Automated Medical Payments

Medicaid Bulletin

Colorado Title XIX

Fiscal Agent

CONSULTEC

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Medicaid bulletins contain important policy and billing information and should be shared promptly with billing staff.

Bulletins supplement information in the Medicaid Provider Manual and should be retained with the provider manual for reference. Retain all bulletins until published notification advises that the information is obsolete or reproduced in subsequent bulletins or provider manual updates.

Please direct questions about bulletins and billing information to Medicaid Provider Services.

Distribution: Supply and Pharmacy Providers **January 2001**

Reference: B0100089

Supply HCFA and Local Codes

The Colorado Medicaid Program uses the Health Care Financing Administration's (HCFA) Common Procedural Coding System (HCPCS) to identify Medicaid services.

This is the HCFA and local code bulletin for Supply and Durable Medical Equipment (DME) services. The codes in this bulletin are **effective for services provided on and after January 1, 2001**. This document is a replacement of Medicaid Bulletin B0000063 (05/00). Insert this bulletin into the Provider Manual for reference. Coding updates and revisions will also be published in Medicaid bulletins.

Table of Contents

Approved HCFA and Local Codes for Medicaid Billing – Supplies & Durable Medical Equipment

Use of the HCPCS listing & special billing instructions

The following list of HCPCS (HCFA Common Procedural Coding System) codes has been approved by the Colorado Department of Health Care Policy and Financing for use in submitting claims for medical supplies and durable medical equipment (DME) to the Colorado Medicaid Program. Use this list when completing Medicaid claims. Updates and revisions will be made available through future Medicaid Bulletins.

Read the following information carefully:

A. General Billing Information

AMP claims: Supply/DME services are submitted on the electronic Colorado 1500 format.

Pharmacies billing for supplies/equipment submit on the electronic Colorado 1500 format.

Paper claims: Supply/DME services are submitted on the Colorado 1500 claim form.

Pharmacies billing for supplies/equipment submit on the Colorado 1500 claim form.

Most DME and medical supplies provided to hospitalized individuals and persons residing in nursing facilities or group homes must be provided by the facility and cannot be submitted for direct payment to the medical supplier or pharmacy. Charges for oxygen contents and certain oxygen delivery systems for nursing facility and group home residents must be billed by the supply provider. Procedure codes for oxygen services provided to nursing facility residents are included in this list.

Deleted procedure codes for capped rental items remain in effect for Medicare Crossover claims only. These procedure codes should not be used except for crossover claims.

Rebates: If a rebate is available for any product, the provider is responsible for doing one of the following:

1. Instant: Cost must reflect Usual and Customary charge minus the rebate received or anticipated from the manufacturer.
2. Mail-in: Obtainable by mail shall indicate the purchaser to be the: Colorado Medicaid Program
   1575 Sherman Street
   Denver CO 80203-1714

State sales tax: Providers cannot bill for state sales tax collection, but may bill for recovery of sales tax paid to manufacturer and distributors.

B. Billing for "Fee Schedule" Services

Under Federal Law and State Regulations, providers are reminded that the Medicaid Program shall not be billed amounts in excess of that charged to non-Medicaid clients.

Providers are requested to submit their Usual and Customary charges to the Medicaid Program.

C. Billing for "By Invoice" Services

Providers submitting claims for which acquisition costs will be utilized as a basis for reimbursement are subject to the following requirements:

- Billed amounts may not exceed actual acquisition costs, including discounts available, and applied to decrease the provider's balance due their vendor.
- Copies of invoices documenting actual acquisition costs shall be maintained in the provider's files in accordance with Department regulations.

Failure to meet the requirements may place the provider in jeopardy of recovery actions and/or State or Federal civil sanctions. Misrepresentation of actual acquisition costs could result in State or Federal, civil, or criminal sanctions.

REQUIREMENTS FOR WHEELCHAIR PURCHASE & EQUIPMENT REPAIRS

Important - prior authorization requests and claims for wheelchair purchase and equipment repair require the following:

1. Prior authorization requests (PARs) for wheelchair purchase (manual, power or 3-wheeled) must identify the model and manufacturer in field 16 on the PAR form.
2. PARs for equipment repair must identify the serial number of the equipment in field 12 on the PAR form.
3. Wheelchair purchase or equipment repair claims must either identify the serial number in field 30 on the paper claim, or if billing through the AMP system, the serial number must be kept in the provider records. Effective September 1, 1997, a physician's prescription is no longer required for wheelchair repairs, and no physician signature is required on repair PARs.

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HCPCS CODING MANUAL INFORMATION

Code column:

HCFA and local codes consist of a letter followed by four numbers. Read the entire entry to determine the benefit status of the item. Codes authorized for the Medicaid program may not correspond to codes approved for Medicare billing. This list contains approved Medicaid, HCFA and local codes. Codes that do not appear in this listing are not benefits of the Medicaid program.

Modifiers:

Modifiers are used with HCPCS codes to describe circumstances that may change or alter payment. The following modifiers are approved for use with DME procedure codes and must be used when applicable:

Mod	Description
-XD	Manufacturer's Invoice Price Use with supply/DME codes & special procedure codes for invoiced tax, shipping & handling fees when the billed charge represents the manufacturer's invoice price to a retail provider. Use -XD to identify invoiced shipping, invoiced tax, and the 20% Medicaid allowed handling fee. For example: MM/DD/YY K0002-XD — Wheelchair (Cost from invoice) $450.00 MM/DD/YY X2125-XD — Linear Seating System (Cost from invoice) $800.00 MM/DD/YY X2360-XD — Handling (20% of cost for both items) $250.00 MM/DD/YY X2355-XD — Invoiced tax (Invoiced tax for both items) $ 82.00 MM/DD/YY X2350-XD — Invoiced shipping charges (Invoiced shipping for both items) $100.00
-XR	1st month DME rental Use with DME codes to identify non-prior authorized 1st month equipment rental provided while obtaining prior authorization for continued rental.
-01	DME rental on a per month basis. Unless otherwise noted in the Medicaid HCFA & Local Codes Bulletin, one item represents one month rental period. The claim date of service must represent the **last day** of the rental period. **Note**: ***Some items are available as a rental or purchase only. If the item is available for rental only, the HCPCS procedure code includes the -01 modifier as part of the listed code.***

Narrative column:

A description of the service. When possible and appropriate, the description of the item includes a notation of the billing unit. Example: A4246 Betadine, per pint. One item represents one pint of Betadine. If the item description does not identify the billing unit for miscellaneous items, add sufficient information on the claim form to identify the billing unit. For disposable supplies, one billing unit represents one item unless otherwise noted. Example: A box of 200 lancets would be billed as 200 items.

Par column: The prior authorization status of the identified item.

Yes A request for prior authorization should be submitted & approved **before the item/service is provided**. Claims for items that have not received prior authorization approval will be denied.

Note: ***Procedures identified by * (asterisk) are reviewed by CFMC (Colorado Foundation for Medical Care).*** Prior Authorizations for these items should be sent directly to CFMC at:

CFMC
Attention: Medicaid/DME PARs
P.O. Box 17300
Denver, CO 80217-0300

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No The identified item is a regular Medicaid benefit that does not require special authorization when provided to an eligible Medicaid client.

Prior Authorization Requests (PARs) must be approved before claims are submitted. PAR approval does not guarantee Medicaid payment and does not serve as a timely filing waiver. PAR approval only assures that the service has been identified as medically necessary. All of the requirements for eligibility and proper claim submission must be met before reimbursement will be made. The provider is responsible for verifying the client's eligibility status on the date of service and securing appropriate primary care physician authorizations and billing information.

Prior authorization does not apply to Medicare crossover claims. If Medicare approves benefits, Medicaid does not require prior authorization. If Medicare does not provide benefit for an item, all applicable Medicaid billing requirements (including prior authorization if indicated) must be met.

Maximum allowable purchase column:

Any dollar amount: Purchase benefit is available up to the identified dollar amount maximum.

BI: Benefit payment is available and based upon a manufacturer's invoice to be maintained in the provider's files. With proper claim completion, payment may include the cost of acquisition from a manufacturer or a wholesale vendor, and an allowance of up to 20% handling plus any invoiced shipping and sales tax. By invoice codes require the -XD modifier.

n/a: Benefit for purchase of the identified item is not allowed.

Maximum allowable rental column:

Any dollar amount: Rental benefit is available up to the identified dollar amount maximum. Accessories, maintenance, and repairs are inclusive in the cost of the rental item.

n/a: Benefit for rental of the identified item is not allowed.

Per PAR Rental payment is based upon attachment of a manufacturer's invoice to the prior authorization request (PAR). Reimbursement will be determined at the time of PAR approval as a percentage of invoice cost. A copy of the PAR must be attached to each submitted claim only if the PAR indicates the amount of reimbursement allowable in the Comments field. Otherwise, they can be billed through the AMP system. All prior authorized miscellaneous codes approved for rental must have a copy of the approved PAR attached to each submitted claim.

Comments column:

Expands on the description and identifies any required special billing instruction and procedures requiring prior authorization. The notation "Deleted" means that the code is invalid effective the day following the date shown in the "Comments" column. Newly added codes become effective on the date shown. Procedure codes deleted effective 12/31/00can be used only on Medicare crossover claims and PARs approved prior to 01/01/01.

Codes for DME Invoice Charges

Use the following special procedure codes for invoiced tax, shipping & handling fees when the billed charge represents the manufacturer's invoice price to a retail provider.

CODE	NARRATIVE	PAR	COMMENTS
X2350	DME invoiced shipping	No	Use to bill shipping charge shown on invoiced DME Item. Bill the shipping charge shown on the manufacturer's invoice.
X2355	DME invoiced tax	No	Use to bill tax that supplier paid to obtain the DME item. Bill the tax amount shown on the manufacturer's invoice. Sales tax is not billable to the Colorado Medicaid program.
X2360	DME handling fee, 20% of manufacturer's invoice cost	No	Use to bill supplier's handling fee for the DME item. Bill up to 20% of the DME cost shown on the manufacturer's invoice.

The following listing is divided into sections to assist providers who bill for specific types of service. If you have questions about billing or the use of the listing, please contact Medicaid Provider Services.

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CODE	NARRATIVE	PAR	MAXIMUM PURCHASE ($)	MAXIMUM RENTAL($)	COMMENTS
AMBULATION DEVICES – GENERAL USE					
	Canes				
E0100	Cane, all materials, adjustable or fixed with tip	No	16.29	n/a	
E0105	Cane, quad or three prong, all materials, adjustable or fixed with tips	No	36.60	11.19	
	Crutches				
E0110	Crutches, forearm, all materials, adjustable or fixed, complete with tips & handgrips, pair	No	70.00	14.59	1 item = 1 pair
E0111	Crutches, forearm, all materials, adjustable or fixed, with tip & handgrip, each	No	35.00	14.59	1 item = 1 crutch
E0112	Crutches, underarm, wood, adjustable or fixed, with pads, tips & handgrips, pair	No	35.00	13.76	1 item = 1 pair
E0113	Crutches, underarm, wood, adjustable or fixed, with pad, tip & handgrip, each	No	17.50	6.88	1 item = 1 crutch
E0114	Crutches, underarm, other than wood, adjustable or fixed, pair with pads, tips and handgrips	No	35.00	13.76	1 item = 1 pair
E0116	Crutch, underarm, other than wood, adjustable or fixed, each with pad, tip and handgrips	No	17.50	6.88	1 item = 1 crutch
	Walkers				
E0130	Walker, rigid (pickup), adjustable or fixed height, each	No	42.00	n/a	
E0135	Walker, folding (pickup), adjustable or fixed height, each	No	59.00	n/a	
E0141	Rigid walker, wheeled, without seat	No	71.00	n/a	
E0142	Walker, rigid, wheeled, with seat, each	No	71.00	n/a	
E0143	Walker, folding, wheeled, without seat, each	No	88.00	n/a	
E0144	Enclosed, framed folding walker, wheeled, with posterior seat	Yes	BI	n/a	
E0145	Walker, wheeled, with seat & crutch attachments, each	No	52.00	n/a	
E0146	Folding walker, wheeled, with seat	No	52.00	n/a	
E0147	Walker, heavy duty, variable wheel resistance with multiple braking system, each	Yes	239.00	n/a	
K0458	Heavy duty walker, without wheels, each	Deleted			Deleted 12/31/00. See E0148.
E0148	Heavy duty walker, without wheels, rigid or folding, any type, each	Yes	BI	n/a	Effective 01/01/01.
K0459	Heavy duty wheeled walker, each	Deleted			Deleted 12/31/00. See E0149.

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CODE	NARRATIVE	PAR	MAXIMUM PURCHASE ($)	MAXIMUM RENTAL($)	COMMENTS
E0149	Heavy duty wheeled walker, rigid or folding, any type, each	Yes	BI	n/a	Effective 01/01/01.
	Accessories for ambulation devices				
A4635	Underarm pad replacement, crutch, each	No	2.40	n/a	
A4636	Handgrip replacement, cane, crutch or walker, each	No	2.40	n/a	
A4637	Tip replacement, cane, crutch or walker, each	No	2.00	n/a	
E0153	Platform attachment, forearm crutch, each	No	85.00	n/a	
E0154	Platform attachment, walker, each	No	85.00	n/a	
E0155	Wheel attachment, rigid pick-up walker, per pair	No	47.00	n/a	1 unit = 1 pair
E0156	Seat attachment, walker, each	No	25.00	n/a	
E0157	Crutch attachment, walker, each	No	69.90	n/a	
E0158	Leg extensions for walker, per set of four (4)	No	23.50	n/a	1 unit = 1 set of four (4)
E0159	Brake attachment for wheeled walker, replacement, each	No	BI	n/a	
BATH AND BATHROOM EQUIPMENT - GENERAL USE					
	Bath equipment				
E0160	Sitz type bath, portable, fits over commode seat, each	Yes	BI	Per PAR	Limited to EPSDT program, up to age 20.
E0163	Commode chair, stationary, with fixed arms, each	No	60.00	n/a	
E0164	Commode chair, mobile, with fixed arms, each	Yes	100.00	20.00	
E0165	Commode chair, stationary, with detachable arms, each	Yes	100.00	21.00	
E0166	Commode chair, mobile, with detachable arms, each	Yes	250.00	21.00	
E0168	Extra wide and/or heavy duty commode chair, stationary or mobile, with or without arms, any type, each	Yes	BI	n/a	Effective 01/01/01.
K0457	Extra wide/heavy duty commode chair, each	Deleted			Deleted 12/31/00. See E0168
E0167	Pail or pan for use with commode chair, each	No	10.00	n/a	Purchase for patient owned equipment only.
E0175	Foot rest, for use with commode chair, each	No	20.00	n/a	Purchase for patient owned equipment only.
E0235	Paraffin bath unit, portable, each	Yes	129.87	12.50	Use A4265 for paraffin.
E0241	Bathtub wall rail, each	Yes	18.00	n/a	
E0242	Bathtub rail, floor base, each	Yes	85.00	n/a	

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CODE	NARRATIVE	PAR	MAXIMUM PURCHASE ($)	MAXIMUM RENTAL($)	COMMENTS
E0243	Toilet rail, each	Yes	33.61	n/a	
E0244	Toilet seat, raised, each	Yes	28.00	n/a	
E0245	Tub stool or bench, each	Yes	50.00	n/a	Use X2065 for transfer bench.
X2065	Transfer bench, each	Yes	79.43	n/a	Use E0245 for tub stool or bench, unpadded.
X2072	Tub stool or bench, padded, each	Yes	188.00	n/a	
X2074	Transfer bench, padded, each	Yes	122.00	n/a	
X2076	Toilet seat, padded, raised, each	Yes	77.00	n/a	
E0246	Transfer tub rail attachment, each	Yes	41.73	n/a	
E0625	Patient lift, kartop, bathroom or toilet, each	Yes	800.00	60.54	Lift for bathtub, includes seat
X2078	Hand held shower	Yes	20.00	n/a	
X2079	Shower commode chair	Yes	BI	n/a	
X2070	Miscellaneous bath equipment not otherwise specified	Yes	BI	n/a	Must be submitted on paper.
	Whirlpool equipment				
E1300	Whirlpool, portable (overtub type)	Yes	185.00	n/a	
BED AND BEDROOM EQUIPMENT - GENERAL USE					
	Beds				
E0194-01	Bed, powered air flotation (low air loss therapy), per day	Yes	n/a	90.55	Air Fluidized, Clinitron. 1 item = 1 day rental. Includes all necessary disposable supplies. Requires Questionnaires #1 & #2. See Appendices D & E.
E0250	Hospital bed, fixed height, with any type side rails, with mattress	Yes	625.00	75.00	Requires Questionnaire # 1. See Appendix D.
E0255	Hospital bed, variable height, Hi-Lo, with any type side rails, with mattress	Yes	625.00	75.00	Requires Questionnaire # 1. See Appendix D.
E0260	Hospital bed, semi-electric (head & foot adjustment), with any type side rails, with mattress	Yes	925.00	112.00	Requires Questionnaire # 1. See Appendix D.
E0265	Hospital bed, total electric (head, foot & height adjustments) with any type side rails, with mattress	Yes	925.00	112.00	Requires Questionnaire # 1. See Appendix D.
E0270	Hospital bed, institutional type includes: oscillating, circulating & stryker frame, with mattress	Yes	BI	175.00	Requires Questionnaire # 1. See Appendix D.
E0298	Hospital bed, heavy duty, extra wide, with any type side rails, with mattress	Yes	BI	Per PAR	Effective 01/01/01. Requires Questionnaire # 1. See Appendix D.

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CODE	NARRATIVE	PAR	MAXIMUM PURCHASE ($)	MAXIMUM RENTAL($)	COMMENTS
K0456	Hospital bed, heavy duty, extra wide, with any type side rails, with mattress	Deleted			Deleted 12/31/00. See E0298
X2088-01	Roto-electric bed, per day	Yes	n/a	100.00	1 item = 1 day rental
E0462-01	Rocking bed with or without side rails, per day	Yes	n/a	97.00	1 item = 1 day rental
E0280	Bed, cradle, any type	Yes	100.00	16.00	
	Mattresses & pads				
A4640	Replacement pad for use with medically necessary alternating pressure pad owned by patient	Yes	35.40	n/a	Purchase for patient owned equipment only.
E0179	Dry pressure pad or cushion, non-positioning	No	5.26	n/a	e.g., egg crate
E0180	Pressure pad, alternating, with pump	Yes	180.00	34.21	Requires Questionnaire #2. See Appendix E.
E0181	Pressure pad, alternating, with pump, heavy duty	Yes	BI	40.00	Requires Questionnaire #2. See Appendix E.
E0182	Pump for alternating pressure pad	Yes	150.00	34.21	
E0271	Mattress, innerspring	Yes	143.40	14.00	Purchase for patient owned hospital bed only.
E0272	Mattress, foam rubber	Yes	100.00	14.00	Purchase for patient owned hospital bed only. Requires Questionnaire #2. See Appendix E.
E0277	Powered pressure-reducing air mattress	Yes	BI	Per PAR	Requires Questionnaire #2. See Appendix E.
E0184	Mattress, dry flotation	Yes	34.35	13.00	Purchase for patient owned hospital bed only. Requires Questionnaire #2. See Appendix E.
E0185	Gel or gel-like pressure pad for mattress, standard mattress length and width	Yes	250.00	13.00	Requires Questionnaire #2. See Appendix E.
E0186	Mattress, air pressure	Yes	BI	13.00	Purchase for patient owned bed only. Requires Questionnaire #2. See Appendix E.
E0187	Mattress, water pressure	Yes	BI	13.00	Purchase for patient owned bed only. Requires Questionnaire #2. See Appendix E.
E0188	Sheepskin pad, synthetic	Yes	15.86	n/a	
E0189	Sheepskin pad, lambs wool, any size	Yes	22.15	n/a	
E0191	Heel or elbow protector, each	Yes	11.23	n/a	
E0192	Low pressure and positioning equalization pad for wheelchair	Yes	BI	n/a	
E0193-01	Air fluidized bed, per day	Yes	n/a	65.00	Air loss bed. Jay, Roho, Stimulate, Therapulse, Kinaire, Flexicair. 1 item = 1 day rental.
E0196	Mattress, Gel pressure	Yes	350.00	13.00	Purchase for patient owned bed only. Requires Questionnaire #2. See Appendix E.

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CODE	NARRATIVE	PAR	MAXIMUM PURCHASE ($)	MAXIMUM RENTAL($)	COMMENTS
E0197	Air pressure pad for mattress, standard mattress length and width	Yes	BI	n/a	Requires Questionnaire #2. See Appendix E.
E0370	Air pressure elevator for heel	Yes	BI	n/a	
E0371	Non-powered advanced pressure reducing overlay for mattress, standard mattress length and width	Yes	BI	n/a	Requires Questionnaire #2. See Appendix E.
E0372	Powered air overlay for mattress, standard mattress length and width	Yes	BI	n/a	Acucair, 1" step. Requires Questionnaire #2. See Appendix E.
E0373	Non-powered advanced pressure reducing mattress	Yes	BI	n/a	Jay, Roho, Rik. Requires Questionnaire #2. See Appendix E.
E0198	Water pressure pad for mattress, standard mattress length and width	Yes	BI	n/a	Requires Questionnaire #2. See Appendix E.
E0199	Dry pressure pad for mattress, standard mattress length and width	No	24.23	n/a	e.g., egg crate, Geo mattress
X2045	Mattresses & pads, miscellaneous	Yes	BI	Per PAR	Must submit manufacturer's invoice with PAR. Rental and purchase based on percentage of invoice & rate will be determined at the time of PAR approval. PAR copy must be submitted with claim. Claim and PAR must be submitted on paper. Requires Questionnaire #2. See Appendix E.
	Accessories/safety equipment				
E0273	Bedboard	Yes	100.00	n/a	
E0275	Bedpan, standard, metal or plastic	No	8.00	n/a	
E0276	Bedpan, fracture, metal or plastic	No	5.25	n/a	
E0305	Bed side rails, half length, pair	Yes	100.00	17.00	
E0310	Bed side rails, full length, pair	Yes	100.00	17.00	
E0315	Bed accessory: board, table, or support device any type	Yes	100.00	17.00	
E0325	Urinal, male, jug-type, any material, each	No	3.00	n/a	
E0326	Urinal, female, jug-type, any material, each	No	7.00	n/a	
E0700	Safety equipment (e.g., belt, harness or vest)	Yes	20.00	n/a	
E0710	Restraints, any type (body, chest, wrist or ankle)	Yes	30.00	n/a	
	Lifts				
E0621	Sling or seat, patient lift, canvas or nylon	Yes	84.57	n/a	Purchase for patient owned equipment only.
E0625	Patient lift, kartop, bathroom or toilet	Yes	800.00	60.54	Lift for bathtub, includes seat.

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CODE	NARRATIVE	PAR	MAXIMUM PURCHASE ($)	MAXIMUM RENTAL($)	COMMENTS
E0627	Seat lift mechanism incorporated into a combination lift-chair mechanism	Yes	575.00	n/a	Requires Questionnaire # 4. See Appendix G.
E0628	Separate seat lift mechanism for use with patient owned furniture, electric	Yes	BI	n/a	Purchase for patient owned equipment only. Requires Questionnaire # 4. See Appendix G.
E0629	Separate seat lift mechanism for use with patient owned furniture, non-electric	Yes	BI	n/a	Purchase for patient owned equipment only. Requires Questionnaire # 4. See Appendix G.
E0630	Patient lift, hydraulic, with seat or sling	Yes	957.00	60.54	Requires Questionnaire # 3. See Appendix F.
E0635	Patient lift, electric, with seat or sling	Yes	BI	55.00	Requires Questionnaire # 3. See Appendix F.
E1035	Multi-positional patient transfer system, with integrated seat operated by caregiver	Yes	BI	n/a	Effective 01/01/01. Requires Questionnaire # 3. See Appendix F.
	Repairs/labor				
E1340	Repair or non-routine service for durable medical equipment requiring the skill of a technician, labor component, per 15 minutes	Yes	BI	n/a	Cost of repair cannot exceed cost to purchase replacement equipment. Serial number of the equipment being repaired must be identified in field 12 of the PAR. Paper claims must include serial number. If codes are available to identify specific components, they must be used (e.g., tires, upholstery, etc.).
X2230	Labor, dealer preparation	Yes	BI	n/a	1 unit per day. Limited to customizing or extensive repair to equipment. If codes are available to identify specific components, they must be used (e.g., tires, upholstery, etc.).
X2975	Repairs & labor to client owned equipment costing less than $150.00 in a 6-month period	No	150.00	n/a	Paper claims must include serial numbers.

CHAIRS, WHEELCHAIRS, ACCESSORIES – GENERAL USE

Providers are instructed to submit the HCPCS code most closely describing the wheelchair or related equipment being requested on the Request for Prior Authorization form. The Department reserves the right to amend the coding for any approved item. **See Appendix A for brand and models appropriate for each code.** If a brand or model does not appear in Appendix A, follow Medicare procedures regarding weight and measurements to code appropriately.

Note: Deleted procedure codes effective 12/31/00 can only be used on Medicare X-over claims and PARS authorized prior to 01/01/01.

Requests for Prior Authorization of chairs and wheelchairs must include in Field 16 the manufacturer and the model number being requested. If not included, the PAR shall be considered incomplete, and will be returned to the provider for the missing information. If the PAR does not identify special billing instructions, the claim can be billed through the AMP system. If billing through the AMP system for an approved item, the provider must keep the serial number of the item provided in their records. If billing on a paper claim, the provider must include the serial number in Field 30 of the Colorado 1500 claim form.

	Chairs				
X2003	Specialized stroller	Yes	600.00	n/a	

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CODE	NARRATIVE	PAR	MAXIMUM PURCHASE ($)	MAXIMUM RENTAL($)	COMMENTS
X2110	Mulholland growth guidance chair	Yes	BI	n/a	
	Wheelchairs - motorized/powered vehicles				
E1230	Power operated vehicle, three or four wheel non-highway	Yes	2,200.00	123.50	Must indicate brand name & model number in field 16 of the PAR. Paper claims must include serial number.
	Wheelchair accessories				
A4631	Replacement batteries for medically necessary electronic wheelchair owned by patient	No	70.00	n/a	Purchase for client owned equipment only.
E0176	Air pressure pad or cushion, non-positioning	Yes	BI	n/a	Must identify manufacturer in field 16 of the PAR.
E0177	Water pressure pad or cushion, non-positioning	Yes	BI	n/a	Must identify manufacturer in field 16 of the PAR.
E0178	Gel or gel-like pressure pad or cushion, non-positioning	Yes	127.38	n/a	Must identify manufacturer in field 16 of the PAR.
E0180	Pressure pad, alternating with pump	Yes	180.00	34.21	
E0181	Pressure pad, alternating with pump, heavy duty	Yes	BI	40.00	
E0182	Pump for alternating pressure pad	Yes	150.00	34.21	
E0188	Sheepskin pad, synthetic	Yes	15.86	n/a	
E0189	Sheepskin pad, lambs wool, any size	Yes	22.15	n/a	
E0191	Heel or elbow protector, each	Yes	11.23	n/a	
E0192	Low pressure & positioning equalization pad for wheelchair	Yes	BI	n/a	e.g., Roho, Jay, Stimulate, Vicair.
X2100	Cushion Covers	Yes	BI	n/a	e.g., Roho, Jay, Stimulate
E0710	Restraints, any type (body, chest, wrist, ankle)	Yes	30.00	n/a	
E0962	Cushion, 1" for wheelchair	Yes	20.00	n/a	e.g., foam
E0963	Cushion, 2" for wheelchair	Yes	30.00	n/a	e.g., foam
E0964	Cushion, 3" for wheelchair	Yes	50.00	n/a	e.g., foam
E0965	Cushion, 4" for wheelchair	Yes	75.00	n/a	e.g., foam
E0968	Commode seat, wheelchair	Yes	BI	n/a	
E0969	Narrowing device, wheelchair	Yes	BI	n/a	
E0977	Wedge cushion for wheelchair	Yes	47.00	n/a	For positioning.
E0980	Safety vest	Yes	80.00	n/a	
E0997	Caster with fork	Conditional	BI	n/a	PAR required for purchase but not required for repair.

