



KANSAS MEDICAL ASSISTANCE PROGRAM
Provider Manual

Durable Medical Equipment

PART II
DURABLE MEDICAL EQUIPMENT PROVIDER MANUAL

Introduction

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FORMS All forms pertaining to this provider manual can be found on the public website at <https://www.kmap-state-ks.us/Public/forms.asp> and on the secure website at <https://www.kmap-state-ks.us/provider/security/logon.asp>.

PART II

DURABLE MEDICAL EQUIPMENT PROVIDER MANUAL

Updated 12/11

This is the provider specific section of the manual. This section (Part II) was designed to provide information and instructions specific to Durable Medical Equipment (DME) providers. It is divided into three subsections: Billing Instructions, Benefits and Limitations, and Appendices.

The **Billing Instructions** subsection gives information on accessing the forms and directions applicable to DME services.

The **Benefits and Limitations** subsection defines specific aspects of the scope of DME services allowed within KMAP.

The **Appendix** subsection contains information concerning codes. These appendices were developed to make finding and using codes easier for the biller.

HIPAA Compliance

As a KMAP participant, providers are required to comply with compliance reviews and complaint investigations conducted by the Secretary of the Department of Health and Human Services as part of the Health Insurance Portability and Accountability Act (HIPAA) in accordance with section 45 of the code of regulations parts 160 and 164. Providers are required to furnish the Department of Health and Human Services all information required by the Department during its review and investigation. The provider is required to provide the same forms of access to records to the Medicaid Fraud and Abuse Division of the Kansas Attorney General's Office upon request from such office as required by K.S.A. 21-3853 and amendments thereto.

A provider who receives such a request for access to or inspection of documents and records must promptly and reasonably comply with access to the records and facility at reasonable times and places. A provider must not obstruct any audit, review, or investigation, including the relevant questioning of the provider's employees. The provider shall not charge a fee for retrieving and copying documents and records related to compliance reviews and complaint investigations.

7000. DURABLE MEDICAL EQUIPMENT BILLING INSTRUCTIONS Updated 12/11

Introduction to the CMS-1500 Claim Form

DME providers must use the CMS-1500 claim form (unless submitting electronically) when requesting payment for medical services and supplies provided under KMAP.

An example of the CMS-1500 claim form and instructions are on the [public](#) and [secure](#) websites. **Complete, line-by-line instructions for completion of the CMS-1500 are available in Section 5800 of the *General Billing Provider Manual*.**

The Kansas MMIS will be using electronic imaging and optical character recognition (OCR) equipment. Therefore, information will not be recognized if not submitted in the correct fields as instructed.

The fiscal agent does not furnish the CMS-1500 claim form to providers. Refer to the Form Reordering section of the *General Billing Provider Manual*.

SUBMISSION OF CLAIM

Send completed first page of each claim and any necessary attachments to:
Office of the Fiscal Agent
P.O. Box 3571
Topeka, KS 66601-3571

Accessing the General Prior Authorization Request Form

The General Prior Authorization Request Form and instructions for completing the form can be accessed from the public website by following the path Publications, Forms or clicking on the following link: <https://www.kmap-state-ks.us/Public/forms.asp>.

7010. DME/MEDICAL SUPPLY SPECIFIC BILLING INFORMATION Updated 11/09

Enteral Supplies

Add modifier "BO" to the base code (XXXXX-BO) and place in field 24D when billing for oral supplemental nutrition.

Hearing Aid Batteries

If hearing aid batteries exceed six per month, indicate in field 21 if services are for a binaural hearing aid.

When dispensing multiple months' supply of batteries, note this in field 19. Enter the number of months, the manufacturer's battery stock number and whether silver or mercury. One unit equals one battery.

Items Requiring Invoice

A copy of the retail itemized invoice must be maintained in your files. It is not necessary to attach this documentation to the claim.

Items Requiring Medical Necessity

Medical necessity (MN) documentation must accompany your claim. (Refer to Section 4100 of the *General Special Requirements Provider Manual* for more information.)

Items Requiring Prior Authorization

Refer to Section 4300 of the *General Special Requirements Provider Manual*.

Medicare Part B

Pharmacy providers are required to bill Healthcare Common Procedure Coding System (HCPCS) codes and common procedural terminology (*CPT*[®]) codes on Medicare Part B designated drugs for Medicare Part B beneficiaries. Providers must be enrolled as a DME provider and supply KMAP with the provider's Medicare provider number so that the claims will automatically cross over from Medicare. This process must be followed for the coinsurance and deductible to be considered for payment.

To process these claims correctly, the claim must be billed with only one detail. If more than one detail is billed, the claim will be denied.

Parenteral Supplies

Add modifier "BA" to the base code (XXXXX-BA) and place in field 24D when billing for items supplies in conjunction with total parenteral nutrition.

Rental Items

The referring physician's name and KMAP provider ID are required in Fields 17-17A of the CMS-1500 claim form. Enter the referring **physician's** NPI in Field 17B.

Add modifier "RR" to the base procedure code (XXXXX-RR) and place in field 24D.

7020. PHARMACY PROVIDERS ENROLLED AS DME PROVIDERS Updated 06/11

Immunization Administration by Certified Pharmacists

Pharmacy providers certified to administer vaccine to adults, in accordance with K.S.A. 65-1626, are allowed to bill KMAP for vaccine administration.

Certified pharmacists are required to submit proof of certification required by K.S.A. 65-1626 to the Provider Enrollment department in order to be eligible for vaccine administration reimbursement. Pharmacists will receive a new specialty which will allow these services to be billed to KMAP under the provider's DME number.

The following is a list of codes that pharmacists are allowed to administer. These codes must be filed on a CMS-1500 claim form using the provider's DME number.

90632	90670	90716
90636	90675	90718
90649	90701	90732
90650	90703	90734
90656	90707	90736
90658	90710	90740
90660	90714	90746
90661	90715	90747
90662		

Providers must bill one of the following administration codes in addition to the vaccine/toxoid code for each dose administered: 90471, 90472, 90473, and 90474.

Injections

Pharmacies can bill for injection codes J1440 and J1441 for bone marrow transplant donors under the beneficiary's KMAP ID number. Pharmacy providers are required to be a DME provider in order to bill and be reimbursed for J1440 and J1441 on a CMS-1500 claim form. The claim must include a comment indicating the injection was administered to a bone marrow transplant donor.

BENEFITS AND LIMITATIONS

8100. COPAYMENT Updated 11/09

DME requires a copayment of \$3 **per claim** (refer to Section 3000 of the *General Third Party Provider Manual* for exceptions).

Rental of durable medical equipment is exempt from copayment requirements.

Medical supplies require no copayment.

Do **not** reduce charges or balance due by the copayment amount. This reduction will be made automatically during claim processing.

8200. MEDICAL ASSESSMENT Updated 11/09

Apnea Monitor

Determination of the medical necessity for a home apnea monitor is based on factors placing the infant at risk for sudden death as well as on the infant's age. The monitoring device must be ordered by a physician. Home monitoring is medically necessary in infants at risk for sudden death for up to six months of (corrected) age, and up to one year of (corrected) age in infants with bronchopulmonary dysplasia requiring home oxygen. Corrected age is defined as the age of the child had he or she been born at full term (i.e., a child born four weeks premature on April 1, 1988 would not become one year of corrected age until May 1, 1989 [four weeks after April 1]). The prescribing physician must indicate the length of time he or she feels the apnea monitor will be necessary.

An infant with the following factor(s) is considered to be at risk:

- One or more apparent life-threatening event(s) requiring adult intervention, such as mouth to mouth resuscitation or tactile stimulation.
- Sibling of one or more sudden infant death syndrome victim(s).
- Symptomatic premature infant, defined as an infant who continues to have apnea when he or she would otherwise be ready for care at home. Gestational age at discharge and frequency and dates of apneic episodes while hospitalized will assist in determining this condition.
- Bronchopulmonary dysplasia. Indicate whether or not oxygen is required following hospital discharge.
- Tracheostomy.
- Certain diseases/conditions associated with apnea or impaired ventilation, such as central hypoventilation.

A risk factor must be demonstrated on each beneficiary through the accurate completion of the HOME MONITOR INFORMATIONAL FORM, or similar medical necessity form providing the same information. The form(s) and valid prescription (dated on or prior to service dates) must be retained in the files of the provider supplying the monitoring device and are to be provided upon request.

If the beneficiary has utilized an apnea monitor longer than six months, the HOME MONITOR INFORMATIONAL FORM and copy of a valid prescription are required to be attached to the claim when billing for the seventh month. Claims (and attachments) billing for apnea monitor rental for the seventh month and beyond, **regardless of provider**, will be reviewed for medical necessity. Documentation should include information from the past six months regarding any apneic episodes or conditions that put the child at risk and indicating continued need of the monitor.

The HOME MONITOR INFORMATIONAL FORM may be found on the [public](#) and [secure](#) websites. Photocopies for your use may be made directly from this page.

8200. Updated 04/10

CPAP for KBH Participants

Continuous positive airway pressure (CPAP) is a covered service for **KBH participants**. PA for medical necessity is required. Criteria for MN requires one of the following:

- 1) Infant Respiratory Distress Syndrome in newborns (e.g., Hyaline Membrane Disease)
- 2) Morbid obesity with documented sleep apnea
 - 30% over average weight for height, sex, and age
 - Sleep study with documented arterial oxygen (O₂) saturation of 80% or less
(A printout of the documented arterial O₂ saturation must be supplied by the provider upon request from the fiscal agent and/or the Adult and Medical Services.)
 - Documented participation in a weight reduction program
(This documentation must be supplied by the provider upon request from the fiscal agent and/or the Adult and Medical Services.)

The CPAP device is covered for rental with prior authorization (PA) for a maximum of six months. When PA is requested beyond six months, the CPAP device is considered purchased at ten months. Every six months thereafter maintenance on the CPAP device is covered.

8300. BENEFIT PLANS Updated 08/08

KMAP beneficiaries will be assigned to one or more benefit plans. These benefit plans entitle the beneficiary to certain services. If there are questions about service coverage for a given benefit plan, refer to Section 2000 of the *General Benefits Provider Manual* for information on the plastic State of Kansas Medical Card and eligibility verification.

8400. MEDICAID Updated 06/08

DME is defined as equipment which is all of the following:

1. Able to withstand repeated use
2. Primarily and customarily used to serve a medical purpose
3. Appropriate for use in the beneficiary's home
4. Generally not useful to a person in the absence of illness or injury

DME may be provided to beneficiaries who:

- Require DME for life support
- Would require higher cost care without DME
- Require DME for employment purposes
- Are participating in the KBH program

A **medical supply** may be provided when all of the following apply:

1. It is necessary and reasonable for the treatment of the patient's illness/injury.
2. It will be used in the beneficiary's home.
3. It is prescribed appropriately.
4. It is indicated as a covered item.

Definition of "**Necessary and Reasonable**"

Although an item is classified as DME or medical supply, it may not be covered in **every** instance. Coverage is based on the fact that the item is necessary **and** reasonable for treatment of an illness/injury or to improve the functioning of a malformed body part.

Definition of "**Beneficiary's Home**"

- His or her own dwelling
- An apartment
- A relative/caretaker's home

Dispensing/Prescribing Requirements

The date of receipt of the prescription (ordering date) will be considered the date of service and the provider may bill KMAP before the actual dispensing of the item(s), since the intent to render service has been confirmed by the acceptance of the prescription.

DME supplies provided on an ongoing routine basis that have limitations may be billed using the dates the services will be used. This allows providers delivery or mailing time. Providers are expected to follow all limitations for the individual supply. If billing for more than one date of service, the full date range must be on the claim.

KMAP will only accept **prescriptions** for DME/Medical Supply items from:

1. Doctors of Medicine (M.D.)
2. Doctors of Osteopathy (D.O.)
3. Doctors of Podiatric Medicine (D.P.M.)
4. Doctors of Chiropractic (D.C.) – may prescribe cervical collars and "soft type" spinal supports only
5. Advanced Registered Nurse Practitioners (ARNP) only if:
 - They are treating the beneficiary for the condition for which the item is needed.
 - They currently are assigned their own individual KMAP provider number.
 - They are permitted to do all of the above in the state in which the services are rendered.

8400. Updated 03/12

6. Physician assistants (PAs) may prescribe only if:
 - They are permitted to perform services in accordance with state law.
 - They are treating the beneficiary for the condition for which the item is needed.
 - They are practicing under the supervision of a M.D. or D.O.
 - They currently are assigned their own individual KMAP provider number.

KMAP will only reimburse the following providers for the **dispensing** of DME/medical supply items:

1. DME/medical supply dealers
2. Pharmacies
3. Home Health Agencies
4. Rural Health Clinics (medical supplies only)
5. Welding shops (oxygen only)

To verify services provided in the course of a postpayment review, providers shall retain in their files the prescription signed by the physician.

Manually Priced Items

All manually priced DME, prosthetics and orthotics (P&O), and DME repair or maintenance requiring prior authorization will be priced according to criteria. Along with the prior authorization request, the provider must submit item-specific documentation which will be identified in the criteria.

KMAP requires providers to follow current policy for DME and P&O.

Current policy requires DME and P&O to be priced at the lesser of 1, 2, or 3:

1. Set Medicaid rate
2. Providers cost plus 35 percent
3. Manufacturer suggested retail price (MSRP) minus 20 percent

All DME and P&O PA requests must be accompanied by an official MSRP.

Providers actual cost and MSRP must be submitted with each PA request on all manually priced DME/P&O items and codes. This must be submitted at the same time as the PA request. All documents submitted must be free of any altering, covering up, or blacking out of information, except to maintain HIPAA requirements.

All MSRPs must be official from the manufacturer. No handwritten MSRPs are allowed. MSRPs cannot be altered or blacked out in any way except to maintain HIPAA requirements. For example, a Medicare explanation of benefits (EOB) can have multiple Medicare beneficiaries information listed on the same sheet.

Provider's cost is the actual cost the provider paid for the item. Any discounts the provider receives must also be submitted. An official invoice from the supplier/manufacturer must be supplied. Handwritten or DME provider-manipulated invoices are not allowed. Invoices cannot be blacked out or altered in any way except to maintain HIPAA requirements.

If an item is bought in bulk (or more than one at a time), the invoice showing the provider's actual cost and the number of units purchased must be submitted (per unit cost will be calculated).

Costs of doing business (such as, employee's time, travel time and expenses, or office expenses) cannot be included in provider's cost.

8400. Updated 03/12

Note: All wheelchairs, wheelchair accessories, wheelchair repairs, and covered specialty walkers are exempt from this requirement. These items will be paid at 75% of MSRP or the current Medicaid rate. Provider cost will not be required with each PA request.

Manually priced mounting systems and accessories for augmentative communication/speech generating devices will be reimbursed at 80% of MSRP.

8410. DME BENEFITS AND LIMITATIONS Updated 04/12

DME Rental

The rental coverage of each specific DME item is designated by an indicator in the column to the left of the procedure code in Appendix I of this manual. (Refer to the legend at the beginning of the appendix for a definition of the coverage indicators). **Many rentable items require PA and are limited to six months of rental.** Other items may be covered beyond six months if a new PA is secured. (PA must continue to be secured every six months for extension of coverage.)

Many low cost items may only be purchased; rental is noncovered.

DME providers may request the address of a beneficiary possessing rental equipment who is no longer present at the address on record. Responses cannot be made to telephone inquiries. Inquiries must be **written** and directed to:

Manager of DME Program
Kansas Department of Health and Environment, Division of Health Care Finance (KDHE-DHCF)
Landon State Office Building
900 SW Jackson, Suite 900
Topeka, KS 66612

DME Rental for KMAP Eligible Beneficiaries with Medicare

KMAP beneficiaries with Medicare coverage are eligible for purchase of DME items only in the following circumstances:

- DME is covered for purchase by Medicare.
- DME is covered by KMAP but **not** covered for rental or purchase by Medicare.

DME covered for rental or capped rental by Medicare will be covered for rental only by KMAP and only for the duration of the capped rental period. No repair or maintenance will be covered for items procured under Medicare rental or capped rental.

DME Purchase/Rental

All DME services are covered for in-home use only. DME services (purchase or rental) are noncovered in nursing facilities, swing bed facilities, state institutions, intermediate care facilities/mental retardation (ICF/MR), psychiatric residential treatment facilities (PRTF), head injury facilities (HI), rehabilitation facilities, and hospitals.

Note: If the facility receives a per diem rate for a beneficiary, the DME services are considered content of the per diem and are the responsibility of the facility.

Refer to **Section 8400** of the *Nursing/Intermediate Care Facility Provider Manual* for further information.

DME Purchase

The purchase coverage of each DME item is designated by an indicator in the column to the right of the procedure code in Appendix I of this manual. The purchase of many DME items requires PA, MN documentation and/or a retail invoice.

Adult Failure Alarms (Medical Alert)

This service may only be provided by DME dealers who enroll as a Home and Community Based Services (HCBS) provider. Adult failure alarms cannot be reimbursed under a DME provider number. Contact the fiscal agent for HCBS enrollment information.

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8410. Updated 03/12

Apnea Monitor

Rental of an apnea monitor is covered. Documentation of MN is required. Providers must retain this information in their files for the first six months of rental. Beginning with the seventh month of rental, documentation demonstrating MN must be submitted with each claim.

Augmentative Communication Devices

Augmentative communication devices (ACDs), speech generating devices (SGDs), and activation accessories are covered with PA when medically necessary. All requests require letters of MN from a physician and an evaluation done by a speech pathologist with recognized training and credentialing in the evaluation and prescribing of ACDs. All criteria must be met.

Beds, Mattresses, Rails, Support Surfaces, Trapeze Bars, and Accessories

MANUAL FIXED HEIGHT HOSPITAL BEDS

A fixed height hospital bed is one with manual head and leg elevation adjustments but no height adjustment. PA is required for all beneficiaries.

Hospital beds are noncovered for caregiver convenience.

Rental of all hospital beds includes bed, mattress, controls, and rails.

A fixed height hospital bed is covered if the beneficiary meets the following:

1. Beneficiary requires frequent changes in body position due to a medical condition.
2. Pillows and wedges have been attempted and failed.

AND at least one of the following:

1. Beneficiary has a medical condition which requires positioning of the body in ways not feasible with an ordinary bed for at least one month. Elevation of the head/upper body less than 30 degrees does not require the use of a hospital bed.
2. The beneficiary requires positioning of the body in ways not feasible with an ordinary bed to alleviate pain.
3. The beneficiary requires the head of the bed to be elevated more than 30 degrees due to congestive heart failure, chronic pulmonary disease, or problems with aspiration.
4. The beneficiary requires traction equipment, which can only be attached to a hospital bed.

