be enrolled with a MO HealthNet managed care health plan. It also states whether the individual is required to pay a copay for certain services. Each letter is slightly different in content.

Spenddown eligibility letters cover the date spenddown is met until the end of the month in which the case was approved. The eligibility letters contain Yes/No boxes to indicate Lock-In, Hospice or QMB. If the "Yes" box is checked, the restrictions apply.

1.7.A(1) Eligibility Letter for Reinstated TANF (ME 81) Individuals

Reinstated Temporary MO HealthNet for Needy Families (TMNF) individuals have received a letter from the Family Support Division that serves as notification of temporary medical eligibility. They may use this letter to contact providers to access services.

1.7.A(2) BCCT Temporary MO HealthNet Authorization Letter

Presumptive Eligibility (PE) determinations are made by Breast and Cervical Cancer Control Project (BCCCP) MO HealthNet providers. When a BCCCP provider determines a woman is eligible for PE coverage, a BCCT Temporary MO HealthNet Authorization letter is issued which provides for temporary, full MO HealthNet benefits. A MO HealthNet ID Card is issued and should be received in approximately five days. MO HealthNet coverage under PE begins on the date the BCCCP provider determines the woman is in need of treatment.

1.7.A(3) Presumptive Eligibility for Children Authorization PC-2 Notice

Eligibility determinations for Presumptive Eligibility for Children are limited to qualified entities approved by the state. Currently only children's hospitals are approved. Upon determination of eligibility, the family is provided with a



Presumptive Eligibility Authorization (PC-2) notice that includes the MO HealthNet number and effective date of coverage. This notice guarantees a minimum of five days of coverage with day one being the beginning date. After the five days, providers should be checking eligibility as for any client.

1.7.B REPLACEMENT LETTER

A participant may also have a replacement letter, which is the MO HealthNet Eligibility Authorization (IM-29, IM-29 QMB and IM-29 TEMP), from the Family Support Division county office as proof of MO HealthNet eligibility in lieu of a MO HealthNet ID card. This letter is issued when a card has been lost or destroyed.

There are check-off boxes on the letter to indicate if the letter is replacing a lost card or letter. A provider should use this letter to verify eligibility as they would the ID Card. Participants who live in a managed care service area may *not* have their managed care health plan identified on the letter. Providers need to contact the IVR or the Internet to verify the managed care health plan enrollment status.

A replacement letter is only prepared upon the request of the participant.

1.7.C NOTICE OF CASE ACTION

A Notice of Case Action (IM-33) advises the participant of application rejections, case closings, changes in the amount of cash grant, or ineligibility status for MO HealthNet benefits resulting from changes in the participant's situation. This form also advises the participant of individuals being added to a case and authorizes MO HealthNet coverage for individuals being added.

1.7.D PARTICIPANT EXPLANATION OF MO HEALTHNET BENEFITS

The MO HealthNet Division randomly selects 300 MO HealthNet participants per month to receive a Participant Explanation of MO HealthNet Benefits (PEOMB) for services billed or managed care health plan encounters reported. The PEOMB contains the following information:

- Date the service was provided;
- Name of the provider;
- Description of service or drug that was billed or the encounter reported; and
- Information regarding how the participant may contact the Participant Services Unit by toll-free telephone number and by written correspondence.

The PEOMB sent to the participant clearly indicates that it is *not* a bill and that it does *not* change the participant's MO HealthNet benefits.



The PEOMB does *not* report the capitation payment made to the managed care health plan in the participant's behalf.

1.7.E PRIOR AUTHORIZATION REQUEST DENIAL

When the MO HealthNet Division *must* deny a Prior Authorization Request for a service that is delivered on a fee-for-service basis, a letter is sent to the participant explaining the reason for the denial. The most common reasons for denial are:

- Prior Authorization Request was returned to the provider for corrections or additional information.
- Service or item requested does *not* require prior authorization.
- Authorization has been granted to another provider for the same service or item.
- Our records indicate this service has already been provided.
- Service or item requested is *not* medically necessary.

The Prior Authorization Request Denial letter gives the address and telephone number that the participant may call or write to if they feel the MO HealthNet Division was wrong in denying the Prior Authorization Request. The participant *must* contact the MO HealthNet Division, Participant Services Unit, within 90 days of the date on the letter, if they want the denial to be reviewed.

Participants enrolled in a managed care health plan do *not* receive the Prior Authorization Request Denial letter from the MO HealthNet Division. They receive notification from the managed care health plan and can appeal the decision from the managed care health plan. The participant's member handbook tells them how to file a grievance or an appeal.

1.7.F PARTICIPANT SERVICES UNIT ADDRESS AND TELEPHONE NUMBER

A participant may send written correspondence to:

Participant Services Agent
P.O. Box 3535
Jefferson City, MO 65102

The participant may also call the Participant Services Unit at (800) 392-2161 toll free, or (573) 751-6527. Providers should *not* call the Participant Services Unit unless a call is requested by the state.

1.8 TRANSPLANT PROGRAM

The MO HealthNet Program provides limited coverage and reimbursement for the transplantation of human organs or bone marrow/stem cell and related medical services. Current policy and procedure



is administered by the MO HealthNet Division with the assistance of its Transplant Advisory Committee.

1.8.A COVERED ORGAN AND BONE MARROW/STEM CELL TRANSPLANTS

With prior authorization from the MO HealthNet Division, transplants may be provided by MO HealthNet approved transplant facilities for transplantation of the following:

- Bone Marrow/Stem Cell
- Heart
- Kidney
- Liver
- Lung
- Small Bowel
- Multiple organ transplants involving a covered transplant

1.8.B PATIENT SELECTION CRITERIA

The transplant prior authorization process requires the transplant facility or transplant surgeon to submit documentation that verifies the transplant candidate has been evaluated according to the facility's Patient Selection Protocol and Patient Selection Criteria for the type of transplant to be performed. The patient *must* have been accepted as a transplant candidate by the facility before prior authorization requests can be considered for approval by the MO HealthNet Division.

Bone Marrow/Stem Cell transplant candidates *must* also meet the general diagnosis and donor guidelines established by the Bone Marrow/Stem Cell Transplant Advisory Committee.

All transplant requests for authorization are reviewed on a case-by-case basis. If the request is approved, an agreement is issued to the transplant facility that *must* be signed and returned to the MO HealthNet Division.

1.8.C CORNEAL TRANSPLANTS

Corneal transplants are covered for eligible MO HealthNet participants and do *not* require prior authorization. Corneal transplants have certain restrictions that are discussed in the physician and hospital manuals.

1.8.D ELIGIBILITY REQUIREMENTS



For the transplant facility or related service providers to be reimbursed by MO HealthNet, the transplant patient *must* be eligible for MO HealthNet on each date of service. A participant *must* have an ID card or eligibility letter to receive MO HealthNet benefits.

Human organ and bone marrow/stem cell transplant coverage is restricted to those participants who are eligible for MO HealthNet. Transplant coverage is *NOT* available for participants who are eligible under a state funded MO HealthNet ME code. (See Section 1.1).

Individuals whose type of assistance does *not* cover transplants should be referred to their local Family Support Division office to request application under a type of assistance that covers transplants. In this instance the MO HealthNet Division Transplant Unit should be advised immediately. The MO HealthNet Division Transplant Unit works with the Family Support Division to expedite the application process.

1.8.E MANAGED CARE PARTICIPANTS

Managed care members receive a transplant as a fee-for-service benefit reimbursed by the MO HealthNet Division. The transplant candidate is allowed freedom of choice of Approved MO HealthNet Transplant Facilities

The transplant surgery, from the date of the transplant through the date of discharge or significant change in diagnosis not related to the transplant surgery and related transplant services (procurement, physician, lab services, etc.) are *not* the managed care health plan's responsibility. The transplant procedure is prior authorized by the MO HealthNet Division. Claims for the pre-transplant assessment and care are the responsibility of the managed care health plan and *must* be authorized by the MO HealthNet managed care health plan.

Any outpatient, inpatient, physician and related support services rendered prior to the date of the actual transplant surgery *must* be authorized by the managed care health plan and are the responsibility of the managed care health plan.

The managed care health plan is responsible for post-transplant follow-up care. In order to assure continuity of care, follow-up services *must* be authorized by the managed care health plan. Reimbursement for those authorized services is made by the managed care health plan. Reimbursement to non-health plan providers *must* be no less than the current MO HealthNet FFS rate.

The MO HealthNet Division only reimburses providers for those charges directly related to the transplant including the organ or bone marrow/stem cell procurement costs, actual inpatient transplant surgery costs, post-surgery inpatient hospital costs associated with the transplant surgery, and the transplant physicians' charges and other physicians' services associated with the patient's transplant.

1.8.F MEDICARE COVERED TRANSPLANTS



Kidney, heart, lung, liver and certain bone marrow/stem cell transplants are covered by Medicare. If the patient has both Medicare and MO HealthNet coverage and the transplant is covered by Medicare, the Medicare Program is the first source of payment. In this case the requirements or restrictions imposed by Medicare apply and MO HealthNet reimbursement is limited to applicable deductible and coinsurance amounts.

Medicare restricts coverage of heart, lung and liver transplants to Medicare-approved facilities. In Missouri, St. Louis University Hospital, Barnes-Jewish Hospital in St. Louis, St. Luke's Hospital in Kansas City, and the University of Missouri Hospital located in Columbia, Missouri are Medicare-approved facilities for coverage of heart transplants. St. Luke's Hospital in Kansas City, Barnes-Jewish Hospital and St. Louis University are also Medicare-certified liver transplant facilities. Barnes-Jewish Hospital is a Medicare approved lung transplant facility. Potential heart, lung and liver transplant candidates who have Medicare coverage or who will be eligible for Medicare coverage within six months from the date of imminent need for the transplant should be referred to one of the approved Medicare transplant facilities. MO HealthNet only considers authorization of a Medicare-covered transplant in a non-Medicare transplant facility if the Medicare beneficiary is too ill to be moved to the Medicare transplant facility.

END OF SECTION

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SECTION 2-PROVIDER CONDITIONS OF PARTICIPATION

2.1 PROVIDER ELIGIBILITY

To receive MO HealthNet reimbursement, a provider of services *must* have entered into, and maintain, a valid participation agreement with the MO HealthNet Division as approved by the Missouri Medicaid Audit and Compliance Unit (MMAC). Authority to take such action is contained in 13 CSR 70-3.020. Each provider type has specific enrollment criteria, e.g., licensure, certification, Medicare certification, etc., which *must* be met. The enrollment effective date cannot be prior to the date the completed application was received by the MMAC Provider Enrollment office. The effective date cannot be backdated for any reason. Any claims billed by a non-enrolled provider utilizing an enrolled provider's National Provider Identifier (NPI) or legacy number will be subject to recoupment of claim payments and possible sanctions and may be grounds for allegations of fraud and will be appropriately pursued by MMAC. Refer to Section 13, Benefits and Limitations, of the applicable provider manual for specific enrollment criteria.

2.1.A QMB-ONLY PROVIDERS

Providers who want to enroll in MO HealthNet to receive payments for only the Qualified Medicare Beneficiary (QMB) services *must* submit a copy of their state license and documentation of their Medicare ID number. They *must* also complete a short enrollment form. For a discussion of QMB covered services refer to Section 1 of this manual.

2.1.B NON-BILLING MO HEALTHNET PROVIDER

MO HealthNet managed care health plan providers who have a valid agreement with one or more managed care health plans but who are *not* enrolled as a participating MO HealthNet provider may access the Internet or interactive voice response (IVR) system if they enroll with MO HealthNet as a "Non-Billing MO HealthNet Provider." Providers are issued a provider identifier that permits access to the Internet or IVR; however, it is *not* valid for billing MO HealthNet on a fee-for-service basis. Information regarding enrollment as a "Non-Billing MO HealthNet Provider" can be obtained by contacting the Provider Enrollment Unit at: mmac.providerenrollment@dss.mo.gov.

2.1.C PROVIDER ENROLLMENT ADDRESS

Specific information about MO HealthNet participation requirements and enrollment can be obtained from:

Provider Enrollment Unit
Missouri Medicaid Audit and Compliance Unit

PRODUCTION : 04/09/2020



P. O. Box 6500
Jefferson City, Missouri 65102
mmac.providerenrollment@dss.mo.gov

2.1.D ELECTRONIC CLAIM/ATTACHMENTS SUBMISSION AND INTERNET AUTHORIZATION

A provider wishing to submit claims or attachments electronically or access the Internet web site, www.emomed.com, *must* be enrolled as an electronic billing provider. Providers wishing to enroll as an electronic billing provider may contact the Wipro Infocrossing Help Desk at (573) 635-3559.

Providers wishing to access the Internet web site, www.emomed.com, *must* complete the on-line Application for MO HealthNet Internet Access Account. Please reference <http://manuals.momed.com/Application.html> and click on the Apply for Internet Access link. Providers are unable to access www.emomed.com without proper authorization. An authorization is required for each individual user.

2.1.E PROHIBITION ON PAYMENT TO INSTITUTIONS OR ENTITIES LOCATED OUTSIDE OF THE UNITED STATES

In accordance with the Affordable Care Act of 2010 (the Act), MO HealthNet must comply with the Medicaid payment provision located in Section 6505 of the Act, entitled “Prohibition on Payment to Institutions or Entities Located Outside of the United States.” The provision prohibits MO HealthNet from making any payments for items or services provided under the State Plan or under a waiver to any financial institutions, telemedicine providers, pharmacies, or other entities located outside of the U.S., Puerto Rico, the Virgin Islands, Guam, the Northern Mariana Islands, and American Samoa. If it is discovered that payments have been made to financial institutions or entities outside of the previously stated approved regions, MO HealthNet must recover these payments. This provision became effective January 1, 2011.

2.2 NOTIFICATION OF CHANGES

A provider *must* notify the Provider Enrollment Unit of any changes affecting the provider’s enrollment records within ninety (90) days of the change, in writing, using the appropriate enrollment forms specified by the Provider Enrollment Unit, with the exception of a change in ownership or control of any provider. Change in ownership or control of any provider *must* be reported within thirty (30) days. The Provider Enrollment Unit is responsible for determining whether a current MO HealthNet provider record should be updated or a new MO HealthNet provider record should be created. A new MO HealthNet provider record is not created for any changes including, but not limited to, a change in ownership, a change of operator, tax identification



change, merger, bankruptcy, name change, address change, payment address change, Medicare number change, National Provider Identifier (NPI) change, or facilities/offices that have been closed and reopened at the same or different locations.

2.3 RETENTION OF RECORDS

MO HealthNet providers *must* retain for 5 years (7 years for the Nursing Home, CSTAR and Community Psychiatric Rehabilitation Programs), from the date of service, fiscal and medical records that coincide with and fully document services billed to the MO HealthNet Agency, and *must* furnish or make the records available for inspection or audit by the Department of Social Services, Missouri Medicaid Audit and Compliance Unit, or its representative upon request. Failure to furnish, reveal and retain adequate documentation for services billed to MO HealthNet may result in recovery of the payments for those services *not* adequately documented and may result in sanctions to the provider's participation in the MO HealthNet Program. This policy continues to apply in the event of the provider's discontinuance as an actively participating MO HealthNet provider through change of ownership or any other circumstance.

2.3.A ADEQUATE DOCUMENTATION

All services provided *must* be adequately documented in the medical record. 13 CSR 70-3.030, Section(2)(A) defines "adequate documentation" and "adequate medical records" as follows:

Adequate documentation means documentation from which services rendered and the amount of reimbursement received by a provider can be readily discerned and verified with reasonable certainty.

Adequate medical records are records which are of the type and in a form from which symptoms, conditions, diagnoses, treatments, prognosis and the identity of the patient to which these things relate can be readily discerned and verified with reasonable certainty. All documentation *must* be made available at the same site at which the service was rendered.

2.4 NONDISCRIMINATION POLICY STATEMENT

Providers *must* comply with the 1964 Civil Rights Act, as amended; Section 504 of the Rehabilitation Act of 1973; the Age Discrimination Act of 1975; the Omnibus Reconciliation Act of 1981 and the Americans with Disabilities Act of 1990 and all other applicable Federal and State Laws that prohibit discrimination in the delivery of services on the basis of race, color, national origin, age, sex, handicap/disability or religious beliefs.



Further, all parties agree to comply with Title VII of the Civil Rights Act of 1964 which prohibits discrimination in employment on the basis of race, color, national origin, age, sex, handicap/disability, and religious beliefs.

2.5 STATE'S RIGHT TO TERMINATE RELATIONSHIP WITH A PROVIDER

Providers of services and supplies to MO HealthNet participants *must* comply with all laws, policies, and regulations of Missouri and the MO HealthNet Division, as well as policies, regulations, and laws of the federal government. A provider *must* also comply with the standards and ethics of his or her business or profession to qualify as a participant in the program. The Missouri Medicaid Audit and Compliance Unit may terminate or suspend providers or otherwise apply sanctions of administrative actions against providers who are in violation of MO HealthNet Program requirements. Authority to take such action is contained in 13 CSR 70-3.030.

2.6 FRAUD AND ABUSE

The Department of Social Services, Missouri Medicaid Audit and Compliance Unit is charged by federal and state law with the responsibility of identifying, investigating, and referring to law enforcement officials cases of suspected fraud or abuse of the Title XIX Medicaid Program by either providers or participants. Section 1909 of the Social Security Act contains federal penalty provisions for fraudulent acts and false reporting on the part of providers and participants enrolled in MO HealthNet.

Fraud is defined as an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to him or herself or some other person. It includes any act that constitutes fraud under applicable Federal and State laws, regulations and policies.

Abuse is defined as provider, supplier, and entity practices that are inconsistent with sound fiscal, business, or medical practices, and result in an unnecessary cost to the Medicaid program, or in reimbursement for services that are *not* medically necessary or that fail to meet professionally recognized standards for health care. It also includes participant practices that result in unnecessary costs to the Medicaid program.

Frequently cited fraudulent or abusive practices include, but are *not* limited to, overcharging for services provided, charging for services *not* rendered, accepting bribes or kickbacks for referring patients, and rendering inappropriate or unnecessary services.

The penalties for such acts range from misdemeanors to felonies with fines *not* to exceed \$25,000 and imprisonment up to 5 years, or both.

Procedures and mechanisms employed in the claims and payment surveillance and audit program include, but are *not* limited to, the following:

- Review of participant profiles of use of services and payment made for such.
- Review of provider claims and payment history for patterns indicating need for closer scrutiny.
- Computer-generated listing of duplication of payments.
- Computer-generated listing of conflicting dates of services.
- Computer-generated overutilization listing.
- Internal checks on such items as claims pricing, procedures, quantity, duration, deductibles, coinsurance, provider eligibility, participant eligibility, etc.
- Medical staff review and application of established medical services parameters.
- Field auditing activities conducted by the Missouri Medicaid Audit and Compliance Unit or its representatives, which include provider and participant contacts.

In cases referred to law enforcement officials for prosecution, the Missouri Medicaid Audit and Compliance Unit has the obligation, where applicable, to seek restitution and recovery of monies wrongfully paid even though prosecution may be declined by the enforcement officials.

2.6.A CLAIM INTEGRITY FOR MO HEALTHNET PROVIDERS

It is the responsibility of each provider to ensure the accuracy of all data transmitted on claims submitted to MO HealthNet, regardless of the media utilized. As provided in 13 CSR 70.3.030, sanctions may be imposed by MO HealthNet against a provider for failure to take reasonable measures to review claims for accuracy. Billing errors, including but not limited to, incorrect ingredient indicators, quantities, days supply, prescriber identification, dates of service, and usual and customary charges, caused or committed by the provider or their employees are subject to adjustment or recoupment. This includes, but is not limited to, failure to review remittance advices provided for claims resulting in payments that do not correspond to the actual services rendered. Ongoing, overt or intentionally misleading claims may be grounds for allegations of fraud and will be appropriately pursued by the agency.

2.7 OVERPAYMENTS

The Missouri Medicaid Audit and Compliance Unit routinely conduct postpayment reviews of MO HealthNet claims. If during a review an overpayment is identified, the Missouri Medicaid Audit and Compliance Unit is charged with recovering the overpayment pursuant to 13 CSR 70-3.030. The Missouri Medicaid Audit and Compliance Unit maintains the position that all providers are held responsible for overpayments identified to their participation agreement regardless of any extrinsic relationship they may have with a corporation or other employing entity. The provider is responsible



for the repayment of the identified overpayments. Missouri State Statute, Section 208.156, RSMo (1986) may provide for appeal of any overpayment notification for amounts of \$500 or more. An appeal *must* be filed with the Administrative Hearing Commission within 30 days from the date of mailing or delivery of the decision, whichever is earlier; except that claims of less than \$500 may be accumulated until such claims total that sum and, at which time, the provider has 90 days to file the petition. If any such petition is sent by registered mail or certified mail, the petition will be deemed filed on the date it is mailed. If any such petition is sent by any method other than registered mail or certified mail, it will be deemed filed on the date it is received by the Commission.

Compliance with this decision does *not* absolve the provider, or any other person or entity, from any criminal penalty or civil liability that may arise from any action that may be brought by any federal agency, other state agency, or prosecutor. The Missouri Department of Social Services, Missouri Medicaid Audit and Compliance Unit, has no authority to bind or restrict in any way the actions of other state agencies or offices, federal agencies or offices, or prosecutors.

2.8 POSTPAYMENT REVIEW

Services reimbursed through the MO HealthNet Program are subject to postpayment reviews to monitor compliance with established policies and procedures pursuant to Title 42 CFR 456.1 through 456.23. Non-compliance may result in monetary recoupments according to 13 CSR 70-3.030 (5) and the provider may be subjected to prepayment review on all MO HealthNet claims.

2.9 PREPAYMENT REVIEW

MMAC may conduct prepayment reviews for all providers in a program, or for certain services or selected providers. When a provider has been notified that services are subject to prepayment review, the provider *must* follow any specific instructions provided by MMAC in addition to the policy outlined in the provider manual. In the event of prepayment review, the provider *must* submit all claims on paper. Claims subject to prepayment review are sent to the fiscal agent who forwards the claims and attachments to the MMAC consultants.

MMAC consultants conduct the prepayment review following the MO HealthNet Division's guidelines and either recommend approval or denial of payment. The claim and the recommendation for approval or denial is forwarded to the MO HealthNet fiscal agent for final processing. Please note, although MMAC consultants recommend payment for a claim, this does *not* guarantee the claim is paid. The claim *must* pass all required MO HealthNet claim processing edits before actual payment is determined. The final payment disposition on the claim is reported to the provider on a MO HealthNet Remittance Advice.



2.10 DIRECT DEPOSIT AND REMITTANCE ADVICE

MO HealthNet providers *must* complete a [Direct Deposit for Individual Provider](#) form to receive reimbursement for services through direct deposit into a checking or savings account. The application should be downloaded, printed, completed and mailed along with a voided check or letter from the provider's financial institution to:

Missouri Medicaid Audit and Compliance (MMAC)

Provider Enrollment Unit

P.O. Box 6500

Jefferson City, MO 65102

This form *must* be used for initial enrollment, re-enrollment, revalidation, or any update or change needed. All providers are required to complete the Application for Provider Direct Deposit form regardless if the reimbursement for their services will be going to another provider.

In addition to completion of the Application for Provider Direct Deposit form, all clinics/groups *must* complete the [Direct Deposit for Clinics & Groups](#) form.

Direct deposit begins following a submission of a properly completed application form to the Missouri Medicaid Audit and Compliance Unit, the successful processing of a test transaction through the banking system and the authorization to make payment using direct deposit. The state conducts direct deposit through the automated clearing house system, utilizing an originating depository financial institution. The rules of the National Clearing House Association and its member local Automated Clearing House Association shall apply, as limited or modified by law.

The Missouri Medicaid Audit and Compliance Unit will terminate or suspend the direct deposit for administrative or legal actions, including but *not* limited to: ownership change, duly executed liens or levies, legal judgments, notice of bankruptcy, administrative sanctions for the purpose of ensuring program compliance, death of a provider, and closure or abandonment of an account.

All payments are direct deposited.

For questions regarding direct deposit or provider enrollment issues, please send an email to mmac.providerenrollment@dss.mo.gov

The MO HealthNet Remittance Advice is available on line. The provider *must* apply online via the [Application for MO HealthNet Internet Access Account](#) link.

Once a user ID and password is obtained, the www.emomed.com website can be accessed to retrieve current and aged remittance advices.

Please be aware that any updates or changes made to the emomed file will *not* update the provider master file. Therefore updates or changes should be requested in writing. Requests can be emailed to



the Missouri Medicaid Audit and Compliance Unit, Provider Enrollment Section
(www.mmac.providerenrollment@dss.mo.gov).

END OF SECTION

[TOP OF SECTION](#)



SECTION 3 - STAKEHOLDER SERVICES

3.1 PROVIDER SERVICES

The MHD has various units to assist providers with questions regarding proper claims filing, claims resolution and disposition, payment problems, participant eligibility verification, prior authorization status, coverage inquiries, and proper billing methods and procedures.

Additionally, the Missouri Medicaid Audit and Compliance Unit (MMAC) assists providers with enrollment as an MHD provider, enrollment questions and verifications. Assistance can be obtained by contacting the appropriate unit.

3.1.A MHD TECHNICAL HELP DESK

The MHD Technical Help Desk provides assistance in establishing the required electronic claims and Remittance Advice (RA) formats, network communication, Health Insurance Portability and Accountability (HIPAA) trading partner agreements, and Internet billing service.

This help desk is for use by Fee-For-Service providers, electronic billers, and Managed Care health plan staff. The dedicated telephone number is (573) 635-3559. The responsibilities of the help desk include:

- Front-line assistance to providers and billing staff in establishing required electronic claim formats for claim submission, as well as assistance in the use and maintenance of billing software developed by the MHD.
- Front-line assistance accessibility to electronic claim submission for all providers via the Internet.
- Front-line assistance to Managed Care health plans in establishing required electronic formats, network communications, and ongoing operations.
- Front-line assistance to providers in submitting claim attachments via the Internet.

3.2 Missouri Medicaid Audit & Compliance (MMAC)

MMAC is responsible for administering and managing Medicaid (Title XIX) audit and compliance initiatives and managing and administering provider enrollment contracts under the Medicaid program. MMAC is charged with detecting, investigating and preventing fraud, waste, and abuse. MMAC can be contacted at (573) 751-3399, or access the webpage at <http://mmac.mo.gov/>.



3.2.A PROVIDER ENROLLMENT UNIT

The MMAC Provider Enrollment Unit processes provider enrollment packets, enrollment applications, and change requests. Information regarding provider participation requirements and enrollment application packets can be obtained by emailing the unit at mmac.providerenrollment@dss.mo.gov.

3.3 PROVIDER COMMUNICATIONS UNIT

The Provider Communications Unit responds to specific provider inquiries concerning MHD eligibility and coverage, claim filing instructions, concerns and questions regarding proper claim filing, claims resolution and disposition, and billing errors. The dedicated telephone number is (573) 751-2896.

Current, old or lost RAs can be obtained from the MHD electronic billing website at www.emomed.com.

- In the section "File Management," the provider can request and print a current RA by selecting "Printable Remittance Advice."
- To retrieve an older RA, select "Request Aged RAs," fill out the required information and submit. The next day, the RA will be under "Printable Aged RAs."
- The requested RA will remain in the system for 5 days.

Providers can verify participant eligibility, check amount information, claim information, provider enrollment status and participant annual review date by calling the Provider Communications Unit, by emailing from the eMOMED Contact tab or by utilizing the Interactive Voice Response (IVR) system.

3.3.A INTERACTIVE VOICE RESPONSE (IVR) SYSTEM

The Interactive Voice Response (IVR) system at (573) 751-2896 allows an active MO HealthNet provider five Main inquiry options:

1. For MO HealthNet Participant Eligibility, Press 1.
2. For Check Amount Information, Press 2.
3. For Claim Information, Press 3.
4. For Provider Enrollment Status, Press 4.
5. For Participant Annual Review Date, Press 5.

The IVR system requires a touch-tone phone and is limited to use by active MO HealthNet providers or inactive providers inquiring on dates of service that occurred during their period of enrollment as an active MO HealthNet provider. The 10-digit



National Provider Identification (NPI) number *must* be entered each time any of the IVR options are accessed.

The provider should listen to all eligibility information, particularly the sub-options.

Main Option 1. Participant Eligibility

The caller is prompted to enter the following information:

- Provider's 10 digit NPI number.
- 8-digit MO HealthNet participant's ID (MO HealthNet Identification Number), or 9-digit Social Security Number (SSN) or case-head ID.
- If the inquiry is by the SSN, once the 9-digit SSN is entered, the IVR prompts for the Date of Birth.
- 6-digit Date of birth (mm/dd/yy).
- Dependent date of birth (if inquiry by case-head ID).
- Once the participant's ID is entered, the IVR prompts for dates of service.
- First date of service (mm/dd/yy): Enter in the 6-digit first date of service.
- Last date of service (mm/dd/yy): Enter the 6-digit last date of service
- Upon entry of dates of service, the IVR retrieves coverage information.

For eligibility inquiries, the caller can inquire by individual date of service or a span of dates. Inquiry for a span of dates may **not** exceed 31 days. The caller may inquire on future service dates for the current month only. The caller may **not** inquire on dates that exceed one year, prior to the current date. The caller is limited to ten inquiries per call.

The caller is given standard MO HealthNet eligibility coverage information, including the Medicaid Eligibility (ME) code, date of birth, date of death (if applicable), county of eligibility, nursing home name and level of care (if applicable), and informational messages about the participant's eligibility or benefits.

The IVR also tells the caller whether the participant has any service restrictions based on the participant's eligibility under Qualified Medicare Beneficiary (QMB) or the Presumptive Eligibility (TEMP) Program. Please reference all the applicable sections of the provider's program manual for QMB and TEMP provisions.

Hospice beneficiaries are identified along with the name and telephone number of the providers of service. Reference the Provider Manuals Section 1 for detailed information on participant eligibility.

Once standard MO HealthNet eligibility information is given, the IVR gives the caller the option to listen to additional eligibility information through a Sub-Option menu.

The Sub-Options menu options include:

- For Health plan and Lock-in Information, Press 1.
- For eye glass and eye exam information, Press 2.



- For Third Party Liability Information, Press 3.
- For Medicare and QMB Information, Press 4.
- For MO HealthNet ID, Name, spelling of name and eligibility information, Press 5.
- For Confirmation Number, Press 6.
- For Another MO HealthNet Participant, Press 7.
- To Return to the Main Menu, Press 8.
- To End this Call, Press 9.
- To speak with a MO HealthNet specialist, Press 0.

The MHD eligibility information is confidential and must be used only for the purpose of providing services and for filing MHD claims.

Sub-Option 1. Health Plan and Lock-in Information

The Health plan and Lock-in Option sub-option 1, if applicable, provides the health plan lock-in information, Primary Care Provider (PCP) lock-in, and other applicable provider lock-in information.

If no lock-in exists for participant, the IVR will state that the participant is not locked in on the date of service requested.

If lock-in exists, then IVR will read up to three records to the caller.

- If health plan lock-in exists, the IVR states the health plan name for services on the applicable dates.
 - “This participant is locked into Health Plan (Health Plan Name) for services on (from date) through (to date). The Health plan Hotline is Are Code (XXX-XXX-XXXX on file).”
- If PCP lock-in exists, the IVR states the provider’s name and phone number for services on the applicable dates.
 - “This participant is locked into Provider (Provider Name) for services on (from date) through (to date). The participant’s primary care provider is (PCP Name). The lock-in provider’s phone number is Area Code (XXX-XXX-XXXX on file).”

This information is also available on www.emomed.com.

Sub-Option 2. Eye Glass and Eye Exam Information

The participant’s eyeglass information and last eye exam information can be obtained through the sub-option 2.

- If no eyeglass information exists, the IVR reads that the participant has not received an eye exam and has not received eye glass frames or lenses to date under the MO HealthNet program.



- If frames, lens, and/or exam information exist, then the IVR will read different types of responses based on the data. A couple of examples include:
 - If frames, lens, and exam information exists and all occur on the same date.
 - Date of last eye exam and last issue of eyeglass frames and lenses is (date on file).
 - If frames, lens exist for different dates and no exam date.
 - Eye glass frames were last issued on (Frames Date).
 - Eye glass lenses were last issued on (Lens Date).
 - This participant has not had an eye examination to date under the MO HealthNet program.

This information is also available on the eMOMED website. The IVR goes back to the sub-options.

Sub-Option 3. Third Party Liability (TPL) Information

The participant's TPL information on file will be provided through sub-option 3.

- If no TPL exists for the participant or TPL Name is blank, the IVR reads that information.
- If Medicare Part C exists, the IVR reads that information.
- If TPL Part C information is not available, the IVR reads to contact the participant for the information.
- If Medicare Part C does not exist, the IVR reads that this participant does not have Third party coverage on the dates of service requested.
- If TPL exists, then IVR will read up to **five** records to the caller.
 - Third party insurance is provided by (TPL NAME).
 - If Court Ordered, the IVR will read that this coverage is court ordered.
 - If Policy Number = 'unknown, the IVR will read that the Policy number is unknown.
 - If Policy Number is known, the IVR will read the policy number is (Policy Number).
 - If Group Number = 'unknown, the IVR will read that the group number is unknown.
 - If the Group Number is known, the IVR will read that the group number is (Group Number).

This information is also available on the eMOMED website. The IVR goes back to the sub-options.

Sub-Option 4 Medicare and QMB Information

If no Part A, B, or QMB information exists on file for the participant, then nothing is read.



If Part A, B, and/or QMB information exists then the IVR will read different types of responses based on the data on file. A couple of examples include:

- If Part A, B, QMB exists and all have same dates, the IVR will read that this participant has Medicare Part A, Part B, and QMB coverage on (from date) through (to date).
- If Part A, B exists for same dates and QMB has different dates, the IVR will read that this participant has Medicare Part A and Part B coverage on (from date) through (to date). This participant has QMB coverage on (QMB from date) through (QMB to date).
- If Part C exists, the IVR will read that this participant has Medicare Part C coverage on (from date) through (to date).

This information is also available on the eMOMED website. The IVR goes back to the sub-options.

Main Option 2. Provider IVR Check Inquiry

Once the provider's 10 digit NPI number is entered, the IVR retrieves the information. The IVR will read if the provider is eligible to submit electronic claims, or if the provider is not eligible to submit electronic claims.

- The IVR will read the most recent provider check information available from the Remittance Advice number (RA Number) dated (RA Date). The check amount is (RA Amount).
- If there has not been checks issued, the IVR will read that the NPI Number (XXXXXXXXXX) has not been issued any checks to date.

This information is also available on the eMOMED website.

The IVR then reads additional navigation options.

- For another Check Inquiry, Press 1. If the caller presses 1, the IVR goes back to Provider Check Inquiry.
- To repeat the information that you just heard, Press 2. If the caller presses 2, the IVR goes back to the Main Menu
- To Speak with a MO HealthNet specialist, Press 0.
- Else, Press 3.

Main Option 3. Provider IVR Claim Information

The provider can access claim status information, including processing status, denial, and approved status.



- Once the 10 digit provider NPI number is entered, then IVR prompts for the 8 digit MO HealthNet ID.
- Once 8 digit number is entered, the IVR prompts for the 6 digit first date of service in (mm/dd/yy) format.
- Once 6 digit number is entered, the IVR prompts for the type of claim.
 - If Drug claim is selected, then IVR prompts for prescription number entry.

Once inputs are received, the IVR retrieves the following results:

- If claim is in process:
 - The IVR reads that the claim accessed with this date of service is being processed.
- If claim is denied:
 - The IVR will read up to five Explanation of Benefits (EOB) applicable codes. The claim accessed with this date of service has been denied with EOB (EOB Code 1-5).
 - After EOB codes are read, the IVR prompts to hear EOB descriptions.
 - Press 1 for EOB Description. If the caller presses 1, the IVR will read the EOB descriptions for the EOB codes (up to **five**).
- IVR then reads RA information. If the claim is denied, the IVR reads that the claim accessed with this date of service is denied on the (RA Number) Remittance Advice dated (RA Date).
- If claim is approved for payment:
- The IVR reads that the claim accessed with this date of service has been approved for payment.
- If claim paid and the claim is being recouped or adjusted, the IVR reads for more information, speak with a MO HealthNet Specialist.
- If claim paid, the IVR will read that the claim accessed with this date of service was paid on the (RA Number) Remittance Advice dated (RA Date) in the amount of (RA Amount).

This information is also available on the eMOMED website. The IVR then reads the following navigation options:

- For another Claim inquiry, Press 1. If the caller presses 1, IVR goes back to Provider Claim Inquiry.
- To repeat the information that you just heard, Press 2. If the caller presses 2, IVR repeats Response information.
- To speak with a MO HealthNet specialist, Press 0.
- If the caller presses 3, IVR goes back to the Main Menu.

Main Option 4. Provider Enrollment Status



The provider's enrollment status can be obtained through this option. The following will be repeated up to five times depending on the number of providers for the inquiry. The caller is prompted to enter the provider's NPI number.

- Please enter the 10 digit NPI number. Once 10 digit NPI number is entered, the IVR prompts for NPI number in which being inquired.
- Please enter the 10 digit NPI number in which being inquired. Once 10 digit number is entered, the IVR prompts for date of service.
- Please enter the 6 digit Date of Service in (MM/DD/YY) format. Once inputs are received, the IVR retrieves results.

The following will be repeated up to **five** times depending on the number of providers for the inquired NPI.

- The Provider Enrollment Status for NPI (NPI Number) with a provider type of (Provider Type Description) is (Active/Not Active) for the date of service (DOS). The confirmation number is (Confirmation Number).

This information is also available on the eMOMED website.

The IVR then reads the following navigation options:

- For another Provider Enrollment Status Inquiry, Press 1. If the caller presses 1, the IVR goes back to the Provider Enrollment Option.
- To repeat the information that you just heard, Press 2. If the caller presses 2, the IVR repeats the Provider Enrollment response.
- To Speak with a MO HealthNet specialist, Press 0
- If the caller presses 3, the IVR goes back to the Main Menu.

Main Option 5. Participant Annual Review Date

The participant's annual review date can be obtained through this option. The only information retrieved is the annual review date. For specific information, call the Family Support Division at 1-855-373-4636.

The caller is prompted to enter the following information.

- Please enter the 10 digit NPI number. Once a valid 10 digit number is entered, the IVR prompts for the participant MO HealthNet ID.
- Please enter the 8 digit MO HealthNet ID. Once a valid 8 digit number is entered, the IVR retrieves Data.
- If valid annual review date found, the IVR reads the following.
 - MO HealthNet ID (MO HealthNet ID) is registered to (First, Last Name). Annual Review Date (date on file). For information specific to the MO



HealthNet Participant Annual Review Date, please call the Family Support Division Information Center at 1-855-373-4636.

- If Annual Review Date is not on file, the IVR reads the following:

“MO HealthNet ID (MO HealthNet ID) Annual Review Date is not on file. For information specific to the MO HealthNet Participant Annual Review Date, please call the Family Support Division Information Center at 1-855-373-4636.”

After valid or error response IVR then reads menu options.

- For Another MO HealthNet Participant, Press 1. If the caller presses 1, IVR goes back to Enter MO HealthNet ID prompt.
- To repeat the information that you just heard, Press two. If the caller presses 2, IVR repeats the Annual Review Date response.
- If the caller presses 3, the IVR goes back to the Main Menu.
- If the provider selects to speak to a specialist, the IVR will route to a specialist.

Transfer Routine

The provider must go through one of the available options on the IVR, prior to requesting an agent. If the inquiry cannot be answered through the IVR, please go through an option and wait to be prompted to be routed to a specialist. The IVR will respond to please hold while we transfer you to a MO HealthNet Specialist. Please have your NPI number ready.

Number of Inquiries

There are 10 inquiries allowed per caller. If 10 inquiries are accessed, the IVR will read that you have used your allotted 10 participant inquiries per call, thank you for calling, and hangs up.

3.3.A(1) Using the Telephone Key Pad

Both alphabetic and numeric entries may be required on the telephone key pad. In some cases, the IVR instructs the caller which numeric values to key to match alphabetic entries.

Please listen and follow the directions given by the IVR, as it prompts the caller for the various information required by each option. Once familiar with the IVR, the caller does *not* have to wait for the entire voice prompt. The caller can enter responses before the prompts are given.

3.3.B MO HEALTHNET SPECIALIST



Specialists are on duty between the hours of 8:00 AM and 5:00 PM, Monday through Friday (except holidays) when information is not clearly provided or available through the IVR system. The IVR number is (573) 751-2896. Providers are urged to do the following prior to calling:

- Review the provider manual and bulletins before calling the IVR.
- Have all material related to the problem (such as RA, claim forms, and participant information) available for discussion.
- Have the provider's NPI number available.
- Limit the call to three questions. The specialist will assist the provider until the problem is resolved or until it becomes apparent that a written inquiry is necessary to resolve the problem.
- Note the name of the specialist who answered the call. This saves a duplication of effort if the provider needs to clarify a previous discussion or to ask the status of a previous inquiry.

Please note that there are no limits on how many inquiries you can access through the MHD web-based www.emomed.com system. Limitations associated with the number of inquiries are only applicable to the IVR, speaking with a specialist, and email communications.

3.3.C INTERNET

Providers may submit claims on the internet via the MHD web based electronic claims filing system. The website address is www.emomed.com. Providers are required to complete the on-line Application for MO HealthNet Internet Access Account. Please access the application <http://manuals.momed.com/Application.html> and select the Apply for Internet Access link. Providers are unable to access www.emomed.com without proper authorization. An authorization is required for each individual user.

The internet inquiry options, located at www.emomed.com, include the same inquiry options available through the IVR system (without limited number of inquiry restrictions). Providers are encouraged to use www.emomed.com as the first option, prior to accessing the IVR. The provider will be able to read and review the data and results, instead of having to call to hear the results. All the same functions and additional functions compared to the IVR are available and include: eligibility verification by Participant ID, case head ID and child's date of birth, or Social Security Number and date of birth, claim status, and check inquiry, provider enrollment status, and participant annual review date. Eligibility verification can be performed on an individual basis or as a batch submission. Individual eligibility verifications occur in real-time similar to the IVR, which means a response is returned immediately. Batch eligibility verifications are returned to the user within 24 hours.



Providers also have the capability to receive and download their RAs from www.emomed.com. Access to this information is restricted to users with authorization. In addition to the RA, the claim reason codes, remark codes and current fiscal year claims processing schedule is available on the Internet for viewing or downloading.

Other options available on this website (www.emomed.com.) include: claim submission, claim attachment submission, inquiries on claim status, attachment status, and check amounts, and credit adjustment(s). Reference the Provider Manuals Section 1 for detailed information on participant eligibility.

3.3.D WRITTEN INQUIRIES

Letters directed to the MHD are answered by MO HealthNet specialists in the Provider Communications Unit. Written or telephone responses are provided to all inquiries. A provider who encounters a complex billing problem, numerous problems requiring detailed and lengthy explanation of such matters as policy, procedures, and coverage, or wishes to submit a complaint should submit the inquiry or complaint in writing to:

Provider Communications Unit
MO HealthNet Division
P.O. Box 5500
Jefferson City, MO 65102-5500

A written inquiry should state the problem as clearly as possible and should include the following:

- Provider's name
- NPI number
- Address
- Telephone number
- MO HealthNet participant's full name
- MO HealthNet participant's identification number
- MO HealthNet participant's birthdate
- A copy of all pertinent information such as the following:
 - Remittance Advice forms
 - Invoices
 - Applicable Participant Information
 - Form letters
 - Timely filing documentation *must* be included with the written inquiry, if applicable.



3.4 PROVIDER EDUCATION UNIT

The Provider Education Unit serves as a communication and assistance liaison between the MHD and the provider community. Provider Education Representatives can provide face-to-face assistance and personalized attention necessary to maintain clear, effective, and efficient provider participation in the MHD. Providers contribute to this process by identifying problems and difficulties encountered with MO HealthNet.

Representatives are available to educate providers and other groups on proper billing methods and procedures for MHD claims. The representatives provide assistance, training, and information to enhance provider participation in MO HealthNet. These representatives schedule seminars, workshops, and Webinar trainings for individuals and associations to provide instructions on procedures, policy changes, and benefit changes, which affect the provider community.

The Provider Education Unit can be contacted for training information and scheduling via telephone at (573) 751-6683 or email at mhd_provtrain@dss.mo.gov. Providers can visit the Provider Participation page at <http://dss.mo.gov/mhd/providers> to schedule training.

3.5 PARTICIPANT SERVICES

The Participant Services Unit assists participants regarding access to providers, eligibility, covered and non-covered services, unpaid medical bills, premium collections questions, and payment information. The Participant Services Number is (800) 392-2161 or (573) 751-6527.

Providers may direct participants to the MO HealthNet Participant Services Unit when they need assistance in any of the above-mentioned situations. For example, when a participant moves to a new area of the state and needs the names of all physicians who are active MO HealthNet providers in the new area.

When participants have problems or questions concerning their MO HealthNet coverage, they should be directed to call or write to the Participant Services Unit at:

Participant Services Unit
MO HealthNet Division
P.O. Box 3535
Jefferson City, MO 65102-3535

All calls or correspondence from providers are referred to the Provider Communications Unit. Please **do not** give participants the Provider Communications' telephone number.



3.6 PENDING CLAIMS

If payment or status information, for a submitted MO HealthNet claim, is **not** received within 60 days, providers should call the Provider Communications Unit at 573-751-2896, to discuss submission of a new claim or status of the previously submitted claim. However, providers should not resubmit a new claim for a claim that remains in pending status. Resubmitting a claim in pending status will delay processing of the claim. Reference the Provider Manuals Section 17 for further discussion of the RA and Suspended Claims.

3.7 FORMS

All MO HealthNet forms necessary for claims processing are available for download on the MHD website at www.dss.mo.gov/mhd/providers/index.htm. Choose the “MO HealthNet forms” link in the right column.

3.8 CLAIM FILING METHODS

Some providers may submit paper claims. All claim types may be submitted electronically through the MHD billing site at www.emomed.com. Most claims that require attachments may also be submitted at this site.

Pharmacy claims may also be submitted electronically through a point of service (POS) system. Medical (CMS-1500), Inpatient and Outpatient (UB-04), Dental (ADA 2002, 2004), Nursing Home and Pharmacy (NCPDP) may also be submitted via the Internet. These methods are described in the Provider Manuals Section 15. **NOTE: Effective November 1, 2020 MHD will accept the 2019 ADA form for dental claims.**

3.9 CLAIM ATTACHMENT SUBMISSION VIA THE INTERNET

The claim attachments available for submission via the Internet include:

- (Sterilization) Consent Form.
- Acknowledgment of Receipt of Hysterectomy Information.
- Medical Referral Form of Restricted Participant (PI-118).
- Certificate of Medical Necessity (for Durable Medical Equipment providers only).

These attachments may *not* be submitted via the Internet when additional documentation is required. The web site address for these submissions is www.emomed.com.

3.10 Pharmacy & Clinical Services Unit



This unit assists with program development and clinical policy decision making for MHD. These responsibilities include policy development, benefit design, and coverage decisions using best practices and evidence-based medicine. The Pharmacy and Clinical Services Unit can be contacted at (573) 751-6963, or by emailing MHD.ClinicalServices@dss.mo.gov, or visit the MHD webpage at <http://dss.mo.gov/mhd/cs/>.

Providers with problems or questions regarding policies and programs, which cannot be answered by any other means, should email Ask.MHD@dss.mo.gov.

3.11 Pharmacy and Medical Pre-certification Help Desk

The MHD requires pre-certification for certain radiological procedures. Certain drugs require a Prior Authorization (PA) or Edit Override (EO), prior to dispensing. To obtain these pre-certifications, PA's or EO's, providers can call 800-392-8030, or use the [CyberAccess](#) website, a web tool that automates this process for MO HealthNet providers.

To become a CyberAccess user, contact the help desk at 888-581-9797 or 573-632-9797, or email cyberaccesshelpdesk@xerox.com. For non-emergency service or equipment exception requests only, please use Fax #: (573) 522-3061; Drug PA Fax #: (573) 636-6470.

3.12 Third Party Liability (TPL)

Providers should contact the TPL Unit to report any MO HealthNet participant who has sustained injuries due to an accident or when they have problems obtaining a response from an insurance carrier. Any unusual situations concerning third party insurance coverage for a MO HealthNet participant should also be reported to the TPL Unit. The TPL Unit's number is 573-751-2005.



SECTION 4 - TIMELY FILING

4.1 TIME LIMIT FOR ORIGINAL CLAIM FILING

4.1.A MO HEALTHNET CLAIMS

Claims from participating providers who request MO HealthNet reimbursement *must* be filed by the provider and *must* be received by the state agency within 12 months from the date of service. The counting of the 12-month time limit begins with the date of service and ends with the date of receipt. Refer to Section 4.5, Definitions, for a detailed explanation of terms.

4.1.B MEDICARE/MO HEALTHNET CLAIMS

Claims that initially have been filed with Medicare within the Medicare timely filing requirement and that require separate filing of a claim with the MHD meet the timely filing requirement by being submitted by the provider and received by the state agency within 12 months from the date of service or 6 months from the date on Medicare's provider notice of the allowed claim, whichever is later. Claims denied by Medicare *must* be filed by the provider and received by the state agency within 12 months from the date of service. The counting of the 12-month time limit begins with the date of service and ends with the date of receipt. The counting of the 6-month period begins with the date of adjudication of Medicare payment and ends with the date of receipt.

Refer to Section 16 for billing instructions of Medicare/MO HealthNet (crossover) claims.

4.1.C MO HEALTHNET CLAIMS WITH THIRD PARTY LIABILITY

Claims for participants who have other insurance *must* first be submitted to the insurance company in most instances. Refer to Section 5 for exceptions to this rule. However, the claim *must* still meet the MHD timely filing guidelines outlined above. (Claim disposition by the insurance company after 1 year from the date of service does *not* serve to extend the filing requirement.) If the provider has *not* had a response from the insurance company prior to the 12-month filing limit, they should contact the Third Party Liability (TPL) Unit at (573) 751-2005 for billing instructions. It is recommended that providers wait *no* longer than 6 months after the date of service before contacting the TPL Unit. If the MHD waives the requirement that the third-party resource's adjudication *must* be attached to the claim, documentation indicating the third-party resource's adjudication of the claim *must* be kept in the provider's records and made available to the division at its request. The claim *must* meet the MHD timely filing requirement by being filed by the provider and received by the state agency within 12 months from the date of service.



The 12 month initial filing rule may be extended if a third-party payer, after making a payment to a provider, being satisfied that the payment is correct, later reverses the payment determination, sometime after the 12 months from the date of service has elapsed, and requests the provider return the payment. Because a third-party resource was clearly available to cover the full amount of liability, and this was known to the provider, the provider may *not* have initially filed a claim with the MHD. Under this set of circumstances, the provider may file a claim with the MHD later than 12 months from the date of service. The provider *must* submit this type of claim to the Third Party Liability Unit at P.O. Box 6500, Jefferson City, MO 65102-6500 for special handling. The MHD may accept and pay this specific type of claim without regard to the 12 month timely filing rule; however, all claims *must* be filed for MO HealthNet reimbursement within 24 months from the date of service in order to be paid.

4.2 TIME LIMIT FOR RESUBMISSION OF A CLAIM

Claims that were originally submitted and received within 12 months from the date of service and were denied or returned to the provider *must* be resubmitted and received within 24 months of the date of service.

4.2.A CLAIMS FILED AND DENIED

Claims that are denied may be resubmitted. A resubmission filed beyond the 12-month filing limit *must* either include an attachment, a Remittance Advice or Return to Provider letter, or the claim *must* have the original ICN entered in the appropriate field for electronic or paper claims (reference Section 15 of the applicable provider manual). Either the attachment or the ICN *must* indicate the claim had originally been filed within 12 months of the date of service. The same Remittance Advice, letter or ICN can be used for each resubmission of that claim.

4.2.B CLAIMS FILED AND RETURNED TO PROVIDER

Some paper claims received by the fiscal agent *cannot* be processed because the wrong claim form is submitted or additional data is required. These claims are *not* processed through the system but are returned to the provider with a Return to Provider letter. When these claims are resubmitted more than 12 months after the date of service (and had been filed timely), a copy of the Return to Provider letter should be attached instead of the required Remittance Advice to document timely filing as explained in the previous paragraph. The date on the letter determines timely filing.



4.3 CLAIMS NOT FILED WITHIN THE TIME LIMIT

In accordance with 13 CSR 70-3.100, claims that are *not* submitted in a timely manner as described in this section are denied. However, at any time in accordance with a court order, the the MHD may make payments to carry out a hearing decision, corrective action or court order to others in the same situation as those directly affected by it. As determined by the state agency, the MHD *may* make payment if a claim was denied due to state agency error or delay. In order for payment to be made, the MHD *must* be informed of any claims denied due to the MHD error or delay within 6 months from the date of the remittance advice on which the error occurred; or within 6 months of the date of completion or determination in the case of a delay; or 12 months from the date of service, whichever is longer.

4.4 TIME LIMIT FOR FILING AN INDIVIDUAL ADJUSTMENT

Adjustments to MO HealthNet payments are only accepted if filed within 24 months from the date of service. If the processing of an adjustment necessitates filing a new claim, the timely limits for resubmitting the new, corrected claim is 24 months from the date of service. Providers can resubmit an adjusted claim via the MHD billing website located at www.emomed.com. When overpayments are discovered, it is the responsibility of the provider to notify the state agency. Providers must submit a [Provider Initiated Self Disclosure Report Form \(here\)](#). The form must be submitted within 24 months of the date of service. Only adjustments or disclosures that are the result of lawsuits or settlements are accepted beyond 24 months.

4.5 DEFINITIONS

Claim: Each individual line item of service on a claim form for which a charge is billed by a provider for all claim form types except inpatient hospital. An inpatient hospital service claim includes all the billed charges contained on one inpatient claim document.

Date of Service: The date that serves as the beginning point for determining the timely filing limit. For such items as dentures, hearing aids, eyeglasses, and items of durable medical equipment such as an artificial larynx, braces, hospital beds, or wheelchairs, the date of service is the date of delivery or placement of the device or item. It applies to the various claim types as follows:

- **Nursing Homes:** The last date of service for the billing period indicated on the participant's detail record. Nursing Homes *must* bill electronically, unless attachments are required.
- **Pharmacy:** The date dispensed.
- **Outpatient Hospital:** The ending date of service for each individual line item on the claim form.



- **Professional Services:** The ending date of service for each individual line item on the claim form.
- **Dental:** The date service was performed for each individual line item on the claim form.
- **Inpatient Hospital:** The through date of service in the area indicating the period of service.

Date of Receipt: The date the claim is received by the fiscal agent. For a claim that is processed, this date appears as the Julian date in the internal control number (ICN). For a claim that is returned to the provider, this date appears on the Return to Provider letter.

Date of Adjudication: The date that appears on the Remittance Advice indicating the determination of the claim.

Internal Control Number (ICN): The 13-digit number printed by the fiscal agent on each document that processes through the claims processing system. The first two digits indicate the type of claim. The year of receipt is indicated by the 3rd and 4th digits, and the Julian date appears as the 5th, 6th, and 7th digits. For example, in the number 4912193510194, “49” is an eMOMED claim, “17” is the year 2017, and “193” is the Julian date for July 11.

Julian Date: The number of a day of the year when the days of the year are numbered consecutively from 001 (January 1) to 365 (December 31) or 366 in a leap year. For example, in 2016, a leap year, June 15 is the 167th day of that year; thus, 167 is the Julian date for June 15, 2016.

Date of Payment/Denials: The date on the Remittance Advice at the top center of each page under the words “Remittance Advice.”

Twelve-Month Time Limit Unit: 366 days.

Six-Month Time Limit: 181 days.

Twenty-four-Month Time Limit: 731 days.

END OF SECTION

[TOP OF PAGE](#)



SECTION 5-THIRD PARTY LIABILITY

5.1 GENERAL INFORMATION

The purpose of this section of the provider manual is to provide a good understanding of Third Party Liability (TPL) and MO HealthNet. The federal government defines a third party resource (TPR) as:

“Any individual, entity or program that is or may be liable to pay all or part of the expenditures for medical assistance furnished under a State Plan.”

The following is a list of common TPRs; however, the list should *not* be considered to be all inclusive.

- Assault—Court Ordered Restitution
- Automobile—Medical Insurance
- CHAMPUS/CHAMPVA
- Health Insurance (Group or Private)
- Homeowner’s Insurance
- Liability & Casualty Insurance
- Malpractice Insurance
- Medical Support Obligations
- Medicare
- Owner, Landlord & Tenant Insurance
- Probate
- Product Liability Insurance
- Trust Accounts for Medical Services Covered by MO HealthNet
- Veterans’ Benefits
- Worker’s Compensation.

5.1.A MO HEALTHNET IS PAYER OF LAST RESORT

MO HealthNet funds are used after all other potential resources available to pay for the medical service have been exhausted. There are exceptions to this rule discussed later in this section. The intent of requiring MO HealthNet to be payer of last resort is to ensure that tax dollars are *not* expended when another liable party is responsible for all or a portion of the medical service charge. It is to the provider’s benefit to bill the liable TPR before billing MO HealthNet because many resources pay in excess of the maximum MO HealthNet allowable.

Federal and state regulations require that insurance benefits or amounts resulting from litigation are to be utilized as the first source of payment for medical expenses incurred by MO HealthNet participants. See 42 CFR 433 subpart D and RSMo 208.215 for further reference. In essence, MO HealthNet does *not* and should *not* pay a claim for medical



expenses until the provider submits documentation that all available third party resources have considered the claim for payment. Exceptions to this rule are discussed later in this section of the provider manual.

All TPR benefits for MO HealthNet covered services *must* be applied against the provider's charges. These benefits *must* be indicated on the claim submitted to MO HealthNet. Subsequently, the amount paid by MO HealthNet is the difference between the MO HealthNet allowable and the TPR benefit amount, capping the payment at the MO HealthNet allowable. For example, a provider submits a charge for \$100 to the MO HealthNet Program for which the MO HealthNet allowable is \$80. The provider received \$75 from the TPR. The amount MO HealthNet pays is the difference between the MO HealthNet allowable (\$80) and the TPR payment (\$75) or \$5.

5.1.B THIRD PARTY LIABILITY FOR MANAGED HEALTH CARE ENROLLEES

Managed care health plans in the MO HealthNet Managed Care program *must* ensure that the health plan and its subcontractors conform to the TPL requirements specified in the managed care contract. The following outlines the agreement for the managed health care plans.

The managed care health plan is responsible for performing third party liability (TPL) activities for individuals with private health insurance coverage enrolled in their managed care health plan.

By law, MO HealthNet is the payer of last resort. This means that the managed care health plan contracted with the State of Missouri shall be used as a source of payment for covered services only after all other sources of payment have been exhausted. The two methods used in the coordination of benefits are cost avoidance and post-payment recovery (i.e., pay and chase). The managed care health plan shall act as an agent of the state agency for the purpose of coordination of benefits.

The managed care health plan shall cost avoid all claims or services that are subject to payment from a third party health insurance carrier. If a third party health insurance carrier (other than Medicare) requires the managed care health plan member to pay any cost-sharing amount (such as copayment, coinsurance or deductible), the managed care health plan is responsible for paying the cost-sharing (even to an out-of-network provider). The managed care health plan's liability for such cost-sharing amounts shall *not* exceed the amount the managed care health plan would have paid under the managed care health plan's payment schedule.

If a claim is cost-avoided, the establishment of liability takes place when the managed care health plan receives confirmation from the provider or the third party health insurance carrier indicating the extent of liability.



If the probable existence of a Third Party Resource (TPR) *cannot* be established or third party benefits are *not* available at the time the claim is filed, the managed care health plan *must* pay the full amount allowed under the managed care health plan's payment schedule.

The requirement to cost avoid applies to all covered services except claims for labor and delivery and postpartum care; prenatal care for pregnant women; preventative pediatric services; or if the claim is for a service provided to a managed care health plan member on whose behalf a child support enforcement order is in effect. The managed care health plan is required to provide such services and then recover payment from the third party health insurance carrier (pay and chase).

In addition to coordination of benefits, the health plan shall pursue reimbursement in the following circumstances:

- Worker's Compensation
- Tort-feasors
- Motorist Insurance
- Liability/Casualty Insurance

The managed care health plan shall immediately report to the MO HealthNet Division any cases involving a potential TPR resulting from any of the above circumstances. The managed care health plan shall cooperate fully with the MO HealthNet Division in all collection efforts. If the managed care health plan or any of its subcontractors receive reimbursement as a result of a listed TPR, that payment *must* be forwarded to the MO HealthNet Division immediately upon receipt.

IMPORTANT: Contact the MO HealthNet Division, Third Party Liability Unit, at (573) 751-2005 for questions about Third Party Liability.

5.1.C PARTICIPANTS LIABILITY WHEN THERE IS A TPR

The provider may *not* bill the participant for any unpaid balance of the total MO HealthNet covered charge when the other resource represents all or a portion of the MO HealthNet maximum allowable amount. The provider is *not* entitled to any recovery from the participant except for services/items which are *not* covered by the MO HealthNet Program or services/items established by a written agreement between the MO HealthNet participant and provider indicating MO HealthNet is *not* the intended payer for the specific service/item but rather the participant accepts the status and liability of a private pay patient.

Missouri regulation does allow the provider to bill participants for MO HealthNet covered services if, due to the participant's action or inaction, the provider is *not* reimbursed by the MO HealthNet Program. It is the provider's responsibility to document the facts of the case. Otherwise, the MO HealthNet agency rules in favor of the participant.



5.1.D PROVIDERS MAY NOT REFUSE SERVICE DUE TO TPL

The Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1985 contained a number of changes affecting the administration of a state's Medicaid TPL Program. A provision of this law implemented by Federal Regulations effective February 15, 1990, is described below:

Under law and federal regulation, a provider may *not* refuse to furnish services covered under a state's Medicaid plan to an individual eligible for benefits because of a third party's potential liability for the service(s). See 42 CFR 447.20(b).

This provision prohibits providers from discriminating against a MO HealthNet participant based on the possible existence of a third party payer. A participant may *not* be denied services based solely on this criterion. Federal regulation does provide the state with authority to sanction providers who discriminate on this basis.

A common misconception is that incorrect information regarding third party liability affects participant eligibility. Providers have refused services to participants until the third party information available to the state is either deleted or changed. Third party information reflects the participant's records at the time the MO HealthNet eligibility is verified and is used to notify providers there is probability of a third party resource. Current MO HealthNet third party information is used when processing provider claims. Therefore, incorrect third party information does *not* invalidate the participant's eligibility for services. The federal regulation cited in the paragraph above prohibits providers from refusing services because of incorrect third party information in the participant's records.

5.2 HEALTH INSURANCE IDENTIFICATION

Many MO HealthNet participants are dually eligible for health insurance coverage through a variety of sources. The provider should always question the participant or caretaker about other possible insurance coverage. While verifying participant eligibility, the provider is provided information about possible insurance coverage. The insurance information on file at the MO HealthNet Division (MHD) does *not* guarantee that the insurance(s) listed is the only resource(s) available nor does it guarantee that the coverage(s) remains available.



5.2.A TPL INFORMATION

MO HealthNet participants may contact Participant Services, (800) 392-2161, if they have any questions concerning their MO HealthNet coverage. Providers may reference a point of service (POS) terminal, the Internet or they may call the interactive voice response (IVR) system at (573) 635-8908 for TPL information. Refer to Sections 1 and 3 for further information.

In addition to the insurance company name, city, state and zip code, the Internet, IVR or POS terminal also gives a code indicating the type of insurance coverage available (see Section 5.3). For example, if “03” appears in this space, then the participant has hospital, professional and pharmacy coverage. If the participant does *not* have any additional health insurance coverage either known or unknown to the MO HealthNet agency, a provider *not* affected by the specified coverage, such as a dental provider, does *not* need to complete any fields relating to TPL on the claim form for services provided to that participant.

5.2.B SOLICITATION OF TPR INFORMATION

There may be coverage available to the participant that is *not* known to MHD. It is the provider’s responsibility and in his/her best interest to solicit TPR information from the participant or caretaker at the time service is provided whether or not MHD is aware of the availability of a TPR. The fact that the TPR information is unknown to MHD at the time service is provided does *not* release the liability of the TPR or the underlying responsibility of the provider to utilize those TPR benefits.

A few of the more common health insurance resources are:

- If the participant is married or employed, coverage may be available through the participant's or spouse’s employment.
- If the participant is a foster child, the natural parent may carry health insurance for that child.
- The noncustodial parent may have insurance on the child or may be ordered to provide health insurance as part of his/her child support obligation.
- CHAMPUS/CHAMPVA or veteran’s benefits may provide coverage for families of active duty military personnel, retired military personnel and their families, and for disabled veterans, their families and survivors. A veteran may have additional medical coverage if the veteran elected to be covered under the “Improved Pension Program,” effective in 1979.
- If the participant is 65 or over, it is very likely that they are covered by Medicare. To meet Medicare Part B requirements, individuals need only be 65 (plus a residency requirement for aliens or refugees) and the Part B premium be paid. Individuals who



have been receiving kidney dialysis for at least 3 months or who have received a kidney transplant may also be eligible for Medicare benefits. (For Medicare related billings, see the Medicare Crossover Section in this manual.)

- If the participant is disabled, coverage may exist under Medicare, Worker’s Compensation, or other disability insurance carriers.
- If the participant is an over age disabled dependent (in or out of school), coverage may exist as an over age dependent on most group plans.
- If the participant is in school, coverage may exist through group plans.
- A relative may be paying for health insurance premiums on behalf of the participant.

5.3 INSURANCE COVERAGE CODES

Listed below are the codes that identify the type of insurance coverage the participant has:

AC	Accident
AM	Ambulance
CA	Cancer
CC	Nursing Home Custodial Care
DE	Dental
DM	Durable Medical Equipment
HH	Home Health
HI	Inpatient Hospital
HO	Outpatient Hospital—includes outpatient and other diagnostic services
HP	Hospice
IN	Hospital Indemnity—refers to those policies where benefits <i>cannot</i> be assigned and it is <i>not</i> an income replacement policy
MA	Medicare Supplement Part A
MB	Medicare Supplement Part B
MD	Physician—coverage includes services provided and billed by a health care professional
MH	Medicare Replacement HMO
PS	Psychiatric—physician coverage includes services provided and billed by a health care professional



- RX Pharmacy
- SC Nursing Home Skilled Care
- SU Surgical
- VI Vision

5.4 COMMERCIAL MANAGED HEALTH CARE PLANS

Employers frequently offer commercial managed health care plans to their employees in an effort to keep insurance costs more reasonable. Most of these policies require the patient to use the plan’s designated health care providers. Other providers are considered “out-of-plan” and those services are *not* reimbursed by the commercial managed health care plan unless a referral was made by the commercial managed health care plan provider or, in the case of emergencies, the plan authorized the services (usually within 48 hours after the service was provided). Some commercial managed-care policies pay an out-of-plan provider at a reduced rate.

At this time, MO HealthNet reimburses providers who are *not* affiliated with the commercial managed health care plan. The provider *must* attach a denial from the commercial managed-care plan to the MO HealthNet claim form for MO HealthNet to consider the claim for payment.

Frequently, commercial managed health care plans require a copayment from the patient in addition to the amounts paid by the insurance plan. MO HealthNet does *not* reimburse copayments. This copayment may *not* be billed to the MO HealthNet participant or the participant's guardian caretaker. In order for a copayment to be collected the parent, guardian or responsible party *must* also be the subscriber or policyholder on the insurance policy and *not* a MO HealthNet participant.

5.5 MEDICAL SUPPORT

It is common for courts to require (usually in the case of divorce or separation) that the noncustodial parent provide medical support through insurance coverage for their child(ren). Medical support is included on all administrative orders for child support established by the Family Support Division.

At the time the provider obtains MO HealthNet and third party resource information from the child’s caretaker, the provider should ask whether this type of resource exists. Medical support is a primary resource. There are new rules regarding specific situations for which the provider can require the MO HealthNet agency to collect from the medical support resource. Refer to Section 5.7 for details.

It *must* be stressed that if the provider opts *not* to collect from the third party resource in these situations, recovery is limited to the MO HealthNet payment amount. By accepting MO HealthNet reimbursement, the provider gives up the right to collect any additional amounts due from the



insurance resource. Federal regulation requires any excess amounts collected by the MO HealthNet agency be distributed to the participant/policyholder.

5.6 PROVIDER CLAIM DOCUMENTATION REQUIREMENTS

MO HealthNet is *not* responsible for payment of claims denied by the third party resource if all required forms were *not* submitted to the TPR, if the TPR's claim filing instructions were *not* followed, if the TPR needs additional information to process the claim or if any other payment precondition was *not* met. Postpayment review of claims may be conducted to verify the validity of the insurance denial. The MO HealthNet payment amount is recovered if the denial is related to reasons noted above and MO HealthNet paid the claim. MO HealthNet's timely filing requirements are *not* extended due to difficulty in obtaining the necessary documentation from the third party resource for filing with MO HealthNet. Refer to Section 4 regarding timely filing limitations.

If the provider or participant is having difficulty obtaining the necessary documentation from the third party resource, the provider should contact Program Relations, (573) 751-2896, or the TPL Unit directly, (573) 751-2005, for further instructions. *Because difficulty in obtaining necessary TPR documentation does not extend MO HealthNet's timely filing limitations, please contact the TPL Unit or Provider Relations early to obtain assistance.*

5.6.A EXCEPTION TO TIMELY FILING LIMIT

The 12-month initial filing rule can be extended if a third party payer, after making a payment to a provider, being satisfied that the payment is proper and correct, later reverses the payment determination, sometimes after 12 months have elapsed, and requests the provider to return the payment. Because TPL was clearly available to cover the full amount of liability, and this was known to the provider, the provider may not have initially filed a claim with the State agency. The problem occurs when the provider, after having repaid the third party, wishes to file the claim with MO HealthNet, and is unable to do so because more than 12 months have elapsed since the date of service. Under this set of circumstances, the provider may file a claim with the MO HealthNet agency later than 12 months from the date of service. The provider *must* submit this type of claim to the Third Party Liability Unit at P.O. Box 6500, Jefferson City, MO 65102-6500 for special handling. The state may accept and pay this type of claim without regard to the 12-month rule; however, the 24-month rule as found in 45 CFR 95.7 still applies.



5.6.B TPR CLAIM PAYMENT DENIAL

If the participant eligibility file indicates there is applicable insurance coverage relating to the provider's claim type and a third party payment amount is *not* indicated on the claim, or documentation is *not* attached to indicate a bonafide denial of payment by the insurance company, the claim is denied for MO HealthNet payment.

A bonafide denial is defined as an explanation of benefits from an insurance plan that clearly states that the submitted services are *not* payable for reasons other than failure to meet claim filing requirements. For instance, a denial from a TPR stating the service is *not* covered by the plan, exceeds usual and customary charges, or was applied to a deductible are all examples of bonafide denials. The MO HealthNet agency *must* be able to identify that the denial originated from the TPR and the reason for the denial is clearly stated. If the insurance company uses denial codes, be sure to include the explanation of that code. A handwritten note from the provider or from an unidentifiable source is *not* a bonafide denial.

The claim is denied if the "Other" accident box in Field #10 of the CMS-1500 claim form is marked and the eligibility file indicates there is an insurance coverage code of 40. MO HealthNet denies payment if the claim does *not* indicate insurance payment or there is no bonafide TPR denial attached to the claim. Do *not* mark this box unless the services are applicable to an accident.

To avoid unnecessary delay in payment of claims, it is extremely important to follow the claim completion instructions relating to third party liability found in the provider manual. Incorrect completion of the claim form may result in denial or a delay in payment of the claim.

5.7 THIRD PARTY LIABILITY BYPASS

There are certain claims that are *not* subjected to Third Party Liability edits in the MO HealthNet payment system. These claims are paid subject to all other claim submission requirements being met. MO HealthNet seeks recovery from the third party resource after MO HealthNet reimbursement has been made to the provider. If the third party resource reimburses MO HealthNet more than the maximum MO HealthNet allowable, by federal regulation this overpayment *must* be forwarded to the participant/policyholder.

The provider may choose *not* to pursue the third party resource and submit a claim to MO HealthNet. The provider's payment is limited to the maximum MO HealthNet allowable. The following services bypass Third Party Liability edits in the MO HealthNet claims payment system:

- The claim is for personal care or homemaker/chore services.
- The claim is for adult day health care.



- The claim is for intellectually disabled/developmentally disabled (ID/DD) waiver services.
- The claim is for a child who is covered by a noncustodial parent's medical support order.
- The claim is related to preventative pediatric care for participants under age 21 and the preventative service is the primary diagnosis on the claim.
- The claim relates to prenatal care for pregnant women and has a primary diagnosis of pregnancy or has one of the following procedure codes listed:

59400	Global Delivery—Vaginal
59425, 59426	Global Prenatal
59510	Global Cesarean

5.8 MO HEALTHNET INSURANCE RESOURCE REPORT (TPL-4)

Many times a provider may learn of a change in insurance information prior to MO HealthNet as the provider has an immediate contact with their patients. If the provider learns of new insurance information or of a change in the TPL information, they may submit the information to the MO HealthNet agency to be verified and updated to the participant's eligibility file.

The provider may report this new information to the MO HealthNet agency using the MO HealthNet Insurance Resource Report. Complete the form as fully as possible to facilitate the verification of the information. Do *not* attach claims to process for payment. They *cannot* be processed for payment due to the verification process.

Please allow six to eight weeks for the information to be verified and updated to the participant's eligibility file. Providers wanting confirmation of the state's response should indicate so on the form and ensure the name and address information is completed in the spaces provided.

5.9 LIABILITY AND CASUALTY INSURANCE

Injuries resulting from an accident/incident (i.e., automobile, work-related, negligence on the part of another person) often place the provider in the difficult position of determining liability. Some situations may involve a participant who:

- is a pedestrian hit by a motor vehicle;
- is a driver or passenger in a motor vehicle involved in an accident;
- is employed and is injured in a work-related accident;
- is injured in a store, restaurant, private residence, etc., in which the owner may be liable.

The state monitors possible accident-related claims to determine if another party may be liable; therefore, information given on the claim form is very important in assisting the state in researching



accident cases. 13 CSR 4.030 and 13 CSR 4.040 requires the provider to report the contingent liability to the MO HealthNet Division.

Often the final determination of liability is *not* made until long after the accident. In these instances, claims for services may be billed directly to MO HealthNet prior to final determination of liability; however, it is important that MO HealthNet be notified of the following:

- details of the accident (i.e., date, location, approximate time, cause);
- any information available about the liability of other parties;
- possible other insurance resources;
- if a lien was filed prior to billing MO HealthNet.

This information may be submitted to MO HealthNet directly on the claim form, by calling the TPL Unit, (573) 751-2005, or by completing the Accident Report. Providers may duplicate this form as needed.

5.9.A TPL RECOVERY ACTION

Accident-related claims are processed for payment by MO HealthNet. The Third Party Liability Unit seeks recovery from the potentially liable third party on a postpayment basis. Once MO HealthNet is billed, the MO HealthNet payment precludes any further recovery action by the provider. The MO HealthNet provider may *not* then bill the participant or his/her attorney.

5.9.B LIENS

Providers may *not* file a lien for MO HealthNet covered services after they have billed MO HealthNet. If a lien was filed prior to billing MO HealthNet, and the provider subsequently receives payment from MO HealthNet, the provider *must* file a notice of lien withdrawal for the covered charges with a copy of the withdrawal notice forwarded to:

MO HealthNet Division
Third Party Liability Unit
P.O. Box 6500
Jefferson City, MO 65102-6500.

5.9.C TIMELY FILING LIMITS

MO HealthNet timely filing rules are *not* extended past specified limits, if a provider chooses to pursue the potentially liable third party for payment. If a court rules there is no liability or the provider is *not* reimbursed in full or in part because of a limited settlement amount, the provider may *not* bill the participant for the amounts in question even if MO Healthnet's timely filing limits have been exceeded.



5.9.D ACCIDENTS WITHOUT TPL

MO HealthNet should be billed directly for services resulting from accidents that do *not* involve any third party liability or where it is probable that MO HealthNet is the only coverage available.

Examples are:

- An accidental injury (e.g., laceration, cut, broken bone) occurs as a result of the participant's own action.
- A MO HealthNet participant is driving (or riding in) an uninsured motor vehicle that is involved in a *one* vehicle accident and the participant or driver has no uninsured motorists insurance coverage.

If the injury is obviously considered to be “no-fault” then it should be clearly stated. *Providers must be sure to fill in all applicable blocks on the claim form concerning accident information.*

5.10 RELEASE OF BILLING OR MEDICAL RECORDS INFORMATION

The following procedures should be followed when a MO HealthNet participant requests a copy of the provider’s billing or medical records for a claim paid by or to be filed with MO HealthNet.

- If an attorney is involved, the provider should obtain the full name of the attorney.
- In addition, the provider should obtain the name of any liable party, the liable insurance company name, address and policy number.
- Prior to releasing bills or medical records to the participant, the provider *must* either contact the MO HealthNet Division, Third Party Liability Unit, P.O. Box 6500, Jefferson City, MO 65102-6500, (573) 751-2005, or complete a MO HealthNet Accident Report or MO HealthNet Insurance Resource Report as applicable. If the participant requires copies of bills or medical records for a reason other than third party liability, it is *not* necessary to contact the Third Party Liability Unit or complete the forms referenced above.
- Prior to releasing bills or medical records to the participant, the provider *must* stamp or write across the bill, “Paid by MO HealthNet” or “Filed with MO HealthNet” in compliance with 13 CSR 70-3.040.

5.11 OVERPAYMENT DUE TO RECEIPT OF A THIRD PARTY RESOURCE

If the provider receives payment from a third party resource after receiving MO HealthNet reimbursement for the covered service, the provider *must* promptly submit an Individual Adjustment Request form to MO HealthNet for the partial or full recovery of the MO HealthNet payment. The



amount to be refunded *must* be the full amount of the other resource payment, *not* to exceed the amount of the MO HealthNet payment. Refer to Section 6 for information regarding adjustments.

5.12 THE HEALTH INSURANCE PREMIUM PAYMENT (HIPP) PROGRAM

The Health Insurance Premium Payment (HIPP) Program is a MO HealthNet Program that pays for the cost of health insurance premiums for certain MO HealthNet participants. The program purchases health insurance for MO HealthNet-eligible participants when it is determined cost effective. Cost effective means that it costs less to buy the health insurance to cover medical care than to pay for the same services with MO HealthNet funds. The HIPP Program *cannot* find health insurance policies for MO HealthNet participants, rather it purchases policies already available to participants through employers, former employers, labor unions, credit unions, church affiliations, other organizations, or individual policies. Certain participants may have to participate in this program as a condition of their continued MO HealthNet eligibility. Other participants may voluntarily enroll in the program. Questions about the program can be directed to:

MO HealthNet Division
TPL Unit - HIPP Section
P.O. Box 6500
Jefferson City, MO 65102-6500
or by calling (573) 751-2005.

5.13 DEFINITIONS OF COMMON HEALTH INSURANCE TERMINOLOGY

COINSURANCE: Coinsurance is a percentage of charges for a specific service, which is the responsibility of the beneficiary when a service is delivered. For example, a beneficiary may be responsible for 20 percent of the charge of any primary care visits. MO HealthNet pays only up to the MO HealthNet allowable minus any amounts paid by the third party resource regardless of any coinsurance amount.

COMPREHENSIVE INSURANCE PLAN: The comprehensive plan is also sometimes called a wraparound plan. Despite the name, comprehensive plans do not supply coverage as extensive as that of traditional insurance. Instead these plans are labeled “comprehensive” because they have no separate categories of insurance coverage. A comprehensive plan operates basically like a full major medical plan, with per-person and per-family deductibles, as well as coinsurance requirements.

COPAYMENT: Copayments are fixed dollar amounts identified by the insurance policy that are the responsibility of the patient; e.g., \$3 that a beneficiary must pay when they use a particular



service or services. MO HealthNet cannot reimburse copayment amounts. An insurance plan's copayment requirements should not be confused with the MO HealthNet cost sharing (copayment, coinsurance, shared dispensing fee) requirements established for specific MO HealthNet services.

DEDUCTIBLE: Deductibles are amounts that an individual must pay out-of-pocket before third party benefits are made available to pay health care costs. Deductibles may be service specific and apply only to the use of certain health care services, or may be a total amount that must be paid for all service use, prior to benefits being available. MO HealthNet pays only up to the MO HealthNet allowable regardless of the deductible amount.

FLEXIBLE BENEFIT OR CAFETERIA PLANS: Flexible benefit plans operate rather like a defined contribution pension plan in that the employer pays a fixed and predetermined amount. Employees generally share some portion of the plan's premium costs and thus are at risk if costs go up. Flexible benefit plans allow employees to pick what benefits they want. Several types of flexible programs exist, and three of the more popular forms include modular packages, core-plus plans, and full cafeteria plans.

Modular plans offer a set number of predetermined policy options at an equal dollar value but includes different benefits. Core-plus plans have a set "core" of employer-paid benefits, which usually include basic hospitalization, physician, and major medical insurance. Other benefit options, such as dental and vision, can be added at the employees' expense. Full cafeteria plans feature employer-paid "benefit dollars" which employees can use to purchase the type of coverage desired.

MANAGED CARE PLANS: Managed care plans generally provide full protection in that subscribers incur no additional expenses other than their premiums (and a copay charge if specified). These plans, however, limit the choice of hospitals and doctors.

Managed care plans come in two basic forms. The first type, sometimes referred to as a staff or group model health maintenance organization, encompasses the traditional HMO model used by organizations like Kaiser Permanente or SANUS. The physicians are salaried employees of the HMO, and a patient's choice of doctors is often determined by who is on call when the patient visits.

The second type of managed care plan is known as an individual (or independent) practice association (IPA) or a preferred provider organization (PPO), each of which is a network of doctors who work individually out of their own offices. This arrangement gives the patient some degree of choice within the group. If a patient goes outside the network, however, the plan reimburses at a lower percentage. Generally an IPA may be prepaid, while a PPO is similar to a traditional plan, in that claims may be filed and reimbursed at a predetermined rate if the services of a participating doctor are utilized. Some IPAs function as HMOs.



SELF-INSURANCE PLANS: An alternative to paying premiums to an insurance company or managed-care plan is for an employer to self-insure. One way to self-insure is to establish a section 501(c)(9) trust, commonly referred to as a VEBA (Voluntary Employee Benefit Association). The VEBA must represent employees' interest, and it may or may not have employee representation on the board. It is, in effect, a separate entity or trust devoted to providing life, illness, or accident benefits to members.

A modified form of self-insurance, called minimum premium, allows the insurance company to charge only a minimum premium that includes a specified percentage of projected annual premiums, plus administrative and legal costs (retention) and a designated percentage of the annual premium. The employer usually holds the claim reserves and earns the interest paid on these funds.

Claims administration may be done by the old insurance carrier, which virtually guarantees replication of the former insurance program's administration. Or the self-insurance program can be serviced through the employer's own benefits office, an option commonly employed by very large companies of 10,000 or more employees. The final option is to hire an outside third-party administrator (TPA) to process claims.

TRADITIONAL INSURANCE PLAN: Provides first-dollar coverage with usually three categories of benefits: (1) hospital, (2) medical/surgical, and (3) supplemental major medical, which provides for protection for medical care not covered under the first two categories. Variations and riders to these plans may offer coverage for maternity care, prescription drugs, home and office visits, and other medical expenses.

<p>END OF SECTION <u>TOP OF SECTION</u></p>
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SECTION 6-ADJUSTMENTS

6.1 GENERAL REQUIREMENTS

MO HealthNet Division (MHD) continues to improve their billing website at www.emomed.com to provide real-time direct access for administrators, providers, and clearinghouse users. This describes the process and tools providers should use to adjust claims.

6.2 INSTRUCTIONS FOR ADJUSTING CLAIMS WITHIN 24 MONTHS OF DATE OF SERVICE

MHD developed an easy to use, web-based tool to adjust incorrectly billed and/or paid Medicaid and Medicare crossover claims. Providers shall utilize the web-based adjustment tool to adjust or void their own claims, if the date of service (DOS) on the claim to be adjusted was within two (2) years of the date of the Remittance Advise on which payment was made.

6.2.A NOTE: PROVIDERS MUST BE ENROLLED AS AN ELECTRONIC BILLING PROVIDER BEFORE USING THE ONLINE CLAIM ADJUSTMENT TOOL

Providers *must* be enrolled as an electronic billing provider before using the online claim adjustment tool. See Section 2.1.D.

To apply for Internet access, please access the [emomed](http://emomed.com) website found on the following website address: www.emomed.com. Access the “[Register Now!](#)” hyperlink to apply online for Internet access and follow the instructions provided. Providers must have proper authorization to access www.emomed.com, for each individual user.

6.2.B ADJUSTING CLAIMS ONLINE

Providers may adjust claims within two (2) years of the DOS, by logging onto the MHD billing site at www.emomed.com. To find the claim to be adjusted, the provider should enter the participant Departmental Client Number (DCN) and DOS in the search box, and choose the highlighted Internal Control Number (ICN). Paid claims can be adjusted by the “Void” option or “Replacement” option. Denied claims can be adjusted by the “Copy Claim Original” or Copy Claim Advanced” option.

6.2.B(1) Options for Adjusting a Paid Claim

If there is a paid claim in the MHD emomed system, then the claim can be voided or replaced.



The provider should choose “Void” to delete a paid claim. A voided claim credits the system and reverses the payment. A void option should be chosen when the entire claim needs to be canceled and the payment is reversed and credited in the system. Providers do not void claims often because this option is only chosen when a claim should not have been submitted. This includes when the wrong DCN or billing Nations Provider Identifier (NPI) was entered on the claim.

The provider should choose “Replacement” to make corrections or additions to a paid claim. A replacement option should be chosen when editing a paid claim. Providers will use this option more often than the void option because the claim was billed incorrectly. This includes when the wrong DOS, diagnosis, charge amount, modifier, procedure code, or POS was entered on the claim.

6.2.B(1)(i) Void

To void a claim from the claim status screen on emomed, choose the void tab. This will bring up the paid claim in the system; scroll to the bottom of the claim and chose select the highlighted ‘submit claim’ button. The claim now has been submitted to be voided or credited in the system.

6.2.B(1)(ii) Replacement

To replace a claim from the claim status screen on emomed, choose the replacement tab. This will bring up the paid claim in the system; here corrections can be made to the claim by selecting the appropriate edit button, then saving the changes. Now scroll to the bottom of the claim and select the highlighted ‘submit claim’ button. The replacement claim with corrections has now been submitted.

6.2.B(2) Options for Adjusting a Denied Claim

If there is a denied claim in the MHD emomed system, then the claim can be resubmitted as a New Claim. A denied claim can also be resubmitted by choosing Timely Filing, Copy Claim-original, or Copy Claim-advanced.

6.2.B(2)(i) Timely Filing

To reference timely filing, choose the Timely Filing tab on the claim status screen on emomed. This function automatically places the ICN of the claim chosen (make sure the claim was the original claim submitted within the timely filing guidelines). Scroll to the bottom and select the highlighted ‘submit claim’ button. The claim has now been submitted for payment.



6.2.B(2)(ii) Copy Claim – Original

This option is used to copy a claim just as it was entered originally on emomed. Corrections can be made to the claim by selecting the appropriate edit button, and then saving the changes. Now scroll to the bottom of the claim and select the highlighted submit claim button. The claim has now been submitted with the corrections made.

6.2.B(2)(iii) Copy Claim – Advanced

This option is used when the claim was filed using the wrong NPI number or wrong claim form. An example would be if the claim was entered under the individual provider NPI and should have been submitted under the group provider NPI. If the claim was originally filed under the wrong claim type, only the participant DCN and Name information will transfer over to the new claim type. An example would be if the claim was submitted on a Medical claim and should have been submitted as a Crossover claim.

6.2.C CLAIM STATUS CODES

After the adjusted claim is submitted, the claim will have one of the following status indicator codes.

C – This status indicates that the claim has been Captured and is still processing. This claim should not be resubmitted until it has a status of I or K.

I – This status indicates that the claim is to be Paid.

K – This status indicates that the claim is to be Denied. This claim can be corrected and resubmitted immediately.

Provider Communications Unit may be contacted at (573) 751-2896, for questions regarding proper claim filing, claims resolution and disposition, and participant eligibility questions and verifications. Please contact Provider Education Unit at (573) 751-6683 or email mhd.provtrain@dss.mo.gov for education and training on proper billing methods and procedures for MHD claims.

6.3 INSTRUCTIONS FOR ADJUSTING CLAIMS OLDER THAN 24 MONTHS OF DOS

Providers who are paid incorrectly for a claim that is older than 24 months are required to complete a Self-Disclosure letter to be submitted to Missouri Medicaid Audit and Compliance (MMAC). Access the MMAC website for the Self-Disclosure Form located at the following website address: <http://mmac.mo.gov/providers/self-audits-Self-Disclosures/>.



MMAC encourages providers and entities to establish and implement a compliance integrity plan. MMAC also encourages providers and entities to self-disclose or report those findings along with funds to compensate for the errors or a suggested repayment plan, which requires MMAC approval, to the Financial Section of MMAC at the address below:

Missouri Medicaid Audit & Compliance
Financial Section – SELF-DISCLOSURE
P.O. Box 6500
Jefferson City, MO 65102-6500

In an effort to ensure Provider Initiated Self-Disclosures are processed efficiently, make sure to complete the form and include the participant's name, DCN, DOS, ICN, Paid Amount, Refund Amount and Reason for Refund. Providers can direct questions regarding Self-Disclosures to MMAC Financial Section at mmac.financial@dss.mo.gov or by calling 573-751-3399.

6.4 EXPLANATION OF THE ADJUSTMENT TRANSACTIONS

There are two (2) types of adjustment transactions:

1. An adjustment that credits the original payment and then repays the claim based on the adjusted information appears on the Remittance Advice as a two-step transaction consisting of two ICN's.
 - An ICN that credits (recoups) the original paid amount and
 - An ICN that repays the claim with the corrected payment amount.
2. An adjustment that credits or recoups the original payment but does not repay the claim (resulting in zero payment) appears on the Remittance Advice with one ICN that credits (recoups) the original paid amount.

END OF SECTION

[TOP OF SECTION](#)



SECTION 7-MEDICAL NECESSITY

7.1 CERTIFICATE OF MEDICAL NECESSITY

The MO HealthNet Program requires that the Certificate of Medical Necessity form accompany claims for reimbursement of certain procedures, services or circumstances. Section 13, Benefits and Limitations, identifies circumstances for which a Certificate of Medical Necessity form is required for each program. Additional information regarding the use of this form may also be found in Section 14, Special Documentation Requirements.

Listed below are several examples of claims for payment that *must* be accompanied by a completed Certificate of Medical Necessity form. This list is *not* all inclusive.

- Claims for services performed as emergency procedures which, under non-emergency circumstances, require special documentation such as a Prior Authorization Request.
- Claims for inpatient hospital private rooms unless all patient rooms in the facility are private.
- Claims for services for TEMP participants that are *not* covered by the TEMP Program but without which the pregnancy would be adversely affected.
- Claims for specific durable medical equipment.

Use of this form for other than the specified conditions outlined in the provider's manual has *no* bearing on the payment of a claim.

The medical reason why the item, service, or supplies were needed *must* be stated fully and clearly on the Certificate of Medical Necessity form. The form *must* be related to the particular patient involved and *must* detail the risk to the patient if the service(s) had *not* been provided.

The Certificate of Medical Necessity form *must* be either submitted electronically with the electronic claim or submitted on paper attached to the original claim form. For information regarding submission of the Certificate of Medical Necessity for claims submitted by a Durable Medical Equipment provider see Section 7.1.A. If a claim is resubmitted, the provider *must* again attach a copy of the Certificate of Medical Necessity form.

Medical consultants and medical review staff review the Certificate of Medical Necessity form and the claim form to make a determination regarding payment of the claim. If the medical necessity of the service is supported by the documentation, the claim is approved for further processing. If medical necessity is *not* documented or supported, the claim is denied for payment.



7.1.A CERTIFICATE OF MEDICAL NECESSITY FOR DURABLE MEDICAL EQUIPMENT PROVIDERS

The Certificate of Medical Necessity for durable medical equipment should *not* be submitted with a claim form. This attachment may be submitted via the Internet (see Section 3.8 and Section 23) or mailed to:

Wipro Infocrossing
 P.O. Box 5900
 Jefferson City, MO 65102-5900

If the Certificate of Medical Necessity is approved, the approved time period is six (6) months from the prescription date. Any claim matching the criteria (including the type of service) on the Certificate of Medical Necessity for the approved time period can be processed for payment without a Certificate of Medical Necessity attached. This includes all monthly claim submissions and any resubmissions.

7.2 INSTRUCTIONS FOR COMPLETING THE CERTIFICATE OF MEDICAL NECESSITY

FIELD NUMBER & NAME	INSTRUCTIONS FOR COMPLETION
1. Patient Name	Enter last name, first name and middle initial as shown on the ID card.
2. Participant MO HealthNet ID Number	Enter the 8-digit MO HealthNet ID number exactly as it appears on the participant’s ID card or letter of eligibility.
3. Procedure/Revenue Codes	Enter the appropriate CPT-4 code, CDT-3 code, revenue code or HCPCS procedure code (maximum of 6 procedure/revenue codes allowed per claim, 1 code per line).
4. Description of Item/Service	For each procedure/revenue code listed, describe in detail the service or item being provided.
5. Reason for Service	For each procedure/revenue code listed, state clearly the medical necessity for this service/item.



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|---|---|
| 6. Months Item Needed
(DME only) | For each procedure code listed, enter the amount of time the item is necessary (Durable Medical Equipment Program only). |
| 7. Name and Signature of
Prescriber | The prescriber's signature, when required, <i>must</i> be an original signature. A stamp or the signature of a prescriber's employee is <i>not</i> acceptable. A signature is <i>not</i> required here if the prescriber is the provider (Fields #12 thru #14). |
| 8. Prescriber's MO HealthNet
Provider Identifier | Enter the NPI number if the prescriber participates in the MO HealthNet Program. |
| 9. Date Prescribed | Enter the date the service or item was prescribed or identified by the prescriber as medically necessary in month/date/year numeric format, if required by program. This date <i>must</i> be prior to or equal to the date of service. |
| 10. Diagnosis | Enter the appropriate ICD code(s) that prompted the request for this service or item, if required by program. |
| 11. Prognosis | Enter the participant's prognosis and the anticipated results of the requested service or item. |
| 12. Provider Name and Address | Enter provider's name, address, and telephone number. |
| 13. MO HealthNet Provider
Identifier | Enter provider's NPI number. |
| 14. Provider Signature | The provider <i>must</i> sign here with an original signature. This certifies that the information given on the form is true, accurate and complete. |

END OF SECTION
[TOP OF PAGE](#)



SECTION 8-PRIOR AUTHORIZATION

8.1 BASIS

Under the MO HealthNet Program, certain covered services and equipment require approval prior to provision of the service as a condition of reimbursement. Prior authorization is used to promote the most effective and appropriate use of available services and to determine the medical necessity of the service.

A prior authorization or precertification determines medical necessity of service(s) provided to the participant. It does *not* guarantee payment nor does it guarantee participant eligibility.

