



Medical Supply Coverage Guide

HCPSC code	Description of Code	Category	Auth. Required	Included in LTC per diem?	Coverage policy / guidelines. An order is always required when dispensing. When dispensing items in greater than typical quantities, or for reasons other than listed below, additional documentation may be required.	Quantity limits (maximum that may be dispensed)	Rental or Purchase	Policy review date
A4206	Syringe with needle, sterile, 1cc or less, each	Miscellaneous supplies	No	Yes	Covered for recipients who administer medications other than insulin themselves or with the assistance of a care giver. Diagnosis required. With a diagnosis of diabetes (205.00-205.90), syringes are billed with S8490	medical necessity	Purchase only	March-09
A4207	Syringe with needle, sterile, 2cc, each	Miscellaneous supplies	No	Yes	Covered for recipients who administer medications other than insulin themselves or with the assistance of a care giver. Diagnosis required. With a diagnosis of diabetes (205.00-205.90), syringes are billed with S8490	medical necessity	Purchase only	March-09
A4208	Syringe with needle, sterile, 3cc, each	Miscellaneous supplies	No	Yes	Covered for recipients who administer medications other than insulin themselves or with the assistance of a care giver. Diagnosis required. With a diagnosis of diabetes (205.00-205.90), syringes are billed with S8490	medical necessity	Purchase only	March-09
A4209	Syringe with needle, sterile, 5 cc or greater, each	Miscellaneous supplies	No	Yes	Covered for recipients who administer medications other than insulin themselves or with the assistance of a care giver. Diagnosis required. With a diagnosis of diabetes (205.00-205.90), syringes are billed with S8490	medical necessity	Purchase only	March-09
A4210	Needle-free injection device, each	Miscellaneous supplies	Always	Yes	Covered for recipients who administer medication themselves or with the assistance of a care giver and are not able to safely administer medication using a conventional syringe with needle	1 per 5 years	Purchase only	March-09
A4211	Supplies for self-administered injections	Miscellaneous supplies	No	Yes	Covered for recipients who administer medications themselves or with the assistance of a caregiver. Only to be used where a more specific code is not available. Used for sharps disposal containers with modifier U3 - see manual	medical necessity	Purchase only	March-09
A4212	Noncoring needle or stylet with or without catheter	Miscellaneous supplies	No	Y - NF N-ICF/DD	Covered when medically necessary. Should not be billed with A4220.	medical necessity	Purchase only	January-08
A4213	Syringe, sterile, 20 cc or greater, each	Miscellaneous supplies	No	Yes	Covered for recipient who administer medications other than insulin themselves or with the assistance of a caregiver or for wound irrigation. With a diagnosis of diabetes (205.00-205.90), syringes are billed with S8490	medical necessity	Purchase only	March-09
A4215	Needle, sterile, any size, each	Miscellaneous supplies	No	Yes	Covered when needles are dispensed without syringes, or when dispensed with a syringe code that does not include needles when medically necessary	medical necessity	Purchase only	January-08

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A4216	Sterile water, saline, and / or dextrose, diluent / flush, 10 ml	Miscellaneous supplies	No	Y - NF N-ICF/DD	Covered when medically necessary. Document reason for need and reason for quantity. Should not be billed with A4221. Only non-legend sterile saline irrigation solutions may be billed as a medical supply, legend sterile saline solutions must be billed by a pharmacy as a drug.	300 units per month	Purchase only	January-08
A4217	Sterile water / saline, 500 ml	Miscellaneous supplies	No	Y - NF N-ICF/DD	Covered when medically necessary. Document reason for need, including need for sterility, and reason for quantity. Only non-legend sterile saline irrigation solutions may be billed as a medical supply, legend sterile saline solutions must be billed by a pharmacy as a drug.	100 units per month	Purchase only	January-08
A4218	Sterile Saline or water, metered dose dispenser, 10 ml	Miscellaneous supplies	No	Y - NF N-ICF/DD	Covered when medically necessary for use with inhaled solutions. Only non-legend sterile saline irrigation solutions may be billed as a medical supply, legend sterile saline solutions must be billed by a pharmacy as a drug. Document reason for need and frequency of use. Use U3 modifier for vials other than 10 ml	300 units per month	Purchase only	January-08
A4220	Refill kit for implantable infusion pump	drug infusion supplies	No	No	Covered for recipients with implanted infusion pump. Includes appropriate noncoring needles, filters, connectors, etc which may not be billed separately. Usual use is 1 per month, document excess need	5 per month	Purchase only	January-08
A4221	Supplies for maintenance of drug infusion catheter, per week (list drug separately)	drug infusion supplies	No	Y - NF N-ICF/DD	Covered for recipients with drug infusion catheters. Includes gloves, alcohol wipes, tapes, catheter insertion devices, dressings for the catheter site and flush solutions not directly related to drug infusion, as well as all cannulas, and needles.	4 per month	Purchase only	January-08
A4222	Infusion supplies for external drug infusion pump, per cassette or bag (list drugs separately)	drug infusion supplies	No	Y - NF N-ICF/DD	Covered for recipients with external drug infusion pumps. Includes the cassette or bag, diluting solutions, tubing and other administration supplies, port cap changes, compounding charges and preparation charges.	60 per month	Purchase only	January-08
A4223	Infusion supplies not used with external infusion pump, per cassette or bag (list drugs separately)	drug infusion supplies	No	Y - NF N-ICF/DD	Covered when medically necessary. Includes the cassette or bag, diluting solutions, tubing and other administration supplies, port cap changes, compounding charges and preparation charges.	60 per month	Purchase only	January-08
A4230	Infusion set for external insulin pump, nonneedle cannula type	diabetes	No	No	Covered for recipients with external insulin pumps. Refer to manual	15 per month	Purchase only	December-07
A4231	Infusion set for external insulin pump, needle type	diabetes	No	No	Covered for recipients with external insulin pumps. Refer to manual	15 per month	Purchase only	December-07
A4232	Syringe with needle for external insulin pump, sterile, 3 cc	diabetes	No	No	Covered for recipients with external insulin pumps. Refer to manual	15 per month	Purchase only	December-07

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A4233	Replacement battery, alkaline (other than J cell), for use with medically necessary home blood glucose monitor owned by patient, each	diabetes	No	Yes	Covered for diabetic recipients who own a blood glucose monitor	5 per year	Purchase only	December-07
A4234	Replacement battery, J cell, for use with medically necessary home blood glucose monitor owned by patient, each	diabetes	No	Yes	Covered for diabetic recipients who own a blood glucose monitor	5 per year	Purchase only	December-07
A4235	Replacement battery, alkaline (other than J cell), for use with medically necessary home blood glucose monitor owned by patient, each	diabetes	No	Yes	Covered for diabetic recipients who own a blood glucose monitor	5 per year	Purchase only	December-07
A4236	Replacement battery, alkaline (other than J cell), for use with medically necessary home blood glucose monitor owned by patient, each	diabetes	No	Yes	Covered for diabetic recipients who own a blood glucose monitor	5 per year	Purchase only	December-07
A4244	Alcohol or peroxide, per pint	Miscellaneous supplies	No	Yes	Covered when medically necessary for injections / sterilizing equipment	5 pints per month	Purchase only	December-08
A4245	Alcohol wipes, per box	Miscellaneous supplies	Sometimes - see	Yes	Covered when medically necessary for injections / sterilizing equipment. PA required for over 6 boxes per month	6 boxes per month	Purchase only	December-08
A4246	Betadine or pHisoHex solution, per pint	Renal Dialysis	No	No	Covered when dispensed by approved dialysis equipment supplier. For indications other than dialysis, must be billed by a pharmacy as a drug. Refer to manual	medical necessity	Purchase only	December-08
A4247	Betadine or iodine swabs/wipes, per box	Renal Dialysis	No	No	Covered when dispensed by approved dialysis equipment supplier. For indications other than dialysis, must be billed by a pharmacy as a drug. Refer to manual	medical necessity	Purchase only	December-08
A4248	Chlorhexidine containing antiseptic, 1 ml	Miscellaneous supplies			Not covered as a medical supply. Must be billed by a pharmacy as a drug. Refer to manual			December-08
A4250	Urine test or reagent strips or tablets (100 tablets or strips)	diabetes	No	Yes	Covered for diabetic recipients who choose not to use blood glucose monitoring or for diabetic recipients at risk for ketoacidosis	2 boxes per month	Purchase only	December-07
A4252	Blood ketone test or reagent strip, each	diabetes	Always	Yes	Covered for diabetics at risk of ketoacidosis for whom urine ketone testing is not sufficient. Refer to manual	90 per month	Purchase only	December-07

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A4253	Blood glucose test or reagent strips for home blood glucose monitor, per 50 strips (1 unit = 50 strips)	diabetes	For excess quantities only	yes	Covered for recipients with diabetes. Refer to manual	4 boxes of 50 strips per month	Purchase only	December-07
A4255	Platforms for home blood glucose monitor, 50 per box	diabetes	No	Yes	Covered for diabetic recipients who do home blood glucose monitoring	4 boxes per month	Purchase only	December-07
A4256	typical, low and high calibrator solution / chips	diabetes	No	Yes	Covered for diabetic recipients who do home blood glucose monitoring	1 per month	Purchase only	December-07
A4257	Replacement lens shield cartridge for use with laser skin piercing device, each	diabetes	No	Y - NF N-ICF/DD	Covered for diabetic recipients who own and use a laser skin piercing device	1 per month	Purchase only	December-07
A4258	Spring-powered device for lancet, each	diabetes	No	Yes	Covered for diabetic recipients who do home blood glucose monitoring	1 per month	Purchase only	December-07
A4259	Lancets, per box	diabetes	No	Yes	Covered for diabetic recipients who do home blood glucose monitoring	4 boxes per month	Purchase only	December-07
A4261	Cervical cap for contraceptive use	Family Planning	No	No	Covered for female recipients when prescribed for contraception	1 / year	Purchase only	January-08
A4264	Permanent implantable contraceptive intratubal occlusion device (s) and delivery system	Family Planning	No	No	Covered effective 1/1/2010 when implanted by a physician. Cannot be dispensed by medical supplier or pharmacy.	2 per lifetime	Purchase only	January-10
A4265	Paraffin, per lb	Wound care	No	Yes	Covered when used as part of a home therapy treatment plan	1 lb / month	Purchase only	January-08
A4266	Diaphragm for contraceptive use	Family Planning	No	No	Covered for female recipients when prescribed for contraception	1 / year	Purchase only	January-08
A4267	Contraceptive supply, condom, male, each	Family Planning	No	No	Covered for male or female recipients when prescribed for contraception or disease prevention	90 / month	Purchase only	January-08
A4268	Contraceptive supply, condom, female, each	Family Planning	No	No	Covered for female recipients when prescribed for contraception or disease prevention	90 / month	Purchase only	January-08
A4269	Contraceptive supply, spermicide (e.g. foam, gel), each	Family Planning	No	No	Covered for male or female recipients when prescribed for contraception	6 / month	Purchase only	January-08
A4280	Adhesive skin support attachment for use with external breast prosthesis, each	Prosthetics	No	No	Covered for recipients with external breast prostheses	60 / month	Purchase only	January-08
A4281	tubing for breast pump, replacement	Breast pump	No	No	Covered for recipients who are nursing or infants of nursing mothers with patient owned breast pumps	1 per 6 months	Purchase only	January-08

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A4282	Adapter for breast pump, replacement	Breast pump	No	No	Covered for recipients who are nursing or infants of nursing mothers with patient owned breast pumps	1 / year	Purchase only	January-08
A4283	Cap for breast pump bottle, replacement	Breast pump	No	No	Covered for recipients who are nursing or infants of nursing mothers with patient owned breast pumps	1 / dispensing	Purchase only	January-08
A4284	Breast shield and splash protector for use with breast pump, replacement	Breast pump	No	No	Covered for recipients who are nursing or infants of nursing mothers with patient owned breast pumps	2 / year	Purchase only	January-08
A4285	Polycarbonate bottle for use with breast pump, replacement	Breast pump			Not covered. Bottles for healthy infants are not a medical supply.			January-08
A4286	Locking ring for breast pump, replacement	Breast pump	No	No	Covered for recipients who are nursing or infants of nursing mothers with patient owned breast pumps	1 per year	Purchase only	January-08
A4305	Disposable drug delivery system, flow rate of 50 ml or greater per hour	Miscellaneous supplies	No	Y - NF N-ICF/DD	Covered for recipients requiring drug infusion using a disposable system	10 per dispensing	Purchase only	May-10
A4306	Disposable drug delivery system, flow rate of less than 50 ml per hour	Miscellaneous supplies	No	Y - NF N-ICF/DD	Covered for recipients requiring drug infusion using a disposable system	10 per dispensing	Purchase only	May-10
A4310	Insertion tray without drainage bag and without catheter (accessories only)	Urological	Sometimes - see manual	Y - NF N-ICF/DD	Covered for recipients with indwelling catheters. Generally, 1 indwelling catheter is appropriate per month. Up to 3 indwelling catheters per month are covered without authorization. Includes sterile lubricant packet (A4332) and non-sterile or sterile gloves (A4927 or A4930)	1 per insertion up to 31 per month when authorized	Purchase only	April-09
A4311	Insertion tray without drainage bag with indwelling catheter, Foley type, two-way latex with coating (Teflon, silicone, silicone elastomer or hydrophilic, etc)	Urological	Sometimes - see manual	Y - NF N-ICF/DD	Covered for recipients with indwelling catheters. Generally, 1 indwelling catheter is appropriate per month. Up to 3 indwelling catheters per month are covered without authorization. Includes sterile lubricant packet (A4332) and non-sterile or sterile gloves (A4927 or A4930) and catheter (A4338)	1 per insertion up to 31 per month when authorized	Purchase only	April-09
A4312	Insertion tray without drainage bag with indwelling catheter, Foley type, two-way, all silicone	Urological	Sometimes - see manual	Y - NF N-ICF/DD	Covered for recipients with indwelling catheters. Generally, 1 indwelling catheter is appropriate per month. Up to 3 indwelling catheters per month are covered without authorization. Includes sterile lubricant packet (A4332) and non-sterile or sterile gloves (A4927 or A4930) and catheter (A4344)	1 per insertion up to 31 per month when authorized	Purchase only	April-09



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A4313	Insertion tray without drainage bag with indwelling catheter, Foley type, three-way, for continuous irrigation	Urological	Sometimes - see manual	Y - NF N-ICF/DD	Covered for recipients with indwelling catheters. Generally, 1 indwelling catheter is appropriate per month. Up to 3 indwelling catheters per month are covered without authorization. Includes sterile lubricant packet (A4332) and non-sterile or sterile gloves (A4927 or A4930) and catheter (A4346)	1 per insertion up to 31 per month when authorized	Purchase only	April-09
A4314	Insertion tray with drainage bag with indwelling catheter, Foley type, two-way latex with coating (Teflon, silicone, silicone elastomer or hydrophilic, etc)	Urological	Sometimes - see manual	Y - NF N-ICF/DD	Covered for recipients with indwelling catheters. Generally, 1 indwelling catheter is appropriate per month. Up to 3 indwelling catheters per month are covered without authorization. Includes sterile lubricant packet (A4332) non-sterile or sterile gloves (A4927 or A4930), bag (A4357, A4358, A5102 or A5112), tubing (A4331), and catheter (A4338)	1 per insertion up to 31 per month when authorized	Purchase only	April-09
A4315	Insertion tray with drainage bag with indwelling catheter, Foley type, two-way, all silicone	Urological	Sometimes - see manual	Y - NF N-ICF/DD	Covered for recipients with indwelling catheters. Generally, 1 indwelling catheter is appropriate per month. Up to 3 indwelling catheters per month may be needed for recipients with frequent UTIs or other medical complications. Includes sterile lubricant packet (A4332) non-sterile or sterile gloves (A4927 or A4930), bag (A4357, A4358, A5102 or A5112), tubing (A4331), and catheter (A4344)	1 per insertion up to 31 per month when authorized	Purchase only	April-09
A4316	Insertion tray with drainage bag with indwelling catheter, Foley type, three-way, for continuous irrigation	Urological	Sometimes - see manual	Y - NF N-ICF/DD	Covered for recipients with indwelling catheters with a history of obstruction of the catheter. Generally, 1 indwelling catheter is appropriate per month. Up to 3 indwelling catheters per month may be needed for recipients with frequent UTIs or other medical complications. Includes sterile lubricant packet (A4332) non-sterile or sterile gloves (A4927 or A4930), bag (A4357, A4358, A5102 or A5112), tubing (A4331), and catheter (A4346)	1 per insertion up to 31 per month when authorized	Purchase only	April-09
A4320	Irrigation tray with bulb or piston syringe, any purpose	Miscellaneous supplies	No	Y - NF N-ICF/DD	Covered for recipients with indwelling catheter or other medical condition requiring irrigation. Includes A4322.	90 irrigation syringes / trays per month	Purchase only	February-09
A4321	Therapeutic agent for urinary catheter irrigation	Urological			Therapeutic solutions with active ingredients and legend sterile saline solutions must be billed by a pharmacy as a drug			April-09
A4322	Irrigation syringe, bulb or piston, each	Urological	No	Yes	Covered for recipients with indwelling catheter or other medical condition requiring irrigation. Includes A4320	90 irrigation syringes / trays per month	Purchase only	April-09

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A4326	Male external catheter with integral collection chamber, any type, each	Urological	No	Y - NF N-ICF/DD	Covered for male recipients with urinary incontinence who do not have an indwelling catheter.	31 per month	Purchase only	April-09
A4327	Female external urinary collection device; meatal cup, each	Urological	No	Y - NF N-ICF/DD	Covered for female recipients with urinary incontinence who do not have an indwelling catheter.	4 per month	Purchase only	April-09
A4328	Female external urinary collection device; pouch, each	Urological	No	Y - NF N-ICF/DD	Covered for female recipients with urinary incontinence who do not have an indwelling catheter.	31 per month	Purchase only	April-09
A4330	Perianal fecal collection pouch with adhesive, each	Urological	No	Y - NF N-ICF/DD	Covered for recipients with fecal incontinence.	31 per month	Purchase only	April-09
A4331	Extension drainage tubing, any type, with connector / adaptor, for use with urinary leg bag or urostomy pouch, each	Urological	No	Y - NF N-ICF/DD	Covered for recipients with urinary incontinence and leg bag or urostomy pouch. Generally, tubing may be needed once per week, but may be replaced daily for frequent UTIs or other medical conditions	31 per month	Purchase only	April-09
A4332	Lubricant, individual sterile packet, each	Miscellaneous supplies	No	Yes	Covered for recipients who use catheters with sterile insertion, as medically necessary for other diagnoses. 1 packet per sterile catheterization is covered.	288 per month	Purchase only	November-09
A4333	Urinary catheter anchoring device, adhesive skin attachment, each	Urological	No	Y - NF N-ICF/DD	Covered for recipients who use indwelling catheters. Use is expected to be 1 every 2-3 days, 1 each day may be needed in some cases.	31 per month	Purchase only	April-09
A4334	Urinary catheter anchoring device, leg strap, each	Urological	No	Y - NF N-ICF/DD	Covered for recipients who use catheters. typical use is expected to be 1 each month, 1 each week may be needed in some cases.	5 per month	Purchase only	April-09
A4335	Incontinence supply, miscellaneous	Urological	No	Y	Covered for recipients with incontinence. Only to be used when a more specific code is not available. See manual for information about billing miscellaneous supplies	medical necessity	Purchase only	April-09
A4336	Incontinence supply, urethral insert, any type, each	Urological	No	Y - NF N-ICF/DD	Covered effective 1/1/2010 for recipients with urinary incontinence.	200 per month	Purchase only	January-10
A4338	Indwelling catheter; Foley type, two-way latex with coating (Teflon, silicone, silicone elastomer, or hydrophilic, etc.), each	Urological	Sometimes - see manual	Y - NF N-ICF/DD	Covered for recipients with indwelling catheters. Generally, 1 indwelling catheter is appropriate per month. Up to 3 indwelling catheters per month are covered without authorization.	1 indwelling catheter per insertion up to 31 per month when authorized	Purchase only	April-09



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A4340	Indwelling catheter; Specialty type (e.g. Coude, mushroom, wing, etc.), each	Urological	Sometimes - see manual	Y - NF N-ICF/DD	Covered for recipients with indwelling catheters. Generally, 1 indwelling catheter is appropriate per month. Up to 3 indwelling catheters per month are covered without authorization.	1 indwelling catheter per insertion up to 31 per month when authorized	Purchase only	April-09
A4344	Indwelling catheter, Foley type, two-way, all silicone, each	Urological	Sometimes - see manual	Y - NF N-ICF/DD	Covered for recipients with indwelling catheters. Generally, 1 indwelling catheter is appropriate per month. Up to 3 indwelling catheters per month are covered without authorization.	1 indwelling catheter per insertion up to 31 per month when authorized	Purchase only	April-09
A4346	Indwelling catheter, Foley type, three-way for continuous irrigation, each	Urological	Sometimes - see manual	Y - NF N-ICF/DD	Covered for recipients who use indwelling catheter and have a history of obstruction of the catheter. Generally 1 indwelling catheter is appropriate per month, up to 3 indwelling catheters per month are covered without authorization	1 indwelling catheter per insertion up to 31 per month when authorized	Purchase only	April-09
A4349	Male external catheter with or without adhesive, disposable, each	Urological	No	Y - NF N-ICF/DD	Covered for male recipients with urinary incontinence. Most recipients can be served with 2 per day.	90 per month	Purchase only	April-09
A4351	Intermittent urinary catheter; straight tip, with or without coating (Teflon, silicone, silicone elastomeric, or hydrophilic, etc.), each	Urological	No	Y - NF N-ICF/DD	Covered for recipients who use intermittent catheterization. Most recipients can be served with 150 - 180 catheters per month. Additional quantities may be needed for recipients with a history of frequent UTIs. Documentation must include frequency of needed catheterization and reason for frequency.	300 intermittent catheters per month	Purchase only	April-09
A4352	Intermittent urinary catheter; Coude (curved) tip, with or without coating (Teflon, silicone, silicone elastomeric, or hydrophilic, etc.), each	Urological	No	Y - NF N-ICF/DD	Covered for recipients who use intermittent catheterization. Most recipients can be served with 150 - 180 catheters per month. Additional quantities may be needed for recipients with a history of frequent UTIs. Documentation must include frequency of needed catheterization, reason for frequency and reason for Coude tip.	300 intermittent catheters per month	Purchase only	April-09

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A4353	Intermittent urinary catheter, with insertion supplies	Urological	Sometimes - see manual	Y - NF N-ICF/DD	Covered for recipients who use intermittent catheterization. Most recipients can be served with 150 - 180 catheters per month. Additional quantities may be needed for recipients with a history of frequent UTIs. Documentation must include frequency of needed catheterization, reason for frequency and reason for sterile catheterization. Up to 200 intermittent catheters per month are covered without authorization. Includes sterile lubricant packet (A4332) and sterile or non-sterile gloves (A4930 or A4327).	300 intermittent catheters per month when authorized	Purchase only	April-09
A4354	Insertion tray with drainage bag but without catheter	Urological	Sometimes - see manual	Y - NF N-ICF/DD	Covered for recipients with indwelling catheters. Generally, 1 indwelling catheter / insertion tray is appropriate per month. Up to 3 indwelling catheters / insertion trays per month are covered without authorization. Includes sterile lubricant packet (A4332) and non-sterile or sterile gloves (A4927 or A4930) and drainage bag (A4357, A4358, A5102, or A5112)	1 per insertion up to 31 per month when authorized	Purchase only	April-09
A4355	Irrigation tubing set for continuous bladder irrigation through a three-way indwelling Foley catheter, each	Urological	No	Y - NF N-ICF/DD	Covered for recipients with three-way indwelling Foley Catheters when the recipient has a history of obstruction of the catheter. Continuous irrigation is rarely necessary for more than 2 consecutive weeks	31 per month	Purchase only	April-09
A4356	External urethral clamp or compression device (not to be used for catheter clamp), each	Urological	No	Y - NF N-ICF/DD	Covered for male recipients with urinary incontinence.	1 per month	Purchase only	April-09
A4357	Bedside drainage bag, day or night, with or without anti-reflux device, with or without tube, each	Urological	Sometimes - see manual	Y - NF N-ICF/DD	Covered for recipients with catheters. Most recipients can be served with 1 per month, additional may needed for recipients with frequent UTIs or other medical complications. Quantities over 10 per month require PA.	31 drainage devices per month when authorized	Purchase only	April-09
A4358	Urinary drainage bag, leg or abdomen, vinyl, with or without tube, with straps, each	Urological	Sometimes - see manual	Y - NF N-ICF/DD	Covered for recipients with catheters. Most recipients can be served with 2 per month, additional may needed for recipients with frequent UTIs or other medical complications. Quantities over 10 per month require PA.	31 drainage devices per month when authorized	Purchase only	April-09
A4360	Disposable external urethral clamp or compression device, with pad and/or pouch, each	Urological	No	Y - NF N-ICF/DD	Covered effective 1/1/2010 for male recipients with minimal urinary incontinence.	30 per month	Purchase only	January-10
A4361	Ostomy faceplate, each	Ostomy	No	Y - NF N-ICF/DD	Covered for recipients with ostomies. Most recipients can be served with 2 per month.	4 per month	Purchase only	January-08
A4362	Skin barrier; solid, four by four or equivalent; each	Ostomy	No	Y - NF N-ICF/DD	Covered for recipients with ostomies. Most recipients can be served with 1 per site per day.	31 per month	Purchase only	January-08



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A4363	Ostomy clamp, any type, replacement only, each	Ostomy	No	Y - NF N-ICF/DD	Covered for recipients with ostomies. Most recipients can be served with 1 per site per 3 - 6 months.	2 per month	Purchase only	January-08
A4364	Adhesive, liquid or equivalent, any type, per oz.	Ostomy	No	Y - NF N-ICF/DD	Covered for recipients with ostomies. Most recipients can be served with 4 - 6 oz per site per month	20 per month	Purchase only	January-08
A4366	Ostomy vent, any type, each	Ostomy	No	Y - NF N-ICF/DD	Covered for recipients with ostomies who use pouches without vent. Maximum use is one per pouch change.	31 per month	Purchase only	January-08
A4367	Ostomy belt, each	Ostomy	No	Y - NF N-ICF/DD	Covered for recipients with ostomies. typical use is 1 per site per month.	3 per month	Purchase only	January-08
A4368	Ostomy filter, any type, each	Ostomy	No	Y - NF N-ICF/DD	Covered for recipients with ostomies who use pouches without filters. Maximum use is 1 per pouch change.	31 per month	Purchase only	January-08
A4369	Ostomy skin barrier, liquid (spray, brush, etc.), per oz	Ostomy	No	Y - NF N-ICF/DD	Covered for recipients with ostomies. typical use is 2 - 3 oz per month per site	15 oz per month	Purchase only	September-08
A4371	Ostomy skin barrier, powder, per oz	Ostomy	No	Y - NF N-ICF/DD	Covered for recipients with ostomies. typical use is 1-2 oz per month per site	6 oz per month	Purchase only	September-08
A4372	Ostomy skin barrier, solid 4x4 or equivalent, standard wear, with built-in convexity, each	Ostomy	No	Y - NF N-ICF/DD	Covered for recipients with ostomies. typical use is 1 per site per day.	31 per month	Purchase only	January-08
A4373	Ostomy skin barrier, with flange (solid, flexible or accordion), with built-in convexity, any size, each	Ostomy	No	Y - NF N-ICF/DD	Covered for recipients with ostomies. typical use is 1 per site per day.	31 per month	Purchase only	January-08
A4375	Ostomy pouch, drainable, with faceplate attached, plastic, each	Ostomy	No	Y - NF N-ICF/DD	Covered for recipients with ostomies. typical use is 1 per site per day. Includes A4361	31 per month	Purchase only	January-08
A4376	Ostomy pouch, drainable, with faceplate attached, rubber, each	Ostomy	No	Y - NF N-ICF/DD	Covered for recipients with ostomies. typical use is 1 per site per day. Includes A4361	31 per month	Purchase only	January-08
A4377	Ostomy pouch, drainable, for use on faceplate, plastic, each	Ostomy	No	Y - NF N-ICF/DD	Covered for recipients with ostomies. typical use is 1 per site per day.	31 per month	Purchase only	January-08
A4378	Ostomy pouch, drainable, for use on faceplate, rubber, each	Ostomy	No	Y - NF N-ICF/DD	Covered for recipients with ostomies. typical use is 1 per site per day.	31 per month	Purchase only	January-08
A4379	Ostomy pouch, urinary, with faceplate attached, plastic, each	Ostomy	No	Y - NF N-ICF/DD	Covered for recipients with urinary ostomies. typical use is 1 per site per day. Includes A4361	31 per month	Purchase only	January-08
A4380	Ostomy pouch, urinary, with faceplate attached, rubber, each	Ostomy	No	Y - NF N-ICF/DD	Covered for recipients with urinary ostomies. typical use is 1 per site per day.	31 per month	Purchase only	January-08

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A4381	Ostomy pouch, urinary, for use on faceplate, plastic, each	Ostomy	No	Y - NF N-ICF/DD	Covered for recipients with urinary ostomies. typical use is 1 per site per day.	31 per month	Purchase only	January-08
A4382	Ostomy pouch, urinary, for use on faceplate, heavy plastic, each	Ostomy	No	Y - NF N-ICF/DD	Covered for recipients with urinary ostomies. typical use is 1 per site per day.	31 per month	Purchase only	January-08
A4383	Ostomy pouch, urinary, for use on faceplate, rubber, each	Ostomy	No	Y - NF N-ICF/DD	Covered for recipients with urinary ostomies. typical use is 1 per site per day.	31 per month	Purchase only	January-08
A4384	Ostomy faceplate equivalent, silicone ring, each	Ostomy	No	Y - NF N-ICF/DD	Covered for recipients with ostomies. typical use is 1 per site per week.	8 per month	Purchase only	January-08
A4385	Ostomy skin barrier, solid 4x4 or equivalent, extended wear, without built-in convexity, each	Ostomy	No	Y - NF N-ICF/DD	Covered for recipients with ostomies. typical use is 1 per site per 2 - 3 days.	31 per month	Purchase only	January-08
A4387	Ostomy pouch, closed, with barrier attached, with built-in convexity, each	Ostomy	No	Y - NF N-ICF/DD	Covered for recipients with ostomies. typical use is 1 per site per day.	31 per month	Purchase only	January-08
A4388	Ostomy pouch, drainable, with extended wear barrier attached (one piece), each	Ostomy	No	Y - NF N-ICF/DD	Covered for recipients with ostomies. typical use is 1 per site per 2-3 days.	31 per month	Purchase only	January-08
A4389	Ostomy pouch, drainable, with barrier attached, with built-in convexity (one piece), each	Ostomy	No	Y - NF N-ICF/DD	Covered for recipients with ostomies. typical use is 1 per site per day.	31 per month	Purchase only	January-08
A4390	Ostomy pouch, drainable, with extended wear barrier attached, with built-in convexity (one piece), each	Ostomy	No	Y - NF N-ICF/DD	Covered for recipients with ostomies. typical use is 1 per site per 2-3 days.	31 per month	Purchase only	January-08
A4391	Ostomy pouch, urinary, with extended wear barrier attached (one piece), each	Ostomy	No	Y - NF N-ICF/DD	Covered for recipients with urinary ostomies. typical use is 1 per site per 2 - 3 days.	31 per month	Purchase only	January-08
A4392	Ostomy pouch, urinary, with standard wear barrier attached, with built-in convexity (one piece), each	Ostomy	No	Y - NF N-ICF/DD	Covered for recipients with urinary ostomies. typical use is 1 per site per day.	31 per month	Purchase only	January-08
A4393	Ostomy pouch, urinary, with extended wear barrier attached, with built-in convexity (one piece), each	Ostomy	No	Y - NF N-ICF/DD	Covered for recipients with urinary ostomies. typical use is 1 per site per 2 - 3 days.	31 per month	Purchase only	January-08

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A4394	Ostomy deodorant, with or without lubricant, for use in ostomy pouch, per fluid ounce	Ostomy	No	Y - NF N-ICF/DD	Covered for recipients with ostomies. typical use is 1 oz per site per day.	32 oz per month	Purchase only	September-08
A4395	Ostomy deodorant for use in ostomy pouch, solid, per tablet	Ostomy	No	Y - NF N-ICF/DD	Covered for recipients with ostomies. typical use is 2 - 3 tabs per day per site	100 per month	Purchase only	January-08
A4396	Ostomy belt with peristomal hernia support	Ostomy	No	Y - NF N-ICF/DD	Covered for recipients with ostomies. typical use is 1 per 3 months per site	1 per month	Purchase only	January-08
A4397	Irrigation supply; sleeve, each	Ostomy	No	Y - NF N-ICF/DD	Covered for recipients with ostomies. typical use is 1 per week per site	10 per month	Purchase only	January-08
A4398	Ostomy irrigation supply, bag, each	Ostomy	No	Y - NF N-ICF/DD	Covered for recipients with ostomies. typical use is 1 per 3 months	1 per month	Purchase only	January-08
A4399	Ostomy irrigation supply; cone / catheter, with or without brush	Ostomy	No	Y - NF N-ICF/DD	Covered for recipients with ostomies. typical use is 1 per 3 months per site	1 per month	Purchase only	January-11
A4400	Ostomy irrigation set	Ostomy	No	Y - NF N-ICF/DD	Covered for recipients with ostomies. A4400 should be used the first time a recipient receives irrigation supplies. After the first time, dispense only those supplies that are needed and bill with A4397, A4398 or A4399 following those guidelines.	1 per site	Purchase only	January-08
A4402	Lubricant, per oz.	Miscellaneous supplies	No	Yes	Covered for recipients with ostomies or who catheterize, or when medically necessary for other recipients	13 oz per month (3 4.3 oz tubes)	Purchase only	January-08
A4404	Ostomy ring, each	Ostomy	No	Y - NF N-ICF/DD	Covered for recipients with ostomies. typical use is 1 per site per 2 -3 days.	25 per month	Purchase only	January-08
A4405	Ostomy skin barrier, non-pectin based, paste, per ounce	Ostomy	No	Y - NF N-ICF/DD	Covered for recipients with ostomies. typical use is approximately 1/8 - 1/4 oz per day per site.	16 oz per month	Purchase only	January-08
A4406	Ostomy skin barrier, pectin-based, paste, per oz	Ostomy	No	Y - NF N-ICF/DD	Covered for recipients with ostomies. typical use is approximately 1/8 - 1/4 oz per day per site.	16 oz per month	Purchase only	January-08
A4407	Ostomy skin barrier, with flange (solid, flexible or accordion), extended wear, with built-in convexity, 4 X 4 or smaller, each	Ostomy	No	Y - NF N-ICF/DD	Covered for recipients with ostomies. typical use is 1 per 2 - 3 days per site. Recipients who need to change the barrier more than once daily should not be using extended wear barriers	31 per month	Purchase only	January-08
A4408	Ostomy skin barrier, with flange (solid, flexible or accordion), extended wear, with built-in convexity, larger than 4 X 4, each	Ostomy	No	Y - NF N-ICF/DD	Covered for recipients with ostomies. typical use is 1 per 2 - 3 days per site. Recipients who need to change the barrier more than once daily should not be using extended wear barriers	31 per month	Purchase only	January-08