Replacements are limited to no more than one every seven years.

VARIABLE HEIGHT HOSPITAL BEDS

A variable height hospital bed is one with manual height adjustment and with manual head and leg elevation adjustments. PA is required for all beneficiaries.

Hospital beds are noncovered for caregiver convenience.

Rental of all hospital beds includes bed, mattress, controls, and rails.

A variable height hospital bed is covered if the beneficiary meets the following:

1. Meets criteria for a fixed height hospital bed
2. Requires a bed height different than a fixed height hospital bed to permit transfers to chair, wheelchair, or standing position

Replacements are limited to no more than one every seven years.

8410. Updated 05/08

SEMI-ELECTRIC HOSPITAL BEDS

A semi-electric bed is one with manual height adjustment and with electric head and leg elevation adjustments. PA is required for all beneficiaries.

Hospital beds are noncovered for caregiver convenience.

Rental of all hospital beds includes bed, mattress, controls, and rails.

A semi-electric hospital bed is covered if the beneficiary meets the following:

1. Meets criteria for a variable height manual hospital bed
2. Can physically work the semi-electric controls without assistance
3. Has an immediate need for a change in body position that cannot be accomplished with a manual hospital bed

Replacements are limited to no more than one every seven years.

HEAVY-DUTY HOSPITAL BEDS

A heavy-duty, extra-wide hospital bed is one that is capable of supporting a beneficiary who weighs more than 350 pounds but no more than 600 pounds. PA is required for all beneficiaries.

Hospital beds are noncovered for caregiver convenience.

Rental of all hospital beds includes bed, mattress, controls, and rails.

A heavy-duty, extra-wide hospital bed may be covered if the beneficiary meets the following:

1. Meets criteria for a fixed height hospital bed
2. Weighs more than 350 pounds but does not exceed 600 pounds

Replacements are limited to no more than one every seven years.

EXTRA HEAVY-DUTY HOSPITAL BEDS

An extra heavy-duty hospital bed is one that is capable of supporting a beneficiary who weighs more than 600 pounds. PA is required for all beneficiaries.

Hospital beds are noncovered for caregiver convenience.

Rental of all hospital beds includes bed, mattress, controls, and rails.

An extra heavy-duty hospital bed is covered if the beneficiary meets the following:

1. Meets criteria for a fixed height hospital bed
2. Weighs more than 600 pounds

Replacements are limited to no more than one every seven years.

TOTAL ELECTRIC HOSPITAL BEDS

A total electric hospital bed is one with electric height adjustment and with electric head and leg elevation adjustments. A total electric hospital bed is noncovered for purchase and rental.

8410. Updated 12/11

ORDINARY BEDS, SPECIALTY BEDS, AND BED ACCESSORIES

Bed boards, over-bed tables, bed cradles, ordinary beds, cribs, pediatric beds, specialty beds, and safety enclosures are noncovered. An ordinary bed is one which is typically sold as furniture. It may consist of a frame, box spring, mattress, and may or may not have head or leg elevation adjustments. Specialty beds (such as totally enclosed beds, cribs, Craftmatic beds) are noncovered.

TRAPEZE EQUIPMENT

PA may be required. Check HCPC code listing.

Trapeze equipment is noncovered for caregiver convenience.

Trapeze equipment is covered if the beneficiary meets one of the following:

- Required to sit up because of a respiratory condition
- Required to change body position for other medical reasons
- Required to get in or out of bed

Note: Trapeze bars are not covered when used on an ordinary bed.

Replacements are limited to no more than one every seven years.

REPLACEMENT MATTRESSES

PA is required for all beneficiaries.

Mattress replacements are noncovered for:

- Caregiver convenience
- Rental
- Mattresses considered furniture for replacement on ordinary, specialty beds, or cribs

Replacement mattresses are covered for beneficiary-owned hospital beds if beneficiary meets all of the following:

- Medical necessity is shown.
- Beneficiary meets the current criteria for the hospital bed being requested.
- Current bed is purchased (not allowed on rental beds).
- Requested mattress has a durable waterproof covering.
- Beneficiary has not had a replacement in last seven years (allowed once per seven years).

Documentation required with each PA request for beds, mattresses, rails, and trapeze:

- 1) Prescription from physician
- 2) Letter of medical necessity with full history and physical from treating physician
- 3) Medical diagnosis
- 4) Description of the bed beneficiary is currently using and why it is not working
- 5) The change in medical condition that requires the different positioning
- 6) Length of need
- 7) Beneficiary's physical capabilities in regard to ability to work the controls without assistance
- 8) Beneficiary's ability to move independently
- 9) Explanation of what types of pillows and wedges have been tried and why they failed
- 10) Explanation of why regular bed will not work
- 11) Statement that the bed being requested is appropriate for beneficiary's height and weight
- 12) How many hours of attendant care/family care does the beneficiary currently receive
- 13) For a semi-electric hospital bed, why a manual bed will not work
- 14) For a variable height hospital bed, why a fixed height bed will not work
- 15) Other information as requested by KMAP

8410. Updated 08/07

SUPPORT SURFACES:

Group II and Group III support surfaces require PA for all beneficiaries.

Definition of pressure ulcer:

A pressure ulcer is localized injury to the skin and/or underlying tissue usually over a bony prominence as a result of pressure, or pressure in combination with shear and/or friction.

Pressure Ulcer Stages:

- Suspected deep tissue injury: Purple or maroon localized area of discolored intact skin or blood-filled blister due to damage of underlying soft tissue from pressure and/or shear. The area may be preceded by tissue that is painful, firm, mushy, boggy, or warmer or cooler as compared to adjacent tissue.
- Stage I – Intact skin with nonblanchable redness of a localized area usually over a bony prominence. Darkly pigmented skin may not have visible blanching; its color may differ from the surrounding area.
- Stage II – Partial thickness loss of dermis presenting as a shallow, open ulcer with a red-pink wound bed, without slough. May also present as an intact or open/ruptured serum-filled blister.
- Stage III – Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon, or muscle is not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunneling.
- Stage IV – Full thickness tissue loss with exposed bone, tendon, or muscle. Slough or eschar may be present on some parts of the wound bed. Often include undermining and tunneling.
- Unstageable – Full thickness tissue loss in which the base of the ulcer is covered by slough (yellow, tan, gray, green, or brown) and/or eschar (tan, brown, or black) in the wound bed.

Reverse Staging: Clinical studies indicate that as deep ulcers heal, the lost muscle, fat, and dermis is NOT replaced. Instead, granulation tissue fills the defect before re-epithelialization. Given this information, it is not appropriate to reverse stage a healing ulcer. For example, a pressure ulcer stage III does not become a stage II or a stage I in your documentation during healing. You must chart the progress by noting an improvement in the characteristics (for example, size, depth, amount of necrotic tissue, or amount of exudate).

Bottoming out is the finding that an outstretched hand can readily palpate the bony prominence (coccyx or lateral trochanter) when it is placed palm up beneath the undersurface of the mattress or overlay and in an area under the bony prominence. This bottoming out criterion should be tested with the patient in the supine position with his/her head flat, in the supine position with his/her head slightly elevated (no more than 30 degrees), and in the sidelying position.

GROUP I SUPPORT SURFACES

Group I support surfaces include: A4640, E0181, E0182, E0184, E0185, E0186, E0187, E0188, E0189, E0196, E0197, E0198, and E0199.

Codes termed “pressure pad for mattress” describe nonpowered pressure reducing mattress overlays. These devices are designed to be placed on top of a standard hospital or home mattress.

A gel/gel-like mattress overlay is characterized by a gel or gel-like layer with a height of two inches or greater.

8410. Updated 05/08

An air mattress overlay is characterized by interconnected air cells having a cell height of three inches or greater that are inflated with an air pump.

A foam mattress overlay is characterized by all of the following:

1. Base thickness of two inches or greater and peak height of three inches or greater if it is a convoluted overlay (such as egg crate) or an overall height of at least three inches if it is a nonconvoluted overlay
2. Foam with a density and other qualities that provide adequate pressure reduction
3. Durable waterproof cover

Noncovered Group I surfaces include:

- A surface which does not have a waterproof cover (not considered durable)
- A surface which allows the beneficiary to “bottom out”
- A surface which does not meet the characteristics specified above

A Group I support surface is covered if beneficiary meets one of the following:

- Criterion 1
- Criterion 2 or 3 and at least one of 4 through 7
 1. Completely immobile – patient cannot make changes in body position without assistance
 2. Limited mobility – patient cannot independently make changes in body position significant enough to alleviate pressure
 3. Any stage pressure ulcer on the trunk or pelvis
 4. Impaired nutritional status
 5. Fecal or urinary incontinence
 6. Altered sensory perception
 7. Compromised circulatory status

Group I support surface replacements are allowed no more than once per year.

Documentation that must be kept in beneficiary’s file:

1. Care plan which has been established by the beneficiary’s physician or home care nurse, which is documented in the beneficiary’s medical records and should include:
 - a. Education of the patient and caregiver on the prevention and management of pressure ulcers
 - b. Regular assessment by a nurse, physician, or other licensed healthcare practitioner
 - c. Appropriate turning and positioning
 - d. Appropriate wound care
 - e. Appropriate management of moisture and incontinence
 - f. Nutritional assessment and intervention consistent with the overall plan of care
2. Order for the overlay or mattress which is signed and dated by the treating physician.
3. It is expected that the patient’s medical records will reflect the need for the care provided.

GROUP II SUPPORT SURFACES

All Group II support surfaces require prior authorization (new placement and renewals).

Group II support surfaces include: E0193, E0277, E0371, E0372, and E0373.

Definition: An overlay that does not have air moving through it and has a weight limit of 250 pounds or a mattress that replaces the beneficiary’s current mattress with air flow and air loss to keep beneficiary drier and can be used for multiple wounds.

8410. Updated 12/11

PA is given for up to 60 days of rental with each request. All renewals must be submitted prior to the end of the previous 60 days of authorization. Purchase of a Group II support surface is at the discretion of KMAP.

Coverage is limited to when the ulcer is healed or, if healing does not continue, there is documentation submitted showing other aspects of the care plan have been modified to promote healing.

A Group II support surface is covered for 60 days at a time if the beneficiary meets one of the following combinations:

- A. Criterion 1, 2, 3, 7, and 9
- B. Criterion 4, 5, and 9
- C. Criterion 6, 7, and 9
- D. Criterion 7, 8, and 9
 1. Beneficiary must have multiple stage II pressure ulcers located on the trunk or pelvis.
 2. Beneficiary has been on a comprehensive ulcer treatment program for at least the past month which has included the use of an appropriate group I support surface. A comprehensive ulcer treatment program should include:
 - a. Education of the beneficiary and caregiver on the prevention and management of pressure ulcers
 - b. Regular assessment by a nurse, physician, or other licensed healthcare practitioner at least weekly
 - c. Appropriate turning and positioning
 - d. Appropriate wound care
 - e. Appropriate management of moisture and incontinence
 - f. Nutritional assessment and intervention consistent with the overall plan of care
 - g. There must be a care plan established by the physician or home care nurse which includes the above elements
 - h. The support surface provided should be one in which the beneficiary does not “bottom out”
 3. The ulcers have worsened or remained the same over the past two months.
 4. Recent myocutaneous flap or skin graft for a pressure ulcer on the trunk or pelvis (surgery within the past 60 days). Coverage is limited to 60 days from the date of discharge from the hospital.
 5. The beneficiary has been on a Group II or III support surface immediately prior to a recent discharge from a hospital or nursing facility (discharge within the past 30 days). Coverage is limited to 60 days from the date of discharge from the facility.
 6. Beneficiary has previously required a Group III support surface for wounds which remain unhealed.
 7. Must have Albumin levels greater than 3.4 and Prealbumin levels greater than 18.
 8. Beneficiary must have large (affects two different areas of pressure bearing on the trunk or pelvis) or multiple (more than one) stage III or IV pressure ulcers located on the trunk or pelvis.
 9. Beneficiary must be compliant with current plan of care.

Group II support surface purchase replacements are allowed no more than once every seven years. Purchase is at the discretion of KMAP.

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Documentation that must be submitted with original request and each renewal:

1. Order for the mattress or overlay which is signed and dated by the treating physician
2. Wound care plan with:
 - a. Location of wounds
 - b. Current (within 30 days) measurements of all wounds to include tunneling, undermining, characteristics (odor, drainage, infection)
 - c. Education of beneficiary and caregiver on the prevention and management of pressure ulcers
 - d. Regular wound assessment by licensed healthcare practitioner
 - e. Turning
 - f. Positioning
 - g. Wound care
 - h. Management of moisture and incontinence
 - i. Nutritional assessment
 - j. Interventions consistent with the overall plan of care
 - k. Future plans including upcoming appointments and possible surgeries
3. For renewal requests, the renewal form must be submitted with each request
4. If beneficiary has Medicare, the EOB must be submitted with each request
5. Current labs (within 30 days) including Albumin and Prealbumin. Hemoglobin and Hematocrit should be submitted if available
6. Other information as requested by KMAP

COVERAGE OF GROUP III SUPPORT SURFACES:

All Group III support surfaces require PA (new placement and renewals).

Group III support surfaces include: E0194.

Definition: An air fluidized bed is a device employing the circulation of filtered air through silicone coated ceramic beads creating the characteristics of fluid (Clinitron).

PA is given for up to one month rental at a time. All PAs must be renewed monthly. Purchase of a Group III support surface is not covered.

Wet-to-dry dressings when used for debridement do not require an occlusive dressing. Use of wet-to-dry dressings for wound debridement begun during the period of conservative treatment and which continue beyond 30 days will not preclude coverage of an air-fluidized bed. The air-fluidized bed will not be denied if additional debridement again becomes necessary while a patient is using an air-fluidized bed (after the first 30-day course of conservative treatment).

Architectural adjustments such as electrical or structural improvement are noncovered. Payment to caregivers is noncovered.

A Group III support surface is covered if the beneficiary meets all of the following criteria:

1. Must have multiple (one or more) stage III (full thickness tissue loss) or stage IV (deep tissue destruction) pressure ulcers that are greater than eight square centimeters each located on the trunk or pelvis.
2. Must have a primary caregiver.
3. Must have Albumin levels greater than 3.4 and Prealbumin levels greater than 18.
4. Must be bedridden or chair bound as a result of severely-limited mobility.

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5. In the absence of an air-fluidized bed, the beneficiary would require institutionalization.
6. The air-fluidized bed is ordered in writing by the beneficiary's attending physician based upon a comprehensive assessment and evaluation of the beneficiary after completion of a course of conservative treatment designed to optimize conditions that would promote healing. The evaluation must be performed within one month prior to initiation of therapy with the air-fluidized bed.
7. The course of conservative treatment must have been at least one month in duration without progression toward wound healing. This month of prerequisite conservative treatment may include some period of an institution as long as there is documentation available to verify that the necessary conservative treatment was rendered. Conservative treatment must include all of the following:
 - a. Frequent repositioning of the beneficiary with particular attention to relief of pressure over bony prominences (usually every two hours)
 - b. Use of a Group II support surface to reduce pressure and shear forces on healing ulcers and to prevent new ulcer formation
 - c. Necessary treatment to resolve any wound infection
 - d. Optimization of nutrition status to promote wound healing
 - e. Debridement by any means, including wet-to-dry gauze dressings, to remove devitalized tissue from the wound bed
 - f. Maintenance of a clean, moist bed of granulation tissue with appropriate moist dressings protected by an occlusive covering, while the wound heals
 - g. Education of the patient and caregiver on the prevention and management of pressure ulcers
 - h. Assessment by a physician, nurse, or other licensed healthcare practitioner at least weekly
 - i. Appropriate management of moisture and incontinence
8. A trained, adult caregiver is available to assist the beneficiary with activities of daily living, fluid balance, dry skin care, repositioning, recognition and management of altered mental status, dietary needs, prescribed treatments, and management and support of the air-fluidized bed system and its problems such as leakage.
9. A physician directs the home treatment regimen and re-evaluates and recertifies the need for the air-fluidized bed monthly.
10. All other alternative equipment have been considered and ruled out.
11. If beneficiary is immediate post-flap surgery, approval will be given for 60 days from the date of discharge. All other criteria must be met for an extension past 60 days post-flap.
12. Treatment plan must be consistent with HHS Clinical Practice Guidelines #15 Treatment of Pressure Ulcers.
13. Monthly, the treating physician must document the continued need for the equipment with a written statement (not a CMN) specifying:
 - a. The size of the ulcer
 - b. If the ulcer is not healing, what other aspects of the care plan that are being modified to promote healing
 - c. Continued use of the bed is medically necessary for wound management

Note: This monthly physician statement must be submitted with each request (or renewal) to KMAP.
14. The continued medical necessity of an air-fluidized bed must be documented by the treating physician every month. Continued use of an air-fluidized bed is covered until all ulcers are less than eight square centimeters each, which at that time the patient will be stepped down. If healing does not continue, there must be documentation sent with the renewal showing that other aspects of the care plan have been modified to promote healing.
15. Beneficiary is compliant with all aspects of plan of care.

8410. Updated 12/11

An air-fluidized bed will be denied under the following circumstances:

1. The patient requires treatment with wet soaks or moist wound dressings that are not protected with an impervious covering such as plastic wrap or other occlusive material.
2. The caregiver is unwilling or unable to provide the type of care required by the patient on an air-fluidized bed.
3. Electrical system is insufficient for the anticipated increase in energy consumption.
4. Structural support is inadequate to support the weight of the air-fluidized bed system (generally weighs 1,600 pounds or more).
5. Current Albumin levels are less than 3.4 and Prealbumin levels are less than 18 (within one month of request). If request is a renewal and lab values have fallen critically below criteria guidelines the request will be denied, unless documentation is submitted showing immediate and long-term changes in care plan to correct the low values. If values continue to be critically below guidelines, healing cannot occur; therefore, the surface will be denied.
6. All necessary documentation is not submitted with request or each monthly renewal.
7. Beneficiary is noncompliant with any aspects of his or her individual plan of care.

Required documentation with each monthly renewal:

1. Order for the bed (or renewal) signed and dated by the attending physician caring for the wounds.
2. Current labs (within 30 days): Albumin levels and Prealbumin levels are required. Submit H&H levels if possible.
3. Current comprehensive treatment plan which addresses wound care, nutrition, and patient and caregiver education.
4. Description of current wounds (within 30 days) including location, measurements, tunneling, undermining, staging, appearance, and drainage.
5. Renewal request signed and dated by the physician caring for the wounds along with monthly written statement by the treating physician.
6. Changes in treatment plan including future plans.
7. If documentation indicates worsening or no improvement, additional documentation should be included which describes any changes in the treatment regimen which have been made or planned (including upcoming appointments with dates, possible flap surgery with approximate date, and so forth).
8. If beneficiary has Medicare, the EOB must be submitted with each request.
9. Other information as requested by KMAP.