A prior authorization or precertification determines the number of units, hours and/or the types of services that may be provided to a participant based on the medical necessity of that service. The provider should *not* submit claims solely on the basis of the prior authorization and/or precertification, but *must* submit claims upon actual services rendered. Providers *must* retain the appropriate documentation that services were provided on the date of service submitted on the claim. Documentation should be retained for five (5) years.

Please refer to Sections 13 and 14 of the applicable provider manual for program-specific information regarding prior authorization.

8.2 PRIOR AUTHORIZATION GUIDELINES

Providers are required to seek prior authorization for certain specified services *before* delivery of the services. In addition to services that are available through the traditional MO HealthNet Program, expanded services are available to children 20 years of age and under through the Healthy Children and Youth (HCY) Program. Some expanded services also require prior authorization. Certain services require prior authorization only when provided in a specific place or when they exceed certain limits. These limitations are explained in detail in Sections 13 and 14 of the applicable provider manuals.

The following general guidelines pertain to all prior authorized services:

- A Prior Authorization (PA) Request *must* be completed and mailed to the appropriate address. Unless otherwise specified in Sections 13 and 14 of the applicable provider manual, mail requests to:

Wipro Infocrossing
P.O. Box 5700
Jefferson City, MO 65102-5700

A PA Request form may be printed and completed by hand or the form may be completed in Adobe and then printed. To enter information into a field, either click in the field or tab to the



field and complete the information. When all the fields are completed, print the PA Request and send to the address listed above.

- The provider performing the service *must* submit the PA Request form. Sufficient documentation or information *must* be included with the request to determine the medical necessity of the service.
- The service *must* be ordered by a physician, nurse practitioner, dentist, or other appropriate health care provider.
- Do *not* request prior authorization for services to be provided to an ineligible person (see Sections 1 and 13 of the applicable provider manual).
- Expanded HCY (EPSDT) services are limited to participants 20 years of age and under and are *not* reimbursed for participants 21 and over even if prior authorized.
- See Section 20 for specific criteria and guidelines regarding prior authorization of non-covered services through the Exceptions Process for participants 21 and over.
- Prior authorization does *not* guarantee payment if the participant is or becomes enrolled in managed care and the service is a covered benefit.
- Payment is *not* made for services initiated before the approval date on the PA Request form or after the authorization deadline.
- For services to continue after the expiration date of an existing PA Request, a new PA Request *must* be completed and submitted prior to the end of the current PA.

8.3 PROCEDURE FOR OBTAINING PRIOR AUTHORIZATION

Complete the Prior Authorization (PA) Request form describing in detail those services or items requiring prior authorization and the reason the services or items are needed. With the exception of x-rays, dental molds, and photos, documentation submitted with the PA Request is *not* returned. Providers should retain a copy of the original PA Request and any supporting documentation submitted for processing. Instructions for completing the PA Request form are on the back of the form. *Unless otherwise stated in Section 13 or 14 of the applicable provider manual*, mail the PA Request form and any required attachments to:

Wipro Infocrossing
P.O. Box 5700
Jefferson City, Missouri 65102-5700

The appropriate program consultant reviews the request. A MO HealthNet Authorization Determination is returned to the provider with any stipulations for approval or reason for denial. If approved, services may *not* exceed the frequency, duration or scope approved by the consultant. If the service or item requested is to be manually priced, the consultant enters the allowed amount on the MO HealthNet



Authorization Determination. The provider should keep the approved MO HealthNet Authorization Determination for their files; do *not* return it with the claim.

After the authorized service or item is provided, the claim form *must* be completed and submitted in the usual manner. **Providers are cautioned that an approved authorization approves only the medical necessity of the service and does *not* guarantee payment. Claim information *must* still be complete and correct, and the provider and the participant *must* both be eligible at the time the service is rendered or item delivered. Program restrictions such as age, category of assistance, managed care, etc., that limit or restrict eligibility still apply and services provided to ineligible participants are *not* reimbursed.**

If the PA Request is denied, the provider receives a MO HealthNet Authorization Determination (reference Section 8.7 of this manual). The participant is notified by letter each time a PA Request is denied. (Reference Section 1 of this manual for additional information regarding the PA Request Denial letter.)

8.4 EXCEPTIONS TO THE PRIOR AUTHORIZATION REQUIREMENT

Exceptions to prior authorization requirements are limited to the following:

- Medicare crossovers when Medicare makes the primary reimbursement and MO HealthNet pays only the coinsurance and deductible.
- Procedures requiring prior authorization that are performed incidental to a major procedure.
- Services performed as an emergency. An emergency medical condition for a MO HealthNet participant means a medical or behavioral health condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in the following:
 1. Placing the physical or behavioral health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; or
 2. Serious impairment of bodily functions; or
 3. Serious dysfunction of any bodily organ or part; or
 4. Serious harm to self or others due to an alcohol or drug abuse emergency; or
 5. Injury to self or bodily harm to others; or
 6. With respect to a pregnant woman having contractions: (a) there is no adequate time to affect a safe transfer to another hospital before delivery; or (b) that transfer may pose a threat to the health or safety of the woman or the unborn child.

Post stabilization care services mean covered services, related to an emergency medical condition that are provided after a participant is stabilized in order to maintain the stabilized condition or to improve or resolve the participant's condition.



In the case of an emergency when prior authorization *cannot* be obtained before the service or item is rendered, the necessary and appropriate emergency service should be provided. Complete the claim form and write “emergency” across the top of the claim form. Do *not* submit a Prior Authorization (PA) Request form.

Attach a Certificate of Medical Necessity form to the claim and submit it to the appropriate address (reference Section 15). The provider *must* state on the Certificate of Medical Necessity form, in detail, the reason for the emergency provision of service. (See Section 7 for information on completing a Certificate of Medical Necessity form.)

Emergency requests are suspended and reviewed by the appropriate medical consultant. If the Certificate of Medical Necessity form is *not* attached or the reason does *not* substantiate the provision of the service on an emergency basis, the claim is denied.

- The participant was *not* eligible for MO HealthNet at the time of service, but eligibility was made retroactive to that time. Submit a claim along with a Certificate of Medical Necessity form to the appropriate address (reference Section 15). The provider *must* state on the Certificate of Medical Necessity form that the participant was *not* eligible on the date of service, but has become eligible retroactively to that date. The provider *must* also include, in detail, the reason for the provision of service. (See Section 7 for information on completing a Certificate of Medical Necessity form.) Retroactive eligibility requests are suspended and reviewed by the appropriate medical consultant. If the Certificate of Medical Necessity form is *not* attached or the reason does *not* substantiate the provision of the service, the claim is denied.

8.5 INSTRUCTIONS FOR COMPLETING THE PRIOR AUTHORIZATION (PA) REQUEST FORM

Instructions for completing the Prior Authorization (PA) Request form are printed on the back of the form. Additional clarification is as follows:

- Section II, HCY Service Request, is applicable for participants 20 years of age and under and should be completed when the information is known.
- In Section III, Service Information, the gray area is for state use only.

Field #24 in Section III, in addition to being used to document medical necessity, can also be used to identify unusual circumstances or to provide detailed explanations when necessary. Additional pages may be attached to the PA Request for documentation.

Also, the PA Request forms *must* reflect the appropriate service modifier with procedure code and other applicable modifiers when requesting prior authorization for the services defined below:

Service



Modifier	Definition
26	Professional Component
54	Surgical Care Only
55	Postoperative Management Only
80	Assistant Surgeon
AA	Anesthesia Service Performed Personally by Anesthesiologist
NU	New Equipment (required for DME service)
QK	Medical Direction of 2, 3, or 4 Concurrent Anesthesia Procedures Involving Qualified Individuals
QX	CRNA (AA) Service; with Medical Direction by a Physician
QZ	CRNA Service; without Medical Direction by a Physician
RB	Replacement and Repair (required for DME service)
RR	Rental (required for DME service)
SG	Ambulatory Surgical Center (ASC) Facility Services
TC	Technical Component

- Complete each field in Section IV. See Sections 13 and 14 of the applicable provider manual to determine if a signature and date are required in this field. Requirements for signature are program specific.
- Section V, Prescribing/Performing Practitioner, *must* be completed for services which require a prescription such as durable medical equipment, physical therapy, or for services which are prescribed by a physician/practitioner that require prior authorization. Reference the applicable provider manual for additional instructions.

The provider receives a MO HealthNet Authorization Determination (refer to Section 8.6) indicating if the request has been approved or denied. Any comments made by the MO HealthNet/MO HealthNet managed care health plan consultant may be found in the comments section of the MO HealthNet Authorization Determination. The provider does *not* receive the PA Request or a copy of the PA Request form back.

It is the provider’s responsibility to request prior authorization or reauthorization, and to notify the MO HealthNet Division of any changes in an existing period of authorization.

8.5.A WHEN TO SUBMIT A PRIOR AUTHORIZATION (PA) REQUEST

Providers may submit a Prior Authorization (PA) Request to:

- Initiate the start of services that require prior authorization.
- Request continued services when services continue to be medically necessary beyond the current approved period of time.



1. The dates for the services requested *cannot* overlap dates that are already approved and *must* be submitted far enough in advance to obtain approval prior to the expiration of the current approved PA Request.
- Correct a participant MO HealthNet number if the original PA Request had a number on it and services were approved.
 1. When submitting a PA Request due to an error in the participant MO HealthNet number on the original PA Request, attach a copy of the MO HealthNet Authorization Determination giving original approval to the new request.
 2. Fields #17 through #23 in Section III *must* be identical to the original approval.
 3. The PA Request form should be clearly marked as a “correction of the participant MO HealthNet number” and the error *must* be explained in detail in Field #24 of Section III.
 4. Mark the PA Request “*Special Handle*” at the top of the form.
 - Change providers within a group during an approved authorization period.
 1. When submitting a PA Request due to a change of provider *within a group*, attach a copy of the MO HealthNet Authorization Determination showing the approval to the new PA Request form.
 2. Section III, Field #19 “FROM” *must* be the date the new provider begins services and Field 20 “THROUGH” *cannot* exceed the through date of the previously approved PA Request.
 3. The PA Request form should be clearly marked at the top “change of provider,” and the change *must* be explained in Field #24 of Section III.
 4. Mark the PA Request “*Special Handle*” at the top of the form. Use Field #24 to provide a detailed explanation.

8.6 MO HEALTHNET AUTHORIZATION DETERMINATION

The MO HealthNet Authorization Determination is sent to the provider who submitted the Prior Authorization (PA) Request. The MO HealthNet Authorization Determination includes all data pertinent to the PA Request. The MO HealthNet Authorization Determination includes the PA number; the authorized National Provider Identifier (NPI); name and address; the participant's DCN, name, and date of birth; the procedure code, the from and through dates (if approved), and the units or dollars (if approved); the status of the PA Request on each detail line ("A"-approved; "C"-closed; "D"-denied; and "I"-incomplete); and the applicable Explanation of Benefit (EOB) reason(s), with the reason code description(s) on the reverse side of the determination.



8.6.A A DENIAL OF PRIOR AUTHORIZATION (PA) REQUESTS

The MO HealthNet Authorization Determination indicates a denied authorization by reflecting a status on each detail line of "D" for a denial of the requested service or "I" for a denial due to incomplete information on the form. With a denial status of "D" or "I", a new PA Request form *must* be submitted for the request to be reconsidered.

8.6.B MO HEALTHNET AUTHORIZATION DETERMINATION EXPLANATION

The following lists the fields found on the MO HealthNet Authorization Determination and an explanation of each field.

FIELD NAME	EXPLANATION OF FIELD
Date	Date of the disposition letter
Request Number (No.)	Prior Authorization Number
Receipt Date	Date the Prior Authorization (PA) Request was received by the fiscal agent
Service Provider	Authorized NPI number, name and address
Participant	Participant's DCN, name, date of birth and sex
Procedure Code	The procedure code
Modifier	The modifier(s)
Authorization Dates	The authorized from and thru dates
Units	The units requested, units authorized (if approved), units used
Dollars	The dollar amount requested, dollar amount authorized (if approved), dollar amount used
Status	The status codes of the PA Request The status codes are: A—Approved C—Closed D—Denied I—Incomplete
Reason	The applicable EOB reason(s)
Comments	Comments by the consultant which may explain denials or make notations referencing specific procedure code(s)
Physician/Provider Signature	Signature of provider when submitting a Request for Change



	(RFC)
Date	Date of provider’s signature when submitting a RFC
Reason Code Description	Reason code description(s) listed in Reason field

8.7 REQUEST FOR CHANGE (RFC) OF PRIOR AUTHORIZATION (PA) REQUEST

To request a change to an approved Prior Authorization (PA) Request, providers are required to make the applicable changes on the MO HealthNet Authorization Determination. Attach additional documentation per program requirement if the requested change is in frequency, amount, duration or scope or if it documents an error on the original request, e.g., plan of care, physician orders, etc. The amended MO HealthNet Authorization Determination *must* be signed and dated and submitted with applicable documentation to the address below. When changes to an approved PA Request are made on the MO HealthNet Authorization Determination, the MO HealthNet Authorization Determination is referred to as a Request For Change (RFC). **Requests for reconsideration of any detail lines that reflect a "D" or "I" status *must not* be included on a RFC. Providers *must* submit a new PA Request form for reconsideration of denied detail lines.**

When a RFC is approved, a MO HealthNet Authorization Determination incorporating the requested changes is sent to the provider. When a RFC is denied, the MO HealthNet Authorization Determination sent to the provider indicates the same information as the original MO HealthNet Authorization Determination that notified the provider of approval, with an Explanation of Benefit (EOB) stating that the requested changes were considered but were *not* approved.

Providers *must not* submit changes to PA Requests until the MO HealthNet Authorization Determination from the initial request is received.

Unless otherwise stated in Section 13 or 14 of the applicable provider manual, PA Request forms and RFCs should be mailed to:

Wipro Infocrossing
 P. O. Box 5700
 Jefferson City, MO 65102

8.7.A WHEN TO SUBMIT A REQUEST FOR CHANGE

Providers may submit a Request For Change to:

- Correct a procedure code.
- Correct a modifier.
- Add a new service to an existing plan of care.
- Correct or change the “from” or “through” dates.



1. The “from” date may *not* precede the approval date on the original request unless the provider can provide documentation that the original approval date was incorrect.
 2. The “through” date *cannot* be extended beyond the allowed amount of time for the specific program. In most instances extending the end date to the maximum number of days allowed requires additional information or documentation.
- Increase or decrease requested units or dollars.
 1. An increase in frequency and or duration in some programs require additional or revised information.
 - Correct the National Provider Identifier (NPI). The NPI number can only be corrected if both of the following conditions are met:
 - The number on the original request is in error; and
 - The provider was *not* reimbursed for any units on the initial Prior Authorization Request.
 - Discontinue services for a participant.

8.8 DEPARTMENT OF HEALTH AND SENIOR SERVICES (DHSS)

Prior Authorization (PA) Requests and Requests For Change (RFC) for the Personal Care and Home Health Programs' services for children under the age of 21 *must* be submitted to Department of Health and Senior Services (DHSS), Bureau of Special Health Care Needs (BSHCN) for approval consideration. The BSHCN submits the request to Wipro Infocrossing. The BSHCN staff continues to complete and submit PA Requests and RFCs for Private Duty Nursing and Medically Fragile Adult waiver services.

PA Requests and RFCs for AIDS Waiver and Personal Care Programs' services for individuals with HIV/AIDS continue to be completed and submitted by the DHSS, Bureau of HIV, STD and Hepatitis contract case management staff.

All services authorized by the DHSS, Division of Senior and Disability Services (DSDS) or it's designee, are authorized utilizing the Home and Community Based Services (HCBS) Web Tool, a component of the Department of Social Services, MO HealthNet Division's Cyber Access system.

Please reference the provider manual for further information.

8.9 OUT-OF-STATE, NON-EMERGENCY SERVICES

All non-emergency, MO HealthNet-covered services that are to be performed or furnished out of state for eligible MO HealthNet participants and for which MO HealthNet is to be billed, *must* be prior



authorized before the services are provided. Services that are *not* covered by the MO HealthNet Program are *not* approved.

Out of state is defined as *not* within the physical boundaries of the state of Missouri or within the boundaries of any state that physically borders on the Missouri boundaries. Border-state providers of services (those providers located in Arkansas, Illinois, Iowa, Kansas, Kentucky, Nebraska, Oklahoma and Tennessee) are considered as being on the same MO HealthNet participation basis as providers of services located within the state of Missouri.

A PA Request *form* is *not* required for out-of-state non-emergency services. To obtain prior authorization for out-of-state, non-emergency services, *a written request must* be submitted by a physician to:

MO HealthNet Division
Participant Services Unit
P.O. Box 6500
Jefferson City, MO 65102-6500

The request may be faxed to (573) 526-2471.

The written request *must* include:

1. A brief past medical history;
2. Services attempted in Missouri;
3. Where the services are being requested and who will provide them; and
4. Why services can't be performed in Missouri.

NOTE: The out-of-state medical provider *must* agree to complete an enrollment application and accept MO HealthNet reimbursement. Prior authorization for out-of-state services expires 180 days from the date the specific service was approved by the state.

8.9.A EXCEPTIONS TO OUT-OF-STATE PRIOR AUTHORIZATION REQUESTS

The following are exempt from the out-of-state prior authorization requirement:

1. All Medicare/MO HealthNet crossover claims;
2. All foster care children living outside the state of Missouri. However, non-emergency services that routinely require prior authorization continue to require prior authorization by out-of-state providers even though the service was provided to a foster care child;
3. Emergency ambulance services; and
4. Independent laboratory services.

END OF SECTION

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SECTION 9-HEALTHY CHILDREN AND YOUTH PROGRAM

9.1 GENERAL INFORMATION

The Healthy Children and Youth (HCY) Program in Missouri is a comprehensive, primary and preventive health care program for MO HealthNet eligible children and youth under the age of 21 years. The program is also known as Early Periodic Screening, Diagnosis and Treatment (EPSDT). The Social Security Act authorizes Medicaid coverage of medical and dental services necessary to treat or ameliorate defects and physical and mental illness identified by an HCY screen. These services are covered by Medicaid regardless of whether the services are covered under the state Medicaid plan. Services identified by an HCY screening that are beyond the scope of the Medicaid state plan may require a plan of care identifying the treatment needs of the child with regard to amount, duration, scope, and prognosis. Prior authorization (PA) of services may be required for service needs and for services of extended duration. Reference Section 13, Benefits and Limitations, for a description of requirements regarding the provision of services.

Every applicant under age 21 (or his or her legal guardian) is informed of the HCY Program by the Family Support Division income-maintenance Eligibility Specialists at the initial application for assistance. The participant is reminded of the HCY Program at each annual redetermination review.

The goal of the Medicaid agency is to have a health care home for each child—that is, to have a primary care provider who manages a coordinated, comprehensive, continuous health care program to address the child’s health needs. The health care home should follow the screening periodicity schedule, perform interperiodic screens when medically necessary, and coordinate the child’s specialty needs.

9.2 PLACE OF SERVICE (POS)

A full or partial HCY screen may be provided in the following places of service (POS):

- 03 School
- 11 Office
- 12 Home
- 19 Off Campus Outpatient Hospital
- 21 Inpatient Hospital
- 22 On Campus Outpatient Hospital
- 25 Birthing Center
- 71 State or Local Public Health Clinic
- 72 Rural Health Clinic
- 99 Other



9.3 DIAGNOSIS CODE

The Early Periodic Screening diagnosis code *must* appear as the primary diagnosis on a claim form submitted for HCY screening services. The appropriate HCY screening procedure code should be used for the initial HCY screen and all other full or partial screens.

9.4 INTERPERIODIC SCREENS

Medically necessary screens outside the periodicity schedule that do *not* require the completion of all components of a full screen may be provided as an interperiodic screen or as a partial screen. An interperiodic screen has been defined by the Centers for Medicare & Medicaid Services (CMS) as any encounter with a health care professional acting within his or her scope of practice. This screen may be used to initiate expanded HCY services. Providers who perform interperiodic screens may use the appropriate level of Evaluation/Management visit (CPT) procedure code, the appropriate partial HCY screening procedure code, or the procedure codes appropriate for the professional's discipline as defined in their provider manual. Office visits and full or partial screenings that occur on the same day by the same provider are *not* covered unless the medical necessity is clearly documented in the participant's record. The diagnosis for the medical condition necessitating the interperiodic screening *must* be entered in the primary diagnosis field, and the appropriate screening diagnosis should be entered in the secondary diagnosis field.

The interperiodic screen does *not* eliminate the need for full HCY screening services at established intervals based on the child's age.

If not all components of the full or unclothed physical are met, the Reduced Preventive Screening codes *must* be billed.

PROCEDURE

CODE	DESCRIPTION
99381 - 99385	Preventive Screen; new patient
99391 - 99395	Preventive Screen; established patient

9.5 FULL HCY/EPSDT SCREEN

PROCEDURE

CODE	DESCRIPTION
99381EP-99385EP	Full Medical Screening
99391EP-99395EP	
99381EPUC-99385EPUC	Full Medical Screening with Referral
99391EPUC-99395EPUC	



A full HCY/EPSDT screen includes the following:

- A comprehensive unclothed physical examination;
- A comprehensive health and developmental history including assessment of both physical and mental health developments;
- Health education (including anticipatory guidance);
- Appropriate immunizations according to age;*
- Laboratory tests as indicated (appropriate according to age and health history unless medically contraindicated);*
- Lead screening according to established guidelines;
- Hearing screening;
- Vision screening; and
- Dental screening.

It is *not* always possible to complete all components of the full medical HCY screening service. For example, immunizations may be medically contraindicated or refused by the parent/guardian. The parent/guardian may also refuse to allow their child to have a lead blood level test performed. When the parent/guardian refuses immunizations or appropriate lab tests, the provider should attempt to educate the parent/guardian with regard to the importance of these services. If the parent/guardian continues to refuse the service the child's medical record *must* document the reason the service was *not* provided. Documentation may include a signed statement by the parent/guardian that immunizations, lead blood level tests, or lab work was refused. By fully documenting in the child's medical record the reason for *not* providing these services, the provider may bill a full medical HCY screening service even though all components of the full medical HCY screening service were *not* provided.

It is mandatory that the Healthy Children and Youth Screening guide be retained in the patient's medical record as documentation of the service that was provided. The Healthy Children and Youth Screening guide is *not* all-inclusive; it is to be used as a guide to identify areas of concern for each component of the HCY screen. Other pertinent information can be documented in the comment fields of the guide. **The screener *must* sign and date the guide and retain it in the patient's medical record.** The HCY screening guide is not the only method a provider can use to document in the patient's medical record that a service was provided. The provider can also document the screenings in an electronic medical record. If the provider uses an electronic medical record, the electronic version must contain all of the components listed on the HCY screening guide for the patient's appropriate age group.

The Title XIX participation agreement requires that providers maintain adequate fiscal and medical records that fully disclose services rendered, that they retain these records for 5 years, and that they make them available to appropriate state and federal officials on request. The Healthy Children and



Youth Screening guide is found at <http://manuals.momed.com/manuals/presentation/forms.jsp>. Providers *must* have a form in the medical record if billing the screening.

The MO HealthNet Division is required to record and report to the Centers for Medicare & Medicaid Services all HCY screens and referrals for treatment. Reference Sections 13 and 15 for billing instructions. *Claims for the full medical screening and/or full medical screening with referral should be submitted promptly within a maximum of 60 days from the date of screening.*

Office Visits and HCY screenings in which an abnormality or a preexisting problem are addressed in the process of performing the preventive medicine evaluation and management (E/M) service are not billable on the same date of service.

An exception would be if the problem or abnormality is significant enough to require additional work to perform the key components of a problem-oriented E/M service. Diagnosis codes must clearly reflect the abnormality or condition for which the additional follow-up care or treatment is indicated. In addition, the medical necessity must be clearly documented in the participant's record, and the Certificate of Medical Necessity form must be fully completed and attached to the claim when submitting for payment.

If an insignificant or trivial problem/abnormality is encountered in the process of performing the preventive medicine E/M service which does not require significant, additional work and the performance of the key components of a problem-oriented E/M service is not documented in the record, then an additional E/M service should not be reported separately.

*Reimbursement for immunizations and laboratory procedures is *not* included in the screening fee and may be billed separately.

9.5.A QUALIFIED PROVIDERS

The full screen *must* be performed by a MO HealthNet enrolled physician, assistant physician, physician assistant, nurse practitioner or nurse midwife*.

*only infants age 0-2 months; and females age 15-20 years

9.6 PARTIAL HCY/EPSTD SCREENS

Segments of the full medical screen may be provided by different providers. The purpose of this is to increase the access to care for all children and to allow providers reimbursement for those separate screens. When expanded HCY services are accessed through a partial or interperiodic screen, it is the responsibility of the provider completing the partial or interperiodic screening service to have a referral source to send the child for the remaining components of a full screening service.

Office visits and screenings that occur on the same day by the same provider are *not* covered unless the medical necessity is clearly documented in the participant's record.



The Healthy Children and Youth Screening guide provides age-specific guidelines for the screener’s assistance.

9.6.A DEVELOPMENTAL ASSESSMENT

PROCEDURE CODE	DESCRIPTION
99429 59	Developmental/Mental Health partial screen
99429 59UC	Developmental/Mental Health partial screen with Referral

This screen includes the following:

- Assessment of social and language development. Age-appropriate behaviors are identified in the HCY Screening guide.
- Assessment of fine and gross motor skill development. Age-appropriate behaviors are identified in the HCY Screening guide.
- Assessment of emotional and psychological status. Some age-appropriate behaviors are found in the HCY Screening guide.

9.6.A(1) Qualified Providers

The Developmental/Mental Health partial screen may be provided by the following MO HealthNet enrolled providers:

- Physician, nurse practitioner, assistant physician, physician assistant or nurse midwife*;
- Speech/language therapist;
- Physical therapist
- Occupational therapist; or
- Professional counselors, social workers, marital and family therapists, and psychologists.

*only infants age 0-2 months; and females age 15-20 years

9.6.B UNCLOTHED PHYSICAL, ANTICIPATORY GUIDANCE, AND INTERVAL HISTORY, LAB/IMMUNIZATIONS AND LEAD SCREEN

PROCEDURE CODE	DESCRIPTION
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9938152EP-9938552EP HCY Unclothed Physical and
 9939152EP-9939552EP History

9938152EPUC-9938552EPUC HCY Unclothed Physical and
 9939152EPUC-9939552EPUC History with Referral

The HCY unclothed physical and history includes the following:

- Check of growth chart;
- Examination of skin, head (including otoscopy and ophthalmoscopy), neck, external genitals, extremities, chest, hips, heart, abdomen, feet, and cover test;
- Appropriate laboratory;
- Immunizations; and
- Lead screening according to established guidelines.

9.6.B(1) Qualified Providers

The screen may be provided by a MO HealthNet enrolled physician, nurse practitioner, assistant physician, physician assistant or nurse midwife*.

*Reimbursement for immunizations and laboratory procedures is *not* included in the screening fee and may be billed separately.

9.6.C VISION SCREENING

PROCEDURE

CODE	DESCRIPTION
9942952	Vision Screening
9942952UC	Vision Screening with Referral

This screen can include observations for blinking, tracking, corneal light reflex, pupillary response, ocular movements. To test for visual acuity, use the Cover test for children under 3 years of age. For children over 3 years of age utilize the Snellen Vision Chart.

9.6.C(1) Qualified Providers

The vision partial screen may be provided by the following MO HealthNet enrolled providers:

- Physician, nurse practitioner, assistant physician, physician assistant or nurse midwife*;



- Optometrist.

* only infants age 0-2 months; and females age 15-20 years

9.6.D HEARING SCREEN

PROCEDURE

CODE	DESCRIPTION
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99429EP	HCY Hearing Screen
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99429EPUC	HCY Hearing Screen with Referral
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This screen can range from reports by parents to assessment of the child’s speech development through the use of audiometry and tympanometry.

If performed, audiometry and tympanometry tests may be billed and reimbursed separately. These tests are *not* required to complete the hearing screen.

9.6.D(1) Qualified Providers

The hearing partial screen may be provided by the following MO HealthNet enrolled providers:

- Physician, nurse practitioner, assistant physician, physician assistant or nurse midwife*;
- Audiologist or hearing aid dealer/fitter; or
- Speech pathologist.

*Reimbursement for immunizations and laboratory procedures is *not* included in the screening fee and may be billed separately.

9.6.E DENTAL SCREEN

PROCEDURE

CODE	DESCRIPTION
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99429	HCY Dental Screen
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99429UC	HCY Dental Screen with Referral
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A dental screen is available to the HCY/EPSTDT population on a periodicity schedule that is different from that of the full HCY/EPSTDT screen.



Children may receive age-appropriate dental screens and treatment services until they become 21 years old. *A child's first visit to the dentist should occur no later than 12 months of age so that the dentist can evaluate the infant's oral health, intercept potential problems such as nursing caries, and educate parents in the prevention of dental disease in their child.* It is recommended that preventive dental services and oral treatment for children begin at age 6 to 12 months and be repeated every six months or as indicated.

When a child receives a full medical screen by a physician, nurse practitioner or nurse midwife*, it includes an oral examination, which is *not* a full dental screen. A referral to a dental provider *must* be made where medically indicated when the child is under the age of 1 year. When the child is 1 year or older, a referral *must* be made, at a minimum, according to the dental periodicity schedule. The physician, nurse practitioner or nurse midwife may *not* bill the dental screening procedure 99429 or 99429UC separately.

*only infants age 0-2 months; and females age 15-20 years

9.6.E(1) Qualified Providers

A dental partial screen may only be provided by a MO HealthNet participating dentist.

9.6.F ALL PARTIAL SCREENERS

The provider of a partial medical screen *must* have a referral source to send the participant for the remaining required components of the full medical screen and is expected to help make arrangements for this service.

9.7 LEAD RISK ASSESSMENT AND TREATMENT—HEALTHY CHILDREN AND YOUTH (HCY)

The Department of Health and Human Services, Centers for Medicare & Medicaid Services (CMS) has identified all children between 6 months and 72 months to be at risk for lead poisoning and has mandated they *must* receive a lead risk assessment as part of the HCY full or partial screening.

A complete lead risk assessment consists of a verbal risk assessment and blood test(s) when indicated, and at the mandatory testing ages of 12 and 24 months. Lead risk assessment is included as a component of a full HCY medical screen, 99381EP through 99385EP and 99391EP through 99395EP, or a partial HCY screen, 9938152EP through 9938552EP and 9939152EP through 9939552EP, which also includes the following components: Interval History, Unclothed Physical, Anticipatory Guidance, Lab, and Immunization. See Section 9.7.B for additional information.

CMS has also determined that there are no guidelines or policies for states or local health departments to reference in determining that an area is a lead free zone. Until there is specific information or guidance from the Centers for Disease Control (CDC) on how lead free zones are

determined, CMS will *not* recognize them in the context of screening Medicaid eligible children for lead poisoning.

9.7.A SIGNS, SYMPTOMS AND EXPOSURE PATHWAYS

The signs and symptoms of lead exposure and toxicity may vary because of differences in individual susceptibility. A continuum of signs and symptoms exist, ranging from asymptomatic persons to those with overt toxicity.

Mild toxicity is usually associated with blood lead levels in the 35 to 50 µg/dL range for children and in the 40 to 60 µg/dL range for adults. Severe toxicity is frequently found in association with blood lead levels of 70 µg/dL or more in children and 100 µg/dL or more in adults.

The following signs and symptoms and exposure pathways are provided to assist providers in identifying children who may have lead poisoning or be at risk of being poisoned.

SIGNS AND SYMPTOMS

MILD TOXICITY

Myalgia or paresthesia
Mild fatigue
Irritability
Lethargy
Occasional abdominal discomfort

SEVERE TOXICITY

Paresis or paralysis
Encephalopathy—may abruptly lead to seizures, changes in level of consciousness, coma and death
Lead line (blue-black) on gingival tissue
Colic (intermittent, severe abdominal cramps)

MODERATE TOXICITY

Arthralgia
General fatigue
Decrease in play activity
Difficulty concentrating
Muscular exhaustibility
Tremor
Headache
Diffuse abdominal pain
Vomiting
Weight loss
Constipation

EXPOSURE PATHWAYS

OCCUPATIONAL

Plumbers, pipe fitters
Lead miners
Lead smelters and refiners
Auto repairers

HOBBIES AND RELATED ACTIVITIES

Glazed pottery making
Target shooting at firing ranges
Lead soldering (e.g., electronics)
Painting



Glass manufacturers
Shipbuilders
Printers
Plastic manufacturers
Police Officers
Steel welders and cutters
Construction workers
Bridge reconstruction workers
Rubber products manufacturers
Gas station attendants
Battery manufacturers
Chemical and chemical preparation
Manufacturers
Industrial machinery and equipment operators
Firing Range Instructors
ENVIRONMENTAL
Lead-containing paint
Soil/dust near industries, roadways, lead-painted homes
painted homes
Plumbing leachate
Ceramic ware
Leaded gasoline

Preparing lead shot, fishing sinkers, bullets
Home remodeling
Stained-glass making
Car or boat repair

SUBSTANCE USE

Folk remedies
“Health foods”
Cosmetics
Moonshine whiskey
Gasoline “huffing”

Regardless of risk, all families *must* be given detailed lead poisoning prevention counseling as part of the anticipatory guidance during the HCY screening visit for children up to 72 months of age.

9.7.B LEAD RISK ASSESSMENT

The HCY Lead Risk Assessment Guide should be used at *each* HCY screening to assess the exposure to lead, and to determine the risk for high dose exposure. The HCY Lead Risk Assessment Guide is designed to allow the same document to follow the child for all visits from 6 months to 6 years of age. The HCY Lead Risk Assessment Guide has space on the reverse side to identify the type of blood test, venous or capillary, and also has space to identify the dates and results of blood lead levels.

A comprehensive lead risk assessment includes both the verbal lead risk assessment and blood lead level determinations. Blood Lead Testing is mandatory at 12 and 24 months of age and if the child is deemed high risk.

The HCY Lead Risk Assessment Guide is available for provider’s use. The tool contains a list of questions that require a response from the parent. A positive response to any of the questions requires blood lead level testing by capillary or venous method.



9.7.C MANDATORY RISK ASSESSMENT FOR LEAD POISONING

All children between the ages of 6 months and 72 months of age MUST receive a lead risk assessment as a part of the HCY full or partial screening. Providers are *not* required to wait until the next HCY screening interval and may complete the lead risk assessment at the next office visit if they choose.

The HCY Lead Risk Assessment Guide and results of the blood lead test *must* be in the patient's medical record even if the blood lead test was performed by someone other than the billing provider. If this information is *not* located in the medical record a full or partial HCY screen may *not* be billed.

9.7.C(1) Risk Assessment

Beginning at six months of age and at each visit thereafter up to 72 months of age, the provider *must* discuss with the child's parent or guardian childhood lead poisoning interventions and assess the child's risk for exposure by using the HCY Lead Risk Assessment Guide.

9.7.C(2) Determining Risk

Risk is determined from the response to the questions on the HCY Lead Risk Assessment Guide. This verbal risk assessment determines the child to be low risk or high risk.

- If the answers to all questions is no, a child is *not* considered at risk for high doses of lead exposure.
- If the answer to any question is yes, a child is considered *at risk* for high doses of lead exposure and a capillary or venous blood lead level *must* be drawn. Follow-up guidelines on the reverse side of the HCY Lead Risk Assessment Guide *must* be followed as noted depending on the blood test results.

Subsequent verbal lead risk assessments can change a child's risk category. As the result of a verbal lead risk assessment, a previously low risk child may be re-categorized as high risk.

9.7.C(3) Screening Blood Tests

The Centers for Medicare & Medicaid Services (CMS) requires mandatory blood lead testing by either capillary or venous method at 12 months and 24 months of age regardless of risk. If the answer to any question on the HCY Lead Risk Assessment Guide is positive, a venous or capillary blood test *must* be performed.

If a child is determined by the verbal risk assessment to be high risk, a blood lead level test is required, beginning at six months of age. If the initial blood lead level test results are less than 10 micrograms per deciliter ($\mu\text{g}/\text{dL}$) no further action is required. Subsequent verbal lead risk assessments can change a child's risk category. A verbal risk assessment is required at every visit prescribed in the EPSDT periodicity schedule through 72 months of age and if considered to be high risk *must* receive a blood lead level test, unless the child has already received a blood lead test within the last six months of the periodic visit.

A blood lead test result equal to or greater than 10 $\mu\text{g}/\text{dL}$ obtained by capillary specimen (finger stick) *must* be confirmed using venous blood according to the time frame listed below:

- 10-19 $\mu\text{g}/\text{dL}$ - confirm within 2 months
- 20-44 $\mu\text{g}/\text{dL}$ - confirm within 2 weeks
- 45-69 $\mu\text{g}/\text{dL}$ - confirm within 2 days
- 70+ $\mu\text{g}/\text{dL}$ - IMMEDIATELY

For future reference and follow-up care, completion of the HCY Lead Risk Assessment Guide is still required at these visits to determine if a child is at risk.

9.7.C(4) MO HealthNet Managed Care Health Plans

The MO HealthNet Managed Care health plans are responsible for mandatory risk assessment for children between the ages of 6 months and 72 months. MO HealthNet Managed Care health plans are also responsible for mandatory blood testing if a child is at risk or if the child is 12 or 24 months of age. MO HealthNet Managed Care health plans *must* follow the HCY Lead Risk Assessment Guide when assessing a child for risk of lead poisoning or when treating a child found to be poisoned.

MO HealthNet Managed Care health plans are responsible for lead case management for those children with elevated blood lead levels. MO HealthNet Managed Care health plans are encouraged to work closely with the MO HealthNet Division and local public health agencies when a child with an elevated blood lead level has been identified.

Referral for an environmental investigation of the child's residence *must* be made to the local public health agency. This investigation is *not* the responsibility of the MO HealthNet Managed Care health plan, but can be reimbursed by the MO HealthNet Division on a fee-for-service basis.



9.7.D LABORATORY REQUIREMENTS FOR BLOOD LEAD LEVEL TESTING

When performing a lead risk assessment in Medicaid eligible children, CMS requires the use of the blood lead level test at 12 and 24 months of age and when a child is deemed high risk. The erythrocyte protoporphyrin (EP) test is *not* acceptable as a blood lead level test for lead poisoning. The following procedure code *must* be used to bill the blood lead test:

(Capillary specimen or venous blood samples.)

PROCEDURE CODE	DESCRIPTION
83655	Lead, quantitative blood

This code *must* be used by MO HealthNet enrolled laboratories. Laboratories *must* be CLIA certified to perform blood lead level tests. All blood lead level tests *must* be reported to the Missouri Department of Health and Senior Services as required in 19 CSR 20-20.

9.7.E BLOOD LEAD LEVEL—RECOMMENDED INTERVENTIONS

9.7.E(1) Blood Lead Level <10 µg/dL

This level is *NOT* indicative of lead poisoning. No action required unless exposure sources change.

Recommended Interventions:

- The provider should refer to Section 9.8.C(3) and follow the guidelines for risk assessment blood tests.

9.7.E(2) Blood Lead Level 10-19 µg/dL

Children with results in this range are in the borderline category. The effects of lead at this level are subtle and are *not* likely to be measurable or recognizable in the individual child.

Recommended Interventions:

- Provide family education and follow-up testing.
- *Retest every 2-3 months.
- If 2 venous tests taken at least 3 months apart both result in elevations of 15 µg/dL or greater, proceed with retest intervals and follow-up guidelines as for blood lead levels of 20-44 µg/dL.

*Retesting *must* always be completed using venous blood.



9.7.E(3) Blood Lead Level 20-44 µg/dL

If the blood lead results are in the 20-44 µg/dL range, a confirmatory venous blood lead level *must* be obtained within 2 weeks. Based upon the confirmation, a complete medical evaluation *must* be conducted.

Recommended Interventions:

- Provide family education and follow-up testing.
- Assure coordination of care (case management) either through the MO HealthNet Managed Care health plan, provider or local public health agency. The provider assures medical management.
- Contact local public health agency to provide environmental investigation and to assure lead-hazard control.
- *Retest every 1-2 months until the blood lead level remains less than 15 µg/dL for at least 6 months, lead hazards have been removed, and there are no new exposures.
- When these conditions are met, proceed with guidelines for blood lead levels 10-19 µg/dL.

*Retesting *must* always be completed using venous blood.

9.7.E(4) Blood Lead Level 45-69 µg/dL

These children require urgent medical evaluation.

If the blood lead results are in the 45-69 µg/dL range, a confirmatory venous blood lead level *must* be obtained within 48 hours.

Children with symptomatic lead poisoning (with or without encephalopathy) *must* be referred to a setting that encompasses the management of acute medical emergencies.

Recommended Interventions:

- Provide family education and follow-up testing.
- Assure coordination of care (case management) either through the MO HealthNet Managed Care health plan, provider or local public health agency. The provider assures medical management.
- Contact local public health agency to provide environmental investigation and to assure lead-hazard control.
- Within 48 hours begin coordination of care (case management), medical management, environmental investigation, and lead hazard control.



- A child with a confirmed blood lead level greater than 44 $\mu\text{g}/\text{dL}$ should be treated promptly with appropriate chelating agents and *not* returned to an environment where lead hazard exposure may continue until it is controlled.
- *Retest every 1-2 months until the blood lead level remains less than 15 $\mu\text{g}/\text{dL}$ for at least 6 months, lead hazards have been removed, and there are no new exposures.
- When these conditions are met, proceed with guidelines for blood lead levels 10-19 $\mu\text{g}/\text{dL}$.

* Retesting *must* always be completed using venous blood.

9.7.E(5) Blood Lead Level 70 $\mu\text{g}/\text{dL}$ or Greater

Children with blood lead levels in this range constitute a medical emergency.

If the blood lead results are in the 70 $\mu\text{g}/\text{dL}$ range, a confirmatory venous blood lead level *must* be obtained immediately.

Recommended Interventions:

- Hospitalize child and begin medical treatment immediately.
- Begin coordination of care (case management), medical management, environmental investigation, and lead hazard control immediately.
- Blood lead levels greater than 69 $\mu\text{g}/\text{dL}$ *must* have an urgent repeat venous test, but chelation therapy should begin immediately (*not* delayed until test results are available.)
- *Retest every 1-2 months until the blood lead level remains less than 15 $\mu\text{g}/\text{dL}$ for at least 6 months, the lead hazards have been removed, and there are no new exposures.
- When these conditions are met, proceed with guidelines for blood lead levels 10-19 $\mu\text{g}/\text{dL}$.

* Retesting *must* always be completed using venous blood.

9.7.F COORDINATION WITH OTHER AGENCIES

Coordination with local health departments, WIC, Head Start, and other private and public resources enables elimination of duplicate testing and ensures comprehensive diagnosis and treatment. Also, local public health agencies' Childhood Lead Poisoning Prevention programs may be available. These agencies may have the authority and ability to investigate a lead-poisoned child's environment and to require remediation. Local public health agencies may have the authority and ability to investigate a lead poisoned child's environment. We



encourage providers to note referrals and coordination with other agencies in the patient's medical record.

9.7.G ENVIRONMENTAL LEAD INVESTIGATION

When two consecutive lab tests performed at least three months apart measure 15 µg/dL or above, an environmental investigation *must be obtained*. Furthermore, where there is a reading above 10 µg/dL, the child *must* be re-tested in accordance to the recommended interventions listed in Section 9.8.E.

9.7.G(1) Environmental Lead Investigation

Children who have a blood lead level 20 µg/dL or greater or children who have had 2 blood lead levels greater than 15 µg/dL at least 3 months apart should have an environmental investigation performed.

The purpose of the environmental lead investigation is to determine the source(s) of hazardous lead exposure in the residential environment of children with elevated blood lead levels. Environmental lead investigations are to be conducted by licensed lead risk assessors who have been approved by the Missouri Department of Health and Senior Services. Approved licensed lead risk assessors shall comply with the Missouri Department of Health and Senior Services Lead Manual and applicable State laws.

All licensed lead risk assessors *must* be registered with the Missouri Department of Health and Senior Services. Approved lead risk assessors who wish to receive reimbursement for MO HealthNet eligible children *must* also be enrolled as a MO HealthNet provider. Lead risk assessors *must* use their MO HealthNet provider number when submitting claims for completing an environmental lead investigation.

The following procedure codes have been established for billing environmental lead investigations:

T1029UATG	Initial Environmental Lead Investigation
T1029UA	First Environmental Lead Reinvestigation
T1029UATF	Second Environmental Lead Reinvestigation
T1029UATS	Subsequent Environmental Lead Reinvestigation
	Certificate of Medical Necessity <i>must</i> be attached to claim for this procedure

Federal Medicaid regulations prohibit Medicaid coverage of environmental lead investigations of locations other than the principle residence. The Missouri



Department of Health and Senior Services recommend that all sites where the child may be exposed be assessed, e.g., day care, grandparents' home, etc.

Federal Health Care Financing policy prohibits Medicaid paying for laboratory testing of paint, soil and water samples.

Contact the local health department to arrange for environmental lead investigation services.

9.7.H ABATEMENT

Medicaid *cannot* pay for abatement of lead hazards. Lead risk assessors may be able to provide information and advice on proper abatement and remediation techniques.

9.7.I LEAD CASE MANAGEMENT

Children with 1 blood lead level of 20 µg/dL or greater, or who have had 2 venous tests at least 3 months apart with elevations of 15 µg/dL or greater *must* be referred for case management services through the HCY Program. In order to be reimbursed for these services the lead case management agency *must* be an enrolled provider with MO HealthNet Division. For additional information on Lead Case Management, go to Section 13.66.D of the Physician's Program Provider Manual.

9.7.J POISON CONTROL HOTLINE TELEPHONE NUMBER

The statewide poison control hotline number is (800) 366-8888. This number may also be used to report suspected lead poisoning. The Department of Health and Senior Services, Section for Environmental Health, hotline number is (800) 392-0272.

9.7.K MO HEALTHNET ENROLLED LABORATORIES THAT PERFORM BLOOD LEAD TESTING

Children's Mercy Hospital
2401 Gillham Rd.
Kansas City, MO 64108

Kneibert Clinic, LLC PO Box
PO Box 220
Poplar Bluff, MO 63902

Hannibal Clinic Lab
711 Grand Avenue
Hannibal, MO 63401

LabCorp Holdings-Kansas City
1706 N. Corrington
Kansas City, MO 64120

Kansas City Health Department Lab
2400 Troost, LL#100
Kansas City, MO 64108

Physicians Reference Laboratory
7800 W. 110 St.
Overland, MO 66210

Missouri State Public Health Laboratory

Quest Diagnostics

Durable Medical Equipment



101 Chestnut St,
Jefferson City, MO 65101

Springfield-Greene County Public Health
227 E. Chestnut
Springfield, MO 65802

St. Luke's Hospital Dept. of Pathology
4401 Wornall
Kansas City, MO

University of MO-Columbia Hospital & Clinics
One Hospital Drive
Columbia, MO 65212

11636 Administration
St. Louis, MO 63146

St. Francis Medical Center
211 St. Francis Drive
Cape Girardeau, MO 63703

St. Louis County Environmental Health Lab
111 S. Meramec
Clayton, MO 63105

9.7.L OUT-OF-STATE LABS CURRENTLY REPORTING LEAD TEST RESULTS TO THE MISSOURI DEPARTMENT OF HEALTH AND SENIOR SERVICES

Arup Laboratories

500 Chipeta Way

Salt Lake City, UT 84108

Iowa Hygenic Lab

Wallace State Office Building

Des Moines, IA 50307

Kansas Department of Health

619 Anne Ave.

Kansas City, KS 66101

Leadcare, Inc.

52 Court Ave.

Stewart Manor, NY 11530

Quincy Medical Group

1025 Main St.

Quincy, IL 62301

Esa

22 Alpha Rd.

Chelmsford, MA 01824

Iowa Methodist Medical Center

1200 Pleasant St.

Des Moines, IA 50309

Mayo Medical Laboratories

2050 Superior Dr. NW

Rochester, MN 55901

Physician's Reference Laboratory

7800 W. 110th St.

Overland Park, KS 66210

Tamarac Medical

7800 Broadway Ste. 2C

Centennial, Co 80122

Specialty Laboratories

2211 Michigan Ave.

Santa Monica, CA 90404

9.8 HCY CASE MANAGEMENT

PROCEDURE

CODE	DESCRIPTION
T1016EP	HCY Case Management
T1016TSEP	HCY Case Management; Follow-up

For more information regarding HCY Case Management, refer to Section 13 of the Physician's Program Provider Manual.

9.9 IMMUNIZATIONS

Immunizations *must* be provided during a full medical HCY screening unless medically contraindicated or refused by the parent or guardian of the patient. When an appropriate immunization is *not* provided, the patient's medical record *must* document why the appropriate immunization was *not* provided. Immunization against polio, measles, mumps, rubella, pertussis, chicken pox, diphtheria, tetanus, haemophilus influenzae type b, and hepatitis B *must* be provided according to the Recommended Childhood Immunization Schedule found on the Department of Health and Senior Services' website at: <http://www.dhss.mo.gov/Immunizations/index.html>.

9.9.A VACCINE FOR CHILDREN (VFC)

For information on the Vaccine for Children (VFC) program, reference Section 13 of the Physician's Program Provider Manual.

9.10 ASSIGNMENT OF SCREENING TIMES

Participants under 21 years of age become eligible for the initial screening, as well as for the periodic screenings, at the time MO HealthNet eligibility is determined regardless of how old they are. A periodic screen should occur thereafter according to the established periodicity schedule. A notification letter is sent in the month the participant again becomes eligible for an HCY screening. The letter is to notify the participant that a screening is due.

9.11 PERIODICITY SCHEDULE FOR HCY (EPSDT) SCREENING SERVICES

The periodicity schedule represents the minimum requirements for frequency of full medical screening services. Its purpose is *not* to limit the availability of needed treatment services between the established intervals of the periodicity schedule.

Note: MO HealthNet recognizes that a full HCY screen is required for children/youth within 30 days of entering Children's Division custody. Such HCY screens are considered medically necessary even though they may occur in addition to the regular periodicity schedule.



Children may be screened at any time the physician, nurse practitioner or nurse midwife* feels it is medically necessary to provide additional screening services. *If it is medically necessary for a full medical screen (see Section 9.6 for procedure list) to occur more frequently than the suggested periodicity schedule, then the screen should be provided. There must, however, be documentation in the patient’s medical record that indicates the medical necessity of the additional full medical screening service.*

The HCY Program makes available to MO HealthNet participants under the age of 21 a full HCY screening examination during each of the age categories in the following periodicity schedule:

Newborn (2-3) days	3 Years
By 1 Month	4 Years
2-3 Months	5 Years
4-5 Months	6-7 Years
6-8 Months	8-9 Years
9-11 Months	10-11 Years
12-14 Months	12-13 Years
15-17 Months	14-15 Years
18-23 Months	16-17 Years
24 Months	18-19 Years
	20 Years

*only infants age 0-2 months; and females age 15-20 years

9.11.A DENTAL SCREENING SCHEDULE

- Twice a year from age 6 months to 21 years.

9.11.B VISION SCREENING SCHEDULE

- Once a year from age 3 to 21 years.

9.11.C HEARING SCREENING SCHEDULE

- Once a year from age 3 to 21 years.

9.12 REFERRALS RESULTING FROM A FULL, INTERPERIODIC OR PARTIAL SCREENING

The full HCY screen is to serve as a complete screen and should *not* result in a referral for an additional partial screen for the component that identified a need for further assessment or treatment. A child referred as a result of a full screen should be referred for diagnostic or treatment services and *not* for additional screening except for dental (see Section 9.7.E).



Diagnostic and treatment services beyond the scope of the Medicaid state plan may require a plan of care and prior authorization (see Section 9.13.A). Additional information regarding specialized services can be found in Section 13, Benefits and Limitations.

9.12.A PRIOR AUTHORIZATION FOR NON-STATE PLAN SERVICES (EXPANDED HCY SERVICES)

Medically necessary services beyond the scope of the traditional Medicaid Program may be provided when the need for these services is identified by a complete, interperiodic or partial HCY screening. When required, a Prior Authorization Request form *must* be submitted to the MO HealthNet Division. Refer to instructions found in Section 13 of the provider manual for information on services requiring prior authorization. Complete the Prior Authorization Request form in full, describing in full detail the service being requested and submit in accordance with requirements in Section 13 of the provider manual.

Section 8 of the provider manual indicates exceptions to the prior authorization requirement and gives further details regarding completion of the form. Section 14 may also include specific requirements regarding the prior authorization requirement.

9.13 PARTICIPANT NONLIABILITY

MO HealthNet covered services rendered to an eligible participant are *not* billable to the participant if MO HealthNet would have paid had the provider followed the proper policies and procedures for obtaining payment through the MO HealthNet Program as set forth in 13 CSR 70-4.030.

9.14 EXEMPTION FROM COST SHARING AND COPAY REQUIREMENTS

Providers *must* refer to appropriate program manuals for specific information regarding cost sharing and copay requirements.

9.15 STATE-ONLY FUNDED PARTICIPANTS

Children eligible under a state-only funded category of assistance are eligible for all services including those available through the HCY Program to the same degree any other person under the age of 21 years is eligible for a service. Refer to Section 1 for further information regarding state-only funded participants.

9.16 MO HEALTHNET MANAGED CARE

MO HealthNet Managed Care health plans are responsible for insuring that Early and Periodic, Screening, Diagnosis and Treatment (EPSDT) screens are performed on all MO HealthNet Managed Care eligibles under the age of 21.



Unclothed Physical and History	99381 through 99385 and 99391 through 99395
Developmental/Mental Health	9942959 9942959UC
Hearing Screen	99429EP 99429EPUC
Vision Screen	9942952 9942952UC
Dental Screen	99429 99429UC

The history and exam of a normal newborn infant and initiation of diagnostic and treatment programs may be reported by the plans with procedure code 99460. Normal newborn care in other than a hospital or birthing room setting may be reported by the plans with procedure code 99461. Both of the above newborn procedure codes are equivalent to a full HCY screening.

Plans are responsible for required immunizations and recommended laboratory tests. Lab services are *not* part of the screen and are reported separately using the appropriate CPT code. Immunizations are recommended in accordance with the Advisory Committee on Immunization Practices (ACIP) guidelines and acceptable medical practice.

If a problem is detected during a screening examination, the child *must* be evaluated as necessary for further diagnosis and treatment services. The MO HealthNet Managed Care health plan is responsible for the treatment services.

9.17 ORDERING HEALTHY CHILDREN AND YOUTH SCREENING AND HCY LEAD SCREENING GUIDE

The Healthy Children and Youth Screening and HCY Lead Screening Guide may be ordered from Wipro Infocrossing Healthcare Services, P.O. Box 5600, Jefferson City, Missouri 65102 by checking the appropriate item on the Forms Request. If a provider needs additional screening forms they can also make copies.

END OF SECTION
[TOP OF SECTION](#)



SECTION 10 - FAMILY PLANNING

Family planning services are services relating to elective sterilizations and birth control products including drugs, diaphragms, and IUDs.

Section 10, The Family Planning Section, is *not* applicable to the following manuals:

Adult Day Care Waiver

Adult Day Health Care (NOTE: The Adult Day Health Care Program ends June 30, 2013)

Aged and Disabled Waiver

AIDS Waiver

Ambulance

Comprehensive Day Rehabilitation

Dental

Durable Medical Equipment

Environmental Lead Assessment

Hearing Aid

Hospice

Independent Living Waiver

Medically Fragile Adult Waiver

Nursing Home

Optical

Personal Care

Private Duty Nursing

Psychology/Counseling

Rehabilitation Centers

Therapy

END OF SECTION

[TOP OF PAGE](#)



SECTION 11 - MO HEALTHNET MANAGED CARE PROGRAM DELIVERY SYSTEM

MO HealthNet provides health care services to Managed Care eligibles who meet the criteria for enrollment through Managed Care arrangements, as follows:

- Under MO HealthNet's Managed Care Program certain eligible individuals are enrolled with a MO HealthNet Managed Care Health Plan. Managed Care has been implemented statewide, operating in four (4) regions of the state: Eastern (St. Louis area), Central, Southwestern, and Western (Kansas City area) regions.

11.1 MO HEALTHNET'S MANAGED CARE PROGRAM

Managed Care eligibles who meet specific eligibility criteria receive services through a Managed Care Health Plan. The Managed Care Program replaces the process of direct reimbursement to individual providers by the MO HealthNet Division (MHD). Participants enroll in a Managed Care Health Plan that contracts with the state to provide a specific scope of benefits. Individuals who are included in the Managed Care Program have the opportunity to choose their own Managed Care Health Plan and primary care provider. A listing of the health plans providing services statewide for the Managed Care Program can be found on the MHD website at: <http://dss.mo.gov/mhd/participants/mc/managed-care-health-plan-options.htm>.

11.1.A EASTERN MISSOURI PARTICIPATING MO HEALTHNET MANAGED CARE HEALTH PLANS

The Eastern Missouri Managed Care Program (St. Louis area) began providing services to members on September 1, 1995. It includes the following counties: Franklin (036), Jefferson (050), St. Charles (092), St. Louis County (096) and St. Louis City (115). On December 1, 2000, five new counties were added to this region: Lincoln (057), St. Genevieve (095), St. Francois (094), Warren (109) and Washington (110). On January 1, 2008, the following three new counties were added to the Eastern region: Madison (062), Perry (079) and Pike (082).

11.1.B CENTRAL MISSOURI PARTICIPATING MO HEALTHNET MANAGED CARE HEALTH PLANS

The central Missouri Managed Care region began providing services to members on March 1, 1996. It includes the following counties: Audrain (004), Boone (010), Callaway (014), Camden (015), Chariton (021), Cole (026), Cooper (027), Gasconade (037), Howard (045), Miller (066), Moniteau (068), Monroe (069), Montgomery (070), Morgan (071), Osage (076), Pettis (080), Randolph (088) and Saline (097). On January 1, 2008, ten new counties were added to this region: Benton (008), Laclede (053), Linn (058), Macon (061), Maries (063), Marion (064), Phelps (081), Pulaski (085), Ralls (087) and Shelby (102). On May 1, 2017, forty new counties were added to this region: Adair (001), Andrew (002), Atchison (003), Bollinger (009), Buchanan (011), Butler (012), Caldwell (013), Cape Girardeau (016), Carroll (017), Carter (018), Clark (023), Clinton (025), Crawford (028), Davies (031), DeKalb (032), Dent (033), Dunklin (035), Gentry (038), Grundy (040), Harrison (041), Holt (044), Iron (047), Knox (052),



Lewis (056), Livingston (059), Mercer (065), Mississippi (067), New Madrid (072), Nodaway (074), Pemiscot (078), Putnam (86), Reynolds (090), Ripley (091), Schuyler (098), Scotland (099), Scott (100), Stoddard (103), Sullivan (105), Wayne (111), and Worth (113).

11.1.D SOUTHWESTERN MISSOURI PARTICIPATING MO HEALTHNET MANAGED CARE HEALTH PLANS

The Southwestern Missouri Managed Care Program began providing services to members on May 1, 2017. The southwestern Managed Care region includes the following counties: Barry (005), Barton (006), Christian (02), Dade (029), Dallas (030), Douglas (034), Greene (039), Hickory (043), Howell (046), Jasper (019), Lawrence (055), McDonald (060), Newton (073), Oregon (075), Ozark (077), Shannon (101), Stone (104), Taney (106), Texas (107), Webster (112), and Wright (114).

11.1.E WESTERN MISSOURI PARTICIPATING MO HEALTHNET MANAGED CARE HEALTH PLANS

The Western Missouri Managed Care Program (Kansas City area) began providing services to members on November 1, 1996. The western Managed Care region includes the following counties: Cass (019), Clay (024), Jackson (048), Johnson (051), Lafayette (054), Platte (083) and Ray (089). St. Clair (093) and Henry (042) counties were incorporated into the Western region effective 2/1/99. On January 1, 2008 four new counties were added to this region: Bates (007), Cedar (020), Polk (084) and Vernon (108).

11.2 MO HEALTHNET MANAGED CARE HEALTH PLAN ENROLLMENT

The state has contracted with an independent enrollment agent to assist current and future MO HealthNet Managed Care participants to make an informed decision in the choice of a MO HealthNet Managed Care Health Plan that meets their needs.

The Managed Care enrollment agent sends mailers/letters, etc., provides MO HealthNet Managed Care Health Plan option information, and has a hot line number available to participants in order to make the selection process easy and informative.

Pregnant women who are identified as eligible for inclusion in the MO HealthNet Managed Care Program have 7 days to select a Managed Care health plan or have a Managed Care health plan assigned for them. After they have selected the Managed Care health plan, they are not enrolled with a MO HealthNet Managed Care health plan until 7 days after they actually select or are assigned to a Managed Care health plan. All other participants who are identified as eligible for inclusion in the MO HealthNet Managed Care Program have 15 days to select a Managed Care health plan or have a Managed Care health plan assigned for them. After they have selected the Managed Care health plan, participants are *not* enrolled with a MO HealthNet Managed Care health plan until 15 days after they actually select or are assigned to a Managed Care health plan. When the selection or assignment is in effect, the name of the MO HealthNet Managed Care health plan appears on the Interactive Voice Response system/eMOMED information. If a MO HealthNet Managed Care health plan name does *not* appear for a particular date of service, the participant is in a Fee-For-Service eligibility status. The participant is in a Fee-For-Service eligibility status for each date of service that a MO HealthNet Managed Care health



plan is *not* listed for the participant.

"OPT OUT" POPULATIONS: The Department of Social Services allows participants the option of choosing to receive services on a Fee-For-Service basis or through the MO HealthNet Managed Care Program. Participants are eligible to opt out if they are in the following classifications:

- Eligible for Supplemental Security Income (SSI) under Title XVI of the Act;
- Described in Section 501(a)(1)(D) of the Act (children with special health care needs);
- Described in Section 1902 €(3) of the Act (18 or younger and qualifies as a disabled individual under section 1614(a));
- Receiving foster care or adoption assistance under part E of Title IV of the Act;
- In foster care or otherwise in out-of-home placement; or
- Meet the SSI disability definition by the Department of Social Services.

Fee-For-Service Members or their parent/guardian should call Participant Services at 1-800-392-2161. Participant Services will provide a form to request "Opt Out". Once all information is received, a determination is made.

11.3 MO HEALTHNET MANAGED CARE HEALTH PLAN INCLUDED INDIVIDUALS

Refer to Section 1.5.C, MO HealthNet Managed Care Participants, and 1.1.A, Description of Eligibility Categories, for more information on Managed Care Health Plan members.

Managed Care Health Plan members fall into four groups:

- Individuals with the following ME Codes fall into Group 1: 05, 06, 10, 19, 21, 24, 26, 40, 60, and 62.
- Individuals with the following ME Codes fall into Group 2: 18, 43, 44, 45, 61, 95, 96, and 98.
- Individuals with the following ME Codes fall into Group 4: 07, 08, 29, 30, 36, 37, 38, 50, 52, 56, 57, 64, 66, 68, 69 and 70.
- Individuals with the following ME Codes fall into Group 5: 71, 72, 73, 74, 75 and 97.

11.4 MO HEALTHNET MANAGED CARE HEALTH PLAN EXCLUDED INDIVIDUALS

The following categories of assistance/individuals are *not* included in the MO HealthNet Managed Care Program.

- Permanently and Totally Disabled and Aged individuals eligible under ME Codes 04 (Permanently and Totally Disabled), 13 (MO HealthNet-PTD), 16 (Nursing Care-PTD), 11 (MO HealthNet Spend down and Non-Spend down), 14 (Nursing Care-OAA), and 01 (Old Age Assistance-OAA);
- Individuals eligible under ME Codes 23 and 41 (MA ICF-MR Poverty) residing in a State



Mental Institution or an Intermediate Care Facility for the Intellectually Disabled (ICF/ID);

- Individuals eligible under ME Codes 28, 49, and 67 (Children placed in foster homes or residential care by the Department of Mental Health);
- Pregnant women eligible under ME Code 58, 59, and 94, the Presumptive Eligibility Program for ambulatory prenatal care only;
- Individuals eligible under ME Codes 2, 3, 12, and 15 (Aid to the Blind and Blind Pension);
- AIDS Waiver participants (individuals twenty-one (21) years of age and over);
- Any individual eligible and receiving either or both Medicare Part A and Part B or Part C benefits;
- Individuals eligible under ME Codes 33 and 34 (MO Children with Developmental Disabilities Waiver);
- Individuals eligible under ME Code 55 (Qualified Medicare Beneficiary – QMB);
- Children eligible under ME Code 65, placed in residential care by their parents, if eligible for MO HealthNet on the date of placement;
- Uninsured women losing their MO HealthNet eligibility 60 days after the birth of their child would be eligible under ME Code 80 for women’s health services for one year plus 60 days, regardless of income level;
- Women eligible for Women's Health Services, 1115 Waiver Demonstration, ME code 89. These are uninsured women who are at least 18 to 55 years of age, with a net family income at or below 185% of the Federal Poverty Level (FPL), and with assets totaling less than \$250,000. These women are eligible for women's health services as long as they continue to meet eligibility requirements;
- Individuals with ME code 81 (Temporary Assignment Category);
- Individuals eligible under ME code 82 (MoRx);
- Women eligible under ME codes 83 and 84 (Breast and Cervical Cancer Treatment);
- Individuals eligible under ME code 87 (Presumptive Eligibility for Children); and



- Individuals eligible under ME code 88 (Voluntary Placement).

11.5 MO HEALTHNET MANAGED CARE MEMBER BENEFITS

The MO HealthNet Managed Care Health Plans are required to provide health benefits to MO HealthNet Managed Care members for each date they are enrolled in the MO HealthNet Managed Care health plan. Managed Care members select a primary care provider (PCP) to provide routine care.

MO HealthNet enrolled providers (also called MO HealthNet Managed Care approved providers) who provide services to a Managed Care member do *not* receive direct reimbursement from the state for Managed Care health plan benefits furnished while the participant is enrolled in a MO HealthNet Managed Care health plan. MO HealthNet enrolled providers who wish to provide services for MO HealthNet Managed Care members *must* contact the Managed Care health plans for participation agreements/contracts or prior authorization.

The MO HealthNet Managed Care member *must* be told in advance of furnishing the service by the non- Managed Care health plan provider that they are able to receive the service from the MO HealthNet Managed Care health plan at no charge. The participant *must* sign a statement that they have been informed that the service is available through the Managed Care health plan but is being provided by the non- MO HealthNet Managed Care health plan provider and they are willing to pay for the service as a private pay patient.

MO HealthNet Managed Care health plan members receive the same standard benefit package regardless of the MO HealthNet Managed Care health plan they select. Managed Care health plans *must* provide services according to guidelines specified in contracts. Managed Care members are eligible for the same range of medical services as under the Fee-For-Service program. The Managed Care health plans may provide services directly, through subcontracts, or by referring the Managed Care member to a specialist. Services are provided according to the medical needs of the individual and within the scope of the Managed Care health plan's administration of health care benefits.

Some services continue to be provided outside the MO HealthNet Managed Care health plan with direct provider reimbursement by the MO HealthNet Division. Refer to Section 11.7.

11.6 STANDARD BENEFITS UNDER THE MO HEALTHNET MANAGED CARE PROGRAM

The following is a listing of the standard benefits under the comprehensive Managed Care Program. Benefits listed are limited to members who are eligible for the service.

- Inpatient hospital services
- Outpatient hospital services
- Emergency medical, behavioral health, and post-stabilization care services
- Ambulatory surgical center, birthing center
- Asthma education and in-home environmental assessments
- Physician services (including advanced practice nurse and certified nurse midwife)



Durable Medical Equipment

- Family planning (requires freedom of choice and may be accessed out of the Managed Care Health Plan)
- Laboratory, radiology and other diagnostic services
- Maternity services (A shorter length of hospital stay for services related to maternity and newborn care may be authorized if a shorter inpatient hospital stay meets with the approval of the attending physician after consulting with the mother and is in keeping with federal and state law. Home visits are required following early discharge. Reference Section 13.20 of the Home Health Manual for more information)
- Prenatal case management
- Home health services
- Emergency (ground or air) transportation
- Nonemergency medical transportation (NEMT), except for CHIP children in ME Codes 73-75, and 97
- Services of other providers when referred by the Managed Care member's primary care provider
- Hospice services: Hospice services for children (ages 0-20) may be concurrent with the care related to curative treatment of the condition for which a diagnosis of a terminal illness has been made.
- Durable medical equipment (including but *not* limited to orthotic and prosthetic devices, respiratory equipment and oxygen, enteral and parenteral nutrition, wheelchairs, walkers, diabetic supplies and equipment) and medically necessary equipment and supplies used in connection with physical, occupational, and speech therapies for all members with an Individualized Educational Program (IEP) or Individualized Family Service Plan (IFSP)
- Limited Podiatry services
- Dental services related to trauma to the mouth, jaw, teeth, or other contiguous sites as a result of injury; treatment of a disease/medical condition without which the health of the individual would be adversely affected; preventive services; restorative services; periodontal treatment; oral surgery; extractions; radiographs; pain evaluation and relief; infection control; and general anesthesia. Personal care/advanced personal care
- Optical services include one comprehensive or limited eye examination every two years for refractive error, services related to trauma or treatment of disease/medical condition (including eye prosthetics), one pair of eyeglasses every two years (during any 24 month period of time), and replacement lens(es) when there is a .50 or greater change.
- Services provided by local public health agencies (may be provided by the MO HealthNet Managed Care Health Plan or through the local public health agency and paid by the MO HealthNet Managed Care Health Plan)
 - Screening, diagnosis and treatment of sexually transmitted diseases
 - HIV screening and diagnostic services
 - Screening, diagnosis and treatment of tuberculosis
 - Childhood immunizations



- Childhood lead poisoning prevention services, including screening, diagnosis and treatment
- Behavioral health services include mental health and substance use disorder services. Medically necessary behavioral health services are covered for children (except Group 4) and adults in all Managed Care regions. Services shall include, but *not* be limited to:
 - Inpatient hospitalization, when provided by an acute care hospital or a private or state psychiatric hospital
 - Outpatient services when provided by a licensed psychiatrist, licensed psychologist, licensed clinical social worker, licensed master social worker, licensed professional counselor, provisionally licensed professional counselor, licensed psychiatric clinical nurse specialist, licensed psychiatric nurse practitioner, or Missouri certified behavioral health programs
 - Crisis intervention/access services
 - Alternative services that are reasonable, cost effective and related to the member's treatment plan
 - Referral for screening to receive case management services.
 - Behavioral health services that are court ordered, 96 hour detentions, and for involuntary commitments.
 - Behavioral health services to transition the Managed Care member who received behavioral health services from an out-of-network provider prior to enrollment with the MO HealthNet Managed Care health plan. The MO HealthNet Managed Care health plan shall authorize out-of-network providers to continue ongoing behavioral health and substance abuse treatment, services, and items for new Managed Care members until such time as the new Managed Care member has been transferred appropriately to the care of an in-network provider.
- Early, periodic, screening, diagnosis and treatment (EPSDT) services also known as healthy children and youth (HCY) services for individuals under the age of 21. Independent foster care adolescents with a Medical Eligibility code of 38 and who are ages twenty-one (21) through twenty-five (25) will receive a comprehensive benefit package for children in State care and custody; however, EPSDT screenings will no longer be covered. Services include but are *not* limited to:
 - HCY screens including interval history, unclothed physical, anticipatory guidance, lab/immunizations, lead screening (verbal risk assessment and blood lead levels, [mandatory 6-72 months]), developmental screen and vision, hearing, and dental screens
 - Orthodontics
 - Private duty nursing
 - Psychology/counseling services (Group 4 children in care and custody receive psychology/counseling services outside the Managed Care Health Plan). Refer to ME



Codes listed for Group 4, Section 1.5.C

- Physical, occupational and speech therapy (IEP and IFSP services may be accessed out of the MO HealthNet Managed Care health plan)
- Expanded services in the Home Health, Optical, Personal Care, Hearing Aid and Durable Medical Equipment Programs
- Transplant-related services. The MO HealthNet Managed Care health plan is financially responsible for any inpatient, outpatient, physician, and related support services including pre-surgery assessment/evaluation prior to the date of the actual transplant surgery. The Managed Care Health Plan is responsible for the pre-transplant and post-transplant follow-up care.

11.6.A BENEFITS FOR CHILDREN AND WOMEN IN A MOHEALTHNET CATEGORY OF ASSISTANCE FOR PREGNANT WOMEN

A child is anyone less than 21 years of age. For some members the age limit may be less than 19 years of age. Some services need prior approval before they are provided. Women must be in a MO HealthNet category of assistance for pregnant women with ME codes 18, 43, 44, 45, 61 and targeted low-income pregnant women and unborn children who are eligible under Show-Me Healthy Babies with ME codes 95, 96, and 98

to receive these extra benefits.

- Comprehensive day rehabilitation, services to help with recovery from a serious head injury;
- Dental services – All preventive, diagnostic, and treatment services as outlined in the MO HealthNet State Plan;
- Diabetes self-management training for persons with gestational, Type I or Type II, diabetes;
- Hearing aids and related services;
- Optical services to include one (1) comprehensive or one (1) limited eye examination per year for refractive error, one (1) pair of eyeglasses every two years, replacement lens(es) when there is a .50 or greater change, and, for children under age 21, replacement framesand/or lenses when lost, broken or medically necessary, and HCY/EPST optical screen and services;
- Podiatry services;
- Services that are included in the comprehensive benefit package, medically necessary, and not identified in the IFSP or IEP.
- Therapy services (physical, occupational, and speech) that are not identified in an IEP or IFSP. This includes maintenance, developmental, and all othertherapies.

11.7 SERVICES PROVIDED OUTSIDE THE MO HEALTHNET MANAGED CARE PROGRAM

The following services are available to MO HealthNet Managed Care members outside the MO



HealthNet Managed Care Program and are reimbursed to MO HealthNet approved providers on a Fee-For-Service basis by the MO HealthNet Division:

- Abortion services (subject to MO HealthNet Program benefits and limitations)
- Adult Day Care Waiver
 - Home and Community based waiver services for Adult Day Care Services include but are not limited to assistance with activities of daily living, planned group activities, food services, client observation, skilled nursing services as specified in the plan of care, and transportation.
 - The health plan shall be responsible for MO HealthNet Managed Care comprehensive benefit package services for ADC waiver clients enrolled in MO HealthNet Managed Care, unless specifically excluded. The health plan shall be responsible for care coordination of services included in the comprehensive benefit package and the ADC waiver. Information regarding the ADC waiver services may be located on the DHSS website at: <http://health.mo.gov/seniors/hcbs/adhccproposalpackets.php>
- Physical, occupational and speech therapy services for children included in:
 - The Individual Education Plan (IEP); or
 - The Individual Family Service Plan (IFSP)
- Parents as Teachers
- Environmental lead assessments for children with elevated blood lead levels
- Community Psychiatric Rehabilitation program services
- ~~Tobacco cessation pharmacologic and behavioral intervention services~~
- Applied Behavior Analysis services for children with Autism Spectrum Disorder
- Comprehensive substance treatment and rehabilitation (CSTAR) services
 - Laboratory tests performed by the Department of Health and Senior Services as required by law (e.g., metabolic testing for newborns)
 - Newborn Screening Collection Kits
 - Special Supplemental Nutrition for Women, Infants and Children (WIC) Program
 - SAFE and CARE exams and related diagnostic studies furnished by a SAFE-CARE trained MO HealthNet approved provider
- Developmental Disabilities (DD) Waiver Services for DD waiver participants included in all Managed Care regions
- Transplant Services: The health plan shall coordinate services for a member requiring a transplant.
 - Solid organ and bone marrow/stem cell transplant services will be paid for all populations on a Fee-For-Service basis outside of the comprehensive benefit package.
 - Transplant services covered by Fee-For-Service are defined as the hospitalization from the date of transplant procedure until the date of discharge, including solid organ or bone marrow/stem cell procurement charges, and related physician services associated with



- both procurement and the transplant procedure.
- The health plan shall not be responsible for the covered transplant but shall coordinate the pre- and post-transplant services.
- Behavioral health services for MO HealthNet Managed Care children (Group 4) in state care and custody
 - Inpatient services—patients with a dual diagnosis admission (physical and behavioral) have their hospital days covered by the MO HealthNet Managed Care Health Plan.
 - Outpatient behavioral health visits are *not* the responsibility of the MO HealthNet Managed Care Health Plan for Group 4 members when provided by a:
 - Licensed psychiatrist;
 - Licensed psychologist, provisionally licensed psychologist, licensed clinical social worker, licensed master social worker, licensed professional counselor or provisionally licensed professional counselor ;
 - Psychiatric Clinical Nurse Specialist, Psychiatric Mental Health Nurse Practitioner state certified behavioral health or substance abuse program; or
 - A qualified behavioral health professional in the following settings:
 - Federally qualified health center (FQHC); and
 - Rural health clinic (RHC).
- Pharmacy services.
- Home birth services.
- Targeted Case Management for Behavioral Health Services.

11.8 QUALITY OF CARE

The state has developed quality improvement measures for the MO HealthNet Managed Care Health Plan and will monitor their performance.

11.9 IDENTIFICATION OF MO HEALTHNET MANAGED CARE PARTICIPANTS

Participants who are included in the MO HealthNet Managed Care Program are identified on eMOMED or the IVR system when verifying eligibility. The response received identifies the name and telephone number of the participant's selected MO HealthNet Managed Care health plan. For MO HealthNet Managed Care members, the response also includes the identity of the MO HealthNet Managed Care member's primary care provider (PCP). For providers who need to contact the PCP, they may contact the Managed Care health plan to confirm the PCP on the state's system has not recently changed. Participants who are eligible for the MO HealthNet Managed Care Program and enrolled with a MO HealthNet Managed Care health plan *must* have their basic benefit services provided by or prior authorized by the MO HealthNet Managed Care health plan. Refer to Section 1 for additional information on identification of participants in MO HealthNet Managed Care Programs.



MO HealthNet Managed Care health plans may also issue their own individual Managed Care health plan ID cards. The individual *must* be eligible for the Managed Care Program and enrolled with the MO HealthNet Managed Care health plan on the date of service for the MO HealthNet Managed Care health plan to be responsible for services. Providers *must* verify the eligibility status and Managed Care health plan enrollment status on all MO HealthNet Managed Care participants before providing service.

11.9.A NON-BILLING MO HEALTHNET PROVIDER

MO HealthNet Managed Care health plan providers who have a valid agreement with one or more Managed Care health plans but who are *not* enrolled as a participating MO HealthNet provider may access eMOMED or the Interactive Voice Response (IVR) only if they enroll with MO HealthNet as a “Non-Billing MO HealthNet Provider.” Providers are issued an atypical provider identifier that permits access to eMOMED or the IVR; however, it is *not* valid for billing MO HealthNet on a Fee-For-Service basis. Information regarding enrollment as a “Non-Billing MO HealthNet Provider” can be obtained by contacting the Provider Enrollment Unit at mmac.providerenrollment@dss.mo.gov.

11.10 EMERGENCY SERVICES

Emergency medical/behavioral health services means covered inpatient and outpatient services that are furnished by a provider that is qualified to furnish these services and are needed to evaluate or stabilize an emergency medical condition.

Emergency medical condition for MO HealthNet Managed Care health plan members means medical or behavioral health condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in the following:

1. Placing the physical or behavioral health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; or
2. Serious impairment of bodily functions; or
3. Serious dysfunction of any bodily organ or part; or
4. Serious harm to self or others due to an alcohol or drug abuse emergency; or
5. Injury to self or bodily harm to others; or
6. With respect to a pregnant woman having contractions: (1) that there is inadequate time to effect a safe transfer to another hospital before delivery or; (2) that transfer may pose a threat to the health or safety of the woman or the unborn.

Post stabilization care services means covered services, related to an emergency medical condition that are provided after a member is stabilized in order to maintain the stabilized conditions or to improve or resolve the member's condition.

11.11 PROGRAM OF ALL-INCLUSIVE CARE FOR THE ELDERLY (PACE)

PACE is a comprehensive service delivery system and finance model for the frail elderly that replicates

the original model pioneered at the San Francisco On Lok site in the early 1980s. The fully capitated service delivery system includes: primary care, restorative therapy, transportation, home health care, inpatient acute care, and nursing facility long-term care when home and community-based services are no longer appropriate. Services are provided at the PACE center, the home, in the hospital, or in a nursing facility, depending upon the needs of the individual. The goal is to maximize each participant's potential and continued residence in the home and community by providing preventive primary care and other support. Enrollment in the PACE program is always voluntary. Participants have the option to disenroll and return to the Fee-For-Service system at any time. A fully capitated PACE provider receives a monthly capitation from Medicare and/or MO HealthNet. All medical services that the individual requires while enrolled in the program are the financial responsibility of the fully capitated PACE provider. A successful PACE site serves 150 to 300 enrollees in a limited geographical area. The Balanced Budget Act of 1997 established PACE as a permanent provider under Medicare and allowed states the option to pay for PACE services under MO HealthNet.

11.11.A ELIGIBILITY FOR PACE

Program of All-Inclusive Care for the Elderly (PACE) is a comprehensive service delivery system and finance model for the frail elderly. The PACE Organization provides a full range of preventive, primary, acute, and long-term care services 24 hours per day, 7 days per week to PACE participants. Services are provided at the PACE center, the home, in the hospital, or in a nursing facility, depending upon the needs of the participant. All medical services that the participant requires, while enrolled in the program, are the financial responsibility of the PACE provider. Enrollment in a PACE program is always voluntary. Participants have the option to disenroll and return to the Fee-For-Service system at any time.

The Department of Health and Senior Services (DHSS), Division of Senior and Disability Services (DSDS), is the entry point for referrals to the PACE provider and assessments for PACE program eligibility. Referrals for the program may be made to DSDS by completing the PACE Referral/Assessment form and faxing to the DSDS Call Center at 314/877-2292 or by calling toll free at 866/835-3505. The PACE Referral/Assessment form can be located at <http://health.mo.gov/seniors/hcbs/hcbsmanual/index.php>.

The target population for this program includes individuals age 55 and older, identified by DHSS through a health status assessment with a score of at least 21 points on the nursing home level of care assessment; and who reside in the service area.

11.11.B INDIVIDUALS NOT ELIGIBLE FOR PACE

Individuals *not* eligible for PACE enrollment include:

- Persons who are under age 55;
- Persons residing in a State Mental Institution or Intermediate Care Facility for the Intellectually Disabled (ICF/ID);
- Persons enrolled in the Managed Care Program; and
- Persons currently enrolled with a MO HealthNet hospice provider.

11.11.C LOCK-IN IDENTIFICATION OF PACE INDIVIDUALS

When a DHSS-assessed individual meets the program criteria and chooses to enroll in the PACE program, the PACE provider has the individual sign an enrollment agreement and the DHSS locks the individual into the PACE provider for covered PACE services. All services are provided solely through the PACE provider. Lock-in information is available to providers through eMOMED and the IVR at (573) 751-2896. Enrollment in a PACE program is always voluntary and participants have the option to disenroll and return to the Fee-For-Service system at any time.

11.11.D PACE COVERED SERVICES

Once the individual is locked into the PACE provider, the PACE provider is responsible for providing the following covered PACE services:

- Physician, clinic, advanced practice nurse, and specialist (ophthalmology, podiatry, audiology, internist, surgeon, neurology, etc.);
- Nursing facility services;
- Physical, occupational, and speech therapies (group or individual);
- Non-emergency medical transportation (including door-to-door services and the ability to provide for a companion to travel with the client when medically necessary);
- Emergency transportation;
- Adult day health care services;
- Optometry and ophthalmology services including eye exams, eyeglasses, prosthetic eyes, and other eye appliances;
- Audiology services including hearing aids and hearing aid services;
- Dental services including dentures;
- Mental health and substance abuse services including community psychiatric rehabilitation services;
- Oxygen, prosthetic and orthotic supplies, durable medical equipment and medical appliances;
- Health promotion and disease prevention services/primary medical care;
- In-home supportive care such as homemaker/chore, personal care and in-home nutrition;
- Pharmaceutical services, prescribed drugs, and over the counter medications;
- Medical and surgical specialty and consultation services;
- Home health services;
- Inpatient and outpatient hospital services;
- Services for chronic renal dialysis chronic maintenance dialysis treatment, and dialysis supplies;
- Emergency room care and treatment room services;



- Laboratory, radiology, and radioisotope services, lab tests performed by DHSS and required by law;
- Interdisciplinary assessment and treatment planning;
- Nutritional counseling;
- Recreational therapy;
- Meals;
- Case management, care coordination;
- Rehabilitation services;
- Hospice services;
- Ambulatory surgical center services; and
- Other services determined necessary by the interdisciplinary team to improve and maintain the participants overall health status.

No Fee-For-Service claims are reimbursed by MO HealthNet for participants enrolled in PACE. Services authorized by MHD prior to the effective enrollment date with the PACE provider are the responsibility of MHD. All other prior authorized services *must* be arranged for or provided by the PACE provider and are *not* reimbursed through Fee-For-Service.

END OF SECTION

[TOP OF SECTION](#)

SECTION 12—REIMBURSEMENT METHODOLOGY

12.1 THE BASIS FOR ESTABLISHING A RATE OF PAYMENT

The MO HealthNet Division (MHD) is charged with establishing and administering the rate of payment for those medical services covered by the Missouri Title XIX Program. The MHD establishes a rate of payment that meets the following goals:

- Ensures access to quality medical care for all participants by encouraging a sufficient number of providers;
- Allows for no adverse impact on private-pay patients;
- Assures a reasonable rate to protect the interests of the taxpayers; and
- Provides incentives that encourage efficiency on the part of medical providers.

Funds used to reimburse providers for services rendered to eligible participants are received in part from federal funds and supplemented by state funds to cover the costs. The amount of funding by the federal government is based on a percentage of the allowable expenditures. The percentage varies from program to program, and in some cases different percentages for some services within the same program may apply. Funding from the federal government may be as little as 60% or as much as 90%; depending on the service and/or program. The balance of the allowable, (10-40%) is paid from state General Revenue appropriated funds.

Under a fee schedule, each procedure, service, medical supply and equipment covered under a specific program has a maximum allowable fee established. The MHD determines a maximum allowable fee for the service based upon the current appropriated funds and the following information:

- Recommendations from the State Medical Consultant and/or the provider subcommittee of the Medical Advisory Committee and/or stakeholders;
- Medicare's allowable reasonable and customary charge payment of cost-related payment;
- Charge information obtained from providers in different areas of the state. Charges refer to the usual and customary fees for various services that are charged to the general public. Implicit in the use of charges as the basis for fees is the objective that charges for service be related to the cost of providing the services.

Total expenditures for MO HealthNet *must* be within the appropriation limits established by the General Assembly. If the expenditures do *not* stay within the appropriation limits set by the General Assembly and funds are insufficient to pay the full amount, then the payment for services may be reduced pro rata in proportion to the deficiency.



12.2 DURABLE MEDICAL EQUIPMENT (DME) SERVICES

Reimbursement for DME services is made on a fee-for-service basis. The maximum allowable fee for a unit of service has been determined by the State Agency to be a reasonable fee, consistent with efficiency, economy, and quality of care. Payment for covered services is the lower of the provider's actual billed charge (should be the provider's usual and customary charge to the general public for the service), or the maximum allowable per unit of service.

12.3 ON-LINE FEE SCHEDULE

The MO HealthNet fee schedules are available on-line at <http://dss.mo.gov/mhd/providers/index.htm>, and identify covered and non-covered procedure codes, restrictions, allowed units and the MO HealthNet allowable fee per unit. The on-line Fee Schedule is updated quarterly and is intended as a reference *not* a guarantee for payment.

The on-line Fee Schedule allows for the downloading of individual files or the search for a specific fee schedule. Some procedure codes may be billed by multiple provider types. Categories within the Fee Schedule are set up by the service rendered and are *not* necessarily provider specific.

Refer to Section 13 of this manual for program specific benefits and limitations.

12.4 MEDICARE/MO HEALTHNET REIMBURSEMENT (CROSSOVER CLAIMS)

For MO HealthNet participants who are also Medicare beneficiaries and receive services covered by the Medicare Program, MO HealthNet pays the deductible and coinsurance amounts otherwise charged to the participant by the provider. See Section 16 of this manual for a detailed explanation of these claims.

12.5 PARTICIPANT COPAY

Certain MO HealthNet services are subject to participant copay. The copay amount is paid by the participant at the time services are rendered. Services of the Durable Medical Equipment Program described in this manual are *not* subject to a copay amount.

12.6 A MO HEALTHNET MANAGED HEALTH CARE DELIVERY SYSTEM METHOD OF REIMBURSEMENT

One method through which MO HealthNet provides services is a MO HealthNet Managed Health Care Delivery System. A basic package of services is offered to the participant by the health plan; however, some services are *not* included and are covered by MO HealthNet on a fee-for-service basis.

Durable Medical Equipment (DME) services are included as a plan benefit in Missouri's MO HealthNet managed care program.



12.6.A MANAGED HEALTH CARE

Under a managed health plan, a basic set of services is provided either directly or through subcontractors. Managed health care plans are reimbursed at an established rate per member per month. Reimbursement is based on predicted need for health care and is paid for each participant for each month of coverage. Rather than setting a reimbursement rate for each unit of service, the total reimbursement for all enrollees for the month *must* provide for all needed health care to all participants in the group covered.

The health plan is at risk for staying within the *overall* budget—that is, within the negotiated rate per member per month multiplied by the number of participants covered. Some individual cases exceed the negotiated rate per member per month, while many cases cost less than the negotiated rate.

The MO HealthNet Program utilizes the managed care delivery system for certain included MO HealthNet eligibles. Refer to Section 1 and Section 11 of this manual for a detailed description.

END OF SECTION

[TOP OF PAGE](#)



SECTION 13-BENEFITS AND LIMITATIONS

13.1 CONDITIONS OF PARTICIPATION

13.1.A PROVIDER PARTICIPATION

To participate in the MO HealthNet Durable Medical Equipment (DME) Program, only the following types of providers are reimbursed by MO HealthNet for items covered under the DME Program. Each of the following provider types *must* be enrolled as a DME provider:

- Rental and Sales Providers;
- Prosthetic Fabricators;
- Rehabilitation Centers;
- Orthotic Fabricators;
- Physicians (M.D., D.O., Podiatrists) (may dispense orthotic devices and artificial larynx);
- Pharmacies; and
- Hospitals.

The following providers may write a prescription for items covered under the DME Program, with the exception of diabetic shoes and inserts:

- Physicians (M.D., D.O., Podiatrists); and
- Advanced Practice Nurses who have a collaborative practice agreement with a physician that allows for prescription of such items.

Providers *must* be Medicare approved prior to enrollment with the MO HealthNet Division (MHD). Providers *must* enroll with the same name and address for which their Medicare number is issued. Each Medicare DME supplier *must* have a separate Medicare number and National Provider Identifier (NPI) for each location and *must* enroll each location where MHD services are provided. MHD will *not* backdate enrollment prior to the Medicare effective date. Representatives of a DME company or warehouse are *not* considered providers and are *not* eligible to enroll.

Providers submitting claims for DME are required to include the Ordering, Prescribing or Referring (OPR) provider's NPI on the claim. The OPR *must* be actively enrolled in the MO HealthNet program even if the provider does not accept MO HealthNet participants. If claims are submitted without the enrolled OPR provider's NPI, or if the OPR provider is not enrolled with MHD, the claim will be denied.

Additional information on provider conditions of participation can be found in Section 2 of this provider manual.

13.1.B Face-to-Face Requirements



The Centers for Medicare and Medicaid Services (CMS) revised federal regulation at 42 CFR 440.70 to require that no Medicaid payment for certain items of DME for which Medicare requires a face-to-face encounter shall be made unless there is documentation of a face-to-face encounter that meets the following criteria:

- related to the primary reason the beneficiary requires medical equipment;
- occurs no more than 6 months prior to the written order;
- occurs prior to the date of service delivery; and
- conducted by a physician (M.D. or D.O.) or one of the following non-physician practitioners (NPP):
 - a nurse practitioner working in collaboration with a physician;
 - a clinical nurse specialist working in collaboration with a physician; or
 - a physician assistant, under the supervision of a physician.

If an allowed NPP performs the face-to-face encounter, the clinical findings of that face-to-face encounter must be communicated to the enrolled ordering physician and be incorporated into the ordering physician's medical record for the participant.

As indicated in 42 CFR 440.70(g)(1), the DME that requires the face-to-face encounter is the same as the DME that requires a face-to-face encounter under the Medicare Program. A list of those items and corresponding HCPCS codes can be found at the following link: <https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Medical-Review/FacetoFaceEncounterRequirementforCertainDurableMedicalEquipment.html>.

13.1.B.2 Face-to-Face Documentation Requirements

The physician responsible for ordering the DME service must document the face-to-face encounter which is related to the primary reason the patient requires DME. The DME provider must ensure that it has received this documentation for each participant for whom it is required. The DME provider must maintain the documentation in the participant's record or files at their own location.

The documentation must, at a minimum, include the following:

- the clinical findings of the face-to-face encounter substantiating the need for the DME;
- the primary reason that the DME is required;
- the name, signature and credentials of the practitioner who conducted the face-to-face encounter; electronic signatures must meet requirements of electronic signatures for the MO HealthNet Program, in accordance with [13 CSR 65-3.050](#); and
- the date of the face-to-face encounter.



13.1.C OUT-OF-STATE SERVICES

Out-of-state (nonbordering) providers who render services to MO HealthNet participants located in Missouri are **ONLY** permitted to receive reimbursement if:

- Medicare coinsurance and/or deductible amounts on covered services are provided to participants who have *BOTH* MO HealthNet and Medicare.
- DME or supplies are *not* available in Missouri or a bordering state of Missouri.

If prior authorization is approved or reimbursement made for a DME item(s) on behalf of a MO HealthNet participant who is *not* Medicare eligible, or for equipment and/or supplies that are available in Missouri or a bordering state, the reimbursement that was paid may be recouped.

13.1.D NONDISCRIMINATION

Providers *must* comply with the 1964 Civil Rights Act, as amended; Section 504 of the Rehabilitation Act of 1973; the Age Discrimination Act of 1975; the Omnibus Reconciliation Act of 1981 and the Americans with Disabilities Act of 1990 and all other applicable Federal and State Laws that prohibit discrimination in the delivery of services on the basis of race, color, national origin, age, sex, handicap/disability or religious beliefs.

Further, all parties agree to comply with Title VII of the Civil Rights Act of 1964 which prohibits discrimination in employment on the basis of race, color, national origin, age, sex, handicap/disability or religious beliefs.

13.1.E RETENTION OF RECORDS

MO HealthNet providers *must* retain for five (5) years, from the date of service, fiscal and medical records that coincide with and fully document services billed to the MO HealthNet Agency, and *must* furnish or make the records available for inspection or audit by the Department of Social Services or its representative upon request. Failure to furnish, reveal and retain adequate documentation for services billed to the MO HealthNet Program may result in recovery of the payments for those services *not* adequately documented and may result in sanctions to the provider's participation in the MO HealthNet Program. This policy continues to apply in the event of the provider's discontinuance as an active MO HealthNet provider through change of ownership or any other circumstance.

13.2 ADEQUATE DOCUMENTATION

All services provided *must* be adequately documented in the medical record. The Code of State Regulations, 13 CSR 70-3.030, Section (2)(A) defines "adequate documentation" and "adequate medical records" as follows:



Adequate documentation means documentation from which services rendered and the amount of reimbursement received by a provider can be readily discerned and verified with reasonable certainty.

