Clinical Policy: Nursing Equipment and Supplies

Reference Number: WNC.CP.215 Coding Implications
Last Review Date: 05/23 Revision Log

See Important Reminder at the end of this policy for important regulatory and legal information.

Note: When state Medicaid coverage provisions conflict with the coverage provisions in this clinical policy, state Medicaid coverage provisions take precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this clinical policy.

Description[1]This policy discusses medical necessity criteria for Nursing Equipment and Supplies.

Policy/Criteria[1]

I. WellCare of North Carolina® shall cover durable medical equipment and related medical supplies when **ALL** the following requirements are met:

A. The item is ordered by a Physician, Physician Assistant, or Nurse Practitioner;
B. The item is medically necessary to maintain or improve a beneficiary's medical, physical or functional level, and appropriate for use in any noninstitutional setting in which normal life activities take place;
C. A documented face-to-face encounter with the beneficiary and the ordering Physician, Physician Assistant, or Nurse Practitioner related to the primary reason the beneficiary requires durable medical equipment and medical supplies has occurred no more than six (6) months prior to the initiation of durable medical equipment and medical supplies; **and**
D. The beneficiary's need for durable medical equipment and medical supplies is reviewed by the ordering Physician, Physician Assistant, or Nurse Practitioner at least annually.

II. WellCare of North Carolina® **shall not** cover convenience items or features.

III. WellCare of North Carolina shall cover **Negative Pressure Wound Therapy (NPWT) Electrical Pump, Stationary or Portable, and Related Supplies** when they are medically necessary for the beneficiary. The following criteria must be met:

A. The beneficiary has a chronic Stage III or Stage IV pressure ulcer, neuropathic ulcer, venous or arterial insufficiency ulcer, or chronic (present for at least 30 calendar days) ulcer of mixed etiology.
B. A complete wound therapy program, as described below, must have been considered and ruled out, or tried, prior to application of NPWT:
   1. For ***all*** ulcers or wounds:
      a. documentation in the beneficiary's health record of evaluation, care, and wound measurement by a licensed medical professional permitted to perform those tasks and responsibilities by their NC state licensing board;
      b. application of dressings to maintain a moist wound environment;

c. debridement of necrotic tissue if present; **and**
d. evaluation of and provision for adequate nutritional status.

2. For ***Stage III or Stage IV*** ulcers:
   a. the beneficiary has been appropriately turned and positioned
   b. a group 2 or 3 support surface has been used for pressure ulcers on the posterior trunk or pelvis (**Note**: A Group 2 or 3 support surface is not required if the ulcer is not on the trunk or pelvis).
   c. moisture and incontinence have been appropriately managed.
3. For ***neuropathic*** (for example, diabetic) ulcers:
   a. the beneficiary has been on a comprehensive diabetic management program, **and**
   b. reduction in pressure on a foot ulcer has been accomplished with appropriate modalities.
4. For ***venous insufficiency*** ulcers:
   a. compression bandages or garments have been consistently applied; or if contraindicated due to Peripheral Artery Disease (PAD);
   b. lower extremity elevation and ambulation have been encouraged.

C. NPWT pumps must be capable of accommodating more than one wound dressing set when a beneficiary has multiple wounds. Therefore, more than one NPWT pump per beneficiary for the same time period is not covered.

IV. WellCare of North Carolina **shall not cover a NPWT pump and supplies** when any of the following are present because they are considered to be not medically necessary:

A. The presence in the wound of necrotic tissue with eschar if debridement is not attempted;
B. Untreated osteomyelitis within the vicinity of the wound;
C. Cancer present in the wound; **or**
D. The presence of a fistula to an organ or body cavity within the vicinity of the wound.
E. For coverage to continue beyond the initial prior approval period, a licensed medical professional shall:
   1.Directly assess the wound(s) treated with the NPWT pump;
   2.Supervise or directly perform the NPWT dressing changes; **AND**
   3.On a monthly basis, document changes in the ulcer's dimension and characteristics.

Note: For the purposes of this policy, a licensed medical professional can be a physician, physician's assistant, registered nurse, licensed practical nurse or physical therapist. The practitioner shall be licensed to assess wounds and administer wound care within the state where the beneficiary is receiving NPWT. Re-authorizations for continued coverage are given for a maximum of one month. If the criteria are not fulfilled, continued coverage of the NPWT pump and supplies are not medically necessary and therefore not covered. Lack of improvement of a wound, as used within this policy, is defined as a lack of progress in quantitative measurements of wound characteristics, including wound length and width (surface area) or depth measured serially and documented over a specified time interval. Wound healing is defined as improvement occurring in either surface area or depth of the wound.

Note: The staging of pressure ulcers used in this policy is as follows:

- Stage I non-blanchable erythema of intact skin
- Stage II partial-thickness skin loss involving epidermis, dermis, or both
- Stage III full-thickness skin loss involving damage or necrosis of subcutaneous tissue that may extend down to, but not through, underlying fascia
- Stage IV full-thickness skin loss with extensive destruction, tissue necrosis, or damage to muscle, bone, or supporting structures

V. WellCare of North Carolina shall cover an **External Insulin Infusion Pump** for a beneficiary who demonstrates medical necessity by meeting **one** of the following criteria:

A. ***Adult Beneficiary (21 years of age or older)*** - Shall have a diagnosis of diabetes mellitus and be insulin dependent. Additionally, a beneficiary shall fulfill the requirements in 1, **or** 2, **and** 3 or 4, below:

1. C-peptide testing requirement - The beneficiary shall meet criterion a **or** b, **and** criterion c:
   a. the C-peptide level is less than or equal to 110% of the lower limit of normal of the laboratory's measurement method.
   b. for a beneficiary with renal insufficiency and creatinine clearance (actual or calculated from age, weight, and serum creatinine) less than or equal to 50 ml/minute, the fasting C-peptide level is less than or equal to 200% of the lower limit of normal of the laboratory's measurement method.
   c. a fasting blood sugar obtained at the same time as the C-peptide level is less than or equal to 225 mg/dl. **OR**
2. The beneficiary's beta cell autoantibody test shall be positive. **AND**
3. The beneficiary must have completed a comprehensive diabetes education program; been on a program of multiple daily injections of insulin (at least three injections per day), with frequent self-adjustments of insulin dose, for at least six months prior to initiation of the insulin pump; documented his or her frequency of glucose self-testing (an average of at least four times per day during the two months prior to initiation of the insulin pump); and experienced one or more of the following events or conditions while on the multiple injection regimen:
   a. glycosylated hemoglobin level (HbA1C) greater than 7%
   b. history of recurring hypoglycemia
   c. wide fluctuations in blood glucose before mealtime
   d. dawn phenomenon (fasting blood sugar frequently exceeding 200 mg/dl)
   e. history of severe glycemic excursions **OR**
4. The beneficiary has been on an external insulin infusion pump prior to enrollment in Medicaid, and that pump is no longer functional, there is documentation from the DME provider that the pump cannot be repaired, and the warranty has expired. These beneficiaries shall document their frequency of glucose self-testing (an average of at least four times per day during the month prior to enrollment).

B. ***Beneficiaries age 0 through 20*** – Covered when meeting **one** of the following criteria:

1. The beneficiary has a diagnosis of diabetes mellitus, is insulin dependent, and has medical record documentation that justifies the medical necessity for the insulin pump.

