Dear Durable Medical Equipment Provider:

Re: Removal of Prior Approval Requirement on Selected DME codes

Effective for order dates on and after December 1, 2005, the procedure codes listed on the reverse of this letter will no longer require a manual prior approval. DVS authorization will be required for purchase. If DVS authorization cannot be obtained due to service limitations, a prior approval request must be submitted with appropriate justification.

Coverage criteria that are listed in the DME Provider Manual Fee Schedule and Policy sections will remain the same, unless otherwise noted in this mailing. It is the responsibility of the ordering practitioner to maintain documentation of medical necessity which meets these coverage criteria in the recipient’s clinical file. In your files, you must maintain the original fiscal order and signed delivery statement for any item for which Medicaid payment is claimed.

The automated claims processing system frequency setting is also noted on the list of codes. If you have dispensed an item to a recipient more frequently than the automated system allows, do not request a DVS authorization. Submit a prior approval request with appropriate justification for an override of the frequency limit. On occasion, a provider might obtain a DVS authorization for an item and then receive a claims denial for Edit 00710. This is due to other DME providers dispensing the same item within the frequency time frame. In these cases, a prior approval request should be submitted with appropriate justification for override of frequency limit.

In addition to the DVS requirement for purchase, the following items should be rented (modifier ‘-RR’) initially for a four month trial period: speech generating devices, hospital beds, and Group II pressure reducing surfaces. At the conclusion of the trial period, the ordering practitioner must sign a new fiscal order for continuing rental or for conversion to purchase, and must maintain medical documentation which specifies how the recipient’s continued use of the device is meeting the goals of the treatment plan. Rentals beyond the four months trial period require prior approval. If the item is to be converted to purchase, obtain a DVS authorization. Payment will only be approved up to the purchase price. All rental payments must be deducted from purchase price regardless of the length of the rental.

Should you have further questions, please call the Medical Prior Approval Unit at (800) 342-3005. Thank you for your participation in the New York State Medicaid Program.

Sincerely,

Joan E. Johnson, Director
Division of Medicaid Fraud Control and Program Integrity
<table>
<thead>
<tr>
<th>CODE</th>
<th>SHORT DESCRIPTION</th>
<th>FREQ</th>
<th>‘-RR’ USE</th>
<th>PRICE</th>
</tr>
</thead>
<tbody>
<tr>
<td>A7025</td>
<td>#CHEST COMPRESSION VEST, REPLACE</td>
<td>2X/LIFE</td>
<td>NO</td>
<td>$275.00</td>
</tr>
<tr>
<td>A7026</td>
<td>#CHEST COMPRESSION HOSE, REPLACE</td>
<td>2X/LIFE</td>
<td>NO</td>
<td>$28.75</td>
</tr>
<tr>
<td>E0193</td>
<td>#POWERED AIR FLOATATION BED</td>
<td>2X/LIFE</td>
<td>YES*</td>
<td>$4,543.50</td>
</tr>
<tr>
<td>E0277</td>
<td>#ALTERNATING PRESSURE MATTRESS</td>
<td>2X/LIFE</td>
<td>YES*</td>
<td>$3,961.75</td>
</tr>
<tr>
<td>E0304</td>
<td>#HOSPITAL BED, EXTRA HVY DTY, &gt;600 LBS</td>
<td>2X/LIFE</td>
<td>YES*</td>
<td>$5,021.36</td>
</tr>
<tr>
<td>E0371</td>
<td>#NONPOWERED ADV PRES RED OVERLAY</td>
<td>2X/LIFE</td>
<td>YES*</td>
<td>$3,801.20</td>
</tr>
<tr>
<td>E0372</td>
<td>#POWERED AIR OVERLAY FOR MATTRESS</td>
<td>2X/LIFE</td>
<td>YES*</td>
<td>$1,412.00</td>
</tr>
<tr>
<td>E0445</td>
<td>#PULSE OXIMETER</td>
<td>1/X/MO</td>
<td>NO+</td>
<td>$165.00/month</td>
</tr>
</tbody>
</table>

The monthly rate for pulse oximeters includes all supplies. Pulse oximeters are only covered in combination with oxygen therapy and are not to be billed in combination with apnea monitors or ventilators unless treatment plan calls for weaning from these devices.