Adequate medical records are records which are of the type and in a form from which symptoms, conditions, diagnoses, treatments, prognosis and the identity of the patient to which these things relate can be readily discerned and verified with reasonable certainty. All documentation *must* be made available at the same site at which the service was rendered.

13.3 PARTICIPANT NONLIABILITY

MO HealthNet covered services rendered to an eligible participant are *not* billable to the participant if MO HealthNet would have paid had the provider followed the proper policies and procedures for obtaining payment through the MO HealthNet Program as set forth in 13 CSR 70-4.030.

13.4 EMERGENCY SERVICES

Emergency medical/behavioral health services means covered inpatient and outpatient services that are furnished by a qualified provider to evaluate or stabilize an emergency medical condition.

Emergency medical conditions for MO HealthNet Managed Care health plan members means medical or behavioral health conditions manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in the following:

1. Placing the physical or behavioral health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; or
2. Serious impairment of bodily functions; or
3. Serious dysfunction of any bodily organ or part; or
4. Serious harm to self or others due to an alcohol or drug abuse emergency; or
5. Injury to self or bodily harm to others; or
6. With respect to a pregnant woman having contractions: (a) there is no adequate time to affect a safe transfer to another hospital before delivery; or (b) that transfer may pose a threat to the health or safety of the woman or the unborn child.

Post stabilization care services mean covered services, related to an emergency medical condition that are provided after a participant is stabilized in order to maintain the stabilized condition or to improve or resolve the participant's condition.

13.5 OUT-OF-STATE, NON-EMERGENCY SERVICES

All non-emergency MO HealthNet covered services that are to be performed or furnished out-of-state for eligible MO HealthNet participants and for which MO HealthNet is to be billed, *must* be



prior authorized before the services are provided. Services that are *not* covered by the MO HealthNet Program are *not* approved.

Out-of-state is defined as *not* within the physical boundaries of the State of Missouri or within the boundaries of any state that physically borders Missouri. Border-state providers of services (those providers located in Arkansas, Illinois, Iowa, Kansas, Kentucky, Nebraska, Oklahoma and Tennessee) are considered on the same MO HealthNet participation basis as providers of services located within the State of Missouri.

A Prior Authorization (PA) Request form is *not* required for out-of-state non-emergency services. To obtain a PA for out-of-state, non-emergency services, a written request *must* be submitted by a physician to:

MO HealthNet Division
Participant Services Unit
P.O. Box 6500
Jefferson City, MO 65102-6500

The request may be faxed to (573) 526-2471.

The written request *must* include:

1. A brief past medical history;
2. Services attempted in Missouri;
3. Where the services are being requested and who will provide them; and
4. An explanation why services cannot be provided in Missouri.

NOTE: The out-of-state medical provider *must* agree to complete an enrollment application and accept MO HealthNet reimbursement. Prior Authorizations for out-of-state services expire 180 days from the date the specific service was approved by the state.

13.5.A EXCEPTIONS TO OUT-OF-STATE PRIOR AUTHORIZATION (PA) REQUESTS

The following are exempt from the out-of-state PA requirement:

1. All Medicare/MO HealthNet crossover claims;
2. All Foster Care children living outside the State of Missouri. However, non-emergency services that routinely require a PA continue to require a PA by out-of-state providers even though the service was provided to a Foster Care child;
3. Emergency ambulance services; and
4. Independent laboratory services.



13.6 PARTICIPANT COPAY

Participants eligible to receive certain MO HealthNet services are required to pay a small portion of the cost of the services. Services of the Durable Medical Equipment Program described in this manual are *not* subject to a copay amount.

13.7 GENERAL INFORMATION

The MO HealthNet Program reimburses qualified participating Durable Medical Equipment (DME) providers for certain DME items, such as: prosthetics; orthotics; respiratory care equipment; parenteral nutrition; ostomy supplies; wheelchairs and hospital beds, etc. These items *must* be ordered in writing by the participant's physician or advanced practice nurse and be suitable for use in any setting in which normal life activities take place, as defined in 42 CFR 440.70(c)(1). Nothing shall prevent services from being provided in any setting in which normal life activities take place, other than a hospital, nursing facility; intermediate care facility for individuals with intellectual disabilities; or any setting in which payment is or could be made under Medicaid for inpatient services that include room and board.

Although an item is classified as DME, it may not be covered in every instance. Coverage is based on the fact that the item is reasonable and necessary for treatment of a disability, an illness or injury, or to improve the functioning of a malformed or permanently inoperative body part, and the equipment meets the definition of DME or prosthesis.

Even though a DME item may serve some useful medical purpose, consideration *must* be given by the physician and the DME supplier to what extent, if any, it is reasonable for MO HealthNet to pay for the item as opposed to another realistically feasible alternative pattern of care.

Consideration should also be given by the physician and the DME provider as to whether the item serves essentially the same purpose as equipment already available to the participant.

If two (2) different items each meet the need of the participant, the less expensive item *must* be employed, all other conditions being equal. Equipment features of an aesthetic or medical nature, which are not medically necessary, are *not* reimbursable.

13.8 DEFINITIONS

MO HealthNet is designed to assist participants in obtaining medical care. Reimbursement may be made for expenses incurred for durable medical equipment services provided the conditions in the following subsections are met.

13.8.A DURABLE MEDICAL EQUIPMENT (DME)

DME is equipment that:

- can withstand repeated use;



- can be reusable or removable;
- is primarily and customarily used to serve a medical purpose;
- is *not* useful to a person in the absence of a disability, an illness or injury; and
- is appropriate for use in any setting in which normal life activities take place as defined in 42 CFR 440.70(c)(1), which specifies that nothing shall prevent services from being provided in any setting in which normal life activities take place, other than a hospital, nursing facility; intermediate care facility for individuals with intellectual disabilities; or any setting in which payment is or could be made under Medicaid for inpatient services that include room and board.

All requirements of the definition *must* be met in order for the equipment to be covered by MO HealthNet.

13.9 PURCHASE OF DURABLE MEDICAL EQUIPMENT (DME)

The participant *must* be eligible for MO HealthNet at the time the equipment or device is delivered or obtained. Items purchased become the property of the participant.

Some items are covered by MO HealthNet as purchase items only, while others are rental items only. Refer to Section 19 to determine if the item to be dispensed can be purchased or rented.

13.9.A PURCHASE OF USED DURABLE MEDICAL EQUIPMENT (DME)

Used equipment is covered only if the item has been solely used by the participant; i.e. the participant previously rented the equipment.

13.9.B DELIVERY OF ITEMS COVERED UNDER THE DURABLE MEDICAL EQUIPMENT (DME) PROGRAM

Items that are covered under the DME Program *must* be dispensed to the participant before the provider bills MO HealthNet for the item. Holding equipment until MO HealthNet payment is received constitutes a payment for a service not provided and is in violation of State Regulation 13 CSR 70-3.030 (23).

All charges for delivery, pickup, shipping, freight, C.O.D. and handling are included in the MO HealthNet allowed reimbursement amount and are *not* paid for separately or billable to the participant.

13.9.C REPLACEMENT OF PURCHASED ITEMS



Replacement of purchased items covered under the DME Program that are medically necessary and are lost, stolen, destroyed or required because of a change in the participant's condition are covered. Items with restriction of pre-certification *must* contact the MHD call center. The call center is available Monday through Friday from 8:00 am to 5:00 pm, excluding state holidays. Items requiring a Prior Authorization (PA) Request form or Certificate of Medical Necessity (CMN) *must* contain the following information:

- Explanation for continuing need of the item;
- How the item was lost or destroyed;
- Copy of the police report if the item was stolen or destroyed in an automobile accident, fire, etc.;
- Nature of the change in the participant's condition.

Replacement of items resulting from participant abuse or neglect is *not* covered and may be billed to the participant.

13.10 RENTAL OF DURABLE MEDICAL EQUIPMENT (DME)

The Certificate of Medical Necessity (CMN) attachment or Prior Authorization (PA) Request form for equipment are reviewed in order to determine initially if the item should be purchased or rented based on the diagnosis and prognosis of the participant and the anticipated period of need prescribed by the participant's physician. Items requiring pre-certification utilizes a management tool to determine the same. If the period of need indicates that it is less expensive to purchase the equipment, MO HealthNet may elect to purchase the equipment. Likewise, if it is less expensive to rent the equipment, MO HealthNet may elect to rent the equipment. If necessary, the routing modifier or service modifier on the PA Request form is changed by the consultant. An explanatory message appears on the disposition letter. Providers *must* request the purchase or rental of equipment based on the anticipated period of need.

13.10.A ELIGIBILITY DURING DURABLE MEDICAL EQUIPMENT (DME) RENTAL

If a participant is not eligible for MO HealthNet-covered services during a portion of the rental month, rental is paid only for the days each month the participant is eligible. A message appears on the Remittance Advice (RA) that reflects the reason for the reduced payment. The participant is responsible for the non-eligible rental period.

13.10.B REACHING THE PURCHASE PRICE OF A DURABLE MEDICAL EQUIPMENT (DME) ITEM

When the rental payments reach the MO HealthNet-allowed purchase price, the item becomes the property of the participant. A message appears on the RA stating that the equipment has been purchased by MO HealthNet and is the property of the participant.



13.10.C REPLACEMENT OF RENTED DURABLE MEDICAL EQUIPMENT (DME) ITEMS

MO HealthNet does *not* reimburse the provider or the participant for the replacement of a rented DME item that is stolen, lost or destroyed.

13.10.D BILLING GUIDELINES FOR DURABLE MEDICAL EQUIPMENT (DME) RENTAL

When billing for the rental of a DME item, the “from” and “to” dates of the claim *must* always be completed. The units of service should always be "1," unless otherwise specified in Section 19 of the DME Provider Manual.

Once the CMN, PA or precertification has been submitted and approved, any claim submitted matching the information on the approved CMN, PA or precertification can be processed for payment. This includes all monthly claims for rental.

13.11 REPAIR OF DURABLE MEDICAL EQUIPMENT (DME)

Repair of participant-owned DME or prosthetic or orthotic device (whether purchased by MO HealthNet outright, purchased through rental payments or paid for by the participant) is covered if:

- The item to be repaired is a covered item under the DME Program.
- The repairs do *not* exceed 60% of the cost of a new piece of equipment, or orthotic or prosthetic device. The repair *must* be calculated at the allowed amount and excludes routine replacement items such as batteries, arm pads, tires, etc. Previously billed repairs cannot be added to the calculation but can be documented to support the need to upgrade equipment to prevent higher costs to the DME program.
- The item is *not* under the provider’s or manufacturer’s warranty.
- The repairs are *not* required as a result of participant abuse.
- The participant is *not* in an institution unless the repair is for a custom or power wheelchair or augmentative communication, orthotic or prosthetic device.
- The equipment is *not* being rented.
- There is a continuing medical need for the equipment.
- The repairs are *not* a result of a defect in materials or workmanship.

Reimbursement for a repair is based on the reasonable charge for parts and the allowable reimbursement amount for labor.



13.11.A BILLING GUIDELINES FOR DURABLE MEDICAL EQUIPMENT (DME) REPAIR

The HCPCS code for the specific item along with the routing modifier, RB, *must* be used to bill when submitting a claim for repair of an item. If there is *not* a specific HCPCS code to use to bill the repair, the following repair codes may be used to bill for pieces and parts:

- Z0160 Repair of equipment, replace or repair minor parts
- L4210 Orthotic repair or replace minor parts
- L7510 Prosthetic repair or replace minor parts

The amount of time required for the repair or modification may be billed under the following labor codes:

- K0739 Repair or non-routine service for DME, other than oxygen equipment, requiring the skill of a technician, labor component, per 15 minutes
- L4205 Repair of orthotic device, labor component, per 15 minutes
- L7520 Repair of prosthetic device, labor component, per 15 minutes

List the actual time in the unit's field of the claim form in 15-minute increments.

A Certificate of Medical Necessity (CMN) is required for most repair claims (refer to Section 19 for specific requirements). The CMN may be submitted through the MO HealthNet Web Portal at www.emomed.com.

Repairs under \$500.00 do *not* require a physician's signature. The CMN must be maintained in the participants file.

Medical necessity for replacement, a detailed description and the age of the item being repaired *must* be documented on the CMN. If there is labor to be billed, a detailed explanation of the time involved *must* also be listed on the CMN.

When billing for a repair, copies of the invoices showing the Manufacturer's Suggested Retail Price (MSRP), or the Invoice of Cost (IOC), *must* be submitted with the claim form through the MO HealthNet Web Portal at www.emomed.com. Claims are manually priced at this time, *not* at the time of the approval of the CMN.

If a repair requires a Prior Authorization (PA), a detailed description and the age of the item being repaired *must* be documented on the PA. If the item(s) requested are manually priced, the IOC or MSRP *must* be submitted with the PA to establish an allowed amount for reimbursement.



13.12 WARRANTIES

When an orthotic device, prosthetic device or other equipment has been purchased, the following warranties *must* be provided by the provider, unless the manufacturer's warranty is for a greater length of time. If the manufacturer's warranty is less than the following, a statement from the manufacturer or copy of their printed policy *must* be submitted.

- 1 year for prosthetic devices
- 90 days for custom orthotics
- 30 days for standard braces
- 1 year for equipment such as walkers, wheelchairs, hospital beds, etc.

13.13 TRADE-IN OF DURABLE MEDICAL EQUIPMENT (DME)

When a DME item is traded in on a new item, the trade-in amount *must* be deducted from the purchase price and the reduced amount billed. An explanation *must* be noted on the Certificate of Medical Necessity or Prior Authorization Request form.

13.14 REIMBURSEMENT GUIDELINES

13.14.A MANUALLY PRICED ITEMS

All items that require manual pricing, with the exception of wheelchairs and accessories, gait trainers, standers and Augmentative Communication Devices (ACDs), are reimbursed based on the actual Invoice of Cost (IOC), of the supply or equipment plus 20%. The actual IOC is submitted with the claims as instructed in Section 13.11 of the DME manual. Items that require manual pricing may be found in Section 19 of the DME manual.

- Wheelchair and accessories, gait trainers, standers and ACDs are priced based on the Manufacturer's Suggested Retail Price (MSRP) as follows:
- MWC and accessories - 90% of MSRP
- PWC and accessories - 95% of MSRP
- Gait Trainers - 90% of MSRP
- Standers - 90% of MSRP
- ACD - 85% of MSRP

13.14.B ADDITIONAL REIMBURSEMENT GUIDELINES



- MO HealthNet payment is the lower of the provider’s usual and customary charge to the general public or the MO HealthNet maximum allowable amount, less any third party resource.
- Sales tax is *not* covered by MO HealthNet, nor can it be billed to the participant. Providers should contact the Tax Administration Bureau on a regular basis to ensure that items covered under the DME Program are *not* subject to Missouri sales tax.
- Providers may *not* request or accept a deposit from a MO HealthNet participant and then refund it after payment is received from MO HealthNet. Accepting a deposit or portion of payment for services from a participant will only be allowed as outlined in State Regulation 13 CSR 70-4.040 and 13 CSR 70-4.050.
- Providers *must* accept the MO HealthNet payment as the full and complete payment and may *not* accept additional payment from the participant. Accepting a portion of payment for services from the participant is in violation of State Regulation 13 CSR 70-3.030.
- Quantities in excess of the limit may be covered if medically necessary. Pre-certification of excess quantities *must* be obtained for items that require pre-certification. For items that do not require pre-certification, medical necessity justification in letter form from the prescriber *must* be submitted along with a paper claim for review by the MO HealthNet State consultant.
- Charges for shipping, freight, C.O.D., handling, delivery and pickup are included in the reimbursement for items covered under the DME Program and are *not* separately billable to the MO HealthNet participant.

13.15 DELIVERY REQUIREMENTS

13.15.A PROOF OF DELIVERY

Proof of delivery is required for verification that equipment or supplies were received by the participant. Durable Medical Equipment (DME) providers *must* maintain proof of delivery documentation in their files for five (5) years for every item provided.

For the purpose of the proof of delivery information provided below, “designee” is defined as “any person who can sign and accept the delivery of durable medical equipment on behalf of the participant.” DME providers, their employees or anyone who may have a financial interest in the delivery of the item are prohibited from signing and accepting an item on behalf of the participant (i.e., acting as a designee on behalf of the participant).

DME providers shall *not* bill for an item prior to receipt of documentation of proof of delivery. In addition, for DME items that require fitting, set-up and/or instruction, the DME provider shall *not* bill prior to providing the participant with proper set-up, fitting and



instruction. Documentation of any set-up fitting and/or instructions provided *must* be maintained in the DME provider's participant record.

13.15.B DIRECT DELIVERY

DME providers may deliver an item or supply directly to the participant or their designee. An example of proof of delivery made directly to a participant is a signed and dated delivery slip. It is recommended the delivery slip include the following:

- Participant's name
- Quantity delivered
- Detailed description of the item being delivered
- Brand name of the item
- Serial number (if applicable)

The date of signature on the delivery slip *must* be the date that the item/supply was received by the participant or designee. In instances where the item/supply is delivered directly by the DME provider, the actual date the participant received the item/supply shall be the date of service on the claim.

13.15.C MAIL ORDER/SHIPPING SERVICE DELIVERY

If a DME provider uses a shipping or mail order service, an example of proof of delivery should include the services tracking slip and the DME provider's own shipping invoice. If possible, the DME provider's record should also include the delivery service's package identification number for the package sent to the participant. The shipping service's tracking slip should reference each individual package, the delivery address, the corresponding package identification number given by the shipping service, and, if possible, the date delivered. DME providers should use the shipping date as the date of service on the claim.

13.15.D SUPPLY REFILLS - NO AUTO REFILLS

For DME items supplied as refills to the original order (e.g. nebulizers supplies, CPAP supplies, diapers, etc.), the DME provider **MUST** contact the participant or caregiver prior to dispensing the refill and not automatically ship on a pre-determined basis, even if authorized by the participant. This shall be done to ensure that the refilled item remains reasonable and necessary, existing supplies are approaching exhaustion, and to confirm any changes/modification to the order. Contact with the participant or designee regarding refills *must* take place no sooner than 14 days prior to the delivery/shipping date.

For all items that are provided on a recurring basis, DME providers are required to have contact with the participant or caregiver/designee prior to dispensing a new supply of items. DME providers *must* not deliver refills without a specific refill request from a participant. Items delivered without a valid, documented refill request are not covered and may not be billed to the participant. For items that the participant obtains in-person at a retail store, the signed delivery slip or a copy of the itemized sales receipt is sufficient documentation of request for refill.

DME providers *must* not dispense a quantity of supplies exceeding a participant's expected utilization. DME providers *must* be attentive to changed or atypical utilization patterns on the part of their clients. DME providers *must* verify with the ordering physicians that any changed or atypical utilization is warranted.

The date of service for items supplied as refills to the original order may be the actual delivery date or ship date depending on the method of delivery, or within three calendar days after the delivery date or ship date. For example, if an item is delivered by the supplier on June 1st, the date of service billed on the claim may be June 1, June 2, June 3 or June 4. This flexibility is allowed to ensure a participant is able to receive the refill of supplies without a gap in service and the provider is able to bill for the supplies provided.

13.15.E EXCEPTIONS TO THE DATE OF SERVICE

A DME provider may deliver a DME item to a participant in a hospital or nursing facility for the purpose of fitting or training the participant in the proper use of them. This may be done up to 2 days prior to the participant's anticipated discharge to their home. The DME provider shall bill the date of discharge as the date of service on the claim and use the place of service (POS) 12 (home). No billing may be made for the item for those days the participant was receiving training or fitting in the hospital or nursing facility. The DME provider *must* ensure the participant's equipment is properly set-up and the patient is instructed on proper use of the equipment prior to billing. Services cannot be billed prior to the date the patient is discharged.

13.16 PAYMENT FOR CUSTOM-MADE ITEMS WHEN DELIVERY OR PLACEMENT CANNOT BE MADE PRIOR TO PARTICIPANT'S LOSS OF ELIGIBILITY OR DEATH

MO HealthNet payment may be made for custom-made items such as orthotics, prosthetics, custom wheelchairs and custom Healthy Children and Youth (HCY) equipment when the participant becomes ineligible (either through complete loss of MO HealthNet eligibility or change of assistance category to one for which the particular service is *not* covered) or dies after the item is ordered or fabricated and prior to the date of delivery or placement of the item.



13.16.A PREREQUISITE FOR PAYMENT OF CUSTOM-MADE ITEMS

The following prerequisites apply to all such payments:

- The participant *must* have been eligible when the service was first initiated (and following receipt of an approved Prior Authorization (PA) Request, if required) and at the time of any subsequent service, preparatory and prior to the actual ordering of fabrication of the device or item; and
- The custom-made device or item *must* have been fitted and fabricated to the specific medical needs of the user in such a manner so as to preclude its use for medical purpose by any other individual; and
- The custom-made device or item *must* have been delivered or placed if the participant is living; and
- The provider *must* have entered “see attachment” in Field #19 of the claim form and *must* have attached a provider-signed statement to the claim. The statement *must* explain the circumstances and include the date of actual delivery or placement for a living participant or the date of death when delivery or placement is not possible due to this reason. The statement *must* also include the total amount of salvage value, which the provider estimate is represented in case where delivery or placement is not possible.

13.16.B PAYMENT OF CUSTOM-MADE ITEMS AND DEVICES

The following explains how payment is determined based on the participant’s eligibility status:

- a. If the item is received by the participant following the loss of MO HealthNet eligibility or eligibility for the service, the payment is the lesser of the “net billed charge” or the MO HealthNet maximum allowable amount for the total service, less any applicable cost sharing or copayment.
- b. If the item cannot be delivered or placed due to death of the participant, the payment is the lesser of the “net billed charge” or the MO HealthNet maximum allowable amount for the total service, less any applicable cost sharing or coinsurance. The “net billed charge” shall be the provider’s usual and customary billed charge(s) as reduced by any salvage value amount.
 - “Salvage value” exists whenever there is further profitable use that can be made by the provider of materials or components of the device or item. Dentures are an example of an item representing no reasonable salvage value, whereas a custom-made wheelchair may, in its components, represent



salvage value. The salvage value *must* be clearly documented in the medical records.

- Any provider-determined retail salvage value of the unplaced or undelivered item *must* be subtracted by the provider from the charge for the item, and only the net-reduced charge entered on the claim form line for the item. These items are subject to review as to salvage value adjustment represented in the billed charge.
- c. The date of service that is shown on the claim form for the item (custom wheelchair, braces, etc.) when situation a. or b. applies *must* be the last date on which service is provided to the eligible participant (and following receipt of an approved PA, if required) prior to the ordering or fabrication of the item. The provider is responsible for verifying participant eligibility each time a service is provided. Use of a date for which the participant is no longer eligible for MO HealthNet coverage of the service results in a denial of the claim. The claim (with attachment) *must* be submitted to the fiscal agent in the same manner as other claims.

Payments made as described in a. or b. constitutes the allowable MO HealthNet payment for the service, and no further collection from the participant or other persons is permitted.

If the provider determines the participant has lost eligibility after the service is first initiated and before the custom-made item is actually ordered or fabricated, the participant *must* be immediately advised that completion of the work and delivery or placement of the item is *not* covered by MO HealthNet. It is then the participant's choice to request completion of the work on a private-payment basis. If participant death is the reason for loss of eligibility, the provider can, of course, proceed no further and there is no claim for the non-provided item of service.

If a participant refuses to accept the item/service, MO HealthNet does *not* reimburse the provider.

13.17 MANAGED CARE HEALTH PLAN

Certain items and/or services that have been initiated or prior authorized by MO HealthNet before the enrollment effective date in a Managed Care health plan are reimbursed on a fee-for-service (FFS) basis by the state agency when placement occurs after the Managed Care health plan enrollment is effective. MO HealthNet is financially responsible for these items or services in accordance with the following:

- Augmentative communication devices (ACDs) and evaluations, prosthetic and orthotic devices that have been ordered, initiated or prior authorized prior to the enrollment effective date in the Managed Care health plan, but placement occurs after the effective date of the Managed Care health plan enrollment.



- Custom and power wheelchairs and custom HCY equipment that have been prior authorized by the MHD prior to the enrollment effective date in the Managed Care health plan, but placement occurs after the effective date of Managed Care health plan enrollment.

Providers may contact the Provider Communications Unit at (573) 751-2896 for instructions on how to bill for these items/services.

Certain items and/or services that have been initiated or prior authorized by the Managed Care health plan before the effective date enrolled in the MO HealthNet's FFS Program are reimbursed by the Managed Care health plan when placement occurs after FFS enrollment is effective. The Managed Care health plan is financially responsible for these items or services in accordance with the following:

- ACDs and evaluations, prosthetic and orthotic devices that have been ordered, initiated or prior authorized prior to the enrollment effective date in the FFS Program, but placement occurs after the effective date of the FFS Program enrollment.
- Custom and power wheelchairs and custom Healthy Children and Youth equipment that have been prior authorized by the Managed Care health plan prior to the enrollment effective date in the FFS Program, but placement occurs after the effective date of FFS Program enrollment.

13.18 COVERAGE OF DURABLE MEDICAL EQUIPMENT (DME) FOR PARTICIPANTS IN A NURSING HOME

DME is *not* covered for those participants residing in a nursing home (place of service 31 or 99 with level of care 1 or 2). DME is included in the nursing home per diem rate and *not* paid for separately with the exception of the following items:

- Augmentative Communication Devices (ACDs) and Accessories;
- Custom Wheelchairs;
- Power Wheelchairs;
- Orthotic and Prosthetic Devices;
- Total Parenteral Nutrition; and
- Volume Ventilators.

MO HealthNet requires all providers of custom and power wheelchairs provide equipment that meets the participant's needs for mobility and positioning in a cost-effective manner for participants in a nursing home. The Prior Authorization (PA Request is denied if the chair is considered *not*



medically necessary, if it is *not* a custom wheelchair or if a less expensive alternative wheelchair is available.

Supporting documentation for custom and power wheelchairs *must* be included with the PA Request. Section 1, Field #9 of the PA Request form *must* clearly list the name and address of the nursing home in which the participant resides.

13.18.A PRIOR AUTHORIZATION (PA) REQUESTS/LETTERS OF MEDICAL NECESSITY (LMN) FOR CUSTOM OR POWER WHEELCHAIRS

When submitting a PA request for a custom or power wheelchair, there *must* be comprehensive written documentation submitted with the PA request. LMN's and supporting documentation *must* be signed by the prescribing physician as well as the nursing home's director of nursing or the nursing home's employed or contracted licensed physical or occupational therapist (the physical or occupational therapist may have no financial relationship with the DME provider, except for hospital-based providers). In addition, letters of medical necessity generated by the supplier *must* be written on the supplier's letterhead and signed by both the supplier and the prescribing physician as well as the nursing home's director of nursing or the nursing home's employed or contracted licensed physical or occupational therapist (the physical or occupational therapist may have no financial relationship with the DME provider, except for hospital-based providers).

Letters of medical necessity *must* clearly and specifically explain the following:

- The diagnosis/comorbidities and conditions relating to the need for a custom or power wheelchair;
- Description and history of limitations/functional deficits;
- Description of physical and cognitive abilities to utilize equipment;
- History of previous interventions/past use of mobility devices;
- Description of existing equipment, age and specifically why it is *not* meeting the participant's needs;
- Explanation as to why a less costly mobility device is unable to meet the participant's needs (i.e., cane, walker, manual wheelchair);
- Documentation and justification of medical necessity of recommended mobility device, accessories and positioning components;
- Documentation/explanation of participant's ability to safely tolerate/utilize the recommended equipment; and



- Documentation/explanation as requested by the State consultant.

13.18.B ASSISTIVE TECHNOLOGY PROFESSIONAL

Custom or power wheelchairs for participants residing in a nursing home *must* be supplied by a DME provider that employs a RESNA-certified Assistive Technology Professional (ATP) who specializes in wheelchairs. The ATP *must* have direct, in-person, face-to-face interaction, after the physician or nurse practitioner's face-to-face examination, and involvement in the wheelchair selection for the participant. The provider record should document how the ATP was involved and directed the wheelchair selection process.

13.18.C PHYSICIAN FACE-TO-FACE EVALUATION

For a custom or power wheelchair to be covered for a participant residing in a nursing home, a treating physician *must* be the first point of contact with the participant and conduct a face-to-face examination of the participant before writing an order for the custom or power wheelchair. The physician's required face to face examination *must* be completed prior to any examination or contact by any person associated with the DME provider, including an ATP. Physicians shall document the face-to-face examination in a detailed narrative note in the participant's chart in the format they use for other entries. Supplier or facility-created forms that the physician completes are not a substitute for the comprehensive medical record/chart note indicated above. The physician face-to-face examination *must* provide information about the following elements but may include other details:

History of the present condition(s) and past medical history that is relevant to mobility needs:

- Symptoms that limit ambulation;
- Diagnoses that is responsible for symptoms;
- Progression of ambulation difficulty over time;
- Other diagnoses that may relate to ambulatory problems;
- Cardiopulmonary examination; and
- Weight and height.

Physical examination that is relevant to mobility needs:

- Existing ambulatory assistance (cane, walker, wheelchair, caregiver) that is currently being utilized;



- Ability to stand up from a seated position without assistance;
- Description of the ability to perform activities of daily living;
- Distance the participant can walk without stopping;
- Pace of ambulation;
- Musculoskeletal examination to include arm and leg strength and range of motion; and
- Neurological examination to include documentation of functional ambulation and balance and coordination.

The physician examination *must* be tailored to the individual participant's condition. The history *must* clearly illustrate the participant's functional abilities and limitations on a typical day, and contain as much objective data as possible. The physical examination *must* be focused on the body systems responsible for the participant's ambulatory difficulty or impact on the participant's ambulatory ability.

After the face-to-face visit with the physician, the physician may choose to refer the participant to a licensed Physical Therapist (PT) or Occupational Therapist (OT) for completion of the physical portion of the exam. The PT or OT may have no financial relationship with the DME provider, except for hospital-based providers. There is no separate reimbursement outside the nursing home per diem for a PT or OT evaluation.

A prior evaluation completed by a licensed PT or OT within the past 90 days may also be utilized for the physical portion of the exam. All areas noted above for the physical exam *must* be addressed. If utilized, the PT or OT exam *must* be reviewed by the physician after completion, agreed on or amended, and signed before issuing the physician order. It is acceptable and considered best practice for the ATP to be present during the PT/OT evaluation. The DME provider record *must* document how the ATP was involved and proceeded through the wheelchair selection process.

The face-to-face examination *must* be completed by the physician or nurse practitioner prior to any examination performed by the DME provider, including the ATP. The DME provider *must* receive the written report of this examination within 90 days after completion of the face-to-face physician examination.

A date stamp or equivalent *must* be used to document the date that the provider receives the report of the face-to-face physician examination. The written report of the physician examination *must* be submitted with the PA request.

13.18.D PHYSICIAN ORDER



When requesting a custom or power wheelchair for a nursing home participant, a physician order must be received by the DME provider within 90 days after completion of the face-to-face physician examination and prior to any DME provider evaluation. The physician order *must* contain all of the following:

- Participant's name;
- Description of the item that is ordered (may be general such as power wheelchair, manual wheelchair);
- Date of the face-to-face examination;
- Pertinent diagnoses/conditions that relate to the need for the custom or power wheelchair;
- Length of need;
- Physician's signature; and
- Date of physician's signature

A date stamp or equivalent must be used to document receipt date of the physician or nurse practitioner order. This order must be included with the PA request. If it is not included, the PA will be returned as incomplete.

13.18.E POWER WHEELCHAIRS (PWC) AND ACCESSORIES FOR NURSING HOME PARTICIPANTS

In addition to the requirements above, requests for Group 2 PWC for nursing home participants *must*:

A. Document one of the following diagnoses groups:

1. Spinal cord injury resulting in quadriplegia or paraplegia (G82.20, G82.21, G82.22, G82.50, G82.51, G82.52, G82.53, G82.54);
2. Other spinal cord diseases (G32.0, G95.0, G95.11, G95.19, G95.899);
3. Multiple Sclerosis (G35);
4. Other demyelinating disease (G36.0, G36.1, G36.8, G36.9, G37.0, G37.1, G37.2, G37.3, G37.4, G37.5, G37.8, G37.9);
5. Cerebral Palsy (G80.0, G80.1, G80.2, G80.3, G80.4, G80.8, G80.9);
6. Anterior Horn Cell Diseases including Amyotrophic Lateral Sclerosis (G12.0, G12.1, G12.20, G12.21, G12.23, G12.24, G12.25, G12.29, G12.8, G12.9);



7. Post-polio paralysis (B91, G14);
8. Traumatic brain injury resulting in quadriplegia (G82.50);
9. Spina Bifida (Q05.0, Q05.1, Q05.2, Q05.3, Q05.4, Q05.5, Q05.6, Q05.7, Q05.8, Q05.9, Q07.01, Q07.03);
10. Childhood cerebral degeneration (E75.23, E75.25, E75.29, F84.2, G31.9, G93.89, G83.9);
11. Huntington's Disease (G10)
12. The participant has had a leg and arm amputation or congenital deformity resulting in non-functional use of 3 or more limbs;
13. The participant has non-functional paralysis for two or more limbs and permanent non-functional use of a third limb;
14. Current stage II or greater pressure ulcer (L89) on the area of contact with the seating surface (trunk, spine or pelvis) (*must* be noted and described by the physician in the face-to-face visit; justification *must* document what other types of skin protection measures have been utilized); or
15. Severe orthopedic abnormality of the hip, spine or pelvis significantly affecting positioning (*must* be documented by the physician in the face-to-face visit); and

- B. Explain why a less costly mobility device is unable to meet the participant's needs including a description of equipment trials and their effectiveness.

The information must be supported by diagnosis in the patients file. It must be included in the detailed physician chart note including the documentation of the physical examination portion of the face to face encounter. The documentation must accompany the PA request from the DME provider.

Requests for Group 3 PWC wheelchairs will only be considered when the following criteria are met:

- A. All criteria for a Group 2 PWC are met;
- B. Medical justification provides extensive documentation of why a Group 2 PWC and other less costly devices will *not* meet the participant's needs;
- C. Documentation includes the length of time the participant has resided in the nursing home; and



D. One of the following:

Documentation includes a copy of the discharge plan from the nursing home's participant record that clearly states the participant's discharge date is in the next 90 days to an independent or less restrictive living environment and that the participant will be involved in activities that require the client to utilize a wheelchair in the community on a frequent basis (e.g. work, shopping, self-transport to appointments). Supporting documentation from a physician, social worker or OT/PT explaining the participant's discharge plans and mobility needs *must* accompany the discharge plan; or

The medical necessity justification provides clear documentation that the participant requires specialty controls other than a joy stick to independently operate the wheelchair; or

If the patient's weight is greater than 300 pounds and there is no availability of a heavy-duty Group 2 PWC, a less costly Group 3 PWC, with single power, will be considered.

The following equipment is *not* considered medically necessary for participants residing in a nursing home:

- Group 1 PWC;
- Group 4 PWC;
- Multiple power seat function (i.e., power tilt and recline); and
- Power elevating leg rests/lower extremity power articulating platform.

13.18.F COVERAGE OF CUSTOM WHEELCHAIRS FOR NURSING HOME PARTICIPANTS

MO HealthNet will reimburse for medically necessary custom wheelchairs for participants residing in a nursing facility. A custom wheelchair is defined as a chair that is tailor made for one participant and cannot be used by anyone else. Prior authorization is required. All PA requests *must* indicate why a less costly wheelchair is unable to meet the participant's needs. Criteria A, B, and C below describes the criteria utilized for a wheelchair to be considered custom. Criteria for individual HCPCS codes are listed following criteria A, B and C below.

- A. Any wheelchair with a custom seating system. A custom seating system is a wheelchair seating system which is individually made for a patient using a plaster model of a patient, a computer generated model of the patient (i.e. CAD-CAM technology), or the detailed measurements of the patient to create either: (a) a



molded, contoured, or carved (foam or other suitable material) custom-fabricated seating system that is incorporated into the wheelchair base; or (b) a custom seating system made from multiple pre-fabricated components or a combination of custom fabricated materials and pre-fabricated components which have been configured and attached to the wheelchair base or incorporated into a wheelchair seat and/or back in a manner that the wheelchair could *not* be easily re-adapted for use by another individual.

To qualify for a custom seating system, an individual *must* meet all the requirements of a custom fabricated seat cushion or a custom fabricated back cushion as described in Section 13.30.G of this manual. The PA request *must* document the following:

1. Why a pre-fabricated system is *not* sufficient to meet the participant's seating and positioning needs;
 2. What orthopedic deformity is present and its fixed or flexible presentation;
 3. What altered muscle tone is present and its increased or decreased presentation that affects seating and positioning; and
 4. Why any existing system is *not* meeting the participant's seating and positioning needs.
- B. A specially-sized or constructed wheelchair that is provided to a participant whose anatomical measurements require the following:
1. Wheelchair seat width of 25 inches or more;
 2. Wheelchair with a weight capacity for 351 or more pounds; or
 3. Wheelchair with a seat to floor height of less than 15 1/2 inches.
- C. A wheelchair for a participant who has absent or impaired sensation in the area of contact with the seating surface or inability to carry out a functional weight shift due to one of the following diagnoses groups or conditions:
1. Spinal cord injury resulting in quadriplegia or paraplegia (G82.20, G82.21, G82.22, G82.50, G82.51, G82.52, G82.53, G82.54);
 2. Other spinal cord diseases (G320, G95.0, G95.11, G95.19, G95.89, G99.2);
 3. Multiple sclerosis (G35);
 4. Other demyelinating disease (G36.0, G36.1, G36.8, G36.9, G37.0, G37.1, G37.2, G37.3, G37.4, G37.5, G37.8, G37.9);



5. Cerebral palsy (G80.0, G80.1, G80.2, G80.3, G80.4, G80.8, G80.9);
6. Anterior horn cell diseases including amyotrophic lateral sclerosis (G12.0, G12.1, G12.20, G12.21, G12.23, G12.24, G12.25, G12.29, G12.8, G12.9);
7. Post-polio paralysis (B91, G14);
8. Traumatic brain injury resulting in quadriplegia (G82.50);
9. Spina bifida (Q05.0, Q05.1, Q05.2, Q05.3, Q05.4, Q05.5, Q05.6, Q05.7, Q05.8, Q05.9, Q07.01, Q07.03);
10. Childhood cerebral degeneration (E75.23, E75.25, E75.29, F84.2, G31.9, G93.89, G93.9);
11. Huntington's disease (G10)
12. Current stage II or greater pressure ulcer (L89) on the area of contact with the seating surface (trunk, spine or pelvis). Current stage II or greater pressure ulcer *must* be noted and described by the physician in the face-to-face visit; justification *must* document what other types of skin protection measures have been utilized; or
13. Severe orthopedic abnormality of the hip, spine or pelvis significantly affecting positioning. Any or all of these abnormalities *must* be noted and described by the physician in the documentation of the face-to-face visit.

HCPCS code specific requirements are as follows:

- Wheelchairs described by HCPCS codes K0001, K0002, and K0003 will *not* be considered custom wheelchairs.
- Wheelchairs described by HCPCS code K0004 may be considered custom if criterion A, B or C above is met. Documentation for K0004 *must* justify why a less costly device cannot be used.
- Wheelchairs described by HCPCS code K0005 may be considered custom if criterion A or B above is met along with one of the following diagnosis groups:
 1. Spinal cord injury resulting in quadriplegia or paraplegia (G82.20, G82.21, G82.22, G82.50, G82.51, G82.52, G82.53, G82.54);
 2. Other spinal cord diseases (G32.0, G95.0, G95.11, G95.19, G95.89, G99.2);
 3. Multiple Sclerosis (G35);
 4. Other demyelinating disease (G36.0, G36.1, G36.8, G36.9, G37.0, G37.1, G37.2, G37.3, G37.4, G37.5, G37.8, G37.9);



5. Cerebral Palsy (G80.0, G80.1, G80.2, G80.3, G80.4, G80.8, G80.);
 6. Anterior Horn Cell Diseases including Amyotrophic Lateral Sclerosis (G12.0, G12.1, G12.20, G12.21, G12.23, G12.24, G12.25, G12.29, G12.8, G12.9);
 7. Post-polio paralysis (B91, G14);
 8. Traumatic brain injury resulting in quadriplegia (G82.50);
 9. Spina Bifida (Q05.0, Q05.1, Q05.2, Q05.3, Q05.4, Q05.5, Q05.6, Q05.7, Q05.8, Q05.9, Q07.01, Q07.03);
 10. Childhood cerebral degeneration (E75.23, E75.25, E75.29, F84.2, G31.9, G93.89, G93.);
 11. Huntington’s Disease (G10)
 12. Current stage II or greater pressure ulcer (L89) on the area of contact with the seating surface (trunk, spine or pelvis) (*must* be noted and described by the physician in the face-to-face visit documentation; justification *must* document what other types of skin protection measures have been utilized); or
 13. Severe orthopedic abnormality of the hip, spine or pelvis significantly affecting positioning (*must* be noted and described by the physician in the face-to-face visit documentation).
- Documentation for a K0005 *must* justify why a K0004 and other less costly device cannot be used.
 - Wheelchairs described by HCPCS code E1161 may be considered custom if criterion C above is met.
 - Wheelchairs described by HCPCS codes K0006 and K0007 may be considered custom if two (2) of the requirements stated in criterion B above are met.
 - Wheelchairs described by HCPCS code K0009 will generally be considered noncovered for participants residing in a nursing home. Requests for K0009 wheelchairs will only be considered in extenuating circumstances and when the following exists:
 - A. Extensive documentation explaining why no other manual wheelchair (K0001-K0007) will meet the participant’s needs; and
 - B. The participant’s anatomical measurements are provided and document the participant requires one of the following:
 - A wheelchair seat width of 25 inches or more; or
 - A wheelchair with a weight capacity of 351 or more pounds.



13.18.G WHEELCHAIRS AND OPTIONS/ACCESSORIES FOR NURSING HOME PARTICIPANTS

Mo HealthNet requires use of the item-specific HCPCS code for all wheelchairs and wheelchair option/accessories for nursing home participants. The modifier SC *must* be added to the HCPCS code along with the appropriate NU (purchase) or RR (rental) modifier.

All wheelchair bases, initial options/accessories, and upgrade options/accessories for participants residing in a nursing home require prior authorization.

PLEASE NOTE: MO HealthNet reimbursement for wheelchairs and wheelchair options/accessories for participants residing in a nursing home is limited to participant-owned custom or power wheelchairs. Custom wheelchairs *must* meet the definition of a custom wheelchair as defined in Section 13.18.F of this manual. Reimbursement for all other manual wheelchairs and options/accessories is included in the nursing home per Diem.

13.8.H DUAL ELIGIBLE (MEDICARE & MO HEALTHNET) PARTICIPANTS

Claims for wheelchair bases, accessories and repairs for nursing home participants who have Medicare Part A and/or B and the stay is not covered by Medicare, a Medicare denial is not required with the claim.

13.19 COVERAGE OF DURABLE MEDICAL EQUIPMENT (DME) FOR PARTICIPANTS IN A HOSPITAL

DME items dispensed to a participant while receiving inpatient or outpatient care is included in the hospital payment and *not* paid for separately under the DME Program.

A hospital, which is enrolled as a DME provider, cannot be paid through the DME Program for any item covered under the DME Program that is used for inpatient/outpatient care.

13.20 AUGMENTATIVE COMMUNICATION DEVICES (ACDs)

13.20.A AUGMENTATIVE COMMUNICATION DEVICE (ACD) DEFINITION

ACD's are speech prostheses and are regarded as Durable Medical Equipment (DME). ACDs are alternative and supplemental communication equipment used to overcome or ameliorate an individual's inability to communicate due to a disease or medical condition that precludes or significantly interferes with the participant's participation in activities of daily living. Examples of ACDs are communication picture boards/books, speech amplifiers, speech enhancers and electronic devices that produce speech or written output. Related accessories such as overlays, batteries, wheelchair mounts, switches, cables, pointing devices, etc. are also considered. A portable or desktop computer is only considered when the primary use of the computer is the participant's communication device. Examples of noncovered items



include, but are *not* limited to: printers, office/business software, software intended for academic purposes, Internet access and computer tables.

13.20.B ELIGIBILITY FOR AUGMENTATIVE COMMUNICATION EQUIPMENT

MO HealthNet reimburses for electronic or manual ACDs, regardless of the participant's age, when the device is deemed medically necessary through pre-certification. DME pre-certification criteria documents may be found at <http://www.dss.mo.gov/mhd/cs/dmeprecert/pages/dmeprecert.htm>. Refer to Section 13.32 for pre-certification guidelines.

The Manufacturer Suggested Retail Price (MSRP) is required for manually-priced procedure codes. Refer to Section 19 for specific procedure code restrictions. The MSRP should be submitted electronically with the claim. The attachment and completion of the MSRP instructions are available at www.emomed.com.

13.20.C AUGMENTATIVE COMMUNICATION DEVICE (ACD) EVALUATION TEAM/SITE

For an ACD team/site currently enrolled as a speech-language pathologist, rehabilitation center or outpatient hospital that wishes to be considered as a MO HealthNet ACD evaluation team/site, please contact the Provider Enrollment Unit via e-mail at: MMAC.ProviderEnrollment@dss.mo.gov. Providers should state if they are currently enrolled as a MO HealthNet provider. Approval is given to speech-language pathologists, rehabilitation centers or outpatient hospitals that meet the following criteria:

- The ACD team/site leader *must* be a Missouri licensed speech-language pathologist who has a certificate of clinical competency from the American Speech-Language-Hearing Association.
- The speech-language pathologist *must* possess at a minimum two (2) years experience in the evaluation and selection of ACDs and *must* have expertise in the determination of which speech and specific ACD and strategies to use to maximize functional communication.
- In addition to the speech-language pathologist, team membership may include but is *not* limited to the following: Missouri licensed audiologist, educator, occupational therapist, physical therapist, physician, manufacturer's representative, social worker, case manager or a second speech pathologist. At least two (2) of these professionals *must* participate in the ACD evaluation. ACD team/site membership may change with each evaluation performed.
- The speech pathologist or any of the ACD team members may *not* be a vendor of ACDs or have a financial relationship with a vendor/manufacturer. This excludes the manufacturer's representative.



A description of the ACD team/site evaluation protocol as well as equipment available for an ACD evaluation *must* be submitted to MHD, Provider Enrollment Unit.

Approval is granted based on an ACD team evaluation concept and compliance with the requirements. The provider is notified in writing of any deficiencies. Approval may be granted upon correction of these deficiencies.

13.20.D AUGMENTATIVE COMMUNICATION EVALUATION FOR AUGMENTATIVE COMMUNICATION DEVICES (ACDs)

The ACD evaluation *must* be performed by a MO HealthNet approved ACD evaluation site. The ACD evaluation *must* be documented in the participant file and *must* include the following information:

- Medical diagnosis related to communication dysfunction leading to the need for an ACD;
- Current communication status and limitations;
- Speech and language skills, which *must* include prognosis for speech and/or written communication;
- Cognitive readiness for use of an ACD;
- Interactional/behavioral and social abilities both verbal and nonverbal;
- Cognitive, postural, mobility, sensory (visual and auditory), capabilities and medical status;
- Limitations of participant's current communication abilities without an ACD (if a device is currently in use, a description of the limitation of this device);
- Motivation to communication via use of an ACD;
- Residential, vocational, educational and other situations requiring communication;
- Participant's name, address, date of birth and MO HealthNet ID number;
- ACD's ability to meet projected communication needs (e.g., ACD growth potential, how long it meets needs);
- Anticipated changes, modification or upgrades for up to two (2) years;
- Training plans;
- Plans for parental/caregiver training and support;



- Statement as to why prescribed ACD is the most appropriate and cost effective device. Comparison of the advantages, limitations and cost of alternative systems evaluated with the participant *must* be included; and
- Complete description of ACD prescribed including all medically necessary accessories or modification.

13.20.E MODIFICATION/REPLACEMENT/REPAIR OF AN AUGMENTATIVE COMMUNICATION DEVICE (ACD)

The initial prescription of an ACD should attempt to take into account all projected changes in a participant's communication abilities for at least two (2) years. However, if changes occur in participant needs, capabilities or potential for communication, necessary modifications/replacements may be considered.

Supporting documentation for the modification or replacement *must* include:

- Reevaluation of the participant by a MO HealthNet approved ACD evaluation team/site; and
- Changes in the participant's communication abilities that support the medical necessity/appropriateness of the requested changes.

If requesting a different ACD from the one currently being used by the participant, a new ACD evaluation by a MO HealthNet approved site *must* be performed. Pre-certification is required.

Replacement of an ACD is considered due to loss, non-repairable damage, or if the ACD is no longer functional. Pre-certification is required.

Routine repairs of an ACD not covered by warranty, are covered. A CMN *must* be submitted and *must* document the reason for the repair. The participant's physician *must* sign the CMN if the repair is \$500.00 and over. Battery replacement is considered a repair.

13.20.F RENTAL OF AN AUGMENTATIVE COMMUNICATION DEVICE (ACD)

Rental of an ACD is approved only if the participant's ACD is being repaired, modified or if the participant is undergoing a limited trial period (3 months) to determine appropriateness and ability to use the ACD. If a trial period (3 months) is recommended, the trial period and the subsequent purchase of an ACD require separate pre-certification. The treating speech-language pathologist *must* confirm the participant is utilizing the selected device daily and accurately in a variety of communication situations and demonstrates the cognitive and physical ability to effectively use the device during the trial period.

In addition to the modifier NU, new equipment, modifier NR, new when rented, will be assigned with the approved pre-certification for the purchase following the required trial



period of an ACD. The DME provider *must* submit the appropriate procedure code with both NU and NR modifiers when billing the purchase of the device.

All rental payments are deducted from the MO HealthNet purchase price should the trial period indicate the need for purchase of the device. The combined reimbursement for each month of the trial period (3 months) and subsequent purchase is complete payment for the device.

13.21 EQUIPMENT

Canes, crutches, walkers, commodes, decubitus care equipment, hospital beds, bed side rails, bed pans, trapeze equipment, etc. are covered equipment. For specific equipment codes and billing requirements, refer to Section 19 of this manual.

13.21.A MANUAL HOSPITAL BEDS

Manual hospital beds are reimbursed on a rent-to-purchase basis only and require pre-certification. Durable Medical Equipment (DME) pre-certification criteria documents may be found at <http://www.dss.mo.gov/mhd/cs/dmeprecert/pages/dmeprecert.htm>. Refer to Section 13.32 for pre-certification guidelines.

13.21.B SEMI-ELECTRIC HOSPITAL BED

Semi-electric hospital beds are reimbursed on a rent-to-purchase basis only and require pre-certification. DME pre-certification criteria documents may be found at <http://www.dss.mo.gov/mhd/cs/dmeprecert/pages/dmeprecert.htm>. Refer to Section 13.32 for pre-certification guidelines.

13.21.C TRAPEZE BAR

A trapeze bar is covered when the participant is bed confined and the device is needed to change body positioning or to get in and out of bed due to respiratory conditions or other medical reasons.

13.21.D MATTRESS AND SIDE RAILS

A mattress and/or side rails cannot be billed in addition to a hospital bed. Mattress and side rails may only be billed when the bed is owned by the participant or if needed for replacement.

Side rails may be covered if the participant is bed confined, disoriented, experiences vertigo, has a neurological disorder, or is paraplegic or quadriplegic.

13.21.E CANES AND CRUTCHES

Canes and crutches require pre-certification. DME pre-certification criteria documents may be found at <http://www.dss.mo.gov/mhd/cs/dmeprecert/pages/dmeprecert.htm>. Refer to Section 13.32 for pre-certification guidelines.



13.21.F COMMODES

Commodes require pre-certification. DME pre-certification criteria documents may be found at <http://www.dss.mo.gov/mhd/cs/dmeprecert/pages/dmeprecert.htm>. Refer to Section 13.32 for pre-certification guidelines.

13.21.G PATIENT LIFT (HYDRAULIC)

Hydraulic patient lifts are reimbursed on a rent-to-purchase basis only and require pre-certification. DME pre-certification criteria documents may be found at <http://www.dss.mo.gov/mhd/cs/dmeprecert/pages/dmeprecert.htm>. Refer to Section 13.32 for pre-certification guidelines.

Electric lifts are *not* covered.

13.21.H PRESSURE REDUCING SUPPORT SURFACES

Pressure reducing support surfaces, other than those listed below, require pre-certification. DME pre-certification criteria documents may be found at <http://www.dss.mo.gov/mhd/cs/dmeprecert/pages/dmeprecert.htm>. Refer to Section 13.32 for pre-certification guidelines.

Pressure reducing support surfaces such as a powered air flotation bed (low air loss therapy—E0193), powered pressure reducing mattresses, or air fluidized beds (E0194) are *not* covered under the HCY or DME Programs. These types of pressure reducing support surfaces may be requested through the Exceptions Process Program. Refer to Section 20, Exception Process, for requirements for consideration of coverage.

13.21.I COVERAGE CRITERIA FOR OSTEOGENESIS STIMULATOR, LOW INTENSITY ULTRASOUND, NON-INVASIVE (E0760NU)

Osteogenesis stimulators are covered for those participants who meet the DME pre-certified medical criteria. DME pre-certification criteria documents may be found at <http://www.dss.mo.gov/mhd/cs/dmeprecert/pages/dmeprecert.htm>. Refer to Section 13.32 for pre-certification guidelines.

Initial pre-certification is limited to the physician-specified length of need up to a 3-month pre-certification. If the device continues to be medically necessary, subsequent pre-certification *must* be requested by the treating physician through the submission of a help ticket through CyberAccesssm or by contacting the MHD helpdesk at 800-392-8030.

The provider of the osteogenesis stimulator *must* assure that the participant utilizing the device is properly instructed in use of the device in support of the ordered treatment and is aware of and understands any emergency procedures regarding the use of the osteogenesis stimulator device. The provider must maintain written documentation in the participant's medical record regarding the instruction of use for the osteogenesis stimulator.



The device *must* be capable of producing a treatment log indicating the participant's use. This information must be available to MHD upon request.

The device is available as a rent-to-purchase item only and may only be supplied once in a lifetime.

13.22 HEALTHY CHILDREN AND YOUTH (HCY) EARLY AND PERIODIC SCREENING, DIAGNOSTIC AND TREATMENT (EPSDT) PROGRAM (FOR PARTICIPANTS 20 AND UNDER)

A medically necessary item or service that is normally noncovered that is identified as a result of a physician, or other health care professional, visit or exam (interperiodic screen) may be covered for participants age 20 and under.

It is important to note that every MO HealthNet eligible child should have a complete HCY/ EPSDT screen. If the child has *not* had a full screen, the provider should refer the child for a full screen to be done at a later date. Refer to Section 9 of this manual for information about screening providers.

Refer to Section 19.1 for reimbursement guidelines, quantity limitations and specific restrictions for each HCY procedure code.

13.22.A UNDER PADS, DIAPERS, BRIEFS AND PROTECTIVE UNDERWEAR/PULL-ONS

Underpads, diapers, briefs and protective underwear/pull-ons require pre-certification. Any combination of incontinence products is limited to 186 per month and will be pre-certified without the EP modifier. Claims submitted for quantities of 186 per month or less should exclude the EP modifier. For quantities exceeding 186 per month, justification of medical necessity *must* be submitted through a CyberAccesssm help ticket or a phone call to the help desk. If approved, pre-certification will include an EP modifier, and claims submitted for quantities of greater than 186 per month should include the EP modifier. Durable Medical Equipment (DME) pre-certification criteria documents may be found at <http://www.dss.mo.gov/mhd/cs/dmeprecert/pages/dmeprecert.htm>. Refer to Section 13.32 for complete pre-certification guidelines.

Providers *must not* dispense any incontinence products unless the participant agrees replacement of the item is desired and necessary; no automatic shipping is allowed.

13.22.B RENT-TO-PURCHASE FOR CHEST WALL OSCILLATION DEVICES (E0483EPRR)

High frequency chest wall oscillation devices (E0483EPRR) are only covered for participants age 20 and under and are reimbursed on a rent-to-purchase basis only. If the device continues to be utilized and is medically necessary, it will be considered purchased after the total of all



rental payments equals the purchase price. If the use of device is discontinued at any time, the provider *must* stop billing for the device.

Chest wall oscillation device rental (E0483EPRR) requires pre-certification. DME pre-certification criteria documents may be found at <http://www.dss.mo.gov/mhd/cs/dmeprecert/pages/dmeprecert.htm>. Refer to Section 13.32 for pre-certification guidelines.

13.22.C PULSE OXIMETER

13.22.C(1) Pulse Oximeter Reimbursement

Pulse oximeters are reimbursed on a rent-to-purchase basis. Pre-certification is required. DME pre-certification criteria documents may be found at <http://www.dss.mo.gov/mhd/cs/dmeprecert/pages/dmeprecert.htm>. Refer to Section 13.32 for pre-certification guidelines.

13.22.C(2) Pulse Oximeter Supplies

All oximeters that are rented include probes, cables, repair, education, maintenance and periodic downloading of recorded data, as requested by the participant's physician.

One (1) non-disposable probe per 12-month period or one (1) disposable probe per 60-day period is allowed per participant for pulse oximeters that have been purchased. A CMN justifying the need for the replacement probe must be maintained in the file. The CMN must also justify the use of disposable probes as opposed to non-disposable probes when disposable probes are utilized.

Providers *must not* dispense supplies based solely on quantity limitations. The participant must agree that replacement of supplies is desired and necessary; no automatic shipping of supplies is allowed. Billing for pulse oximeter probes above the quantity allowed as the usual maximum quantity, in the absence of documentation clearly explaining the medical necessity of the excess quantity, is denied as not medically necessary. A letter of justification from the participant's physician *must* be submitted with the claim form for probes in excess of those allowed.

13.22.D COUGH STIMULATING DEVICE

Cough stimulating devices are covered for participants age 20 and under and are reimbursed on a rent-to-purchases basis only. Pre-certification is required. DME pre-certification criteria documents may be found at



<http://www.dss.mo.gov/mhd/cs/dmeprecert/pages/dmeprecert.htm>. Refer to Section 13.32 for pre-certification guidelines.

13.22.E CRANIAL REMOLDING ORTHOSIS

Cranial remolding orthosis, pediatric, rigid with soft interface material (S1040EPNU) is reimbursed as a purchase item only. A neurosurgeon and/or cranial facial team *must* prescribe use of the cranial remolding orthosis as an appropriate form of treatment for participants from birth through 12 months of age.

The orthotist providing the cranial orthosis must be trained and certified to evaluate, modify and dispense the cranial orthosis for proper fit, and the fabricated cranial orthosis must have FDA 510(K) clearance.

Cranial remolding orthosis require pre-certification. Any replacement of the cranial orthosis due to growth during the post-operative period for the diagnosis of craniosynostosis will require a new pre-certification. DME pre-certification criteria documents may be found at <http://www.dss.mo.gov/mhd/cs/dmeprecert/pages/dmeprecert.htm>. Refer to Section 13.32 for pre-certification guidelines.

13.23 TOTAL PARENTERAL NUTRITION (TPN)

Total Parenteral Nutrition (TPN) is covered for participants with severe permanent disease of the gastrointestinal tract that prevents absorption of sufficient nutrients to maintain weight and strength.

The participant must have a condition involving the gastrointestinal tract that results in significant malabsorption. TPN is noncovered for conscious participants whose need for parenteral nutrition is due to lack of appetite or a cognitive problem. The participant *must* require TPN to sustain life. Adequate nutrition *must not* be possible by dietary adjustment, oral supplements, or tube enteral nutrition.

TPN is covered under the Durable Medical Equipment (DME) Program for participants in a nursing home.

One (1) supply kit (B4220 or B4222) and one (1) administration kit (B4224) is covered for each day that parenteral nutrition is administered, when such kits are used and medically necessary.

When homemix TPN solutions are used the component carbohydrates amino acids, additives, and lipids are separately billable.

When premix TPN solutions are used there is no separate authorization for the carbohydrates, amino acids, or additives (vitamins, trace elements, heparin, electrolytes). However, lipids may be separately authorized with premix solutions. An invoice of cost is required when billing for B5200.

TPN procedure codes that are defined as one (1) unit equals one (1) day may be billed by date of service or by consecutive dates of service. Participants receiving TPN on Monday, Wednesday and

Friday *must* be billed by date of service while participants with daily infusions should be billed with from and through dates of service. The number of units billed *must* equal the number of days when billing consecutive from and through dates of service.

TPN procedure codes that are defined as one (1) unit equals 500 ml *must* be billed as such. These procedure codes should be billed on the date the item is initially dispensed regardless of the number of days it covers. Refer to Section 19 for TPN procedure codes and restrictions.

Parenteral nutrition infusion pumps, portable or stationary, are reimbursed on a rent-to-purchase basis only. It will be considered purchased after the total of rental payments equals the purchase price. Refer to Section 19 for reimbursement guidelines. If use of the device is discontinued at any time, the provider *must* discontinue billing of the device.

TPN formula, supplies and infusion pumps require pre-certification. DME pre-certification criteria documents may be found at <http://www.dss.mo.gov/mhd/cs/dmeprecert/pages/dmeprecert.htm>. Refer to Section 13.32 for pre-certification guidelines.

13.24 ENTERAL NUTRITION

MO HealthNet Division (MHD) covers medically necessary enteral nutrition products for children under the age of 21.

13.24.A ENTERAL NUTRITION FORMULA

Enteral nutrition is covered for a patient under the age of 21 when criteria A or B are met, and both C and D are met.

- A. WIC (Special Supplemental Nutrition program for Women, Infants and Children) eligibility has been ruled out; OR
- B. The WIC benefit is exhausted (as determined by the Department of Health and Senior Services); AND
- C. The WIC eligibility information from A or B above is documented in the DME Provider Record; AND
- D. The child also meets one of the following medical criteria:
 1. Has a nasogastric tube, gastrostomy tube or jejunostomy tube for feeding purposes; OR
 2. Is under 6 years of age and has a diagnosis of failure to thrive (defined as: oral intake less than bodily requirements; an imbalance possibly related to the inability to ingest/digest/absorb nutrients); OR
 3. Meets the criteria below in a and also meets either criterion b or c:
 - a. Has one of the following diagnoses: ALS, cystic fibrosis, esophageal/stomach cancer, pulmonary insufficiency, non-healing/chronic wounds, dysphagia, renal failure (on dialysis),



- advanced AIDS with gastrointestinal co-morbidity, severe trauma or burns, traumatic brain injury; AND
- b. During the past 6 weeks has a documented serum protein level below 6 and/or serum albumin level below 3.5 performed by an accredited lab; OR
 - c. Recent dietician evaluation determines sufficient caloric intake is not obtainable through regular food preparation alternatives (i.e. liquefied/pureed foods); or a speech pathologist evaluation documents a failed swallow study; OR
4. Has an unplanned weight loss of 10% or more over the past 3 months plus at least one of the following conditions:
 - a. On-going cancer treatment; OR
 - b. Advanced AIDS; OR
 - c. Pulmonary insufficiency; OR
 - d. Status post severe trauma/burn/brain injury; OR
 - e. One of the following malabsorption diagnoses: Short bowel syndrome, celiac sprue, tropical sprue, gastrointestinal fistula, nutritional marasmus, Whipple's disease, intestinal lymphangiectasis, chronic carbohydrate intolerance; OR
 5. The participant has one of the conditions listed in 4 a-e above and a history of body weight maintained by supplementation within the past 6-12 months (documentation must be in the DME provider record and may be requested for State review); OR
 6. The participant meets criterion 3b or 3c above and has a medical condition for which the DME provider record contains detailed documentation from the prescribing physician's progress notes justifying the medical necessity of enteral formula.

A list of covered enteral formula HCPCS (Healthcare Common Procedure Coding System) codes can be found in Section 19 of this manual. Section 19 also lists reimbursement requirements (i.e. medical necessity form, invoice of cost) and maximum allowable amounts for each HCPCS code.

13.24.B. SPECIAL ENTERAL FORMULA

Special nutrient formulas (HCPCS codes B4149, B4153-B4157, B4161, and B4162) are produced to meet unique nutrient needs for specific disease conditions. The DME provider's record for the participant must adequately document the specific condition and the need for the special nutrient. This information shall be made available to the State upon request.

13.24.C ENTERAL NUTRITION SUPPLIES

Enteral nutrition may be administered by oral intake or by feeding tube via gravity, syringe or pump. Pump administration is covered only when one of the following criteria is met:

1. The patient has a jejunostomy tube; OR
2. The patient has a gastrostomy tube or NG tube and the medical record documents one of the following:
 - a. A trial and failure of administration by both gravity and syringe or documentation that those methods of administration are medically contraindicated; OR
 - b. A pump is medically necessary due to reflux and/or aspiration; severe diarrhea; dumping syndrome; administration rate less than 100 ml/hr; blood glucose fluctuations; or circulatory overload.

The appropriate feeding supply kit must correspond to the prescribed and documented method of administration based on medical need.

13.25 ORTHOTIC DEVICES

Orthotic devices are covered by MO HealthNet when prescribed by a physician (M.D. or D.O.) or a podiatrist (except for diabetic shoes and inserts). The orthotic device *must* be necessary and reasonable for the treatment of the participant's illness or injury. It *must* be used to support a weak or deformed body member, or restrict or eliminate motion in a diseased or injured part of the body.

13.25.A ORTHOPEDIC SHOES

Orthopedic shoes, and modifications or additions to shoes, are covered only if they are an integral part of a brace, or the participant is diabetic or 20 years of age or under. "Integral" means that the shoes are necessary for completeness of the brace. A pair of shoes may be reimbursed even if only one (1) shoe is an integral part of a unilateral brace.

13.25.B SHOES FOR DIABETIC PARTICIPANTS

Shoes, inserts and and/or modifications for diabetic participants require pre-certification. Durable Medical Equipment (DME) pre-certification criteria documents may be found at <http://www.dss.mo.gov/mhd/cs/dmeprecert/pages/dmeprecert.htm>. Refer to Section 13.32 for pre-certification guidelines.

A modification of a custom molded or depth shoe may be covered as a substitute for an insert. Although not intended as a comprehensive list, the following are the most common shoe modifications: rigid rocker bottoms (A5503), roller bottoms (A5503), wedges



(A5504), metatarsal bars (A5505) or offset heels (A5506). Other modifications of diabetic shoes (A5507) include, but are not limited to flared heels.

Quantities of shoes, inserts, and/or modifications greater than those allowed will be denied.

Inserts used in noncovered shoes are not covered.

Deluxe features of diabetic shoes (A5508) are not covered.

There is no separate reimbursement for certification of need or prescription of footwear, or for fitting of shoes, inserts, or modifications.

The particular type of footwear (shoes, inserts, modifications) which is necessary must be prescribed by a podiatrist or physician knowledgeable in the fitting of diabetic shoes and inserts. The footwear must be fitted and furnished by a podiatrist or other qualified individual, such as a pedorthist, orthotist or prosthetist.

The certifying physician provides the medical care for and manages the beneficiary's systemic diabetic condition. The certifying physician must be an M.D. or D.O. and may *not* be a podiatrist, physician assistant, nurse practitioner or clinical nurse specialist.

13.25.C SERVICES INCLUDED IN REIMBURSEMENT OF ORTHOTIC DEVICES

The following items are included in the MO HealthNet maximum allowable reimbursement for orthotic devices and are not reimbursed separately and may *not* be billed to the participant:

- Cost of the orthosis;
- Design of the orthosis;
- Required visits or fittings with the provider prior to receiving the orthosis; and
- Proper fitting of the orthosis.

13.25.D BILLING REQUIREMENTS FOR ORTHOTIC DEVICES

Refer to Section 19 for a list of covered orthotic procedure codes, the MO HealthNet maximum allowed amount and the billing guidelines for each procedure code.

13.26 OSTOMY SUPPLIES

Non-sterile ostomy supplies are covered for ostomates if prescribed by the participant's attending physician. Ostomy supplies are *not* covered for participants in a hospital or nursing home. Refer to Section 19 of this manual for a list of covered ostomy procedure codes, the MO HealthNet maximum allowed amount and the quantity limitations for each procedure code.

13.26.A NONCOVERED OSTOMY SUPPLIES

The following ostomy supplies are *not* reimbursable under the Durable Medical Equipment (DME) Program:

Absorption Flakes, Absorption Pad, Aerszoin Spray, Allucotton Dressing, Benzoin Tincture, Carrying Case, Catheter Shields, Cellucotton, Chux, Cleansers, Covers, Cutting Tools, Deodorizers, Dilating Glove, Disposable Liners, Drain Eez, Drying Hanger, Drying Rack, Dusting Powder, Enema Bags, Fiberall, Filters, Finger Cots, Flannellets, Foxy Covers, Fresh Tales, Gauze Pads, Gauze Sponges, Germicide, Gloves, Hexon, Incontinent Pads, Lemon Hexon, Nitrazine Paper, Ostomy Skin Bond or Cement Remover, Oxy-Chinol Tablets, Ozium, Spray, Perma-Type, Post-Op Bags, Post-Op Pouches, Post-Op Sets, Skin Barrier Dispensers, Skin Conditioners, Soaking Tray, Spreader, Staphine Spray, Stericol Tablets, Sterile Gloves, Stoma Centering Collars, Stoma Centering Guide, Surgical Sponges, Surge Pads, Syringes, Tape Dispensers, Toppers, Torbot Sanitizer, Travel Bag, Wash Bottle, and Waterproof Sheeting.

13.26.B BILLING AND REIMBURSEMENT OF OSTOMY SUPPLIES

An invoice of the provider's cost for manually-priced ostomy supplies *must* accompany each CMS-1500 claim for payment. The invoice must be legible, include the price that was paid for the ostomy supply, and document the quantity in a box or case. Manually-priced ostomy supplies are reimbursed at the provider's cost plus 20%.

13.27 OXYGEN AND RESPIRATORY EQUIPMENT

Oxygen and respiratory equipment is covered for home use when it is determined to be medically necessary and appropriate and prescribed by the participant's attending physician.

13.27.A OXYGEN

Home oxygen therapy is covered for participants who meet the Durable Medical Equipment (DME) pre-certified medical criteria. DME pre-certification criteria documents may be found at <http://www.dss.mo.gov/mhd/cs/dmeprecert/pages/dmeprecert.htm>. Refer to Section 13.32 for pre-certification guidelines.

If a participant travels out of their provider's usual service area, it is the participant's responsibility to arrange for oxygen during that time period. MO HealthNet will only pay one (1) provider for oxygen during any one (1) rental month.



13.27.A(1) Certification Requirements

Certification of the need for oxygen therapy will be completed when the authorized prescriber requests pre-certification as indicated below.

- The blood gas study reported for initial certification requests must be the most recent study obtained prior to the pre-certification request. This blood gas study *must* be obtained within 30 days prior to the date of the pre-certification request.
- For participants' age 21 and older initially meeting criteria in Group I of the medical criteria document and for children meeting criterion 3A of the medical criteria document, the most recent qualifying blood gas study prior to the thirteenth month of therapy *must* be reported on the recertification request. Recertification of Group I participants is required 12 months after the initial certification. If the participant is not seen and reevaluated within 90 days prior to recertification, but is subsequently seen, payment may be made for dates of service between the scheduled recertification date and the physician visit date. No additional certification will be required after the 12-month recertification.
- For participants age 21 and older initially meeting criteria in Group II of the medical criteria document, the most recent blood gas study which was performed between the 61st and 90th day following the initial certification *must* be reported on the recertification request.
- Recertification of Group II participants is required every three (3) months. Any Group II participant who meets Group I criteria on recertification will be subject to Group I recertification requirements. If a qualifying test is not obtained between the 61st and 90th day of home oxygen therapy, but the participant continues to use oxygen and a test is obtained later, and if that test meets Group I or II criteria, coverage resumes with the date of that test.
- The participant *must* be seen and evaluated by the treating physician within 30 days prior to the date of the initial certification request. The participant *must* be seen and reevaluated by the treating physician within 90 days prior to any recertification.
- For any revised certification, the blood gas study reported on the revised certification request must be the most recent test performed prior to the revised date.



- A revised certification is required when there is a change in the type of oxygen delivery system or there is the addition of a portable system to a stationary system.

A revised oxygen therapy certification must be filed when the prescribed maximum flow rate changes from one of the following categories to another: (a) less than one (1) Liter Per Minute (LPM); (b) one (1) to four (4) LPM; (c) greater than four (4) LPM. If the change is from category (a) or (b) to category (c), a repeat blood gas study with the participant on four (4) LPM must be performed within 30 days prior to the start of the greater than four (4) LPM flow rate.

13.27.A(2) Testing Specifications

The qualifying blood gas study *must* be performed by a physician or a qualified provider of laboratory services. Blood gas studies performed by a provider of oxygen equipment are not acceptable. In addition, the qualifying blood gas study may not be paid for by any provider of oxygen equipment.

For sleep oximetry studies, the oximeter provided to the participant must be tamper-proof and *must* have the capability to download data that allows documentation of the duration of oxygen desaturation below a specified value.

When oxygen therapy meets criteria based on an oxygen study obtained during exercise, there *must* be documentation of three (3) oxygen studies in the participant's medical record – i.e., testing at rest without oxygen, testing during exercise without oxygen, and testing during exercise with oxygen applied (to demonstrate the improvement of the hypoxemia).

The qualifying blood gas study may be performed while the participant is on oxygen as long as the gas values meet the Group I or Group II criteria.

13.27.A(3) Modifier

The monthly payment amount for stationary oxygen is subject to adjustment depending on the gen prescribed (liters per minute or LPM) and whether or not portable oxygen is also prescribed.

If a participant qualifies for additional payment for greater than four (4) LPM of oxygen and also meets the requirement for portable oxygen, payment will not be made for the portable oxygen. The provider *must* use the QF modifier on the stationary code.

The following modifiers *must* be used when billing oxygen for a participant who requires more than four (4) LPM:

- QF – greater than four (4) LPM and portable oxygen is prescribed



- QG – greater than four (4) LPM

13.27.A(4) Oxygen Contents

Reimbursement for portable oxygen contents, gas and liquid, may be reimbursed in addition to the portable system, one time per month.

Oxygen contents are *not* billable with any type of stationary oxygen system rental.

13.27.A(5) Oxygen Therapy *Not* Covered

1. Angina pectoris in the absence of hypoxemia.
2. Dyspnea without cor pulmonale or evidence of hypoxemia.
3. Severe peripheral vascular disease resulting in clinically evident desaturation in one (1) or more extremities but in the absence of systemic hypoxemia. There is no evidence that increased PO₂ will improve the oxygenation of tissues with impaired circulation.
4. Terminal illnesses that do *not* affect the respiratory system.

13.27.B OXYGEN SUPPLIES, MAINTENANCE AND REPAIR

Cannulas, masks, or any supply used with an oxygen concentrator, portable or stationary oxygen system is included in the monthly rental of that device and is *not* paid for separately.

Delivery, set-up, maintenance and repair fees are also included in the monthly rental reimbursement and are *not* paid for separately.

13.27.C PORTABLE OXYGEN SYSTEMS

Portable oxygen systems are only covered for participants when:

- The qualifying ABG/oximetry testing is performed at rest or exercise; and
- There is a physician prescription for portable oxygen.
- The provider record *must* include a description of the activities or exercise routine (e.g., amount and frequency of ambulation) that the participant undertakes on a regular basis, and that requires the portable system in the home (i.e., the documentation *must* describe the medical therapeutic purpose to be served by the portable system that cannot be met by a stationary system).

13.27.D VENTILATOR

A volume ventilator or pressure support ventilator may be covered by MO HealthNet if prescribed and pre-certified by the participant's attending physician. DME pre-certification criteria documents may be found at



<http://www.dss.mo.gov/mhd/cs/dmeprecert/pages/dmeprecert.htm>. Refer to Section 13.32 for pre-certification guidelines.

The monthly reimbursement includes but is not limited to the following:

- All Circuits, Brackets and Filters
- Ambu Bag
- Batteries and Battery Charger
- Cleaning Solution and Supplies
- Initial Set-Up and Participant Training
- Maintenance of the Ventilator
- Professional Support
- Trach Care Supplies not billable separately (see below)
- Ventilator Unit

Non-invasive ventilators such as BiPap ST may *not* be billed under the ventilator code.

Equipment and supplies that may be billed in addition to a ventilator when medically appropriate and necessary are:

- Humidifiers;
- Oxygen, Oxygen Concentrators and Oxygen Delivery Systems; or
- Suction Pumps;
- Supplies to include sterile saline water, trach suction catheters, inner cannula, suction tube, oropharyngeal suction catheter, trachea care kit, larynx tube cuffed and uncuffed and collar holder.

Ventilators are covered for participants residing in a nursing home.

13.27.E BACK-UP VENTILATOR

A back-up ventilator may be covered if a volume or pressure support ventilator has been previously pre-certified and the participant requires ventilation 24 hours per day. The monthly rental reimbursement shall include all items and services as listed for the ventilator.

For participants residing in a nursing home, a back-up ventilator is included in the nursing home per diem rate and is *not* paid separately.



A back-up ventilator requires pre-certification. DME pre-certification criteria documents may be found at <http://www.dss.mo.gov/mhd/cs/dmeprecert/pages/dmeprecert.htm>. Refer to Section 13.32 for pre-certification guidelines.

13.27.F NEBULIZER, COMPRESSOR, SUCTION PUMP AND IPPB

Delivery, set-up, maintenance, pick-up and repair are included in the monthly rental reimbursement and are *not* reimbursed separately. All supplies, with the exception of disposable breathing circuits (A4618) for an IPPB, are also included in the monthly rental reimbursement and are *not* reimbursed separately.

Two (2) nebulizer administration sets per month are allowed for participant-owned nebulizers.

For respiratory equipment that has been purchased through monthly rental payments or has been purchased outright, supplies for this equipment, with the exception of a nebulizer kit, may be requested through the Exceptions Process. Refer to Section 20 for Exception Process instructions.

Nebulizers, compressors and suction pumps require pre-certification. DME pre-certification criteria documents may be found at <http://www.dss.mo.gov/mhd/cs/dmeprecert/pages/dmeprecert.htm>. Refer to Section 13.32 for pre-certification guidelines.

13.27.G APNEA MONITOR

Apnea monitors are defined as cardiorespiratory monitoring devices capable of providing continuous or periodic two-channel monitoring of heart rate and respiratory rate and must meet current Food and Drug Administration (FDA) guidelines for products in this class. Apnea monitors *must* have alarming mechanisms to alert caregivers of cardiorespiratory distress or other events which require immediate intervention and *must* be capable of recording and storing events and of providing event recording downloads or printouts of such data.

Apnea monitors may be authorized for infants. An infant is described as a child whose age ranges from birth to 12 months of age. Infant Cardiopulmonary Resuscitations (CPR) training of caregivers by certified trainers is recommended.

The following diagnosis or conditions alone are not indications for monitoring, and are *not* covered:

- 1) Seizure disorders (without life threatening events);
- 2) Hydrocephalus, uncomplicated;
- 3) Mental Retardation;



- 4) Irreversible terminal conditions;
- 5) Congenital heart defects, with or without associated arrhythmias;
- 6) Distant family history of apnea or SIDS (other than an immediate sibling);
- 7) History of an apnea monitor use with other siblings;
- 8) History of apnea with other sibling(s);
- 9) Parental anxiety or family member request of a monitor; and
- 10) Monitoring of blood oxygen saturation.

Apnea monitors require pre-certification. DME pre-certification criteria documents may be found at <http://www.dss.mo.gov/mhd/cs/dmeprecert/pages/dmeprecert.htm>. Refer to Section 13.32 for pre-certification guidelines.

13.27.H(1) Apnea Monitor Reimbursement

Apnea monitors are reimbursed on a rental basis. The maximum months of rental which may be reimbursed for an apnea monitor is limited to a total of 12 months. Pre-certification is required for months one (1) through four (4). Additional pre-certification is required for months five (5) through 12. For the appropriate procedure code, reference Section 19.

All supplies such as electrodes, wires and belts are included in the monthly rental reimbursement and are *not* reimbursed separately. Repair, maintenance, initial set-up, event recording, pneumogram and professional support are also included in the monthly rental reimbursement.

13.28 RESPIRATORY ASSIST DEVICES (RAD) AND CONTINUOUS POSITIVE AIRWAY PRESSURE (CPAP) DEVICES

Any RAD or CPAP device that has been rented by MO HealthNet for 12 or more months is considered purchased. No further rental payments are made and providers may only bill for supplies and repairs needed for continued use after the initial 12-month rental period. If utilization of the RAD or CPAP device is discontinued at any time, the provider *must* stop billing for the equipment, related accessories and supplies.

RAD and CPAP devices require pre-certification. Durable Medical Equipment (DME) pre-certification criteria documents may be found at <http://www.dss.mo.gov/mhd/cs/dmeprecert/pages/dmeprecert.htm>. Refer to Section 13.32 for pre-certification guidelines.



13.28.A COVERAGE FOR A CONTINUOUS POSITIVE AIRWAY PRESSURE (CPAP) DEVICE (E0601RR)

A single-level CPAP device (E0601RR) may be covered if the participant has a diagnosis of Obstructive Sleep Apnea (OSA) documented by an attended, facility-based polysomnogram and is pre-certified.

Polysomnographic studies must be performed in a facility-based sleep study laboratory, and not in the home, and may not be performed by a DME provider. Portable multi-channel home sleep testing devices are also not acceptable.

13.28.B CONTINUED COVERAGE FOR A CONTINUOUS POSITIVE AIRWAY PRESSURE (CPAP) DEVICE BEYOND THE FIRST THREE (3) MONTHS (E0601KJRR)

Continued coverage for a CPAP device beyond the first three (3) months of therapy requires that, no sooner than the 61st day after initiating therapy, the DME provider ascertains from either the participant or the treating physician that the participant is continuing to use the CPAP device. This information must be documented in the DME provider's record. If this criterion is met, pre-certification must be obtained and services should be billed utilizing the KJ modifier.

If the above criterion is *not* met, continued rental coverage of the device is *not* approved.

13.28.C COVERAGE FOR A RESPIRATORY ASSIST DEVICE (RAD) (E0470 AND E0471) FOR THE FIRST THREE (3) MONTHS OF THERAPY

The treating physician *must* be qualified by virtue of experience and training in non-invasive respiratory assistance to order and monitor use of a RAD. Physicians who treat participants for other medical conditions may or may not be so qualified, and if not, though they may be the treating physician of the participant for other conditions, they are *not* considered the treating physician for the prescribing of Non-invasive Positive Pressure Respiratory Assistance (NPPRA) therapy.

In order for a RAD (E0470 or E0471) to be covered, the treating physician must fully document in the participant's medical record symptoms characteristic of sleep-associated hypoventilation, such as daytime hypersomnolence, excessive fatigue, morning headache, cognitive dysfunction, dyspnea, etc., in addition to a copy of the polysomnogram.

A RAD (E0470 or E0471) used to administer NPPRA therapy is covered for participants with clinical disorder groups characterized as restrictive thoracic disorders (i.e., progressive neuromuscular diseases or severe thoracic cage abnormalities), severe Chronic Obstructive



Pulmonary Disease (COPD), Central Sleep Apnea (CSA) or OSA (E0470 only), and participants that meet criteria in the DME pre-certification criteria document.

Polysomnographic studies *must* be performed in a facility-based sleep study laboratory, not in the home, and may not be performed by a DME provider. Portable multi-channel home sleep testing devices are also not acceptable.

13.28.D CONTINUED COVERAGE CRITERIA FOR A RESPIRATORY ASSIST DEVICE (RAD) BEYOND THE FIRST THREE (3) MONTHS OF THERAPY

Participants covered for the first three (3) months of a RAD without a backup rate feature (E0470) or a RAD with a backup rate feature (E0471) *must* be reevaluated to establish the medical necessity of continued coverage by MO HealthNet. While the participant may certainly need to be evaluated at earlier intervals after therapy is initiated, the reevaluation upon which MO HealthNet will base a decision to continue coverage beyond this time *must* occur no sooner than 61 days after initiating therapy by the treating physician. MO HealthNet will not continue coverage for the 4th and succeeding months of NPPRA therapy until this reevaluation has been completed.

Continued coverage for RAD beyond the first three (3) months of therapy requires additional pre-certification. If the medical criteria is met, services should be billed utilizing the KJ modifier for months four (4) through 12.

13.28.E SUPPLIES FOR RESPIRATORY ASSIST DEVICES (RADs) AND CONTINUOUS POSITIVE AIRWAY PRESSURE (CPAP) DEVICES

Supplies used with RAD and CPAP devices are covered when the coverage criteria for the device is met. If the coverage criteria is *not* met, the supplies are noncovered. Repairs and maintenance are included in the first 12 months of rental reimbursement and are *not* reimbursed separately. Providers *must not* dispense supplies based solely on quantity limitations. The participant must agree that replacement of supplies is desired and necessary; no automatic shipping of supplies is allowed.

The supplies provided *must* be based on the type of delivery system the participant utilizes. Supplies billed that are inconsistent with the delivery system utilized by the participant are subject to denial or recoupment.

Procedure codes A7044 (oral interface used with positive airway pressure device, each) and A7045 (exhalation port with or without swivel used with accessories for positive airway devices, replacement only) are covered up to one every 180 days; however, these items are rarely needed.

A non-heated (E0561) or heated humidifier (E0562) is covered separately when ordered by the treating physician and pre-certified for use with a covered BIPAP device. A replacement



water chamber for a humidifier used with a positive airway pressure device (A7046) may also be covered (a maximum of one per 180 days) when this replacement item is medically necessary.

13.29 PROSTHETIC DEVICES

Prosthetic devices (excluding dentures, hearing aids and artificial eyes) are covered by MO HealthNet when prescribed by a physician (M.D./D.O) and when the device replaces all or a portion of the function of a permanently inoperative or malfunctioning body member.

13.29.A PROSTHETIC SOCKS AND SHEATHS

Prosthetic socks and sheaths are limited to six (6) socks and sheaths per limb per participant per 12-month period.

13.29.B MASTECTOMY BRAS AND BREAST PROSTHESIS

Mastectomy bras are limited to three (3) per year, per participant.

Silicone breast prostheses are limited to one (1) per side, every 24 months. Form prostheses are limited to one (1) per side every six (6) months.

Mastectomy bras and breast prosthesis require pre-certification. Durable Medical Equipment (DME) pre-certification criteria documents may be found at <http://www.dss.mo.gov/mhd/cs/dmeprecert/pages/dmeprecert.htm>. Refer to Section 13.32 for pre-certification guidelines.

The modifier LT (left) or RT (right) along with the appropriate procedure code *must* be used when submitting a claim for a breast prosthesis. If filing for a bilateral prosthesis, bill on two (2) separate lines of the claim form.

13.29.C SERVICES INCLUDED IN REIMBURSEMENT

The following items/services are included in the MO HealthNet maximum allowable reimbursement for a prosthetic device:

- Cost of the prosthesis;
- Design of the prosthesis;
- Required visits or fittings with the provider prior to receiving the prosthesis;
- Proper fitting of the prosthesis;
- All necessary post-fitting and adjustment visits for one (1) year after receiving the prosthesis;



- Necessary modifications for one (1) year after receiving the prosthesis, unless the required because of physical growth or excessive stump shrinkage; and
- One-year warranty to cover defects in materials and workmanship.

Refer to Section 19 for a complete list of covered prosthetic codes, the MO HealthNet maximum allowed amount and the billing guidelines for each procedure code.

13.30 WHEELCHAIRS

Standard, power and custom wheelchairs are covered by MO HealthNet when determined to be medically appropriate and necessary and prescribed by the participant's attending physician.

13.30.A STANDARD WHEELCHAIRS

Standard wheelchairs are covered when the participant's condition is such that the alternative is chair or bed confinement. A Certificate of Medical Necessity (CMN) is required for the purchase or rental of a manual wheelchair. Refer to Section 19 of this manual for a complete list of covered codes and the MO HealthNet maximum allowed amount.

13.30.A(1) Manual Wheelchair Basic Equipment Package

Manual wheelchairs are required to include certain items as part of the basic equipment package. There is no separate reimbursement for these items at the time of initial issue.

To keep in alignment with Medicare guidelines, below is a list of items included in the basic equipment package for manual wheelchairs.

- Seat width: 15"-19"
- Seat depth: 15"-19"
- Calf rests
- Wheel lock assembly
- Hand rims
- Upholstery
- Bearings
- Complete set of tires and casters (with the exception of the items listed below that can be billed separately)
 - Insert for pneumatic propulsion tire (removable), any type

- Foam-filled propulsion tire, any size
- Foam-filled caster tire, any size
- Foam propulsion tire, any size
- Foam caster tire, any size
- Front caster assembly with solid tire
- Armrests: fixed, swingaway or detachable; fixed height
- Footrests: fixed, swingaway or detachable

13.30.A(2) MANUAL WHEELCHAIR (MWC) RENTAL OF 3 MONTHS

To allow quicker access to a MWC with a reclining back, for participants age 20 and under, up to a 3 month rental will be granted. The need must be due to at least one of the following reasons:

- A surgical procedure performed that prevents the participant from a 90 degree flexion of the hips and knees;
- Participant has been placed in a Spica cast; or
- Any proven medically necessary situation where the participant requires immediate access of a short-term basis.

The following procedure codes will be allowed for a 3 month rental or less with the addition of the EP modifier and an approved CMN on file:

- E1014EPRR – reclining back for pediatric size wheelchair
- E1226EPRR – manual fully reclining back
- E1236EPRR – manual wheelchair, folding, adjustable, with seating system
- K0001EPRR – standard wheelchair
- K0002EPRR – standard hemi (low seat) wheelchair
- K0003EPRR – lightweight wheelchair
- K0004EPRR – high strength lightweight wheelchair

If a MWC is needed beyond the 3 month rental, a new request will be required following the regular procedure and process.

13.30.A.(3) Push Rim Power Asssit Wheels

The MO HealthNet Division (MHD) will reimburse push rim power assist wheels (procedure code E0986RR) as a rent to purchase item only. The monthly rental fee is \$417.61 per month for 12 months, until reaching the purchase price of \$5,011.26.

If the participant's condition changes, is in need of a power wheelchair, and the purchase price has not been met, the push rim power assist wheels must be returned to the provider.

Power assist wheels will not be covered for participants residing in nursing facilities.

Qualifying Criteria

The following criteria must be met to obtain power assist wheels for a manual wheelchair:

- The participant's mobility limitation cannot be sufficiently and resolved by the use of an appropriately fitted cane or walker.
- The participant has a mobility limitation that significantly impairs his/her ability to participate in one or more mobility related activities of daily living (MRADL's).
- The participant has been self-propelling in a manual wheelchair for at least 1 year.
- The participant no longer has sufficient upper extremity function to self-propel an optimally configured manual wheelchair for functional mobility.
- The participant must have a specialty evaluation performed by a licensed/certified medical professional, such as PT or OT; or a practitioner who has specific training and experience in rehabilitation wheelchair evaluations. The PT/OT or practitioner may have no financial relationship with the supplier.
- A RESNA certified Assistive Technology Professional (ATP), employed by the DME provider must have direct, in person, involvement in the wheelchair selection for the beneficiary.
- Documentation must include, in detail, the need for the device for functional mobility.

13.30.B POWER WHEELCHAIRS

Power mobility devices are covered by MO HealthNet if prescribed by the participant's attending physician and prior authorized. The participant's condition is such that a power mobility device is medically appropriate and necessary and the participant is unable to propel a manual wheelchair.

13.30.B(1) Power Wheelchair Basic Equipment Package



Power wheelchairs are required to include certain items as part of the basic equipment package. There is no separate reimbursement at the time of initial issue for these items unless otherwise noted.

To keep in alignment with Medicare guidelines, below is a list of the items included in the basic equipment package for power wheelchairs.

- Lap belt or safety belt (shoulder harness/straps or chest straps/vest may be billed separately)
- Battery charger
- Complete set of tires and casters, any type
- Leg rests (no separate reimbursement if fixed, swingaway, or detachable non-elevating leg rests with or without calf pad are provided, elevating leg rests may be billed separately)
- Footrests/foot platform (no separate reimbursement if fixed, swingaway or detachable footrests or a foot platform without angle adjustment are provided)
- Angle adjustable footplates (no separate reimbursement for Group 1 or 2 power wheelchairs, angle adjustable footplates may be billed separately for Group 3, 4 and 5 power wheelchairs)
- Armrests (no separate reimbursement if fixed, swingaway, or detachable non-adjustable height armrests with arm pad are provided, adjustable height armrests may be billed separately)
- Weight-specific components (braces, bars, upholstery, brackets, motors, gears, etc. as required by participant weight capacity)
- Any seat width and depth (with the exception of the list of items below that may be billed separately for Group 3 and 4 power wheelchairs with a sling/solid seat/back)
 - For Standard Duty, seat width and/or depth greater than 20 inches
 - For Heavy Duty, seat width and/or depth greater than 22 inches
 - For Very Heavy Duty, seat width and/or depth greater than 24 inches
 - For Extra Heavy Duty, no separate billing



- Any back width (with the exception of the items listed below for Group 3 and 4 power wheelchairs with a sling/solid seat/back that may be billed separately)
 - For Standard Duty, back width greater than 20 inches
 - For Heavy Duty, back width greater than 22 inches
 - For Very Heavy Duty, back width greater than 24 inches
 - For Extra Heavy Duty, no separate billing
- Controller and Input device. There is no separate billing/reimbursement if a non-expandable controller and a standard proportional joystick (integrated or remote) is provided. An expandable controller, a non-standard joystick (i.e., nonproportional or mini, compact or short throw proportional), or other alternative control device may be billed separately.

Non-standard seat dimensions and non-standard back dimensions should be billed with code K0108. No separate billing at the time of initial issue is to be submitted for these items unless otherwise noted.

13.30.C POWER WHEELCHAIR ACCESSORIES

Wheelchair accessories for power chairs *must* be billed under the specific code(s). If there is no specific code(s), K0108 may be used. K0108 may only be listed one (1) time on the Prior Authorization (PA) Request form.

13.30.C(1) Power-Operated Vehicle (Scooters) Basic Equipment Package

Power-operated vehicles (scooters) are required to include certain items as part of the basic equipment package. There is no separate reimbursement for these items at the time of initial issue.

To keep in alignment with Medicare guidelines, below is a listing of the items included in the basic equipment package for power-operated vehicles.

- Battery or batteries required for operation
- Battery charger
- 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



- All options and accessories are included in the initial issue.

13.30.D WHEELCHAIR BATTERIES

Providers may bill up to a half-hour of labor under K0739 when billing for the replacement of batteries.

13.30.E CUSTOM WHEELCHAIRS

A custom wheelchair is defined as a chair that is tailor made for one (1) participant and cannot be used by anyone else. Custom wheelchairs and accessories are covered if prescribed by the participant's attending physician and prior authorized.

Custom wheelchairs are covered for participants in a nursing home when certain criteria are met. Refer to Section 13.18 for additional nursing home guidelines.

13.30.F WHEELCHAIR ACCESSORIES *NOT* OTHERWISE LISTED

Procedure code K0108 may only be used in the following circumstances and always requires prior authorization.

- When there is no specific accessory code(s) for the wheelchair accessory to be dispensed for custom or standard wheelchairs.

13.30.F(1) Wheelchair Option/Accessory Replacement And Repair

The following are claim filing requirements for replacement of wheelchair options/accessories.