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CODE	NARRATIVE	PAR	MAXIMUM PURCHASE ($)	MAXIMUM RENTAL($)	COMMENTS
E0998	Caster without fork	Yes	BI	n/a	
E1069	Battery, deep cycle	Conditional	70.00	n/a	PAR required for purchase but not required for repair.
K0460	Power add-on, to convert manual wheelchair to motorized wheelchair, joystick control	Yes	BI	n/a	
K0461	Power add-on, to convert manual wheelchair to power operated vehicle, tiller control	Yes	BI	n/a	
E1340	Repair or non-routine service for durable medical equipment requiring the skill of a technician, labor component, per 15 minutes	Yes	BI	n/a	The cost of repair cannot exceed cost to purchase replacement equipment. For batteries, see A4631, E1069 or K0082-K0087. The serial number of equipment being repaired must be identified in field 12 of the PAR. Paper claims must include serial number. If codes are available to identify specific components, they must be used (e.g., tires, upholstery etc.).
X2230	Labor, dealer preparation	Yes	BI	n/a	1 unit per day. Limited to customizing or extensive repair to equipment. Paper claims must include serial number. If codes are available to identify specific components, they must be used (e.g., tires, upholstery, etc.).
X2975	Repairs & labor to client owned equipment costing less than $150.00 in a 6 month period	No	150.00	n/a	Paper claims must include serial number.
K0462-01	Temporary replacement for patient owned equipment being repaired, any type	Yes	n/a	150.00	
E1399	Miscellaneous durable medical equipment	Yes	BI	Per PAR	**Important, please note**: Use only for miscellaneous wheelchair equipment. Charges over $35.00 require invoice. Rental benefit based upon attached manufacturer's invoice as a percentage of invoice cost. Copy of approved PAR must be attached to each submitted claim. Must be submitted on paper.
	Wheelchairs - "K" codes				
	Providers are instructed to submit the HCPCS code most closely describing the wheelchair or related equipment being requested on the Request for Prior Authorization form. The Department reserves the right to amend the coding for any approved item. **See Appendix A for brand and models appropriate for each code**. If a brand or model does not appear in Appendix A, follow Medicare procedures regarding weight and measurements to code appropriately.				
K0001	Standard wheelchair	Yes	571.73	50.00	See Appendix A.

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CODE	NARRATIVE	PAR	MAXIMUM PURCHASE ($)	MAXIMUM RENTAL($)	COMMENTS
K0002	Standard Hemi (low seat) wheelchair	Yes	BI	50.00	See Appendix A.
K0003	Lightweight wheelchair	Yes	BI	50.00	See Appendix A.
K0004	High strength, lightweight wheelchair	Yes	BI	55.00	See Appendix A.
K0005	Ultra lightweight wheelchair	Yes	BI	55.00	See Appendix A.
K0006	Heavy duty wheelchair	Yes	BI	58.00	Patient greater than 200 lbs. See Appendix A.
K0007	Extra heavy duty wheelchair	Yes	BI	58.00	Patient greater than 300 lbs. See Appendix A.
K0008	Custom manual wheelchair/base	Yes	BI	n/a	See Appendix A.
K0009	Other manual wheelchair/base	Yes	BI	n/a	e.g., Tilt in Space. See Appendix A.
K0010	Standard - weight frame motorized/power wheelchair	Yes*	BI	135.00	See Appendix A.
K0011	Standard - weight frame motorized/power wheelchair with programmable control parameters for speed adjustment, tremor dampening, acceleration control and braking	Yes*	BI	135.00	See Appendix A.
K0012	Lightweight portable motorized/power wheelchair	Yes*	BI	135.00	See Appendix A.
K0013	Custom motorized/power wheelchair base	Yes*	BI	n/a	See Appendix A.
K0014	Other motorized/power wheelchair base	Yes*	BI	n/a	See Appendix A.
K0015	Detachable, non-adjustable height armrest, each	Yes	14.00	n/a	1 item = 1 armrest
K0016	Detachable, adjustable height armrest, complete assembly, each	Yes	BI	n/a	1 item = 1 armrest
K0017	Detachable, adjustable height armrest, base, each	Yes	BI	n/a	1 item = 1 armrest
K0018	Detachable, adjustable height armrest, upper portion each	Yes	BI	n/a	1 item = 1 armrest
K0019	Arm pad, each	Yes	14.00	n/a	For repair only. 1 item = 1 arm pad
K0020	Fixed, adjustable height armrest, pair	Yes	BI	n/a	1 item = 1 pair
K0021	Anti-tipping device, each	Yes	32.00	n/a	1 item = 1 device
K0022	Reinforced back upholstery	Yes	60.00	n/a	1 item
K0023	Solid back insert, planar back, single density foam, attached with straps	Yes	65.00	n/a	1 item = 1 insert
K0024	Solid back insert, planar back, single density foam, with adjustable hook-on hardware	Yes	BI	n/a	1 item = 1 insert
K0025	Hook-on headrest extension	Yes	65.00	n/a	1 item = 1 extension
K0026	Back upholstery for ultra lightweight or high strength lightweight wheelchair	Yes	50.00	n/a	1 item = 1 upholstery

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CODE	NARRATIVE	PAR	MAXIMUM PURCHASE ($)	MAXIMUM RENTAL($)	COMMENTS
K0027	Back upholstery for wheelchair type other than ultra lightweight or high strength lightweight wheelchair	Yes	BI	n/a	1 item = 1 upholstery
K0028	Manual, fully reclining back	Yes	BI	26.45	1 item
K0029	Reinforced seat upholstery	Yes	60.00	n/a	1 item
K0030	Solid seat insert, planar seat, single density foam	Yes	65.00	n/a	1 item = 1 insert
X2105	Hook in solid seat insert	Yes	BI	n/a	1 item = 1 insert.
K0031	Safety belt/pelvic strap, each	Yes	29.00	n/a	1 item = 1 strap
K0032	Seat upholstery for ultra lightweight or high strength lightweight wheelchair	Yes	BI	n/a	1 item = 1 upholstery
K0033	Seat upholstery for wheelchair type other than ultra lightweight or high strength lightweight wheelchair	Yes	BI	n/a	1 item = 1 upholstery
K0034	Heel loop, each	Yes	15.00	n/a	1 item = 1 heel loop
K0035	Heel loop with ankle strap, each	Yes	15.00	n/a	1 item = 1 heel loop with ankle strap
K0036	Toe loop, each	Yes	15.00	n/a	1 item = 1 toe loop
K0037	High mount flip-up footrest, each	Yes	BI	n/a	1 item = 1 leg strap
K0038	Leg strap, each	Yes	22.00	n/a	1 item = 1 leg strap
K0039	Leg strap, H style, each	Yes	30.00	n/a	1 item = 1 leg strap
K0040	Adjustable angle footplate, each	Yes	BI	n/a	1 item = 1 footplate
K0041	Large size footplate, each	Yes	33.40	n/a	1 item = 1 footplate
K0042	Standard size footplate, each	Yes	33.40	n/a	1 item = 1 footplate
K0043	Footrest, lower extension tube, each	Yes	BI	n/a	For repair only.
K0044	Footrest, lower extension bracket, each	Yes	BI	n/a	For repair only.
K0045	Footrest, complete assembly	Yes	BI	n/a	
K0046	Elevating leg rest, lower extension tube, each	Yes	BI	n/a	For repair only.
K0047	Elevating leg rest, upper hanger bracket, each	Yes	BI	n/a	For repair only.
K0048	Elevating leg rest, complete assembly	Yes	35.40	n/a	1 item = 1 leg rest
K0049	Calf pad, each	Yes	20.00	n/a	1 item = 1 calf pad
K0050	Ratchet assembly	Yes	BI	n/a	For repair only.
K0051	Cam release assembly, footrest or leg rest, each	Yes	BI	n/a	For repair only.
K0052	Swingaway, detachable footrests, each	Yes	BI	n/a	New or repair.

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CODE	NARRATIVE	PAR	MAXIMUM PURCHASE ($)	MAXIMUM RENTAL($)	COMMENTS
K0054	Seat width of 10", 11", 12", 15", 17", or 20" for a high strength, lightweight or ultra lightweight wheelchair	Yes	243.18	n/a	
K0055	Seat depth of 15", 17", or 18" for a high strength, lightweight or ultra lightweight wheelchair	Yes	243.18	n/a	
K0056	Seat height < 17" or equal to or greater than 21" for a high strength, lightweight, or ultra lightweight wheelchair	Yes	326.40	n/a	
K0057	Seat width 19" or 20" for heavy duty or extra heavy duty chair	Yes	BI	n/a	
K0058	Seat depth 17" or 18" for motorized/power wheelchair	Yes	BI	n/a	
K0059	Plastic coated handrim, each	Yes	BI	n/a	
K0060	Steel handrim, each	Yes	BI	n/a	For repair only.
K0061	Aluminum handrim, each	Yes	BI	n/a	For repair only.
K0062	Handrim with 8-10 vertical or oblique projections, each	Yes	65.00	n/a	1 item = 1 handrim
K0063	Handrim with 12-16 vertical or oblique projections, each	Yes	70.00	n/a	
K0064	Zero pressure tube (flat free inserts), any size, each	Conditional	BI	n/a	PAR required for purchase but not required for repair.
K0065	Spoke protectors, each	Yes	BI	n/a	1 item = 1 spoke protector
K0066	Solid tire, any size, each	Conditional	65.00	n/a	PAR required for purchase but not required for repair.
K0067	Pneumatic tire, any size, each	Conditional	17.50	n/a	PAR required for purchase but not required for repair.
K0068	Pneumatic tire tube, each	Conditional	8.50	n/a	PAR required for purchase but not required for repair.
K0069	Rear wheel assembly, complete, with solid tire, spokes or molded, each	Conditional	46.00	n/a	PAR required for purchase but not required for repair.
K0070	Rear wheel assembly, complete, with pneumatic tire, spokes or molded, each	Conditional	82.00	n/a	PAR required for purchase but not required for repair. 1 item = 1 assembly.
K0071	Front caster assembly, complete, with pneumatic tire, each	Conditional	BI	n/a	PAR required for purchase but not required for repair. 1 item = 1 assembly.
K0072	Front caster assembly, complete, with semi-pneumatic tire, each	Conditional	85.00	n/a	PAR required for purchase but not required for repair. 1 item = 1 assembly.
K0073	Caster pin lock, each	No	BI	n/a	1 item = 1 pin.

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CODE	NARRATIVE	PAR	MAXIMUM PURCHASE ($)	MAXIMUM RENTAL($)	COMMENTS
K0074	Pneumatic caster tire, any size, each	Conditional	15.00	n/a	PAR required for purchase but not required for repair. 1 item = 1 tire.
K0075	Semi-pneumatic caster tire, any size, each	Conditional	15.00	n/a	PAR required for purchase but not required for repair. 1 item = 1 tire.
K0076	Solid caster tire, any size, each	Conditional	BI	n/a	PAR required for purchase but not required for repair. 1 item = 1 tire.
K0077	Front caster assembly, complete, with solid tire, each	Conditional	BI	n/a	PAR required for purchase but not required for repair. 1 item = 1 tire.
K0078	Pneumatic caster tire tube, each	Conditional	BI	n/a	PAR required for purchase but not required for repair. 1 item = 1 tire tube.
K0079	Wheel lock extension, pair	Yes	15.00	n/a	1 item = 1 pair
K0080	Anti-rollback device, pair	Yes	30.00	n/a	1 item = 1 device
K0081	Wheel lock assembly, complete, each	Yes	BI	n/a	For repair only.
K0082	22 NF deep cycle lead acid battery, each	Conditional	56.00	n/a	PAR required for purchase but not required for repair.
K0083	22 NF gel cell battery, each	Conditional	106.00	n/a	PAR required for purchase but not required for repair.
K0084	Group 24 deep cycle lead acid battery, each	Conditional	75.00	n/a	PAR required for purchase but not required for repair.
K0085	Group 24 gel cell battery, each	Conditional	131.00	n/a	PAR required for purchase but not required for repair.
K0086	U-1 lead acid battery, each	Conditional	56.00	n/a	PAR required for purchase but not required for repair.
K0087	U-1 gel cell battery, each	Conditional	75.00	n/a	PAR required for purchase but not required for repair.
K0088	Battery charger, lead acid or gel cell	Conditional	BI	n/a	PAR required for purchase but not required for repair. 1 item = 1 charger. Lead acid available only with repairs or replacement. If gel cell battery is being ordered with a new chair, order dual mode charger also.
K0089	Battery charger, dual mode	Conditional	BI	n/a	PAR required for purchase but not required for repair.

*PARs must be submitted to CFMC. See page 4.

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CODE	NARRATIVE	PAR	MAXIMUM PURCHASE ($)	MAXIMUM RENTAL($)	COMMENTS
K0090	Rear wheel tire for power wheelchair, any size, each	Conditional	BI	n/a	PAR required for purchase but not required for repair.
K0091	Rear wheel tire tube other than zero pressure for power wheelchair, any size, each	Conditional	BI	n/a	PAR required for purchase but not required for repair.
K0092	Rear wheel assembly for power wheelchair, complete each	Yes	BI	n/a	For repair only.
K0093	Rear wheel, zero pressure tire tube (flat free insert) for power wheelchair, any size, each	Conditional	BI	n/a	PAR required for purchase but not required for repair.
K0094	Wheel tire for power base, any size, each	Conditional	BI	n/a	PAR required for purchase but not required for repair.
K0095	Wheel tire tube other than zero pressure for each base, any size, each	Conditional	BI	n/a	PAR required for purchase but not required for repair.
K0096	Wheel assembly for power base, complete, each	Yes	BI	n/a	For repair only.
K0097	Wheel zero pressure tire tube (flat free insert) for power base, any size, each	Conditional	BI	n/a	PAR required for purchase but not required for repair.
K0098	Drive belt for power wheelchair	Yes	BI	n/a	For repair only.
K0099	Front caster for power wheelchair, each	Yes	BI	n/a	For repair only. 1 item = 1 caster.
K0452	Wheelchair bearings, any type	Conditional	BI	n/a	PAR required for purchase but not required for repair.
X2115	Stroller handle	Yes	BI	n/a	1 item = 1 pair
X2117	Weather Guard	Yes	BI	n/a	1 item = 1 pair
X2119	Quick Release Axle	Yes	BI	n/a	1 item = 1 pair
K0100	Wheelchair adapter for amputee, pair	Yes	85.00	n/a	1 item = 1 pair
K0101	One-arm drive attachment, each	Yes	510.00	67.50	1 item = 1 attachment
K0102	Crutch and cane holder, each	Yes	BI	n/a	1 item = 1 crutch and cane holder
K0103	Transfer board, < 25"	Yes	30.00	n/a	1 item = 1 board
K0104	Cylinder tank carrier, each	Yes	BI	n/a	1 item = 1 carrier
K0105	IV hanger, each	Yes	BI	n/a	1 item = 1 IV hanger
K0106	Arm trough, each	Yes	BI	n/a	1 item = 1 arm trough
K0107	Wheelchair tray	Yes	BI	n/a	1 item = 1 tray
K0108	Wheelchair component or accessory, not otherwise specified	Yes	BI	n/a	Specific accessory must be identified on PAR. Claim must be submitted on paper.

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CODE	NARRATIVE	PAR	MAXIMUM PURCHASE ($)	MAXIMUM RENTAL($)	COMMENTS
K0109	Customization of wheelchair base frame (options or accessories)	Yes	BI	n/a	Claim must be submitted on paper.
	Support systems				
K0112	Trunk support device, vest type, with inner frame, prefabricated	Yes	BI	n/a	1 item = 1 device
K0113	Trunk support device, vest type, without inner frame, prefabricated	Yes	BI	n/a	1 item = 1 device
K0114	Back support system for use with a wheelchair, with inner frame, prefabricated	Yes	BI	n/a	Jay, Jay 2 Back, Personal Back
K0115	Orthotic seating system, back module, posteriorlateral control, with or without lateral supports, custom fabricated for attachment to wheelchair base	Yes	BI	n/a	
K0116	Orthotic seating system, combined back and seat module, custom fabricated for attachment to wheelchair base	Yes	BI	n/a	Pin dot matrix
X2125	Linear seating system	Yes	BI	n/a	

Note: Deleted procedure codes effective 12/31/00 can only be used on Medicare X-over claims and PARS authorized prior to 01/01/01.

COCHLEAR EQUIPMENT & SUPPLIES

L8619	Cochlear implant external speech processor, replacement	Yes*	BI	n/a	

DIABETIC MONITORING EQUIPMENT & SUPPLIES

Glucometers – Benefit is limited to a basic model.

Providers are requested to submit their Usual and Customary charge to the Medicaid Program.

Under Federal Law and State Regulations, providers are reminded that the Medicaid Program shall not be billed in excess of that charged to non-Medicaid clients.

Rebates: If a rebate is available, the provider is responsible for doing one of the following:

1. Instant: Cost must reflect Usual and Customary charge minus the rebate received or anticipated from the manufacturer.
2. Mail-In: Rebate obtainable by mail shall indicate the purchaser to be the: Colorado Medicaid Program
   1575 Sherman Street
   Denver CO 80203-1714

A4206	Syringe with needle, sterile, 1 cc, each	No	.15	n/a	Use for diabetic syringes. All syringes must be billed on the supply claim form. 1 item = 1 syringe.
A4230	Infusion set for external insulin pump, non needle cannula type	Yes	BI	n/a	
A4231	Infusion set for external insulin pump, needle type	Yes	BI	n/a	
E0607	Home blood glucose monitor	No	50.00	n/a	

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CODE	NARRATIVE	PAR	MAXIMUM PURCHASE ($)	MAXIMUM RENTAL($)	COMMENTS
E0609	Blood glucose monitor with special features, (e.g., voice synthesizers, automatic timers, etc.)	Yes	350.00	42.87	Requires supporting documentation of medical necessity for special feature on PAR.
A4250	Urine test or reagent strips or tablets, each	No	.50	n/a	1 item = 1 strip/tablet. Albustix
A4253	Blood glucose test or reagent strips for home blood glucose monitor, each	No	.64	n/a	1 item = 1 strip/tablet.
XX002	Blood glucose test or reagent strip for home blood glucose monitor, per 25 strips	No	16.00	n/a	1 item = 25 strips.
A4254	Replacement battery, any type, for use with medically necessary home blood glucose monitor owned by patient, each	No	BI	n/a	1 item = 1 replacement battery.
A4255	Platforms for home blood glucose monitor, 50 per box	No	BI	n/a	1 item = 50 per box.
A4258	Spring-powered device for lancet, each	No	BI	n/a	1 item = 1 device.
A4259	Lancets, each	No	.08	n/a	1 item = 1 lancet.
A4772	Dextrostix or glucose test strips	No	.75	n/a	1 item = 1 strip.
X2008	Syringe with needle, sterile, 0.3 cc or other special syringe or needle for use with insulin	Yes	.20	n/a	Diabetic use only. Must be medically justified. 1 item = 1 syringe.
E0784	External ambulatory infusion pump, insulin	Yes	5,250.00	n/a	1 item = 1 system
X2010	Miscellaneous diabetic supplies not otherwise classified	No	10.00	n/a	Control solution. Charges greater than $10.00, must attach manufacturer's invoice, description & amounts. Must be submitted on paper.

DISPOSABLE SUPPLIES – GENERAL USE

Disposable supplies

Disposable supplies, including gloves, are a benefit of the Medicaid Program for use by the client in his/her home. With the exception of gloves, the Home Health care agency is responsible for providing all supplies necessary to meet the OSHA universal precaution requirement during a visit.

Bill only per information in Comments column. Example: X2130 per 240 ml equals only 1 UOS.

Antiseptics/solutions

X2130	Respiratory sterile saline; 240 ml	Yes	6.48	n/a	1 item = 240 cc.
X2132	Respiratory sterile saline; 90 ml	Yes	4.98	n/a	1 item = 90 cc
A4244	Alcohol or peroxide, per pint	Yes	.50	n/a	1 item = 1 pint.
A4245	Alcohol wipes, each	No	.03	n/a	1 item = 1 wipe.
A4246	Betadine, per pint	Yes	3.50	n/a	1 item = 1 pint.
A4247	Betadine or Iodine swabs/wipes, each	Yes	.13	n/a	1 item = 1 swab/wipe.

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CODE	NARRATIVE	PAR	MAXIMUM PURCHASE ($)	MAXIMUM RENTAL($)	COMMENTS
X2273	Anti-microbial soap	Yes	BI	n/a	e.g., Hibiclens, Cholohex
X2134	Antibiotic ointment	Yes	BI	n/a	1 item = 1 oz. e.g., Neosporin
A4712	Water, sterile, per liter	Yes	6.02	n/a	1 item = 1 liter.
A4319	Sterile water irrigation solution, 1000 ml	No	7.70	n/a	Effective 01/01/01.
	First aid/dressings - **See Appendix B for products and manufacturers appropriate for each code.**				
A6025	Silicone gel sheet, each	Yes	BI	n/a	1 item = 1 sheet.
A6154	Wound pouch, each	Yes	BI	n/a	1 item = 1 pouch.
A6257	Transparent film, 16 sq. in. or less, each dressing	Yes	BI	n/a	
A6258	Transparent film, more than 16 sq. in. but less than or equal to 48 sq. in., each dressing	Yes	BI	n/a	
A6259	Transparent film, more than 48 sq. in., each dressing	Yes	BI	n/a	
A4200	Gauze pad(s) sterile or non-sterile, medicated or non-medicated, each	Yes	.50	n/a	
A6020	Collagen based wound dressing, each dressing	Yes	BI	n/a	
A6021	Collagen dressing, pad size 16 sq. in. or less, each	Yes	BI	n/a	Effective 01/01/01.
A6022	Collagen dressing, pad size more than 16 sq. in. but less than or equal to 48 sq. in., each	Yes	BI	n/a	Effective 01/01/01.
A6023	Collagen dressing, pad size more than 48 sq. in., each	Yes	BI	n/a	Effective 01/01/01.
A6024	Collagen dressing wound filler, per 6 inches	Yes	BI	n/a	Effective 01/01/01.
A6200	Composite dressing, pad size 16 sq. in. or less, without adhesive border, each dressing	Yes	BI	n/a	
A6201	Composite dressing, pad size more than 16 sq. in. but less than or equal to 48 sq. in., without adhesive border, each dressing	Yes	BI	n/a	
A6202	Composite dressing, pad size more than 48 sq. in., without adhesive border, each dressing	Yes	BI	n/a	
A6216	Gauze, non-impregnated, non-sterile, pad size 16 sq. in. or less, without adhesive border, each dressing	Yes	BI	n/a	
A6217	Gauze, non-impregnated, non-sterile, pad size more than 16 sq. in. but less than or equal to 48 sq. in., without adhesive border, each dressing	Yes	BI	n/a	
A6218	Gauze, non-impregnated, non-sterile, pad size more than 48 sq. in., without adhesive border, each dressing	Yes	BI	n/a	
A6219	Gauze, non-impregnated, pad size 16 sq. in. or less, with any size adhesive border, each dressing	Yes	BI	n/a	

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CODE	NARRATIVE	PAR	MAXIMUM PURCHASE ($)	MAXIMUM RENTAL($)	COMMENTS
A6220	Gauze, non-impregnated, pad size more than 16 sq. in. but less than or equal to 48 sq. in., with any size adhesive border, each dressing	Yes	BI	n/a	
A6221	Gauze, non-impregnated, pad size more than 48 sq. in., with any size adhesive border, each dressing	Yes	BI	n/a	
A6402	Gauze, non-impregnated, sterile, pad size 16 sq. in. or less, without adhesive border, each dressing	Yes	BI	n/a	
A6403	Gauze, non-impregnated, sterile, pad size more than 16 sq. in. but less than or equal to 48 sq. in., without adhesive border, each dressing	Yes	BI	n/a	
A6404	Gauze, non-impregnated, sterile, pad size more than 48 sq. in., without adhesive border, each dressing	Yes	BI	n/a	
A6222	Gauze, impregnated with other than water, normal saline, or hydrogel, pad size 16 sq. in. or less, without adhesive border, each dressing	Yes	BI	n/a	
A6223	Gauze, impregnated with other than water, normal saline, or hydrogel, pad size more than 16 sq. in. but less than or equal to 48 sq. in., without adhesive border, each dressing	Yes	BI	n/a	
A6224	Gauze, impregnated with other than water, normal saline, or hydrogel, pad size more than 48 sq. in., without adhesive border, each dressing	Yes	BI	n/a	
A6228	Gauze, impregnated, water or normal saline, pad size 16 sq. in. or less, without adhesive border, each dressing	Yes	BI	n/a	
A6229	Gauze, impregnated, water or normal saline, pad size more than 16 sq. in. but less than or equal to 48 sq. in., without adhesive border, each dressing	Yes	BI	n/a	
A6230	Gauze, impregnated, water or normal saline, pad size more than 48 sq. in., without adhesive border, each dressing	Yes	BI	n/a	
A6231	Gauze, impregnated, hydrogel, for direct wound contact, pad size 16 sq. in. or less, each dressing	Yes	BI	n/a	Effective 01/01/01.
A6232	Gauze, impregnated, hydrogel, for direct wound contact, pad size greater than 16 sq. in. but less than or equal to 48 sq. in., each dressing	Yes	BI	n/a	Effective 01/01/01.
A6233	Gauze, impregnated, hydrogel, for direct wound contact, pad size more than 48 sq. in., each dressing	Yes	BI	n/a	Effective 01/01/01.
A6264	Gauze, non-elastic, non-sterile, per linear yard	Yes	BI	n/a	
A6266	Gauze, impregnated, other than water or normal saline, any width, per linear yard	Yes	BI	n/a	
A6263	Gauze, elastic, non-sterile, all types, per linear yard	Yes	BI	n/a	

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CODE	NARRATIVE	PAR	MAXIMUM PURCHASE ($)	MAXIMUM RENTAL($)	COMMENTS
A6405	Gauze, elastic, sterile, all types, per linear yard	Yes	BI	n/a	
A6406	Gauze, non-elastic, sterile, all types per linear yard	Yes	BI	n/a	
A6242	Hydrogel dressing, wound cover, pad size 16 sq. in. or less, without adhesive border, each dressing	Yes	BI	n/a	
A6243	Hydrogel dressing, wound cover, pad size more than 16 sq. in. but less than or equal to 48 sq. in., without adhesive border, each dressing	Yes	BI	n/a	
A6244	Hydrogel dressing, wound cover, pad size more than 48 sq. in., without adhesive border, each dressing	Yes	BI	n/a	
A6245	Hydrogel dressing, wound cover, pad size 16 sq. in. or less, with any size adhesive border, each dressing	Yes	BI	n/a	
A6246	Hydrogel dressing, wound cover, pad size more than 16 sq. in. but less than or equal to 48 sq. in., with any size adhesive border, each dressing	Yes	BI	n/a	
A6247	Hydrogel dressing, wound cover, pad size more than 48 sq. in., with any size adhesive border, each dressing	Yes	BI	n/a	
A6248	Hydrogel dressing, wound filler, gel, per fluid ounce	Yes	BI	n/a	
A6234	Hydrocolloid dressing, wound cover, pad size 16 sq. in. or less, without adhesive border, each dressing	Yes	BI	n/a	
A6235	Hydrocolloid dressing, wound cover, pad size more than 16 sq. in but less than or equal to 48 sq. in., without adhesive border, each dressing	Yes	BI	n/a	
A6236	Hydrocolloid dressing, wound cover, pad size more than 48 sq. in., without adhesive border, each dressing	Yes	BI	n/a	
A6237	Hydrocolloid dressing, wound cover, pad size 16 sq. in. or less, with any size adhesive border, each dressing	Yes	BI	n/a	
A6238	Hydrocolloid dressing, wound cover, pad size more than 16 sq. in. but less than or equal to 48 sq. in., with any size adhesive border, each dressing	Yes	BI	n/a	
A6239	Hydrocolloid dressing, wound cover, pad size more than 48 sq. in., with any size adhesive border, each dressing	Yes	BI	n/a	
A6240	Hydrocolloid dressing, wound filler, paste, per fluid ounce	Yes	BI	n/a	
A6241	Hydrocolloid dressing, wound filler, dry form, per gram	Yes	BI	n/a	
A6196	Alginate dressing, wound cover, pad size 16 sq. in. or less, each dressing	Yes	BI	n/a	
A6197	Alginate dressing, wound cover, pad size more than 16 sq. in. but less than or equal to 48 sq. in., each dressing	Yes	BI	n/a	

*PARs must be submitted to CFMC. See page 4.