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A4409	Ostomy skin barrier, with flange (solid, flexible or accordion), extended wear, without built-in convexity, 4 X 4 or smaller, each	Ostomy	No	Y - NF N-ICF/DD	Covered for recipients with ostomies. typical use is 1 per 2 - 3 days per site. Recipients who need to change the barrier more than once daily should not be using extended wear barriers	31 per month	Purchase only	January-08
A4410	Ostomy skin barrier, with flange (solid, flexible or accordion), extended wear, without built-in convexity, larger than 4 X 4, each	Ostomy	No	Y - NF N-ICF/DD	Covered for recipients with ostomies. typical use is 1 per 2 - 3 days per site. Recipients who need to change the barrier more than once daily should not be using extended wear barriers	31 per month	Purchase only	January-08
A4411	Ostomy skin barrier, solid 4 x 4 or equivalent, extended wear, with built-in convexity, each	Ostomy	No	Y - NF N-ICF/DD	Covered for recipients with ostomies. typical use is 1 per 2 - 3 days per site. Recipients who need to change the barrier more than once daily should not be using extended wear barriers	31 per month	Purchase only	January-08
A4412	Ostomy pouch, drainable, high output, for use on a barrier with flange (2 piece system), without filter, each	Ostomy	No	Y - NF N-ICF/DD	Covered for recipients with ostomies. typical use is 1 per 4-5 days per site.	31 per month	Purchase only	January-08
A4413	Ostomy pouch, drainable, high output, for use on a barrier with flange (2 piece system), with filter, each	Ostomy	No	Y - NF N-ICF/DD	Covered for recipients with ostomies. typical use is 1 per 4-5 days per site.	31 per month	Purchase only	January-08
A4414	Ostomy skin barrier, with flange (solid, flexible or accordion), without built-in convexity, 4 X 4 or smaller, each	Ostomy	No	Y - NF N-ICF/DD	Covered for recipients with ostomies. typical use is 1 per day per site.	31 per month	Purchase only	January-08
A4415	Ostomy skin barrier, with flange (solid, flexible or accordion), without built-in convexity, larger than 4 X 4, each	Ostomy	No	Y - NF N-ICF/DD	Covered for recipients with ostomies. typical use is 1 per day per site.	31 per month	Purchase only	January-08
A4416	Ostomy pouch, closed, with filter (one piece), each	Ostomy	No	Y - NF N-ICF/DD	Covered for recipients with ostomies. typical use is 2 per day per site.	62 per month	Purchase only	September-08
A4417	Ostomy pouch, closed, with barrier attached, with built-in convexity, with filter (one piece), each	Ostomy	No	Y - NF N-ICF/DD	Covered for recipients with ostomies. typical use is 2 per day per site.	62 per month	Purchase only	September-08

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A4418	Ostomy pouch, closed; without barrier attached, with filter (one piece), each	Ostomy	No	Y - NF N-ICF/DD	Covered for recipients with ostomies. typical use is 2 per day per site.	62 per month	Purchase only	September-08
A4419	Ostomy pouch, closed; for use on barrier with nonlocking flange, with filter (two piece), each	Ostomy	No	Y - NF N-ICF/DD	Covered for recipients with ostomies. typical use is 2 per day per site.	62 per month	Purchase only	September-08
A4420	Ostomy pouch, closed; for use on barrier with locking flange (two piece), each	Ostomy	No	Y - NF N-ICF/DD	Covered for recipients with ostomies. typical use is 2 per day per site.	62 per month	Purchase only	September-08
A4421	Ostomy supply, miscellaneous	Ostomy	No	Y - NF N-ICF/DD	Covered for recipients with ostomies. Only to be used when a more specific code is not available. See manual for information about billing miscellaneous supplies	medical necessity	Purchase only	January-08
A4422	Ostomy absorbent material (sheet/ pad/ crystal packet) for use in ostomy pouch to thicken liquid stomal output, each	Ostomy	No	Y - NF N-ICF/DD	Covered for recipients with ostomies. typical use is 2 -3 per day. If product is not available in packing less than 100, providers may dispense 100 at a time, but should not dispense additional until needed.	100 per month	Purchase only	January-08
A4423	Ostomy pouch, closed; for use on barrier with locking flange, with filter (two piece), each	Ostomy	No	Y - NF N-ICF/DD	Covered for recipients with ostomies. typical use is 2 per day per site.	62 per month	Purchase only	January-08
A4424	Ostomy pouch, drainable, with barrier attached, with filter (one piece), each	Ostomy	No	Y - NF N-ICF/DD	Covered for recipients with ostomies. typical use is 1 per 1 - 2 days per site.	31 per month	Purchase only	January-08
A4425	Ostomy pouch, drainable; for use on barrier with nonlocking flange, with filter (two piece system), each	Ostomy	No	Y - NF N-ICF/DD	Covered for recipients with ostomies. typical use is 1 per 1 - 2 days per site.	31 per month	Purchase only	February-08
A4426	Ostomy pouch, drainable; for use on barrier locking flange, (two piece system), each	Ostomy	No	Y - NF N-ICF/DD	Covered for recipients with ostomies. typical use is 1 per 1 - 2 days per site.	31 per month	Purchase only	February-08
A4427	Ostomy pouch, drainable; for use on barrier locking flange, with filter (two piece system), each	Ostomy	No	Y - NF N-ICF/DD	Covered for recipients with ostomies. typical use is 1 per 1 - 2 days per site.	31 per month	Purchase only	February-08

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A4428	Ostomy pouch, urinary, with extended wear barrier attached, with faucet-type tap with valve (one piece), each	Ostomy	No	Y - NF N-ICF/DD	Covered for recipients with urinary ostomies. typical use is 1 per 1 - 2 days per site.	31 per month	Purchase only	February-08
A4429	Ostomy pouch, urinary, with barrier attached, with built-in convexity, with faucet-type tap with valve (one piece), each	Ostomy	No	Y - NF N-ICF/DD	Covered for recipients with urinary ostomies. typical use is 1 per 1 - 2 days per site.	31 per month	Purchase only	February-08
A4430	Ostomy pouch, urinary, with extended wear barrier attached, with built-in convexity, with faucet-type tap with valve (one piece), each	Ostomy	No	Y - NF N-ICF/DD	Covered for recipients with urinary ostomies. typical use is 1 per 1 - 2 days per site.	31 per month	Purchase only	February-08
A4431	Ostomy pouch, urinary, with barrier attached, with faucet-type tap with valve (one piece), each	Ostomy	No	Y - NF N-ICF/DD	Covered for recipients with urinary ostomies. typical use is 1 per 1 - 2 days per site.	31 per month	Purchase only	February-08
A4432	Ostomy pouch, urinary; for use on barrier with nonlocking flange, with faucet-type tap with valve (two piece), each	Ostomy	No	Y - NF N-ICF/DD	Covered for recipients with urinary ostomies. typical use is 1 per 1 - 2 days per site.	31 per month	Purchase only	February-08
A4433	Ostomy pouch, urinary; for use on barrier with locking flange (two piece), each	Ostomy	No	Y - NF N-ICF/DD	Covered for recipients with ostomies. typical use is 1 per day per site.	31 per month	Purchase only	February-08
A4434	Ostomy pouch, urinary; for use on barrier with locking flange, with faucet-type tap with valve (two piece), each	Ostomy	No	Y - NF N-ICF/DD	Covered for recipients with urinary ostomies. typical use is 1 per 1 - 2 days per site.	31 per month	Purchase only	February-08
A4450	Tape, nonwaterproof, per 18 sq inches	Miscellaneous supplies	No	Yes	Covered for patients with wounds or when medically necessary	400 units per month	Purchase only	February-08
A4452	Tape, waterproof, per 18 sq inches	Miscellaneous supplies	No	Yes	Covered for patients with wounds or when medically necessary	400 units per month	Purchase only	February-08
A4455	Adhesive remover or solvent (for tape, cement or other adhesive), per oz.	Miscellaneous supplies	No	Yes	Covered for patients using adhesive on the skin.	15 oz per month	Purchase only	February-08
A4456	Adhesive remover, wipes, any type, each	Ostomy	No	Y - NF N-ICF/DD	Covered for recipients with ostomies. Most recipients can be served with 3 - 4 wipes per day per site	250 per month	Purchase only	January-10

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A4458	Enema bag with tubing, reusable	Miscellaneous supplies	No	Yes	Covered for patients with constipation or when medically necessary.	1 per 3 months	Purchase only	February-08
A4461	Surgical dressing holder, nonreusable, each	Wound care	No	Y - NF N-ICF/DD	Covered for patients with dressings on the abdomen or for whom adhesives are contraindicated	31 per month	Purchase only	February-08
A4463	Surgical dressing holder, reusable, each	Wound care	No	Y - NF N-ICF/DD	Covered for patients with dressings on the abdomen or for whom adhesives are contraindicated	5 per month	Purchase only	February-08
A4465	Nonelastic binder for extremity	Miscellaneous supplies	No	Y - NF N-ICF/DD	Covered for patients with lymphedema. typical use is one per affected extremity.	4 per month	Purchase only	February-08
A4466	Garment, belt, sleeve or other covering, elastic or similar stretchable material, any type, each	Orthotics	No	No	Covered for recipients requiring support of a weak body part, but not needing the support of a rigid support	2 per year	Purchase only	January-10
A4481	Tracheostoma filter, any type, any size, each	Respiratory	No	Y - NF N-ICF/DD	Covered for patients with tracheostomy.	90 per month	Purchase only	October-08
A4483	Moisture exchanger, disposable, for use with invasive mechanical ventilation	Respiratory	No	No	Covered for patients using invasive ventilation. Most recipients can be served with 60 per month.	90 per month	Purchase only	October-08
A4490	Surgical stockings above knee length, each	Miscellaneous supplies	For excess quantities only	No	Covered for patients with edema or varicose veins, or other medical conditions requiring compression. Note: this code is only to be used for stockings with at least 15 mmHg compression at the ankle, which is the minimum considered therapeutic	4 units per 6 months	Purchase only	October-08
A4495	Surgical stockings thigh length, each	Miscellaneous supplies	For excess quantities only	No	Covered for patients with edema or varicose veins, or other medical conditions requiring compression. Note: this code is only to be used for stockings with at least 15 mmHg compression at the ankle, which is the minimum considered therapeutic	4 units per 6 months	Purchase only	October-08
A4500	Surgical stockings below knee length, each	Miscellaneous supplies	For excess quantities only	No	Covered for patients with edema or varicose veins, or other medical conditions requiring compression. Note: this code is only to be used for stockings with at least 15 mmHg compression at the ankle, which is the minimum considered therapeutic	4 units per 6 months	Purchase only	October-08
A4510	Surgical stockings full length, each	Miscellaneous supplies	For excess quantities only	No	Covered for patients with edema or varicose veins, or other medical conditions requiring compression. Note: this code is only to be used for stockings with at least 15 mmHg compression at the ankle, which is the minimum considered therapeutic	4 units per 6 months	Purchase only	October-08
A4520	Incontinence garment, any type (e.g. brief, diaper), each	incontinence			Not covered. Use more specific codes for incontinence garments (T4521-T4543)			October-08
A4550	Surgical trays	Miscellaneous supplies			Not covered when dispensed by medical supply or pharmacy provider.			January-09



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A4554	Disposable underpads, all sizes	incontinence			Not covered. Use more specific codes for underpads (T4542, T4541)			October-08
A4556	Electrodes (e.g. apnea monitor), per pair	Miscellaneous supplies	No	Y - NF N-ICF/DD	Covered for patients with medically necessary apnea monitors, etc. With typical care, electrodes can generally be reused repeatedly. Most recipients can be served with no more than 8 pair per month. Not to be used for recipients getting monthly TENS supplies (A4595).	32 pairs per month	Purchase only	October-08
A4557	Lead wires (e.g. apnea monitor), per pair	Miscellaneous supplies	No	Y - NF N-ICF/DD	Covered for patients with medically necessary apnea monitors, TENS units, etc. With typical care, lead wires can generally be reused repeatedly. Most recipients can be served with no more than 2 pair of leads per 6 months. Refer to manual for quantity limits when used with specific equipment, ie, TENS	2 pairs per dispensing, 4 pairs per 6 months	Purchase only	January-11
A4558	Conductive gel or paste, for use with electrical device (e.g. TENS, NMES), per ounce	Miscellaneous supplies	No	Y - NF N-ICF/DD	Covered for use in the home by patients with medically necessary apnea monitors, etc. Not to be used for recipients getting monthly TENS supplies (A4595).	10 oz per month	Purchase only	October-08
A4559	Coupling gel or paste, for use with ultrasound device	Miscellaneous supplies	No	Y - NF N-ICF/DD	Covered for use in the home by patients with medically necessary ultrasound device	10 oz per month	Purchase only	October-08
A4561	Pessary, rubber, any type	Miscellaneous supplies	No	No	Covered for female recipients with prolapsed bladder or uterus	1 per 6 months	Purchase only	October-08
A4562	Pessary, nonrubber, any type	Miscellaneous supplies	No	No	Covered for female recipients with prolapsed bladder or uterus	1 per 6 months	Purchase only	October-08
A4565	Slings	Miscellaneous supplies	No	No	Covered when needed to support an impaired or injured body part.	2 per month	Purchase only	October-08
A4566	Shoulder sling or vest design, abduction restrainer, with or without swathe control, prefabricated, includes fitting and adjustment	Orthotics	No	No	Covered when needed for immobilizaion or to support injured, post-surgical, and / or weak areas of the shoulder girdle	1 per year	Purchase only	January-11
A4570	Splint	Miscellaneous supplies	No	No	Covered when need to support an impaired or injured body part. Most recipients can be served with 2 per incident/injury (one to use, one to wash)	2 per month	Purchase only	October-08
A4575	Topical hyperbaric oxygen chamber, disposable	Wound care			Not covered. Technology is not proven effective and is not the standard of care in the community.			June-07
A4580	Cast supplies (e.g. plaster)	Miscellaneous supplies			Not covered. Included in payment for the service			October-08
A4590	Special casting material (e.g. fiberglass)	Miscellaneous supplies			Not covered. Included in payment for the service			October-08



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A4595	Electrical stimulator supplies, 2 lead, per month, (e.g. TENS, NMES)	TENS	No	No	Covered for recipients using medically necessary TENS units. Includes all supplies necessary for use of the TENS unit for one month, including adhesive, adhesive remover, batteries, conductive paste or gel and electrodes. Not to be billed with A4556, A4558, A4630. One unit covered for 2 lead TENS, two units covered for 4 lead TENS.	2 per month	Purchase only	December-08
A4600	Sleeve for intermittent limb compression device, replacement only, each	Compression devices	No	No	Covered for recipients with patient owned intermittent limb compression device.	1 per affected limb per year	Purchase only	October-08
A4601	Lithium ion battery for nonprosthetic use, replacement	Miscellaneous supplies	No	No	Covered for use in patient owned equipment other than prostheses	2 per 3 months	Purchase only	October-08
A4604	Tubing with integrated heating element for use with positive airway pressure device	Positive Airway Pressure	No	No	Covered for use with humidified positive airway pressure devices. typical use is 1 per 3 months. Up to 4 per month may be necessary for individuals using PAP via trach or invasive ventilation. Maintain documentation of medical need for quantity dispensed.	4 per month	Purchase only	October-08
A4605	Tracheal Suction Catheter, closed system, each	Respiratory	No	No	Covered for ventilator dependent recipients with tracheostomy who require closed suctioning to prevent hypoxemia. Most recipients can be served with one per week, one per day may be required for medically fragile patients in order to prevent infection.	31 per month	Purchase only	July-08
A4606	Oxygen probe for use with oximeter device, replacement	Respiratory	No	No	Covered for recipients with medically necessary oximeter device. When dispensing reusable, rather than disposable, probes, use modifier U3 and include a description "reusable oximeter probe"	10 per month	Purchase only	October-08
A4608	Transtracheal oxygen catheter, each	Tracheostomy supplies	No	No	Covered for recipients requiring transtracheal oxygen administration. typical usage is one per 3 months	1 per month	Purchase only	October-08
A4611	Battery, heavy duty; replacement for patient-owned ventilator	Respiratory	No	No	Covered for recipients with patient owned ventilators.	2 per year	Purchase only	October-08
A4612	Battery Cables, replacement for patient-owned ventilator	Respiratory	No	No	Covered for recipients with patient owned ventilators.	4 per year	Purchase only	October-08
A4613	Battery charger; replacement for patient-owned ventilator	Respiratory	No	No	Covered for recipients with patient owned ventilators.	1 per year	Purchase only	October-08
A4614	Peak expiratory flow rate meter, hand held	Respiratory	No	Yes	Covered for patients with asthma or similar conditions requiring regular tracking of peak expiratory flow	1 per year	Purchase only	October-08
A4615	Cannula, nasal	Respiratory	No	No	Covered for recipients with respiratory equipment. Most recipients can be served with one per month. Additional may be required for recipients with respiratory infections or nasal discharge. Not separately billable for recipients receiving oxygen service	4 per month	Purchase only	October-08

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A4616	tubing (oxygen) per foot	Respiratory	No	No	Covered for recipients with respiratory equipment. Not separately billable for recipients receiving oxygen service	90 feet per month	Purchase only	October-08
A4617	Mouthpiece	Respiratory	No	No	Covered for recipients receiving medication via nebulizer.	1 per month	Purchase only	October-08
A4618	Breathing circuits	Respiratory	No	No	Covered for recipients with respiratory equipment. Most recipients can be served with 1 every 3 -4 days.	15 per month	Purchase only	October-08
A4619	Face tent	Respiratory	No	No	Covered for recipients receiving oxygen who cannot tolerate mask / cannula	4 per month	Purchase only	October-08
A4620	Variable concentration mask	Respiratory	No	No	Covered for recipients with respiratory equipment who do not require a fixed concentration of oxygen. Not separately billable for recipients receiving oxygen service	1 per month	Purchase only	October-08
A4623	Tracheostomy, inner cannula	Tracheostomy supplies	No	No	Covered for recipients with tracheostomy. Most recipients can be served with 1 per day, additional may be required for recipients with vulnerability to infection.	90 per month	Purchase only	November-08
A4624	Tracheal suction catheter, any type other than closed system, each	Tracheostomy supplies	No	Y - NF N-ICF/DD	Covered for recipients with tracheostomy. Most recipients can be served with 2 - 3 per day, additional may be required for recipients with vulnerability to infection.	200 per month	Purchase only	November-08
A4625	Tracheostomy care kit for new tracheostomy	Tracheostomy supplies	No	Y - NF N-ICF/DD	Covered for recipients with new tracheostomy for up to 14 days following surgery. Includes plastic tray, basin, sterile gloves (A4930), tube brush (A4626), 3 pipe cleaners, 1 pre-cut trach dressing, 1 roll of gauze, 4 4x4 sponges, 2 cotton tip applicators (S8189), 30" twill tape.	14 per surgical tracheostomy	Purchase only	November-08
A4626	Tracheostomy cleaning brush, each	Tracheostomy supplies	No	Y - NF N-ICF/DD	Covered for recipients with tracheostomy. Not to be billed with A4624 or A4629.	31 per month	Purchase only	November-08
A4627	Spacer, bag or reservoir, with or without mask, for use with metered dose inhaler	Miscellaneous supplies	No	Y - NF N-ICF/DD	Covered for recipients using metered dose inhalers. Most recipients can be served with 1 per 3 months. A second spacer is covered for recipients who keep a metered dose inhaler at school or work.	2 per 3 months	Purchase only	November-08
A4628	Oropharyngeal suction catheter, each	Tracheostomy supplies	No	Y - NF N-ICF/DD	Covered for recipients requiring oropharyngeal suctioning. Because oropharyngeal suctioning is not sterile, most recipients can be served with 1 every 2 - 3 days.	12 per month	Purchase only	November-08
A4629	Tracheostomy care kit for established tracheostomy	Tracheostomy supplies	No	Y - NF N-ICF/DD	Covered for recipients with tracheostomy more than 14 days established. Includes tube brush (A4626), 2 pipe cleaners, 2 cotton tip applicators (S8189), 30" twill tape, 2 4x4 sponges.	31 per month	Purchase only	November-08



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A4630	Replacement batteries, medically necessary, transcutaneous electrical stimulator, owned by patient	TENS	No	No	Covered for use with patient owned TENS unit. Included in A4695.	2 per 6 months	Purchase only	December-08
A4633	Replacement bulb / lamp for ultraviolet light therapy system, each	Miscellaneous supplies	No	Y - NF N-ICF/DD	Covered for use in patient owned ultraviolet light therapy system	2 per year	Purchase only	January-09
A4634	Replacement bulb for therapeutic light box, tabletop model	SAD lights	No	Yes	Covered for use in patient owned SAD light.	1 per year	Purchase only	December-08
A4635	Underarm pad, crutch, replacement, each	Miscellaneous supplies	No	Yes	Covered for use on patient owned crutches	2 per 6 months	Purchase only	January-09
A4636	Replacement, handgrip, cane, crutch or walker, each	Miscellaneous supplies	No	Yes	Covered for use on patient owned equipment	2 per 6 months	Purchase only	January-09
A4637	Replacement, tip, cane, crutch, walker, each	Miscellaneous supplies	No	Yes	Covered for use on patient owned equipment	4 per 6 months	Purchase only	January-09
A4638	Replacment battery for patient-owned ear pulse generator	Miscellaneous supplies			Not covered, as the underlying device is not covered (E2120)			January-09
A4639	Replacement pad for infrared heating pad system	Miscellaneous supplies			Not covered, as the underlying device is not covered because it is investigative (E0221)			January-09
A4640	Replacement pad for use with medically necessary alternating pressure pad owned by patient	Pressure reducing support surfaces	No	Y - NF N-ICF/DD	Covered for use with patient owned alternating pressure pad for recipients meeting criteria for Group 1 Pressure Reducing Support Surfaces. Refer to manual	1 per 6 months	Purchase only	November-08
A4649	Surgical Supply; miscellaneous	Miscellaneous supplies	Sometimes - see manual	Y - NF N-ICF/DD	Only to be used when a more specific code is not available. Refer to manual for billing information.	medical necessity	Purchase only	January-09
A4651	Calibrated microcapillary tube, each	Renal Dialysis	No	No	Covered as part of Method II dialysis billing. Refer to manual	medical necessity	Purchase only	January-09
A4652	Microcapillary tube sealant	Renal Dialysis	No	No	Covered as part of Method II dialysis billing. Refer to manual	medical necessity	Purchase only	January-09
A4653	Peritoneal dialysis catheter anchoring device, belt, each	Renal Dialysis	No	No	Covered as part of Method II dialysis billing. Refer to manual	medical necessity	Purchase only	January-09
A4657	Syringe, with or without needle, each	Miscellaneous supplies	No	No	Covered when medically necessary, or as part of Method II dialysis billing. Refer to manual for dialysis billing.	400 per month	Purchase only	January-09

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A4660	Sphygmomanometer / blood pressure apparatus with cuff and stethoscope	Miscellaneous supplies	No	Yes	Covered for recipients for whom frequent monitoring of blood pressure is medically necessary, or as part of Method II dialysis billing. Refer to manual for dialysis billing	1 per 5 years	Purchase only	January-09
A4663	Blood pressure cuff only	Miscellaneous supplies	No	Yes	Covered for use with recipient owned sphygmomanometer. Not to be billed with A4660 or A4670	1 per year	Purchase only	January-09
A4670	Automatic blood pressure monitor	Miscellaneous supplies	No	Yes	Covered for recipients for whom frequent monitoring of blood pressure is medically necessary and who cannot accurately use a manual sphygmomanometer, or as part of Method II dialysis billing. Refer to manual for dialysis billing	1 per 5 years	Purchase only	January-09
A4671	Disposable cyclor set used with cyclor dialysis machine, each	Renal Dialysis	No	No	Covered as part of Method II dialysis billing. Refer to manual	medical necessity	Purchase only	January-09
A4672	Drainage extension line, sterile, for dialysis, each	Renal Dialysis	No	No	Covered as part of Method II dialysis billing. Refer to manual	medical necessity	Purchase only	January-09
A4673	Extension line with easy lock connectors, used with dialysis	Renal Dialysis	No	No	Covered as part of Method II dialysis billing. Refer to manual	medical necessity	Purchase only	January-09
A4674	Chemicals / antiseptics solutions used to clean / sterilize dialysis equipment, per 8 oz	Renal Dialysis	No	No	Covered as part of Method II dialysis billing. Refer to manual	medical necessity	Purchase only	January-09
A4680	Activated carbon filter for hemodialysis, each	Renal Dialysis	No	No	Covered as part of Method II dialysis billing. Refer to manual	medical necessity	Purchase only	January-09
A4690	Dialyzer (artificial kidneys), all types, all sizes, for hemodialysis, each	Renal Dialysis	No	No	Covered as part of Method II dialysis billing. Refer to manual	medical necessity	Purchase only	January-09
A4706	Bicarbonate concentrate, solution, for hemodialysis, per gallon	Renal Dialysis	No	No	Covered as part of Method II dialysis billing. Refer to manual	medical necessity	Purchase only	January-09
A4707	Bicarbonate concentrate, powder, for hemodialysis, per packet	Renal Dialysis	No	No	Covered as part of Method II dialysis billing. Refer to manual	medical necessity	Purchase only	January-09
A4708	Acetate concentrate solution, for hemodialysis, per gallon	Renal Dialysis	No	No	Covered as part of Method II dialysis billing. Refer to manual	medical necessity	Purchase only	January-09
A4709	Acid concentrate, solution, for hemodialysis, per gallon	Renal Dialysis	No	No	Covered as part of Method II dialysis billing. Refer to manual	medical necessity	Purchase only	January-09
A4714	Treated water (deionized, distilled, or reverse osmosis) for peritoneal dialysis, per gallon	Renal Dialysis	No	No	Covered as part of Method II dialysis billing. Refer to manual	medical necessity	Purchase only	January-09

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A4719	"Y set" tubing for peritoneal dialysis	Renal Dialysis	No	No	Covered as part of Method II dialysis billing. Refer to manual	medical necessity	Purchase only	January-09
A4720	Dialysate solution, any concentration of dextrose, fluid volume greater than 249 cc, but less than or equal to 999 cc, for peritoneal dialysis	Renal Dialysis	No	No	Covered as part of Method II dialysis billing. Refer to manual	medical necessity	Purchase only	January-09
A4721	Dialysate solution, any concentration of dextrose, fluid volume greater than 999 cc, but less than or equal to 1999 cc, for peritoneal dialysis	Renal Dialysis	No	No	Covered as part of Method II dialysis billing. Refer to manual	medical necessity	Purchase only	January-09
A4722	Dialysate solution, any concentration of dextrose, fluid volume greater than 1999 cc, but less than or equal to 2999 cc, for peritoneal dialysis	Renal Dialysis	No	No	Covered as part of Method II dialysis billing. Refer to manual	medical necessity	Purchase only	January-09
A4723	Dialysate solution, any concentration of dextrose, fluid volume greater than 2999 cc, but less than or equal to 3999 cc, for peritoneal dialysis	Renal Dialysis	No	No	Covered as part of Method II dialysis billing. Refer to manual	medical necessity	Purchase only	January-09
A4724	Dialysate solution, any concentration of dextrose, fluid volume greater than 3999 cc, but less than or equal to 4999 cc, for peritoneal dialysis	Renal Dialysis	No	No	Covered as part of Method II dialysis billing. Refer to manual	medical necessity	Purchase only	January-09
A4725	Dialysate solution, any concentration of dextrose, fluid volume greater than 4999 cc, but less than or equal to 5999 cc, for peritoneal dialysis	Renal Dialysis	No	No	Covered as part of Method II dialysis billing. Refer to manual	medical necessity	Purchase only	January-09
A4726	Dialysate solution, any concentration of dextrose, fluid volume greater than 5999 cc, for peritoneal dialysis	Renal Dialysis	No	No	Covered as part of Method II dialysis billing. Refer to manual	medical necessity	Purchase only	January-09

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A4728	Dialysate solution, nondextrose containing, 500 ml	Renal Dialysis	No	No	Covered as part of Method II dialysis billing. Refer to manual	medical necessity	Purchase only	January-09
A4730	Fistula cannulation set for hemodialysis, each	Renal Dialysis	No	No	Covered as part of Method II dialysis billing. Refer to manual	medical necessity	Purchase only	January-09
A4736	Topical anesthetic, for dialysis, per gram	Renal Dialysis	No	No	Covered as part of Method II dialysis billing. Refer to manual	medical necessity	Purchase only	January-09
A4737	Injectable anesthetic, for dialysis, per 10 ml	Renal Dialysis	No	No	Covered as part of Method II dialysis billing. Refer to manual	medical necessity	Purchase only	January-09
A4740	Shunt accessory, for hemodialysis, any type, each	Renal Dialysis	No	No	Covered as part of Method II dialysis billing. Refer to manual	medical necessity	Purchase only	January-09
A4750	Blood tubing, arterial or venous, for hemodialysis, each	Renal Dialysis	No	No	Covered as part of Method II dialysis billing. Refer to manual	medical necessity	Purchase only	January-09
A4755	Blood tubing, arterial and venous combined, for hemodialysis, each	Renal Dialysis	No	No	Covered as part of Method II dialysis billing. Refer to manual	medical necessity	Purchase only	January-09
A4760	Dialysate solution test kit, for peritoneal dialysis, any type, each	Renal Dialysis	No	No	Covered as part of Method II dialysis billing. Refer to manual	medical necessity	Purchase only	January-09
A4765	Dialysate concentrate, powder, additive for peritoneal dialysis, per packet	Renal Dialysis	No	No	Covered as part of Method II dialysis billing. Refer to manual	medical necessity	Purchase only	January-09
A4766	Dialysate concentrate, solution, additive for peritoneal dialysis, per 10 ml	Renal Dialysis	No	No	Covered as part of Method II dialysis billing. Refer to manual	medical necessity	Purchase only	January-09
A4770	Blood collection tube, vacuum, for dialysis, per 50	Renal Dialysis	No	No	Covered as part of Method II dialysis billing. Refer to manual	medical necessity	Purchase only	January-09
A4771	Serum clotting time tube, for dialysis, per 50	Renal Dialysis	No	No	Covered as part of Method II dialysis billing. Refer to manual	medical necessity	Purchase only	January-09
A4772	Blood glucose test strips, for dialysis, per 50	Renal Dialysis	No	No	Covered as part of Method II dialysis billing. For conditions other than dialysis, use A4253. Refer to manual	5 boxes of 50 per month	Purchase only	January-09
A4773	Occult blood test strips, for dialysis, per 50	Renal Dialysis	No	No	Covered as part of Method II dialysis billing. Refer to manual	medical necessity	Purchase only	January-09
A4774	Ammonia test strips, for dialysis	Renal Dialysis	No	No	Covered as part of Method II dialysis billing. Refer to manual	medical necessity	Purchase only	January-09
A4780	Contracts, repair and maintenance, for hemodialysis equipment	Renal Dialysis	No	No	Covered as part of Method II dialysis billing. Refer to manual	medical necessity	Purchase only	January-09

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A4802	Protamine sulfate, for hemodialysis, per 50 mg	Renal Dialysis	No	No	Covered as part of Method II dialysis billing. Refer to manual	medical necessity	Purchase only	January-09
A4860	Disposable catheter tips for peritoneal dialysis, per 10	Renal Dialysis	No	No	Covered as part of Method II dialysis billing. Refer to manual	medical necessity	Purchase only	January-09
A4870	Plumbing and / or electrical work for home hemodialysis equipment	Renal Dialysis	No	No	Covered as part of Method II dialysis billing. Refer to manual	medical necessity	Purchase only	January-09
A4911	Drain bag / bottle, for dialysis, each	Renal Dialysis	No	No	Covered as part of Method II dialysis billing. Refer to manual	medical necessity	Purchase only	January-09
A4913	Miscellaneous dialysis supplies, not otherwise specified	Renal Dialysis	No	No	Covered as part of Method II dialysis billing. Refer to manual	medical necessity	Purchase only	January-09
A4918	Venous pressure clamp, for hemodialysis, each	Renal Dialysis	No	No	Covered as part of Method II dialysis billing. Refer to manual	medical necessity	Purchase only	January-09
A4927	Gloves, nonsterile, per 100	Miscellaneous supplies	Sometimes - see manual	Yes	Covered for use by the recipient or by caregivers when ordered by the prescribing provider for use in performing cares for the recipient. Refer to manual	4 boxes of 100 per month	Purchase only	November-08
A4928	Tourniquet, for dialysis, each	Renal Dialysis	No	No	Covered as part of Method II dialysis billing. Refer to manual	medical necessity	Purchase only	January-09
A4928	Surgical mask, per 20	Renal Dialysis	No	No	Covered as part of Method II dialysis billing. Only billable by Method II dialysis providers. Refer to manual	medical necessity	Purchase only	January-09
A4930	Gloves, sterile, per pair	Miscellaneous supplies	Sometimes - see manual	Yes	Covered when ordered by the physician for use during sterile procedures. Refer to manual	200 pair per month	Purchase only	January-09
A4931	Oral thermometer, reusable, any type, each	Miscellaneous supplies	No	Yes	Covered for recipients with medical necessity to regularly monitor temperature. Not covered as a routine "just in case" supply.	1 per year	Purchase only	January-09
A4932	Rectal thermometer, reusable, any type, each	Miscellaneous supplies	No	Yes	Covered for recipients with medical necessity to regularly monitor temperature. Not covered as a routine "just in case" supply.	1 per year	Purchase only	January-09
A5051	Ostomy pouch, closed; with barrier attached (1 piece), each	Ostomy	No	Y - NF N-ICF/DD	Covered for recipients with ostomies. Most recipients can be served with 60 per month, additional may be required due to high output or adhesion problems.	90 per month	Purchase only	October-08
A5052	Ostomy pouch, closed; without barrier attached (1 piece), each	Ostomy	No	Y - NF N-ICF/DD	Covered for recipients with ostomies. Most recipients can be served with 60 per month, additional may be required due to high output or adhesion problems.	90 per month	Purchase only	October-08
A5053	Ostomy pouch, closed; for use on faceplate, each	Ostomy	No	Y - NF N-ICF/DD	Covered for recipients with ostomies. Most recipients can be served with 60 per month, additional may be required due to high output or adhesion problems.	90 per month	Purchase only	October-08

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A5054	Ostomy pouch, closed; for use on barrier with flange (2 piece), each	Ostomy	No	Y - NF N-ICF/DD	Covered for recipients with ostomies. Most recipients can be served with 60 per month, additional may be required due to high output or adhesion problems.	90 per month	Purchase only	October-08
A5055	Stoma cap	Ostomy	No	Y - NF N-ICF/DD	Covered for recipients with ostomies. Most recipients can be served with 1 per day.	31 per month	Purchase only	October-08
A5056	Ostomy pouch, drainable, with extended wear barrier attached, with filter, (1 piece), each	Ostomy	No	Y - NF N-ICF/DD	Covered for recipients with ostomies. Typical use is 1 per 2 - 3 days per site. Not to be billed with A4368	31 per month	Purchase only	January-12
A5057	Ostomy pouch, drainable, with extended wear barrier attached, with filter, (1 piece), each	Ostomy	No	Y - NF N-ICF/DD	Covered for recipients with ostomies. Typical use is 1 per 2 - 3 days per site. Not to be billed with A4368	31 per month	Purchase only	January-12
A5061	Ostomy pouch, drainable; with barrier attached, (1 piece), each	Ostomy	No	Y - NF N-ICF/DD	Covered for recipients with ostomies. Most recipients can be served with 1 per day.	31 per month	Purchase only	October-08
A5062	Ostomy pouch, drainable; without barrier attached, (1 piece), each	Ostomy	No	Y - NF N-ICF/DD	Covered for recipients with ostomies. Most recipients can be served with one per day.	31 per month	Purchase only	October-08
A5063	Ostomy pouch, drainable; for use on barrier with flange (2-piece system), each	Ostomy	No	Y - NF N-ICF/DD	Covered for recipients with ostomies. Most recipients can be served with one per day.	31 per month	Purchase only	October-08
A5071	Ostomy pouch, urinary; with barrier attached (1 piece), each	Ostomy	No	Y - NF N-ICF/DD	Covered for recipients with ostomies. Most recipients can be served with one per day.	31 per month	Purchase only	October-08
A5072	Ostomy pouch, urinary; without barrier attached (1 piece), each	Ostomy	No	Y - NF N-ICF/DD	Covered for recipients with ostomies. Most recipients can be served with one per day.	31 per month	Purchase only	October-08
A5073	Ostomy pouch, urinary; for use on barrier with flange (2 piece), each	Ostomy	No	Y - NF N-ICF/DD	Covered for recipients with ostomies. Most recipients can be served with one per day.	31 per month	Purchase only	October-08
A5081	Continent device; plug for continent stoma	Ostomy	No	Y - NF N-ICF/DD	Covered for recipients with continent stomas. Most recipients can be served with one per day.	31 per month	Purchase only	October-08
A5082	Continent device, catheter for continent stoma	Ostomy	No	Y - NF N-ICF/DD	Covered for recipients with continent stomas. Most recipients can be served with one per month.	31 per month	Purchase only	October-08
A5083	Continent device, stoma absorptive cover for continent stoma	Ostomy	No	Y - NF N-ICF/DD	Covered for recipient with Continent Intestinal Reservoir. Most recipients can be served with 5 - 7 per day.	200 per month	Purchase only	December-07