- The appropriate HCPCS code for the specific option/accessory *must* be billed. The routing modifier, RB, must always be used when the accessory is a replacement for the same part. The RB modifier and the SC modifier must be used for participants residing in a nursing home.
- The procedure code Z0160RB or Z0160RBSC may be used for replacement items that do not have a HCPCS code and have an MSRP of \$500 or less. Items with an MSRP greater than \$500 *must* be prior authorized utilizing procedure code K0108RB and K0108RBSC.
- Items that are new additions or upgrades to a wheelchair *must not* be billed with the RB modifier. The RB modifier is only utilized for replacement of existing options/accessories.
- Labor required for replacement of an option or accessory, or repair of a wheelchair maybe billed under the procedure code K0739RB or K0739RBSC (Repair or non-routine service for DME, other than



oxygen, requiring the skill of a technician, labor component, per 15 minutes). One unit of labor is equal to 15 minutes of time.

- A CMN is required for most option/accessory replacement codes and labor code. The labor code and option/accessory codes should be included on the same CMN. The CMN *must* document the following:
 - Make and model name of the wheelchair;
 - The initial date of service for purchase of the wheelchair;
 - Medical necessity for replacement for each option/accessory code; and
 - An explanation of the time involved.

13.30.G WHEELCHAIR SEAT AND BACK CUSHIONS

MO HealthNet utilizes the following coverage criteria when reviewing PA requests for wheelchair seat and back cushions.

A general use seat cushion (E2601, E2602) and a general use wheelchair back cushion (E2611-E2612) may be covered for a participant who has a manual wheelchair or who has a power wheelchair with a sling/solid seat/back which meets MO HealthNet coverage guidelines. If the participant has a power-operated vehicle or a power wheelchair with a captain's chair seat, a general use seat and back cushion is *not* covered.

A skin protection seat cushion (E2603, E2604, E2622, E2623,) is covered for a participant who meets both of the following criteria:

1. The participant has a manual wheelchair or a power wheelchair with a sling/solid seat/back and meets MO HealthNet coverage guidelines for it; and
2. The participant has either of the following:
 - Current or past history of a pressure ulcer (L89.130, L89.140, L89.150, L89.200, L89.210, L89.220, L89.300, L89.310, L89.320, L89.41) on the area of contact with the seating surface; or
 - Absent or impaired sensation in the area of contact with the seating surface or inability to carry out a functional weight shift due to one of the following diagnoses: B91, E75.02, E75.19, E75.23, E75.25, E75.29, E75.4, E84.2, G10, G11.0, G11.1, G11.2, G11.3, G11.4, G11.8, G112.0, G12.1, G12.20, G12.21, G12.23, G12.24, G12.25, G12.29, G12.8, G12.9, G14, G20, G24.1, G30.0, G30.1, G30.8, G30.9, G31.81, G31.82, G32.0, G35, G36.0, G36.1, G36.8, G36.9, G37.0, G37.1, G37.2, G37.3, G37.4, G37.5, G37.8, G37.9, G71.0,



G71.2, G80.0, G80.1, G80.2, G80.3, G80.4, G80.8, G80.9, G81.00, G81.01, G80.01, G81.03, G81.04, G81.10, G81.11, G81.12, G81.13, G81.14, G81.90, G81.91, G81.92, G81.93, G81.94, G82.20, G82.21, G82.22, G82.50, G82.51, G82.52, G82.53, G82.54, G93.89, G93.9, G95.0, G95.11, G95.19, G99.2, I69.051, I69.052, I69.053, I69.054, I69.059, I69.151, I69.152, I69.153, I69.154, I69.159, I69.251, I69.252, I69.253, I69.254, I69.259, I169.351, I69.352, I69.353, I69.354, I69.359, I69.851, I69.852, I69.853, I69.854, I69.859, I69.951, I69.952, I69.953, I69.954, I69.959, M62.3, Q05.0, Q05.1, Q05.2, Q05.3, Q05.4, Q05.5, Q05.6, Q05.7, Q05.8, Q05.9, Q07.01, Q07.02, Q07.03,

A positioning seat cushion (E2605, E2606) and positioning back cushion (E2613-E2616, E2620, E2621) are covered for a participant who meets both of the following criteria:

1. The participant has a manual wheelchair or a power wheelchair with a sling/solid seat/back and the meets MO HealthNet guidelines for it; and
2. The participant has any significant postural asymmetries that are due to a diagnosis listed in criterion 2b above or to one of the following diagnoses: G83.10, G83.11, G8.12, G83.13, G83.14, I69.041, I69.042, I69.043, I69.044, I69.049, I69.141, I69.142, I69.143, I69.144, I69.149, I69.241, I69.242, I69.243, I69.244, I69.249, I69.341, I69.343, I69.344, I69.349, I69.841, I69.842, I69.843, I69.844, I69.849, I69.941, I69.942, I69.943, I69.94, I69.949

A combination skin protection and positioning seat cushion (E2607, E2608, E2624, E2625) is covered for a participant who meets the criteria for both a skin protection seat cushion and a positioning seat cushion. A custom fabricated seat cushion (E2609) is covered if criteria (1) and (3) are met.

A custom fabricated back cushion (E2617) is covered if criteria (2) and (3) are met.

1. Participant meets all of the criteria for a prefabricated skin protection seat cushion or positioning seat cushion.
2. Participant meets all of the criteria for a prefabricated positioning back cushion.
3. There is comprehensive written documentation submitted with the PA request that clearly and specifically explains the following:
 - Why a prefabricated system is *not* sufficient to meet participant's seating and positioning needs;
 - What orthopedic deformity is present; and it's fixed or flexible presentation;
 - What altered muscle tone is present; and it's increased or decreased presentation that affects seating and positioning; and



- Why any existing system is *not* meeting participant seating and positioning needs.

For amputee patients the following positioning cushions will be allowed based solely on an amputee of a lower limb:

- E2605, positioning wheelchair seat cushions, width less than 22 inches
- E2606, positioning wheelchair seat cushions, width greater than 22 inches
- E2607, skin protection and positioning wheelchair cushions, width less than 22 inches
- E2608, skin protections and postiomomh width less than 22 inches

If the above information is *not* included with the documentation submitted or if additional documentation is needed, the PA request is denied and additional information requested.

13.30.H CUSTOM MOLDED SEAT AND BACK CUSHION REIMBURSEMENT

Custom molded wheelchair seat (E2609) and back (E2617) cushions are reimbursed at 90% of the Manufacturer's Suggested Retail Price (MSRP) for manual wheelchairs and 95% of MSRP for power wheelchairs. The maximum reimbursement for each code is \$1,300. Charges for all modifications and mounting hardware is added together to determine the total MSRP. Charges for molding fees and other labor charges are not to be included in the MSRP rate. These charges are *not* reimbursed separately for cushions for new wheelchairs. Labor is allowed for repairs and replacement cushions.

13.30.I DOCUMENTATION FOR WHEELCHAIR PRIOR AUTHORIZATION (PA) REQUESTS

Justification must accompany the PA Request form when requesting prior authorization for a custom or power wheelchair. Justification must include comprehensive written documentation that clearly and specifically explains all of the following:

- The diagnosis/comorbidities and conditions relating to the need for a custom or power wheelchair;
- Description and history of limitations/functional deficits;
- Description of physical and cognitive abilities to utilize equipment;
- History of previous interventions/past use of mobility devices;
- Descriptions of existing equipment, age and specifically why it is *not* meeting participant needs;
- Why a less costly mobility device is unable to meet participant needs (i.e., cane, walker, standard wheelchair);



- Documentation and justification of medical necessity of recommended mobility device, accessories and positioning components; and
- Documentation/explanation of participant's ability to safely tolerate/utilize the recommended equipment.

If the participant has been evaluated by a physical therapist, occupational therapist or in a wheelchair clinic, the information obtained in the evaluation must also be included. The DME provider *must* ensure that the wheelchair being requested is adequate to meet the participant's physical needs as well as environmental needs (e.g., the wheelchair fits through the doors of the participant's home).

13.31 PRIOR AUTHORIZATION (PA)

A PA approves the medical necessity of the requested service only. It does *not* guarantee payment, nor does it guarantee that the amount billed is the amount reimbursed. The participant *must* be MO HealthNet eligible and eligible for the service on the date of the service or the date the equipment or prosthesis is received by the participant.

13.31.A SUBMISSION OF DURABLE MEDICAL EQUIPMENT (DME) PRIOR AUTHORIZATION (PA) REQUEST

DME PA Requests and supporting documentation *must* be submitted to MO HealthNet's claim processing agent, Wipro Infocrossing by facsimile (fax) to (573) 659-0207 or by mail at P.O. Box 5700, Jefferson City, MO 65102. Disposition letters for Prior Authorization (PA) Requests received by fax will be returned via the fax number through which the request was sent. Providers are encouraged to ensure requests are sent only from fax numbers that are not blocked. Disposition letters that cannot be successfully returned via fax will be mailed to the provider.

A PA request for an HCY item must clearly be marked as an HCY request.

The following documentation must be included on, or submitted with, the PA Request form:

- A detailed explanation from the prescribing physician and/or therapist that includes the nature of the item to be provided, the duration of time the item is needed, and the projected outcome the item should provide. Listing only a diagnosis code and description does *not* provide sufficient information to determine the medical necessity of the item being requested; and
- An invoice showing the provider's cost of the item(s) being requested, unless Section 19.1 indicates that a prior authorized code has a maximum allowed amount established. The invoice *must* indicate the number of items in a box or case if applicable.



DME items that require prior authorization can be identified by the abbreviation "PA" (prior authorization) under the "Reimbursement Guidelines" column in Section 19 of this manual.

13.31.B CLARIFICATION OF PRIOR AUTHORIZATION (PA) REQUEST FOR CHANGE (RFC)

Providers should only submit a RFC to an approved PA Request when there is something on the disposition letter that needs to be corrected, changed or discontinued. Only the disposition letter should be submitted with the changes made directly on the disposition letter. Invoices *must* be included if a price has changed. A PA change request should be submitted when:

- A correction needs to be made to the modifier;
- A procedure code needs to be corrected or changed;
- A new item needs to be added to an existing PA Request;
- A correction or change to the from and/or through date;
- An increase or decrease in requested units or dollars; or
- Services have been discontinued to a participant.

DO *NOT* submit a PA change request for the following situations. A new PA Request must be submitted when:

- The participant's MO HealthNet number is incorrect. (The existing PA Request *must* be closed and a new PA Request submitted under the correct number); or
- An initial PA Request or renewal request is denied and resubmitted with corrections.

13.32 PRE-CERTIFICATION PROCESS FOR DURABLE MEDICAL EQUIPMENT (DME)

Pre-certification serves as a utilization management tool allowing payment for services that are medically necessary, appropriate and cost-effective without compromising the quality of care to participants. Pre-certification of specific items and services will be implemented incrementally by individual HCPCS code or groups of codes.

Pre-certification of DME is a two-step process. Requests for pre-certification *must* be initiated by an authorized DME prescriber who writes prescriptions for items covered under the DME Program. Authorized DME prescribers include physicians, podiatrists and nurse practitioners who have a collaborative practice agreement with a physician that allows for prescription of such items. Speech



pathologists are an authorized prescriber for augmentative communication devices only. The enrolled DME provider will access the pre-certification process. All requests *must* be approved by MO HealthNet. Providers are encouraged to sign up for the MO HealthNet Web tool - CyberAccess- which automates the pre-certification process. To become a CyberAccess user, contact the Conduent help desk at 1-888-581-9797 or 573-632-9797, or send an e-mail to cyberaccesshelpdesk@conduent.com. The CyberAccess tool allows each pre-certification to automatically reference the participant's claim history including applicable ICD diagnosis codes and CPT procedure codes. Requests for pre-certification are also received by the MO HealthNet call center at 800-392-8030. Requests for pre-certification *must* meet medical criteria established by the MHD in order to be approved. Medical criteria is published in provider bulletins and posted on the MHD web site at www.dss.mo.gov/mhd prior to implementation. DME pre-certification criteria documents may be found at <http://www.dss.mo.gov/mhd/cs/dmeprecert/pages/dmeprecert.htm>. If a pre-certification request submitted through CyberAccess is denied, providers may select the help ticket box to have a MO HealthNet call center representative contact them. The call center is available Monday through Friday from 8:00 am to 5:00 pm, excluding state holidays.

Items of DME that require pre-certification can be identified by the abbreviation "PC" (pre-certification) under the "Reimbursement Guidelines" column in Section 19 of this manual.

PLEASE NOTE: An approved pre-certification request does *not* guarantee payment. The provider *must* verify participant eligibility on the date of service using the Interactive Voice Response (IVR) System at (573) 751-2896 or by logging in to the MO HealthNet Web portal.

13.33 DURABLE MEDICAL EQUIPMENT (DME) PROGRAM BILLING REMINDERS

Prior authorization approves the medical necessity of the item. It does *not* guarantee payment for the item as the participant *must* be MO HealthNet eligible on the date the equipment is dispensed. It is the responsibility of the MO HealthNet provider to ascertain the participant's MO HealthNet status.

Charges for delivery, pick-up, shipping, freight, handling and COD are included in the MO HealthNet reimbursement of all purchased or rented equipment, medical supplies, oxygen, orthotics and prosthetics, TPN, IV therapy and enteral therapy and cannot be billed to the participant.

DME provided to participants in a nursing home is not covered under the DME Program with the exception of: volume ventilators, TPN, custom and power wheelchairs, orthotics, prosthetics, and augmentative communication devices.

Reimbursement for items through the DME Program is the lower of the provider's usual and customary charge or the MO HealthNet allowable amount.

For participants with both Medicare and MO HealthNet coverage, a Medicare denial is *not* required for submitting a MO HealthNet claim for volume ventilators for participants in a nursing home.



A Certificate of Medical Necessity is valid for six (6) months. A new Certificate of Medical Necessity must be completed every six (6) months.

For specific equipment codes and billing requirements refer to Section 19.

Medical criteria documents for items requiring pre-certification may be found at <http://www.dss.mo.gov/mhd/cs/dmeprecert/pages/dmeprecert.htm>.

13.34 NONCOVERED SERVICES UNDER THE DURABLE MEDICAL EQUIPMENT (DME) PROGRAM

13.34.A NONCOVERED ITEMS

MO HealthNet does *not* cover items which primarily serve the following purposes: personal comfort, convenience, education, hygiene, safety, cosmetic, new equipment of unproven value and equipment of questionable current usefulness or therapeutic value.

- Adaptive Toys
- Air conditioners
- Back-up manual wheelchairs or stroller to a manual wheelchair (adults & children)
- Bathtub rails
- Canopy/safety beds
- Car Seats
- Computers (unless determined to be used for an augmentative communication device)
- Dialysis equipment
- Electric bathtub lifts
- Elevators
- Environmental control systems
- Equipment used in non-medical context
- External power or electronic prosthetic devices
- Furniture
- Home modifications
- Labor for the assembling of wheelchairs or equipment
- Massage equipment
- Medical alert system
- Medical necessity bags
- Motivation-type devices
- Multiple positioning equipment such as a mobile floor sitter and a wheelchair with a seating system
- Pacemaker monitor
- Power wheelchair seat elevations system
- Power wheelchair power standing system
- Refrigerators



- Repair, replacement or continued rental of equipment for which a continuing need *cannot* be established
- Repair to non-covered items are non-covered
- Sales tax
- Seat lift chairs
- Stair lifts or glides
- Standers
- Sunshade/canopies
- Transits option
- Treadmill
- Vehicle Modifications
- Water softening systems
- Wheelchair lifts
- Wheelchair ramps
- Whirlpool tubs or pumps

This list is *not* all-inclusive. If there is *not* a specific code listed in Section 19, the item is *not* covered.

13.34.B DUAL ELIGIBLES IN MEDICARE COMPETITIVE BIDDING AREA (CBA)

Medicare implemented a competitive bidding program in January 2011, for certain Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS). For Medicare beneficiaries whose permanent residence is in a statistical area affected by the CBA program, only contract suppliers will be eligible to provide competitive bid items and receive payment from Medicare. Complete information on the competitive bidding process can be found on the Center for Medicare & Medicaid Services (CMS) website at <http://www.cms.hhs.gov/DMEPOSCompetitiveBid/>.

MO HealthNet will align policy with Medicare for dual-eligible participants who reside in a CBA. If Medicare denies reimbursement for a DME competitively bid service that was provided to a participant by a non-contract or non-demonstration supplier, the service is not covered by MO HealthNet and *must* not be billed to MO HealthNet for reimbursement. The participant is not liable for payment *unless* the non-contract supplier in a CBA has informed the participant in writing prior to receiving the item that there would be no Medicare or MO HealthNet coverage due to the supplier's contract status, and the participant understands that he/she will be liable for all costs that the non-contract supplier may charge the participant for the item.

END OF SECTION

[TOP OF PAGE](#)



SECTION 14—SPECIAL DOCUMENTATION REQUIREMENTS

Program limits may require a Prior Authorization Request form, Certificate of Medical Necessity attachment or a Pre-Certification. Refer to Section 14.2 for durable medical equipment (DME) instructions for requesting prior authorization.

The MO HealthNet Program has requirements for other documentation when processing claims under certain circumstances. Refer to Section 19, Procedure Codes, for specific documentation requirements. Refer to Sections 1-11 and Section 20 for general program documentation requirements.

Please be aware that when a specific procedure requires an attachment, the attachment remains a positive requirement and *must* accompany the claim form or Prior Authorization Request form.

14.1 CERTIFICATE OF MEDICAL NECESSITY

A Certificate of Medical Necessity attachment is required for many DME services. Refer to Section 19 for a complete list of procedure codes covered under the DME Program and their specific documentation requirements.

The determination of medical necessity is based on the information contained on the Certificate of Medical Necessity attachment. Therefore, it is important that every field on the form be completed. It is also important to include on the Certificate of Medical Necessity attachment the procedure code, a complete description of the item; brand name; model number, if applicable; accessories or components, if applicable; diagnosis; prognosis; the reason why the equipment/item is needed and the anticipated length of need.

When the medical consultant *cannot* determine medical necessity based on the information provided, the claim may be denied.

The Certificate of Medical Necessity attachment should be submitted electronically. The attachment and completion instructions are available at www.emomed.com.

14.2 PRIOR AUTHORIZATION

Many items covered under the DME Program require prior approval by the MO HealthNet Division. Refer to Section 8 for complete instructions on completing the Prior Authorization Request form.

Procedure codes that require prior authorization are listed in Section 19.



14.2.A REQUESTING PRIOR AUTHORIZATION

When requesting prior authorization for approval to dispense certain DME items, providers should submit as much information as possible as to why the specific item is being requested. The information *must* include the description of the item to be provided, the anticipated length of need, the projected outcome the item should provide, and the diagnosis and prognosis of the recipient. If there is *not* enough room on the Prior Authorization Request form, include the information on an additional sheet of paper. The participant's attending physician *must* sign the Prior Authorization Request form. If in Section 19 it is indicated that a procedure code requires an evaluation or an invoice of cost, those documentation requirements *must* accompany the Prior Authorization Request form.

14.2.B RETURN OF PRIOR AUTHORIZATION REQUEST FORMS

The fiscal agent returns processed Prior Authorization Request forms to the provider. The Prior Authorization Request form is marked approved, denied, or additional information required. The MO HealthNet allowable reimbursement amount is entered on approved Prior Authorization Request forms. Authorization expires three months (unless otherwise indicated) following the date of approval, which is located at the very bottom of the Prior Authorization Request form.

14.2.C RETURNED/DENIED PRIOR AUTHORIZATION REQUEST FORMS

If the Prior Authorization Request is returned for additional information or for further clarification, the provider is urged to explain in detail or attach as much documentation as possible to support the medical necessity of the item being requested.

14.3 OXYGEN AND RESPIRATORY EQUIPMENT MEDICAL JUSTIFICATION (OREMJ) FORM

The Oxygen and Respiratory Equipment Medical Justification (OREMJ) attachment is no longer required for claims submitted for oxygen and oxygen delivery systems. The OREMJ should be maintained in the participant's file. A Pre-Certification must be submitted to request oxygen systems and equipment. Refer to Section 19 for specific oxygen codes.



14.4 PRE-CERTIFICATION PROCESS FOR DURABLE MEDICAL EQUIPMENT

Pre-certification serves as a utilization management tool, allowing payment for services that are medically necessary, appropriate and cost-effective without compromising the quality of care to participants. Pre-certification of specific items and services will be implemented incrementally by individual HCPCS code or groups of codes.

Pre-certification of DME is a two-step process. Requests for pre-certification must be initiated by an authorized DME prescriber who writes prescriptions for items covered under the DME Program. Authorized DME prescribers include physicians, podiatrists and nurse practitioners who have a collaborative practice agreement with a physician that allows for prescription of such items. The enrolled DME provider will access the pre-certification initiated by the prescriber to complete the second step of the pre-certification process. All requests must be approved by the MHD. Providers are encouraged to sign up for the MO HealthNet Web tool – [CyberAccessSM](#)- which automates the pre-certification process. To become a CyberAccessSM user, contact the ACS-Heritage help desk at 1-888-581-9797 or 573-632-9797 or send an e-mail to MOHealthNetCyberaccess@heritage-info.com. The CyberAccessSM tool allows each pre-certification to automatically reference the individual participant's claim history, including applicable ICD diagnosis codes and CPT procedure codes. Requests for pre-certification will also be taken by the MO HealthNet call center at 800-392-8030. Requests for pre-certification must meet medical criteria established by the MHD in order to be approved. [Medical criteria](#) is published in [provider bulletins](#) and posted on the [MHD Web site](#) prior to implementation. If a pre-certification request submitted through CyberAccessSM is denied, providers may click on the box to have a MO HealthNet call center representative contact them. The call center is available Monday through Friday, from 8:00 am to 5:00 pm, excluding state holidays.

Items of DME that require pre-certification can be identified by the abbreviation "PC" (pre-certification) under the "Reimbursement Guidelines" column in Section 19 of the [DME Provider Manual](#).

PLEASE NOTE: An approved pre-certification request does not guarantee payment. The provider must verify participant eligibility on the date of service using the Interactive Voice Response (IVR) System at (573) 635-8908 or by logging the [MO HealthNet](#) Web portal.

END OF SECTION

[TOP OF PAGE](#)

SECTION 15-BILLING INSTRUCTIONS

15.1 CMS-1500 CLAIM FORM

The CMS-1500 claim form is always used to bill MO HealthNet for Durable Medical Equipment (DME) services. Instructions on how to complete the CMS-1500 claim form are in Section 15.5.

15.2 PROVIDER COMMUNICATIONS UNIT

The Provider Communications Unit is available for MO HealthNet providers to call with inquiries, concerns or questions regarding proper claim filing, claims resolution and disposition, participant eligibility questions and verifications. Providers may contact Provider Communications via telephone at (573) 751-2896, or via the [MO HealthNet Web Portal](#), Provider Communications Management icon. Section 3 of this manual contains a detailed explanation of the role of the Provider Communications Unit. If assistance is needed regarding establishing required electronic claim formats for claims submissions, accessibility to electronic claim submission via the Internet, network communications, or ongoing operations, the provider should contact the Wipro Infocrossing Help Desk at (573) 635-3559.

15.3 RESUBMISSION OF CLAIMS

Any line item on a claim that resulted in a zero payment can be resubmitted if it denied due to a correctable error. The error that caused the claim to deny *must* be corrected before resubmitting the claim. The provider may resubmit on a CMS-1500 claim form. An example of a correctable error is the use of an invalid procedure code or an incorrect type of service code.

If a line item on a claim paid but the payment was incorrect do *not* resubmit that line item. For instance, a provider bills for a partial month rental and should have billed for the entire month. If everything else on the claim is correct, the claim will pay. That claim *cannot* be resubmitted. It will deny as a duplicate. In order to correct that payment, the provider *must* submit an Individual Adjustment Request. Section 6 of this manual explains the adjustment request process.

15.4 BILLING PROCEDURES FOR MEDICARE/MO HEALTHNET

When a participant has both Medicare Part B and MO HealthNet coverage, a claim *must* be filed with Medicare first as primary payer. If the patient has Medicare Part B and the service is *not* covered or the limits of coverage have been reached previously, a paper claim *must* be submitted to MO HealthNet with the Medicare Remittance Advice information attached indicating the denial.



Reference Section 16 of this manual for instructions for submission of Medicare/MO HealthNet crossover claims.

Claims for wheelchair bases, accessories and repairs for nursing home participants who are not under a Medicare Part A nursing home stay, do not require a Medicare denial for the claim to be processed. Diapers, pull-ons and underpads are also exempt from the Medicare denial.

If a claim was submitted to Medicare indicating that the participant also had MO HealthNet and disposition of the claim is *not* received from MO HealthNet within 60 days of the Medicare remittance advice date (a reasonable period for transmission for Medicare and MO HealthNet processing), a crossover claim *must* be submitted to MO HealthNet. Reference Section 16 of this manual for billing instructions.

15.5 CMS-1500 CLAIM FILING INSTRUCTIONS

The CMS-1500 claim form should be typed or legibly printed. It may be duplicated if the copy is legible. MO HealthNet claims should be mailed to:

Wipro Infocrossing
P.O. Box 5600
Jefferson City, MO 65102

NOTE: An asterisk (*) beside field numbers indicates required fields. These fields *must* be completed or the claim is denied. All other fields should be completed as applicable. Two asterisks (**) beside the field number indicate a field is required in specific situations.

FIELD NUMBER & NAME	INSTRUCTIONS FOR COMPLETION
1. Type of Health Insurance Coverage	Show the type of health insurance coverage applicable to this claim by checking the appropriate box. For example, if a Medicare claim is being filed, check the Medicare box, if a MO HealthNet claim is being filed, check the Medicaid box and if the participant has both Medicare and MO HealthNet, check both boxes.
*1a. Insured's I.D.	Enter the patient's eight-digit MO HealthNet number as shown on the patient's ID card.
*2. Patient's Name	Enter last name, first name, middle initial <i>in that order</i> as it appears on the ID card.
3. Patient's Birth Date	Enter month, day, and year of birth.
Sex	Mark appropriate box.



- (See Note)(1)
- **11. Insured's Policy or Group Number
Enter the primary policyholder's insurance policy number or group number, if the insurance is through a group, such as an employer, union, etc. (See Note)(1)
 - **11a. Insured's Date of Birth and Sex
Enter primary policyholder's date of birth and mark the appropriate box reflecting the sex of the primary policyholder. (See Note)(1)
 - **11b. Employer's Name
Enter the primary policyholder's employer name. (See Note)(1)
 - **11c. Insurance Plan Name
Enter the primary policyholder's insurance plan name.
If the insurance plan denied payment for the item provided, attach valid denial from the insurance plan. (See Note)(1)
 - **11d. Other Health Plan
Indicate whether the participant has another health insurance plan; if so, complete Fields #9-#9d with the secondary insurance information. (See Note)(1)
 - 12. Patient's Signature
Leave blank.
 - 13. Insured's Signature
This field should be completed only when the participant has another health insurance policy. Obtain the policyholder's or authorized person's signature for assignment of benefits. The signature is necessary to ensure the insurance plan pays any benefits directly to the provider or MO HealthNet. Otherwise payment may be issued to the policyholder requiring the provider to collect insurance benefits from the policyholder.
 - 14. Date of Current Illness, Injury or Pregnancy
Leave blank.
 - 15. Date Same/Similar Illness
Leave blank.
 - 16. Dates Patient Unable to Work
Leave blank.
 - **17. Name of referring provider or
Enter the name of the referring provider or



Other Source	other source. If multiple providers are involved, enter one provider using the following priority order 1. Referring provider 2. Ordering Provider 3. Supervising Provider
**17a Other ID	Enter ID, and the MO HealthNet legacy number of the provider.
**17b NPI	Enter the NPI number of referring, ordering, or supervising provider.
18. Hospitalization Dates	Leave blank.
19. Reserved for Local Use	This field may be used for additional remarks or descriptions.
20. Lab Work Performed Outside Office	Leave blank.
*21. Diagnosis	Enter the complete applicable ICD CM diagnosis code(s). Enter the primary diagnosis under No. 1, the secondary diagnosis under No. 2, etc.
22. Medicaid Resubmission	For timely filing purposes, if this is a resubmitted claim, enter the Internal Control Number (ICN) of the previous related claim.
23. Prior Authorization Number	Leave blank.
*24a. Date of Service	Enter the date of service under “from” in month/day/year format, using six-digit format. All line <i>items must</i> have a from date. <i>A “to” date is required when billing for DME rental, (TOS “T”).</i>
*24b. Place of Service	Enter the appropriate place of service code. 11 Office, Community Health Centers 12 Home 22 Outpatient Hospital 24 Ambulatory Surgical Center 26 Military Treatment Facility 31 Skilled Nursing Facility 32 Nursing Facility 33 Custodial Care Facility



- 34 Hospice
- 53 Community Mental Health Center
- 54 Intermediate Care Facility/Mentally Retarded
- 61 Comprehensive Inpatient Rehabilitation Facility
- 62 Comprehensive Outpatient Rehabilitation Facility
- 71 State or Local Public Health Clinic
- 97 Non-Public School
- 98 Public School
- 99 Other Unlisted Facility

*24c. EMG-Emergency Enter the appropriate type of service code for the procedure code billed. The valid TOS codes for DME are:

- A DME Purchase
- T DME Rental
- 0 (zero) DME Repair, Replacement or Modification

*24d. Procedure Code Enter the appropriate HCPCS code corresponding to the item dispensed. Description of the service is required for DME providers. Enter the description in the modifier field and/or use the next line.

*24e. Diagnosis Pointer Enter 1, 2, 3, 4 or the actual diagnosis code(s) from Field #21.

*24f. Charges Enter the provider’s usual and customary charge for each line item. This should be the total charge for multiple days or units. When an item has been prior authorized, the amount approved *must* be billed instead of the usual and customary charge.

*24g. Days or Units Enter the number of days or units of service provided for each detail line. The system automatically plugs a “1” if the field is left blank.

DME—for DME rental of equipment under the *regular* DME Program (TOS T), the



“from” and “to” dates of service should reflect the month, or portion of the month, in which the item is rented. The quantity *must* always be a “1.” When billing ostomy supplies under procedure code A4421, the quantity is always a “1.” Please refer to the specific procedure code instructions in Section 19.

- **24h. EPSDT/Family Planning **If the service is HCY/EPSDT, enter “E.”**
- 24i. ID Qualifier Enter in the shaded area of 24I, ID. The other ID# of the rendering provider is reported in 24J in the shaded area.
- 24j. Rendering Provider ID Leave blank.
- 24k.
- 25. SS#/Fed. Tax ID Leave blank.
- 26. Patient Account Number For the provider’s own information, a maximum of 12 alpha and/or numeric characters may be entered here.
- 27. Assignment Not required on MO HealthNet claims.
- *28. Total Charge Enter the sum of the line item charges for each claim form.
- 29. Amount Paid Enter the total amount received by all other insurance resources. Previous MO HealthNet payments, Medicare payments and copay amounts are *not* to be entered in this field.
- 30. Balance Due Enter the difference between the total charge (Field #28) and the insurance amount paid (Field #29).
- 31. Provider Signature Not Required.
- **32. Name and Address of Facility If equipment was delivered to a facility other than the home or office, enter the name and location of the facility.
- **32a NPI# Enter the 10-digit NPI number of the service facility location in 32.
- **32b Other ID# Enter the MO HealthNet legacy number.



*33. Provider Name/
Number/Address

Affix the provider label or write or type the information *exactly* as it appears on the label.

* These fields are mandatory on *all* CMS-1500 claim forms.

** These fields are mandatory only in specific situations, as described.

(1) NOTE: This field is for private insurance information **only**. If no private insurance is involved LEAVE BLANK. If Medicare, MO HealthNet, employers name or other information appears in this field, the claim will deny. See Section 5 for further TPL information.

15.6 PLACE OF SERVICE CODES

CODE	DEFINITION
11 Office	Location, other than a hospital, skilled nursing facility (SNF), military treatment facility, community health center, state or local public health clinic or nursing facility, where the health professional routinely provides health examinations, diagnosis and treatment of illness or injury on an ambulatory basis.
12 Home	Location, other than a hospital or other facility, where the patient receives care in a private residence.
22 Outpatient Hospital	The portion of a hospital that provides diagnostic, therapeutic (both surgical and nonsurgical), and rehabilitation services to sick or injured persons who do <i>not</i> require hospitalization or institutionalization.
24 Ambulatory Surgical Center	A freestanding facility, other than a physician's office, where surgical and diagnostic services are provided on an ambulatory basis.
26 Military Treatment Facility	A medical facility operated by one or more of the Uniformed Services. Military Treatment Facility (MTF) also refers to certain former U.S. Public Health Service (USPHS) facilities now designated as Uniformed Services Treatment Facilities (USTF).



- 31 Skilled Nursing Facility

A facility that primarily provides inpatient skilled nursing care and related services to patients who require medical, nursing, or rehabilitative services that does *not* provide the level of care or treatment available in a hospital.
- 32 Nursing Facility

A facility that primarily provides to residents skilled nursing care and related services for the rehabilitation of individuals with injury, disability or illness, or on a regular basis health-related care services above the level of custodial care to other than individuals with developmental disabilities.
- 33 Custodial Care Facility

A facility that provides room, board and other personal assistance services, generally on a long-term basis, and that does *not* include a medical component.
- 34 Hospice

A facility other than a patient’s home, in which palliative and supportive care for patients with terminal illness and their families is provided.

NOTE: This place of service should only be used when the actual service is performed in a hospice facility. If a hospice patient receives services in a setting other than a hospice facility, then the specific location for that service should be used.
- 53 Community Mental Health Center

A facility that provides comprehensive mental health services on an ambulatory basis primarily to individuals residing or employed in a defined area.
- 54 Intermediate Care Facility/
Mentally Retarded

A facility that primarily provides health-related care and services above the level of custodial care to individuals with developmental disabilities but does *not* provide the level of care or treatment available in a hospital or SNF.
- 61 Comprehensive Inpatient
Rehabilitation Facility

A facility that provides comprehensive rehabilitation services under the supervision of a physician to inpatients with physical disabilities. Services include rehabilitation nursing, physical therapy, occupational therapy, speech pathology, social or psychological services, and orthotics and



	prosthetics services.
62 Comprehensive Outpatient Rehabilitation Facility	A facility that provides comprehensive rehabilitation services under the supervision of a physician to outpatients with physical disabilities. Services include physical therapy, occupational therapy, and speech pathology services.
71 State or Local Public Health Clinic	A facility maintained by either state or local health departments that provides ambulatory primary medical care under the general direction of a physician.
97 Non-Public School	A parochial or private school supported by private funds and governed by a private body.
98 Public School	A school open to any child in the community, supported by tax dollars and governed by a local school district.
99 Other Unlisted Facility	Other service facilities <i>not</i> identified above.

15.7 INSURANCE COVERAGE CODES

Type of insurance coverage codes identified on the interactive voice response (IVR) system, a point of service (POS) terminal, or eligibility files accessed via the Internet are listed in Section 5 of this manual, Third Party Liability.

While providers are verifying the patient's eligibility, they can obtain the TPL information contained on the MO HealthNet Divisions' participant file. Eligibility may be verified by calling the Interactive Voice Response (IVR) system at (573) 635-8908, which allows the provider to inquire on third party resources. The provider may also use a point of service (POS) terminal or the Internet at www.emomed.com to verify eligibility and inquire on third party resources. Participants *must* always be asked if they have third party insurance regardless of the TPL information given by the IVR, POS terminal or Internet. IT IS THE PROVIDER'S RESPONSIBILITY TO OBTAIN FROM THE PARTICIPANT THE NAME AND ADDRESS OF THE INSURANCE COMPANY, THE POLICY NUMBER, AND THE TYPE OF COVERAGE. Reference Section 5 of this manual, Third Party Liability.

END OF SECTION

[TOP OF PAGE](#)



SECTION 16—MEDICARE/MEDICAID CROSSOVER CLAIMS

16.1 GENERAL INFORMATION

This section includes general information about the Medicare and MO HealthNet Programs, comparisons between them, and how they relate to one another in cases in which an individual has concurrent entitlement to medical care benefits under both programs.

- Both Medicare and MO HealthNet are part of the Social Security Act.
- Medicare is an insurance program designed and administered by the federal government. Medicare is also called Title XVIII (18) of the Social Security Act. Medicare services and rules for payment are the same for all states in the United States. Applications for this program can be made at local Social Security Offices, which can also provide some details regarding services.

Medicare claims are processed by federally contracted private insurance organizations called carriers and intermediaries located throughout the U.S.

- MO HealthNet is an assistance program that is a federal-state partnership. Some services, as established by the federal government, are required to be provided. Additional services may be provided at the option of individual states. MO HealthNet is also called Title XIX (19) of the Social Security Act. Each state designs and operates its own program within federal guidelines; therefore, programs vary among states. In Missouri, an individual may apply for Mo HealthNet benefits by completing an application form at a Family Support Division (FSD) office.

In Missouri, MO HealthNet claims are processed by a state-contracted fiscal agent that operates according to the policies and guidelines of the MO HealthNet Division within the Department of Social Services, which is the single state agency for the administration of the MO HealthNet Program.

- For participants having both Medicare and MO HealthNet eligibility, the MO HealthNet Program pays the cost-sharing amounts indicated by Medicare due on the Medicare allowed amount. These payments are referred to as “Crossovers.”
- “Cost-sharing” amounts include the participant’s co-insurance, deductible, and any co-pays that are due for any Medicare-covered service.



16.2 BILLING PROCEDURES FOR MEDICARE/MO HEALTHNET CLAIMS (CROSSOVERS)

When a participant has both Medicare and MO HealthNet coverage, a claim *must* be filed with Medicare first. After making payment, the Medicare contractor forwards the claim information to MO HealthNet for payment of cost-sharing amounts. (Reference Section 16.3 for instructions to bill MO HealthNet when Medicare denies a service.)

The MO HealthNet payment of the cost-sharing appears on the provider's MO HealthNet Remittance Advice (RA).

Some crossover claims *cannot* be processed in the usual manner for one of the following reasons:

- The Medicare contractor does *not* send crossovers to MO HealthNet
- The provider did *not* indicate on his claim to Medicare that the beneficiary was eligible for MO HealthNet.
- The MO HealthNet participant information on the crossover claim does *not* match the fiscal agent's participant file.
- The provider's National Provider Identifier (NPI) number is *not* on file in the MO HealthNet Division's provider files.

MO HealthNet no longer accepts paper crossover claims. Medicare/MO HealthNet (crossover) claims that do not cross automatically from Medicare to MO HealthNet must be filed through the MO HealthNet billing web portal at www.emomed.com or through the 837 electronic claims transaction. Before filing an electronic crossover claim, providers should wait 30 days from the date of Medicare payment to avoid duplication. The following tips are provided to make filing a claim at the MO HealthNet billing web portal successful:

- 1) Through the MO HealthNet billing web portal at www.emomed.com, choose the claim form that corresponds with the claim form used to bill Medicare. Enter all appropriate information from that form.
- 2) HELP screens are accessible to provide instructions in completing the crossover claim forms, the "Other Payer" header and "Other Payer" detail screens. The HELP screens are identified by a "?" and is located in the upper right-hand corner.
- 3) There must be an "Other Payer" header form completed for every crossover claim type. This provides information that pertains to the whole claim.
- 4) Part A crossover claims need only the "Other Payer" header form completed and not the "Other Payer" detail form.



- 5) Part B and B of A crossover claims need the “Other Payer” header form completed. An “Other Payer” detail form is required for each claim line detail with the group code, reason code and adjustment amount information.
- 6) Choose the appropriate codes that can be entered in the “Group Code” field on the “Other Payer” header and detail forms from the dropdown box. For example, the “PR” code (Patient Responsibility) is understood to be the code assigned for the cost-sharing amounts shown on the Medicare EOMB.
- 7) The codes to enter in the “Reason Code” field on the “Other Payer” header and detail forms are also found on the Medicare EOMB. If not listed there, choose the most appropriate code from the list of “Claim Adjustment Reason Codes”. These HIPAA mandated codes can be found at www.wpc-edi.com/codes. For example, on the “Claim Adjustment Reason Codes” list the code for “deductible amount” is 1 and for “coinsurance amount” it is 2. Therefore, choose a “Reason Code” of “1” for deductible amounts due and a “Reason Code” of “2” for coinsurance amounts due.
- 8) The “Adjust Amount” should reflect any amount not paid by Medicare including any cost-sharing amounts and any non-allowed amounts.
- 9) If there is a commercial insurance payment or denial to report on the crossover claim, complete an additional “Other Payer” header form. Complete an additional “Other Payer” detail form(s) as appropriate.

Note: For further assistance on how to bill crossover claims, please contact Provider Education at (573) 751-6683.

16.3 BILLING OF SERVICES NOT COVERED BY MEDICARE

Not all services covered under the MO HealthNet Program are covered by Medicare. (Examples are: eyeglasses, most dental services, hearing aids, adult day health care, personal care or most eye exams performed by an optometrist.) In addition, some benefits that are provided under Medicare coverage may be subject to certain limitations. The provider will receive a Medicare Remittance Advice that indicates if a service has been denied by Medicare. The provider may submit a Medicare denied claim to MO HealthNet electronically using the proper claim form for consideration of reimbursement through the 837 electronic claims transaction or through the MO HealthNet web portal at www.emomed.com. If the 837 electronic claims transaction is used, providers should refer to the implementation guide for assistance. The following are tips to assist in successfully filing Medicare denied claims through the MO HealthNet web portal at www.emomed.com:



- 1) To bill through the MO HealthNet web portal, providers should select the appropriate claim type (CMS 1500, UB-04, Nursing Home, etc.) Do *not* select the Medicare crossover claim form. Complete all pertinent data for the MO HealthNet claim.
- 2) Some fields are required for Medicare and not for Third Party Liability (TPL). The code entered in the “Filing Indicator” field will determine if the attachment is linked to TPL or Medicare coverage.

16.4 MEDICARE PART C CROSSOVER CLAIMS FOR QMB PARTICIPANTS

Medicare Advantage/Part C plans do not forward electronic crossover claims to MHD. Therefore, providers must submit Medicare Advantage/Part C crossover claims through the MHD Web portal at www.emomed.com. The following are tips to assist in successfully filing Medicare Advantage/Part C crossover claim through the MO HealthNet web portal at www.emomed.com:

- 1) Access the MHD web portal at www.emomed.com. Choose the appropriate Part C crossover claim format. Enter all appropriate information from the Medicare Advantage/Part C plan claim. Do not use the Medicare Part A or Part B crossover claim format.
- 2) HELP screens are accessible to provide instructions in completing the crossover claim forms, the “Other Payer” header and “Other Payer” detail screens. The HELP screens are identified by a “?” and is located in the upper right-hand corner.
- 3) The filing indicator for Medicare Advantage/Part C crossover claims is 16 followed by the appropriate claim type.
- 4) There must be an “Other Payer” header detail screen completed for every crossover claim format. This provides information that pertains to the whole claim.
- 5) Medicare Advantage/Part C institutional claims need only the “Other Payer” header detail screen completed and not the “Other Payer” line detail screen.
- 6) Medicare Advantage/Part C outpatient and professional crossover claims need the “Other Payer” header detail screen completed. An “Other Payer” line detail screen is required to be completed for each claim detail line with group code, reason code and adjustment amount information.
- 7) The appropriate code from the codes available in the “Group Code” drop down box on the “Other Payer” header and detail screens *must* be selected. For example, the “PR” code (patient responsibility) is understood to be the code assigned for the cost-sharing amounts shown on the Medicare Advantage/Part C explanation of benefits.



- 8) The codes to enter in the “Reason Code” field on the “Other Payer” header and detail screens are found on the Medicare Advantage/Part C Plan explanation of benefits. If no codes are listed, choose the most appropriate code from the list of “Claim Adjustment Reason Codes” that can be accessed at <http://www.wpc-edi.com/codes/Codes.asp>. For example, enter “Reason Code” of “1” for deductible amounts, “2” for coinsurance amounts and “3” for co-payment amounts.

16.4.A MEDICARE PART C COORDINATION OF BENEFITS FOR NON-QMB PARTICIPANTS

For non-QMB MO HealthNet participants enrolled with a Medicare Advantage/Part C Plan, MO HealthNet will process claims in accordance with the established MHD coordination of benefits policy. The policy can be viewed in Section 5.1.A of the MO HealthNet provider manual at <http://manuals/momed.com>. In accordance with this policy, the amount paid by MO HealthNet is the difference between the MO HealthNet allowable amount and the amount paid by the third party resource (TPR). Claims should be filed using the appropriate claim format (i.e., CMS-1500, UB-04). ***Do not use a crossover claim.***

16.5 TIMELY FILING

Claims that have been initially filed with Medicare within the Medicare timely filing requirements, and which are submitted as a crossover through an 837 electronic claim transaction or through the MO HealthNet Web portal at www.emomed.com meet the timely filing requirement by being submitted by the provider and received by the MO HealthNet Division within six months of the date of the allowed Medicare RA/EOMB or one (1) year from the date of service. Refer to Section 4 for further instructions on timely filing.

16.6 REIMBURSEMENT

The MO HealthNet Division reimburses the cost-sharing amount as determined by the Medicare contractor and reflected on the Medicare RA/EOMB. MHD prorates the reimbursement amount allowing a prorated amount for each date the individual was MO HealthNet eligible. Days on which the participant was not MO HealthNet eligible are not reimbursed.

16.6.A REIMBURSEMENT OF MEDICARE PART A AND MEDICARE ADVANTAGE/PART C INPATIENT HOSPITAL CROSSOVER CLAIMS

MO HealthNet is responsible for deductible and coinsurance amounts for Medicare Part A and deductible, coinsurance and copayment amounts for Medicare Advantage/Part C crossover claims only when the MO HealthNet applicable payment schedule exceeds the amount paid by Medicare plus calculated pass-through costs. In those situations where MO HealthNet has an obligation to pay a crossover claim, the amount of MO HealthNet’s



payment is limited to the lower of the actual crossover amount or the amount the MO HealthNet fee exceeds the Medicare payment plus pass-through costs. Medicare/Advantage/Part C primary claims must have been provided to QMB or QMB Plus participant to be considered a Medicare/Medicaid crossover claim. For further information, please see 12.4 of the Hospital Program Manual.

16.6.B REIMBURSEMENT OF OUTPATIENT HOSPITAL MEDICARE CROSSOVER CLAIMS

MO HealthNet reimbursement of Medicare/Medicaid crossover claims for Medicare Part B and Medicare Advantage/Part C outpatient hospital services is seventy-five percent (75%) of the allowable cost sharing amount. The cost sharing amount includes the coinsurance, deductible and/or copayment amounts reflected on the Medicare RA/EOMB from the Medicare carrier or fiscal intermediary. The crossover claims for Medicare Advantage/Part C outpatient hospital services must have been provided to QMB or QMB Plus participant to be reimbursed at seventy-five percent (75%) of the allowable cost sharing amount. This methodology results in payment which is comparable to the fee-for-service (FFS) amount that would be paid by MHD for those same services.

END OF SECTION

[TOP OF SECTION](#)



SECTION 17-CLAIMS DISPOSITION

This section of the manual provides information used to inform the provider of the status of each processed claim.

MO HealthNet claims submitted to the fiscal agent are processed through an automated claims payment system. The automated system checks many details on each claim, and each checkpoint is called an edit. If a claim *cannot* pass through an edit, it is said to have failed the edit. A claim may fail a number of edits and it then drops out of the automated system; the fiscal agent tries to resolve as many edit failures as possible. During this process, the claim is said to be suspended or still in process.

Once the fiscal agent has completed resolution of the exceptions, a claim is adjudicated to pay or deny. A statement of paid or denied claims, called a Remittance Advice (RA), is produced for the provider twice monthly. Providers receive the RA via the Internet. New and active providers wishing to download and receive their RAs via the Internet are required to sign up for Internet access. Providers may apply for Internet access at <http://manuals.momed.com/Application.html>. Providers are unable to access the web site without proper authorization. An authorization is required for each individual user.

17.1 ACCESS TO REMITTANCE ADVICES

Providers receive an electronic RA via the eMOMED Internet website at www.emomed.com or through an ASC X12N 835.

Accessing the RA via the Internet gives providers the ability to:

- Retrieve the RA following the weekend Financial Cycle;
- Have access to RAs for 62 days (the equivalent of the last four cycles);
- View and print the RA from an office desktop; and
- Download the RA into the office operating system.

The Internet RA is viewable and printable in a ready to use format. Just point and click to print the RA or save it to the office PC and print at any convenient time.

Access to this information is restricted to users with the proper authorization. The Internet site is available 24 hours a day, 7 days a week with the exception of scheduled maintenance.



17.2 INTERNET AUTHORIZATION

If a provider uses a billing service to submit and reconcile MO HealthNet claims, proper authorization *must* be given to the billing service to allow access to the appropriate provider files.

If a provider has several billing staff who submit and reconcile MO HealthNet claims, each Internet access user *must* obtain a user ID and password. Internet access user IDs and passwords *cannot* be shared by co-workers within an office.

17.3 ON-LINE HELP

All Internet screens at www.emomed.com offer on-line help (both field and form level) relative to the current screen being viewed. The option to contact the Wipro Infocrossing Help Desk via e-mail is offered as well. As a reminder, the help desk is only responsible for the Application for MO HealthNet Internet Access Account and technical issues. The user should contact the Provider Relations Communication Unit at (573) 751-2896 for assistance on MO HealthNet Program related issues.

17.4 REMITTANCE ADVICE

The Remittance Advice (RA) shows payment or denial of MO HealthNet claims. If the claim has been denied or some other action has been taken affecting payment, the RA lists message codes explaining the denial or other action. A new or corrected claim form *must* be submitted as corrections *cannot* be made by submitting changes on the RA pages.

Claims processed for a provider are grouped by paid and denied claims and are in the following order within those groups:

- Crossovers
- Inpatient
- Outpatient (Includes Rural Health Clinic and Hospice)
- Medical
- Nursing Home
- Home Health
- Dental
- Drug
- Capitation
- Credits



Claims in each category are listed alphabetically by participant’s last name. Each category starts on a separate RA page. If providers do *not* have claims in a category, they do *not* receive that page.

If a provider has both paid and denied claims, they are grouped separately and start on a separate page. The following lists the fields found on the RA. Not all fields may pertain to a specific provider type.

FIELD NAME	FIELD DESCRIPTION
PAGE	The remittance advice page number.
CLAIM TYPE	The type of claim(s) processed.
RUN DATE	The financial cycle date.
PROVIDER IDENTIFIER	The provider’s NPI number.
RA #	The remittance advice number.
PROVIDER NAME	The name of the provider.
PROVIDER ADDR	The provider’s address.
PARTICIPANT NAME	The participant’s last name and first name.
	NOTE: If the participant’s name and identification number are <i>not</i> on file, only the first two letters of the last name and the first letter of the first name appear.
MO HEALTHNET ID	The participant’s current 8-digit MO HealthNet identification number.
ICN	The 13-digit number assigned to the claim for identification purposes. The first two digits of an ICN indicate the type of claim:
	11— Paper Drug
	13— Inpatient
	14— Dental
	15— Paper Medical
	16— Outpatient
	17— Part A Crossover
	18— Paper Medicare/MO HealthNet Part B Crossover Claim
	21— Nursing Home
	40— Magnetic Tape Billing (MTB)—includes crossover claims sent by Medicare intermediaries.
	41— Direct Electronic MO HealthNet Information (DEMI)
	43— MTB/DEMI
	44— Direct Electronic File Transfer (DEFT)
	45— Accelerated Submission and Processing (ASAP)
	46— Adjudicated Point of Service (POS)
	47— Captured Point of Service (POS)



- 49— Internet
- 50— Individual Adjustment Request
- 55— Mass Adjustment

The third and fourth digits indicate the year the claim was received.

The fifth, sixth and seventh digits indicate the Julian date. In a Julian system, the days of a year are numbered consecutively from “001” (January 1) to “365” (December 31) (“366” in a leap year).

The last digits of an ICN are for internal processing.

For a drug claim, the last digit of the ICN indicates the line number from the Pharmacy Claim form.

SERVICE DATES FROM	The initial date of service in MMDDYY format for the claim.
SERVICE DATES TO	The final date of service in MMDDYY format for the claim.
PAT ACCT	The provider’s own patient account name or number. On drug claims this field is populated with the prescription number.
CLAIM: ST	This field reflects the status of the claim. Valid values are: <ul style="list-style-type: none"> 1 — Processed as Primary 3 — Processed as Tertiary 4 — Denied 22 — Reversal of Previous Payment
TOT BILLED	The total claim amount submitted.
TOT PAID	The total amount MO HealthNet paid on the claim.
TOT OTHER	The combined totals for patient liability (surplus), participant copay and spenddown total withheld.
LN	The line number of the billed service.
SERVICE DATES	The date of service(s) for the specific detail line in MMDDYY.
REV/PROC/NDC	The submitted procedure code, NDC, or revenue code for the specific detail line. NOTE: The revenue code only appears in this field if a procedure code is <i>not</i> present.
MOD	The submitted modifier(s) for the specific detail line.
REV CODE	The submitted revenue code for the specific detail line. NOTE: The revenue code only appears in this field if a procedure code has also been submitted.



QTY	The units of service submitted.
BILLED AMOUNT	The submitted billed amount for the specific detail line.
ALLOWED AMOUNT	The MO HealthNet maximum allowed amount for the procedure/service.
PAID AMOUNT	The amount MO HealthNet paid on the claim.
PERF PROV	The NPI number for the performing provider submitted at the detail.
SUBMITTER LN ITM CNTL	The submitted line item control number.
GROUP CODE	The Claim Adjustment Group Code, which is a code identifying the general category of payment adjustment. Valid values are: CO—Contractual Obligation CR—Correction and Reversals OA—Other Adjustment PI—Payer Initiated Reductions PR—Patient Responsibility
RSN	The Claim Adjustment Reason Code, which is the code identifying the detailed reason the adjustment was made. Valid values can be found at http://www.wpc-edi.com/codes/claimadjustment .
AMT	The dollar amount adjusted for the corresponding reason code.
QTY	The adjustment to the submitted units of service. This field is <i>not</i> printed if the value is zero.
REMARK CODES	The Code List Qualifier Code and the Health Care Remark Code (Remittance Advice Remark Codes). The Code List Qualifier Code is a code identifying a specific industry code list. Valid values are: HE—Claim Payment Remark Codes RX—National Council for Prescription Drug Programs Reject/Payment Codes The Health Care Remark Codes (Remittance Advice Remark Codes) are codes used to convey information about remittance processing or to provide a supplemental explanation for an adjustment already described by a Claim Adjustment Reason Code. Valid values can be found at http://www.wpc-edi.com/codes/remittanceadvice .
CATEGORY TOTALS	Each category (i.e., paid crossover, paid medical, denied crossover, denied medical, drug, etc.) has separate totals for number of claims, billed amount, allowed amount, and paid amount.
CHECK AMOUNT	The total check amount for the provider.



EARNINGS REPORT

PROVIDER IDENTIFIER The provider's NPI number.

RA # The remittance advice number.

EARNINGS DATA

NO. OF CLAIMS PROCESSED The total number of claims processed for the provider.

DOLLAR AMOUNT PROCESSED The total dollar amount processed for the provider.

CHECK AMOUNT The total check amount for the provider.

17.5 CLAIM STATUS MESSAGE CODES

Missouri no longer reports MO HealthNet-specific Explanation of Benefits (EOB) and Exception message codes on any type of remittance advice. As required by the Health Insurance Portability & Accountability Act of 1996 (HIPAA) national standards, administrative code sets Claim Adjustment Reason Codes, Remittance Advice Remark Codes and NCPDP Reject Codes for Telecommunication Standard are used.

Listings of the Claim Adjustment Reason Codes and Remittance Advice Remark Codes can be found at <http://www.wpc-edi.com/content/view/180/223/>. A listing of the NCPDP Reject Codes for Telecommunication Standard can be found in the NCPDP Reject Codes For Telecommunication Standard appendix.

17.5.A FREQUENTLY REPORTED REDUCTIONS OR CUTBACKS

To aid providers in identifying the most common payment reductions or cutbacks by MO HealthNet, distinctive Claim Group Codes and Claim Adjustment Reason Codes were selected and are being reported to providers on all RA formats when the following claim payment reduction or cutback occurs:

Claim Payment Reduction/Cutback	Claim Group Code	Description	Claim Adjustment Reason Code	Description
Payment reimbursed at the maximum allowed	CO	Contractual Obligation	45	Charges exceed our fee schedule, maximum allowable or contracted or legislated fee arrangement.
Payment reduced by other insurance amount	OA	Other Adjustment	23	Payment adjusted because charges have been paid by another payer



Medicare Part A Repricing	OA	Other Adjustment	45	Charges exceed our fee schedule, maximum allowable or contracted or legislated fee arrangement.
Payment cut back to federal percentage (IEP therapy services)	OA	Other Adjustment	A2	Contractual adjustment
Payment reduced by co-payment amount	PR	Patient Responsibility	3	Co-Payment amount
Payment reduced by patient spenddown amount	PR	Patient Responsibility	178	Payment adjusted because patient has <i>not</i> met the required spenddown
Payment reduced by patient liability amount	PR	Patient Responsibility	142	Claim adjusted by monthly MO HealthNet patient liability amount

17.6 SPLIT CLAIM

An ASC X12N 837 electronic claim submitted to MO HealthNet may, due to the adjudication system requirements, have service lines separated from the original claim. This is commonly referred to as a split claim. Each portion of a claim that has been split is assigned a separate claim internal control number and the sum of the service line(s) charge submitted on each split claim becomes the split claim total charge. Currently, within MO HealthNet's MMIS, a maximum of 28 service lines per claim are processed. The 837 Implementation Guides allow providers to bill a greater number of service detail lines per claim.

All detail lines that exceed the size allowed in the internal MMIS detail record are split into subsequent detail lines. Any claim that then exceeds the number of detail lines allowed on the internal MMIS claim record is used to create an additional claim.

17.7 ADJUSTED CLAIMS

Adjustments are processed when the original claim was paid incorrectly and an adjustment request is submitted.

The RA will show a credit (negative payment) ICN for the incorrect amount and a payment ICN for the correct amount.

If a payment should *not* have been made at all, there will not be a corrected payment ICN.



17.8 SUSPENDED CLAIMS (CLAIMS STILL BEING PROCESSED)

Suspended claims are *not* listed on the Remittance Advice (RA). To inquire on the status of a submitted claim *not* appearing on the RA, providers may either submit a 276 Health Care Claim Status Request or may submit a View Claim Status query using the Real Time Queries function online at www.emomed.com. The suspended claims are shown as either paid or denied on future RAs without any further action by the provider.

17.9 CLAIM ATTACHMENT STATUS

Claim attachment status is not listed on the Remittance Advice (RA). Providers may check the status of six different claim attachments using the Real Time Queries function on-line at www.emomed.com. Claim attachment status queries are restricted to the provider who submitted the attachment. Providers may view the status for the following claim attachments on-line:

- Acknowledgement of Receipt of Hysterectomy Information
- Certificate of Medical Necessity (for Durable Medical Equipment only)
- Medical Referral Form of Restricted Participant (PI-118)
- Oxygen and Respiratory Equipment Medical Justification Form (OREMJ)
- Second Surgical Opinion Form
- (Sterilization) Consent Form

Providers may use one or more of the following selection criteria to search for the status of a claim attachment on-line:

- Attachment Type
- Participant ID
- Date of Service/Certification Date
- Procedure Code/Modifiers
- Attachment Status

Detailed Help Screens have been developed to assist providers searching for claim attachment status on-line. If technical assistance is required, providers are instructed to call the Wipro Infocrossing Help Desk at (573) 635-3559.



17.10 PRIOR AUTHORIZATION STATUS

Providers may check the status of Prior Authorization (PA) Requests using the Real Time Queries function on-line at www.emomed.com. PA status queries are restricted to the provider who submitted the Prior Authorization Request.

END OF SECTION

[TOP OF PAGE](#)

SECTION 18—DIAGNOSIS CODES

18.1 GENERAL INFORMATION

The diagnosis code is a required field and the accuracy of the code that describes the participant's condition is important.

The diagnosis code *must* be entered on the claim form exactly as it appears in the applicable ICD-CM. Note that the appropriate code(s) may be three, four or five digits, depending upon the patient's diagnosis. The fourth and fifth digits give greater detail or specificity, and *must* be used as applicable to the patient's diagnosis(es) when available.

Diagnosis codes are *not* included in this section. Claims may be denied if a three digit code is used. The applicable ICD-CM may require a fourth or fifth digit. The applicable ICD-CM (Volume I) should be used as a guide in the selection of the appropriate three, four or five digit diagnosis code. The applicable ICD-CM may be purchased in softbound or binder. The binder contains all three volumes, which are:

Volume 1: Diseases: Tabular List

Volume 2: Diseases: Alphabetic Index

Volume 3: Procedures: Tabular List and Alphabetic Index

Additional information regarding the applicable ICD-CM may be found at www.cdc.gov/nchs/icd.htm.

END OF SECTION

[TOP OF PAGE](#)



SECTION 19 - PROCEDURE CODES

- 19.1 HEALTHY CHILDREN AND YOUTH (HCY) COVERED *ONLY* FOR PARTICIPANTS AGE 0 - 20
- 19.2 DURABLE MEDICAL EQUIPMENT (DME), INCLUDES ALL AGE PARTICIPANTS

IOC = Invoice of Cost

MN = Medical Necessity

MNF = Medical Necessity on File

MP = Manually Priced

PA = Prior Authorization

PC = Pre-Certification

SECTION 19 - DME PROCEDURE CODES							
19.1 HEALTHY CHILDREN AND YOUTH (HCY) COVERED ONLY FOR PARTICIPANTS AGE 0-20							
Procedure Code	Modifiers			Description	Reimbursement Guidelines		Limits qty/days and Comments
A4206	NU	EP		1 CC STERILE SYRINGE&NEEDLE	MNF		100/30
A4207	NU	EP		SYRINGE WITH NEEDLE, STERILE 2 CC EACH	MNF		30/30
A4208	NU	EP		SYRINGE WITH NEEDLE, STERILE 3 CC EACH	MNF		100/30
A4209	NU	EP		SYRINGE WITH NEEDLE, STERILE 5 CC OR GREATER, EACH	MNF		100/30
A4211	NU	EP		SUPPLIES FOR SELF-ADMIN INJECT.	PA	IOC	
A4212	NU	EP		NON-CORING NEEDLE OR SYLET W/WO CATHETER	MNF		15/30
A4213	NU	EP		SYRINGE STERILE 20CC OR GREAT, EACH	MNF		100/30
A4215	NU	EP		NEEDLE, STERILE, ANY SIZE, EACH	MNF		100/30
A4216	NU	EP		STERILE WATER/SALINE, 10 ML	MNF		100/30
A4217	NU	EP		STERILE WATER/SALINE, 500 ML	MNF		30/30
A4221	NU	EP		SUPP NON-INSULIN INF CATH/WK			1/7
A4222	NU	EP		SUPPLIES FOR EXTERNAL DRUG INFUSION PUMP, PER CASSETTE OR BAG LIST DRUG SEPARATELY			
A4223	NU	EP		INFUSION SUPPLIES NOT USED WITH INFUSION PUMP, PER CASSETTE/BAG	CMN	IOC	
A4224	NU	EP		SUPPLY INSULIN INF CATH/WK	MNF		
A4225	NU	EP		SUP EXT INSULIN INF PUMP SYR	MNF		
A4244	NU	EP		ALCOHOL OR PEROXIDE, PER PINT			1/30
A4245	NU	EP		ALCOHOL WIPES, PER BOX			1/30
A4246	NU	EP		BETADINE OR PHISOHEX SOLUTION, PER PINT	MNF		2/30
A4247	NU	EP		BETADINE OR IODINE SWABS/WIPES, PER BOX	MNF		2/30
A4248	NU	EP		CHLORHEXIDINE CONTAINING ANTISEPTIC, 1 ML	MNF		2/30
A4310	NU	EP		INSERTION TRAY W/O DRAIN BAG & W/O CATH	PC		1/30
A4311	NU	EP		INSERT TRAY W/O DRAINBAG WITH INDWELL CATH FOLEY TYPE	PC		1/30
A4312	NU	EP		W INDWELL CATH FOLEY TYPE 2-WAY ALL SILICONE	PC		1/30

Durable Medical Equipment



A4313	NU	EP		W INDWELL CATH FOLEY TYPE 3-WAY	PC		1/30
A4314	NU	EP		INSERT TRAY W/DRAIN BAG W/INDWELL CATH FOLEY TYPE	PC		1/30
A4315	NU	EP		WITH INDWELL CATH FOLEY TYPE 2-WAY ALL SILICONE	PC		1/30
A4316	NU	EP		W/INDWELL CATH, FOLEY TYPE 3-WAY FOR CONTINOUS	PC		1/30
A4320	NU	EP		IRRIG TRAY W BULB OR PISTON SYRINGE, ANY PURPOSE	PC		1/30
A4322	NU	EP		IRRIG SYRINGE, BULB OR PISTON, EACH	PC		1/30
A4326	NU	EP		MALE EXTERNAL CATH SPECIAL TYPE EACH	PC		30/30
A4327	NU	EP		FEMALE EXTERANL URINARY COLL DEVICE METAL CUP, EACH	PC		1/7
A4328	NU	EP		FEMALE ESTERNAL URINARY COLL DEVICE POUCH, EACH	PC		1/1
A4330	NU	EP		PERIANAL FECAL COLLECTION POUCH WITH ADHESIVE, EACH	MNF		30/30
A4331	NU	EP		EXT DRNG TUBING, ANY TYPE/LENGTH, W/CONNECTOR/ADAPTOR; USE W/URINARY LEGBAG OR UROSTOMY POUCH, EACH	PC		1/30
A4331	NU	AU		EXT DRNG TUBING, ANY TYPE/LENGTH, W/CONNECTOR/ADAPTOR; USE W/URINARY LEGBAG OR UROSTOMY POUCH, EACH	PC		
A4332	NU	EP		LUB INDIVID STER PACKET FOR URI CATH INSERT, EACH	PC		30/30
A4333	NU	EP		URINARY CATH ANCHOR DEVICE ADHESIVE SKIN ATTCH	PC		3/7
A4334	NU	EP		URINARY CATH ANCHORING DEVICE, LEG STRAP, EACH	PC		1/30
A4335	NU	EP		INCONTINENCE SUPPLY, MISC	PC	IOC	
A4338	NU	EP		INDWELL CATH, FOLEY TYPE, 2-WAY LATEX WITH COATING	PC		1/30
A4340	NU	EP		INDWELL CATH SPECIAL TYPE EACH	PC		1/30
A4344	NU	EP		INDWELL CATH FOLEY TYPE 2-WAY ALL SILICONE	PC		1/30
A4346	NU	EP		INDWELL CATH 3-WAY CONTIN IRRIG, EACH	PC		1/30
A4349	NU	EP		MALE EXTERNAL CATH W/WO ADHESIVE, DISPOSABLE, EACH	PC		30/30
A4351	NU	EP		INTERMITT URINARY CATH STRAIGHT TIP W/WO COATING EACH	PC		120/30
A4352	NU	EP		INTERMITT. URINA CATH COUDE W/WO COATING EACH	PC		4/30
A4353	NU	EP		INTERMITTENT URINARY CATHETER, WITH INSERTION SUPPLIES	PC		120/30
A4354	NU	EP		INSERT TRAY WITH DRAIN BAG	PC		1/30
A4355	NU	EP		IRRIGAT. TUBE SET FOR CONTINOUS BLADDER IRRIG EACH	PC		30/30
A4356	NU	EP		EXTERNAL URETHRAL CLAMP EACH	PC		1/90
A4357	NU	EP		BEDSIDE DRAIN BAG EACH	PC		1/60

PRODUCTION : 04/09/2020

Durable Medical Equipment



A4357	NU	AU		BEDSIDE DRAIN BAG EACH	PC		+1/60
A4358	NU	EP		URINARY DRAIN BAG LEG OR ABDOMENT, W/STRAPS, EACH	PC		1/60
A4400	NU			OSTOMY IRRIGATION SET	MNF		1/90
A4402	NU	EP		LUBRICANT, PER OUNCE	PC		8/30
A4402	NU	AU		LUBRICANT, PER OUNCE	PC		+8/30
A4450	NU	EP		TAPE, NON-WATERPROOF, PER 18 SQUARE INCHES			10/30
A4452	NU	EP		TAPE, WATERPROOF, PER 18 SQUARE INCHES			10/30
A4461	NU	EP		SURGICAL DRESSING HOLDER, NON-REUSABLE, EACH			8/30
A4463	NU	EP		SURGICAL DRESSING HOLDER, REUSABLE, EACH	IOC		1/30
A4465	NU	EP		NON-ELASTIC BINDER FOR EXTREMITY	MNF		2/30
A4480	NU	EP		VABRA ASPIRATOR	MNF		
A4481	NU	EP		TRACH FILTER ANY TYPE ANY SZ, EA	MNF		30/30
A4520	NU			INCONT. GARMENT, ANY TYPE, EACH	PC		186/30, non-covered for children 3 years and under
A4520	NU	EP		INCONT. GARMENT, ANY TYPE, EACH	PC		+186/30 non-covered for children 3 years and under
A4550	NU	EP		SURGICAL TRAYS	MNF		12/30
A4554	NU			DISPOSABLE UNDERPADS, ALL SIZES	PC	IOC	186/30, non-covered for children 3 years and under
A4554	NU	EP		DISPOSABLE UNDERPADS, ALL SIZES	PC	IOC	+186/30, non-covered for children 3 years and under
A4605	NU	EP		TRACHEAL SUCTION CATHETER, CLOSED SYSTEM, EACH	MNF		13/30
A4606	NU	EP		OXYGEN PROBE USED W OXIMETER, DISPOSABLE	MNF		1/60
A4614	NU	EP		PEAK EXPIRATORY FLOW RATE METER, HAND HELD	MNF		
A4623	NU	EP		TRACH, INNER CANNULA REPLACE ONLY	MNF		8/30

Durable Medical Equipment



A4624	NU	EP		TRACH SUCTION TUBE	MNF		90/30
A4625	NU	EP		TRACH CARE KT FOR NEW TRACH	MNF		1/1
A4626	NU	EP		TRACH CLEANING BRUSH, EACH	MNF		2/30
A4628	NU	EP		OROPHARYNGEAL SUCT. CATH, EACH	MNF		1/30
A4629	NU	EP		TRACH CARE KIT FOR EST. TRACH	MNF		1/1
A4649	NU	EP		SURGICAL SUPPLY, MISCELLANEOUS	PA	MSRP	
A4657	NU	EP		SYRINGE, WITH OR WITHOUT NEEDLE, EACH	MNF		4/30
A4660	NU	EP		SPHYGMOMANOMETER/BLOOD PRESSURE APPARATUS WITH CUFF AND STETHOSCOPE	MNF		1/365
A4663	NU	EP		BLOOD PRESSURE CUFF ONLY	MNF		1/30
A4670	NU	EP		AUTOMATIC BLOOD PRESSURE MONITOR	MNF		1/365
A4927	NU	EP		NON-STERILE GLOVES, PER 100	MNF		2/30
A4930	NU	EP		GLOVES, STERILE, PER PAIR	MNF		30/30
A5102	NU	EP		BEDSIDE DRAINAGE BOTTLE WITH OR W/O TUBING, RIGID OR EXPANDABLE, EACH	PC		1/90
A5102	NU	AU		BEDSIDE DRAINAGE BOTTLE WITH OR W/O TUBING, RIGID OR EXPANDABLE, EACH	PC		+1/90
A5105	NU			URINARY SUSPENSORY	PC		+1/30
A5105	NU	EP		URINARY SUSPENSORY	PC		1/30
A5112	NU	EP		URINARY LEG BAG	PC		
A5120	NU	EP		SKIN BARRIER, WIPES OR SWABS, EACH	MNF		30/30
A5121	NU	EP		SKIN BARRIER; SOLID, 6X6 OR EQUIVALENT, EACH			20/30
A5122	NU	EP		SKIN BARRIER; SOLID, 8X8 OR EQUIVALENT, EACH			20/30
A5126	NU	EP		ADHESIVE OR NON-ADHESIVE; DISK OR FOAM PAD			20/30
A5200	NU	EP	BA	PERCUTANEOUS CATHETER/TUBE ANCHORING DEVICE, ADHESIVE SKIN ATTACHMENT.	PC		1/30
A5200	NU	EP		PERCUTANEOUS CATHETER/TUBE ANCHORING DEVICE ADHES.SKIN ATTACHMENT	PC		
A6000	NU	EP		NON-CONTACT WOUND WARMING WOUND COVER FOR USE WITHNON-CONTACT WOUND WARMING DEVICE AND WARMING CARD	PA	IOC	
A6000	RR	EP		NON-CONTACT WOUND WARMING WOUND COVER FOR USE WITHNON-CONTACT WOUND WARMING DEVICE AND WARMING	PA	IOC	

PRODUCTION : 04/09/2020

Durable Medical Equipment



			CARD			
A6010	NU	EP	COLLAGEN BASED WOUND FILLER	MNF		30/30
A6011	NU	EP	COLLAGEN GEL/PASTE WOUND FIL	MNF		30/30
A6021	NU	EP	COLLAGEN DRESSING <=16 SQ IN	MNF		30/30
A6022	NU	EP	COLLAGEN DRSG>16<=48 SQ IN	MNF		30/30
A6023	NU	EP	COLLAGEN DRESSING >48 SQ IN	MNF		30/30
A6024	NU	EP	COLLAGEN DSG WOUND FILLER	MNF		30/30
A6025	NU	EP	SILICONE GEL SHEET, EACH	CMN	IOC	
A6154	NU	EP	WOUND POUCH, EACH	MNF		30/30
A6196	NU	EP	ALGINATE DRESSING <=16 SQ IN	MNF		30/30
A6197	NU	EP	ALGINATE DRSG >16 <=48 SQ IN	MNF		30/30
A6198	NU	EP	ALGINATE DRESSING > 48 SQ IN	MNF		
A6199	NU	EP	ALGINATE DRSG WOUND FILLER	MNF		30/30
A6203	NU	EP	COMPOSITE DRSG <= 16 SQ IN	MNF		12/30
A6204	NU	EP	COMPOSITE DRSG >16<=48 SQ IN	MNF		12/30
A6205	NU	EP	COMPOSITE DRSG > 48 SQ IN	MNF		
A6206	NU	EP	CONTACT LAYER <= 16 SQ IN	MNF		4/30
A6207	NU	EP	CONTACT LAYER >16<= 48 SQ IN	MNF		4/30
A6208	NU	EP	CONTACT LAYER > 48 SQ IN	MNF		
A6209	NU	EP	FOAM DRSG <=16 SQ IN W/O BDR	MNF		12/30
A6210	NU	EP	FOAM DRG >16<=48 SQ IN W/O B	MNF		12/30
A6211	NU	EP	FOAM DRG > 48 SQ IN W/O BRDR	MNF		12/30
A6212	NU	EP	FOAM DRG <=16 SQ IN W/BORDER	MNF		12/30
A6213	NU	EP	FOAM DRG >16<=48 SQ IN W/BDR	MNF		12/30
A6214	NU	EP	FOAM DRG > 48 SQ IN W/BORDER	MNF		12/30
A6215	NU	EP	FOAM DRESSING WOUND FILLER	MNF		
A6216	NU	EP	GAUZE, NON-IMPREGNATED/STERILE, 16 SQ IN OR LESS, W/O ADHESIVE BORDER, EACH DRESSING			60/30
A6217	NU	EP	GAUZE, NON IMPREGNATED, NON/STERILE 16 SQ IN OR LESS	MNF		90/30
A6218	NU	EP	GAUZE NON-IMPREG, NON-STERILE PAD MORE THAN 48 SQ IN	MNF		
A6219	NU	EP	GAUZE <= 16 SQ IN W/BORDER	MNF		30/30
A6220	NU	EP	GAUZE >16 <=48 SQ IN W/BORDR	MNF		30/30

PRODUCTION : 04/09/2020

Durable Medical Equipment



A6221	NU	EP		GAUZE > 48 SQ IN W/BORDER	MNF		30/30
A6222	NU	EP		GAUZE <=16 IN NO W/SAL W/O B	MNF		30/30
A6223	NU	EP		GAUZE >16<=48 NO W/SAL W/O B	MNF		30/30
A6224	NU	EP		GAUZE > 48 IN NO W/SAL W/O B	MNF		30/30
A6228	NU	EP		GAUZE <= 16 SQ IN WATER/SAL	MNF		30/30
A6229	NU	EP		GAUZE >16<=48 SQ IN WATR/SAL	MNF		30/30
A6230	NU	EP		GAUZE > 48 SQ IN WATER/SALNE	MNF		30/30
A6231	NU	EP		HYDROGEL DSG<=16 SQ IN	MNF		30/30
A6232	NU	EP		HYDROGEL DSG>16<=48 SQ IN	MNF		30/30
A6233	NU	EP		HYDROGEL DRESSING >48 SQ IN	MNF		
A6234	NU	EP		HYDROCOLLD DRG <=16 W/O BDR	MNF		12/30
A6235	NU	EP		HYDROCOLLD DRG >16<=48 W/O B	MNF		12/30
A6236	NU	EP		HYDROCOLLD DRG > 48 IN W/O B	MNF		12/30
A6237	NU	EP		HYDROCOLLD DRG <=16 IN W/BDR	MNF		12/30
A6238	NU	EP		HYDROCOLLD DRG >16<=48 W/BDR	MNF		12/30
A6239	NU	EP		HYDROCOLLD DRG > 48 IN W/BDR	MNF		12/30
A6240	NU	EP		HYDROCOLLD DRG FILLER PASTE	MNF		30/30
A6241	NU	EP		HYDROCOLLOID DRG FILLER DRY	MNF		30/30
A6242	NU	EP		HYDROGEL DRG <=16 IN W/O BDR	MNF		30/30
A6243	NU	EP		HYDROGEL DRG >16<=48 W/O BDR	MNF		30/30
A6244	NU	EP		HYDROGEL DRG >48 IN W/O BDR	MNF		12/30
A6245	NU	EP		HYDROGEL DRG <= 16 IN W/BDR	MNF		12/30
A6246	NU	EP		HYDROGEL DRG >16<=48 IN W/B	MNF		12/30
A6247	NU	EP		HYDROGEL DRG > 48 SQ IN W/B	MNF		12/30
A6248	NU	EP		HYDROGEL DRSG GEL FILLER	MNF		30/30
A6251	NU	EP		ABSORPT DRG <=16 SQ IN W/O B	MNF		30/30
A6252	NU	EP		ABSORPT DRG >16 <=48 W/O BDR	MNF		30/30
A6253	NU	EP		ABSORPT DRG > 48 SQ IN W/O B	MNF		30/30
A6254	NU	EP		ABSORPT DRG <=16 SQ IN W/BDR	MNF		15/30
A6255	NU	EP		ABSORPT DRG >16<=48 IN W/BDR	MNF		15/30
A6256	NU	EP		ABSORPT DRG > 48 SQ IN W/BDR	MNF		
A6257	NU	EP		TRANSPARENT FILM <= 16 SQ IN	MNF		12/30

Durable Medical Equipment



A6258	NU	EP		TRANSPARENT FILM >16<=48 IN	MNF		12/30
A6259	NU	EP		TRANSPARENT FILM > 48 SQ IN	MNF		12/30
A6260	NU	EP		WOUND CLEANSER ANY TYPE/SIZE	CMN	IOC	
A6261	NU	EP		WOUND FILLER GEL/PASTE /OZ	MNF		
A6262	NU	EP		WOUND FILLER DRY FORM / GRAM	MNF		
A6266	NU	EP		IMPREG GAUZE NO H2O/SAL/YARD	MNF		
A6402	NU	EP		GAUZE, NON-IMPREG. STERILE, PAD SZ 16 SQ IN OR LESS	MNF		100/30
A6403	NU	EP		GAUZE, NON IMPREG STERILE PAD SIZE MORE THAN 16 SQ IN	MNF		100/30
A6404	NU	EP		GAUZE ELASTIC STERILE ALL TYPES, PER LINEAR YARD	MNF		
A6407	NU	EP		PACKING STRIPS, NON-IMPREG	MNF		100/30
A6441	NU	EP		PADDDING BANDAGE W >=3 <5 /YD	MNF		90/30
A6442	NU	EP		CONFROM BAND S/S W<3 /YD	MNF		180/30
A6443	NU	EP		CONFROM BAND N/S W>=3 <5 /YD	MNF		180/30
A6444	NU	EP		CONFORM BAND N/S W>=5 /YD	MNF		180/30
A6445	NU	EP		CONFORM BAND S W < 3 /YD	MNF		180/30
A6446	NU	EP		CONFORM BAND S W >=3 < 5 /YD	MNF		180/30
A6447	NU	EP		CONFORM BAND S W >= 5 /YD	MNF		180/30
A6448	NU	EP		LT COMP BAND <3 /YD	MNF		12/30
A6449	NU	EP		LT COMP BAND >=3 <5 /YD	MNF		12/30
A6450	NU	EP		LT COMP BAND >+ =5 /yd	MNF		12/30
A6451	NU	EP		MOD COMP BAND W>=3 <5 /YD	MNF		12/30
A6452	NU	EP		HIGH COMP BAND W >= 3 <5 YD	MNF		12/30
A6453	NU	EP		SELF-ADHER BAND W<3 /YD	MNF		12/30
A6454	NU	EP		SELF ADHER BAND W >=3 <5 /YD	MNF		12/30
A6455	NU	EP		SELF ADHER BAND >=5 /YD	MNF		12/30
A6456	NU	EP		ZINC PASTE BAND W>=3 <5 /YD	MNF		12/30
A6457	NU	EP		TUBULAR DRESSING W/WO ELASTIC, ANY WDTN, PER LINEAR YARD			12/30
A6460	NU	EP		SYNTHETIC DRSG <= 16 sq in	PA, IOC		
A6461	NU	EP		SYNTHETIC DRSG >16<=48 sq in	PA, IOC		
A6501	NU	EP		COMPRESS BURN GARMENT BODYSUIT	MNF		
A6502	NU	EP		COMPRESS BURN GARMENT CHINSTRP	CMN	IOC	
A6503	NU	EP		COMPRES BURN GARMENT FACE HOOD	MNF		

PRODUCTION : 04/09/2020

Durable Medical Equipment



A6504	NU	EP		COMPRES BURN GARMENT GLOVE-WRIST	CMN	IOC	
A6505	NU	EP		COMPRES BURN GARMENT GLOVE - ELBOW	CMN	IOC	
A6506	NU	EP		COMPRES BURN GARMENT GLOVE AXILLA	CMN	IOC	
A6507	NU	EP		COMPRES BURN GARMENT FOOT-KNEE	MNF		
A6508	NU	EP		COMPRES BURN GARMENT FOOT - THIGH	CMN	IOC	
A6509	NU	EP		COMPRESS BURN GARMENT JACKET	CMN	IOC	
A6510	NU	EP		COMPRESS BURN GARMENT LEOTARD	CMN	IOC	
A6511	NU	EP		COMPRESS BURN GARMENT PANTY	MNF		
A6512	NU	EP		COMPRESS BURN GARMENT, NOC	CMN	IOC	
A6513	NU	EP		COMPRESSION BURN MASK, FACE AND/OR NECK PLASTIC OR =, CUSTOM	IOC	IOC	
A6530	NU	EP		GRADIENT COMPRESSION STOCKING, BELOW KNEE, 18-30 MMHG, EACH	IOC	IOC	
A6531	NU	EP		GRADIENT COMPRESSION STOCKING, BELOW KNEE, 30-40 MMHG, EACH			
A6532	NU	EP		GRADIENT COMPRESSION STOCKING, BELOW KNEE, 40-50 MMHG, EACH			
A6533	NU	EP		GRADIENT COMPRESSION STOCKING, THIGH LENGTH, 18-30 MMHG, EACH	IOC		
A6534	NU	EP		GRADIENT COMPRESSION STOCKING, THIGH LENGTH, 30-40 MMHG, EACH	IOC		
A6535	NU	EP		GRADIENT COMPRESSION STOCKING, THIGH LENGTH, 40-50 MMHG, EACH	IOC		
A6536	NU	EP		GRADIENT COMPRESSION STOCKING, FULL LENGTH/CHAP STYLE, 18-30 MMHG, EACH	IOC		
A6537	NU	EP		GRADIENT COMPRESSION STOCKING, FULL LENGTH/CHAP STYLE, 30-40 MMHG, EACH	IOC		
A6538	NU	EP		GRADIENT COMPRESSION STOCKING, FULL LENGTH/CHAP STYLE, 40-50 MMHG,EACH	IOC		
A6539	NU	EP		GRADIENT COMPRESSION STOCKING, WASTE LENGTH, 18-30 MMHG, EACH	IOC		
A6540	NU	EP		GRADIENT COMPRESSION STOCKING, WASTE, LENGTH, 30-40 MMHG, EACH	IOC		

PRODUCTION : 04/09/2020

Durable Medical Equipment



A6541	NU	EP		GRADIENT COMPRESSION STOCKING, WASTE, LENGTH, 40-50 MMHG, EACH	IOC		
A6544	NU	EP		GRADIENT COMPRESSION STOCKING, GARTER BELT	IOC		
A6545	NU	EP		GRADIENT COMPRESSION WRAP, NON-ELASTIC, BELOW KNEE, 30-50 MM HG, EACH	IOC		
A6549	NU	EP		G COMPRESSION STOCKING	PA	IOC	
A6550	NU	EP		NEG PRES WOUND THER DRSG SET	MNF		
A7000	NU	EP		CANNISTER, DISPOSABLE	MNF		2/30
A7002	NU	EP		TUBING	MNF		2/30
A7020	RB	EP		INTERFACE, COUGH STIM DEVICE	CMN	IOC	
A7501	NU	EP		TRACHEOSTOMA VALVE, INCLUDING DIAPHRAM, EACH	MNF		1/120
A7502	NU	EP		REPLACEMENT DIAPHRAM/FACEPLATE FOR TRACHEOSTOMA VALVE, EACH	MNF		
A7503	NU	EP		FILTER HOLDER OR FILTER CAP, REUSE, USE IN TRACH	MNF		
A7504	NU	EP		FLTR FOR USE IN A TRACH HEAT AND MOISTURE EXCHANGE SYSTEM	MNF		
A7505	NU	EP		HOUSING REUSABLE W/O ADHESIVE FOR USE IN A HEAT AND MOISTURE EXCHANGE	MNF		
A7506	NU	EP		ADHESIVE DISC FOR USE IN A HEAT AND MOISTURE EXCHANGE SYSTEM	MNF		30/30
A7507	NU	EP		FLTR HLDR AND INTEGRATED FLTR W/O ADHESIVE FOR USE IN A TRACH	MNF		60/30
A7508	NU	EP		HOUSING AND INTEGRATED ADHESIVE FOR USE IN A TRACH	MNF		1/30
A7509	NU	EP		FILTER HOLDER AND INTEGRATED FILTER HOUSING AND ADHESIVE	MNF		1/30
A7520	NU	EP		TRACH LARYN TUBE NON-CUFFED	MNF		2/30
A7521	NU	EP		TRACH/LARYN TUBE CUFFED	MNF		2/30
A7522	NU	EP		TRACH LARYN TUBE STAINLESS	MNF		1/30
A7523	NU	EP		TRACHEOSTOMY SHOWER PROTECT	MNF		1/120
A7524	NU	EP		TRACH STENT/STUD/BUTTON	MNF		1/90
A7525	NU	EP		TRACH MASK	MNF		1/30
A7526	NU	EP		TRACH TUBE COLLAR/HOLDER, EACH	MNF		15/30
A7527	NU	EP		TRACH/LARYNGECTOMY TUBE, PLUG, STOP, EACH	MNF		

PRODUCTION : 04/09/2020

Durable Medical Equipment



A8000	NU	EP		HELMET, PROTECTIVE, SOFT, PREFABRICATED, INCLUDES ALL COMPONENTS AND ACCESSORIES	MNF		
A8001	NU	EP		HELMET, PROTECTIVE, HARD, PREFABRICATED, INCLUDES ALL COMPONENTS AND ACCESSORIES	MNF		
A9270	RB	EP		NON-COVERED ITEM OR SERVICE	CMN	IOC	
A9270	NU	EP		NON-COVERED ITEM OR SERVICE	CMN	IOC	
A9270	RR	EP		NON-COVERED ITEM OR SERVICE	CMN	IOC	
A9900	NU	EP		MISCELLANEOUR DME SUPPLY, ACCESSORY, AND/OR SERVICE COMPONENT OF ANOTHER HCPCS CODE	PA	IOC	
A9999	NU	EP		MISC. DME SUPPLY OR ACCESSORY, NOT OTHERWISE SPECIFIED	PA	IOC	
A9999	RR	EP		MISC. DME SUPPLY OR ACCESSORY, NOT OTHERWISE SPECIFIED	PA	IOC	
A9999	RB	EP		MISC. DME SUPPLY OR ACCESSORY, NOT OTHERWISE SPECIFIED	CMN	IOC	
B4034	NU	EP	BA	ENTER FEED SUPKIT SYR BY DAY			date span # of days =# of units
B4035	NU	EP	BA	ENTERAL FEED SUPP PUMP PER D			date span # of days =# of units
B4036	NU	EP	BA	ENTERAL FEED SUP KIT GRAV BY			date span # of days =# of units
B4081	NU	EP	BA	NASOGASTRIC TUBING:WITH SYLET			1/30
B4082	NU	EP	BA	NASOGASTRIC TUBING WITHOUT STYLET			1/30
B4083	NU	EP	BA	STOMACH TUBE, LEVINE TYPE			1/30
B4087	NU	EP	BA	GASTRO/JEJUNO TUBE, STD			1/90
B4088	NU	EP	BA	GASTRO/JEJUNO TUBE, LOW-PRO			1/90
B4100	NU	EP	BO	FOOD THICKENER ORAL	MNF		
B4103	NU	EP	BA	ENTERAL FORMULA, FOR PEDS, USED TO REPLACE FULIDS AND ELECTROLYTES, 500ml = 1 UNIT	MNF		Must be over WIC allotment.
B4103	NU	EP	BO	ENTERAL FORMULA, FOR PEDS, USED TO REPLACE FULIDS AND ELECTROLYTES, 500ml = 1 UNIT	MNF		Must be over WIC allotment.
B4104	NU	EP	BA	FIBER ADDITIVE FOR ENTERAL FORMULA		IOC	
B4104	NU	EP	BO	FIBER ADDITIVE FOR ENTERAL FORMULA		IOC	
B4149	NU	EP	BA	ENTERAL FORMULA, MANUFACTURED BLENDERIZED NATURAL FOODS WITH INTACT NUTRIENTS, INCLUDES PROTEINS, 100 VALORIES - 1 UNIT	MNF		Must be over WIC allotment.

PRODUCTION : 04/09/2020

B4149	NU	EP	BO	ENTERAL FORMULA, MANUFACTURED BLENDERIZED NATURAL FOODS WITH INTACT NUTRIENTS, INCLUDES PROTEINS, 100 CALORIES = 1 UNIT	MNF		Must be over WIC allotment.
B4150	NU	EP	BA	CATEGORY I SEMI-SYNTH PROTEIN ISOLATES 100 CALORIES = 1 UNIT	MNF		Must be over WIC allotment.
B4150	NU	EP	BO	CATEGORY I SEMI-SYNTH PROTEIN ISOLATES 100 CALORIES = 1 UNIT	MNF		Must be over WIC allotment.
B4152	NU	EP	BA	CATEGORY II INTACT PROTEIN ISOLATES CALORICALLY DENSE 100 CALORIES = 1 UNIT	MNF		Must be over WIC allotment.
B4152	NU	EP	BO	CATEGORY II INTACT PROTEIN ISOLATES CALORICALLY DENSE 100 CALORIES = 1 UNIT	MNF		Must be over WIC allotment.
B4153	NU	EP	BA	CATEGORY III HYDROLYZED PROTEIN AA 100 CALORIES = 1 UNIT	MNF		Must be over WIC allotment.
B4153	NU	EP	BO	CATEGORY III HYDROLYZED PROTEIN AA 100 CALORIES = 1 UNIT	MNF		Must be over WIC allotment.
B4154	NU	EP	BA	CATEGORY IV FORM FOR SPECIAL METABOLIC NEED 100 CALORIES = 1 UNIT	MNF		Must be over WIC allotment.
B4154	NU	EP	BO	CATEGORY IV FORM FOR SPECIAL METABOLIC NEED 100 CALORIES = 1 UNIT	MNF		Must be over WIC allotment.
B4155	NU	EP	BA	CATEGORY V MODULAR COMPONENTS 100 CALORIES = 1 UNIT	MNF		Must be over WIC allotment.
B4155	NU	EP	BO	CATEGORY V MODULAR COMPONENTS 100 CALORIES = 1 UNIT	MNF		Must be over WIC allotment.
B4157	NU	EP	BA	NUTRITION COMPLETE, FOR SPECIAL METABOLIC NEEDS, 100 CALORIES = 1 UNIT		IOC	Must be over WIC allotment.
B4157	NU	EP	BO	NUTRITION COMPLETE, FOR SPECIAL METABOLIC NEEDS, 100 CALORIES = 1 UNIT		IOC	Must be over WIC allotment.
B4158	NU	EP	BA	ENTERAL FORMULA, FOR PEDS, NUTRITIONALLY COMPLETE WITH INTACT NUTRIENTS, 100 CALORIES = 1 UNIT		IOC	Must be over WIC allotment.
B4158	NU	EP	BO	ENTERAL FORMULA, FOR PEDS, NUTRITIONALLY COMPLETE WITH INTACT NUTRIENTS, 100 CALORIES = 1 UNIT		IOC	Must be over WIC allotment.
B4159	NU	EP	BA	ENTERAL FORMULA FOR PEDS, NUTRITION, COMPLETE SOY BASED W/INTACT, 100 CALORIES = 1 UNIT		IOC	Must be over WIC allotment.