Breast Pumps

Codes E0602 and E0603 are covered for all KMAP female beneficiaries ages 10 through 65. Breast pumps are limited to a combined total of no more than one pump every year. A prescription written by a physician must be kept in the beneficiary's file.

The following breast pump replacement parts are limited to no more than two of each per year:

- A4281
- A4282
- A4283
- A4285
- A4286

Noncovered breast pumps and accessories:

- E0604
- A4284

8410. Updated 04/12

Canes and Crutches

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

- The beneficiary has a mobility limitation that significantly impairs his or her ability to participate in one or more mobility-related activities of daily living (MRADLs) in the home. The MRADLs to be considered are toileting, feeding, dressing, grooming, and bathing performed in customary locations in the home. A mobility limitation is any one of the following:
 - The beneficiary is prevented from accomplishing the MRADL entirely.
 - The beneficiary is placed at a reasonably determined heightened risk of morbidity or mortality secondary to the attempts to perform an MRADL.
 - The beneficiary is prevented from completing the MRADL within a reasonable time frame.
- The beneficiary is able to safely use the cane or crutch.
- The functional mobility deficit can be sufficiently resolved by use of a cane or crutch.

Canes and crutches are covered for purchase. Canes and crutches are limited to a combined total of one replacement every five years. All canes and crutches must have a five-year warranty. Rental of canes and crutches is noncovered. Cane and crutch tips, underarm pads, and handgrips may be replaced when current tips, pads, or grips are at least 75 percent worn and no longer functional. Cane and crutch tips, underarm pads, and handgrips may be replaced no more than one time per 365 days.

Crutches dispensed as a pair must be billed using the pair code. Billing the individual crutch code with two units is not allowed.

Noncovered items include:

- Underarm, articulating, spring assisted crutch
- Crutch substitute

~~Canes and crutches are noncovered for beneficiaries in nursing facilities, head injury facilities, intermediate care facilities for mental retardation (ICFs/MR), Level V, Level VI, swing beds, and hospitals.~~

Commodes

A commode is covered when the beneficiary is physically incapable of using regular toilet facilities. This would occur in any of the following situations:

- The beneficiary is confined to a single room.
- The beneficiary is confined to one level of the home environment, and there is no toilet on that level.
- The beneficiary is confined to the home, and there are no toilet facilities in the home.

An extra wide/heavy duty commode chair is covered for a patient who weighs 300 pounds or more.

A commode chair with detachable arms is covered if the detachable arms feature is necessary to facilitate transferring the beneficiary.

Commodes are limited to a combined total of one replacement every five years. All commodes must come with a five-year warranty. Pails and pans may be replaced no more than two times per 365 days.

Commode chairs with seat lift mechanisms are noncovered.

~~Commodes are noncovered for beneficiaries in any kind of nursing facilities, head injury facilities, ICFs/MR, Level V, Level VI, swing beds, and hospitals.~~

8410. Updated 10/10

Rentals of commodes and pails require PA for all beneficiaries. All rentals will be at the discretion of KMAP. PA request must include:

- Length of need
- Why rental versus purchase
- PA request form
- Prescription
- Other information as requested by KMAP

Competitive Bidding Project

Effective January 1, 2011, the DME competitive bidding project (CBP) will be implemented by the Centers for Medicare and Medicaid Services (CMS). This will affect beneficiaries with Medicare and KMAP coverage who are provided the following DME CBP services:

- Continuous positive airway pressure devices, respiratory assist devices and related supplies, accessories
- Enteral nutrients equipment supplies
- Hospital beds and related supplies
- Mail order diabetic supplies
- Oxygen supplies/equipment
- Power/manual mobility devices and accessories (complex and standard)
- Walkers and related accessories

RULES FOR CBP COVERAGE

The rules for CBP coverage as they apply to Kansas Medicaid are as follows:

- Providers who are established inside the competitive bidding area (CBA) must be specifically accredited by Medicare in order to bill the CBP services listed. (See Appendices I and II). Providers not accredited by Medicare to bill the CBP services will not be reimbursed by Medicaid. Accredited providers will be reimbursed at the **CBP rate**. This will apply when providing CBP services to Medicaid beneficiaries covered by Medicare who live inside and outside the CBA.
- Providers who are established outside the CBA do not need accreditation to bill the CBP services. It is the provider's responsibility to determine if a beneficiary is from a CBA in Kansas or in another state. These providers will be reimbursed at the **CBP rate** if the beneficiary lives within the CBA.
- Beneficiaries who reside inside the CBA will be required to use a CMS-accredited provider for the DME items included in the CBP. These items will be reimbursed at the **CBP rate**. Beneficiaries who reside outside of the CBA can use any provider of their choice. Providers will be reimbursed the Medicaid rate.

GRANDFATHERING

Providers established in the CBA who furnish oxygen and oxygen equipment or rentals where the service period began before or on the date of service January 1, 2011, have the option of being "grandfathered in" as providers by Medicare. These nonaccredited providers can continue to furnish these services as specified by Medicare and receive reimbursement when billed for KMAP/Medicare beneficiaries. Items billed by "grandfathered" providers will be reimbursed at the Medicaid rate.

8410. Updated 04/12

CBP REIMBURSEMENT AND BILLING RULES

CBP services are required to be billed to KMAP with the CBP-specific Medicare remittance advice (RA) remark code provided by Medicare. Claims that crossover electronically will already include these remark codes. Claims submitted through the Internet must have the Medicare remark codes submitted by the provider. Claims submitted on paper must have the Medicare RA attached, which includes the Medicare remark codes. If the electronic claim does not crossover with the CBP remark code(s), providers will need to resubmit the claim on paper or through the Internet.

CBP claims will be subject to postpayment review. Claims will be recouped if the provider does not submit the Medicare RA remark code(s) correctly.

Delivery, Repair, Maintenance and Installation

The delivery of a DME item is covered only when the equipment is initially purchased or rented **and** the supplier customarily makes a separate charge for delivery. However, only delivery charges over 100 miles (round trip) are billable to KMAP.

Proof of Delivery is required in order to verify that the beneficiary received the DME supplies or prosthesis. DME and Prosthetic and Orthotic suppliers are required to maintain proof of delivery in their files. Proof of delivery documentation must be made available to KMAP upon request. KMAP will recoup payment for services in a postpay review if providers do not have adequate proof of delivery in their records. If suppliers have a pattern of not providing documentation to support claimed services, KMAP may refer suppliers for investigation by the KMAP Fraud Unit and may terminate the provider agreement.

For the purpose of the delivery methods listed below, designee is defined as: "Any person who can sign and accept the delivery of durable medical equipment on behalf of the beneficiary."

Direct Delivery by the KMAP Provider

DME and Prosthetic and Orthotic suppliers, their employees, or anyone else having a financial interest in the delivery of the item are prohibited from signing and accepting an item on behalf of a beneficiary (such as acting as a designee on behalf of the beneficiary). The relationship of the designee to the beneficiary must be noted on the delivery slip obtained by the supplier (such as spouse or ~~guardian, or nursing facility designee~~). The signature of the designee must be legible. If the signature of the designee is not legible, the supplier must note the name of the designee on the delivery slip. Documentation of the relationship of the designee to the beneficiary is required for this type of shipping.

DME and Prosthetic and Orthotic suppliers may deliver directly to the beneficiary or the designee. An example of proof of delivery to a beneficiary is having a signed delivery slip that includes all of the following:

1. Beneficiary's name
2. Delivery address
3. Quantity delivered
4. Detailed description of the item being delivered
5. Brand name
6. Serial number, if applicable
7. Signature of the beneficiary or designee
8. Relationship of the designee to the beneficiary, if signed by the designee
9. Date of signature on the delivery slip

(Must be the date that the item was received by the beneficiary or designee.)

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Delivery to Beneficiary by Shipping Service (such as UPS, Federal Express)

DME and Prosthetic and Orthotic suppliers, their employees, or anyone else having a financial interest in the delivery of the item are prohibited from signing and accepting an item on behalf of a beneficiary (acting as a designee on behalf of the beneficiary). The relationship of the designee to the beneficiary should be noted on the delivery slip, if possible, but is not required for this type of shipping. If the DME or Prosthetic and Orthotic supplier uses a shipping service or mail order, an example of proof of delivery would include the service's tracking slip and the supplier's own shipping invoice. If possible, the supplier's records should also include the delivery service's package ID number for that package sent to the beneficiary. The shipping service's tracking slip should reference each individual package, the delivery address, the corresponding package ID number given by the shipping service, and the date delivered, if possible.

DME and Prosthetic and Orthotic suppliers may also use a return postage-paid delivery invoice from the beneficiary or designee as a form of proof of delivery. The descriptive information concerning the item (beneficiary's name, quantity, detailed description, brand name, and serial number) as well as the required signatures from either the beneficiary or the beneficiary's designee should be included on this invoice as well.

Repairs of DME equipment require PA. Providers may bill for the labor component under K0739 or K0740 plus the appropriate part code.

Maintenance of rental equipment (testing, cleaning, regulating and checking equipment) is considered the responsibility of the supplier and is not covered by KMAP. Extensive maintenance on purchased equipment requiring an authorized technician may be billed by the supplier as a repair.

Installation of rented or purchased equipment is covered in most situations. If charges are going to exceed \$25, PA is required. Construction as part of installation is not covered. Installation of DME also requires an invoice.

Dressings and Supplies

~~Dressings and supplies are content of service for all nursing facilities, head injury facilities, rehab facilities, clinics, offices, and hospitals.~~

Dressings and supplies are only allowed for place of service 12 (home).

Dressings are covered when either of the following criteria is met:

- They are required for the treatment of a wound.
- They are required after debridement of a wound.

Dressings are noncovered for the following:

- Drainage from a cutaneous fistula which has not been caused by or treated by a surgical procedure
- Stage 1 pressure ulcer
- First degree burn
- Wounds caused by trauma which do not require surgical closure or debridement (skin tear or abrasion)
- Venipuncture or arterial puncture site (blood sample) other than the site of an indwelling catheter or needle
- Silicone gel sheets used for the treatment of keloids or other scars

8410. Updated 10/10

Dressings include:

- Primary dressings: therapeutic or protective coverings applied directly to wounds or lesions either on the skin or caused by an opening to the skin.
- Secondary dressings: materials that serve a therapeutic or protective function and are needed to secure a primary dressing.

Debridement of a wound may be any type:

- Surgical (sharp instrument or laser)
- Mechanical (irrigation or wet-to-dry dressings)
- Chemical (topical application of enzymes)
- Autolytic (application of occlusive dressings to an open wound)

Products containing multiple materials are categorized according to the clinically predominant component (alginate, collagen, foam, gauze, hydrocolloid, hydrogel). Other multicomponent wound dressings not containing these specified components may be classified as composite or specialty absorptive dressings if the definition of these categories has been met. Multicomponent products may not be unbundled and billed as the separate components of the dressing.

For all dressings, if a single dressing is divided into multiple portion/pieces, the code and quantity billed must represent the originally manufactured size and quantity.

Modifiers A1, A2, A3, A4, A5, A6, A7, A8, and A9 indicate that a particular item is being used as a primary or secondary dressing on a surgical or debrided wound and also to indicate the number of wounds on which that dressing is being used. The modifier number must correspond to the number of wounds on which the dressing is being used, not the total number of wounds treated. Modifiers A1-A9 are used for informational purposes and are not required.

Surgical dressings are covered for as long as they are medically necessary. Dressings over a percutaneous catheter or tube are covered as long as the catheter or tube remains in place and after removal until the wound heals.

Dressing size must be based on and appropriate to the size of the wound. For wound covers, the pad size is usually about two inches greater than the dimensions of the wound. For example, a five cm. x five cm. (two in. x two in.) wound requires a four in. x four in. pad size.

The quantity and type of dressings dispensed at any one time must take into account the current status of the wound, the likelihood of change, and the recent use of dressings.

Dressing needs may change frequently in the early phases of wound treatment with heavily draining wounds. Suppliers are expected to have a mechanism for determining the quantity of dressing that the patient is actually using and to adjust their provision of dressings accordingly. No more than a one month's supply of dressings may be provided at one time.

Dressings must be tailored to the specific needs of an individual patient. When dressings are provided in kits, only those components of the kit that meet the definition of a dressing, that are ordered by the physician, and that are medically necessary are covered.

8410. Updated 10/10

It may not be appropriate to use some combinations of a hydrating dressing on the same wound at the same time as an absorptive dressing. Because composite dressings, foam wound covers, hydrocolloid wound covers, and transparent film, when used as a secondary dressing, are meant to be changed at frequencies less than daily, appropriate clinical judgment should be used to avoid their use with primary dressings which require more frequent dressing changes. While a highly exudative wound might require such a combination initially, with continued proper management, the wound usually progresses to a point where the appropriate selection of these products results in the less frequent dressing changes which they are designed to allow. An example of an inappropriate combination is the use of a specialty absorptive dressing on top of nonimpregnated gauze being used as a primary dressing.

ALGINATE DRESSINGS

Codes A6196, A6197, A6198, and A6199 are covered for:

- Moderately to highly exudative full thickness wounds (stage III or IV ulcers)
- Alginate or other fiber gelling dressing fillers for moderately to highly exudative full thickness wound cavities (stage III or IV ulcers)

Alginate or other fiber gelling dressing covers are not medically necessary on dry wounds or wounds covered with eschar. Usual dressing change is up to once per day. One wound cover sheet of the approximate size of the wound or up to two units of wound filler (one unit equals six inches of alginate or other fiber gelling dressing rope) is usually used at each dressing change. It is usually inappropriate to use alginates or other fiber gelling dressings in combination with hydrogels. The medical necessity for more frequent change of dressing must be documented.

COMPOSITE DRESSINGS

Composite dressings are products combining physically distinct components into a single dressing that provides multiple functions. These functions must include, but are not limited to:

- A bacterial barrier
- An absorptive layer other than an alginate or other fiber gelling dressing, foam, hydrocolloid, or hydrogel
- A semi-adherent or nonadherent property over the wound site

For codes A6203, A6204, and A6205, usual composite dressing change is up to three times per week, one wound cover per dressing change. The medical necessity for more frequent change of dressing must be documented.

COMPRESSION BANDAGES

All of these bandages are noncovered when used for strains, sprains, edema, or situations other than as a dressing for a wound.

Light compression bandages, self-adherent bandages, and conforming bandages are covered when they are used to hold wound cover dressings in place over any wound type.

Moderate or high compression bandages, conforming bandages, self-adherent bandages, and padding bandages are covered when they are part of a multilayer compression bandage system used in the treatment of a venous stasis ulcer.

Elastic bandages are those that contain fibers of rubber (latex, neoprene), spandex, or elastane. Roll bandages that do not contain these fibers are considered nonelastic bandages even though many of them (such as gauze bandages) are stretchable.

8410. Updated 10/10

Codes A6442, A6443, A6444, A6445, A6446, and A6447 describe roll gauze-type bandages made either of cotton or of synthetic materials such as nylon, viscose, polyester, rayon, or polyamide. These bandages are stretchable, but do not contain elastic fibers. These codes include short-stretch bandages.

Codes A6448, A6449, and A6450 describe ACE-type elastic bandages.

Codes A6451 and A6452 describe elastic bandages that produce moderate or high compression that is sustained typically for one week. They are commonly included in multilayer compression bandage systems.

Suppliers billing these codes must be able to provide documentation from the manufacturer verifying that the performance characteristics specified in the code narratives have been met.

When multilayer compression bandage systems are used for the treatment of a venous stasis ulcer, each component is billed using a specific code for the component – A6451, A6452, A6443, A6444, A6454, A6441 or A6456.

Most compression bandages are reusable. Usual frequency of replacement would be no more than one per week unless they are part of a multilayer compression bandage system. The medical necessity for more frequent change of dressing must be documented.

Conforming bandage dressing change is determined by the frequency of change of the selected underlying dressing.

FOAM DRESSINGS

Codes A6209, A6210, A6211, A6212, A6213, A6214, and A6215:

Foam dressings are covered when used on full thickness wounds (stage III or IV ulcers) with moderate to heavy exudates.

Usual dressing change for a foam wound cover used as a primary dressing is up to three times per week. When a foam wound cover is used as a secondary dressing for a wound with very heavy exudates, dressing change may be up to three times per week.

Usual dressing change for foam wound fillers is up to once per day. The medical necessity for more frequent change of dressing must be documented.

GAUZE DRESSINGS

Impregnated gauze dressings are woven or nonwoven materials into which substances such as iodinated agents, petrolatum, zinc paste, crystalline sodium chloride, chlorhexadine gluconate, bismuth tribromophenate, water, aqueous saline, hydrogel, or other agents have been incorporated into the dressing material by the manufacturer.

Codes A6216, A6217, A6218, A6219, A6220, A6221, A6402, A6403, A6404, and A6407:

Usual nonimpregnated gauze dressing change is up to three times per day for a dressing without a border and once per day for a dressing with a border. It is usually not necessary to stack more than two gauze pads on top of each other in any one area. The medical necessity for more frequent change of dressing must be documented.

8410. Updated 10/10

Codes A6222, A623, A6224 and A6266:

Usual dressing change for gauze dressings impregnated with other than water, normal saline, or hydrogel is up to once per day. The medical necessity for more frequent change of dressing must be documented.

Codes A6228, A6229, and A6230:

Usual dressing change for gauze dressings impregnated with water or normal saline is up to once per day. The medical necessity for more frequent change of dressing must be documented.

Gauze or gauze-like products are typically manufactured as a single piece of material folded into a multi-ply gauze pad. Coding must be based on the functional size of the pad as it is commonly used in clinical practice.

GLOVES (NONSTERILE)

For code A4927, PA required.

Nonsterile gloves are covered for patient or family use if the patient is currently infected with MRSA or VRE. A culture (C&S) performed within 30 days of the request must be submitted with each PA request. Upon each renewal, a new culture (C&S) performed within 30 days of the request must be submitted. This new culture must document current MRSA or VRE infection. Once the beneficiary no longer shows current MRSA or VRE infection, nonsterile gloves are noncovered.

Nonsterile gloves for use by home health staff, HCBS staff, or staff from any other paid company are considered content of service and will not be paid separately. Nonsterile gloves allowed for patient or family use may not be used by paid staff.

Nonsterile gloves are limited to no more than one box (100 gloves) every three months.

HYDROCOLLOID DRESSINGS

Codes A6234, A6235, A6236, A6237, A6238, A6239, A6240, and A6241:

Hydrocolloid dressings are covered for use on wounds with light to moderate exudates.