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CODE	NARRATIVE	PAR	MAXIMUM PURCHASE ($)	MAXIMUM RENTAL($)	COMMENTS
A6198	Alginate dressing, wound cover, pad size more than 48 sq. in., each dressing	Yes	BI	n/a	
A6199	Alginate dressing, wound filler, per 6 inches	Yes	BI	n/a	
A6203	Composite dressing, pad size 16 sq. in. or less, with any size adhesive border, each dressing	Yes	BI	n/a	
A6204	Composite dressing, pad size more than 16 sq. in. but less than or equal to 48 sq. in. with any size adhesive border, each dressing	Yes	BI	n/a	
A6205	Composite dressing, pad size more than 48 sq. in., with any size adhesive border, each dressing	Yes	BI	n/a	
A6206	Contact layer, 16 sq. in. or less, each dressing	Yes	BI	n/a	
A6207	Contact layer, more than 16 sq. in. but less than or equal to 48 sq. in., each dressing	Yes	BI	n/a	
A6208	Contact layer, more than 48 sq. in., each dressing	Yes	BI	n/a	
A6209	Foam dressing, wound cover, pad size 16 sq. in. or less, without adhesive border, each dressing	Yes	BI	n/a	
A6210	Foam dressing, wound cover, pad size more than 16 sq. in. but less than or equal to 48 sq. in., without adhesive border, each dressing	Yes	BI	n/a	
A6211	Foam dressing, wound cover, pad size more than 48 sq. in., without adhesive border, each dressing	Yes	BI	n/a	
A6212	Foam dressing, wound cover, pad size 16 sq. in. or less, with any size adhesive border, each dressing	Yes	BI	n/a	
A6213	Foam dressing, wound cover, pad size more than 16 sq. in. but less than or equal to 48 sq. in., with any size adhesive border, each dressing	Yes	BI	n/a	
A6214	Foam dressing, wound cover, pad size more than 48 sq. in., with any size adhesive border, each dressing	Yes	BI	n/a	
A6215	Foam dressing, wound filler, per gram	Yes	BI	n/a	
A6251	Specialty absorptive dressing, wound cover, pad size 16 sq. in. or less, without adhesive border, each dressing	Yes	BI	n/a	
A6252	Specialty absorptive dressing, wound cover, pad size more than 16 sq. in. but less than or equal to 48 sq. in., without adhesive border, each dressing	Yes	BI	n/a	
A6253	Specialty absorptive dressing, wound cover, pad size more than 48 sq. in., without adhesive border, each dressing	Yes	BI	n/a	
A6254	Specialty absorptive dressing, wound cover, pad size 16 sq. in. or less, with any size adhesive border, each dressing	Yes	BI	n/a	

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CODE	NARRATIVE	PAR	MAXIMUM PURCHASE ($)	MAXIMUM RENTAL($)	COMMENTS
A6255	Specialty absorptive dressing, wound cover, pad size more than 16 sq. in. but less than or equal to 48 sq. in., with any size adhesive border, each dressing	Yes	BI	n/a	
A6256	Specialty absorptive dressing, wound cover, pad size more than 48 sq. in., with any size adhesive border, each dressing	Yes	BI	n/a	
A6260	Wound cleansers, any type, any size	Yes	BI	n/a	
A6261	Wound filler, gel/paste, per fluid ounce, not elsewhere classified	Yes	BI	n/a	
A6262	Wound filler, dry form, per gram, not elsewhere classified	Yes	BI	n/a	
A4454	Tape, all types, all sizes, per roll	Yes	2.00	n/a	1 item = 1 roll.
A6265	Tape, all types, per 18 sq. in.	Yes	BI	n/a	
A4455	Adhesive remover or solvent, each	No	14.50	n/a	
A4460	Elastic bandage, per roll	Yes	5.50	n/a	e.g., compression bandage, Ace. 1 item = 1 roll.
A4464	Joint supportive device/garment, elastic or equal, each	No	BI	n/a	Effective 01/01/01. 1 item = 1 device/garment.
A4462	Abdominal dressing holder/binder, each	No	BI	n/a	I item = 1 holder/binder
A4565	Sling, each	No	19.02	n/a	
A4570	Splint, each	No	17.41	n/a	
A4572	Rib belt, each	No	16.30	n/a	
A4649	Miscellaneous surgical supply not otherwise classified	Yes	BI	n/a	Must attach manufacturer's invoice, amounts, & description. Must be submitted on paper.
A4560	Pessary, each	Deleted			Deleted 12/31/00. See A4561, A4562
A4561	Pessary, rubber, any type	No	30.00	n/a	Effective 01/01/01.
A4562	Pessary, non-rubber, any type	No	30.00	n/a	Effective 01/01/01.
X2136	Suture removal tray	Yes	BI	n/a	
A4927	Glove, non-sterile, each	Yes	.17	n/a	1 item = 1 glove.
X2050	Glove, sterile, each	Yes	.65	n/a	1 item = 1 glove.
Y2820	Sterile applicator, cotton, each	Yes	.07	n/a	1 item = 1 applicator, sterile only.
	Ostomy care				
A4361	Ostomy face plate, all sizes, each	No	7.43	n/a	1 item = 1 faceplate.
A4384	Ostomy faceplate equivalent, silicone ring, each	No	BI	n/a	1 item = 1 faceplate, silicone ring

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CODE	NARRATIVE	PAR	MAXIMUM PURCHASE ($)	MAXIMUM RENTAL($)	COMMENTS
A4372	Ostomy skin barrier; solid 4x4 or equivalent, standard wear, with built-in convexity, each	No	4.25	n/a	1 item = 1 skin barrier.
A4373	Ostomy skin barrier; with flange (solid, flexible or accordion), with built-in convexity, any size, each	No	6.80	n/a	1 item = 1 skin barrier.
A4374	Ostomy skin barrier; with flange (solid, flexible or accordion), extended wear with built-in convexity, any size, each	No	7.65	n/a	1 item = 1 skin barrier.
A4386	Ostomy skin barrier, with flange (solid, flexible or accordion), extended wear, without built-in convexity, any size, each	No	5.40	n/a	1 item = 1 skin barrier.
A4362	Skin barrier, solid, 4x4 or equivalent, each	No	3.12	n/a	
A4385	Ostomy skin barrier, solid 4x4 or equivalent, extended wear, without built-in convexity, each	No	4.55	n/a	1 item = 1 skin barrier.
A6250	Skin sealants, protectants, moisturizers, ointments, any type, any size	No	BI	n/a	
A4364	Adhesive for ostomy or catheter, liquid (spray, brush, etc.), cement, powder or paste, any composition, per ounce	No	3.84	n/a	e.g., silicone, latex. 1 item = 1 ounce.
A4365	Adhesive remover wipes, any type, per 50	No	BI	n/a	1 item = 1 box of 50.
A4367	Ostomy belt, each	No	7.55	n/a	1 item = 1 belt.
A4368	Ostomy filter, any type, each	No	BI	n/a	1 item = 1 filter.
A4398	Ostomy irrigation supply; bag, each	No	16.09	n/a	1 item = 1 bag.
A4399	Ostomy irrigation supply; cone/catheter, including brush	No	3.50	n/a	1 item = cone/catheter and brush
A4400	Ostomy irrigation set, each	No	22.72	n/a	1 item = 1 set.
A4402	Lubricant, per ounce	No	.33	n/a	e.g., KY Gel, Vaseline. 1 item = 1 ounce.
A4404	Adhesive rings (washers, wafers, discs, etc.), each	No	3.90	n/a	1 item = 1 ring.
A4421	Miscellaneous ostomy supply not otherwise classified	No	25.00	n/a	Charges greater than $25.00 must attach manufacturer's invoice, description & amounts. Claim must be submitted on paper.
A4394	Ostomy deodorant for use in ostomy pouch, liquid, per fluid ounce	No	2.45	n/a	.
A4395	Ostomy deodorant for use in ostomy pouch, solid, per tablet	No	.40	n/a	1 item = 1 tablet
XX007	Adhesive remover wipes, 50 per box	No	8.33	n/a	1 item = 1 box of 50.
XX011	Non-adhesive appliance disc, each	No	BI	n/a	1 item = 1 disc.
A5051	Pouch, closed, with barrier attached (1 piece), each	No	2.56	n/a	1 item = 1 pouch.

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CODE	NARRATIVE	PAR	MAXIMUM PURCHASE ($)	MAXIMUM RENTAL($)	COMMENTS
A4387	Ostomy pouch, closed; with standard wear barrier attached, with built-in convexity (1 piece), each	No	BI	n/a	1 item = 1 pouch.
A5052	Pouch, closed, without barrier attached (1 piece), each	No	2.89	n/a	1 item = 1 pouch.
A5053	Pouch, closed, for use on faceplate, each	No	2.01	n/a	1 item = 1 pouch.
A5054	Pouch, closed, for use on barrier, with flange, 2 piece set	No	1.12	n/a	1 item = one 2 piece set.
A5055	Stoma cap, each	No	1.21	n/a	1 item = 1 cap.
A5061	Pouch, drainable, with barrier attached (1 piece), each	No	3.69	n/a	1 item = 1 pouch.
A4388	Ostomy pouch, drainable, with extended wear barrier attached, without built-in convexity (1 piece), each	No	BI	n/a	1 item = 1 pouch.
A4389	Ostomy pouch, drainable, with standard wear barrier attached with built-in convexity (1 piece), each	No	BI	n/a	1 item = 1 pouch.
A5062	Pouch, drainable, without barrier attached (1 piece), each	No	3.30	n/a	1 item = 1 pouch.
A5063	Pouch, drainable, for use on barrier with flange, 2 piece set	No	2.40	n/a	1 item = one 2 piece set.
A5064	Pouch, drainable, with faceplate attached, plastic or rubber, each	No	6.50	n/a	1 item = 1 pouch.
A4375	Ostomy pouch, drainable, with faceplate attached, plastic, each	No	BI	n/a	Effective 01/01/00. 1 item = 1 pouch.
A4376	Ostomy pouch, drainable, with faceplate attached, rubber, each	No	BI	n/a	1 item = 1 pouch.
A5065	Pouch, drainable, for use on faceplate, plastic or rubber, each	Deleted			Deleted 12/31/00. See A4377 or A4378.
A4377	Ostomy pouch drainable, for use on faceplate, plastic, each	No	BI	n/a	1 item = 1 pouch.
A4378	Ostomy pouch, drainable, for use on faceplate, rubber, each	No	BI	n/a	1 item = 1 pouch.
A5071	Pouch, urinary, with barrier attached (1 piece), each	No	3.16	n/a	1 item = 1 pouch.
A4390	Ostomy pouch, drainable, with extended wear barrier attached, with built-in convexity (1 piece), each	No	6.85	n/a	1 item = 1 pouch.
A4391	Ostomy pouch, urinary, with extended wear barrier attached, without built-in convexity (1 piece), each	No	BI	n/a	1 item = 1 pouch.
A4392	Ostomy pouch, urinary, with standard wear barrier attached, with built-in convexity (1 piece), each	No	BI	n/a	1 item = 1 pouch.
A4393	Ostomy pouch, urinary, with extended wear barrier attached, with built-in convexity (1 piece), each	No	8.55	n/a	1 item = 1 pouch.
A5072	Pouch, urinary, without barrier attached (1 piece), each	No	3.15	n/a	1 item = 1 pouch.
A5073	Pouch, urinary, for use on barrier, with flange, per 2 piece set	No	3.40	n/a	1 item = one 2 piece set.
A5074	Pouch, urinary, with faceplate attached, plastic or rubber, each	No	3.87	n/a	1 item = 1 pouch.

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CODE	NARRATIVE	PAR	MAXIMUM PURCHASE ($)	MAXIMUM RENTAL($)	COMMENTS
A5075	Pouch, urinary, for use on faceplate, plastic or rubber, each	No	3.37	n/a	1 item = 1 pouch.
A4381	Ostomy pouch, urinary, for use on faceplate, plastic, each	No	5.70	n/a	1 item = 1 pouch.
A4382	Ostomy pouch, urinary, for use on faceplate, heavy plastic, each	No	BI	n/a	1 item = 1 pouch.
A4383	Ostomy pouch, urinary, for use on faceplate, rubber, each	No	BI	n/a	1 item = 1 pouch.
A4379	Ostomy pouch, urinary, with faceplate attached, plastic, each	No	BI	n/a	1 item = 1 pouch.
A4380	Ostomy pouch, urinary, with faceplate attached, rubber, each	No	BI	n/a	1 item = 1 pouch.
A5081	Continent device, plug for continent stoma, each	No	2.92	n/a	1 item = 1 device.
A5082	Continent device, catheter for continent stoma, each	No	7.00	n/a	1 item = 1 catheter.
A5093	Ostomy accessory, convex insert, each	No	7.01	n/a	1 item = 1 insert.
A5102	Bedside drainage bottle, with or without tubing rigid or expandable, each	No	7.95	n/a	1 item = 1 bottle.
A5105	Urinary suspensory, with leg bag, with or without tube, each	No	56.05	n/a	1 item = 1 suspensory.
A5112	Urinary leg bag, latex, each	No	49.67	n/a	1 item = 1 bag.
A5113	Leg strap; latex, replacement only, per set	No	.79	n/a	1 item = 1 set.
A5114	Leg strap; foam or fabric, replacement only, per set	No	6.97	n/a	1 item = 1 set.
A5119	Skin barrier, wipes, each	No	.18	n/a	1 item = 1 wipe.
A5121	Skin barrier, solid, 6x6 or equivalent, each	No	11.30	n/a	1 item = 1 skin barrier.
A5122	Skin barrier, solid, 8x8 or equivalent, each	No	11.30	n/a	1 item = 1 skin barrier.
A5123	Skin barrier, with flange (solid, flexible or accordion), any size, each	No	7.95	n/a	1 item = 1 skin barrier with flange.
A4369	Ostomy skin barrier; liquid (spray, brush, etc.), per ounce	No	1.75	n/a	1 item = 1 ounce.
A4370	Ostomy skin barrier; paste, per ounce	No	1.75	n/a	1 item = 1 ounce.
A4371	Ostomy skin barrier; powder, per ounce	No	1.75	n/a	1 item = 1 ounce.
A5126	Adhesive or non-adhesive disc or foam pad	No	6.50	n/a	1 item = 1 pad.
A5131	Appliance cleaner, incontinence or ostomy appliance, per ounce	No	.81	n/a	1 item = 1 ounce.
A5149	Miscellaneous incontinence ostomy supply not otherwise classified	Deleted			Deleted 12/31/00. See A4335, A4421.
	Syringes & needles				
A4206	Syringe with needle, sterile, 1 cc, each	No	.15	n/a	Use for diabetic syringes. All syringes must be billed on the Colorado 1500 claim form. 1 item = 1 syringe.
A4207	Syringe with needle, sterile, 2 cc, each	Yes	.26	n/a	1 item = 1 syringe.

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CODE	NARRATIVE	PAR	MAXIMUM PURCHASE ($)	MAXIMUM RENTAL($)	COMMENTS
A4208	Syringe with needle, sterile, 3 cc, each	Yes	.26	n/a	1 item = 1 syringe.
A4209	Syringe with needle, sterile, 5 cc up to 20 cc, each	Yes	.35	n/a	1 item = 1 syringe.
A4213	Syringe, sterile, 20 cc or greater, each	Yes	1.90	n/a	1 item = 1 syringe.
A4215	Needle (only), sterile, any size, each	Yes	.17	n/a	1 item = 1 needle.
X2008	Syringe with needle, sterile, 0.3 cc or other special syringe or needle for use with insulin	Yes	.20	n/a	Diabetic use only. Must be medically justified. 1 item = 1 syringe
A4232	Syringe with needle for external insulin pump, sterile, 3cc	Yes	BI	n/a	
	Urinary care				
A4310	Insertion tray without drainage bag & without catheter (accessories only), each	No	6.50	n/a	
A4311	Insertion tray without drainage bag, with indwelling catheter, foley type, two-way latex with coating (Teflon, silicone, silicone elastomer or hydrophilic, etc.), per set	No	12.36	n/a	1 item = 1 set.
A4312	Insertion tray without drainage bag with indwelling catheter, foley type, two-way, all silicone, per set	No	15.67	n/a	1 item = 1 set.
A4314	Insertion tray with drainage bag with indwelling catheter, foley type, two-way latex with coating (Teflon, silicone, silicone elastomer or hydrophilic, etc.), per set	No	21.07	n/a	1 item = 1 set.
A4315	Insertion tray with drainage bag with indwelling catheter, foley type, two-way, all silicone, per set	No	21.07	n/a	1 item = 1 set.
A4320	Irrigation tray with bulb or piston syringe, each	No	4.16	n/a	1 item = 1 set.
A4322	Irrigation syringe, bulb or piston, each	No	2.15	n/a	1 item = 1 syringe.
A4323	Sterile saline irrigation solution, per 1000 ml	No	7.70	n/a	1 item = 1,000 ml.
A4324	Male external catheter, with adhesive coating, each	No	1.10	n/a	Effective 01/01/01. 1 item = 1 catheter
A4325	Male external catheter, with adhesive strip, each	No	1.02	n/a	Effective 01/01/01. 1 item = 1 catheter
A4326	Male external catheter, specialty type, each	No	7.00	n/a	e.g., inflatable, faceplate, etc., 1 item = 1 catheter.
A4327	Female external urinary collection device, metal cup, each	No	7.00	n/a	1 item = 1 cup.
A4328	Female external urinary collection device, pouch, each	No	8.40	n/a	1 item = 1 pouch.
A4329	External catheter starter set, male or female, includes catheters/urinary collection device, bag/pouch & accessories (tubing, clamps, etc.), per set containing 7 day supply	No	39.95	n/a	1 item = 1 set containing supplies sufficient for 7 days.

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CODE	NARRATIVE	PAR	MAXIMUM PURCHASE ($)	MAXIMUM RENTAL($)	COMMENTS
A4330	Perianal fecal collection pouch with adhesive, each	No	6.09	n/a	1 item = 1 pouch.
A4331	Extension drainage tubing, any type, any length, with connector/adapter, for use with urinary leg bag or urostomy pouch, each	No	1.94	n/a	Effective 01/01/01. 1 item = 1 extension drainage tubing
A4332	Lubricant, individual sterile packet, for insertion of urinary catheter, each	No	.11	n/a	Effective 01/01/01. 1 item = 1 packet
A4333	Urinary catheter anchoring device, adhesive skin attachment, each	No	3.00	n/a	Effective 01/01/01. 1 item = 1 device
A4334	Urinary catheter anchoring device, leg strap, each	No	BI	n/a	Effective 01/01/01. 1 item = 1 device
A4335	Miscellaneous incontinence supply not otherwise classified	Conditional	25.00	n/a	Claim must be submitted on paper. No PAR required if used for urinary tubing, clamps, connectors, and adapters. Billing must include specific reference to urinary item. Charges greater than $25.00 must attach manufacturer's invoice, description & amounts.
A4338	Indwelling catheter, foley type, two-way latex with coating (Teflon, silicone, silicone elastomer or hydrophilic, etc.), each	No	19.98	n/a	1 item = 1 catheter.
A4340	Indwelling catheter, specialty type (coude, mushroom, wing, etc.), each	No	15.49	n/a	1 item = 1 catheter.
A4344	Indwelling catheter, foley type, two-way, all silicone, each	No	12.75	n/a	1 item = 1 catheter.
A4347	Male external catheter with or without adhesive, with or without anti-reflux device, each	No	2.14	n/a	1 item = 1 catheter.
A4348	Male external catheter with integral collection compartment, extended wear, each (e.g., 2 per month)	No	2.14	n/a	Effective 01/01/01. 1 item = 1 catheter.
XX004	Urinary intermittent catheter with insertion tray	No	7.80	n/a	1 item = 1 catheter & tray.
K0407	Urinary catheter anchoring device, adhesive skin attachment	Deleted			Deleted 12/31/00. See A4333.
K0408	Urinary catheter anchoring device, leg strap	Deleted			Deleted 12/31/00. See A4334.
A4354	Insertion tray with drainage bag, without catheter, each	No	4.03	n/a	1 item = 1 tray & bag.
K0281	Lubricant, individual sterile packet, for insertion of urinary catheter, each	Deleted			Deleted 12/31/00. See A4332.
A4356	External urethral clamp or compression device (not to be used for catheter clamp), each	No	38.07	n/a	1 item = 1 clamp.
A4357	Bedside drainage bag, day or night, with or without anti-reflux device, with or without tube, per set	No	8.58	n/a	1 item = 1 set.
K0280	Extension drainage tubing, any type, any length, with connector/adapter, for use with urinary leg bag or urostomy pouch, each	Deleted			Deleted 12/31/00. See A4331.
A4358	Urinary leg bag, vinyl, with or without tube, each	No	5.17	n/a	1 item = 1 bag

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CODE	NARRATIVE	PAR	MAXIMUM PURCHASE ($)	MAXIMUM RENTAL($)	COMMENTS
A4359	Urinary suspensory without leg bag, each	No	43.00	n/a	1 item = 1 suspensory.
A4396	Ostomy belt with peristomal hernia support	No	BI	n/a	Effective 01/01/01. 1 item = 1 belt.
A4397	Irrigation supply, sleeve, each	No	2.49	n/a	1 item = 1 sleeve.
A4554	Underpads, disposable, each	Yes	.41	n/a	e.g., Chux. 1 item = 1 pad. **Note:** Pads with 36" x 72" dimensions are not a benefit.
A4860	Catheter caps, disposable, each	No	.64	n/a	1 item = 1 cap.
A4927	Glove, nonsterile, each	Yes	.17	n/a	1 item = 1 glove.
X2050	Glove, sterile, each	Yes	.65	n/a	1 item = 1 glove.
K0410	Male external catheter, with adhesive coating, each	Deleted			Deleted 12/31/00. See A4324.
A4351	Intermittent urinary catheter; straight tip each	No	1.30	n/a	1 item = 1 catheter.
K0411	Male external catheter, with adhesive strip, each	Deleted			Deleted 12/31/00. See A4325.
A4352	Intermittent urinary catheter; coude (curved) tip, each	No	2.02	n/a	1 item = 1 catheter.
A4353	Intermittent urinary catheter, with insertion supplies	No	BI	n/a	1 item = 1 catheter and supplies.
K0409	Sterile water irrigation solution, 1000 ml	Deleted			Deleted 12/31/00. See A4319
X2016	Child briefs	No	.32	n/a	1 item =1 child brief. Limited to 10 per day in any combination of diapers, liners, and undergarments
X2017	Belted undergarment	No	.60	n/a	1 item =1 belted undergarment. Limited to 10 per day in any combination of diapers, liners, and undergarments
X2019	Incontinence pad	Deleted			Deleted 12/31/00. See S8405.
S8405	Incontinence liners, each	No	.43	n/a	Effective 01/01/01. 1 item = 1 incontinence liner. Limited to 10 per day in any combination of diapers, liners, and undergarments
X2021	Child pull-up briefs (sizes small, medium, and large)	No	.59	n/a	1 item = 1child pull-up brief. Limited to 10 per day in any combination of diapers, liners, and undergarments
X2022	Youth brief	No	.59	n/a	1 item = 1youth brief. Limited to 10 per day in any combination of diapers, liners, and undergarments.
X2023	Adult brief-small	No	.67	n/a	1 item = 1 adult brief, small. Limited to 10 per day in any combination of diapers, liners, and undergarments.

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CODE	NARRATIVE	PAR	MAXIMUM PURCHASE ($)	MAXIMUM RENTAL($)	COMMENTS
X2024	Adult brief-medium	No	.78	n/a	1 item = 1 adult brief, medium. Limited to 10 per day in any combination of diapers, liners, and undergarments.
X2026	Adult brief-large	No	.92	n/a	1 item = 1adult brief, large. Limited to 10 per day in any combination of diapers, liners, and undergarments.
X2027	Adult brief-extra large	No	.94	n/a	1 item = 1 adult brief, extra large. Limited to 10 per day in any combination of diapers, liners, and undergarments
	PARs for X2028, **X2029**, and **X2030** require the following information: 1) # of briefs needed per day; weight of child; 2) Medical and independence needs that will be addressed by using the product; 3) Medical need for higher absorption level; 4) Medical need for increased leakage protection; 5) Medical inability to utilize other products; 6) Reason for better fit of brief; and 7) If other pull-up briefs have been tried and did not meet the client's needs, explain the problem.				
X2028	Adolescent pull-up training brief, medium	Yes	.83	n/a	1 item = 1 adolescent pull-up brief, medium. Limited to 10 per day in any combination of diapers, liners, and undergarments.
X2029	Adolescent pull-up training brief, large	Yes	1.02	n/a	1 item = 1 adolescent pull-up brief, large. Limited to 10 per day in any combination of diapers, liners, and undergarments.
X2030	Adolescent pull-up training brief, extra large	Yes	1.02	n/a	1 item = 1 adolescent pull-up brief, extra large. Limited to 10 per day in any combination of diapers, liners, and undergarments.
X2031	Child pull-up brief, extra large	No	.65	n/a	1 item = 1 child pull-up brief, extra large. Limited to 10 per day in any combination of diapers, liners, and undergarments.
	Miscellaneous				
A4265	Paraffin, per pound	Yes	3.60	n/a	1 item = 1 pound.
E0235	Paraffin bath unit, portable, each	Yes	129.87	12.50	1 item = 1 unit.
ELASTIC SUPPORTS & STOCKINGS – GENERAL USE					
A4490	Surgical stocking, above knee length, each	No	6.50	n/a	1 item = 1 stocking.
A4495	Surgical stocking, thigh length, each	No	8.50	n/a	1 item = 1 stocking.
A4500	Surgical stocking, below knee length, each	No	6.14	n/a	1 item = 1 stocking.
A4510	Surgical stocking, full length, each	No	13.90	n/a	1 item = 1 stocking.
L8100	Elastic support/stocking, below knee, medium weight, each	No	16.25	n/a	1 item = 1 stocking.

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CODE	NARRATIVE	PAR	MAXIMUM PURCHASE ($)	MAXIMUM RENTAL($)	COMMENTS
L8110	Elastic support/stocking, below knee, heavy weight, each	No	53.76	n/a	1 item = 1 stocking.
L8120	Elastic support/stocking, below knee, surgical weight (Linton type or equal), each	No	27.64	n/a	1 item = 1 stocking.
L8130	Elastic support/stocking, above knee, medium weight, each	No	17.30	n/a	1 item = 1 stocking.
L8140	Elastic support/stocking, above knee, heavy weight, each	No	27.01	n/a	1 item = 1 stocking.
L8150	Elastic support/stocking, above knee, surgical weight (Linton type or equal), each	No	17.54	n/a	1 item = 1 stocking.
L8160	Elastic support/stocking, full length, medium weight, each	No	28.12	n/a	1 item = 1 stocking.
L8170	Elastic support/stocking, full length, heavy weight, each	No	29.37	n/a	1 item = 1 stocking.
L8180	Elastic support/stocking, full length, surgical weight (Linton type or equal), each	No	65.70	n/a	1 item = 1 stocking.
L8190	Elastic support/stocking, leotards, medium weight, each	No	32.27	n/a	1 item = 1 leotard.
L8195	Gradient compression stocking, waist length, 30-40 MMHG, each	No	BI	n/a	1 item = 1 stocking.
L8200	Elastic support/stocking, leotards, surgical weight (Linton type), each	No	49.69	n/a	1 item = 1 leotard.
L8210	Elastic support/stocking, custom made, each	No	62.32	n/a	1 item = 1 stocking.
L8220	Elastic support/stocking, lymphedema, each	No	41.07	n/a	1 item = 1 stocking.
L8230	Elastic support/stocking, garter belt, each	No	BI	n/a	1 item = 1 stocking.
HEAT & COLD APPLICATION EQUIPMENT – GENERAL USE					
E0200	Heat lamp, without stand (table model), includes bulb or infrared element, each	Yes	BI	5.00	
E0205	Heat lamp, with stand, includes bulb or infrared element, each	Yes	BI	5.00	
E0217	Water circulating heat pad with pump	Yes	BI	n/a	
E0218	Water circulating cold pad with pump	Yes	BI	n/a	
E0236	Pump for water circulating pad, each	Yes	BI	38.00	
E0249	Pad for water circulating heat unit, each	Yes	18.00	n/a	Purchase for patient owned equipment only.
MONITORING EQUIPMENT & SUPPLIES – GENERAL USE					
E0607	Home blood glucose monitor, each	No	50.00	n/a	
A4660	Blood pressure unit, complete, with stethoscope & sphygmomanometer/cuff, per set	Yes	40.00	n/a	Requires Questionnaire #5. See Appendix H.
A4663	Blood pressure cuff (only), each	Yes	21.00	n/a	1 item = 1 cuff only.

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CODE	NARRATIVE	PAR	MAXIMUM PURCHASE ($)	MAXIMUM RENTAL($)	COMMENTS
A4670	Automatic blood pressure monitor, each	Yes	70.76	n/a	Digital. Requires Questionnaire #5. See Appendix H.
E0608-01	Apnea monitor, each	Yes	n/a	170.00	Includes cardiac monitoring (belts included). 1 unit = 1 month. Beyond 6 months requires Questionnaire #7. See Appendix J.
X2131-01	Pulse Oximeter, per month	Deleted			Deleted 12/31/00. See S8105
S8105	Oximeter for measuring blood oxygen levels non-invasively	Yes	n/a	375.00	Effective 01/01/01. 1 unit = 1 month. Beyond 3 months requires Questionnaire #6. See Appendix I.
X2014-01	Pulse Oximeter, per day	Yes	n/a	50.00	1 unit = 1 day. Limited to overnight or 24 hour test period.
E0609	Blood glucose monitor with special features (e.g., voice synthesizers, automatic timers, etc.)	Yes	350.00	42.87	Requires supporting documentation of medical necessity.
E0610	Pacemaker monitor, self-contained (checks battery depletion, includes audible & visual check systems), each	Yes	BI	n/a	
E0615	Pacemaker monitor, self-contained, checks battery depletion & other pacemaker components, includes digital/visual check systems, each	Yes	BI	n/a	
A4245	Alcohol wipes, each	No	.03	n/a	1 item = 1 wipe.
A4556	Electrodes (e.g., apnea monitor), per pair	No	8.00	n/a	1 item = 1 pair. **Note**: Purchase for patient owned equipment only. Must be provided by supplier for rented equipment.
A4557	Lead wires or cables, per pair	No	21.40	n/a	1 item = 1 pair. **Note**: Purchase for patient owned equipment only. Must be provided by supplier for rented equipment.
A4558	Electrodes gel, per tube	No	5.00	n/a	1 item = 1 tube of gel.
S9001	Home uterine monitor with or without associated nursing services	Yes	n/a	Per PAR	Equipment only. Limited to 1 unit per day- no more than 31 days at a time. NAB with essential nursing services. Telephonic transmission & interpretation are not benefits.
PHOTOTHERAPY – GENERAL USE					
E0202-01	Phototherapy (bilirubin) light with photometer, per day	No	n/a	52.58	1 item = 1 day rental.
E0690-01	Ultraviolet cabinet, appropriate for home use	Yes	n/a	52.50	1 item = 1 month rental.