Durable Medical Equipment



B4159	NU	EP	BO	ENTERAL FORMULA FOR PEDS, NUTRITION, COMPLETE SOY BASED W/INTACT, 100 CALORIES = 1 UNIT		IOC	Must be over WIC allotment.
B4160	NU	EP	BA	ENTERAL FORMULA FOR PEDS NUTRITION COMPLETE CALORICALLY DENSE, 100 CALORIES = 1 UNIT	MNF		Must be over WIC allotment.
B4160	NU	EP	BO	ENTERAL FORMULA FOR PEDS NUTRITION COMPLETE CALORICALLY DENSE, 100 CALORIES = 1 UNIT	MNF		Must be over WIC allotment.
B4161	NU	EP	BA	ENTERAL FORMULA FOR PEDS NUTRITION COMPLETE CALORICALLY DENSE, 100 CALORIES = 1 UNIT	MNF		Must be over WIC allotment.
B4161	NU	EP	BO	ENTERAL FORMULA FOR PEDS NUTRITION COMPLETE CALORICALLY DENSE, 100 CALORIES = 1 UNIT	MNF		Must be over WIC allotment.
B4162	NU	EP	BA	ENTERAL FORMULA FOR PEDS NUTRITION COMPLETE CALORICALLY DENSE, 100 CALORIES = 1 UNIT	MNF	IOC	Must be over WIC allotment.
B4162	NU	EP	BO	ENTERAL FORMULA FOR PEDS NUTRITION COMPLETE CALORICALLY DENSE, 100 CALORIES = 1 UNIT	MNF	IOC	Must be over WIC allotment.
B9002	NU	EP	BA	ENTER NUTR INF PUMP ANY TYPE			
B9998	NU	EP	BA	NOC FOR ENTERAL SUPPLIES		IOC	
B9998	NU	EP	BO	NOC FOR ENTERAL SUPPLIES		IOC	
E0171	NU	EP		COMMUNE CHAIR WITH INTEGRATED SEAT LIFT MECHANISM, NON-ELECTRIC, ANY TYPE	PA	IOC	
E0171	RR	EP		COMMUNE CHAIR WITH INTEGRATED SEAT LIFT MECHANISM, NON-ELECTRIC, ANY TYPE	PA	IOC	
E0172	NU	EP		SEAT LIFT MECHANISM PLACED OVER OR ON TOP OF TOILET, ANY TYPE	PA	IOC	
E0202	RR	EP		PHOTOTHERAPY (BILIRUBIN) LIGHT WITH PHOTOMETER	MNF		Maximum of 6 days.
E0231	NU	EP		NON-CONTACT WOUND WARMING DEVICE (TEMP CNTRL, AC ADAPTER & POWER CORD), USE W/WARMING CARD & COVER	PA	IOC	
E0231	RR	EP		NON-CONTACT WOUND WARMING DEVICE (TEMP CNTRL, AC ADAPTER, POWER CORD), USE W/WARMING CARD AND COVER	PA	IOC	
E0232	NU	EP		WARMING CARD, USE W/NON-CONTACT WOUND WARMING DEVICE & NON-CONTACT WOUND WARMING WOUND COVER	PA	IOC	
E0232	RR	EP		WARMING CARD, USE W/NON-CONTACT WOUND WARMING DEVICE & NON-CONTACT WOUND WRMING WOUND COVER	PA	IOC	
E0240	NU	EP		BATH/SHOWER CHAIR W/WO WHEELS, ANY SIZE	PA	IOC	

PRODUCTION : 04/09/2020

Durable Medical Equipment



E0240	RR	EP		BATH/SHOWER CHAIR W/WO WHEELS, ANY SIZE	PA	IOC	
E0240	RB	EP		BATH/SHOWER CHAIR W/WO WHEELS, ANY SIZE	CMN	IOC	
E0328	NU	EP		PED HOSPITAL BED, MANUAL	PA	IOC	
E0328	RR	EP		PED HOSPITAL BED, MANUAL	PA	IOC	
E0328	RB	EP		PED HOSPITAL BED, MANUAL	CMN	IOC	
E0329	NU	EP		PED HOSPITAL BED SEMI/ELECT	PA	IOC	
E0329	RR	EP		PED HOSPITAL BED SEMI/ELECT	PA	IOC	
E0329	RB	EP		PED HOSPITAL BED SEMI/ELECT	CMN	IOC	
E0350	NU	EP		CONTROL UNIT FOR ELECTRONIC BOWEL IRRIGATION/ EVACUATION SYSTEM	PA	IOC	
E0350	RR	EP		CONTROL UNIT FOR ELECTRONIC BOWEL IRRIGATION/ EVACUATION SYSTEM	PA	IOC	
E0352	NU	EP		DISPOSABLE PACK-WATER RESERVOIR BAG, SPECULUM, VALVING MECHANISM & COLLECT BAG/BOX-USE W/E0350	PA	IOC	
E0445	RB	EP		OXIMETER NON-INVASIVE	CMN		
E0445	RR	EP		OXIMETER NON-INVASIVE (PER MONTH)	PC		Continuous monthly monitoring.
E0482	RB	EP		COUGH STIMULATING DEVICE, ALTERNATING POSITIVE AND NEGATIVE AIRWAY PRESSURE, REPAIR ONLY	CMN	IOC	
E0482	RR	EP		COUGH STIMULATING DEVICE, ALTERNATING POSITIVE ANDNEGATIVE AIRWAY PRESSURE, RENTAL	PC		
E0483	RR	EP		HIGH FREQUENCY CHEST WALL OSCILLATION AIR-PULSE GENERATOR SYSTEM-INCLUDES HOSES AND VEST-EACH	PC		Rent to purchase.
E0484	NU	EP		OSCILLATORY POSITIVE EXPIRATORY PRESSURE DEVICE, NON- ELECTRIC, ANY TYPE, EACH	MNF		
E0484	RR	EP		OSCILLATORY POSITIVE EXPIRATORY PRESSURE DEVICE, NON- ELECTRIC, ANY TYPE, EACH, RENTAL	MNF		
E0485	NU	EP		ORAL DEVICE/APPLIANCE USED TO REDUCE UPPER AIRWAY COLLAPSIBILITY	PA	IOC	
E0486	NU	EP		ORAL DEVICE/APPLIANCE USED TO REDUCE UPPER AIRWAY COLLAPSIBILITY	PA	IOC	
E0602	RR	EP		BREAST PUMP, MANUAL, ANY TYPE	MNF		

E0603	RR	EP		BREAST PUMP, ELECTRIC AC/DC, ANY TYPE	PA	IOC	
E0617	NU	EP		EXTERNAL DEFIBRILLATOR W/INTEGRATED ELECTROCARDIOGRAM ANALYSIS	PA	IOC	
E0638	NU	EP		STANDING FRAME SYS	PA	IOC	
E0638	RB	EP		STANDING FRAME SYS	CMN	IOC	
E0641	NU	EP		MULTI-POSITION STND FRAM SYS	PA	IOC	
E0642	NU	EP		DYNAMIC STANDING FRAME	PA	IOC	
E0705	NU	EP		TRANSFER DEVICE	CMN		
E0720	NU	EP		TENS, TWO LEAD, LOCALIZED STIMULATION	PA		
E0730	NU	EP		TENS; FOUR OR MORE LEADS, FOR MULTIPLE NERVE STIMULATION	PA		
E0731	NU	EP		FORM FITTING CONDUCTIVE GARMENT FOR DELIVERY OF TENS/NMES-W/LAYERS OF FABRIC SEPARATING FROM SKIN	PA		
E0744	NU	EP		NEUROMUSCULAR STIMULATOR FOR SCOLIOSIS	PA	IOC	
E0744	RR	EP		NEUROMUSCULAR STIMULATOR FOR SCOLIOSIS	PA	IOC	
E0745	NU	EP		NEUROMUSCULAR STIMULATOR, ELECTRONIC SHOCK UNIT	PA	IOC	
E0745	RR	EP		NEUROMUSCULAR STIMULATOR, ELECTRONIC SHOCK UNIT	PA	IOC	
E0747	NU	EP		OSTEOGENESIS STIMULATOR; ELECTRICAL, NON-INVASIVE, OTHER THAN SPINAL APPLICATIONS	PA		
E0747	RR	EP		OSTEOGENESIS STIMULATOR; ELECTRICAL, NON-INVASIVE, OTHER THAN SPINAL APPLICATIONS	PA		
E0748	NU	EP		OSTEOGENESIS STIMULATOR; ELECTRICAL, NON-INVASIVE, SPINAL APPLICATIONS	PA		
E0748	RR	EP		OSTEOGENESIS STIMULATOR; ELECTRICAL, NON-INVASIVE, SPINAL APPLICATIONS	PA		
E0762	NU	EP		TRANSCUTANEOUS ELECTRICAL JOINT STIMULATION DEVICE SYSTEM	PA	IOC	
E0764	NU	EP		FUNCTIONAL NEUROMUSCULAR STIMULATOR, TRANSUTANEOUS STIMULATION OF MUSCLES	PA		
E0764	RR	EP		FUNCTIONAL NEUROMUSCULARSTIM	PA		
E0769	NU	EP		ELECTRICAL STIMULATION OR ELECTROMAGNETIC WOUND TREATMENT DEVICE	PA	IOC	

Durable Medical Equipment



E0769	RR	EP		ELECTRICAL STIMULATION OR ELECTROMAGNETIC WOUND TREATMENT DEVICE	PA	IOC	
E0770	NU	EP		FUNCTIONAL ELECTRICAL STIMULATOR, TRANSCUTANEOUS STIMULATION OF NERVE AND/OR	PA	IOC	
E0770	RR	EP		FUNCTIONAL ELECTRICAL STIMULATOR, TRANSCUTANEOUS STIMULATION OF NERVE AND/OR	PA	IOC	
E0770	RB	EP		FUNCTIONAL ELECTRICAL STIMULATOR, TRANSCUTANEOUS STIMULATION OF NERVE AND/OR	CMN	IOC	
E0776	NU	EP		IV POLE			Purchase
E0776	NU	EP	BA	IV POLE			Purchase
E0776	RR	EP		IV POLE			Rental
E0776	RR	EP	BA	IV POLE			Rental
E0781	NU	EP		AMB.INFUSION PUMP, SINGLE OR MULTI CHANNELS ELEC/BATTERY OPERATED WITH ADMIN. EQUIP. WORN BY PATIENT			
E0849	RR	EP		Traction Equipment, cervical , free standing	MNF		
E0870	NU	EP		TRACTION FRAME ATTACHED TO FOOTBOARD, EXTREMITY TRACTION (E.G. BUCK'S)	PA	IOC	
E0870	RR	EP		TRACTION FRAME ATTACHED TO FOOTBOARD, EXTREMITY TRACTION (E.G. BUCK'S)	PA	IOC	
E0911	NU	EP		TRAPEZE BAR, HEAVY DUTY, FOR PATIENT WEIGHT CAPACITY GREATER THAN 250 LBS ATTACHED TO BED	PA	IOC	
E0911	RR	EP		TRAPEZE BAR, HEAVY DUTY, FOR PATIENT WEIGHT CAPACITY GREATER THAN 250 LBS ATTACHED TO BED	PA	IOC	
E0912	NU	EP		TRAPEZE BAR, HEAVY DUTY, FOR PATIENT WEIGHT CAPACITY GREATER THAN 250 LBS FREE STANDING	PA	IOC	
E0912	RR	EP		TRAPEZE BAR, HEAVY DUTY, FOR PATIENT WEIGHT CAPACITY GREATER THAN 250 LBS FREE STANDING	PA	IOC	
E1014	RR	EP		RECLINING BACK FOR PEDIATRIC SZ CHAIR	CMN		
E1037	NU	EP		TRANSPORT CHAIR, PEDIATRIC SIZE	PA	IOC	
E1037	RR	EP		TRANSPORT CHAIR, PEDIATRIC SIZE	PA	IOC	
E1037	RB	EP		TRANSPORT CHAIR, PEDIATRIC SIZE	CMN	IOC	
E1038	NU	EP		TRANSPORT CHAIR, ADULT SIZE, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS	PA	IOC	

Durable Medical Equipment



E1038	RR	EP		TRANSPORT CHAIR, ADULT SIZE, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS	PA	IOC	
E1038	RB	EP		TRANSPORT CHAIR, ADULT SIZE, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS	CMN	IOC	
E1226	RR	EP		MANUAL FULLY RECLINING BACK	CMN		Limited to a 3 month rental.
E1236	RR	EP		FOLDING PEDIACRIC CHAIR ADJUSTABLE	CMN		Limited to a 3 month rental.
E1372	NU	EP		IMMERSION EXTERNAL HEATER FOR NEBULIZER	PA	IOC	
E1372	RR	EP		IMMERSION EXTERNAL HEATER FOR NEBULIZER	PA	IOC	
E1399	RB	EP		DME, MISC	PA	IOC	
E1399	NU	EP		DME, MISC	PA	IOC	
E1399	RR	EP		DME, MISC	PA	IOC	
E2000	RR	EP		GASTRIC SUCTION PUMP	PA	IOC	
E2402	RB	EP		NEG PRESS WOUND THERAPY PUMP	PA	IOC	
E2402	NU	EP		NEG PRESS WOUND THERAPY PUMP	PA	IOC	
E2402	RR	EP		NEG PRESS WOUND THERAPY PUMP	PA		
E8000	NU	EP		GAIT TRAINER, PED SZ, POSTERIOR SUPPORT, INCLUDES ALL ACCESS.	PA	MSRP	
E8000	RR	EP		GAIT TRAINER, PED SZ, POSTERIOR SUPPORT, INCLUDES ALL ACCESS.	PA	MSRP	
E8001	NU	EP		GAIT TRAINER, PED SZ, UPRIGHT SUPPORT, INCLUDES ALL ACCESS.	PA	MSRP	
E8001	RR	EP		GAIT TRAINER, PED SZ, UPRIGHT SUPPORT, INCLUDES ALL ACCESS.	PA	MSRP	
E8002	NU	EP		GAIT TRAINER, PED SZ, ANTERIOR SUPPORT, INCLUDES ALL ACCESSORIES	PA	MSRP	
E8002	RR	EP		GAIT TRAINER, PED SZ, ANTERIOR SUPPORT, INCLUDES ALL ACCESSORIES	PA	MSRP	
K0001	RR	EP		STANDARD WHEELCHAIR	MNF		Limited to a 3 month rental.
K0002	RR	EP		STND HEMI (LOW SEAT) WHLCHR	MNF		Limited to a 3 month rental.

Durable Medical Equipment



K0003	RR	EP		LIGHTWEIGHT WHEELCHAIR	MNF		Limited to a 3 month rental
K0004	RR	EP		HIGH STRENGTH LTWT WHLCHR	MNF		Limited to a 3 month rental.
K0552	NU	EP		SUP/EXT NON-INS INF PUMP SYR			
K0606	NU	EP		AUTOMATIC DEFIB GARMENT WITH ANALYSIS	PA	IOC	
K0606	RR	EP		AUTOMATIC DEBIC GARMENT WITH ANALYSIS	PA	IOC	
K0607	NU	EP		REPLACEMENT BATTERY FOR AED	MNF		
K0608	NU	EP		REPL GARMENT FOR AED	PA	IOC	
K0609	NU	EP		REPL ELECTRODE FOR AED	PA	IOC	
L0112	NU	EP		CRANIAL CERVICAL ORTHOSIS	PA	IOC	
L0113	NU	EP		CRANIAL CERVICAL ORTHOSIS, TORTICOLLIS TYPE, WITH OR WITHOUT JOINT, WITH OR	PA	IOC	
L0113	RB	EP		CRANIAL CERVICAL ORTHOSIS, TORTICOLLIS TYPE, WITH OR WITHOUT JOINT, WITH OR	CMN	IOC	
L6711	RB	EP		TERMINAL DEVICE, HOOK, MECHANICAL, VOLUNTARY OPENING, ANY MATERIAL, ANY SIZE,	CMN		
L6711	NU	EP		TERMINAL DEVICE, HOOK, MECHANICAL, VOLUNTARY OPENING, ANY MATERIAL, ANY SIZE,	CMN		
L6712	RB	EP		TERMINAL DEVICE, HOOK, MECHANICAL, VOLUNTARY CLOSING, ANY MATERIAL, ANY SIZE,	CMN		
L6712	NU	EP		TERMINAL DEVICE, HOOK, MECHANICAL, VOLUNTARY CLOSING, ANY MATERIAL, ANY SIZE,	CMN		
L8515	NU	EP		GELATIN CAPSULE FOR TRACHEOOESOPHAGEAL VOICE	MNF		
S1002	NU	EP		CUSTOMIZED ITEM-LIST IN ADDITION TO CODE FOR BASICITEM	PA	IOC	
S1015	NU	EP		IV TUBING EXTENSION SET	MNF		
S1040	NU	EP		CRANIAL REMOLDING ORTHOSIS, PEDIATRIC, RIGID, WITH SOFT INTERFACE MATERIAL, CUSTOM FABRICATED, INCLU	PC		
S8189	NU	EP		TRACHEOSTOMY SUPPLY, NOT OTHERWISE CLASSIFIED	1	IOC	1/30
S8265	NU	EP		HABERMAN FEEDER	PA	IOC	
S9001	RR	EP		HOME UTERINE MONITOR	CMN		
S9434	NU	EP	BA	MODIFIED SOLID FOOD SUPPLEMENTS FOR INBORN ERRORS OF METABOL.	CMN	IOC	Must be over WIC allotment.



S9434	NU	EP	BO	MODIFIED SOLID FOOD SUPPLEMENTS FOR INBORN ERRORS OF METABOL.	CMN	IOC	Must be over WIC allotment.
S9435	NU	EP	BA	METABOLIC FOOD FOR INBORN ERRORS OF METABOL.		IOC	Must be over WIC allotment.
S9435	NU	EP	BO	METABOLIC FOOD FOR INBORN ERRORS OF METABOL.		IOC	Must be over WIC allotment.
T1999	NU	EP		MISC THERAPEUTIC ITEMS AND SUPPLIES, RETAIL PURCHASE NOC	PA	IOC	
T4521	NU			ADULT SIZE BRIEF/DIAPER SIZE SMALL,EACH	PC		186/30, non-covered for children 3 years and under
T4521	NU	EP		ADULT SIZE BRIEF/DIAPER SIZE SMALL,EACH	PC		+186/30, non-covered for children 3 years and under
T4522	NU			ADULT SIZE BRIEF/DIAPER SIZE MEDIUM, EACH	PC		186/30, non-covered for children 3 years and under
T4522	NU	EP		ADULT SIZE BRIEF/DIAPER SIZE MEDIUM, EACH	PC		+186/30, non-covered for children 3 years and under
T4523	NU			ADULT SIZE BRIEF/DIAPER SIZE LARGE, EACH	PC		186/30, non-covered for children 3 years and under
T4523	NU	EP		ADULT SIZE BRIEF/DIAPER SIZE LARGE, EACH	PC		+186/30, non-covered for children 3 years and under

Durable Medical Equipment



T4524	NU			ADULT SIZE BRIEF/DIAPER SIZE X-LARGE, EACH	PC		186/30, non-covered for children 3 years and under
T4524	NU	EP		ADULT SIZE BRIEF/DIAPER SIZE X-LARGE, EACH	PC		+186/30, non-covered for children 3 years and under
T4525	NU			ADULT SIZED PROTECTIVE UNDERWEAR, PULL-ON, SMALL	PC		186/30, non-covered for children 3 years and under
T4525	NU	EP		ADULT SIZED PROTECTIVE UNDERWEAR, PULL-ON, SMALL	PC		+186/30, non-covered for children 3 years and under
T4526	NU			ADULT SIZED PROTECTIVE UNDERWEAR, PULL-ON, MEDIUM	PC		186/30, non-covered for children 3 years and under
T4526	NU	EP		ADULT SIZED PROTECTIVE UNDERWEAR, PULL-ON, MEDIUM	PC		+186/30, non-covered for children 3 years and under
T4527	NU			ADULT SIZED PROTECTIVE UNDERWEAR, PULL-ON LARGE	PC		186/30, non-covered for children 3 years and under
T4527	NU	EP		ADULT SIZED PROTECTIVE UNDERWEAR, PULL-ON LARGE	PC		+186/30, non-covered for children 3 years and under

Durable Medical Equipment



T4528	NU			ADULT SIZED PROTECTIVE UNDERWEAR, PULL-ON, EXTRA LARGE, EACH	PC		186/30, non-covered for children 3 years and under
T4528	NU	EP		ADULT SIZED PROTECTIVE UNDERWEAR, PULL-ON, EXTRA LARGE, EACH	PC		+186/30, non-covered for children 3 years and under
T4529	NU			PEDIATRIC SIZE, BRIEF DIAPER, SMALL/MEDIUM, EACH	PC		186/30, non-covered for children 3 years and under
T4529	NU	EP		PEDIATRIC SIZE, BRIEF DIAPER, SMALL/MEDIUM, EACH	PC		+186/30, non-covered for children 3 years and under
T4530	NU			PEDIATRIC SIZE, BRIEF DIAPER, LARGE, EACH	PC		186/30, non-covered for children 3 years and under
T4530	NU	EP		PEDIATRIC SIZE, BRIEF DIAPER, LARGE, EACH	PC		+186/30, non-covered for children 3 years and under
T4531	NU			PEDIATRIC SIZE DISPOSABLE PROTECTIVE UNDERWEAR/PULLON SM/MED	PC		186/30, non-covered for children 3 years and under
T4531	NU	EP		PEDIATRIC SIZE DISPOSABLE PROTECTIVE UNDERWEAR/PULLON SM/MED	PC		+186/30, non-covered for children 3 years and under

Durable Medical Equipment



T4532	NU			PEDIATRIC SIZE DISPOSABLE PROTECTIVE UNDERWEAR, PULL/ON LARGE, EACH	PC		186/30, non-covered for children 3 years and under
T4532	NU	EP		PEDIATRIC SIZE DISPOSABLE PROTECTIVE UNDERWEAR, PULL/ON LARGE, EACH	PC		+186/30, non-covered for children 3 years and under
T4533	NU			YOUTH SIZE DISPOSABLE INCONTINENCE PRODUCT, BRIEF/DIAPER, EACH	PC		186/30, non-covered for children 3 years and under
T4533	NU	EP		YOUTH SIZE DISPOSABLE INCONTINENCE PRODUCT, BRIEF/DIAPER, EACH	PC		+186/30, non-covered for children 3 years and under
T4534	NU			YOUTH SIZE DISPOSABLE INCONTINENCE PRODUCT, PROTECTIVE UNDERWEAR/PULL-ON, EACH	PC		186/30, non-covered for children 3 years and under
T4534	NU	EP		YOUTH SIZE DISPOSABLE INCONTINENCE PRODUCT, PROTECTIVE UNDERWEAR/PULL-ON, EACH	PC		+186/30, non-covered for children 3 years and under
T4537	NU			BED SIZE, PROTECTIVE UNDERPAD, REUSABLE	PC	IOC	4/30
T4537	NU	EP		BED SIZE, PROTECTIVE UNDERPAD, REUSABLE	PC	IOC	4/30
T4541	NU			DISPOSABLE UNDERPAD, LARGE EACH	PC	IOC	186/30, non-covered for children 3 years and under
T4541	NU	EP		DISPOSABLE UNDERPAD, LARGE EACH	PC	IOC	+186/30, non-covered for children 3 years and under

Durable Medical Equipment



T4542	NU			DISPOSABLE UNDERPAD, SMALL, EACH	PC	IOC	186/30, non-covered for children 3 years and under
T4542	NU	EP		DISPOSABLE UNDERPAD, SMALL, EACH	PC	IOC	+186/30, non-covered for children 3 years and under
T4543	NU			ADULT DISP BRIEF/DIAP ABV XL	PC		186/30, non-covered for children 3 years and under
T4543	NU	EP		ADULT DISP BRIEF/DIAP ABV XL	PC		+186/30, non-covered for children 3 years and under
T4544	NU			ADLT DISP UND/PULL ON ABV XL	PC		186/30, non-covered for children 3 years and under
T4544	NU	EP		ADLT DISP UND/PULL ON ABV XL	PC		+186/30, non-covered for children 3 years and under
T5999	NU	EP		SUPPLY, NOT OTHERWISE SPECIFIED	PA	IOC	
V5266	NU	EP		BATTERY FOR USE IN HEARING AID DEVICE	MNF		Per pkg of 4.

19.2 DURABLE MEDICAL EQUIPMENT (DME), INCLUDES ALL AGE PARTICIPANTS					
Procedure Code	Modifiers	Description	Reimbursement Guidelines		Limits and Comments
A4216	NU	STERILE SALINE WATER, 10ML			100/30
A4217	NU	STERILE SALINE WATER, 500ML			30/30
A4230	NU	INFUSION SET FOR EXTERNAL INSULIN PUMP, NON NEEDLECANNULA TYPE			
A4231	NU	INFUSION SET FOR EXTERNAL INSULIN PUMP, NEEDLE TYPE	MNF		
A4232	NU	SYRINGE WITH NEEDLE FOR EXTERNAL INSULIN PUMP, STERILE, 3CC			
A4247	NU	BETADINE OR IODINE SWABS/WIPES, PER BOX	MNF		
A4310	NU	INSERTION TRAY WITHOUT DRAINAGE BAG AND WITHOUT CATHETER (ACCESSORIES ONLY)	PC		
A4311	NU	INSERTION TRAY WITHOUT DRAINAGE BAG WITH INDWELLING CATHETER, FOLEY TYPE,TWO-WAY LATEX WITH COATING	PC		
A4312	NU	INSERTION TRAY WITHOUT DRAINAGE BAG WITH INDWELLING CATHETER,FOLEY TYPE,TWO-WAY, ALL SILICONE	PC		
A4313	NU	INSERTION TRAY WITHOUT DRAINAGE BAG WITH INDWELLING CATHETER,FOLEY TYPE,THREE-WAY,FOR CONTINUOUS IRR	PC		
A4314	NU	INSERTION TRAY WITH DRAINAGE BAG WITH INDWELLING CATHETER,FOLEY TYPE,TWO-WAY LATEX WITH COATING(TEF	PC		
A4315	NU	INSERTION TRAY WITH DRAINAGE BAG WITH INDWELLING CATHETER,FOLEY TYPE,TWO-WAY, ALL SILICONE	PC		
A4316	NU	INSERTION TRAY WITH DRAINAGE BAG WITH INDWELLING CATHETER,FOLEY TYPE,THREE-WAY,FOR CONTINUOUS IRRIG	PC		
A4320	NU	IRRIGATION TRAY WITH BULB OR PISTON SYRINGE, ANY PURPOSE	PC		
A4322	NU	IRRIGATION SYRINGE, BULB OR PISTON, EACH	PC		
A4326	NU	MALE EXTERNAL CATHETER	PC		
A4327	NU	FEMALE EXTERNAL URINARY COLLECTION DEVICE; METAL CUP, EACH	PC		
A4328	NU	FEMALE EXTERNAL URINARY COLLECTION DEVICE; POUCH, EACH	PC		
A4331	NU	EXTENSION DRAINAGE TUBING,ANY TYPE,ANY LENGTH,WITHCONNECTOR/ADAPTOR,FOR USE WITH URINARY LEG BAG OR	MNF		1/30

Durable Medical Equipment



A4332	NU	LUBRICANT, INDIVIDUAL STERILE PACKET, FOR INSERTION OF URINARY CATHETER, EACH	PC		
A4333	NU	URINARY CATHETER ANCHORING DEVICE, ADHESIVE SKIN ATTACHMENT, EACH	PC		
A4334	NU	URINARY CATHETER ANCHORING DEVICE, LEG STRAP, EACH	PC		
A4335	NU	INCONTINENCE SUPPLY; MISCELLANEOUS	PC	IOC	
A4338	NU	INDWELLING CATHETER; FOLEY TYPE, TWO-WAY LATEX WITH COATING (TEFLON, SILICONE, SI. ELASTOMER, OR HYDRO), EA	PC		
A4340	NU	INDWELLING CATHETER; SPECIALTY TYPE (E.G., COUDE, MUSHROOM, WING, ETC.), EACH	PC		
A4344	NU	INDWELLING CATHETER, FOLEY TYPE, TWO-WAY, ALL SILICONE, EACH	PC		
A4346	NU	INDWELLING CATHETER; FOLEY TYPE, THREE WAY FOR CONTINUOUS IRRIGATION, EACH	PC		
A4349	NU	MALE EXTERNAL CATH W/WO ADHESIVE, DISPOSABLE, EACH	PC		
A4351	NU	INTERMITTENT URINARY CATHETER; STRAIGHT TIP, EACH	PC		
A4352	NU	INTERMITTENT URINARY CATHETER; COUDE (CURVED) TIP, EACH	PC		
A4353	NU	INTERMITTENT URINARY CATHETER, WITH INSERTION SUPPLIES	PC		
A4354	NU	INSERTION TRAY WITH DRAINAGE BAG BUT WITHOUT CATHETER	PC		
A4355	NU	IRRIGATION TUBING SET FOR CONTINUOUS BLADDER IRRIGATION THROUGH A THREE-WAY INDWELLING FOLEY CATH, EA	PC		
A4356	NU	EXTERNAL URETHRAL CLAMP OR COMPRESSION DEVICE (NOT TO BE USED FOR CATHETER CLAMP), EACH	PC		
A4357	NU	BEDSIDE DRAINAGE BAG, DAY OR NIGHT, WITH OR WITHOUT ANTI-REFLUX DEVICE, WITH OR WITHOUT TUBE, EACH	MNF		2/30
A4358	NU	URINARY LEG BAG; VINYL, WITH OR WITHOUT TUBE, EACH	PC		
A4361	NU	OSTOMY FACEPLATE, EACH	MNF		3/180
A4362	NU	SKIN BARRIER; SOLID, 4X4 OR EQUIVALENT; EACH	MNF		20/30
A4363	NU	OSTOMY CLAMP, ANY TYPE, EACH	MNF		
A4364	NU	ADHESIVE, LIQUID, OR EQUAL ANY TYPE, PER OUNCE ONLY, PER OUNCE	MNF		4/30
A4366	NU	OSTOMY VENT, ANY TYPE, EACH	MNF		10/30
A4367	NU	OSTOMY BELT, EACH	MNF		1/30
A4368	NU	OSTOMY FILTER, ANY TYPE, EACH	MNF		30/30
A4369	NU	OSTOMY SKIN BARRIER, LIQUID (SPRAY, BRUSH, ETC), PER OZ	MNF		2/30

PRODUCTION : 04/09/2020

Durable Medical Equipment



A4371	NU	OSTOMY SKIN BARRIER,POWDER,PER OZ	MNF	10/180
A4372	NU	SKIN BARRIER SOLID 4X4 EQUIV	MNF	20/30
A4373	NU	SKIN BARRIER WITH FLANGE	MNF	20/30
A4375	NU	OSTOMY POUCH,DRAINABLE,WITH FACEPLATE ATTACHED PLASTIC, EACH	MNF	2/30
A4376	NU	OSTOMY POUCH, DRAINABLE, WITH FACEPLATE ATTACHED, RUBBER, EACH	MNF	1/30
A4377	NU	OSTOMY POUCH, DRAINABLE, FOR USE ON FACEPLATE, PLASTIC, EACH	MNF	10/30
A4378	NU	OSTOMY POUCH, DRAINABLE, FOR USE ON FACEPLATE, RUBBER, EACH	MNF	4/30
A4379	NU	OSTOMY POUCH, URINARY, WITH FACEPLATE ATTACHED, PLASTIC, EACH	MNF	4/30
A4380	NU	OSTOMY POUCH, URINARY, WITH FACEPLATE ATTACHED, RUBBER, EACH	MNF	4/30
A4381	NU	OSTOMY POUCH, URINARY, FOR USE ON FACEPLATE, PLASTIC, EACH	MNF	10/30
A4382	NU	OSTOMY POUCH, URINARY, FOR USE ON FACEPLATE, HEAVY PLASTIC, EACH	MNF	4/30
A4383	NU	OSTOMY POUCH, URINARY, FOR USE ON FACEPLATE, RUBBER, EACH	MNF	4/30
A4384	NU	OSTOMY FACEPLATE EQUIVALENT, SILICONE RING, EACH	MNF	4/30
A4385	NU	OSTOMY SKIN BARRIER, SOLID 4X4 OR EQUIVALENT, EXTENDED WEAR,WITHOUT BUILT-IN CONVEXITY,EACH	MNF	4/30
A4387	NU	OST POUCH CLOSED, WITH BARRIER,W/BLT IN CONVEXITY 1 PIECE, EACH	MNF	10/30
A4388	NU	DRAINABLE PCH W EX WEAR BARR	MNF	10/30
A4389	NU	DRAINABLE PCH W ST WEAR BARR	MNF	10/30
A4390	NU	OSTOMY POUCH, DRAINABLE,WITH EXTENDED WEAR BARRIER ATTACHED,WITH BUILT-IN CONVEXITY (1 PIECE),EACH	MNF	10/30
A4391	NU	OST POUCH, URINARY W/EXTENDED WEAR BARRIER ATTCHD 1 PIECE, EACH	MNF	8/30
A4392	NU	OSTOMY POUCH, URINARY, WITH STANDARD WEAR BARRIER ATTACHED, WITH BUILT-IN CONVEXITY (1 PIECE), EACH	MNF	10/30
A4393	NU	OSTOMY POUCH, URINARY, WITH EXTENDED WEAR BARRIER ATTACHED, WITH BUILT-IN CONVEXITY (1 PIECE), EACH	MNF	10/60
A4396	NU	OSTOMY BELT WITH PERISTOMAL HERNIA SUPPORT	MNF	
A4397	NU	IRRIGATION SUPPLY; SLEEVE, EACH	MNF	4/30
A4398	NU	OSTOMY IRRIGATION SUPPLY; BAG, EACH	MNF	2/180
A4399	NU	OSTOMY IRRIG CONE/CATH W BRS	MNF	1/90
A4402	NU	LUBRICANT, PER OUNCE	MNF	4/30
A4404	NU	OSTOMY RING, EACH	MNF	10/30
A4405	NU	NONPECTIN BASED OSTOMY PASTE		4/30
A4406	NU	PECTIN BASED OSTOMY PASTE		4/30

PRODUCTION : 04/09/2020

Durable Medical Equipment



A4407	NU	OST SKIN BARR W/FLANGE SOLID,FLEXIBLE,ACCORDIAN EXTENDED WEAR WITH BLT IN CONVEXITY 4X4 OR SM EACH			10/0
A4408	NU	OST SKN BARR W/FLANGE SOLID,FLEXIBLE,ACCORDIAN EXTWEAR WITH BLT IN CONVEXITY,LARGER THAN 4X4 IN EACH			10/30
A4409	NU	OST SKN BARR W FLNG(SOLID,FLEX OR ACCORDION) EXT WEAR W/OUT BLT IN CONVEX 4X4 IN OR SMALLER EACH			10/30
A4410	NU	OST SKN BARR W FLNG(SOLID,FLEX OR ACCORDION) EXT WEAR W/OUT BLT IN CONVEX LARGER THAN 4X4 IN EACH			10/30
A4411	NU	OSTOMY SKIN BARRIER, SOLID 4X4, EXTENDED WEAR WITH BUILT IN	IOC		10/30
A4412	NU	OSTOMY POUCH, DRAINABLE, FOR USE ON A BARRIER W/FLANGE 2 PIECE	IOC		20/30
A4413	NU	OST POUCH,DRAINABLE,HIGH OUTPUT,FOR USE ON A BARRIER WITH FLANGE(2 PIECE SYSTEM)WITH FILTER,EACH			20/30
A4414	NU	OSTOMY SKNBARR W FLNG SOLID,FLEX,ACCOR WO/CONVEXIT4X4, EACH			20/30
A4415	NU	OSTOMY SKN BARR W FLNG SOLID,FLEX,ACCOR WO/CONVEXILARGER THAN 4X4 INCHES EACH			20/30
A4416	NU	OSTOMY POUCH COSED WBARRIER/FLTR			60/30
A4417	NU	OST POUCH W BAR/BLTINCONV/FLTR			60/30
A4418	NU	OST PCH CLSD W/O BAR W FILTR			60/30
A4419	NU	OST PCH FOR BAR W FLANGE/FLT			60/30
A4420	NU	OST PCH CLSD FOR BAR W IK FL	MNF		60/30
A4421	NU	OSTOMY SUPPLY, MISCELLANEOUS	IOC		
A4422	NU	OST POUCH ABSORBENT MATERIAL, EACH			30/30
A4423	NU	OST PCH FOR BAR W LK FL/FLTR	MNF		60/30
A4424	NU	OST PCH DRAIN W BAR & FILTER			20830
A4425	NU	OST PCH DRAIN FOR BARRIER FL			20/30
A4426	NU	OST PCH DRAIN 2 PIECE SYSTEM			20/30
A4427	NU	OST PCH DRAIN/BARR LK FLNG/F	MNF		20/30
A4428	NU	URINE OST POUCH W FAUCE/TAP			20/30
A4429	NU	URINE OST POUCH W BLTIN CONV			20/30
A4430	NU	OST URINE POUCH W B/BLTIN CONV			20/30
A4431	NU	OST PCH URINE W BARRIER/TAPV			20/30
A4432	NU	OST PCH URINE W BAR/FANGE/TAP			20/30
A4433	NU	URINE OST PCH BAR W LOCK FLN			20/30

PRODUCTION : 04/09/2020

Durable Medical Equipment



A4434	NU	OST PCH URINE W LOCK FLNG/FT			20/30
A4435	NU	1PC OST PCH DRAIN HGH OUTPUT	MNF		20/30
A4450	NU	NON-WATERPROOF TAPE,PER 18 SQ. INCHES			40/30
A4452	NU	WATERPROOF TAPE, PER 18 SQ. INCHES			40/30
A4554	NU	DISPOSABLE UNDERPADS, ALL SIZES, (E.G., CHUX'S)	PC	IOC	186/30
A4565	RB	SLINGS	CMN	IOC	
A4565	NU	SLINGS	CMN		
A4604	NU	TUBING WITH INTEGRATED HEATING ELEMENT FOR POSITIVE PRESSURE DEVICE			1/180
A4605	NU	TRACH SUCTION CATHETER, CLOSED	MNF		13/30
A4606	NU	OXYGEN PROBE USED W OXIMETER			1/year
A4618	NU	BREATHING CIRCUITS	MNF		1/180
A4623	NU	TRACH, INNER CANNULA REPLACE	MMF		8/30
A4624	NU	TRACH SUCTION TUBE	MNF		90/30
A4628	NU	OROPHARYNGEAL SUCTION CATHETER, EA	MNF		1/30
A4629	NU	TRACH CARE KIT FOR EST TRACH	MNF		1/1
A4635	RB	UNDERARM PAD, CRUTCH, REPLACEMENT, EACH	MNF		
A4636	RB	REPLACEMENT, HANDGRIP, CANE, CRUTCH, OR WALKER, EACH	MNF		
A4637	RB	REPLACEMENT, RIP, CANE, CRUTCH, WALKER, EACH	MNF		
A4640	RB	REPLACEMENT PAD FOR USE W/MEDICALLY NECESSARY ALTERNATING PRESSURE PAD OWNED BY PATIENT	MNF		
A5051	NU	POUCH CLSD W BARR ATTACHED 1 PIECE, EACH	MNF		60/30
A5052	NU	CLSD OSTOMY POUCH W/O BARR 1 PIECE, EACH	MNF		60/30
A5053	NU	CLSD OSTOMY POUCH FACEPLATE EACH	MNF		60/30
A5054	NU	CLSD OSTOMY POUCH W/FLANGE (2 PIECE), EACH	MNF		60/30
A5055	NU	STOMA CAP	MNF		31/30
A5056	NU	1 PC OST POUCH W FILTER	MNF		10/30
A5057	NU	1 PC OST POU W BUILT-IN CONV	MNF		10/30
A5061	NU	POUCH DRAINABLE W BARRIER ATTACHED, EACH	MNF		20/30
A5062	NU	DRNBLE OSTOMY POUCH W/O BARR, EACH	MNF		20/30
A5063	NU	DRAIN OSTOMY POUCH W/FLANGE, EACH	MNF		20/30
A5071	NU	OSTOMY POUCH W/BARRIER, EACH	MNF		20/30
A5072	NU	URINARY POUCH W/O BARRIER, EACH	MNF		20/30

PRODUCTION : 04/09/2020

Durable Medical Equipment



A5073	NU	URINARY POUCH ON BARR W/FLNG, EACH	MNF	20/30
A5081	NU	STOMA PLUG OR SEAL, ANY TYPE	MNF	31/30
A5082	NU	CONTINENT DEVICE; CATHETER FOR CONTINENT STOMA	MNF	2/180
A5083	NU	STOMA ABSORPTIVE COVER	IOC	31/30
A5093	NU	OSTOMY ACCESSORY; CONVEX INSERT	MNF	10/30
A5102	NU	BEDSIDE DRAINAGE BOTTLE WITH OR WITHOUT TUBING, RIGID OR EXPANDABLE, EACH	MNF	2/180
A5112	NU	URINARY LEG BAG	PC	1/30
A5113	NU	LEG STRAP; LATEX, REPLACEMENT ONLY, PER SET	MNF	1/30
A5114	NU	LEG STRAP; FOAM OR FABRIC, REPLACEMENT ONLY, PER SET	MNF	18/30
A5120	NU	SKIN BARRIER, WIPES OR SWABS, EACH	MNF	150/180
A5121	NU	SKIN BARRIER; SOLID, 6X6 OR EQUIVALENT, EACH	MNF	20/30
A5122	NU	SKIN BARRIER; SOLID, 8X8 OR EQUIVALENT, EACH	MNF	20/30
A5126	NU	ADHESIVE OR NON-ADHESIVE; DISK OR FOAM PAD	MNF	20/30
A5200	NU	PERCUTANEOUS CATHETER/TUBE ANCHORING DEVICE, ADHESIVE SKIN ATTACHMENT	PC	
A5500	NU	FOR DIABETICS ONLY OFF-THE-SHELF DEPTH-INLAY SHOE MAN. TO ACC. MULTIDENSITY INSERTS PER SHOE	PC	
A5501	NU	DIABETICS ONLY, CUSTOM SHOE MOLDED FROM CAST OF PATIENTS FOOT CUSTOM MOLDED SHOE, PER SHOE	PC	
A5503	NU	DIABETICS ONLY, OFFTHESHELF DEPTHINLAY W/ROLLER OR RIGID ROCKER BOTTOM, PER SHOE	PC	
A5504	NU	DIABETICS ONLY, OFFTHESHELF DEPTH INLAY SHOE OR CUSTOM MOLDED WITH WEDGES, PER SHOE	PC	
A5505	NU	DIABETICS ONLY, OFFTHESHELF DEPTH INLAY SHOE OR CUSTOM MOLDED WITH METATARSAL BAR, PER SHOE	PC	
A5506	NU	DIABETICS ONLY, OFFTHESHELF DEPTH INLAY OR CUSTOM MOLDED WITH OFF-SET HEEL, PER SHOE	PC	
A5507	NU	DIABETICS ONLY, OFF THE SHELF DEPTH INLAY SHOE OR CUSTOM MOLDED SHOE, PER SHOE.	PC	
A5512	NU	FOR DIABETICS ONLY, MULTIPLE DENSITY INSERT, DIRECT FORMED, MOLDED TO FOOT	PC	

Durable Medical Equipment



A5513	NU		FOR DIABETICS ONLY, MULTIPLE DENSITY INSERT, CUSTOM MOLDED FROM MODEL	PC		
A5514	NU		MULTI DENSITY INSERT DIR CARV/CAM			
A6257	NU		TRANSPARENT FILM <= 16 SQ IN			
A7000	NU		CANNISTER, DISPOSABLE	MNF		2/30
A7002	NU		TUBING	MNF		2/30
A7003	NU		ADMINISTRATION SET, WITH SMALL VOLUME NONFILTERED PENUMATIC NEBULIZER, DISPOSABLE	MNF		2/30
A7005	NU		ADMINISTRATION SET, WITH SMALL VOLUME NONFILTERED PENUMATIC NEBULIZER, NON-DISPOSABLE	MNF		1/180
A7013	NU		DISPOSABLE COMPRESSOR FILTER	MNF		2/30
A7027	NU		COMBINATION ORAL/NASAL MASK			1/180
A7028	NU		REPL ORAL CUSHION COMBO MASK			1/180
A7029	NU		REPL NASAL PILLOW COMB MASK			
A7030	NU		CPAP FULL FACE MASK	MNF		1/180
A7031	NU		REPLACEMENT FACEMASK INTERFA	MNF		1/90
A7032	NU		REPLACEMENT CUSHION FOR NASAL APPLICATION DEVICE,EACH	MNF		1/90
A7033	NU		REPLACEMENT PILLOWS FOR NASAL APPLICATION DEVICE, PAIR	MNF		1/30
A7034	NU		NASAL INTERFACE(MASK OR CANNULA TYPE) USED WITH POSITIVE AIRWAY PRESSURE DEVICE, W/WO HEAD STRAP	MNF		1/180
A7035	NU		HEADGEAR USED WITH POSITIVE AIRWAY PRESSURE DEVICE	MNF		1/180
A7036	NU		CHINSTRAP USED WITH POSITIVE AIRWAY PRESSURE DEVICE	MNF		1/180
A7037	NU		TUBING USED WITH POSITIVE AIRWAY PRESSURE DEVICE	MNF		1/180
A7038	NU		FILTER, DISPOSABLE USED WITH POSITIVE AIRWAY PRESSURE DEVICE	MNF		
A7039	NU		FILTER, NON DISPOSABLE USED WITH POSITIVE AIRWAY PRESSURE DEVICE	MNF		1/180
A7044	NU		ORAL INTERFACE USED WITH POSITIVE AIRWAY PRESSURE DEVICE, EACH	MNF		1/180
A7045	NU		EXHALATION PORT W/WO SWIVEL USED WITH ACCESS FOR POSITIVE AIRWAY DEVICES, REPLACEMENT ONLY	MNF		1/180
A7046	NU		WATER CHAMBER FOR HUMIDIFIER, USED WITH POSITIVE AIRWAY PRESSURE DEVICE, REPLACEMENT, EACH	MNF		
A7520	NU		TRACH/LARYNX TUBE NON-CUFFED	MNF		2/30
A7521	NU		TRACH/LARYNX TUBE CUFFED	MNF		2/30
A7522	NU		TRACH/LARYNX TUBE STAINLESS			1/30

PRODUCTION : 04/09/2020

Durable Medical Equipment



A7526	NU		TRACH/COLLAR HOLDER, EA	MNF		15/30
A8000	RB		SOFT PROTECT HELMET PREFAB	CMN	IOC	
A8000	NU		SOFT PROTECT HELMET PREFAB	CMN		
A8001	RB		HARD PROTECT HELMET PREFAB	CMN	IOC	
A8001	NU		HARD PROTECT HELMET PREFAB	CMN		
A8002	RB		SOFT PROTECT HELMET CUSTOM	CMN	IOC	
A8002	NU		HELMET, PROTECTIVE, SOFT, CUSTOM FABRICATED, INCLUDES ALL COMPONENTS AND ACCESSORIES	CMN		
A8003	RB		HELMET, PROTECTIVE, HARD, CUSTOM FABRICATED, INCLUDES ALL COMPONENTS AND ACCESSORIES	CMN	IOC	
A8003	NU		HELMET, PROTECTIVE, HARD, CUSTOM FABRICATED, INCLUDES ALL COMPONENTS AND ACCESSORIES	CMN		
A8004	RB		SOFT INTERFACE FOR HELMET, REPLACEMENT ONLY	CMN	IOC	
B4164	NU		PARENTERAL NUTRITION SOLUTION: CARBOHYDRATES(DEXTROSE)50% OR LESS(500ML=1 UNIT)HOME MIX	PC		
B4168	NU		PARENTERAL NUTRITION SOLUTION; AMINO ACID, 3.5%, (500 ML = 1 UNIT) - HOMEMIX	PC		
B4172	NU		PARENTERAL NUTRITION SOLUTION; AMINO ACID, 5.5% THROUGH 7%, (500 ML = 1 UNIT) - HOMEMIX	PC		
B4176	NU		PARENTERAL NUTRITION SOLUTION; AMINO ACID, 7% THROUGH 8.5%, (500 ML = 1 UNIT) - HOMEMIX	PC		
B4178	NU		PARENTERAL NUTRITION SOLUTION: AMINO ACID, GREATER THAN 8.5% (500 ML = 1 UNIT) - HOMEMIX	PC		
B4180	NU		PARENTERAL NUTRITION SOLUTION; CARBOHYDRATES (DEXTROSE), GREATER THAN 50% (500 ML=1 UNIT) - HOMEMIX	PC		
B4185	NU		PARENTERAL NUTRITION SOLUTION, PER 10 GRAMS LIPIDS	PC		
B4189	NU		COM.AMINO ACID & CARB WITH ELECT,TRACE ELE & VITA IN PRE ANY STREN,10TO51 GRAMS OF PROTEIN PREMIX	PC		
B4193	NU		COM AMINO ACID & CARB WITH ELECT,TRACE ELE,& VITA IN PRE,ANY STREN,52TO73 GRAMS OF PROTEIN PREMIX	PC		
B4197	NU		COM AMINO ACID & CARB WITH ELECTR,TRACE ELE & VITAIN PRE, ANY STREN, 74TO100 GRAMS OF PROTEIN PREMIX	PC		

Durable Medical Equipment



B4199	NU		COM AMINO ACID & CARB WITH ELECTR,TRACE ELE & VITAIN PRE,ANY STREN,OVER 100 GRAMS OR PROTEIN PREMIX	PC		
B4216	NU		PARENTERAL NUTRITION; ADDITIVES (VITAMINS, TRACE ELEMENTS, HEPARIN, ELECTROLYTES) HOMEMIX PER DAY	PC		
B4220	NU		PARENTERAL NUTRITION SUPPLY KIT - PREMIX; PER DAY	PC		
B4222	NU		PARENTERAL NUTRITION SUPPLY KIT-HOMEMIX, PER DAY	PC		
B4224	NU		PARENTERAL NUTRITION ADMINISTRATION KIT, PER DAY	PC		
B5000	NU		PARENTERAL SOL RENAL-AMIROSY	PC		
B5100	NU		PARENTERAL SOLUTION HEPATIC	PC		
B5200	NU		PARENTERAL SOL HEPATIC FREAM	PC	IOC	
B9004	RR		PARENTERAL NUTRITION INFUSION PUMP, PORTABLE	PC		Rent to purchase.
B9006	RR		PARENTERAL NUTRITION INFUSION PUMP, STATIONARY	PC		Rent to purchase.
B9999	NU		NOC FOR PARENTERAL SUPPLIES	PC	IOC	
E0100	NU		CANE, INCLUDES CANES OF ALL MATERIALS, ADJUSTABLE OR FIXED, WITH TIP	PC		
E0105	NU		CANE, QUAD OR THREE PRONG, INCLUDES CANES OF ALL MATERIALS, ADJUSTABLE OR FIXED, WITH TIPS	PC		
E0110	NU		CRUTCHES, FOREARM, INCLUDES CRUTCHES OF VARIOUS MATERIALS, ADJUSTABLE OR FIXED, PAIR, COMPLETE WIT	PC		
E0111	NU		CRUTCH FOREARM, INCLUDES CRUTCHES OF VARIOUS MATERIALS, ADJUSTABLE OR FIXED, EACH, WITH TIP AND HA	PC		
E0112	NU		CRUTCHES UNDERARM, WOOD, ADJUSTABLE OR FIXED, PAIR, WITH PADS, TIPS AND HANDGRIPS	PC		
E0113	NU		CRUTCH UNDERARM, WOOD, ADJUSTABLE OR FIXED, EACH, WITH PAD, TIP AND HANDGRIP	PC		
E0114	NU		CRUTCHES UNDERARM, OTHER THAN WOOD, ADJUSTABLE OR FIXED, PAIR, WITH PADS, TIPS AND HANDGRIPS	PC		
E0116	NU		CRUTCH, UNDERARM, OTHER THAN WOOD, ADJUSTABLE OR FIXED, WITH PAD, TIP, HANDGRIP, WITH OR WITHOUT SHO	PC		
E0118	NU		CRUTCH SUBSTITUTE, LOWER LEG PLATFORM WITH OR W/O WHEELS	MNF		
E0130	RR		WALKER, RIGID (PICKUP), ADJUSTABLE OR FIXED HEIGHT	PC		

Durable Medical Equipment



E0130	NU	WALKER, RIGID (PICKUP), ADJUSTABLE OR FIXED HEIGHT	PC		
E0135	RR	WALKER, FOLDING (PICKUP), ADJUSTABLE OR FIXED HEIGHT	PC		
E0135	NU	WALKER, FOLDING (PICKUP), ADJUSTABLE OR FIXED HEIGHT	PC		
E0140	RB	WALKER WITH TRUNK SUPPORT ADJUST. OR FXD HEIGHT, ANY TYPE	CMN	IOC	
E0140	RR	WALKER WITH TRUNK SUPPORT ADJUST. OR FXD HEIGHT, ANY TYPE	PC		
E0140	NU	WALKER WITH TRUNK SUPPORT ADJUST. OR FXD HEIGHT, ANY TYPE	PC		
E0141	RR	RIGID WHEELED WALKER ADJ/FX	PC		
E0141	NU	RIGID WHEELED WALKER ADJ/FX	PC		
E0143	RR	WALKER FOLDING WHEELED W/O S	PC		10 mo rent to purchase.
E0143	NU	WALKER FOLDING WHEELED W/O S	PC		
E0147	RR	WALKER VARIABLE WHEEL RESIST	PC		
E0147	NU	WALKER VARIABLE WHEEL RESIST	PC		
E0148	RR	WALKER, HEAVY DUTY, WITHOUT WHEELS, RIGID OR FOLDING, ANY TYPE, EACH	PC		
E0148	NU	WALKER, HEAVY DUTY, WITHOUT WHEELS, RIGID OR FOLDING, ANY TYPE, EACH	PC		
E0149	RR	HEAVY DUTY WHEELED WALKER	PC		10 mo rent to purchase.
E0149	NU	HEAVY DUTY WHEELED WALKER	PC		
E0153	RR	PLATFORM ATTACHMENT, FOREARM CRUTCH, EACH	MNF		
E0153	NU	PLATFORM ATTACHMENT, FOREARM CRUTCH, EACH	MNF		
E0154	RR	PLATFORM ATTACHMENT, WALKER, EACH	MNF		
E0154	NU	PLATFORM ATTACHMENT, WALKER, EACH	MNF		
E0155	NU	WHEEL ATTACHMENT, RIGID PICK-UP WALKER, PER PAIR	MNF		
E0156	NU	SEAT ATTACHMENT, WALKER	MNF		
E0157	RR	CRUTCH ATTACHMENT, WALKER, EACH	MNF		
E0157	NU	CRUTCH ATTACHMENT, WALKER, EACH	MNF		
E0158	NU	LEG EXTENSIONS FOR A WALKER, PER SET OF FOUR (4)	MNF		
E0159	NU	BRAKE ATTACHMENT FOR WHEELED WALKER, REPLACEMENT, EACH	MNF		
E0163	RR	COMMODE CHAIR, MOBILE OR STATIONARY, WITH FIXED ARMS	PC		
E0163	NU	COMMODE CHAIR, MOBILE OR STATIONARY, WITH FIXED ARMS	PC		
E0165	RR	COMMODE CHAIR, MOBILE OR STATIONARY, WITH DETACHABLE ARMS	PC		

Durable Medical Equipment



E0165	NU	COMMODE CHAIR, MOBILE OR STATIONARY, WITH DETACHABLE ARMS	PC		
E0167	RB	PAIL OR PAN FOR USE WITH COMMODE CHAIR, REPLACEMENT ONLY	MNF		
E0168	RR	COMMODE CHAIR, EXTRA WIDE AND/OR HEAVY DUTY, STATIONARY OR MOBILE, WITH OR WITHOUT ARMS, ANY TYPE	PC		
E0168	NU	COMMODE CHAIR, EXTRA WIDE AND/OR HEAVY DUTY, STATIONARY OR MOBILE, WITH OR WITHOUT ARMS, ANY TYPE	PC		
E0175	RR	FOOT REST, FOR USE WITH COMMODE CHAIR, EACH	MNF		
E0175	NU	FOOT REST, FOR USE WITH COMMODE CHAIR, EACH	MNF		
E0181	RB	PRESSURE PAD, ALTERNATING WITH PUMP	CMN	IOC	
E0181	RR	PRESSURE PAD, ALTERNATING WITH PUMP	PC		
E0181	NU	PRESSURE PAD, ALTERNATING WITH PUMP	PC		
E0182	RR	PUMP FOR ALTERNATING PRESSURE PAD	MNF		
E0182	NU	PUMP FOR ALTERNATING PRESSURE PAD	MNF		
E0182	RB	PUMP FOR ALTERNATING PRESSURE PAD	CMN		
E0184	NU	DRY PRESSURE MATTRESS	PC		
E0185	RR	DECUBITUS CARE PAD, FLOTATION OR GEL PAD WITH FOAM LEVELING PAD (MATTRESS SIZE)	PC		10 mo rent to purchase.
E0185	NU	GEL OR GEL-LIKE PRESSURE PAD FOR MATTRESS, STANDARD MATTRESS LENGTH AND WIDTH	PC		
E0186	NU	AIR PRESSURE MATTRESS	PC		
E0187	NU	WATER PRESSURE MATTRESS	PC		
E0190	NU	POSITIONING CUSHION/PILLOW/WEDGE, ANY SHAPE OR SIZE, INCLUDES ALL COMPONENTS AND ACCESSORIES	CMN	IOC	
E0196	NU	GEL PRESSURE MATTRESS	PC		
E0197	RR	AIR PRESSURE PAD FOR MATTRESS, STANDARD MATTRESS LENGTH AND WIDTH	PC		Rent to purchase.
E0197	NU	AIR PRESSURE PAD FOR MATTRESS, STANDARD MATTRESS LENGTH AND WIDTH	PC		
E0217	NU	WATER CIRCULATING HEAT PAD WITH PUMP	MNF		
E0218	NU	WATER CIRCULATING COLD PAD WITH PUMP	MNF		
E0250	RB	HOSPITAL BED, WITH SIDE RAILS, FIXED HEIGHT, WITH MATTRESS	CMN	IOC	
E0250	RR	HOSPITAL BED, WITH SIDE RAILS, FIXED HEIGHT, WITH MATTRESS	PC		
E0250	NU	HOSPITAL BED, WITH SIDE RAILS, FIXED HEIGHT, WITH MATTRESS	PC		

Durable Medical Equipment



E0251	RB	HOSPITAL BED, WITH SIDE RAILS, FIXED HEIGHT, WITHOUT MATTRESS	CMN	IOC	
E0251	RR	HOSPITAL BED, WITH SIDE RAILS, FIXED HEIGHT, WITHOUT MATTRESS	PC		
E0251	NU	HOSPITAL BED, WITH SIDE RAILS, FIXED HEIGHT, WITHOUT MATTRESS	PC		
E0255	RB	HOSPITAL BED, WITH SIDE RAILS VARIABLE HEIGHT, HI-LO, WITH MATTRESS	CMN		
E0255	RR	HOSPITAL BED, WITH SIDE RAILS VARIABLE HEIGHT, HI-LO, WITH MATTRESS	PC		
E0255	NU	HOSPITAL BED, WITH SIDE RAILS VARIABLE HEIGHT, HI-LO, WITH MATTRESS	PC		
E0256	RR	HOSP BED, VARIABLE HGHT, HI/LO, WITH ANY TYPE SIDERAILS WITHOUT MATTRESS	PC		
E0256	NU	HOSPITAL BED, VARIABLE HEIGHT, HI-LO, WITH ANY TYPE SIDE RAILS, WITHOUT MATTRESS	PC		
E0260	RB	HOSPITAL BED, WITH SIDE RAILS, SEMI-ELECTRIC, HEAD AND FOOT ADJUSTMENT, WITH MATTRESS	CMN	IOC	
E0260	RR	HOSPITAL BED, WITH SIDE RAILS, SEMI-ELECTRIC, HEAD AND FOOT ADJUSTMENT, WITH MATTRESS	PC		20 mo rent to purchase.
E0260	NU	HOSPITAL BED, WITH SIDE RAILS, SEMI-ELECTRIC, HEAD AND FOOT ADJUSTMENT, WITH MATTRESS	PC		
E0261	RR	HOSP BED, SEMI ELECT. WITH ANY TYPE SIDE RAILS WITHOUT MATTRESS.	PC		
E0261	NU	HOSPITAL BED, SEMIELECTRIC (HEAD AND FOOT ADJUSTMENT), WITH ANY TYPE SIDE RAILS, WITHOUT MATTRESS	PC		
E0271	NU	MATTRESS, INNERSPRING	CMN		
E0271	RR	MATTRESS, INNERSPRING	CMN 1st claim only		
E0272	NU	MATTRESS, FOAM RUBBER	CMN		
E0272	RR	MATTRESS, FOAM RUBBER	CMN 1st claim only		
E0275	NU	BED PAN STANDARD METAL OR PLASTIC	PC		
E0276	NU	BED PAN, FRACTURE METAL OR PLASTIC	PC		
E0290	RB	HOSPITAL BED, FIXED HEIGHT, WITHOUT SIDE RAILS, WITH MATTRESS	CMN	IOC	
E0290	RR	HOSPITAL BED, FIXED HEIGHT, WITHOUT SIDE RAILS, WITH MATTRESS	PC		
E0290	NU	HOSPITAL BED, FIXED HEIGHT, WITHOUT SIDE RAILS, WITH MATTRESS	PC		

Durable Medical Equipment



E0291	RR		HOSPITAL BED. FXD HGHT,W/O SIDERAILS W/O MATTRESS	PC		
E0291	NU		HOSPITAL BED, FIXED HEIGHT, WITHOUT SIDE RAILS,WITHOUT MATTRESS	PC		
E0292	RR		HOSP BED VAR HT NO SR W/MATT	PC		
E0292	NU		HOSP BED VAR HT NO SR W/MATT	PC		
E0293	RR		HOSP BED VAR HT NO SR NO MAT	PC		
E0293	NU		HOSP BED VAR HT NO SR NO MAT	PC		
E0294	RR		HOSPITAL BED, SEMI ELECTRIC, WITHOUT SIDERAILS, W/MATTRESS	PC		
E0294	NU		HOSPITAL BED, SEMIELECTRIC (HEAD AND FOOT ADJUSTMENT), WITHOUT SIDE RAILS, WITH MATTRESS	PC		
E0295	RR		HOSP BED, SEMI ELECTRIC, W/O SIDERAILS WITHOUT MATTRESS	PC		
E0295	NU		HOSPITAL BED, SEMIELECTRIC (HEAD AND FOOT ADJUSTMENT), WITHOUT SIDE RAILS, WITHOUT MATTRESS	PC		
E0305	RR		BED SIDE RAILS, HALF LENGTH	CMN		
E0305	NU		BED SIDE RAILS, HALF LENGTH	CMN		
E0310	RR		BED SIDE RAILS, FULL LENGTH	CMN		
E0310	NU		BED SIDE RAILS, FULL LENGTH	CMN		
E0325	NU		URINAL MALE JUG TYPE ANY MATERIAL	PC		
E0326	NU		URINAL FEMALE, JUG TYPE, ANY MATERIAL	PC		
E0424	RR		STATIONARY COMPRESSED GASEOUS OXYGEN SYSTEM,RENTAL	PC		
E0424	RR	QF	STATIONARY COMPRESSED GASEOUS OXYGEN SYSTEM,RENTAL	PC		
E0424	RR	QG	STATIONARY COMPRESSED GASEOUS OXYGEN SYSTEM,RENTAL	PC		
E0431	RR		PORTABLE GAS OXYGEN SYSTEM RENTAL	PC		Continuous rental.
E0434	RR		PORTABLE LIQUID OXYGEN SYSTEM RENTAL	PC		Continuous rental.
E0439	RR		STATIONARY LIQUID SYSTEM, RENTAL	PC		
E0439	RR	QF	STATIONARY LIQUID SYSTEM, RENTAL > 4 LPM & PORTABLE OXYGEN IS PRESCRIBED	PC		
E0439	RR	QG	STATIONARY LIQUID SYSTEM, RENTAL >4 LPM????????????	PC		
E0441	NU		STATIONARY O2 CONTENTS, GAS	PC		One month supply = one unit.

Durable Medical Equipment



E0442	NU		STATIONARY O2 CONTENTS, LIQ	PC		One month supply = one unit.
E0443	NU		PORTABLE O2 CONTENTS, GAS	PC		One month supply = one unit. 1/30
E0444	NU		PORTABLE O2 CONTENTS, LIQUID	PC		One month supply = one unit. 1/30
E0465	RR	TW	HOME VENT INVASIVE INTERFACE	PC		Back up for vol vent.
E0465	RR		HOME VENT INVASIVE INTERFACE	PC		
E0470	RB		RAD W/O BACKUP NON-INV INTFC	CMN	IOC	
E0470	RR		RAD W/O BACKUP NON-INV INTFC	PC		Months 1-3, rent to purchase.
E0470	RR	KJ	RAD W/O BACKUP NON-INV INTFC	PC		Months 4-12, rent to purchase.
E0471	RB		RAD W/BACKUP NON-INV INTFC	CMN	IOC	
E0471	RR		RAD W/BACKUP NON INV INTRFC	PC		Months 1-3, rent to purchase.
E0471	RR	KJ	RAD W/BACKUP NON INV INTRFC	PC		Months 4-21, rent to purchase.
E0500	RR		IPPB MACHINE W/MANUAL VALVES EXTERNAL POWER SOURCE INCLUDES CYLINDER REGULATOR, BUILT-IN NEBULIZATION	MNF		
E0500	NU		IPPB MACHINE W/MANUAL VALVES EXTERNAL POWER SOURCE INCLUDES CYLINDER REGULATOR, BUILT-IN NEBULIZATION	MNF		
E0500	RB		IPPB MACHINE W/MANUAL VALVES EXTERNAL POWER SOURCE INCLUDES CYLINDER REGULATOR, BUILT-IN NEBULIZATION	CMN	IOC	
E0550	RB		HUMIDIFIER, DURABLE FOR EXTENSIVE SUPPLEMENTAL HUMIDIFICATION DURING IPPB TREATMENTS OR OXYGEN DELIV	CMN	IOC	

Durable Medical Equipment



E0550	NU		HUMIDIFIER, DURABLE FOR EXTENSIVE SUPPLEMENTAL HUMIDIFICATION DURING IPPB TREATMENTS OR OXYGEN DELIV	CMN		
E0550	RR		HUMIDIFIER, DURABLE FOR EXTENSIVE SUPPLEMENTAL HUMIDIFICATION DURING IPPB TREATMENTS OR OXYGEN DELIV	CMN 1st claim only		
E0561	NU		HUMIDIFIER, NON-HEATED, USED WITH POSITIVE AIRWAY PRESSURE DEVICE	PC		
E0562	NU		HUMIDIFIER, HEATED, USED WITH POSITIVE AIRWAY PRESSURE	PC		
E0565	RR		COMPRESSOR, AIR POWER SOURCE FOR EQUIPMENT WHICH IS NOT SELF-CONTAINED OR CYLINDER DRIVEN	PC		
E0570	RB		NEBULIZER, WITH COMPRESSOR E.G., DEVILBISS PULMO-AID	CMN		
E0570	NU		NEBULIZER, WITH COMPRESSOR E.G., DEVILBISS PULMO-AID	PC		
E0575	RR		NEBULIZER, SELF-CONTAINED, ULTRASONIC	MNF		
E0575	NU		NEBULIZER, SELF-CONTAINED, ULTRASONIC	MNF		
E0575	RB		NEBULIZER, SELF-CONTAINED, ULTRASONIC	CMN	IOC	
E0585	RB		NEBULIZER, WITH COMPRESSOR AND HEATER	CMN	IOC	
E0585	RR		NEBULIZER, WITH COMPRESSOR AND HEATER	PC		
E0585	NU		NEBULIZER, WITH COMPRESSOR AND HEATER	PC		
E0598	RB	SC	WHEELCHAIR ATTACHMENT TO CONVERT ANY WHEELCHAIR TO ONE ARM DRIVE	CMN		
E0598	NU	SC	WHEELCHAIR ATTACHMENT TO CONVERT ANY WHEELCHAIR TO ONE ARM DRIVE	PA		
E0600	RB		SUCTION PUMP, HOME MODEL, PORTABLE	CMN	IOC	
E0600	RR		SUCTION PUMP, HOME MODEL, PORTABLE	PC		
E0600	NU		SUCTION PUMP, HOME MODEL, PORTABLE	PC		
E0601	RB		CONT AIRWAY PRESSURE DEVICE	CMN	IOC	
E0601	RR		CONT AIRWAY PRESSURE DEVICE	PC, Sleep study		Months 1-3, rent to purchase.
E0601	RR	KJ	CONT AIRWAY PRESSURE DEVICE	PC, compliant with use		Months 4-21, rent to purchase.
E0619	RR		APNEA MONITOR W RECORDER	PC		Months 1-4
E0619	RR	KJ	APNEA MONITOR W RECORDER MONTHS 5-12	PC		Months 5-12

Durable Medical Equipment



E0621	NU		SLING OR SEAT, PATIENT LIFT, CANVAS OR NYLON	MNF		
E0630	RB		PATIENT LIFT HYDRAULIC	CMN	IOC	
E0630	RR		PATIENT LIFT HYDRAULIC	PC		15 mo rent to purchase.
E0630	NU		PATIENT LIFT HYDRAULIC	PC		
E0705	NU		TRANSFER DEVICE	CMN		
E0705	NU	SC	TRANSFER BOARD OR DEVICE, ANY TYPE, EACH	PA		
E0760	RR		OSTOGENESIS STIMIULATOR, LOW INTENSITY ULTRASOUND, NON-INVASIVE	PC		Rent to purchase.
E0760	NU		OSTOGENESIS STIMULATOR, LOW INTENSITY ULTRASOUND, NON-INVASIVE	PC		
E0784	RR		EXTERNAL AMBULATORY INFUSION PUMP, INSULIN	PC		Rent to purchase.
E0784	NU		EXTERNAL AMBULATORY INFUSION PUMP, INSULIN	PC		
E0910	RR		TRAPEZE BARS AKA PATIENT HELPER, ATTACHED TO BED, WITH GRAB BAR	MNF		
E0910	NU		TRAPEZE BARS AKA PATIENT HELPER, ATTACHED TO BED, WITH GRAB BAR	MNF		
E0910	RB		TRAPEZE BARS AKA PATIENT HELPER, ATTACHED TO BED, WITH GRAB BAR	CMN	IOC	
E0940	RR		TRAPEZE BAR, FREE STANDING, COMPLETE WITH GRAB BAR	MNF		
E0940	NU		TRAPEZE BAR, FREE STANDING, COMPLETE WITH GRAB BAR	MNF		
E0940	RB		TRAPEZE BAR, FREE STANDING, COMPLETE WITH GRAB BAR	CMN	IOC	
E0950	RB		TRAY	CMN		
E0950	RB	SC	TRAY	CMN		
E0950	NU		TRAY	CMN		
E0950	NU	SC	TRAY	PA		
E0951	RB		HEEL LOOP/HOLDER ANY TYPE WITH/WO ANKLE STRAP EACH	CMN		
E0951	RB	SC	HEEL LOOP/HOLDER ANY TYPE WITH/WO ANKLE STRAP EACH	CMN		
E0951	NU		HEEL LOOP/HOLDER, ANY TYPE WITH/WO ANKLE STRAP, EACH	CMN		
E0951	NU	SC	HEEL LOOP/HOLDER ANY TYPE WITH/WO ANKLE STRAP EACH	PA		
E0952	RB		TOE LOOP/HOLDER ANY TYPE EACH	CMN		
E0952	RB	SC	TOE LOOP/HOLDER ANY TYPE EACH	CMN		
E0952	NU		TOE LOOP/HOLDER, ANY TYPE, EACH	CMN		
E0952	NU	SC	TOE LOOP/HOLDER ANY TYPE EACH	PA		
E0953	NU		W/C LATERAL THIGH/KNEE SUP	CMN		

PRODUCTION : 04/09/2020

Durable Medical Equipment



E0953	NU	SC	W/C LATERAL THIGH/KNEE SUP	PA		
E0953	RB		W/C LATERAL THIGH/KNEE SUP	CMN		
E0953	RB	SC	W/C LATERAL THIGH/KNEE SUP	CMN		
E0954	NU		FOOT BOX, ANY TYPE EACH FOOT	CMN		
E0954	NU	SC	FOOT BOX, ANY TYPE EACH FOOT	PA		
E0954	RB		FOOT BOX, ANY TYPE EACH FOOT	CMN		
E0954	RB	SC	FOOT BOX, ANY TYPE EACH FOOT	CMN		
E0955	RB		HEADREST CUSHIONED ANY TYPE INCLUDING FXD MNTG WHEELCHAIR ACCESS	CMN		
E0955	RB	SC	HEADREST CUSHIONED ANY TYPE INCLUDING FXD MNTG WHEELCHAIR ACCESS	CMN		
E0955	NU		HEADREST, CUSHIONED ANY TYPE INCLUDING FXD MNTG, WHEELCHAIR ACCESS	CMN		
E0955	NU	SC	HEADREST CUSHIONED ANY TYPE INCLUDING FXD MNTG WHEELCHAIR ACCESS	PA		
E0956	RB		LATERAL TRUNK OR HIP SUPPORT W/C ACCESS	CMN		
E0956	RB	SC	LATERAL TRUN OR HIP SUPPORT W/C ACCESS	CMN		
E0956	NU		LATERAL TRUNK OR HIP SUPPORT, W/C ACCESS	CMN		
E0956	NU	SC	LATERAL TRUN OR HIP SUPPORT W/C ACCESS	PA		
E0957	RB		MEDIAL THIGH SUPPORT ANY TYPE INCLUDING FSD MNTG W/C ACCESS	CMN		
E0957	RB	SC	MEDIAL THIGH SUPPORT ANY TYPE INCLUDING FSD MNTG W/C ACCESS	CMN		
E0957	NU		MEDIAL THIGH SUPPORT, ANY TYPED INCLUDING FSD MNTG, W/C ACCESS	CMN		
E0957	NU	SC	MEDIAL THIGH SUPPORT ANY TYPE INCLUDING FSD MNTG W/C ACCESS	PA		
E0958	RR	SC	WHEELCHAIR ATTACHMENT TO CONVERT ANY WHEELCHAIR TO ONE ARM DRIVE	CMN		
E0958	RB		WHEELCHAIR ATTACHMENT TO CONVERT ANY WHEELCHAIR TO ONE ARM DRIVE	CMN		
E0958	RB	SC	WHEELCHAIR ATTACHMENT TO CONVERT ANY WHEELCHAIR TO ONE ARM DRIVE	CMN		
E0958	NU		WHEELCHAIR ATTACHMENT TO CONVERT ANY WHEELCHAIR TO ONE ARM DRIVE	CMN		
E0958	NU	SC	WHEELCHAIR ATTACHMENT TO CONVERT ANY WHEELCHAIR TO ONE ARM DRIVE	PA		

Durable Medical Equipment



E0958	RR		WHEELCHAIR ATTACHMENT TO CONVERT ANY WHEELCHAIR TO ONE ARM DRIVE	CMN 1st claim only		
E0959	RB		MANUAL WHEELCHAIR ACCESSORY, ADAPTER FOR AMPUTEE, EACH	CMN		
E0959	RB	SC	MANUAL WHEELCHAIR ACCESSORY, ADAPTER FOR AMPUTEE, EACH	CMN		
E0959	NU		MANUAL WHEELCHAIR ACCESSORY, ADAPTER FOR AMPUTEE, EACH	CMN		
E0959	RR	SC	MANUAL WHEELCHAIR ACCESSORY, ADAPTER FOR AMPUTEE, EACH	PA		
E0959	NU	SC	MANUAL WHEELCHAIR ACCESSORY, ADAPTER FOR AMPUTEE, EACH	PA		
E0959	RR		MANUAL WHEELCHAIR ACCESSORY, ADAPTER FOR AMPUTEE, EACH	CMN 1st claim only		
E0960	RB		W/C SHOULDER HARNESS/STRAP	CMN		
E0960	RB	SC	W/C SHOULDER HARNESS/STRAP	CMN		
E0960	NU		W/C SHOULDER HARNESS/STRAP	CMN		
E0960	NU	SC	W/C SHOULDER HARNESS/STRAP	PA		
E0961	RB		BRAKE EXTENSION FOR WHEELCHAIR	CMN		
E0961	RB	SC	BRAKE EXTENSION FOR WHEELCHAIR	CMN		
E0961	NU		BRAKE EXTENSION, FOR WHEELCHAIR	CMN		
E0961	NU	SC	BRAKE EXTENSION FOR WHEELCHAIR	PA		
E0966	RB		HOOK ON HEAD REST EXTENSION	CMN		
E0966	RB	SC	HOOK ON HEAD REST EXTENSION	CMN		
E0966	NU		HOOK ON HEAD REST EXTENSION	CMN		
E0966	RR	SC	HOOK ON HEAD REST EXTENSION	PA		
E0966	NU	SC	HOOK ON HEAD REST EXTENSION	PA		
E0966	RR		HOOK ON HEAD REST EXTENSION	CMN 1st claim only		
E0967	NU		MAN WC RIM/PROJECTION REP EA	CMN		
E0967	RB		MAN WC RIM/PROJECTION REP EA	CMN		
E0967	RB	SC	MAN WC RIM/PROJECTION REP EA	CMN		
E0967	NU	SC	MAN WC RIM/PROJECTION REP EA	PA		
E0968	RR		COMMODE SEAT WHEELCHAIR	CMN		
E0968	RB		COMMODE SEAT, WHEELCHAIR	CMN		
E0968	RB	SC	COMMODE SEAT, WHEELCHAIR	CMN		
E0968	NU		COMMODE SEAT, WHEELCHAIR	CMN		
E0968	RR	SC	COMMODE SEAT, WHEELCHAIR	PA		

Durable Medical Equipment



E0968	NU	SC	COMMODE SEAT, WHEELCHAIR	PA		
E0969	RB		WHEELCHAIR NARROWING DEVICE	CMN		
E0969	RB	SC	WHEELCHAIR NARROWING DEVICE	CMN		
E0969	NU		WHEELCHAIR NARROWING DEVICE	CMN		
E0969	NU	SC	WHEELCHAIR NARROWING DEVICE	PA		
E0970	RB		NO. 2 FOOTPLATES EXCEPT FOR ELEVATING LEG REST	CMN		
E0970	RB	SC	NO. 2 FOOTPLATES EXCEPT FOR ELEVATING LEG REST	CMN		
E0970	NU		NO.2 FOOTPLATES, EXCEPT FOR ELEVATING LEG REST	CMN		
E0970	NU	SC	NO. 2 FOOTPLATES EXCEPT FOR ELEVATING LEG REST	PA		
E0971	RB		ANTI-TIPPING DEVICE, WHEELCHAIRS	CMN		
E0971	RB	SC	ANTI-TIPPING DEVICE, WHEELCHAIRS	CMN		
E0971	NU		WHEELCHAIR ACCESS., ANTI TIPPING DEVICE, EACH	CMN		
E0971	NU	SC	ANTI-TIPPING DEVICE, WHEELCHAIRS	PA		
E0973	RB		ADJUSTABLE HEIGHT DETACHABLE ARMS DESK OR FULL LENGTH WHEELCHAIR	CMN		
E0973	RB	SC	ADJUSTABLE HEIGHT DETACHABLE ARMS DESK OR FULL LENGTH WHEELCHAIR	CMN		
E0973	NU		ADJUSTABLE HEIGHT DETACHABLE ARMS,DESK OR FULL LENGTH, WHEELCHAIR	CMN		
E0973	RR	SC	ADJUSTABLE HEIGHT DETACHABLE ARMS DESK OR FULL LENGTH WHEELCHAIR	PA		
E0973	NU	SC	ADJUSTABLE HEIGHT DETACHABLE ARMS DESK OR FULL LENGTH WHEELCHAIR	PA		
E0973	RR		ADJUSTABLE HEIGHT DETACHABLE ARMS, DESK OR FULL LENGTH, WHEELCHAIR	CMN 1st claim only		
E0974	RB		GRADE-AID (DEVICE TO PREVENT ROLLING BACK ON AN INCLINE) FOR WHEELCHAIR	CMN		
E0974	RB	SC	GRADE-AID (DEVICE TO PREVENT ROLLING BACK ON AN INCLINE) FOR WHEELCHAIR	CMN		
E0974	NU		GRADE-AID (DEVICE TO PREVENT ROLLING BACK ON AN INCLINE) FOR WHEELCHAIR	CMN		
E0974	NU	SC	GRADE-AID (DEVICE TO PREVENT ROLLING BACK ON AN INCLINE) FOR WHEELCHAIR	PA		
E0978	NU		POSITIONING BELT/SAFETY BELT/PELVIC STRAP EACH, W/C ACCESS	CMN		

Durable Medical Equipment



E0978	RB		POSITIONING BELT/SAFETY BELT/PELVIC STRAP EACH W/C ACCESS	CMN		
E0978	RB	SC	POSITIONING BELT/SAFETY BELT/PELVIC STRAP EACH W/CACCESS	CMN		
E0978	NU	SC	POSITIONING BEL/SAFETY BELT/PELVIC STRAP EACH W/C ACCESS	PA		
E0980	RB		SAFETY VEST, WHEELCHAIR	CMN		
E0980	RB	SC	SAFETY VEST WHEELCHAIR	CMN		
E0980	NU		SAFETY VEST, WHEELCHAIR	CMN		
E0980	NU	SC	SAFETY VEST WHEELCHAIR	PA		
E0981	RB		SEAT UPHOLSTERY, REPLACEMENT	CMN		
E0981	RB	SC	SEAT UPHOLSTERY REPLACEMENT	CMN		
E0982	RB		BACK UPHOLSTERY, REPLACEMENT	CMN		
E0982	RB	SC	BACK UPHOLSTERY REPLACEMENT	CMN		
E0983	RB		ADD POWER JOYSTICK	PA		
E0983	RB	SC	ADD POWER JOYSTICK	PA		
E0983	NU		ADD POWER JOYSTICK	PA		
E0983	NU	SC	ADD POWER JOYSTICK	PA		
E0984	RB		ADD POWER TILLER	CMN		
E0984	RB	SC	ADD POWER TILLER	CMN		
E0984	NU		ADD POWER TILLER	PA		
E0984	NU	SC	ADD POWER TILLER	PA		
E0986	RB		MAN W/C PUSH-RIM POWR SYSTEM	PA		
E0986	RR		MAN W/C PUSH-RIM POWR SYSTEM	PA		
E0988	RB		LEVER-ACTIVATED WHEEL DRIVE	CMN		
E0988	RB	SC	LEVER-ACTIVATED WHEEL DRIVE	CMN		
E0988	RR		LEVER-ACTIVATED WHEEL DRIVE	PA		
E0988	RR	SC	LEVER-ACTIVATED WHEEL DRIVE	PA		
E0988	NU		LEVER-ACTIVATED WHEEL DRIVE	PA		
E0988	NU	SC	LEVER-ACTIVATED WHEEL DRIVE	PA		
E0990	RB	SC	ELEVATING LEG REST; EACH	CMN		
E0990	RB		ELEVATING LEG REST EACH	CMN		
E0990	NU		ELEVATING LEG REST, EACH	CMN		
E0990	NU	SC	ELEVATING LEG REST; EACH	PA		
E0992	RB		SOLID SEAT INSERT	CMN		

Durable Medical Equipment



E0992	RB	SC	SOLID SEAT INSERT	CMN		
E0992	NU		SOLID SEAT INSERT	CMN		
E0992	NU	SC	SOLID SEAT INSERT	PA		
E0994	RB		ARM REST, EACH	CMN		
E0994	RB	SC	ARM REST; EACH	CMN		
E0994	NU		ARM REST, EACH	CMN		
E0994	NU	SC	ARM REST; EACH	PA		
E0995	RB		WC CALF REST, PAD REPLACEMNT	CMN		
E0995	RB	SC	WC CALF REST, PAD REPLACEMNT	CMN		
E0995	NU		WC CALF REST, PAD REPLACEMNT	CMN		
E1002	RB		PWR SEAT TILT	CMN		
E1002	RB	SC	PWR SEAT TILT	CMN		
E1002	NU		PWR SEAT TILT	PA		
E1002	NU	SC	PWR SEAT TILT	PA		
E1003	RB		PWR SEAT RECLINE	CMN		
E1003	RB	SC	PWR SEAT RECLINE	CMN		
E1003	NU		PWR SEAT RECLINE	PA		
E1003	NU	SC	PWR SEAT RECLINE	PA		
E1004	RB		PWR SEAT RECLINE MECH	CMN		
E1004	RB	SC	PWR SEAT RECLINE MECH	CMN		
E1004	NU		PWR SEAT RECLINE MECH	PA		
E1004	NU	SC	PWR SEAT RECLINE MECH	PA		
E1005	RB		PWR SEAT RECLINE PWR	CMN		
E1005	RB	SC	PWR SEAT RECLINE	CMN		
E1005	NU		PWR SEAT RECLINE PWR	PA		
E1005	NU	SC	PWR SEAT RECLINE	PA		
E1006	RB		PWR SEAT COMBO W/O SHEAR	CMN		
E1006	RB	SC	PWR SEAT COMBO W/O SHEAR	CMN		
E1006	NU		PWR SEAT COMBO W/O SHEAR	PA		
E1006	NU	SC	PWR SEAT COMBO W/O SHEAR	PA		
E1007	RB		PWR SEAT COMBO W/SHEAR	CMN		
E1007	RB	SC	PWR SEAT COMBO W/SHEAR	CMN		

Durable Medical Equipment



E1007	NU		PWR SEAT COMVO W/SHEAR	PA		
E1007	NU	SC	PWR SEAT COMBO W/SHEAR	PA		
E1008	RB		PWR SEAT COMBO PWR SHEAR	CMN		
E1008	RB	SC	PWR SEAT COMBO PWR SHEAR	CMN		
E1008	NU		PWR SEAT COMBO PWR SHEAR	PA		
E1008	NU	SC	PWR SEAT COMBO PWR SHEAR	PA		
E1009	RB		ADD MECH LEG ELEVATION	PA	MSRP	
E1009	RB	SC	ADD MECH LEG ELEVATION	PA	MSRP	
E1009	NU		ADD MECH LEG ELEVATION	PA	MSRP	
E1009	NU	SC	ADD MECH LEG	PA	MSRP	
E1010	RB		ADDITION TO POWER SEATING SYSTEM, POWER LEG ELEVATION	CMN		
E1010	RB	SC	ADDITION TO POWER SEATING SYSTEM POWER LEG ELEVATION	CMN		
E1010	NU		ADDITION TO POWER SEATING SYSTEM, POWER LEG ELEVATION	PA		
E1010	NU	SC	ADDITION TO POWER SEATING SYSTEM POWER LEG ELEVATION	PA		
E1011	RB		MOD TO PEDIATRIC SZ CHAIR WIDTH	CMN	MSRP	
E1011	RB	SC	MOD TO PEDIATRIC SZ CHAIR WIDTH	CMN	MSRP	
E1011	NU		MOD TO PEDIATRIC SZ CHAIR WIDTH ADJUSTMENT PACKAGE	PA	MSRP	
E1011	NU	SC	MOD TO PEDIATRIC SZ CHAIR WIDTH	PA	MSRP	
E1012	RB		CTR MOUNT PWR ELEV LEG REST	CMN	MSRP	
E1012	NU		CTR MOUNT PWR ELEV LEG REST	PA	MSRP	
E1012	RR		CTR MOUNT PWR ELEV LEG REST	PA	MSRP	
E1014	NU		RECLINING BACK FOR PEDIATRIC SZ CHAIR	PA		
E1014	NU	SC	RECLINING BACK FOR PEDIATRIC SZ CHAIR	PA		
E1014	RB		RECLINING BACK FOR PEDIATRIC SZ CHAIR	PA		
E1014	RB	SC	RECLINING BACK FOR PEDIATRIC SZ CHAIR	PA		
E1015	RB		SHOCK ABSORBER FOR MAN W/C	CMN		
E1015	RB	SC	SHOCK ABSORBER FOR MAN W/C	CMN		
E1015	NU		SHOCK ABSORBER FOR MAN W/C	CMN		
E1015	NU	SC	SHOCK ABSORBER FOR MAN W/C	PA		
E1016	RB		SHOCK ABSORBER FOR PWR W/C	CMN		
E1016	RB	SC	SHOCK ABSORBER FOR PWR W/C	CMN		
E1016	NU		SHOCK ABSORBER FOR POWER W/C	CMN		

Durable Medical Equipment



E1016	NU	SC	SHOCK ABSORBER FOR PWR W/C	PA		
E1017	RB		HD SHCK ABSRBR FOR HD MAN WC	CMN	MSRP	
E1017	RB	SC	HD SHCK ABSRBR FOR HD MAN WC	CMN	MSRP	
E1017	NU		HD SHCK ABSRBR FOR HD MAN WC	CMN	MSRP	
E1017	NU	SC	HD SHCK ABSRBR FOR HD MAN WC	PA	MSRP	
E1018	RB		HD SHCK ABSRBER FOR HD POWWC	CMN	MSRP	
E1018	RB	SC	HD SHCK ABSRBER FOR HD POWWC	CMN	MSRP	
E1018	NU		HD SHCK ABSRBER FOR HD POWWC	PA	MSRP	
E1018	NU	SC	HD SHCK ABSRBER FOR HD POWWC	PA	MSRP	
E1020	RB		RESIDUAL LIMB SUPPORT SYSTEM	CMN		
E1020	RB	SC	RESIDUAL LIMB SUPPORT SYSTEM	CMN		
E1020	NU		RESIDUAL LIMB SUPPORT SYSTEM	CMN		
E1020	NU	SC	RESIDUAL LIMB SUPPORT SYSTEM	PA		
E1028	RB		W/C MANUAL SWINGAWAY RETRACT/REMOV MNTG HARDWARE FOR JOYSTICK OTHER CONTROL INTERFACE OR POST ACCES	CMN		8
E1028	RB	SC	W/C MANUAL SWINGAWAY RETRACT/REMOV MNTG HARDWARE FOR JOYSTICK OTHER CONTROL INTERFACE OR POST ACCES	CMN		8
E1028	NU		W/C MANUAL SWINGAWAY RETRACT/REMOV MNTGY HARDWARE FOR JOYSTICK OTHER CONTROL INTERFACE OR POST ACCES	CMN		8
E1028	NU	SC	W/C MANUAL SWINGAWAY RETRACT/REMOV MNTG HARDWARE FOR JOYSTICK OTHER CONTROL INTERFACE OR POST ACCES	PA		Max limit of 5. Additional units must be included under K0108.
E1029	RB		W/C VENT TRAY FIXED	CMN		

Durable Medical Equipment



E1029	RB	SC	W/C VENT TRAY FIXED	CMN		
E1029	NU		W/C VENT TRAY FIXED	CMN		
E1029	NU	SC	W/C VENT TRAY FIXED	PA		
E1030	RB		ROLLABOUT CHAIR, WITHOUT ARMS	CMN		
E1030	RB	SC	W/C VENT TRAY GIMBALED	CMN		
E1030	NU		W/C VENT TRAY GIMBALED	CMN		
E1030	NU	SC	W/C VENT TRAY GIMBALED	PA		
E1031	RB		GERIATRIC CHAIR	CMN	MSRP	
E1031	NU		GERIATRIC CHAIR	CMN		
E1031	RR		GERIATRIC CHAIR	CMN 1st claim only		
E1066	RB		BATTERY CHARGER	CMN		
E1161	RB		MANUAL ADULT WC W TILTINSPAC	CMN	MSRP	
E1161	RB	SC	MANUAL ADULT WC W TILTINSPAC	CMN	MSRP	
E1161	RR		MANUAL ADULT WC W TILTINSPAC	PA		
E1161	RR	SC	MANUAL ADULT WC W TILTINSPAC	PA		
E1161	NU		MANUAL ADULT WC W TILTINSPACE	PA		
E1161	NU	SC	MANUAL ADULT WC W TILTINSPACE	PA		
E1225	NU		MANUAL SEMI RECLINING BACK, RECLINE GREATER THAN 15	PA		
E1225	NU	SC	MANUAL SEMI RECLINING BACK RECLINE GREATER THAN 15	PA		
E1226	NU		MANUAL FULLY RECLINING BACK, RECLINE GREATER THAN 80	PA		
E1226	NU	SC	MANUAL FULLY RECLINING BACK RECLINE GREATER THAN 80	PA		
E1227	RB		SPECIAL HEIGHT ARMS FOR WHEELCHAIR	CMN		
E1227	RB	SC	SPECIAL HEIGHT ARMS FOR WHEELCHAIR	CMN		
E1227	NU		SPECIAL HEIGHT ARMS FOR WHEELCHAIR	CMN		
E1227	NU	SC	SPECIAL HEIGHT ARMS FOR WHEELCHAIR	PA		
E1228	RB		SPECIAL BACK HEIGHT FOR WHEELCHAIR	CMN		
E1228	RB	SC	SPECIAL BACK HEIGHT FOR WHEELCHAIR	CMN		
E1228	NU		SPECIAL BACK HEIGHT FOR WHEELCHAIR	CMN		
E1228	NU	SC	SPECIAL BACK HEIGHT FOR WHEELCHAIR	PA		
E1229	RB		PEDIATRIC WHEELCHAIR NOS	CMN	MSRP	
E1229	RB	SC	PEDIATRIC WHEELCHAIR NOS	CMN	MSRP	

Durable Medical Equipment



E1229	NU		NOS PEDIATRIC SIZE WHEELCHAIR	PA	MSRP	
E1229	NU	SC	NOS PEDIATRIC SIZE WHEELCHAIR	PA	MSRP	
E1229	RR		NOS PEDIATRIC SIZE WHEELCHAIR	PA	MSRP	
E1229	RR	SC	NOS PEDIATRIC SIZE WHEELCHAIR	PA	MSRP	
E1231	RB		RIGID PED W/C TILT-IN-SPACE	CMN	MSRP	
E1231	NU		RIGID PED W/C TILT-IN-SPACE	PA	MSRP	
E1232	RB		FOLDING PED WC TILT-IN-SPACE	CMN	MSRP	
E1232	RB	SC	FOLDING PED WC TILT-IN-SPACE	CMN	MSRP	
E1232	NU		FOLDING PED WC TILT-IN-SPACE	PA	MSRP	
E1232	NU	SC	FOLDING PED WC TILT-IN-SPACE	PA	MSRP	
E1233	RB		RIG PED WC TLTNPC W/O SEAT	CMN	MSRP	
E1233	RB	SC	RIG PED WC TLTNPC W/O SEAT	CMN	MSRP	
E1233	NU		RIG PED WC TLTNPC W/O SEAT	PA	MSRP	
E1233	NU	SC	RIG PED WC TLTNPC W/O SEAT	PA	MSRP	
E1234	RB		FLD PED WC TLTNPC W/O SEAT	CMN	MSRP	
E1234	RB	SC	FLD PED WC TLTNPC W/O SEAT	CMN	MSRP	
E1234	NU		FLD PED WC TLTNPC W/O SEAT	PA	MSRP	
E1234	NU	SC	FLD PED WC TLTNPC W/O SEAT	PA	MSRP	
E1235	RB		RIGID PED WC ADJUSTABLE	CMN	MSRP	
E1235	RB	SC	RIGID PED WC ADJUSTABLE	CMN	MSRP	
E1235	NU		RIGID PED WC ADJUSTABLE	PA	MSRP	
E1235	NU	SC	RIGID PED WC ADJUSTABLE	PA	MSRP	
E1236	RB		FOLDING PED WC ADJUSTABLE	CMN	MSRP	
E1236	RB	SC	FOLDING PED WC ADJUSTABLE	CMN	MSRP	
E1236	NU		FOLDING PED WC ADJUSTABLE	PA	MSRP	
E1236	NU	SC	FOLDING PED WC ADJUSTABLE	PA	MSRP	
E1236	RR		FOLDING PED WC ADJUSTABLE	PA	MSRP	
E1237	RB		RGD PED WC ADJSTABL W/O SEAT	CMN	MSRP	
E1237	RB	SC	RGD PED WC ADJSTABL W/O SEAT	CMN	MSRP	
E1237	NU		RGD PED WC ADJSTABL W/O SEAT	PA	MSRP	
E1237	NU	SC	RGD PED WC ADJSTABL W/O SEAT	PA	MSRP	
E1238	RB		FLD PED WC ADJSTABL W/O SEAT	CMN	MSRP	