Usual dressing change for hydrocolloid wound covers or hydrocolloid wound fillers is up to three times per week. The medical necessity for more frequent change of dressing must be documented.

HYDROGEL DRESSINGS

Codes A6231, A6232, A6233, A6242, A6243, A6244, A6245, A6246, A6247, and A6248:

Hydrogel dressings are covered when used on full thickness wounds with minimal or no exudates (stage III or IV ulcers).

Hydrogel dressings are not usually medically necessary for stage II ulcers. Documentation must substantiate the medical necessity for use of hydrogel dressings for stage II ulcers (location of ulcer is sacro-coccygeal area).

Usual dressing change for hydrogel wound covers without adhesive border or hydrogel wound fillers is up to once per day. Usual dressing change for hydrogel wound covers with adhesive border is up to three times per week. The medical necessity for more frequent change of dressing must be documented.

8410. Updated 10/10

The quantity of hydrogel filler used for each wound must not exceed the amount needed to line the surface of the wound. Additional amounts used to fill a cavity are not medically necessary. Documentation must substantiate the medical necessity for code A6248 billed in excess of three units (fluid ounces) per wound in 30 days.

Use of more than one type of hydrogel dressing (filler, cover, or impregnated gauze) on the same wound at the same time is not medically necessary.

SPECIALTY ABSORPTIVE DRESSINGS

Specialty absorptive dressings are unitized multilayer dressings which provide:

- A semi-adherent quality or nonadherent layer
- Highly absorptive layers of fibers such as absorbent cellulose, cotton, or rayon

These may or may not have an adhesive border.

Codes A6251, A6252, A6253, A6254, A6255, and A6256:

Specialty absorptive dressings are covered when used for moderately or highly exudative wounds (stage III or IV ulcers). Usual specialty absorptive dressing change is up to once per day for a dressing without an adhesive border and up to every other day for a dressing with a border. The medical necessity for more frequent change of dressing must be documented.

TAPE

Codes A4450 and A4452:

Tape is covered when needed to hold on a wound cover, elastic roll gauze, or nonelastic roll gauze. Additional tape is usually not required when a wound cover with an adhesive border is used. The medical necessity for tape in these situations must be documented.

Tape change is determined by the frequency of change of the wound cover. Quantities of tape submitted must reasonably reflect the size of the wound cover being secured.

Usual use for wound covers measuring 16 square inches or less is up to two units per dressing change; for wound covers measuring 16 to 48 square inches, up to three units per dressing change; for wound covers measuring greater than 48 square inches, up to four units per dressing change.

TRANSPARENT DRESSINGS

Codes A6257, A6258, and A6259:

Transparent film dressings are covered when used for an open, partial-thickness wound with minimal exudates or closed wounds.

Usual dressing change is up to three times per week. The medical necessity for more frequent change of dressing must be documented.

TUBULAR DRESSINGS

Code K0620 may be used to bill for either an elastic or nonelastic tubular dressing.

8410. Updated 10/10

WOUND COVERS

Wound covers are flat dressing pads. A wound cover with adhesive border is one which has an integrated cover and distinct adhesive border designed to adhere tightly to the skin.

Some wound covers are available both without and with an adhesive border. For wound covers with an adhesive border, the code to be used is determined by the pad size, not by the outside adhesive border dimensions.

When a wound cover with an adhesive border is being used, no other dressing is needed on top of it and additional tape is usually not required. Reasons for use of additional tape must be well documented. An adhesive border is usually more binding than that obtained with separate taping and is therefore indicated for use with wounds requiring less frequent dressing changes.

WOUND FILLERS

Wound fillers are dressing materials which are placed into open wounds to eliminate dead space, absorb exudates, or maintain a moist wound surface.

Wound fillers come in hydrated forms (pastes, gels), dry forms (powder, granules, beads), or other forms such as rope, spiral, and pillows. Wound fillers not falling into any of these categories are noncovered.

The units of service for wound fillers are one gram, one fluid ounce, six-inch length, or one yard depending on the product. If the individual product is packaged as a fraction of a unit, determine the units billed by multiplying the number of dispensed items by the individual product size and rounding to the nearest whole number.

For some wound fillers, the units on the package do not correspond to the units of the code. For example, some pastes or gels are labeled as grams (instead of fluid ounces); some wound fillers are labeled as cc or ml (instead of fluid ounces or grams); some are described by linear dimensions (instead of grams). In these situations, the supplier must contact the manufacturer to determine the appropriate conversion factor or unit of service which corresponds to the code.

Use of more than one type of wound filler or more than one type of wound cover in a single wound is rarely medically necessary, and the reasons must be well documented.

WOUND POUCH

Code A6154:

Limited to 12 units per 30 days. A wound pouch is a waterproof, collection device with a drainable port that adheres to the skin around a wound.

Enteral Infusion Pumps

Enteral pumps require PA for all ages whether purchase or rental (one unit equals one month's rental). The provider of the enteral infusion pump is required to provide the necessary educational services. It is recommended the provider of the pump also supply cleansing/dressing supplies and fluid administration supplies (pump kits, syringes, and so forth), but this is not required. The enteral nutrients may be provided by another provider or WIC if applicable. Providers should make every effort to supply both the pump and the nutrients.

8410. Updated 04/12

IV poles are considered content of service with a pump rental and will not be paid separately to any provider when pump is being rented. The provider supplying the rental pump must supply the pole as content of service.

For KBH beneficiaries with purchased pumps, gravity or bolus feedings, IV poles may be purchased without PA and are limited to no more than one every 730 days.

For non-KBH beneficiaries, all IV poles, rented or purchased, require PA (one unit equals one month rental).

~~Enteral pumps are considered part of the per diem rate in nursing facilities and will not be paid separately.~~

High Frequency Chest Wall Oscillation System

A high frequency chest wall oscillation system is covered with an approved PA for a KBH beneficiary if all criteria is met. It is only covered for use in the home. The system must be prescribed by two Kansas-licensed physicians with at least one being a Kansas-licensed pulmonologist. All documentation must be originated and signed by the prescribing physicians and must be completed on official letterhead. Any documentation that appears to be written by the DME provider will not be accepted. All required test results must be preformed prior to the beneficiary beginning treatment with this system and must be within the six months immediately prior to the date of the request. Please see the complete requirements included in this section. Non-KBH beneficiaries may be considered if supported by medical documentation. This device is not covered for MediKan beneficiaries.

PA must be requested prior to usage or placement of this system.

- If this system is dispensed to a beneficiary prior to obtaining an approved PA, it will be at the expense of the DME provider. The beneficiary may not be billed.
- Any PAs requested after dispensing will be denied.

The DME provider is responsible for the following:

- Ensure a PA has been approved prior to dispensing
- Provide complete training for the beneficiary and caregivers free of charge
- Submit all required documentation

The generator, vest, and hoses are a complete package under E0483. The vest and hoses cannot be purchased separately unless for a replacement. The device must have a lifetime warranty. The DME provider is responsible for all maintenance and repairs as stated under the warranty. Vest and hose replacements will only be allowed once every five years, with PA, if they are not working and cannot be repaired. Vest replacements will be allowed more frequently for KBH beneficiaries if they outgrow the current size. New generators will not be allowed for upgrade purposes.

All systems must be rented for an initial three-month trial period. At the end of the trial period, documentation must be submitted showing a positive change in the beneficiary's health status and 100 percent compliance with the treatment plan. If the generator is capable, a compliance report must be printed showing the minutes used per day (three days each month). If criteria are met, a final payment will be made for purchase of the item, otherwise coverage will be terminated. The three-month trial period must be billed using the RR modifier. The decision to terminate use, continue renting, or purchase will be at the discretion of KMAP.

8410. Updated 10/10

The system must be effective for the condition which it is being prescribed. There must not be any equally effective service that is covered, and the positive effects must be cost effective.

The beneficiary must meet all of the following:

- Be currently diagnosed with a chronic lung condition characterized by a daily productive cough, significant amount of secretions, and the inability to mobilize those secretions for at least six months immediately prior to the date of request
- Have this condition confirmed by a high resolution or spiral CT scan
- Have attempted and failed using a flutter valve device for at least eight weeks immediately prior to the date of request
- Have attempted and failed chest physiotherapy for at least six months immediately prior to the date of request
- Have a treatment plan which includes use of the system no less than 15 minutes twice per day
- Have 100% compliance with all aspects of care
- Have no contraindications for use of this system
- Be fully trained (along with caregivers) on the usage and safety features of the device by the DME provider

Note: This training must be provided at no charge to the beneficiary.

Required documentation for the initial request of a trial period includes the following:

- Completed PA request form
- History and current physical report from both prescribing physicians (written and signed by the physicians)
- Official results of high resolution or spiral CT scan
- Current diagnosis
- Treatment plan including the number of times per day and minutes prescribed
- Current medications including route, dosage, and frequency
- Quantity of daily secretions including full description of secretions
- Most recent pulmonary function test results
- Number of hospitalizations in last six months for this condition, including reasons for hospitalization
- History of all attempted methods of airway clearance, the reasons they failed, and the number of times they were attempted
- Explanation of why chest physiotherapy is not sufficient

Required documentation for final purchase (following a three-month trial period):

- Completed PA request form
- Updated history and physical report from both prescribing physicians showing a positive change in the beneficiary's condition (written and signed by the physicians)
- Report form printed directly off the generator (three days for each month) showing 100 percent compliance with the prescribed care, if device is capable
- Results of any pulmonary tests performed within the three-month trial period
- Number of hospitalizations during the three-month trial period, including reasons for hospitalization

8410. Updated 10/10

Home Blood Glucose Monitors and Supplies

Home blood glucose monitors and supplies are covered for insulin treated diabetes (Type 1) and noninsulin treated diabetes (Type 2). PA is required on voice-synthesized monitors and reusable pens. For regular monitors and other supplies, PA is not required unless the request exceeds the covered limits. For requests over the limits covered by KMAP, a PA must be obtained. All types of home blood glucose monitors are limited to one device every two years per beneficiary (no matter what kind).

Modifier KX must be used if the beneficiary is insulin treated (insulin-dependent diabetic). Modifier KS must be used if the beneficiary is not insulin treated (noninsulin-dependent diabetic). Modifiers KX and KS cannot be billed together on each detail line. If no modifier is included, the claim will deny.

Code E2100 requires PA and is allowed only for beneficiaries with a severe visual impairment defined as a best corrected visual acuity of 20/200 or worse.

Insulin delivery devices (reusable pens) are covered with a limit of one 1.5 ml or 3 ml size per year. Beneficiary must have impaired visual acuity of 20/200 or worse and/or severely impaired manual dexterity. Medical necessity must be shown why a beneficiary cannot use a multidose vial and must not have home health visits for purpose of filling insulin syringes.

The following devices are noncovered by KMAP:

- Replacement battery, any type, for use with medically necessary home blood glucose monitor owned by beneficiary
- Replacement lens shield cartridge for use with laser skin piercing device
- Blood glucose monitor with integrated lancing/blood sample
- Skin piercing device for collection of capillary blood, laser

For home blood glucose supplies, providers must not dispense a quantity of supplies exceeding a beneficiary's expected usage. Regardless of usage, a supplier must not dispense more than a three month quantity of glucose testing supplies at a time. Suppliers should stay attuned to atypical usage patterns on behalf of their clients and verify with the ordering physicians that the atypical usage is, in fact, warranted. Suppliers must not automatically dispense a quantity of supplies on a predetermined regular basis, even if the beneficiary has authorized this in advance. The ordering physician does not have to approve the order refill; however, a beneficiary or the beneficiary's caregiver must specifically request refills of glucose monitor supplies before they are dispensed.

Testing strips are to be billed ONE UNIT is equal to ONE BOTTLE (50 strips). Billing of testing strips will be reviewed at least yearly. Any inappropriate billing will be recouped.

Providers must keep the order for home blood glucose monitoring supplies and monitors on file. The order must include all of the following elements:

- Item to be dispensed
- Quantity of item(s) to be dispensed
- Specific frequency of testing
- Whether the beneficiary has insulin-treated or noninsulin treated diabetes
- Treating physician's signature
- Date of the treating physician's signature
- Start date of the order (only required if start date is different than signature date)

8410. Updated 10/10

Orders that state “as needed” are not acceptable and will result in those items being denied as not medically necessary.

The supplier is required to have a renewal order from the treating physician every 12 months. This renewal order must also contain the required information specified above.

For beneficiaries to be eligible for home blood glucose monitors and supplies, they must meet all of the following basic criteria:

- Beneficiary must have diabetes (ICD-9 codes 250.00-250.93) which is being treated by a physician.
- Glucose monitor and related accessories and supplies are ordered by a physician who is treating the beneficiary’s diabetes, and the treating physician maintains records reflecting the care provided including, but not limited to, evidence of medical necessity for the prescribed frequency of testing.
- Beneficiary (or beneficiary’s caregiver) successfully completes training or is scheduled to begin training in the use of the monitor, test strips, and lancing devices.
- Beneficiary (or beneficiary’s caregiver) is capable of using the test results to ensure appropriate glycemic control of the beneficiary’s diabetes.
- Device is designed for home use.

For beneficiaries to be eligible for more than the limits listed on the previous page, PA is required and the beneficiary must meet the following criteria:

- Coverage criteria-for glucose monitoring supplies are met.
- Supplier of test strips and lancets or lens shield cartridge maintains in its records the order from the treating physician.
- Beneficiary has nearly exhausted the supply of test strips and lancets or useful life of one lens shield cartridge previously dispensed.
- Treating physician has ordered a frequency of testing that exceeds the usage guidelines and has documented in the beneficiary’s medical record the specific reason for the additional materials for that particular beneficiary.
- Treating physician has seen the beneficiary and has evaluated his or her diabetes control within six months prior to ordering quantities of strips and lancets or lens shield cartridges that exceed the usage guidelines.
- If refill of supply quantities is dispensed that exceeds the usage guidelines, there must be documentation in the physician’s records (such as a specific narrative statement that adequately documents the frequency at which the beneficiary is actually testing or a copy of the beneficiary’s log) or in the supplier’s records (such as a copy of the beneficiary’s log) that the beneficiary is actually testing at a frequency that corroborates the quantity of supplies that have been dispensed. If the beneficiary is regularly using supply quantities that exceed the usage guidelines, new documentation must be present at least every six months.

Home blood glucose monitor and supplies limits for insulin treated diabetes (Type 1) are:

- One monitor is allowed every two years, regardless of the type
- Test strips (1 unit = 1 bottle) are allowed at 6 units (300 strips or 6 bottles) every 30 days
- Platforms (1 unit = 1 box) are allowed at 1 unit (1 box) every 30 days
- Calibration solution/chips are allowed at 4 units per year
- Spring-powered device for lancet is allowed at 1 unit every six months

8410. Updated 10/10

- Lancets (1 unit = 1 box) are allowed at 3 units (3 boxes) every 30 days
- One reusable pen insulin delivery device (either size) is allowed every year

Home blood glucose monitor and supplies limits for noninsulin treated diabetes (Type 2) are:

- One monitor is allowed every two years, regardless of the type.
- Test strips (1 unit = 1 bottle) are allowed at 2 units (100 strips or 2 bottles) every 30 days.
- Platforms (1 unit = 1 box) are allowed at 1 unit (1 box) every 90 days.
- Calibration solution/chips are allowed at 2 units per year.
- Spring-powered device for lancet is allowed at 1 unit every six months.
- Lancets (1 unit = 1 box) are allowed at 1 unit (1 box) every 30 days.

Insulin Pumps

Insulin pumps and limited supplies are covered for beneficiaries meeting KMAP criteria who have a current diagnosis of insulin dependent type 1 diabetes mellitus. The following limitations apply:

- PA must be submitted and approved prior to placement of the pump.
- Insulin pumps are noncovered for MediKan.
- Pumps are limited to no more than one every three years per beneficiary.
- All services are restricted to place of service “home” (12).
- Continuous glucose monitoring is noncovered by KMAP.

KMAP will make the final decision whether to purchase or rent an insulin pump. KMAP will also determine the length of PA, not to exceed 12 months at a time.

Replacements are only allowed for lost, stolen or malfunctioning pumps damaged beyond repair. For lost or stolen pumps, a police report must be submitted to KMAP. Replacements are noncovered for upgrading.

All documentation regarding insulin pumps must be written and signed by the treating physician and submitted to KMAP by the DME provider. All correspondence will be with the DME provider. Documentation submitted to KMAP by someone other than the DME provider will be returned unprocessed.

Insulin Pump Request Criteria

If a beneficiary has never been on an insulin pump, he or she must meet all of the following to be eligible:

- Beneficiary must have a current diagnosis of type 1 diabetes mellitus (insulin dependent).
- Beneficiary must have a current diagnosis of one of the following diagnosis codes:

250.01	250.23	250.51	250.73
250.03	250.31	250.53	250.81
250.11	250.33	250.61	250.83
250.13	250.41	250.63	250.91
250.21	250.43	250.71	250.93

- Beneficiary must have a serum C-peptide level less than or equal to 110% of the lower limit of normal of the laboratory’s measurement method (drawn within 60 days prior to request).
- If diagnosed for less than five years, a beneficiary must have completed a comprehensive diabetes education program. Completion and contents of training must be submitted.

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8410. Updated 05/11

- If diagnosed for more than five years, a physician may confirm education has been completed.
- Beneficiary must have been on a program of multiple daily injections of insulin (at least three injections per day) with frequent self-adjustments of the insulin dose for at least six months immediately prior to the request for the insulin pump.
- Beneficiary must have documented frequency of glucose self-testing on average of at least four times per day during the immediate two months prior to the request.
- Beneficiary must have documented glycosylated hemoglobin level (HbA1C) greater than seven percent (drawn within 60 days prior to request).
- Beneficiary must have a history of recurring hypoglycemia.
- Beneficiary must have wide fluctuations (plus or minus 100 mg/dL) in blood glucose before mealtime.
- Beneficiary must have dawn phenomenon with fasting blood sugars frequently exceeding 200 mg/dL.
- Beneficiary must have a history of severe glycemic excursions (plus or minus at least 200 mg/dL).
- Beneficiary must be physically seen and evaluated by the treating physician at least every three months.

Insulin Pump Supplies

A beneficiary entering KMAP currently using an insulin pump purchased by another entity must meet all of the following criteria. (Documentation must be submitted to address all points.)

- Beneficiary must have documented frequency of glucose self-testing an average of at least four times per day during the two months immediately prior to the date of request.
- Beneficiary must be physically seen and evaluated by the treating physician at least every three months.
- Beneficiary must have a diagnosis of insulin dependent diabetes mellitus type 1.
- Beneficiary must have a letter of medical necessity including how long he or she has been on an insulin pump and why originally put on a pump.
- Beneficiary must provide current HbA1C level which has been drawn within 60 days immediately prior to the date of request.