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CODE	NARRATIVE	PAR	MAXIMUM PURCHASE ($)	MAXIMUM RENTAL($)	COMMENTS
OXYGEN & RESPIRATORY CARE- General Use- Respiratory care equipment requires a physician's prescription. The supplier must maintain a copy of the prescription on file at all times.					
	Humidifiers				
E0550	Humidifier, durable, for EXTENSIVE supplemental humidification during IPPB treatment or oxygen delivery (e.g., Cascade)	No	271.50	8.00	
E0555	Humidifier, durable, glass or autoclavable plastic bottle type, for use with regulator or flowmeter	No	51.76	n/a	
E0560	Humidifier, durable for supplemental humidification during IPPB treatment or oxygen delivery (e.g., Cascade Jr.)	No	53.95	6.88	
K0268	Humidifier, non-heated, used with Positive Airway Pressure device	Yes	BI	n/a	Purchase for patient owned equipment only.
K0531	Humidifier, heated, used with Positive Airway Pressure device	Yes	BI	n/a	Purchase for patient owned equipment only.
X2911	Humidifier bottle, disposable, each	No	3.46	n/a	1 item = 1 bottle.
X2935	Room air filter/purifier	Yes	217.93	41.25	
A4483	Moisture exchanger, disposable, for use with invasive mechanical ventilation	Yes	BI	n/a	
	IPPB machines				
E0500-01	IPPB machine(s), all types, with built in nebulization, manual or automatic valves, internal or external power source (Manual valves external power source includes cylinder regulator built-in nebulization)	No	n/a	70.00	1 item = 1 month rental.
	Oxygen contents – For services provided to nursing facility residents, look under heading "Oxygen Services in Nursing Facility"				
X0400	Oxygen contents, gaseous (for use with rental equipment)	No	.07	n/a	1 unit = 1 cubic ft.
X0410	Oxygen contents, liquid (for use with rental equipment)	No	.82	n/a	1 unit = 1 lb.
X0416	Oxygen refill for portable gaseous system only; up to 23 cubic feet	No	8.67	n/a	Bill 1 unit per tank only, regardless of cubic feet (1 unit = up to 23 cubic ft.)
Y2997-01	Compressed air cylinder (large cylinder)	No	n/a	4.25	
Y2185-01	Oxygen cylinder, small, type B tank	No	n/a	3.75	
ZZ009	Oxygen supply or accessory, component of another item	Yes	BI	n/a	
E0441	Oxygen contents, gaseous (for use with owned gaseous stationary systems or when both a stationary and portable gaseous system are owned)	No	3.50	n/a	1 unit = 50 cubic ft.

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CODE	NARRATIVE	PAR	MAXIMUM PURCHASE ($)	MAXIMUM RENTAL($)	COMMENTS
E0442	Oxygen contents, liquid (for use with owned liquid stationary systems or when both a stationary and portable liquid system are owned)	No	8.20	n/a	1 unit = 10 lbs.
E0443	Portable oxygen contents, gaseous (for use only with portable gaseous systems when no stationary gas or liquid system is used)	No	.35	n/a	1 unit = 5 cubic ft.
E0444	Portable oxygen contents, liquid (for use only with portable liquid systems when no stationary gas or liquid system is used)	No	.82	n/a	1 unit = 1 lb.
X0417-01	Monthly rental of centrally located stationary liquid oxygen system (reservoir) used to refill portable units for multiple patients	No	n/a	By report	Bill usual & customary charge divided by total number of ***all*** patients utilizing reservoir. The total, unduplicated count of patients (regardless of payment source) using the equipment during the month must be maintained in each patient's file.
X0418-01	Monthly rental of centrally located stationary liquid oxygen system to be filled through a centrally located/shared stationary reservoir, includes portable container, flow humidifier, cannula or mask, tubing and refill adapter	No	n/a	57.00	
	Oxygen systems – For services provided to nursing facility residents, look under heading "Oxygen Services in Nursing Facility"				
E0424-01	Stationary compressed gaseous oxygen system, rental; includes container, contents, regulator, flowmeter, humidifier, nebulizer, cannula or mask, & tubing	No	n/a	38.50	1 unit = 10 lbs. Use for Medicare/Medicaid dually eligible clients.
X0425-01	Stationary gaseous O_2 system Medicaid only rental without contents; includes regulator, flow meter, humidifier, nebulizer, cannula or mask & tubing	No	n/a	35.00	
E0431-01	Portable gaseous oxygen system, rental; includes portable container, regulator, flow meter, humidifier, cannula or mask, and tubing	No	n/a	28.00	
E0434-01	Portable liquid oxygen system, rental; includes portable container, supply reservoir, humidifier, flow meter, refill adapter, contents gauge, cannula or mask, and tubing	No	n/a	37.00	Portable only. Bill with X0440-01 for total system.
E0439-01	Stationary liquid oxygen system, rental; includes container, contents, regulator, flow meter, humidifier, nebulizer, cannula or mask, & tubing	No	n/a	33.20	1 unit = 10 lbs. Use for Medicare/Medicaid dually eligible clients.
X0440-01	Stationary liquid O_2 system Medicaid only rental, without contents; includes use of reservoir, contents indicator, regulator, flow meter, humidifier, nebulizer, cannula or mask & tubing	No	n/a	45.00	
X2035	Miscellaneous Oxygen equipment not otherwise classified	Yes	BI	n/a	Par & claim must include equipment description. Must be submitted on paper.

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CODE	NARRATIVE	PAR	MAXIMUM PURCHASE ($)	MAXIMUM RENTAL($)	COMMENTS
	Ventilators, percussors, & respirators				
E0450-01	Volume ventilator, stationary or portable, with backup rate feature used with invasive interface (e.g. tracheostomy, tube)	Yes	n/a	652.00	e.g., LP-6, LP-10, PLV 100, PLV 102, Bear 33, PB2800, PB2801. PAR must include equipment description. 1 item = 1 month rental.
X2171	Pediatric CPAP	Yes	BI	270.00	Includes humidifier, compressor, alarm, CPAP. Requires Questionnaire #8. See Appendix K.
X2173	Servo-controlled heated respiratory humidifier	Yes	BI	185.00	
X2175	External Alarm	Yes	BI	40.00	
X2177	Humidification System	Yes	BI	100.00	For ventilator.
X2179	Biochem Monitor	Yes	BI	Per PAR	Must be submitted on paper. Must submit manufacturer's invoice with PAR. Rental and purchase based on percentage of invoice & rate will be determined at the time of PAR approval. PAR copy must be submitted with claim. 1 item = 1 month rental.
E0457	Chest Shell (cuirass)	Yes	BI	n/a	Must be provided if equipment is rented. Purchase for patient owned equipment only.
E0459	Chest wrap	Yes	BI	n/a	Must be provided if equipment is rented. Purchase for patient owned equipment only.
E0460	Negative pressure ventilator, portable or stationary	Yes	n/a	475.00	e.g., Porta-Lung
E0480	Percussor, electric or pneumatic, home model	Yes	BI	35.00	
E0601	Continuous positive airway pressure (CPAP) device, nasal	Yes	792.00	104.00	Requires sleep study with PAR. Rental includes mask & headgear. Use X2037 for mask purchase. Use K0185 for headgear purchase. Requires Questionnaire #8. See Appendix K.
X2037	CPAP mask, each	Yes	46.64	n/a	Purchase for patient owned equipment only.
K0183	Nasal application device used with Positive Airway Pressure device	Yes	BI	n/a	Purchase for patient owned equipment only.
K0184	Nasal pillows/seals, replacement for nasal application device, pair	Yes	BI	n/a	Purchase for patient owned equipment only.
K0185	Headgear used with Positive Airway Pressure device	Yes	35.75	n/a	Purchase for patient owned equipment only.
K0186	Chin strap used with Positive Airway Pressure device	Yes	BI	n/a	Purchase for patient owned equipment only.
K0187	Tubing used with Positive Airway Pressure device	Yes	BI	n/a	Purchase for patient owned equipment only.
K0188	Filter, disposable, used with Positive Airway Pressure device	Yes	BI	n/a	Purchase for patient owned equipment only.
K0189	Filter, non-disposable, used with Positive Airway Pressure device	Yes	BI	n/a	Purchase for patient owned equipment only.

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CODE	NARRATIVE	PAR	MAXIMUM PURCHASE ($)	MAXIMUM RENTAL($)	COMMENTS
K0268	Humidifier, non-heated, used with Positive Airway Pressure device	Yes	BI	n/a	Purchase for patient owned equipment only.
ZZ004	CPAP supply, component of another item	Yes	BI	n/a	
K0532	Respiratory assist device, bi-level pressure capability without backup rate feature, used with noninvasive interface, e.g., nasal or facial mask (intermittent assist device with continuous positive airway pressure device)	Yes	BI	Per PAR	Must be submitted on paper. Must submit manufacturer's invoice with PAR. Purchase based on percentage of invoice and rate will be determined at the time of PAR approval. PAR copy must be submitted with claim. Requires Questionnaire #8. See Appendix K.
K0533	Respiratory assist device, bi-level pressure capability with backup rate feature, used with noninvasive interface, e.g., nasal or facial mask (intermittent assist device with continuous positive airway pressure device)	Yes	BI	Per PAR	Must be submitted on paper. Must submit manufacturer's invoice with PAR. Purchase based on percentage of invoice and rate will be determined at the time of PAR approval. PAR copy must be submitted with claim. Requires Questionnaire #8. See Appendix K.
K0534	Respiratory assist device, bi-level pressure capability with backup rate feature, used with invasive interface, e.g., tracheostomy tube (intermittent assist device with continuous positive airway pressure device)	Yes	BI	Per PAR	Must be submitted on paper. Must submit manufacturer's invoice with PAR. Purchase based on percentage of invoice and rate will be determined at the time of PAR approval. PAR copy must be submitted with claim. Requires Questionnaire #8. See Appendix K.
X2015	Miscellaneous high tech equipment not otherwise classified	Yes	BI	Per PAR	Must be submitted on paper. Must submit manufacturer's invoice with PAR. Purchase based on percentage of invoice and rate will be determined at the time of PAR approval. PAR copy must be submitted with the claim.
X3030	High frequency chest oscillation; air pulse generator	Yes*	9,475.00	850.00	Effective 05/09/00. I.e., ThAirapy vest system. Requires Questionnaire #14. See Appendix Q.
X3031	High frequency chest wall oscillation; inflatable vest	Yes*	300.00	n/a	Effective 05/09/00. I.e., ThAirapy vest system. Requires Questionnaire #14. See Appendix Q.
	Oxygen concentrators – For services provided to nursing facility residents, look under heading "Oxygen Services in Nursing Facility"				
E1377-01	Oxygen concentrator, high humidity system, equivalent to 244 cubic feet, per month	Deleted			Deleted 12/31/00. See E1390-01.
E1378-01	Oxygen concentrator, high humidity system, equivalent to 488 cubic feet, per month	Deleted			Deleted 12/31/00. See E1390-01.
E1379-01	Oxygen concentrator, high humidity system, equivalent to 732 cubic feet, per month	Deleted			Deleted 12/31/00. See E1390-01.

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CODE	NARRATIVE	PAR	MAXIMUM PURCHASE ($)	MAXIMUM RENTAL($)	COMMENTS
E1380-01	Oxygen concentrator, high humidity system, equivalent to 976 cubic feet, per month	Deleted			Deleted 12/31/00. See E1390-01.
E1381-01	Oxygen concentrator, high humidity system, equivalent to 1,220 cubic feet, per month	Deleted			Deleted 12/31/00. See E1390-01.
E1382-01	Oxygen concentrator, high humidity system, equivalent to 1,464 cubic feet, per month	Deleted			Deleted 12/31/00. See E1390-01.
E1383-01	Oxygen concentrator, high humidity system, equivalent to 1,708 cubic feet, per month	Deleted			Deleted 12/31/00. See E1390-01.
E1384-01	Oxygen concentrator, high humidity system, equivalent to 1,952 cubic feet, per month	Deleted			Deleted 12/31/00. See E1390-01.
E1385-01	Oxygen concentrator, high humidity system, equivalent to over 1,952 cubic feet, per month	Deleted			Deleted 12/31/00. See E1390-01.
E1390-01	Oxygen concentrator, capable of delivering 85 percent or greater oxygen concentration at the prescribed flow rate	No	n/a	175.00	
E1405	Oxygen & water vapor enriching system with heated delivery	Yes	Per PAR	297.19	
E1406	Oxygen & water vapor enriching system without heated delivery	Yes	Per PAR	262.60	
	Oxygen services in nursing facility – See Medicaid Bulletins A9102072 (2/91), B9102083 (6/91), & B0000073 (8/00) for additional information				
X2400	Oxygen contents, gaseous, per cubic foot, nursing facility resident	No	.07	n/a	1 item = 1 cubic foot
X2410	Oxygen contents, liquid, per pound, nursing facility resident	No	.82	n/a	1 item = 1 pound
X2416	Oxygen refill for portable gaseous system only, up to 23 cubic feet, nursing facility resident	No	8.67	n/a	1 item = 23 cubic feet or less
X2425	Stationary compressed gas system; includes regulator flowmeter, humidifier, nebulizer, cannula or mask, & tubing, nursing facility resident	No	n/a	35.00	
X2430	Portable gaseous oxygen system, includes regulator flowmeter, humidifier, cannula or mask, & tubing, nursing facility resident	No	n/a	28.00	
X2435	Portable liquid oxygen system, includes portable container, supply reservoir, flowmeter, humidifier, contents gauge, cannula or mask, tubing, & refill adapter, nursing facility resident	No	n/a	82.00	

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CODE	NARRATIVE	PAR	MAXIMUM PURCHASE ($)	MAXIMUM RENTAL($)	COMMENTS
X2436-01	Monthly rental of centrally located stationary liquid oxygen system (reservoir) used to refill portable units for multiple patients, nursing facility resident	No	n/a	By report	Bill usual & customary charge divided by total number of ***all*** patients utilizing reservoir. The total, unduplicated count of patients (regardless of payment source) using the equipment during the month must be maintained in each patient's file.
X2437-01	Monthly rental of a portable liquid oxygen system to be filled through a centrally located/shared stationary reservoir, includes portable container, flow humidifier, cannula or mask, tubing & refill adapter, nursing facility resident	No	n/a	57.00	
X2440-01	Oxygen system, liquid, stationary, includes use of reservoir, contents indicator, flow meter, humidifier, cannula or masks, & tubing, per month, nursing facility resident	No	n/a	25.00	
X2477-01	Oxygen concentrator, includes flow meter, humidifier, cannula or mask, & tubing, per hour, nursing facility resident	No	n/a	.24	1 item = 1 hour usage. $175 (or 729 units) per month maximum for concentrator/equipment.
NEBULIZERS, VAPORIZERS, SUCTION					
E1375	Nebulizer, portable with small compressor with limited flow	Deleted			Deleted 12/31/00. See E0570.
E0565	Compressor, air power source for equipment which is not self-contained or cylinder driven	No	421.20	n/a	
A7017	Nebulizer, durable glass, or autoclavable plastic, bottle type, not used with oxygen	No	BI	n/a	1 unit = 1 nebulizer
E0570	Nebulizer with compressor	No	110.00	n/a	e.g., Devilbiss, Pulmo-Aid.
E0571	Aerosol compressor, battery powered, for use with small volume nubulizer	No	BI	n/a	Effective 01/01/01.
E0572	Aerosol compressor, adjustable pressure, light duty for intermittent use	No	BI	n/a	Effective 01/01/01.
E0574	Ultrasonic generator with small volume ultrasonic nebulizer	No	BI	n/a	Effective 01/01/01.
E0575	Nebulizer, ultrasonic, large volume	No	BI	n/a	e.g., Mistogen.
E0580	Nebulizer, durable glass or autoclavable plastic bottle type for use with regulator or flowmeter, each	No	5.00	n/a	
E0585	Nebulizer with compressor & heater	No	200.00	n/a	
E0600	Suction pump, home model, portable	No	296.90	26.00	Rental includes suction tubing.
A7000	Canister, disposable, used with suction pump	No	.50	n/a	1 unit = 1 canister
A7001	Canister, non-disposable, used with suction pump	No	BI	n/a	1 unit = 1 canister

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CODE	NARRATIVE	PAR	MAXIMUM PURCHASE ($)	MAXIMUM RENTAL($)	COMMENTS
A7002	Tubing, used with suction pump	No	3.00	n/a	1 unit = 1 tubing
ZZ003	Suction pump supply or accessory, component of another item	No	BI	n/a	Must attach manufacturer's invoice, amounts, & description. Must be submitted on paper.
A7004	Small volume non-filtered pneumatic nebulizer, disposable	No	BI	n/a	1 unit = 1 nebulizer
A7007	Large volume nebulizer, disposable, unfilled, used with aerosol compressor	No	5.60	n/a	1 unit = 1 nebulizer
A7008	Large volume nebulizer, disposable, prefilled, used with aerosol compressor	No	BI	n/a	1 unit = 1 nebulizer
A7009	Reservoir bottle, non-disposable, used with large volume ultrasonic nebulizer	No	52.00	n/a	1 unit = 1 reservoir bottle
A7010	Corrugated tubing, disposable, used with large volume nebulizer, 100 feet	No	3.50	n/a	1 unit = 100 feet
A7011	Corrugated tubing, non-disposable, used with large volume nebulizer, 10 feet	No	12.00	n/a	1 unit = 10 feet
A7012	Water collection device, used with large volume nebulizer	No	1.75	n/a	1 unit = 1 device
A7013	Filter, disposable, used with aerosol compressor	No	2.35	n/a	1 unit = 1 filter
A7014	Filter, non-disposable, used with aerosol compressor or ultrasonic generator	No	BI	n/a	1 unit = 1 filter
A7015	Aerosol mask, used with DME nebulizer	No	1.00	n/a	1 unit = 1 mask
A7016	Dome and mouthpiece, used with small volume ultrasonic nebulizer	No	7.75	n/a	1 unit = dome and mouthpiece
K0182	Water, distilled, used with large volume nebulizer, 1000 ml	Deleted			Deleted 12/31/00. See A7018.
A7018	Water, distilled, used with large volume nebulizer, 1000 ml	No	7.70	n/a	Effective 01/01/01. 1 unit = 1,000 ml.
K0529	Sterile water or sterile saline, 1000ml, used with large volume nebulizer	Deleted			Deleted 12/31/00. See A7020.
A7020	Sterile water or sterile saline, 1000ml, used with large volume nebulizer	No	7.70	n/a	Effective 01/01/01. 1 unit = 1,000ml.
K0269	Aerosol compressor, adjustable pressure, light duty for intermittent use	Deleted			Deleted 12/31/00. See E0572.
K0501	Aerosol compressor, battery powered, for use with small volume nebulizer	Deleted			Deleted 12/31/00. See E0571.
K0270	Ultrasonic generator with small volume ultrasonic nebulizer	Deleted			Deleted 12/31/00. See E0574.
	Respiratory care accessories, supplies & related services				
	Note: All belts, leads, pads, & tubing are included in the rental price. Items may be purchased only for patient-owned equipment. Medication for use with respiratory equipment must be provided by a pharmacy and may require prior authorization and billing on pharmacy claim format with NDC number.				
E0455	Oxygen tent excluding croup or pediatric tents, each	No	8.00	n/a	
A4615	Cannula, nasal, each	No	2.50	n/a	Must be provided with rental equipment. Purchase for patient owned equipment only.
A4616	Tubing (oxygen), per foot	No	.25	n/a	Must be provided with rental equipment. Purchase for patient owned equipment only.

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CODE	NARRATIVE	PAR	MAXIMUM PURCHASE ($)	MAXIMUM RENTAL($)	COMMENTS
E1353	Regulator, each	No	49.00	n/a	Must be provided with rental equipment. Purchase for patient owned equipment only.
A4617	Mouthpiece, each	No	.50	n/a	
E1355	Stand/rack, each	No	29.00	n/a	Purchase for patient owned equipment only.
A4618	Breathing circuits, each	No	16.49	n/a	
A4619	Face tent, each	No	5.00	n/a	
A4620	Variable concentration mask, each	No	7.50	n/a	
S8210	Mucus trap	No	BI	n/a	Effective 01/01/01.
A4614	Peak expiratory flow rate meter, hand held	No	11.00	n/a	
A4621	Tracheotomy mask or collar, each	No	5.00	n/a	
A4622	Tracheostomy or laryngectomy tube, each	No	BI	n/a	
L8501	Tracheostomy, speaking valve, each	No	45.00	n/a	
A4623	Tracheostomy, inner cannula (replacement only), each	No	4.89	n/a	
A4624	Tracheal suction catheter, any type, each	No	1.25	n/a	
A4628	Oropharyngeal suction catheter, each	No	1.38	n/a	1 item = 1 catheter.
A4481	Tracheostomy filter, any type, any size, each	No	BI	n/a	1 item = 1 filter.
A4629	Tracheostomy care kit for established tracheostomy	No	5.40	n/a	1 item = 1 kit.
A7501	Tracheostoma valve, including diaphragm, each	No	BI	n/a	Effective 01/01/01.
A7502	Replacement diaphragm/faceplate for tracheostoma valve, each	No	BI	n/a	Effective 01/01/01.
A7503	Filter holder or filter cap, reusable, for use with tracheostoma heat and moisture exchange system, each	No	BI	n/a	Effective 01/01/01.
A7504	Filter for use with tracheostoma heat and moisture exchange system, each	No	BI	n/a	Effective 01/01/01.
A7505	Housing, reusable without adhesive, for use in a heat and moisture exchange system and/or with a tracheostoma valve, each	No	BI	n/a	Effective 01/01/01.
A7506	Adhesive disc for use in a heat and moisture exchange system and/or with a tracheostoma valve, any type, each	No	BI	n/a	Effective 01/01/01.
A7507	Filter holder and integrated filter without adhesive, for use in a tracheostoma heat and moisture exchange system, each	No	BI	n/a	Effective 01/01/01.

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CODE	NARRATIVE	PAR	MAXIMUM PURCHASE ($)	MAXIMUM RENTAL($)	COMMENTS
A7508	Housing and integrated adhesive, for use in a tracheostoma heat and moisture exchange system and/or with a tracheostoma valve, each	No	BI	n/a	Effective 01/01/01.
A7509	Filter holder and integrated filter housing, and adhesive, for use as a tracheostoma heat and moisture exchange system, each	No	BI	n/a	Effective 01/01/01.
X2182	Twill tape	No	BI	n/a	
ZZ007	Tracheostomy supply, component of another component	No	3.75	n/a	Trach ties, humidivent.
A4627	Spacer, bag or reservoir, with or without mask, for use with metered dose inhaler, each	No	34.00	n/a	Includes aerochamber.
A4611	Battery, heavy duty, replacement for patient owned ventilator, each	No	BI	n/a	
A4612	Battery cables, replacement for patient owned ventilator, each	No	BI	n/a	
A4613	Battery charger, replacement for patient owned ventilator, each	No	331.00	n/a	
E0755	Electronic salivary reflex stimulator, intra oral/non-invasive, each	Yes	BI	n/a	
Y2998	Transtracheal oxygen catheter, each	Deleted			Deleted 12/31/00. See A4608.
A4608	Transtracheal oxygen catheter, each	No	BI	n/a	Effective 01/01/01. 1 item = 1 catheter.
ZZ010	Transtracheal oxygen catheter for patient owned equipment	Deleted			Deleted 12/31/00. See A4608.
ZZ011	Transtracheal oxygen catheter, component of another item	Deleted			Deleted 12/31/00. See A4608.
X2990	Home resuscitation laerdal ambubag	Deleted			Deleted 12/31/00. See S8999.
S8999	Resuscitation bag (For use by patient on artificial respiration during power failure or other catastrophic event)	No	111.24	n/a	Effective 01/01/01.
E1340	Repair or non-routine service for durable medical equipment requiring the skill of a technician, labor component, per 15 minutes	Yes	BI	n/a	Cost of repair cannot exceed cost to purchase replacement equipment. The serial number of equipment being repaired must be identified in field 16 of the PAR. Paper claims must include serial number. If codes are available to identify specific components, they must be used.
X2230	Labor, dealer preparation	Yes	BI	n/a	1 unit per day. Limited to customizing or extensive repair to equipment. Paper claims must include serial number. If codes are available to identify specific components, they must be used.
X2975	Repairs & labor to client owned equipment costing less than $150.00 in a 6 month period	No	150.00	n/a	Paper claims must include serial number.
X2985	Cleaning solution for home respiratory equipment	No	9.72	n/a	

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CODE	NARRATIVE	PAR	MAXIMUM PURCHASE ($)	MAXIMUM RENTAL($)	COMMENTS
TENS OR NMES (TRANSCUTANEOUS OR NEUROMUSCULAR ELECTRICAL NERVE STIMULATOR) EQUIPMENT & SUPPLIES – GENERAL USE					
Note: TENS or NMES require 2-month rental before purchase. **Requires Questionnaire #9. See Appendix L.**					
A4630	Batteries, rechargeable, replacement for medically necessary, patient owned TENS, each	No	15.00	n/a	Limited to maximum of 4 per year.
A4595	TENS supplies, 2 lead, per month	No	BI	n/a	Purchase for client owned equipment only.
X2013	TENS supplies, 4 lead, per month	No	BI	n/a	Purchase for client owned equipment only.
E0720	TENS, two lead, localized stimulation, each	Yes	BI	35.00	
E0730	TENS, four lead, larger area or multiple nerve stimulation, each	Yes	BI	35.00	
E0731	Form fitting conductive garment for delivery of TENS or NMES with conducting fibers separated from the patient's skin by layers of fabric, each	Yes	BI	n/a	
E0744	Neuromuscular stimulator for scoliosis, each	Yes	BI	100.00	
E0745	Neuromuscular stimulator electronic shock unit, each	Yes	420.00	92.67	
E0747-01	Osteogenesis stimulator, electrical noninvasive, other than spinal applications	Yes	n/a	485.00	
E0748	Osteogenic stimulator, noninvasive, spinal applications	Yes	BI	Per PAR	
E0760	Osteogenesis stimulator, low intensity ultrasound, non-invasive	Yes	BI	n/a	
X2260	TENS trial rental, per month (2 months allowed)	Yes	n/a	35.00	**Do not use -01 modifier**. *All* TENS rental requires PAR. 1st month rental without PAR is not available. PAR is required for both months. 1 item = 1 month rental.
Y3240	Battery charger, TENS, each	Yes	50.00	n/a	Must be provided for rental equipment. Purchase for patient owned equipment only.
X2005	TENS unit, disposable, for acute or postoperative pain, each	Yes	75.00	n/a	Disposable unit only.
Y3250	TENS tape/adhesive patches, for use with nondisposable electrodes, each	No	.13	n/a	
Y3255	TENS disposable electrodes with tape, any type, each	No	1.10	n/a	Must be provided for rental equipment. Purchase for patient owned equipment only.
A4245	Alcohol wipes, each	No	.03	n/a	
ZZ006	TENS supply or accessory, component of another item	Yes	BI	n/a	Must attach manufacturer's invoice, description and amounts. Must be submitted on paper.