Durable Medical Equipment



E1238	RB	SC	FLD PED WC ADJSTABL W/O SEAT	CMN	MSRP	
E1238	NU		FLD PED WC ADJSTABL W/O SEAT	PA	MSRP	
E1238	NU	SC	FLD PED WC ADJSTABL W/O SEAT	PA	MSRP	
E1239	RB		NOS PEDIATRIC SZ W/CH POWER	CMN	MSRP	
E1239	RB	SC	NOS PEDIATRIC SZ W/CH PWR	CMN	MSRP	
E1239	NU		NOS PEDIATRIC SZ W/CH POWER	PA	MSRP	
E1239	NU	SC	NOS PEDIATRIC SZ W/CH PWR	PA	MSRP	
E1239	RR		NOS PEDIATRIC SZ W/CH POWER	PA	MSRP	
E1239	RR	SC	NOS PEDIATRIC SZ W/CH PWR	PA	MSRP	
E1296	RB		SPECIAL WHEELCHAIR SEAT HEIGHT FROM FLOOR	PA		
E1296	RB	SC	SPECIAL WHEELCHAIR SEAT HEIGHT FROM FLOOR	PA		
E1296	NU		SPECIAL WHEELCHAIR SEAT HEIGHT FROM FLOOR	PA		
E1296	NU	SC	SPECIAL WHEELCHAIR SEAT HEIGHT FROM FLOOR	PA		
E1297	RB		SPECIAL WHEELCHAIR SEAT DEPTH, BY UPHOLSTERY	PA		
E1297	RB	SC	SPECIAL WHEELCHAIR SEAT DEPTH BY UPHOLSTERY	PA		
E1297	NU		SPECIAL WHEELCHAIR SEAT DEPTH, BY UPHOLSTERY	PA		
E1297	NU	SC	SPECIAL WHEELCHAIR SEAT DEPTH BY UPHOLSTERY	PA		
E1298	RB		SPECIAL WHEELCHAIR SEAT DEPTH AND/OR WIDTH, BY CONSTRUCTION	PA		
E1298	RB	SC	SPECIAL WHEELCHAIR SEAT DEPTH AND/OR WIDTH BY CONSTRUCTION	PA		
E1298	NU		SPECIAL WHEELCHAIR SEAT DEPTH AND/OR WIDTH, BY CONSTRUCTION	PA		
E1298	NU	SC	SPECIAL WHEELCHAIR SEAT DEPTH AND/OR WIDTH BY CONSTRUCTION	PA		
E1390	RR	QG	OXYGEN CONCENTRATOR, CAPABLE OF DEL 85% OR > OXYGEN CONCENTRATION; > 4 LPM;	PC		Continuous rental.
E1390	RR		OXYGEN CONCENTRATOR,CAPABLE OF DELIVERING 85 PERCENT OR GREATER OXYGEN CONCENTRATION AT THE PRESCRIB	PC		Continuous rental.
E1390	RR	QF	OXYGEN CONCENTRATOR, CAPABLE OF DEL 85% OR > OXYGEN CONCENTRATION; > 4LPM W/ PORTABLE OXYGEN PRESCRI	PC		Continuous rental.
E1800	RB		DYNAMIC ADJUSTABLE ELBOW EXTENSION/FLEXION DEVICE	CMN	IOC	
E1800	NU		DYNAMIC ADJUSTABLE ELBOW EXTENSION/FLEXION DEVICE	CMN		
E1801	NU		SPS ELBOW DEVICE	CMN		
E1805	RB		DYNAMIC ADJUSTABLE WRIST EXTENSION/FLEXION DEVICE	CMN	IOC	
E1805	NU		DYNAMIC ADJUSTABLE WRIST EXTENSION/FLEXION DEVICE	CMN		
E1806	NU		SPS WRIST DEVICE	CMN		

Durable Medical Equipment



E1810	RB		DYNAMIC ADJUSTABLE KNEE EXTENSION/FLEXION DEVICE	CMN	IOC	
E1810	NU		DYNAMIC ADJUSTABLE KNEE EXTENSION/FLEXION DEVICE	CMN		
E1811	NU		SPS KNEE DEVICE	CMN		
E1812	NU		DYNAMIC KNEE, EXTENSION/FLEXION DEVICE W/ACTIVE RESISTANCE CONTROL	CMN	IOC	
E1815	RB		DYNAMIC ADJUSTABLE ANKLE EXTENSION/FLEXION DEVICE	CMN	IOC	
E1815	NU		DYNAMIC ADJUSTABLE ANKLE EXTENSION/FLEXION DEVICE	CMN		
E1816	NU		SPS ANKLE DEVICE	CMN		
E1818	NU		SPS FOREARM DEVICE	CMN		
E1820	RB		SOFT INTERFACE MATERIAL, DYNAMIC ADJUSTABLE EXTENSION/FLEXION DEVICE	CMN	IOC	
E1820	NU		SOFT INTERFACE MATERIAL, DYNAMIC ADJUSTABLE EXTENSION/FLEXION DEVICE	CMN		
E1821	NU		REPLACEMENT SOFT INTERFACE MATERIAL/CUFFS FOR BI-DIRECTIONAL STATIC PROGRESSIVE STRETCH DEVICE	CMN		
E1825	RB		DYNAMIC ADJUSTABLE FINGER EXTENSION/FLEXION DEVICE	CMN	IOC	
E1825	NU		DYNAMIC ADJUSTABLE FINGER EXTENSION/FLEXION DEVICE	CMN		
E1830	RB		DYNAMIC ADJUSTABLE TOE EXTENSION/FLEXION DEVICE	CMN	IOC	
E1830	NU		DYNAMIC ADJUSTABLE TOE EXTENSION/FLEXION DEVICE	CMN		
E1831	NU		STATIC STR TOE DEV EXT/FLEX	CMN	IOC	
E1840	NU		DYNAMIC ADJUSTABLE SHOULDER FLEXION/ABDUCTION/ROTATION DEVICE, INCLUDES SOFT INTERFACE MATERIAL	CMN		
E1841	NU		STATIC STR SHLDR DEV ROM ADJ	PA	IOC	
E1902	RB		COMMUNICATION BOARD, NONELEC.	CMN	IOC	
E1902	NU		COMMUNICATION BOARD, NONELEC.	PC	IOC	
E1902	NU	NR	COMMUNICATION BOARD, NONELEC.	PC	IOC	
E1902	RR		COMMUNICATION BOARD, NONELEC.	PC	IOC	
E2201	RB		MAN W/C ACC SEAT W>20 <24	CMN		
E2201	RB	SC	MAN W/C ACC SEAT W>20 <24	CMN		
E2201	NU		MAN W/C ACC SEAT W>=20 <24	CMN		
E2201	NU	SC	MAN W/C ACC SEAT W>20 <24	PA		
E2202	RB		SEAT WIDTH 24-27 IN	CMN		
E2202	RB	SC	SEAT WIDTH 24-27 IN	CMN		

Durable Medical Equipment



E2202	NU		SEAT WIDTH 24-27 IN	CMN		
E2202	NU	SC	SEAT WIDTH 24-27 IN	PA		
E2203	RB		FRAME DEPTH LESS THAN 22 IN	CMN		
E2203	RB	SC	FRAME DEPTH LESS THAN 22 IN	CMN		
E2203	NU		FRAME DEPTH LESS THAN 22 IN	CMN		
E2203	NU	SC	FRAME DEPTH LESS THAN 22 IN	PA		
E2204	RB		FRAME DEPTH 22 TO 25 IN	CMN		
E2204	RB	SC	FRAME DEPTH 22 TO 25 IN	CMN		
E2204	NU		FRAME DEPT 22 TO 25 IN	CMN		
E2204	NU	SC	FRAME DEPTH 22 TO 25 IN	PA		
E2205	RB	SC	WC ACCESS HANDRIM W/O PROJECTIONS ANY TYPE REPLACEMENT	CMN		
E2205	RB		MANUAL WC ACCESSORY, HANDRIM	CMN		
E2206	RB		MAN WC WHL LOCK COMP REPL EA	CMN		
E2206	RB	SC	MAN WC WHL LOCK COMP REPL EA	CMN		
E2206	NU		MAN WC WHL LOCK COMP REPL EA	CMN		
E2207	RB		WHEELCHAIR ACCESSORY, CRUTCH AND CANE HOLDER; EACH	CMN		
E2207	RB	SC	WHEELCHAIR ACCESSORY, CRUTCH AND CANE HOLDER; EACH	CMN		
E2207	NU		MANUAL CHAIR ACCESS. CRUTH AND CANE HOLDER, EACH	CMN		
E2207	NU	SC	WHEELCHAIR ACCESSORY, CRUTCH AND CANE HOLDER; EACH	PA		
E2208	RB		WHEELCHAIR ACCESSORY, CYLINDER TANK CARRIER; EACH	CMN		
E2208	RB	SC	WHEELCHAIR ACCESSORY, CYLINDER TANK CARRIER; EACH	CMN		
E2208	NU		MANUAL CHAIR ACCESS. CYLINDER TANK CARRIER, EACH	CMN		
E2208	NU	SC	WHEELCHAIR ACCESSORY, CYLINDER TANK CARRIER; EACH	PA		
E2209	RB		WHEELCHAIR ACCESSORY, ARM TROUGH; EACH	CMN		
E2209	RB	SC	WHEELCHAIR ACCESSORY, ARM TROUGH; EACH	CMN		
E2209	NU		ACCESSORY, ARM TROUGH, WITH OR WITHOUT HAND SUPPORT, EACH	CMN		
E2209	NU	SC	WHEELCHAIR ACCESSORY, ARM TROUGH, EACH	PA		
E2210	RB		MANUAL CHAIR ACCESS. BEARINGS, ANY TYPE, REPLACEMENT ONLY, EACH	CMN		
E2210	RB	SC	WHEELCHAIR ACCESSORY, BEARINGS, ANY TYPE, REPLACEMENT ONLY; EACH	CMN		
E2211	RB		MANUAL WHEELCHAIR ACCESSORY, PNEUMATIC PROPULSION TIRE, ANY SIZE; EACH	CMN		
E2211	RB	SC	MANUAL WHEELCHAIR ACCESSORY, PNEUMATIC PROPULSION TIRE, ANY SIZE; EACH	CMN		

PRODUCTION : 04/09/2020

Durable Medical Equipment



E2211	NU		MANUAL CHAIR ACCESS., PNEUMATIC PROPULSION TIRE, ANY SIZE, EACH	CMN		
E2211	NU	SC	MANUAL WHEELCHAIR ACCESSORY, PNEUMATIC PROPULSION TIRE, ANY SIZE; EACH	PA		
E2212	RB		MANUAL WHEELCHAIR ACCESSORY, TUBE FOR PNEUMATIC PROPULSION TIRE, ANY SIZE; EACH	CMN		
E2212	RB	SC	MANUAL WHEELCHAIR ACCESSORY, TUBE FOR PNEUMATIC PROPULSION TIRE, ANY SIZE; EACH	CMN		
E2212	NU		MANUAL CHAIR ACCESS., TUBE FOR PNEUMATIC PROPULSION TIRE, ANY SIZE, EACH	CMN		
E2212	NU	SC	MANUAL WHEELCHAIR ACCESSORY, TUBE FOR PNEUMATIC PROPULSION TIRE, ANY SIZE; EACH	PA		
E2213	RB		MANUAL WHEELCHAIR ACCESSORY, INSERT FOR PNEUMATIC PROPULSION TIRE (REMOVABLE)	CMN		
E2213	RB	SC	MANUAL WHEELCHAIR ACCESSORY, INSERT FOR PNEUMATIC PROPULSION TIRE (REMOVABLE)	CMN		
E2213	NU		MANUAL CHAIR ACCESS., INSERT FOR PNEUMATIC PROPULSION TIRE, ANY SIZE, EACH	CMN		
E2213	NU	SC	MANUAL WHEELCHAIR ACCESSORY, INSERT FOR PNEUMATIC PROPULSION TIRE (REMOVABLE)	PA		
E2214	RB		MANUAL WHEELCHAIR ACCESSORY, PNEUMATIC CASTER TIRE, ANY SIZE; EACH	CMN		
E2214	RB	SC	MANUAL WHEELCHAIR ACCESSORY, PNEUMATIC CASTER TIRE, ANY SIZE; EACH	CMN		
E2214	NU		MANUAL CHAIR ACCESS. PNEUMATIC CASTER TIRE, ANY SIZE, EACH	CMN		
E2214	NU	SC	MANUAL WHEELCHAIR ACCESSORY, PNEUMATIC CASTER TIRE, ANY SIZE; EACH	PA		
E2215	RB		MANUAL WHEELCHAIR ACCESSORY, TUBE FOR PNEUMATIC CASTER TIRE, ANY SIZE; EACH	CMN		
E2215	RB	SC	MANUAL WHEELCHAIR ACCESSORY, TUBE FOR PNEUMATIC CASTER TIRE, ANY SIZE; EACH	CMN		
E2215	NU		MANUAL CHAIR ACCESS., TUBE FOR PNEUMATIC CASTER TIRE, ANY SIZE, EACH	CMN		
E2215	NU	SC	MANUAL WHEELCHAIR ACCESSORY, TUBE FOR PNEUMATIC CASTER TIRE, ANY SIZE; EACH	PA		

Durable Medical Equipment



E2216	RB		MANUAL WHEELCHAIR ACCESSORY, FOAM FILLED PROPULSION TIRE, ANY SIZE; EACH	CMN	MSRP	
E2216	RB	SC	MANUAL WHEELCHAIR ACCESSORY, FOAM FILLED PROPULSION TIRE, ANY SIZE; EACH	CMN	MSRP	
E2216	NU		MANUAL CHAIR ACCESS. FOAM FILLED PROPULSION TIRE, ANY SIZE, EACH	CMN	MSRP	
E2216	NU	SC	MANUAL WHEELCHAIR ACCESSORY, FOAM FILLED PROPULSION TIRE, ANY SIZE; EACH	PA	MSRP	
E2217	RB		MANUAL WHEELCHAIR ACCESSORY, FOAM FILLED CASTER TIRE, ANY SIZE; EACH	CMN	MSRP	
E2217	RB	SC	MANUAL WHEELCHAIR ACCESSORY, FOAM FILLED CASTER TIRE, ANY SIZE; EACH	CMN	MSRP	
E2217	NU		MANUAL CHAIR ACCESS., FOAM FILLED CASTER TIRE, ANY SIZE, EACH	CMN	MSRP	
E2217	NU	SC	MANUAL WHEELCHAIR ACCESSORY, FOAM FILLED CASTER TIRE, ANY SIZE; EACH	PA	MSRP	
E2218	RB		MANUAL WHEELCHAIR ACCESSORY, FOAM PROPULSION TIRE, ANY SIZE; EACH	CMN	MSRP	
E2218	RB	SC	MANUAL WHEELCHAIR ACCESSORY, FOAM PROPULSION TIRE, ANY SIZE; EACH	CMN	MSRP	
E2218	NU		MANUAL CHAIR ACCESS., FOAM PROPULSION TIRE, ANY SIZE, EACH	CMN	MSRP	
E2218	NU	SC	MANUAL WHEELCHAIR ACCESSORY, FOAM PROPULSION TIRE, ANY SIZE; EACH	PA	MSRP	
E2219	RB		MANUAL WHEELCHAIR ACCESSORY, FOAM CASTER TIRE, ANY SIZE; EACH	CMN		
E2219	RB	SC	MANUAL WHEELCHAIR ACCESSORY, FOAM CASTER TIRE, ANY SIZE; EACH	CMN		
E2219	NU		MANUAL CHAIR ACCESS., FOAM CASTER TIRE, ANY SIZE, EACH	CMN		
E2219	NU	SC	MANUAL WHEELCHAIR ACCESSORY, FOAM CASTER TIRE, ANY SIZE; EACH	PA		
E2220	RB		SOLID PROPULS TIRE, REPL, EA	CMN		
E2220	RB	SC	SOLID PROPULS TIRE, REPL, EA	CMN		
E2220	NU		SOLID PROPULS TIRE, REPL, EA	CMN		
E2220	NU	SC	SOLID PROPULS TIRE, REPL, EA	PA		
E2221	RB		SOLID CASTER TIRE REPL, EACH	CMN		
E2221	RB	SC	SOLID CASTER TIRE REPL, EACH	CMN		
E2221	NU		SOLID CASTER TIRE REPL, EACH	CMN		
E2221	NU	SC	SOLID CASTER TIRE REPL, EACH	PA		
E2222	RB		SOLID CASTER INTEG WHL, REPL	CMN		

PRODUCTION : 04/09/2020

Durable Medical Equipment



E2222	RB	SC	SOLID CASTER INTEG WHL, REPL	CMN		
E2222	NU		SOLID CASTER INTEG WHL, REPL	CMN		
E2222	NU	SC	SOLID CASTER INTEG WHL, REPL	PA		
E2224	RB		PROPULSION WHL EXCL TIRE REP	CMN		
E2224	RB	SC	PROPULSION WHL EXCL TIRE REP	CMN		
E2224	NU		PROPULSION WHL EXCL TIRE REP	CMN		
E2224	NU	SC	PROPULSION WHL EXCL TIRE REP	PA		
E2225	RB		MANUAL CHAIR ACCESS., CASTER WHEEL EXCLUDES TIRE, ANY SIZE, REPLACEMENT ONLY, EACH	CMN		
E2225	RB	SC	MANUAL WHEELCHAIR ACCESSORY, CASTER WHEEL EXCLUDES TIRE, ANY SIZE, REPLACEMENT ONLY	CMN		
E2226	RB		MANUAL CHAIR ACCESS., CASTER FORK, ANY SIZE, REPLACEMENT ONLY, EACH	CMN		
E2226	RB	SC	MANUAL WHEELCHAIR ACCESSORY, CASTER FORK, ANY SIZE, REPLACEMENT ONLY; EACH	CMN		
E2228	RB		MWC ACC, WHEELCHAIR BRAKE	CMN	MSRP	
E2228	RB	SC	MWC ACC, WHEELCHAIR BRAKE	CMN	MSRP	
E2228	NU		MWC ACC, WHEELCHAIR BRAKE	PA	MSRP	
E2228	NU	SC	MWC ACC, WHEELCHAIR BRAKE	PA	MSRP	
E2231	RB		MANUAL WHEELCHAIR ACCESSORY, SOLID SEAT SUPPORT BASE (REPLACES SLING SEAT),	CMN		
E2231	RB	SC	MANUAL WHEELCHAIR ACCESSORY, SOLID SEAT SUPPORT BASE (REPLACES SLING SEAT),	CMN		
E2231	NU		MANUAL WHEELCHAIR ACCESSORY, SOLID SEAT SUPPORT BASE (REPLACES SLING SEAT),	CMN		
E2231	NU	SC	MANUAL WHEELCHAIR ACCESSORY, SOLID SEAT SUPPORT BASE (REPLACES SLING SEAT),	PA		
E2291	RB		BACK PLANAR FOR PED W/C INCLUDING FXD ATTACH HARDWARE	CMN	MSRP	
E2291	RB	SC	BACK PLANAR FOR PED W/C INCLUDING FXD ATTACH HARDWARE	CMN	MSRP	
E2291	NU		BACK PLANAR, FOR Ped. W/C INCLUDING FXD ATTACH HARDWARE	PA	MSRP	
E2291	NU	SC	BACK PLANAR FOR PED W/C INCLUDING FXD ATTACH HARDWARE	PA	MSRP	
E2292	RB		SEAT PLANAR PED SZ W/C INCLUDES FXD ATTACH HARDWARE	CMN	MSRP	
E2292	RB	SC	SEAT PLANAR PED SZ W/C INCLUDES FXD ATTACH HARDWARE	CMN	MSRP	

PRODUCTION : 04/09/2020

Durable Medical Equipment



E2292	NU		SEAT, PLANAR, PED SZ, W/C INCLUDES FXD ATTACHING HARDWARE	PA	MSRP	
E2292	NU	SC	SEAT PLANAR PED SZ W/C INCLUDES FXD ATTACH HARDWARE	PA	MSRP	
E2293	RB		PED SZ W/C BACK CONTOURED FXD ATTACHING	CMN	MSRP	
E2293	RB	SC	PED SZ W/C BACK CONTOURED FXD ATTACHING	CMN	MSRP	
E2293	NU		PED SZ W/C BACK CONTOURED FIXED ATTACHING	PA	MSRP	
E2293	NU	SC	PED SZ W/C BACK CONTOURED FXD ATTACHING	PA	MSRP	
E2294	RB		SEAT CONTOURED PED SZ WC INCLUDING FXD ATTACHING	CMN	MSRP	
E2294	RB	SC	SEAT CONTOURED PED SZ WC INCLUDING FXD ATTACHING	CMN	MSRP	
E2294	NU		SEAT CONTOURED PED SZ, W.C INCLUDING FXD ATTACHINIG	PA	MSRP	
E2294	NU	SC	SEAT CONTOURED PED SZ WC INCLUDING FXD ATTACHING	PA	MSRP	
E2295	RB		MANUAL WHEELCHAIR ACCESSORY, FOR PEDIATRIC SIZE WHEELCHAIR, DYNAMIC SEATING	CMN	MSRP	
E2295	NU		MANUAL WHEELCHAIR ACCESSORY, FOR PEDIATRIC SIZE WHEELCHAIR, DYNAMIC SEATING	PA	MSRP	
E2310	RB		ELECTRO CONNECT BTW CONTROL	CMN		
E2310	RB	SC	ELECTRO CONNECT BTW CONTROL	CMN		
E2310	NU		ELECTRO CONNECT BTW CONTROL	PA		
E2310	NU	SC	ELECTRO CONNECT BTW CONTROL	PA		
E2311	RB		ELECTRO CONNECT BTW 2 SYS	CMN		
E2311	RB	SC	ELECTRO CONNECT BTW 2 SYS	CMN		
E2311	NU		ELECTRO CONNECT BTW 2 SYS	PA		
E2311	NU	SC	ELECTRO CONNECT BTW 2 SYS	PA		
E2312	RB		MINI-PROP REMOTE JOYSTICK	CMN		
E2312	RB	SC	MINI-PROP REMOTE JOYSTICK	CMN		
E2312	NU		MINI-PROP REMOTE JOYSTICK	PA		
E2312	NU	SC	MINI-PROP REMOTE JOYSTICK	PA		
E2313	RB		PWC HARNESS, EXPAND CONTROLLER	CMN		
E2313	RB	SC	PWC HARNESS, EXPAND CONTROLLER	CMN		
E2313	NU		PWC HARNESS, EXPAND CONTROL	PA		
E2313	NU	SC	PWC HARNESS, EXPAND CONTROLLER	PA		
E2321	RB		HAND INTERFACE JOYSTICK	CMN		
E2321	RB	SC	HAND INTERFACE JOYSTICK	CMN		
E2321	NU		HAND INTERFACE JOYSTICK	PA		

PRODUCTION : 04/09/2020

Durable Medical Equipment



E2321	NU	SC	HAND INTERFACE JOYSTICK	PA		
E2322	RB		MULT MECH SWITCHES	CMN		
E2322	RB	SC	MULT MECH SWITCHES	CMN		
E2322	NU		MULT MECH SWITCHES	PA		
E2322	NU	SC	MULT MECH SWITCHES	PA		
E2323	RB		SPECIAL JOYSTICK HANDLE	CMN		
E2323	RB	SC	SPECIAL JOYSTICK HANDLE	CMN		
E2323	NU		SPECIAL JOYSTICK HANDLE	CMN		
E2323	NU	SC	SPECIAL JOYSTICK HANDLE	PA		
E2324	RB		CHIN CUP INTERFACE	CMN		
E2324	NU		CHIN CUP INTERFACE	CMN		
E2324	RB	SC	CHIN CUP INTERFACE	PA		
E2324	NU	SC	CHIN CUP INTERFACE	PA		
E2325	RB		SIP AND PUFF INTERFACE	CMN		
E2325	RB	SC	SIP AND PUFF INTERFACE	CMN		
E2325	NU		SIP AND PUFF INTERFACE	PA		
E2325	NU	SC	SIP AND PUFF INTERFACE	PA		
E2326	RB		BREATH TUBE KIT	CMN		
E2326	RB	SC	BREATH TUBE KIT	CMN		
E2326	NU		BREATH TUBE KIT	CMN		
E2326	NU	SC	BREATH TUBE KIT	PA		
E2327	RB		HEAD CONTROL INTERFACE MECH	CMN		
E2327	RB	SC	HEAD CONTROL INTERFACE MECH	CMN		
E2327	NU		HEAD CONTROL INTERFACE MECH	PA		
E2327	NU	SC	HEAD CONTROL INTERFACE MECH	PA		
E2328	RB		HEAD EXTREMITY CONTROL INTER	CMN		
E2328	RB	SC	HEAD EXTREMITY CONTROL INTER	CMN		
E2328	NU		HEAD EXTREMITY CONTROL INTER	PA		
E2328	NU	SC	HEAD EXTREMITY CONTROL INTER	PA		
E2329	RB		HEAD CONTROL NONPROPORTIONAL	CMN		
E2329	RB	SC	HEAD CONTROL NONPROPORTIONAL	CMN		
E2329	NU		HEAD CONTROL NONPROPORTIONAL	PA		

Durable Medical Equipment



E2329	NU	SC	HEAD CONTROL NONPROPORTIONAL	PA		
E2330	RB		HEAD CONTROL PROXIMITY SWITCH	CMN		
E2330	RB	SC	HEAD CONTROL PROXIMITY SWITCH	CMN		
E2330	NU		HEAD CONTROL PROXIMITY SWITCH	PA		
E2330	NU	SC	HEAD CONTROL PROXIMITY SWITCH	PA		
E2331	RB		ATTENDANT CONTROL	PA	MSRP	
E2331	RB	SC	ATTENDANT CONTROL	PA	MSRP	
E2331	NU		ATTENDANT CONTROL	PA	MSRP	
E2331	NU	SC	ATTENDANT CONTROL	PA	MSRP	
E2340	RB		W/C WIDTH 20-23 IN SEAT FRAME	PA		
E2340	RB	SC	W/C WIDTH 20-23 IN SEAT FRAME	PA		
E2340	NU		W/C WIDTH 20-23 IN SEAT FRAME	PA		
E2340	NU	SC	W/C WIDTH 20-23 IN SEAT FRAME	PA		
E2341	RB		W/C WIDTH 24-27 IN SEAT FRAME	PA		
E2341	RB	SC	W/C WIDTH 24-27 IN SEAT FRAME	PA		
E2341	NU		W/C WIDTH 24-27 IN SEAT FRAME	PA		
E2341	NU	SC	W/C WIDTH 24-27 IN SEAT FRAME	PA		
E2342	RB		W/C DEPTH 20-21 IN SEAT FRAME	PA		
E2342	RB	SC	W/C DEPTH 20-21 IN SEAT FRAME	PA		
E2342	NU		W/C DEPTH 20-21 IN SEAT FRAME	PA		
E2342	NU	SC	W/C DEPTH 20-21 IN SEAT FRAME	PA		
E2343	RB		W/C DEPTH 22-25 IN SEAT FRAME	PA		
E2343	RB	SC	W/C DEPTH 22-25 IN SEAT FRAME	PA		
E2343	NU		W/C DEPTH 22-25 IN SEAT FRAME	PA		
E2343	NU	SC	W/C DEPTH 22-25 IN SEAT FRAME	PA		
E2351	RB		ELECTRONIC SGD INTERFACE	CMN		
E2351	RB	SC	ELECTRONIC SGD INTERFACE	CMN		
E2351	NU		ELECTRONIC SGD INTERFACE	PA		
E2351	NU	SC	ELECTRONIC SGD INTERFACE	PA		
E2359	RB		GR34 SEALED LEADACID BATTERY	MNF		
E2359	RB	SC	GR34 SEALED LEADACID BATTERY	MNF		
E2359	NU		GR34 SEALED LEADACID BATTERY	MNF		

Durable Medical Equipment



E2359	NU	SC	GR34 SEALED LEADACID BATTERY	PA		
E2360	NU		22 NF NON-SEALED LEAD ACID BATTERY, EACH			
E2360	RB		22 NF NON-SEALED ACID BATTERY; EACH	MNF		
E2360	RB	SC	22 NF NON-SEALED ACID BATTERY; EACH	MNF		
E2360	NU	SC	22 NF NON-SEALED ACID BATTERY; EACH	PA		
E2361	NU		22 NF SEALED LEAD ACID BATTERY, EACH			
E2361	RB		22 NF SEALED LEAD ACID BATTERY; EACH	MNF		
E2361	RB	SC	22 NF SEALED LEAD ACID BATTERY; EACH	MNF		
E2361	NU	SC	22 NF SEALED LEAD ACID BATTERY; EACH	PA		
E2362	NU		GROUP 24NON-SEALED LEAD ACID BATTERY EACH			
E2362	RB		GROUP 24 NON-SEALED LEAD ACID BATTERY; EACH	MNF		
E2362	RB	SC	GROUP 24 NON-SEALED LEAD ACID BATTERY; EACH	MNF		
E2362	NU	SC	GROUP 24 NON-SEALED LEAD ACID BATTERY; EACH	PA		
E2363	NU		GROUP 24 SEALED LEAD ACID BATTERY, EACH			
E2363	RB		GROUP 24 SEALED LEAD ACID BATTERY; EACH	MNF		
E2363	RB	SC	GROUP 24 SEALED LEAD ACID BATTERY; EACH	MNF		
E2363	NU	SC	GROUP 24 SEALED LEAD ACID BATTERY; EACH	PA		
E2364	NU		U-1 NON-SEALED LEAD ACID BATTERY			
E2364	RB		U-1 NON-SEALED LEAD ACID BATTERY	MNF		
E2364	RB	SC	U-1 NON-SEALED LEAD ACID BATTERY	MNF		
E2364	NU	SC	U-1 NON-SEALED LEAD ACID BATTERY	PA		
E2365	NU		U-1 SEALED LEAD ACID BATTERY EACH			
E2365	RB		U-1 SEALED LEAD ACID BATTERY; EACH	MNF		
E2365	RB	SC	U-1 SEALED LEAD ACID BATTERY; EACH	MNF		
E2365	NU	SC	U-1 SEALED LEAD ACID BATTERY; EACH	PA		
E2366	NU		BATTERY CHARGER SINGLE MODE			
E2366	RB		BATTERY CHARGER SINGLE MODE	MNF		
E2366	RB	SC	BATTERY CHARGER SINGLE MODE	MNF		
E2367	RB		BATTERY CHARGER DUAL MODE	MNF		
E2367	RB	SC	BATTERY CHARGER DUAL MODE	MNF		
E2368	RB		PWR WC DRIVEWHEEL MOTOR REPL	CMN		
E2368	RB	SC	PWR WC DRIVEWHEEL MOTOR REPL	CMN		

Durable Medical Equipment



E2369	RB		PWR WC DRIVEWHEEL GEAR REPL	CMN		
E2369	RB	SC	PWR WC DRIVEWHEEL GEAR REPL	CMN		
E2370	RB		PWR WC DR WH MOTOR/GEAR COMB	CMN		
E2370	RB	SC	PWR WC DR WH MOTOR/GEAR COMB	CMN		
E2371	RB		PWR W/C ACCESSORY, GROUP 27 SEALED LEAD ACID BATTERY (E.G. GELL CELL, ABSORBED GLASSMAT)	CMN		
E2371	RB	SC	PWR W/C ACCESSORY, GROUP 27 SEALED LEAD ACID BATTERY (E.G. GELL CELL, ABSORBED GLASSMAT)	CMN		
E2371	NU		POWER CHAIR ACCESS., GROUP 27 SEALED LEAD ACID BATTERY, (E.G. GEL), EACH	CMN		
E2371	NU	SC	PWR W/C ACCESSORY, GROUP 27 SEALED LEAD ACID BATTERY (E.G. GELL CELL, ABSORBED GLASSMAT)	PA		
E2372	RB		PWR W/C ACCESSORY, GROUP 27 NON-SEALED LEAD ACID BATTERY; EACH	CMN	MSRP	
E2372	RB	SC	PWR W/C ACCESSORY, GROUP 27 NON-SEALED LEAD ACID BATTERY; EACH	CMN	MSRP	
E2372	NU		POWER CHAIR ACCESS., GROUP 27 NON-SEALED LEAD ACID BATTERY, EACH	CMN	MSRP	
E2372	NU	SC	PWR W/C ACCESSORY, GROUP 27 NON-SEALED LEAD ACID BATTERY; EACH	PA	MSRP	
E2373	NU		HAND/CHIN CTRL SPEC JOYSTICK	CMN		
E2373	RB		HAND CHIN CONTROL	CMN		
E2373	RB	SC	HAND CHIN CONTROL	CMN		
E2373	NU	SC	HAND CHIN CONTROL	PA		
E2374	RB		POWER WHEELCHAIR ACCESSORY, HAND OR CHIN CONTROL INTERFACE, STANDARD REMOTE JOYSTICK (NOT INCLUDING	CMN		
E2374	RB	SC	HAND CHIN CONTROL	CMN		
E2375	RB		POWER WHEELCHAIR ACCESSORY, NON-EXPANDABLE CONTROLLER, INCLUDING ALL RELATED ELECTRONICS AND MOUNTIN	CMN		
E2375	RB	SC	PWC ACCESSORY, NON-EXPANDABLE CONTROLLER	CMN		
E2376	RB		POWER WHEELCHAIR ACCESSORY, EXPANDABLE CONTROLLER, INCLUDING ALL RELATED ELECTRONICS AND MOUNTING HA	CMN		
E2376	RB	SC	PWC ACCESSORY, EXPANDABLE CONTROLLER	CMN		
E2377	RB		PWC ACCESSORY, EXPANDABLE CONTROLLER	CMN		
E2377	RB	SC	PWC ACCESSORY, EXPANDABLE CONTROLLER	PA		
E2377	NU		POWER WHEELCHAIR ACCESSORY, EXPANDABLE CONTROLLER, INCLUDING ALL RELATED ELECTRONICS AND MOUNTING HA	PA		

Durable Medical Equipment



E2377	NU	SC	PWC ACCESSORY, EXPANDABLE CONTROLLER	PA		
E2378	RB		PW ACTUATOR REPLACEMENT	PA	MSRP	
E2378	RB	SC	PW ACTUATOR REPLACEMENT	PA	MSRP	
E2381	RB		POWER WHEELCHAIR ACCESSORY, PNEUMATIC DRIVE WHEEL TIRE, ANY SIZE, REPLACEMENT ONLY, EACH	CMN		
E2381	RB	SC	PWC ACCESSORY, PNEUMATIC DRIVE WHEEL TIRE, ANY SIZE, REPLACEMENT ONLY; EACH	CMN		
E2382	RB		POWER WHEELCHAIR ACCESSORY, TUBE FOR PNEUMATIC DRIVE WHEEL TIRE, ANY SIZE, REPLACEMENT ONLY, EACH	CMN		
E2382	RB	SC	TUBE FOR PNEUMATIC TIRE WHEEL, ANY SIZE, REPLACEMENT ONLY	CMN		
E2383	RB		POWER WHEELCHAIR ACCESSORY, INSERT FOR PNEUMATIC DRIVE WHEEL TIRE (REMOVABLE), ANY TYPE, ANY SIZE, R	CMN		
E2383	RB	SC	INSERT FOR PNEUMATIC TIRE WHEEL (REMOVABLE)	CMN		
E2384	RB		POWER WHEELCHAIR ACCESSORY, PNEUMATIC CASTER TIRE, ANY SIZE, REPLACEMENT ONLY, EACH	CMN		
E2384	RB	SC	PNEUMATIC CASTER TIRE	CMN		
E2385	RB		POWER WHEELCHAIR ACCESSORY, TUBE FOR PNEUMATIC CASTER TIRE, ANY SIZE, REPLACEMENT ONLY, EACH	CMN		
E2385	RB	SC	TUBE FOR PNEUMATIC CASTER TIRE	CMN		
E2386	RB		POWER WHEELCHAIR ACCESSORY, FOAM FILLED DRIVE WHEEL TIRE, ANY SIZE, REPLACEMENT ONLY, EACH	CMN		
E2386	RB	SC	FOAM FILLED DRIVE WHEEL TIRE	CMN		
E2387	RB		POWER WHEELCHAIR ACCESSORY, FOAM FILLED CASTER TIRE, ANY SIZE, REPLACEMENT ONLY, EACH	CMN		
E2387	RB	SC	FOAM FILLED CASTER TIRE	CMN		
E2388	RB		POWER WHEELCHAIR ACCESSORY, FOAM DRIVE WHEEL TIRE, ANY SIZE, REPLACEMENT ONLY, EACH	CMN	IOC	
E2388	RB	SC	FOAM DRIVE WHEEL TIRE	CMN		
E2389	RB		POWER WHEELCHAIR ACCESSORY, FOAM CASTER TIRE, ANY SIZE, REPLACEMENT ONLY, EACH	CMN	IOC	
E2389	RB	SC	FOAM CASTER TIRE	CMN		
E2390	RB		POWER WHEELCHAIR ACCESSORY, SOLID (RUBBER/PLASTIC) DRIVE WHEEL TIRE, ANY SIZE, REPLACEMENT ONLY, EAC	CMN	IOC	

Durable Medical Equipment



E2390	RB	SC	SOLID (RUBBER/PLASTIC) DRIVE WHEEL TIRE	CMN		
E2391	RB		POWER WHEELCHAIR ACCESSORY, SOLID (RUBBER/PLASTIC) CASTER TIRE (REMOVABLE), ANY SIZE, REPLACEMENT ON	CMN		
E2391	RB	SC	SOLID (RUBBER/PLASTIC) CASTER TIRE	CMN		
E2392	RB		POWER WHEELCHAIR ACCESSORY, SOLID (RUBBER/PLASTIC) CASTER TIRE WITH INTEGRATED WHEEL, ANY SIZE, REPL	CMN		
E2392	RB	SC	SOLID (RUBBER/PLASTIC) CASTER TIRE WITH INTEGRATED WHEEL	CMN		
E2394	RB		POWER WHEELCHAIR ACCESSORY, DRIVE WHEEL EXCLUDES TIRE, ANY SIZE, REPLACEMENT ONLY, EACH	CMN		
E2394	RB	SC	DRIVE WHEEL EXCLUDES TIRE	CMN		
E2395	RB		POWER WHEELCHAIR ACCESSORY, CASTER WHEEL EXCLUDES TIRE, ANY SIZE, REPLACEMENT ONLY, EACH	CMN		
E2395	RB	SC	CASTER WHEEL EXLUDES TIRE	CMN		
E2396	RB		POWER WHEELCHAIR ACCESSORY, CASTER FORK, ANY SIZE, REPLACEMENT ONLY, EACH	CMN		
E2396	RB	SC	CASTER WITH A FORK	CMN		
E2397	RB		PWC ACCESSORY, LITHIUM BASED BATTERY; EACH	IOC	MSRP	
E2397	RB	SC	PWC ACCESSORY, LITHIUM BASED BATTERY; EACY	IOC	MSRP	
E2397	NU		PWC ACC, LITH-BASED BATTERY	IOC	MSRP	
E2397	NU	SC	PWC ACCESSORY, LITHIUM BASED BATTERY; EACH	PA	MSRP	
E2398	NU		WC DYNAMIC POS BACK HARDWARE	PA	MSRP	
E2398	NU	SC	WC DYNAMIC POS BACK HARDWARE	PA	MSRP	
E2398	RB		WC DYNAMIC POS BACK HARDWARE	PA	MSRP	
E2398	RB	SC	WC DYNAMIC POS BACK HARDWARE	PA	MSRP	
E2398	RR		WC DYNAMIC POS BACK HARDWARE	PA	MSRP	
E2398	RR		WC DYNAMIC POS BACK HARDWARE	PA	MSRP	
E2500	RB		SPCH GEN. DEVICE DIGITIZED SPCH PRERECORD <=8 min	CMN	MSRP	
E2500	RR		SPCH GEN. DEVICE DIGITIZED SPCH PRERECORD <=8 min	PC, Aug Com Eval	MSRP	
E2500	NU	NR	SPCH GEN. DEVICE DIGITIZED SPCH PRERECORD <=8 MIN	PC, Aug Com Eval	MSRP	
E2500	NU		SPCH GEN. DEVICE DIGITIZED SPCH PRERECORD <=8 min	PC, Aug Com Eval	MSRP	

PRODUCTION : 04/09/2020



E2502	RB		SPCH GEN DEVICE DIGITIZED SPCH PRERECORDED >8min<=20min	CMN	MSRP	
E2502	RR		SPCH GEN DEVICE DIGITIZED SPCH PRERECORDED >8min<=20min	PC, Aug Com Eval		
E2502	NU	NR	SPCH GEN DEVICE DIGITIZED SPCH PREECORDED >8MIN<= 20 MIN	PC, Aug Com Eval		
E2502	NU		SPCH GEN DEVICE DIGITIZED SPCH PRERECORDED >8min<=20min	PC, Aug Com Eval		
E2504	RB		SPCH GEN DEVICE DIGITIZED SPCH PRERECORDED >20min<=40min	CMN	MSRP	
E2504	RR		SPCH GEN DEVICE DIGITIZED SPCH PRERECORDED >20min<=40min	PC, Aug Com Eval		
E2504	NU	NR	SPCH GEN DEVICE DIGITIZED SPCH PRERECORDED >20MIN<=40 MIN	PC, Aug Com Eval		
E2504	NU		SPCH GEN DEVICE DIGITIZED SPCH PRERECORDED >20min<=40min	PC, Aug Com Eval		
E2506	RB		SPCH GEN DEVICE DIGITIZED SPCH PRERECORDED >40min	CMN	MSRP	
E2506	NU		SPCH GEN DEVICE DIGITIZED SPCH PRERECORDED >40min	PC, Aug Com Eval	MSRP	
E2506	NU	NR	SPCH GEN DEVICE DIGITIZED SPCH PRERECORDED >40MIN	PC, Aug Com Eval	MSRP	
E2506	RR		SPCH GEN DEVICE DIGITIZED SPCH PRERECORDED >40min	PC, Aug Com Eval	MSRP	
E2508	RB		SPCH GEN DEVICE SYNTHESIZED SPCH SPELLING PHYS. CONTACT	CMN		
E2508	NU		SPCH GEN DEVICE SYNTHESIZED SPCH SPELLING PHYS. CONTACT	PC, Aug Com Eval	MSRP	
E2508	NU	NR	SPCH GEN DEVICE SYNTHESIZED SPCH SPELLING PHYS. CONTACT	PC, Aug Com Eval	MSRP	
E2508	RR		SPCH GEN DEVICE SYNTHESIZED SPCH SPELLING PHYS. CONTACT	PC, Aug Com Eval	MSRP	
E2510	RB		SPCH GEN DEVICE SYNTHESIZED SPCH PERMIT W MULTI METHODS MSG/ACCS	CMN		
E2510	NU		SPCH GEN DEVICE SYNTHESIZED SPCH PERMIT W MULTI METHODS MSG/ACCS	PC, Aug Com Eval	MSRP	
E2510	NU	NR	SPCH GEN DEVICE SYNTHESIZED SPCH PERMIT W MULTI METHODS MSG/ACCS	PC, Aug Com Eval	MSRP	

Durable Medical Equipment



E2510	RR		SPCH GEN DEVICE SYNTHESIZED SPCH PERMIT W MULTI METHODS MSG/ACCS	PC, Aug Com Eval	MSRP	
E2511	RB		SPCH GEN SOFTWARE PROGRAM FOR PC/PDA	CMN		
E2511	NU		SPCH GEN SOFTWARE PROGRAM FOR PC/PDA	PC, Aug Com Eval	MSRP	
E2511	RR		SPCH GEN SOFTWARE PROGRAM FOR PC/PDA	PC, Aug Com Eval	MSRP	
E2512	RB		ACCESSORY FOR SPEECH GENERATING DEVICE, MOUNTING SYSTEM	CMN		
E2512	NU		ACCESSORY FOR SPEECH GENERATING DEVICE, MOUNTING SYSTEM	PC, Aug Com Eval	MSRP	
E2512	RR		ACCESSORY FOR SPEECH GENERATING DEVICE, MOUNTING SYSTEM	PC, Aug Com Eval	MSRP	
E2599	RB		ACCESSORY FOR SPEECH GENERATING DEVICE, NOT OTHERWISE CLASSIFIED	CMN		
E2599	NU		ACCESSORY FOR SPEECH GENERATING DEVICE, NOT OTHERWISE CLASSIFIED	PC, Aug Com Eval	MSRP	
E2599	RR		ACCESSORY FOR SPEECH GENERATING DEVICE, NOT OTHERWISE CLASSIFIED	PC, Aug Com Eval	MSRP	
E2601	RB		WHEELCHAIR SEAT CUSHION WIDTH LESS THAN 22 IN ANY DEPTH	CMN		
E2601	RB	SC	WHEELCHAIR SEAT CUSHION WIDTH LESS THAN 22 IN ANY DEPTH	CMN		
E2601	NU		WHEELCHAIR SEAT CUSHION WIDTH LESS THAN 22 IN. ANY DEPTH	CMN		
E2601	NU	SC	WHEELCHAIR SEAT CUSHION WIDTH LESS THAN 22 IN ANY DEPTH	PA		
E2602	RB		WHEELCHAIR SEAT CUSHION WIDTH 22 IN OR GREAT ANY DEPTH	CNN		
E2602	RB	SC	WHEELCHAIR SEAT CUSHION WIDTH 22 IN OR GREAT ANY DEPTH	CMN		
E2602	NU		WHEELCHAIR SEAT CUSHION WIDTH 22 INCHES OR GREATER ANY DEPTH	CMN		
E2602	NU	SC	WHEELCHAIR SEAT CUSHION WIDTH 22 IN OR GREAT ANY DEPTH	PA		
E2603	RB		WHEELCHAIR SEAT CUSHION SKIN PROTECTION WIDTH LESS THAN 22 IN ANY DEPTH	CMN		
E2603	RB	SC	WHEELCHAIR SEAT CUSHION SKIN PROTECTION WIDTH LESS THAN 22 IN ANY DEPTH	CMN		
E2603	NU		WHEELCHAIR SEAT CUSHION, SKIN PROTECTION, WIDTH LESS THAN 22 IN. ANY DEPTH.	PA		

Durable Medical Equipment



E2603	NU	SC	WHEELCHAIR SEAT CUSHION SKIN PROTECTION WIDTH LESS THAN 22 IN ANY DEPTH	PA		
E2604	RB		WHEELCHAIR SEAT CUSHION SKIN PROTECTION WIDTH 22 IN	CMN		
E2604	RB	SC	WHEELCHAIR SEAT CUSHION SKIN PROTECTION WIDTH 22 IN	CMN		
E2604	NU		WHEELCHAIR SEAT CUSHION SKIN PROTECT WIDTH 22 IN.	PA		
E2604	NU	SC	WHEELCHAIR SEAT CUSHION SKIN PROTECTION WIDTH 22 IN	PA		
E2605	RB		SEAT CUSHION POSITIONING WIDTH LESS THAN 22 IN ANY DEPTH	CMN		
E2605	RB	SC	SEAT CUSHION POSITIONING WIDTH LESS THAN 22 IN ANY DEPTH	CMN		
E2605	NU		SEAT CUSHION POSITIONING WIDTH LESS THAN 22 INCHES, ANY DEPTH	PA		
E2605	NU	SC	SEAT CUSHION POSITIONING WIDTH LESS THAN 22 IN ANY DEPTH	PA		
E2606	RB		SEAT CUSHION WIDTH 22 IN OR GREATER ANY DEPTH	CMN		
E2606	RB	SC	SEAT CUSHION WIDTH 22 IN OR GREATER ANY DEPTH	CMN		
E2606	NU	SC	SEAT CUSHION WIDTH 22 IN OR GREATER ANY DEPTH	PA		
E2606	NU		SEAT CHUSHION, WIDTH 22 INCHES OR GREATER, ANY DEPTH	PA		
E2607	RB		SKIN PROTECTION & POSITIONING SEAT CUSHION WIDTH LESS THAN 22	CMN		
E2607	RB	SC	SKIN PROTECTION & POSITIONING SEAT CUSHION WIDTH LESS THAN 23	CMN		
E2607	NU		SKIN PROTECTION & POSITIONING SEAT CUSHION, WIDTH LESS THAN 22	PA		
E2607	NU	SC	SKIN PROTECTION & POSITIONING SEAT CUSHION WIDTH LESS THAN 22	PA		
E2608	RB		SKIN PROTECTION & POSITIONING SEAT CUSHION WIDTH 22 IN	CMN		
E2608	RB	SC	SKIN PROTECTION & POSITIONING SEAT CUSHION WIDTH 22 IN	CMN		
E2608	NU		SKIN PROTECTION AND POSITIONING SEAT CUSHION, WIDTH 22 INCHES	PA		
E2608	NU	SC	SKIN PROTECTION & POSITIONING SEAT CUSHION WIDTH 22 IN	PA		
E2609	RB		CUSTOM FABRICATED SEAT CUSHION ANY SIZE	PA	MSRP	
E2609	RB	SC	CUSTOM FABRICATED SEAT CUSHION ANY SIZE	PA	MSRP	
E2609	NU		CUSTOM FABRICATED SEAT CUSHION, ANY SIZE	PA	MSRP	
E2609	NU	SC	CUSTOM FABRICATED SEAT CUSHION ANY SIZE	PA	MSRP	
E2611	RB		BACK CUSHION WIDTH LESS THAN 22 IN ANY HEIGHT	CMN		
E2611	RB	SC	BACK CUSHION WIDTH LESS THAN 22 IN ANY HEIGHT	CNN		
E2611	NU		BACK CUSHION, WIDTH LESS THAN 22 INCHES, ANY HEIGHT	CMN		
E2611	NU	SC	BACK CUSHION WIDTH LESS THAN 22 IN ANY HEIGHT	PA		
E2612	RB		BACK CUSHION WIDTH 22 IN OR GREATER ANY HEIGHT	CMN		
E2612	RB	SC	BACK CUSHION WIDTH 22 IN OR GREATER ANY HEIGHT	CMN		

Durable Medical Equipment



E2612	NU		BACK CUSHION, WIDTH 22 INCHES OR GREATER, ANY HEIGHT	CMN		
E2612	NU	SC	BACK CUSHION WIDTH 22 IN OR GREATER ANY HEIGHT	PA		
E2613	RB		BACK CUSHION POSTERIOR WIDTH LESS THAN 22 IN	CMN		
E2613	RB	SC	BACK CUSHION POSTERIOR WIDTH LESS THAN 22 IN	CMN		
E2613	NU		BACK CUSHION, POSTERIOR, WIDTH LESS THAN 22 INCHES	PA		
E2613	NU	SC	BACK CUSHION POSTERIOR WIDTH LESS THAN 22 IN	PA		
E2614	RB		BACK CUSHION POSTERIOR WIDTH 22 IN OR GREATER	CMN		
E2614	RB	SC	BACK CUSHION POSTERIOR WIDTH 22 IN OR GREATER	CMN		
E2614	NU		BACK CUSHION, POSTERIOR, WIDTH 22 INCHES OR GREATER	PA		
E2614	NU	SC	BACK CUSHION POSTERIOR WIDTH 22 IN OR GREATER	PA		
E2615	RB		BACK CUSHION POSTERIOR-LATERAL WIDTH LESS THAN 22 IN	CMN		
E2615	RB	SC	BACK CUSHION POSTERIOR-LATERAL WIDTH LESS THAN 22 IN	CMN		
E2615	NU		BACK CUSHION, POSTERIOR-LATERAL WIDTH LESS THAN 22 INCHES	PA		
E2615	NU	SC	BACK CUSHION POSTERIOR-LATERAL WIDTH LESS THAN 22 IN	PA		
E2616	RB		BACK CUSHION POSTERIOR-LATERAL WIDTH 22 IN	CMN		
E2616	RB	SC	BACK CUSHION POSTERIOR-LATERAL WIDTH 22 IN	CMN		
E2616	NU		BACK CUSHION POSTERIOR-LATERAL, WIDTH 22 INCHES	PA		
E2616	NU	SC	BACK CUSHION POSTERIOR-LATERAL WIDTH 22 IN	PA		
E2617	RB		CUSTOM FABRICATED BACK CUSHION ANY SIZE INCLUDING ANY TYPE	PA	MSRP	
E2617	RB	SC	CUSTOM FABRICATED BACK CUSHION ANY SIZE INCLUDING ANY TYPE	PA	MSRP	
E2617	NU		CUSTOM FABRICATED BACK CUSHION, ANY SIZE, INCLUDING ANY TYPE	PA	MSRP	
E2617	NU	SC	CUSTOM FABRICATED BACK CUSHION ANY SIZE INCLUDING ANY TYPE	PA	MSRP	
E2619	RB		REPLACEMENT COVER FOR SEAT OR BACK CUSHION FOR CHAIR	CMN		
E2619	RB	SC	REPLACEMENT COVER FOR SEAT OR BACK CUSHION FOR CHAIR	CMN		
E2619	NU		REPLACEMENT COVER FOR SEAT OR BACK CUSHION FOR CHAIR	CMN		
E2619	NU	SC	REPLACEMENT COVER FOR SEAT OR BACK CUSHION FOR CHAIR	PA		
E2620	RB		POSITIONING BACK CUSHION PLANAR BACK WITH LATERAL SUPPORTS	CMN		
E2620	RB	SC	POSITIONING BACK CUSHION PLANAR BACK WITH LATERAL SUPPORTS	CMN		
E2620	NU		POSITIONING BACK CUSHION, PLANAR BACK WITH LATERAL SUPPORTS	PA		
E2620	NU	SC	POSITIONING BACK CUSHION PLANAR BACK WITH LATERAL SUPPORTS	PA		
E2621	RB		POSITIONING BACK CUSHION PLANAR BACK WITH LATERAL SUPPORTS	CMN		
E2621	RB	SC	POSITIONING BACK CUSHION PLANAR BACK WITH LATERAL SUPPORTS	CMN		

Durable Medical Equipment



E2621	NU		POSITIONING BACK CUSHION, PLANAR BACK WITH LATERAL SUPPORTS	PA		
E2621	NU	SC	POSITIONING BACK CUSHION PLANAR BACK WITH LATERAL SUPPORTS	PA		
E2622	RB		ADJ SKIN PRO W/C CUS WD<22IN	CMN		
E2622	RB	SC	ADJ SKIN PRO W/C CUS WD<22IN	CMN		
E2622	NU		ADJ SKIN PRO W/C CUS WD<22IN	PA		
E2622	NU	SC	ADJ SKIN PRO W/C CUS WD<22IN	PA		
E2623	RB		ADJ SKIN PRO WC CUS WD>=22IN	CMN		
E2623	RB	SC	ADJ SKIN PRO WC CUS WD>=22IN	CMN		
E2623	NU		ADJ SKIN PRO WC CUS WD>=22IN	PA		
E2623	NU	SC	ADJ SKIN PRO WC CUS WD>=22IN	PA		
E2624	RB		ADJ SKIN PRO/POS CUS<22IN	CMN		
E2624	RB	SC	ADJ SKIN PRO/POS CUS<22IN	CMN		
E2624	NU		ADJ SKIN PRO/POS CUS<22IN	PA		
E2624	NU	SC	ADJ SKIN PRO/POS CUS<22IN	PA		
E2625	RB		ADJ SKIN PRO/POS WC CUS>=22	CMN		
E2625	RB	SC	ADJ SKIN PRO/POS WC CUS>=22	CMN		
E2625	NU		ADJ SKIN PRO/POS WC CUS>=22	PA		
E2625	NU	SC	ADJ SKIN PRO/POS WC CUS>=22	PA		
K0001	RB		STANDARD WHEELCHAIR	CMN	MSRP	
K0001	RB	SC	STANDARD WHEELCHAIR	CMN	MSRP	
K0001	RR		STANDARD WHEELCHAIR	CMN		24 month rent to purchase.
K0001	RR	SC	STANDARD WHEELCHAIR	PA		24 month rent to purchase.
K0002	RB		STND HEMI (LOW SEAT) WHLCHR	CMN	90% of MSRP	
K0002	RB	SC	STND HEMI (LOW SEAT) WHLCHR	CMN	90% of MSRP	
K0002	RR		STND HEMI (LOW SEAT) WHLCHR	CMN		12 month rent to purchase.
K0002	RR	SC	STND HEMI (LOW SEAT) WHLCHR	PA		12 month rent to purchase.
K0003	RB		LIGHTWEIGHT WHEELCHAIR	CMN	MSRP	

PRODUCTION : 04/09/2020

Durable Medical Equipment



K0003	RB	SC	LIGHTWEIGHT WHEELCHAIR	CMN	MSRP	
K0003	RR		LIGHTWEIGHT WHEELCHAIR	CMN		24 month rent to purchase.
K0003	RR	SC	LIGHTWEIGHT WHEELCHAIR	PA		24 month rent to purchase.
K0004	RB		HIGH STRENGTH LTWT WHLCHR	CMN	MSRP	
K0004	RB	SC	HIGH STRENGTH LTWT WHLCHR	CMN	MSRP	
K0004	RR		HIGH STRENGTH LTWT WHLCHR	CMN		12 month rent to purchase.
K0004	RR	SC	HIGH STRENGTH LTWT WHLCHR	PA		12 month rent to purchase.
K0005	RB		ULTRALIGHTWEIGHT WHEELCHAIR	CMN		
K0005	RB	SC	ULTRALIGHTWEIGHT WHEELCHAIR	CMN	MSRP	
K0005	RR		ULTRALIGHTWEIGHT WHEELCHAIR	PA		
K0005	RR	SC	ULTRALIGHTWEIGHT WHEELCHAIR	PA		
K0005	NU		ULTRALIGHTWEIGHT WHEELCHAIR	PA		
K0005	NU	SC	ULTRALIGHTWEIGHT WHEELCHAIR	PA		
K0006	RB		HEAVY DUTY WHEELCHAIR	CMN	MSRP	
K0006	RB	SC	HEAVY DUTY WHEELCHAIR	CMN	MSRP	
K0006	RR		HEAVY DUTY WHEELCHAIR	CMN		23 month rent to purchase.
K0006	RR	SC	HEAVY DUTY WHEELCHAIR	PA		23 month rent to purchase.
K0007	RB		EXTRA HEAVY DUTY WHEELCHAIR	CMN	MSRP	
K0007	RB	SC	EXTRA HEAVY DUTY WHEELCHAIR	CMN	MSRP	
K0007	RR		EXTRA HEAVY DUTY WHEELCHAIR	CMN		23 month rent to purchase.
K0007	RR	SC	EXTRA HEAVY DUTY WHEELCHAIR	PA		23 month rent to purchase.
K0008	RB		CSTM MANUAL WHEELCHAIR/BASE	CMN	90% of MSRP	
K0008	RB	SC	CSTM MANUAL WHEELCHAIR/BASE	CMN	90% of MSRP	

Durable Medical Equipment



K0008	NU		CSTM MANUAL WHEELCHAIR/BASE	PA	90% of MSRP	
K0008	NU	SC	CSTM MANUAL WHEELCHAIR/BASE	PA	90% of MSRP	
K0009	RB		OTHER MANUAL WHEELCHAIR/BASE	CMN	90% of MSRP	
K0009	RB	SC	OTHER MANUAL WHEELCHAIR/BASE	CMN	90% of MSRP	
K0009	NU		OTHER MANUAL WHEELCHAIR/BASE	PA	90% of MSRP	
K0009	NU	SC	OTHER MANUAL WHEELCHAIR/BASE	PA	90% of MSRP	
K0013	RB		CUSTOM POWER WHLCHR BASE	CMN	95% of MSRP	
K0013	RB	SC	CUSTOM POWER WHLCHR BASE	CMN	95% of MSRP	
K0013	NU		CUSTOM POWER WHLCHR BASE	PA	95% of MSRP	
K0013	NU	SC	CUSTOM POWER WHLCHR BASE	PA	95% of MSRP	
K0015	RB		DETACHABLE NON-ADJUSTABLE HEIGHT ARMREST EACH			
K0015	NU		DETACHABLE, NON-ADJUSTABLE HEIGHT ARMREST, EACH			
K0015	RB	SC	DETACHABLE NON-ADJUSTABLE HEIGHT ARMREST; EACH	MNF		
K0017	RB		DETACH ADJUST ARMREST BASE	CMN		
K0017	RB	SC	DETACH ADJUST ARMREST BASE	CMN		
K0017	NU		DETACH ADJUST ARMREST BASE	CMN		
K0018	RB	SC	DETACH ADJUST ARMREST UPPER	CMN		
K0018	NU		DETACH ADJUST ARMREST UPPER	CMN		
K0018	RB		DETACH ADJUST ARMREST UPPER	CMN		
K0019	RB		ARM PAD REPL, EACH	CMN		
K0019	RB	SC	ARM PAD REPL, EACH	CMN		
K0019	NU		ARM PAD REPL, EACH	CMN		
K0020	RB		FIXED ADJUSTABLE HEIGHT ARMREST; PAIR	CMN		

Durable Medical Equipment



K0020	RB	SC	FIXED ADJUSTABLE HEIGHT ARMREST; PAIR	CMN		
K0020	NU		FIXED, ADJUSTABLE HEIGHT ARMREST, PAIR	CMN		
K0020	NU	SC	FIXED ADJUSTABLE HEIGHT ARMREST; PAIR	PA		
K0037	RB		HI MOUNT FLIP-UP FTREST REPL	CMN		
K0037	RB	SC	HI MOUNT FLIP-UP FTREST REPL	CMN		
K0037	NU		HI MOUNT FLIP-UP FTREST REPL	CMN		
K0037	NU	SC	HI MOUNT FLIP-UP FTREST REPL	PA		
K0038	RB		LEG STRAP; EACH	CMN		
K0038	RB	SC	LEG STRAP; EACH	CMN		
K0038	NU		LEG STRAP, EACH	CMN		
K0038	NU	SC	LEG STRAP; EACH	PA		
K0039	RB		LEG STRAP H STYLE; EACH	CMN		
K0039	RB	SC	LEG STRAP H STYLE; EACH	CMN		
K0039	NU		LEG STRAP, H STYLE, EACH	CMN		
K0039	NU	SC	LEG STRAP H STYLE; EACH	PA		
K0040	NU		ADJUSTABLE ANGLE FOOTPLATE, EACH	CMN		
K0040	RB		ADJUSTABLE ANGLE FOOTPLATE; EACH	CMN		
K0040	RB	SC	ADJUSTABLE ANGLE FOOTPLATE; EACH	CMN		
K0040	NU	SC	ADJUSTABLE ANGLE FOOTPLATE; EACH	PA		
K0041	RB		LARGE SIZE FOOTPLATE; EACH	CMN		
K0041	RB	SC	LARGE SIZE FOOTPLATE; EACH	CMN		
K0041	NU		LARGE SIZE FOOTPLATE, EACH	CMN		
K0041	NU	SC	LARGE SIZE FOOTPLATE; EACH	PA		
K0042	RB		STANDARD SIZE FTPLATE REP EA	CMN		
K0042	RB	SC	STANDARD SIZE FTPLATE REP EA	CMN		
K0042	NU		STANDARD SIZE FTPLATE REP EA	CMN		
K0043	RB		FTRST LOWR EXTEN TUBE REP EA	CMN		
K0043	RB	SC	FTRST LOWR EXTEN TUBE REP EA	CMN		
K0043	NU		FTRST LOWR EXTEN TUBE REP EA	CMN		
K0044	RB		FTRST UPR HANGER BRAC REP EA	CMN		
K0044	RB	SC	FTRST UPR HANGER BRAC REP EA	CMN		
K0044	NU		FTRST UPR HANGER BRAC REP EA	CMN		

Durable Medical Equipment



K0045	RB		FTRST COMPL ASSEMBLY REPL EA	CMN		
K0045	RB	SC	FTRST COMPL ASSEMBLY REPL EA	CMN		
K0045	NU		FTRST COMPL ASSEMBLY REPL EA	CMN		
K0046	RB		ELEV LGRST LWR EXTEN REPL EA	CMN		
K0046	RB	SC	ELEV LGRST LWR EXTEN REPL EA	CMN		
K0046	NU		ELEV LGRST LWR EXTEN REPL EA	CMN		
K0047	RB		ELEV LEGRST UPR HANGR REP EA	CMN		
K0047	RB	SC	ELEV LEGRST UPR HANGR REP EA	CMN		
K0047	NU		ELEV LEGRST UPR HANGR REP EA	CMN		
K0050	RB		RATCHET ASSEMBLY REPLACEMENT	CMN		
K0050	RB	SC	RATCHET ASSEMBLY REPLACEMENT	CMN		
K0050	NU		RATCHET ASSEMBLY REPLACEMENT	CMN		
K0050	NU	SC	RATCHET ASSEMBLY REPLACEMENT	PA		
K0051	RB		CAM REL ASM FT/LEGRST REP EA	CMN		
K0051	RB	SC	CAM REL ASM FT/LEGRST REP EA	CMN		
K0051	NU		CAM REL ASM FT/LEGRST REP EA	CMN		
K0051	NU	SC	CAM REL ASM FT/LEGRST REP EA	PA		
K0052	RB		SWINGAWAY DETACH FTREST REPL	CMN		
K0052	RB	SC	SWINGAWAY DETACH FTREST REPL	CMN		
K0052	NU		SWINGAWAY DETACH FTREST REPL	CMN		
K0053	RB		ELEVATING FOOT RESTS ARTICULATING (TELESCOPING); EACH	CMN		
K0053	RB	SC	ELEVATING FOOT RESTS ARTICULATING (TELESCOPING); EACH	CMN		
K0053	NU		ELEVATING FOOT RESTS, ARTICULATING (TELESCOPING), EACH	CMN		
K0053	NU	SC	ELEVATING FOOT RESTS ARTICULATING (TELESCOPING); EACH	PA		
K0056	RB		SEAT HT LESS THAN 17 OR EQUAL TO/GREATER THAN 21 FOR HIGH STRENGTH LT WT/ULTRA LT WT W/C'	CMN		
K0056	RB	SC	SEAT HT LESS THAN 17 OR EQUAL TO/GREATER THAN 21 FOR HIGH STRENGTH LT WT/ULTRA LT WT W/C'	CMN		
K0056	NU		SEAT HT.LESS THAN 17 OR EQUAL TO/GREATER THAN 21 FOR HIGH STRENGTH, LT. WT./ULTRA-LT.WT WHEELCHAIR	CMN		
K0056	NU	SC	SEAT HT LESS THAN 17 OR EQUAL TO/GREATER THAN 21 FOR HIGH STRENGTH LT WT/ULTRA LT WT W/C'	PA		
K0065	RB		SPOKE PROTECTORS EACH	CMN		

PRODUCTION : 04/09/2020

Durable Medical Equipment



K0065	RB	SC	SPOKE PROTECTORS; EACH	CMN		
K0065	NU		SPOKE PROTECTORS; EACH	CMN		
K0065	NU	SC	SPOKE PROTECTORS; EACH	PA		
K0069	RB		RR WHL COMPL SOL TIRE REP EA	CMN		
K0069	RB	SC	RR WHL COMPL SOL TIRE REP EA	CMN		
K0069	NU		RR WHL COMPL SOL TIRE REP EA	CMN		
K0069	NU	SC	RR WHL COMPL SOL TIRE REP EA	PA		
K0070	RB		REAR WHEEL ASSEMBLY COMPLETE; WITH PNEUMATIC TIRE SPOKE OR MOLDED; EACH	CMN		
K0070	RB	SC	REAR WHEEL ASSEMBLY COMPLETE; WITH PNEUMATIC TIRE SPOKE OR MOLDED; EACH	CMN		
K0070	NU		REAR WHEEL ASSEMBLY,COMPLETE; WITH PNEUMATIC TIRE,SPOKES OR MOLDED, EACH	CMN		
K0070	NU	SC	REAR WHEEL ASSEMBLY COMPLETE; WITH PNEUMATIC TIRE SPOKE OR MOLDED; EACH	PA		
K0071	RB		FR CSTR COMP PNE TIRE REP EA	CMN		
K0071	RB	SC	FR CSTR COMP PNE TIRE REP EA	CMN		
K0071	NU		FR CSTR COMP PNE TIRE REP EA	CMN		
K0071	NU	SC	FR CSTR COMP PNE TIRE REP EA	PA		
K0072	RB		FR CSTR SEMI-PNE TIRE REP EA	CMN		
K0072	RB	SC	FR CSTR SEMI-PNE TIRE REP EA	CMN		
K0072	NU		FR CSTR SEMI-PNE TIRE REP EA	CMN		
K0072	NU	SC	FR CSTR SEMI-PNE TIRE REP EA	PA		
K0073	RB		CASTER PIN LOCK; EACH	CMN		
K0073	RB	SC	CASTER PIN LOCK; EACH	CMN		
K0073	NU		CASTER PIN LOCK, EACH	CMN		
K0073	NU	SC	CASTER PIN LOCK; EACH	PA		
K0077	RB		FR CSTR ASMB SOL TIRE REP EA	CMN		
K0077	RB	SC	FR CSTR ASMB SOL TIRE REP EA	CMN		
K0077	NU		FR CSTR ASMB SOL TIRE REP EA	CMN		
K0077	NU	SC	FR CSTR ASMB SOL TIRE REP EA	PA		
K0098	RB		DRIVE BELT FOR PWC, REPL	CMN		
K0098	RB	SC	DRIVE BELT FOR PWC, REPL	CMN		

PRODUCTION : 04/09/2020

Durable Medical Equipment



K0098	NU		DRIVE BELT FOR PWC, REPL	CMN		
K0098	NU	SC	DRIVE BELT FOR PWC, REPL	PA		
K0105	RB		IV HANGER; EACH	CMN		
K0105	RB	SC	IV HANGER EACH	CMN		
K0105	NU		IV HANGER, EACH	CMN		
K0105	NU	SC	IV HANGER; EACH	PA		
K0108	RB		WHEELCHAIR COMPONENT OR ACCESSORY NOT OTHERWISE SPECIFIED	PA	MSRP	
K0108	RB	SC	WHEELCHAIR COMPONENT OR ACCESSORY NOS	PA	MSRP	
K0108	NU		WHEELCHAIR COMPONENT OR ACCESSORY NOT OTHERWISE SPECIFIED	PA	MSRP	
K0108	NU	SC	WHEELCHAIR COMPONENT OR ACCESSORY NOS	PA	MSRP	
K0108	RR		WHEELCHAIR COMPONENT OR ACCESSORY NOT OTHERWISE SPECIFIED	PA	MSRP	
K0108	RR	SC	WHEELCHAIR COMPONENT OR ACCESSORY NOS	PA	MSRP	
K0195	RR		ELEVATING LEGREST, PAIR (FOR USE WITH RENTAL WHEELCHAIR BASE)	CMN		
K0195	RR	SC	ELEVATING LEG REST, PAIR (FOR USE WITH RENTAL W/C BASE)	PA		
K0603	NU		REPLACE BATTERY 1.5V	MNF		
K0669	NU		SEAT/BACK CUS NO DMEPDAC VER	PA	MSRP	
K0672	NU		ADDITION TO LOWER EXTREMITY ORTHOSIS, REMOVABLE SOFT INTERFACE, ALL COMPONENTS,	CMN		
K0730	RR		CTRL DOSE INH DURG DELIV SYS			
K0730	NU		CTRL DOSE INH DRUG DELIV SYS			
K0733	RB		PWC 12 TO 24 AMP HOUR SEALED LEAD ACID BATTERY (E.G. GELL CELL, ABSORB)	CMN		
K0733	RB	SC	PWC 12 TO 24 AMP HOUR SEALED LEAD ACID BATTERY (E.G. GELL CELL, ABSORB)	CMN		
K0733	NU		POWER WHEELCHAIR ACCESSORY, 12 TO 24 AMP HOUR SEALED LEAD ACID BATTERY, EACH (E.G., GEL CELL, ABSORB)	CMN		
K0733	NU	SC	PWC 12 TO 24 AMP HOUR SEALED LEAD ACID BATTERY (E.G. GELL CELL, ABSORB)	PA		
K0738	RR		PORTABLE GAS OXYGEN SYSTEM	PC		Continuous rental.
K0739	RB		REPAIR/SVC DME NON-OXYGEN EQ	CMN		
K0739	RB	SC	REPAIR/SVC DME NON-OXYGEN EQ	CMN		
K0800	RB		POV GROUP 1 STD UP TO 300LBS	CMN	MSRP	

PRODUCTION : 04/09/2020

Durable Medical Equipment



K0800	RR		POV GROUP 1 STD UP TO 300LBS	PA		
K0800	NU		POV GROUP 1 STD UP TO 300LBS	PA		
K0801	RB		POV GROUP 1 HD 301-450 LBS	CMN	MSRP	
K0801	RR		POV GROUP 1 HD 301-450 LBS	PA		
K0801	NU		POV GROUP 1 HD 301-450 LBS	PA		
K0802	RB		POV GROUP 1 VHD 451-600 LBS	CMN	MSRP	
K0802	RR		POV GROUP 1 VHD 451-600 LBS	PA		
K0802	NU		POV GROUP 1 VHD 451-600 LBS	PA		
K0806	RB		POV GROUP 2 STD UP TO 300LBS	CMN	MSRP	
K0806	RR		POV GROUP 2 STD UP TO 300LBS	PA		
K0806	NU		POV GROUP 2 STD UP TO 300LBS	PA		
K0807	RB		POV GROUP 2 HD 301-450 LBS	CMN	MSRP	
K0807	RR		POV GROUP 2 HD 301-450 LBS	PA		
K0807	NU		POV GROUP 2 HD 301-450 LBS	PA		
K0808	RB		POV GROUP 2 VHD 451-600 LBS	CMN	MSRP	
K0808	RR		POV GROUP 2 VHD 451-600 LBS	PA		
K0808	NU		POV GROUP 2 VHD 451-600 LBS	PA		
K0812	RB		POWER OPERATED VEHICLE NOC	CMN	MSRP	
K0812	NU		POWER OPERATED VEHICLE NOC	PA	MSRP	
K0813	RB		PWC GP 1 STD PORT SEAT/BACK	CMN	MSRP	
K0813	RB	SC	PWC GP 1 STD PORT SEAT/BACK	CMN	MSRP	
K0813	RR		PWC GP 1 STD PORT SEAT/BACK	PA		
K0813	RR	SC	PWC GP 1 STD PORT SEAT/BACK	PA		
K0813	NU		PWC GP 1 STD PORT SEAT/BACK	PA		
K0813	NU	SC	PWC GP 1 STD PORT SEAT/BACK	PA		
K0814	RB		PWC GP 1 STD PORT CAP CHAIR	CMN	MSRP	
K0814	RB	SC	PWC GP 1 STD PORT CAP CHAIR	CMN	MSRP	
K0814	RR		PWC GP 1 STD PORT CAP CHAIR	PA		
K0814	RR	SC	PWC GP 1 STD PORT CAP CHAIR	PA		
K0814	NU		PWC GP 1 STD PORT CAP CHAIR	PA		
K0814	NU	SC	PWC GP 1 STD PORT CAP CHAIR	PA		
K0815	RB		PWC GP 1 STD SEAT/BACK	CMN	MSRP	

Durable Medical Equipment



K0815	RB	SC	PWC GP 1 STD SEAT/BACK	CMN	MSRP	
K0815	RR		PWC GP 1 STD SEAT/BACK	PA		
K0815	RR	SC	PWC GP 1 STD SEAT/BACK	PA		
K0815	NU		PWC GP 1 STD SEAT/BACK	PA		
K0815	NU	SC	PWC GP 1 STD SEAT/BACK	PA		
K0816	RB		PWC GP 1 STD CAP CHAIR	CMN	MSRP	
K0816	RB	SC	PWC GP 1 STD CAP CHAIR	CMN	MSRP	
K0816	RR		PWC GP 1 STD CAP CHAIR	PA		
K0816	RR	SC	PWC GP 1 STD CAP CHAIR	PA		
K0816	NU		PWC GP 1 STD CAP CHAIR	PA		
K0816	NU	SC	PWC GP 1 STD CAP CHAIR	PA		
K0820	RB		PWC GP 2 STD PORT SEAT/BACK	CMN	MSRP	
K0820	RB	SC	PWC GP 2 STD PORT SEAT/BACK	CMN	MSRP	
K0820	RR		PWC GP 2 STD PORT SEAT/BACK	PA		
K0820	RR	SC	PWC GP 2 STD PORT SEAT/BACK	PA		
K0820	NU		PWC GP 2 STD PORT SEAT/BACK	PA		
K0820	NU	SC	PWC GP 2 STD PORT SEAT/BACK	PA		
K0821	RB		PWC GP 2 STD PORT CAP CHAIR	CMN	MSRP	
K0821	RB	SC	PWC GP 2 STD PORT CAP CHAIR	CMN	MSRP	
K0821	RR		PWC GP 2 STD PORT CAP CHAIR	PA		
K0821	RR	SC	PWC GP 2 STD PORT CAP CHAIR	PA		
K0821	NU		PWC GP 2 STD PORT CAP CHAIR	PA		
K0821	NU	SC	PWC GP 2 STD PORT CAP CHAIR	PA		
K0822	RB		PWC GP 2 STD SEAT/BACK	CMN	MSRP	
K0822	RB	SC	PWC GP 2 STD SEAT/BACK	CMN	MSRP	
K0822	RR		PWC GP 2 STD SEAT/BACK	PA		
K0822	RR	SC	PWC GP 2 STD SEAT/BACK	PA		
K0822	NU		PWC GP 2 STD SEAT/BACK	PA		
K0822	NU	SC	PWC GP 2 STD SEAT/BACK	PA		
K0823	RB		PWC GP 2 STD CAP CHAIR	CMN	MSRP	
K0823	RB	SC	PWC GP 2 STD CAP CHAIR	CMN	MSRP	

Durable Medical Equipment



K0823	RR		PWC GP 2 STD CAP CHAIR	PA		12 mo rent to purchase.
K0823	RR	SC	PWC GP 2 STD CAP CHAIR	PA		12 mo rent to purchase.
K0823	NU		PWC GP 2 STD CAP CHAIR	PA		
K0823	NU	SC	PWC GP 2 STD CAP CHAIR	PA		
K0824	RB		PWC GP 2 HD SEAT/BACK	CMN	MSRP	
K0824	RB	SC	PWC GP 2 HD SEAT/BACK	CMN	MSRP	
K0824	RR		PWC GP 2 HD SEAT/BACK	PA		
K0824	RR	SC	PWC GP 2 HD SEAT/BACK	PA		
K0824	NU		PWC GP 2 HD SEAT/BACK	PA		
K0824	NU	SC	PWC GP 2 HD SEAT/BACK	PA		
K0825	RB		PWC GP 2 HD CAP CHAIR	CMN	MSRP	
K0825	RB	SC	PWC GP 2 HD CAP CHAIR	CMN	MSRP	
K0825	RR		PWC GP 2 HD CAP CHAIR	PA		
K0825	RR	SC	PWC GP 2 HD CAP CHAIR	PA		
K0825	NU		PWC GP 2 HD CAP CHAIR	PA		
K0825	NU	SC	PWC GP 2 HD CAP CHAIR	PA		
K0826	RB		PWC GP 2 VHD SEAT/BACK	CMN	MSRP	
K0826	RB	SC	PWC GP 2 VHD SEAT/BACK	CMN	MSRP	
K0826	RR		PWC GP 2 VHD SEAT/BACK	PA		
K0826	RR	SC	PWC GP 2 VHD SEAT/BACK	PA		
K0826	NU		PWC GP 2 VHD SEAT/BACK	PA		
K0826	NU	SC	PWC GP 2 VHD SEAT/BACK	PA		
K0827	RB		PWC GP VHD CAP CHAIR	CMN	MSRP	
K0827	RB	SC	PWC GP VHD CAP CHAIR	CMN	MSRP	
K0827	RR		PWC GP VHD CAP CHAIR	PA		
K0827	RR	SC	PWC GP VHD CAP CHAIR	PA		
K0827	NU		PWC GP VHD CAP CHAIR	PA		
K0827	NU	SC	PWC GP VHD CAP CHAIR	PA		
K0828	RB		PWC GP 2 XTRA HD SEAT/BACK	CMN	MSRP	

PRODUCTION : 04/09/2020

Durable Medical Equipment



K0828	RB	SC	PWC GP 2 XTRA HD SEAT/BACK	CMN	MSRP	
K0828	RR		PWC GP 2 XTRA HD SEAT/BACK	PA		
K0828	RR	SC	PWC GP 2 XTRA HD SEAT/BACK	PA		
K0828	NU		PWC GP 2 XTRA HD SEAT/BACK	PA		
K0828	NU	SC	PWC GP 2 XTRA HD SEAT/BACK	PA		
K0829	RB		PWC GP 2 XTRA HD CAP CHAIR	CMN	MSRP	
K0829	RB	SC	PWC GP 2 XTRA HD CAP CHAIR	CMN	MSRP	
K0829	RR		PWC GP 2 XTRA HD CAP CHAIR	PA		
K0829	RR	SC	PWC GP 2 XTRA HD CAP CHAIR	PA		
K0829	NU		PWC GP 2 XTRA HD CAP CHAIR	PA		
K0829	NU	SC	PWC GP 2 XTRA HD CAP CHAIR	PA		
K0835	RB		PWC GP2 STD SING POW OPT S/B	CMN	MSRP	
K0835	RB	SC	PWC GP2 STD SING POW OPT S/B	CMN	MSRP	
K0835	RR		PWC GP2 STD SING POW OPT S/B	PA		
K0835	RR	SC	PWC GP2 STD SING POW OPT S/B	PA		
K0835	NU	SC	PWC GP2 STD SING POW OPT S/B	PA		
K0835	NU		PWC GP2 STD SING POW OPT S/B	PA		
K0836	RB		PWC GP2 STD SING POW OPT CAP	CMN	MSRP	
K0836	RB	SC	PWC GP2 STD SING POW OPT CAP	CMN	MSRP	
K0836	RR		PWC GP2 STD SING POW OPT CAP	PA		
K0836	RR	SC	PWC GP2 STD SING POW OPT CAP	PA		
K0836	NU		PWC GP2 STD SING POW OPT CAP	PA		
K0836	NU	SC	PWC GP2 STD SING POW OPT CAP	PA		
K0837	RB		PWC GP 2 HD SING POW OPT S/B	CMN	MSRP	
K0837	RB	SC	PWC GP 2 HD SING POW OPT S/B	CMN	MSRP	
K0837	RR		PWC GP 2 HD SING POW OPT S/B	PA		
K0837	RR	SC	PWC GP 2 HD SING POW OPT S/B	PA		
K0837	NU		PWC GP 2 HD SING POW OPT S/B	PA		
K0837	NU	SC	PWC GP 2 HD SING POW OPT S/B	PA		
K0838	RB		PWC GP 2 HD SING POW OPT CAP	CMN	MSRP	
K0838	RB	SC	PWC GP 2 HD SING POW OPT CAP	CMN	MSRP	
K0838	RR		PWC GP 2 HD SING POW OPT CAP	PA		

Durable Medical Equipment



K0838	RR	SC	PWC GP 2 HD SING POW OPT CAP	PA		
K0838	NU		PWC GP 2 HD SING POW OPT CAP	PA		
K0838	NU	SC	PWC GP 2 HD SING POW OPT CAP	PA		
K0839	RB		PWC GP2 VHD SING POW OPT S/B	CMN	MSRP	
K0839	RB	SC	PWC GP2 VHD SING POW OPT S/B	CMN	MSRP	
K0839	RR		PWC GP2 VHD SING POW OPT S/B	PA		
K0839	RR	SC	PWC GP2 VHD SING POW OPT S/B	PA		
K0839	NU		PWC GP2 VHD SING POW OPT S/B	PA		
K0839	NU	SC	PWC GP2 VHD SING POW OPT S/B	PA		
K0840	RB		PWC GP2 XHD SING POW OPT S/B	CMN	MSRP	
K0840	RB	SC	PWC GP2 XHD SING POW OPT S/B	CMN	MSRP	
K0840	RR		PWC GP2 XHD SING POW OPT S/B	PA		
K0840	RR	SC	PWC GP2 XHD SING POW OPT S/B	PA		
K0840	NU		PWC GP2 XHD SING POW OPT S/B	PA		
K0840	NU	SC	PWC GP2 XHD SING POW OPT S/B	PA		
K0841	RB		PWC GP2 STD MULT POW OPT S/B	CMN	MSRP	
K0841	RB	SC	PWC GP2 STD MULT POW OPT S/B	CMN	MSRP	
K0841	RR		PWC GP2 STD MULT POW OPT S/B	PA		
K0841	RR	SC	PWC GP2 STD MULT POW OPT S/B	PA		
K0841	NU		PWC GP2 STD MULT POW OPT S/B	PA		
K0841	NU	SC	PWC GP2 STD MULT POW OPT S/B	PA		
K0842	RB		PWC GP2 STD MULT POW OPT CAP	CMN	MSRP	
K0842	RB	SC	PWC GP2 STD MULT POW OPT CAP	CMN	MSRP	
K0842	RR		PWC GP2 STD MULT POW OPT CAP	PA		
K0842	RR	SC	PWC GP2 STD MULT POW OPT CAP	PA		
K0842	NU		PWC GP2 STD MULT POW OPT CAP	PA		
K0842	NU	SC	PWC GP2 STD MULT POW OPT CAP	PA		
K0843	RB		PWC GP2 HD MULT POW OPT S/B	CMN	MSRP	
K0843	RB	SC	PWC GP2 HD MULT POW OPT S/B	CMN	MSRP	
K0843	RR		PWC GP2 HD MULT POW OPT S/B	PA		
K0843	RR	SC	PWC GP2 HD MULT POW OPT S/B	PA		
K0843	NU		PWC GP2 HD MULT POW OPT S/B	PA		

Durable Medical Equipment



K0843	NU	SC	PWC GP2 HD MULT POW OPT S/B	PA		
K0848	RB		PWC GP 3 STD SEAT/BACK	CMN	MSRP	
K0848	RB	SC	PWC GP 3 STD SEAT/BACK	CMN	MSRP	
K0848	RR		PWC GP 3 STD SEAT/BACK	PA		
K0848	RR	SC	PWC GP 3 STD SEAT/BACK	PA		
K0848	NU		PWC GP 3 STD SEAT/BACK	PA		
K0848	NU	SC	PWC GP 3 STD SEAT/BACK	PA		
K0849	RB		PWC GP 3 STD CAP CHAIR	CMN	MSRP	
K0849	RB	SC	PWC GP 3 STD CAP CHAIR	CMN	MSRP	
K0849	RR		PWC GP 3 STD CAP CHAIR	PA		
K0849	RR	SC	PWC GP 3 STD CAP CHAIR	PA		
K0849	NU		PWC GP 3 STD CAP CHAIR	PA		
K0849	NU	SC	PWC GP 3 STD CAP CHAIR	PA		
K0850	RB		PWC GP 3 HD SEAT/BACK	CMN	MSRP	
K0850	RB	SC	PWC GP 3 HD SEAT/BACK	CMN	MSRP	
K0850	RR		PWC GP 3 HD SEAT/BACK	PA		
K0850	RR	SC	PWC GP 3 HD SEAT/BACK	PA		
K0850	NU		PWC GP 3 HD SEAT/BACK	PA		
K0850	NU	SC	PWC GP 3 HD SEAT/BACK	PA		
K0851	RB		PWC GP 3 HD CAP CHAIR	CMN	MSRP	
K0851	RB	SC	PWC GP 3 HD CAP CHAIR	CMN	MSRP	
K0851	RR		PWC GP 3 HD CAP CHAIR	PA		
K0851	RR	SC	PWC GP 3 HD CAP CHAIR	PA		
K0851	NU		PWC GP 3 HD CAP CHAIR	PA		
K0851	NU	SC	PWC GP 3 HD CAP CHAIR	PA		
K0852	RB		PWC GP 3 VHD SEAT/BACK	CMN	MSRP	
K0852	RB	SC	PWC GP 3 VHD SEAT/BACK	CMN	MSRP	
K0852	RR		PWC GP 3 VHD SEAT/BACK	PA		
K0852	RR	SC	PWC GP 3 VHD SEAT/BACK	PA		
K0852	NU		PWC GP 3 VHD SEAT/BACK	PA		
K0852	NU	SC	PWC GP 3 VHD SEAT/BACK	PA		
K0853	RB		PWC GP 3 VHD CAP CHAIR	CMN	MSRP	

Durable Medical Equipment



K0853	RB	SC	PWC GP 3 VHD CAP CHAIR	CMN	MSRP	
K0853	RR		PWC GP 3 VHD CAP CHAIR	PA		
K0853	RR	SC	PWC GP 3 VHD CAP CHAIR	PA		
K0853	NU		PWC GP 3 VHD CAP CHAIR	PA		
K0853	NU	SC	PWC GP 3 VHD CAP CHAIR	PA		
K0854	RB		PWC GP 3 XHD SEAT/BACK	CMN	MSRP	
K0854	RB	SC	PWC GP 3 XHD SEAT/BACK	CMN	MSRP	
K0854	RR		PWC GP 3 XHD SEAT/BACK	PA		
K0854	RR	SC	PWC GP 3 XHD SEAT/BACK	PA		
K0854	NU	SC	PWC GP 3 XHD SEAT/BACK	PA		
K0854	NU		PWC GP 3 XHD SEAT/BACK	PA		
K0855	RB		PWC GP 3 XHD CAP CHAIR	CMN	MSRP	
K0855	RB	SC	PWC GP 3 XHD CAP CHAIR	CMN	MSRP	
K0855	RR		PWC GP 3 XHD CAP CHAIR	PA		
K0855	RR	SC	PWC GP 3 XHD CAP CHAIR	PA		
K0855	NU		PWC GP 3 XHD CAP CHAIR	PA		
K0855	NU	SC	PWC GP 3 XHD CAP CHAIR	PA		
K0856	RB		PWC GP3 STD SING POW OPT S/B	CMN	MSRP	
K0856	RB	SC	PWC GP3 STD SING POW OPT S/B	CMN	MSRP	
K0856	RR		PWC GP3 STD SING POW OPT S/B	PA		
K0856	RR	SC	PWC GP3 STD SING POW OPT S/B	PA		
K0856	NU		PWC GP3 STD SING POW OPT S/B	PA		
K0856	NU	SC	PWC GP3 STD SING POW OPT S/B	PA		
K0857	RB		PWC GP3 STD SING POW OPT CAP	CMN	MSRP	
K0857	RB	SC	PWC GP3 STD SING POW OPT CAP	CMN	MSRP	
K0857	RR		PWC GP3 STD SING POW OPT CAP	PA		
K0857	RR	SC	PWC GP3 STD SING POW OPT CAP	PA		
K0857	NU		PWC GP3 STD SING POW OPT CAP	PA		
K0857	NU	SC	PWC GP3 STD SING POW OPT CAP	PA		
K0858	RB		PWC GP3 HD SING POW OPT S/B	CMN	MSRP	
K0858	RB	SC	PWC GP3 HD SING POW OPT S/B	CMN	MSRP	
K0858	RR		PWC GP3 HD SING POW OPT S/B	PA		

Durable Medical Equipment



K0858	RR	SC	PWC GP3 HD SING POW OPT S/B	PA		
K0858	NU		PWC GP3 HD SING POW OPT S/B	PA		
K0858	NU	SC	PWC GP3 HD SING POW OPT S/B	PA		
K0859	RB		PWC GP3 HD SING POW OPT CAP	CMN	MSRP	
K0859	RB	SC	PWC GP3 HD SING POW OPT CAP	CMN	MSRP	
K0859	RR		PWC GP3 HD SING POW OPT CAP	PA		
K0859	RR	SC	PWC GP3 HD SING POW OPT CAP	PA		
K0859	NU		PWC GP3 HD SING POW OPT CAP	PA		
K0859	NU	SC	PWC GP3 HD SING POW OPT CAP	PA		
K0860	RB		PWC GP3 VHD SING POW OPT S/B	CMN	MSRP	
K0860	RB	SC	PWC GP3 VHD SING POW OPT S/B	CMN	MSRP	
K0860	RR		PWC GP3 VHD SING POW OPT S/B	PA		
K0860	RR	SC	PWC GP3 VHD SING POW OPT S/B	PA		
K0860	NU		PWC GP3 VHD SING POW OPT S/B	PA		
K0860	NU	SC	PWC GP3 VHD SING POW OPT S/B	PA		
K0861	RB		PWC GP3 STD MULT POW OPT S/B	CMN	MSRP	
K0861	RB	SC	PWC GP3 STD MULT POW OPT S/B	CMN	MSRP	
K0861	RR		PWC GP3 STD MULT POW OPT S/B	PA		
K0861	RR	SC	PWC GP3 STD MULT POW OPT S/B	PA		
K0861	NU		PWC GP3 STD MULT POW OPT S/B	PA		
K0861	NU	SC	PWC GP3 STD MULT POW OPT S/B	PA		
K0862	RB		PWC GP3 HD MULT POW OPT S/B	CMN	MSRP	
K0862	RB	SC	PWC GP3 HD MULT POW OPT S/B	CMN	MSRP	
K0862	RR		PWC GP3 HD MULT POW OPT S/B	PA		
K0862	RR	SC	PWC GP3 HD MULT POW OPT S/B	PA		
K0862	NU		PWC GP3 HD MULT POW OPT S/B	PA		
K0862	NU	SC	PWC GP3 HD MULT POW OPT S/B	PA		
K0863	RB		PWC GP3 VHD MULT POW OPT S/B	CMN	MSRP	
K0863	RB	SC	PWC GP3 VHD MULT POW OPT S/B	CMN	MSRP	
K0863	RR		PWC GP3 VHD MULT POW OPT S/B	PA		
K0863	RR	SC	PWC GP3 VHD MULT POW OPT S/B	PA		
K0863	NU		PWC GP3 VHD MULT POW OPT S/B	PA		

Durable Medical Equipment



K0863	NU	SC	PWC GP3 VHD MULT POW OPT S/B	PA		
K0864	RB		PWC GP3 XHD MULT POW OPT S/B	CMN	MSRP	
K0864	RB	SC	PWC GP3 XHD MULT POW OPT S/B	CMN	MSRP	
K0864	RR		PWC GP3 XHD MULT POW OPT S/B	PA		
K0864	RR	SC	PWC GP3 XHD MULT POW OPT S/B	PA		
K0864	NU		PWC GP3 XHD MULT POW OPT S/B	PA		
K0864	NU	SC	PWC GP3 XHD MULT POW OPT S/B	PA		
K0868	RB		PWC GP 4 STD SEAT/BACK	CMN	MSRP	
K0868	RB	SC	PWC GP 4 STD SEAT/BACK	CMN	MSRP	
K0868	NU		PWC GP 4 STD SEAT/BACK	PA	MSRP	
K0868	NU	SC	PWC GP 4 STD SEAT/BACK	PA	MSRP	
K0869	RB		PWC GP 4 STD CAP CHAIR	CMN	MSRP	
K0869	RB	SC	PWC GP 4 STD CAP CHAIR	CMN	MSRP	
K0869	NU		PWC GP 4 STD CAP CHAIR	PA	MSRP	
K0869	NU	SC	PWC GP 4 STD CAP CHAIR	PA	MSRP	
K0870	RB		PWC GP 4 HD SEAT/BACK	CMN	MSRP	
K0870	RB	SC	PWC GP 4 HD SEAT/BACK	CMN	MSRP	
K0870	NU		PWC GP 4 HD SEAT/BACK	PA	MSRP	
K0870	NU	SC	PWC GP 4 HD SEAT/BACK	PA	MSRP	
K0871	RB		PWC GP 4 VHD SEAT/BACK	CMN	MSRP	
K0871	RB	SC	PWC GP 4 VHD SEAT/BACK	CMN	MSRP	
K0871	NU		PWC GP 4 VHD SEAT/BACK	PA	MSRP	
K0871	NU	SC	PWC GP 4 VHD SEAT/BACK	PA	MSRP	
K0877	RB		PWC GP4 STD SING POW OPT S/B	CMN	MSRP	
K0877	RB	SC	PWC GP4 STD SING POW OPT S/B	CMN	MSRP	
K0877	NU		PWC GP4 STD SING POW OPT S/B	PA	MSRP	
K0877	NU	SC	PWC GP4 STD SING POW OPT S/B	PA	MSRP	
K0878	RB		PWC GP4 STD SING POW OPT CAP	CMN	MSRP	
K0878	RB	SC	PWC GP4 STD SING POW OPT CAP	CMN	MSRP	
K0878	NU		PWC GP4 STD SING POW OPT CAP	PA	MSRP	
K0878	NU	SC	PWC GP4 STD SING POW OPT CAP	PA	MSRP	
K0879	RB		PWC GP4 HD SING POW OPT S/B	CMN	MSRP	