Except for neonatal diabetes, a diagnosis of diabetes for six weeks is required before the pump is approved; **or**

2. The beneficiary has been on an external insulin infusion pump prior to enrollment in Medicaid, when health record documentation justifies the medical necessity for the insulin pump and that pump is no longer functional, there is documentation from the DME provider that the pump cannot be repaired, and the warranty has expired.

C. ***Beneficiaries with Gestational Diabetes***

1. External insulin infusion pumps are covered for beneficiaries who have a diagnosis of gestational diabetes and are insulin dependent when there is either a health record documentation of erratic blood glucose readings, despite maximum compliance, or other documented evidence that adequate control is not being achieved.

VI. WellCare of North Carolina shall cover **Standard Blood Glucose Monitors, Continuous Glucose Monitors and Related Supplies** as follows:

A. Standard blood glucose monitors (BGMs), syringes, strips, lancets, and other related supplies may be considered medically necessary when **all** the following coverage criteria are met:
   1. The beneficiary has a diagnosis of insulin dependent diabetes mellitus, non-insulin dependent diabetes, gestational diabetes, or glycogen storage disease which is being treated by a physician, physician assistant, or nurse practitioner;
   2. The BGM and related supplies have been ordered by the practitioner treating the beneficiary's diabetes;
   3. The beneficiary or the beneficiary's caregiver has completed sufficient training or is scheduled to begin training in self-monitoring of blood glucose (SMBG) using the monitor, test strips and lancets; **and**
   4. The beneficiary or the beneficiary's caregiver is willing and able to use the test results to assure optimal glycemic control.

B. BGMs with an integrated voice synthesizer may be considered medically necessary when all the coverage criteria for a standard BGM have been met, **plus** these additional criteria:
   1. The beneficiary's physician, physician assistant, or nurse practitioner documents that:
      a. the beneficiary has a severe visual impairment; **and**
      b. the beneficiary's best corrected visual acuity is 20/200 or worse.

C. A **non-therapeutic** Continuous Glucose Monitoring (CGM) system and related supplies may be considered medically necessary when criteria **1-6** below, **or 1 and 7** below are met, and a face-to-face encounter is performed. Medical necessity documentation must contain the brand and model of the CGM system provided:
   1. The beneficiary has a diagnosis of insulin-dependent diabetes mellitus;
   2. The beneficiary has been using a standard BGM and testing four (4) or more times daily;
   3. The beneficiary requires two (2) or more insulin injections daily;
   4. The beneficiary's insulin treatment regimen requires frequent adjustment based on standard BGM testing;
   5. The beneficiary or caregiver(s) is willing and able to use the CGM system as prescribed;

6. The beneficiary has had a face-to-face encounter with the treating practitioner to evaluate the beneficiary's glycemic control and determine that criteria one through five (1-5) above have been met, within six (6) months of the initiation of non-therapeutic CGM use;
7. The beneficiary uses an external insulin pump.
8. After the first six (6) months of nontherapeutic CGM use, continuation may be considered medically necessary if:
   a. the beneficiary has been using the CGM system as prescribed; **and**,
   b. the beneficiary has been able to improve glycemic control; **or**,
   c. the beneficiary continues to use an external insulin pump.
9. After the initial determination and first redetermination of medical necessity, the following criteria must be met annually:
   a. the beneficiary has had a face-to-face encounter with the ordering practitioner to evaluate the efficacy of the CGM system no more than three (3) months prior to the annual redetermination; **and**
   b. the beneficiary has been using the CGM system as prescribed; **and**
   c. the beneficiary has been able to maintain or further improve glycemic control; **or**,
   d. the beneficiary continues to use an external insulin pump.

Note: The beneficiary must meet the FDA age limits and other restrictions or requirements for the specific device prescribed.

Note: Simultaneous coverage for a standard BGM and supplies, and a nontherapeutic CGM system is permitted.

Note: **Therapeutic** CGM systems are covered under the Pharmacy benefit.

VII. WellCare of North Carolina shall cover **Ultraviolet light therapy** when **all** the following criteria are met.

A. The severity of the beneficiary's condition is such that it has not been significantly improved by conventional treatment;
B. The beneficiary has involvement over more than 20 percent of his or her body; and
C. A trial period of light treatment in a clinical setting has been successful.

VIII. WellCare of North Carolina shall cover the **Farrell Valve Enteral Gastric Pressure Relief System** when all the following criteria are met:

A. The beneficiary is receiving continuous enteral feedings via gravity or pump;
B. There is documented evidence of disorders or complications with enteral feedings, such as gastric dysmotility, abdominal distention, pain, aspiration pneumonia or risk, excessive gastric residuals, neurological impairments, anti-reflux surgery, gastric pseudo-obstruction, tracheoesophageal fistula, or atresia repair; **and**
C. Other attempted gastric decompression measures have failed.
D. The inability of the beneficiary to tolerate enteral feedings without the Farrell valve must be documented.

E. The Farrell valve is not covered when clinical documentation demonstrates that the beneficiary is tolerating continuous enteral feedings without difficulty or complications.

Note: The Farrell valve is not provided under routine enteral feeding supply kits.

IX. WellCare of North Carolina shall cover **Nutrition** as follows:

A. ***Oral Nutrition Products - Metabolic Formulas*** - Considered medically necessary when **all** the following conditions are met:

1. There is a documented diagnosis in which caloric or dietary nutrients cannot be safely or adequately consumed, absorbed, or metabolized; **and**
2. The oral nutrition product is an integral component of a documented medical treatment plan and is ordered in writing by the treating physician, physician's assistant, or nurse practitioner.
3. Medical necessity of the oral nutrition product is substantiated by documented physical findings, and laboratory data if available, that demonstrate malnutrition or risk of nutritional depletion.
4. Requirements for coverage
   a. a beneficiary shall be under the care of the ordering physician, physician's assistant, or nurse practitioner who develops a medical treatment plan that incorporates oral nutrition products.
   b. the prescriber may order a nutritional assessment to aid if it aids in the development of a comprehensive oral nutrition therapy plan.
   c. if a nutritional assessment is ordered, it must be conducted by a licensed dietitian/nutritionist (LDN) or registered dietitian (RD).
   d. the prescriber may order a feeding or swallowing evaluation performed by a licensed therapist (SLP-CCC or OTR/L).

Note: Oral nutrition products are not covered when medical necessity is not established, or when they are used as convenient food substitutes.

B. ***Enteral Nutrition*** - a beneficiary shall meet **all** the following criteria:

1. Require infusion therapy on an ongoing basis that is medically indicated for the treatment of his or her condition;
2. Have a clinical status that allows EN to be safely administered in his or her environment;
3. Be unable to tolerate nutrients orally sufficient to maintain life. The beneficiary is either unable to take oral nutrition or unable to tolerate oral intake. EN is considered reasonable and necessary for a beneficiary with a functioning gastrointestinal tract who, due to non-function of the structures that normally permit food to reach the digestive tract, cannot maintain weight and strength commensurate with his or her general condition. Some conditions that may indicate the need for EN include dysphagia or aphagia due to a cerebrovascular accident, a comatose condition, myasthenia gravis causing inability to swallow due to paralysis of the structure that permits swallowing, or a brain tumor with neurological deficit resulting in the lack of a gag reflex;

4. Understand the purpose and need for the therapy, accepts the associated requirements, and wants to pursue the treatment. When the beneficiary is unable to comprehend all that is involved, there must be a primary caregiver responsible for the beneficiary and acting in the beneficiary's behalf to meet this requirement;
5. Be in an environment conducive to the provision of EN—that is, a clean environment with electricity, water, telephone access, refrigeration, and enough space to support EN;
6. Be capable of self-administering EN or have a primary caregiver who is adequately trained, capable, and willing to administer EN safely and effectively; **and**
7. Be psychologically stable—the prospect of adhering to a disciplined medical regimen and coping with infusion therapy is realistic.