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A5102	Bedside drainage bottle, with or without tubing, rigid or expandable, each	Urological	Sometimes - see manual	Yes	Covered for recipients with catheters. Most recipients can be served with 1 per month, additional may be needed for recipients with frequent UTIs or other medical complications. Quantities over 10 per month require PA.	31 drainage devices per month when authorized	Purchase only	April-09
A5105	Urinary suspensory with leg bag, with or without tube, each	Urological	No	Y - NF N-ICF/DD	Covered for recipients who are incontinent of bladder. Most recipients can be served with 3 - 5 per month	5 per month	Purchase only	April-09
A5112	Urinary drainage bag, leg or abdomen, latex, with or without tube, with straps, each	Urological	Sometimes - see manual	Yes	Covered for recipients with catheters. Most recipients can be served with 1 per month, additional may be needed for recipients with frequent UTIs or other medical complications. Quantities over 10 per month require PA.	31 drainage devices per month when authorized	Purchase only	January-11
A5113	Leg strap; latex, replacement only, per set	Urological	No	Y - NF N-ICF/DD	Most recipients can be served with 1 per 3 months.	1 per month	Purchase only	April-09
A5114	Leg strap; foam or fabric, replacement only, per set	Urological	No	Y - NF N-ICF/DD	Most recipients can be served with 2 per month.	3 per month	Purchase only	April-09
A5120	Skin barrier, wipes or swabs, each	Ostomy	No	Y - NF N-ICF/DD	Covered for recipients with ostomies. Most recipients can be served with 6 - 7 per day	250 per month	Purchase only	October-08
A5121	Skin barrier; solid, 6 x 6 or equivalent; each	Ostomy	No	Y - NF N-ICF/DD	Covered for recipients with ostomies. Most recipients can be served with 1 per site per day.	31 per month	Purchase only	October-08
A5122	Skin barrier; solid 8 x 8 or equivalent; each	Ostomy	No	Y - NF N-ICF/DD	Covered for recipients with ostomies. Most recipients can be served with 1 per site per day.	31 per month	Purchase only	October-08
A5126	Adhesive or nonadhesive; disk or foam pad	Ostomy	No	Y - NF N-ICF/DD	Covered for recipients with ostomies. Most recipients can be served with 1 per site per day.	31 per month	Purchase only	October-08
A5131	Appliance cleaner, incontinence and ostomy appliances, per 16 oz	Ostomy	Sometimes - see manual	Y - NF N-ICF/DD	Covered for recipients with incontinence or ostomy devices. Most recipients can be served with two 16 ounce bottles per month. More than 3 sixteen ounce bottles in a month requires PA	3 sixteen ounce bottles per month	Purchase only	October-08
A5200	Percutaneous catheter / tube anchoring device, adhesive skin attachment	Ostomy	No	No	Covered for recipients with percutaneous catheter. Most recipients can be served with 2 per month.	5 per month	Purchase only	January-09
A5500	For diabetics only, fitting (including follow-up), custom preparation and supply of off-the-shelf depth-inlay shoe manufactured to accommodate multidensity insert(s), per shoe	Footwear	No	No	Covered for diabetic recipients with history of amputation of all or part of either foot, history of previous foot ulceration or pre-ulcerative calluses of either foot; peripheral neuropathy of either foot; foot deformity of either foot or poor circulation of either foot. Most recipients can be served with 1 pair (2 units) per 6 months. A maximum of 4 units may be dispensed at a time	4 shoes per year	Purchase only	January-09



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A5501	For diabetics only, fitting (including follow-up), custom preparation and supply of shoe molded from cast(s) of patient's foot (custom molded shoe), per shoe	Footwear	No	No	Covered for diabetic recipients with history of amputation of all or part of either foot, history of previous foot ulceration or pre-ulcerative calluses of either foot; peripheral neuropathy of either foot; foot deformity of either foot or poor circulation of either foot. Most recipients can be served with 1 pair (2 units) per 6 months. A maximum of 4 units may be dispensed at a time	4 shoes per year	Purchase only	January-09
A5503	For diabetics only, modification (including fitting) of off-the-shelf depth-inlay shoe or custom molded shoe with roller or rigid rocker bottom, per shoe	Footwear	No	No	Covered for diabetic recipients with history of amputation of all or part of either foot, history of previous foot ulceration or pre-ulcerative calluses of either foot; peripheral neuropathy of either foot; foot deformity of either foot or poor circulation of either foot. Most recipients can be served with 1 pair (2 units) per 6 months. A maximum of 4 units may be dispensed at a time	4 shoes per year	Purchase only	January-09
A5504	For diabetics only, modification (including fitting) of off-the-shelf depth-inlay shoe or custom molded shoe with wedge(s), per shoe	Footwear	No	No	Covered for diabetic recipients with history of amputation of all or part of either foot, history of previous foot ulceration or pre-ulcerative calluses of either foot; peripheral neuropathy of either foot; foot deformity of either foot or poor circulation of either foot. Most recipients can be served with 1 pair (2 units) per 6 months. A maximum of 4 units may be dispensed at a time	4 shoes per year	Purchase only	January-09
A5505	For diabetics only, modification (including fitting) of off-the-shelf depth-inlay shoe or custom molded shoe with metatarsal bar, per shoe	Footwear	No	No	Covered for diabetic recipients with history of amputation of all or part of either foot, history of previous foot ulceration or pre-ulcerative calluses of either foot; peripheral neuropathy of either foot; foot deformity of either foot or poor circulation of either foot. Most recipients can be served with 1 pair (2 units) per 6 months. A maximum of 4 units may be dispensed at a time	4 shoes per year	Purchase only	January-09
A5506	For diabetics only, modification (including fitting) of off-the-shelf depth-inlay shoe or custom molded shoe with off-set heel(s), per shoe	Footwear	No	No	Covered for diabetic recipients with history of amputation of all or part of either foot, history of previous foot ulceration or pre-ulcerative calluses of either foot; peripheral neuropathy of either foot; foot deformity of either foot or poor circulation of either foot. Most recipients can be served with 1 pair (2 units) per 6 months. A maximum of 4 units may be dispensed at a time	4 shoes per year	Purchase only	January-09
A5507	For diabetics only, not otherwise specified modification (including fitting) of off-the-shelf depth-inlay shoe or custom molded shoe, per shoe	Footwear	No	No	Covered for diabetic recipients with history of amputation of all or part of either foot, history of previous foot ulceration or pre-ulcerative calluses of either foot; peripheral neuropathy of either foot; foot deformity of either foot or poor circulation of either foot. Most recipients can be served with 1 pair (2 units) per 6 months. A maximum of 4 units may be dispensed at a time	4 shoes per year	Purchase only	January-09



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A5508	For diabetics only, deluxe feature of off-the-shelf depth-inlay or custom molded shoe, per shoe	Footwear			Not covered - deluxe features are not an efficient use of Medicaid funds			January-09
A5510	For diabetics only, direct formed, compression molded to patient's foot without external heat source, multiple-density insert(s) prefabricated, per shoe	Footwear	No	No	Covered for diabetic recipients with history of amputation of all or part of either foot, history of previous foot ulceration or pre-ulcerative calluses of either foot; peripheral neuropathy of either foot; foot deformity of either foot or poor circulation of either foot. Most recipients can be served with 1 pair (2 units) per 6 months. A maximum of 4 units may be dispensed at a time	4 shoes per year	Purchase only	January-09
A5512	For diabetics only, multiple density insert, direct formed, molded to foot after external heat source of 230 degrees Fahrenheit or higher, total contact with patient's foot, including arch, base layer minimum of 1/4 inch material of shore a 35 durometer or 3/16 inch material of shore a 40 durometer (or higher), prefabricated, each	Footwear	No	No	Covered for diabetic recipients with history of amputation of all or part of either foot, history of previous foot ulceration or pre-ulcerative calluses of either foot; peripheral neuropathy of either foot; foot deformity of either foot or poor circulation of either foot. Most recipients can be served with 1 pair (2 units) per 6 months. A maximum of 4 units may be dispensed at a time	6 inserts per year	Purchase only	January-09
A5513	For diabetics only, multiple density insert, custom molded from model of patient's foot, total contact with patient's foot, including arch, base layer minimum of 3/16 inch material of shore a 35 durometer (or higher), includes arch filler and other shaping material, custom fabricated, each	Footwear	No	No	Covered for diabetic recipients with history of amputation of all or part of either foot, history of previous foot ulceration or pre-ulcerative calluses of either foot; peripheral neuropathy of either foot; foot deformity of either foot or poor circulation of either foot. Most recipients can be served with 1 pair (2 units) per 6 months. A maximum of 4 units may be dispensed at a time	6 inserts per year	Purchase only	January-09
A6000	Noncontact wound-warming wound cover for use with the noncontact wound warming device and warming card	Wound care			Not covered. Technology is not proven effective and is not the standard of care in the community.			January-09

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A6010	Collagen based wound filler, dry form, sterile, per gram of collagen	Wound care	No	Y - NF N-ICF/DD	Covered for recipients with chronic wounds and dermal ulcers. Most recipients can be served with less than 10 grams per wound per month. Use A1-A9 modifiers as appropriate	90 units per month	Purchase only	January-09
A6011	Collagen based wound filler, gel/paste, per gram of collagen	Wound care	No	Y - NF N-ICF/DD	Covered for recipients with chronic wounds and dermal ulcers. Most recipients can be served with less than 10 grams per wound per month. Use A1-A9 modifiers as appropriate	90 units per month	Purchase only	January-11
A6021	Collagen dressing, sterile, pad size 16 sq in or less, each	Wound care	No	Y - NF N-ICF/DD	Covered for recipients with moderate to heavily draining wounds. Most recipients can be served with 1 collagen dressing change every 4 -7 days for each wound. Additional dressing changes may be required if infection is present. Use A1-A9 modifiers as appropriate	10 per month	Purchase only	January-09
A6022	Collagen dressing, sterile, pad size more than 16 sq in but less than or equal to 48 sq in, each	Wound care	No	Y - NF N-ICF/DD	Covered for recipients with moderate to heavily draining wounds. Most recipients can be served with 1 collagen dressing change every 4 -7 days for each wound. Additional dressing changes may be required if infection is present. Use A1-A9 modifiers as appropriate	10 per month	Purchase only	January-09
A6023	Collagen dressing, sterile, pad size more than 48 sq in, each	Wound care	No	Y - NF N-ICF/DD	Covered for recipients with moderate to heavily draining wounds. Most recipients can be served with 1 collagen dressing change every 4 -7 days for each wound. Additional dressing changes may be required if infection is present. Use A1-A9 modifiers as appropriate	10 per month	Purchase only	January-09
A6024	Collagen dressing wound filler, sterile, per 6 in	Wound care	No	Y - NF N-ICF/DD	Covered for recipients with chronic wounds and dermal ulcers. Most recipients can be served with less than 24 inches per wound per month. Use A1-A9 modifiers as appropriate	10 (6 inch) units per month	Purchase only	January-09
A6025	Gel sheet for dermal or epidermal application (e.g., silicone, hydrogel, other), each	Wound care	No	Y - NF N-ICF/DD	Covered for recipients with wounds with little or no drainage. Most recipients can be served with 1 gel sheet per wound per week. Use A1-A9 modifiers as appropriate.	5 per month	Purchase only	January-09
A6154	Wound pouch, each	Wound care	No	Y - NF N-ICF/DD	Covered for recipients with fistulas or other wounds with significant drainage. Most recipients can be served with 1 pouch per week per wound. Use A1-A9 modifiers as appropriate	15 per month	Purchase only	January-09
A6196	Alginate or other fiber gelling dressing, wound cover, sterile, pad size 16 sq in or less, each dressing	Wound care	No	Y - NF N-ICF/DD	Covered for recipients with moderate to heavily draining full thickness wounds. Most recipients can be served with 1 alginate dressing change every day for each wound. Additional dressing changes may be required if infection is present. Use A1-A9 modifiers as appropriate	60 per month	Purchase only	January-09



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A6197	Alginate or other fiber gelling dressing, wound cover, sterile, pad size more than 16 sq in but less than or equal to 48 sq in, each dressing	Wound care	No	Y - NF N-ICF/DD	Covered for recipients with moderate to heavily draining full thickness wounds. Most recipients can be served with 1 alginate dressing change every day for each wound. Additional dressing changes may be required if infection is present. Use A1-A9 modifiers as appropriate	60 per month	Purchase only	January-09
A6198	Alginate or other fiber gelling dressing, wound cover, sterile, pad size more than 48 sq in, each dressing	Wound care	No	Y - NF N-ICF/DD	Covered for recipients with moderate to heavily draining full thickness wounds. Most recipients can be served with 1 alginate dressing change every day for each wound. Additional dressing changes may be required if infection is present. Use A1-A9 modifiers as appropriate	60 per month	Purchase only	January-09
A6199	Alginate or other fiber gelling dressing, wound filler, sterile, per 6 inches	Wound care	No	Y - NF N-ICF/DD	Covered for recipients with moderate to heavily draining full thickness wounds. Most recipients can be served with 2 units of alginate wound filler every day for each wound. Additional dressing changes may be required if infection is present. Use A1-A9 modifiers as appropriate	120 per month	Purchase only	January-09
A6203	Composite dressing, pad size 16 sq in or less, with adhesive border, each dressing	Wound care	No	Yes	Covered for recipients with wounds. Most recipients can be served with 3 composite dressing changes per week. Additional dressing changes may be required for heavy exudate or when infection is present. Use A1-A9 modifiers as appropriate.	30 per month	Purchase only	January-09
A6204	Composite dressing, pad size more than 16 sq in but less than or equal to 48 sq in, with adhesive border, each dressing	Wound care	No	Yes	Covered for recipients with wounds. Most recipients can be served with 3 composite dressing changes per week. Additional dressing changes may be required for heavy exudate or when infection is present. Use A1-A9 modifiers as appropriate.	30 per month	Purchase only	January-09
A6205	Composite dressing, pad size more than 48 sq in, with adhesive border, each dressing	Wound care	No	Yes	Covered for recipients with wounds. Most recipients can be served with 3 composite dressing changes per week. Additional dressing changes may be required for heavy exudate or when infection is present. Use A1-A9 modifiers as appropriate.	30 per month	Purchase only	January-09
A6206	Contact layer, sterile, 16 sq in or less, each dressing	Wound care	No	Yes	Covered for recipients with open wounds. Most recipients can be served with 1 dressing change per week. Use A1-A9 modifiers as appropriate	60 per month	Purchase only	January-09
A6207	Contact layer, sterile, more than 16 sq in but less than or equal to 48 sq in, each dressing	Wound care	No	Yes	Covered for recipients with open wounds. Most recipients can be served with 1 dressing change per week. Use A1-A9 modifiers as appropriate	60 per month	Purchase only	January-09
A6208	Contact layer, sterile, more than 48 sq in, each dressing	Wound care	No	Yes	Covered for recipients with open wounds. Most recipients can be served with 1 dressing change per week. Use A1-A9 modifiers as appropriate	60 per month	Purchase only	January-09

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A6209	Foam dressing, wound cover, sterile, pad size 16 sq in or less, without adhesive border, each dressing.	Wound care	No	Y - NF N-ICF/DD	Covered for recipients with full thickness wounds with moderate to heavy exudate. Most recipients can be served with 3 dressing changes per week. More may be necessary when infection is present or for very heavy exudate. Use A1-A9 modifiers as appropriate	30 per month	Purchase only	January-09
A6210	Foam dressing, wound cover, sterile, pad size more than 16 sq in but less than or equal to 48 sq in, without adhesive border, each dressing.	Wound care	No	Y - NF N-ICF/DD	Covered for recipients with full thickness wounds with moderate to heavy exudate. Most recipients can be served with 3 dressing changes per week. More may be necessary when infection is present or for very heavy exudate. Use A1-A9 modifiers as appropriate	30 per month	Purchase only	January-09
A6211	Foam dressing, wound cover, sterile, pad size more than 48 sq in, without adhesive border, each dressing.	Wound care	No	Y - NF N-ICF/DD	Covered for recipients with full thickness wounds with moderate to heavy exudate. Most recipients can be served with 3 dressing changes per week. More may be necessary when infection is present or for very heavy exudate. Use A1-A9 modifiers as appropriate	30 per month	Purchase only	January-09
A6212	Foam dressing, wound cover, sterile, pad size 16 sq in or less, with any size adhesive border, each dressing.	Wound care	No	Y - NF N-ICF/DD	Covered for recipients with full thickness wounds with moderate to heavy exudate. Most recipients can be served with 3 dressing changes per week. More may be necessary when infection is present or for very heavy exudate. Use A1-A9 modifiers as appropriate	30 per month	Purchase only	January-09
A6213	Foam dressing, wound cover, sterile, pad size more than 16 sq in but less than or equal to 48 sq in, with any size adhesive border, each dressing.	Wound care	No	Y - NF N-ICF/DD	Covered for recipients with full thickness wounds with moderate to heavy exudate. Most recipients can be served with 3 dressing changes per week. More may be necessary when infection is present or for very heavy exudate. Use A1-A9 modifiers as appropriate	30 per month	Purchase only	January-09
A6214	Foam dressing, wound cover, sterile, pad size more than 48 sq in, with any size adhesive border, each dressing.	Wound care	No	Y - NF N-ICF/DD	Covered for recipients with full thickness wounds with moderate to heavy exudate. Most recipients can be served with 3 dressing changes per week. More may be necessary when infection is present or for very heavy exudate. Use A1-A9 modifiers as appropriate	30 per month	Purchase only	January-09
A6215	Foam dressing, wound filler, sterile, per gram	Wound care	No	Y - NF N-ICF/DD	Covered for recipients with full thickness wounds with moderate to heavy exudate. Most recipients can be served with 1 dressing change per day. More may be necessary when infection is present or for very heavy exudate. Use A1-A9 modifiers as appropriate	90 per month	Purchase only	January-09

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A6216	Gauze, nonimpregnated, nonsterile, pad size 16 sq in or less, without adhesive border, each dressing	Miscellaneous supplies	No	Yes	Covered for recipients with wounds, tracheostomies or other medical conditions requiring gauze pads that do not require sterile gauze pads. For wound care, most recipients can be served with 3 dressing changes per day. For other indications, most recipients can be served with 12 dressings per day. Use A1-A9 modifiers as appropriate	500 per month	Purchase only	January-09
A6217	Gauze, nonimpregnated, nonsterile, pad size more than 16 sq in but less than or equal to 48 sq in, without adhesive border, each dressing	Wound care	No	Yes	Covered for recipients with wounds that do not require sterile gauze pads. Most recipients can be served with 3 dressing changes per day. Use A1-A9 modifiers as appropriate.	120 per month	Purchase only	January-09
A6218	Gauze, nonimpregnated, nonsterile, pad size more than 48 sq in, without adhesive border, each dressing	Wound care	No	Yes	Covered for recipients with wounds that do not require sterile gauze pads. Most recipients can be served with 3 dressing changes per day. Use A1-A9 modifiers as appropriate.	120 per month	Purchase only	January-09
A6219	Gauze, nonimpregnated, sterile, pad size 16 sq in or less, with any size adhesive border, each dressing	Wound care	No	Yes	Covered for recipients with wounds that require sterile gauze pads. Most recipients can be served with 1 - 2 dressing changes per day. Use A1 - A9 modifiers as appropriate	120 per month	Purchase only	January-09
A6220	Gauze, nonimpregnated, sterile, pad size more than 16 sq in but less than or equal to 48 sq in, with any size adhesive border, each dressing	Wound care	No	Yes	Covered for recipients with wounds that require sterile gauze pads. Most recipients can be served with 1 - 2 dressing changes per day. Use A1 - A9 modifiers as appropriate	120 per month	Purchase only	January-09
A6221	Gauze, nonimpregnated, sterile, pad size more than 48 sq in, with any size adhesive border, each dressing	Wound care	No	Yes	Covered for recipients with wounds that require sterile gauze pads. Most recipients can be served with 1 - 2 dressing changes per day. Use A1 - A9 modifiers as appropriate	120 per month	Purchase only	January-09
A6222	Gauze, impregnated with other than water, typical saline, or hydrogel, sterile, pad size 16 sq in or less, without adhesive border, each dressing	Wound care	No	Yes	Covered for recipients with wounds requiring impregnated gauze for moisture or antimicrobial properties. Most recipients can be served with one dressing change per day. Use A1 - A9 modifiers as appropriate.	90 per month	Purchase only	January-09

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A6223	Gauze, impregnated with other than water, typical saline, or hydrogel, sterile, pad size more than 16 sq in but less than 48 sq in, without adhesive border, each dressing	Wound care	No	Yes	Covered for recipients with wounds requiring impregnated gauze for moisture or antimicrobial properties. Most recipients can be served with one dressing change per day. Use A1 - A9 modifiers as appropriate.	90 per month	Purchase only	January-09
A6224	Gauze, impregnated with other than water, typical saline, or hydrogel, sterile, pad size more than 48 sq in, without adhesive border, each dressing	Wound care	No	Yes	Covered for recipients with wounds requiring impregnated gauze for moisture or antimicrobial properties. Most recipients can be served with one dressing change per day. Use A1 - A9 modifiers as appropriate.	90 per month	Purchase only	January-09
A6228	Gauze, impregnated, water or typical saline, sterile, pad size 16 sq in or less, without adhesive border, each dressing	Wound care	No	Yes	Covered for recipients needing only a few gauze pads impregnated with sterile water or saline. If more than a few will be needed, it is more cost effective to dispense gauze pads and sterile water/saline separately. Use A1-A9 modifiers as appropriate.	20 per month	Purchase only	January-09
A6229	Gauze, impregnated with other than water, typical saline, or hydrogel, sterile, pad size more than 16 sq in but less than 48 sq in, without adhesive border, each dressing	Wound care	No	Yes	Covered for recipients needing only a few gauze pads impregnated with sterile water or saline. If more than a few will be needed, it is more cost effective to dispense gauze pads and sterile water/saline separately. Use A1-A9 modifiers as appropriate.	20 per month	Purchase only	January-09
A6230	Gauze, impregnated with other than water, typical saline, or hydrogel, sterile, pad size more than 48 sq in, without adhesive border, each dressing	Wound care	No	Yes	Covered for recipients needing only a few gauze pads impregnated with sterile water or saline. If more than a few will be needed, it is more cost effective to dispense gauze pads and sterile water/saline separately. Use A1-A9 modifiers as appropriate.	20 per month	Purchase only	January-09
A6231	Gauze, impregnated, hydrogel, for direct wound contact, sterile, pad size 16 sq in for less, each dressing	Wound care	No	Yes	Covered for recipients with full thickness wounds with minimal or no exudate. Most recipients can be served with 1 dressing change per wound per day. Use A1-A9 modifiers as appropriate	90 per month	Purchase only	January-09
A6232	Gauze, impregnated, hydrogel, for direct wound contact, sterile, pad size more than 16 sq in but less than 48 sq in, each dressing	Wound care	No	Yes	Covered for recipients with full thickness wounds with minimal or no exudate. Most recipients can be served with 1 dressing change per wound per day. Use A1-A9 modifiers as appropriate	90 per month	Purchase only	January-09

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A6233	Gauze, impregnated, hydrogel, for direct wound contact, sterile, pad size more than 48 sq in, each dressing	Wound care	No	Yes	Covered for recipients with full thickness wounds with minimal or no exudate. Most recipients can be served with 1 dressing change per wound per day. Use A1-A9 modifiers as appropriate	90 per month	Purchase only	January-09
A6234	Hydrocolloid dressing, wound cover, sterile, pad size 16 sq in or less, without adhesive border, each dressing	Wound care	No	Y - NF N-ICF/DD	Covered for recipients with wounds with light to moderate exudate. Typical use is 3 - 4 dressing changes per week per wound. Use A1-A9 modifiers as appropriate.	60 per month	Purchase only	January-09
A6235	Hydrocolloid dressing, wound cover, sterile, pad size more than 16 sq in but less than 48 sq in, without adhesive border, each dressing	Wound care	No	Y - NF N-ICF/DD	Covered for recipients with wounds with light to moderate exudate. Typical use is 3 - 4 dressing changes per week per wound. Use A1-A9 modifiers as appropriate.	60 per month	Purchase only	January-09
A6236	Hydrocolloid dressing, wound cover, sterile, pad size more than 48 sq in, without adhesive border, each dressing	Wound care	No	Y - NF N-ICF/DD	Covered for recipients with wounds with light to moderate exudate. Typical use is 3 - 4 dressing changes per week per wound. Use A1-A9 modifiers as appropriate.	60 per month	Purchase only	January-09
A6237	Hydrocolloid dressing, wound cover, sterile, pad size 16 sq in or less, with any size adhesive border, each dressing	Wound care	No	Y - NF N-ICF/DD	Covered for recipients with wounds with light to moderate exudate. Typical use is 3 - 4 dressing changes per week per wound. Use A1-A9 modifiers as appropriate.	60 per month	Purchase only	January-09
A6238	Hydrocolloid dressing, wound cover, sterile, pad size more than 16 sq in but less than 48 sq in, with any size adhesive border, each dressing	Wound care	No	Y - NF N-ICF/DD	Covered for recipients with wounds with light to moderate exudate. Typical use is 3 - 4 dressing changes per week per wound. Use A1-A9 modifiers as appropriate.	60 per month	Purchase only	January-09
A6239	Hydrocolloid dressing, wound cover, sterile, pad size more than 48 sq in, with any size adhesive border, each dressing	Wound care	No	Y - NF N-ICF/DD	Covered for recipients with wounds with light to moderate exudate. Typical use is 3 - 4 dressing changes per week per wound. Use A1-A9 modifiers as appropriate.	60 per month	Purchase only	January-09
A6240	Hydrocolloid dressing, wound filler, paste, sterile, per oz	Wound care	No	Y - NF N-ICF/DD	Covered for recipients with wounds with light to moderate exudate. Typical use is 3 - 4 dressing changes per week per wound with 1 - 2 oz per change. Use A1-A9 modifiers as appropriate.	90 per month	Purchase only	January-09
A6241	Hydrocolloid dressing, wound filler, dry form, sterile, per gram	Wound care	No	Y - NF N-ICF/DD	Covered for recipients with wounds with light to moderate exudate. Typical use is 3 - 4 dressing changes per week per wound with 1 - 2 gram per change. Use A1-A9 modifiers as appropriate.	90 per month	Purchase only	January-09

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A6242	Hydrogel dressing, wound cover, sterile, pad size 16 sq in or less, without adhesive border, each dressing	Wound care	No	Y - NF N-ICF/DD	Covered for recipients with full thickness wounds with minimal or no exudate. Most recipients can be served with 1 dressing change per wound per day. Use A1-A9 modifiers as appropriate	90 per month	Purchase only	January-09
A6243	Hydrogel dressing, wound cover, sterile, pad size more than 16 sq in but less than 48 sq in, without adhesive border, each dressing	Wound care	No	Y - NF N-ICF/DD	Covered for recipients with full thickness wounds with minimal or no exudate. Most recipients can be served with 1 dressing change per wound per day. Use A1-A9 modifiers as appropriate	90 per month	Purchase only	January-09
A6244	Hydrogel dressing, wound cover, sterile, pad size more than 48 sq in, without adhesive border, each dressing	Wound care	No	Y - NF N-ICF/DD	Covered for recipients with full thickness wounds with minimal or no exudate. Most recipients can be served with 1 dressing change per wound per day. Use A1-A9 modifiers as appropriate	90 per month	Purchase only	January-09
A6245	Hydrogel dressing, wound cover, sterile, pad size 16 sq in or less, with any size adhesive border, each dressing	Wound care	No	Y - NF N-ICF/DD	Covered for recipients with full thickness wounds with minimal or no exudate. Most recipients can be served with 3 dressing changes per wound per week. Use A1-A9 modifiers as appropriate	60 per month	Purchase only	January-09
A6246	Hydrogel dressing, wound cover, sterile, pad size more than 16 sq in but less than 48 sq in, with any size adhesive border, each dressing	Wound care	No	Y - NF N-ICF/DD	Covered for recipients with full thickness wounds with minimal or no exudate. Most recipients can be served with 3 dressing changes per wound per week. Use A1-A9 modifiers as appropriate	60 per month	Purchase only	January-09
A6247	Hydrogel dressing, wound cover, sterile, pad size more than 48 sq in, with any size adhesive border, each dressing	Wound care	No	Y - NF N-ICF/DD	Covered for recipients with full thickness wounds with minimal or no exudate. Most recipients can be served with 3 dressing changes per wound per week. Use A1-A9 modifiers as appropriate	60 per month	Purchase only	January-09
A6248	Hydrogel dressing, wound filler, gel, per fluid ounce	Wound care	No	Y - NF N-ICF/DD	Covered for recipients with full thickness wounds with minimal or no exudate. Most recipients can be served with 1 dressing change per wound per day. Use A1-A9 modifiers as appropriate	90 per month	Purchase only	January-11
A6250	Skin sealants, protectants, moisturizers, ointments, any type, any size	Renal Dialysis	No	No	Covered when dispensed by approved dialysis equipment supplier. For indications other than dialysis, must be billed by a pharmacy as a drug. Refer to manual	medical necessity	Purchase only	January-09
A6251	Specialty absorptive dressing, wound cover, sterile, pad size 16 sq in or less, without adhesive border, each dressing	Wound care	No	Y - NF N-ICF/DD	Covered for recipients with moderately or highly exudative wounds. Most recipients can be served with 1 dressing change per day per wound. Use A1-A9 modifiers as appropriate	90 per month	Purchase only	January-09

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A6252	Specialty absorptive dressing, wound cover, sterile, pad size more than 16 sq in but less than 48 sq in, without adhesive border, each dressing	Wound care	No	Y - NF N-ICF/DD	Covered for recipients with moderately or highly exudative wounds. Most recipients can be served with 1 dressing change per day per wound. Use A1-A9 modifiers as appropriate	90 per month	Purchase only	January-09
A6253	Specialty absorptive dressing, wound cover, sterile, pad size more than 48 sq in, without adhesive border, each dressing	Wound care	No	Y - NF N-ICF/DD	Covered for recipients with moderately or highly exudative wounds. Most recipients can be served with 1 dressing change per day per wound. Use A1-A9 modifiers as appropriate	90 per month	Purchase only	January-09
A6254	Specialty absorptive dressing, wound cover, sterile, pad size 16 sq in or less, with any size adhesive border, each dressing	Wound care	No	Y - NF N-ICF/DD	Covered for recipients with moderately or highly exudative wounds. Most recipients can be served with 1 dressing change every other day per wound. Use A1-A9 modifiers as appropriate	90 per month	Purchase only	January-09
A6255	Specialty absorptive dressing, wound cover, sterile, pad size more than 16 sq in but less than 48 sq in, with any size adhesive border, each dressing	Wound care	No	Y - NF N-ICF/DD	Covered for recipients with moderately or highly exudative wounds. Most recipients can be served with 1 dressing change every other day per wound. Use A1-A9 modifiers as appropriate	90 per month	Purchase only	January-09
A6256	Specialty absorptive dressing, wound cover, sterile, pad size more than 48 sq in, with any size adhesive border, each dressing	Wound care	No	Y - NF N-ICF/DD	Covered for recipients with moderately or highly exudative wounds. Most recipients can be served with 1 dressing change every other day per wound. Use A1-A9 modifiers as appropriate	90 per month	Purchase only	January-09
A6257	Transparent film, sterile, 16 sq in or less, each dressing	Wound care	No	Y - NF N-ICF/DD	Covered for recipients with open partial thickness wounds with minimal exudate, or with closed wounds. Typical use is 1 dressing change 3 - 4 times per week per wound. Use A1 - A9 modifiers as appropriate.	60 per month	Purchase only	January-09
A6258	Transparent film, sterile, more than 16 sq in but less than 48 sq in, each dressing	Wound care	No	Y - NF N-ICF/DD	Covered for recipients with open partial thickness wounds with minimal exudate, or with closed wounds. Typical use is 1 dressing change 3 - 4 times per week per wound. Use A1 - A9 modifiers as appropriate.	60 per month	Purchase only	January-09
A6259	Transparent film, sterile, more than 48 sq in, each dressing	Wound care	No	Y - NF N-ICF/DD	Covered for recipients with open partial thickness wounds with minimal exudate, or with closed wounds. Typical use is 1 dressing change 3 - 4 times per week per wound. Use A1 - A9 modifiers as appropriate.	60 per month	Purchase only	January-09

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A6260	Wound cleansers, any type, any size	Wound care	No	Yes	Covered for recipients with wounds. If a legend wound cleanser is prescribed, refer to pharmacy policy. Typical use is 1 per week. Use A1-A9 modifiers as appropriate.	10 per month	Purchase only	January-11
A6261	Wound filler, gel/paste, per fluid ounce, not otherwise specified	Wound care	No	Y - NF N-ICF/DD	Covered for recipients with wounds requiring fillers. Only to be used when a more specific code is not available for wound filler prescribed by the physician. Typical use is less than one ounce per day per wound. Use A1-A9 modifiers as appropriate.	30 per month	Purchase only	January-11
A6262	Wound filler, dry form, per gram, other otherwise specified.	Wound care	No	Y - NF N-ICF/DD	Covered for recipients with wounds requiring fillers. Only to be used when a more specific code is not available for wound filler prescribed by the physician. Typical use is one gram per day per wound. Use A1-A9 modifiers as appropriate.	60 per month	Purchase only	January-11
A6266	Gauze, impregnated, other than water, normal saline, or zinc paste, sterile, any width, per linear yard.	Wound care	No	Yes	Covered for recipients with wounds requiring impregnated gauze for moisture or antimicrobial properties. Most recipients can be served with one dressing change per day. Use A1 - A9 modifiers as appropriate.	60 per month	Purchase only	January-09
A6402	Gauze, nonimpregnated, sterile, pad size 16 sq in or less, without adhesive border, each dressing	Miscellaneous supplies	No	Yes	Covered for recipients with wounds, tracheostomies or other medical conditions requiring gauze pads that require sterile gauze pads. For wound care, most recipients can be served with 3 dressing changes per day. For other indications, most recipients can be served with 12 dressings per day. Use A1-A9 modifiers as appropriate	500 per month	Purchase only	January-09
A6403	Gauze, nonimpregnated, nonsterile, pad size more than 16 sq in but less than or equal to 48 sq in, without adhesive border, each dressing	Wound care	No	Yes	Covered for recipients with wounds that do not require sterile gauze pads. Most recipients can be served with 3 dressing changes per day. Use A1-A9 modifiers as appropriate.	120 per month	Purchase only	January-09
A6404	Gauze, nonimpregnated, nonsterile, pad size more than 48 sq in, without adhesive border, each dressing	Wound care	No	Yes	Covered for recipients with wounds that do not require sterile gauze pads. Most recipients can be served with 3 dressing changes per day. Use A1-A9 modifiers as appropriate.	120 per month	Purchase only	January-09
A6407	Packing strips, nonimpregnated, sterile, up to 2 in in width, per linear yard	Wound care	No	Y - NF N-ICF/DD	Covered for recipients with wounds that require packing for wet-to-dry treatment. Typical use depends on size of wound, most recipients can be served with 30 yards per month. Use A1-A9 modifiers as appropriate	60 per month	Purchase only	January-09
A6410	Eye pad, sterile, each	Miscellaneous supplies	No	Yes	Covered to protect an injured eye from further injury.	30 per month	Purchase only	January-09

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A6411	Eye pad, nonsterile, each	Miscellaneous supplies	No	Yes	Covered to protect an injured eye from further injury.	30 per month	Purchase only	January-09
A6412	Eye pad, occlusive, each	Miscellaneous supplies	No	Yes	Covered to protect an eye from damage due to light, or to treat conditions such as amblyopia	30 per month	Purchase only	January-09
A6413	Adhesive bandage, first-aid type, any size, each	Wound care			Not covered - not efficient use of Medicaid funds			December-07
A6441	Padding bandage, nonelastic, nonwoven/nonknitted, width greater than or equal to 3 in and less than 5 in, per yd	Wound care	No	Y - NF N-ICF/DD	Covered to pad and protect the wound surface. Most recipients can be served with 30 yards per month per wound. Use A1-A9 modifiers as appropriate.	60 per month	Purchase only	January-09
A6442	Conforming bandage, nonelastic, knitted/woven, nonsterile, width less than 3 in, per yd	Wound care	No	Y - NF N-ICF/DD	Covered to wrap wounds and to secure other dressings. Most recipients can be served with 1 yard per dressing change. Use A1-A9 modifiers as appropriate.	120 per month	Purchase only	January-09
A6443	Conforming bandage, nonelastic, knitted/woven, nonsterile, width greater than or equal to 3 in and less than 5 in, per yd	Wound care	No	Y - NF N-ICF/DD	Covered to wrap wounds and to secure other dressings. Most recipients can be served with 1 yard per dressing change. Use A1-A9 modifiers as appropriate.	120 per month	Purchase only	January-09
A6444	Conforming bandage, nonelastic, knitted/woven, nonsterile, width greater than or equal to 5 in, per yd	Wound care	No	Y - NF N-ICF/DD	Covered to wrap wounds and to secure other dressings. Most recipients can be served with 1 yard per dressing change. Use A1-A9 modifiers as appropriate.	120 per month	Purchase only	January-09
A6445	Conforming bandage, nonelastic, knitted/woven, sterile, width less than 3 in, per yd	Wound care	No	Y - NF N-ICF/DD	Covered to wrap wounds and to secure other dressings. Most recipients can be served with 1 yard per dressing change. Use A1-A9 modifiers as appropriate.	120 per month	Purchase only	January-09
A6446	Conforming bandage, nonelastic, knitted/woven, sterile, width greater than or equal to 3 in and less than 5 in, per yd	Wound care	No	Y - NF N-ICF/DD	Covered to wrap wounds and to secure other dressings. Most recipients can be served with 1 yard per dressing change. Use A1-A9 modifiers as appropriate.	120 per month	Purchase only	January-09
A6447	Conforming bandage, nonelastic, knitted/woven, sterile, width greater than or equal to 5 in, per yd	Wound care	No	Y - NF N-ICF/DD	Covered to wrap wounds and to secure other dressings. Most recipients can be served with 1 yard per dressing change. Use A1-A9 modifiers as appropriate.	120 per month	Purchase only	January-09