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CODE	NARRATIVE	PAR	MAXIMUM PURCHASE ($)	MAXIMUM RENTAL($)	COMMENTS
TRAPEZE, TRACTION & FRACTURE FRAMES – GENERAL USE					
E0910	Trapeze bars (also known as "patient helper"), attached to bed, with grab bar	Yes	118.99	19.03	
E0920	Fracture frame, attached to bed, includes weights	Yes	BI	35.00	
E0930	Fracture frame, free standing, includes weights	Yes	BI	35.00	
E0935	Passive motion exercise device, per day	Yes	BI	21.70	Rental per day. First 7 days post-op.
E0940	Trapeze bar, free standing, complete with grab bar	Yes	210.00	25.00	
E0941	Traction device, gravity assisted, any type	Yes	221.81	35.00	
E0942	Cervical head harness or halter, each	Yes	5.70	n/a	
E0943	Cervical pillow, each	Yes	14.90	n/a	
E0944	Pelvic belt, harness or boat, each	Yes	45.00	n/a	
E0945	Extremity belt or harness, each	Yes	BI	n/a	
E0946	Fracture frame, dual, with cross bars, attached to bed	Yes	BI	35.00	e.g., Balken, 4 poster.
E0947	Fracture frame, attachments for complex pelvic traction	Yes	BI	35.00	
E0948	Fracture frame, attachments for complex cervical traction	Yes	BI	35.00	
Y2003	Dynasplint, each	Yes	BI	n/a	
Y3440	Dynasplint software	Yes	BI	n/a	
YY005	Replace soft interface material, dynamic adjustable extension/flexion orthosis	Yes	BI	n/a	
E0830	Ambulatory traction device, all types, each	Yes	BI	Per PAR	Effective 01/01/01.
E0840	Traction frame, attached to headboard, cervical traction	Yes	62.50	17.50	
E0850	Traction stand, free standing, cervical traction	Yes	BI	17.50	
E0855	Cervical traction equipment not requiring additional stand or frame	Yes	BI	n/a	
E0860	Traction equipment, over door, cervical	Yes	23.33	n/a	
E0870	Traction frame, attached to footboard, extremity traction	Yes	BI	17.00	e.g., Bucks.
E0880	Traction stand, free standing, extremity traction	Yes	BI	35.00	e.g., Bucks.
E0890	Traction frame, attached to footboard, pelvic traction	Yes	120.00	17.00	
E0900	Traction stand, free standing, pelvic traction	Yes	BI	17.00	e.g., Bucks.

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CODE	NARRATIVE	PAR	MAXIMUM PURCHASE ($)	MAXIMUM RENTAL($)	COMMENTS
LYMPHEDEMA PUMPS & COMPRESSORS – SPECIALIZED USE					
E0650	Pneumatic compressor, non-segmental home model	Yes	690.00	50.00	
E0651	Pneumatic compressor, segmental home model without calibrated gradient pressure	Yes	1,685.78	50.00	
E0652	Pneumatic compressor, segmental home model with calibrated gradient pressure	Yes	2,106.00	50.00	
E0655	Non-segmental pneumatic appliance for use with pneumatic compressor, half arm	Yes	BI	n/a	
E0660	Non-segmental pneumatic appliance for use with pneumatic compressor, full leg	Yes	87.00	n/a	
E0665	Non-segmental pneumatic appliance for use with pneumatic compressor, full arm	Yes	BI	n/a	
E0666	Non-segmental pneumatic appliance for use with pneumatic compressor, half leg	Yes	BI	n/a	
E0667	Segmental pneumatic appliance for use with pneumatic compressor, full leg	Yes	281.00	50.00	
E0668	Segmental pneumatic appliance for use with pneumatic compressor, full arm	Yes	BI	50.00	
E0669	Segmental pneumatic appliance for use with pneumatic compressor, half leg	Yes	BI	n/a	
WOUND THERAPY EQUIPMENT					
K0538	Negative pressure wound therapy electrical pump, stationary or portable	Yes	n/a	Per PAR	Effective 10/09/00. Price includes equipment & all supplies. 1 unit = one day rental. Requires Questionnaire #12. See Appendix O.
REHABILITATION EQUIPMENT – SPECIALIZED USE					
X2018	Miscellaneous rehabilitation equipment not otherwise classified	Yes	BI	Per PAR	Must be submitted on paper. Must submit manufacturer's invoice with PAR. Rental and purchase based on percentage of invoice and rate will be determined at the time of PAR approval. PAR copy must be submitted with the claim.
X2196	Helmet (to prevent injury from seizure/other medical condition)	Yes	BI	n/a	1 unit = 1 helmet. Not for prevention of sports related injuries.

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CODE	NARRATIVE	PAR	MAXIMUM PURCHASE ($)	MAXIMUM RENTAL($)	COMMENTS
ORAL & ENTERAL NUTRITION, FORMULAE, EQUIPMENT & SUPPLIES – SPECIALIZED USE					
Equipment, supplies & nutrients for enteral feeding or food supplements are a benefit when prescribed by a physician and prior authorized.					
Items for oral & enteral formulae are based on caloric values. Except for X4155 and B4155, one item (unit) represents 100 calories. If a patient requires 1,200 calories per day, total units for one month equals 360 (12 units per day times 30 days). If one can of formula contains 1,200 calories, a case of 12 cans represents 144 units (12 units per can times 12 cans per case). Do not enter units as the number of cans or cases of formulae provided. When submitting PARS, **complete Questionnaire #10, Appendix M**. When submitting claims, be sure to calculate & enter the number of items correctly. Bill X4155 and B4155 per unit as designated on invoice.					
	Oral food supplements				
X4150	Oral formulae category I: Intact protein, protein isolates, per 100 calories	Yes	.60	n/a	e.g. Resource Diabetic, NuBasic, Boost, Kindercal, Ensure, Osmolite, Isocal, Resource, Resource Crystals, Profiber, Enfamil, Promote, Prosobee, Supal Cal, Supal bars, Scundi shake, Sustacal. 1 item = 100 calories.
X4151	Oral formulae category I-A: Blenderized nutrients, per 100 calories	Yes	1.40	n/a	e.g., Compleat B, Compleat B modified, Vitaneed, Alumentum, Ensure with fiber, Enlive. 1 item = 100 calories.
X4152	Oral formulae Category II: Intact protein/protein isolates, calorically dense, per 100 calories	Yes	.50	n/a	e.g., Magnacal, Tramacal, Isosource, Resource Plus, Portagen, Nutren, Ensure Plus, Comply, Promed, Sustacal HC, Ensure HP, Sustacal+, Boost+. 1 item = 100 calories.
X4153	Oral formulae Category III: Hydrolized protein/amino acids, per 100 calories	Yes	1.70	n/a	e.g., Nutri Vir, Vivonex HN, TEN, Vipep, Enfamil with iron, Pediasure with fiber. 1 item = 100 calories.
X4154	Oral formulae Category IV: Defined formulae for special metabolic needs, per 100 calories	Yes	1.64	n/a	e.g., Hepatic acid, Amino aid, Isomil, Hi Cal, Pulmocare, Progestimil, Isomil with iron, Nutramagen, Similac with Iron, Glucerna, Isomil DF, Suplena, Respalor, Nepro, Phenylade Bars Renal Cal, Vrovnex Plus, Paraflex Bars, Choice DM. 1 item = 100 calories.
X4155	Oral formulae Category V: Modular components (protein, carbohydrates, fat)	Yes	BI	n/a	e.g., Propac, Boost Pudding, Gerval Protein, Glucerna fiber, Nubar, HiCal, Nubasic, Promix, Casec, Moducal, Perative, Promod, Controlyte, Polycose Liquid or Powder, Sumacal, Resource, Microlipids, MCT Oil, NutriSource, Nutrathick Promod, Pedialyte, Try, Nursoy, Vitacam, Ultracal, Thicket, Advero, Regain, Ensure pudding, Neocate plus one, Phenylade, Phenylade Amino Acid, Phenex 1 and 2, Prophree, Phenyl Free Powder. Bill per unit as designated on invoice. Must be submitted on paper.

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CODE	NARRATIVE	PAR	MAXIMUM PURCHASE ($)	MAXIMUM RENTAL($)	COMMENTS
X4156	Oral formulae category VI: Standardized nutrients, per 100 calories	Yes	1.21	n/a	e.g., Vivonex Std., Travasorb Std., Precision LR, Pediasure, Tolenex. 1 item = 100 calories.
	Enteral formulae				
B4150	Enteral formulae; category I; Semi-synthetic intact protein/protein isolates, administered through an enteral feeding tube, 100 calories = 1 unit	Yes	.60	n/a	e.g., Enrich, Ensure HN, Ensure powder, Ensure, Isocal, Nubar-Supplacal, Lonalac Powder, Meritene, Meritene Powder, RCF, Osmolite, Osmolite HN, Portagen Powder, Sustacal, Renu, Sustagen Powder, Soy, Travasorb, Resource, Profiber, Enfamil, Replena, Suplena, Promote, Prosobee, Sustacal Plus, Fibersource, Jevity, Next Step, Kindercal. 1 item = 100 calories.
B4151	Enteral formulae; category I; Natural intact protein/protein isolates, administered through an enteral feeding tube, 100 calories = 1 unit	Yes	1.40	n/a	e.g., Compleat B, Vitaneed, Compleat B Modified, Alumentum, Ensure with fiber. 1 item = 100 calories.
B4152	Enteral formulae; category II; Intact protein/protein isolates (calorically dense) administered through an enteral feeding tube, 100 calories = 1 unit	Yes	.50	n/a	e.g., Magnacal, Isocal HCN HC, Ensure plus, Ensure Plus HN, Nutren, Isosource, Pentagen, Ross Pro Med, Portagen, Ross Pro Mod, Comply, Sustacal HC, TwoCal HN, Resource plus, Ensure HP. 1 item = 100 calories.
B4153	Enteral formulae; category III; Hydrolized protein/amino acids, administered through an enteral feeding tube, 100 calories = 1 unit	Yes	1.70	n/a	e.g., Criticare HN, Vivonex TEN (Total Enteral Nutrition), Vivonex HN, Vital, Vital HN, Travasorb HN, Isotein HN, Precision HN, Precision Isotonic, Enfamil with iron, Liposorb, Vivonex TEN, Pediasure with fiber, Jevity with fiber. 1 item = 100 calories.
B4154	Enteral formulae; category IV; Defined formulae for special metabolic need, administered through an enteral feeding tube, 100 calories = 1 unit	Yes	1.64	n/a	e.g., Hepatic-Aid, Travasorb Hepatic, Travasorb MCT, Travasorb Renal, Trauma-Aid, Tramacal, Aminaid Jevity, Isomil, Alitrap, Respalor, Pulmocare, Progestimil, Isomil with iron, Nutramagen, Similac with iron, Calcilo, Glucerna, Nepro, Suplena, Isomil DF. 1 item = 100 calories.
B4155	Enteral formulae; category V: Modular components, administered through an enteral feeding tube, 100 calories = 1 unit	Yes	BI	n/a	Must be submitted on paper. e.g., Propac, Gerval Protein, Promix, Casec, Moducal, Controlyte, Polycose Liquid or Powder, Tyr, Sumacal, Microlipids, Nutri-Source, MCT Oil, Pedialyte, CitroSorce, Nursoy, Vitacam, Peptamin, Promed, Ultasome, Neocal, Peptamin Jr., Pediasure Elect, Sandisource Peptide, Phenyl Free Powder, Prophree. Bill per unit as designated on invoice. Must be submitted on paper.

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CODE	NARRATIVE	PAR	MAXIMUM PURCHASE ($)	MAXIMUM RENTAL($)	COMMENTS
B4156	Enteral formulae; category VI; Standardized nutrients, administered through an enteral feeding tube, 100 calories = 1 unit	Yes	1.21	n/a	e.g., Vivonex Std., Travasorb Std., Pediasure, Precision LR, Tolerex. 1 item = 100 calories.
	Enteral equipment & supplies				
	Note: See the feeding tube/changes and modifications in descriptions, and quantities specific to skin level devices. Quantities exceeding the allowed amount will require additional supporting documentation. See Appendix C for Feeding Tube Devices descriptions.				
B9000-01	Enteral nutrition infusion pump, without alarm, each	Yes	n/a	75.00	
B9002-01	Enteral nutrition infusion pump, with alarm, each	Yes	n/a	75.00	
E0776	IV pole, each	Yes	100.00	15.00	
B4034	Enteral feeding supply kit: Syringe type, to include syringes, tape and wipes, per day	Yes	5.00	n/a	1 item = 1 day's supplies which includes all or part of the listed items. Do not bill included items separately.
B4035	Enteral feeding supply kit: Pump fed type, to include pump sets, containers, syringes, tape & wipes, per day	Yes	9.17	n/a	1 item = 1 day's supplies which includes all or part of the listed items. Do not bill included items separately.
B4036	Enteral feeding supply kit: Gravity fed type, to include gavage sets, containers, syringes, tape & wipes, per day	Yes	6.50	n/a	1 item = 1 day's supplies which includes all or part of the listed items. Do not bill included items separately.
B4081	Nasogastric tubing with stylet, each	Yes	16.75	n/a	
B4082	Nasogastric tubing without stylet, each	Yes	12.98	n/a	
B4083	Stomach tube, Levine type, each	Yes	1.90	n/a	
X2263	Decompression tube (for skin level device), each	Yes	15.00	n/a	1 unit = 1 tube. Quantity Allowed: 5-8 per month
X2267	Gastrostomy skin Level Device (not including decompression tube or feeding tube)	Yes	BI	n/a	1 unit = 1 kit, i.e., Bard Button, Mic-Key, Surgiteck. Quantity Allowed: 1 per month
X2269	Gastrostomy feeding tube for skin level device	Yes	15.00	n/a	1 unit = 1 tube. Quantity Allowed: 5-8 per month
B4084	Gastrostomy/Jejunostomy tube (not skin level device).	Yes	15.00	n/a	1 unit = 1 tube. Quantity Allowed: 2 per month
B4085	Gastrostomy tube, silicone with sliding ring, each	Yes	BI	n/a	1 unit = 1 tube.
A5200	Percutaneous catheter/tube anchoring device, adhesive skin attachment	Yes	BI	n/a	1 unit = 1 device.
B9998	Miscellaneous enteral supplies not otherwise classified. (Extension sets [not included in feeding kit code] 24 hour use-one time use only as stated by manufacturer).	Yes	BI	Per PAR	Include description & quantities on PAR. For rental, must submit manufacturer's invoice with PAR. Rental based on percentage of invoice & rate will be determined at the time of PAR approval. PAR copy must be submitted with claim. Do not use for items included in supply kits. Quantity Allowed: 30 per month

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CODE	NARRATIVE	PAR	MAXIMUM PURCHASE ($)	MAXIMUM RENTAL($)	COMMENTS
X2193	Breast Pump, Manual	No	20.00	n/a	Includes kit and all supplies. Only available for use with premature infants and infants in critical care, and only during period of infant hospitalization.
E0602	Breast Pump, Electric only	Yes	43.50	2.25	Includes breast pump and all supplies. Purchase is available only for use with premature infants and infants in critical care, and only during period of anticipated infant hospitalization of 27 days or more. Rental is available only for periods of infant hospitalization anticipated to be less than 27 days. When renting: 1 unit = 1 day.

HOME IV THERAPY – SPECIALIZED USE

Home IV therapy, when utilized for total parenteral nutrition (TPN), the administration of antibiotics, the maintenance of electrolyte balances or hydration is a benefit of the Colorado Medicaid Program. Services must be prescribed by a physician and prior authorization is required.

Home IV therapy equipment & supplies may be provided by pharmacies or suppliers.

Biological preparation (IV nutrients, drug or other solutions), antibiotic solutions, and TPN solutions must be provided by a pharmacy & are billed on the Pharmacy claim form using NDC numbers. Prior authorization requests must reflect the appropriate NDC numbers.

	Parenteral equipment & supplies				
B9004-01	Parenteral nutrition infusion pump, portable	Yes	n/a	250.00	1 unit = 1 month rental.
B9006-01	Parenteral nutrition infusion pump, stationary	Yes	n/a	145.00	1 unit = 1 month rental.
E0791-01	Parenteral infusion pump, stationary, single or multi channel	Yes	n/a	145.00	1 unit = 1 month rental.
E0781	Ambulatory infusion pump, single or multiple channels, electric or battery operated, with administration equipment, worn by patient	Yes	344.16	n/a	1 unit = 1 month supply.
A4305	Disposable Drug Delivery System, flow rate of 50 ml or greater per hour	Yes	BI	n/a	1 item = 1 system.
A4306	Disposable Drug Delivery System, flow rate of 5 ml or less per hour	Yes	BI	n/a	1 item = 1 system.
E0782	Infusion Pump, implantable	Yes	BI	n/a	
E0779	Ambulatory infusion pump, mechanical, reusable, for infusion 8 hours or greater	Yes	BI	Per PAR	1 item =1 pump. 8 hours or greater.
E0780	Ambulatory infusion pump, mechanical, reusable, for infusion less than 8 hours.	Yes	BI	Per PAR	1 item =1 pump. Less than 8 hours.
K0455	Infusion pump used for uninterrupted administration of epoprostenol	Yes	BI	Per PAR	1 item = 1 system. 1 item = 1 month rental.

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CODE	NARRATIVE	PAR	MAXIMUM PURCHASE ($)	MAXIMUM RENTAL($)	COMMENTS
B4220	Parenteral nutrition supply kit: Premix, including gloves, wipes, alcohol, acetone, providone iodine scrub, ointment, swab sticks, sponges, Heparin flush, tape, caps, syringes, needles, ketodiastic & destruclip, per day	Yes	6.10	n/a	1 item = 1 day's supplies which includes all or part of the listed items. Do not bill included items separately.
B4224	Parenteral nutrition administration kit, includes luer lok & microfilter, pump cassettes, clamps, extension sets & connectors, per day	Yes	20.00	n/a	1 item = 1 day's supplies which includes all or part of the listed items. Do not bill included items separately.
B9999	Miscellaneous Parenteral supplies not otherwise classified	Yes	BI	n/a	Include description & quantity on PAR. Do not use for items included in kits. Submit paper claim with manufactures invoice attached.

PROSTHETICS & ORTHOTICS

Effective for service dates on or after July 1, 1998, prostheses and orthoses are a covered Medicaid benefit for the adult Medicaid population. The benefit includes such items as breast prostheses, braces, artificial limbs, augmentative communication devices, and orthopedic shoes for diabetic clients. These items must be prescribed by the client's physician and prior authorized before services are rendered. Prior authorization requests must be submitted to CFMC for review. The request must include the completed Questionnaire #11, (Appendix N). or Questionnaire #13 (Appendix P). Refer to DMERC orthotic and prosthetic list or HCPCS book 2001 for a complete listing of procedure codes. Medicaid coverage generally follows Medicare coverage.

A4280	Adhesive skin support attachment for use with external breast prosthesis, each	No	BI	n/a	1 unit = 1 attachment.

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INDEX

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INDEX

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INDEX

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Manufacturer/ Brand Name	Model Name/Number	Type	HCPCS Code
Amigo Mobility	Amigo Excite	Power	K0011
Canadian Wheelchair Mfg.	Magic VM Hemi	Manual	K0003
	Magic VM Semihemi	Manual	K0003
	Magic VM Standard	Manual	K0003
	Magic VM Superlow	Manual	K0003
Damaco	Electro Lite (N)	Manual	K0004
	Electro Lite Elite	Manual	K0001
DCC Shoprider	Streamer 888W	Power	K0011
	Streamer 888WS	Power	K0011
Electric Mobility	Chauffeur Model 305	Power	E1230
	Rascal 250 (M), Rascal 255 (M), Rascal 270 (M), Rascal 275 with joystick (M)	Power	K0010
	Rascal Powerchair	Power	K0011
	Viva Powerchair	Power	K0011
Enduro Wheelchair Co.	Libra	Manual	K0009
	Little Star	Manual	K0009
	Pegasus	Manual	K0009
	Taurus	Manual	K0002
	Tyke	Manual	K0009
Etac	Swede Basic, Swede F3	Manual	K0004
	Swede ACT, Swede Cross, Swede Elite	Manual	K0005
Everest & Jennings	New Traveler (I)*, Premier Classic (D)** (09/95), Traveler (A)*, Traveler L, Universal (A)*, Vista	Manual	K0001
	New Traveler Hemi, Traveler (B), Universal (B)	Manual	K0002
	EZ Lite** (03/96), Lightning	Manual	K0003
	Lightning LX, Vision Millenium, Metro, Metro LE	Manual	K0004
	Metro Lx, Vision Millenium, Vision Epic, Vision FX** (12/95), Vision Nitro, Vision Reactor, Vision Record	Manual	K0005
	Universal (C)	Manual	K0006
	Premier Classic (F)** (09/95)	Manual	K0007
	Magnum, MX, Sabre, Sprint, Vortex (J), Solaire	Power	K0011
	Sprint II	Power	K0010
	Metro Power, Tempest, Quest	Power	K0012
	Lancer, Xcaliber	Power	K0014
Gendron	5810LFW, 5812, 5814 (D), 5825 (D), 5830 (D), 7108, 7810 (D), 8555	Manual	K0001
	5811(G)	Manual	K0002
	2058, 2811(D), 5810	Manual	K0003
	4000	Manual	K0004
	2811(F), 5811(F), 5830 (F), 6500, 7810 (F), 5814 (F), 5825 (F), 58184Q, 6518Q	Manual	K0007
	Acti-lite Recliner	Manual	K0001(I)
	Acti-lite Youth 3000	Manual	K0009
Gunnell	GS-2000 (A), H-1000, H-2000 (A)	Manual	K0001
	GL-2000 (B), GS-2000 (B), H-2000 (A)	Manual	K0002
	GL-2000(H)	Manual	K0003
Guardian	MAC Complete, MAC Mobility Base, TNT Lite	Manual	K0009
Hoveround	LTV, MPV, Teknique HVR	Power	K0011
Invacare	9000 Recliner (I), Rolls 4000 (D), Tracer, Tracer LX-SA (A), Tracer Plus, Futuro 4800, Futuro 4130, CareGuard, Invacare MG, Tracer EX	Manual	K0001
	Tracer LX-Hemi (B), Tracer DLX	Manual	K0002
	Tracer LT, Tracer SX	Manual	K0003
Invacare	9000 SL Series, 9000 Tall, 9000 XT Series, Action Patriot, Ride Lite 2000, Ride Lite 9000, CareGuard Titan, Patriot SL	Manual	K0004
	Action Allegro, Action Xtra, Action MVP, Action Style, Action Pro-T, Super Action Pro-T, Action Pro, Action A4, Action F4, Action Top End Terminator	Manual	K0005
	Rolls 900 (E)	Manual	K0006
	Rolls 4000 (F), 9000XDT	Manual	K0007
	Action AT, Action Comet, Action Jr., Action Orbit, Solo Wheelchair	Manual	K0009

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Manufacturer/ Brand Name	Model Name/Number	Type	HCPCS Code
Invacare	Action Excel	Power	K0010
	Ranger II, Ranger X, Storm Ranger X, Storm Torque, MP-3 Power Base Chair	Power	K0011
	Power 9000	Power	K0012
	Arrow, Storm Arrow, XT, Action Tiger	Power	K0014
Kuschall	Champion 1000	Manual	K0004
	Champion 3000, Competitor, Rebel	Manual	K0005
Labac	MRC (I)	Manual	K0001
	BTC, MTRC	Manual	K0009
Leisure Lift, Inc.	PaceSaver Scout	Power	K0011
	PaceSaver Scout	Power	K0010
Love Lift	Love Lift System 2214P	Power	K0014
Lumex	1000 Series, 5000 Series Transport, 4000 Series	Manual	K0001
	5000 Series Hemi	Manual	K0002
	3000 Series	Manual	K0003
	6000 Series, 6000 Series Hemi	Manual	K0004
	5000 Series Wide 20” (K)	Manual	K0006
	5000 Series Wide 22” (L), 5000 Series Wide 24” (L)	Manual	K0007
	Wheeled Chair Table (model 528)	Manual	E1031
Medline	Excel (MDS806100)	Manual	K0001
	Excel Extra Wide (MDS806700)	Manual	K0007
	Excel Hemi (MDS806400)	Manual	K0002
	Excel Lightweight (MDS806600)	Manual	K0003
	Excel Narrow (MDS806150N)	Manual	K0001
Medbloc	Eclipse 350	Manual	K0007
Merits Health Products	M11	Manual	K0003
	Pioneer II	Power	E1230
	Travel-Ease	Power	K0011
Morgan Tech, Inc.	SL, SLS	Manual	K0003
Optiway Technology, Inc.	Corsair	Power	K0011
Ortho Fab	Grizzly	Power	K0011
Otto Bock Group	Protege	Manual	K0004
	Z-700B, Z-700C, Z-700L	Manual	K0005
Permobil	Avenger, G Force, Boing, Challenger, Eclipse 600, Impact, Swoosh, Xtreme	Manual	K0005
	Little Dipper	Manual	K0009
	Chairman Basic	Power	K0011
	Chairman (J), Hexior (J), Max 90 (J)	Power	K0014
Pride	Jazzy 1100, Jazzy 1115, Jazzy Mini Power	Power	K0011
	Jazzy 1420	Power	K0014
	Jazzy 1470	Power	K0014
	Jazzy PHC-10	Power	K0010
	Jet 1 Power Wheelchair	Power	K0011
Quickie	Recliner (I), Breezy, EX, RX, LX, Breezy 600	Manual	K0004
	LXI, Carbon, GP, GPS, GPS Swing-away, GPS Ti, GPV, Quickie 2, Quickie 2 HP, Revolution, Quickie ST/DT, Ti, Triumph	Manual	K0005
	TS	Manual	K0009
	P190, P-200, P-210 (J), G424, S525	Power	K0011
	P-100, P-110, Quickie V-121 (formerly Quickie P-120)	Power	K0012
	P-300, P320	Power	K0014
Redman	Geronimo RC, Geronimo PR (J), Power Road Warrior, Road Savage	Power	K0011
Redman	Chief RU, Chief SR	Power	K0014
The Standing Company	Lifestand	Manual	K0001
Suiter Medical	World Class Wheeled Chair	Manual	K0009

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Manufacturer/ Brand Name	Model Name/Number	Type	HCPCS Code
Theradyne	Envoy Recliner, Maxim Recliner	Manual	K0001
	Envoy Hemi, Envoy Standard, Integra, T-Bird Standard, Maxim Hemi, Maxim SL, Maxim SL Hemi, Maxim Standard, Maxim SL Standard, Venture Hemi, Venture Hemi Lightweight, Venture Lightweight, Venture Standard	Manual	K0003
	Envoy Lightweight, Maxim Lightweight	Manual	K0004
	Envoy Wide, Maxim Wide, Venture Wide	Manual	K0007
	Rover LWF Plus, Rover LWF T1, Vasselli T1, Vassilli T2,	Power	K0011
	T-Bird Adjustable	Manual	K0005
	T-Bird Youth	Manual	K0009
	Vassilli Tilt, Vassilli T2 Junior, Rover TS, Rover R, Vassilli T1 Junior, TheradyneRover LWF T1 Junior, Vassilli Lifestyle, Vassilli Manual Stander, Vassilli Manual Stander Junior, Vassilli Power Stander, Vassilli Power Stander Junior, Vassilli Recline, Vasselli T2 Junior	Power	K0014
Tuffcare	Challenger 2000, Challenger DX 1500, Challenger Recliner 2040	Power	K0011
	Challenger Extra Wide 2500, Challenger Pediatric 1000	Power	K0014
	Compact 777, Compact Super	Manual	K0004
	Eagle, Reliance, Tuffy Deluxe 867/877, Tuffy Recliner 477, Tuffy Standard 257/267/277	Manual	K0001
	Hemi Deluxe/Adult	Manual	K0002
	Hawk Convertible 795, Hawk Super Hemi, Falcon, Falcon Hemi/Adult, Economy 247	Manual	K0003
	Newport Extra Wide (L), Super Extra Wide, Tuffy Super Extra Wide 397	Manual	K0007
	Newport Recliner/Adult, Newport Recliner/Pediatric, Falcon Pediatric, Falcon Pediatric Recliner, Transporter, Ultra Lightweight Transporter, Falcon Hemi/Pediatric, Hemi/Deluxe Pediatric, Compact Pediatric 997, Newport Recliner 475 (pediatric), Newport Recliner 475/477E/477WE (adult)	Manual	K0009
	Super Eagle		K0006
Wheelchairs of Kansas	WIZZ-ard	Manual	K0006
	BCW 600, BCW recliner	Manual	K0007
	BCW Power	Power	K0014
XL Manufacturing	WIZZ-ard	Manual	K0006
	Pacer	Manual	K0003
	Comp	Manual	K0004
	Challenger	Manual	K0009

Footnotes:

(A): Use K0001 if seat height is ≥ 19 inches and seat width is < 22 inches.
(B): Use K0002 if seat height is < 19 inches and seat width is < 22 inches.
(C): Use K0006 if seat width is ≥ 22 inches.
(D): Use K0001 if seat width is < 20 inches.
(E): Use K0006 if seat width is ≥ 20 inches.
(F): Use K0007 if seat width is ≥ 20 inches.
(G): Use K0002 if seat width is < 20 inches.
(H): Use K0003 if seat height is< 19 inches.
(I): Code the reclining back separately using K0028.
(J): Code the power recline/tilt separately using K0108.
(K): Code seat width of 10 or 20 inches separately using K0057.
(L): Code seat width > 18 inches separately using K0108.
(M): Use code K0010 only if the model comes with joystick control. Use E1230 if the model comes with side-mounted tiller control.
(N): Code the power module separately using K0108.
* E & J Traveler and Universal were consolidated to create the New Traveler.
** These models have been discontinued. The effective date is listed beside each model name