C. ***Infusion Pumps***

1. Covered when a beneficiary requires medically necessary covered enteral and parenteral nutrition

D. ***In-line Digestive Enzyme Cartridges***

In-line digestive enzyme cartridges, such as Relizorb, may be considered medically necessary when all the following criteria are met:

1. Beneficiary is at least five years of age;
2. Beneficiary has a diagnosis of exocrine pancreatic insufficiency (EPI); and
3. Beneficiary meets the criteria for enteral nutrition as documented in this policy.

X. WellCare of North Carolina shall cover an **Automatic External Defibrillator, With Integrated Electrocardiogram Analysis, Garment Type** for a beneficiary who is at risk for sudden cardiac death, is not a suitable candidate for immediate internal cardiac defibrillator (ICD); **and** meets any **one** of the following criteria:

A. A documented episode of ventricular fibrillation or sustained run of ventricular tachycardia lasting 30 seconds or longer. These dysrhythmias may either be spontaneous or induced during an electrophysiologic (EP) study, but may not be due to a transient or reversible cause and not occurring during the first 48 hours of an acute myocardial infarction;
B. Familial or inherited conditions with a high risk of life-threatening ventricular tachyarrhythmias such as long QT syndrome, hypertrophic cardiomyopathy;
C. Either a documented prior myocardial infarction or a dilated cardiomyopathy and measured left ventricular ejection fraction less than or equal to 35%;
D. Documentation of a previously implanted defibrillator that due to infection, injury or illness requires a waiting period before ICD reinsertion; **or**
E. Documentation of an infection or other temporary medical condition that prevents the initial implantation of an ICD.
F. The FDA has **not** approved use of the WCD for the indications listed below. Therefore, the WCD is **not medically necessary and not covered** for a beneficiary who meets **any one** of the following:
   1. Already has an ICD implanted and operating;
   2. Has a vision or hearing problem that may interfere with reading or hearing the WCD messages;
   3. Is taking medication that would interfere with pushing the response buttons on the WCD alarm module;

4. Is unwilling or unable to wear the device continuously, except when bathing or showering;
5. Is pregnant or breast feeding;
6. Is of childbearing age and not attempting to prevent pregnancy; or
7. Is exposed to excessive electromagnetic interference (EMI) from machinery, such as powerful electric motors, radio transmitters, power lines or electronic security scanners, EMI can prevent the WCD from detecting an abnormal heart rhythm.

Note: The WCD must be ordered by a physician who is experienced in management of a beneficiary at risk for sudden cardiac death, agrees to closely monitor the beneficiary during the coverage period, and is willing to obtain documentation of beneficiary's compliance with the WCD.

Note: WCD is for rental only and the initial prior approval is given for a time period of three months when the beneficiary meets all medical necessity and coverage criteria.

XI. WellCare of North Carolina shall cover **Incontinence, Ostomy, and Urinary Catheter Supplies** only when they are medically necessary due to a disease, illness or injury. The supplies must be prescribed by a physician, physician assistant, or nurse practitioner, and the amount delivered must be supported by the beneficiary's actual medical needs. Medical equipment providers shall obtain the written, signed, and dated prescription for the supplies prior to submitting their claim for reimbursement. The prescription must document the type(s) of supplies ordered and the quantity to be used for a specified time (such as per month). All requests for specialty supplies (such as silicone catheter instead of regular latex catheters) must have medical necessity documentation from the physician, physician assistant, or nurse practitioner stating the medical necessity for the specialty supply.

A. Incontinence supplies (such as diapers) are only covered for beneficiaries three years of age and older who are incontinent due to disease, illness or injury. Incontinence supplies must comply with industry-wide quality standards for rate acquisition, rewet and capacity.
B. Pre-moistened incontinence wipes must not be billed using A4335 or any other HCPCS code without prior authorization.
C. Home health agencies shall provide supplies to beneficiaries receiving other home health services.

XII. WellCare of North Carolina shall cover a **Manual Pump-Operated Enema System**, such as the Peristeen® Anal Irrigation System, when all the following coverage criteria are met:

A. Beneficiary has a diagnosis of neurogenic bowel dysfunction;
B. Beneficiary is two years of age and older;
C. Beneficiary suffers from fecal incontinence, chronic constipation, and time-consuming bowel management procedures; **and**
D. Initial management involving diet, bowel habit, laxatives, or constipating medication has failed.

XIII. WellCare of North Carolina shall cover **Electric Breast Pumps** when criteria below are met. A breast pump is a device used to extract milk from the breast of a lactating mother for infant feeding when the mother cannot be present at feeding time or when the infant is too sick or too weak to suckle. An electric breast pump is considered medically necessary when one of the following criteria is met:

A. During the time when a newborn is detained in the hospital after the mother is discharged; or
B. The newborn has a congenital anomaly that interferes with feeding (such as cleft palate, neuromuscular disease or congenital heart defect); or
C. A medical condition that causes low milk production is present (such as prematurity, thyroid conditions, polycystic ovarian syndrome, diabetes, or obesity).

Note: If a rental hospital grade breast pump is medically necessary, then the PA may be limited to one (1) month at a time.

XIV. WellCare of North Carolina shall cover **Sterile and Non-Sterile Gloves** when used with covered Durable Medical Equipment and Medical Supplies by the beneficiary or to protect the beneficiary from infection. Gloves used by an outside agency for the caregiver's protection, are considered the agency's overhead cost and must not be billed.

XV. WellCare of North Carolina shall cover an **ambulatory infusion pump** when a beneficiary requires covered IV medications.

XVI. WellCare of North Carolina shall cover an **IV pole** when a beneficiary receives either parenteral or enteral fluids.

XVII. WellCare of North Carolina shall cover **Automatic Blood Pressure (BP) Monitors** for beneficiaries who are required by their medical provider to independently monitor and report their blood pressure from home due to conditions such as hypertension, hypotension, renal failure, or complications of pregnancy.

XVIII. WellCare of North Carolina shall cover a **floor scale,** regular capacity or extra capacity, for beneficiaries who are required by their medical provider to independently monitor and report their body weight from home due to conditions such as heart failure, renal failure, or complications of pregnancy.

XIX. Covered **wound care supplies** may be considered medically necessary for a beneficiary who is required by their medical provider to independently perform dressing changes at home, due to conditions such as the presence of an open wound, surgical site or ventricular assist device driveline site.