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A6448	Light compression bandage, elastic, knitted/woven, width less than 3 in, per yd	Miscellaneous supplies	No	Y - NF N-ICF/DD	Covered for support for conditions such as sprains, strains and venous ulcers. Most recipients who do not have a multi-layer bandage system can be served with 2 per week. Recipients using a multi-layer bandage system may need to change dressings up to twice per day. Use A1-A9 modifiers as appropriate.	60 per month	Purchase only	January-09
A6449	Light compression bandage, elastic, knitted/woven, width greater than or equal to 3 in and less than 5 in, per yd	Miscellaneous supplies	No	Y - NF N-ICF/DD	Covered for support for conditions such as sprains, strains and venous ulcers. Most recipients who do not have a multi-layer bandage system can be served with 2 per week. Recipients using a multi-layer bandage system may need to change dressings up to twice per day. Use A1-A9 modifiers as appropriate.	60 per month	Purchase only	January-09
A6450	Light compression bandage, elastic, knitted/woven, width greater than or equal to 5 in, per yd	Miscellaneous supplies	No	Y - NF N-ICF/DD	Covered for support for conditions such as sprains, strains and venous ulcers. Most recipients who do not have a multi-layer bandage system can be served with 2 per week. Recipients using a multi-layer bandage system may need to change dressings up to twice per day. Use A1-A9 modifiers as appropriate.	60 per month	Purchase only	January-09
A6451	Moderate compression bandage, elastic, knitted/woven, load resistance of 1.25 to 1.34 fl lbs at 50% maximum stretch, width greater than or equal to 3 in and less than 5 in, per yd	Miscellaneous supplies	No	Y - NF N-ICF/DD	Covered for support for conditions such as sprains, strains and venous ulcers. Most recipients who do not have a multi-layer bandage system can be served with 2 per week. Recipients using a multi-layer bandage system may need to change dressings up to twice per day. Use A1-A9 modifiers as appropriate.	60 per month	Purchase only	January-09
A6452	High compression bandage, elastic, knitted/woven, load resistance greater than or equal to 1.35 ft lbs at 50% maximum stretch, width greater than or equal to 3 in and less than 5 in, per yd.	Miscellaneous supplies	No	Y - NF N-ICF/DD	Covered for support for conditions such as sprains, strains and venous ulcers. Most recipients who do not have a multi-layer bandage system can be served with 2 per week. Recipients using a multi-layer bandage system may need to change dressings up to twice per day. Use A1-A9 modifiers as appropriate.	60 per month	Purchase only	January-09
A6453	Self-adherent bandage, elastic, nonknitted/nonwoven, width less than 3 in, per yd	Miscellaneous supplies	No	Y - NF N-ICF/DD	Covered for support for conditions such as sprains, strains and venous ulcers. Most recipients who do not have a multi-layer bandage system can be served with 1 - 2 per week. Recipients using a multi-layer bandage system may need to change dressings up to twice per day. Use A1-A9 modifiers as appropriate.	60 per month	Purchase only	January-09

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A6454	Self-adherent bandage, elastic, nonknitted/nonwoven, width greater than or equal to 3 in and less than 5 in, per yd	Miscellaneous supplies	No	Y - NF N-ICF/DD	Covered for support for conditions such as sprains, strains and venous ulcers. Most recipients who do not have a multi-layer bandage system can be served with 1 - 2 per week. Recipients using a multi-layer bandage system may need to change dressings up to twice per day. Use A1-A9 modifiers as appropriate.	60 per month	Purchase only	January-09
A6455	Self-adherent bandage, elastic, nonknitted/nonwoven, width greater than or equal to 5 in, per yd	Miscellaneous supplies	No	Y - NF N-ICF/DD	Covered for support for conditions such as sprains, strains and venous ulcers. Most recipients who do not have a multi-layer bandage system can be served with 1 - 2 per week. Recipients using a multi-layer bandage system may need to change dressings up to twice per day. Use A1-A9 modifiers as appropriate.	60 per month	Purchase only	January-09
A6456	Zinc paste impregnated bandage, nonelastic, knitted/woven, width greater than or equal to 3 in and less than 5 in, per yd	Miscellaneous supplies	No	Y - NF N-ICF/DD	Covered for recipients for whom a soft, flexible wrap is required. Most recipients can be served with 30 yards per month. Use A1-A9 modifiers as appropriate	60 per month	Purchase only	January-09
A6457	Tubular dressing with or without elastic, any width, per linear yd	Wound care	No	Yes	Covered for recipients who require a tubular dressing to secure a dressing. Use A1-A9 modifiers as appropriate	90 per month	Purchase only	January-09
A6501	Compression burn garment, bodysuit (head to foot), custom fabricated	Burn treatment	No	No	Covered for recipients with burn injuries. Most recipients can be served with 1 per 3 months	1 per month	Purchase only	January-09
A6502	Compression burn garment, chin strap, custom fabricated	Burn treatment	No	No	Covered for recipients with burn injuries. Most recipients can be served with 1 per 3 months	1 per month	Purchase only	January-09
A6503	Compression burn garment, facial hood, custom fabricated	Burn treatment	No	No	Covered for recipients with burn injuries. Most recipients can be served with 1 per 3 months	1 per month	Purchase only	January-09
A6504	Compression burn garment, glove to wrist, custom fabricated	Burn treatment	No	No	Covered for recipients with burn injuries. Most recipients can be served with 2 per 3 months	2 per month	Purchase only	January-09
A6505	Compression burn garment, glove to elbow, custom fabricated	Burn treatment	No	No	Covered for recipients with burn injuries. Most recipients can be served with 2 per 3 months	2 per month	Purchase only	January-09
A6506	Compression burn garment, glove to axilla, custom fabricated	Burn treatment	No	No	Covered for recipients with burn injuries. Most recipients can be served with 2 per 3 months	2 per month	Purchase only	January-09
A6507	Compression burn garment, foot to knee length, custom fabricated	Burn treatment	No	No	Covered for recipients with burn injuries. Most recipients can be served with 2 per 3 months	2 per month	Purchase only	January-09

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A6508	Compression burn garment, foot to thigh length, custom fabricated	Burn treatment	No	No	Covered for recipients with burn injuries. Most recipients can be served with 2 per 3 months	2 per month	Purchase only	January-09
A6509	Compression burn garment, upper trunk to waist, including arm openings (vest), custom fabricated	Burn treatment	No	No	Covered for recipients with burn injuries. Most recipients can be served with 1 per 3 months	1 per month	Purchase only	January-09
A6510	Compression burn garment, trunk, including arms down to leg openings (leotard), custom fabricated	Burn treatment	No	No	Covered for recipients with burn injuries. Most recipients can be served with 1 per 3 months	1 per month	Purchase only	January-09
A6511	Compression burn garment, lower trunk including leg openings (panty), custom fabricated	Burn treatment	No	No	Covered for recipients with burn injuries. Most recipients can be served with 1 per 3 months	1 per month	Purchase only	January-09
A6512	Compression burn garment, not otherwise classified	Burn treatment	No	No	Covered for recipients with burn injuries. Most recipients can be served with 1 per 3 months	1 per month	Purchase only	January-09
A6513	Compression burn mask, face and/or neck, plastic or equal, custom fabricated	Burn treatment	No	No	Covered for recipients with burn injuries. Most recipients can be served with 1 per 3 months	1 per month	Purchase only	January-09
A6530	Gradient compression stocking, below knee, 18 - 30 mm Hg, each	Compression devices	No	No	Covered for recipients requiring mild compression. Most recipients can be served with 2 pair (4 units) per 6 months.	4 units per 3 months	Purchase only	January-09
A6531	Gradient compression stocking, below knee, 30 - 40 mm Hg, each	Compression devices	No	No	Covered for recipients requiring firm compression. Most recipients can be served with 2 pair (4 units) per 6 months	4 units per 3 months	Purchase only	January-09
A6532	Gradient compression stocking, below knee, 40 - 50 mm Hg, each	Compression devices	No	No	Covered for recipients requiring extra firm compression. Most recipients can be served with 2 pair (4 units) per 6 months.	4 units per 3 months	Purchase only	January-09
A6533	Gradient compression stocking, thigh length, 18 - 30 mm Hg, each	Compression devices	No	No	Covered for recipients requiring mild compression. Most recipients can be served with 2 pair (4 units) per 6 months.	4 units per 3 months	Purchase only	January-09
A6534	Gradient compression stocking, thigh length, 30 - 40 mm Hg, each	Compression devices	No	No	Covered for recipients requiring firm compression. Most recipients can be served with 2 pair (4 units) per 6 months	4 units per 3 months	Purchase only	January-09

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A6535	Gradient compression stocking, thigh length, 40 - 50 mm Hg, each	Compression devices	No	No	Covered for recipients requiring extra firm compression. Most recipients can be served with 2 pair (4 units) per 6 months.	4 units per 3 months	Purchase only	January-09
A6536	Gradient compression stocking, full-length/chap style, 18 - 30 mm Hg, each	Compression devices	No	No	Covered for recipients requiring mild compression. Most recipients can be served with 2 units per 6 months.	2 units per 3 months	Purchase only	January-09
A6537	Gradient compression stocking, full-length/chap style, 30 - 40 mm Hg, each	Compression devices	No	No	Covered for recipients requiring firm compression. Most recipients can be served with 2 units per 6 months	2 units per 3 months	Purchase only	January-09
A6538	Gradient compression stocking, full-length/chap style, 40 - 50 mm Hg, each	Compression devices	No	No	Covered for recipients requiring extra firm compression. Most recipients can be served with 2 units per 6 months.	2 units per 3 months	Purchase only	January-09
A6539	Gradient compression stocking, waist length, 18 - 30 mm Hg, each	Compression devices	No	No	Covered for recipients requiring mild compression. Most recipients can be served with 2 units per 6 months.	2 units per 3 months	Purchase only	January-09
A6540	Gradient compression stocking, waist length, 30 - 40 mm Hg, each	Compression devices	No	No	Covered for recipients requiring firm compression. Most recipients can be served with 2 units per 6 months	2 units per 3 months	Purchase only	January-09
A6541	Gradient compression stocking, waist length, 40 - 50 mm Hg, each	Compression devices	No	No	Covered for recipients requiring extra firm compression. Most recipients can be served with 2 units per 6 months.	2 units per 3 months	Purchase only	January-09
A6544	Gradient compression stocking, garter belt	Compression devices	No	No	Covered for recipients with gradient compression stockings who require a garter belt to secure the stockings. Most recipients can be served with 1 per 6 months.	1 per 3 months	Purchase only	January-09
A6545	Gradient compression wrap, non-elastic, below knee, 30-50 mm Hg, each	Compression devices	No	No	Covered when medically necessary for treatment of venous disease of the lower extremities including active venous stasis ulcers and lymphedema. Most recipients can be served with 2 units per 6 months for each leg.	4 units per 3 months	Purchase only	December-08
A6549	Gradient compression stocking/sleeve, not otherwise specified	Compression devices	No	No	Covered for recipients requiring compression only when a more specific code is not available. Most recipients can be served with 4 units per 6 months.	4 units per 3 months	Purchase only	January-10
A6550	Wound care set, for negative pressure wound therapy electrical pump, includes all supplies and accessories	Wound care	No	No	Covered for recipients using approved negative pressure wound therapy (E2402). Typical care requires changing dressings used with negative pressure wound therapy 3 times per week per wound. Documentation must support dressing changes over 15 per month. Includes all dressings and tubing required for treatment.	30 per month	Purchase only	January-09

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A7000	Canister, disposable, used with suction pump	Miscellaneous supplies	No	Y - NF N-ICF/DD	Covered for recipients using suction pumps. Most recipients can be served with 10 per month. Recipients with frequent suctioning may require additional. When used with negative pressure wound therapy device, additional canisters are appropriate when wound exudate exceeds 90 ml per day.	30 per month	Purchase only	January-09
A7001	Canister, nondisposable, used with suction pump	Miscellaneous supplies	No	Y - NF N-ICF/DD	Covered for recipients using suction pumps. Most recipients can be served with 1 per 2 - 3 months.	1 per month	Purchase only	January-09
A7002	Tubing, used with suction pump, each	Miscellaneous supplies	No	Y - NF N-ICF/DD	Covered for recipients using suction pumps. Most recipients can be served with 1 - 2 per month. Recipients with 2 suction pumps or with significant risk of infection may need 4 per month.	4 per month	Purchase only	January-09
A7003	Administration set, with small volume nonfiltered pneumatic nebulizer, disposable	Nebulizer	No	Y - NF N-ICF/DD	Covered for recipients requiring nebulized administration of medications using E0570 or E0571. Most recipients can be served with 1 per week, additional quantities may be required for children receiving nebulizer treatments at school and home, or for recipients receiving multiple medications via nebulizer. Includes lid, jar, baffles, tubing, T-piece and mouthpiece. Used with A7003	15 per month	Purchase only	January-09
A7004	Small volume nonfiltered nebulizer, disposable	Nebulizer	No	Y - NF N-ICF/DD	Covered for recipients requiring nebulized administration of medications using E0570 or E0571. Most recipients can be served with 1 per week, additional quantities may be required for children receiving nebulizer treatments at school and home, or for recipients receiving multiple medications via nebulizer. Includes lid, jar, baffles. Used with A7003	15 per month	Purchase only	January-09
A7005	Administration set, with small volume nonfiltered pneumatic nebulizer, nondisposable	Nebulizer	No	Y - NF N-ICF/DD	Covered for recipients requiring nebulized administration of medications using K0730, E0570 or E0571. Most recipients can be served with 1 per 6 months, additional quantities may be required for children receiving nebulizer treatments at school and home, or for recipients receiving multiple medications via nebulizer. Includes lid, jar, baffles, tubing, T-piece and mouthpiece.	1 per month	Purchase only	January-09
A7006	Administration set, with small volume filtered pneumatic nebulizer	Nebulizer	No	Y - NF N-ICF/DD	Covered for recipients requiring nebulized administration of medications using E0565, E0570, E0571, E0572 or E0585. Most recipients can be served with 1 per month, additional quantities may be required for children receiving nebulizer treatments at school and home, or for recipients receiving multiple medications via nebulizer. Includes filter, lid, jar, baffles, tubing, T-piece and mouthpiece.	1 per month	Purchase only	January-09

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A7007	Large volume nebulizer, disposable, unfilled, used with aerosol compressor	Nebulizer	No	Y - NF N-ICF/DD	Covered for recipients requiring nebulized administration of humidified gas and medications using E0565. Most recipients can be served with 2 per month, additional quantities may be required for children receiving nebulizer treatments at school and home, or for recipients receiving multiple medications via nebulizer. Not to be billed with E0585	6 per month	Purchase only	January-09
A7008	Large volume nebulizer, disposable, prefilled, used with aerosol compressor	Nebulizer	No	Y - NF N-ICF/DD	Covered for recipients requiring nebulized administration of humidified gas and medications using E0565 only when there is a compelling reason why neither the patient nor the caregiver can perform the fill. Not to be billed with E0585	31 per month	Purchase only	January-09
A7009	Reservoir bottle, non-disposable, used with large volume ultrasonic nebulizer	Nebulizer	No	Y - NF N-ICF/DD	Covered for recipients with cystic fibrosis using large volume ultrasonic nebulizers (E0575) for delivery of Tobramycin. Because there is no proven medical benefit to nebulizing particles of other drugs to diameters smaller than achievable with a pneumatic model, ultrasonic nebulizers and associated supplies are not covered for recipients with other diagnoses. Most recipients can be served with 1 every 2 - 3 months	1 per month	Purchase only	January-09
A7010	Corrugated tubing, disposable, used with large volume nebulizer, 100 feet	Nebulizer	No	Y - NF N-ICF/DD	Covered for recipients requiring nebulized administration of humidified gas and medications using E0565 or E0585. Most recipients can be served with 1 per 2 months.	1 per month	Purchase only	January-09
A7011	Corrugated tubing, non-disposable, used with large volume nebulizer, 10 feet	Nebulizer	No	Y - NF N-ICF/DD	Covered for recipients requiring nebulized administration of humidified gas and medications using E0565 or E0585. Most recipients can be served with 1 per year.	1 per 6 months	Purchase only	January-09
A7012	Water collection device used with large volume nebulizer	Nebulizer	No	Y - NF N-ICF/DD	Covered for recipients requiring nebulized administration of humidified gas and medications using E0565 or E0585. Most recipients can be served with 2 per month.	4 per month	Purchase only	January-09
A7013	Filter, disposable, with aerosol compressor or ultrasonic generator	Nebulizer	No	Y - NF N-ICF/DD	Covered for recipients requiring nebulized administration of medications using E0565, E0570, E0571, E0572, E0574 or E0585. Most recipients can be served with 2 per month, additional quantities may be required for children receiving nebulizer treatments at school and home.	4 per month	Purchase only	January-11
A7014	Filter, non-disposable, used with aerosol compressor or ultrasonic generator	Nebulizer	No	Y - NF N-ICF/DD	Covered for recipients requiring nebulized administration of medications using E0565, E0570, E0571, E0572, or E0585, or for recipients with cystic fibrosis using ultrasonic nebulizers (E0574, E0575) for delivery of Tobramycin. Most recipients can be served with 1 per 2 -3 months, additional quantities may be required for children receiving nebulizer treatments at school and home..	1 per month	Purchase only	January-09

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A7015	Aerosol mask, used with DME nebulizer	Nebulizer	No	Y - NF N-ICF/DD	Covered for recipients requiring nebulized administration of medications. Most recipients can be served with 1 per month.	15 per month	Purchase only	January-09
A7016	Dome and mouthpiece, used with small volume ultrasonic nebulizer	Nebulizer	No	Y - NF N-ICF/DD	Covered for recipients with cystic fibrosis using small volume ultrasonic nebulizers (E0574) for delivery of Tobramycin. Because there is no proven medical benefit to nebulizing particles of other drugs to diameters smaller than achievable with a pneumatic model, ultrasonic nebulizers and associated supplies are not covered for recipients with other diagnoses. Most recipients can be served with 1 per 6 months.	1 per 3 months	Purchase only	January-09
A7017	Nebulizer, durable, glass or autoclavable plastic, bottle type, not used with oxygen	Nebulizer	No	Y - NF N-ICF/DD	Covered for recipients requiring nebulized administration of medications using E0565. Most recipients can be served with 1 per 2 - 3 years. Not to be billed with E0585.	1 per year	Purchase only	January-09
A7018	Water, distilled, used with large volume nebulizer, 1000 ml	Nebulizer	No	Yes	Covered for recipients requiring nebulized administration of medications using E0565 or E0585, or for recipients with cystic fibrosis using E0575 for delivery of Tobramycin. Most recipients can be served with 20 units (20 liters) per month.	30 units (30 liters) per month	Purchase only	January-09
A7020	Interface for cough stimulating device, includes all components, replacement only	Respiratory	No	No	Covered when needed for use with a patient-owned cough stimulating device. Most patients can be served with 1 every 2 months. Breathing circuit includes tubing, filter and patient interface (face mask, mouthpiece or tracheal adapter)	1 per month	Purchase only	January-11
A7025	High frequency chest wall oscillation system vest, replacement for use with patient-owned equipment, each	Respiratory	Always	No	Covered for recipients with patient owned high frequency chest wall oscillation air-pulse generator systems (E0483). Cannot be billed with E0483. Authorization for replacement vest will only be considered when the current vest is broken beyond repair and not under warranty. Refer to manual.	1 per 3 years	Purchase only	January-09
A7026	High frequency chest wall oscillation system hose, replacement for use with patient-owned equipment, each	Respiratory	No	No	Covered for recipients with patient owned high frequency chest wall oscillation air-pulse generator systems (E0483). Cannot be billed with E0483. Hoses are expected to last 2 years. Refer to manual.	1 per year	Purchase only	January-09
A7027	Combination oral/nasal mask, used with continuous positive airway pressure device, each	Positive Airway Pressure	No	No	Covered for recipient with PAP device due to a diagnosis of sleep apnea made by a physician with experience diagnosing and treating sleep apnea. Most recipients can be served with 1 per 6 months. Suppliers must verify with the recipient that the PAP device is still in use, and that a new mask is required because the existing mask is damaged or otherwise worn out.	1 per dispensing, up to 3 per 365 days	Purchase only	January-09

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A7028	Oral cushion for combination oral/nasal mask, replacement only, each	Positive Airway Pressure	No	No	Covered for recipient with PAP device and combination oral/nasal mask due to a diagnosis of sleep apnea made by a physician with experience diagnosing and treating sleep apnea. Most recipients can be served with 1 per 1 - 2 months. Suppliers must verify with the recipient that the PAP device is still in use, and that a new oral cushion is required because the existing cushion is damaged or otherwise worn out.	1 per month	Purchase only	January-09
A7029	Nasal pillows for combination oral/nasal mask, replacement only, pair	Positive Airway Pressure	No	No	Covered for recipient with PAP device and combination oral/nasal mask due to a diagnosis of sleep apnea made by a physician with experience diagnosing and treating sleep apnea. Most recipients can be served with 1 pair per 1 - 2 months. Suppliers must verify with the recipient that the PAP device is still in use, and that new nasal pillows are required because the existing pillows are damaged or otherwise worn out. 1 unit equals 1 pair of nasal pillows.	1 unit (1 pair) per month	Purchase only	January-09
A7030	Full face mask used with positive airway pressure device, each	Positive Airway Pressure	No	No	Covered for recipient with PAP device due to a diagnosis of sleep apnea made by a physician with experience diagnosing and treating sleep apnea. Most recipients can be served with 1 per 6 months. Suppliers must verify with the recipient that the CPAP device is still in use, and that a new mask is required because the existing mask is damaged or otherwise worn out.	1 per dispensing, up to 3 per 365 days	Purchase only	January-09
A7031	Face mask interface, replacement for full face mask, each	Positive Airway Pressure	No	No	Covered for recipient with PAP device and full face mask due to a diagnosis of sleep apnea made by a physician with experience diagnosing and treating sleep apnea. Most recipients can be served with 1 per 1 - 2 months. Suppliers must verify with the recipient that the PAP device is still in use, and that a new interface is required because the existing interface is damaged or otherwise worn out.	1 per month	Purchase only	January-09
A7032	Cushion for use on nasal mask interface, replacement only, each	Positive Airway Pressure	No	No	Covered for recipient with PAP device and nasal mask interface due to a diagnosis of sleep apnea made by a physician with experience diagnosing and treating sleep apnea. Most recipients can be served with 1 per 1 - 2 months. Suppliers must verify with the recipient that the PAP device is still in use, and that a new cushion is required because the existing cushion is damaged or otherwise worn out.	1 per month	Purchase only	January-09



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A7033	Pillow for use on nasal cannula type interface, replacement only, pair	Positive Airway Pressure	No	No	Covered for recipient with PAP device and nasal cannula interface due to a diagnosis of sleep apnea made by a physician with experience diagnosing and treating sleep apnea. Most recipients can be served with 1 per 1 - 2 months. Suppliers must verify with the recipient that the PAP device is still in use, and that new pillows are required because the existing pillows are damaged or otherwise worn out. 1 unit = 1 pair	1 unit (1 pair) per month	Purchase only	January-09
A7034	Nasal interface (mask or cannula type) used with positive airway pressure device, with or without head strap	Positive Airway Pressure	No	No	Covered for recipient with PAP device due to a diagnosis of sleep apnea made by a physician with experience diagnosing and treating sleep apnea. Most recipients can be served with 1 per 6 months. Suppliers must verify with the recipient that the PAP device is still in use, and that a new mask is required because the existing mask is damaged or otherwise worn out.	1 per dispensing, up to 3 per 365 days	Purchase only	January-09
A7035	Headgear used with positive airway pressure device	Positive Airway Pressure	No	No	Covered for recipient with PAP device due to a diagnosis of sleep apnea made by a physician with experience diagnosing and treating sleep apnea. Most recipients can be served with 1 per year. Suppliers must verify with the recipient that the PAP device is still in use, and that a new headgear is required because the existing headgear is damaged or otherwise worn out.	1 per dispensing, up to 3 per 365 days	Purchase only	January-09
A7036	Chinstrap used with positive airway pressure device	Positive Airway Pressure	No	No	Covered for recipient with PAP device due to a diagnosis of sleep apnea made by a physician with experience diagnosing and treating sleep apnea. Most recipients can be served with 1 per year. Suppliers must verify with the recipient that the PAP device is still in use, and that a new chinstrap is required because the existing chinstrap is damaged or otherwise worn out.	1 per 6 months	Purchase only	January-09
A7037	Tubing used with positive airway pressure device	Positive Airway Pressure	No	No	Covered for recipient with PAP device due to a diagnosis of sleep apnea made by a physician with experience diagnosing and treating sleep apnea. Most recipients can be served with 1 per 3 months. Suppliers must verify with the recipient that the PAP device is still in use, and that new tubing is required because the existing tubing is damaged or otherwise worn out.	1 per month	Purchase only	January-09
A7038	Filter, disposable, used with positive airway pressure device	Positive Airway Pressure	No	No	Covered for recipient with PAP device due to a diagnosis of sleep apnea made by a physician with experience diagnosing and treating sleep apnea. Most recipients can be served with 2 per month. Suppliers must verify with the recipient that the PAP device is still in use.	3 per month	Purchase only	January-09



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A7039	Filter, non-disposable, used with positive airway pressure device	Positive Airway Pressure	No	No	Covered for recipient with PAP device due to a diagnosis of sleep apnea made by a physician with experience diagnosing and treating sleep apnea. Most recipients can be served with 1 per 6 months. Suppliers must verify with the recipient that the PAP device is still in use.	1 per dispensing, up to 3 per 365 days	Purchase only	January-09
A7040	One way chest drain valve	Miscellaneous supplies	No	No	Covered for recipient with chest tube.	1 per month	Purchase only	January-09
A7041	Water seal drainage container and tubing for use with implanted chest tub	Miscellaneous supplies	No	No	Covered for recipient with chest tube.	1 per month	Purchase only	January-09
A7042	Implanted pleural catheter, each	Miscellaneous supplies			Not dispensed by medical supply providers			January-09
A7043	Vacuum drainage bottle and tubing for use with implanted catheter	Miscellaneous supplies	No	No	Covered for recipient with pleural drainage catheter	2 per month	Purchase only	October-10
A7044	Oral interface used with positive airway pressure device, each	Positive Airway Pressure	No	No	Covered for recipient with PAP device due to a diagnosis of sleep apnea made by a physician with experience diagnosing and treating sleep apnea. Most recipients can be served with 1 per 3 - 4 months. Suppliers must verify with the recipient that the PAP device is still in use.	1 per dispensing, up to 3 per 365 days	Purchase only	January-09
A7045	Exhalation port with or without swivel used with accessories for positive airway devices, replacement only	Positive Airway Pressure	No	No	Covered for recipient with PAP device due to a diagnosis of sleep apnea made by a physician with experience diagnosing and treating sleep apnea. Most recipients need no more than 1 per year. Suppliers must verify with the recipient that the PAP device is still in use.	1 per 6 months	Purchase only	January-09
A7046	Water chamber for humidifier, used with positive airway pressure device, replacement, each	Positive Airway Pressure	No	Y - NF N-ICF/DD	Covered for recipient with PAP device due to a diagnosis of sleep apnea made by a physician with experience diagnosing and treating sleep apnea. Most recipients need no more than 1 per 3 - 6 months. Recipients who receive positive airway pressure via invasive interface may need 1 per month or 1 per week if there is significant risk of infection. Suppliers must verify with the recipient that the PAP device is still in use.	5 per month	Purchase only	January-09
A7501	Tracheostoma valve, including diaphragm, each	Tracheostomy supplies	No	Y - NF N-ICF/DD	Covered for recipients with laryngectomy. Typical use is one per year.	1 per 6 months	Purchase only	January-09
A7502	Replacement diaphragm/faceplate for tracheostoma valve, each	Tracheostomy supplies	No	Y - NF N-ICF/DD	Covered for recipients with laryngectomy. Typical use is one per year.	1 per 6 months	Purchase only	January-09

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A7503	Filter holder or filter cap, reusable, for use in a tracheostoma heat and moisture exchange system, each	Tracheostomy supplies	No	Y - NF N-ICF/DD	Covered for recipients with tracheostoma using heat and moisture exchange system. Typical use is one per 3 months.	1 per month	Purchase only	January-09
A7504	Filter for use in a tracheostoma heat and moisture exchange system, each	Tracheostomy supplies	No	Y - NF N-ICF/DD	Covered for recipients with tracheostoma using heat and moisture exchange system. Typical use is one per day.	30 per month	Purchase only	January-09
A7505	Housing, reusable without adhesive, for use in a heat and moisture exchange system and/or with a tracheostoma valve, each	Tracheostomy supplies	No	Y - NF N-ICF/DD	Covered for recipients with tracheostoma using heat and moisture exchange system or a tracheostoma valve. Typical use is one per month.	1 per month	Purchase only	January-09
A7506	Adhesive disc for use in a heat and moisture exchange system and/or with tracheostoma valve, any type, each	Tracheostomy supplies	No	Y - NF N-ICF/DD	Covered for recipients with tracheostoma using heat and moisture exchange system or a tracheostoma valve. Typical use is one per day.	30 per month	Purchase only	January-09
A7507	Filter holder and integrated filter without adhesive, for use in a tracheostoma heat and moisture exchange system, each	Tracheostomy supplies	No	Y - NF N-ICF/DD	Covered for recipients with tracheostoma using heat and moisture exchange system. Typical use is one per day.	90 per month	Purchase only	January-09
A7508	Housing and integrated adhesive, for use in a tracheostoma heat and moisture exchange system and/or with a tracheostoma valve, each	Tracheostomy supplies	No	Y - NF N-ICF/DD	Covered for recipients with tracheostoma using heat and moisture exchange system. Typical use is one per 2 - 3 days.	20 per month	Purchase only	January-09
A7509	Filter holder and integrated filter and adhesive, for use as a tracheostoma heat and moisture exchange system, each	Tracheostomy supplies	No	Y - NF N-ICF/DD	Covered for recipients with tracheostoma using heat and moisture exchange system. Typical use is one per day.	30 per month	Purchase only	January-09
A7520	Tracheostomy/laryngectomy tube, non-cuffed, polyvinylchloride (PVC), silicone or equal, each	Tracheostomy supplies	No	No	Covered for recipients with tracheostoma. Usual quantity is two per month. Refer to miscellaneous codes section of MHCP Provider Manual when dispensing specialized items.	5 per month	Purchase only	January-09
A7521	Tracheostomy/laryngectomy tube, cuffed, polyvinylchloride (PVC), silicone or equal, each	Tracheostomy supplies	No	No	Covered for recipients with tracheostoma. Usual quantity is two per month. Refer to miscellaneous codes section of MHCP Provider Manual when dispensing specialized items.	5 per month	Purchase only	January-09

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A7522	Tracheostomy/laryngectomy tube, stainless steel or equal (sterilizable and reusable), each	Tracheostomy supplies	No	No	Covered for recipients with tracheostoma. Usual quantity is one per month.	2 per month	Purchase only	January-09
A7523	Tracheostomy shower protector, each	Tracheostomy supplies	No	Yes	Covered for recipients with tracheostoma. Usual quantity is one per year.	1 per 6 months	Purchase only	January-09
A7524	Tracheostomy stent/stud/button, each	Tracheostomy supplies	No	No	Covered for recipients with tracheostoma. Usual quantity is one per year.	1 per month	Purchase only	January-09
A7525	Tracheostomy mask, each	Tracheostomy supplies	No	No	Covered for recipients with tracheostoma who use a nebulizer. Usual quantity is one per day.	30 per month	Purchase only	January-09
A7526	Tracheostomy tube collar/holder, each	Tracheostomy supplies	No	No	Covered for recipients with tracheostoma. Usual quantity is one per day.	30 per month	Purchase only	January-09
A7527	Trachostomy / laryngectomy tube / stop, each	Tracheostomy supplies	No	No	Covered for recipients with tracheostoma. Usual quantity is one per 2 - 3 months.	1 per month	Purchase only	January-09
A8000	Helmet, protective, soft, prefabricated, includes all components and accessories	Miscellaneous supplies	No	No	Covered for recipients at risk of head injury due to medical condition such as seizures or developmental disability. Most recipients over age 2 can be served with 1 per year. Recipients under age 2 may need more frequent replacements	1 per 3 months	Purchase only	January-09
A8001	Helmet, protective, hard, prefabricated, includes all components and accessories	Miscellaneous supplies	No	No	Covered for recipients at risk of head injury due to medical condition such as seizures or developmental disability. Most recipients over age 2 can be served with 1 per year. Recipients under age 2 may need more frequent replacements	1 per 3 months	Purchase only	January-09
A8002	Helmet, protective, soft, custom fabricated, includes all components and accessories	Miscellaneous supplies	No	No	Covered for recipients at risk of head injury due to medical condition such as seizures or developmental disability. Most recipients over age 2 can be served with 1 per year. Recipients under age 2 may need more frequent replacements. Document why a prefabricated helmet will not work for the recipient.	1 per 3 months	Purchase only	January-09
A8003	Helmet, protective, hard, custom fabricated, includes all components and accessories	Miscellaneous supplies	No	No	Covered for recipients at risk of head injury due to medical condition such as seizures or developmental disability. Most recipients over age 2 can be served with 1 per year. Recipients under age 2 may need more frequent replacements. Document why a prefabricated helmet will not work for the recipient.	1 per 3 months	Purchase only	January-09
A8004	Soft interface for helmet, replacement only	Miscellaneous supplies	No	No	Covered for recipients with protective helmets because they are at risk of head injury due to medical condition such as seizures or developmental disability. Most recipients can be billed with 1 per 6 months. Not to be billed with A8000-A8003.	1 per 6 months	Purchase only	January-09

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A9155	Artificial saliva, 30 ml	Miscellaneous supplies	Sometimes - see manual	No	Covered for recipients with mucositis caused by radiation therapy or chemotherapy, or with chronic dryness of the mouth or throat which has not responded to other treatments. Most individuals can be served with 120 units per month (treatment 4 times daily). Request Prior Authorization if quantity greater than 150 units per month is required.	150 units per month	Purchase only	October-09
A9270	Noncovered item or service	Miscellaneous supplies			Not covered by definition. For recipients for whom MHCP is not the first payer, do not bill A9270 to first payer and then change HCPCS when billing MHCP. Coding on remittance advice from primary payer(s) must match coding on claim to MHCP			January-09
A9272	Mechanical wound suction, disposable, includes dressings, all accessories and components, each	Wound care			Not covered. Investigative.			January-12
A9273	Hot water bottle, ice cap or collar, heat and/or cold wrap, any type	Cold or heat therapy	No	Yes	Effective 1/1/2011, replaces E0220, E0230 and E0238. Covered for recipients who require application of heat or cold for treatment of a medical condition	1 heat and 1 cold device per year	Purchase only	January-11
A9274	External ambulatory insulin delivery system, disposable, each, includes all supplies and accessories	diabetes			Not covered. Not efficient use of Medicaid funds. Cost of this system over 4 years is greater than cost of E0784 plus infusion sets over 4 years			December-07
A9275	Home glucose disposable meter, includes test strips	diabetes	No	Yes	Covered for insulin dependent diabetics. Refer to manual	4 per month	Purchase only	February-08
A9276	Sensor, invasive (e.g. subcutaneous), disposable, for use with interstitial continuous glucose monitor, one unit = 1 day supply	diabetes	no	Yes	Covered for insulin dependent diabetics with a history of hypoglycemic unawareness. Refer to manual.	31 per month	Purchase only	August-10
A9277	Transmitter, external, for use with interstitial continuous glucose monitor	diabetes	Always	Yes	Covered for insulin dependent diabetics with a history of hypoglycemic unawareness. Refer to manual.	31 per month	Purchase only	March-09
A9278	Receiver (monitor), external, for use with interstitial continuous glucose monitoring system	diabetes	Always	Yes	Covered for insulin dependent diabetics with a history of hypoglycemic unawareness. Refer to manual.	31 per month	Purchase only	March-09