For beneficiaries not currently using an insulin pump, the initial request and supplies must be included on the same PA. If the initial pump request is approved, the supplies will be covered if requested. The following restrictions apply to supplies:

- Batteries of any kind are not covered.
- PA for supplies will only be given for up to 12 months at a time.
- Only one type of infusion set is allowed (needle or non-needle).
- Covered supplies are limited to no more than 10 per month per beneficiary.

With each 12-month PA request for supplies (renewals only), the following must be submitted:

- HbA1C level drawn within 60 days immediately prior to the date of request
- New prescription written by treating physician
- Confirmation the beneficiary is seeing a treating physician at least every three months

If the beneficiary no longer needs the insulin pump, it must be given to the KMAP Kansas Equipment Exchange Program along with any unused supplies.

8410. Updated 04/10

Incontinence Supplies

Incontinence supplies are covered only for KMAP KBH-eligible beneficiaries five years of age and older. A brief/diaper is a basic garment consisting of absorbent material placed between the legs and fastened about the waist. A protective underwear/pull-on is an absorbent material pulled up the legs and worn like underwear. A disposable liner/shield/guard/pad/undergarment is a small shield made of absorbent material that is placed within and attaches to the underclothing. The DME provider must obtain a PA from KMAP before dispensing incontinence products. Refer to the Medical Supply Codes in Appendix II for a complete list of the covered codes.

All beneficiaries must meet current criteria before PA is considered. All information required must be sent at the same time as the PA request. Only one type of incontinence product (one procedure code) is approved or reimbursed within each PA time period (no combinations are allowed). Initial PAs for incontinence supplies begin at the beginning of a month. For existing PAs that require a size change, the PA can be revised at any time during a month.

All beneficiaries are limited to a combined total of six units per day or a cumulative total not to exceed \$150 per calendar month/per beneficiary, whichever is less.

Beneficiaries must meet the following PA criteria to obtain coverage:

- Be incontinent
- Demonstrate toilet training efforts have failed or medical reasons why toilet training or toilet regulation is not possible
- Be age five or older and be KBH-eligible
- Must have a medical diagnosis that shows neurological or physiological damage to the body that is directly causing incontinence
- Provide a prescription and letter of medical necessity from the attending physician and the school (if applicable) that includes:
 - Height and weight
 - Medical diagnosis
 - Neurological or physiological damage to the body that is a direct cause for the incontinence
 - Explanation of all attempts that have been made to toilet train and/or regulate

If approved, a PA will be issued for up to one year at a time. With each PA renewal, a new prescription (written and dated no more than 30 days prior to the date of request) must be submitted along with a completed PA request form.

The following reasons are not sufficient justification for approval:

- Behavioral incontinence
- Encopresis
- Toilet training
- Toilet regulation
- Enuresis

8410. Updated 12/11

Mechanical In-exsufflation Device

This cough assist device is a portable electric device which uses a blower and a valve to alternately apply positive and negative pressure to a patient's airway in order to assist the patient in clearing retained bronchopulmonary secretions. Air is delivered to and from the patient through a breathing circuit incorporating a flexible tube, a bacterial filter and either a face mask, a mouthpiece or an adapter to a tracheostomy or endotracheal tube.

PA is required for purchase and rental for all beneficiaries. This device must be requested using the proper HCPCS code not a miscellaneous code.

PA must be requested and approved prior to usage or placement of this device. If this system is dispensed to a beneficiary prior to obtaining an approved PA, it will be at the expense of the DME provider. The beneficiary cannot be billed. Any PAs requested after dispensing will be denied.

Purchase is limited to no more than one every five years. Rental is limited to no more than six months. All rental reimbursement applies towards the purchase, unless a brand new machine is placed at the time of purchase approval.

Based on medical documentation and length of need, the decision whether to purchase or rent the device will be at the discretion of KMAP. Approved PAs for rental will be at six-month intervals. All accessories are considered content of rental.

For coverage of an in-exsufflation device all of the following must be met:

- Beneficiary must be currently diagnosed with a neuromuscular disease.
- The current neuromuscular disease must be causing a significant impairment of chest wall and/or diaphragmatic movement, such that it results in an inability to clear retained secretions.
- It must be for use in the home.
- It must be prescribed for at least daily use.
- Beneficiary must be 100% compliant with prescribed usage.

The following documentation must be submitted with each PA request:

- Fully completed PA request form
- Letter of medical necessity (LMN) written and signed by the prescribing physician that includes:
 - Diagnosis
 - Discussion of current condition
 - Why suctioning, chest physical therapy (CPT), and a flutter valve will not meet MN
 - Length of need
 - Tracheostomy status, if applicable
 - Ventilator dependency, if applicable
- All other documentation as requested by KMAP
- Documentation of 100% compliance by the beneficiary

Note: For renewals of rentals, an updated LMN with documentation discussing the effect the device is having on the condition is required with each request.

8410. Updated 12/11

Replacement parts for purchased devices

Once a device is purchased, replacement parts are allowed according to the following:

- Filter – no more than one per month at \$1 each
- Tubing (all types) – no more than one per month at \$0.25 per foot
- Mask (all types) – no more than one per 365 days at \$4 each
- Mouthpiece (all types) – no more than one per 365 days at \$1 each
- Trach adapters (all types) – no more than one per 365 days at \$1 each

Oxygen

All oxygen equipment (stationary and portable), supplies, and accessories must be supplied by the same provider. Only one provider can bill for these services at a time.

All claims for monthly rental items must be billed using appropriate date ranges.

- Claims must range from the first day of service through the last day of service for the month being billed. (One unit equals one month/30 days.)
- Claims billed using the same date for the beginning and the ending dates will be denied.
- If a beneficiary changes providers, the dates billed by the previous provider and the new provider cannot overlap.

Once a beneficiary no longer requires oxygen services, it is the responsibility of the DME provider to obtain a discharge order from the physician or have the beneficiary sign a medical release of liability form and immediately pick up all equipment. All rented oxygen systems must be billed using modifier RR. DME suppliers cannot bill KMAP or the beneficiary for equipment left in the home unused.

If a beneficiary wants to switch providers, it is the DME supplier's responsibility to obtain a physician's order or a medical records release signed by the beneficiary. It is the responsibility of both DME suppliers to coordinate delivery and pick-up of the equipment with each other. The new provider cannot bill KMAP until he or she has a pick-up ticket from the old company to prove he or she is the new supplier. The new supplier must obtain a new certificate of medical necessity signed by the physician and have it on file at all times.

COVERAGE CRITERIA

Home oxygen is covered if the beneficiary meets all of criteria 1-5 and at least one of criteria 6-9.

1. The treating physician has diagnosed the beneficiary with a severe lung disease or hypoxia-related symptoms that are expected to improve with oxygen.
2. The beneficiary meets the laboratory values listed under the following section, Qualifying Laboratory Value Requirements.
3. The qualifying laboratory values were performed by a physician or qualified provider of laboratory services.
4. The qualifying laboratory values were obtained under either of the following conditions:
 - If the qualifying laboratory value is performed during an inpatient hospital stay, the reported test must be the one obtained closest to, but no earlier than two days prior to, the hospital discharge date.
 - If the qualifying laboratory value is not performed during an inpatient hospital stay, the reported test must be performed while the beneficiary is in a chronic stable state not during a period of acute illness or an exacerbation of their underlying disease.
5. Alternative treatment measures have been tried or considered and deemed clinically ineffective.

8410. Updated 04/12

6. Beneficiary has an arterial PO₂ at or below 55 mm Hg or arterial oxygen saturation at or below 88 percent taken at rest (awake).
7. Beneficiary has an arterial PO₂ at or below 55 mm Hg or an arterial oxygen saturation at or below 88 percent for at least five minutes during sleep with an arterial PO₂ at or above 56 mm Hg or an arterial oxygen saturation at or above 88 percent while awake.
8. Beneficiary has a decrease in arterial PO₂ more than 10 mm Hg or a decrease in arterial oxygen saturation more than 5 percent for at least five minutes during sleep and associated symptoms or signs reasonably attributable to hypoxemia (such as cor pulmonale, “P” pulmonale on EKG, documented pulmonary hypertension and erythrocytosis).
9. Beneficiary has an arterial PO₂ at or below 55 mm Hg or an arterial oxygen saturation at or below 88 percent during exercise with an arterial PO₂ at or above 56 mm Hg or an arterial oxygen saturation at or above 89 percent during the day while at rest lasting at least five minutes. *In this case, oxygen is provided during exercise if it is documented that the use of oxygen improves the hypoxemia demonstrated during exercise when the beneficiary was breathing room air.*

Oxygen therapy is not covered in the following conditions:

- Angina pectoris in the absence of hypoxemia
Note: This condition is generally not the result of a low oxygen level in the blood, and there are other preferred treatments.
- Dyspnea without cor pulmonale or evidence of hypoxemia
- Severe peripheral vascular disease resulting in clinically evident desaturation in one or more extremities but in the absence of systemic hypoxemia
Note: There is no evidence that increased PO₂ will improve the oxygenation of tissues with impaired circulation.
- Terminal illnesses that do not affect the respiratory system
- Beneficiaries enrolled in any type of clinical trial
- Treatment of sleep apnea (when medical necessity indicates a CPAP machine is needed but oxygen is being used instead)
- Back-up oxygen
Note: Back-up is considered extra equipment in case one fails; extra refillable tanks stored for use when one runs out is not considered back-up.
- Oxygen furnished by an airline
- Any place of service other than home (such as skilled nursing facility [SNF], nursing facility [NF], psychiatric residential treatment facility [PRTF], intermediate care facility for mental retardation [ICF/MR], or hospital)
- Stand-by or emergency (oxygen in place just in case something happens) oxygen for beneficiaries who do not have severe lung disease
Note: Acute infections/episodes are not considered severe lung disease.

QUALIFYING LABORATORY VALUE REQUIREMENTS

The term “qualifying laboratory value” refers to either an arterial blood gas (ABG) test or an oximetry test. An ABG is the direct measurement of the partial pressure of oxygen (PO₂) on a sample of arterial blood. The PO₂ is reported as mm Hg. An oximetry test is the indirect measurement of arterial oxygen saturation using a sensor on the ear or finger. The saturation is reported as a percentage.

8410. Updated 12/11

If a beneficiary is receiving home oxygen prior to May 1, 2010, and has a current qualifying laboratory value that was performed and on file with the DME provider between November 1, 2009, and May 1, 2010, a new laboratory value will not be required until November 1, 2010. All beneficiaries must meet new laboratory value requirements on November 1, 2010. Beneficiaries with a laboratory value performed and on file prior to November 1, 2009, will be required to have a qualifying laboratory value performed and on file starting May 1, 2010.

When both ABG and oximetry tests have been performed on the same day under the same conditions (such as at rest [awake], during exercise, or during sleep), the ABG result will be used to determine if the coverage criteria were met. If an ABG test at rest (awake) is nonqualifying, but an exercise oximetry test on the same day is qualifying, the oximetry test result will determine coverage.

The qualifying laboratory value must be performed by a provider who is qualified to bill Medicaid for the test (Part A provider, laboratory, independent diagnostic testing facility [IDTF]) or a physician. A DME supplier is not considered a qualified provider or a qualified laboratory. Laboratory value studies performed by a supplier are not acceptable. In addition, the qualifying laboratory value cannot be paid for by any DME supplier.

When oxygen is covered based on an oxygen study obtained during exercise, there must be documentation of three oxygen studies in the beneficiary's medical record (testing at rest without oxygen, testing during exercise without oxygen, and testing during exercise with oxygen applied demonstrating the improvement of the hypoxemia). All results must be maintained in the beneficiary's file with the DME provider.

Qualifying laboratory value studies must be performed annually (every three months for acute conditions) for all beneficiaries, and they must continue to meet all criteria. The DME provider must maintain all results in the beneficiary's file. When a physician orders to extend oxygen coverage, a repeat qualifying blood gas study must be performed within 30 days prior to the date of extension, and the beneficiary must continue to meet criteria.

For a beneficiary with acute, short-term conditions (for example, bronchitis or pneumonia) a new qualifying laboratory value and a new physician's order must be obtained prior to initiation of oxygen and every three months following. The beneficiary must continue to meet oxygen criteria. Once the beneficiary no longer meets oxygen criteria, providers are to cease billing KMAP.

An order for each item billed must be signed and dated by the treating physician, kept on file by the supplier, and made available upon request. The physician's order or prescription must include: diagnosis, flow rate, frequency, and estimated duration. A generic prescription only stating "Oxygen PRN" is not acceptable.

Patients who cannot be removed from oxygen for laboratory studies and for whom hypoxemia is not documented require signed statements from two physicians, preferably one being a pulmonary specialist, documenting the effects of oxygen supply removal on the beneficiary. These statements must be retained in the provider's files and provided upon request.

Neonates with bronchopulmonary dysplasia for whom hypoxemia cannot be documented require a signed letter from a physician, preferably a neonatologist, documenting the patient's condition and prognosis. This letter must be retained in the provider's files and available for review by the medical staff upon request.

8410. Updated 03/11

CERTIFICATION

A Certificate of Medical Necessity – Oxygen form which has been completed in its entirety, signed, and dated by the treating physician must be kept on file by the supplier and made available upon request. All providers must use the CMS-484 Certificate of Medical Necessity – Oxygen form. This form must be completed in its entirety according to the CMS instructions and be in the beneficiary's file at all times. According to CMS instructions, Section B of this form cannot be completed by the DME supplier. A new, updated form must be completed each time a beneficiary's oxygen needs change. This form must be updated no less than every 12 months. The form can be found on the CMS website at <http://www.cms.hhs.gov/CMSForms/CMSForms/list.asp>.

For initial certifications, the laboratory value study must be the most recent study which is no more than 30 days prior to the first day of oxygen use.

Initial CMNs are required:

- With the first claim for home oxygen (even if the beneficiary was on oxygen prior to Medicaid eligibility or oxygen was initially covered by another entity)
- When there has been a change in the beneficiary's condition causing a break in medical necessity of at least 60 days plus the remaining days in the rental month during which the need for oxygen ended
- When there is a change of supplier

Recertification CMN is required:

- 12 months after the initial certification and every 12 months following for all beneficiaries
- For short-term acute conditions, initial certification and every three months following until oxygen is discontinued

Note: Beneficiary must be seen and re-evaluated by the treating physician within 90 days prior to the date of recertification.

A revised CMN is required:

- When portable oxygen systems are added
- When a stationary system is added subsequent to a portable system
- When the length of need expires
- When there is a new treating physician
- When there is a change from one type of system to another (such as concentrator, liquid, or gaseous)

STATIONARY OXYGEN SYSTEMS

A stationary oxygen system is covered if the beneficiary meets oxygen criteria. All stationary oxygen systems will be reimbursed on a monthly rental basis (one unit equals a one month rental). All supplies, repairs, maintenance, and contents are considered content of the rental and are not reimbursed separately. A system is considered beneficiary-owned if the ownership of the entire system has been previously transferred to the beneficiary. For those beneficiary-owned systems, the supplies, repairs, maintenance, and oxygen contents will be allowed separate reimbursement.

PORTABLE OXYGEN

A portable oxygen system is covered if the beneficiary meets oxygen criteria, is mobile within the home, and the qualifying blood gas study was performed while at rest (awake) or during exercise. If the only qualifying blood gas study was performed during sleep, portable oxygen is noncovered. If a portable oxygen system is covered, the supplier must provide whatever quantity of oxygen the beneficiary uses.

8410. Updated 04/12

All portable oxygen systems will be reimbursed on a monthly rental basis (one unit equals a one month rental). All supplies, repairs, maintenance, and contents are considered contents of the rental and are not reimbursed separately. A system is considered beneficiary-owned if the ownership of the entire system has been previously transferred to the beneficiary. For those beneficiary-owned systems, the supplies, repairs, maintenance, and oxygen contents will be allowed separate reimbursement.

OXYGEN CONTENTS

Stationary and portable oxygen contents are payable separately only when the coverage criteria for home oxygen have been met, and they are used with a beneficiary-owned stationary or portable gaseous or liquid system respectively. One unit equals a one month supply.

ACCESSORIES

All oxygen accessories, parts, and supplies are included in the allowance for rented oxygen systems. The supplier must provide any accessory ordered by the physician. Accessories are separately payable only when used with a beneficiary-owned oxygen system. Kansas Medicaid limitations will apply.

DELIVERY, MAINTENANCE AND REPAIRS

All delivery charges are content of service and cannot be billed separately. The DME supplier can deliver no more than a three-month supply at a time. The DME supplier is responsible for all delivery and pick up of oxygen and supplies for all oxygen systems and services. The DME supplier is responsible for maintenance and repairs. All maintenance and repairs of rented systems are considered content of service and cannot be billed separately. Maintenance and repair of beneficiary-owned systems requires prior authorization. Routine maintenance on beneficiary-owned systems will be allowed no more than once every six months with PA.

Parenteral Infusion Pumps

Purchase of parenteral pumps is noncovered for all ages. Rental of a parenteral pump is allowed for all ages (one unit equals one month rental) without PA. One unit is allowed every 30 days.

IV poles are considered content of service with a pump rental and will not be paid separately to any provider when pump is being rented. The provider supplying the rental pump must supply the pole as content of service.

~~Parenteral pumps are considered part of the per diem rate in nursing facilities and will not be paid separately.~~

Passive Motion Exercise

Rental of a passive motion exercise device is covered for outpatient use for a maximum period of 14 consecutive days postoperatively. Use code E0935RR.

Patient Lifts

All lifts and accessories require PA.

Lifts are covered if the transfer of a beneficiary between the bed and a chair, wheelchair, or commode requires the assistance of more than one person, and, without the use of a lift, the beneficiary would be bed confined. Lifts are covered for home use only.

Electric and track type lifts are noncovered.

8410. Updated 12/11

A sling or seat for a lift is covered for purchase as an accessory when ordered as a replacement for the original equipment item. When a new lift is purchased, the sling or seat is content of the cost of the lift. If the lift is being rented, the sling or seat is content of the rental payment.

Lifts are limited to a combined total of one replacement every five years. All lifts must come with a five-year warranty. Replacement slings and seats are limited to a total of no more than one unit every 365 days.

Phototherapy

Phototherapy is covered for newborns with a total bilirubin level above 12/dL. Use code E0202RR for phototherapy (bilirubin) light or blanket with photometer. When billing E0202RR, one unit equals one day and is limited to 10 consecutive days per lifetime.