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Product	Manufacturer	Category	HCPCS Code
A & D Barrier Ointment	3M	Skin sealants, protectants, moisturizers, ointments, any type, any size	A6250
A & D Emollient Cream	3M	Skin sealants, protectants, moisturizers, ointments, any type, any size	A6250
Antiseptic Skin Cleanser	3M	Wound cleansers, any type, any size	A6260
Blenderm Surgical Tape	3M	Tape, all types, per 18 sq. in.	A6265
Cloth Adhesive Tape	3M	Tape, all types, per 18 sq. in.	A6265
Coban LF Latex Free Self-Adherent Wrap	3M	Elastic bandage, per roll (e.g., compression bandage)	A4460
Coban Self-Adherent Wrap	3M	Elastic bandage, per roll (e.g., compression bandage)	A4460
Durable Barrier Cream	3M	Skin sealants, protectants, moisturizers, ointments, any type, any size	A6250
Foot Emollient Cream	3M	Skin sealants, protectants, moisturizers, ointments, any type, any size	A6250
Medipore H Soft Cloth Surgical Tape	3M	Tape, all types, per 18 sq. in.	A6265
Medipore Pre-Cut Dressing Covers	3M	Tape, all types, per 18 sq. in.	A6265
Medipore Soft Cloth Surgical Tape	3M	Tape, all types, per 18 sq. in.	A6265
Microdon Soft Cloth Adhesive Wound Dressing	3M	Gauze, non-impregnated, with any size adhesive border	A6219-A6221
Microdon Surgical Dressings	3m	Specialty absorptive dressing, wound cover	A6251-A6256
Micropore Surgical Tape	3M	Tape, all types, per 18 sq. in.	A6265
Soft Cloth Adhesive Wound Dressing	3M	Gauze, non-impregnated	A6219-A6221
No Sting Barrier	3M	Skin barrier; liquid (spray, brush, etc.), per oz.	K0137
One-Step Skin Care Lotion	3M	Skin sealants, protectants, moisturizers, ointments, any type, any size	A6250
Opticlude Orthoptic Eye Patches	3M	Surgical supply; miscellaneous	A4649
Soft Cloth Adhesive Wound Dressing	3M	Gauze, non-impregnated, with any size adhesive border	A6219-A6221
Stomaseal Adhesive Disk	3M	Adhesive; disk or foam pad	A5126
Stomaseal Colostomy Dressing	3M	Gauze, non-impregnated, pad size 16 sq. in. or less, with any size adhesive border	A6219
Tegaderm	3M	Transparent film, each dressing	A6257-A6259
Tegaderm HP Transparent Dressing	3M	Transparent film, each dressing	A6257-A6259
Tegaderm IV Transparent Dressing	3M	Transparent film, each dressing	A6257-A6259
Tegaderm Plus #9524	3M	Transparent film, each dressing	A6257-A6259
Tegaderm Transparent Dressing w/ Absorbent Pad	3M	Composite dressing, with any size adhesive border; each dressing	A6203-A6205
Tegagel Hydrogel Wound Filler	3M	Hydrogel dressing, wound filler, gel, per fluid ounce	A6248
Tegagel Hydrogel Wound Filler w/ Gauze	3M	Hydrogel dressing, wound cover, pad size 16 sq. in. or less, without adhesive border, each dressing	A6242
Tegagen HG Wound Cover	3M	Alginate dressing, wound cover, each dressing	A6196-A6198
Tegagen HG Wound Filler	3M	Alginate dressing, wound filler, per 6 inches	A6199
Tegagen HI Wound Cover	3M	Alginate dressing, wound cover, each dressing	A6196-A6198
Tegagen HI Wound Filler	3M	Alginate dressing, wound filler, per 6 inches	A6199
Tegapore	3M	Contact layer, each dressing	A6206-A6208
Tegasorb	3M	Gauze, impregnated, other than water or normal saline, without adhesive border, each dressing	A6234-A6239
Tegasorb Hydrocolloid Dressing-Sacral Design	3M	Hydrocolloid dressing, wound cover, without adhesive border, each dressing	A6238

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Product	Manufacturer	Category	HCPCS Code
Zinc Oxide Vanishing Cream	3M	Skin sealants, protectants, moisturizers, ointments, any type, any size	A6250
Chronicure	ABS Life Sciences	Wound filler, not elsewhere classified	A6261-A6162
Acu-derm	Acme United	Transparent film, each dressing	A6257-A6259
Lyofoam	Acme United	Foam dressing, wound cover, without adhesive border, each dressing	A6209-A6214
Lyofoam A	Acme United	Foam dressing, wound cover, without adhesive border, each dressing	A6209-A6214
Lyofoam C	Acme United	Foam dressing, wound cover, without adhesive border, each dressing	A6209-A6214
Royl-derm	Acme United	Hydrogel dressing, wound filler, gel, per fluid ounce	A6248
Acryderm	AcryMed	Hydrogel dressing, wound cover, without adhesive border, each dressing	A6242-A6244
Acryderm Absorbent Wound Strands	AcryMed	Wound filler, dry form, per gram, not elsewhere classified	A6262
Medipore Adhesive Cover	AcryMed	Tape, all types, per 18 sq. in.	A6265
Gauze Fluffs	American White Cross	Gauze, non-impregnated, sterile, pad size 16 sq. in. or less, without adhesive border, each dressing	A6402
Amerigel topical ointment (A6020 prior to 9-15-98)	Amerx	Wound filler, gel/paste, per fluid ounce, not elsewhere classified	A6261
Bard Absorption Dressing Gel	Bard	Wound filler, gel/paste, per fluid ounce, not elsewhere classified	A6261
Bard Absorption Dressing Dry	Bard	Wound filler, dry form, per gram, not elsewhere classified	A6262
Biolex #5501B	Bard	Hydrogel dressing, wound filler, gel, per fluid ounce	A6248
Biolex #5503B	Bard	Hydrogel dressing, wound filler, gel, per fluid ounce	A6248
Biolex #5504B	Bard	Gauze, non-impregnated, sterile, pad size 16 sq. in. or less, without adhesive border, each dressing	A6242
Biolex #5508B	Bard	Hydrogel dressing, wound cover, pad size more than 16 sq. in. but less than or equal to 48 sq. in., without adhesive border, each dressing	A6243
Vigilon	Bard	Hydrogel dressing, wound cover, without adhesive border, each dressing	A6242-A6247
Hydragran	Baxter	Wound filler, not elsewhere classified	A6261-A6262
Hydrapad	Baxter	Hydrocolloid dressing, wound cover, without adhesive border, each dressing	A6234-A6239
Intact	Baxter	Hydrocolloid dressing, wound cover, without adhesive border, each dressing	A6234-A6239
Aquaphor Gauze Non-adhering	Beiersdorf	Gauze, impregnated, other than water or normal saline, without adhesive border, each dressing	A6222-A6224
Comprilan Low Stretch Bandage	Beiersdorf	Elastic bandage, per roll (e.g., compression bandage)	A4460
Coverlet	Beiersdorf	Tape, all types, per 18 sq. in.	A6265
Cultifilm	Beiersdorf	Transparent film, each dressing	A6257-A6258
Cultifilm Plus	Beiersdorf	Gauze, non-impregnated, non-sterile, without adhesive border, each dressing	A6219-A6221
Cultiplast	Beiersdorf	Gauze, non-impregnated, with any size adhesive border, each dressing	A6219-A6221
Cutinova Alginate Cover	Beiersdorf	Alginate dressing, wound cover, each dressing	A6196-A6197
Cutinova Alginate Filler	Beiersdorf	Alginate dressing, wound filler, per 6 inches	A6199
Cutinova Cavity	Beiersdorf	Foam dressing, wound cover, without adhesive border, per dressing	A6209-A6210
Cutinova Foam	Beiersdorf	Foam dressing, wound cover, without adhesive border, each dressing	A6209-A6211

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Product	Manufacturer	Category	HCPCS Code
Cutinova Gel	Beiersdorf	Hydrogel dressing, wound filler, gel, per fluid ounce	A6248
Cutinova Hydro Hydrocolloid Dressing	Beiersdorf	Hydrocolloid dressing, wound cover, without adhesive border, each dressing	A6234-A6239
Cutinova Thin	Beiersdorf	Foam dressing, wound cover, without adhesive border, each dressing	A6209-A6211
Elastonull Elastic Gauze Nonsterile	Beiersdorf	Gauze, elastic, non-sterile, all types, per linear foot	A6263
Leukotape P Combo Pack	Beiersdorf	Noncovered item or service	A9270
Medifil Gel	Bio-Core	Wound filler, gel/paste, per fluid ounce, not elsewhere classified	A6261
Medifil Pad	Bio-Core	Collagen based wound dressing, wound cover, each dressing	A6020
Medifil Particles	Bio-Core	Wound filler, dry form, per gram, not elsewhere classified	A6262
Skintemp	Bio-Core	Collagen based wound dressing, wound cover, each dressing	A6020
Epi-Derm	Biodermis	Non-covered item or service	A9270
A.R.D. Anoperineal Dressing	Birchwood Laboratories	Gauze, non-impregnated, non-sterile, pad size 16 sq. in. or less, without adhesive border, each dressing	A6216
Fuller Shield	Birchwood Laboratories	Non-covered item or service	A9270
Transorb	Brady Medical Products	Hydrogel dressing, wound cover	A6242-A6247
Fybron Calcium Alginate Dressing (cover)	Braun	Alginate dressing, wound cover, each dressing	A6196-A6197
Fybron Calcium Alginate Dressing (filler)	Braun	Alginate dressing, wound filler, per 6 inches	A6199
Hyfil Wound Gel	Braun	Hydrogel dressing, wound filler, gel, per fluid ounce	A6248
Thinsite	Braun	Composite dressing, with any size adhesive border, each dressing	A6203-A6205
Transorbent Hydrogel Dressing	Braun	Composite dressing, with any size adhesive border, each dressing	A6203-A6205
BGC Matrix	Brennan	Surgical supply, miscellaneous	A4649
Dermafit	Brennan	Elastic bandage, per roll (e.g., compression bandage)	A4460
Elasinet	Brennan	Surgical supply, miscellaneous	A4649
EZ Derm	Brennan	Surgical supply, miscellaneous	A4649
Glucan II	Brennan	Surgical supply, miscellaneous	A4649
GlucanPro Cream	Brennan	Skin sealants, protecants, moisturizers, ointments, any type, any size	A6250
Mediskin	Brennan	Surgical supply, miscellaneous	A4649
NovaGel Silicone	Brennan	Silicone Gel sheet, each	A6025
Sterile Saline Solution Spray	Brennan	Wound cleansers, any type, any size	A6260
Pin Care Kit	Brown Medical Industries	Noncovered item or service	A9270
Epigard	Calgon Vestal	Foam dressing, wound cover	A6209-A6214
Fortex	Calgon Vestal	Alginate dressing, wound cover, each dressing	A6196-A6198
Hydrasorb	Calgon Vestal	Foam dressing, wound cover	A6209-A6214
Kaltosat (cover)	Calgon Vestal	Alginate dressing, wound cover, each dressing	A6196-A6198
Kaltosat (filler)	Calgon Vestal	Alginate dressing, wound filler, per 6 inches	A6199
Pro-clude	Calgon Vestal	Transparent film, each dressing	A6257-A6259
Carra Sorb 12" Rope	Carrington	Alginate dressing, wound filler, per 6 inches	A6199
Carra Sorb FDG	Carrington	Surgical supply, miscellaneous	A4649
Carra Sorb Gel Pad (4x4)	Carrington	Gauze, impregnated, other than water or normal saline, pad size 16 sq. in. or less, without adhesive border, each dressing	A6222

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Product	Manufacturer	Category	HCPCS Code
Carra Sorb Gel Pad (5x5)	Carrington	Gauze, impregnated, other than water or normal saline, pad size more than 16 sq. in. but less than or equal to 48 sq. in., without adhesive border, each dressing	A6223
Carra Sorb H	Carrington	Alginate dressing, wound cover, pad size 16 sq. in. or less, each dressing	A6196
Carra Sorb M	Carrington	Surgical supply, miscellaneous	A4649
Carradres Hydrogel Sheet	Carrington	Hydrogel dressing, wound cover, pad size 16 s. in. or less, without adhesive border, each dressing	A6242
Carrafilm Transparent Film Dressing	Carrington	Transparent film, each dressing	A6257-A6258
Carragauze	Carrington	Hydrogel dressing, wound cover	A6242-A6247
Carraginate Dressing Wound Cover	Carrington	Alginate dressing, wound cover, each dressing	A6196-A6197
Carraginate Dressing Wound Filler	Carrington	Alginate dressing, wound filler, per 6 inches	A6199
Carrasmart Film Dressing	Carrington	Transparent film, each dressing	A6257-A6258
Carrasmart Foam	Carrington	Transparent film, each dressing	A6257-A6258
Carrasmart Hydrocolloid Dressing	Carrington	Hydrocolloid dressing, wound cover, without adhesive border, each dressing	A6234-A6235
Carrasyn V	Carrington	Hydrogel dressing, wound filler, gel, per fluid ounce	A6248
Carrington Bordered Gauze	Carrington	Gauze, non-impregnated, pad size more than 16 sq. in. but less than or equal to 48 sq. in., with any size adhesive border, each dressing	A6220
Carrington Gel Pads	Carrington		A6242-A6243
Carrington Gel Wound Dressing	Carrington	Hydrogel dressing, wound filler, gel, per fluid ounce	A6248
Silicone Gel Sheeting	CICA Care	Silicone gel sheet, each	A6025
AquaGuard	ClearMedical, LLC	Non-covered procedure (not a Medicaid benefit)	A9270
Comfeel Contour Dressing	Coloplast	Hydrocolloid dressing, wound cover, with any size adhesive border, each dressing	A6237-A6239
Comfeel Paste	Coloplast	Hydrocolloid dressing, wound filler, paste, per fluid ounce	A6240
Comfeel Plus Clear Dressing	Coloplast	Hydrocolloid dressing, wound cover, without adhesive border, each dressing	A6234-A6236
Comfeel Plus Contour Dressing	Coloplast	Hydrocolloid dressing, wound cover, with any size adhesive border, each dressing	A6237-A6239
Comfeel Plus PRD	Coloplast	Hydrocolloid dressing, wound cover, with any size adhesive border, each dressing	A6237-A6239
Comfeel Plus Ulcer Dressing	Coloplast	Hydrocolloid dressing, wound cover, without adhesive border, each dressing	A6234-A6236
Comfeel Powder	Coloplast	Hydrocolloid dressing, wound filler, dry form, per gram	A6241
Comfeel Pressure Relief Dressing	Coloplast	Hydrocolloid dressing, wound cover, with any size adhesive border, each dressing	A6237-A6239
Comfeel Seasorb Dressing (Filler)	Coloplast	Alginate dressing, wound filler, per 6 inches	A6199
Comfeel Seasorb Dressing (Pad)	Coloplast	Alginate dressing, wound cover, each dressing	A6196-A6199
Comfeel Transparent Hydrocolloid Dressing	Coloplast	Hydrocolloid dressing, wound cover, without adhesive border, each dressing	A6134-A6236
Comfeel Ulcer Care Dressing	Coloplast	Hydrocolloid dressing, wound cover, without adhesive border, each dressing	A6234-A6236
Sween-A-Peel	Coloplast	Hydrocolloid dressing	A6234-A6239
Triad Hydrophilic Wound Dressing	Coloplast	Hydrocolloid dressing, wound filler, paste, per fluid ounce	A6240

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Product	Manufacturer	Category	HCPCS Code
Wound'ress	Coloplast	Hydrogel dressing, wound filler, gel, per fluid ounce	A6248
Actiderm	Convatec	Hydrocolloid dressing	A6234-A6239
Algiderm (Filler)	Convatec	Alginate dressing, wound filler, per 6 inches	A6199
Algiderm (Cover)	Convatec	Alginate dressing, wound cover, each dressing	A6196-A6198
Aquacel	Convatec	Surgical supply, miscellaneous	A4649
CarboFlex Dressing	Convatec	Alginate dressing, wound cover, each dressing	A6196-A6197
CombiDerm ACD	Convatec	Hydrocolloid dressing, wound cover, with any size adhesive border, each dressing	A6237-A6239
CombiDerm Non-Adhesive Dressing	Convatec	Hydrocolloid dressing, wound cover, pad size more than 16 sq. in. but less than or equal to 48 sq. in., without adhesive border, each dressing	A6235
Dermasorb	Convatec	Alginate dressing, wound filler, per 6 inches	A6199
Duoderm CGF Border Triangle Dressing	Convatec	Hydrocolloid dressing, wound cover, pad size 16 sq. in. or less, with any size adhesive border, each dressing	A6237
Duoderm Hydroactive Gel	Convatec	Hydrogel dressing, wound filler, gel, per fluid ounce	A6248
Duoderm (Cover)	Convatec	Hydrocolloid dressing, wound cover	A6234-A6239
Duoderm (Filler)	Convatec	Hydrocolloid dressing, wound filler	A6240-A6241
EpiVIEW	Convatec	Transparent film, each dressing	A6257-A6259
SafGel	Convatec	Hydrogel dressing, wound filler, gel, per fluid ounce	A6248
SignaDress Hydrocolloid Dressing	Convatec	Hydrocolloid dressing, wound cover, without adhesive border, each dressing	A6234-A6236
SurePress High Compression Bandage	Convatec	Elastic bandage, per roll (e.g., compression bandage)	A4460
Wound Manager	Convatec	Wound pouch, each	A6154
Coversite Dressings	Cush	Composite dressing, with any size adhesive border, each dressing	A6203-A6204
Protect-All Dressings	Cush	Gauze, non-impregnated, with any size adhesive border, each dressing	A6219-A6220
Aquacel Hydrofiber Wound Dressing		Specialty absorptive dressing, wound cover	A6251-A6243
Dale Secondary Wound Dressings/Holders	Dale Medical Products	Surgical supply, miscellaneous	A4649
Damor Cream	Damor	Skin sealants, protecants, moisturizers, ointments, any type, any size	A6250
Damor Cream Gauze	Damor	Surgical supply, miscellaneous	A4649
DermaMend – 2"	Dermarx	Foam dressing, wound cover, pad size 16 sq. in. or less, without adhesive border, each dressing	A6209
DermaMend – 4 3/8"	Dermarx	Foam dressing, wound cover, pad size more than 16 sq. in. but less than or equal to 48 sq. in., without adhesive border, each dressing	A6210
DermaCol	Derma Sciences	Hydrocolloid dressing, wound cover, without adhesive border, each dressing	A6234-A6235
DermaFilm	Derma Sciences	Transparent film, each dressing	A6257-A6258
Dermagran Hydrogel	Derma Sciences	Hydrogel dressing, wound filler, gel, per fluid ounce	A6248
Dermagran Hydrophylic B Dressing	Derma Sciences	Wound filler, gel/paste, per fluid ounce, not elsewhere classified	A6261
Dermagran Hydrophylic Dressing	Derma Sciences	Hydrogel dressing, wound cover	A6242-A6247
Dermagran Ointment	Derma Sciences	Surgical supply, miscellaneous	A4649
Dermagran Wet Dressing	Derma Sciences	Gauze, impregnated, water or normal saline, without adhesive border, each dressing	A6228-A6230
Dermagran Wound Cleanser with Zinc	Derma Sciences	Wound cleansers, any type, any size	A6260

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Product	Manufacturer	Category	HCPCS Code
Dermagran Zinc Saline	Derma Sciences	Gauze, impregnated, other than water or normal saline, pad size more than 16 sq. in. b less than or equal to 48 sq. in., without adhesive border, each dressing	A6223
DermaSite	Derma Sciences	Transparent film, each dressings	A6257-a6258
DermaStat	Derma Sciences	Alginate dressing, wound cover	A6196-A6199
NutraCol	Derma Sciences	Hydrocolloid dressing, wound cover, without adhesive border, each dressing	A6234-A6235
NutrStat	Derma Sciences	Alginate dressing, wound cover	A6196-A6199
DermaMend 2”	DermaRx	Foam dressing, wound cover, pad size 16 sq. in. or less, without adhesive border, each dressing	A6209
Dermamend 4 3/8”	DermaRx	Foam dressing, wound cover, pad size more than 16 sq. in. but less than or equal to 48 sq. in., without adhesive border, each dressing	A6210
Aquasorb	DeRoyal	Hydrogel dressing, wound cover	A6242-A6247
Convaderm Plus	DeRoyal	Composite dressing, with any size adhesive border, each dressing	A6203-A6205
Convaderm	DeRoyal	Specialty absorptive dressing, wound cover	A6251-A6256
Dermanet	DeRoyal	Contact layer, each dressing	A6206-A6208
Kalginate 12” Rope	DeRoyal	Alginate dressing, wound filler, per 6 inches	A6199
Kalginate 2x2	DeRoyal	Alginate dressing, wound cover, pad size 16 sq. in. or less, each dressing	A6196
Kalginate 4x4	DeRoyal	Alginate dressing, wound cover, pad size 16 sq. in. or less, each dressing	A6196
Kalginate 4x8	DeRoyal	Alginate dressing, wound cover, pad size more than 16 sq. in. but less than or equal to 48 sq. in., each dressing	A6197
Kalginate 6” Rope	DeRoyal	Alginate dressing, wound filler, per 6 inches	A6199
Multidex Gel	DeRoyal	Wound filler, gel/paste, per fluid ounce, not elsewhere classified	A6261
Multidex Powder	DeRoyal	Wound filler, dry form, per gram, not elsewhere classified	A6262
Multipad	DeRoyal	Specialty absorptive dressing, wound cover, without adhesive border, each dressing	A6251-A6253
Sof-sorb	DeRoyal	Specialty absorptive dressing, wound cover	A6251-A6256
Transeal	DeRoyal	Transparent film, each dressing	A6257-A6259
Ensure-It	DeRoyal	Transparent film, each dressing	A6257-A6259
Biobrane II	Dow Hickam	Noncovered item or service	A9270
Flexderm	Dow Hickam	Hydrogen dressing, wound cover, without adhesive border, each dressing	A6242-A6244
Flexzan	Dow Hickam	Foam dressing, wound cover	A6209-A6214
Granulex	Dow Hickam	Non-covered item or service	A9270
Proderm	Dow Hickam	Non-covered item or service	A9270
Sorbsan (Cover)	Dow Hickam	Alginate dressing, wound cover, each dressing	A6196-A6198
Sorbsan (Filler)	Dow Hickam	Alginate dressing, wound filler, per 6 inches	A6199
Elta Dermal Gel Filler	Elta	Hydrogel dressing, wound filler, gel, per fluid ounce	A6248
Elta Hydrogel Gauze Pads	Elta	Hydrogel dressing, wound cover, without adhesive border, each dressing	A6242-A6244

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Product	Manufacturer	Category	HCPCS Code
Polymen	Ferris Manufacturing Corp.	Foam dressing, wound cover	A6209-A6214
PolyWic Wound Filler	Ferris Manufacturing Corp.	Foam dressing, wound cover, pad size 16 sq., in. or less, without adhesive border, each dressing	A6209
Geliperm Wet/Granulate	Fougera	Hydrogel dressing, wound cover	A6242-A6247
Conformant 2	Fraztec	Contact layer, each dressing	A6206-A6208
EXU-DRY	Fraztec	Specialty absorptive dressing, wound cover	A6251-A6256
Comfor tell (fomerly Covertell)	Gentell	Composite dressing, with any size adhesive border, each dressing	A6203-A6205
Dermatell	Gentell	Hydrocolloid dressing, wound cover, without adhesive border, each dressing	A6234-A6239
Gentell Hydrogel (Cover)	Gentell	Hydrogel dressing, wound cover	A6242-A6247
Gentel Hydrogel (Filler)	Gentell	Gauze, impregnated, water or normal saline, without adhesive border, each dressing	A6228-A6230
Gentell Isotonic Saline	Gentell	Gauze, impregnated, water or normal saline, without adhesive border, each dressing	A6228-A6230
Calcium Alginate Pads	Genus Biomedical	Alginate dressing	A6196-6197
Calcium Alginate Ribbons	Genus Biomedical	Alginate dressing	A6199
Genus Bordered Gauze Dressing	Genus Biomedical	Gauze, non-impregnated, with any size adhesive border, each dressing	A6219-A6220
Genus Hydrocolloid Pad Low Gel Thin Version	Genus Biomedical	Hydrocolloid dressing, wound cover, without adhesive border, each dressing	A6234-A6236
Genus Hydrocolloid Pad Low Gel Thick Version	Genus Biomedical	Hydrocolloid dressing, wound cover, without adhesive border, each dressing	A6234-A6236
Genus Hydrocolloid Pad Standard Gel	Genus Biomedical	Hydrocolloid dressing, wound cover, without adhesive border, each dressing	A6234-A6236
Medicell PVP Foam Pads	Genus Biomedical	foam dressing	A6209-A6211
Medicell PVP Foam Rolls	Genus Biomedical	foam dressing	A6211
Medicell PVP HC Pads	Genus Biomedical	foam dressing	A6209-A6211
Curative Amorphous Hydrogel Dressing	Gericare	Hydrogel dressing, wound filler, gel, per fluid ounce	A6248
Curative HydroGel Gauze Dressing	Gericare	Hydrogel dressing, wound cover, pad size 16 sq. in. or less, without adhesive border, each dressing	A6242
GRX DermaDrox Ointment	Geritrex	Skin sealants, protectants, moisturizers, ointments, any type, any size	A6252
GRX DermaDrox Spray	Geritrex	Skin sealants, protectants, moisturizers, ointments, any type, any size	A6252
GRX Hydrogel Gauze	Geritrex	Hydrogel dressing, wound cover	A6242-A6247
GRX Hyrophore Gauze 3x3	Geritrex	Gauze, impregnated, other than water or normal saline, each dressing	A6222-A6224
GRX Hyrophore Gauze 3x8	Geritrex	Gauze, impregnated, other than water or normal saline, pad size more than 16 sq. in. but less than or equal to 48 sq. in., without adhesive border, each dressing	A6223
GRX Saline Wet Dressing	Geritrex	Gauze, impregnated, water or normal saline, without adhesive border, each dressing	A6228-A6230
Curasol Gel	Healthpoint	Hydrogel dressing, wound filler, gel, per fluid ounce	A6248
Restore	Hollister	Hydrocolloid dressing, wound cover	A6234-A6239
Wound Drainage Collector	Hollister	Wound pouch, each	A6154
Hydroderm	Hydroderm	Transparent film, each dressing	A6257-A6259

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Product	Manufacturer	Category	HCPCS Code
HyCure Gel	Hymed Group	Wound filler, gel/paste, per fluid ounce, not elsewhere classified	A6261
HyCure Powder	Hymed Group	Wound filler, dry form, per gram, not elsewhere classified	A6262
Hyperion Advanced Alginate Dressings (Cover)	Hyperion Medical	Alginate dressing, wound cover, each dressing	A6196-A6197
Hyperion Advanced Alginate Dressings (Filler)	Hyperion Medical	Alginate dressing, wound filler, per 6 inches	A6199
Hyperion Advanced Dressing with Variable MTVR	Hyperion Medical	Transparent film, each dressing	A6257-A6258
Hyperion Advanced Dressing with Fixed MTVR	Hyperion Medical	Transparent film, each dressing	A6257-A6258
Hyperion Bordered Gauze	Hyperion Medical	Gauze, non-impregnated, with any size adhesive border, each dressing	A6219-A6220
Hyperion Hydrogel Dressing	Hyperion Medical	Hydrogel dressing, wound filler, gel, per fluid ounce	A6248
Hyperion Hydrophilic Impregnated Gauze	Hyperion Medical	Hydrogel dressing, wound cover, without adhesive border, each dressing	A6242-A6244
Iso-Gel Hydrogel Dressing	Hyperion Medical	Hydrogel dressing, wound filler, gel, per fluid ounce	A6248
Iso-Gel Hydrophilic Impregnated Gauze	Hyperion Medical	Hydrogel dressing, wound cover, without adhesive border, each dressing	A6242-A6244
QueGel Hydrophillic Impregnated Gauze	Hyperion Medical	Hydrogel dressing, wound cover, without adhesive border, each dressing	A6242-A6244
QueGel Hydrophillic Wound Dressings	Hyperion Medical	Hydrogel dressing, wound filler, gel, per fluid ounce	A6248
Snugs Tapeless Secondary Dressings	Incare Medical	Surgical supplies, miscellaneous	A4649
SpyroCAVITY	Innovative Technologies, Inc.	Surgical supplies, miscellaneous	A4649
SpyroCOLLOID	Innovative Technologies, Inc.	Hydrocolloid dressing, wound cover, without adhesive border, each dressing	A6234-A6236
SpyroDERM Film	Innovative Technologies, Inc.	Transparent film, each dressing	A6257-A6259
SpyroFOAM	Innovative Technologies, Inc.	Transparent film, each dressing	A6257-A6259
SpyroGEL Hydrogel	Innovative Technologies, Inc.	Transparent film, each dressing	A6257-A6259
SpyroSORB Film/Foam	Innovative Technologies, Inc.	Transparent film, each dressing	A6257-A6259
Omiderm	ITG Labs	Contact layer, each dressing	A6206-A6208
Adaptic	Johnson & Johnson	Gauze, impregnated, other than water or normal saline, without adhesive border, each dressing	A6222-A6224
Adaptic (roll)	Johnson & Johnson	Gauze, impregnated, other than water or normal saline, any width, per linear yard	A6266
Band-Aid Island Dressing	Johnson & Johnson	Specialty absorptive dressing, wound cover	A6251-A6256
Bioclusive	Johnson & Johnson	Transparent film, each dressing	A6257-A6259
Biopatch	Johnson & Johnson	Foam dressing, wound cover, pad size 16 sq. in. or less, without adhesive border, each dressing	A6209
Debrisan	Johnson & Johnson	Wound cleansers, any type, any size	A6260
Dermicel Hypo-Allergenic Cloth Tape	Johnson & Johnson	Tape, all types, per 18 sq. in.	A6265
Dermicel Montgomery Straps	Johnson & Johnson	Abdominal dressing holder/binder, each	A4462
Dermiform Hypo-Allergenic Knitted Tape	Johnson & Johnson	Tape, all types, per 18 sq. in.	A6265
Dermiview Hypo-Allergenic Transparent Tape	Johnson & Johnson	Tape, all types, per 18 sq. in.	A6265
Dyna-Flex Cohesive Compression Bandage	Johnson & Johnson	Elastic bandage, per roll (e.g., compression bandage)	A4460
Dyna-Flex Elastic Bandage	Johnson & Johnson	Elastic bandage, per roll (e.g., compression bandage)	A4460
Dyna-Flex Multiple Layer Compression System	Johnson & Johnson	Surgical supply, miscellaneous	A4649
Elasticon Elastic Tape	Johnson & Johnson	Tape, all types, per 18 sq. in.	A6265