Coding Implications

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Lifetime Expectancies & Quantity Limitations for Durable Medical equipment & Supplies

HCPCS Code	Item Description	Lifetime Expectancy or Quantity Limitation
	Negative Pressure Wound Therapy	
E2402	Negative pressure wound therapy electrical pump, stationary or portable	N/A (Rental only)
A6550	Wound care set, for negative pressure wound therapy electrical pump, includes all supplies and accessories	15 per month
	External Insulin Infusion Pump	
E0784	External ambulatory infusion pump, insulin	5 years
A4230	Infusion set for external insulin pump, non-needle cannula type	16 per month
A4231	Infusion set for external insulin pump, needle type	16 per month
A6257	Transparent film, sterile, 16 sq. in. or less, each dressing	16 per month
A6258	Transparent film, sterile, more than 16 sq. in. but less than or equal to 48 sq. in., each dressing	16 per month
A9274	External ambulatory insulin delivery system, disposable, each, includes all supplies and accessories	16 per month
K0552	Supplies for external drug infusion pump, syringe type cartridge, sterile, each	16 per month
K0601	Replacement battery for external infusion pump owned by patient, silver oxide, 1.5 volt, each	18 per year
K0602	Replacement battery for external infusion pump owned by patient, silver oxide, 3 volts, each	18 per year
K0603	Replacement battery for external infusion pump owned by patient, alkaline, 1.5 volt, each	18 per year
K0604	Replacement battery for external infusion pump owned by patient, lithium, 3.6 volt, each	18 per year

K0605	Replacement battery for external infusion pump owned by patient, lithium, 4.5 volt each	18 per year
	External Defibrillator	
K0606	Automatic external defibrillator, with integrated electrocardiogram analysis, garment type	N/A (Rental only)
	Glucose Monitors and Supplies	
E0607	Home blood glucose monitor	2 years
E2100	Blood glucose monitor with integrated voice synthesizer	3 years
A4215	Needle, sterile, any size, each	200 per month
A4233	Replacement battery, alkaline (other than J cell), for use with medically necessary home blood glucose monitor owned by patient, each	8 per year
A4234	Replacement battery, alkaline, J cell, for use with medically necessary home blood glucose monitor owned by patient, each	8 per year
A4235	Replacement battery, lithium, for use with medically necessary home blood glucose monitor owned by patient, each	8 per year
A4236	Replacement battery, silver oxide, for use with medically necessary home blood glucose monitor owned by patient, each	8 per year
A4238	Supply allowance for adjunctive continuous glucose monitor (CGM), includes all supplies and accessories, 1 month supply = 1 unit of service	1 per month
A4244	Alcohol or peroxide, per pint	4 pints per month
A4250	Urine test or reagent strips or tablets (100 tablets or strips)	1 per month
A4252	Blood Ketone test or reagent strip, each	100 test strips per calendar month
A4253	Blood glucose test or reagent strips for home blood glucose monitor, per 50 strips	6 per month ages 0-20; 4 per month age 21 and older
A4256	Normal, low and high calibrator solution/chips	4 per year
A4258	Spring-powered device for lancet, each	2 per year
A4259	Lancets, per box of 100	2 per month
A9276	Sensor; invasive (e.g., subcutaneous), disposable, for use with non-durable medical equipment interstitial continuous glucose monitoring system, one unit = 1 day supply	Allow a 31-day supply per calendar month
A9277	Transmitter; external, for use with non-durable medical equipment interstitial continuous glucose monitoring system	Per manufacturer's warranty
A9278	Receiver (monitor); external, for use with non-durable medical equipment interstitial continuous glucose monitoring system	Per manufacturer's warranty

E2102	Adjunctive continuous glucose monitor or receiver	Per manufacturer's warranty
S5560	Insulin delivery device, reusable pen; 1.5 ml size	3 years
S5561	Insulin delivery device, reusable pen; 3 ml size	3 years
S8490	Insulin syringes (100 syringes, any size)	2 per month
	Phototherapy	
E0202	Phototherapy (bilirubin) light with photometer	7 days max. Ages birth to 1 month only
E0691	Ultraviolet light therapy system, includes bulbs/lamps, timer, and eye protection; treatment area 2 square feet or less	N/A (Rental only)
E0692	Ultraviolet light therapy system panel, includes bulbs/lamps, timer and eye protection, 4-foot panel	N/A (Rental only)
	Farrell Valve	
A9999	Miscellaneous DME supply or accessory, not otherwise specified (for use with Farrell Valve only)	31 per month
	Electric Breast Pumps	
E0603	Breast pump, electric (ac and/or dc), any type	1 per pregnancy
E0604	Breast pump, hospital grade, electric (ac and / or dc), any type	N/A (Rental only)
A4281	Tubing for breast pump, replacement	2 per year
A4282	Adapter for breast pump, replacement	2 per year
A4283	Cap for breast pump bottle, replacement	2 per year
A4284	Breast shield and splash protector for use with breast pump, replacement	2 per year
A4285	Polycarbonate bottle for use with breast pump, replacement	2 per year
A4286	Locking ring for breast pump, replacement	2 per year
K1005	Disposable collection and storage bag for breast milk, any size, any type, each	200 per month
	Miscellaneous Durable Medical Equipment and Supplies	
A4927	Gloves, non-sterile, per 100	4 boxes/month
A4930	Gloves, sterile, per pair	75 pair/month
E0781	Ambulatory infusion pump, single or multiple channels electric or battery operated with administrative equipment, worn by patient	N/A (Rental only)
A4213	Syringe, sterile, 20cc or greater, each	50 per month
A4217	Sterile water/saline, 500 ml	100 per month
A4245	Alcohol wipes, per box	1 box per month
A4246	Betadine or pHisoHex solution, per pint	10 per month

A4247	Betadine or iodine swabs/wipes, per box	1 box per month
A4248	Chlorhexidine containing antiseptic, 1 ml	80 per month
A4333	Urinary catheter anchoring device, adhesive skin attachment, each	10 per month
A4456	Adhesive remover, wipes, any type, each	50 wipes per month
A6207	Contact layer, sterile, more than 16 sq. in but less than or equal to 48 sq. in., each dressing	36 per month
A6228	Gauze, impregnated, water or normal saline, sterile, pad size 16 sq. in. or less, without adhesive border, each dressing	75 per month
A6259	Transparent film, sterile, more than 48 sq. in., each dressing	10 per month
A6402	Gauze, non-impregnated, sterile, pad size 16 sq. in. or less, without adhesive border, each dressing	300 per month
A7048	Vacuum drainage collection unit and tubing kit, including all supplies needed for collection unit change, for use with implanted catheter, each	31 per month
E0776	IV pole	3 years
W4047	Miscellaneous for DME	N/A
A4670	Automatic blood pressure monitor	3 years
E1639	Scale, each	3 years
	Nutrition – Formula and Supplies	
B4034	Enteral feeding supply kit; syringe fed, per day, includes but not limited to feeding/flushing syringe, administration set tubing, dressings, tape	31 per month
B4035	Enteral feeding supply kit; pump fed, per day, includes but not limited to feeding/flushing syringe, administration set tubing, dressings, tape	31 per month
B4036	Enteral feeding supply kit; gravity fed, per day, includes but not limited to feeding/flushing syringe, administration set tubing, dressings, tape	31 per month
B4081	Nasogastric tubing with stylet	3 every 3 months, not to exceed 12 per year
B4082	Nasogastric tubing without stylet	3 every 3 months, not to exceed 12 per year
B4083	Stomach tube—Levine type	3 every 3 months, not to exceed 12 per year
B4087	Gastrostomy/jejunostomy tube, standard, any material, any type, each	1 every 3 months, not to exceed 4 per year