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A9279	Monitoring feature / device, stand-alone or integrated, any type, includes all accessories, components and electronics, not otherwise classified	Miscellaneous supplies			Not covered. Replacement / repair of monitoring feature of DME item should be billed with the HCPCS code of that item and appropriate modifiers. Payment rates for DME item include all features. No separate payment is made.			January-09
A9280	Alert or alarm device	Miscellaneous supplies			Not covered. Replacement / repair of alert or alarm feature of DME item should be billed with the HCPCS code of that item and appropriate modifiers.			January-09
A9282	Wig, any type, each	Wigs	No	No	Covered for recipients with alopecia areata only, diagnosis 704.01.	1 per 366 days	Purchase only	December-07
A9283	Foot pressure off loading / supporting device, any type, each	Wound care	No	Yes	Covered for pressure reduction for existing pressure ulcers on the foot. Diagnoses 707.06-707.07 and 707.13-707.15 only. Refer to manual.	2 per year	Rental or Purchase	December-07
A9284	Spirometer, non-electronic, includes all accessories	Respiratory	Always	Y - NF N-ICF/DD	Covered with authorization for home monitoring following lung or heart/lung transplant. See manual	1 per year	Rental or Purchase	December-08
A9900	Miscellaneous DME supply, accessory and / or service component of another HCPCS code	Miscellaneous supplies			Not covered. There is no separate payment for these items.			January-09
A9901	DME delivery, set up, and / or dispensing service component of another HCPCS code	Miscellaneous supplies			Not covered. Delivery and set up is included in all DMEPOS rates.			January-09
A9999	Miscellaneous DME supply or accessory, not otherwise specified.	Miscellaneous supplies	Sometimes - see manual	Y - NF N-ICF/DD	Only to be used when a more specific code is not available. PA required for items when the submitted charge is over \$400. Refer to manual for billing information	medical necessity	Rental or Purchase	January-09
B4034	Enteral feeding supply kit; syringe fed, per day, includes but not limited to feeding / flushing syringe, administration set tubing, dressings, tape	Nutritional products	No	Y - NF N-ICF/DD	31 feeding kits per month are covered for recipients who receive enteral nutrition products through a feeding tube. Up to 51 feeding kits of any type (B4034-B4036) per month may be covered for individuals who need additional kits due to work or school. Cannot be billed with feeding/flushing syringe, administration set tubing, dressings, tape under B9998. Refer to manual.	51 in any combination	Purchase only	January-11
B4035	Enteral feeding supply kit; pump fed, per day, includes but not limited to feeding / flushing syringe, administration set tubing, dressings, tape	Nutritional products	No	Y - NF N-ICF/DD	31 feeding kits per month are covered for recipients who receive enteral nutrition products through a feeding tube. Up to 51 feeding kits of any type (B4034-B4036) per month may be covered for individuals who need additional kits due to work or school. Cannot be billed with feeding/flushing syringe, administration set tubing, dressings, tape under B9998. Refer to manual.	51 in any combination	Purchase only	January-11

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B4036	Enteral feeding supply kit; gravity fed, per day, includes but not limited to feeding / flushing syringe, administration set tubing, dressings, tape	Nutritional products	No	Y - NF N-ICF/DD	31 feeding kits per month are covered for recipients who receive enteral nutrition products through a feeding tube. Up to 51 feeding kits of any type (B4034-B4036) per month may be covered for individuals who need additional kits due to work or school. Cannot be billed with feeding/flushing syringe, administration set tubing, dressings, tape under B9998. Refer to manual.	51 in any combination	Purchase only	July-09
B4081	Nasogastric tubing with stylet	Nutritional products	No	Y - NF N-ICF/DD	Covered for recipients requiring enteral nutrition through nasogastric tubing	31 per month	Purchase only	July-09
B4082	Nasogastric tubing without stylet	Nutritional products	No	Y - NF N-ICF/DD	Covered for recipients requiring enteral nutrition through nasogastric tubing	31 per month	Purchase only	July-09
B4083	Stomach tube, levine type	Nutritional products	No	Y - NF N-ICF/DD	Covered for recipients requiring levine type stomach tube	31 per month	Purchase only	July-09
B4087	Gastrostomy/Jejunostomy tube, standard, any material, any type	Nutritional products	No	Y - NF N-ICF/DD	Covered for recipients requiring enteral nutrition through gastrostomy / jejunostomy tube. Most individuals require one feeding tube every 2 - 3 months. Up to 2 tubes per month may be medically necessary for some individuals. Refer to policy.	2 units per month	Purchase only	July-09
B4088	Gastrostomy/Jejunostomy tube, low-profile, any material, any type	Nutritional products	No	Y - NF N-ICF/DD	Covered for recipients requiring enteral nutrition through gastrostomy / jejunostomy tube. Most individuals require one feeding tube every 2 - 3 months. Up to 2 tubes per month may be medically necessary for some individuals. Low profile tubes may be medically necessary for infants and children and some other individuals. Refer to policy.	2 units per month	Purchase only	July-09
B4100	Food thickener, administered orally, per oz	Nutritional products			Not covered. Does not meet the definition of a nutritional product in Statute or Rule.			July-09
B4102	Enteral formula, for adults, used to replace fluids and electrolytes (e.g. clear liquids), 500 ml = 1 unit	Nutritional products			Not covered. Does not meet the definition of a nutritional product in Statute or Rule. May be covered as a pharmacy benefit using NDC code.			July-09
B4103	Enteral formula, for pediatrics, used to replace fluids and electrolytes (e.g. clear liquids), 500 ml = 1 unit	Nutritional products			Not covered. Does not meet the definition of a nutritional product in Statute or Rule. May be covered as a pharmacy benefit using NDC code.			July-09
B4104	Additive for enteral formula (e.g. fiber)	Nutritional products			Not covered. Does not meet the definition of a nutritional product in Statute or Rule. May be covered as a pharmacy benefit using NDC code.			July-09

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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	Nutritional products	Sometimes - see manual	Yes	Covered for recipients with specific medical needs. Refer to manual	1050 units per month	Purchase only	July-09
B4150	Enteral formula, 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	Nutritional products	Sometimes - see manual	Yes	Covered for recipients with specific medical needs. Refer to manual	1050 units per month	Purchase only	July-09
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	Nutritional products	Sometimes - see manual	Yes	Covered for recipients with specific medical needs. Refer to manual	1050 units per month	Purchase only	July-09
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	Nutritional products	Sometimes - see manual	Yes	Covered for recipients with specific medical needs. Refer to manual	1050 units per month	Purchase only	July-09

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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	Nutritional products	Sometimes - see manual	Yes	Covered for recipients with specific medical needs. Refer to manual	1050 units per month	Purchase only	July-09
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 = 1 unit	Nutritional products	Sometimes - see manual	Yes	Covered for recipients with specific medical needs. Refer to manual	1050 units per month	Purchase only	July-09
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	Nutritional products	Sometimes - see manual	Yes	Covered for recipients with specific medical needs. Refer to manual	1050 units per month	Purchase only	July-09

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B4158	Enteral formula, for pediatrics, 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 calories = 1 unit	Nutritional products	Sometimes - see manual	Yes	Covered for recipients with specific medical needs. Refer to manual	1050 units per month	Purchase only	July-09
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 calories = 1 unit	Nutritional products	Sometimes - see manual	Yes	Covered for recipients with specific medical needs. Refer to manual	1050 units per month	Purchase only	July-09
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 calories = 1 unit	Nutritional products	Sometimes - see manual	Yes	Covered for recipients with specific medical needs. Refer to manual	1050 units per month	Purchase only	July-09
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 calories = 1 unit	Nutritional products	Sometimes - see manual	Yes	Covered for recipients with specific medical needs. Refer to manual	1050 units per month	Purchase only	July-09

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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 calories = 1 unit	Nutritional products	Sometimes - see manual	Yes	Covered for recipients with specific medical needs. Refer to manual	1050 units per month	Purchase only	July-09
B4164	Parenteral nutrition solution: carbohydrates (dextrose), 50% or less (500 ml = 1 unit), home mix	Nutritional products			Not covered as a medical supply. Must be billed by a pharmacy as a drug. Refer to manual			July-09
B4168	Parenteral nutrition solution: amino acid, 3.5%,(500 ml = 1 unit), home mix	Nutritional products			Not covered as a medical supply. Must be billed by a pharmacy as a drug. Refer to manual			July-09
B4172	Parenteral nutrition solution: amino acid, 5.5% through 7% (500 ml = 1 unit), home mix	Nutritional products			Not covered as a medical supply. Must be billed by a pharmacy as a drug. Refer to manual			July-09
B4176	Parenteral nutrition solution: amino acid, 7% through 8.5% (500 ml = 1 unit), home mix	Nutritional products			Not covered as a medical supply. Must be billed by a pharmacy as a drug. Refer to manual			July-09
B4178	Parenteral nutrition solution: amino acid, greater than 8.5% (500 ml = 1 unit), home mix	Nutritional products			Not covered as a medical supply. Must be billed by a pharmacy as a drug. Refer to manual			July-09
B4180	Parenteral nutrition solution: carbohydrates (dextrose), greater than 50% (500 ml = 1 unit), home mix	Nutritional products			Not covered as a medical supply. Must be billed by a pharmacy as a drug. Refer to manual			July-09
B4185	Parenteral nutrition solution,per 10 grams lipids	Nutritional products			Not covered as a medical supply. Must be billed by a pharmacy as a drug. Refer to manual			July-09



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B4189	Parenteral nutrition solution: compounded amino acid and carbohydrates with electrolytes, trace elements, and vitamins, including preparation, any strength, 10 to 51 g of protein, premix	Nutritional products			Not covered as a medical supply. Must be billed by a pharmacy as a drug. Refer to manual			July-09
B4193	Parenteral nutrition solution: compounded amino acid and carbohydrates with electrolytes, trace elements, and vitamins, including preparation, any strength, 52 to 73 g of protein, premix	Nutritional products			Not covered as a medical supply. Must be billed by a pharmacy as a drug. Refer to manual			July-09
B4197	Parenteral nutrition solution: compounded amino acid and carbohydrates with electrolytes, trace elements, and vitamins, including preparation, any strength, 74 to 100 g of protein, premix	Nutritional products			Not covered as a medical supply. Must be billed by a pharmacy as a drug. Refer to manual			July-09
B4199	Parenteral nutrition solution: compounded amino acid and carbohydrates with electrolytes, trace elements, and vitamins, including preparation, any strength, over 100 g of protein, premix	Nutritional products			Not covered as a medical supply. Must be billed by a pharmacy as a drug. Refer to manual			July-09
B4216	Parenteral nutrition; additives (vitamins, trace elements, Heparin, electrolytes), home mix, per day	Nutritional products			Not covered as a medical supply. Must be billed by a pharmacy as a drug. Refer to manual			July-09
B4220	Parenteral nutrition supply kit; premix, per day	Nutritional products	No	Y - NF N-ICF/DD	Covered for recipients receiving premixed parenteral nutrition.	31 per month	Purchase only	July-09
B4222	Parenteral nutrition supply kit; home mix, per day	Nutritional products	No	Y - NF N-ICF/DD	Covered for recipients receiving home mix parenteral nutrition.	31 per month	Purchase only	July-09

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B4224	Parenteral nutrition administration kit, per day	Nutritional products	No	Y - NF N-ICF/DD	Covered for recipients receiving parenteral nutrition	31 per month	Purchase only	July-09
B5000	parenteral nutrition solution: compounded amino acid and carbohydrates with electrolytes, trace elements and vitamins, including preparation, any strength, renal - Amirosyn RF, NephroAmine, RenAmine - premix	Nutritional products			Not covered as a medical supply. Must be billed by a pharmacy as a drug. Refer to manual			July-09
B5100	Parenteral nutrition solution: compounded amino acid and carbohydrates with electrolytes, trace elements, and vitamins, including preparation, any strength, hepatic - FreAmine HBC, HepatAmine - premix	Nutritional products			Not covered as a medical supply. Must be billed by a pharmacy as a drug. Refer to manual			July-09
B5200	Parenteral nutrition solution: compounded amino acid and carbohydrates with electrolytes, trace elements, and vitamins, including preparation, any strength, stress - branch chain amino acids - premix	Nutritional products			Not covered as a medical supply. Must be billed by a pharmacy as a drug. Refer to manual			July-09
B9000	Enteral nutrition infusion pump - without alarm	Nutritional products	Sometimes - see manual	Y - NF N-ICF/DD	Covered for recipients receiving enteral nutrition through a feeding tube for whom gravity or syringe feeding is not appropriate. Refer to manual	1 per 5 years	Rental or Purchase	July-09
B9002	Enteral nutrition infusion pump - with alarm	Nutritional products	Sometimes - see manual	Y - NF N-ICF/DD	Covered for recipients receiving enteral nutrition through a feeding tube for whom gravity or syringe feeding is not appropriate. Refer to manual	1 per 5 years	Rental or Purchase	July-09
B9004	Parenteral nutrition infusion pump - portable	Nutritional products	Sometimes - see manual	Y - NF N-ICF/DD	Covered for recipients receiving parenteral nutrition	1 per 5 years	Rental or Purchase	July-09
B9006	Parenteral nutrition infusion pump - Stationary	Nutritional products	Sometimes - see manual	Y - NF N-ICF/DD	Covered for recipients receiving parenteral nutrition	1 per 5 years	Rental or Purchase	July-09

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B9998	Not otherwise classified for enteral supplies	Nutritional products	Sometimes - see manual	Y - NF N-ICF/DD	Covered for recipients receiving enteral nutrition when a more specific code is not available. Refer to manual	refer to manual	Rental or Purchase	July-09
B9999	Not otherwise classified for parenteral supplies	Nutritional products	Sometimes - see manual	Y - NF N-ICF/DD	Covered for recipients receiving parenteral nutrition when a more specific code is not available. Refer to manual.	refer to manual	Rental or Purchase	July-09
E0100	Cane, includes all materials adjustable or fixed, with tip	Ambulatory Assist devices	No	Yes	Covered for recipients who are unable to safely ambulate in one or more locations they routinely access due to a temporary or permanent medical condition. Refer to manual	1 per year	Rental or Purchase	August-09
E0105	Cane, quad or three prong, includes canes of all materials, adjustable or fixed, with tips	Ambulatory Assist devices	No	Yes	Covered for recipients who are unable to safely ambulate in one or more locations they routinely access due to a temporary or permanent medical condition. Refer to manual	1 per year	Rental or Purchase	August-09
E0110	Crutches, forearm, includes crutches of various materials, adjustable or fixed, pair, complete with tips and handgrips	Ambulatory Assist devices	No	Yes	Covered for recipients who are unable to safely ambulate in one or more locations they routinely access due to a temporary or permanent medical condition. Refer to manual	1 pair per year	Rental or Purchase	August-09
E0111	Crutch, forearm, includes crutches of various materials, adjustable or fixed, each, with tips and handgrips	Ambulatory Assist devices	No	Yes	Covered for recipients who are unable to safely ambulate in one or more locations they routinely access due to a temporary or permanent medical condition when only one crutch is being dispensed. Refer to manual	1 per dispensing, up to 2 per year	Rental or Purchase	August-09
E0112	Crutches, underarm, wood, adjustable or fixed, pair, with pads, tips and handgrips	Ambulatory Assist devices	No	Yes	Covered for recipients who are unable to safely ambulate in one or more locations they routinely access due to a temporary or permanent medical condition. Refer to manual	1 pair per year	Rental or Purchase	August-09
E0113	Crutch, underarm, wood, adjustable or fixed, each, with pads, tips, handgrips	Ambulatory Assist devices	No	Yes	Covered for recipients who are unable to safely ambulate in one or more locations they routinely access due to a temporary or permanent medical condition when only one crutch is being dispensed. Refer to manual	1 per dispensing, up to 2 per year	Rental or Purchase	August-09
E0114	Crutches, underarm, other than wood, adjustable or fixed, pair, with pads, tips, handgrips	Ambulatory Assist devices	No	Yes	Covered for recipients who are unable to safely ambulate in one or more locations they routinely access due to a temporary or permanent medical condition. Refer to manual	1 pair per year	Rental or Purchase	August-09
E0116	Crutch, underarm, other than wood, adjustable or fixed, with pad, tip, handgrip, with or without shock absorber, each	Ambulatory Assist devices	No	Yes	Covered for recipients who are unable to safely ambulate in one or more locations they routinely access due to a temporary or permanent medical condition. Refer to manual	1 per dispensing, up to 2 per year	Rental or Purchase	August-09

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E0117	Crutch, underarm, articulating, spring assisted, each	Ambulatory Assist devices	No	Yes	Covered for recipients who are unable to safely ambulate in one or more locations they routinely access due to a temporary or permanent medical condition when standard crutches will not meet the recipient's medical needs. Refer to manual	2 per year	Rental or Purchase	August-09
E0118	Crutch substitute, lower leg platform, with or without wheels, each	Ambulatory Assist devices	No	Yes	Covered for recipients who are unable to safely ambulate in one or more locations they routinely access due to a temporary or permanent medical condition when standard crutches will not meet the recipient's medical needs. Refer to manual	1 per month	Capped Rental only	August-09
E0130	Walker, rigid (pickup), adjustable or fixed height	Ambulatory Assist devices	Sometimes - see manual	Yes	Covered for recipients who are unable to safely ambulate in one or more locations they routinely access due to a temporary or permanent medical condition. Authorization required only when requesting payment over the fee schedule rate for pediatric walker.	1 per 5 years	Rental or Purchase	October-09
E0135	Walker, folding (pickup), adjustable or fixed height	Ambulatory Assist devices	Sometimes - see manual	Yes	Covered for recipients who are unable to safely ambulate in one or more locations they routinely access due to a temporary or permanent medical condition. Authorization required only when requesting payment over the fee schedule rate for pediatric walker.	1 per 5 years	Rental or Purchase	October-09
E0140	Walker, with trunk support, adjustable or fixed height, any type	Ambulatory Assist devices	Sometimes - see manual	Yes	Covered for recipients who are unable to safely ambulate in one or more locations they routinely access due to a temporary or permanent medical condition, and who require trunk support. Authorization required only when requesting payment over the fee schedule rate for pediatric walker.	1 per 5 years	Rental or Purchase	October-09
E0141	Walker, rigid, wheeled, adjustable or fixed height	Ambulatory Assist devices	Sometimes - see manual	Yes	Covered for recipients who are unable to safely ambulate in one or more locations they routinely access due to a temporary or permanent medical condition. Authorization required only when requesting payment over the fee schedule rate for pediatric walker.	1 per 5 years	Rental or Purchase	October-09
E0143	Folding walker, wheeled, adjustable or fixed height	Ambulatory Assist devices	Sometimes - see manual	Yes	Covered for recipients who are unable to safely ambulate in one or more locations they routinely access due to a temporary or permanent medical condition. Authorization required only when requesting payment over the fee schedule rate for pediatric walker.	1 per 5 years	Rental or Purchase	October-09
E0144	Walker, enclosed, 4 sided framed, rigid or folding, wheeled, with posterior seat	Ambulatory Assist devices	Sometimes - see manual	Yes	Covered for recipients who are unable to safely ambulate in one or more locations they routinely access due to a temporary or permanent medical condition, and who require the enclosed walker. Authorization required only when requesting payment over the fee schedule rate for pediatric walker.	1 per 5 years	Rental or Purchase	October-09

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E0147	Walker, heavy duty, multiple breaking system, variable wheel resistance	Ambulatory Assist devices	Sometimes - see manual	Yes	Covered for recipients who are unable to safely ambulate in one or more locations they routinely access due to a temporary or permanent medical condition, and who have another medical condition. Authorization required only when requesting payment over the fee schedule rate for pediatric walker.	1 per 5 years	Rental or Purchase	October-09
E0148	Walker, heavy duty, without wheels, rigid or folding, any type, each	Ambulatory Assist devices	Sometimes - see manual	Yes	Covered for recipients who are unable to safely ambulate in one or more locations they routinely access due to a temporary or permanent medical condition, and who have another medical condition. Authorization required only when requesting payment over the fee schedule rate for pediatric walker.	1 per 5 years	Rental or Purchase	October-09
E0149	Walker, heavy duty, wheeled, rigid or folding, any type, each	Ambulatory Assist devices	Sometimes - see manual	Yes	Covered for recipients who are unable to safely ambulate in one or more locations they routinely access due to a temporary or permanent medical condition, and who have another medical condition. Authorization required only when requesting payment over the fee schedule rate for pediatric walker.	1 per 5 years	Rental or Purchase	October-09
E0153	Platform attachment, forearm crutch, each	Ambulatory Assist devices	No	Yes	Covered for recipients using forearm crutch	2 per year	Rental or Purchase	October-09
E0154	Platform attachment, walker, each	Ambulatory Assist devices	No	Yes	Covered for recipients requiring a platform attachment for a walker	2 per year	Rental or Purchase	October-09
E0155	Wheel attachment, rigid pick-up walker, per pair	Ambulatory Assist devices	No	Yes	Covered for addition to recipient owned walker.	2 per year	Purchase only	January-11
E0156	Seat attachment, walker	Ambulatory Assist devices	No	Yes	Covered for recipients requiring a seat for use with a walker	1 per 3 years	Rental or Purchase	October-09
E0157	Crutch attachment, walker, each	Ambulatory Assist devices	No	Yes	Covered for recipients requiring a crutch attachment for use with a walker	2 per year	Rental or Purchase	October-09
E0158	Leg extensions for walker, per set of 4	Ambulatory Assist devices	No	Yes	Covered for recipients requiring leg extensions to make a walker the correct height for safe use.	1 set per 3 years	Rental or Purchase	October-09
E0159	Brake attachment for wheeled walker, replacement, each	Ambulatory Assist devices	No	Yes	Covered to replace hand or glide-type brakes on recipient owned walker.	2 per 2 years	Rental or Purchase	October-09
E0160	Sitz type bath or equipment, portable, used with or without commode	bath and toilet equipment	No	Yes	Covered for recipients with a current or past infection or injury of the perineal area	1 per year	Rental or Purchase	August-09
E0161	Sitz type bath or equipment, portable, used with or without commode, with faucet attachment(s)	bath and toilet equipment	No	Yes	Covered for recipients with a current or past infection or injury of the perineal area	1 per year	Rental or Purchase	August-09

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E0162	Sitz bath chair	bath and toilet equipment	No	Yes	Covered for recipients with a current or past infection or injury of the perineal area	1 per year	Rental or Purchase	August-09
E0163	Commode chair, mobile or stationary, with fixed arms	bath and toilet equipment	Sometimes - see manual	Yes	Covered for recipients who are unable to safely and promptly access the bathrooms in their homes due to medical conditions. Refer to manual	1 per 5 years	Rental or Purchase	August-09
E0165	Commode chair, mobile or stationary, with detachable arms	bath and toilet equipment	Sometimes - see manual	Yes	Covered for recipients who are unable to safely and promptly access the bathrooms in their homes due to medical conditions. Refer to manual	1 per 5 years	Rental or Purchase	August-09
E0167	Pail or pan for use with commode chair, replacement only	bath and toilet equipment	No	Yes	Covered for recipients with commodes.	1 per 3 months	Rental or Purchase	August-09
E0168	Commode chair, extra wide and/or heavy duty, stationary or mobile, with or without arms, any type, each	bath and toilet equipment	Sometimes - see manual	Yes	Covered for recipients who are unable to safely and promptly access the bathrooms in their homes due to medical conditions. Refer to manual	1 per 5 years	Rental or Purchase	August-09
E0170	Commode chair with integrated seat lift mechanism, electric, any type	bath and toilet equipment	Always	Y - NF N-ICF/DD	Covered for recipients who meet criteria for a commode, but who are unable to safely raise or lower himself to use the commode. Refer to manual	1 per 5 years	Rental or Purchase	August-09
E0171	Commode chair with integrated seat lift mechanism, non-electric, any type	bath and toilet equipment	No	Y - NF N-ICF/DD	Covered for recipients who meet criteria for a commode, but who are unable to safely raise or lower himself to use the commode. Refer to manual	1 per 5 years	Rental or Purchase	August-09
E0172	Seat lift mechanism placed over or on top of toilet, any type	bath and toilet equipment	Always	Y - NF N-ICF/DD	Covered for recipients who are unable to safely raise or lower themselves to use the toilet in their bathrooms when less costly alternatives do not meet the recipient's needs. Refer to manual	1 per 5 years	Rental or Purchase	August-09
E0175	Foot rest for use w/commode chair	bath and toilet equipment	No	Y - NF N-ICF/DD	Covered for recipient's who require support for the feet when using a commode chair.	2 per year	Rental or Purchase	August-09
E0181	Powered pressure reducing mattress overlay/pad, alternating, with pump, includes heavy duty	Pressure reducing support surfaces	No	Yes	Covered for recipients who meet criteria for a Group 1 pressure reducing support surface. Refer to manual	1 per 3 years	Rental or Purchase	December-09
E0182	Pump for alternating pressure pad, for replacement only	Pressure reducing support surfaces	No	Yes	Covered for recipients who meet criteria for a Group 1 pressure reducing support surface, and who own an alternating pressure pad. Refer to manual	1 per 3 years	Purchase only	November-10

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E0184	Dry pressure mattress	Pressure reducing support surfaces	No	Yes	Covered for recipients who meet criteria for a Group 1 pressure reducing support surface. Refer to manual	1 per 3 years	Rental or Purchase	December-09
E0185	Gel or gel-like pressure pad for mattress, standard mattress length and width	Pressure reducing support surfaces	No	Yes	Covered for recipients who meet criteria for a Group 1 pressure reducing support surface. Refer to manual	1 per 3 years	Rental or Purchase	December-09
E0186	Air pressure mattress	Pressure reducing support surfaces	No	Yes	Covered for recipients who meet criteria for a Group 1 pressure reducing support surface. Refer to manual	1 per 3 years	Rental or Purchase	December-09
E0187	Water pressure mattress	Pressure reducing support surfaces	No	Yes	Covered for recipients who meet criteria for a Group 1 pressure reducing support surface. Refer to manual	1 per 3 years	Rental or Purchase	December-09
E0188	Synthetic sheepskin pad	Pressure reducing support surfaces	No	Yes	Covered for recipients who meet criteria for a Group 1 pressure reducing support surface. Refer to manual	1 per year	Rental or Purchase	December-09
E0189	Lambswool sheepskin pad, any size	Pressure reducing support surfaces	No	Yes	Covered for recipients who meet criteria for a Group 1 pressure reducing support surface. Refer to manual	1 per year	Rental or Purchase	December-09
E0190	Positioning cushion/pillow/wedge, any shape or size, includes all components and accessories	Positioning equipment	Sometimes - see manual	No	Covered for recipients who require significant postural support which cannot be accommodated with items commonly found in the home. Refer to manual.	1 per 2 years	Rental or Purchase	December-09
E0191	Heel or elbow protector, each	Positioning equipment	No	Yes	Covered for recipients at risk of developing sores on heels and/or elbows due to positioning.	4 per year	Purchase only	December-09
E0193	Powered air flotation bed (low air loss therapy)	Pressure reducing support surfaces	Always	Y - NF N-ICF/DD	Covered for recipients who meet criteria for a Group 2 pressure reducing support surface. Refer to manual.	1 per month	Capped Rental only	December-09

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E0194	Air fluidized bed	Pressure reducing support surfaces	Always	Y - NF N-ICF/DD	Covered for recipients who meet criteria for a Group 3 pressure reducing support surface. Refer to manual.	1 per month	Capped Rental only	December-09
E0196	Gel pressure mattress	Pressure reducing support surfaces	No	Yes	Covered for recipients who meet criteria for a Group 1 pressure reducing support surface. Refer to manual	1 per 3 years	Rental or Purchase	December-09
E0197	Air pressure pad for mattress, standard mattress length and width	Pressure reducing support surfaces	No	Yes	Covered for recipients who meet criteria for a Group 1 pressure reducing support surface. Refer to manual	1 per 3 years	Rental or Purchase	December-09
E0198	Water pressure pad for mattress, standard mattress length and width	Pressure reducing support surfaces	No	Yes	Covered for recipients who meet criteria for a Group 1 pressure reducing support surface. Refer to manual	1 per 3 years	Rental or Purchase	December-09
E0199	Dry pressure pad for mattress, standard mattress length and width	Pressure reducing support surfaces	No	Yes	Covered for recipients who meet criteria for a Group 1 pressure reducing support surface. Refer to manual	1 per year	Rental or Purchase	December-09
E0200	Heat lamp, without stand (table model), includes bulb, or infrared element	Cold or heat therapy	No	Yes	Covered for recipients who require application of heat for treatment of a medical condition but who cannot tolerate direct application of heat.	1 per 5 years	Rental or Purchase	December-09
E0202	Phototherapy (bilirubin) light with photometer	Equipment	No	Y - NF N-ICF/DD	Covered for recipients under 60 days of age for treatment of jaundice.	1 month rental only	Capped Rental only	August-09
E0203	Therapeutic Light Box, minimum 10,000 Lux, table top model	SAD lights	Always	Yes	Covered for recipients with demonstrated seasonal affective disorder. Refer to manual	1 per 5 years	Rental or Purchase	December-09
E0205	Heat lamp, with stand, includes bulb or infrared element	Cold or heat therapy			Not covered. Only table top models (E0200) are covered.			December-09
E0210	Electric heat pad, standard	Cold or heat therapy	No	Yes	Covered for recipients who require application of heat for treatment of a medical condition.	1 per 5 years	Purchase only	December-09
E0215	Electric heat pad, moist	Cold or heat therapy	No	Yes	Covered for recipients who require application of heat for treatment of a medical condition.	1 per 5 years	Purchase only	December-09
E0217	Water circulating heat pad with pump	Cold or heat therapy			Not covered. No evidence of superior outcomes vs standard or moist heating pad.			December-09
E0218	Water circulating cold pad with pump	Cold or heat therapy			Not covered. No evidence of superior outcomes vs passive ice packs			December-09

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E0221	Infrared heating pad system	Cold or heat therapy			Not covered. Investigative. No evidence of superior outcomes vs other heating pads.			December-09
E0225	Hydrocollator unit, includes pads	Cold or heat therapy			Not covered. Not efficient use of Medicaid funds. No evidence of superior outcomes vs other heating pads. Not appropriate for use without supervision by medical professional			December-09
E0231	Noncontact wound-warming wound device (temperature control unit, AC adapter and power cord) for use with warming card and wound cover	Wound care			Not covered. Investigational for all indications			December-09
E0232	Warming card for use with the noncontact device and non-contact wound warming wound cover	Wound care			Not covered. Investigational for all indications.			December-09
E0235	Paraffin bath unit, portable (see medical supply code A4265 for paraffin)	Cold or heat therapy	No	Yes	Covered for recipients for use in the home under supervision of medical professional when standard and moist heating pad have failed	1 per 5 years	Rental or Purchase	December-09
E0236	Pump for water circulating pad	Cold or heat therapy			Not covered. No evidence of superior outcomes for water circulating heat/cold pads vs standard treatment			December-09
E0239	Hydrocollator unit, portable	Cold or heat therapy			Not covered. Not efficient use of Medicaid funds. No evidence of superior outcomes vs other heating pads. Not appropriate for use without supervision by medical professional			December-09
E0240	Bath/shower chair, with or without wheels, any size	bath and toilet equipment	Sometimes - see manual	Yes	Covered for recipients who are unable to safely use the bathtub or shower in their homes	1 per 5 years	Rental or Purchase	November-09
E0241	Bathtub wall rail, each	bath and toilet equipment			Not covered. Items that attach to the home are home modifications. Recipients who require home modification should contact their county to ask about waived services			November-09
E0242	Bathtub rail, floor base	bath and toilet equipment			Not covered. Items that attach to the home are home modifications. Recipients who require home modification should contact their county to ask about waived services			November-09
E0243	Toilet rail, each	bath and toilet equipment			Not covered. Items that attach to the home are home modifications. Recipients who require home modification should contact their county to ask about waived services			November-09
E0244	Raised toilet seat	bath and toilet equipment	No	Yes	Covered for recipients who are unable to safely raise or lower themselves to use a standard height toilet	1 per 3 years	Purchase only	November-09

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E0245	Tub stool or bench	bath and toilet equipment	Sometimes - see manual	Yes	Covered for recipients who are unable to safely use the bathtub or shower in their homes	1 per 5 years	Purchase only	November-09
E0246	Transfer tub rail attachment	bath and toilet equipment			Not covered. Items that attach to the home are home modifications. Recipients who require home modification should contact their county to ask about waived services			November-09
E0247	Transfer bench for tub or toilet with or without commode opening	bath and toilet equipment	Sometimes - see manual	Yes	Covered for recipients who are unable to safely transfer from a wheelchair to the toilet or bath/shower chair without the use of a transfer bench	1 per 5 years	Rental or Purchase	November-09
E0248	Transfer bench, heavy duty, for tub or toilet with or without commode opening	bath and toilet equipment	Sometimes - see manual	Yes	Covered for recipients who are unable to safely transfer from a wheelchair to the toilet or bath/shower chair without the use of a transfer bench	1 per 5 years	Rental or Purchase	November-09
E0249	Pad for water circulating heat unit, for replacement only	Heat/cold therapy			Not covered. No evidence of superior outcomes for water circulating heat/cold pads vs standard treatment			January-10
E0250	Hospital bed, fixed height, with any type side rails, with mattress	Hospital beds	Sometimes - see manual	Yes	Covered for recipients with medical conditions requiring positioning, whose positioning needs cannot be met with attachments or pillows - refer to manual	1 per 5 years	Rental or Purchase	January-10
E0251	Hospital bed, fixed height, with any type side rails, without mattress	Hospital beds	Sometimes - see manual	Yes	Covered for recipients with medical conditions requiring positioning, whose positioning needs cannot be met with attachments or pillows - refer to manual	1 per 5 years	Rental or Purchase	January-10
E0255	Hospital bed, variable height, hi-lo, with any type side rails, with mattress	Hospital beds	Sometimes - see manual	Yes	Covered for recipients with medical conditions requiring positioning, whose positioning needs cannot be met with attachments or pillows - refer to manual	1 per 5 years	Rental or Purchase	January-10
E0256	Hospital bed, variable height, hi-lo, with any type side rails, without mattress	Hospital beds	Sometimes - see manual	Yes	Covered for recipients with medical conditions requiring positioning, whose positioning needs cannot be met with attachments or pillows - refer to manual	1 per 5 years	Rental or Purchase	January-10
E0260	Hospital bed, semi-electric (head and foot adjustment) with any type side rails, with mattress	Hospital beds	Sometimes - see manual	Yes	Covered for recipients with medical conditions requiring immediate positioning changes, whose positioning needs cannot be met with attachments or pillows - refer to manual	1 per 5 years	Rental or Purchase	January-10
E0261	Hospital bed, semi-electric (head and foot adjustment) with any type side rails, without mattress	Hospital beds	Sometimes - see manual	Yes	Covered for recipients with medical conditions requiring immediate positioning changes, whose positioning needs cannot be met with attachments or pillows - refer to manual	1 per 5 years	Rental or Purchase	January-10