Respiratory Supplies

Suction Pumps

Purchase of suction pumps (all types) is limited to one unit every two years with PA. Purchase includes batteries, charger, filter, nondisposable canister, and tubing.

Rental of suction pumps (all types) is limited to six units (one unit equals one month rental) per lifetime without PA. Rental may be extended if requested by the DME provider and approved by KMAP. Rental includes all canisters (any type), tubing, and filters. These supply items cannot be billed separately when suction pump is rented.

Supply items for beneficiary-owned suction pumps can be obtained without PA. These supplies are limited to:

- Disposable canisters – two units every 30 days
- Nondisposable canisters – one unit every 180 days
- Tubing – 24 units every 180 days

Nebulizers

Purchase of codes E0570 and E0572 is limited to a combined total of one unit every three years. PA is not required.

Rental of codes E0570RR and E0572RR is limited to a combined total of two units (one unit equals one month rental) per lifetime. PA is not required.

Air Compressors

Purchase of air compressors (all types) is limited to one unit every two years with PA.

Rental of air compressors (all types) is limited to three units (one unit equals one month rental) every 365 days without PA. Rental may be extended if requested by the DME provider and approved by KMAP. Rental includes all tubing, filters, connectors, and hoses. These supply items cannot be billed separately when an air compressor is rented.

Humidifiers

Purchase of codes E0550, E0555, E0560, E0561, and E0562 is limited to a combined total of one unit every two years. Please check the Appendix section for PA requirements.

8410. Updated 04/10

Rental of codes E0550RR, E0555RR, E0560RR, E0561RR, and E0562RR is limited to a combined total of six units (one unit equals one month rental) per lifetime without PA. Rental includes tubing, connectors, filters, canisters, and hoses. These supply items cannot be billed separately when a humidifier is rented. Rental may be extended if requested by the DME provider and approved by KMAP.

Pulse Oximeters

Purchase of pulse oximeters (all types) is limited to one unit every three years with PA. Purchase is only covered for KBH-eligible beneficiaries.

Rental of pulse oximeters (all types) is limited to three units (one unit equals one month rental) with PA. Rental is only covered for KBH-eligible beneficiaries.

Tracheostomy Supplies

Tracheostomy supplies are covered without PA. These supplies are limited to:

- Inner cannula – 48 units every 180 days
- Tracheostomy tube – three units every 180 days
- Tracheostomy mask – four units every 30 days
- Tracheostomy tube/collar holder – 24 units every 180 days
- Speaking valve – one unit every 180 days

Suction Catheters

Codes A4624 and A4628 are limited to a combined total of 100 units every 30 days.

Peak Flow Meters

Codes A4614 and S8096 are limited to a combined total of one unit every 180 days.

Holding Chambers

Codes S8100 and S8101 are limited to a combined total of one unit every 90 days.

Miscellaneous Respiratory Supplies

Flutter devices are limited to one unit every 365 days.

Swivel adaptors are limited to six units every 365 days.

Resuscitation bags are limited to one unit every 365 days.

Spacer, bag, or reservoir, with or without mask, for use with metered dose inhaler is limited to two units every 180 days.

Disposable filters for use with purchased aerosol compressors are limited to six units every 180 days. If compressor is rented, filters are content of service and should not be billed separately.

Nondisposable filters for use with purchased aerosol compressors are limited to one unit every 180 days. If compressor is rented, filters are content of service and cannot be billed separately.

Batteries, cables, and battery chargers for beneficiary-owned ventilators are limited to one unit every 365 days with PA. If ventilator is rented, these items are content of service and cannot be billed separately.

8410. Updated 06/10

Specialized Seating Equipment

Specialized seating equipment is covered with approved PA for **noninstitutionalized** KBH participants. (Refer to Section 4300 of the *General Special Requirements Provider Manual*.) Documentation from an approved KMAP seating clinic for medical necessity must be attached to the PA request.

A sign-off statement from the prescribing seating clinic will be required, indicating the seating clinic's recommended system has been provided. If the statement is not received, claims will be subject to recoupment.

TENS Units

A transcutaneous electrical nerve stimulator (TENS) is covered for the treatment of patients with chronic, intractable pain that has been present for no less than three consecutive months. Other appropriate treatment modalities must have been tried and failed.

TENS units are noncovered for:

- Headache
- Visceral abdominal pain
- Experimental treatments
- Pelvic pain
- Temporomandibular joint (TMJ) pain

TENS units may be replaced if the current unit is nonoperable no more than one time every two years. Upgrades are noncovered.

A TENS unit may be used with either two or four leads, depending on the characteristics of the patient's pain. If it is ordered for use with four leads, the DME record must show documentation why two leads are medically insufficient to meet the patient's needs.

All supplies (lead wires, electrodes, paste or gel, batteries, battery chargers, pouches, and carrying cases) are considered content of purchase of new codes E0720 and E0730. Lead wire, electrodes, and paste or gel may not be billed separately for the first 30 days after purchase of a TENS unit.

Code A4556 is limited to no more than one pair (one unit equals one pair) every six months for a two-lead unit. If using a four-lead unit, two pairs are allowed every six months.

Code A4557 is limited to no more than one pair (one unit equals one pair) every 12 months for a two-lead unit. If using a four-lead unit, two pairs are allowed every 12 months.

Code A4558 is limited to no more than one unit (one ounce equals one unit) every six months for a two-lead unit. If using a four-lead unit, two units (one ounce equals one unit) are allowed every six months. The type of electrodes currently being used must require the use of paste or gel.

The following items are noncovered:

- Form-fitting conductive garments
- Adapters, belt clips
- Additional connecting cable for lead wires
- Carrying pouches

8410. Updated 12/11

- Covers
- Pouches
- Batteries
- Battery chargers
- Tape
- Adhesives or adhesive removers
- Skin preparation materials
- TENS units with more than four leads

Used Equipment

Rental of used DME is covered. Used DME may be purchased when it is determined by KDHE-DHCF to be more economical and in the best interest of KDHE-DHCF. Purchase of used DME will require PA.

Vacuum Assisted Wound Closure Therapy

Negative pressure wound therapy (NPWT) must be requested and supplied by an enrolled DME supplier. The DME supplier is responsible for all aspects of PA, including obtaining and submitting all necessary documentation.

All providers must use the Negative Pressure Wound Therapy Prior Authorization Request form for initial requests. For renewal requests, providers must use the Negative Pressure Wound Therapy Renewal Prior Authorization Request form. The DME provider is not allowed to complete any part of these forms. These forms must be completed by the medical professional actually caring for the beneficiary's wound issues on a regular basis. The forms can be found at <https://www.kmap-state-ks.us/Public/forms.asp>.

All NPWT PA requests must include a completed General Prior Authorization Request Form (completed by the DME provider) and the appropriate NPWT PA request form (completed by the performing medical provider) and all pertinent information as stated on the form. PA requests must be for no more than one month at a time.

Reimbursement for NPWT pumps will be on a daily rate. (One unit equals one day.) Canisters for NPWT are considered content of service of the wound care sets for NPWT and will not be reimbursed separately. Providers cannot bill separately for the canisters.

NPWT is covered for rental for no more than four months with PA (one month at a time) if all of 1 through 3 and one of 4 through 6 are met from the list below. (Greater than four months will be reviewed on a case-by-case basis.)

1. Beneficiary is enrolled in a Kansas Medicaid program that allows for DME coverage (noncovered for MediKan).
2. NPWT is prescribed by the treating physician (script must be signed and dated).
3. A complete wound therapy program has been tried for no less than 30 days, which includes all of the following:
 - Documentation of evaluation, care, and wound measurements by a licensed medical professional.
 - Application of dressings to maintain a moist wound environment has been tried and failed.
 - Debridement of necrotic tissue has been done before vacuum application.

8410. Updated 10/10

- Nutritional status has been evaluated and Albumin levels must be greater than 3.4 gm/dl and Pre-Albumin levels must be greater than 18 gm/dl. Only one level is required but both should be submitted if available. If the most current lab levels do not meet criteria, the service is noncovered.
 - Patient is currently being turned and positioned.
 - Patient has used support surface (for past 30 days) for pressure ulcers on the posterior trunk or pelvis.
 - Patient's moisture and incontinence issues have been addressed and managed appropriately.
 - For neuropathic ulcers (diabetic), patient has been on a comprehensive diabetic management program and reduction in pressure on a foot ulcer has been accomplished with appropriate modalities.
 - For venous insufficiency ulcers, compression bandages/garments have been consistently applied and leg elevation/ambulation have been encouraged and performed.
 - All other wound treatment possibilities have been attempted.
 - Patient is compliant with all aspects of care.
 - Appropriate ICD-9 diagnosis code is used describing the wound that is being treated.
4. Chronic stage III or IV pressure ulcer, neuropathic ulcer, venous or arterial insufficiency ulcer, or a chronic ulcer of mixed etiology has been present for at least 30 days or more.
 5. Dehiscence of surgically created wound or a traumatic wound where there is documentation of medical necessity for accelerated formation of granulation tissue which cannot be achieved by other available topical wound treatments that has been present for at least 30 days or more.
 6. Cases of traumatic injury or burns resulting in a skin graft of the injured area, if the purpose is to increase the chances of skin graft success. NPWT must be placed immediately following the grafting. These skin graft cases will be exempt from the 30-day time limit of wound therapy program.

NPWT is noncovered for pylonidal cysts, abscesses, and nonhealing surgical wounds that have not dehisced.

If NPWT is applied prior to the wound being 30 days old, coverage will only be considered once the wound reaches 30 days of age and a five percent healing has occurred during the time the NPWT has been in use.

NPWT pumps must be capable of accommodating more than one wound dressing set for multiple wounds on a patient. Therefore, more than one E2402 billed per patient for the same time period will be denied. NPWT pumps and supplies which have not been specifically designated as being qualified for use of code E2402 for billing are noncovered.

Coverage is provided up to a maximum of 15 dressing kits per wound per month unless there is documentation that the wound size requires more than one dressing kit for each dressing change. Canisters are considered content of service of dressing kits and cannot be billed separately.

A licensed healthcare professional, for the purposes of this policy, may be a physician, physician's assistant, registered nurse, licensed practical nurse, or physical therapist. The practitioner should be licensed to assess wounds and/or administer wound care within the state where the beneficiary is receiving NPWT.

For coverage to continue once a NPWT pump is placed, the following must continue to occur the entire time the pump is in place:

- A professional must directly evaluate and assess the wound being treated no less than weekly.

8410. Updated 06/10

- Precise wound measurements must be documented twice a month. Weekly measurements may be submitted.
- A professional must supervise or directly perform the NPWT dressing changes.
- A professional must document changes in ulcer dimensions and characteristics with each dressing change.
- The beneficiary must remain compliant to all aspects of care (documentation must support).

NPWT pumps will be denied if:

- The wound contains necrotic tissue with eschar, and debridement has not been attempted.
- The wound contains untreated osteomyelitis within the vicinity of the wound.
- The wound contains cancer.
- The wound contains a fistula to an organ or body cavity within the vicinity of the wound.
- The beneficiary is noncompliant with care.

NPWT coverage will end if:

- The wound is not being treated and evaluated at least weekly.
- A professional is not supervising the dressing changes.
- Ulcer dimensions and characteristics are not being documented with each dressing change.
- Measurable wound healing is not shown for two weeks. Wound healing is defined as improvement occurring in either surface area (length times width) or depth of the wound.
- Four months have elapsed using a NPWT pump in the treatment of the most recent wound. (Greater than four months will be reviewed on a case-by-case basis).
- Equipment or supplies are no longer being used.
- The beneficiary is noncompliant with wound care.

Documentation to be submitted for initial request (all information must be within 30 days prior to the date of request):

- Qualifications of professional evaluating the wound no less than weekly
- Current stage of wound
- Previous treatment regimen including dressing types and reasons for failure
- Beneficiary's current mobility and activity
- Caregiver status
- Positioning and pressure relief
- Current wound management
- Frequency of dressing changes
- Date each wound was staged and at what level
- Letter of medical necessity written by treating physician
- Documentation addressing incontinence issues, if applicable
- Precise wound measurements
- Quantity of exudates
- Presence of granulation and necrotic tissue
- Presence of infection or disease
- Pre-Albumin and Albumin lab values performed within 30 days prior to request
- Plan of care including lifestyle changes to promote healing and prevent reoccurrence
- Documentation of beneficiary compliance with all aspects of care

8410. Updated 06/10

Documentation to be submitted with each renewal request must include (all information must be within last 30 days):

- Current wound management
- Current dressing type
- Frequency of changes
- Changes in wound conditions
- Weekly precise wound measurements
- Quantity of exudates
- Presence of granulation and necrotic tissue
- Positioning and pressure relief
- Pre-Albumin and Albumin lab values performed within 30 days prior to renewal request
- Plan of care for step down and changes to promote healing and prevent reoccurrence

Definition of Pressure Ulcer

A pressure ulcer is a localized injury to the skin and/or underlying tissue usually over a bony prominence, as a result of pressure, or pressure in combination with shear and/or friction.

Pressure Ulcer Stages

- Suspected Deep Tissue Injury: Purple or maroon localized area of discolored intact skin or blood-filled blister due to damage of underlying soft tissue from pressure and/or shear. The area may be preceded by tissue that is painful, firm, mushy, boggy, or warmer or cooler as compared to adjacent tissue.
- Stage I – Intact skin with nonblanchable redness of a localized area usually over a bony prominence. Darkly pigmented skin may not have visible blanching; its color may differ from the surrounding area.
- Stage II – Partial thickness loss of dermis presenting as a shallow open ulcer with a red pink wound bed, without slough. May also present as an intact or open/ruptured serum-filled blister.
- Stage III – Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon, or muscle are not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunneling.
- Stage IV – Full thickness tissue loss with exposed bone, tendon, or muscle. Slough or eschar may be present on some parts of the wound bed. Often include undermining and tunneling.
- Unstageable – Full thickness tissue loss in which the base of the ulcer is covered by slough (yellow, tan, gray, green, or brown) and/or eschar (tan, brown, or black) in the wound bed.

Walkers

Standard Walkers

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

- The beneficiary has a mobility limitation that significantly impairs their ability to participate in one or more mobility-related activities of daily living (MRADL) in the home.
- A mobility limitation is one that:
 - The beneficiary is prevented from accomplishing the MRADL entirely.
 - The beneficiary is placed at a reasonably determined heightened risk of morbidity or mortality secondary to the attempts to perform an MRADL.
 - The beneficiary is prevented from completing the MRADL within a reasonable time frame.
 - The beneficiary is able to safely use the walker.
 - The functional mobility deficit can be sufficiently resolved with use of a walker.

8410. Updated 06/10

All walkers are limited to a combined total of one replacement every five years. All standard walkers must have a five-year warranty. Rental of walkers is noncovered.

Walker wheels and walker tips are limited to a combined total of no more than four (individually or a combination of the two) per 365 days. Code E0155 is to be billed as a pair (one unit equals one pair).

Wheels and tips must be 75% worn and no longer functional to be replaced. Wheels may not be billed separately on purchase of new walkers. Rental of wheels and tips is noncovered.

Heavy Duty Walkers

A heavy duty walker is covered for beneficiaries who meet coverage criteria for a standard walker and weigh more than 300 pounds.

All walkers are limited to a combined total of one replacement every five years. All walkers must have a five-year warranty. Rental of walkers is noncovered.

Walker wheels and walkers tips are limited to a combined total of no more than four (individually or a combination of the two) per 365 days. Code E0155 is to be billed as a pair (one unit equals one pair).

Wheels and tips must be 75% worn and no longer functional to be replaced. Wheels may not be billed separately on the purchase of new walkers. Rental of wheels and tips is noncovered.

Noncovered items include:

- Heavy duty walker, multiple braking system, variable wheel resistance walker
- Walker with an enclosed frame
- Walker with trunk support
- Seat attachment
- Crutch attachment
- Leg attachments
- Leg extensions
- Braking systems

Wheelchair Purchase

Wheelchair purchase is limited to one per five years when repair to an existing wheelchair will exceed 75% of the allowance for a similar new model. KBH participants are exempt from this limitation.

Wheelchair Prior Authorization

Approved code must be used for all requests.

When requesting PA for wheelchair purchase or rental, please supply the following information:

Manual Wheelchair

- Diagnosis code
- Date, height, weight
- Is condition stable?
- Manufacturer and model
- Manufacturer retail pricing including wheelchair options (or invoice if renting a used in-stock wheelchair)
- Warranty information

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8410. Updated 04/12

- Signed and dated prescription including medical necessity for any wheelchair options being requested
- Wheelchair is being requested for purchase or rental
- Length of time the wheelchair will be needed
- Information regarding the beneficiary's mobility without the wheelchair
- Distance the beneficiary can ambulate
- ~~Nursing facility the beneficiary resides in, if applicable~~
- Hours per day manual wheelchair is used
- Age of the current wheelchair, if applicable
- Estimated repair costs or an explanation of why wheelchair cannot be repaired
- How the beneficiary has been managing without a wheelchair up until now
- Plans or options for beneficiary if wheelchair is not provided
- If rental – new or used in-stock wheelchair
- If rental – purchase price information is needed if provider is willing to consider rental towards purchase

The reimbursement approved includes the assembly of the wheelchair and all components of the wheelchair. Wheelchair rental includes all repairs or modifications needed.

Power Wheelchair Rental

- Diagnosis code
- Date, height, weight
- Is condition stable?
- Manufacturer and model
- Manufacturer retail pricing including wheelchair options (or invoice if renting a used, in-stock wheelchair)
- Signed and dated prescription including medical necessity for any wheelchair options being requested
- Signed and dated verification of school or work including the number of hours attending or working
- Does the beneficiary need the wheelchair to be mobile?
- What distance can the beneficiary ambulate?
- Will the power wheelchair eliminate the need for a para-professional or an attendant?
- How many hours per day will the power wheelchair be used?
- Does the beneficiary have a manual wheelchair? If so, how old is it?
- How many hours per day is the manual wheelchair used?
- Can beneficiary operate the manual without the help of attendant?
- How long will the power wheelchair be needed?
- Does beneficiary reside in an adult care home?
- What type of work does beneficiary do? (employment, volunteer, sheltered workshop-therapy)
- Can beneficiary operate the power wheelchair controls independently?
- How does the use of a manual versus a power wheelchair prevent school attendance or the ability of beneficiary to work?
- How has the beneficiary been managing without a power wheelchair up until now?
- What are the plans/options for beneficiary if wheelchair is not provided?

The reimbursement approved includes the assembly of the wheelchair and all components of the wheelchair. Wheelchair rental includes all repairs or modifications needed.

Note: Power options for wheelchairs are not covered.