B4088	Gastrostomy/jejunostomy tube, low-profile, any material, any type, each	1 every 3 months, not to exceed 4 per year
B4100	Food thickener, administered orally, per ounce	N/A
B4103	Enteral formula, for pediatrics, used to replace fluids and electrolytes (e.g., clear liquids), 500 ml = 1 unit	Maximum allowed per calendar month is 100 units
B4104	Additive for enteral formula (e.g., fiber)	N/A
B4105	In-line cartridge containing digestive enzyme(s) for enteral feeding each	62 units per month
B4149	Enteral formula, manufactured blenderized natural foods with intact nutrients, includes proteins, fats, carbohydrates, vitamins and minerals, may include fiber, administered through an enteral feeding tube, 100 calories=1 unit	Monthly limits depend on the individual beneficiary's medical/nutritional needs and physician's orders not to exceed 775 units per calendar month
B4150	Enteral formulae, nutritionally complete with intact nutrients, includes proteins, fats, carbohydrates, vitamins, and minerals, may include fiber, administered through an enteral feeding tube, 100 calories= 1 unit	Monthly limits depend on the individual beneficiary's medical/nutritional needs and physician's orders not to exceed 775 units per calendar month
B4152	Enteral formula, nutritionally complete, calorically dense (equal to or greater than 1.5 kcal/ml) with intact nutrients, includes proteins, fats, carbohydrates, vitamins and minerals, may include fiber, administered through an enteral feeding tube, 100 calories=1 unit	Monthly limits depend on the individual beneficiary's medical/nutritional needs and physician's orders not to exceed 775 units per calendar month

B4153	Enteral formula, nutritionally complete, hydrolyzed proteins (amino acids and peptide chain), includes fats, carbohydrates, vitamins and minerals, may include fiber, administered through an enteral feeding tube, 100 calories=1 unit	Monthly limits depend on the individual beneficiary's medical/nutritional needs and physician's orders not to exceed 775 units per calendar month
B4154	Enteral formula, nutritionally complete, for special metabolic needs, excludes inherited disease of metabolism, includes altered composition of proteins, fats, carbohydrates, vitamins and/or minerals, may include fiber, administered through an enteral feeding tube, 100 calories=1 unit	Monthly limits depend on the individual beneficiary's medical/nutritional needs and physician's orders not to exceed 775 units per calendar month
B4155	Enteral formula, nutritionally incomplete/modular nutrients, includes specific nutrients, carbohydrates (e.g., glucose polymers), proteins/amino acids (e.g., glutamine, arginine), fat (e.g., medium chain triglycerides) or combination, administered through an enteral feeding tube, 100 calories= 1unit	Monthly limits depend on the individual beneficiary's medical/nutritional needs and physician's orders not to exceed 775 units per calendar month
B4157	Enteral formula, nutritionally complete, for special metabolic needs for inherited disease of metabolism, includes proteins, fats, carbohydrates, vitamins and minerals, may include fiber, administered through an enteral feeding tube, 100 calories = 1 unit	Monthly limits depend on the individual beneficiary's medical/nutritional needs and physician's orders not to exceed 775 units per calendar month
B4158	Enteral formula, for pediatric nutritionally complete with intact nutrients, includes proteins, fats, carbohydrates, vitamins and minerals, may include fiber and/or iron, administered through an enteral feeding tube, 100 cal = 1 unit	Monthly limits depend on the individual beneficiary's medical/nutritional

		needs and physician's orders not to exceed 775 units per calendar month
B4159	Enteral formula, for pediatrics, nutritionally complete soy based with intact nutrients, includes proteins, fats, carbohydrates, vitamins and minerals, may include fiber and/or iron, administered through an enteral feeding tube, 100 Cal = 1 unit	Monthly limits depend on the individual beneficiary's medical/nutritional needs and physician's orders not to exceed 775 units per calendar month.
B4160	Enteral formula, for pediatrics, nutritionally complete calorically dense (equal to or greater than 0.7 kcal/ml) with intact nutrients, includes proteins, fats, carbohydrates, vitamins and minerals, may include fiber, administered through an enteral feeding tube, 100 Cal = 1 unit	Monthly limits depend on the individual beneficiary's medical/nutritional needs and physician's orders not to exceed 775 units per calendar month.
B4161	Enteral formula, for pediatrics, hydrolyzed/amino acids and peptide chain proteins, includes fats, carbohydrates, vitamins and minerals, may include fiber, administered through an enteral feeding tube, 100 Cal = 1 unit	Monthly limits depend on the individual beneficiary's medical/nutritional needs and physician's orders not to exceed 775 units per calendar month.
B4162	Enteral formula, for pediatrics, special metabolic needs for inherited disease of metabolism, includes proteins, fats, carbohydrates, vitamins and minerals, may include fiber, administered through an enteral feeding tube, 100 Cal = 1 unit	Monthly limits depend on the individual beneficiary's medical/nutritional needs and physician's orders not to exceed 775 units per calendar month .

B9002	Enteral nutrition infusion pump - with alarm	2 years
B9004	Parenteral nutrition infusion pump, portable	2 years
B9006	Parenteral nutrition infusion pump, stationary	2 years
S8265	Haberman Feeder for cleft lip/palate	N/A
W4211	Low profile gastrostomy extension/replacement kit tubes for cont. feed.	2 per month
W4212	Low profile gastrostomy extension/replacement kit for bolus feeding	2 per month
	Incontinence, Ostomy, and Urinary Catheter Supplies	
A4310	Insertion tray without drainage bag and without catheter (accessories only)	2 per month
A4311	Insertion tray without drainage bag with indwelling catheter, Foley type, two-way latex with coating (Teflon, silicone, silicone elastomer, or hydrophilic, etc.)	1 per month
A4313	Insertion tray without drainage bag with indwelling catheter, Foley type, three-way, for continuous irrigation	1 per month
A4314	Insertion tray with drainage bag with indwelling catheter, Foley type, two-way latex with coating (Teflon, silicone, silicone elastomer, or hydrophilic, etc.)	1 per month
A4315	Insertion tray with drainage bag with indwelling catheter, Foley type, two-way, all silicone	1 per month
A4316	Insertion tray with drainage bag with indwelling catheter, Foley type, three-way, for continuous irrigation	1 per month
A4320	Irrigation tray with bulb or piston syringe, any purpose	3 per month
A4321	Therapeutic agent for urinary catheter irrigation	2 per month
A4322	Irrigation syringe, bulb or piston, each	2 per month
A4328	Female external urinary collection device; pouch, each	31 per month
A4331	Extension drainage tubing, any type, any length, with connector/adapter, for use with urinary leg bag or urostomy pouch, each	2 per month
A4334	Urinary catheter anchoring device, leg strap, each	2 per month
A4335	Incontinence supply; miscellaneous	2 per month
A4338	Indwelling catheter; Foley type, two-way latex with coating (Teflon, silicone, silicone elastomer, or hydrophilic, etc.), each	1 per month
A4340	Indwelling catheter; specialty type (e.g., coude, mushroom, wing, etc.), each	1 per month
A4344	Indwelling catheter, Foley type, two-way, all silicone, each	1 per month
A4349	Male external catheter, with or without adhesive, disposable, each	35 per month
A4351	Intermittent urinary catheter; straight tip, with or without coating (Teflon, silicone, silicone elastomer, or hydrophilic, etc.), each	200 per month
A4352	Intermittent urinary catheter; coude (curved) tip, with or without coating	200 per month