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E0265	Hospital bed, total electric (head, foot and height adjustment) with any type side rails, with mattress	Hospital beds	Always	Yes	Covered for recipients with medical conditions requiring immediate positioning changes, whose positioning needs cannot be met with attachments or pillows, and who require a change of bed height to enable the caregiver to assist with recipient cares - refer to manual	1 per 5 years	Rental or Purchase	January-10
E0266	Hospital bed, total electric (head, foot and height adjustment) with any type side rails, without mattress	Hospital beds	Always	Yes	Covered for recipients with medical conditions requiring immediate positioning changes, whose positioning needs cannot be met with attachments or pillows, and who require a change of bed height to enable the caregiver to assist with recipient cares - refer to manual	1 per 5 years	Rental or Purchase	January-10
E0270	Hospital bed, institutional type includes: oscillating, circulating and Stryker frame, with mattress	Hospital beds			Not covered. Not medically necessary for use in the home.			January-10
E0271	Mattress, innerspring	Hospital beds	Sometimes - see manual	Yes	Covered for use with recipient owned hospital bed. Not to be used within 180 days of billing of any code that includes a mattress. Use modifier U3 when a bariatric mattress is being dispensed. Refer to manual	1 per 3 years	Rental or Purchase	January-10
E0272	Mattress, foam rubber	Hospital beds	Sometimes - see manual	Yes	Covered for use with recipient owned hospital bed. Not to be used within 180 days of billing of any code that includes a mattress. Use modifier U3 when a bariatric mattress is being dispensed. Refer to manual	1 per 2 years	Rental or Purchase	January-10
E0273	Bed board	Hospital beds			Not covered. Not the standard of care for transfers in the home.			January-10
E0274	Over-bed table	Hospital beds			Not covered. Over-bed tables are furniture and convenience items			January-10
E0275	Bed pan, standard, metal or plastic	Hospital beds	No	Yes	Reusable bed pans are covered for continent recipients confined to their beds.	1 per year	Purchase only	January-10
E0276	Bed pan, fracture, metal or plastic	Hospital beds	No	Yes	Reusable bed pans are covered for continent recipients confined to their beds.	1 per year	Purchase only	January-10
E0277	Powered pressure reducing air mattress	Pressure reducing support surfaces	Always	Y - NF N-ICF/DD	Covered for recipients who meet criteria for a Group 2 pressure reducing support surface. Refer to manual.	1 per month	Capped Rental only	December-09
E0280	Bed, cradle, any type	Hospital beds	No	Yes	Covered when medically necessary to hold bedding off the recipient's body	1 per 3 years	Rental or Purchase	December-09
E0290	Hospital bed, fixed height, without side rails, with mattress	Hospital beds	No	Yes	Covered for recipients with medical conditions requiring positioning, whose positioning needs cannot be met with attachments or pillows - refer to manual	1 per 5 years	Rental or Purchase	December-09

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E0291	Hospital bed fixed height without side rails, without mattress	Hospital beds	No	Yes	Covered for recipients with medical conditions requiring positioning, whose positioning needs cannot be met with attachments or pillows - refer to manual	1 per 5 years	Rental or Purchase	December-09
E0292	Hospital bed variable height, hi-lo, without side rails, with mattress	Hospital beds	No	Yes	Covered for recipients with medical conditions requiring positioning, whose positioning needs cannot be met with attachments or pillows - refer to manual	1 per 5 years	Rental or Purchase	December-09
E0293	Hospital bed variable height, hi-lo, without side rails, without mattress	Hospital beds	No	Yes	Covered for recipients with medical conditions requiring positioning, whose positioning needs cannot be met with attachments or pillows - refer to manual	1 per 5 years	Rental or Purchase	December-09
E0294	Hospital bed, semi-electric (head and foot adjustment), without side rails, with mattress	Hospital beds	Sometimes - see manual	Yes	Covered for recipients with medical conditions requiring immediate positioning changes, whose positioning needs cannot be met with attachments or pillows - refer to manual	1 per 5 years	Rental or Purchase	December-09
E0295	Hospital bed, semi-electric (head and foot adjustment), without side rails, without mattress	Hospital beds	Sometimes - see manual	Yes	Covered for recipients with medical conditions requiring immediate positioning changes, whose positioning needs cannot be met with attachments or pillows - refer to manual	1 per 5 years	Rental or Purchase	December-09
E0296	Hospital bed, total-electric (head, foot and height adjustment) without out side rails, with mattress	Hospital beds	Always	Yes	Covered for recipients with medical conditions requiring immediate positioning changes, whose positioning needs cannot be met with attachments or pillows, and who require a change of bed height to enable the caregiver to assist with recipient cares - refer to manual	1 per 5 years	Rental or Purchase	December-09
E0297	Hospital bed, total-electric (head, foot and height adjustment) without side rails, without mattress	Hospital beds	Always	Yes	Covered for recipients with medical conditions requiring immediate positioning changes, whose positioning needs cannot be met with attachments or pillows, and who require a change of bed height to enable the caregiver to assist with recipient cares - refer to manual	1 per 5 years	Rental or Purchase	December-09
E0300	Pediatric crib, hospital grade, fully enclosed	Hospital beds	Always	Y - NF N-ICF/DD	Covered for recipients who are mobile but cognitively impaired, when unrestricted mobility results in documented injuries if less costly and less restrictive methods have failed. Refer to manual	1 per 5 years	Rental or Purchase	December-09
E0301	Hospital bed, heavy duty, extra wide, with weight capacity greater than 350 pounds, but less than or equal to 600 pounds, with any type side rails, without mattress	Hospital beds	Always	Y - NF N-ICF/DD	Covered for recipients who meet criteria for a hospital bed, and require the heavy duty bed because of weight.	1 per 5 years	Rental or Purchase	December-09

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E0302	Hospital bed, extra heavy duty, extra wide, with weight capacity greater than 600 pounds, with any type side rails, without mattress	Hospital beds	Always	Y - NF N-ICF/DD	Covered for recipients who meet criteria for a hospital bed, and require the heavy duty bed because of weight.	1 per 5 years	Rental or Purchase	December-09
E0303	Hospital bed, heavy duty, extra wide, with weight capacity greater than 350 pounds, but less than or equal to 600 pounds, with any type side rails, with mattress	Hospital beds	Always	Y - NF N-ICF/DD	Covered for recipients who meet criteria for a hospital bed, and require the heavy duty bed because of weight.	1 per 5 years	Rental or Purchase	December-09
E0304	Hospital bed, extra heavy duty, extra wide, with weight capacity greater than 600 pounds, with any type side rails, with mattress	Hospital beds	Always	Y - NF N-ICF/DD	Covered for recipients who meet criteria for a hospital bed, and require the heavy duty bed because of weight.	1 per 5 years	Rental or Purchase	December-09
E0305	Bed side rails, half length	Hospital beds	No	Yes	Covered when added to patient owned hospital bed. Not to be billed within 180 days of billing any code that includes bedrails	2 per 5 years	Rental or Purchase	December-09
E0310	Bed side rails, full length	Hospital beds	No	Yes	Covered when added to patient owned hospital bed. Not to be billed within 180 days of billing any code that includes bedrails	2 per 5 years	Rental or Purchase	December-09
E0315	Bed accessory; board, table, or support device, any type	Hospital beds			Not covered. These accessories are consider convenience items			December-09
E0316	Safety enclosure frame/canopy for use with hospital bed, any type	Hospital beds	Always	Y - NF N-ICF/DD	Covered for recipients who are mobile but cognitively impaired, when unrestricted mobility results in documented injuries if less costly and less restrictive methods have failed. Refer to manual	1 per 5 years	Rental or Purchase	December-09
E0325	Urinal, male, jug type, any material	Urological	No	Yes	Covered for recipients who are continent but have limited ability to access a toilet / commode	1 per year	Purchase only	December-09
E0326	Urinal, female, jug type, any material	Urological	No	Yes	Covered for recipients who are continent but have limited ability to access a toilet / commode	1 per year	Purchase only	December-09
E0328	Hospital bed, pediatric, manual, 360 degree side enclosures, top of headboard, footboard and side rails up to 24 inches above the spring, includes mattress	Hospital beds	Always	Yes	Covered for recipients who meet criteria for a hospital bed, and require the pediatric size bed because of size	1 per 5 years	Rental or Purchase	December-09

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E0329	Hospital bed, pediatric, electric or semi-electric, 360 degree side enclosures, top of headboard, footboard and side rails up to 24 inches above the spring, includes mattress	Hospital beds	Always	Yes	Covered for recipients who meet criteria for a hospital bed, and require the pediatric size bed because of size	1 per 5 years	Rental or Purchase	December-09
E0350	Control unit for electronic bowel irrigation / evacuation system	Miscellaneous supplies			Not covered. Not demonstrated to provide better outcomes than less costly alternatives.			December-09
E0352	Disposable pack (water reservoir bag, speculum, valving mechanism and collection bag/box) for use with the electronic bowel irrigation/evacuation system	Miscellaneous supplies			Not covered. Not demonstrated to provide better outcomes than less costly alternatives.			December-09
E0370	Air pressure pad elevator for heel	Footwear	No	Yes	Covered for recipients at risk of ulcers caused by pressure areas.	2 per year	Purchase only	December-09
E0371	Non-powered advanced pressure reducing overlay for mattress, standard mattress length and width	Pressure reducing support surfaces	Always	Y - NF N-ICF/DD	Covered for recipients who meet criteria for a Group 2 pressure reducing support surface. Refer to manual.	1 per month	Capped Rental only	December-09
E0372	Powered air overlay for mattress, standard mattress length and width	Pressure reducing support surfaces	Always	Y - NF N-ICF/DD	Covered for recipients who meet criteria for a Group 2 pressure reducing support surface. Refer to manual.	1 per month	Capped Rental only	December-09
E0373	Nonpowered advanced pressure reducing mattress	Pressure reducing support surfaces	Always	Y - NF N-ICF/DD	Covered for recipients who meet criteria for a Group 2 pressure reducing support surface. Refer to manual.	1 per month	Capped Rental only	December-09
E0424	Stationary compressed gaseous oxygen system, rental; includes container, contents, regulator, flowmeter, humidifier, nebulizer, cannula or mask, and tubing	Oxygen	No	No	Covered through the volume purchase oxygen contract. Refer to manual.	1 per month	Monthly Rental only	January-10

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E0425	Stationary compressed gaseous oxygen system, purchase; includes regulator, flowmeter, humidifier, nebulizer, cannula or mask, and tubing	Oxygen			Not covered. MHCP covers rental of oxygen equipment only			January-10
E0430	Portable gaseous oxygen system, purchase; includes regulator, flowmeter, humidifier, cannula or mask, and tubing	Oxygen			Not covered. MHCP covers rental of oxygen equipment only			January-10
E0431	Portable gaseous oxygen system, rental; includes portable container, regulator, flowmeter, humidifier, cannula or mask, and tubing	Oxygen	No	No	Covered through the volume purchase oxygen contract. Refer to manual.	1 per month	Monthly Rental only	January-10
E0433	Portable liquid oxygen system, rental; home liquifier used to fill portable liquid oxygen containers, includes portable containers, regulator, flowmeter, humidifier, cannula or mask and tubing, with or without supply reservoir and contents gauge.	Oxygen			Not covered. MHCP finds this to not be cost effective when compared with other oxygen delivery models			January-10
E0434	Portable liquid oxygen system, rental; includes portable container, supply reservoir, humidifier, flowmeter, refill adaptor, contents gauge, cannula or mask, and tubing.	Oxygen	No	No	Covered through the volume purchase oxygen contract. Refer to manual.	1 per month	Monthly Rental only	January-10
E0435	Portable liquid oxygen system, purchase; includes portable container, supply reservoir, humidifier, flowmeter, refill adaptor, contents gauge, cannula or mask, and tubing.	Oxygen			Not covered. MHCP covers rental of oxygen equipment only			January-10

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E0439	Stationary liquid oxygen system, rental; includes container, contents, regulator, flowmeter, humidifier, nebulizer, cannula or mask and tubing	Oxygen	No	No	Covered through the volume purchase oxygen contract. Refer to manual.	1 per month	Monthly Rental only	January-10
E0440	Stationary liquid oxygen system, purchase; includes container, contents, regulator, flowmeter, humidifier, nebulizer, cannula or mask and tubing	Oxygen			Not covered. MHCP covers rental of oxygen equipment only			January-10
E0441	Stationary oxygen contents, gaseous, 1 month's supply = 1 unit	Oxygen	No	No	Covered for recipients who use stationary gas systems when use of this code is required by a primary payer. Refer to manual	1 per month	Purchase only	January-10
E0442	Stationary oxygen contents, liquid, 1 month's supply = 1 unit	Oxygen	No	No	Covered for recipients who use stationary liquid systems when use of this code is required by a primary payer. Refer to manual	1 per month	Purchase only	January-10
E0443	Portable oxygen contents, Gaseous, 1 month's supply = 1 unit	Oxygen	No	No	Covered for recipients who use portable gas systems when use of this code is required by a primary payer. Refer to manual	1 per month	Purchase only	January-10
E0444	Portable oxygen contents, liquid, 1 month's supply = 1 unit	Oxygen	No	No	Covered for recipients who use portable liquid systems when use of this code is required by a primary payer. Refer to manual	1 per month	Purchase only	January-10
E0445	Oximeter device for measuring blood oxygen levels non-invasively	Respiratory	Sometimes - see manual	No	Covered for recipients requiring monitoring of oxygen levels. Requires authorization for purchase and for maintenance service. For overnight sat checks, use modifiers RR and U4. For spot check, use modifiers RR and U7.	1 per 5 years	Rental or Purchase	December-09
E0446	Topical oxygen delivery system, not otherwise specified, includes all supplies and accessories	Wound care			Not covered. Investigative for all indications			January-11
E0450	Volume control ventilator, without pressure support mode, may include pressure control mode, used with invasive interface (e.g., tracheostomy tube)	Respiratory	No	No	Covered for recipients requiring volume control ventilator. Both a stationary and a portable ventilator may be covered if the recipient requires both. E0450 has been found by Medicare to require frequent and substantial servicing, therefore the 10 month rental limit does not apply. Refer to manual	2 per month	Monthly Rental only	December-09
E0455	Oxygen tent, excluding croup or pediatric tents	Respiratory	No	No	Covered for recipients requiring oxygen tent for administration of medically necessary oxygen.	1 per 3 years	Purchase only	December-09

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E0457	Chest shell (cuirass)	Respiratory	Sometimes - see manual	No	Covered for recipients requiring a chest shell for use with a ventilator	1 per dispensing, as medically necessary	Rental or Purchase	December-09
E0459	Chest wrap	Respiratory	Sometimes - see manual	No	Covered for recipients requiring a chest wrap for use with a ventilator	1 per dispensing, as medically necessary	Rental or Purchase	December-09
E0460	Negative pressure ventilator, portable or stationary	Respiratory	No	No	Covered for recipients requiring negative pressure ventilator. Both a stationary and a portable ventilator may be covered if the recipient requires both. E0460 has been found by Medicare to require frequent and substantial servicing, therefore the 10 month rental limit does not apply. Refer to manual	2 per month	Monthly Rental only	December-09
E0461	Volume control ventilator, without pressure support mode, may include pressure control mode, used with non-invasive interface (e.g., mask)	Respiratory	No	No	Covered for recipients requiring negative pressure ventilator. Both a stationary and a portable ventilator may be covered if the recipient requires both. E0461 has been found by Medicare to require frequent and substantial servicing, therefore the 10 month rental limit does not apply. Refer to manual	2 per month	Monthly Rental only	December-09
E0462	Rocking bed, with or without side rails	Respiratory	Always	No	May be covered as an alternative to other noninvasive ventilation methods following evaluation by a physician who is skilled in pulmonology.	1 per month	Capped Rental only	December-09
E0463	Pressure support ventilator with volume control mode, may include pressure control mode, used with invasive interface (e.g., tracheostomy tube)	Respiratory	No	No	Covered for recipients requiring pressure support ventilator. Both a stationary and a portable ventilator may be covered if the recipient requires both. E0463 has been found by Medicare to require frequent and substantial servicing, therefore the 10 month rental limit does not apply. Refer to manual	2 per month	Monthly Rental only	December-09
E0464	Pressure support ventilator with volume control mode, may include pressure control mode, used with non-invasive interface (e.g., mask)	Respiratory	No	No	Covered for recipients requiring pressure support ventilator. Both a stationary and a portable ventilator may be covered if the recipient requires both. E0464 has been found by Medicare to require frequent and substantial servicing, therefore the 10 month rental limit does not apply. Refer to manual	2 per month	Monthly Rental only	December-09

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E0470	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)	Respiratory	Sometimes - see manual	No	Covered for recipients with obstructive sleep apnea who have failed with CPAP, and for recipients with other diagnoses which require ventilation assistance for 12 hours or less each day. Authorization is required for maintenance.	1 per 5 years	Capped Rental only	July-10
E0471	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)	Respiratory	Sometimes - see manual	No	Covered for recipients with diagnoses which require ventilation assistance for 12 hours or less each day. Authorization is required for maintenance.	1 per 5 years	Capped Rental only	July-10
E0472	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)	Respiratory	Sometimes - see manual	No	Covered for recipients recipients with diagnoses which require ventilation assistance for 12 hours or less each day. Authorization is required for maintenance.	1 per 5 years	Capped Rental only	July-10
E0480	Percussor, electric or pneumatic, home model	Respiratory	No	Y - NF N-ICF/DD	Purchase is covered only for recipients requiring long term assistance to clear the lungs. Rental is covered for recipients requiring short term assistance to clear the lungs, or as a trial prior to purchase	1 per 5 years	Rental or Purchase	December-09
E0481	Intrapulmonary percussive ventilation system and related accessories	Respiratory			Not covered. Investigative for all indications			September-10
E0482	Cough stimulating device, alternating positive and negative airway pressure	Respiratory	Always	No	Covered for recipients with severe lung conditions such as cystic fibrosis, ciliary dyskinesia, or bronchiectasis who have failed at other methods of clearing the lungs.	1 per 5 years	Rental or Purchase	December-09
E0483	High frequency chest wall oscillation air-pulse generator system (includes hoses and vest), each	Respiratory	Always	No	Covered for recipients with cystic fibrosis, or chronic bronchiectasis who have failed at other methods of clearing the lungs. Refer to manual	1 per 5 years	Rental or Purchase	December-09

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E0484	Oscillatory positive expiratory pressure device, non-electric, any type, each	Respiratory	No	No	Covered for recipients that require assistance with clearing the airways	1 per 3 years	Rental or Purchase	December-09
E0485	Oral device/appliance used to reduce upper airway collapsibility, adjustable or non-adjustable, prefabricated, includes fitting and adjustment	Sleep Apnea	Sometimes - see manual	No	Covered for recipients with sleep apnea. Requires prior authorization if submitted charge is over \$400.	1 per 5 years	Purchase only	December-09
E0486	Oral device/appliance used to reduce upper airway collapsibility, adjustable or non-adjustable, custom fabricated, includes fitting and adjustment	Sleep Apnea	Sometimes - see manual	No	Covered for recipients with sleep apnea. Requires prior authorization if submitted charge is over \$400.	1 per 5 years	Purchase only	December-09
E0487	Spirometer, electronic, includes all accessories	Respiratory	Always	Y - NF N-ICF/DD	Covered with authorization for home monitoring following lung or heart/lung transplant. See manual.	1 per 5 years	Rental or Purchase	December-09
E0500	IPPB machine, all types with built in nebulization, manual or automatic valves, internal or external power source	Respiratory	Sometimes - see manual	Y - NF N-ICF/DD	Covered for recipients with atelectasis or other conditions where the recipient's needs cannot be met with a nebulizer or other equipment. E0500 has been found by Medicare to require frequent and substantial servicing, so the 10 month rental limit does not apply	1 per month	Monthly Rental only	December-09
E0550	Humidifier, durable for extensive supplemental humidification during IPPB treatment or oxygen delivery	Respiratory	Sometimes - see manual	No	Covered for recipients requiring extensive supplemental humidification where less costly alternatives are not appropriate	1 per 3 years	Rental or Purchase	December-09
E0555	Humidifier, durable glass or autoclavable plastic bottle type, for use with regulator or flowmeter	Respiratory	No	Y - NF N-ICF/DD	Covered for recipients requiring supplemental humidification during respiratory treatments	1 per 3 months	Purchase only	December-09
E0560	Humidifier, durable for supplemental humidification during IPPB treatment or oxygen delivery	Respiratory	No	Y - NF N-ICF/DD	Covered for recipients requiring supplemental humidification during respiratory treatments	1 per year	Purchase only	December-09
E0561	Humidifier, non-heated, used with positive airway pressure device	Positive Airway Pressure	No	No	Covered for recipients requiring humidification during PAP treatment.	1 per 3 years	Rental or Purchase	December-09
E0562	Humidifier, heated, used with positive airway pressure device	Positive Airway Pressure	No	No	Covered for recipients requiring humidification during PAP treatment.	1 per 3 years	Rental or Purchase	December-09

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E0565	Compressor, air power source for equipment which is not self-contained or cylinder driven	Nebulizer	No	Y - NF N-ICF/DD	Covered for recipients receiving nebulized medications. Refer to manual	1 per 5 years	Rental or Purchase	December-09
E0570	Nebulizer with compressor	Nebulizer	No	Y - NF N-ICF/DD	Covered for recipients receiving nebulized medications. Refer to manual	1 per 5 years	Rental or Purchase	December-09
E0571	Aerosol compressor, battery powered, for use with small volume nebulizer	Nebulizer			Not valid for submission for dates of service 1/1/12 and beyond. Please see E0570			January-12
E0572	Aerosol compressor, adjustable pressure, light duty for intermittent use	Nebulizer	No	Y - NF N-ICF/DD	Covered for recipients receiving nebulized medications. Refer to manual	1 per 5 years	Rental or Purchase	December-09
E0574	Ultrasonic/electronic aerosol generator with small volume nebulizer	Nebulizer	No	Yes	Covered for recipients with cystic fibrosis receiving tobramycin treatment via nebulizer, or for recipients with pulmonary artery hypertension receiving treprostinil inhalation solution.	1 per 5 years	Rental or Purchase	January-12
E0575	Nebulizer, ultrasonic, large volume	Nebulizer	Always	Y - NF N-ICF/DD	Covered for recipients with cystic fibrosis receiving tobramycin treatment via nebulizer. As of 1/1/2011, E0575 is a capped rental item.	1 per month	Capped Rental only	January-11
E0580	Nebulizer, durable, glass or autoclavable plastic, bottle type, for use w/regulator or flowmeter	Nebulizer	No	Y - NF N-ICF/DD	Covered for recipients receiving nebulized medications. Refer to manual	1 per 3 years	Rental or Purchase	December-09
E0585	Nebulizer with compressor and heater	Nebulizer	No	Y - NF N-ICF/DD	Covered for recipients receiving nebulized medications. Refer to manual	1 per 5 years	Rental or Purchase	December-09
E0600	Respiratory suction pump, home model, portable or stationary, electric	Respiratory	No	Y - NF N-ICF/DD	Covered for recipients requiring oral pharyngeal or tracheal suctioning. A portable suction pump can function as a stationary pump. MHCP will not cover both a portable and a stationary pump unless substantial documentation establishes the medical necessity of both. No more than 1 unit can be billed per date of service.	1 per 5 years	Rental or Purchase	December-09
E0601	Continuous airway pressure (CPAP) device	Positive Airway Pressure	No	No	Covered for recipients with obstructive sleep apnea. Refer to manual.	1 per 5 years	Capped Rental only	July-10
E0602	Breast pump, manual, any type	Breast pump	No	Yes	Covered when ordered by the treating provider for any nursing mother experiencing separation from her infant because of work, school, illness or any other medical reason. Inform recipients that breast pumps are a personal care item that cannot be shared by mothers, but that can be used for future pregnancies. Bill using the mother's MHCP ID number, or the infant's MHCP ID number if the mother is ineligible	1 per 3 years	Purchase only	August-09

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E0603	Breast pump, electric (AC and / or DC), any type	Breast pump	No	No	Covered when ordered by the treating provider for any nursing mother experiencing separation from her infant because of work, school, illness or any other medical reason. Inform recipients that breast pumps are a personal care item that cannot be shared by mothers, but that can be used for future pregnancies. Bill using the mother's MHCP ID number, or the infant's MHCP ID number if the mother is ineligible	1 per 3 years	Purchase only	August-09
E0604	Breast pump, hospital grade, electric (AC and / or DC), any type	Breast pump	Sometimes - see manual	Yes	Covered when ordered by the treating provider for any nursing mother experiencing separation from her infant because of work, school, illness or any other medical reason. Bill accessory kits for E0604 breast pumps with modifier RA. Bill using the mother's MHCP ID number, or the infant's MHCP ID number if the mother is ineligible. PA required after 3 months rental.	1 per episode of need	Capped Rental only	March-11
E0605	Vaporizer, room type	Equipment	No	Yes	Covered when medically necessary for treatment of respiratory illness.	1 per year	Purchase only	December-09
E0606	Postural drainage board	Respiratory	No	Yes	Covered when medically necessary for treatment of respiratory conditions.	1 per 5 years	Rental or Purchase	December-09
E0607	Home blood glucose monitor	diabetes	No	Yes	Covered for monitoring of type 1 or type 2 diabetes, or when ordered by the physician for monitoring of other medical conditions that cause variations in blood glucose levels.	1 per 5 years	Purchase only	December-09
E0617	External defibrillator with integrated electrocardiogram analysis	External defibrillator	Always	Yes	Covered for recipients at risk of sudden cardiac death due to ventricular fibrillation or ventricular tachyarrhythmia. See manual	1 per 5 years	Capped Rental only	Dec-07
E0618	Apnea monitor, without recording feature	Apnea monitors	Sometimes - see manual	Y - NF N-ICF/DD	Covered for recipients under age 2 at risk of morbidity and mortality due to apnea	1 per 5 years	Rental or Purchase	August-10
E0619	Apnea Monitor, with recording feature	Apnea monitors	Sometimes - see manual	Y - NF N-ICF/DD	Covered for recipients under age 2 at risk of morbidity and mortality due to apnea when a monitor without recording feature will not meet the recipient's needs. Refer to manual.	1 per 5 years	Rental or Purchase	August-10
E0620	Skin piercing device for collection of capillary blood, laser, each	durable medical equipment	Always	Y - NF N-ICF/DD	Covered when demonstrated to be the least costly, medically appropriate way to meet the recipient's medical needs	1 per 5 years	Rental or Purchase	August-10
E0621	Sling or seat, patient lift, canvas or nylon	patient lifts	No	Yes	Covered to replace a worn sling or seat on a patient-owned lift.	1 per year	Rental or Purchase	August-10
E0625	Patient lift, bathroom or toilet, not otherwise classified	bath and toilet equipment	Always	yes	Covered for recipients unable to safely access the bath or toilet. Refer to manual.	1 per 5 years	Rental or Purchase	August-10

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E0627	Seat lift mechanism incorporated into a combination lift-chair mechanism	patient lifts	Always	Yes	Covered for recipients who are unable to rise from an armchair but who are able to walk. Refer to manual	1 per 5 years	Rental or Purchase	August-10
E0628	Separate seat lift mechanism for use with patient-owned furniture, electric	patient lifts	Always	Yes	Covered for recipients who are unable to rise from an armchair but who are able to walk. Refer to manual	1 per 5 years	Rental or Purchase	August-10
E0629	Separate seat lift mechanism for use with patient-owned furniture, nonelectric	patient lifts	Always	Yes	Covered for recipients who are unable to rise from an armchair but who are able to walk. Refer to manual	1 per 5 years	Rental or Purchase	August-10
E0630	Patient lift, hydraulic or mechanical, includes any seat, sling, strap(s), or pad(s)	patient lifts	No	Yes	Covered for recipients who are unable to safely transfer from chair to bed or similar. Refer to manual	1 per 5 years	Rental or Purchase	August-10
E0635	Patient lift, electric, with seat or sling	patient lifts	No	Yes	Covered for recipients who are unable to safely transfer from chair to bed or similar. Refer to manual	1 per 5 years	Rental or Purchase	August-10
E0636	Multipositional patient support system, with integrated lift, patient accessible controls	patient lifts	Always	Yes	Covered for recipients who are unable to safely transfer from chair to bed or similar when less costly alternatives cannot meet the recipient's specific medical needs. Refer to manual	1 per 5 years	Rental or Purchase	August-10
E0637	Combination sit to stand frame/table system, any size including pediatric, with seat lift feature, with or without wheels	standers	Always	Y - NF N-ICF/DD	Covered for recipients who cannot stand unassisted for appreciable amounts of time and who require weight bearing. Refer to manual	1 per 5 years	Rental or Purchase	August-10
E0638	Standing frame/table system, one position (e.g., upright, supine or prone stander), any size including pediatric, with or without wheels	standers	Always	Y - NF N-ICF/DD	Covered for recipients who cannot stand unassisted for appreciable amounts of time and who require weight bearing. Refer to manual	1 per 5 years	Rental or Purchase	August-10
E0639	Patient lift, moveable from room to room with disassembly and reassembly, includes all components/accessories	patient lifts	Always	Y - NF N-ICF/DD	Covered for recipients who are unable to safely transfer from chair to bed or similar when less costly alternatives cannot meet the recipient's specific medical needs. Refer to manual	1 per 5 years	Rental or Purchase	August-10
E0640	Patient lift, fixed system, includes all components / accessories	patient lifts			Not covered. A fixed system is a home modification, which is not covered by MHCP			August-10
E0641	Standing frame/table system, multi-position (e.g., three-way stander), any size including pediatric, with or without wheels	standers	Always	Y - NF N-ICF/DD	Covered for recipients who cannot stand unassisted for appreciable amounts of time and who require weight bearing. Refer to manual	1 per 5 years	Rental or Purchase	August-10

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E0642	Standing frame/table system, mobile (dynamic stander), any size including pediatric	standers	Always	Y - NF N-ICF/DD	Covered for recipients who cannot stand unassisted for appreciable amounts of time and who require weight bearing. Refer to manual	1 per 5 years	Rental or Purchase	August-10
E0650	Pneumatic compressor, non-segmental home model	pneumatic compression	Sometimes - see manual	No	Covered for recipients with chronic venous insufficiency of the lower extremities or lymphedema where conservative therapy has failed. Refer to manual	1 per 5 years	Rental or Purchase	August-10
E0651	Pneumatic compressor, segmental home model, without calibrated gradient pressure	pneumatic compression	Sometimes - see manual	No	Covered for recipients with chronic venous insufficiency of the lower extremities or lymphedema where conservative therapy has failed. Refer to manual	1 per 5 years	Rental or Purchase	August-10
E0652	Pneumatic compressor, segmental home model, with calibrated gradient pressure	pneumatic compression	Always	No	Covered for recipients with chronic venous insufficiency of the lower extremities or lymphedema where conservative therapy has failed and where non-segmental devices or segmental devices without calibrated gradient pressure cannot meet the recipient's medical needs. Refer to manual	1 per 5 years	Rental or Purchase	August-10
E0655	Non-segmental pneumatic appliance for use with pneumatic compressors, half arm	pneumatic compression	No	No	Covered for use with medically necessary pneumatic compression device. Refer to manual	2 per year	Rental or Purchase	August-10
E0656	Segmental pneumatic appliance for use with pneumatic compressor, trunk	pneumatic compression			Not covered. No additional payment is made for trunk, pelvis or chest appliances.			August-10
E0657	Segmental pneumatic appliance for use with pneumatic compressor, chest	pneumatic compression			Not covered. No additional payment is made for trunk, pelvis or chest appliances.			August-10
E0660	Non-segmental pneumatic appliance for use with pneumatic compressor, full leg	pneumatic compression	No	No	Covered for use with medically necessary pneumatic compression device. Refer to manual	2 per year	Rental or Purchase	August-10
E0665	Non-segmental pneumatic appliance for use with pneumatic compressor, full arm	pneumatic compression	No	No	Covered for use with medically necessary pneumatic compression device. Refer to manual	2 per year	Rental or Purchase	August-10
E0666	Non-segmental pneumatic appliance for use with pneumatic compressor, half leg	pneumatic compression	No	No	Covered for use with medically necessary pneumatic compression device. Refer to manual	2 per year	Rental or Purchase	August-10
E0667	Segmental pneumatic appliance for use with pneumatic compressor, full leg	pneumatic compression	No	No	Covered for use with medically necessary pneumatic compression device. Refer to manual	2 per year	Rental or Purchase	August-10

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E0668	Segmental pneumatic appliance for use with pneumatic compressor, full arm	pneumatic compression	No	No	Covered for use with medically necessary pneumatic compression device. Refer to manual	2 per year	Rental or Purchase	August-10
E0669	Segmental pneumatic appliance for use with pneumatic compressor, half leg	pneumatic compression	No	No	Covered for use with medically necessary pneumatic compression device. Refer to manual	2 per year	Rental or Purchase	August-10
E0671	Segmental gradient pressure pneumatic appliance, full leg	pneumatic compression	No	No	Covered for use with medically necessary pneumatic compression device. Refer to manual	2 per year	Rental or Purchase	August-10
E0672	Segmental gradient pressure pneumatic appliance, full arm	pneumatic compression	No	No	Covered for use with medically necessary pneumatic compression device. Refer to manual	2 per year	Rental or Purchase	August-10
E0673	Segmental gradient pressure pneumatic appliance, half leg	pneumatic compression	No	No	Covered for use with medically necessary pneumatic compression device. Refer to manual	2 per year	Rental or Purchase	August-10
E0675	Pneumatic compression device, high pressure, rapid inflation / deflation cycle, for arterial insufficiency (unilateral or bilateral system)	pneumatic compression	Always	No	Covered with authorization for treatment of peripheral artery disease for patients who might otherwise require surgical treatment of the arterial insufficiency.	1 unit per month	Capped Rental only	September-11
E0676	Intermittent limb compression device (includes all accessories), not otherwise specified	pneumatic compression	Sometimes - see manual	No	Covered when conservative treatment for phlebitis or similar conditions has failed. Authorization required for submitted charge over \$400.	1 unit per month	Capped Rental only	August-10
E0691	Ultraviolet light therapy system, includes bulbs/lamps, timer and eye protection	Phototherapy	Always	Y - NF N-ICF/DD	Covered with authorization for treatment of severe psoriasis when conservative treatment is contraindicated	1 unit per month	Rental or Purchase	February-12
E0692	Ultraviolet light therapy system, includes bulbs/lamps, timer and eye protection	Phototherapy	Always	Y - NF N-ICF/DD	Covered with authorization for treatment of severe psoriasis when conservative treatment is contraindicated	1 unit per month	Rental or Purchase	February-12
E0693	Ultraviolet light therapy system, includes bulbs/lamps, timer and eye protection	Phototherapy	Always	Y - NF N-ICF/DD	Covered with authorization for treatment of severe psoriasis when conservative treatment is contraindicated	1 unit per month	Rental or Purchase	February-12
E0694	Ultraviolet light therapy system, includes bulbs/lamps, timer and eye protection	Phototherapy			Not covered. Not proven to produce better outcomes than less costly systems.			February-12



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E0700	Safety equipment, device or accessory, any type	Miscellaneous supplies	Sometimes - see manual	Yes	Safety equipment that is attached to the home or vehicle is a non-covered home or vehicle modification. Other safety equipment may be covered. Authorization is required if the submitted charge is over \$400. Only one device may be dispensed per date of service	medical necessity	Rental or Purchase	January-10
E0705	Transfer device, any type, each	Miscellaneous supplies	Sometimes - see manual	Yes	Transfer devices that are attached to the home or vehicle are non-covered home or vehicle modifications. Other transfer devices, including transfer belts, may be covered. Authorization is required if the submitted charge is over \$400. Only one device may be dispensed per date of services	medical necessity	Rental or Purchase	February-12
E0710	restraints, any type (body, chest, wrist, or ankle)	Miscellaneous supplies	Always	Yes	Restraints are covered only as part of written home care plan of care, when needed for no longer than 15 minutes at a time during medical treatment where the recipient has demonstrated actions that pose a risk to the safe completion of the medical treatment. Restraints are not a substitute for supervision or behavioral intervention and must not be used for caregiver convenience.	medical necessity	Purchase only	February-12
E0720	Transcutaneous electrical nerve stimulation (TENS) device, 2 lead, localized stimulation	TENS	Always	No	Covered for acute pain and for chronic pain other than chronic low back pain. Refer to manual	1 unit per month	Rental or Purchase	February-12
E0730	Transcutaneous electrical nerve stimulation (TENS) device, 4 or more leads, for multiple nerve stimulation	TENS	Always	No	Covered for acute pain and for chronic pain other than chronic low back pain. Refer to manual	1 unit per month	Rental or Purchase	February-12
E0731	Form-fitting conductive garment for delivery of TENS or NMES (with conductive fibers separated from the patient's skin by layers of fabric)	TENS	Always	No	Covered for use with authorized TENS or NMES units when the recipient's needs cannot be met with conventional electrodes. Refer to manual	1 per 3 years	Purchase only	February-12
E0740	Incontinence treatment system, pelvic floor stimulator, monitor, sensor, and / or trainer	Miscellaneous supplies	Always	No	Pelvic floor electrical stimulation devices may be covered for recipients with stress and/or urge incontinence. Refer to manual.	1 per 5 years	Rental or Purchase	February-12
E0744	Neuromuscular stimulator for scoliosis	electrical stimulators	Sometimes - see manual	No	Neuromuscular stimulators may be covered for recipients with juvenile or adolescent single or double major idiopathic scoliosis. Refer to manual	1 per 5 years	Rental or Purchase	February-12
E0745	Neuromuscular stimulator, electronic shock unit	electrical stimulators	Always	No	Covered when criteria are met - refer to manual	1 per 5 years	Rental or Purchase	February-12