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Product	Manufacturer	Category	HCPCS Code
Fibracol	Johnson & Johnson	Collagen based wound dressing, wound cover, each dressing	A6020
Fibracol Plus	Johnson & Johnson	Collagen based wound dressing, wound cover, each dressing	A6020
J & J Cohering Bandage	Johnson & Johnson	Elastic bandage, per roll (e.g., compression bandage)	A4460
J & J Eye Pads	Johnson & Johnson	Gauze, non-impregnated, sterile, pad size 16 sq. in. or less, without adhesive border, each dressing	A6402
J & J Gauze Sponges (Sterile)	Johnson & Johnson	Gauze, non-impregnated, sterile, pad size 16 sq. in. or less, without adhesive border, each dressing	A6402
J & J Non-Stick Pads	Johnson & Johnson	Gauze, non-impregnated, sterile, pad size 16 sq. in. or less, without adhesive border, each dressing	A6402
J & J Waterproof Tape	Johnson & Johnson	Tape, all types, per 18 sq. in.	A6265
King Fluff Rolls (Non-Sterile)	Johnson & Johnson	Gauze, non-elastic, non-sterile, per linear yard	A6264
King Fluff Rolls (Sterile)	Johnson & Johnson	Gauze, elastic, sterile, per linear yard	A6406
King Fluff Sponges	Johnson & Johnson	Gauze, non-impregnated, sterile, pad size more than 16 sq. in. but less than or equal to 48 sq. in., without adhesive border, each dressing	A6403
Mirasorb (Non-Sterile)	Johnson & Johnson	Gauze, non-impregnated	A6216-A6221
Mirasorb (Sterile)	Johnson & Johnson	Gauze, non-impregnated, sterile, pad size 16 sq. in. or less, without adhesive border, each dressing	A6402
Nu-Brede	Johnson & Johnson	Gauze, non-impregnated, sterile, without adhesive border, each dressing	A6402-A6404
Nu-Derm	Johnson & Johnson	Foam dressing, wound cover, each dressing	A6209-A6214
Nu-Gauze Packing Strips – Iodaform Saturated	Johnson & Johnson	Gauze, impregnated, other than water or normal saline, any width, per linear yard	A6266
Nu-Gauze Packing Strips – Plain	Johnson & Johnson	Gauze, elastic, sterile, all types, per linear yard	A6406
Nu-Gauze Sponges (Non-Sterile)	Johnson & Johnson	Gauze, non-impregnated, non-sterile, without adhesive border, each dressing	A6216-A6221
Nu-Gauze Sponges (Sterile)	Johnson & Johnson	Gauze, non-impregnated, sterile, pad size 16 sq. in. or less, without adhesive border, each dressing	A6402
Nu-Gel	Johnson & Johnson	Hydrogel dressing, wound cover	A6242-A6247
Nu-Gel Collagen Wound Gel	Johnson & Johnson	Hydrogel dressing, wound filler, gel, per fluid ounce	A6248
Prevacare Extra Protective Ointment	Johnson & Johnson	Skin sealants, protectants, moisturizers, ointments, any type, any size	A6250
Prevacare Moisturizing Cream	Johnson & Johnson	Skin sealants, protectants, moisturizers, ointments, any type, any size	A6250
Prevacare Personal Protective Ointment	Johnson & Johnson	Skin sealants, protectants, moisturizers, ointments, any type, any size	A6250
Release	Johnson & Johnson	Gauze, non-impregnated, non-sterile, without adhesive border, each dressing	A6216-A6221
Release Non-Adherent	Johnson & Johnson	Gauze, non-impregnated, sterile, without adhesive border, each dressing	A6402-A6403
Sof-Band Bulky Bandage (Non-Sterile)	Johnson & Johnson	Gauze, non-elastic, non-sterile, per linear yard	A6264
Sof-Band Bulky Bandage (Sterile)	Johnson & Johnson	Gauze, elastic, sterile, all types, per linear yard	A6206
Sof-Foam Dressing	Johnson & Johnson	Foam dressing, wound cover, without adhesive border, each dressing	A6209-A6210
Sof-Kling Conforming Bandage (Non-Sterile)	Johnson & Johnson	Gauze, non-elastic, non-sterile, per linear yard	A6264
Sof-Kling Conforming Bandage (Sterile)	Johnson & Johnson	Gauze, elastic, sterile, all types, per linear yard	A6406
Sof-Wick (Non-Sterile)	Johnson & Johnson	Gauze, non-impregnated	A6216-A6221
Sof-Wick (Sterile)	Johnson & Johnson	Gauze, non-impregnated, sterile, pad size 16 sq. in. or less, without adhesive border, each dressing	A6402
Steri-Pad Gauze Pads	Johnson & Johnson	Gauze, non-impregnated, sterile, pad size 16 sq. in. or less, without adhesive border, each dressing	A6402

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Product	Manufacturer	Category	HCPCS Code
Surgicel	Johnson & Johnson	Non-covered item	A9270
Surgi-Pad	Johnson & Johnson	Specialty absorptive dressing, wound cover	A6251-A6256
Tielle	Johnson & Johnson	Foam dressing, wound cover, with any size adhesive border, each dressing	A6212-A6214
Tielle Plus	Johnson & Johnson	Foam dressing, wound cover, with any size adhesive border, each dressing	A6212-A6214
Topper Dressing Sponges (Non-Sterile)	Johnson & Johnson	Gauze, non-impregnated	A6216-A6221
Topper Dressing Sponges (Sterile)	Johnson & Johnson	Gauze, non-impregnated, sterile, pad size 16 sq. in. or less, without adhesive border, each dressing	A6402
Zonas Porous Tape	Johnson & Johnson	Tape, all types, per 18 sq. in.	A6265
Conform	Kendall	Gauze, elastic, non-sterile, all types, per linear yard	A6263
Curaderm	Kendall	Hydrocolloid dressing, wound cover, gel, per fluid ounce	A6234-A6236
Curafil	Kendall	Hydrogel dressing, wound filler, gel, per fluid ounce	A6248
Curafoam	Kendall	Foam dressing, wound cover, without adhesive border, each dressing	A6209-A6211
Curafoam Plus	Kendall	Foam dressing, wound cover, without adhesive border, each dressing	A6209-A6211
Curagel	Kendall	Hydrogel dressing, wound cover	A6242-A6247
Curasalt	Kendall	Gauze, impregnated, other than water or normal saline, without adhesive border, each dressing	A6222-A6224
Curasorb (Cover)	Kendall	Alginate dressing, wound cover, each dressing	A6196-A6198
Curasorb (Filler)	Kendall	Alginate dressing, wound filler, per 6 inches	A6199
Curity Elastic Bandage	Kendall	Elastic bandage, per roll (e.g., compression bandage)	A4460
Curity Oil Emulsion Dressing	Kendall	Gauze, impregnated, other than water or normal saline, without adhesive border, each dressing	A6222-A6224
Curity Xeroform Dressing	Kendall	Gauze, impregnated, other than water or normal saline, without adhesive border, each dressing	A6222-A6224
Excillon	Kendall	Gauze, non-impregnated	A6216-A6221
Flex-Wrap	Kendall	Elastic bandage, per roll (e.g., compression bandage)	A4460
Kerlix Lite Gauze Bandage	Kendall	Gauze, non-elastic, non-sterile, per linear yard	A6264
Kerlix Zinc Saline	Kendall	Gauze, impregnated, other than water or normal saline, without adhesive border, each dressing	A6222-A6224
Polyskin	Kendall	Transparent film, each dressing	A6257-A6259
Telfa	Kendall	Gauze, non-impregnated, non-sterile, without adhesive border, each dressing	A6216-A6218
Telfa Island Dressing	Kendall	Gauze, non-impregnated, with any size adhesive border, each dressing	A6219-A6221
Telfa Max	Kendall	Specialty absorptive dressing, wound cover, each dressing	A6252-A6253
Telfa Plus Island Dressing	Kendall	Composite dressing, with any size adhesive border, each dressing	A6203-A6205
Telfa Xtra	Kendall	Composite dressing, with any size adhesive border, each dressing	A6203-A6205
Tendersorb	Kendall	Specialty absorptive dressing, wound cover	A6251-A6256
Tenderwrap	Kendall	Surgical supply, miscellaneous	A4649
Ultec Pro	Kendall	Surgical supply, miscellaneous	A4649
Ventex Absorptive	Kendall	Composite dressing, with any size adhesive border, each dressing	A6203-A6205
Ventex Vented	Kendall	Contact layer, each dressing	A6206-A6208

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Product	Manufacturer	Category	HCPCS Code
Versalon	Kendall	Gauze, non-impregnated	A6216-A6221
Iodoform Packing Strip	Kimberly-Clark	Gauze, any width	A6266
Plain Packing Strip	Kimberly-Clark	Gauze, non-elastic, sterile	A6406
Shur-Conform Oil Emulsion Non-Adhering Dressing	Kimberly-Clark	Gauze, impregnated, other than water or normal saline	A6222-A6223
Catrix	Lescardin	Wound filler, dry form, per gram, not elsewhere classified	A6262
Repliderm	Lescardin	Wound filler, dry form, per gram, not elsewhere classified	A6262
MaRRayels LaFeet OTC Ointment	MaRRayels LaFeet	Skin sealants, protectants, moisturizers, ointments, any type, any size	A6250
Spandage	Medi-Tech	Surgical supply, miscellaneous	A4649
Spand-Gel	Medi-Tech	Hydrogel dressing, wound filler, gel, per fluid ounce	A6248
Spand-Gel Hydrogel Gauze Dressing	Medi-Tech	Gauze, impregnated, other than water or normal saline, pad size 16 sq. in. or less, without adhesive border, each dressing	A6222
Spand-Gel Sterile Occlusive Foam Dressing	Med-Tech	Foam dressing, wound cover, pad size more than 16 sq. in. but less than or equal to 48 sq. in., without adhesive border, each dressing	A6210
Biafine	Medix Pharmaceuticals	Skin sealants, protectants, moisturizers, ointments, any type, any size	A6250
Derma-Gel Hydrogel Wafer	Medline	Hydrogel dressing, wound cover, pad size 16 sq. in. or less, without adhesive border, each dressing	A6242
ExuDerm	Medline	Hydrocolloid dressing, wound cover, without adhesive border, each dressing	A6234-A6236
ExuDerm LP	Medline	Hydrocolloid dressing, wound cover, without adhesive border, each dressing	A6234-A6236
ExuDerm RCD	Medline	Hydrocolloid dressing, wound cover, without adhesive border, each dressing	A6234-A6236
Exuderm Sacrum	Medline	Hydrocolloid dressing, wound cover, any size adhesive border, each dressing	A6238
Exuderm Ultra	Medline	Hydrocolloid dressing, wound cover	A6234
Maxorb Hydrofiber Alginate Dressing Cover	Medline	Alginate dressing, wound cover, each dressing	A6196-A6197
Maxorb Hydrofiber Alginate Dressing Rope	Medline	Alginate dressing, wound cover, each dressing	A6199
Medline Bordered Gauze	Medline	Gauze, non-impregnated, with any size adhesive border, each dressing	A6219-A6220
Suresite	Medline	Composite dressing, with any size adhesive border, each dressing	A6203-A6205
Suresite IV	Medline	Transparent film, each dressing	A6257-A6258
SkinTegrity Hydrogel	Medline	Hydrogel dressing, wound filler, gel, per fluid ounce	A6248
SkinTegrity Hydrogel Gauze	Medline	Gauze, impregnated, other than water or normal saline, without adhesive border, each dressing	A6222-A6224
StrataSorb	Medline	Composite dressing, with any size adhesive border, each dressing	A6203-A6205
Suresite	Medline	Composite dressing, with any size adhesive border, each dressing	A6203-A6205
Suresite IV	Medline	Transparent film, each dressing	A6257-A6258
Dermatell	MKM Healthcare	Hydrocolloid dressing, wound cover	A6234-A6239
Gentell Covertell	MKM Healthcare	Specialty absorptive dressing, wound cover	A6251-A6256
Gentell Hydrogel (Cover)	MKM Healthcare	Hydrogel dressing, wound cover	A6242-A6247
Gentell Hydrogel (Filler)	MKM Healthcare	Hydrogel dressing, wound filler, gel, per fluid ounce	A6248

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Product	Manufacturer	Category	HCPCS Code
Gentell Isotonic Saline	MKM Healthcare	Gauze, impregnated, water or normal saline, without adhesive border, each dressing	A6228-A6230
Alldress	Molnlycke	Composite dressing, with any size adhesive border, each dressing	A6203-A6205
Hypergel (Cover)	Molnlycke	Hydrogel dressing, wound cover	A6242-A6247
Hypergel (Filler)	Molnlycke	Hydrogel dressing, wound filler, gel, per fluid ounce	A6248
Mefix Dressing Fixation Fabric	Molnlycke	Tape, all types, per 18 sq. in.	A6265
Mefilm Adhesive Polyurethane Film	Molnlycke	Transparent film	A6257-A6259
Melgisorb Calcium Alginate Dressing (Cover)	Molnlycke	Alginate dressing, wound cover, each dressing	A6196-A6198
Melgisorb Calcium Alginate Dressing (Filler)	Molnlycke	Alginate dressing, wound filler, per 6 inches	A6199
Mepilex Self-Adherent Absorbent Dressing	Molnlycke	Foam dressing 16 sq in-w/adhesive ea/dressing	A6212-A6214
Mepitel	Molnlycke	Contact layer, each dressing	A6206-A6208
Mepore #570805	Molnlycke	Gauze, non-impregnated, pad size 16 sq. in. or less, with any size adhesive border, each dressing	A6219
Mepore #670905	Molnlycke	Gauze, non-impregnated, pad size 16 sq. in. or less, with any size adhesive border, each dressing	A6219
Mepore #671005	Molnlycke	Gauze, non-impregnated, pad size 16 sq. in. or less, with any size adhesive border, each dressing	A6219
Mepore #671105	Molnlycke	Gauze, non-impregnated, pad size 16 sq. in. or less, with any size adhesive border, each dressing	A6219
Mepore #671205	Molnlycke	Gauze, non-impregnated, pad size 16 sq. in. or less, with any size adhesive border, each dressing	A6219
Mepore #671305	Molnlycke	Gauze, non-impregnated, pad size more than 16 sq. in. but less than or equal to 48 sq. in., with any size adhesive border, each dressing	A6220
Mesalt Pads	Molnlycke	Gauze, impregnated, other than water or normal saline, without adhesive border, each dressing	A6222-A6224
Mesalt Strips	Molnlycke	Gauze, impregnated, other than water or normal saline, any width, per linear yard	A6266
Mitraflex Plus	Molnlycke	Foam dressing, wound cover	A6209-A6214
Mitraflex SC	Molnlycke	Foam dressing, wound cover	A6209-A6214
Normigel	Molnlycke	Hydrogel dressing, wound filler, gel, per fluid ounce	A6248
Normigel Saline Impregnated Gauze	Molnlycke	Hydrogel dressing, wound cover	A6242-A6243
MPM Gel Pad	MPM	Hydrogel dressing, wound cover	A6242-A6247
MPM Wet Saline	MPM	Gauze, impregnated, water or normal saline, without adhesive border, each dressing	A6228-A6230
Clearsite	New Dimensions in Medicine (NDM)	Hydrogel dressing, wound cover	A6242-A6247
Clearsite Hydrogauze Dressing	New Dimensions in Medicine (NDM)	Hydrogel dressing, wound cover	A6242-A6247
HydroFoam	O.R. Resources	Foam dressing, wound cover, without adhesive border, each dressing	A6209-A6211
Hydrogel	O.R. Resources	Hydrogel dressing, wound filler, per fluid ounce	A6248
Iodoflex	Oclassen Pharmaceuticals Inc.	Wound filler, not elsewhere classified	A6261-A6262
Iodosorb Gel	Oclassen Pharmaceuticals Inc.	Wound filler, gel/paste, per fluid ounce, not elsewhere classified	A6261
Iodosorb Powder	Oclassen Pharmaceuticals Inc.	Wound filler, dry form, per gram, not elsewhere classified	A6262

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Product	Manufacturer	Category	HCPCS Code
Selan Protective Cream	P.J. Noyes Company, Inc	Skin sealants, protectants, moisturizers, ointments, any type, any size	A6250
Selan Protective Lotion	P.J. Noyes Company, Inc	Skin sealants, protectants, moisturizers, ointments, any type, any size	A6250
Selan + Zinc Oxide Barrier Cream	P.J. Noyes Company, Inc	Skin sealants, protectants, moisturizers, ointments, any type, any size	A6250
Selan + Zinc Oxide Barrier Lotion	P.J. Noyes Company, Inc	Skin sealants, protectants, moisturizers, ointments, any type, any size	A6250
Phytacare Alginate Wound Dressing	Phytatec Labs	Gauze, impregnated, other than water or normal saline, pad size 16 sq. in. or less, without adhesive border, each dressing	A6222
OsmoCyte Pillow Wound Dressing	Procyte	Surgical Supply; miscellaneous	A4649
Procyte Transparent Film Dressing	Procyte	Transparent film, each dressing	A6257-A6259
Epitech Foam Dressing	Rynel Ltd.	Foam dressing, wound cover, each dressing	A6209-A6214
SeptiCare	Sage Laboratories	Wound Cleansers, any type, any size	A6260
Blisterfilm	Sherwood	Transparent film, each dressing	A6257-A6259
Dermacea Alginate Wound Dressing	Sherwood	Alginate dressing, wound cover, each dressing	A6196-A6199
Dermacea Aquaflo Hydrogel Wound Dressing	Sherwood	Hydrogel dressing, wound cover, without adhesive border, each dressing	A6242-A6243
Dermacea Ultec Thin Hdrocolloid	Sherwood	Hydrocolloid dressing, wound cover, without adhesive border, each dressing	A6234-A6236
Interpan	Sherwood	Surgical supply; miscellaneous	A4649
Intersorb	Sherwood	Specialty absorptive dressing, wound cover	A6251-A6256
Scarlet Red Ointment Dressing	Sherwood	Gauze, impregnated, other than water or normal saline, without adhesive border each dressing	A6222-A6224
Ultec	Sherwood	Hydrocolloid dressing, wound cover	A234-A6239
Vaseline Petrolatum Gauze	Sherwood	Gauze, impregnated, other than water or normal saline, without adhesive border each dressing	A6222-A6224
Viasorb	Sherwood	Composite dressing, with any size adhesive border, each dressing	A6203-A6205
Xeroflo	Sherwood	Gauze, impregnated, other than water or normal saline, without adhesive border each dressing	A6222-A6224
Airstrip	Smith & Nephew United	Composite dressing, with any size adhesive border, each dressing	A6203-A6205
Allevyn (cover)	Smith & Nephew United	Foam dressing, wound cover, each dressing	A6209-A6214
Allevyn (filler)	Smith & Nephew United	Foam dressing, wound filler, per gram	A6215
Intrasite Gel	Smith & Nephew United	Hydrogel dressing, wound filler, gel, per fluid ounce	A6248
Lymwrap Bandaging Kits	Smith & Nephew United	Surgical supply; miscellaneous	A4649
Opsite	Smith & Nephew United	Transparent film, each dressing	A6257-A6259
Opsite Postop	Smith & Nephew United	Composite dressing, with any size adhesive border, each dressing	A6203-A6205
Primapore	Smith & Nephew United	Specialty absorptive dressing, wound cover	A6251-A6256
Profore	Smith & Nephew United	Surgical supply; miscellaneous	A4649
Replicare (cover)	Smith & Nephew United	Hydrocolloid dressing, wound cover	A6234-A6239
Replicare (filler)	Smith & Nephew United	Hydrocolloid dressing, wound filler	A6240-A6241
Solo-Site Wound Gel	Smith & Nephew United	Hydrogel dressing, wound filler, gel, per fluid ounce	A6248
Transigel Conformable Gel Dressing	Smith & Nephew United	Hydrogel dressing, wound cover, without adhesive border, each dressing	A6242-A6243

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Product	Manufacturer	Category	HCPCS Code
Uniflex	Smith & Nephew United	Transparent film, each dressing	A6257-A6259
Elasto-Gel	Southwest Tech, Inc.	Hydrogel dressing, wound cover	A6242-A6247
Elasto-Gel Island Dressing	Southwest Tech, Inc.	Hydrogel dressing, wound cover	A6245-A6247
Elasto-Gel Plus	Southwest Tech, Inc.	Hydrogel dressing, wound cover, without adhesive border, each dressing	A6242-A6244
Elasto-Gel Tape	Southwest Tech, Inc.	Tape, all types, per 18 sq. inch	A6265
Horseshoe Dressing	Southwest Tech, Inc.	Hydrogel dressing, wound cover, pad size more than 48 sq. inches, with any size adhesive border, each dressing	A6247
Toe-Aid	Southwest Tech, Inc.	Hydrogel dressing, wound cover, pad size 16 sq. in. or less, with any size adhesive border, each dressing	A6245
Second Skin	Spenco	Hydrogel dressing, wound cover	A6242-a6247
Tapeless Secondary Dressing	Tapeless Tech, Inc.	Surgical supply; miscellaneous	A4649
Sparta Hypertonic Saline Dressing	Tecnol*	Gauze, impregnated, other than water or normal saline, without adhesive border, each dressing	A6222-A6224
Sparta Iodoform Packing Strips	Tecnol*	Gauze, elastic, sterile, all types, per linear yard	A6406
Sparta Isotonic Saline Dressing	Tecnol*	Gauze, impregnated, water or normal saline, without adhesive border, each dressing	A6228-A6230
Sparta Oil Emulsion Dressing	Tecnol	Gauze, impregnated, other than water or normal saline, without adhesive border, each dressing	A6222-A6224
Sparta Plain Packing Strips	Tecnol*	Gauze, non-elastic, non-sterile, per linear yard	A6264
Sparta Sterile Water	Tecnol*	Gauze, impregnated, water or normal saline, without adhesive border, each dressing	A6228-A6230
Acticoat Antimicrobial Barrier Dressing	Westaim Biomedical, Inc.	Surgical supply, miscellaneous	A4649
Dermassist Petrolatum Gauze	Wilshire	Gauze, impregnated, other than water or normal saline, without adhesive border, each dressing	A6222-A6224
Dermassist Oil Emulsion Dressing	Wilshire	Gauze, impregnated, other than water or normal saline, without adhesive border, each dressing	A6222-A6224
Dermassist Site Dressing	Wilshire	Transparent film, each dressing	A6257-A6259
Dermassist Wet Dressing	Wilshire	Gauze, impregnated, water or normal saline, without adhesive border, each dressing	A6228-A6230
Breakaway	Winfield Labs, Inc.	Specialty absorptive dressing, wound cover without adhesive border	A6251-A6253
N-terface	Winfield Labs, Inc.	Contact layer, each dressing	A6206-A6208

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Manufacturer	Code	Product Number	Description
MIC KEY	X2267	012014-0.8	MIC KEY Skin Level Gastrostomy Kit 14FR 5cc 0.8 cm Stoma length
MIC KEY	X2267	012014-1.0	MIC KEY Skin Level Gastrostomy Kit 14FR 5cc 1.0 cm Stoma length
MIC KEY	X2267	012014-1.2	MIC KEY Skin Level Gastrostomy Kit 14FR 5cc 1.2 cm Stoma length
MIC KEY	X2267	012014-1.5	MIC KEY Skin Level Gastrostomy Kit 14FR 5cc 1.5 cm Stoma length
MIC KEY	X2267	012014-1.7	MIC KEY Skin Level Gastrostomy Kit 14FR 5cc 1.7 cm Stoma length
MIC KEY	X2267	012014-2.0	MIC KEY Skin Level Gastrostomy Kit 14FR 5cc 2.0 cm Stoma length
MIC KEY	X2267	012014-2.3	MIC KEY Skin Level Gastrostomy Kit 14FR 5cc 2.3 cm Stoma length
MIC KEY	X2267	012014-2.5	MIC KEY Skin Level Gastrostomy Kit 14FR 5cc 2.5 cm Stoma length
MIC KEY	X2267	012014-2.7	MIC KEY Skin Level Gastrostomy Kit 14FR 5cc 2.7 cm Stoma length
MIC KEY	X2267	012014-3.0	MIC KEY Skin Level Gastrostomy Kit 14FR 5cc 3.0 cm Stoma length
MIC KEY	X2267	012014-3.5	MIC KEY Skin Level Gastrostomy Kit 14FR 5cc 3.5 cm Stoma length
MIC KEY	X2267	012014-4.0	MIC KEY Skin Level Gastrostomy Kit 14FR 5cc 4.0 cm Stoma length
MIC KEY	X2267	012014-4.5	MIC KEY Skin Level Gastrostomy Kit 14FR 5cc 4.5 cm Stoma length
MIC KEY	X2267	012016-0.8	MIC KEY Skin Level Gastrostomy Kit 16FR 5cc 0.8 cm Stoma length
MIC KEY	X2267	012016-1.0	MIC KEY Skin Level Gastrostomy Kit 16FR 5cc 1.0 cm Stoma length
MIC KEY	X2267	012016-1.2	MIC KEY Skin Level Gastrostomy Kit 16FR 5cc 1.2 cm Stoma length
MIC KEY	X2267	012016-1.5	MIC KEY Skin Level Gastrostomy Kit 16FR 5cc 1.5 cm Stoma length
MIC KEY	X2267	012016-1.7	MIC KEY Skin Level Gastrostomy Kit 16FR 5cc 1.7 cm Stoma length
MIC KEY	X2267	012016-2.0	MIC KEY Skin Level Gastrostomy Kit 16FR 5cc 2.0 cm Stoma length
MIC KEY	X2267	012016-2.3	MIC KEY Skin Level Gastrostomy Kit 16FR 5cc 2.3 cm Stoma length
MIC KEY	X2267	012016-2.5	MIC KEY Skin Level Gastrostomy Kit 16FR 5cc 2.5 cm Stoma length
MIC KEY	X2267	012016-2.7	MIC KEY Skin Level Gastrostomy Kit 16FR 5cc 2.7 cm Stoma length
MIC KEY	X2267	012016-3.0	MIC KEY Skin Level Gastrostomy Kit 16FR 5cc 3.0 cm Stoma length
MIC KEY	X2267	012016-3.5	MIC KEY Skin Level Gastrostomy Kit 16FR 5cc 3.5 cm Stoma length
MIC KEY	X2267	012016-4.0	MIC KEY Skin Level Gastrostomy Kit 16FR 5cc 4.0 cm Stoma length
MIC KEY	X2267	012016-4.5	MIC KEY Skin Level Gastrostomy Kit 16FR 5cc 4.5 cm Stoma length
MIC KEY	X2267	012018-0.8	MIC KEY Skin Level Gastrostomy Kit 18FR 5cc 0.8 cm Stoma length
MIC KEY	X2267	012018-1.0	MIC KEY Skin Level Gastrostomy Kit 18FR 5cc 1.0 cm Stoma length
MIC KEY	X2267	012018-1.2	MIC KEY Skin Level Gastrostomy Kit 18FR 5cc 1.2 cm Stoma length
MIC KEY	X2267	012018-1.5	MIC KEY Skin Level Gastrostomy Kit 18FR 5cc 1.5 cm Stoma length
MIC KEY	X2267	012018-1.7	MIC KEY Skin Level Gastrostomy Kit 18FR 5cc 1.7 cm Stoma length
MIC KEY	X2267	012018-2.0	MIC KEY Skin Level Gastrostomy Kit 18FR 5cc 2.0 cm Stoma length
MIC KEY	X2267	012018-2.3	MIC KEY Skin Level Gastrostomy Kit 18FR 5cc 2.3 cm Stoma length
MIC KEY	X2267	012018-2.5	MIC KEY Skin Level Gastrostomy Kit 18FR 5cc 2.5 cm Stoma length
MIC KEY	X2267	012018-2.7	MIC KEY Skin Level Gastrostomy Kit 18FR 5cc 2.7 cm Stoma length
MIC KEY	X2267	012018-3.0	MIC KEY Skin Level Gastrostomy Kit 18FR 5cc 3.0 cm Stoma length
MIC KEY	X2267	012018-3.5	MIC KEY Skin Level Gastrostomy Kit 18FR 5cc 3.5 cm Stoma length
MIC KEY	X2267	012018-4.0	MIC KEY Skin Level Gastrostomy Kit 18FR 5cc 4.0 cm Stoma length
MIC KEY	X2267	012018-4.5	MIC KEY Skin Level Gastrostomy Kit 18FR 5cc 4.5 cm Stoma length
MIC KEY	X2267	012020-0.8	MIC KEY Skin Level Gastrostomy Kit 20FR 5cc 0.8 cm Stoma length
MIC KEY	X2267	012020-1.0	MIC KEY Skin Level Gastrostomy Kit 20FR 5cc 1.0 cm Stoma length
MIC KEY	X2267	012020-1.2	MIC KEY Skin Level Gastrostomy Kit 20FR 5cc 1.2 cm Stoma length
MIC KEY	X2267	012020-1.5	MIC KEY Skin Level Gastrostomy Kit 20FR 5cc 1.5 cm Stoma length
MIC KEY	X2267	012020-1.7	MIC KEY Skin Level Gastrostomy Kit 20FR 5cc 1.7 cm Stoma length
MIC KEY	X2267	012020-2.0	MIC KEY Skin Level Gastrostomy Kit 20FR 5cc 2.0 cm Stoma length
MIC KEY	X2267	012020-2.3	MIC KEY Skin Level Gastrostomy Kit 20FR 5cc 2.3 cm Stoma length
MIC KEY	X2267	012020-2.5	MIC KEY Skin Level Gastrostomy Kit 20FR 5cc 2.5 cm Stoma length
MIC KEY	X2267	012020-2.7	MIC KEY Skin Level Gastrostomy Kit 20FR 5cc 2.7 cm Stoma length
MIC KEY	X2267	012020-3.0	MIC KEY Skin Level Gastrostomy Kit 20FR 5cc 3.0 cm Stoma length
MIC KEY	X2267	012020-3.5	MIC KEY Skin Level Gastrostomy Kit 20FR 5cc 3.5 cm Stoma length
MIC KEY	X2267	012020-4.0	MIC KEY Skin Level Gastrostomy Kit 20FR 5cc 4.0 cm Stoma length
MIC KEY	X2267	012020-4.5	MIC KEY Skin Level Gastrostomy Kit 20FR 5cc 4.5 cm Stoma length
MIC KEY	X2267	012024-0.8	MIC KEY Skin Level Gastrostomy Kit 24FR 5cc 0.8 cm Stoma length
MIC KEY	X2267	012024-1.5	MIC KEY Skin Level Gastrostomy Kit 24FR 5cc 1.5 cm Stoma length
MIC KEY	X2267	012024-1.7	MIC KEY Skin Level Gastrostomy Kit 24FR 5cc 1.7 cm Stoma length
MIC KEY	X2267	012024-2.0	MIC KEY Skin Level Gastrostomy Kit 24FR 5cc 2.0 cm Stoma length