Durable Medical Equipment



K0879	RB	SC	PWC GP4 HD SING POW OPT S/B	CMN	MSRP	
K0879	NU		PWC GP4 HD SING POW OPT S/B	PA	MSRP	
K0879	NU	SC	PWC GP4 HD SING POW OPT S/B	PA	MSRP	
K0880	RB		PWC GP4 VHD SING POW OPT S/B	CMN	MSRP	
K0880	RB	SC	PWC GP4 VHD SING POW OPT S/B	CMN	MSRP	
K0880	NU		PWC GP4 VHD SING POW OPT S/B	PA	MSRP	
K0880	NU	SC	PWC GP4 VHD SING POW OPT S/B	PA	MSRP	
K0884	RB		PWC GP4 STD MULT POW OPT S/B	CMN	MSRP	
K0884	RB	SC	PWC GP4 STD MULT POW OPT S/B	CMN	MSRP	
K0884	NU		PWC GP4 STD MULT POW OPT S/B	PA	MSRP	
K0884	NU	SC	PWC GP4 STD MULT POW OPT S/B	PA	MSRP	
K0885	RB		PWC GP4 STD MULT POW OPT CAP	CMN	MSRP	
K0885	RB	SC	PWC GP4 STD MULT POW OPT CAP	CMN	MSRP	
K0885	NU		PWC GP4 STD MULT POW OPT CAP	PA	MSRP	
K0885	NU	SC	PWC GP4 STD MULT POW OPT CAP	PA	MSRP	
K0886	RB		PWC GP4 HD MULT POW S/B	CMN	MSRP	
K0886	RB	SC	PWC GP4 HD MULT POW S/B	CMN	MSRP	
K0886	NU		PWC GP4 HD MULT POW S/B	PA	MSRP	
K0886	NU	SC	PWC GP4 HD MULT POW S/B	PA	MSRP	
K0890	RB		PWC GP5 PED SING POW OPT S/B	CMN	MSRP	
K0890	RB	SC	PWC GP5 PED SING POW OPT S/B	CMN	MSRP	
K0890	NU		PWC GP5 PED SING POW OPT S/B	PA	MSRP	
K0890	NU	SC	PWC GP5 PED SING POW OPT S/B	PA	MSRP	
K0891	RB		PWC GP5 PED MULT POW OPT S/B	CMN	MSRP	
K0891	RB	SC	PWC GP5 PED MULT POW OPT S/B	CMN	MSRP	
K0891	NU		PWC GP5 PED MULT POW OPT S/B	PA	MSRP	
K0891	NU	SC	PWC GP5 PED MULT POW OPT S/B	PA	MSRP	
K0898	RB		POWER WHEELCHAIR NOC	CMN	MSRP	
K0898	RB	SC	POWER WHEELCHAIR NOC	CMN	MSRP	
K0898	NU		POWER WHEELCHAIR NOC	PA	MSRP	
K0898	NU	SC	POWER WHEELCHAIR NOC	PA	MSRP	
K0900	RB		CSTM DME OTHER THAN WHEELCHR	CMN	MSRP	

Durable Medical Equipment



K0900	RB	SC	CSTM DME OTHER THAN WHEELCHR	CMN	MSRP	
K0900	NU		CSTM DME OTHER THAN WHEELCHR	PA	MSRP	
K0900	NU	SC	CSTM DME OTHER THAN WHEELCHR	PA	MSRP	
L0120	RB		CERV FLEX N/ADJ FOAM PRE OTS	CMN	IOC	
L0120	NU		CERV FLEX N/ADJ FOAM PRE OTS	CMN		
L0130	RB		CERVICAL, FLEXIBLE, THERMOPLASTIC COLLAR, MOLDED TO PATIENT	CMN	IOC	
L0130	NU		CERVICAL, FLEXIBLE, THERMOPLASTIC COLLAR, MOLDED TO PATIENT	CMN		
L0140	RB		CERVICAL, SEMI-RIGID, ADJUSTABLE (PLASTIC COLLAR)	CMN	IOC	
L0140	NU		CERVICAL, SEMI-RIGID, ADJUSTABLE (PLASTIC COLLAR)	CMN		
L0150	RB		CERVICAL, SEMI-RIGID, ADJUSTABLE MOLDED CHIN CUP (PLASTIC COLLAR WITH MANDIBULAR/OCCIPITAL PIECE)	CMN	IOC	
L0150	NU		CERVICAL, SEMI-RIGID, ADJUSTABLE MOLDED CHIN CUP (PLASTIC COLLAR WITH MANDIBULAR/OCCIPITAL PIECE)	CMN		
L0160	RB		CERV SR WIRE OCC/MAN PRE OTS	CMN	IOC	
L0160	NU		CERV SR WIRE OCC/MAN PRE OTS	CMN		
L0170	RB		CERVICAL, COLLAR, MOLDED TO PATIENT MODEL	CMN	IOC	
L0170	NU		CERVICAL, COLLAR, MOLDED TO PATIENT MODEL	CMN		
L0172	RB		CERV COL SR FOAM 2PC PRE OTS	CMN	IOC	
L0172	NU		CERV COL SR FOAM 2PC PRE OTS	CMN		
L0174	RB		CERV SR 2PC THOR EXT PRE OTS	CMN	IOC	
L0174	NU		CERV SR 2PC THOR EXT PRE OTS	CMN		
L0180	RB		CERVICAL, MULTIPLE POST COLLAR, OCCIPITAL/MANDIBULAR SUPPORTS, ADJUSTABLE	CMN	IOC	
L0180	NU		CERVICAL, MULTIPLE POST COLLAR, OCCIPITAL/MANDIBULAR SUPPORTS, ADJUSTABLE	CMN		
L0190	RB		CERVICAL, MULTIPLE POST COLLAR, OCCIPITAL/MANDIBULAR SUPPORTS, ADJUSTABLE CERVICAL BARS (SOMI, GUILF	CMN	IOC	
L0190	NU		CERVICAL, MULTIPLE POST COLLAR, OCCIPITAL/MANDIBULAR SUPPORTS, ADJUSTABLE CERVICAL BARS (SOMI, GUILF	CMN		
L0200	RB		CERVICAL, MULTIPLE POST COLLAR, OCCIPITAL/MANDIBULAR SUPPORTS, ADJUSTABLE CERVICAL BARS, AND THORACI	CMN	IOC	
L0200	NU		CERVICAL, MULTIPLE POST COLLAR, OCCIPITAL/MANDIBULAR SUPPORTS, ADJUST CERVIVAL BARS,AND THORACIC EXT	CMN		

PRODUCTION : 04/09/2020

Durable Medical Equipment



L0220	RB	THORACIC, RIB BELT, CUSTOM FABRICATED	CMN	IOC
L0220	NU	THORACIC, RIB BELT, CUSTOM FABRICATED	PA	
L0450	NU	TLSO FLEX TRUNK/THOR PRE OTS	CMN	
L0452	NU	TLSO FLEX CUSTOM FAB THORACI	CMN	
L0454	NU	TLSO TRNK SJ-T9 PRE CST	CMN	
L0455	NU	TLSO FLEX TRNK SJ-T9 PRE OTS	CMN	
L0456	NU	TLSO FLEX TRNK SJ-SS PRE CST	CMN	
L0457	NU	TLSO FLEX TRNK SJ-SS PRE OTS	CMN	
L0458	NU	TLSO 2MOD SYMPHIS-XIPHO PRE	CMN	
L0460	NU	TLSO 2 SHL SYMPHYS-STERN CST	CMN	
L0462	NU	TLSO 3MOD SACRO-SCAP PRE	CMN	
L0464	NU	TLSO 4MOD SACRO-SCAP PRE	CMN	
L0466	NU	TLSO R FRAM SOFT ANT PRE CST	CMN	
L0467	NU	TLSO R FRAM SOFT PRE OTS	CMN	
L0468	NU	TLSO RIG FRAM PELVIC PRE CST	CMN	
L0469	NU	TLSO RIG FRAM PELVIC PRE OTS	CMN	
L0470	NU	TLSO RIGID FRAME PRE SUBCLAV	CMN	
L0472	NU	TLSO RIGID FRAME HYPEREX PRE	CMN	
L0480	NU	TLSO RIGID PLASTIC CUSTOM FA	CMN	
L0482	NU	TLSO RIGID LINED CUSTOM FAB	CMN	
L0484	NU	TLSO RIGID PLASTIC CUST FAB	CMN	
L0486	NU	TLSO RIGIDLINED CUST FAB TWO	CMN	
L0488	NU	TLSO RIGID LINED PRE ONE PIE	CMN	
L0490	NU	TLSO RIGID PLASTIC PRE ONE	CMN	
L0491	NU	TLSO 2-PIECE RIGID SHELL SPINAL SYSTEM	CMN	
L0492	NU	TLSO 3A-PIECE RIGID SHELL SPINAL SYSTEM	CMN	
L0621	NU	SIO FLEX PELVIC/SACR PRE OTS	CMN	
L0622	NU	SIO FLEX PELVISACRAL CUSTOM	CMN	
L0623	NU	SIO RIG PNL PELV/SAC PRE OTS	CMN	
L0624	NU	SIO PANEL CUSTOM	CMN	IOC
L0625	NU	LO FLEX L1-BELOW L5 PRE OTS	CMN	
L0626	NU	LO SAG RIG PNL STAYS PRE CST	CMN	

Durable Medical Equipment



L0627	NU	LO SAG RI AN/POS PNL PRE CST	CMN		
L0628	NU	LSO FLEX NO RI STAYS PRE OTS	CMN		
L0629	NU	LSO FLEX W/RIGID STAYS CUST	CMN		
L0630	NU	LSO R POST PNL SJ-T9 PRE CST	CMN		
L0631	NU	LSO SAG R AN/POS PNL PRE CST	CMN		
L0632	NU	LUMBAR-SACRAL ORTHOSIS, SAGITTAL CONTROL, WITH RIGID ANTERIOR AND POSTERIOR	CMN		
L0633	NU	LSO SC R POS/LAT PNL PRE CST	CMN		
L0634	NU	LUMBAR-SACRAL ORTHOSIS, SAGITTAL-CORONAL CONTROL, WITH RIGID POSTERIOR	CMN		
L0635	NU	LUMBAR-SACRAL ORTHOSIS, SAGITTAL-CORONAL CONTROL, LUMBAR FLEXION, RIGID	CMN		
L0636	NU	LUMBAR SACRAL ORTHOSIS, SAGITTAL-CORONAL CONTROL, LUMBAR FLEXION, RIGID	CMN		
L0637	NU	LSO SC R ANT/POS PNL PRE CST	CMN		
L0638	NU	LUMBAR-SACRAL ORTHOSIS, SAGITTAL-CORONAL CONTROL, WITH RIGID ANTERIOR AND	CMN		
L0639	NU	LSO S/C SHELL/PANEL PREFAB	CMN		
L0640	NU	LUMBAR-SACRAL ORTHOSIS, SAGITTAL-CORONAL CONTROL, RIGID SHELL(S)/PANEL(S),	CMN		
L0641	NU	LO RIG POS PNL L1-L5 PRE OTS	CMN		
L0642	NU	LO SAG RI AN/POS PNL PRE OTS	CMN		
L0643	NU	LSO SAG CTR RIGI POS PRE OTS	CMN		
L0648	NU	LSO SAG R AN/POS PNL PRE OTS	CMN		
L0649	NU	LSO SC R POS/LAT PNL PRE OTS	CMN		
L0650	NU	LSO SC R ANT/POS PNL PRE OTS	CMN		
L0651	NU	LSO SAG-CO SHELL PNL PRE OTS	CMN		
L0700	RB	CERVICAL-THORACIC-LUMBAR-SACRAL-ORTHOSES (CTLSO), ANTERIOR-POSTERIOR-LATERAL CONTROL, MOLDED TO PATI	CMN		
L0700	NU	CTLSO, ANTERIOR-POSTERIOR-LATERAL CONTROL, MOLDED TO PATIENT (MINERRA TYPE)	CMN		
L0710	RB	CTLSO, ANTERIOR-POSTERIOR-LATERAL-CONTROL, MOLDED TO PATIENT MODEL, WITH INTERFACE MATERIAL, (MINERV	CMN		

Durable Medical Equipment



L0710	NU		CTLSO, ANTERIOR-POSTERIOR-LATERAL-CONTROL, MOLDED TO PATIENT MODEL, WITH INTERFACE MATERIAL, (MINERV	CMN		
L0810	RB		HALO PROCEDURE, VEST	CMN	IOC	
L0810	NU		HALO PROCEDURE, CERVICAL INC. INTO JACKET VEST	CMN		
L0820	RB		HALO PROCEDURE, JACKET	CMN	IOC	
L0820	NU		HALO PROCEDURE, CERVICAL HALO INC INTO PLASTER BODY JACKET	CMN		
L0830	RB		HALO PROCEDURE, ORTHOSIS	CMN	IOC	
L0830	NU		HALO PROCEDURE, CERVICAL HALOINC INTO MILWAUKEE TYPE ORTHOSIS	CMN		
L0859	RB		MRI COMPATIBLE SYSTEM	CMN	IOC	
L0859	NU		MRI COMPATIBLE SYSTEM	CMN		
L0861	NU		HALO REPL LINER/INTERFACE	PA		
L0970	NU		TLSO, CORSET FRONT	CMN		
L0972	NU		LSO, CORSET FRONT	CMN		
L0974	NU		TLSO, FULL CORSET	CMN		
L0976	NU		LSO, FULL CORSET	CMN		
L0978	NU		AXILLARY CRUTCH EXTENSION	CMN		
L0984	NU		PROTECT BODY SOCK EA PRE OTS	CMN		
L0999	NU		ADDITION TO SPINAL ORTHOSIS, NOT OTHERWISE SPECIFIED	PA	IOC	
L1000	RB		CERVICAL-THORACIC-LUMBAR-SACRAL ORTHOSIS (CTLSO) (MILWAUKEE), INCLUSIVE OF FURNISHING INITIAL ORTHOS	CMN		
L1000	NU		CTLSO (MILWAUKEE), INCLUSIVE OF FURNISHING INITIAL ORTHOSIS, INCLUDING MODEL	CMN		
L1010	NU		ADDITION TO CERVICAL-THORACIC-LUMBAR-SACRAL ORTHOSIS (CTLSO) OR SCOLIOSIS ORTHOSIS, AXILLA SLING	CMN		
L1020	NU		ADDITION TO CTLSO OR SCOLIOSIS ORTHOSIS, KYPHOSIS PAD	CMN		
L1025	NU		ADDITION TO CTLSO OR SCOLIOSIS ORTHOSIS, KYPHOSIS PAD, FLOATING	CMN		
L1030	NU		ADDITION TO CTLSO OR SCOLIOSIS ORTHOSIS, LUMBAR BOLSTER PAD	CMN		
L1040	NU		ADDITION TO CTLSO OR SCOLIOSIS ORTHOSIS, LUMBAR OR LUMBAR RIB PAD	CMN		
L1050	NU		ADDITION TO CTLSO OR SCOLIOSIS ORTHOSIS, STERNAL PAD	CMN		
L1060	NU		ADDITION TO CTLSO OR SCOLIOSIS ORTHOSIS, THORACIC PAD	CMN		
L1070	NU		ADDITION TO CTLSO OR SCOLIOSIS ORTHOSIS, TRAPEZE SLING	CMN		
L1080	NU		ADDITION TO CTLSO OR SCOLIOSIS ORTHOSIS, OUTRIGGER	CMN		

PRODUCTION : 04/09/2020

Durable Medical Equipment



L1085	NU		ADDITION TO CTLSO OR SCOLIOSIS ORTHOSIS, OUTRIGGER, BILATERAL WITH VERTICAL EXTENSIONS	CMN		
L1090	NU		ADDITION TO CTLSO OR SCOLIOSIS ORTHOSIS, LUMBAR SLING	CMN		
L1100	NU		ADDITION TO CTLSO OR SCOLIOSIS ORTHOSIS, RING FLANGE, PLASTIC OR LEATHER	CMN		
L1110	NU		ADDITION TO CTLSO OR SCOLIOSIS ORTHOSIS, RING FLANGE, PLASTIC OR LEATHER, MOLDED TO PATIENT MODEL	CMN		
L1120	NU		ADDITION TO CTLSO, SCOLIOSIS ORTHOSIS, COVER FOR UPRIGHT, EACH	CMN		
L1200	NU		THORACIC-LUMBAR-SACRAL-ORTHOSES (TLSO), INCLUSIVE OF FURNISHING INITIAL ORTHOSIS ONLY	CMN		
L1210	NU		ADDITION TO TLSO, (LOW PROFILE), LATERAL THORACIC EXTENSION	CMN		
L1220	NU		ADDITION TO TLSO, (LOW PROFILE), ANTERIOR THORACIC EXTENSION	CMN		
L1230	NU		ADDITION TO TLSO, (LOW PROFILE), MILWAUKEE TYPE SUPERSTRUCTURE	CMN		
L1240	NU		ADDITION TO TLSO (LOW PROFILE), LUMBAR DEROTATION PAD	CMN		
L1250	NU		ADDITION TO TLSO (LOW PROFILE), ANTERIOR ASIS PAD	CMN		
L1260	NU		ADDITION TO TLSO (LOW PROFILE), ANTERIOR THORACIC DEROTATION PAD	CMN		
L1270	NU		ADDITION TO TLSO (LOW PROFILE), ABDOMINAL PAD	CMN		
L1280	NU		ADDITION TO TLSO (LOW PROFILE), RIB GUSSET (ELASTIC), EACH	CMN		
L1290	NU		ADDITION TO TLSO (LOW PROFILE), LATERAL TROCHANTERIC PAD	CMN		
L1300	RB		OTHER SCOLIOSIS PROCEDURE, BODY JACKET MOLDED TO PATIENT MODEL	CMN		
L1300	NU		OTHER SCOLIOSIS PROCEDURE, BODY JACKET MOLDED TO PATIENT MODEL	CMN		
L1310	RB		OTHER SCOLIOSIS PROCEDURE,	CMN	IOC	
L1310	NU		OTHER SCOLIOSIS PROCEDURE, POST OPERATIVE BODY JACKET	CMN		
L1499	NU		SPINAL ORTHOSIS, NOT OTHERWISE SPECIFIED	PA	IOC	
L1600	RB		HO FLEX FREJKA W/COV PRE CST	CMN	IOC	
L1600	NU		HO FLEX FREJKA W/COV PRE CST	CMN		
L1610	RB		HO FREJKA COV ONLY PRE CST	CMN	IOC	
L1610	NU		HO FREJKA COV ONLY PRE CST	CMN		
L1620	RB		HO FLEX PAVLIK HARNS PRE CST	CMN	IOC	
L1620	NU		HO FLEX PAVLIK HARNS PRE CST	CMN		
L1630	RB		HO, ABDUCTION CONTROL OF HIP JOINTS, SEMI-FLEXIBLE (VON ROSEN TYPE)	CMN	IOC	
L1630	NU		HO, ABDUCTION CONTROL OF HIP JOINTS, SEMI-FLEXIBLE (VON ROSEN	CMN		

PRODUCTION : 04/09/2020

			TYPE)			
L1640	RB		HO, ABDUCTION CONTROL OF HIP JOINTS, STATIC, PELVIC BAND OR SPREADER BAR, THIGH CUFFS	CMN	IOC	
L1640	NU		HO, ABDUCTION CONTROL OF HIP JOINTS, STATIC, PELVIC BAND OR SPREADER BAR, THIGH CUFFS	CMN		
L1650	RB		HO, ABDUCTION CONTROL OF HIP JOINTS, STATIC, ADJUSTABLE, (ILFLED TYPE)	CMN	IOC	
L1650	NU		HO, ABDUCTION CONTROL OF HIP JOINTS, STATIC, ADJUSTABLE, (ILFLED TYPE)	CMN		
L1652	NU		HO BI THIGHCUFFS W SPRDR BAR	CMN		
L1660	RB		HO, ABDUCTION CONTROL OF HIP JOINTS, STATIC, PLASTIC,	CMN	IOC	
L1660	NU		HO, ABDUCTION CONTROL OF HIP JOINTS, STATIC, PLASTIC,PREFABRICATED,INCLUDES FITTING & ADJUSTMENTS	CMN		
L1680	RB		HO, ABDUCTION CONTROL OF HIP JOINTS, DYNAMIC, PELVIC CONTROL, ADJUSTABLE HIP MOTION CONTROL, THIGH C	CMN	IOC	
L1680	NU		HO, ABDUCTION CONTROL OF HIP JOINTS, DYNAMIC, PELVIC CONTROL, ADJUST HIP MOTION CONTROL, THIGH CUFFS	CMN		
L1685	RB		HO, ABDUCTION CONTROL OF HIP JOINT, POST-OPERATIVE HIP ABDUCTION TYPE, CUSTOM FABRICATED	CMN	IOC	
L1685	NU		HO, ABDUCTION CONTROL OF HIP JOINT, POST-OPERATIVE HIP ABDUCTION TYPE, CUSTOM FABRICATED	CMN		
L1686	RB		HO, ABDUCTION CONTROL OF HIP JOINT, POST-OPERATIVE HIP ABDUCTION TYPE	CMN	IOC	
L1686	NU		HO, POST-OPERATIVE HIP ABDUCTION TYPE,PREFABRICATED, INCLUDES FITTING & ADJUSTMENTS	CMN		
L1690	NU		COMBINATION,BILATERAL,LUMBO-SACRAL,HIP,FEMUR, ORTHOSIS PROVIDING ADDUCTION & INTERNAL ROTATION CONTR	CMN		
L1700	RB		LEGG PERTHES ORTHOSIS, TORONTO TYPE	CMN	IOC	
L1700	NU		LEGG PERTHES ORTHOSIS, TORONTO TYPE	CMN		
L1710	RB		LEGG PERTHES ORTHOSIS, NEWINGTON TYPE	CMN	IOC	
L1710	NU		LEGG PERTHES ORTHOSIS, NEWINGTON TYPE	CMN		
L1720	RB		LEGG PERTHES ORTHOSIS, TRILATERAL, (TACHDIJAN TYPE)	CMN	IOC	
L1720	NU		LEGG PERTHES ORTHOSIS, TRILATERAL, (TACHDIJAN TYPE)	CMN		
L1730	RB		LEGG PERTHES ORTHOSIS, SCOTTISH RITE TYPE	CMN	IOC	

Durable Medical Equipment



L1730	NU	LEGG PERTHES ORTHOSIS, SCOTTISH RITE TYPE	CMN		
L1755	RB	LEGG PERTHES ORTHOSIS, PATTEN BOTTOM TYPE	CMN	IOC	
L1755	NU	LEGG PERTHES PATTEN BOTTOM TYPE, CUDTOM FABRICATED	CMN		
L1810	RB	KO ELASTIC WITH JOINTS	CMN	IOC	
L1810	NU	KO ELASTIC WITH JOINTS	CMN		
L1812	NU	KO ELASTIC W/JOINTS PRE OTS	CMN		
L1820	RB	KNEE ORTHOSIS, ELASTIC WITH CONDYLAR PADS/JOINTS W/WO PATELLAR	CMN	IOC	
L1820	NU	KNEE ORTHOSIS, ELASTIC WITH CONDYLAR PADS/JOINTS W/WO PATELLAR	CMN		
L1830	RB	KO IMMOB CANVAS LONG PRE OTS	CMN	IOC	
L1830	NU	KO IMMOB CANVAS LONG PRE OTS	CMN		
L1831	NU	KNEE ORTH POS LOCKING JOINT	CMN		
L1832	RB	KO ADJ JNT POS R SUP PRE CST	CMN	IOC	
L1832	NU	KO ADJ JNT POS R SUP PRE CST	CMN		
L1833	NU	KO ADJ JNT POS R SUP PRE OTS	CMN		
L1834	RB	KO, WITHOUT KNEE JOINT, RIGID, MOLDED TO PATIENT MODEL	CMN	IOC	
L1834	NU	KO, WITHOUT KNEE JOINT, RIGID, MOLDED TO PATIENT MODEL	CMN		
L1836	NU	KO RIGID W/O JOINTS PRE OTS	CMN		
L1840	RB	KO, DEROTATION, MEDIAL-LATERAL, ANTERIOR CRUCIATE LIGAMENT, CUSTOM FABRICATED TO PATIENT MODEL	CMN	IOC	
L1840	NU	KO, DEROTATION, MEDIAL-LATERAL, ANTERIOR CRUCIATE LIGAMENT, CUSTOM FABRICATED TO PATIENT MODEL	CMN		
L1843	NU	KO SINGLE UPRIGHT PRE CST	PA		
L1845	RB	KO DOUBLE UPRIGHT PRE CST	CMN	IOC	
L1845	NU	KO DOUBLE UPRIGHT PRE CST	CMN		
L1846	RB	KO W ADJ FLEX/EXT ROTAT MOLD	CMN	IOC	
L1846	NU	KO W ADJ FLEX/EXT ROTAT MOLD	CMN		
L1847	NU	KO DBL UPRIGHT W/AIR PRE CST	CMN		
L1848	NU	KO DBL UPRIGHT W/AIR PRE OTS	CMN		
L1850	RB	KO SWEDISH TYPE PRE OTS	CMN	IOC	
L1850	NU	KO SWEDISH TYPE PRE OTS	CMN		
L1851	NU	KO SINGLE UPRIGHT PREFAB OTS	CMN		
L1852	NU	KO DOUBLE UPRIGHT PREFAB OTS	CMN		

L1860	RB		KO, MODIFICATION OF SUPRACONDYLAR PROSTHETIC SOCKET, MOLDED TO PATIENT MODEL (SK)	CMN	IOC	
L1860	NU		KO, MODIFICATION OF SUPRACONDYLAR PROSTHETIC SOCKET, MOLDED TO PATIENT MODEL (SK)	CMN		
L1885	RB		KO, SINGLE OR DOUBLE UPRIGHT, THIGH AND CALF, WITH FUNTIONAL ACTIVE RESISTANCE CONTROL	CMN	IOC	
L1900	RB		ANKLE-FOOT ORTHOSIS (AFO), SPRING WIRE, DORSIFLEXION ASSIST CALF BAND	CMN	IOC	
L1900	NU		ANKLE-FOOT ORTHOSIS (AFO), SPRING WIRE, DORSIFLEXION ASSIST CALF BAND	CMN		
L1902	RB		AFO ANKLE GAUNTLET PRE OTS	CMN	IOC	
L1902	NU		AFO ANKLE GAUNTLET PRE OTS	CMN		
L1904	RB		AFO MOLDED ANKLE GAUNTLET	CMN	IOC	
L1904	NU		AFO MOLDED ANKLE GAUNTLET	CMN		
L1906	RB		AFO MULTILIG ANK SUP PRE OTS	CMN	IOC	
L1906	NU		AFO MULTILIG ANK SUP PRE OTS	CMN		
L1907	NU		AFO SUPRAMALLEOLAR CUSTOM	CMN		
L1910	RB		AFO, POSTERIOR, SINGLE BAR, CLASP ATTACHMENT TO SHOE COUNTER	CMN	IOC	
L1910	NU		AFO, POSTERIOR, SINGLE BAR, CLASP ATTACHMENT TO SHOE COUNTER	CMN		
L1920	RB		AFO, SINGLE UPRIGHT WITH STATIC OR ADJUSTABLE STOP (PHELPS OR PERLSTEIN TYPE)	CMN	IOC	
L1920	NU		AFO, SINGLE UPRIGHT WITH STATIC OR ADJUSTABLE STOP (PHELPS OR PERLSTEIN TYPE) CUSTOM FABRICATED	CMN		
L1930	RB		AFO, PLASTIC	CMN	IOC	
L1930	NU		AFO, PLASTIC	CMN		
L1932	NU		AFO,RIGID ANTERIOR TIBIAL SECTION, TOTAL CARBON FIBER OR EQUAL	CMN		
L1940	RB		AFO, MOLDED TO PATIENT MODEL, PLASTIC	CMN	IOC	
L1940	NU		AFO, MOLDED TO PATIENT MODEL, PLASTIC	CMN		
L1945	RB		AFO, MOLDED TO PATIENT MODEL, PLASTIC, RIGID ANTERIOR TIBIAL SECTION (FLOOR REACTION)	CMN	IOC	
L1945	NU		AFO, MOLDED TO PATIENT MODEL, PLASTIC, RIGID ANTERIOR TIBIAL SECTION (FLOOR REACTION)	CMN		
L1950	RB		AFO, SPIRAL, MOLDED TO PATIENT MODEL (IRM TYPE), PLASTIC	CMN	IOC	

Durable Medical Equipment



L1950	NU	AFO, SPIRAL, MOLDED TO PATIENT MODEL (IRM TYPE), PLASTIC	CMN		
L1951	NU	AFO SPIRAL PREFABRICATED	CMN		
L1960	RB	AFO, POSTERIOR SOLID ANKLE, MOLDED TO PATIENT MODEL, PLASTIC	CMN	IOC	
L1960	NU	AFO, POSTERIOR SOLID ANKLE, MOLDED TO PATIENT MODEL, PLASTIC	CMN		
L1970	RB	AFO, PLASTIC MOLDED TO PATIENT MODEL, WITH ANKLE JOINT	CMN	IOC	
L1970	NU	AFO, PLASTIC MOLDED TO PATIENT MODEL, WITH ANKLE JOINT	CMN		
L1971	NU	AFO W/ANKLE JOINT, PREFAB	CMN		
L1980	RB	AFO, SINGLE UPRIGHT FREE PLANTAR DORSIFLEXION, SOLID STIRRUP, CALF BAND/CUFF (SINGLE BAR BK ORTHOS	CMN	IOC	
L1980	NU	AFO, SINGLE UPRIGHT FREE PLANTAR DORSIFLEXION, SOLID STIRRUP, CALF BAND/CUFF (SINGLE BAR BK ORTHOS	CMN		
L1990	RB	AFO, DOUBLE UPRIGHT FREE PLANTAR DORSIFLEXION, SOLID STIRRUP, CALF BAND/CUFF (DOUBLE BAR BK ORTHOS	CMN	IOC	
L1990	NU	AFO, DOUBLE UPRIGHT FREE PLANTAR DORSIFLEXION, SOLID STIRRUP, CALF BAND/CUFF (DOUBLE BAR BK ORTHOS	CMN		
L2000	RB	KNEE-ANKLE-FOOT-ORTHOSES (KAFO), SINGLE UPRIGHT, FREE KNEE, FREE ANKLE, SOLID STIRRUP, THIGH AND CAL	CMN	IOC	
L2000	NU	KAFO,SINGLE UPRIGHT, FREE KNEE ANKLE, SOLID STIRUP, THIGH AND CALF BANDS/CUFF SINGLE BAR AK ORTHOSIS	CMN		
L2005	NU	KAFO SNG/DBL MECHANICAL ACT	CMN		
L2006	NU	KAF SNG/DBL SWG/STN MCPR CUS	PA	IOC	
L2006	RB	KAF SNG/DBL SWG/STN MCPR CUS	PA	IOC	
L2010	RB	KAFO, SINGLE UPRIGHT, FREE ANKLE, SOLID STIRRUP, THIGH AND CALF BANDS/CUFFS (SINGLE BAR AK ORTHOSI	CMN	IOC	
L2010	NU	KAFO, SNGL UPRIGHT,FREE ANKLE,SOLID STIRUP, THIGH AND CALF BANDS/CUFFS (SINGLE BAR AK ORTHOSIS WO KN	CMN		
L2020	RB	KAFO, DOUBLE UPRIGHT, FREE KNEE, FREE ANKLE, SOLID STIRRUP, THIGH AND CALF BANDS/CUFFS (DOUBLE BAR	CMN	IOC	
L2020	NU	KAFO, DOUBLE UPRIGHT, FREE ANKLE,SOLID STIRRUP,THIGH AND CALF BANDS/CUFFS(DOUBLE BAR AK ORTHOSIS)	CMN		
L2030	RB	KAFO, DOUBLE UPRIGHT, FREE ANKLE, SOLID STIRRUP, THIGH AND CALF BANDS/CUFFS, (DOUBLE BAR AK ORTHOS	CMN	IOC	

Durable Medical Equipment



L2030	NU		KAFO, DOUBLE UPRIGHT, FREE ANKLE, SOLID STIRRUP, THIGH AND CALF BANDS/CUFFS, (DOUBLE BAR AK ORTHOS	CMN		
L2034	RB		KAFO PLA SIN UP W/WO K/A CUS	CMN	IOC	
L2034	NU		KAFO PLA SIN UP W/WO K/A CUS	CMN		
L2035	NU		KAFO,FULL PLASTIC, STATIC (PED SZ) W/O FREE	PA		
L2036	RB		KAFO PLAS DOUB FREE KNEE MOL	CMN	IOC	
L2036	NU		KAFO PLAS DOUB FREE KNEE MOL	CMN		
L2037	RB		KAFO PLAS SING FREE KNEE MOL	CMN	IOC	
L2037	NU		KAFO PLAS SING FREE KNEE MOL	CMN		
L2038	RB		KAFO, FULL PLASTIC, W/O KNEE JOINT, MULTI-AXIS ANKLE	CMN	IOC	
L2038	NU		KAFO, FULL PLASTIC, W/O KNEE JOINT, MULTI-AXIS ANKLE	CMN		
L2040	RB		HIP-KNEE-ANKLE-FOOT ORTHOSIS (HKAFO) TORSION CONTROL, BILATERAL ROTATION STRAPS, PELVIC BAND/BELT	CMN	IOC	
L2040	NU		HIP-KNEE-ANKLE-FOOT ORTHOSIS (HKAFO) TORSION CONTROL, BILATERAL ROTATION STRAPS, PELVIC BAND/BELT	CMN		
L2050	RB		HKAFO, TORSION CONTROL, BILATERAL TORSION CABLES, HIP JOINT, PELVIC BAND/BELT	CMN	IOC	
L2050	NU		HKAFO, TORSION CONTROL, BILATERAL TORSION CABLES, HIP JOINT, PELVIC BAND/BELT	CMN		
L2060	RB		HKAFO, TORSION CONTROL, BILATERAL TORSION CABLES, BALL BEARING HIP JOINT, PELVIC BAND/ BELT	CMN	IOC	
L2060	NU		HKAFO, TORSION CONTROL, BILATERAL TORSION CABLES, BALL BEARING HIP JOINT, PELVIC BAND/ BELT	CMN		
L2070	RB		HKAFO, TORSION CONTROL, UNILATERAL ROTATION STRAPS, PELVIC BAND/BELT	CMN	IOC	
L2070	NU		HKAFO, TORSION CONTROL, UNILATERAL ROTATION STRAPS, PELVIC BAND/BELT	CMN		
L2080	RB		HKAFO, TORSION CONTROL, UNILATERAL TORSION CABLE, HIP JOINT, PELVIC BAND/BELT	CMN	IOC	
L2080	NU		HKAFO, TORSION CONTROL, UNILATERAL TORSION CABLE, HIP JOINT, PELVIC BAND/BELT	CMN		
L2090	RB		HKAFO, TORSION CONTROL, UNILATERAL TORSION CABLE, BALL BEARING HIP JOINT, PELVIC BAND/ BELT	CMN	IOC	

PRODUCTION : 04/09/2020

Durable Medical Equipment



L2090	NU	HKAFO, TORSION CONTROL, UNILATERAL TORSION CABLE, BALL BEARING HIP JOINT, PELVIC BAND/ BELT	CMN		
L2106	RB	AFO, FRACTURE ORTHOSIS, TIBIAL FRACTURE CAST ORTHOSIS, THERMOPLASTIC TYPE CASTING MATERIAL, MOLDED T	CMN	IOC	
L2106	NU	AFO, FRACTURE ORTHOSIS, TIBIAL FRACTURE CAST ORTHOSIS, THERMOPLASTIC TYPE CASTING MATERIAL, MOLDED T	CMN		
L2108	RB	AFO, FRACTURE ORTHOSIS, TIBIAL FRACTURE CAST ORTHOSIS, MOLDED TO PATIENT MODEL	CMN	IOC	
L2108	NU	AFO, FRACTURE ORTHOSIS, TIBIAL FRACTURE CAST ORTHOSIS, MOLDED TO PATIENT MODEL	CMN		
L2112	RB	AFO, FRACTURE ORTHOSIS, TIBIAL FRACTURE ORTHOSIS, SOFT	CMN	IOC	
L2112	NU	AFO, FRACTURE ORTHOSIS, TIBIAL FRACTURE CAST ORTHOSIS,SOFT, PRE-FABRICATED,INCLUDES FITTING & ADJUST	CMN		
L2114	RB	AFO, FRACTURE ORTHOSIS, TIBIAL FRACTURE ORTHOSIS, SEMI-RIGID	CMN	IOC	
L2114	NU	AFO, FRACTURE ORTHOSIS, TIBIAL FRACTURE ORTHOSIS, SEMI-RIGID	CMN		
L2116	RB	AFO, FRACTURE ORTHOSIS, TIBIAL FRACTURE ORTHOSIS, RIGID	CMN	IOC	
L2116	NU	AFO, FRACTURE ORTHOSIS, TIBIAL FRACTURE ORTHOSIS, RIGID	CMN		
L2126	RB	KAFO, FRACTURE ORTHOSIS, FEMORAL FRACTURE CAST ORTHOSIS, THERMOPLASTIC TYPE CASTING MATERIAL, MOLDED	CMN	IOC	
L2126	NU	KAFO, FRACTURE ORTHOSIS, FEMORAL FRACTURE CAST ORTHOSIS, THERMOPLASTIC TYPE CASTING MATERIAL, MOLDED	CMN		
L2128	RB	KAFO, FRACTURE ORTHOSIS, FEMORAL FRACTURE CAST ORTHOSIS, MOLDED TO PATIENT MODEL	CMN	IOC	
L2128	NU	KAFO, FRACTURE ORTHOSIS, FEMORAL FRACTURE CAST ORTHOSIS, MOLDED TO PATIENT MODEL	CMN		
L2132	RB	KAFO, FRACTURE ORTHOSIS, FEMORAL FRACTURE CAST ORTHOSIS, SOFT	CMN	IOC	
L2132	NU	KAFO, FRACTURE ORTHOSIS, FEMORAL FRACTURE CAST ORTHOSIS, SOFT	CMN		
L2134	RB	KAFO, FRACTURE ORTHOSIS, FEMORAL FRACTURE CAST ORTHOSIS, SEMI-RIGID	CMN	IOC	
L2134	NU	KAFO, FRACTURE ORTHOSIS, FEMORAL FRACTURE CAST ORTHOSIS, SEMI-RIGID	CMN		
L2136	RB	KAFO, FRACTURE ORTHOSIS, FEMORAL FRACTURE CAST ORTHOSIS, RIGID	CMN	IOC	
L2136	NU	KAFO, FRACTURE ORTHOSIS, FEMORAL FRACTURE CAST ORTHOSIS, RIGID	CMN		

Durable Medical Equipment



L2180	NU		ADDITION TO LOWER EXTREMITY FRACTURE ORTHOSIS, PLASTIC SHOE INSERT WITH ANKLE JOINTS	CMN		
L2182	NU		ADDITION TO LOWER EXTREMITY FRACTURE ORTHOSIS, DROP LOCK KNEE JOINT	CMN		
L2184	NU		ADDITION TO LOWER EXTREMITY FRACTURE ORTHOSIS, LIMITED MOTION KNEE JOINT	CMN		
L2186	NU		ADDITION TO LOWER EXTREMITY FRACTURE ORTHOSIS, ADJUSTABLE MOTION KNEE JOINT, LERMAN TYPE	CMN		
L2188	NU		ADDITION TO LOWER EXTREMITY FRACTURE OTHOSIS, QUADRILATERAL BRIM	CMN		
L2190	NU		ADDITION TO LOWER EXTREMITY FRACTURE ORTHOSIS, WAIST BELT	CMN		
L2192	NU		ADDITION TO LOWER EXTREMITY FRACTURE ORTHOSIS, HIP JOINT, PELVIC BAND, THIGH FLANGE, AND PELVIC BELT	CMN		
L2200	NU		ADDITION TO LOWER EXTREMITY, LIMITED ANKLE MOTION, EACH JOINT	CMN		
L2210	NU		ADDITION TO LOWER EXTREMITY, DORSIFLEXION ASSIST (PLANTAR FLEXION RESIST), EACH JOINT	CMN		
L2220	NU		ADDITION TO LOWER EXTREMITY, DORSIFLEXION AND PLANTAR FLEXION ASSIST/RESIST, EACH JOINT	CMN		
L2230	NU		ADDITION TO LOWER EXTREMITY, SPLIT FLAT CALIPER STIRRUPS AND PLATE ATTACHMENT	CMN		
L2232	NU		ADDITION TO LOWER EXTREMITY ORTHOSIS, ROCKER BOTTOM FOR TOTAL CONTACT ANKLE	CMN		
L2240	NU		ADDITION TO LOWER EXTREMITY, ROUND CALIPER AND PLATE ATTACHMENT	CMN		
L2250	NU		ADD TO LOWER EXTREMITY, FOOT PLATE MOLDED, STIRUP ATTACHMENT	CMN		
L2260	NU		ADD TO LOWER EXTREMITY, REINFORCED SOLID STIRUP SCOTT-CRAIG TYPE	CMN		
L2265	NU		ADDITION TO LOWER EXTREMITY, LONG TONGUE STIRRUP	CMN		
L2270	NU		ADD LOWER EXTREMITY VARUS/VULGUS CORRECTION T STRAP, PADDED/LINED OR MALLEOLUS PAD	CMN		
L2275	NU		ADDITION TO LOWER EXTREMITY, VARUS/VULGUS CORRECTION, PLASTIC MODIFICATION, PADDED/LINED	CMN		
L2280	NU		ADDITION TO LOWER EXTREMITY, MOLDED INNER BOOT	CMN		
L2300	NU		ADD, ABDUCTION BAR BILATERAL HIP INVOLVEMENT, JOINTED, ADJUSTABLE	CMN		
L2310	NU		ADDITION, ABDUCTION BAR STRAIGHT	CMN		

Durable Medical Equipment



L2320	NU	NON MOLDED LACER, FOR CUSTOM FABRICATED ORTHOSIS, LOWER EXTREMITY	CMN		
L2330	NU	LACER MOLDED TO PATIENT MODEL, FOR CUSTOM LOWER EXT	CMN		
L2335	NU	ADDITION, ANTERIOR SWING BAND	CMN		
L2340	NU	ADDITION PRE TIBIAL SHELL MOLDED TO PATIENT	CMN		
L2350	NU	ADDITION PROSTHETIC TYPE BK SOCKET, MOLDED TO PATIENT (USED FOR PTB AFO)	CMN		
L2360	NU	ADDITION, EXTENDED STEEL SHANK	CMN		
L2370	NU	ADDITION TO LOWER EXTREMITY, PATTEN BOTTOM	CMN		
L2375	NU	ADDITION TO LOWER EXTREMITY, TORSION CONTROL,ANKLEJOINT & HALF SOLID STIRRUP	CMN		
L2380	NU	ADDITION TO LOWER EXTREMITY, TORSION CONTROL,STRAIGHT KNEE JOINT, EACH JOINT	CMN		
L2385	NU	ADDITION, STRAIGHT KNEE JOINT, HEAVY DUTY EACH JOINT	CMN		
L2387	RB	ADD LE POLY KNEE CUSTOM KAFO	CMN	IOC	
L2387	NU	ADD LE POLY KNEE CUSTOM KAFO	CMN		
L2390	RB	ADDITION	CMN	IOC	
L2390	NU	ADDITION, OFFSET KNEE JOINT, EACH JOINT	CMN		
L2395	NU	ADDITION, OFFSET KNEE JOINT, HEAVY DUTY EACH JOINT	CMN		
L2397	NU	ADDITION TO LOWER EXTREMITY ORTHOSIS, SUSPENSION SLEEVE	CMN		
L2405	NU	KNEE JOINT DROP LOCK EA JNT	CMN		
L2415	NU	ADDITION TO KNEE LOCK WITH INTEGRATED RELEASE MECHANISM(BAIL,CABLE, OR EQUAL)ANY MATERIAL,EACH JOINT	CMN		
L2425	NU	ADDITION TO KNEE JOINT, DISC OR DIAL LOCK FOR ADJUSTABLE KNEE FLEXION, EACH JOINT	CMN		
L2430	NU	ADDITION TO KNEE JOINT, RATCHET LOCK FOR ACTIVE AND PROGRESSIVE KNEE EXTENSION, EACH JOINT	CMN		
L2492	NU	ADDITION TO KNEE JOINT, LIFT LOOP FOR DROP LOCK RING	CMN		
L2500	NU	ADDITION TO LOWER EXTREMITY, THIGH/WEIGHT BEARING, GLUTEAL/ ISCHIAL WEIGHT BEARING, RING	CMN		
L2510	NU	ADDITION TO LOWER EXTREMITY, THIGH/WEIGHT BEARING, QUADRI-LATERAL BRIM, MOLDED TO PATIENT MODEL	CMN		
L2520	NU	ADDITION QUADRILATERAL BRIM, CUSTOM FITTED	CMN		

PRODUCTION : 04/09/2020

Durable Medical Equipment



L2525	NU		ADDITION TO LOWER EXTREMITY, THIGH/WEIGHT BEARING, ISCHIAL CONTAINMENT/NARROW M-L BRIM MOLDED TO PAT	CMN		
L2526	NU		ADDITION TO LOWER EXTREMITY, THIGH/WEIGHT BEARING, ISCHIAL CONTAINMENT/NARROW M-L BRIM, CUSTOM FITTE	CMN		
L2530	NU		ADDITION, THIGH WEIGHT BEARING, LACER NON MOLDED	CMN		
L2540	NU		ADDITION THIGH WEIGHT BEARING LACER MOLDED TO PATIENT	CMN		
L2550	NU		ADDITION THIGH WEIGHT BEARING HIGH ROLL CUFF	CMN		
L2570	NU		ADDITION TO LOWER EXTREMITY, PELVIC CONTROL, HIP JOINT, CLEVIS TYPE TWO POSITION JOINT, EACH	CMN		
L2580	NU		ADDITION TO LOWER EXTREMITY, PELVIC CONTROL, PELVIC SLING	CMN		
L2600	NU		ADDITION TO LOWER EXTREMITY, PELVIC CONTROL, HIP JOINT, CLEVIS TYPE, OR THRUST BEARING, FREE, EACH	CMN		
L2610	NU		ADDITION TO LOWER EXTREMITY, PELVIC CONTROL, HIP JOINT, CLEVIS OR THRUST BEARING, LOCK, EACH	CMN		
L2620	NU		ADDITION TO LOWER EXTREMITY, PELVIC CONTROL, HIP JOINT, HEAVY DUTY, EACH	CMN		
L2622	NU		ADDITION TO LOWER EXTREMITY, PELVIC CONTROL, HIP JOINT, ADJUSTABLE FLEXION, EACH	CMN		
L2624	NU		ADDITION TO LOWER EXTREMITY, PELVIC CONTROL, HIP JOINT, ADJUSTABLE FLEXION, EXTENSION, ABDUCTION CON	CMN		
L2627	NU		ADDITION TO LOWER EXTREMITY, PELVIC CONTROL, PLASTIC, MOLDED TO PATIENT MODEL, RECIPROCATING HIP JOI	CMN		
L2628	NU		ADDITION TO LOWER EXTREMITY, PELVIC CONTROL, METAL FRAME, RECIPROCATING HIP JOINT AND CABLES	CMN		
L2630	NU		ADDITION TO LOWER EXTREMITY, PELVIC CONTROL, BAND AND BELT, UNILATERAL	CMN		
L2640	NU		ADDITION TO LOWER EXTREMITY, PELVIC CONTROL, BAND AND BELT, BILATERAL	CMN		
L2650	NU		ADDITION TO LOWER EXTREMITY, PELVIC AND THORACIC CONTROL, GLUTEAL PAD, EACH	CMN		
L2660	NU		ADDITION TO LOWER EXTREMITY, THORACIC CONTROL, THORACIC BAND	CMN		
L2670	NU		ADDITION TO LOWER EXTREMITY, THORACIC CONTROL, PARASPINAL UPRIGHTS	CMN		



L2680	NU		ADDITION TO LOWER EXTREMITY, THORACIC CONTROL, LATERAL SUPPORT UPRIGHTS	CMN		
L2750	NU		ADDITION TO LOWER EXTREMITY ORTHOSIS, PLATING CHROME OR NICKEL, PER BAR	CMN		
L2755	NU		HIGH STRENGTH LIGHTWEIGHT LOWER EXTREMITY ORTHOSIS	CMN		
L2760	NU		ADDITION TO LOWER EXTREMITY ORTHOSIS, EXTENSION, PER EXTENSION, PER BAR (FOR LINEAL ADJUSTMENT FOR G	CMN		
L2780	NU		ADDITION TO LOWER EXTREMITY ORTHOSIS, NON-CORROSIVE FINISH, PER BAR	CMN		
L2785	NU		ADDITION TO LOWER EXTREMITY ORTHOSIS, DROP LOCK RETAINER, EACH	CMN		
L2795	NU		ADDITION TO LOWER EXTREMITY ORTHOSIS, KNEE CONTROL, FULL KNEECAP	CMN		
L2800	NU		KNEE CONTROL KNEE CAP, MEDIAL OR LATERAL LOWER EXTREMITY ORTHOSIS	CMN		
L2810	NU		ADDITION TO LOWER EXTREMITY ORTHOSIS, KNEE CONTROL, CONDYLAR PAD	CMN		
L2820	NU		ADDITION TO LOWER EXTREMITY ORTHOSIS, SOFT INTERFACE FOR MOLDED PLASTIC, BELOW KNEE SECTION	CMN		
L2830	NU		ADDITION TO LOWER EXTREMITY ORTHOSIS, SOFT INTERFACE FOR MOLDED PLASTIC, ABOVE KNEE SECTION	CMN		
L2840	NU		ADDITION TO LOWER EXTREMITY ORTHOSIS, TIBIAL LENGTH SOCK, FRACTURE OR EQUAL, EACH	CMN		
L2850	NU		ADDITION TO LOWER EXTREMITY ORTHOSIS, FEMORAL LENGTH SOCK, FRACTURE OR EQUAL, EACH	CMN		
L2861	NU		TORSION MECHANISM KNEE/ANKLE	CMN	IOC	
L2999	NU		LOWER EXTREMITY ORTHOSES, NOT OTHERWISE SPECIFIED	PA	IOC	
L3000	NU		FOOT, INSERT, REMOVABLE, MOLDED TO PATIENT MODEL, UCB TYPE, BERKELEY SHELL, EACH	CMN		
L3001	NU		FOOT, INSERT, REMOVABLE, MOLDED TO PATIENT MODEL, SPENCO, EACH	CMN		
L3002	NU		FOOT, INSERT, REMOVABLE, MOLDED TO PATIENT MODEL, PLASTAZOTE OR EQUAL, EACH	CMN		
L3003	NU		FOOT, INSERT, REMOVABLE, MOLDED TO PATIENT MODEL, SILICONE GEL, EACH	CMN		

Durable Medical Equipment



L3010	NU	FOOT, INSERT, REMOVABLE, MOLDED TO PATIENT MODEL, LONGITUDINAL ARCH SUPPORT, EACH	CMN		
L3020	NU	FOOT, INSERT, REMOVABLE, MOLDED TO PATIENT MODEL, LONGITUDINAL/METATARSAL SUPPORT, EACH	CMN		
L3030	NU	FOOT, INSERT, REMOVABLE, FORMED TO PATIENT FOOT, EACH	CMN		
L3031	NU	FOOT LAMIN/PREPREG COMPOSITE	CMN		
L3040	NU	FOOT, ARCH SUPPORT, REMOVABLE, PREMOLDED, LONGITUDINAL, EACH	CMN		
L3050	NU	FOOT, ARCH SUPPORT, REMOVABLE, PREMOLDED, METATARSAL, EACH	CMN		
L3060	NU	FOOT, ARCH SUPPORT, REMOVABLE, PREMOLDED, LONGITUDINAL/METATARSAL, EACH	CMN		
L3070	NU	FOOT, ARCH SUPPORT, NON-REMOVABLE ATTACHED TO SHOE, LONGITUDINAL, EACH	CMN		
L3080	NU	FOOT, ARCH SUPPORT, NON-REMOVABLE ATTACHED TO SHOE, METATARSAL, EACH	CMN		
L3090	NU	FOOT, ARCH SUPPORT, NON-REMOVABLE ATTACHED TO SHOE, LONGITUDINAL/METATARSAL, EACH	CMN		
L3100	NU	HALLUS-VALGUS NT DYN PRE OTS	CMN		
L3140	NU	FOOT, ABDUCTION ROTATION BAR, INCLUDING SHOES	CMN		
L3150	NU	FOOT, ABDUCTION ROTATION BAR, WITHOUT SHOES	CMN		
L3160	NU	FOOT, ADJUSTABLE SHOE-STYLED POSITIONING DEVICE	CMN		
L3170	NU	FOOT PLAS HEEL STABI PRE OTS	CMN		
L3201	NU	ORTHOPEDIC SHOE, OXFORD WITH SUPINATOR OR PRONATOR, INFANT, EACH	CMN		
L3202	NU	ORTHOPEDIC SHOE, OXFORD WITH SUPINATOR OR PRONATOR, CHILD, EACH	CMN		
L3203	NU	ORTHOPEDIC SHOE, OXFORD WITH SUPINATOR OR PRONATOR, JUNIOR, EACH	CMN		
L3204	NU	ORTHOPEDIC SHOE, HIGHTOP WITH SUPINATOR OR PRONATOR, INFANT, EACH	CMN		
L3206	NU	ORTHOPEDIC SHOE, HIGHTOP WITH SUPINATOR OR PRONATOR, CHILD, EACH	CMN		
L3207	NU	ORTHOPEDIC SHOE, HIGHTOP WITH SUPINATOR OR PRONATOR, JUNIOR, EACH	CMN		
L3208	NU	SURGICAL BOOT, EACH, INFANT	CMN		

PRODUCTION : 04/09/2020

Durable Medical Equipment



L3209	NU	SURGICAL BOOT, EACH, CHILD	CMN		
L3211	NU	SURGICAL BOOT, EACH, JUNIOR	CMN		
L3212	NU	BENESCH BOOT, PAIR, INFANT	CMN		
L3213	NU	BENESCH BOOT, PAIR, CHILD	CMN		
L3214	NU	BENESCH BOOT, PAIR, JUNIOR	CMN		
L3215	NU	ORTHOPEdic FTWEAR LADIES OXF	CMN		
L3216	NU	ORTHOPEdic LADIES SHOES DPTH I	CMN		
L3217	NU	ORTHOPEdic FOOTWEAR, LADIES SHOE, HIGHTOP, DEPTH INLAY, EACH	CMN		
L3219	NU	ORTHOPEdic MENS SHOES OXFORD	CMN		
L3221	NU	ORTHOPEdic MENS SHOES DPTH I	CMN		
L3222	NU	MENS SHOES HIGHTOP DEPTH INL	CMN		
L3224	NU	ORTHOPEdic FOOTWEAR, WOMAN'S SHOE, OXFORD, USED ASAN INTEGRAL PART OF A BRACE (ORTHOsis)	CMN		
L3225	NU	ORTHOPEdic FOOTWEAR, MAN'S SHOE, OXFORD, USED AS AN INTEGRAL PART OF A BRACE (ORTHOsis)	CMN		
L3230	NU	CUSTOM SHOES DEPTH INLAY	CMN		
L3250	NU	ORTHOPEdic FOOTWEAR, CUSTOM MOLDED SHOE, REMOVABLE INNER MOLD, PROSTHETIC SHOE, EACH	PA	IOC	
L3251	NU	FOOT, SHOE MOLDED TO PATIENT MODEL, SILICONE SHOE, EACH	PA	IOC	
L3252	NU	FOOT, SHOE MOLDED TO PATIENT MODEL, PLASTAZOTE (OR SIMILAR), CUSTOM FABRICATED, EACH	PA	IOC	
L3253	NU	FOOT, MOLDED SHOE PLASTAZOTE (OR SIMILAR) CUSTOM FITTED, EACH	CMN	IOC	
L3254	NU	NON-STANDARD SIZE OR WIDTH	PA	IOC	
L3255	NU	NON-STANDARD SIZE OR LENGTH	PA	IOC	
L3260	NU	AMBULATORY SURGICAL BOOT EAC	CMN		
L3300	NU	LIFT, ELEVATION, HEEL, TAPERED TO METATARSALS, PER INCH	CMN		
L3310	NU	LIFT, ELEVATION, HEEL AND SOLE, NEOPRENE, PER INCH	CMN		
L3320	NU	LIFT, ELEVATION, HEEL AND SOLE, CORK, PER INCH	CMN		
L3330	NU	LIFT, ELEVATION, METAL EXTENSION (SKATE)	CMN		
L3332	NU	LIFT, ELEVATION, INSIDE SHOE, TAPERED, UP TO ONE-HALF INCH	CMN		
L3334	NU	LIFT, ELEVATION, HEEL, PER INCH	CMN		
L3340	NU	HEEL WEDGE, SACH	CMN		
L3350	NU	HEEL WEDGE	CMN		

Durable Medical Equipment



L3360	NU	SOLE WEDGE, OUTSIDE SOLE	CMN
L3370	NU	SOLE WEDGE, BETWEEN SOLE	CMN
L3380	NU	CLUBFOOT WEDGE	CMN
L3390	NU	OUTFLARE WEDGE	CMN
L3400	NU	METATARSAL BAR WEDGE, ROCKER	CMN
L3410	NU	METATARSAL BAR WEDGE, BETWEEN SOLE	CMN
L3420	NU	FULL SOLE AND HEEL WEDGE, BETWEEN SOLE	CMN
L3430	NU	HEEL, COUNTER, PLASTIC REINFORCED	CMN
L3440	NU	HEEL, COUNTER, LEATHER REINFORCED	CMN
L3450	NU	HEEL, SACH CUSHION TYPE	CMN
L3455	NU	HEEL, NEW LEATHER, STANDARD	CMN
L3460	NU	HEEL, NEW RUBBER, STANDARD	CMN
L3465	NU	HEEL, THOMAS WITH WEDGE	CMN
L3470	NU	HEEL, THOMAS EXTENDED TO BALL	CMN
L3480	NU	HEEL, PAD AND DEPRESSION FOR SPUR	CMN
L3485	NU	HEEL, PAD, REMOVABLE FOR SPUR	CMN
L3500	NU	ORTHOPEDIC SHOE ADDITION; INSOLE, LEATHER	CMN
L3510	NU	INSOLE, RUBBER	CMN
L3520	NU	INSOLE, FELT COVERED WITH LEATHER	CMN
L3530	NU	SOLE, HALF	CMN
L3540	NU	SOLE, FULL	CMN
L3550	NU	TOE TAP, STANDARD	CMN
L3560	NU	TOE TAP, HORSESHOE	CMN
L3570	NU	SPECIAL EXTENSION TO INSTEP (LEATHER WITH EYELETS)	CMN
L3580	NU	CONVERT INSTEP TO VELCRO CLOSURE	CMN
L3590	NU	CONVERT FIRM SHOE COUNTER TO SOFT COUNTER	CMN
L3595	NU	MARCH BAR	CMN
L3600	NU	TRANSFER OF ORTHOSIS FROM ONE SHOE TO ANOTHER, CALIPER PLATE EXISTING	CMN
L3610	NU	TRANSFER CALIPER PLATE, NEW	CMN
L3620	NU	TRANSFER SOLID STIRRUP, EXISTING	CMN
L3630	NU	TRANSFER SOLID STIRRUP, NEW	CMN

Durable Medical Equipment



L3640	NU	TRANSFER, DENNIS BROWNE SPLINT (RIVETON) BOTH SHOES	CMN		
L3649	NU	ORTHOPEDIC SHOE, MODIFICATION, ADDITION OR TRANSFER, NOT OTHERWISE SPECIFIED	PA	IOC	
L3650	RB	SO 8 ABD RESTRAINT PRE OTS	CMN	IOC	
L3650	NU	SO 8 ABD RESTRAINT PRE OTS	CMN		
L3660	RB	SO 8 AB RSTR CAN/WEB PRE OTS	CMN	IOC	
L3660	NU	SO 8 AB RSTR CAN/WEB PRE OTS	CMN		
L3670	RB	SO ACRO/CLAV CAN WEB PRE OTS	CMN	IOC	
L3670	NU	SO ACRO/CLAV CAN WEB PRE OTS	CMN		
L3671	RB	SO CAP DESIGN W/O JNTS CF	CMN	IOC	
L3671	NU	SO CAP DESIGN W/O JNTS CF	CMN		
L3674	NU	SO AIRPLANE W/WO JOINT CF	CMN		
L3675	NU	SO VEST CANVAS/WEB PRE OTS	CMN		
L3702	RB	EO W/O JOINTS CF	CMN	IOC	
L3702	NU	EO W/O JOINTS CF	CMN		
L3710	RB	EO ELAS W/METAL JNTS PRE OTS	CMN	IOC	
L3710	NU	EO ELAS W/METAL JNTS PRE OTS	CMN		
L3720	RB	EO, DOUBLE UPRIGHT WITH FOREARM/ARM CUFFS, FREE MOTION	CMN	IOC	
L3720	NU	EO, DOUBLE UPRIGHT WITH FOREARM/ARM CUFFS, FREE MOTION	CMN		
L3730	RB	EO, DOUBLE UPRIGHT WITH FOREARM/ARM CUFFS, EXTENSION/ FLEXION ASSIST	CMN	IOC	
L3730	NU	EO, DOUBLE UPRIGHT WITH FOREARM/ARM CUFFS, EXTENSION/ FLEXION ASSIST	CMN		
L3740	RB	EO, DOUBLE UPRIGHT WITH FOREARM/ARM CUFFS, ADJUSTABLE POSITION LOCK WITH ACTIVE CONTROL	CMN	IOC	
L3740	NU	EO, DOUBLE UPRIGHT WITH FOREARM/ARM CUFFS, ADJUSTABLE POSITION LOCK WITH ACTIVE CONTROL,CUSTOM FABRI	CMN		
L3760	NU	WITH ADJUSTABLE POSITION LOCKING JOINT(S),PREFABRICATED, INCLUDES FITTING AND ADJUSTMENT	CMN		
L3761	NU	EO, ADJ LOCK JOINT PREFAB QT	CMN		
L3761	RB	EO, ADJ LOCK JOINT PREFAB QT	CMN		
L3762	NU	EO RIGID W/O JOINTS PRE OTS	CMN		
L3763	RB	EWHO RIGID W/O JNTS CF	CMN	IOC	

Durable Medical Equipment



L3763	NU		EWHO RIGID W/O JNTS CF	CMN		
L3764	RB		EWHO W/JOINT(S) CF	CMN	IOC	
L3764	NU		EWHO W/JOINT(S) CF	CMN		
L3765	RB		EWHFO RIGID W/O JNTS CF	CMN	IOC	
L3765	NU		EWHFO RIGID W/O JNTS CF	CMN		
L3766	RB		EWHFO W/JOINT(S) CF	CMN	IOC	
L3766	NU		EWHFO W/JOINT(S) CF	CMN		
L3806	RB		WHFO W/JOINT(S) CUSTOM FAB	CMN	IOC	
L3806	NU		WHFO W/JOINT(S) CUSTOM FAB	CMN	IOC	
L3808	NU		WHFO, RIGID W/O JOINTS	CMN	IOC	
L3891	NU		TORSION MECHANISM WRIST/ELBO	CMN	IOC	
L3900	NU		WHFO, DYNAMIC FLEXOR HINGE, RECIP. WRIST EXTEN/FLEX, FINGER FLEXION/EXTEN, WRIST OR FINGER DRIVE	CMN		
L3901	NU		WHFO, DYNAMIC FLEXOR HINGE, RECIP. WRIST EXTEN./FLEX., FINGER FLEX./EXTEN., CABLE DRIVEN,CUSTOM FABR	CMN		
L3905	RB		WHO W/NONTORSION JNT(S) CF	CMN	IOC	
L3905	NU		WHO W/NONTORSION JNT(S) CF	CMN		
L3906	RB		WRIST HAND ORTHOSIS, WITHOUT JOINTS, MAY INCLUDE SOFT INTERFACE, STRAPS, CUSTOM FABRICATED, INCLUDES	CMN	IOC	
L3906	NU		WRIST HAND ORTHOSIS, WITHOUT JOINTS, MAY INCLUDE SOFT INTERFACE, STRAPS, CUSTOM FABRICATED, INCLUDES	CMN		
L3908	RB		WHO COCK-UP NONMOLDE PRE OTS	CMN	IOC	
L3908	NU		WHO COCK-UP NONMOLDE PRE OTS	CMN		
L3912	RB		HFO FLEXION GLOVE PRE OTS	CMN	IOC	
L3912	NU		HFO FLEXION GLOVE PRE OTS	CMN		
L3913	RB		HFO W/O JOINTS CF	CMN	IOC	
L3913	NU		HFO W/O JOINTS CF	CMN		
L3915	RB		WHO NONTORSION JNTS PRE CST	CMN	IOC	
L3915	NU		WHO NONTORSION JNTS PRE CST	CMN		
L3916	NU		WHO NONTORSION JNTS PRE OTS	CMN		
L3917	NU		METACARP FX ORTHOSIS PRE CST	CMN		
L3918	NU		METACARP FX ORTHOSIS PRE OTS	CMN		
L3919	RB		HO W/O JOINTS CF	CMN	IOC	

PRODUCTION : 04/09/2020

Durable Medical Equipment



L3919	NU	HO W/O JOINTS CF	CMN		
L3921	RB	HFO W/JOINT(S) CF	CMN	IOC	
L3921	NU	HFO W/JOINT(S) CF	CMN		
L3923	NU	HFO WITHOUT JOINTS PRE CST	CMN		
L3924	NU	HFO WITHOUT JOINTS PRE OTS	CMN		
L3925	RB	FO PIP DIP JNT/SPRNG PRE OTS	CMN	IOC	
L3925	NU	FO PIP DIP JNT/SPRNG PRE OTS	CMN		
L3927	RB	FO PIP DIP NO JT SPR PRE OTS	CMN	IOC	
L3927	NU	FO PIP DIP NO JT SPR PRE OTS	CMN		
L3929	RB	HFO NONTORSION JNTS PRE CST	CMN	IOC	
L3929	NU	HFO NONTORSION JNTS PRE CST	CMN		
L3930	NU	HFO NONTORSION JNTS PRE OTS	CMN		
L3931	RB	WHFO NONTORSION JOINT PREFAB	CMN	IOC	
L3931	NU	WHFO NONTORSION JOINT PREFAB	CMN		
L3933	RB	FO W/O JOINTS CF	CMN	IOC	
L3933	NU	FO W/O JOINTS CF	CMN		
L3935	RB	FO NONTORSION JOINT CF	CMN		
L3935	NU	FO NONTORSION JOINT CF	CMN		
L3956	NU	ADDITION OF JOINT TO UPPER EXTREMITY ORTHOSIS, ANYMATERIAL; PER JOINT	CMN	IOC	
L3960	RB	SHOULDER-ELBOW-WRIST-HAND ORTHOSIS, (SEWHO), ABDUCTION POSITIONING, AIRPLANE DESIGN	CMN	IOC	
L3960	NU	SHOULDER-ELBOW-WRIST-HAND ORTHOSIS, (SEWHO), ABDUCTION POSITIONING, AIRPLANE DESIGN,PREFABRICATED IN	CMN		
L3961	RB	SEWHO CAP DESIGN W/O JNTS CF	CMN	IOC	
L3961	NU	SEWHO CAP DESIGN W/O JNTS CF	CMN		
L3967	RB	SEWHO AIRPLANE W/O JNTS CF	CMN	IOC	
L3967	NU	SEWHO AIRPLANE W/O JNTS CF	CMN		
L3971	RB	SEWHO CAP DESIGN W/JNT(S) CF	CMN	IOC	
L3971	NU	SEWHO CAP DESIGN W/JNT(S) CF	CMN		
L3973	RB	SEWHO AIRPLANE W/JNT(S) CF	CMN	IOC	
L3973	NU	SEWHO AIRPLANE W/JNT(S) CF	CMN		
L3975	RB	SEWHFO CAP DESIGN W/O JNT CF	CMN	IOC	

PRODUCTION : 04/09/2020



L3975	NU	SEWHFO CAP DESIGN W/O JNT CF	CMN		
L3976	RB	SEWHFO AIRPLANE W/O JNTS CF	CMN	IOC	
L3976	NU	SEWHFO AIRPLANE W/O JNTS CF	CMN		
L3977	RB	SEWHFO CAP DESGN W/JNT(S) CF	CMN	IOC	
L3977	NU	SEWHFO CAP DESGN W/JNT(S) CF	CMN		
L3978	RB	SEWHFO AIRPLANE W/JNT(S) CF	CMN	IOC	
L3978	NU	SEWHFO AIRPLANE W/JNT(S) CF	CMN		
L3980	RB	UP EXT FX ORTHOS HUMERAL NOS	CMN	IOC	
L3980	NU	UP EXT FX ORTHOS HUMERAL NOS	CMN		
L3981	NU	UE FX ORTH SHOUL CAP FOREARM	CMN		
L3982	RB	UPPER EXTREMITY FRACTURE ORTHOSIS, RADIUS/ULNAR	CMN	IOC	
L3982	NU	UPPER EXTREMITY FRACTURE ORTHOSIS, RADIUS/ULNAR	CMN		
L3984	RB	UPPER EXTREMITY FRACTURE ORTHOSIS, WRIST	CMN	IOC	
L3984	NU	UPPER EXTREMITY FRACTURE ORTHOSIS, WRIST	CMN		
L3999	NU	UPPER LIMB ORTHOSIS, NOT OTHERWISE SPECIFIED	PA	IOC	
L4000	RB	REPLACE GIRDLE FOR MILWAUKEE ORTHOSIS	CMN		
L4002	NU	REPLACEMENT STRAP FOR AN ORTHOSIS, INCLUDES ALL COMPONENTS, AND LENGTH, ANY TYPE	CMN	IOC	
L4010	RB	REPLACE TRILATERAL SOCKET BRIM	CMN		
L4020	RB	REPLACE QUADRILATERAL SOCKET BRIM, MOLDED TO PATIENT MODEL	CMN		
L4030	RB	REPLACE QUADRILATERAL SOCKET BRIM, CUSTOM FITTED	CMN		
L4040	RB	REPLACE MOLDED THIGH LACER	CMN		
L4045	RB	REPLACE NON-MOLDED THIGH LACER, FOR CUSTOM FABRICATED ORTHOSIS	CMN		
L4050	RB	REPLACE MOLDED CALF LACER, FOR CUSTOM FABRICATED ORTHOSIS ONLY	CMN		
L4055	RB	REPLACE NON/MOLDED CALF LACER, FOR CUSTOM FABRICATED ORTHOSIS ONLY	CMN		
L4060	RB	REPLACE HIGH ROLL CUFF	CMN		
L4070	RB	REPLACE PROXIMAL AND DISTAL UPRIGHT FOR KAFO	CMN		
L4080	RB	REPLACE METAL BANDS KAFO, PROXIMAL THIGH	CMN		
L4090	RB	REPLACE METAL BANDS KAFO-AFO, CALF OR DISTAL THIGH	CMN		
L4100	RB	REPLACE LEATHER CUFF KAFO, PROXIMAL THIGH	CMN		
L4110	RB	REPLACE LEATHER CUFF KAFO-AFO, CALF OR DISTAL THIGH	CMN		
L4130	RB	REPLACE PRETIBIAL SHELL	CMN		

Durable Medical Equipment



L4205	RB	REPAIR OF ORTHOTIC DEVICE. LABOR COMPONENT.	CMN		
L4210	RB	REPAIR OF ORTHOTIC DEVICE, REPAIR OR REPLACE MINOR PARTS	CMN	IOC	
L4360	NU	PNEUMA/VAC WALK BOOT PRE OTS	CMN		
L4361	NU	PNEUMA/VAC WALK BOOT PRE OTS	CMN		
L4386	NU	NON-PNEUM WALK BOOT PRE CST	CMN		
L4387	NU	NON-PNEUM WALK BOOT PRE OTS	CMN		
L4390	RB	REPLACE SOFT INTERFACE MATERIAL, MULTI-PODUS TYPE SPLINT	CMN	IOC	
L4392	RB	REPLACE SOFT INTERFACE MATERIAL, STATIC AFO	CMN	IOC	
L4394	RB	REPLACE SOFT INTERFACE MATERIAL, FOOT DROP SPLINT	CMN	IOC	
L4396	NU	STATIC OR DYNAMI AFO PRE CST	CMN		
L4397	NU	STATIC OR DYNAMI AFO PRE OTS	CMN		
L4398	NU	FOOT DROP SPLINT PRE OTS	CMN		
L4631	NU	AFO, WALK BOOT TYPE, CUS FAB	PA		
L5000	RB	PARTIAL FOOT, SHOE INSERT WITH LONGITUDINAL ARCH, TOE FILLER	CMN	IOC	
L5000	NU	PARTIAL FOOT, SHOE INSERT WITH LONGITUDINAL ARCH, TOE FILLER	CMN		
L5010	RB	PARTIAL FOOT, MOLDED SOCKET, ANKLE HEIGHT, WITH TOE FILLER	CMN	IOC	
L5010	NU	PARTIAL FOOT, MOLDED SOCKET, ANKLE HEIGHT, WITH TOE FILLER	CMN		
L5020	RB	PARTIAL FOOT, MOLDED SOCKET, TIBIAL TUBERCLE HEIGHT, WITH TOE FILLER	CMN	IOC	
L5020	NU	PARTIAL FOOT, MOLDED SOCKET, TIBIAL TUBERCLE HEIGHT, WITH TOE FILLER	CMN		
L5050	RB	ANKLE, SYMES, MOLDED SOCKET, SACH FOOT	CMN	IOC	
L5050	NU	ANKLE, SYMES, MOLDED SOCKET, SACH FOOT	CMN		
L5060	RB	ANKLE, SYMES, METAL FRAME, MOLDED LEATHER SOCKET, ARTICULATED ANKLE/FOOT	CMN	IOC	
L5060	NU	ANKLE, SYMES, METAL FRAME, MOLDED LEATHER SOCKET, ARTICULATED ANKLE/FOOT	CMN		
L5100	RB	BELOW KNEE, MOLDED SOCKET, SHIN, SACH FOOT	CMN	IOC	
L5100	NU	BELOW KNEE, MOLDED SOCKET, SHIN, SACH FOOT	CMN		
L5105	RB	BELOW KNEE, PLASTIC SOCKET, JOINTS AND THIGH LACER, SACH FOOT	CMN	IOC	
L5105	NU	BELOW KNEE, PLASTIC SOCKET, JOINTS AND THIGH LACER, SACH FOOT	CMN		
L5150	RB	KNEE DISARTICULATION (OR THROUGH KNEE), MOLDED SOCKET, EXTERNAL KNEE JOINTS, SHIN, SACH FOOT	CMN	IOC	

L5150	NU		KNEE DISARTICULATION (OR THROUGH KNEE), MOLDED SOCKET, EXTERNAL KNEE JOINTS, SHIN, SACH FOOT	CMN		
L5160	RB		KNEE DISARTICULATION (OR THROUGH KNEE), MOLDED SOCKET, BENT KNEE CONFIGURATION, EXTERNAL KNEE JOINTS	CMN	IOC	
L5160	NU		KNEE DISARTICULATION (OR THROUGH KNEE), MOLDED SOCKET, BENT KNEE CONFIGURATION, EXTERNAL KNEE JOINTS	CMN		
L5200	RB		ABOVE KNEE, MOLDED SOCKET, SINGLE AXIS CONSTANT FRICTION KNEE, SHIN, SACH FOOT	CMN	IOC	
L5200	NU		ABOVE KNEE, MOLDED SOCKET, SINGLE AXIS CONSTANT FRICTION KNEE, SHIN, SACH FOOT	CMN		
L5210	RB		ABOVE KNEE, SHORT PROSTHESIS, NO KNEE JOINT (STUBBIES), WITH FOOT BLOCKS, NO ANKLE JOINTS, EACH	CMN	IOC	
L5210	NU		ABOVE KNEE, SHORT PROSTHESIS, NO KNEE JOINT (STUBBIES), WITH FOOT BLOCKS, NO ANKLE JOINTS, EACH	CMN		
L5220	RB		ABOVE KNEE, SHORT PROSTHESIS, NO KNEE JOINT (STUBBIES), WITH ARTICULATED ANKLE/FOOT, DYNAMICALLY A	CMN	IOC	
L5220	NU		ABOVE KNEE, SHORT PROSTHESIS, NO KNEE JOINT (STUBBIES), WITH ARTICULATED ANKLE/FOOT, DYNAMICALLY A	CMN		
L5230	RB		ABOVE KNEE, FOR PROXIMAL FEMORAL FOCAL DEFICIENCY, CONSTANT FRICTION KNEE, SHIN, SACH FOOT	CMN	IOC	
L5230	NU		ABOVE KNEE, FOR PROXIMAL FEMORAL FOCAL DEFICIENCY, CONSTANT FRICTION KNEE, SHIN, SACH FOOT	CMN		
L5250	RB		HIP DISARTICULATION, CANADIAN TYPE; MOLDED SOCKET, HIP JOINT, SINGLE AXIS CONSTANT FRICTION KNEE, SH	CMN	IOC	
L5250	NU		HIP DISARTICULATION, CANADIAN TYPE; MOLDED SOCKET, HIP JOINT, SINGLE AXIS CONSTANT FRICTION KNEE, SH	CMN		
L5270	RB		HIP DISARTICULATION, TILT TABLE TYPE; MOLDED SOCKET, LOCKING HIP JOINT, SINGLE AXIS CONSTANT FRICTIO	CMN	IOC	
L5270	NU		HIP DISARTICULATION, TILT TABLE TYPE; MOLDED SOCKET, LOCKING HIP JOINT, SINGLE AXIS CONSTANT FRICTIO	CMN		
L5280	RB		HEMIPELVECTOMY, CANADIAN TYPE; MOLDED SOCKET, HIP JOINT, SINGLE AXIS CONSTANT FRICTION KNEE, SHIN, S	CMN	IOC	
L5280	NU		HEMIPELVECTOMY, CANADIAN TYPE; MOLDED SOCKET, HIP JOINT, SINGLE AXIS CONSTANT FRICTION KNEE, SHIN, S	CMN		

Durable Medical Equipment



L5301	RB		BELOW KNEE, MOLDED SOCKET, SHIN, EACH FOOT, ENDOSKELETAL SYSTEM	CMN	IOC	
L5301	NU		BELOW KNEE, MOLDED SOCKET, SHIN, EACH FOOT, ENDOSKELETAL SYSTEM	CMN		
L5312	RB		KNEE DISART, SACH FT, ENDO	CMN	IOC	
L5312	NU		KNEE DISART, SACH FT, ENDO	CMN		
L5321	RB		ABOVE KNEE, MOLDED SOCKET, OPEN END, SACH FOOT, ENDOSKELETAL SYSTEM, SINGLE AXIS KNEE	CMN	IOC	
L5321	NU		ABOVE KNEE, MOLDED SOCKET, OPEN END, SACH FOOT, ENDOSKELETAL SYSTEM, SINGLE AXIS KNEE	CMN		
L5331	RB		HIP DISARTICULATION, CANADIAN TYPE, MOLDED SOCKET, ENDOSKELETAL SYSTEM, HIP JOINT, SINGLE AXIS KNEE,	CMN	IOC	
L5331	NU		HIP DISARTICULATION, CANADIAN TYPE, MOLDED SOCKET, ENDOSKELETAL SYSTEM, HIP JOINT, SINGLE AXIS KNEE,	CMN		
L5341	RB		HEMIPELVECTOMY, CANADIAN TYPE, MOLDED SOCKET, ENDOSKELETAL SYSTEM, HIP JOINT, SINGLE AXIS KNEE, SACH	CMN	IOC	
L5341	NU		HEMIPELVECTOMY, CANADIAN TYPE, MOLDED SOCKET, ENDOSKELETAL SYSTEM, HIP JOINT, SINGLE AXIS KNEE, SACH	CMN		
L5400	NU		IMMEDIATE POST SURGICAL OR EARLY FITTING, APPLICATION OF INITIAL RIGID DRESSING, INCLUDING FITTING,	CMN		
L5410	NU		IMMEDIATE POST SURGICAL OR EARLY FITTING, APPLICATION OF INITIAL RIGID DRESSING, INCLUDING FITTING,	CMN		
L5420	NU		IMMEDIATE POST SURGICAL OR EARLY FITTING, APPLICATION OF INITIAL RIGID DRESSING, INCLUDING FITTING,	CMN		
L5430	NU		IMMEDIATE POST SURGICAL OR EARLY FITTING, APPLICATION OF INITIAL RIGID DRESSING, INCL. FITTING, ALIG	CMN		
L5450	NU		IMMEDIATE POST SURGICAL OR EARLY FITTING, APPLICATION OF NON-WEIGHT BEARING RIGID DRESSING, BELOW K	CMN		
L5460	RB		IMMEDIATE POST SURGICAL OR EARLY FITTING, APPLICATION OF NON-WEIGHT BEARING RIGID DRESSING, ABOVE K	CMN	IOC	
L5460	NU		IMMEDIATE POST SURGICAL OR EARLY FIT, APPLICATION OF NON-WEIGHT BEARING RIGID DRESSING, ABOVE KNEE	CMN		
L5500	RB		INITIAL, BELOW KNEE PTB TYPE SOCKET, NON-ALIGNABLE SYSTEM, PYLON, NO COVER, SACH FOOT, PLASTER SOCK	CMN	IOC	



L5500	NU	INITIAL, BELOW KNEE PTB TYPE SOCKET, NON-ALIGNABLE SYSTEM, PYLON, NO COVER, SACH FOOT, PLASTER SOCK	CMN		
L5505	RB	INITIAL, ABOVE KNEE-KNEE DISARTICULATION, ISCHIAL LEVEL SOCKET, NON-ALIGNABLE SYSTEM, PYLON, NO COVER, SAC	CMN	IOC	
L5505	NU	INITIAL, ABOVE KNEE-KNEE DISARTICULATION, ISCHIAL LEVEL SOCKET, NON-ALIGNABLE SYSTEM, PYLON, NO COVER, SAC	CMN		
L5510	RB	PREPARATORY, BELOW KNEE PTB TYPE SOCKET, NON-ALIGNABLE SYSTEM, PYLON, NO COVER, SACH FOOT, PLASTER SOCKET	CMN	IOC	
L5510	NU	PREPARATORY, BELOW KNEE PTB TYPE SOCKET, NON-ALIGNABLE SYSTEM, PYLON, NO COVER, SACH FOOT, PLASTER SOCKET	CMN		
L5520	RB	PREPARATORY, BELOW KNEE PTB TYPE SOCKET, NON-ALIGNABLE SYSTEM, PYLON, NO COVER, SACH FOOT THERMOPLASTI	CMN	IOC	
L5520	NU	PREPARATORY, BELOW KNEE PTB TYPE SOCKET, NON-ALIGNABLE SYSTEM, PYLON, NO COVER, SACH FOOT, THERMOPLASTI	CMN		
L5530	RB	PRE BK, PTB TYPE SOCKET, NON-ALIGNABLE SYSTEM, PYLON, NO COVER, SACH FOOT, THERMO OR EQUAL, MOLDED TO	CMN	IOC	
L5530	NU	PREP BK, PTB TYPE SOCKET, NON-ALIGNABLE SYSTEM, PYLON, NO COVER, SACH FOOT, THERMO OR EQUAL, MOLDED TO	CMN		
L5535	RB	PREP, BK PTB TYPE SOCKET, NON-ALIGNABLE SYSTEM, PYLON, NO COVER, SACH FOOT, PREFABRICATED, ADJ OPEN END	CMN	IOC	
L5535	NU	PREP, BK PTB TYPE SOCKET, NON-ALIGNABLE SYSTEM, PYLON, NO COVER, SACH FOOT, PREFABRICATED, ADJ OPEN END	CMN		
L5540	RB	PREP, BK PTB TYPE SOCKET, NON-ALIGNABLE SYSTEM, PYLON, NO COVER, SACH FOOT, LAMINATED SOCKET, MOLDED TO	CMN	IOC	
L5540	NU	PREP, BK PTB TYPE SOCKET, NON-ALIGNABLE SYSTEM, PYLON, NO COVER, SACH FOOT, LAMINATED SOCKET, MOLDED TO	CMN		
L5560	RB	PREP, ABOVE KNEE-KNEE DISARTIC, ISCHIAL LEVEL SOCKET, NON-ALIGNABLE SYS, PYLON, NO COVER, SACH FOOT, PLAS	CMN	IOC	
L5560	NU	PREP, ABOVE KNEE-KNEE DISARTIC, ISCHIAL LEVEL SOCKET, NON-ALIGNABLE SYS, PYLON, NO COVER, SACH FOOT, PLAS	CMN		
L5570	RB	PREP, AK KNEE DISARTIC, ISCHIAL LEVEL SOCKET, NON-ALIGNABLE SYS, PYLON, NO COVER, SACH FOOT, THERMOPLASTIC	CMN	IOC	
L5570	NU	PREP AK KNEE DISARTIC, ISCHIAL LEVEL SOCKET, NON-ALIGNABLE SYS, PYLON, NO COVER, SACH FOOT, THERMOPLASTIC	CMN		



L5580	RB	PREP, AK KNEE DISARTIC, ISCHIAL LEVEL SOCKET, NON-ALIGNABLE SYS, PYLON, NO COVER, SACH FOOT, THERMOPLASTIC	CMN	IOC	
L5580	NU	PREP AK KNEE DISARTIC, ISCHIAL LEVEL SOCKET, NON-ALIGNABLE SYS, PYLON, NO COVER, SACH FOOT, THERMOPLASTIC	CMN		
L5585	RB	PREP AK KNEE DISARTIC, ISCHIAL LEVEL SOCKET, NON-ALIGN SYS, PYLON, NO COVER, SACH FOOT, PREFABRICATED ADJ	CMN	IOC	
L5585	NU	PREP AK KNEE DISARTIC, ISCHIAL LEVEL SOCKET, NON-ALIGN SYS, PYLON, NO COVER, SACH FOOT, PREFABRICATED ADJ	CMN		
L5590	RB	PREP AK KNEE DISARTIC, ISCHIAL LEVEL SOCKET, NON-ALIGN SYS, PYLON, NO COVER, SACH FOOT, LAMINATED SOCKET,	CMN	IOC	
L5590	NU	PREP AK KNEE DISARTIC, ISCHIAL LEVEL SOCKET, NON-ALIGN SYS, PYLON, NO COVER, SACH FOOT, LAMINATED SOCKET,	CMN		
L5595	RB	PREPARATORY, HIP DISARTICULATION-HEMIPELVECTOMY, PYLON, NO COVER, SACH FOOT, THERMOPLASTIC OR EQUAL,	CMN	IOC	
L5595	NU	PREP, HIP DISARTIC-HEMIPELVECTOMY, PYLON, NO COVER, SACH FOOT, THERMOPLASTIC OR EQUAL, MOLDED TO PAT	CMN		
L5600	RB	PREPARATORY, HIP DISARTICULATION-HEMIPELVECTOMY, PYLON, NO COVER, SACH FOOT, LAMINATED SOCKET, MOLDE	CMN	IOC	
L5600	NU	PREPARATORY, HIP DISARTICULATION-HEMIPELVECTOMY, PYLON, NO COVER, SACH FOOT, LAMINATED SOCKET, MOLDE	CMN		
L5610	RB	ADDITION TO LOWER EXTREMITY, ENDOSKELETAL SYSTEM, ABOVE KNEE, HYDRACADENCE SYSTEM	CMN	IOC	
L5610	NU	ADDITION TO LOWER EXTREMITY, ENDOSKELETAL SYSTEM, ABOVE KNEE, HYDRACADENCE SYSTEM	CMN		
L5611	RB	ADD TO LOWER EXTREMITY, ENDOSKELETAL SYS, AK-KNEE DISARTIC, 4 BAR LINKAGE, WITH FRICTION SWING PHASE CO	CMN	IOC	
L5611	NU	ADD TO LOWER EXTREMITY, ENDOSKELETAL SYS, AK-KNEE DISARTIC, 4 BAR LINKAGE, WITH FRICTION SWING PHASE CO	CMN		
L5613	RB	ADD TO LOWER EXTREMITY, ENDOSKELETAL SYS, AK-KNEE DISARTIC, 4 BAR LINKAGE, WITH HYDRAULIC SWING PHASE	CMN	IOC	
L5613	NU	ADD TO LOWER EXTREMITY, ENDOSKELETAL SYS, ABOVE KNEE-KNEE DISARTICULATION, 4-BAR LINKAGE, WITH HYDRAULI	CMN		
L5614	NU	ADD TO LOWER EXTREMITY, ENDOSKELETAL SYS, AK-KNEE DISARTIC, 4 BAR LINKAGE, WITH PNEUMATIC SWING PHASE	CMN		

Durable Medical Equipment



L5616	RB		ADD TO LOWER EXTREMITY,ENDOSKELETAL SYS,ABOVE KNEEUNIVERSAL MULTIPLEX SYS,FRICITION SWING PHASE CONTR	CMN	IOC	
L5616	NU		ADD TO LOWER EXTREMITY,ENDOSKELETAL SYS,ABOVE KNEEUNIVERSAL MULTIPLEX SYS,FRICITION SWING PHASE CONTR	CMN		
L5617	RB		ADDITION TO LOWER EXTREMITY, QUICK CHANGE SELF-ALIGNING UNIT, ABOVE OR BELOW KNEE, EACH	CMN	IOC	
L5617	NU		ADDITION TO LOWER EXTREMITY, QUICK CHANGE SELF-ALIGNING UNIT, ABOVE OR BELOW KNEE, EACH	CMN		
L5618	RB		ADDITION TO LOWER EXTREMITY, TEST SOCKET, SYMES	CMN	IOC	
L5618	NU		ADDITION TO LOWER EXTREMITY, TEST SOCKET, SYMES	CMN		
L5620	RB		ADDITION TO LOWER EXTREMITY, TEST SOCKET, BELOW KNEE	CMN	IOC	
L5620	NU		ADDITION TO LOWER EXTREMITY, TEST SOCKET, BELOW KNEE	CMN		
L5622	RB		ADDITION TO LOWER EXTREMITY, TEST SOCKET, KNEE DISARTICULATION	CMN	IOC	
L5622	NU		ADDITION TO LOWER EXTREMITY, TEST SOCKET, KNEE DISARTICULATION	CMN		
L5624	RB		ADDITION TO LOWER EXTREMITY, TEST SOCKET, ABOVE KNEE	CMN	IOC	
L5624	NU		ADDITION TO LOWER EXTREMITY, TEST SOCKET, ABOVE KNEE	CMN		
L5626	RB		ADDITION TO LOWER EXTREMITY, TEST SOCKET, HIP DISARTICULATION	CMN	IOC	
L5626	NU		ADDITION TO LOWER EXTREMITY, TEST SOCKET, HIP DISARTICULATION	CMN		
L5628	RB		ADDITION TO LOWER EXTREMITY, TEST SOCKET, HEMIPELVECTOMY	CMN	IOC	
L5628	NU		ADDITION TO LOWER EXTREMITY, TEST SOCKET, HEMIPELVECTOMY	CMN		
L5629	RB		ADDITION TO LOWER EXTREMITY, BELOW KNEE, ACRYLIC SOCKET	CMN	IOC	
L5629	NU		ADDITION TO LOWER EXTREMITY, BELOW KNEE, ACRYLIC SOCKET	CMN		
L5630	RB		ADDITION TO LOWER EXTREMITY, SYMES TYPE, EXPANDABLE WALL SOCKET	CMN	IOC	
L5630	NU		ADDITION TO LOWER EXTREMITY, SYMES TYPE, EXPANDABLE WALL SOCKET	CMN		
L5631	RB		ADDITION TO LOWER EXTREMITY, ABOVE KNEE OR KNEE DISARTICULATION, ACRYLIC SOCKET	CMN	IOC	
L5631	NU		ADDITION TO LOWER EXTREMITY, ABOVE KNEE OR KNEE DISARTICULATION, ACRYLIC SOCKET	CMN		
L5632	RB		ADDITION TO LOWER EXTREMITY, SYMES TYPE, SOCKET	CMN	IOC	
L5632	NU		ADDITION TO LOWER EXTREMITY, SYMES TYPE, PTB BRIM DESIGN SOCKET	CMN		
L5634	RB		ADDITION TO LOWER EXTREMITY, SYMES TYPE, POSTERIOR OPENING (CANADIAN) SOCKET	CMN	IOC	

Durable Medical Equipment



L5634	NU		ADDITION TO LOWER EXTREMITY, SYMES TYPE, POSTERIOR OPENING (CANADIAN) SOCKET	CMN		
L5636	RB		ADDITION SOCKET	CMN	IOC	
L5636	NU		ADD TO LOWER EXTREMITY, SYMES TYPE MEDIAL OPENING SOCKET	CMN		
L5637	RB		ADDITION TO LOWER EXTREMITY, BELOW KNEE, TOTAL CONTACT	CMN	IOC	
L5637	NU		ADDITION TO LOWER EXTREMITY, BELOW KNEE, TOTAL CONTACT	CMN		
L5638	RB		ADDITION	CMN	IOC	
L5638	NU		ADDITION TO LOWER EXTREMITY, BELOW KNEE, TOTAL CONTACT LEATHER SOCKET	CMN		
L5639	RB		ADDITION TO LOWER EXTREMITY, BELOW KNEE, WOOD SOCKET	CMN	IOC	
L5639	NU		ADDITION TO LOWER EXTREMITY, BELOW KNEE, TOTAL CONTACT WOOD SOCKET	CMN		
L5640	RB		ADDITION SOCKET	CMN	IOC	
L5640	NU		ADD KNEE DISARTICULATION, LEATHER SOCKET	CMN		
L5642	RB		ADDITION	CMN	IOC	
L5642	NU		ADD, ABOVE KNEE, LEATHER SOCKET	CMN		
L5643	RB		ADDITION EXTERNAL FRAME	CMN	IOC	
L5643	NU		ADDITION TO LOWER EXTREMITY, HIP DISARTICULATION, FLEXIBLE INNER SOCKET, EXTERNAL FRAME	CMN		
L5644	RB		ADDITION	CMN	IOC	
L5644	NU		ADDITION, TO LOWER EXTREMITY, ABOVE KNEE, WOOD SOCKET	CMN		
L5645	RB		ADDITION	CMN	IOC	
L5645	NU		ADD BELOW KNEE FLEXIBLE INNER SOCKET EXTERNAL FRAME	CMN		
L5646	RB		ADDITION	CMN	IOC	
L5646	NU		ADDITION, BELOW KNEE, AIR CUSHION SOCKET	CMN		
L5647	RB		ADDITION	CMN	IOC	
L5647	NU		ADDITION, BELOW KNEE SUCTION SOCKET	CMN		
L5648	RB		ADDITION	CMN	IOC	
L5648	NU		ADDITION, ABOVE KNEE AIR CUSHION SOCKET	CMN		
L5649	RB		ADDITION	CMN	IOC	
L5649	NU		ADDITION, ISCHIAL CONTAINMENT NARROW ML SOCKET CAT CAM SOCKET	CMN		
L5650	RB		ADDITIONS TO LOWER EXTREMITY, TOTAL CONTACT, ABOVE KNEE OR KNEE DISARTICULATION SOCKET	CMN	IOC	