E0483  #CHEST COMPRESSION GENERATOR SYS                     | 1/X/MO | NO+       | $195.00/month |

A three month trial is required for chest compression systems and continued only with documented treatment success.

E0550  #HUMIDIFIER , EXTENSIVE SUPPL IPPB/O2 TX               | 1X/5YR | YES^      | $136.64 |
E0565  #COMPRESSOR, AIR POW SOURCE FOR EQUIP                  | 1X/5YR | YES^      | $377.69 |
E0747  #OSTEOGENESIS STIMULATOR, NOT SPINAL                   | 6X/2YR | NO+       | $333.00/month |
E0748  #OSTEOGENIC STIMULATOR, SPINAL                         | 6X/2YR | NO+       | $333.00/month |
E0760  #OSTEOGEN STIM LOW-INTEN ULTRASONIC                    | 6X/2YR | NO+       | $333.00/month |
E0784  #EXTERNAL AMB INSULIN INFUSION PUMP                     | 2X/LIFE| NO        | $5,128.83 |

An external insulin infusion pump will be covered for Diabetes Mellitus as medically necessary when ordered by an endocrinologist if the following criteria are demonstrated:

- Failure to achieve acceptable control of blood sugars on 3-4 injections unexplained by poor motivation or compliance
- Patient has completed a comprehensive diabetes education program, has been on multiple injections with frequent self adjustments for at least 6 months
- Documented frequency of glucose testing at least 4 times/day during 2 months prior to initiation of pump therapy
- Must have one or more of the following criteria while receiving multiple daily injections:
  1. HbA1c >7%
  2. History of recurring hypoglycemic (<60mg/dl)
  3. Wide fluctuations in blood glucose before mealtime (>140mg/dl)
  4. Dawn phenomenon fasting (>200mg/dl)
  5. History of severe glycemic excursions

E2402  #NEGATIVE PRESSURE WOUND THERAPY PUMP                 | 2X/LIFE| NO+       | $81.00/day |
E2500  #SPEECH GEN DEVICE, <= 8 MIN                           | 2X/LIFE| YES*      | $391.06 |
E2502  #SPEECH GEN DEVICE, > 8 MIN <= 20 MIN                   | 2X/LIFE| YES*      | $1,195.80 |
E2504  #SPEECH GEN DEVICE, > 20 MIN <= 40 MIN                 | 2X/LIFE| YES*      | $1,577.42 |
E2506  #SPEECH GEN DEVICE, >40 MIN                             | 2X/LIFE| YES*      | $2,312.96 |
E2508  #SPEECH GEN DEVICE, SPELLING/CONTACT                    | 2X/LIFE| YES*      | $3,576.61 |
E2510  #SPEECH GEN DEVICE, MULTIPLE METHODS                   | 2X/LIFE| YES*      | $6,768.25 |

Devices which can be unlocked or used for non-speech generating functions are only covered when the ordering practitioner documents in the recipient’s clinical file that no available forever dedicated device meets the medical need.

L8500  #ARTIFICIAL LARYNX ANY TYPE                             | 2X/LIFE| NO        | $830.20 |

**RENTAL NOTES:**

Use the ‘–RR’ modifier when DME is to be rented. When ‘–RR’ use is indicated above (‘YES’ in ‘–RR’ Use column), up to four months rental at 10% of the price listed is allowed without prior approval. DVS authorization is not required when billing ‘–RR’. DVS is required when converting to purchase. Payment will only be approved up to the purchase price. All rental payments must be deducted from purchase price regardless of the length of the rental.

*Item which should be rented for an initial four month trial period using ‘–RR’ modifier.

^Item can be rented using ‘–RR’ modifier, but an initial four month trial period is not required.
+Item that is not purchased but provided on an ongoing basis and reimbursed via a monthly rate; obtain DVS authorization monthly, "RR" not required.