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Manufacturer	Code	Product Number	Description
MIC KEY	X2267	012024-2.3	MIC KEY Skin Level Gastrostomy Kit 24FR 5cc 2.3 cm Stoma length
MIC KEY	X2267	012024-2.5	MIC KEY Skin Level Gastrostomy Kit 24FR 5cc 2.5 cm Stoma length
MIC KEY	X2267	012024-2.7	MIC KEY Skin Level Gastrostomy Kit 24FR 5cc 2.7 cm Stoma length
MIC KEY	X2267	012024-3.0	MIC KEY Skin Level Gastrostomy Kit 24FR 5cc 3.0 cm Stoma length
MIC KEY	X2267	012024-3.5	MIC KEY Skin Level Gastrostomy Kit 24FR 5cc 3.5 cm Stoma length
MIC KEY	X2267	012024-4.0	MIC KEY Skin Level Gastrostomy Kit 24FR 5cc 4.0 cm Stoma length
MIC KEY	X2267	012024-4.5	MIC KEY Skin Level Gastrostomy Kit 24FR 5cc 4.5 cm Stoma length
BARD	X2267	000292	Bard Button Replacement Gastrostomy Device 18FR 1.2 cm
BARD	X2267	000282	Bard Button Replacement Gastrostomy Device 18FR 1.7 cm
BARD	X2267	000283	Bard Button Replacement Gastrostomy Device 18FR 2.4 cm
BARD	X2267	000284	Bard Button Replacement Gastrostomy Device 18FR 3.4 cm
BARD	X2267	000293	Bard Button Replacement Gastrostomy Device 24FR 1.2 cm
BARD	X2267	000285	Bard Button Replacement Gastrostomy Device 24FR 1.7 cm
BARD	X2267	000286	Bard Button Replacement Gastrostomy Device 24FR 2.4 cm
BARD	X2267	000287	Bard Button Replacement Gastrostomy Device 24FR 3.4 cm
BARD	X2267	000296	Bard Button Replacement Gastrostomy Device 28FR 1.2 cm
BARD	X2267	000261	Bard Button Replacement Gastrostomy Device 28FR 1.7 cm
BARD	X2267	000262	Bard Button Replacement Gastrostomy Device 28FR 2.4 cm
BARD	X2267	000263	Bard Button Replacement Gastrostomy Device 28FR 3.4 cm
BARD	X2263	000361	Bard Button Device Decompression tube 18FR 1.2 cm
BARD	X2263	000350	Bard Button Device Decompression tube 18FR 1.7 cm
BARD	X2263	000351	Bard Button Device Decompression tube 18FR 2.4 cm
BARD	X2263	000352	Bard Button Device Decompression tube 18FR 3.4 cm
BARD	X2263	000362	Bard Button Device Decompression tube 24FR 1.2 cm
BARD	X2263	000363	Bard Button Device Decompression tube 24FR 1.7 cm
BARD	X2263	000354	Bard Button Device Decompression tube 24FR 2.4 cm
BARD	X2263	000355	Bard Button Device Decompression tube 24FR 3.4 cm
BARD	X2263	000356	Bard Button Device Decompression tube 28FR 1.2 cm
BARD	X2263	000357	Bard Button Device Decompression tube 28FR 1.7 cm
BARD	X2263	000358	Bard Button Device Decompression tube 28FR 2.4 cm
BARD	X2263	000359	Bard Button Device Decompression tube 28FR 3.4 cm
MIC KEY	X2269	0121-12	SECUR-LOK Extension Set with 2 Port “Y” and Clamp – 12” length
MIC KEY	X2269	0121-24	SECUR-LOK Extension Set with 2Port “Y” and Clamp – 24” length
MIC KEY	X2269	0123-12	Bolus Feeding Set with blue cath tip and Clamp - 12” length
MIC KEY	X2269	0123-24	Bolus Feeding Set with blue cath tip and Clamp - 24” length
MIC KEY	X2269	0124-12	SECUR-LOK Extension Set with blue cath tip and Clamp - 12” length
MIC KEY	X2269	0124-24	SECUR-LOK Extension Set with blue cath tip and Clamp - 24” length
BARD	X2269	000256	Bard Button Device Feeding Tube 18FR with Continuous 90 degree adapter
BARD	X2269	000258	Bard Button Device Feeding Tube 24FR with Continuous 90 degree adapter
BARD	X2269	000268	Bard Button Device Feeding Tube 28FR with Continuous 90 degree adapter
BARD	X2269	000257	Bard Button Device Feeding Tube 18FR with Straight adapter
BARD	X2269	000257	Bard Button Device Feeding Tube 24FR with Straight adapter
BARD	X2269	000269	Bard Button Device Feeding Tube 28FR with Straight adapter
Various Manufacturers	B4084		Gastrostomy Tube (not skin level device)
MIC KEY	B9998	0122-02	SECUR-LOK Med Set with 2 port “Y” – 2” length
MIC KEY	B9998	0125-00	Stoma Measuring Device
Various Manufacturers	B9998		Additional extension sets i.e., Kangaroo to add additional length from feeding bag-pouch to feeding tube

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Consultec
Medical Review Department

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1-800-237-7647
Fax: 303-534-0439

QUESTIONNAIRE #1
HOSPITAL BED

Client Name: _____

Client ID: _____

The information requested below is required in order to determine medical necessity. If you have questions related to this Questionnaire or PAR, please contact the Medical Review Department at the phone numbers listed above. After you have completed this form, mail it with the completed Prior Authorization Request (PAR) to the address listed above. Thank you for your cooperation.

Relevant Diagnosis(es): _____

How many hours per day is this client in bed? _____

What type of bed/mattress does this client presently use? Why doesn't it meet this client's needs? _____

What other alternatives have been tried? _____

What type of bed is necessary to meet the client's needs? _____

If request is for a semi or fully electric hospital bed, explain why a manual hospital bed will not provide for this client's needs:

Can the client work the controls of an electric bed independently? _____ Can the client change positions independently? _____

Is a caregiver available to assist this client in changing position? _____ If so, how many hours per day? _____

Is the caregiver at risk for injury? _____

List client's approximate current height and weight: _____

Please supply any additional information that will assist us in determining **medical necessity** for your request:

Physician Signature: _____ Date: _____

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QUESTIONNAIRE #2
PRESSURE RELIEF MATTRESS

Client Name _____

Client ID _____

The information requested below is required in order to determine medical necessity. If you have questions related to this Questionnaire or PAR, please contact the Medical Review Department at the phone numbers listed above. After you have completed this form, mail it with the completed Prior Authorization Request (PAR) to the address listed above. Thank you for your cooperation.

Relevant Diagnosis(es): _____

What type of mattress is necessary to meet the client's needs _____

How many hours per day is this client in bed? _____

Does this client have a history of skin breakdown? _____ If yes, explain: _____

Does client currently have skin breakdown? _____ If yes, explain level and location: _____

Level 1 _____

Level 2 _____

Level 3 _____

Level 4 _____

What other alternatives have been tried? _____

What is the client currently using? _____

Why isn't this meeting the client's needs? _____

For what length of time is this mattress necessary? _____

Please supply any additional information that will assist us in determining **medical necessity** for this request: _____

Physician Signature: _____ Date: _____

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QUESTIONNAIRE #3
LIFT

Client Name: _____

Client ID: _____

The information requested below is required in order to determine medical necessity. If you have questions related to this Questionnaire or PAR, please contact the Medical Review Department at the phone numbers listed above. After you have completed this form, mail it with the completed Prior Authorization Request (PAR) to the address listed above. Thank you for your cooperation.

Relevant Diagnosis(es): _____

What type of lift is necessary to meet the client's needs? _____

Will the client be confined to bed without the use of a lift? _____

If requested lift is electric, indicate why the electric is necessary, as opposed to a manual lift: _____

_____

What other alternatives have been tried? _____

Indicate client's approximate height, weight, and age: _____

List any specific weaknesses and/or impairments of the client: _____

What is the client currently using? _____

Why isn't this meeting the client's needs? _____

Does this client's condition require the assistance of more than one caregiver to transfer between bed, chair, wheelchair, or commode? _____

Indicate *caregiver's* approximate height, weight, and age: _____

To what degree can this client assist the caregiver with transfers? _____

_____

Can this client ambulate? _____ If yes, how far and with what degree of assistance? _____

_____

How long will this client require the lift? _____ If life, indicate life expectancy: _____

Who will operate this lift? _____

Please supply any additional information that will assist us in determining **medical necessity** for this request: _____

_____

_____

Physician Signature: _____ Date: _____

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QUESTIONNAIRE #4
SEAT LIFT

Client Name: _____

Client ID: _____

The information requested below is required in order to determine medical necessity. If you have questions related to this Questionnaire or PAR, please contact the Medical Review Department at the phone numbers listed above. After you have completed this form, mail it with the completed Prior Authorization Request (PAR) to the address listed above. Thank you for your cooperation.

Relevant Diagnosis(es): _____

Does the client have one of the following conditions?

- ❑ severe arthritis of the knee
- ❑ severe arthritis of the hip
- ❑ neuromuscular disease
- ❑ other

Is the seat lift mechanism intended to effect improvement or arrest or retard deterioration in the patient's condition?

- ❑ effect improvement
- ❑ arrest the client's condition
- ❑ retard deterioration

Is the client completely incapable of standing from any chair in the home? _____

Once standing can the client ambulate independently? _____

What other alternatives have been tried? _____

What is the client currently using? _____

Why isn't this meeting the client's needs? _____

Please supply any additional information that will assist us in determining **medical necessity** for this request: _____

Physician Signature: _____ Date: _____

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Consultec
Medical Review Department

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QUESTIONNAIRE #5
BLOOD PRESSURE UNIT/MONITOR

Client Name: _____

Client ID: _____

The information requested below is required in order to determine medical necessity. If you have questions related to this Questionnaire or PAR, please contact the Medical Review Department at the phone numbers listed above. After you have completed this form, mail it with the completed Prior Authorization Request (PAR) to the address listed above. Thank you for your cooperation.

Relevant Diagnosis(es): _____

Indicate the dates and the latest three blood pressure readings of the client: _____

How frequently does the blood pressure need to be monitored? _____

What medication(s) is the client on? _____

If ordering an automatic monitor, please explain why a manual monitor will not meet the client's needs: _____

Please supply any additional information that will assist us in determining **medical necessity** for this request: _____

Physician Signature: _____ Date: _____

PLEASE PHOTOCOPY THIS BLANK FORM AS NEEDED

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Denver CO 80201-0030

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Consultec
Medical Review Department

303-534-0279
1-800-237-7647
Fax: 303-534-0439

QUESTIONNAIRE #6
PULSE OXIMETER

Client Name: _____

Client ID: _____

Generally, a physician should be able to assess whether a client's medical condition necessitates the continued use of a pulse oximeter beyond the initial 3-month monitoring period. Medical necessity must be documented for the continued use of a pulse oximeter after this period.

The information requested below is required in order to determine medical necessity. If you have questions related to this Questionnaire or PAR, please contact the Medical Review Department at the phone numbers listed above. After you have completed this form, mail it with the completed Prior Authorization Request (PAR) to the address listed above. Thank you for your cooperation.

Relevant Diagnosis(es): _____

Client's age: _____

Provide the dates and readings for one month of pulse oximetry: _____

_____

_____

_____

Are pulse ox readings being taken on a daily basis? _____ If yes, how many times per day? _____

What type of treatment is done when client desaturates? _____

_____

_____

Is client using oxygen as needed? Yes No Is client on continuous oxygen? Yes No If yes, is client stable? Yes No

If so, how many liters per minute: _____

How long will client need routine oximetry? _____

Please supply any additional information that will assist us in determining **medical necessity** for this request: _____

_____

_____

_____

_____

Physician Signature: _____ Date: _____

PLEASE PHOTOCOPY THIS BLANK FORM AS NEEDED

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QUESTIONNAIRE #7
APNEA MONITOR

Client Name: _____

Client ID: _____

Generally, a physician should be able to assess whether a client's medical condition necessitates the continued use of an apnea monitor beyond the initial 6-month monitoring period. Medical necessity must be documented for the continued use of an apnea monitor after this period.

The information requested below is required in order to determine medical necessity. If you have questions related to this Questionnaire or PAR, please contact the Medical Review Department at the phone numbers listed above. After you have completed this form, mail it with the completed Prior Authorization Request (PAR) to the address listed above. Thank you for your cooperation.

Relevant Diagnosis(es): _____

Client's age: _____ How frequently have apneic episodes occurred? _____

Dates: _____

_____

Is apnea monitoring continuous? _____ At night only? _____ During feedings? _____

Provide the dates and readings for one month of apnea monitoring. _____

_____

_____

Has client been hospitalized due to apneic episodes or related diagnosis? _____ If yes, what dates?

_____

_____

List all documented apneic episodes during the initial 6-month monitoring period: _____

_____

_____

Is client using oxygen as needed? Yes No Is client on continuous oxygen? Yes No If yes, is client stable? Yes No

If so, how many liters per minute: _____

How long will client need apnea monitoring? _____

Please supply any additional information that will assist us in determining **medical necessity** for this request: _____

_____

_____

_____

Physician Signature: _____ Date: _____

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QUESTIONNAIRE #8
CPAP/BIPAP

Client Name: _____

Client ID: _____

The information requested below is required in order to determine medical necessity. If you have questions related to this Questionnaire or PAR, please contact the Medical Review Department at the phone numbers listed above. After you have completed this form, mail it with the completed Prior Authorization Request (PAR) to the address listed above. Thank you for your cooperation.

Relevant Diagnosis(es): _____

Send a written sleep study report with written results for CPAP. _____

If BIPAP is utilized for sleep apnea, has a sleep study been done? ☐ Yes ☐ No

If yes, please include written results of study.

Supply any additional information that will assist us in determining **medical necessity** for this request: _____

Physician Signature: _____ Date: _____

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QUESTIONNAIRE #9

TENS or NMES (TRANSCUTANEOUS OR NEUROMUSCULAR ELECTRICAL NERVE STIMULATOR)

Client Name: _____

Client ID: _____

Transcutaneous or neuromuscular electrical nerve stimulation (TENS or NMES) is an acceptable treatment modality for some types of chronic intractable pain. Generally, a physician should be able to assess whether or not a client is likely to derive a significant therapeutic benefit from continuous use of a TENS or NMES unit within a trial period of 2 months. Medical necessity must be documented for continued use of TENS or NMES beyond the initial 2-month trial period.

The information requested below is required in order to determine medical necessity. If you have questions related to this Questionnaire or PAR, please contact the Medical Review Department at the phone numbers listed above. After you have completed this form, mail it with the completed Prior Authorization Request (PAR) to the address listed above. Thank you for your cooperation.

Relevant Diagnosis(es): _____

During the trial period, did the TENS or NMES:

A. Produce no relief? B. Produce greater discomfort than the original pain? C. Significantly alleviate pain?

List any used or prescribed analgesics (drug/dose/route/frequency) *prior* to using TENS or NMES: _____

Identify any of the above medications that were reduced in dosage/frequency as a result of the use of TENS or NMES: _____

Identify any of the above medications that were discontinued as a result of the use of TENS or NMES: _____

What was the degree of range of motion or mobility prior to initiation of treatment? _____

Did the client's range of motion or mobility improve as a result of using a TENS or NMES? _____ If yes, describe:

Do you feel your client derived significant therapeutic benefits to warrant continued (long term) use of a nerve stimulator? _____

Does this client presently own a TENS unit (regardless of payment source) or has this client owned or utilized a TENS unit in the past? _____

Provision of a TENS unit is considered the final alternative in pain management. Comment on the following alternative treatments for this client and, if appropriate, the clinical results of each. This information is REQUIRED to establish medical necessity. ***Failure to respond fully will result in denial of your request.***

A. Traction _____

B. Trigger point _____

C. Surgery _____

D. Drugs _____

Physician Signature: _____ Date: _____

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QUESTIONNAIRE #10
ORAL AND ENTERAL NUTRITION FORMULAE

Client Name: _____

Client ID: _____

The information requested below is required in order to determine medical necessity. If you have questions related to this Questionnaire or PAR, please contact the Medical Review Department at the phone numbers listed above. After you have completed this form, mail it with the completed Prior Authorization Request (PAR) to the address listed above. Thank you for your cooperation.

Relevant Diagnosis(es): _____

Client's height: _____ Client's current weight: _____ Client's ideal body weight: _____

What brand name(s) of formula are requested to meet the client's need? _____

Number of calories this formula will provide for the client *per day*: _____

Is the requested formula a supplement or the sole source of nutrition? _____

Route of delivery for the requested formula: _____

Does this client have difficulty with chewing/swallowing? _____ If yes, describe: _____

If therapeutic intent of this formula is to serve as a protein supplement, indicate most recent serum albumin level:

Please supply any additional information that will assist us in determining **medical necessity** for this request:

Physician Signature: _____ Date: _____

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QUESTIONNAIRE #11
ADULT ORTHOTICS and PROSTHETICS

This form must accompany all prior authorization requests, and may be completed by the physical therapist, prosthetist, or other medical professional familiar with the O/P needs of the client.

Client's Name: _____ State ID#: _____

Name and title of person completing this form: _____

General information questions:

1. Why does the client require this equipment? (be specific, include diagnosis, co-morbidities, brief history, current condition, etc.)

_____

_____

_____

2. If the client previously lacked this equipment, what medical repercussions has the client experienced in the past 12 months? (check all that apply)

_____ Increased disability
_____ Loss of independence
_____ Lack of rehabilitation
_____ Continuing pain/discomfort/increased use of medication
_____ Surgery
_____ Physician assessment
_____ Disability related hospitalizations
_____ Related ER care required
_____ Use of other DME support function; specify type: _____

3. In the next year, if the equipment is supplied, what medical events and costs can be avoided? (check all that apply)

_____ Surgery (CPT code) _____
_____ Medication reduction
_____ Hospitalizations
_____ Physician assessment
_____ Continuing use of durable medical equipment named in #2 above
_____ Other, Describe: _____

4. What change in the client's condition do you anticipate if the equipment is supplied?

_____ Problem correction
_____ Problem alleviation
_____ Prevention of associated problems
_____ Potential of avoiding surgery with use of orthotic or prosthetic

Questions specific to prostheses:

5. Functional level as defined by Medicare. Circle one.

Level 0 Level 1 Level 2 Level 3 Level 4

6. What is the client's height? _____ Weight? _____

7. Is this a replacement? ____ Yes ____ No If this is a replacement, in what year was the current O/P issued? _____

If this is a new prosthesis, when was the amputation/surgery performed? Month _____ Year _____

Questions specific to orthosis:

8. Is the orthosis pre-manufactured/custom fitted? _____ Custom fabricated? _____

9. What is the reason a pre-manufactured device is not appropriate? _____

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QUESTIONNAIRE # 12
WOUND CLOSURE THERAPY

Client Name: _____ **Client ID:** _____

The information requested below is required in order to determine medical necessity. If you have questions related to this Questionnaire or PAR, please contact the Medical Review Department at the phone numbers listed above. After you have completed this form, mail it with the completed Prior Authorization Request (PAR) to the address listed above. Thank you for your cooperation.

1. Wound description, including: size, depth, any tunneling, undermining, etc. _____

_____

2. Has the patient had one or more of the following:

Stage III or Stage IV pressure ulcer	☐ Yes ☐ No	Diabetic Ulcer	☐ Yes ☐ No
Previous myocutaneous flap or graft	☐ Yes ☐ No	Chronic open wound	☐ Yes ☐ No
Recent (within 14 days) myocutaneous flap or graft	☐ Yes ☐ No	Venous stasis ulcer	☐ Yes ☐ No

3. Does the patient's history reflect one or more of the following:

Previous failed wound interventions ☐ Yes ☐ No

How long ago? _____ How was it resolved? _____

Severe coexisting chronic illness ☐ Yes ☐ No

Frequent reoccurrence of advanced pressure ulcers related to severely limited mobility ☐ Yes ☐ No

Wound care therapy was initiated in the hospital or SNF. If Yes, complete the information below. ☐ Yes ☐ No

Admission date: _____ Admitting diagnosis: _____ Discharge date: _____

	Initial	3 month follow-up	6 month follow-up
4. Does the patient use a pressure-reducing surface:			
Non-powered mattress overlay	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Non-powered mattress replacement	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Powered mattress overlay	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Powered mattress replacements	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Powered bed system	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Air fluidized bed	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
If No, why not? _____			
5. Does the patient have an albumin greater than 3mg/dl:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Date of last albumin: _____			
Result: _____			
If the patient has an albumin level less than 3 mg/dl, please list the albumin level and describe the type of nutritional support that the patient is receiving or requires.			
6. Is the patient's wound free of necrotic infection:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
If the wound has recently been debrided, identify the type and date of debridement.	☐ Surgical ☐ Chemical ☐ Physical ☐ Autolytic		
	Date: _____	Date: _____ Date: _____	Date: _____
7. Is the patient's wound free of infection:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
If the wound is infected, identify the wound treatment, including dosage, frequency, route, and duration of any medications.			
8. Will the patient's overall health status, including nutritional status, affect wound healing:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Describe all medical conditions that might affect wound healing. Address incontinence if pertinent, and what is being done to decrease the contamination of the wound.			

9. Name of family member/friend/caregiver who has been trained to provide the service: _____ **Training date:** _____

10. Physician's signature: _____ **Date:** _____

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QUESTIONNAIRE #13
AUGMENTATIVE COMMUNICATION DEVICE QUESTIONNAIRE

This form, a speech and language evaluation, and an evaluation of the client's ability to utilize the requested device effectively must accompany all Prior Authorization Requests (PAR). The questionnaire may be completed by a speech therapist or other medical professional familiar with the medical communication needs of the client. The two evaluations must be completed by a speech therapist. If the questionnaire is not fully completed, or the evaluations are not submitted, the PAR will be denied.

Client's name _____ State ID # _____

1. Why does the client require this device? Please specify related diagnoses, including ICD-9 code(s), co-morbidity, brief history, current condition, etc _____

2. Is the client capable of intelligible speech? Yes ☐ No ☐

3. Is lack of speech permanent or temporary? Permanent ☐ Temporary ☐

   Is improvement expected? Yes ☐ No ☐

   If so, how soon? _____

4. Is client able to communicate in writing? Yes ☐ No ☐

5. Using a scale of 1(lowest) to 5 (highest), rate the client's motivation to use an augmentative communication device: _____

   Comments _____

6. Using a scale of 1(lowest) to 5 (highest), rate the client's ability to express thoughts _____

   Comments _____

7. Using a scale of 1(lowest) to 5 (highest), rate the client's ability to use the system and memorize necessary codes _____

   Comments _____

8. Has the client had a course of speech therapy? Yes ☐ No ☐

   Using a scale of 1(lowest) to 5 (highest), rate the client's progress in the area of expressive language _____

   Comments _____

Name and title of person completing this form _____

Address _____ Telephone # _____

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QUESTIONNAIRE # 14
MECHANICAL HIGH FREQUENCY CHEST WALL OSCILLATION

Date: _____

Medical center information:
Address: _____

Prescribing physician:
Name: _____
Phone number: _____

Patient information:
Name: _____ Medicaid ID #: _____
Address: _____ Date: _____
Height: _____
Weight: _____
Birth date: _____ Age: _____

Has patient received ThAIRapy Vest treatment in the past? ☐ Yes ☐ No

If yes, how recently was treatment given (in months)? ☐ Current ☐ 1-6 months ago ☐ More than 6 months ago

For how long? _____ If treatments were discontinued, why? _____

Most recent pulmonary function tests results

Date: _____ ☐ Check if additional information is included.

FVC (L): _____ / _____ % FEVI (L): _____ / _____ % FEF25-75 (L/sec): _____ / _____ %

Medications (in past 6 months)

Inhaled	Dosage	Days	Other (excluding antibiotics)	Dosage	Days
☐ Intal					
☐ Albuterol					
☐ Pulmozyme					
☐ Mucomist					
☐ Corticosteroid					

Antibiotic (excluding home IV therapy)	Dosage	Days	Home IV therapy Date	Medication	Dosage	Circle one	Days
						Q_BID TID QID	
						Q_BID TID QID	
						Q_BID TID QID	

☐ Check if additional information is included.

Hospitalization history (in the past 6 months or 6 months prior to ThAIRapy Vest treatment for patients currently using system):

Admit date: _____ Discharge date: _____ Reason: _____
Admit date: _____ Discharge date: _____ Reason: _____

☐ Check if additional information is included.

Manual percussion therapy (in past 6 mos)
Times per day prescribed/required: _____ For how long? _____
Primary caregiver: _____
Results/Comments: _____

Flutter therapy (in past 6 mos)
Times per day prescribed/required: _____ For how long? _____
Primary caregiver: _____
Results/Comments: _____

Other mechanical therapy (in past 6 mos)
Times per day prescribed/required: _____ For how long? _____
Primary caregiver: _____
Results/Comments: _____

How would ThAIRapy Vest promote or allow greater independence? _____

Does patient have any of the following conditions?

Suspected pulmonary tuberculosis	☐ Yes ☐ No	Lung contusion	☐ Yes ☐ No
Complaint of chest wall pain	☐ Yes ☐ No	Subcutaneous emphysema	☐ Yes ☐ No
Head &/or neck injury which is not yet stabilized	☐ Yes ☐ No	Active hemorrhage with hemodynamic instability	☐ Yes ☐ No
Recent epidural spinal infusion or spinal anesthesia	☐ Yes ☐ No	Recent skin grafts, or flaps on the thorax	☐ Yes ☐ No
Recently placed transvenous pacemaker or subcutaneous pacemaker	☐ Yes ☐ No		

Summary of health status (including severity and frequency of bronchitis): _____

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