PRODUCTION : 04/09/2020

Durable Medical Equipment



L5650	NU		ADDITIONS TO LOWER EXTREMITY, TOTAL CONTACT, ABOVE KNEE OR KNEE DISARTICULATION SOCKET	CMN		
L5651	RB		ADDITION	CMN	IOC	
L5651	NU		ADDITION, TO LOWER EXTREMITY, ABOVE KNEE, FLEXIBLE INNER SOCKET, EXTERNAL FRAME	CMN		
L5652	RB		ADDITION OR KNEE DISARTICULATION SOCKET	CMN	IOC	
L5652	NU		ADD SUCTION SUSPENSION AK OR KNEE DISARTICULATION SOCKET	CMN		
L5653	RB		ADDITION WALL SOCKET	CMN	IOC	
L5653	NU		ADDITION KNEE DISARTICULATION, EXPANDABLE WALL SOCKET	CMN		
L5654	RB		ADDITION PELITE, ALIPLAST, PLASTAZOTE OR EQUAL)	CMN	IOC	
L5654	NU		ADDITION SYMES (KEMBLO, PELITE, ALIPLAST PLASTAZOTE OR EQUAL)	CMN		
L5655	RB		ADDITION (KEMBLO, PELITE, ALIPLAST, PLASTAZOTE OR EQUAL)	CMN	IOC	
L5655	NU		ADDITION TO LOWER EXTREMITY, SOCKET INSERT; BELOW KNEE, (KEMBLO, PELITE, ALIPLAST, PLASTAZOTE OR EQUAL)	CMN		
L5656	RB		ADDITION (KEMBLO, PELITE, ALIPLAST, PLASTAZOTE OR EQUAL)	CMN	IOC	
L5656	NU		ADD KNEE DISARTIC (KEMBLO, PELITE, ALIPLAST, PLASTAZOTE OR EQUAL)	CMN		
L5658	RB		ADDITION (KEMBLO, PELITE, ALIPLAST, PLASTAZOTE OR EQUAL)	CMN	IOC	
L5658	NU		ADD ABOVE KNEE (KEMBLO, PELITE, ALIPLAST, PLASTAZOTE OR EQUAL)	CMN		
L5661	RB		ADDITION	CMN	IOC	
L5661	NU		ADDITION, MULTI-DUROMETIC, SYMES	CMN		
L5665	RB		ADDITION	CMN	IOC	
L5665	NU		ADDITION, MULTI-DUROMETER, BELOW KNEE	CMN		
L5666	RB		ADDITION	CMN	IOC	
L5666	NU		ADDITION, BELOW KNEE CUFF SUSPENSION	CMN		
L5668	RB		BK MOLDED DISTAL CUSHION	CMN	IOC	
L5668	NU		BK MOLDED DISTAL CUSHION	CMN		
L5670	RB		ADDITION SUSPENSION (PTS OR SIMILAR)	CMN	IOC	
L5670	NU		ADDITION BK MOLDED SUPRACONDYLAR SUSPENSION (PTS OR SIMILAR)	CMN		
L5671	RB		ADDITION TO LOWER EXTREMITY; BELOW KNEE/ABOVE KNEE SUSPENSION LOCKING MECHANISM (SHUTTLE, LANYARD O	CMN	IOC	
L5671	NU		ADDITION TO LOWER EXTREMITY; BELOW KNEE/ABOVE KNEE SUSPENSION LOCKING MECHANISM (SHUTTLE, LANYARD O	CMN		
L5672	RB		ADDITION BRIM SUSPENSION	CMN	IOC	

Durable Medical Equipment



L5672	NU		ADDITION BELOW KNEE REMOVABLE MEDIAL BRIM SUSPENSION	CMN		
L5673	NU		SOCKET INSERT W LOCK MECH	CMN		
L5676	RB		ADDITIONS TO LOWER EXTREMITY, BELOW KNEE, KNEE JOINTS, SINGLE AXIS, PAIR	CMN	IOC	
L5676	NU		ADDITIONS TO LOWER EXTREMITY, BELOW KNEE, KNEE JOINTS, SINGLE AXIS, PAIR	CMN		
L5677	RB		ADDITIONS TO LOWER EXTREMITY, BELOW KNEE, KNEE JOINTS, POLYCENTRIC, PAIR	CMN	IOC	
L5677	NU		ADDITIONS TO LOWER EXTREMITY, BELOW KNEE, KNEE JOINTS, POLYCENTRIC, PAIR	CMN		
L5678	RB		ADDITIONS TO LOWER EXTREMITY, BELOW KNEE, JOINT COVERS, PAIR	CMN	IOC	
L5678	NU		ADDITIONS TO LOWER EXTREMITY, BELOW KNEE, JOINT COVERS, PAIR	CMN		
L5679	NU		SOCKET INSERT W/O LOCK MECH	CMN		
L5680	RB		ADDITION MOLDED	CMN	IOC	
L5680	NU		ADDITION BELOW KNEE, THIGH LACER, NON-MOLDED	CMN		
L5681	NU		BELOW KNEE/ABOVE KNEE CUSTOM FAB. SOCKET	CMN		
L5682	RB		ADDITION GLUTEAL/ISCHIAL, MOLDED	CMN	IOC	
L5682	NU		ADDITION TO LOWER EXTREMITY,BELOW KNEE,THIGH LACERGLUTEAL/ISCHIAL MOLDED	CMN		
L5683	NU		INITIAL SOCKET INSERT	CMN		
L5684	RB		ADDITION	CMN	IOC	
L5684	NU		ADDITION, BELOW KNEE, FORK STRAP	CMN		
L5685	NU		ADDITION TO BELOW KNEE PROSTHESIS, SUSPENSION/SEALING SLEEVE	CMN		
L5686	RB		ADDITION (EXTENSION CONTROL)	CMN	IOC	
L5686	NU		ADDITION BELOW KNEE, BACK CHECK EXTENSION CONTROL	CMN		
L5688	RB		ADDITION	CMN	IOC	
L5688	NU		ADDITION, BELOW KNEE WAIST BELT WEBBING	CMN		
L5690	RB		ADDITION AND LINED	CMN	IOC	
L5690	NU		ADDITION BELOW KNEE, WAIST BELT PADDED AND LINED	CMN		
L5692	RB		ADDITION LIGHT	CMN	IOC	
L5692	NU		ADDITION ABOVE KNEE PELVIC CONTROL BELT LIGHT	CMN		
L5694	RB		ADDITION PADDED AND LINED	CMN	IOC	
L5694	NU		ADDITION PELVIC CONTROL BELT PADDED AND LINED	CMN		

PRODUCTION : 04/09/2020

Durable Medical Equipment



L5695	RB		ADDITION TO LOWER EXTREMITY, ABOVE KNEE, PELVIC CONTROL, SLEEVE SUSPENSION, NEOPRENE OR EQUAL, EACH	CMN	IOC	
L5695	NU		ADDITION TO LOWER EXTREMITY, ABOVE KNEE, PELVIC CONTROL, SLEEVE SUSPENSION, NEOPRENE OR EQUAL, EACH	CMN		
L5696	RB		ADDITION PELVIC JOINT	CMN	IOC	
L5696	NU		ADDITION ABOVE KNEE, OR KNEE DISARTICULATION PELVIC JOINT	CMN		
L5697	RB		ADDITION PELVIC BAND	CMN	IOC	
L5697	NU		ADDITION ABOVE KNEE OR KNEE DISARTIC PELVIC BAND	CMN		
L5698	RB		ADDITION SILESIA BANDAGE	CMN	IOC	
L5698	NU		ADDITION ABOVE KNEE OR KNEE DISARTIC SILESIA BANDAGE	CMN		
L5699	RB		ALL LOWER EXTREMITY PROSTHESES, SHOULDER HARNESS	CMN	IOC	
L5699	NU		ALL LOWER EXTREMITY PROSTHESES, SHOULDER HARNESS	CMN		
L5700	NU		REPLACEMENT, SOCKET, BELOW KNEE, MOLDED TO PATIENT MODEL	CMN		
L5701	NU		REPLACEMENT, SOCKET, ABOVE KNEE/KNEE DISARTICULATION, INCULDING ATTACHMENT PLATE, MOLDED TO PATIENT	CMN		
L5702	NU		REPLACEMENT, SOCKET, HIP DISARTICULATION, INCUUDING HIP JOINT, MOLDED TO PATIENT MODEL	CMN		
L5703	RB		SYMES ANKLE W/O (SACH) FOOT	CMN	IOC	
L5703	NU		SYMES ANKLE W/O (SACH) FOOT	CMN		
L5704	NU		REPLACEMENT, CUSTOM SHAPED PROTECTIVE COVER, BELOW KNEE	CMN		
L5705	NU		REPLACEMENT, CUSTOM SHAPED PROTECTIVE COVER, ABOVE KNEE	CMN		
L5706	NU		REPLACEMENT, CUSTOM SHAPED PROTECTIVE COVER, KNEE DISARTICULATION	CMN		
L5707	NU		REPLACEMENT, CUSTOM SHAPED PROTECTIVE COVER, HIP DISARTICULATION	CMN		
L5710	RB		ADDITION,	CMN	IOC	
L5710	NU		ADDITION, SINGLE AXIS, MANUAL LOCK	CMN		
L5711	RB		ADDITIONS EXOSKELETAL KNEE-SHIN SYSTEM, SINGLE AXIS, MANUAL LOCK, ULTRA-LIGHT MATERIAL	CMN	IOC	
L5711	NU		ADDITIONS EXOSKELETAL KNEE-SHIN SYSTEM, SINGLE AXIS, MANUAL LOCK, ULTRA-LIGHT MATERIAL	CMN		
L5712	RB		ADDITION, AND STANCE PHASE CONTROL (SAFETY KNEE)	CMN	IOC	

L5712	NU		ADDITION, SINGLE AXIS. FRICTION SWING AND STANCE PHASE CONTROL (SAFETY KNEE)	CMN		
L5714	RB		ADDITION, SWING PHASE CONTROL	CMN	IOC	
L5714	NU		ADDITION, SINGLE AXIS VARIABLE FRICTION SWING PHASE CONTROL	CMN		
L5716	RB		ADDITION, STANCE PHASE LOCK	CMN	IOC	
L5716	NU		ADDITION, POLYCENTRIC, MECHANICAL STANCE PHASE LOCK	CMN		
L5718	RB		ADDITION, AND STANCE PHASE CONTROL	CMN	IOC	
L5718	NU		ADDITION, POLYCENTRIC, FRICTION SWING AND STANCE PHASE CONTROL	CMN		
L5722	RB		ADDITION, FRICTION STANCE PHASE CONTROL	CMN	IOC	
L5722	NU		ADDITION, SINGLE AXIS PNEUMATIC SWING FRICTION STANCE PHASE CONTROL	CMN		
L5724	RB		ADDITION, CONTROL	CMN	IOC	
L5724	NU		ADDITION, SINGLE AXIS FLUID SWING PHASE CONTROL	CMN		
L5726	RB		ADDITION, FLUID SWING PHASE CONTROL	CMN	IOC	
L5726	NU		ADDITION SINGLE AXIS EXTERNAL JOINTS FLUID SWING PHASE CONTROL	CMN		
L5728	RB		ADDITION, AND STANCE PHASE CONTROL	CMN	IOC	
L5728	NU		ADDITION SINGLE AXIS FLUID SWING AND STANCE PHASE CONTROL	CMN		
L5780	RB		ADDITION, PNEUMATIC SWING PHASE CONTROL	CMN	IOC	
L5780	NU		ADDITION SINGLE AXIS PNEUMATIC/HYDRAPNEUMATIC SWING PHASE CONTROL	CMN		
L5785	RB		ADDITION, EXOSKELETAL SYSTEM, BELOW KNEE, ULTRA-LIGHT MATERIAL (TITANIUM, CARBON FIBER OR EQUAL)	CMN	IOC	
L5785	NU		ADDITION, EXOSKELETAL SYSTEM, BELOW KNEE, ULTRA-LIGHT MATERIAL (TITANIUM, CARBON FIBER OR EQUAL)	CMN		
L5790	RB		ADDITION, EXOSKELETAL SYSTEM, ABOVE KNEE, ULTRA-LIGHT MATERIAL (TITANIUM, CARBON FIBER OR EQUAL)	CMN	IOC	
L5790	NU		ADDITION, EXOSKELETAL SYSTEM, ABOVE KNEE, ULTRA-LIGHT MATERIAL (TITANIUM, CARBON FIBER OR EQUAL)	CMN		
L5795	RB		ADDITION, EXOSKELETAL SYSTEM, HIP DISARTICULATION, ULTRA-LIGHT MATERIAL (TITANIUM, CARBON FIBER OR E	CMN	IOC	
L5795	NU		ADDITION, EXOSKELETAL SYSTEM, HIP DISARTICULATION, ULTRA-LIGHT MATERIAL (TITANIUM, CARBON FIBER OR E	CMN		
L5810	RB		ADDITION, ENDOSKELETAL KNEE-SHIN SYSTEM, SINGLE AXIS, MANUAL LOCK	CMN	IOC	

L5810	NU		ADDITION, ENDOSKELETAL KNEE-SHIN SYSTEM, SINGLE AXIS, MANUAL LOCK	CMN		
L5811	RB		ADDITION, ENDOSKELETAL KNEE-SHIN SYSTEM, SINGLE AXIS, MANUAL LOCK, ULTRA-LIGHT MATERIAL	CMN	IOC	
L5811	NU		ADDITION, ENDOSKELETAL KNEE-SHIN SYSTEM, SINGLE AXIS, MANUAL LOCK, ULTRA-LIGHT MATERIAL	CMN		
L5812	RB		ADDITION, ENDOSKELETAL KNEE-SHIN SYSTEM, SINGLE AXIS, FRICTION SWING AND STANCE PHASE CONTROL (SAFET	CMN	IOC	
L5812	NU		ADDITION, ENDOSKELETAL KNEE-SHIN SYSTEM, SINGLE AXIS, FRICTION SWING AND STANCE PHASE CONTROL (SAFET	CMN		
L5814	NU		ADDITION,ENDOSKELETAL KNEE-SHIN SYSTEM,POLYCENTRICHYDRAULIC SWING PHASE CONTROL,MECHANICAL STANCE PH	CMN		
L5816	RB		ADDITION, ENDOSKELETAL KNEE-SHIN SYSTEM, POLYCENTRIC, MECHANICAL STANCE PHASE LOCK	CMN	IOC	
L5816	NU		ADDITION, ENDOSKELETAL KNEE-SHIN SYSTEM, POLYCENTRIC, MECHANICAL STANCE PHASE LOCK	CMN		
L5818	RB		ADDITION, ENDOSKELETAL KNEE-SHIN SYSTEM, POLYCENTRIC, FRICTION SWING, AND STANCE PHASE CONTROL	CMN	IOC	
L5818	NU		ADDITION, ENDOSKELETAL KNEE-SHIN SYSTEM, POLYCENTRIC, FRICTION SWING, AND STANCE PHASE CONTROL	CMN		
L5822	RB		ADDITION, ENDOSKELETAL KNEE-SHIN SYSTEM, SINGLE AXIS, PNEUMATIC SWING, FRICTION STANCE PHASE CONTROL	CMN	IOC	
L5822	NU		ADDITION, ENDOSKELETAL KNEE-SHIN SYSTEM, SINGLE AXIS, PNEUMATIC SWING, FRICTION STANCE PHASE CONTROL	CMN		
L5824	RB		ADDITION, ENDOSKELETAL KNEE-SHIN SYSTEM, SINGLE AXIS, FLUID SWING PHASE CONTROL	CMN	IOC	
L5824	NU		ADDITION, ENDOSKELETAL KNEE-SHIN SYSTEM, SINGLE AXIS, FLUID SWING PHASE CONTROL	CMN		
L5826	NU		HYDRAULIC SWING PHASE CONTROL, WITH MINIATURE HIGHACTIVITY FRAME	PA		
L5828	RB		ADDITION, ENDOSKELETAL KNEE-SHIN SYSTEM, SINGLE AXIS, FLUID SWING AND STANCE PHASE CONTROL	CMN	IOC	
L5828	NU		ADDITION, ENDOSKELETAL KNEE-SHIN SYSTEM, SINGLE AXIS, FLUID SWING AND STANCE PHASE CONTROL	CMN		

L5830	RB		ADDITION, ENDOSKELETAL KNEE-SHIN SYSTEM, SINGLE AXIS, PNEUMATIC/SWING PHASE CONTROL	CMN	IOC	
L5830	NU		ADDITION, ENDOSKELETAL KNEE-SHIN SYSTEM, SINGLE AXIS, PNEUMATIC/SWING PHASE CONTROL	CMN		
L5840	NU		ADDITION, ENDOSKELETAL KNEE-SHIN SYSTEM, 4-BAR LINKAGE OR MULTIAXIAL, PNEUMATIC SWING PHASE CONTROL	CMN		
L5845	RB		ADDITION, ENDOSKELETAL KNEE-SHIN SYSTEM, STANCE FLEXION FEATURE, ADJUSTABLE	CMN	IOC	
L5845	NU		ADDITION, ENDOSKELETAL KNEE-SHIN SYSTEM, STANCE FLEXION FEATURE, ADJUSTABLE	CMN		
L5848	NU		KNEE-SHIN SYS HYDRAUL STANCE	CMN		
L5850	RB		ADDITION, AK OR KNEE DISARTIC KNEE EXTENSION ASSIST	CMN	IOC	
L5850	NU		ADDITION, ENDOSKELETAL SYSTEM; ABOVE KNEE OR HIP DISARTICULATION, KNEE EXTENSION ASSIST	CMN		
L5855	NU		ADDITION, ENDOSKELETAL SYSTEM, HIP DISARTICULATION MECHANICAL HIP EXTENSION ASSIST	CMN		
L5856	NU		ADDITION TO ENDOSKELETAL KNEE-SHIN SYSTEM	CMN		
L5857	NU		ADDITION FOR ENDOSKELETAL KNEE-SHIN SYSTEM	CMN		
L5858	RB		STANCE PHASE ONLY	CMN	IOC	
L5858	NU		STANCE PHASE ONLY	CMN		
L5910	RB		ADDITION, BELOW KNEE ALIGNABLE SYSTEM	CMN	IOC	
L5910	NU		ADDITION, BELOW KNEE ALIGNABLE SYSTEM	CMN		
L5920	RB		ADDITION, ENDOSKELETAL SYSTEM, ABOVE KNEE OR HIP DISARTICULATION, ALIGNABLE SYSTEM	CMN	IOC	
L5920	NU		ADDITION, ENDOSKELETAL SYSTEM, ABOVE KNEE OR HIP DISARTICULATION, ALIGNABLE SYSTEM	CMN		
L5925	NU		ADDITION, ENDOSKELETAL SYSTEM, ABOVE KNEE, KNEE DISARTICULATION OR HIP DISARTICULATION, MANUAL	CMN		
L5930	RB		ADDITION, ENDOSKELETAL SYSTEM, HIGH ACTIVITY KNEE CONTROL FRAME	CMN	IOC	
L5930	NU		ADDITION, ENDOSKELETAL SYSTEM, HIGH ACTIVITY KNEE CONTROL FRAME	CMN		
L5940	RB		ADDITION, ENDOSKELETAL SYSTEM, BELOW KNEE, ULTRA-LIGHT MATERIAL (TITANIUM, CARBON FIBER OR EQUAL)	CMN	IOC	

L5940	NU		ADDITION, ENDOSKELETAL SYSTEM, BELOW KNEE, ULTRA-LIGHT MATERIAL (TITANIUM, CARBON FIBER OR EQUAL)	CMN		
L5950	RB		ABOVE KNEE, ULTRA-LIGHT MATERIAL (TITANIUM, CARBON FIBER OR EQUAL)	CMN		
L5950	NU		ABOVE KNEE, ULTRA-LIGHT MATERIAL (TITANIUM, CARBON FIBER OR EQUAL)	CMN		
L5960	RB		HIP DISARTICULATION, ULTRA LIGHT MATERIAL (TITANIUM, CARBON FIBER OR EQUAL)	CMN	IOC	
L5960	NU		HIP DISARTICULATION, ULTRA LIGHT MATERIAL (TITANIUM, CARBON FIBER OR EQUAL)	CMN		
L5961	NU		ENDO POLY HIP, PNEU/HYD/ROT	CMN	IOC	
L5962	NU		ADDITION, ENDOSKELETAL SYSTEM, BELOW KNEE, FLEXIBLE PROTECTIVE OUTER SURFACE COVERING SYSTEM	CMN		
L5964	NU		ADDITION, ENDOSKELETAL SYSTEM, ABOVE KNEE, FLEXIBLE PROTECTIVE OUTER SURFACE COVERING SYSTEM	CMN		
L5966	NU		ADDITION, ENDOSKELETAL SYSTEM, HIP DISARTICULATION, FLEXIBLE PROTECTIVE OUTER SURFACE COVERING SYSTE	CMN		
L5968	NU		ADDITION TO LOWER LIMB PROSTHESIS,MULTIAXIAL ANKLEWITH SWING PHASE ACTIVE DORSIFLEXION FEATURE	CMN		
L5970	RB		ALL LOWER EXTREMITY PROSTHESES, FOOT, EXTERNAL KEEL, SACH FOOT	CMN	IOC	
L5970	NU		ALL LOWER EXTREMITY PROSTHESES, FOOT, EXTERNAL KEEL, SACH FOOT	CMN		
L5971	RB		SACH FOOT, REPLACEMENT	CMN	IOC	
L5971	NU		SACH FOOT, REPLACEMENT	CMN		
L5972	RB		FLEXIBLE KEEL FOOT	CMN	IOC	
L5972	NU		FLEXIBLE KEEL FOOT	CMN		
L5974	RB		ALL LOWER EXTREMITY PROSTHESES, FOOT, SINGLE AXIS ANKLE/FOOT	CMN	IOC	
L5974	NU		FOOT, SINGLE AXIS ANKLE/FOOT	CMN		
L5975	NU		ALL LOWER EXTREMITY PROTHESIS; COMBINATION SINGLE AXIS ANKLE AND FLEXIBLE KEEL FOOT	CMN		
L5976	RB		ALL LOWER EXTREMITY PROSTHESES, ENERGY STORING FOOT (SEATTLE CARBON COPY II OR EQUAL)	CMN	IOC	
L5976	NU		ALL LOWER EXTREMITY PROSTHESES, ENERGY STORING FOOT (SEATTLE CARBON COPY II OR EQUAL)	CMN		
L5978	RB		ALL LOWER EXTREMITY PROSTHESES, FOOT, MULTIAXIAL ANKLE/FOOT	CMN	IOC	

Durable Medical Equipment



L5978	NU		ALL LOWER EXTREMITY PROSTHESES, FOOT, MULTIAXIAL ANKLE/FOOT	CMN		
L5979	NU		ALL LOWER EXTREMITY PROSTHESES, MULTIAXIAL ANKLE/FOOT, DYNAMIC RESPONSE	CMN		
L5980	RB		ALL LOWER EXTREMITY PROSTHESES, FLEX FOOT SYSTEM	CMN	IOC	
L5980	NU		ALL LOWER EXTREMITY PROSTHESES, FLEX FOOT SYSTEM	CMN		
L5981	NU		ALL LOWER EXTREMITY PROSTHESES, FLEX-WALK SYSTEM OR EQUAL	CMN		
L5982	RB		ALL EXOSKELETAL LOWER EXTREMITY PROSTHESES, AXIAL ROTATION UNIT	CMN	IOC	
L5982	NU		ALL EXOSKELETAL LOWER EXTREMITY PROSTHESES, AXIAL ROTATION UNIT	CMN		
L5984	RB		ALL ENDOSKELETAL LOWER EXTREMITY PROSTHESES, AXIALROTATION UNIT	CMN	IOC	
L5984	NU		ALL ENDOSKELETAL LOWER EXTREMITY PROSTHESES, AXIAL ROTATION UNIT	CMN		
L5985	RB		ALL ENDOSKELETAL LOWER EXTREMITY PROSTHESES, DYNAMIC PROSTHETIC PYLON	CMN	IOC	
L5985	NU		ALL ENDOSKELETAL LOWER EXTREMITY PROSTHESES, DYNAMIC PROSTHETIC PYLON	CMN		
L5986	RB		ALL LOWER EXTREMITY PROSTHESES, MULTI-AXIAL ROTATION OR UNIT (MCP OR EQUAL)	CMN	IOC	
L5986	NU		ALL LOWER EXTREMITY PROSTHESES, MULTI-AXIAL ROTATION UNIT (MCP OR EQUAL)	CMN		
L5987	NU		ALL LOWER EXTREMITY PROSTHESIS, SHANK FOOT SYSTEM WITH VERTICAL LOADING PYLON	CMN		
L5988	NU		ADDITION TO LOWER LIMB PROSTHESIS, VERTICAL SHOCK REDUCING PYLON FEATURE	CMN		
L5990	NU		ADDITION TO LOWER EXTREMITY PROSTHESIS, USER ADJUSTABLE HEEL HEIGHT	CMN		
L5999	NU		LOWER EXTREMITY PROSTHESIS, NOT OTHERWISE SPECIFIED	PA	IOC	
L6000	RB		PART HAND THUMB REM	CMN	IOC	
L6000	NU		PART HAND THUMB REM	CMN		
L6010	RB		PART HAND LITTLE/RING	CMN	IOC	
L6010	NU		PART HAND LITTLE/RING	CMN		
L6020	RB		PART HAND NO FINGERS	CMN	IOC	
L6020	NU		PART HAND NO FINGERS	CMN		

L6050	RB		WRIST DISARTICULATION, MOLDED SOCKET, FLEXIBLE ELBOW HINGES, TRICEPS PAD	CMN	IOC	
L6050	NU		WRIST DISARTICULATION, MOLDED SOCKET, FLEXIBLE ELBOW HINGES, TRICEPS PAD	CMN		
L6055	RB		WRIST DISARTICULATION, MOLDED SOCKET WITH EXPANDABLE INTERFACE, FLEXIBLE ELBOW HINGES, TRICEPS PAD	CMN	IOC	
L6055	NU		WRIST DISARTICULATION, MOLDED SOCKET WITH EXPANDABLE INTERFACE, FLEXIBLE ELBOW HINGES, TRICEPS PAD	CMN		
L6100	RB		BELOW ELBOW, MOLDED SOCKET, FLEXIBLE ELBOW HINGE, TRICEPS PAD	CMN	IOC	
L6100	NU		BELOW ELBOW, MOLDED SOCKET, FLEXIBLE ELBOW HINGE, TRICEPS PAD	CMN		
L6110	RB		BELOW ELBOW, MOLDED SOCKET, (MUENSTER OR NORTHWESTERN SUSPENSION TYPES)	CMN	IOC	
L6110	NU		BELOW ELBOW, MOLDED SOCKET, (MUENSTER OR NORTHWESTERN SUSPENSION TYPES)	CMN		
L6120	RB		BELOW ELBOW, MOLDED DOUBLE WALL SPLIT SOCKET, STEP-UP HINGES, HALF CUFF	CMN	IOC	
L6120	NU		BELOW ELBOW, MOLDED DOUBLE WALL SPLIT SOCKET, STEP-UP HINGES, HALF CUFF	CMN		
L6130	RB		BELOW ELBOW, MOLDED DOUBLE WALL SPLIT SOCKET, STUMP ACTIVATED LOCKING HINGE, HALF CUFF	CMN	IOC	
L6130	NU		BELOW ELBOW, MOLDED DOUBLE WALL SPLIT SOCKET, STUMP ACTIVATED LOCKING HINGE, HALF CUFF	CMN		
L6200	RB		ELBOW DISARTICULATION, MOLDED SOCKET, OUTSIDE LOCKING HINGE, FOREARM	CMN	IOC	
L6200	NU		ELBOW DISARTICULATION, MOLDED SOCKET, OUTSIDE LOCKING HINGE, FOREARM	CMN		
L6205	RB		ELBOW DISARTICULATION, MOLDED SOCKET WITH EXPANDABLE INTERFACE, OUTSIDE LOCKING HINGES, FOREARM	CMN	IOC	
L6205	NU		ELBOW DISARTICULATION, MOLDED SOCKET WITH EXPANDABLE INTERFACE, OUTSIDE LOCKING HINGES, FOREARM	CMN		
L6250	RB		ABOVE ELBOW, MOLDED DOUBLE WALL SOCKET, INTERNAL LOCKING ELBOW, FOREARM	CMN	IOC	
L6250	NU		ABOVE ELBOW, MOLDED DOUBLE WALL SOCKET, INTERNAL LOCKING ELBOW, FOREARM	CMN		



L6300	RB	SHOULDER DISARTICULATION, MOLDED SOCKET, SHOULDER BULKHEAD, HUMERAL SECTION, INTERNAL LOCKING ELBOW,	CMN	IOC	
L6300	NU	SHOULDER DISARTICULATION, MOLDED SOCKET, SHOULDER BULKHEAD, HUMERAL SECTION, INTERNAL LOCKING ELBOW,	CMN		
L6310	RB	SHOULDER DISARTICULATION, PASSIVE RESTORATION (COMPLETE PROSTHESIS)	CMN	IOC	
L6310	NU	SHOULDER DISARTICULATION, PASSIVE RESTORATION (COMPLETE PROSTHESIS)	CMN		
L6320	RB	SHOULDER DISARTICULATION, PASSIVE RESTORATION (SHOULDER CAP ONLY)	CMN	IOC	
L6320	NU	SHOULDER DISARTICULATION, PASSIVE RESTORATION (SHOULDER CAP ONLY)	CMN		
L6350	RB	INTERSCAPULAR THORACIC, MOLDED SOCKET, SHOULDER BULKHEAD, HUMERAL SECTION, INTERNAL LOCKING ELBOW, F	CMN	IOC	
L6350	NU	INTERSCAPULAR THORACIC, MOLDED SOCKET, SHOULDER BULKHEAD, HUMERAL SECTION, INTERNAL LOCKING ELBOW, F	CMN		
L6360	RB	INTERSCAPULAR THORACIC, PASSIVE RESTORATION (COMPLETE PROSTHESIS)	CMN	IOC	
L6360	NU	INTERSCAPULAR THORACIC, PASSIVE RESTORATION (COMPLETE PROSTHESIS)	CMN		
L6370	RB	INTERSCAPULAR THORACIC, PASSIVE RESTORATION (SHOULDER CAP ONLY)	CMN	IOC	
L6370	NU	INTERSCAPULAR THORACIC, PASSIVE RESTORATION (SHOULDER CAP ONLY)	CMN		
L6380	NU	IMMEDIATE POST SURGICAL OR EARLY FITTING, APPLICATION OF INITIAL RIGID DRESSING, INCLUDING FITTING A	CMN		
L6382	NU	IMMEDIATE POST SURGICAL OR EARLY FITTING, APPLICATION OF INITIAL RIGID DRESSING INCLUDING FITTING A	CMN		
L6384	NU	IMMEDIATE POST SURGICAL OR EARLY FITTING, APPLICATION OF INITIAL RIGID DRESSING INCLUDING FITTING A	CMN		
L6386	NU	IMMEDIATE POST SURGICAL OR EARLY FITTING, EACH ADDITIONAL CAST CHANGE AND REALIGNMENT	CMN		
L6388	NU	IMMEDIATE POST SURGICAL OR EARLY FITTING, APPLICATION OF RIGID DRESSING ONLY	CMN		
L6400	RB	BELOW ELBOW, MOLDED SOCKET, ENDOSKELETAL SYSTEM, INCLUDING SOFT PROSTHETIC TISSUE SHAPING	CMN	IOC	



L6400	NU		BELOW ELBOW, MOLDED SOCKET, ENDOSKELETAL SYSTEM, INCLUDING SOFT PROSTHETIC TISSUE SHAPING	PA		
L6450	RB		ELBOW DISARTICULATION, MOLDED SOCKET, ENDOSKELETAL SYSTEM, INCLUDING SOFT PROSTHETIC TISSUE SHAPING	CMN	IOC	
L6450	NU		ELBOW DISARTICULATION, MOLDED SOCKET, ENDOSKELETAL SYSTEM, INCLUDING SOFT PROSTHETIC TISSUE SHAPING	PA		
L6500	RB		ABOVE ELBOW, MOLDED SOCKET, ENDOSKELETAL SYSTEM, INCLUDING SOFT PROSTHETIC TISSUE SHAPING	CMN	IOC	
L6500	NU		ABOVE ELBOW, MOLDED SOCKET, ENDOSKELETAL SYSTEM, INCLUDING SOFT PROSTHETIC TISSUE SHAPING	PA		
L6550	RB		SHOULDER DISARTICULATION, MOLDED SOCKET, ENDOSKELETAL SYSTEM, INCLUDING SOFT PROSTHETIC TISSUE SHAPI	CMN	IOC	
L6550	NU		SHOULDER DISARTICULATION, MOLDED SOCKET, ENDOSKELETAL SYSTEM, INCLUDING SOFT PROSTHETIC TISSUE SHAPI	PA		
L6570	RB		INTERSCAPULAR THORACIC, MOLDED SOCKET, ENDOSKELETAL SYSTEM, INCLUDING SOFT PROSTHETIC TISSUE SHAPING	CMN	IOC	
L6570	NU		INTERSCAPULAR THORACIC, MOLDED SOCKET, ENDOSKELETAL SYSTEM, INCLUDING SOFT PROSTHETIC TISSUE SHAPING	PA		
L6580	RB		PREPARATORY, WRIST DISARTICULATION OR BELOW ELBOW, SINGLE WALL PLASTIC SOCKET, FRICTION WRIST, FLEXI	CMN	IOC	
L6580	NU		PREPARATORY, WRIST DISARTICULATION OR BELOW ELBOW, SINGLE WALL PLASTIC SOCKET, FRICTION WRIST, FLEXI	CMN		
L6582	RB		PREPARATORY, WRIST DISARTICULATION OR BELOW ELBOW, SINGLE WALL SOCKET, FRICTION WRIST, FLEXIBLE ELBO	CMN	IOC	
L6582	NU		PREPARATORY, WRIST DISARTICULATION OR BELOW ELBOW, SINGLE WALL SOCKET, FRICTION WRIST, FLEXIBLE ELBO	CMN		
L6584	RB		PREPARATORY, ELBOW DISARTICULATION OR ABOVE ELBOW, SINGLE WALL PLASTIC SOCKET, FRICTION WRIST, LOCKI	CMN	IOC	
L6584	NU		PREPARATORY, ELBOW DISARTICULATION OR ABOVE ELBOW, SINGLE WALL PLASTIC SOCKET, FRICTION WRIST, LOCKI	CMN		
L6586	RB		PREPARATORY, ELBOW DISARTICULATION OR ABOVE ELBOW, SINGLE WALL SOCKET, FRICTION WRIST, LOCKING ELBOW	CMN	IOC	
L6586	NU		PREPARATORY, ELBOW DISARTICULATION OR ABOVE ELBOW, SINGLE WALL SOCKET, FRICTION WRIST, LOCKING ELBOW	CMN		

Durable Medical Equipment



L6588	RB		PREPARATORY, SHOULDER DISARTICULATION OR INTERSCAPULAR THORACIC, SINGLE WALL PLASTIC SOCKET, SHOULDE	CMN	IOC	
L6588	NU		PREPARATORY, SHOULDER DISARTICULATION OR INTERSCAPULAR THORACIC, SINGLE WALL PLASTIC SOCKET, SHOULDE	CMN		
L6590	RB		PREPARATORY, SHOULDER DISARTICULATION OR INTERSCAPULAR THORACIC, SINGLE WALL SOCKET, SHOULDER JOINT,	CMN	IOC	
L6590	NU		PREPARATORY, SHOULDER DISARTICULATION OR INTERSCAPULAR THORACIC, SINGLE WALL SOCKET, SHOULDER JOINT,	CMN		
L6600	NU		UPPER EXTREMITY ADDITIONS, POLYCENTRIC HINGE, PAIR	CMN		
L6605	NU		UPPER EXTREMITY ADDITIONS, SINGLE PIVOT HINGE, PAIR	CMN		
L6610	NU		UPPER EXTREMITY ADDITIONS, FLEXIBLE METAL HINGE, PAIR	CMN		
L6615	NU		UPPER EXTREMITY ADDITION, DISCONNECT LOCKING WRIST UNIT	CMN		
L6616	NU		UPPER EXTREMITY ADDITION, ADDITIONAL DISCONNECT INSERT FOR LOCKING WRIST UNIT, EACH	CMN		
L6620	NU		UPPER EXTREMITY ADDITION, FLEXION FRICTION WRIST UNIT	CMN		
L6621	RB		FLEX/EXT WRIST W/NO FRICTION	CMN	IOC	
L6621	NU		FLEX/EXT WRIST W/NO FRICTION	CMN		
L6623	NU		UPPER EXTREMITY ADDITION, SPRING ASSISTED ROTATIONAL WRIST WITH LATCH RELEASE	CMN		
L6625	NU		UPPER EXTREMITY ADDITION, ROTATION WRIST UNIT WITH CABLE LOCK	CMN		
L6628	NU		UPPER EXTREMITY ADDITION, QUICK DISCONNECT HOOK ADAPTER OTTO BOCK OR EQUAL	CMN		
L6629	NU		UPPER EXTREMITY ADDITION, QUICK DISCONNECT LAMINATION COLLAR WITH COUPLING PIECE OTTO BOCK OR EQUAL	CMN		
L6630	NU		UPPER EXTREMITY ADDITION, STAINLESS STEEL, ANY WRIST	CMN		
L6632	NU		UPPER EXTREMITY ADDITION, LATEX SUSPENSION SLEEVE EACH	CMN		
L6635	NU		UPPER EXTREMITY ADDITION, LIFT ASSIST FOR ELBOW	CMN		
L6637	NU		UPPER EXTREMITY ADDITIONS;NUDGE CONTROL ELBOW LOCK	CMN		
L6640	NU		UPPER EXTREMITY ADDITIONS, SHOULDER ABDUCTION JOINT, PAIR	CMN		
L6641	NU		UPPER EXTREMITY ADDITION, EXCURSION AMPLIFIER, PULLEY TYPE	CMN		
L6642	NU		UPPER EXTREMITY ADDITION, EXCURSION AMPLIFIER, LEVER TYPE	CMN		
L6645	NU		UPPER EXTREMITY ADDITION, SHOULDER FLEXION ABDUCTION JOINT, EACH	CMN		
L6650	NU		UPPER EXTREMITY ADDITION, SHOULDER UNIVERSAL JOINT, EACH	CMN		

PRODUCTION : 04/09/2020

Durable Medical Equipment



L6655	NU	UPPER EXTREMITY ADDITION, STANDARD CONTROL CABLE, EXTRA	CMN		
L6660	NU	UPPER EXTREMITY ADDITION, HEAVY DUTY CONTROL	CMN		
L6665	NU	UPPER EXTREMITY ADDITION;TEFLON,OR EQUAL, CALBLE LINING			
L6670	NU	UPPER EXTREMITY ADDITION, HOOK TO HAND CABLE ADAPTER	CMN		
L6672	NU	UPPER EXTREMITY ADDITION, HARNESS CHEST OR SHOULDER SADDLE TYPE	CMN		
L6675	NU	UPPER EXTREMITY ADDITION, HARNESS FIGURE OF 8 FOR SINGLE CONTROL	CMN		
L6676	NU	UPPER EXTREMITY ADDITION, HARNESS FIGURE OF 8 FOR DUAL CONTROL	CMN		
L6677	RB	UE TRIPLE CONTROL HARNESS	CMN	IOC	
L6677	NU	UE TRIPLE CONTROL HARNESS	CMN		
L6680	NU	UPPER EXTREMITY ADDITION, TEST SOCKET WRIST DISARTICULATION OR BELOW ELBOW	CMN		
L6682	NU	UPPER EXTREMITY ADDITION, TEST SOCKET ELBOW DISARTICULATION OR ABOVE ELBOW	CMN		
L6684	NU	UPPER EXTREMITY ADDITION, TEST SOCKET, SHOULDER DISARTIC OR INTERSCA PULAR THORACIC	CMN		
L6686	NU	UPPER EXTREMITY ADDITIONS; SUCTION SOCKET	CMN		
L6687	NU	UPPER EXTREMITY ADDITIONS;FRAME TYPE SOCKET, BELOWOR WRIST DISARTICULATION	CMN		
L6688	NU	UPPER EXTREMITY ADDITIONS;FRAME TYPE SOCKET, ABOVE ELBOW OR ELBOW DISARTICULATION	CMN		
L6689	NU	UPPER EXTREMITY ADDITIONS;FRAME TYPE SOCKET,SHOULDER DISARTICULATION	CMN		
L6690	NU	UPPER EXTREMITY ADDITIONS;FRAME TYPE SOCKET INTERSCAPULAR THORACIC	CMN		
L6691	NU	UPPER EXTREMITY ADDITION, REMOVABLE INSERT, EACH	CMN		
L6692	NU	UPPER EXTREMITY ADDITIONS;SILICONE GEL INSERT OR EQUAL, EACH	CMN		
L6693	NU	UPPER EXTREMITY ADDITION, LOCKING ELBOW,FOREARM COUNTERBALANCE	CMN		
L6694	NU	ADDITION FOR BELOW ELBOW/ABOVE ELBOW, CUSTOM	PA		
L6695	NU	ADDITON FOR BELOW ELBOW/ABOVE ELBOW, CUSTOM	PA		
L6696	NU	ADDITION FOR BELOW ELBOW/ABOVE ELBOW, CUSTOM	PA		
L6697	NU	ADDITION FOR BELOW ELBOW/ABOVE ELBOW, CUSTOM	PA		
L6698	NU	ADDITION FOR BELOW ELBOW/ABOVE ELBOW, CUSTOM	PA		

Durable Medical Equipment



L6706	NU		TERM DEV MECH HOOK VOL OPEN	CMN		
L6707	NU		TERMINAL DEVICE, HOOK, MECHANICAL, VOLUNTARY CLOSING, ANY MATERIAL, ANY SIZE, LINED OR UNLINED	CMN		
L6805	NU		ADDITION TO TERMINAL DEVICE, MODIFIER WRIST UNIT	CMN		
L6810	NU		ADDITION TO TERMINAL DEVICE, PRECISION PINCH DEVICE	CMN		
L6883	NU		REPLC SOCKT BELOW E/W DISA	CMN		
L6884	NU		REPLC SOCKT ABOVE ELBOW DISA	CMN		
L6885	NU		REPLC SOCKT SHLDR DIS/INTERC	CMN		
L7400	NU		ADD UE PROST BE/WD, ULTLITE	CMN		
L7401	NU		ADD UE PROST A/E ULTLITE MAT	CMN		
L7402	NU		ADD UE PROST S/D ULTLITE MAT	CMN		
L7403	NU		ADD UE PROST B/E ACRYLIC	CMN		
L7404	NU		ADD UE PROST A/E ACRYLIC	CMN		
L7405	NU		ADD UE PROST S/D ACRYLIC	CMN		
L7499	NU		UPPER EXTREMITY PROSTHESIS, NOT OTHERWISE SPECIFIED	PA	IOC	
L7510	RB		PROSTHETIC DEVICE REPAIR REP	CMN	IOC	
L7520	RB		REPAIR PROSTHESIS PER 15 MIN	CMN		
L7600	NU		PROSTHETIC DONNING SLEEVE	CMN	IOC	
L8000	NU		MASTECTOMY BRA	PC		3 per 12 months.
L8020	NU	LT	BREAST PROSTHESIS, MASTECTOMY FORM	PC		1 every 6 months.
L8020	NU	RT	BREAST PROSTHESIS, MASTECTOMY FORM	PC		1 every 6 months.
L8030	NU	LT	BREAST PROSTHES W/O ADHESIVE	PC		1 every 24 months.
L8030	NU	RT	BREAST PROSTHES W/O ADHESIVE	PC		1 every 24 months.
L8031	NU	LT	BREAST PROSTHESIS W ADHESIVE	PC		1 every 24 months.
L8031	NU	RT	BREAST PROSTHESIS W ADHESIVE	PC		1 every 24 months.
L8400	NU		PROSTHETIC SHEATH, BELOW KNEE, EACH	CMN		

Durable Medical Equipment



L8410	NU		PROSTHETIC SHEATH, ABOVE KNEE, EACH	CMN		
L8415	NU		PROSTHETIC SHEATH, UPPER LIMB, EACH	CMN		
L8417	NU		PROSTHETIC SHEATH/SOCK, INCLUDING A GEL CUSHION LAYER, BELOW KNEE OR ABOVE KNEE, EACH	CMN		
L8420	NU		PROSTHETIC SOCK, MULTIPLE PLY; BELOW KNEE, EACH	CMN		
L8430	NU		PROSTHETIC SOCK, MULTIPLE PLY; ABOVE KNEE, EACH	CMN		
L8435	NU		PROSTHETIC SOCK MULTIPLE PLY UPPER LIMB EACH	CMN		
L8440	NU		PROSTHETIC SHRINKER, BELOW KNEE, EACH	CMN		
L8460	NU		PROSTHETIC SHRINKER, ABOVE KNEE, EACH	CMN		
L8465	NU		PROSTHETIC SHRINKER, UPPER LIMB, EACH	CMN		
L8470	NU		PROSTHETIC SOCK, SINGLE PLY, FITTING; BELOW KNEE EACH	CMN		
L8480	NU		ABOVE KNEE, EACH	CMN		
L8485	NU		UPPER LIMB, EACH	CMN		
L8499	NU		UNLISTED PROCEDURE FOR MISCELLANEOUS PROSTHETIC SERVICES	PA	IOC	
L8500	RB		ARTIFICIAL LARYNX	CMN	IOC	
L8500	NU		ARTIFICIAL LARYNX	CMN		
L8501	NU		TRACHEOSTOMY SPEAKING VALVE	CMN		
L8505	NU		ARTIFICIAL LARYNX REPLACEMENT BATTER/ACCESSORY, ANY TYPE	CMN	IOC	
L8511	NU		INDWELLING TRACH INSERT	MNF		
L8512	NU		GEL CAP FOR TRACH VOICE PROST	MNF		
L8513	NU		TRACH PROS CLEANING DEVICE	MNF		
L8514	NU		REPL TRACH PUNCTURE DILATOR	MNF		
S8189	NU		TRACHEOSTOMY SUPPLY, NOC	CMN	IOC	
Z0160	RB		REPAIR OF EQUIPMENT REPLACE OR REPAIR MINOR PARTS	CMN	IOC	
Z0160	RB	SC	REPAIR OF EQUIPMENT, REPLACE OR REPAIR MINOR PARTS	CMN		



SECTION 20-EXCEPTION PROCESS

20.1 EXCEPTION PRINCIPLE

Under certain conditions of medical need, the MO HealthNet Division may authorize payment for a MO HealthNet eligible participant to receive an *essential* medical service or item of equipment that otherwise exceeds the benefits and limitations of any one of the various medical service programs administered by the Division. Under specific criteria and on a case-by-case basis, an administrative exception may be made to limitations and restrictions set by agency policy. No exception can be made where requested items or services are restricted or specifically prohibited by state or federal law or regulation, or excluded under the restrictions section of this rule. The director of the MO HealthNet Division has the final authority to approve payment on a request made to the exception process. These decisions are made with appropriate medical or pharmaceutical advice and consultation.

With the exception of group 2 and group 3 pressure reducing support surfaces, mattress rentals, all services for individuals under age 21 determined to be medically necessary, may be considered for coverage under the EPSDT/HCY Program. Reference Section 9 for more information. Group 2 and group 3 pressure reducing support surface, mattress rentals, *must* be approved through the Exception Process prior to being dispensed, regardless of the participant's age.

Exception requests are only accepted from authorized health care prescribers licensed as a physician or advanced practice nurse.

20.2 REQUIREMENTS

Requirements for consideration and provision of a service as an exception to the normal limitations of MO HealthNet coverage are as follows:

- A prescriber *must* certify that MO HealthNet covered treatment or items of services appropriate to the illness or condition have been determined to be medically inappropriate or have been used and found to be ineffective in treatment of the participant for whom the exception is being requested;
- While requests may be approved, documentation verifying that all third party resource benefits have been exhausted *must* accompany claims for payment before the MO HealthNet Program pays for any item or service; for example,
 - Medicare
 - Private Insurance
 - The American Diabetes Society
 - The Veterans Administration
 - The American Cancer Society
 - A United Way Agency;



Except in the case of retroactive MO HealthNet eligibility determination, requests *must* be submitted prior to delivery of the service. Do *not* wait until after receipt of documentation of noncoverage from an alternative payor to submit the completed Exception Request form.

- Any requested medical, surgical or diagnostic service which is to be provided under the authority of the treating prescriber, *must* be listed in the most recent publication of *A Comprehensive Guide to Current Procedural Terminology*, (CPT) or the CMS-approved list of HCPCS codes. The CPT and HCPCS books may be purchased at any medical bookstore;
- Any individual for whom an exception request is made *must* be eligible for MO HealthNet on the date the item or service is provided. If requested, approval may be granted in the case of retroactive MO HealthNet eligibility determinations.
- The provider of the service *must* be an enrolled provider in the MO HealthNet Program on the date the item or service is provided;
- The item or service for which an exception is requested *must* be of a type and nature that falls within the broad scope of a medical discipline included in the MO HealthNet Program and does *not* represent a departure from the accepted standards and precepts of good medical practice. *No* consideration can be given to requests for experimental therapies or services;
- All requests for exception consideration *must* be initiated by the treating prescriber of an eligible participant and *must* be submitted as prescribed by policy of the MO HealthNet Division, 13 CSR 70-2.100;
- Requests for exception consideration *must* support and demonstrate that one (1) or more of the following conditions is met:
 1. The item or service is required to sustain the participant's life;
 2. The item or service would substantially improve the quality of life for a terminally ill patient;
 3. The item or service is necessary as a replacement due to an act occasioned by violence of nature without human interference, such as a tornado or flood; or
 4. The item or service is necessary to prevent a higher level of care.
- All requests *must* be made and approval granted before the requested item or service is provided. An exception to that requirement may be granted in cases in which the participant's eligibility for MO HealthNet is retroactively established or when emergency circumstances preclude the use of the established procedures for submitting a request, and a request is received *not* more than one (1) state working day following the provision of the service.

An emergency medical condition for a MO HealthNet participant means a medical or a behavioral health condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in the following:

1. Placing the physical or behavioral health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; or
2. Serious impairment of bodily functions; or
3. Serious dysfunction of any bodily organ or part; or
4. Serious harm to self or others due to an alcohol or drug abuse emergency; or
5. Injury to self or bodily harm to others; or
6. With respect to a pregnant woman having contractions: (a) that there is inadequate time to affect a safe transfer to another hospital before delivery or; (b) that transfer may pose a threat to the health or safety of the woman or the unborn child.

Post stabilization care services mean covered services, related to an emergency medical condition, that are provided after a participant is stabilized in order to maintain the stabilized condition or to improve or resolve the participant's condition.

- All exception requests *must* represent cost-effective utilization of MO HealthNet funds. When an exception item or service is presented as an alternative, lesser level-of-care than the level otherwise necessary, the exception *must* be less program costly; and
- Reimbursement of services and items approved under this exception procedure shall be made in accordance with the MO HealthNet established fee schedules or rates for the same or comparable services. For those services for which no MO HealthNet-established fee schedule or rate is applicable, reimbursement is determined by the state agency considering costs and charges.

20.3 RESTRICTIONS

The following are examples of types of requests that are *not* considered for approval as an exception. This is *not* an all-inclusive list:

- Requests for restricted program areas. Refer to Section 1 for a list of restricted program areas.
- Requests for expanded HCY/EPSTDT services (individuals under age 21). These should be directed to the HCY/EPSTDT coordinator. (Reference manual Section 9).
- Requests for orthodontic services;
- Requests for inpatient hospital services;



- Requests for alternative services (Personal Care, Adult Day Health Care, AIDS Waiver, Aged and Disabled Waiver, Hospice, and Respite Care) regardless of authorization by the Missouri Department of Health and Senior Services;
- Requests for chiropractic services;
- Requests for services that are provided by individuals whose specialty is *not* covered by the MO HealthNet Program;
- Requests for psychological testing or counseling *not* otherwise covered by the MO HealthNet Program;
- Requests for waiver of program requirements for documentation, applicable to services requiring a second surgical opinion, hysterectomy, voluntary sterilizations, and legal abortions;
- Requests for drug products excluded from coverage by the MO HealthNet Program;
- Requests relating to the failure to obtain prior authorization or pre-certification as required for a service otherwise covered by MO HealthNet;
- Requests for payment of dentures and/or partials placed after the participant is ineligible when fabrication occurred prior to that time;
- Requests for delivery or placement of any custom-made items following the participant's death or loss of eligibility for the service;
- Requests for removal from the Lock-In or Prepaid Health Programs;
- Requests for additional reimbursement for items or services otherwise covered by the MO HealthNet Program;
- Requests for air ambulance transportation;
- Requests for Qualified Medicare Beneficiary (QMB) services;
- Requests for MO HealthNet Waiver services such as AIDS Waiver;
- Requests for services exceeding the limits of the Transplant Program;
- Requests for services exceeding the limits of the regular MO HealthNet Program.

20.4 REQUESTING AN EXCEPTION

All Exception Request forms *must* be signed by the treating prescriber of an eligible participant. The requests are to be submitted to the Exceptions Unit. This unit processes the request, obtains a decision from the appropriate medical or pharmaceutical consultant and/or administrative official, and informs the treating prescriber, provider of service, and participant of all approved decisions. In the event of a denial, only the prescriber and participant are notified.

There are two categories of exception request—emergency and nonemergency, each of which are processed differently.



20.4.A LIFE-THREATENING EMERGENCY EXCEPTION REQUESTS

Requests for life-threatening emergencies may be submitted by the treating prescriber by calling the toll-free number (800) 392-8030. The office hours for the Exceptions Unit are from 8:00 A.M. to 5:00 P.M. Monday through Friday, except on observed holidays. All other provider inquiries regarding covered program benefits *must* be directed the Provider Communications Unit at (573) 751-2896.

The treating prescriber *must* provide Exceptions Unit personnel with information consistent with that required on the Exception Request form. The request is processed within one (1) state working day with notification of approval communicated by fax to the provider of service. If the request is denied, the prescriber is notified within one (1) state working day.

20.4.B NON-EMERGENCY EXCEPTION REQUESTS

In order to ensure access to the Exceptions Unit for life-threatening emergency requests, all non-emergency requests *must* be submitted on an Exception Request form. Requests may be faxed to (573) 522-3061.

Non-emergency requests may also be submitted by mailing to:

MO HealthNet Division
Exceptions Unit
P.O. Box 6500
Jefferson City, MO 65102-6500

Upon receipt, the MO HealthNet Division processes these requests within 15 state business working days, with notification letters being sent to the prescriber and participant. If approval is given, the provider of service also receives written notification.

END OF SECTION

[TOP OF PAGE](#)



SECTION 21- ADVANCE HEALTH CARE DIRECTIVES

This section describes the responsibility of certain providers to inform adult participants of their rights under state law to make medical care decisions and the right to make an advanced health care directive.

Section 21, Advance Health Care Directives, is *not* applicable to the following manuals:

- Adult Day Health Care
- Aged and Disabled Waiver
- Ambulance
- Ambulatory Surgical Centers
- Community Psychiatric Rehabilitation
- Comprehensive Day Rehabilitation
- CSTAR
- Dental
- Durable Medical Equipment
- Environmental Lead Assessment
- Hearing Aid
- MRDD Waiver
- Nurse Midwife
- Optical
- Pharmacy
- Private Duty Nursing
- Psychology/Counseling
- Rehabilitation Centers
- Therapy

END OF SECTION

[TOP OF PAGE](#)

SECTION 22-NON-EMERGENCY MEDICAL TRANSPORTATION (NEMT)

22.1 INTRODUCTION

This section contains information pertaining to the Non-Emergency Medical Transportation's (NEMT) direct service program. The NEMT Program provides for the arrangement of transportation and ancillary services by a transportation broker. The broker may provide NEMT services either through direct service by the broker and/or through subcontracts between the broker and subcontractor(s).

The purpose of the NEMT Program is to assure transportation to MO HealthNet participants who do *not* have access to free appropriate transportation to and from scheduled MO HealthNet covered services.

The Missouri NEMT Program is structured to utilize and build on the existing transportation network in the state. The federally-approved method used by Missouri to structure the NEMT Program allows the state to have one statewide transportation broker to coordinate the transportation providers. The broker determines which transportation provider will be assigned to provide each transport.

22.2 DEFINITIONS

The following definitions apply for this program:

Action	The denial, termination, suspension, or reduction of an NEMT service.
Ancillary Services	Meals and lodging are part of the transportation package for participants, when the participant requires a particular medical service which is only available in another city, county, or state and the distance and travel time warrants staying in that place overnight. For children under the age of 21, ancillary services may include an attendant and/or one parent/guardian to accompany the child.
Appeal	The mechanism which allows the right to appeal actions of the broker to a transportation provider who as (1) has a claim for reimbursement or request for authorization of service delivery denied or not acted upon with reasonable promptness; or (2) is aggrieved by an rule or policy or procedure or decision by the broker.
Attendant	An individual who goes with a participant under the age of 21 to the MO HealthNet covered service to assist the participant because the participant



cannot travel alone or *cannot* travel a long distance without assistance. An attendant is an employee of, or hired by, the broker or an NEMT transportation provider.

Basic/Urban/ Rural Counties	As defined in 20 CSR, the following counties are categorized as: <ul style="list-style-type: none"> • Urban – Clay, Greene, Jackson, Jefferson, St. Charles, St. Louis, and St. Louis City; • Basic – Boone, Buchanan, Cape Girardeau, Cass, Christian, Cole, Franklin, Jasper, Johnson, Lincoln, Newton, Platte, Pulaski, St. Francois and Taney; • Rural – All other counties.
Broker	Contracted entity responsible for enrolling and paying transportation providers, determining the least expensive and most appropriate type of transportation, authorizing transportation and ancillary services, and arranging and scheduling transportation for eligible participants to MO HealthNet covered services.
Call Abandonment	Total number of all calls which disconnect prior to reaching a live voice for all incoming lines for callers to make reservations, trip inquiries or file complaints.
Call Wait Time	Total amount of time after a call is received into the queue until reaching a live voice for all incoming lines for callers to make reservations, trip inquiries or file complaints.
Clean Claim	A claim that can be processed without obtaining additional information from the transportation provider of the NEMT service or from a third party.
Complaint	A verbal or written expression by a transportation provider which indicates dissatisfaction or dispute with a participant, broker policies and procedures, claims, or any aspect of broker functions.
DCN	Departmental Client Number. A unique eight-digit number assigned to each individual who applies for MO HealthNet benefits. The DCN is also known as the MO HealthNet Identification Number.
Denial Reason	The category utilized to report the reason a participant is not authorized for transportation. The denial categories are: <ul style="list-style-type: none"> • Non-covered Service • Lack of Day’s Notice



- Participant Ineligible
- Exceeds Travel Standards
- Urgency Not Verified by Medical Provider
- Participant has Other Coverage
- No Vehicle Available
- Access to Vehicle
- Not Closest Provider
- MHD Denied: Over Trip Leg Limit
- Access to Free Transportation
- Not Medicaid Enrolled Provider
- Incomplete Information
- Refused Appropriate Mode
- Minor Without Accompaniment
- Participant Outside Service Area

Emergency

An emergency medical condition for a MO HealthNet participant means a medical or a behavioral health condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in the following:

1. Placing the physical or behavioral health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; or
2. Serious impairment of bodily functions; or
3. Serious dysfunction of any bodily organ or part; or
4. Serious harm to self or others due to an alcohol or drug abuse emergency; or
5. Injury to self or bodily harm to others; or
6. With respect to a pregnant woman having contractions: (a) that there is inadequate time to affect a safe transfer to another hospital before delivery or; (b) that transfer may pose a threat to the health or safety of the woman or the unborn child.

Post stabilization care services mean covered services, related to an emergency medical condition, that are provided after a participant is stabilized in order to maintain the stabilized condition or to improve or resolve the participant's condition.

Fraud

Any type of intentional deception or misrepresentation made by an entity or person with the knowledge that the deception could result in some unauthorized benefit to the entity, himself/herself, or some other person.



Free Transportation	Any appropriate mode of transportation that can be secured by the participant without cost or charge, either through volunteers, organizations/associations, relatives, friends, or neighbors.
Grievance (Participant)	A verbal or written expression of dissatisfaction from the participant about any matter, other than an action. Possible subjects for grievances include, but are <i>not</i> limited to, the quality of care or services received, condition of mode of transportation, aspects of interpersonal relationships such as rudeness of a transportation provider or broker’s personnel, or failure to respect the participant’s rights.
Grievance (Transportation Provider)	A written request for further review of a transportation provider’s complaint that remains unresolved after completion of the complaint process.
Inquiry	A request from a transportation provider regarding information that would clarify broker’s policies and procedures, or any aspect of broker function that may be in question.
Most Appropriate	The mode of transportation that accommodates the participant’s physical, mental, or medical condition.
MO HealthNet Covered Services	Covered services under the MO HealthNet program.
Medically Necessary	Service(s) furnished or proposed to be furnished that is (are) reasonable and medically necessary for the prevention, diagnosis, or treatment of a physical or mental illness or injury; to achieve age appropriate growth and development; to minimize the progression of a disability; or to attain, maintain, or regain functional capacity; in accordance with accepted standards of practice in the medical community of the area in which the physical or mental health services are rendered; and service(s) could <i>not</i> have been omitted without adversely affecting the participant’s condition or the quality of medical care rendered; and service(s) is (are) furnished in the most appropriate setting. Services <i>must</i> be sufficient in amount, duration, and scope to reasonably achieve their purpose and may only be limited by medical necessity.
Medical Service Provider	An individual firm, corporation, hospital, nursing facility, or association that is enrolled in MO HealthNet as a participating provider of service, or MO HealthNet services provided free of charge by the Veterans Administration or Shriners Hospital.



NEMT Services	Non-Emergency Medical Transportation (NEMT) services are a ride, or reimbursement for a ride, and ancillary services provided so that a MO HealthNet participant with no other transportation resources can receive MO HealthNet covered services from a medical service provider. By definition, NEMT does <i>not</i> include transportation provided on an emergency basis, such as trips to the emergency room in life-threatening situations, unloaded miles, or transportation provider wait times.
No Vehicle Available	Any trip the broker does not assign to a transportation provider due to inability or unwillingness of the transportation provider to accommodate the trip. All “no vehicle available” trips shall be reported as denials in the category of no vehicle available.
Participant	A person determined by the Department of Social Services, Family Support Division (FSD) to be eligible for a MO HealthNet category of assistance.
Pick-up Time	The actual time the participant boarded the vehicle for transport. Pick up time must be documented for all trips and must be no later than 5 minutes from the scheduled pick-up time. Trips completed or cancelled due to transportation provider being late must be included in the pick-up time reporting.
Public Entity	State, county, city, regional, non-profit agencies, and any other entity, who receive state general revenue or other local monies for transportation and enter into an interagency agreement with the MO HealthNet Division to provide transportation to a specific group of eligibles.
Transportation Leg	From pick up point to destination.
Transportation Provider	Any individual, including volunteer drivers, or entity who, through arrangement or subcontract with the broker, provides non-emergency medical transportation services. Transportation providers are not enrolled as MO HealthNet providers.
Urgent	A serious, but <i>not</i> life threatening illness/injury. Examples include, but are <i>not</i> limited to, high temperature, persistent vomiting or diarrhea, symptoms which are of sudden or severe onset but which do <i>not</i> require emergency room services, and persistent rash. The broker shall arrange urgent trips, as deemed urgent and requested by the participant or the participant’s medical provider.
Will Call	An unscheduled pick-up time when the participant calls the broker or



transportation provider directly for a return trip. Transportation shall pick-up participant within 60 minutes of the participants call requesting return trip.

22.3 COVERED SERVICES

The broker shall ensure the provision of Non-Emergency Medical Transportation (NEMT) services for participants to MO HealthNet covered services for the Department of Social Services, MO HealthNet Division. The broker *must* ensure that NEMT services are available 24 hours per day, 7 days per week, when medically necessary. To provide adequate time for NEMT services to be arranged, a participant should call at least two (2) business days in advance when they live within an urban county and at least three (3) business days advance notice if they live in the a rural or basic county, with the exception of an urgent care or hospital discharge.

NEMT services may be scheduled with less than the required days' notice if they are of an urgent nature. Urgent calls are defined as a serious, but *not* life threatening illness/injury. Urgent trips may be requested by the participant or participant's medical provider. The number for scheduling transportation is (866) 269-5927. This number is accessible 24 hours a day, 7 days a week. Non-urgent trips can be scheduled Monday thru Friday, 8:00 am-5:00 pm.

The broker shall provide NEMT services to MO HealthNet covered services that do *not* include transportation. In addition, the broker *must* arrange NEMT services for one parent/guardian to accompany children under the age of 21, if requested. The broker *must* also arrange NEMT services for an attendant, if appropriate, to accompany children under the age of 21. If the participant is under the age of 17, a parent/guardian must ride with them.

In addition to authorizing the transportation services, the broker shall authorize and arrange the least expensive and most appropriate ancillary services. Ancillary services shall only be authorized if:

1. The medical appointment requires an overnight stay, AND
2. Volunteer, community, or other ancillary services are *not* available at no charge to the participant.

The broker shall also authorize and arrange ancillary services for one parent/guardian when a MO HealthNet eligible child is inpatient in a hospital setting and meets the following criteria:

1. Hospital does not provide ancillary services without cost to the participant's parent/guardian, AND
2. Hospital is more than 120 miles from the participant's residence, OR
3. Hospitalization is related to a MO HealthNet covered transplant service.

The broker shall obtain prior authorization from the state agency for out-of-state transportation to non-bordering states.



If the participant meets the criteria specified above, the broker shall also authorize and arrange ancillary services to eligible participants who have access to transportation at no charge to the participant or receive transportation from a Public Entity and such ancillary services were not included as part of the transportation service.

The broker shall direct or transfer participants with requests that are of an emergent nature to 911 or an appropriate emergency (ambulance) service.

22.4 PARTICIPANT ELIGIBILITY

The participant *must* be eligible for MO HealthNet to receive transportation services.

The broker shall verify whether the individual seeking NEMT services is eligible for NEMT services on the date of transport by accessing eligibility information. Information regarding participant eligibility may be found in Section 1 of this manual.

22.5 NON-COVERED PARTICIPANTS

The following participants are *not* eligible for NEMT services provided by the broker:

1. Participants with the following MO HealthNet Eligibility (ME) codes: 02, 08, 52, 55, 57, 59, 64, 65, 73, 74, 75, 80, 82, 89, 91, 92, 93, and 97.
2. Participants who have access to transportation at no cost to the participant. However, such participants may be eligible for ancillary services.
3. Participants who have access to transportation through a Public Entity. However, such participants may be eligible for ancillary services.
4. Participants who have access to NEMT through the Medicare program.
5. Participants enrolled in the Hospice Program. However, the broker shall arrange NEMT services for such participants accessing MO HealthNet covered services that are *not* related to the participant's terminal illness.
6. Participants in a MO HealthNet managed care health plan.
 - a. NEMT services for participants enrolled in MO HealthNet Managed Care Health Plans is arranged by those programs for services included in the benefit package. The broker shall *not* be responsible for arranging NEMT services for the health plans.

22.6 TRAVEL STANDARDS

The participant *must* request NEMT services to a MO HealthNet qualified; enrolled medical service provider located within the travel standards, willing to accept the participant. The travel standards

are based on the participant's county of residence. Counties are classified as urban, basic, and rural. The counties are categorized as follows:

1. Urban-Clay, Greene, Jackson, Jefferson, St. Charles, St. Louis, and St. Louis City;
2. Basic-Boone, Buchanan, Cape Girardeau, Cass, Christian, Cole, Franklin, Jasper, Johnson, Lincoln, Newton, Platte, Pulaski, St. Francois and Taney;
3. Rural-all other counties.

The mileage that a participant can travel is based on the county classification and the type of provider being seen. The following table contains the mileage allowed under the travel standards.

TRAVEL STANDARDS: MAXIMUM MILEAGE

Provider/Service Type	Urban Access County	Basic Access County	Rural Access County
Physicians			
PCPs	10	20	30
Obstetrics/Gynecology	15	30	60
Neurology	25	50	100
Dermatology	25	50	100
Physical Medicine/Rehab	25	50	100
Podiatry	25	50	100
Vision Care/Primary Eye Care	15	30	60
Allergy	25	50	100
Cardiology	25	50	100
Endocrinology	25	50	100
Gastroenterology	25	50	100
Hematology/Oncology	25	50	100
Infectious Disease	25	50	100
Nephrology	25	50	100



Durable Medical Equipment

Ophthalmology	25	50	100
Orthopedics	25	50	100
Otolaryngology	25	50	100
Pediatric	25	50	100
Pulmonary Disease	25	50	100
Rheumatology	25	50	100
Urology	25	50	100
General surgery	15	30	60
Psychiatrist-Adult/General	15	40	80
Psychiatrist-Child/Adolescent	22	45	90
Psychologists/Other Therapists	10	20	40
Chiropractor	15	30	60

Hospitals

Basic Hospital	30	30	30
Secondary Hospital	50	50	50

Tertiary Services

Level I or Level II trauma unit	100	100	100
Neonatal intensive care unit	100	100	100
Perinatology services	100	100	100
Comprehensive cancer services	100	100	100
Comprehensive cardiac services	100	100	100
Pediatric subspecialty care	100	100	100

Mental Health Facilities

Inpatient mental health treatment facility	25	40	75
Ambulatory mental health treatment providers	15	25	45



Residential mental health treatment providers	20	30	50
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Ancillary Services

Physical Therapy	30	30	30
Occupational Therapy	30	30	30
Speech Therapy	50	50	50
Audiology	50	50	50

The broker *must* transport the participant when the participant has chosen a qualified, enrolled medical service provider who is *not* within the travel standards if the participant is eligible for one of the exceptions listed below and can provide proof of the exception:

1. The participant has a previous history of other than routine medical care with the qualified, enrolled medical service provider for a special condition or illness.
2. The participant has been referred by a Primary Care Provider (PCP) to a qualified, enrolled medical service provider for a special condition or illness.
3. There is *not* a routine or specialty care appointment available within thirty (30) calendar days to a qualified, enrolled medical service provider within the travel standards.

The broker shall transport the participant to the following MO HealthNet services without regard to the travel standards.

1. The participant is scheduled for an appointment arranged by the family Support Division (FSD) eligibility specialist for a Medical Review Determination (MRD) to determine continued MO HealthNet eligibility.
2. The participant has been locked into a medical service provider by the state agency. The broker shall receive prior authorization from the state agency for lock-in trips that exceed the travel standards.
3. The broker must transport the participant when the participant has chosen to receive MO HealthNet covered services free of charge from the Veterans Administration or Shriners Hospitals. Transportation to the Veterans Administration or Shriners Hospital must be to the closest, most appropriate Veterans Administration or Shriners Hospital. The broker must document and maintain verification of service for each transport provided to free care. The broker must verify each request of such transport meets all NEMT criteria including, but not limited to:
 - Participant eligibility; and
 - MO HealthNet covered service.



22.7 COPAYMENTS

The participant is required to pay a \$2.00 copayment for transportation services. The \$2.00 is charged regardless if the trip is a single destination trip, a round trip, or a multiple destination trip. The broker *cannot* deny transportation services because a participant is unable to pay the copay. The copay does *not* apply for public transportation or bus tokens, or for participant's receiving gas reimbursement. The following individuals are exempt from the copayment requirements:

1. Children under the age of 19;
2. Persons receiving MO HealthNet under a category of assistance for pregnant women or the blind:
 - 03 - Aid to the blind;
 - 12 - MO HealthNet-Aid to the blind; and
 - 15 - Supplemental Nursing Care-Aid to the blind;
 - 18 - MO HealthNet for pregnant women;
 - 43 - Pregnant women-60 day assistance;
 - 44 - Pregnant women-60 day assistance-poverty;
 - 45 - Pregnant women-poverty; and
 - 61 - MO HealthNet for pregnant women-Health Initiative Fund;
3. Residents of a skilled nursing facility, intermediate care nursing home, residential care home, adult boarding home, or psychiatric hospital;
4. Participants receiving NEMT services for CSTAR and CPR under DMH,
5. Foster care participants, and
6. Participant's attendant.

A participant's inability to pay a required copayment amount, as due and charged when a service is delivered, in no way shall extinguish the participant's liability to pay the due amount or prevent a provider from attempting to collect a copayment.

If it is the routine business practice of a transportation provider to discontinue future services to an individual with uncollected debt, the transportation provider may include uncollected co-payments under this practice. However, a transportation provider shall give a MO HealthNet participant a reasonable opportunity to pay an uncollected co-payment. If a transportation provider is *not* willing to provide services to a MO HealthNet participant with uncollected co-payment, the transportation provider *must* give the participant advance notice and a reasonable opportunity to arrange care with a different transportation provider before services can be discontinued.



22.8 MODES OF TRANSPORTATION

The broker *must* arrange the least expensive and most appropriate mode of transportation based on the participant's medical needs. The modes of transportation that may be utilized by the broker include, but are *not* limited to:

1. Public transit/bus tokens;
2. Gas reimbursement;
3. Para-lift van;
4. Taxi;
5. Ambulance (for non-emergent transportation only);
6. Stretcher van;
7. Multi-passenger van; and
8. Volunteer driver program if approved by the state agency.

The broker *must not* utilize public transit/bus token/pass for the following situations:

1. High-risk pregnancy;
2. Pregnancy after the eighth month;
3. High risk cardiac conditions;
4. Severe breathing problems;
5. More than three (3) block walk or more than one-quarter (1/4) of a mile, whichever is the least amount of distance, to the bus stop; and
6. Any other circumstance in which utilization of public transit/bus token/pass may not be medically appropriate.

Prior to reimbursing a participant for gas, the broker shall verify that the participant actually saw a medical service provider on the date of request for gas reimbursement and verify the mileage from the participant's trip origin street address to the trip destination street address. If the street address is not available, the broker shall use the zip code for mileage verification. Gas reimbursement shall be made at the IRS standard mileage rate for medical reason in effect on the date of service.

The broker shall limit the participant to no more than three (3) transportation legs (2 stops) per day unless the broker received prior authorization from the state agency.

The broker shall ensure that the transportation provided to the participant is comparable to transportation resources available to the general public (e.g. buses, taxis, etc.).



22.9 LEVEL OF SERVICE

The type of vehicle needed is determined by the level of service (LOS) required. Please note that LogistiCare provides shared transportation, so participants should expect to share their ride with other participants (excluding stretcher services). Levels of service include:

1. Ambulatory includes those using a manual wheelchair who can stand or pivot on their own. This may include the use of public transportation and/or taxis.
2. Wheelchair those participants who have an electric wheelchair or a manual wheelchair but cannot transfer.
3. Stretcher Service those participants confined to a bed. Please refer to the Stretcher Assessment Form.
4. Non-emergency Ambulance participants need equipment only available on an ambulance (i.e. non-portable oxygen) or when travel by other means could be detrimental to the participant's health (i.e. body cast).

The Facility Service Worker or Case Manager can assist LogistiCare by providing the necessary information to determine the LOS and by keeping this information updated on the Standing Orders (SOs).

22.10 ARRANGING TRANSPORTATION

When calling to arrange for transport, the caller *must* provide the following information:

- The patient/participant's name, date of birth, address, phone number, and the MO HealthNet ID number;
- The name, address, and phone number of the medical provider that will be seen by the participant;
- The date and time of the medical appointment;
- Any special transportation needs of the patient/participant, such as the patient/participant uses a wheelchair;
- Whether the patient/participant is under 21 years of age and needs someone to go along to the appointment; and
- For facilities arranging transportation for your dialysis participants, please refer to Section 22.17 of this manual.

22.11 NON-COVERED SERVICES

The following services are *not* eligible for NEMT:



1. The broker shall *not* provide NEMT services to a pharmacy.
2. Transportation to services included in the Intellectually Disabled/Developmentally Disabled (ID/DD) Waiver Programs, Comprehensive Substance Treatment Abuse and Rehabilitation (CSTAR) Program, Community Psychiatric Rehabilitation Program, and Department of Health and Senior Services Waiver Programs are arranged by those programs. Community psychiatric rehabilitation program only provides transportation to attend the psychosocial rehabilitation services and to receive medication services. The broker shall *not* be responsible for arranging NEMT services for these programs or services. However, the broker shall arrange NEMT services for the participants to other qualified, enrolled medical service providers such as physician, outpatient hospital, lab, etc.
3. School districts *must* supply a ride to services covered in a child's Individual Education Plan (IEP).
4. The broker shall *not* arrange NEMT services to a Durable Medical Equipment (DME) provider that provides free delivery or mail order services. The broker shall *not* provide delivery of DME products in lieu of transporting the participant.
5. The broker shall *not* provide NEMT services for MO HealthNet covered services provided in the home such as personal care, home health, etc.
6. The broker shall *not* provide NEMT services for discharges from a nursing home.
7. The broker shall *not* authorize nor arrange NEMT services to case management services.

22.12 PUBLIC ENTITY REQUIREMENTS

The state agency has existing interagency agreements with public entities to provide access (subject to availability) to transportation services for a specific group(s) of participants. The broker shall refer participants to public entities when the participant qualifies for transportation services under such agreements. The following is a list of the public entities and the specific individuals for which transportation is covered:

1. **Children's Division (CD)** CD provides reimbursement for transportation services to MO HealthNet covered services for some children. Eligible individuals are identified by the CD.
2. **School-based NEMT Services** Some school districts provide transportation for children to obtain medically necessary services provided as a result of a child's Individual Education Plan (IEP). Eligible children are identified by the school district.
3. **Kansas City Area Transit Authority/Share-A-Fare Program (KCATA)** Share-A-Fare provides door-to-door accessible transportation to persons with disabilities and the elderly. Services are available to residents of Kansas City, Missouri. Individuals *must* complete an application and be approved to participate in the program.

4. **Bi-State Development Call-A-Ride** Call-A-Ride provides curb-to-curb accessible transportation to persons with disabilities and the elderly who reside in St. Louis City and County.
5. **City Utilities of Springfield** City Utilities operates a para-transit service to serve disabled who are unable to ride a fixed route bus. This service is operated on a demand-responsive curb to curb basis. A one-day notice is required for reservations.
6. **Jefferson City Transit System, Handi-Wheels** Handi-Wheels is a curb-to-curb, origin to destination transportation service with wheelchair, lift-equipped buses. Handi-Wheels is provided to all eligible individuals with disability without priority given for trip purpose. Handi-Wheels is intended to be used by individuals who, because of disability, *cannot* travel to or from a regular fixed route bus stop or *cannot* get on, ride, or get off a regular fixed route bus *not* wheelchair lift-equipped. This service operates to and from any location within Jefferson City.
7. **Nevada Regional Medical Center (NRMC)** NRMC transports individuals who live within a 20 mile radius of Nevada.
8. **City of Columbia, Columbia Transit** Columbia Transit transports individuals with disabilities within the Columbia City Limits. This service provides buses on peak hours including para-transit curb to curb services.

22.13 PROVIDER REQUIREMENTS

The broker shall maintain a network of appropriate transportation providers that is sufficient to provide adequate access to all MO HealthNet covered services. In establishing and maintaining the network, the broker *must* consider the following:

1. The anticipated MO HealthNet enrollment;
2. The expected utilization of services taking into consideration the characteristics and health care needs of MO HealthNet populations;
3. The numbers and types (in terms of training, experience, and specialization) of transportation providers required to furnish services;
4. The capacity of transportation providers to provide services; and
5. If the broker is unable to provide necessary NEMT services to a particular participant utilizing the services of an in-network transportation provider, the broker *must* adequately and timely provide the NEMT services for the participant utilizing the services of a transportation provider outside the broker's network, for as long as the broker is unable to provide such NEMT services utilizing an in-network transportation provider. Out-of-network transportation providers *must* coordinate with the broker with respect to payment. The broker *must* ensure that cost to the participant is no greater than it would be if the



NEMT services were furnished utilizing the services of an in-network transportation provider.

The broker and all transportation providers shall comply with applicable city, county, state, and federal requirements regarding licensing and certification of all personnel and vehicles.

The broker shall ensure the safety of the participants while being transported. The broker shall ensure that the vehicles operated by the transportation providers are in compliance with federal motor vehicle safety standards (49 Code of Federal Regulations Part 571). This provision does *not* apply when the broker provides direct reimbursement for gas.

The broker shall maintain evidence of providers' non-compliance or deficiencies, as identified either through individual reports or as a result of monitoring activities, the corrective action taken, and improvements made by the provider.

The broker shall *not* utilize any person as a driver or attendant whose name, when checked against the Family Care Safety Registry, registers a "hit" on any list maintained and checked by the registry.

22.14 PROVIDER INQUIRY, COMPLAINT, GRIEVANCE AND APPEAL PROCESS

All transportation provider inquiries, complaints, grievances and appeals as defined under 'Definition', *must* be filed with the NEMT broker. The broker *must* resolve all complaints, grievances and appeals in a timely manner. The transportation provider will be notified in writing of the outcome of each complaint, grievance and appeal.

In order to inquire about a broker policy or procedure or to file a complaint, grievance or appeal, contact the broker at the following address or telephone number:

LogistiCare Solutions, LLC
1807 Park 270 Drive, Suite 518
St. Louis, MO 63146
866-269-5944

22.15 PARTICIPANT RIGHTS

Participants *must* be given the rights listed below:

1. General rule. The broker *must* comply with any applicable federal and state laws that pertain to participant rights and ensure that the broker's personnel and transportation providers take those rights into account when furnishing services to participants.



2. Dignity and privacy. Each participant is guaranteed the right to be treated with respect and with due consideration for his or her dignity and privacy.
3. Copy of transportation records. Each participant is guaranteed the right to request and receive a copy of his or her transportation records.
4. Free exercise of rights. Each participant is free to exercise his or her rights, and that the exercise of those rights does *not* adversely affect the way the broker and the broker's transportation providers or the state agency treat the participant.

22.16 DENIALS

The broker shall make a decision to arrange for NEMT services within 24 hours of the request. If the broker denies the request for services, the broker shall provide written notification to the participant. The notice *must* indicate that the broker has denied the services, the reasons for the denial, the participant's right to request a State fair hearing, and how to request a State fair hearing. The broker shall review all denials for appropriateness and provide prior verbal notification of the denial in addition to written notification.

The state agency shall maintain an independent State fair hearing process as required by federal law and regulation, as amended. The State fair hearing process shall provide participants an opportunity for a State fair hearing before an impartial hearing officer. The parties to the state fair hearing include the broker as well as the participant and his or her representative or the representative of a deceased participant's estate.

22.17 PARTICIPANT GRIEVANCE PROCESS

If a participant is unhappy with the services that NEMT provides, a grievance can be filed. The broker thoroughly investigates each grievance and shall acknowledge receipt of each grievance in writing within ten business days after receiving the grievance. The number to call is (866) 269-5944. Written grievances can be sent to:

LogistiCare Solutions LLC
1807 Park 270 Drive, Suite 518
St. Louis, MO 63146

22.18 STANDING ORDERS

Authorized clinicians (i.e., FSW, CM, or RN) at a treatment facility may request a LogistiCare facility representative to enter a SO for ongoing NEMT services for their MO HealthNet participants who are required to attend a covered appointment for at least three days per week for a period of at least 90 days or greater.



1. The following is the process for coordinating SOs:
2. The MO HealthNet participant's social worker or other medical professional at the treating facility faxes the Standing Order Form for Regularly Scheduled Appointments to the LogistiCare facility department at 1-866-269-5944. The facility representative reviews the information to ensure the requested SO meets the criteria as discussed above and enters the treatment times and dates as a SO.
3. The facility representative returns the SO by fax or calls the requesting clinician as confirmation that the SO has been received and entered. The facility representative also calls the requesting clinician if the transportation request does not meet the criteria for a SO.
4. FSWs or CMs are required to report any change to the SO (i.e. death, transplant, address, time, LOS or facility) as soon as they are aware of the change. The information is faxed to 1-866-269-8875. Upon notification, LogistiCare will inactivate SOs for participants who are hospitalized. When the participant is discharged from the hospital and is ready to resume transportation, a new SO will need to be faxed to LogistiCare.
5. All SOs are required to be recertified every 90 days. The facility representative calls to confirm all SOs as a requirement of our Utilization Review protocol. Facilities are sent a monthly Standing Order Trip Verification Report and Standing Order Report by the 5th day of every month, with each participant's name and MO HealthNet number. These reports allow the clinician to make changes to existing SOs and also inform LogistiCare of any days, in the prior month, the MO HealthNet participant did not attend a scheduled treatment. FSWs or CMs are encouraged to respond promptly to the reports to continue to assure appropriate confirmation and verification of trips.
6. The Dialysis Mileage Reimbursement Log & Invoice Form is sent, upon request, to participants who wish to provide their own transportation. The FSW also has copies or can request copies of this form. Participants complete the form and have it signed by a facility clinician. The participant then sends the form to LogistiCare so that it is received within 45 days of the appointment.

22.19 ANCILLARY SERVICES

A medical provider may request ancillary services (meals and lodging) for adults and children and one parent/guardian, if necessary to accompany the child, if: 1) the medical appointment requires an overnight stay; and, 2) volunteer, community or other ancillary services are not available free of charge to the participant. (Note: due to the Free Care Rule, if services are available to any non-MO HealthNet family at no cost, a MO HealthNet family may not be charged for the services.) For further information regarding Ancillary Services, please refer to Section 22.17.E(1) of this manual and the Ancillary Services Form.



22.19.A ANCILLARY SERVICES REQUEST PROCEDURE

A medical provider may request ancillary services for adults and children with one parent/guardian to accompany the child, if:

1. The medical appointment requires an overnight stay, and
2. Volunteer, community, or other ancillary services are not available at no charge to the participant. (Note: due to the free care rule, if services are available to any non-MO HealthNet family at no cost, a MO HealthNet family may not be charged for the services.)

Non-emergency medical transportation services are tied to a MO HealthNet covered medical appointments/services for a MO HealthNet participant. Lodging is provided only when the participant is staying in the room. Meals are available for both the participant and one parent or guardian when he/she is traveling with a child to the medical appointment that requires an overnight stay.

The following is the process in which Ancillary Services will be coordinated:

1. The request for Ancillary Services Form is to be faxed to the LogistiCare Facility Department at 1-866-269-8875 by the participant's case manager, social worker, or a medical professional.
2. A LogistiCare Facility Representative will contact a non-profit housing facility (i.e. Ronald McDonald House) prior to contacting hotels, as this would be the least expensive accommodation if one is available within the hospital's geographic area. Should a room not be available, LogistiCare will arrange the least expensive, most appropriate hotel accommodation. The hotel will be paid directly by LogistiCare.
3. LogistiCare will provide two (2) meals per day, per child and one parent/guardian. Most hotels provide a continental breakfast for their guests.
4. If a meal ticket can be provided by the hospital, the hospital will, in turn, invoice LogistiCare along with a copy of the LogistiCare Authorized Ancillary Services Form for the meals to LogistiCare MO NEMT Billing, 2552 West Erie Drive, Suite 101, Tempe, AZ 85282.
5. If a hospital is unable to provide meal tickets, the parent/guardian will need to submit the original receipts for reimbursement to the LogistiCare Facility Department, 1807 Park 270 Drive, St. Louis, MO 63146. They must reference the Job number and date of service on the receipt for



reimbursement. The Job number or confirmation number is found on the authorization form faxed to the requesting facility.

6. Should the participant's family request gas reimbursement, a Gas Reimbursement Voucher will be sent to the parent/guardian for submission of gas expenses. Unlike dialysis gas reimbursement that allows 45 days for submission, this form must be submitted within 30 days of the actual trip.
7. The confirmation number (Job number) along with the hotel name and address will be entered on the Ancillary Services Form and the form will be signed authorizing the services. The form will be faxed back to the requesting facility.

22.20 WHERE'S MY RIDE? (WMR)

All facilities are provided with the WMR contact information located on the Missouri Contact Information Sheet which is included in the information packets. The WMR line is 1-866-269-5944.

Facilities are encouraged to have these numbers available for participants.

1. The Transportation Provider (TP) is allowed a grace period of 15 minutes past the SO appointment and pickup time. If a TP is more than 15 minutes late for a SO appointment or pick-up time, FSWs, participants, or any facility designee are encouraged to call the WMR line. The LogistiCare staff determines where the driver is and ensures the participant is transported.
2. The WMR line may also be used when a participant is ready to return home after dialysis or any other medical appointment when the pickup time is not scheduled.
3. This line is also used when participants know they are going to be late. They should contact WMR or the designated provider immediately.
4. The WMR line is manned 24 hours a day, seven days a week and is available for questions or concerns with after hours' appointments.

22.21 QUALITY ASSURANCE (QA) PROCEDURE

Complaints may be filed by the MO HealthNet participant or by another person on behalf of the participant.

1. TP may also file a complaint against a participant should his/her behavior warrant such a complaint. LogistiCare's QA staff researches and resolves all complaints filed, and submits all information and outcomes to MHD. Complaints are filed through the WMR line. The FSWs and/or any facility representative can file a complaint to any LogistiCare



representative by stating "I would like to file a complaint." As a part of the complaint investigation, it is noted whether the WMR line was utilized by facility or participant, with hopes of tracking issues immediately and avoiding situations which warrant complaints and to ensure appropriate transportation is received.

2. Participants also have the right to file a complaint through the MO HealthNet Participant Services Unit toll-free at 800-392-2161.

22.22 FREQUENTLY ASKED QUESTIONS

- A. What is the policy on TP's notifying participants the night before a trip?

All transportation companies are required to attempt to contact the participant 24 hours in advance to inform the participant they will be the TP and the expected pick up time. In cases where TPs are not notifying the participants, the participant should call LogistiCare at 866-269-5944 and report this issue.

- B. How are the drivers credentialed and trained for these trips?

All LogistiCare-approved TPs are required to meet a rigorous credentialing process. This process mandates that all drivers must have a current driver's license, a clean driving record (including the Missouri State Highway Patrol Request for Criminal Record Check and the Family Care Safety Registry), and tested negative on a stringent drug test. Once all this information is received, LogistiCare's Compliance Department will review it to make sure the driver meets all the standards set forth by the State of Missouri. The driver is then either approved or denied to transport participants for LogistiCare.

Once approved to transport MO HealthNet NEMT participants, each driver must complete specific training related to NEMT transportation. Training, which is administered by the TP, includes several key topics: defensive driving; use of safety equipment; basic first aid and universal precautions for handling body fluids; operation of lifts, ramps and wheelchair securement devices; methods of handling wheelchairs; use of common assistive devices; methods of moving, lifting and transferring passengers with mobility limitations; and instructions on proper actions to be taken in problem situations.

- C. Are the vehicles used for NEMT inspected on a regular basis?

Along with the driver credentialing process and training, each vehicle operated by a TP must undergo an initial 45 point vehicle inspection by a LogistiCare Field Monitor before that vehicle can be used to transport MO HealthNet NEMT participants. Once approved, each vehicle is reinspected every six months. Wheelchair and stretcher vehicles receive more in-depth inspections with regards to the special equipment needed for transport. Once inspected, a LogistiCare window decal is applied to the vehicle. This provides for a quick visual identification of a LogistiCare approved vehicle.

- D. Who do I contact for reoccurring issues?



All issues should be reported to LogistiCare through the WMR line referenced above. For reoccurring issues, the LogistiCare Healthcare Manager or Ombudsman may be contacted at 866-269-4717.

E. Can a participant choose his/her TP?

A participant may request a preferred provider. LogistiCare will attempt to schedule transport with the preferred provider; however LogistiCare is unable to guarantee that the provider will be available for the specific trip.

F. Can a participant request not to ride with a specific TP?

A participant may request not to ride with a specific provider. LogistiCare will investigate any incident causing such a request.

END OF SECTION

[TOP OF SECTION](#)



SECTION 23 - CLAIM ATTACHMENT SUBMISSION AND PROCESSING

This section of the manual provides examples and instructions for submitting claim attachments.

23.1 CLAIM ATTACHMENT SUBMISSIONS

Four claim attachments required for payment of certain services are separately processed from the claim form. The four attachments are:

- (Sterilization) Consent Form
- Acknowledgment of Receipt of Hysterectomy Information
- Medical Referral Form of Restricted Participant (PI-118)
- Certificate of Medical Necessity (**only for the Durable Medical Equipment Program**)

These attachments *should not* be submitted with a claim form. These attachments *should* be mailed separately to:

Wipro Infocrossing
P.O. Box 5900
Jefferson City, MO 65102

These attachments may also be submitted to Wipro Infocrossing via the Internet when additional documentation is *not* required. The web site address for these submissions is www.emomed.com.

The data from the attachment is entered into MO HealthNet Management Information System (MMIS) and processed for validity editing and MO HealthNet program requirements. Refer to specific manuals for program requirements.

Providers do *not* need to alter their claim submittal process or wait for an attachment to be finalized before submitting the corresponding claim(s) for payment. A claim for services requiring one of the listed attachments remains in suspense for up to 45 days. When an attachment can be systematically linked to the claim, the claim continues processing for adjudication. If after 45 days a match is *not* found, the claim denies for the missing attachment.

An approved attachment is valid only for the procedure code indicated on the attachment. If a change in procedure code occurs, a new attachment *must* be submitted incorporating the new procedure code.



23.2 CERTIFICATE OF MEDICAL NECESSITY FOR DURABLE MEDICAL EQUIPMENT PROVIDERS ONLY

The data from the Certificate of Medical Necessity for DME services is entered into MMIS and processed for validity editing and MO HealthNet program requirements. **DME providers are required to include the correct modifier (NU, RR, RB) in the procedure code field with the corresponding procedure code.**

A Certificate of Medical Necessity that has been submitted by a DME provider is reviewed and approved or denied. Denied requests may be resubmitted with additional information. If approved, a certificate of medical necessity is approved for six months from the prescription date. Any claim matching the criteria on the Certificate of Medical Necessity for that time period can be processed without submission of an additional Certificate of Medical Necessity. This includes all monthly claim submissions and any resubmissions.

END OF SECTION

[TOP OF PAGE](#)