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E0746	Electromyography (EMG), biofeedback device	electrical stimulators			not covered			February-12
E0747	Osteogenesis stimulator, electrical, non-invasive other than spinal	bone growth stimulator	Always	No	Covered for treatment of nonfusion of fractures, and for pseudoarthroses. Refer to manual	1 unit per month	Rental or Purchase	May-10
E0748	Osteogenesis stimulator, electric, non-invasive spinal	bone growth stimulator	Always	No	Covered for nonhealing of spinal fusion and as an adjunct treatment for spinal fusion. Refer to manual	1 unit per month	Rental or Purchase	May-10
E0749	Osteogenesis stimulator, electrical, surgically implanted	bone growth stimulator	Always	No	Covered as an adjunct to spinal fusion. Refer to manual	1 per fusion	Rental or Purchase	May-10
E0755	Electronic salivary reflex stimulator (intraoral/noninvasive)	electrical stimulators			not covered			February-12
E0760	Osteogenesis stimulator, low intensity ultrasound, non-invasive	bone growth stimulator	Always	No	Covered for treatment of nonfusion of fractures. Refer to manual	1 unit per month	Rental or Purchase	May-10
E0761	Nonthermal pulsed high frequency radiowaves, high peak power electromagnetic energy treatment device	electrical stimulators			Not covered. Investigative			February-12
E0762	Transcutaneous electrical joint stimulation device system, includes all accessories	electrical stimulators			Not covered. Investigative.			December-11
E0764	Functional neuromuscular stimulation, transcutaneous stimulation of sequential muscle groups of ambulation with computer control, used for walking by spinal cord injured, entire system, after completion of training program	electrical stimulators			not covered. Investigative			February-12
E0765	FDA approved nerve stimulators, with replaceable batteries, for treatment of nausea and vomiting	electrical stimulators			Not covered. Investigative.			February-12
E0769	Electrical stimulation or electromagnetic wound treatment device, not otherwise classified	Wound care			Not covered. Investigative			February-12

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E0770	Functional electrical stimulator, transcutaneous stimulation of nerve and / or muscle groups, any type, complete system, not otherwise specified.	electrical stimulators	Always	No	Upper extremity functional electrical stimulators may be covered for recipient with upper limb paralysis due to cervical spine cord injury or chronic upper extremity paresis due to stroke. Refer to manual	1 per month	Rental or Purchase	February-12
E0776	IV Pole	Equipment	No	Y - NF N-ICF/DD	Covered for recipients receiving IV medications / fluids / nutrition. E0776 is not to be used when dispensing an IV holder that is part of or attached to a wheelchair.	1 per 3 years	Rental or Purchase	March-12
E0779	Ambulatory infusion pump, mechanical, reusable, for infusion 8 hours or greater	drug infusion supplies	No	Y - NF N-ICF/DD	Covered for recipients receiving drug infusion services. Document the following in the recipient's file at the medical supplier's office: the physician's order which includes the length of need (# of days per month and/or total number of months), diagnosis, name of drug, frequency of administration and a copy of the treatment plan	1 per episode of need	Capped Rental only	August-09
E0780	Ambulatory infusion pump, mechanical, reusable, for infusion less than 8 hours	drug infusion supplies	No	Y - NF N-ICF/DD	Covered for recipients receiving drug infusion services. Document the following in the recipient's file at the medical supplier's office: the physician's order which includes the length of need (# of days per month and/or total number of months), diagnosis, name of drug, frequency of administration and a copy of the treatment plan	1 per episode of need	Purchase only	August-09
E0781	Ambulatory infusion pump, single or multiple channels, electric or battery operated, with administrative equipment, worn by patient	drug infusion supplies	No	Y - NF N-ICF/DD	Covered for recipients receiving drug infusion services. Document the following in the recipient's file at the medical supplier's office: the physician's order which includes the length of need (# of days per month and/or total number of months), diagnosis, name of drug, frequency of administration and a copy of the treatment plan	1 per episode of need	Capped Rental only	August-09
E0784	External ambulatory infusion pump, insulin	diabetes	Always	No	Covered for diabetic recipients for whom self injection of insulin has provided insufficient control. Refer to manual	1 per 5 years	Purchase only	May-10
E0791	Parenteral infusion pump, stationary, single or multichannel	Nutritional products	Sometimes - see manual	Y - NF N-ICF/DD	Covered for recipients receiving parenteral nutrition.	1 per 5 years	Rental or Purchase	July-09
E0830	Ambulatory traction device, all types, each	Traction Equipment	Sometimes - see manual	Y - NF N-ICF/DD	Covered for recipients requiring traction. Authorization needed for submitted charge over \$400.	1 unit per month	Rental or Purchase	March-12
E0840	Traction frame, attached to headboard, cervical traction	Traction Equipment	No	Y - NF N-ICF/DD	Covered for recipients requiring cervical traction.	1 unit per month	Rental or Purchase	March-12
E0849	Traction equipment, cervical, free-standing stand/frame, pneumatic, applying traction force to other than mandible	Traction Equipment	Sometimes - see manual	Y - NF N-ICF/DD	Covered for recipients requiring cervical traction. Authorization required for repairs over \$400.	1 unit per month	Rental or Purchase	March-12

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E0850	Traction stand, freestanding, cervical traction	Traction Equipment	No	Y - NF N-ICF/DD	Covered for recipients requiring cervical traction.	1 unit per month	Rental or Purchase	March-12
E0855	Cervical traction equipment not requiring additional stand or frame	Traction Equipment	No	yes	Covered for recipients requiring traction.	1 unit per month	Capped Rental only	March-12
E0856	Cervical traction device, cervical collar with inflatable air bladder	Traction Equipment	No	Y - NF N-ICF/DD	Covered for recipients requiring cervical traction	1 unit per month	Rental or Purchase	March-12
E0860	Traction equipment, overdoor, cervical	Traction Equipment	No	Y - NF N-ICF/DD	Covered for recipients requiring cervical traction	1 unit per month	Rental or Purchase	March-12
E0870	Traction frame, attached to footboard, extremity traction (e.g. Buck's)	Traction Equipment	No	Y - NF N-ICF/DD	Covered for recipients requiring extremity traction	1 unit per month	Rental or Purchase	March-12
E0880	Traction stand, freestanding, extremity traction (e.g. Buck's)	Traction Equipment	No	Y - NF N-ICF/DD	Covered for recipients requiring extremity traction	1 unit per month	Rental or Purchase	March-12
E0890	Traction frame, attached to footboard, pelvic traction	Traction Equipment	No	Y - NF N-ICF/DD	Covered for recipients requiring pelvic traction	1 unit per month	Rental or Purchase	March-12
E0900	Traction stand, freestanding, pelvic traction (e.g. Buck's)	Traction Equipment	No	Y - NF N-ICF/DD	Covered for recipients requiring pelvic traction	1 unit per month	Rental or Purchase	March-12
E0910	Trapeze bars, also known as Patient Helper, attached to bed, with grab bar	Orthopedic devices	No	Yes	Covered for recipients who require a device to assist with movement in bed.	1 per 5 years	Rental or Purchase	February-12
E0911	Trapeze bar, heavy duty, for patient weight capacity greater than 250 pounds, attached to bed, with grab bar	Orthopedic devices	Sometimes - see manual	No	Covered for recipients who require a device to assist with movement in bed. Authorization required for repairs over \$400.	1 per 5 years	Rental or Purchase	February-12
E0912	Trapeze bar, heavy duty, for patient weight capacity greater than 250 pounds, free standing, complete with grab bar	Orthopedic devices	Sometimes - see manual	Y - NF N-ICF/DD	Covered for recipients who require a device to assist with movement in bed. Authorization required for repairs over \$400.	1 per 5 years	Rental or Purchase	February-12
E0920	Fracture frame, attached to bed, includes weights	Orthopedic devices	Sometimes - see manual	Y - NF N-ICF/DD	Covered for recipients with fractures requiring traction. Authorization required for repairs over \$400.	1 per 5 years	Rental or Purchase	February-12
E0930	Fracture frame, freestanding, includes weights	Orthopedic devices	Sometimes - see manual	Y - NF N-ICF/DD	Covered for recipients with fractures requiring traction. Authorization required for repairs over \$400.	1 per 5 years	Rental or Purchase	February-12

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E0935	Continuous passive motion exercise device; for knee only	Passive motion	No	Y - NF N-ICF/DD	Covered for recipients following knee replacement surgery.	2 units per day for up to 30 days	Daily rental	April-12
E0936	Continuous passive motion exercise device for use other than knee	Passive motion	No	Y - NF N-ICF/DD	Covered for recipients following joint surgery.	2 units per day for up to 30 days	Daily rental	April-12
E0940	Trapeze bar, freestanding, complete w/grab bar	Orthopedic devices	No	Y - NF N-ICF/DD	Covered for recipients who require a device to assist with movement in bed.	1 unit per month	Rental or Purchase	May-12
E0941	Gravity assisted traction device, any type	Orthopedic devices	Sometimes - see manual	Y - NF N-ICF/DD	Covered for recipients who require a device to assist with movement in bed. Authorization required for repairs over \$400.	1 unit per month	Rental or Purchase	May-12
E0942	Cervical head harness/halter	Orthopedic devices	No	Y - NF N-ICF/DD	Covered for recipients requiring a harness for rehabilitative therapy.	1 unit per month	Rental or Purchase	May-12
E0944	Pelvic belt/harness/boot	Orthopedic devices	No	Y - NF N-ICF/DD	Covered for recipients with lumbosacral pain.	1 unit per month	Rental or Purchase	May-12
E0945	Extremity belt/harness	Orthopedic devices	No	Y - NF N-ICF/DD	Covered for recipients requiring traction of the extremities.	1 unit per month	Rental or Purchase	May-12
E0946	Fracture frame, dual w/cross bars, attached to bed	Orthopedic devices	Sometimes - see manual	Y - NF N-ICF/DD	Covered for recipients requiring traction due to fracture. Authorization required for repairs over \$400.	1 unit per month	Rental or Purchase	May-12
E0947	Fracture frame, attachments for complex pelvic traction	Orthopedic devices	Sometimes - see manual	Y - NF N-ICF/DD	Covered for recipients requiring traction due to fracture. Authorization required for repairs over \$400.	1 unit per month	Rental or Purchase	May-12
E0948	Fracture frame, attachments for complex cervical traction	Orthopedic devices	Sometimes - see manual	Y - NF N-ICF/DD	Covered for recipients requiring traction due to fracture. Authorization required for repairs over \$400.	1 unit per month	Rental or Purchase	May-12
E0988	Manual wheelchair accessory, lever-activated, wheel drive, pair	Mobility devices			Not covered. No evidence of reduction of repetitive motion injury, not the standard of care.			January-12
E1015	Shock absorber for manual wheelchair, each	Mobility devices	Sometimes - see manual	Usually in NF per diem, never in ICF	1 shock absorber per wheel is covered when needed to minimize jarring of a recipient who uses a manual wheelchair.	2 per year	Rental or Purchase	October-10

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E1016	Shock absorber for power wheelchair, each	Mobility devices	Sometimes - see manual	Usually in NF per diem, never in ICF	1 shock absorber per wheel covered when needed to minimize jarring of a recipient who uses a power wheelchair.	4 per year	Rental or Purchase	October-10
E1017	Heavy duty shock absorber for heavy duty or extra heavy duty manual wheelchair, each	Mobility devices	Sometimes - see manual	Usually in NF per diem, never in ICF	1 shock absorber per wheel covered when needed to minimize jarring of a recipient who uses a heavy duty or extra heavy duty manual wheelchair.	2 per year	Rental or Purchase	October-10
E1018	Heavy duty shock absorber for heavy duty or extra heavy duty power wheelchair, each	Mobility devices	Sometimes - see manual	Usually in NF per diem, never in ICF	1 shock absorber per wheel covered when needed to minimize jarring of a recipient who uses a heavy duty or extra heavy duty power wheelchair.	4 per year	Rental or Purchase	October-10
E1028	Wheelchair accessory, manual swingaway, retractable or removable mounting hardware for joystick, other control interface or positioning accessory	Mobility devices	Sometimes - see manual	Usually in NF per diem, never in ICF	Covered when needed to allow accessories to be moved for transfers or personal or medical cares.	7 per year	Rental or Purchase	October-10
E1035	Multi-positional patient transfer system, with integrated seat, operated by a caregiver, patient weight capacity up to and including 300 lbs	Mobility Devices	Sometimes - see manual	Y - NF N-ICF/DD	Covered for recipients who require a manual wheelchair to complete activities of daily living. Refer to manual	1 per 5 years	Rental or Purchase	January-10
E1036	Multi-positional patient transfer system, extra-wide, with integrated seat, operated by a caregiver, patient weight capacity greater than 300 lbs	Mobility Devices	Sometimes - see manual	Y - NF N-ICF/DD	Covered for recipients who require a manual wheelchair to complete activities of daily living. Refer to manual	1 per 5 years	Rental or Purchase	January-10
E1831	Static progressive stretch toe device, extension and / or flexion, with or without range of motion adjustment, includes all components and accessories	Orthopedic devices	No	No	Covered when medically necessary for treatment of decreased range of motion when less costly alternatives have been tried and failed.	2 per 5 years	Rental or Purchase	January-11

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E2100	Blood glucose monitor with integrated voice synthesizer	diabetes	Always	Yes	Covered for diabetic recipients with severe visual impairment. Refer to manual	1 per 5 years	Rental or Purchase	May-10
E2101	Blood glucose monitor with integrated lancing/blood sample	diabetes	Always	Yes	Covered for diabetic recipients with impairment of manual dexterity. Refer to manual.	1 per 5 years	Rental or Purchase	May-10
E2358	Power wheelchair accessory, group 34 non-sealed lead acid battery, each	Mobility devices	Sometimes - see manual	No	Covered for recipients who use power wheelchairs that require this kind of battery.	2 per year	Rental or Purchase	January-12
E2359	Power wheelchair accessory, group 34 sealed lead acid battery, each (e.g. gel cell, absorbed glassmat)	Mobility devices	Sometimes - see manual	No	Covered for recipients who use power wheelchairs that require this kind of battery.	2 per year	Rental or Purchase	January-12
E2622	Skin protection wheelchair seat cushion, adjustable, width less than 22 inches, any depth	Mobility Devices	Sometimes - see manual	Y - NF N-ICF/DD	Covered for recipients who use wheelchairs and are vulnerable to skin breakdown. Refer to manual for complete information regarding mobility devices	1 per year	Rental or Purchase	January-11
E2623	Skin protection wheelchair seat cushion, adjustable, width 22 inches or greater, any depth	Mobility Devices	Sometimes - see manual	Y - NF N-ICF/DD	Covered for recipients who use wheelchairs and are vulnerable to skin breakdown. Refer to manual for complete information regarding mobility devices	1 per year	Rental or Purchase	January-11
E2624	Skin protection and positioning wheelchair seat cushion, adjustable, width less than 22 inches, any depth	Mobility Devices	Sometimes - see manual	Y - NF N-ICF/DD	Covered for recipients who use wheelchairs, require some positioning assistance and are vulnerable to skin breakdown. Refer to manual for complete information regarding mobility devices	1 per year	Rental or Purchase	January-11
E2625	Skin protection and positioning wheelchair seat cushion, adjustable, width 22 inches or greater, any depth	Mobility Devices	Sometimes - see manual	Y - NF N-ICF/DD	Covered for recipients who use wheelchairs, require some positioning assistance and are vulnerable to skin breakdown. Refer to manual for complete information regarding mobility devices	1 per year	Rental or Purchase	January-11
E2626	Wheelchair accessory, shoulder elbow, mobile arm support attached to wheelchair, balanced, adjustable	Mobility devices	Sometimes - see manual	No	Covered for recipients requiring a mobile arm support to complete activities of daily living in a wheelchair	1 per 5 years	Rental or Purchase	January-12
E2627	Wheelchair accessory, shoulder elbow, mobile arm support attached to wheelchair, balanced, adjustable Rancho type	Mobility devices	Sometimes - see manual	No	Covered for recipients requiring a mobile arm support to complete activities of daily living in a wheelchair	1 per 5 years	Rental or Purchase	January-12

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E2628	Wheelchair accessory, shoulder elbow, mobile arm support attached to wheelchair, balanced, reclining	Mobility devices	Sometimes - see manual	No	Covered for recipients requiring a mobile arm support to complete activities of daily living in a wheelchair	1 per 5 years	Rental or Purchase	January-12
E2629	Wheelchair accessory, shoulder elbow, mobile arm support attached to wheelchair, balanced, friction arm support (friction dampening to proximal and distal joints)	Mobility devices	Sometimes - see manual	No	Covered for recipients requiring a mobile arm support to complete activities of daily living in a wheelchair	1 per 5 years	Rental or Purchase	January-12
E2630	Wheelchair accessory, shoulder elbow, mobile arm support, monosuspension arm and hand support, overhead elbow forearm hand sling support, yoke type suspension support	Mobility devices	Sometimes - see manual	No	Covered for recipients requiring a mobile arm support to complete activities of daily living in a wheelchair	1 per 5 years	Rental or Purchase	January-12
E2631	Wheelchair accessory, addition to mobile arm support, elevating proximal arm	Mobility devices	Sometimes - see manual	No	Covered for recipients requiring a mobile arm support to complete activities of daily living in a wheelchair	1 per 3 years	Rental or Purchase	January-12
E2632	Wheelchair accessory, addition to mobile arm support, offset or lateral rocker arm with elastic balance control	Mobility devices	Sometimes - see manual	No	Covered for recipients requiring a mobile arm support to complete activities of daily living in a wheelchair	1 per 3 years	Rental or Purchase	January-12
E2633	Wheelchair accessory, addition to mobile arm support, supinator	Mobility devices	Sometimes - see manual	No	Covered for recipients requiring a mobile arm support to complete activities of daily living in a wheelchair	1 per 3 years	Rental or Purchase	January-12
E8000	Gait trainer, pediatric size, posterior support, includes all accessories and components	Ambulatory Assist devices	Always	No	Covered for recipients who require moderate to maximum support to walk, and who require the equipment to establish or maintain functional gait. Refer to manual	1 per 5 years	Rental or Purchase	January-11
E8001	Gait trainer, pediatric size, upright support, includes all accessories and components	Ambulatory Assist devices	Always	No	Covered for recipients who require moderate to maximum support to walk, and who require the equipment to establish or maintain functional gait. Refer to manual	1 per 5 years	Rental or Purchase	January-11
E8002	Gait trainer, pediatric size, anterior support, includes all accessories and components	Ambulatory Assist devices	Always	No	Covered for recipients who require moderate to maximum support to walk, and who require the equipment to establish or maintain functional gait. Refer to manual	1 per 5 years	Rental or Purchase	January-11

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K0001	Standard wheelchair	Mobility Devices	Sometimes - see manual	Usually in NF per diem, never in ICF	Covered for recipients who require a manual wheelchair to complete activities of daily living. Refer to manual	1 per 5 years	Rental or Purchase	February-09
K0002	Standard hemi (low seat) wheelchair	Mobility Devices	Sometimes - see manual	Usually in NF per diem, never in ICF	Covered for recipients who require a manual wheelchair to complete activities of daily living. Refer to manual	1 per 5 years	Rental or Purchase	February-09
K0003	Lightweight wheelchair	Mobility Devices	Sometimes - see manual	Usually in NF per diem, never in ICF	Covered for recipients who require a manual wheelchair to complete activities of daily living. Refer to manual	1 per 5 years	Rental or Purchase	February-09
K0004	High strength, lightweight wheelchair	Mobility Devices	Sometimes - see manual	Usually in NF per diem, never in ICF	Covered for recipients who require a manual wheelchair to complete activities of daily living. Refer to manual	1 per 5 years	Rental or Purchase	February-09
K0005	Ultra lightweight wheelchair	Mobility Devices	Sometimes - see manual	Usually in NF per diem, never in ICF	Covered for recipients who require a manual wheelchair to complete activities of daily living. Refer to manual	1 per 5 years	Rental or Purchase	February-09
K0006	Heavy duty wheelchair	Mobility Devices	Sometimes - see manual	Usually in NF per diem, never in ICF	Covered for recipients who require a manual wheelchair to complete activities of daily living. Refer to manual	1 per 5 years	Rental or Purchase	February-09
K0007	Extra heavy duty wheelchair	Mobility Devices	Sometimes - see manual	Usually in NF per diem, never in ICF	Covered for recipients who require a manual wheelchair to complete activities of daily living. Refer to manual	1 per 5 years	Rental or Purchase	February-09

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K0009	Other manual wheelchair / base	Mobility Devices	Sometimes - see manual	Usually in NF per diem, never in ICF	Covered for recipients who require a manual wheelchair to complete activities of daily living. Refer to manual	1 per 5 years	Rental or Purchase	February-09
K0011	Standard-weight frame motorized / power wheelchair with programmable control parameters for speed adjustment, tremor dampening, acceleration control and braking	Mobility Devices	Sometimes - see manual	No	As of 3/1/2008, this code may only be used for repair of a recipient owned device that was originally purchased using this code. See manual.			February-09
K0012	Lightweight portable motorized / power wheelchair	Mobility Devices	Sometimes - see manual	No	As of 3/1/2008, this code may only be used for repair of a recipient owned device that was originally purchased using this code. See manual.			February-09
K0014	Other motorized / power wheelchair base	Mobility Devices	Sometimes - see manual	No	As of 3/1/2008, this code may only be used for repair of a recipient owned device that was originally purchased using this code. See manual.			February-09
K0015	Detachable, non-adjustable height armrest, each	Mobility Devices	Sometimes - see manual	Usually in NF per diem, never in ICF	Covered when attached to a covered wheelchair. Usually don't need replacement more than every 3 years. Cannot be billed with initial issue of manual or power wheelchair. Refer to manual.	2 per year	Rental or Purchase	February-09
K0017	Detachable, adjustable height armrest, base, each	Mobility Devices	Sometimes - see manual	Usually in NF per diem, never in ICF	Covered when attached to a covered wheelchair. Usually don't need replacement more than every 3 years. Cannot be billed with initial issue of manual or power wheelchair. Refer to manual.	2 per year	Rental or Purchase	February-09
K0018	Detachable, adjustable height armrest, upper portion, each	Mobility Devices	Sometimes - see manual	Usually in NF per diem, never in ICF	Covered when attached to a covered wheelchair. Usually don't need replacement more than every 3 years. Cannot be billed with initial issue of manual or power wheelchair. Refer to manual.	2 per year	Rental or Purchase	February-09
K0019	Arm pad, each	Mobility Devices	Sometimes - see manual	Usually in NF per diem, never in ICF	Covered when attached to a covered wheelchair. Usually don't need replacement more than once per year. Cannot be billed with initial issue of manual or power wheelchair. Refer to manual.	4 per year	Rental or Purchase	February-09

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K0020	Fixed, adjustable height armrest, pair	Mobility Devices	Sometimes - see manual	Usually in NF per diem, never in ICF	Covered when attached to a covered wheelchair. Usually don't need replacement more than every 3 years. Cannot be billed with initial issue of power wheelchair. Refer to manual.	2 per year	Rental or Purchase	February-09
K0037	High mount flip-up footrest, each	Mobility Devices	Sometimes - see manual	Usually in NF per diem, never in ICF	Covered when attached to a covered wheelchair. Usually don't need replacement more than every 3 years. Cannot be billed with initial issue of power wheelchair. Refer to manual.	2 per year	Rental or Purchase	February-09
K0038	Leg strap, each	Mobility Devices	Sometimes - see manual	Usually in NF per diem, never in ICF	Covered when attached to a covered wheelchair. Usually don't need replacement more than once per year. Refer to manual.	2 per year	Rental or Purchase	February-09
K0039	Leg strap, H style, each	Mobility Devices	Sometimes - see manual	Usually in NF per diem, never in ICF	Covered when attached to a covered wheelchair. Usually don't need replacement more than once per year. Refer to manual.	2 per year	Rental or Purchase	February-09
K0040	Adjustable angle footplate, each	Mobility Devices	Sometimes - see manual	Usually in NF per diem, never in ICF	Covered when attached to a covered wheelchair. Usually don't need replacement more than every 3 years. Refer to manual.	2 per year	Rental or Purchase	February-09
K0041	Large size footplate, each	Mobility Devices	Sometimes - see manual	Usually in NF per diem, never in ICF	Covered when attached to a covered wheelchair. Usually don't need replacement more than every 3 years. Cannot be billed with initial issue of power wheelchair. Refer to manual.	2 per year	Rental or Purchase	February-09
K0042	Standard size footplate, each	Mobility Devices	Sometimes - see manual	Usually in NF per diem, never in ICF	Covered when attached to a covered wheelchair. Usually don't need replacement more than every 3 years. Cannot be billed with initial issue of manual or power wheelchair. Refer to manual.	2 per year	Rental or Purchase	February-09

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K0043	Footrest, lower extension tube, each	Mobility Devices	Sometimes - see manual	Usually in NF per diem, never in ICF	Covered when attached to a covered wheelchair. Usually don't need replacement more than every 3 years. Cannot be billed with initial issue of manual or power wheelchair. Refer to manual.	2 per year	Rental or Purchase	February-09
K0044	Footrest, upper hanger bracket, each	Mobility Devices	Sometimes - see manual	Usually in NF per diem, never in ICF	Covered when attached to a covered wheelchair. Usually don't need replacement more than every 3 years. Cannot be billed with initial issue of manual or power wheelchair. Refer to manual.	2 per year	Rental or Purchase	February-09
K0045	Footrest, complete assembly	Mobility Devices	Sometimes - see manual	Usually in NF per diem, never in ICF	Covered when attached to a covered wheelchair. Usually don't need replacement more than every 3 years. Cannot be billed with initial issue of manual or power wheelchair. Refer to manual.	2 per year	Rental or Purchase	February-09
K0046	Elevating legrest, lower extension tube, each	Mobility Devices	Sometimes - see manual	Usually in NF per diem, never in ICF	Covered when attached to a covered wheelchair. Usually don't need replacement more than every 3 years. Cannot be billed with initial issue of manual or power wheelchair. Refer to manual.	2 per year	Rental or Purchase	February-09
K0047	Elevating legrest, upper hanger bracket, each	Mobility Devices	Sometimes - see manual	Usually in NF per diem, never in ICF	Covered when attached to a covered wheelchair. Usually don't need replacement more than every 3 years. Cannot be billed with initial issue of manual or power wheelchair. Refer to manual.	2 per year	Rental or Purchase	February-09
K0050	Ratchet assembly	Mobility Devices	Sometimes - see manual	Usually in NF per diem, never in ICF	Covered when attached to a covered wheelchair. Usually don't need replacement more than every 3 years. Cannot be billed with initial issue of manual or power wheelchair. Refer to manual.	2 per year	Rental or Purchase	February-09
K0051	Cam release assembly, footrest or legrest, each	Mobility Devices	Sometimes - see manual	Usually in NF per diem, never in ICF	Covered when attached to a covered wheelchair. Usually don't need replacement more than every 3 years. Cannot be billed with initial issue of manual or power wheelchair. Refer to manual.	2 per year	Rental or Purchase	February-09

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K0052	Swingaway, detachable footrests, each	Mobility Devices	Sometimes - see manual	Usually in NF per diem, never in ICF	Covered when attached to a covered wheelchair. Usually don't need replacement more than every 3 years. Cannot be billed with initial issue of manual or power wheelchair. Refer to manual.	2 per year	Rental or Purchase	February-09
K0053	Elevating legrest, articulating (telescoping), each	Mobility Devices	Sometimes - see manual	Usually in NF per diem, never in ICF	Covered when attached to a covered wheelchair. Usually don't need replacement more than every 3 years. Cannot be billed with initial issue of manual or power wheelchair. Refer to manual.	2 per year	Rental or Purchase	February-09
K0056	Seat height of less than 17" or equal to or greater than 21" for high strength, lightweight or ultra lightweight wheelchair	Mobility Devices	Sometimes - see manual	Usually in NF per diem, never in ICF	Covered when part of a covered wheelchair. Because this is a modification to the base chair, it should not require replacement. Refer to manual.	1 per 5 years	Rental or Purchase	February-09
K0065	Spoke protectors, each	Mobility Devices	Sometimes - see manual	Usually in NF per diem, never in ICF	Covered when part of a covered manual wheelchair. Usually does not require replacement more than every 2 - 3 years. Refer to manual	2 per year	Rental or Purchase	February-09
K0069	Rear wheel assembly, complete, with solid tier, spokes or molded, each	Mobility Devices	Sometimes - see manual	Usually in NF per diem, never in ICF	Covered when part of a covered wheelchair. Usually does not require replacement more than once per 3 years. Cannot be billed with initial issue of a wheelchair. Refer to manual	2 per year	Purchase only	February-09
K0070	Rear wheel assembly, complete, w/ pneumatic tire, spokes or molded, each	Mobility Devices	Sometimes - see manual	Usually in NF per diem, never in ICF	Covered when part of a covered wheelchair. Usually does not require replacement more than once per 3 years. Cannot be billed with initial issue of a wheelchair. Refer to manual	2 per year	Purchase only	February-09
K0071	Front caster assembly, complete w/pneumatic tire, each	Mobility Devices	Sometimes - see manual	Usually in NF per diem, never in ICF	Covered when part of a covered wheelchair. Usually does not require replacement more than once per 3 years. Cannot be billed with initial issue of a wheelchair. Refer to manual	2 per year	Purchase only	February-09

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K0072	Front caster assembly, complete w/semi-pneumatic tire, each	Mobility Devices	Sometimes - see manual	Usually in NF per diem, never in ICF	Covered when part of a covered wheelchair. Usually does not require replacement more than once per 3 years. Cannot be billed with initial issue of a wheelchair. Refer to manual	2 per year	Purchase only	February-09
K0073	Caster pin lock, each	Mobility Devices	Sometimes - see manual	Usually in NF per diem, never in ICF	Covered when part of a covered wheelchair. Usually does not require replacement more than once per 2 years. Refer to manual	2 per year	Purchase only	February-09
K0077	Front caster assembly, complete w/solid tire, each	Mobility Devices	Sometimes - see manual	Usually in NF per diem, never in ICF	Covered when part of a covered wheelchair. Usually does not require replacement more than once per 3 years. Cannot be billed with initial issue of a wheelchair. Refer to manual	2 per year	Purchase only	February-09
K0098	Drive belt for power wheelchair	Mobility Devices	Sometimes - see manual	Usually in NF per diem, never in ICF	Covered when part of a covered wheelchair. Usually does not require replacement more than once per 2 years. Cannot be billed with initial issue of a wheelchair. Refer to manual	1 per year	Purchase only	February-09
K0105	IV Hanger, each	Equipment	No	Y - NF N-ICF/DD	Covered for recipients receiving IV medications / fluids / nutrition.	1 per year	Rental or Purchase	July-09
K0108	Wheelchair component or accessory, not otherwise specified	Mobility Devices	Sometimes - see manual	Usually in NF per diem, never in ICF	Covered when part of a covered wheelchair. Only to be used when a more specific code is not available. Refer to manual	medical necessity	Rental or Purchase	July-09
K0195	Elevating legrests, pair (for use with capped rental wheelchair base)	Mobility Devices	Sometimes - see manual	Usually in NF per diem, never in ICF	Covered when part of a covered wheelchair. Refer to manual	1 per year	Rental or Purchase	July-09

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K0455	Infusion pump used for uninterrupted parenteral administration of medication (e.g. epoprostenol or trepostinol)	drug infusion supplies	Always	No	Covered when the recipient is receiving a medication that requires continuous parenteral infusion. Only one pump is covered, but the supplier is responsible for ensuring that there is an appropriate contingency plan to address any emergency situations. K0455 has been found by Medicare to require frequent and substantial servicing, therefore the 10 month rental limit does not apply.	1 per month during period of infusion	Monthly Rental only	July-09
K0462	Temporary replacement for patient-owned equipment being repaired, any type	Equipment	Sometimes - see manual	No	Covered when providers do not have appropriate loaner equipment for the recipient to use while their equipment is being repaired.	1 per month	Capped Rental only	October-10
K0552	Supplies for external drug infusion pump, syringe type cartridge, sterile, each	drug infusion supplies	No	Y - NF N-ICF/DD	Covered when medically necessary for recipients using external drug infusion pump.	30 per month	Purchase only	July-09
K0601	Replacement battery for external infusion pump owned by patient, silver oxide, 1.5 volt, each	drug infusion supplies	No	No	Covered for recipient owned external infusion pumps.	4 per month	Purchase only	July-09
K0602	Replacement battery for external infusion pump owned by patient, silver oxide, 3 volt, each	drug infusion supplies	No	No	Covered for recipient owned external infusion pumps.	4 per month	Purchase only	July-09
K0603	Replacement battery for external infusion pump owned by patient, alkaline, 1.5 volt, each	drug infusion supplies	No	No	Covered for recipient owned external infusion pumps.	4 per month	Purchase only	July-09
K0604	Replacement battery for external infusion pump owned by patient, lithium, 3.6 volt, each	drug infusion supplies	No	No	Covered for recipient owned external infusion pumps.	4 per month	Purchase only	July-09
K0605	Replacement battery for external infusion pump owned by patient, lithium, 4.5 volt, each	drug infusion supplies	No	No	Covered for recipient owned external infusion pumps.	4 per month	Purchase only	July-09
K0606	Automatic external defibrillator, with integrated electrocardiogram analysis, garment type	External defibrillator	Always	No	Covered for adult recipients at risk of sudden cardiac death due to ventricular fibrillation or ventricular tachyarrhythmia. See manual	1 per 5 years	Capped Rental only	December-07
K0607	Replacement battery for automated external defibrillator, garment type only, each	External defibrillator	No	No	Covered for adult recipients at risk of sudden cardiac death due to ventricular fibrillation or ventricular tachyarrhythmia with patient-owned garment type external defibrillator. See manual	1 per year	Purchase only	December-07



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K0608	Replacement garment for use with automated external defibrillator	External defibrillator	No	No	Covered for adult recipients at risk of sudden cardiac death due to ventricular fibrillation or ventricular tachyarrhythmia with patient-owned garment type external defibrillator. See manual	1 per 6 months	Purchase only	December-07
K0609	Replacement electrodes for use with automated external defibrillator, garment type only, each	External defibrillator	No	No	Covered for adult recipients at risk of sudden cardiac death due to ventricular fibrillation or ventricular tachyarrhythmia with patient-owned garment type external defibrillator. See manual	1 per 2 years	Purchase only	December-07
K0669	Wheelchair accessory, wheelchair seat or back cushion, does not meet specific code criteria or no written coding verification from DME PDAC	Mobility Devices	Sometimes - see manual	Usually in NF per diem, never in ICF	Covered for recipients for whom a cushion with a specific code is not appropriate.	2 per year	Rental or Purchase	July-09
K0672	Addition to lower extremity orthosis, removable soft interface, all components, replacement only, each	Orthotics	Sometimes - see manual	No	Covered when patient owns a lower extremity orthosis requiring a soft interface replacement.	2 per year	Purchase only	April-08
K0730	Controlled dose inhalation drug delivery system	Respiratory	No	Y - NF N-ICF/DD	Covered only if there is an approved prior authorization for Ventavis. Enter PA # in notes field.	1 per month during treatment period	Capped Rental only	July-09
K0733	Power wheelchair accessory, 12 to 24 amp hour sealed lead acid battery, each (e.g., gel cell, absorbed glassmat)	Mobility Devices	Sometimes - see manual	Usually in NF per diem, never in ICF	Covered for power wheelchairs requiring this kind of battery. Refer to manual for complete information regarding mobility devices	2 per year	Rental or Purchase	February-08
K0738	Portable gaseous oxygen system, rental; home compressor used to fill portable oxygen cylinders; includes portable containers, regulator, flowmeter, humidifier, cannula or mask, and tubing	Respiratory	Sometimes - see manual	No	Covered for recipients who require portable oxygen and are willing and capable to use the home compressor to fill their own cylinders. MHCP will not pay for portable liquid or portable gas oxygen for recipients using the home compressor. Refer to manual for complete information regarding oxygen and the oxygen contract.	1 per month	Capped Rental only	July-09

