STATE OF NEW YORK
DEPARTMENT OF HEALTH

Riverview Center 150 Broadway Albany, New York 12204-2736

Antonia C. Novello, M.D., M.P.H., Dr.P.H.
Commissioner

Dennis P. Whalen
Executive Deputy Commissioner

October 28, 2005

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

Joan E. Johnson, Director
Division of Medicaid Fraud Control
and Program Integrity

CODE	SHORT DESCRIPTION	FREQ	*'-RR'* USE	PRICE
A7025	#CHEST COMPRESSION VEST,REPLACE	2X/LIFE	NO	$275.00
A7026	#CHEST COMPRESSION HOSE, REPLACE	2X/LIFE	NO	$28.75
E0193	#POWERED AIR FLOATATION BED	2X/LIFE	YES*	$4,543.50
E0277	#ALTERNATING PRESSURE MATTRESS	2X/LIFE	YES*	$3,961.75
E0304	#HOSPITAL BED,EXTRA HVY DTY,>600 LBS	2X/LIFE	YES*	$5,021.36
E0371	#NONPOWERED ADV PRES RED OVERLAY	2X/LIFE	YES*	$3,801.20
E0372	#POWERED AIR OVERLAY FOR MATTRESS	2X/LIFE	YES*	$1,412.00
E0445	#PULSE OXIMETER	1X/MO	NO+	$165.00/month

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	1X/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	#ARTIFICAL 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.