	(Teflon, silicone, silicone elastomer, or hydrophilic, etc.), each	
A4353	Intermittent urinary catheter, with insertion supplies	200 per month
A4354	Insertion tray with drainage bag but without catheter	2 per month
A4357	Bedside drainage bag, day or night, with or without anti-reflux device, with or without tube, each	2 per month
A4358	Urinary drainage bag, leg or abdomen, vinyl, with or without tube, with straps, each	2 per month
A4361	Ostomy faceplate, each	3 per 6 months
A4362	Skin barrier; solid, 4X4 or equivalent; each	20 per month
A4364	Adhesive, liquid or equal, any type, per oz.	4 oz. per month
A4367	Ostomy belt, each	1 per month
A4368	Ostomy filter, any type, each	60 per month
A4369	Ostomy skin barrier, liquid (spray, brush, etc.), per oz.	2 oz. per month
A4371	Ostomy skin barrier, powder, per oz.	10 oz. per month
A4372	Ostomy skin barrier, solid 4X4 or equivalent, standard wear, with built-in convexity, each	20 per month
A4373	Ostomy skin barrier, with flange (solid, flexible, or accordion), with built-in convexity, any size, each	20 per month
A4375	Ostomy pouch, drainable, with faceplate attached, plastic, each	15 per month
A4376	Ostomy pouch, drainable, with faceplate attached, rubber, each	3 per month
A4377	Ostomy pouch, drainable, for use on faceplate, plastic each	10 per month
A4378	Ostomy pouch, drainable, for use on faceplate, rubber, each	3 per month
A4379	Ostomy pouch, urinary, with faceplate attached, plastic, each	15 per month
A4380	Ostomy pouch, urinary, with faceplate attached, rubber, each	3 per month
A4381	Ostomy pouch, urinary, for use on faceplate, plastic each	10 per month
A4382	Ostomy pouch, urinary, for use on faceplate, heavy plastic, each	3 per month
A4383	Ostomy pouch, urinary, for use on faceplate, rubber, each	3 per month
A4384	Ostomy faceplate equivalent, silicone ring, each	3 per 6 months
A4385	Ostomy skin barrier, solid 4X4 or equivalent, extended wear, without built-in convexity, each	20 per month
A4388	Ostomy pouch, drainable, with extended wear barrier attached (1 piece), each	20 per month
A4389	Ostomy pouch, drainable, with barrier attached, with built-in convexity (1 piece), each	20 per month
A4390	Ostomy pouch, drainable, with extended wear barrier attached, with built-in convexity (1 piece), each	20 per month

A4391	Ostomy pouch, urinary, with extended wear barrier attached (1 piece), each	20 per month
A4392	Ostomy pouch, urinary, with standard wear barrier attached, with built-in convexity (1 piece), each	20 per month
A4393	Ostomy pouch, urinary, with extended wear barrier attached, with built-in convexity (1 piece), each	20 per month
A4394	Ostomy deodorant, with or without lubricant, for use in ostomy pouch, per fluid ounce	16 oz. per month
A4395	Ostomy deodorant, for use in ostomy pouch, solid, per tablet	100 per month
A4436	Irrigation supply; sleeve, reusable, per month	1 per month
A4437	Irrigation supply; sleeve, disposable, per month	1 per month
A4398	Ostomy irrigation supply; bag, each	2 per 6 months
A4399	Ostomy irrigation supply; cone/catheter, with or without brush	2 per 6 months
A4400	Ostomy irrigation set	2 per month
A4402	Lubricant, per ounce	4 oz. per month
A4404	Ostomy ring, each	10 per month
A4405	Ostomy skin barrier, non-pectin based, paste, per ounce	4 oz. per month
A4406	Ostomy skin barrier, pectin-based, paste, per ounce	4 oz. per month
A4407	Ostomy skin barrier, with flange (solid, flexible, or accordion), extended wear, with built-in convexity, 4X4 inches or smaller, each	20 per month
A4408	Ostomy skin barrier, with flange (solid, flexible, or accordion), extended wear, with built-in convexity, larger than 4X4 inches, each	20 per month
A4409	Ostomy skin barrier, with flange (solid, flexible, or accordion), extended wear, without built-in convexity, 4X4 inches or smaller, each	20 per month
A4410	Ostomy skin barrier, with flange (solid, flexible, or accordion), extended wear, without built-in convexity, larger than 4X4 inches, each	20 per month
A4411	Ostomy skin barrier, solid 4X4 or equivalent, extended wear, with built-in convexity, each	20 per month
A4414	Ostomy skin barrier, with flange (solid, flexible, or accordion), without built-in convexity, 4X4 inches or smaller, each	20 per month
A4415	Ostomy skin barrier, with flange (solid, flexible, or accordion), without built-in convexity, larger than 4X4 inches, each	20 per month
A4416	Ostomy pouch, closed, with barrier attached, with filter (1 piece), each	60 per month
A4417	Ostomy pouch, closed, with barrier attached, with built-in convexity, with filter (1 piece), each	60 per month
A4418	Ostomy pouch, closed, without barrier attached, with filter (1 piece), each	60 per month

A4419	Ostomy pouch, closed; for use on barrier with non-locking flange, with filter (2 piece), each	60 per month
A4423	Ostomy pouch, closed; for use on barrier with locking flange, with filter (2 piece), each	60 per month
A4424	Ostomy pouch, drainable, with barrier attached, with filter (1 piece), each	20 per month
A4425	Ostomy pouch, drainable; for use on barrier with non-locking flange, with filter (2-piece system), each	20 per month
A4426	Ostomy pouch, drainable; for use on barrier with locking flange (2-piece system), each	20 per month
A4427	Ostomy pouch, drainable; for use on barrier with locking flange, with filter (2-piece system), each	20 per month
A4428	Ostomy pouch, urinary, with extended wear barrier attached, with faucet type tap with valve (1 piece), each	20 per month
A4429	Ostomy pouch, urinary, with barrier attached, with built-in convexity, with faucet-type tap with valve (1 piece), each	20 per month
A4430	Ostomy pouch, urinary, with extended wear barrier attached, with built-in convexity, with faucet-type tap with valve (1 piece), each	15 per month
A4431	Ostomy pouch, urinary; with barrier attached, with faucet-type tap with valve (1 piece), each	20 per month
A4432	Ostomy pouch, urinary; for use on barrier with non-locking flange, with faucet-type tap with valve (2 piece), each	20 per month
A4433	Ostomy pouch, urinary; for use on barrier with locking flange (2 piece), each	20 per month
A4434	Ostomy pouch, urinary; for use on barrier with locking flange, with faucet-type tap with valve (two piece), each	20 per month
A4435	Ostomy pouch, drainable, high output, with extended wear barrier (one-piece system), with or without filter, each	20 per month
A4450	Tape, non-waterproof, per 18 square inches	80 units per month
A4452	Tape, waterproof, per 18 square inches	80 units per month
A4455	Adhesive remover or solvent (for tape, cement or other adhesive), per ounce	16 oz. per 6 months
A4554	Disposable under pads, all sizes	150 per month
A5051	Ostomy pouch, closed; with barrier attached (1 piece), each	60 per month
A5052	Ostomy pouch, closed; without barrier attached (1 piece), each	60 per month
A5053	Ostomy pouch, closed; for use on faceplate, each	60 per month
A5054	Ostomy pouch, closed; for use on barrier with flange (2 piece), each	60 per month
A5055	Stoma cap	31 per month