8410. Updated 04/12

Wheelchair Cushions

Seating cushions for wheelchairs are covered with PA. A prescription from a physician or physical therapist is required to be maintained in the provider's files. ~~For beneficiaries residing in a nursing home or head injury facility, cushions are considered part of the per diem rate and are the responsibility of the facility.~~

Batteries

Power wheelchair batteries require PA and are considered content of service if the wheelchair is rented. Power wheelchair batteries are limited to two per year.

Tires

Wheelchair tire replacement requires PA and is considered content of service if the wheelchair is rented. Tire replacement is limited to one set every six months.

8420. MEDICAL SUPPLY BENEFITS AND LIMITATIONS **Updated 04/12**

All DME services are covered for in-home use only. DME services (purchase or rental) are noncovered in nursing facilities, swing bed facilities, state institutions, intermediate care facilities/mental retardation (ICF/MR), psychiatric residential treatment facilities (PRTF), head injury facilities (HI), rehabilitation facilities, and hospitals.

Note: If the facility receives a per diem rate for a beneficiary, the DME services are considered content of the per diem and are the responsibility of the facility.

Refer to **Section 8400** of the *Nursing/Intermediate Care Facility Provider Manual* for further information.

Coverage of medical supply items is designated by criteria given in the coverage column to the left of the code in Appendix II of this manual. Some items require KBH participation, PA, medical necessity documentation, and/or an itemized retail invoice. This list represents all medical supplies covered by KMAP.

If it is medically necessary to dispense more than the amount allowed for a particular item, document the reason for additional units on a Certificate of Medical Necessity form and attach to your claim. (Refer to Section 4100 of the *General Special Requirements Provider Manual*.)

Batteries

Hearing aid batteries are limited to six batteries per month for monaural aids and 12 per month for binaural aids. Batteries for use with cochlear devices are limited to lithium ion (three per 30 days) or zinc air (six per 30 days). Batteries for cochlear devices are covered for KBH-eligible beneficiaries only. Only one type of battery is allowed every 30 days.

Enteral Nutrition

For enteral pump information, see Section 8410 of this manual.

Modifiers

Modifier BO is required when applicable for oral supplemental nutrition.

General Requirements

All enteral nutrition, pumps, and miscellaneous supplies must be prescribed. Providers must maintain a copy of the prescription in the beneficiary's file. Nutrients and supply items are to be billed for quantities expected to supply the beneficiary for no more than one month.

Enteral Nutritional Products

PA must be obtained for all enteral nutritional products provided to non-KBH beneficiaries.

Any new or existing enteral nutritional product that has been reviewed by CMS and assigned a HCPC code may be covered when the beneficiary meets criteria. The provider must identify the CMS assigned procedure code when requesting a PA. Enteral nutritional products that have not been reviewed by CMS and assigned a procedure code are considered noncovered. KBH-eligible beneficiaries must determine WIC eligibility before obtaining enteral nutrition from KMAP. If the beneficiary is eligible for WIC, enteral nutrition must be obtained from WIC services before obtaining from KMAP. Enteral nutrition products provided to KBH-eligible beneficiaries do not require PA.

Food Thickener

Food thickener requires PA for all beneficiaries.

8420. Updated 04/10

Oral Supplementation

Oral supplemental nutrition is covered for KBH-eligible beneficiaries who require supplemental nutrition over and above normal daily nutrition due to medical conditions. Normal daily nutrition is not considered supplemental and is noncovered.

Oral supplemental nutrition is noncovered for non-KBH beneficiaries. Extreme medical cases in which a beneficiary is in immediate life-threatening jeopardy may be reviewed for coverage.

Enteral Supplies

Enteral supplies that have an assigned HCPC code must be requested under the appropriate code. Enteral supplies that do not have an assigned HCPC code may be covered under B9998 with PA. B9998 requires PA for all ages.

Note: PA must be obtained for all enteral supplies provided to non-KBH beneficiaries with the exception of B4087 and B4088.

- Button G-Tubes are covered under B4087 and B4088 up to a combined total of six per year without PA.
- Extension sets are covered with PA under B9998 up to a maximum of four per month.
- Enteral feeding supply kits are limited to one per day. Providers may dispense one month supply at a time. An individual 60cc syringe is not considered a feeding supply kit and may not be billed as such. If supplying an individual 60cc syringe, PA must be requested under B9998.
- Nasogastric tubing, with or without stylet or a combination of the two, are limited to a combined total of three tubes per 90 days, regardless of provider.
- Stomach and gastrostomy tubing are limited to a combined total of six per year, regardless of provider.
- Haberman Feeders for cleft lip/palate are covered for KBH beneficiaries. They are limited to two per six months and require PA at all times.
- Individual 60cc syringes may be covered under B9998 with PA up to a maximum of four per month.

Total Parenteral Nutrition

For parenteral pump information, see Section 8410 and Appendix I.

Modifiers

Modifier BA is required when applicable for items being supplied in conjunction with total parenteral nutrition (TPN).

General Requirements

All parenteral nutrition, pumps, and miscellaneous supplies must be prescribed. Providers must maintain a copy of the prescription in the beneficiary's file. DME services provided for parenteral administration of total nutritional replacements and intravenous medications in the beneficiary's home require the participation of services from a local home health agency, physician, advanced registered nurse practitioner or pharmacist.

Parenteral Nutrition

TPN in conjunction with enteral or oral feedings is covered for KBH-eligible beneficiaries when enteral/oral nutrition constitutes a small portion of the beneficiary's dietary intake and/or beneficiary is being weaned from TPN feedings. Nutrients and supply items are to be billed for quantities expected to supply the beneficiary for no more than one month.

8420. Updated 04/10

Parenteral Supplies

Parenteral supplies that have an assigned HCPC code must be requested under the appropriate code.

Parenteral supplies that do not have an assigned HCPC code may be covered (with PA) under B9999 if beneficiary meets criteria.

Parenteral kits and their components are generally considered all-inclusive items necessary to administer therapy. Payment will not be made to suppliers or beneficiaries for additional components billed separately. Usual items in the different kits include but are not limited to these items:

A4221

Gloves	Gauze Sponges
Alcohol Wipes	Micropore Tape
Iso. Alcohol	Plastic Tape
Acetone	Injection Caps
Providone Iodine Scrub	Syringes
Providone Iodine Ointment	Needles
Providone Swabs	Ketodistix
Providone Sticks	Destructclip

A4222

Admin Sets/Leur Lock & Micron Filter	Clamps
Extension Sets	Two- or three-way connectors
Pump Cassettes	

A4223

Admin Sets/Leur Lock & Micron Filter	Clamps
Extension Sets	Two- or three-way connectors
Pump Cassettes	

B4222

Containers	Gauze Sponges
Gloves	Injection Caps
Alcohol Wipes	Micropore Tape
Iso. Alcohol	Plastic Tape
Acetone	Needles
Providone Iodine Scrub	Syringes
Providone Iodine Ointment	Ketodistix
Providone Sticks	Destructclip

Ostomy Adhesives

Ostomy adhesives are limited to one type every 30 days. Liquid adhesive is limited to four units every 30 days and disk or foam pad is limited to 20 units every 30 days.

Ostomy Belts

Purchase of ostomy belts (all kinds) is limited to one unit every 30 days.

Ostomy Deodorants

Ostomy deodorants are limited to one type every 30 days. Liquid deodorant is limited to eight units every 30 days, and solid deodorant is limited to 100 units every 30 days.

8420. Updated 04/10

Ostomy Skin Barriers

Only one selection of the following skin barriers is allowed within a 30-day time frame with the following limits, regardless of provider:

- Ostomy skin barrier, liquid, is limited to two units every 30 days.
- Ostomy skin barrier, powder, is limited to 10 units every 30 days.
- Ostomy skin barrier, nonpectin-based paste, is limited to four units every 30 days.
- Ostomy skin barrier, pectin-based paste, is limited to four units every 30 days.
- Skin barrier, wipes or swabs, is limited to 150 units every 30 days (one unit equals one wipe/swab).

The following items (or combinations of these items) are limited to a combined total of 20 units every 30 days, regardless of provider:

- Ostomy skin barrier, solid 4x4 or equivalent
- Ostomy skin barrier, with flange
- Skin barrier, solid, 6x6 or equivalent
- Skin barrier, solid, 8x8 or equivalent

Ostomy Pouches

Drainable and urinary ostomy pouches are limited to a combined total of 20 units every 30 days. Closed ostomy pouches are limited to a combined total of 60 units every 30 days.

Miscellaneous Ostomy Supplies

Stoma caps and continent device stoma plugs are limited to a combined total of 31 units every 30 days.

The following individual items are limited to the amount stated every 30 days:

- Percutaneous catheter/tube anchoring device, adhesive skin attachment – 10 units
- Appliance cleaner, incontinence and ostomy appliances – One unit
- Ostomy accessory, convex insert – 10 units
- Continent device, catheter for continent stoma – One unit
- Ostomy absorbent material (sheet/pad/crystal packet) – 60 units
- Ostomy ring – 10 units
- Ostomy lubricant – Four units
- Ostomy irrigation supply, bag – Two units
- Ostomy irrigation set – Two units
- Ostomy irrigation supply, cone/catheter – Two units
- Ostomy irrigation supply, sleeve – Two units
- Ostomy faceplate equivalent, silicone ring – Three units
- Ostomy filters (any type) – 50 units
- Adhesive remover wipes – 150 units
- Ostomy faceplate – Three units
- Ostomy clamps – 10 units

KANSAS MEDICAL ASSISTANCE PROGRAM
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BENEFITS & LIMITATIONS

8420. Updated 04/10

Ostomy vents are limited to two units every 180 days.
Code A4421 is noncovered.

Stockings, Compression and Surgical

The following limitations apply to coverage of compression and surgical stockings:

- Stockings are limited to no more than a combined total of eight units per 365 days for the following codes:

A4490	A4495	A4500	A4510	A6530
A6531	A6532	A6533	A6534	A6535
A6536	A6537	A6538	A6539	A6540
A6541	A6545			
- Stockings are limited to no more than four units per 365 days for code A6544.
- Code A6549 is noncovered.
- Place of service is equal to 12 (Home).
- Each time new stockings (any kind) are ordered, the provider is required to remeasure the beneficiary for proper size.
- Custom made and lymphedema stockings require PA.

Urinary Equipment

Insertion Trays

Codes A4310, A4311, A4312, A4313, A4314, A4315, A4316, and A4354 are limited to a combined total of two units per month.

One insertion tray is covered per episode of indwelling catheter insertion up to the KMAP limit. Catheter insertion trays are not medically necessary for clean, nonsterile, intermittent catheterization and are noncovered.

Irrigation Trays/Bulb

Codes A4320 and A4322 are limited to a combined total of up to 15 per month.

Routine, intermittent irrigations are defined as those performed at predetermined intervals. Routine, intermittent irrigations of a catheter are noncovered. Irrigation solutions containing antibiotics and chemotherapeutic agents are noncovered. Irrigating solutions such as acetic acid or hydrogen peroxide are noncovered.

When sterile saline, water, syringes, and trays are used for routine irrigation, those items are noncovered. Therapeutic agents for irrigation are noncovered.

Continuous irrigation is a temporary measure. Continuous irrigation for more than two weeks is rarely medically necessary. The beneficiary's medical records should indicate this medical necessity and be maintained in the beneficiary's DME file. The beneficiary's medical records may be requested by KMAP.

External Catheters and Collection Devices

Codes A4326 and A4349 are limited to 30 per month.
Code A4327 is limited to one per 365 days.

8420. Updated 04/10

Codes A4328 and A4330 are limited to four per month.

Male external catheters or female external urinary collection devices are covered for beneficiaries who have permanent, urinary incontinence when used as an alternative to an indwelling catheter. Male external catheters or female external urinary collection devices are noncovered when ordered for beneficiaries who also use an indwelling catheter.

Extension/Drainage Tubes

Code A4331 is limited to two per month.

Code A4355 is limited to 15 units per month.

Miscellaneous

Code A4332 is limited to 30 per month.

Code A4333 is limited to 12 per month.

Codes A4334, A5113, and A5114 are limited to a combined total of one per month.

Codes A4335, A4336, A4356, A4360, and A5105 are noncovered.

Code A4554 is limited to three units per 30 days (one unit equals 50 pads).

Catheters

Codes A4338, A4340, A4344, and A4346 are limited to a combined total of two per month.

Codes A4351, A4352, and A4353 are limited to a combined total of 10 per month.

When codes A4340, A4344, A4312, or A4315 are used, there must be documentation in the beneficiary's medical record (and DME record) of the medical necessity for that catheter rather than a straight Foley-type catheter with coating (such as recurrent encrustation, inability to pass a straight catheter, or sensitivity to latex). In addition, the particular catheter must be necessary for the beneficiary. For example, use of code A4340 for female beneficiaries is rarely medically necessary. Documentation of medical necessity may be requested by KMAP and must be kept in the beneficiary's DME file.

Codes A4346, A4313 or A4316 are covered only in continuous catheter irrigation if medically necessary.

When a clean, nonsterile catheterization technique is used, replacement of intermittent catheters should be twice a week.

Drainage Bags and Bottles

Codes A4357 and A5102 are limited to a combined total of two per month.

Codes A4358 and A5112 are limited to a combined total of two per month.

Leg bags are indicated for beneficiaries who are ambulatory or are chair or wheelchair bound. The use of leg bags for bedridden beneficiaries is noncovered. Payment is made for either a vinyl leg bag or a latex bag. The use of both is not medically necessary and is noncovered.

APPENDIX I

DME CODES Updated 12/11

The following codes represent an all-inclusive list of DME services billable to KMAP. Procedures not listed here are considered noncovered.

Use the following resources to determine current coverage and pricing information. For accuracy, use your provider type and specialty as well as the beneficiary ID number or benefit plan.

- Information from the public website is available at:
<https://www.kmap-state-ks.us/Provider/PRICING/RefCode.asp>.
- Information from the secure website is available under Pricing and Limitations at:
<https://www.kmap-state-ks.us/provider/security/logon.asp>.

COVERAGE INDICATORS

- C = Covered – no special requirements
 NC = Noncovered KMAP service
 (Also used if coverage would be inappropriate, i.e., rental of oxygen contents.)
 MN = MN documentation required
 PA = PA required
Note: DME claims will not bypass PA when there is a partial payment by a third-party payer or Medicare.
 KBH = Services covered for KBH participants only
 INV = An itemized retail invoice must be kept available in provider's files.
 KS = KS modifier, noninsulin dependent
 KX = KX modifier, insulin dependent

Be sure to add modifier "RR" to the five-digit base code if billing for rental.

Refer to Section 8410 for additional benefits and limitations.

BEDS

Rental	Purchase	Code		Rental	Purchase	Code
NC	C	A4640		PA	PA	E0255
NC	C	E0181		PA	PA	E0260
NC	C	E0182		NC	PA	E0271
NC	C	E0184		NC	PA	E0272
NC	C	E0185		PA	PA	E0277
NC	C	E0186		PA	PA	E0303
NC	C	E0187		PA	PA	E0304
NC	C	E0188		NC	C	E0305
NC	C	E0189		NC	C	E0310
NC	C	E0191		PA	PA	E0371
PA	PA	E0193		PA	PA	E0372
PA	NC	E0194		PA	PA	E0373
NC	C	E0196		PA	C	E0910
NC	C	E0197		PA	C	E0911
NC	C	E0198		PA	PA	E0912
NC	C	E0199		PA	C	E0940
PA	PA	E0250				

DME CODES Updated 11/09

BREAST PUMPS

Rental	Purchase	Code		Rental	Purchase	Code
NC	C	E0602		NC	C	A4283
NC	C	E0603		NC	C	A4285
NC	C	A4281		NC	C	A4286
NC	C	A4282				

CANES

Rental	Purchase	Code		Rental	Purchase	Code
NC	C	E0100		NC	C	E0105

CRUTCHES

Rental	Purchase	Code		Rental	Purchase	Code
NC	C	A4635		NC	C	E0113
NC	C	A4636		NC	C	E0114
NC	C	A4637		NC	C	E0116
NC	C	E0110		NC	MN	E0153
NC	C	E0111		NC	C	E0154
NC	C	E0112		NC	C	E0155

DECUBITUS CARE EQUIPMENT

Rental	Purchase	Code		Rental	Purchase	Code
NC	C	E0185		NC	C	E0197
NC	C	E0188		NC	C	E0199
NC	C	E0189				

ENTERAL PUMP

Rental	Purchase	Code		Rental	Purchase	Code
PA	PA	B9000		PA	PA	B9002

HELMETS

Rental	Purchase	Code		Rental	Purchase	Code
NC	C	A8001		NC	C	A8004
NC	PA	A8003				

IV POLES

Rental	Purchase	Code		Rental	Purchase	Code
PA	PA	E0776		KBH, PA	KBH, C	E0776

DME CODES Updated 04/10

NEBULIZERS

Rental	Purchase	Code		Rental	Purchase	Code
C	C	E0570		NC	C	A7013
NC	C	A7004		NC	C	A7014
NC	C	A7007		NC	C	A7017
NC	C	A7008		NC	C	E0580

OXYGEN CONTENTS

Rental	Purchase	Code		Rental	Purchase	Code
NC	C	E0441		NC	C	E0443
NC	C	E0442		NC	C	E0444

OXYGEN DELIVERY EQUIPMENT

Rental	Purchase	Code		Rental	Purchase	Code
C	NC	E0424		C	NC	K0738
C	NC	E0431		NC	C	E1353
C	NC	E0433		NC	C	E1354
C	NC	E0434		NC	C	E1356
C	NC	E0439		NC	C	E1357
C	NC	E1390		C	NC	E1392
C	NC	E1391				

PARENTERAL PUMPS

Rental	Purchase	Code		Rental	Purchase	Code
C	NC	B9004		C	NC	E0781
C	NC	B9006		C	NC	E0791
C	NC	E0780				

PASSIVE MOTION EXERCISE DEVICE

Rental	Purchase	Code		Rental	Purchase	Code
C	NC	E0935				

PATIENT LIFTS

Rental	Purchase	Code		Rental	Purchase	Code
NC	PA	E0621		PA	PA	E0630-RR
PA	PA	E0630				