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K0739	Repair or nonroutine service for durable medical equipment other than oxygen equipment requiring the skill of a technician, labor component, per 15 minutes	labor/repairs	Sometimes - see manual	No	Covered for necessary repairs to patient owned medically necessary equipment.	48 units per day	Purchase only	January-10
K0740	Repair or nonroutine service for oxygen equipment requiring the skill of a technician, labor component, per 15 minutes	labor/repairs	Sometimes - see manual	No	Covered for necessary repairs to patient owned medically necessary equipment.	48 units per day	Purchase only	January-10
K0741	Portable gaseous oxygen system, rental, includes portable container, regulator, flowmeter, humidifier, cannula or mask, and tubing, for cluster headaches	Oxygen			not covered. Use E0431			July-11
K0742	Portable oxygen contents, gaseous, 1 month's supply = 1 unit, for cluster headaches, for initial month's supply or to replace used contents	Oxygen			Not covered. Use E0443 or S8120			July-11
K0743	Suction pump, home model, portable, for use on wounds	Wound care	Always	No	Covered for recipients with chronic non-healing wounds. Refer to manual	1 per month	Capped Rental only	July-11
K0744	Absorptive wound dressing for use with suction pump, home model, portable, pad size 16 square inches or less	Wound care	No	No	covered for recipients with approved K0743.	31 per month	Purchase only	July-11
K0745	Absorptive wound dressing for use with suction pump, home model, portable, pad size more than 16 square inches but less than or equal to 48 square inches	Wound care	No	No	covered for recipients with approved K0743.	31 per month	Purchase only	July-11
K0746	Absorptive wound dressing for use with suction pump, home model, portable, pad size greater than 48 square inches	Wound care	No	No	covered for recipients with approved K0743.	31 per month	Purchase only	July-11

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K0800	Power operated vehicle, group 1 standard, patient weight capacity up to and including 300 pounds	Mobility Devices	Sometimes - see manual	No	Mobility devices are covered for eligible MHCP recipients with a mobility limitation that significantly impairs their ability to participate in one or more mobility-related activities of daily living and the mobility limitation cannot be sufficiently resolved by the use of an appropriately fitted cane or walker. Refer to manual for complete information	1 per 5 years	Rental or Purchase	February-08
K0801	Power operated vehicle, group 1 heavy duty, patient weight capacity 301 to 450 pounds	Mobility Devices	Sometimes - see manual	No	Mobility devices are covered for eligible MHCP recipients with a mobility limitation that significantly impairs their ability to participate in one or more mobility-related activities of daily living and the mobility limitation cannot be sufficiently resolved by the use of an appropriately fitted cane or walker. Refer to manual for complete information	1 per 5 years	Rental or Purchase	February-08
K0802	Power operated vehicle, group 1 very heavy duty, patient weight capacity 451 to 600 pounds	Mobility Devices	Sometimes - see manual	No	Mobility devices are covered for eligible MHCP recipients with a mobility limitation that significantly impairs their ability to participate in one or more mobility-related activities of daily living and the mobility limitation cannot be sufficiently resolved by the use of an appropriately fitted cane or walker. Refer to manual for complete information	1 per 5 years	Rental or Purchase	February-08
K0806	Power operated vehicle, group 2 standard, patient weight capacity up to and including 300 pounds	Mobility Devices	Sometimes - see manual	No	Mobility devices are covered for eligible MHCP recipients with a mobility limitation that significantly impairs their ability to participate in one or more mobility-related activities of daily living and the mobility limitation cannot be sufficiently resolved by the use of an appropriately fitted cane or walker. Refer to manual for complete information	1 per 5 years	Rental or Purchase	February-08
K0807	Power operated vehicle, group 2 heavy duty, patient weight capacity 301 to 450 pounds	Mobility Devices	Sometimes - see manual	No	Mobility devices are covered for eligible MHCP recipients with a mobility limitation that significantly impairs their ability to participate in one or more mobility-related activities of daily living and the mobility limitation cannot be sufficiently resolved by the use of an appropriately fitted cane or walker. Refer to manual for complete information	1 per 5 years	Rental or Purchase	February-08
K0808	Power operated vehicle, group 2 very heavy duty, patient weight capacity 451 to 600 pounds	Mobility Devices	Sometimes - see manual	No	Mobility devices are covered for eligible MHCP recipients with a mobility limitation that significantly impairs their ability to participate in one or more mobility-related activities of daily living and the mobility limitation cannot be sufficiently resolved by the use of an appropriately fitted cane or walker. Refer to manual for complete information	1 per 5 years	Rental or Purchase	February-08

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K0812	Power operated vehicle, not otherwise classified	Mobility Devices	Sometimes - see manual	No	As of 3/1/2008, this code may only be used for repair of a recipient owned device that was originally purchased using this code. See manual.			February-08
K0813	Power wheelchair, group 1 standard, portable, sling/solid seat and back, patient weight capacity up to and including 300 pounds	Mobility Devices	Sometimes - see manual	No	Mobility devices are covered for eligible MHCP recipients with a mobility limitation that significantly impairs their ability to participate in one or more mobility-related activities of daily living and the mobility limitation cannot be sufficiently resolved by the use of an appropriately fitted cane or walker. Refer to manual for complete information	1 per 5 years	Rental or Purchase	February-08
K0814	Power wheelchair, group 1 standard, portable, captains chair, patient weight capacity up to and including 300 pounds	Mobility Devices	Sometimes - see manual	No	Mobility devices are covered for eligible MHCP recipients with a mobility limitation that significantly impairs their ability to participate in one or more mobility-related activities of daily living and the mobility limitation cannot be sufficiently resolved by the use of an appropriately fitted cane or walker. Refer to manual for complete information	1 per 5 years	Rental or Purchase	February-08
K0815	Power wheelchair, group 1 standard, sling/solid seat and back, patient weight capacity up to and including 300 pounds	Mobility Devices	Sometimes - see manual	No	Mobility devices are covered for eligible MHCP recipients with a mobility limitation that significantly impairs their ability to participate in one or more mobility-related activities of daily living and the mobility limitation cannot be sufficiently resolved by the use of an appropriately fitted cane or walker. Refer to manual for complete information	1 per 5 years	Rental or Purchase	February-08
K0816	Power wheelchair, group 1 standard, captains chair, patient weight capacity up to and including 300 pounds	Mobility Devices	Sometimes - see manual	No	Mobility devices are covered for eligible MHCP recipients with a mobility limitation that significantly impairs their ability to participate in one or more mobility-related activities of daily living and the mobility limitation cannot be sufficiently resolved by the use of an appropriately fitted cane or walker. Refer to manual for complete information	1 per 5 years	Rental or Purchase	February-08
K0820	Power wheelchair, group 2 standard, portable, sling/solid seat and back, patient weight capacity up to and including 300 pounds	Mobility Devices	Sometimes - see manual	No	Mobility devices are covered for eligible MHCP recipients with a mobility limitation that significantly impairs their ability to participate in one or more mobility-related activities of daily living and the mobility limitation cannot be sufficiently resolved by the use of an appropriately fitted cane or walker. Refer to manual for complete information	1 per 5 years	Rental or Purchase	February-08

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K0821	Power wheelchair, group 2 standard, portable, captains chair, patient weight capacity up to and including 300 pounds	Mobility Devices	Sometimes - see manual	No	Mobility devices are covered for eligible MHCP recipients with a mobility limitation that significantly impairs their ability to participate in one or more mobility-related activities of daily living and the mobility limitation cannot be sufficiently resolved by the use of an appropriately fitted cane or walker. Refer to manual for complete information	1 per 5 years	Rental or Purchase	February-08
K0822	Power wheelchair, group 2 standard, sling/solid seat and back, patient weight capacity up to and including 300 pounds	Mobility Devices	Sometimes - see manual	No	Mobility devices are covered for eligible MHCP recipients with a mobility limitation that significantly impairs their ability to participate in one or more mobility-related activities of daily living and the mobility limitation cannot be sufficiently resolved by the use of an appropriately fitted cane or walker. Refer to manual for complete information	1 per 5 years	Rental or Purchase	February-08
K0823	Power wheelchair, group 2 standard, captains chair, patient weight capacity up to and including 300 pounds	Mobility Devices	Sometimes - see manual	No	Mobility devices are covered for eligible MHCP recipients with a mobility limitation that significantly impairs their ability to participate in one or more mobility-related activities of daily living and the mobility limitation cannot be sufficiently resolved by the use of an appropriately fitted cane or walker. Refer to manual for complete information	1 per 5 years	Rental or Purchase	February-08
K0824	Power wheelchair, group 2 heavy duty, sling/solid seat and back, patient weight capacity 301 to 450 pounds	Mobility Devices	Sometimes - see manual	No	Mobility devices are covered for eligible MHCP recipients with a mobility limitation that significantly impairs their ability to participate in one or more mobility-related activities of daily living and the mobility limitation cannot be sufficiently resolved by the use of an appropriately fitted cane or walker. Refer to manual for complete information	1 per 5 years	Rental or Purchase	February-08
K0825	Power wheelchair, group 2 heavy duty, captains chair, patient weight capacity 301 to 450 pounds	Mobility Devices	Sometimes - see manual	No	Mobility devices are covered for eligible MHCP recipients with a mobility limitation that significantly impairs their ability to participate in one or more mobility-related activities of daily living and the mobility limitation cannot be sufficiently resolved by the use of an appropriately fitted cane or walker. Refer to manual for complete information	1 per 5 years	Rental or Purchase	February-08
K0826	Power wheelchair, group 2 very heavy duty, sling/solid seat and back, patient weight capacity 451 to 600 pounds	Mobility Devices	Sometimes - see manual	No	Mobility devices are covered for eligible MHCP recipients with a mobility limitation that significantly impairs their ability to participate in one or more mobility-related activities of daily living and the mobility limitation cannot be sufficiently resolved by the use of an appropriately fitted cane or walker. Refer to manual for complete information	1 per 5 years	Rental or Purchase	February-08

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K0827	Power wheelchair, group 2 very heavy duty, captains chair, patient weight capacity 451 to 600 pounds	Mobility Devices	Sometimes - see manual	No	Mobility devices are covered for eligible MHCP recipients with a mobility limitation that significantly impairs their ability to participate in one or more mobility-related activities of daily living and the mobility limitation cannot be sufficiently resolved by the use of an appropriately fitted cane or walker. Refer to manual for complete information	1 per 5 years	Rental or Purchase	February-08
K0828	Power wheelchair, group 2 extra heavy duty, sling/solid seat and back, patient weight capacity 601 pounds or more	Mobility Devices	Sometimes - see manual	No	Mobility devices are covered for eligible MHCP recipients with a mobility limitation that significantly impairs their ability to participate in one or more mobility-related activities of daily living and the mobility limitation cannot be sufficiently resolved by the use of an appropriately fitted cane or walker. Refer to manual for complete information	1 per 5 years	Rental or Purchase	February-08
K0829	Power wheelchair, group 2 extra heavy duty, captains chair, patient weight capacity 601 pounds or more	Mobility Devices	Sometimes - see manual	No	Mobility devices are covered for eligible MHCP recipients with a mobility limitation that significantly impairs their ability to participate in one or more mobility-related activities of daily living and the mobility limitation cannot be sufficiently resolved by the use of an appropriately fitted cane or walker. Refer to manual for complete information	1 per 5 years	Rental or Purchase	February-08
K0830	Power wheelchair, group 2 standard, seat elevator, sling/solid seat/back, patient weight capacity up to and including 300 pounds	Mobility Devices	Sometimes - see manual	No	Mobility devices are covered for eligible MHCP recipients with a mobility limitation that significantly impairs their ability to participate in one or more mobility-related activities of daily living and the mobility limitation cannot be sufficiently resolved by the use of an appropriately fitted cane or walker. Refer to manual for complete information	1 per 5 years	Rental or Purchase	February-08
K0831	Power wheelchair, group 2 standard, seat elevator, captains chair, patient weight capacity up to and including 300 pounds	Mobility Devices	Sometimes - see manual	No	Mobility devices are covered for eligible MHCP recipients with a mobility limitation that significantly impairs their ability to participate in one or more mobility-related activities of daily living and the mobility limitation cannot be sufficiently resolved by the use of an appropriately fitted cane or walker. Refer to manual for complete information	1 per 5 years	Rental or Purchase	February-08
K0835	Power wheelchair, group 2 standard, single power option, sling/solid seat/back, patient weight capacity up to and including 300 pounds	Mobility Devices	Sometimes - see manual	No	Mobility devices are covered for eligible MHCP recipients with a mobility limitation that significantly impairs their ability to participate in one or more mobility-related activities of daily living and the mobility limitation cannot be sufficiently resolved by the use of an appropriately fitted cane or walker. Refer to manual for complete information	1 per 5 years	Rental or Purchase	February-08

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K0836	Power wheelchair, group 2 standard, single power option, captains chair, patient weight capacity up to and including 300 pounds	Mobility Devices	Sometimes - see manual	No	Mobility devices are covered for eligible MHCP recipients with a mobility limitation that significantly impairs their ability to participate in one or more mobility-related activities of daily living and the mobility limitation cannot be sufficiently resolved by the use of an appropriately fitted cane or walker. Refer to manual for complete information	1 per 5 years	Rental or Purchase	February-08
K0837	Power wheelchair, group 2 heavy duty, single power option, sling/solid seat/back, patient weight capacity 301 to 450 pounds	Mobility Devices	Sometimes - see manual	No	Mobility devices are covered for eligible MHCP recipients with a mobility limitation that significantly impairs their ability to participate in one or more mobility-related activities of daily living and the mobility limitation cannot be sufficiently resolved by the use of an appropriately fitted cane or walker. Refer to manual for complete information	1 per 5 years	Rental or Purchase	February-08
K0838	Power wheelchair, group 2 heavy duty, single power option, captains chair, patient weight capacity 301 to 450 pounds	Mobility Devices	Sometimes - see manual	No	Mobility devices are covered for eligible MHCP recipients with a mobility limitation that significantly impairs their ability to participate in one or more mobility-related activities of daily living and the mobility limitation cannot be sufficiently resolved by the use of an appropriately fitted cane or walker. Refer to manual for complete information	1 per 5 years	Rental or Purchase	February-08
K0839	Power wheelchair, group 2 very heavy duty, single power option, sling/solid seat/back, patient weight capacity 451 to 600 pounds	Mobility Devices	Sometimes - see manual	No	Mobility devices are covered for eligible MHCP recipients with a mobility limitation that significantly impairs their ability to participate in one or more mobility-related activities of daily living and the mobility limitation cannot be sufficiently resolved by the use of an appropriately fitted cane or walker. Refer to manual for complete information	1 per 5 years	Rental or Purchase	February-08
K0840	Power wheelchair, group 2 extra heavy duty, single power option, sling/solid seat/back, patient weight capacity 601 pounds or more	Mobility Devices	Sometimes - see manual	No	Mobility devices are covered for eligible MHCP recipients with a mobility limitation that significantly impairs their ability to participate in one or more mobility-related activities of daily living and the mobility limitation cannot be sufficiently resolved by the use of an appropriately fitted cane or walker. Refer to manual for complete information	1 per 5 years	Rental or Purchase	February-08
K0841	Power wheelchair, group 2 standard, multiple power option, sling/solid seat/back, patient weight capacity up to and including 300 pounds	Mobility Devices	Sometimes - see manual	No	Mobility devices are covered for eligible MHCP recipients with a mobility limitation that significantly impairs their ability to participate in one or more mobility-related activities of daily living and the mobility limitation cannot be sufficiently resolved by the use of an appropriately fitted cane or walker. Refer to manual for complete information	1 per 5 years	Rental or Purchase	February-08



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K0842	Power wheelchair, group 2 standard, multiple power option, captains chair, patient weight capacity up to and including 300 pounds	Mobility Devices	Sometimes - see manual	No	Mobility devices are covered for eligible MHCP recipients with a mobility limitation that significantly impairs their ability to participate in one or more mobility-related activities of daily living and the mobility limitation cannot be sufficiently resolved by the use of an appropriately fitted cane or walker. Refer to manual for complete information	1 per 5 years	Rental or Purchase	February-08
K0843	Power wheelchair, group 2 heavy duty, multiple power option, sling/solid seat/back, patient weight capacity 301 to 450 pounds	Mobility Devices	Sometimes - see manual	No	Mobility devices are covered for eligible MHCP recipients with a mobility limitation that significantly impairs their ability to participate in one or more mobility-related activities of daily living and the mobility limitation cannot be sufficiently resolved by the use of an appropriately fitted cane or walker. Refer to manual for complete information	1 per 5 years	Rental or Purchase	February-08
K0848	Power wheelchair, group 3 standard, sling/solid seat/back, patient weight capacity up to and including 300 pounds	Mobility Devices	Sometimes - see manual	No	Mobility devices are covered for eligible MHCP recipients with a mobility limitation that significantly impairs their ability to participate in one or more mobility-related activities of daily living and the mobility limitation cannot be sufficiently resolved by the use of an appropriately fitted cane or walker. Refer to manual for complete information	1 per 5 years	Rental or Purchase	February-08
K0849	Power wheelchair, group 3 standard, captains chair, patient weight capacity up to and including 300 pounds	Mobility Devices	Sometimes - see manual	No	Mobility devices are covered for eligible MHCP recipients with a mobility limitation that significantly impairs their ability to participate in one or more mobility-related activities of daily living and the mobility limitation cannot be sufficiently resolved by the use of an appropriately fitted cane or walker. Refer to manual for complete information	1 per 5 years	Rental or Purchase	February-08
K0850	Power wheelchair, group 3 heavy duty, sling/solid seat/back, patient weight capacity 301 to 450 pounds	Mobility Devices	Sometimes - see manual	No	Mobility devices are covered for eligible MHCP recipients with a mobility limitation that significantly impairs their ability to participate in one or more mobility-related activities of daily living and the mobility limitation cannot be sufficiently resolved by the use of an appropriately fitted cane or walker. Refer to manual for complete information	1 per 5 years	Rental or Purchase	February-08
K0851	Power wheelchair, group 3 heavy duty, captains chair, patient weight capacity 301 to 450 pounds	Mobility Devices	Sometimes - see manual	No	Mobility devices are covered for eligible MHCP recipients with a mobility limitation that significantly impairs their ability to participate in one or more mobility-related activities of daily living and the mobility limitation cannot be sufficiently resolved by the use of an appropriately fitted cane or walker. Refer to manual for complete information	1 per 5 years	Rental or Purchase	February-08

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K0852	Power wheelchair, group 3 very heavy duty, sling/solid seat/back, patient weight capacity 451 to 600 pounds	Mobility Devices	Sometimes - see manual	No	Mobility devices are covered for eligible MHCP recipients with a mobility limitation that significantly impairs their ability to participate in one or more mobility-related activities of daily living and the mobility limitation cannot be sufficiently resolved by the use of an appropriately fitted cane or walker. Refer to manual for complete information	1 per 5 years	Rental or Purchase	February-08
K0853	Power wheelchair, group 3 very heavy duty, captains chair, patient weight capacity 451 to 600 pounds	Mobility Devices	Sometimes - see manual	No	Mobility devices are covered for eligible MHCP recipients with a mobility limitation that significantly impairs their ability to participate in one or more mobility-related activities of daily living and the mobility limitation cannot be sufficiently resolved by the use of an appropriately fitted cane or walker. Refer to manual for complete information	1 per 5 years	Rental or Purchase	February-08
K0854	Power wheelchair, group 3 extra heavy duty, sling/solid seat/back, patient weight capacity 601 pounds or more	Mobility Devices	Sometimes - see manual	No	Mobility devices are covered for eligible MHCP recipients with a mobility limitation that significantly impairs their ability to participate in one or more mobility-related activities of daily living and the mobility limitation cannot be sufficiently resolved by the use of an appropriately fitted cane or walker. Refer to manual for complete information	1 per 5 years	Rental or Purchase	February-08
K0855	Power wheelchair, group 3 extra heavy duty, captains chair, patient weight capacity 601 pounds or more	Mobility Devices	Sometimes - see manual	No	Mobility devices are covered for eligible MHCP recipients with a mobility limitation that significantly impairs their ability to participate in one or more mobility-related activities of daily living and the mobility limitation cannot be sufficiently resolved by the use of an appropriately fitted cane or walker. Refer to manual for complete information	1 per 5 years	Rental or Purchase	February-08
K0856	Power wheelchair, group 3 standard, single power option, sling/solid seat/back, patient weight capacity up to and including 300 pounds	Mobility Devices	Sometimes - see manual	No	Mobility devices are covered for eligible MHCP recipients with a mobility limitation that significantly impairs their ability to participate in one or more mobility-related activities of daily living and the mobility limitation cannot be sufficiently resolved by the use of an appropriately fitted cane or walker. Refer to manual for complete information	1 per 5 years	Rental or Purchase	February-08
K0857	Power wheelchair, group 3 standard, single power option, captains chair, patient weight capacity up to and including 300 pounds	Mobility Devices	Sometimes - see manual	No	Mobility devices are covered for eligible MHCP recipients with a mobility limitation that significantly impairs their ability to participate in one or more mobility-related activities of daily living and the mobility limitation cannot be sufficiently resolved by the use of an appropriately fitted cane or walker. Refer to manual for complete information	1 per 5 years	Rental or Purchase	February-08

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K0858	Power wheelchair, group 3 heavy duty, single power option, sling/solid seat/back, patient weight capacity 301 to 450 pounds	Mobility Devices	Sometimes - see manual	No	Mobility devices are covered for eligible MHCP recipients with a mobility limitation that significantly impairs their ability to participate in one or more mobility-related activities of daily living and the mobility limitation cannot be sufficiently resolved by the use of an appropriately fitted cane or walker. Refer to manual for complete information	1 per 5 years	Rental or Purchase	February-08
K0859	Power wheelchair, group 3 heavy duty, single power option, captains chair, patient weight capacity 301 to 450 pounds	Mobility Devices	Sometimes - see manual	No	Mobility devices are covered for eligible MHCP recipients with a mobility limitation that significantly impairs their ability to participate in one or more mobility-related activities of daily living and the mobility limitation cannot be sufficiently resolved by the use of an appropriately fitted cane or walker. Refer to manual for complete information	1 per 5 years	Rental or Purchase	February-08
K0860	Power wheelchair, group 3 very heavy duty, single power option, sling/solid seat/back, patient weight capacity 451 to 600 pounds	Mobility Devices	Sometimes - see manual	No	Mobility devices are covered for eligible MHCP recipients with a mobility limitation that significantly impairs their ability to participate in one or more mobility-related activities of daily living and the mobility limitation cannot be sufficiently resolved by the use of an appropriately fitted cane or walker. Refer to manual for complete information	1 per 5 years	Rental or Purchase	February-08
K0861	Power wheelchair, group 3 standard, multiple power option, sling/solid seat/back, patient weight capacity up to and including 300 pounds	Mobility Devices	Sometimes - see manual	No	Mobility devices are covered for eligible MHCP recipients with a mobility limitation that significantly impairs their ability to participate in one or more mobility-related activities of daily living and the mobility limitation cannot be sufficiently resolved by the use of an appropriately fitted cane or walker. Refer to manual for complete information	1 per 5 years	Rental or Purchase	February-08
K0862	Power wheelchair, group 3 heavy duty, multiple power option, sling/solid seat/back, patient weight capacity 301 to 450 pounds	Mobility Devices	Sometimes - see manual	No	Mobility devices are covered for eligible MHCP recipients with a mobility limitation that significantly impairs their ability to participate in one or more mobility-related activities of daily living and the mobility limitation cannot be sufficiently resolved by the use of an appropriately fitted cane or walker. Refer to manual for complete information	1 per 5 years	Rental or Purchase	February-08
K0863	Power wheelchair, group 3 very heavy duty, multiple power option, sling/solid seat/back, patient weight capacity 451 to 600 pounds	Mobility Devices	Sometimes - see manual	No	Mobility devices are covered for eligible MHCP recipients with a mobility limitation that significantly impairs their ability to participate in one or more mobility-related activities of daily living and the mobility limitation cannot be sufficiently resolved by the use of an appropriately fitted cane or walker. Refer to manual for complete information	1 per 5 years	Rental or Purchase	February-08

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K0864	Power wheelchair, group 3 extra heavy duty, multiple power option, sling/solid seat/back, patient weight capacity 601 pounds or more	Mobility Devices	Sometimes - see manual	No	Mobility devices are covered for eligible MHCP recipients with a mobility limitation that significantly impairs their ability to participate in one or more mobility-related activities of daily living and the mobility limitation cannot be sufficiently resolved by the use of an appropriately fitted cane or walker. Refer to manual for complete information	1 per 5 years	Rental or Purchase	February-08
K0868	Power wheelchair, group 4 standard, sling/solid seat/back, patient weight capacity up to and including 300 pounds	Mobility Devices	Sometimes - see manual	No	Mobility devices are covered for eligible MHCP recipients with a mobility limitation that significantly impairs their ability to participate in one or more mobility-related activities of daily living and the mobility limitation cannot be sufficiently resolved by the use of an appropriately fitted cane or walker. Refer to manual for complete information	1 per 5 years	Rental or Purchase	February-08
K0869	Power wheelchair, group 4 standard, captains chair, patient weight capacity up to and including 300 pounds	Mobility Devices	Sometimes - see manual	No	Mobility devices are covered for eligible MHCP recipients with a mobility limitation that significantly impairs their ability to participate in one or more mobility-related activities of daily living and the mobility limitation cannot be sufficiently resolved by the use of an appropriately fitted cane or walker. Refer to manual for complete information	1 per 5 years	Rental or Purchase	February-08
K0870	Power wheelchair, group 4 heavy duty, sling/solid seat/back, patient weight capacity 301 to 450 pounds	Mobility Devices	Sometimes - see manual	No	Mobility devices are covered for eligible MHCP recipients with a mobility limitation that significantly impairs their ability to participate in one or more mobility-related activities of daily living and the mobility limitation cannot be sufficiently resolved by the use of an appropriately fitted cane or walker. Refer to manual for complete information	1 per 5 years	Rental or Purchase	February-08
K0871	Power wheelchair, group 4 very heavy duty, sling/solid seat/back, patient weight capacity 451 to 600 pounds	Mobility Devices	Sometimes - see manual	No	Mobility devices are covered for eligible MHCP recipients with a mobility limitation that significantly impairs their ability to participate in one or more mobility-related activities of daily living and the mobility limitation cannot be sufficiently resolved by the use of an appropriately fitted cane or walker. Refer to manual for complete information	1 per 5 years	Rental or Purchase	February-08
K0877	Power wheelchair, group 4 standard, single power option, sling/solid seat/back, patient weight capacity up to and including 300 pounds	Mobility Devices	Sometimes - see manual	No	Mobility devices are covered for eligible MHCP recipients with a mobility limitation that significantly impairs their ability to participate in one or more mobility-related activities of daily living and the mobility limitation cannot be sufficiently resolved by the use of an appropriately fitted cane or walker. Refer to manual for complete information	1 per 5 years	Rental or Purchase	February-08

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K0878	Power wheelchair, group 4 standard, single power option, captains chair, patient weight capacity up to and including 300 pounds	Mobility Devices	Sometimes - see manual	No	Mobility devices are covered for eligible MHCP recipients with a mobility limitation that significantly impairs their ability to participate in one or more mobility-related activities of daily living and the mobility limitation cannot be sufficiently resolved by the use of an appropriately fitted cane or walker. Refer to manual for complete information	1 per 5 years	Rental or Purchase	February-08
K0879	Power wheelchair, group 4 heavy duty, single power option, sling/solid seat/back, patient weight capacity 301 to 450 pounds	Mobility Devices	Sometimes - see manual	No	Mobility devices are covered for eligible MHCP recipients with a mobility limitation that significantly impairs their ability to participate in one or more mobility-related activities of daily living and the mobility limitation cannot be sufficiently resolved by the use of an appropriately fitted cane or walker. Refer to manual for complete information	1 per 5 years	Rental or Purchase	February-08
K0880	Power wheelchair, group 4 very heavy duty, single power option, sling/solid seat/back, patient weight capacity 451 to 600 pounds	Mobility Devices	Sometimes - see manual	No	Mobility devices are covered for eligible MHCP recipients with a mobility limitation that significantly impairs their ability to participate in one or more mobility-related activities of daily living and the mobility limitation cannot be sufficiently resolved by the use of an appropriately fitted cane or walker. Refer to manual for complete information	1 per 5 years	Rental or Purchase	February-08
K0884	Power wheelchair, group 4 standard, multiple power option, sling/solid seat/back, patient weight capacity up to and including 300 pounds	Mobility Devices	Sometimes - see manual	No	Mobility devices are covered for eligible MHCP recipients with a mobility limitation that significantly impairs their ability to participate in one or more mobility-related activities of daily living and the mobility limitation cannot be sufficiently resolved by the use of an appropriately fitted cane or walker. Refer to manual for complete information	1 per 5 years	Rental or Purchase	February-08
K0885	Power wheelchair, group 4 standard, multiple power option, captains chair, patient weight capacity up to and including 300 pounds	Mobility Devices	Sometimes - see manual	No	Mobility devices are covered for eligible MHCP recipients with a mobility limitation that significantly impairs their ability to participate in one or more mobility-related activities of daily living and the mobility limitation cannot be sufficiently resolved by the use of an appropriately fitted cane or walker. Refer to manual for complete information	1 per 5 years	Rental or Purchase	February-08
K0886	Power wheelchair, group 4 heavy duty, multiple power option, sling/solid seat/back, patient weight capacity 301 to 450 pounds	Mobility Devices	Sometimes - see manual	No	Mobility devices are covered for eligible MHCP recipients with a mobility limitation that significantly impairs their ability to participate in one or more mobility-related activities of daily living and the mobility limitation cannot be sufficiently resolved by the use of an appropriately fitted cane or walker. Refer to manual for complete information	1 per 5 years	Rental or Purchase	February-08

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K0890	Power wheelchair, group 5 pediatric, single power option, sling/solid seat/back, patient weight capacity up to and including 125 pounds	Mobility Devices	Sometimes - see manual	No	Mobility devices are covered for eligible MHCP recipients with a mobility limitation that significantly impairs their ability to participate in one or more mobility-related activities of daily living and the mobility limitation cannot be sufficiently resolved by the use of an appropriately fitted cane or walker. Refer to manual for complete information	1 per 5 years	Rental or Purchase	February-08
K0891	Power wheelchair, group 5 pediatric, multiple power option, sling/solid seat/back, patient weight capacity up to and including 125 pounds	Mobility Devices	Sometimes - see manual	No	Mobility devices are covered for eligible MHCP recipients with a mobility limitation that significantly impairs their ability to participate in one or more mobility-related activities of daily living and the mobility limitation cannot be sufficiently resolved by the use of an appropriately fitted cane or walker. Refer to manual for complete information	1 per 5 years	Rental or Purchase	February-08
K0898	Power wheelchair, not otherwise classified	Mobility Devices	Sometimes - see manual	No	As of 3/1/2008, this code may only be used for repair of a recipient owned device that was originally purchased using this code. See manual.			February-08
K0899	Power mobility device, not coded by SADMERC or does not meet criteria	Mobility Devices			Not covered. Only power mobility devices reviewed and classified by the SADMERC are covered. See manual.			February-08
S9435	Medical foods for inborn errors of metabolism	Nutritional products	No	Yes	Covered for recipients with disorders of amino-acid transport and metabolism when dispensed by an enrolled medical foods supplier. Refer to manual	\$525 per month	Purchase only	February-09
T4521	Adult sized disposable incontinence product, brief/diaper, small, each	incontinence	Sometimes - see manual	Yes	Covered for recipients who are incontinent of bladder or bowel. Refer to manual for complete information	Varies - refer to manual	Purchase only	June-09
T4522	Adult sized disposable incontinence product, brief/diaper, medium, each	incontinence	Sometimes - see manual	Yes	Covered for recipients who are incontinent of bladder or bowel. Refer to manual for complete information	Varies - refer to manual	Purchase only	June-09
T4523	Adult sized disposable incontinence product, brief/diaper, large, each	incontinence	Sometimes - see manual	Yes	Covered for recipients who are incontinent of bladder or bowel. Refer to manual for complete information	Varies - refer to manual	Purchase only	June-09
T4524	Adult sized disposable incontinence product, brief/diaper, extra large, each	incontinence	Sometimes - see manual	Yes	Covered for recipients who are incontinent of bladder or bowel. Refer to manual for complete information	Varies - refer to manual	Purchase only	June-09
T4525	Adult sized disposable incontinence product, protective underwear/pull-on, small size, each	incontinence	Sometimes - see manual	Yes	Covered for recipients who are incontinent of bladder or bowel. Refer to manual for complete information	Varies - refer to manual	Purchase only	June-09

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T4526	Adult sized disposable incontinence product, protective underwear/pull-on, medium size, each	incontinence	Sometimes - see manual	Yes	Covered for recipients who are incontinent of bladder or bowel. Refer to manual for complete information	Varies - refer to manual	Purchase only	June-09
T4527	Adult sized disposable incontinence product, protective underwear/pull-on, large size, each	incontinence	Sometimes - see manual	Yes	Covered for recipients who are incontinent of bladder or bowel. Refer to manual for complete information	Varies - refer to manual	Purchase only	June-09
T4528	Adult sized disposable incontinence product, protective underwear/pull-on, extra large size, each	incontinence	Sometimes - see manual	Yes	Covered for recipients who are incontinent of bladder or bowel. Refer to manual for complete information	Varies - refer to manual	Purchase only	June-09
T4529	Pediatric sized disposable incontinence product, brief/diaper, small/medium size, each	incontinence	Sometimes - see manual	Yes	Covered for recipients who are incontinent of bladder or bowel. Refer to manual for complete information	Varies - refer to manual	Purchase only	June-09
T4530	Pediatric sized disposable incontinence product, brief/diaper, large size, each	incontinence	Sometimes - see manual	Yes	Covered for recipients who are incontinent of bladder or bowel. Refer to manual for complete information	Varies - refer to manual	Purchase only	June-09
T4531	Pediatric sized disposable incontinence product, protective underwear/pull-on, small/medium size, each	incontinence	Sometimes - see manual	Yes	Covered for recipients who are incontinent of bladder or bowel. Refer to manual for complete information	Varies - refer to manual	Purchase only	June-09
T4532	Pediatric sized disposable incontinence product, protective underwear/pull-on, large size, each	incontinence	Sometimes - see manual	Yes	Covered for recipients who are incontinent of bladder or bowel. Refer to manual for complete information	Varies - refer to manual	Purchase only	June-09
T4533	Youth sized disposable incontinence product, brief/diaper, each	incontinence	Sometimes - see manual	Yes	Covered for recipients who are incontinent of bladder or bowel. Refer to manual for complete information	Varies - refer to manual	Purchase only	June-09
T4534	Youth sized disposable incontinence product, protective underwear/pull-on, each	incontinence	Sometimes - see manual	Yes	Covered for recipients who are incontinent of bladder or bowel. Refer to manual for complete information	Varies - refer to manual	Purchase only	June-09
T4535	Disposable liner/ shield/ guard/ pad/ undergarment, for incontinence, each	incontinence	Sometimes - see manual	Yes	Covered for recipients who are incontinent of bladder or bowel. Refer to manual for complete information	Varies - refer to manual	Purchase only	June-09

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T4536	Incontinence product, protective underwear/pull on, reusable, any size, each	incontinence			Not covered. Only disposable incontinence products are covered.			June-09
T4537	Incontinence product, protective underpad, reusable, bed size, each	incontinence			Not covered. Only disposable incontinence products are covered.			June-09
T4538	Diaper service, reusable diaper, each diaper	incontinence	Sometimes - see manual	Yes	Covered for recipients who are incontinent of bladder or bowel. Refer to manual for complete information	Varies - refer to manual	Monthly Rental only	June-09
T4539	Incontinence product, diaper/brief, reusable, any size, each	incontinence			Not covered. Only disposable incontinence products are covered.			June-09
T4540	Incontinence product, protective underpad, reusable, chair size, each	incontinence			Not covered. Only disposable incontinence products are covered.			June-09
T4541	Incontinence product, disposable underpad, large, each	incontinence	Sometimes - see manual	Yes	Covered for recipients who are incontinent of bladder or bowel. Refer to manual for complete information	Varies - refer to manual	Purchase only	June-09
T4542	Incontinence product, disposable underpad, small size, each	incontinence	Sometimes - see manual	Yes	Covered for recipients who are incontinent of bladder or bowel. Refer to manual for complete information	Varies - refer to manual	Purchase only	June-09
T4543	Disposable incontinence product, brief/diaper, bariatric, each	incontinence	Sometimes - see manual	Yes	Covered for recipients who are incontinent of bladder or bowel. Refer to manual for complete information	Varies - refer to manual	Purchase only	June-09
T5001	Positioning seat for persons with special orthopedic needs (this is for custom seating/positioning car seats e.g. Gorilla, Snug Seat, Columbia)	Equipment	Always	No	Covered for recipients who require substantial positioning to safely ride in a vehicle and who are not transported in a mobility device.	1 per 5 years	Rental or Purchase	July-09
T5999	Supply, not otherwise classified	Miscellaneous supplies	No	Yes	Use for covered disposable supplies that do not fit into any of the other more specific miscellaneous supply codes. Refer to manual.	medical necessity	Purchase only	July-09

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