A5056	Ostomy pouch, drainable, with extended wear barrier attached, with filter, (one piece), each	40 per month
A5057	Ostomy pouch, drainable, with extended wear barrier attached, with built in convexity, with filter, (one piece), each	40 per month
A5061	Ostomy pouch, drainable; with barrier attached, (1 piece), each	20 per month
A5062	Ostomy pouch, drainable; without barrier attached (1 piece), each	20 per month
A5063	Ostomy pouch, drainable; for use on barrier with flange (2-piece system), each	20 per month
A5071	Ostomy pouch, urinary; with barrier attached (1 piece), each	20 per month
A5072	Ostomy pouch, urinary; without barrier attached (1 piece), each	20 per month
A5073	Ostomy pouch, urinary; for use on barrier with flange (2 piece), each	20 per month
A5081	Stoma plug or seal, any type	31 per month
A5082	Continent device; catheter for continent stoma	1 per month
A5083	Continent device, stoma absorptive cover for continent stoma	150 per month
A5093	Ostomy accessory; convex insert	10 per month
A5102	Bedside drainage bottle with or without tubing, rigid or expandable, each	2 per 6 months
A5112	Urinary drainage bag, leg or abdomen, latex, with or without tube, with straps, each	1 per month
A5120	Skin barrier, wipes, or swabs, each	150 per 6 months
A5121	Skin barrier; solid, 6X6 or equivalent, each	20 per month
A5122	Skin barrier; solid, 8X8 or equivalent, each	20 per month
A5126	Adhesive or non-adhesive; disk or foam pad	20 per month
A5131	Appliance cleaner, incontinence and ostomy appliances, per 16 oz.	1 per month
A6216	Gauze, non-impregnated, non-sterile, pad size 16 sq. in or less, without adhesive boarder, each dressing	60 per month
T4521	Adult sized disposable incontinence product, brief/diaper, small, each	192 per month
T4522	Adult sized disposable incontinence product, brief/diaper, medium, each	192 per month
T4523	Adult sized disposable incontinence product, brief/diaper, large, each	192 per month
T4524	Adult sized disposable incontinence product, brief/diaper, extra-large, each	192 per month
T4525	Adult sized disposable incontinence product, protective underwear/pull on, small size, each	200 per month
T4526	Adult sized disposable incontinence product, protective underwear/pull on, medium size, each	200 per month
T4527	Adult sized disposable incontinence product, protective underwear/pull on, large size, each	200 per month

T4528	Adult sized disposable incontinence product, protective underwear/pull on, extra-large size, each	200 per month
T4529	Pediatric sized disposable incontinence product, brief/diaper, small/ medium size, each	192 per month
T4530	Pediatric sized disposable incontinence product, brief/diaper, large size, each	192 per month
T4531	Pediatric sized disposable incontinence product, protective underwear/pull on, small/medium size, each	200 per month
T4532	Pediatric sized disposable incontinence product, protective underwear/pull on, large size, each	200 per month
T4533	Youth sized disposable incontinence product, brief/diaper, each	192 per month
T4534	Youth-sized disposable incontinence product, protective underwear/pull on, each	200 per month
T4543	Disposable incontinence product, brief/diaper, bariatric, each	192 per month
T4544	Adult sized disposable incontinence product, protective underwear/pull-on, above extra-large, each	200 per month
	Manual Pump-Operated Enema System	
A4453	Rectal catheter for use with the manual pump-operated enema system, replacement only	90 units per 3 months
A4459	Manual pump-operated enema system, includes balloon, catheter and all accessories, reusable, any type	4 per year
	Equipment Service and Repair	
K0739	Repair or non-routine service for durable medical equipment other than oxygen equipment requiring the skill of a technician, labor component, per 15 minutes	N/A

ICD-10-CM Diagnosis Codes that Support Coverage Criteria
See State of North Carolina Medicaid. Medicaid and Health Choice Clinical Coverage Policy No: 5A-3 Nursing Equipment and Supplies. Program Specific Clinical Coverage Policies | NC Medicaid (ncdhhs.gov)
for a list of applicable codes.

Reviews, Revisions, and Approvals	Reviewed Date	Approval Date
Original approval date	04/21	06/21
Added non-covered criteria in Section IV for "NPWT pump and supplies" Deleted phototherapy criteria. Added Criteria XII "cover a Manual Pump-Operated Enema System" Coverage and quantity limits were added for HCPCS codes: A4245, A4247, A4248, A4333, A6207, A6228, A6259, A6402, A4453, A4459, A4436, A4437. Deleted HCPCS code A4397. Updated language for quantity limit for	06/22	08/22

Reviews, Revisions, and Approvals	Reviewed Date	Approval Date
HCPCS codes A4450 and A4452 from "80 units" to "80 units per month".		
Annual Review. NCHC verbiage removed from NC Guidance Verbiage. **CRITERIA Added:** VIII. B. "pain,..or risk, excessive gastric residuals, neurological impairments…" VIII.D."The inability of the beneficiary to tolerate enteral feedings without the Farrell valve must be documented." VIII.E."The Farrell valve is not covered when clinical documentation demonstrates that the beneficiary is tolerating continuous enteral feedings without difficulty or complications." IX.A.3."Medical necessity of the oral nutrition product is substantiated by documented physical findings, and laboratory data if available, that demonstrate malnutrition or risk of nutritional depletion." IX.A.4."Note: Oral nutrition products are not covered when medical necessity is not established, or when they are used as convenient food substitutes." MEDICALLY NECESSARY CRITERIA ADDED FOR IX.D. In-Line Digestive Enzyme Cartridges, . XI."Incontinence, Ostomy, and Urinary Catheter Supplies. XIII.Electric Breast Pumps. XVI. IV Pole XIX.Covered Wound Care Supply Under X.F.Wearable Cardiac Defibrillator, added "Not Medically Necessary" criteria. **CRITERIA Deleted:** V.B.1. deleted verbiage, "has an HbA1C greater than 6.5%" HCPCS E0202 Phototherapy (bilirubin) light with photometer added "7 days max." Coverage and quantity limits were added for HCPCS codes, A4281, A4282, A4283, A4284, A4285, A4286, A4315, A4434, A5081, A5082, A5083, A5112, B4105, E0603, E0604, K1005, A4238 and E2102. Updated "over" to "older." Revised the descriptions for HCPCS codes A9276, A9277 and A9278. Updated quantity limitation for HCPCS codes A5056 (Ostomy pouch, drainable, with extended wear barrier attached, with filter, (one piece), each) and A5057 (Ostomy pouch, drainable, with extended wear barrier attached, with built in convexity, with filter, (one piece), each) from 20 per month to 40 per month. Updated quantity limitation for HCPCS code A4371 (Ostomy skin barrier, powder, per oz.) from 2 oz. per month to 10 oz. per month.	05/23	05/23

References

1. State of North Carolina Medicaid. Medicaid and Health Choice Clinical Coverage Policy No: 5A-3 Nursing Equipment and Supplies. Program Specific Clinical Coverage Policies | NC Medicaid (ncdhhs.gov) Published March 1, 2023. Accessed March 9, 2023.

North Carolina Guidance

Eligibility Requirements

a. An eligible beneficiary shall be enrolled in the NC Medicaid Program (Medicaid is NC Medicaid program, unless context clearly indicates otherwise);
b. Provider(s) shall verify each Medicaid beneficiary's eligibility each time a service is rendered.
c. The Medicaid beneficiary may have service restrictions due to their eligibility category that would make them ineligible for this service.

EPSDT Special Provision: Exception to Policy Limitations for a Medicaid Beneficiary under 21 Years of Age

a. 42 U.S.C. § 1396d(r) [1905(r) of the Social Security Act]

Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) is a federal Medicaid requirement that requires the state Medicaid agency to cover services, products, or procedures for Medicaid beneficiary under 21 years of age if the service is medically necessary health care to correct or ameliorate a defect, physical or mental illness, or a condition [health problem] identified through a screening examination (includes any evaluation by a physician or other licensed practitioner).