INTERMITTENT POSITIVE PRESSURE BREATHING (IPPB) MACHINE

Rental	Purchase	Code		Rental	Purchase	Code
PA	NC	E0500				

DME CODES Updated 12/11

PHOTOTHERAPY

Rental	Purchase	Code		Rental	Purchase	Code
C	NC	E0202				

RACKS OR STANDS

Rental	Purchase	Code		Rental	Purchase	Code
NC	C	E1355				

RESPIRATORY/CARDIAC EQUIPMENT

Rental	Purchase	Code		Rental	Purchase	Code
NC	PA	A4611		KBH, NC	KBH, PA	A4604
NC	PA	A4612		KBH, NC	KBH, PA	A4606
NC	PA	A4613		NC	C	A4614
PA, KBH	PA, KBH	E0445		KBH, NC	KBH, PA	A7027
C	NC	E0450		KBH, NC	KBH, PA	A7028
C	NC	E0461		KBH, NC	KBH, PA	A7029
C	NC	E0463		KBH, NC	KBH, PA	A7030
C	NC	E0464		KBH, NC	KBH, PA	A7031
KBH, PA	NC	E0470		KBH, NC	KBH, PA	A7032
KBH, PA	NC	E0471		KBH, NC	KBH, PA	A7033
KBH, PA	NC	E0472		KBH, NC	KBH, PA	A7034
KBH, NC	KBH, PA	E0480		KBH, NC	KBH, PA	A7035
PA	PA	E0482		KBH, NC	KBH, PA	A7036
PA	PA	E0483		KBH, NC	KBH, PA	A7037
NC	PA	A7025		KBH, NC	KBH, PA	A7038
NC	PA	A7026		KBH, NC	KBH, PA	A7039
KBH, PA	KBH, PA	E0484		KBH, NC	KBH, PA	A7044
NC	C	E0550		KBH, NC	KBH, PA	A7045
NC	C	E0555		KBH, NC	KBH, PA	A7046
NC	C	E0560		NC	C	A4608
KBH, PA	KBH, C	E0561		NC	C	A4615
KBH, PA	KBH, C	E0562		NC	C	A4616
C	PA	E0565		NC	C	A4617
C	C	E0572		NC	C	A4619
KBH, PA	KBH, NC	E0601		NC	C	A4620
KBH, C	KBH, PA	E0618		NC	C	E0455
KBH, C	KBH, PA	E0619				

DME CODES Updated 04/10

SPECIALIZED SEATING EQUIPMENT

Rental	Purchase	Code		Rental	Purchase	Code
KBH, NC	KBH, PA	E2291		KBH, NC	KBH, PA	E0956
KBH, NC	KBH, PA	E2292		KBH, NC	KBH, PA	E0957
KBH, NC	KBH, PA	E2293		KBH, NC	KBH, PA	E0966
KBH, NC	KBH, PA	E2294		C	PA	K0108
KBH, NC	KBH, PA	E2295				

SUCTION AND TRACHEOSTOMY EQUIPMENT/SUPPLIES

Rental	Purchase	Code		Rental	Purchase	Code
C	PA	E0600		NC	C	A7002
C	NC	E2000		NC	C	A7520
NC	C	A4623		NC	C	A7521
NC	C	A4624		NC	C	A7522
NC	C	A4628		NC	C	A7525
NC	C	A4629		NC	C	A7526
NC	C	A7000		NC	PA	A4605
NC	C	A7001				

TENS UNITS

Rental	Purchase	Code		Rental	Purchase	Code
NC	C	E0720		NC	C	A4556
NC	C	E0730		NC	C	A4557
NC	C	E0770		NC	C	A4558

VACUUM ASSISTED WOUND CLOSURE THERAPY

Rental	Purchase	Code		Rental	Purchase	Code
PA	NC	E2402		NC	C	A7000
NC	PA	A6550				

WALKERS

Rental	Purchase	Code		Rental	Purchase	Code
NC	C	E0130		NC	C	E0148
NC	C	E0135		NC	C	E0149
NC	C	E0141		NC	C	E0155
NC	C	E0143				

COMMUNE CHAIRS

Rental	Purchase	Code		Rental	Purchase	Code
PA	C	E0163		PA	C	E0167
PA	C	E0165		PA	C	E0168

DME CODES Updated 11/09

WHEELCHAIRS, MANUAL

Rental	Purchase	Code		Rental	Purchase	Code
PA	PA	K0001		PA	PA	E1161
PA	PA	K0002		KBH, PA	KBH, PA	E1231
PA	PA	K0003		KBH, PA	KBH, PA	E1232
PA	PA	K0004		KBH, PA	KBH, PA	E1233
PA	PA	K0005		KBH, PA	KBH, PA	E1234
PA	PA	K0006		KBH, PA	KBH, PA	E1235
PA	PA	K0007		KBH, PA	KBH, PA	E1236
PA	PA	K0009		KBH, PA	KBH, PA	E1237
KBH, NC	KBH, PA	E1037		KBH, PA	KBH, PA	E1238
KBH, PA	KBH, PA	E1038				

WHEELCHAIRS, POWER

Rental	Purchase	Code		Rental	Purchase	Code
PA	NC	K0010		PA	PA	K0851
PA	NC	K0011		PA	PA	K0852
PA	NC	K0012		PA	PA	K0853
PA	NC	K0014		PA	PA	K0854
PA	PA	K0815		PA	PA	K0855
PA	PA	K0816		PA	PA	K0856
PA	PA	K0822		PA	PA	K0857
PA	PA	K0823		PA	PA	K0858
PA	PA	K0824		PA	PA	K0859
PA	PA	K0825		PA	PA	K0861
PA	PA	K0826		PA	PA	K0862
PA	PA	K0827		PA	PA	K0868
PA	PA	K0828		PA	PA	K0869
PA	PA	K0829		PA	PA	K0870
PA	PA	K0835		PA	PA	K0871
PA	PA	K0836		PA	PA	K0877
PA	PA	K0837		PA	PA	K0878
PA	PA	K0838		PA	PA	K0879
PA	PA	K0841		PA	PA	K0884
PA	PA	K0842		PA	PA	K0885
PA	PA	K0843		PA	NC	E1230
PA	PA	K0848		NC	PA	E2368
PA	PA	K0849		NC	PA	E2369
PA	PA	K0850		NC	PA	E2370

DME CODES Updated 12/11

WHEELCHAIR ACCESSORIES

Rental	Purchase	Code		Rental	Purchase	Code
NC	PA	E0981		NC	PA	E2395
NC	PA	E0982		NC	PA	E2396
KBH, NC	KBH, PA	E1011		NC	PA	E2601
KBH, PA	KBH, PA	E1014		NC	PA	E2602
KBH, PA	KBH, PA	E1020		NC	PA	E2603
KBH, PA	KBH, PA	E1802		NC	PA	E2604
NC	PA, INV	E2211		NC	PA	E2605
NC	PA, INV	E2212		NC	PA	E2606
NC	PA, INV	E2213		NC	PA	E2607
NC	PA, INV	E2214		NC	PA	E2608
NC	PA, INV	E2215		NC	PA	E2609
NC	PA, INV	E2216		KBH, NC	KBH, PA	E2611
NC	PA, INV	E2217		KBH, NC	KBH, PA	E2612
NC	PA, INV	E2218		KBH, NC	KBH, PA	E2613
NC	PA, INV	E2219		KBH, NC	KBH, PA	E2614
NC	PA, INV	E2220		KBH, NC	KBH, PA	E2615
NC	PA, INV	E2221		KBH, NC	KBH, PA	E2616
NC	PA, INV	E2222		KBH, NC	KBH, PA	E2617
NC	PA, INV	E2224		NC	PA	E2619
NC	PA, INV	E2225		KBH, NC	KBH, PA	E2620
NC	PA, INV	E2226		KBH, NC	KBH, PA	E2621
NC	PA, INV	E2227		NC	PA	E2622
NC	PA	E2231		NC	PA	E2623
NC	PA	E2381		NC	PA	E2624
NC	PA	E2382		NC	PA	E2625
NC	PA	E2383				E2626
NC	PA	E2384				E2627
NC	PA	E2385				E2628
NC	PA	E2386				E2629
NC	PA	E2387				E2630
NC	PA	E2388				E2631
NC	PA	E2389				E2632
NC	PA	E2390				E2633
NC	PA	E2391		NC	PA	K0056
NC	PA	E2392		NC	PA, INV	K0065
NC	PA	E2394				

SAFETY BELTS AND HARNESSSES

Rental	Purchase	Code		Rental	Purchase	Code
NC	C	E0978		NC	PA	E0960
NC	C	E0980				

DME CODES Updated 12/09

SPEECH DEVICES

Rental	Purchase	Code		Rental	Purchase	Code
NC	PA	E1902		NC	MN, PA	E2508
NC	MN, PA	E2500		NC	MN, PA	E2510
NC	MN, PA	E2502		NC	MN, PA	E2511
NC	MN, PA	E2504		NC	MN, PA	E2512
NC	MN, PA	E2506		NC	MN, PA	E2599

MISCELLANEOUS DME

Rental	Purchase	Code		Rental	Purchase	Code
NC	C	E0607		NC	C	A4255-KS
NC	PA	E2100		NC	C	A4255-KX
PA, INV	PA, INV	E1399		NC	C	A4256-KS
NC	C	S8999		NC	C	A4256-KX
NC	PA	A4230		NC	C	A4258
NC	PA	A4231		NC	C	A4259-KS
NC	PA	A4232		NC	C	A4259-KX
PA	PA	A4600		NC	C	E0607
NC	C	E0190		NC	PA	S5560
PA	PA	E0676		NC	PA	S5561
PA	PA	E0784		PA, INV	PA, INV	E0911
NC	C	A4253-KS		PA, INV	PA, INV	E0912
NC	C	A4253-KX				

REPAIR/DELIVERY/INSTALLATION/MAINTENANCE

Rental	Purchase	Code		Rental	Purchase	Code
NC	C	K0739		NC	C	K0740

APPENDIX II

MEDICAL SUPPLY CODES Updated 12/11

The following codes represent an all-inclusive list of medical supply services billable to KMAP. Procedures not listed here are considered noncovered.

COVERAGE INDICATORS

- C = Covered – no special requirements
- MN = MN documentation required
- PA = PA required
- INV = An itemized retail invoice must be kept available in provider's files.
- KBH = Service covered for KBH participants only
- NC = Noncovered KMAP service

Refer to Section 4300 of the *General Third Party Payment Provider Manual* for additional PA information and Section 8420 of this manual for specific benefits and limitations.

ANTISEPTIC PRODUCTS

<u>Coverage</u>	<u>Code</u>		<u>Coverage</u>	<u>Code</u>
C	A4244		INV	A4246
C	A4245		INV	A4247

BATTERIES

<u>Coverage</u>	<u>Code</u>		<u>Coverage</u>	<u>Code</u>
PA	E2360		PA	E2397
PA	E2361		PA	K0733
PA	E2362		C	V5266
PA	E2363		KBH	L8621
PA	E2364		KBH	L8622
PA	E2365		KBH	L8623
PA	E2371		KBH	L8624
PA	E2372			

CERVICAL COLLARS

<u>Coverage</u>	<u>Code</u>		<u>Coverage</u>	<u>Code</u>
C	L0120			

MEDICAL SUPPLY CODES Updated 12/09

DRESSINGS/PADS

<u>Coverage</u>	<u>Code</u>		<u>Coverage</u>	<u>Code</u>
C	A4554		C	A6232
PA	A4927		C	A6233
C	A6010		C	A6234
C	A6011		C	A6235
C	A6024		C	A6236
C	A6154		C	A6237
C	A6196		C	A6238
C	A6197		C	A6239
C	A6198		C	A6240
C	A6199		C	A6241
C	A6021		C	A6242
C	A6022		C	A6243
C	A6023		C	A6244
C	A6203		C	A6245
C	A6204		C	A6246
C	A6205		C	A6247
PA	A6206		C	A6248
PA	A6207		C	A6251
PA	A6208		C	A6252
C	A6209		C	A6253
C	A6210		C	A6254
C	A6211		C	A6255
C	A6212		C	A6256
C	A6410		C	A6257
C	A6411		C	A6258
C	A6412		C	A6259
C	A6213		C	A6260
C	A6214		C	A6266
C	A6215		C	A6402
C	A6216		C	A6403
C	A6217		C	A6404
C	A6218		C	A6441
C	A6219		C	A6442
C	A6220		C	A6443
C	A6221		C	A6444
C	A6222		C	A6445
C	A6223		C	A6446
C	A6224		C	A6447
C	A6228		C	A6448
C	A6229		C	A6449
C	A6230		C	A6450
C	A6231		C	A6451

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DRESSINGS/PADS (continued)

<u>Coverage</u>	<u>Code</u>		<u>Coverage</u>	<u>Code</u>
C	A6452		C	A6456
C	A6453		C	A6407
C	A6454		C	A6457
C	A6455			

ENTERAL THERAPY

<u>Coverage</u>	<u>Code</u>		<u>Coverage</u>	<u>Code</u>
PA	B4034		PA, INV	B4152
PA	B4035		PA, INV	B4153
PA	B4036		PA, INV	B4154
C	B4081		PA, INV	B4155
C	B4082		PA, INV	B4157
C	B4083		PA, INV	B4158
C	B4087		PA, INV	B4159
C	B4088		PA, INV	B4160
PA	B4100		PA, INV	B4161
PA, INV	B4102		PA, INV	B4162
PA, INV	B4103		PA, INV	B9998
PA, INV	B4149		PA, KBH	S8265
PA, INV	B4150			

Note: See Section 8410 regarding PA requirements for KBH.

Note: Add modifier “BO” to the base code (XXXXX-BO) and place in field 24D when billing for oral supplemental nutrition.

IV DRUG THERAPY

<u>Coverage</u>	<u>Code</u>		<u>Coverage</u>	<u>Code</u>
C	A4221*		C	A4223*
C	B4222*		C	J7060
C	A4222*			

* Reference Section 8420 for a complete definition of these kits.

GLUCOSE MONITORING SUPPLIES

<u>Coverage</u>	<u>Code</u>		<u>Coverage</u>	<u>Code</u>
C	A4253		C, INV	A4256
C	A4255		C	A4259

MEDICAL SUPPLY CODES Updated 12/09

NEEDLES/SYRINGES

<u>Coverage</u>	<u>Code</u>		<u>Coverage</u>	<u>Code</u>
C	A4206		C	A4213
C	A4207		C	A4215
C	A4208		C	A4657
C	A4209		C	S8490
C	A4212			

OSTOMY SUPPLIES

<u>Coverage</u>	<u>Code</u>		<u>Coverage</u>	<u>Code</u>
C	A4366		C	A4414
C	A4361		C	A4415
C	A4384		C	A4416
C	A4362		C	A4417
C	A4369		C	A4418
C	A4371		C	A4419
C	A4372		C	A4420
C	A4385		C	A4423
C	A4373		C	A4424
C	A4363		C	A4425
C	A4364		C	A4426
C	A4368		C	A4427
C	A4367		C	A4428
C	A4396		C	A4429
C	A4394		C	A4430
C	A4395		C	A4431
C	A4397		C	A4432
C	A4398		C	A4433
C	A4399		C	A4434
C	A4400		C	A4422
INV	A4402		C	A4450
C	A4404		C	A4452
C	A4455		C	A4387
C	A4456		C	A5051
C	A4405		C	A5052
C	A4406		C	A5053
C	A4407		C	A5054
C	A4408		C	A5055
C	A4409		C	A5061
C	A4410		C	A5062
C	A4411		C	A5063
C	A4412		C	A4375
C	A4413		C	A4376

MEDICAL SUPPLY CODES Updated 12/09

OSTOMY SUPPLIES (continued)

<u>Coverage</u>	<u>Code</u>		<u>Coverage</u>	<u>Code</u>
C	A4377		C	A4380
C	A4378		C	A4381
C	A4388		C	A4382
C	A4389		C	A4383
C	A4390		C	A4391
C	A5071		C	A4392
C	A5072		C	A4393
C	A5073		C	A5120
C	A5081		C	A5121
C	A5082		C	A5122
C	A5083		C	A5126
C	A5093		C	A5131
C	A4379		C	A5200

OTHER MEDICAL SUPPLIES

<u>Coverage</u>	<u>Code</u>		<u>Coverage</u>	<u>Code</u>
C	A7018		C	J7302
C	S8100		C	J7306
C	S8101		PA	A4264
C	A4627		C	A4266
C	A4216		PA	A4267
C	A4217		PA	A4268
C	A4663		PA	A4269
C	A4660		C	L8501
PA	A4483		C	S8096
C	A4561		C	S8185
C	A4562		C	S8186
C	A4261			

SPLINTS

<u>Coverage</u>	<u>Code</u>		<u>Coverage</u>	<u>Code</u>
C	A4565		C	S8451
C	A4570			

MEDICAL SUPPLY CODES Updated 12/09

SUPPORTS

<u>Coverage</u>	<u>Code</u>		<u>Coverage</u>	<u>Code</u>
C	A4461		INV	A6534
C	A4463		INV	A6535
INV	A4490		INV	A6536
INV	A4495		INV	A6537
INV	A4500		INV	A6538
INV	A4510		INV	A6539
INV	A6530		INV	A6540
INV	A6531		INV	A6541
INV	A6532		INV	A6544
INV	A6533		INV	A6545

PARENTERAL THERAPY

<u>Coverage</u>	<u>Code</u>		<u>Coverage</u>	<u>Code</u>
C	B4164		C	B4199
C	B4168		C	B4216
C	B4172		C	B4220
C	B4176		C	B4222*
C	B4178		C	B4224
C	B4180		C	B5000
C	B4185		C	B5100
C	B4189		C	B5200
C	B4193		PA, INV	B9999
C	B4197			

Note: Add modifier BA to the base code (XXXXX-BA) and place in field 24D when billing for item supplies in conjunction with total parenteral nutrition.

* Reference Section 8420 for a complete definition of these kits.

MEDICAL SUPPLY CODES Updated 11/09

URINARY EQUIPMENT

<u>Coverage</u>	<u>Code</u>		<u>Coverage</u>	<u>Code</u>
C	A4250		C	A4340
C	A4310		C	A4344
C	A4311		C	A4346
C	A4312		C	A4333
C	A4313		C	A4334
C	A4314		C	A4351
C	A4315		C	A4352
C	A4316		C	A4353
C	A4320		C	A4354
C	A4322		C	A4355
C	A4326		C	A4357
C	A4327		C	A4358
C	A4328		C	A5102
C	A4330		C	A5112
C	A4349		C	A5113
C	A4332		C	A5114
C	A4338		C	A4331

INCONTINENCE SUPPLIES

<u>Coverage</u>	<u>Code</u>		<u>Coverage</u>	<u>Code</u>
KBH, PA	T4521		KBH, PA	T4529
KBH, PA	T4522		KBH, PA	T4530
KBH, PA	T4523		KBH, PA	T4531
KBH, PA	T4524		KBH, PA	T4532
KBH, PA	T4525		KBH, PA	T4533
KBH, PA	T4526		KBH, PA	T4534
KBH, PA	T4527		KBH, PA	T4535
KBH, PA	T4528			