This means EPSDT covers most of the medical or remedial care a child needs to improve or maintain his or her health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems.

Medically necessary services will be provided in the most economic mode, as long as the treatment made available is similarly efficacious to the service requested by the beneficiary's physician, therapist, or other licensed practitioner; the determination process does not delay the delivery of the needed service; and the determination does not limit the beneficiary's right to a free choice of providers.

EPSDT does not require the state Medicaid agency to provide any service, product or procedure:

1. that is unsafe, ineffective, or experimental or investigational.
2. that is not medical in nature or not generally recognized as an accepted method of medical practice or treatment.

Service limitations on scope, amount, duration, frequency, location of service, and other specific criteria described in clinical coverage policies may be exceeded or may not apply as long as the provider's documentation shows that the requested service is medically necessary "to correct or ameliorate a defect, physical or mental illness, or a condition" [health problem]; that is, provider documentation shows how the service, product, or procedure meets all EPSDT criteria, including to correct or improve or maintain the beneficiary's health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems.

EPSDT and Prior Approval Requirements

1. If the service, product, or procedure requires prior approval, the fact that the beneficiary is under 21 years of age does NOT eliminate the requirement for prior approval.

2. **IMPORTANT ADDITIONAL INFORMATION** about EPSDT and prior approval is found in the *NCTracks Provider Claims and Billing Assistance Guide*, and on the EPSDT provider page. The Web addresses are specified below:
   NCTracks Provider Claims and Billing Assistance Guide:
   https://www.nctracks.nc.gov/content/public/providers/provider-manuals.html
   EPSDT provider page: https://medicaid.ncdhhs.gov/

Provider(s) Eligible to Bill for the Procedure, Product, or Service
To be eligible to bill for the procedure, product, or service related to this policy, the provider(s) shall:

a. meet Medicaid qualifications for participation;
b. have a current and signed Department of Health and Human Services (DHHS) Provider Administrative Participation Agreement; and
c. bill only for procedures, products, and services that are within the scope of their clinical practice, as defined by the appropriate licensing entity.

Compliance
Provider(s) shall comply with the following in effect at the time the service is rendered:

a. All applicable agreements, federal, state and local laws and regulations including the Health Insurance Portability and Accountability Act (HIPAA) and record retention requirements; and
b. All NC Medicaid's clinical (medical) coverage policies, guidelines, policies, provider manuals, implementation updates, and bulletins published by the Centers for Medicare and Medicaid Services (CMS), DHHS, DHHS division(s) or fiscal contractor(s).

Claims-Related Information
Provider(s) shall comply with the NC Tracks Provider Claims and Billing Assistance Guide, Medicaid bulletins, fee schedules, NC Medicaid's clinical coverage policies and any other relevant documents for specific coverage and reimbursement for Medicaid:

a. Claim Type - as applicable to the service provided:
   Professional (CMS-1500/837P transaction)
   Institutional (UB-04/837I transaction)
   Unless directed otherwise, Institutional Claims must be billed according to the National Uniform Billing Guidelines. All claims must comply with National Coding Guidelines.
b. International Classification of Diseases and Related Health Problems, Tenth Revisions, Clinical Modification (ICD-10-CM) and Procedural Coding System (PCS) - Provider(s) shall report the ICD-10-CM and Procedural Coding System (PCS) to the highest level of specificity that supports medical necessity. Provider(s) shall use the current ICD-10 edition and any subsequent editions in effect at the time of service. Provider(s) shall refer to the applicable edition for code description, as it is no longer documented in the policy.
c. Code(s) - Provider(s) shall report the most specific billing code that accurately and completely describes the procedure, product or service provided. Provider(s) shall use the Current Procedural Terminology (CPT), Health Care Procedure Coding System (HCPCS), and UB-04 Data Specifications Manual (for a complete listing of valid revenue codes) and any subsequent editions in effect at the time of service. Provider(s) shall refer to the applicable edition for the code description, as it is no longer documented in the

policy. If no such specific CPT or HCPCS code exists, then the provider(s) shall report the procedure, product or service using the appropriate unlisted procedure or service code.

Unlisted Procedure or Service

CPT: The provider(s) shall refer to and comply with the Instructions for Use of the CPT Codebook, Unlisted Procedure or Service, and Special Report as documented in the current CPT in effect at the time of service.

HCPCS: The provider(s) shall refer to and comply with the Instructions For Use of HCPCS National Level II codes, Unlisted Procedure or Service and Special Report as documented in the current HCPCS edition in effect at the time of service

d. Modifiers - Providers shall follow applicable modifier guidelines.
e. Billing Units - Provider(s) shall report the appropriate code(s) used which determines the billing unit(s).
f. Co-payments -
   For Medicaid refer to Medicaid State Plan:
   https://medicaid.ncdhhs.gov/get-involved/nc-health-choice-state-plan

g. Reimbursement - Provider(s) shall bill their usual and customary charges. For a schedule of rates, refer to: https://medicaid.ncdhhs.gov/.

Important Reminder

This clinical policy has been developed by appropriately experienced and licensed health care professionals based on a review and consideration of currently available generally accepted standards of medical practice; peer-reviewed medical literature; government agency/program approval status; evidence-based guidelines and positions of leading national health professional organizations; views of physicians practicing in relevant clinical areas affected by this clinical policy; and other available clinical information. The Health Plan makes no representations and accepts no liability with respect to the content of any external information used or relied upon in developing this clinical policy. This clinical policy is consistent with standards of medical practice current at the time that this clinical policy was approved. “Health Plan” means a health plan that has adopted this clinical policy and that is operated or administered, in whole or in part, by Centene Management Company, LLC, or any of such health plan’s affiliates, as applicable.

The purpose of this clinical policy is to provide a guide to medical necessity, which is a component of the guidelines used to assist in making coverage decisions and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage decisions and the administration of benefits are subject to all terms, conditions, exclusions and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy, contract of insurance, etc.), as well as to state and federal requirements and applicable Health Plan-level administrative policies and procedures.

This clinical policy is effective as of the date determined by the Health Plan. The date of posting may not be the effective date of this clinical policy. This clinical policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this clinical policy and any applicable legal or

regulatory requirement, the requirements of law and regulation shall govern. The Health Plan retains the right to change, amend or withdraw this clinical policy, and additional clinical policies may be developed and adopted as needed, at any time.

This clinical policy does not constitute medical advice, medical treatment or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise professional medical judgment in providing the most appropriate care, and are solely responsible for the medical advice and treatment of members/enrollees. This clinical policy is not intended to recommend treatment for members/enrollees. Members/enrollees should consult with their treating physician in connection with diagnosis and treatment decisions.

Providers referred to in this clinical policy are independent contractors who exercise independent judgment and over whom the Health Plan has no control or right of control. Providers are not agents or employees of the Health Plan.

This clinical policy is the property of the Health Plan. Unauthorized copying, use, and distribution of this clinical policy or any information contained herein are strictly prohibited. Providers, members/enrollees and their representatives are bound to the terms and conditions expressed herein through the terms of their contracts. Where no such contract exists, providers, members/enrollees and their representatives agree to be bound by such terms and conditions by providing services to members/enrollees and/or submitting claims for payment for such services.