# MEDICARE & MEDI-CAL
# QUICK REFERENCE GUIDE FOR PROFESSIONALS

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| **Alternating Pressure Pad with Pump and Mattress E 0181** | **Y** | **Y** | **Medicare:**<br>An alternating Pressure Pad is a Group I Support Surface and is covered if the patient meets the following criterion:<br>a) Criterion 1, or<br>b) Criteria 2 or 3 and at least one of criteria 4-7<br>1) Completely immobile – i.e., patient cannot make changes in body position without assistance.<br>2) Limited mobility – i.e., patient cannot independently make changes in body position significant enough to alleviate pressure.<br>3) Any stage pressure ulcer on the trunk or pelvis<br>4) Impaired Nutritional Status (per lab results)<br>5) Fecal or Urinary Incontinence<br>6) Altered sensory perception<br>7) Compromised circulatory status<br>Note: All Group I, II, and III Support Surface products belong to a category of items requiring a Hard Copy Prescription Signed and dated by the prescribing physician prior to delivery. This regulation applies to certain items billed to Medicare only.<br><br>**Medi-Cal:**<br>Physician's prescription required; Follow Medicare's guidelines. |
| **Bed Pan E 0275 E 0276** | **Y** | **Y** | **Medicare:**<br>A bed pan (E0275) or fracture pan (E0276) is covered ONLY if patient is bed confined and is NOT covered when patient is ambulatory or in conjunction with a bedside commode. Prescription required.<br><br>**Medi-Cal:**<br>Prescription required. |

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| **BiPAP E0470 Bi-Level Positive Airway Pressure also known as RAD - Respiratory Assist Device (RAD w/o backup feature/ non-invasive interface) E0471 BiPAP ST RAD w/Back Up** | **Y** | **Y** | **Medicare:**<br>Four Categories of coverage:<br>I. Obstructive Sleep Apnea (OSA) Dx: G47.33<br>Both Criteria A and B must be met<br>A. A complete facility based, attended, polysomnogram has established the diagnosis of OSA according to the following criteria:<br>1. AHI (Apnea Hypopnea Index) is equal to or greater than 15 events per hour, or<br>2. The AHI is from 5-14 events per hour with documented symptoms of:<br>a. excessive daytime sleepiness, impaired cognition, mood disorders, or insomnia, or<br>b. hypertension, ischemic heart disease, or a history of stroke, and<br>B. A CPAP (E0601) has been tried and there is documentation of failure in the patient's medical record.<br>*In each of the above categories, when criteria are met, coverage will be paid as medically necessary for three months. In order for there to be a continuation of coverage beyond the three month period the following documentation must be obtained.<br><br>A. A signed and dated statement completed by the treating physician stating that the physician has re-evaluated the patient no sooner than the 31st day nor later than the 90th day following the initiation of therapy and that the patient is compliant with the use of the device (average of 4 hours daily use) and is benefiting from the therapy, and<br>B. A signed and dated statement from the patient obtained AFTER the 31st day of initial equipment use stating that the patient is using the equipment for at least 4 hours per day, that the patient intends to continue use, and that the person completing the beneficiary compliance statement is either the patient, family member or caregiver and NOT the supplier or supplier's contractor. |

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| **BiPAP**<br>**E0470**<br>**Bi-Level Positive Airway Pressure also known as RAD - Respiratory Assist Device (RAD w/o backup feature/ non-invasive interface)**<br>**E0471**<br>**BiPAP ST RAD w/backup** | | | II. Restrictive Thoracic Disorders Dx: G12.21, G35.<br>A. Evidence in patient's medical record of progressive neuromuscular disease (i.e., ALS or MS), or severe thoracic cage abnormality, and<br>B. An arterial blood gas (ABG) done while awake and breathing usual FIO2 equal to or greater than 45 mmHg, or<br>C. Sleep oximetry demonstrates O2 saturation less than or equal to 88% for at least five continuous minutes breathing patient's usual FIO2, or<br>D. For progressive neuromuscular disease (only), maximal inspiratory pressure is less than 60 cm H2O or forced vital capacity is less than 50% predicted, and<br>E. COPD does not contribute significantly to the patient's pulmonary limitation.<br>III. Severe COPD Dx:J44.9.<br>A. An ABG PaCO2, done while awake and breathing the patient's usual FIO2 is great than or equal to 52 mmHg<br>B. Sleep oximetry demonstrates O2 saturation less than or equal to 88% for at least five continuous minutes, test being performed while patient is breathing oxygen at 2 lpm or the patient's usual FIO2 (whichever is higher), and<br>C. Prior to initiating therapy, OSA (and treatment with CPAP) has been considered and ruled out. Dx: G47.37<br>IV. Central Sleep Apnea or Complex Sleep Apnea<br>Prior to initiating therapy, a complete facility based, attended sleep study must be performed documenting the following:<br>A. Diagnosis of Central Sleep Apnea (CSA) or Complex Sleep Apnea (CompSA), and<br>B. The ruling out of CPAP as effective therapy if either CSA or OSA is a component of the initially observed sleep associated hypoventilation, and<br>C. Significant improvement of the sleep associated hypoventilation with use of an E0470 device on the settings that will be prescribed for initial use at home while breathing the patient's usual FIO2.<br>E0471 BiPAP ST allowed only if split sleep study shows failure on CPAP and successful BiPAP ST Test, or, if patient is stepping down from a vent<br><br>For BiPAP Supplies (Masks, Headgear, Tubing, Filters) see Section following CPAP page 13<br><br>**Medi-Cal:**<br>Requires TAR, submit documents per Medicare guidelines. |

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| **Blood Glucose Monitor**<br>**E 0607**<br><br>**Blood Glucose strips & lancets** | **Y** | **Y** | **Medicare:**<br>To be eligible the patient must meet ALL of the following criteria:<br>I. The patient must have diabetes (ICD.10 codes E10.8 – E10.65) that is being treated by a physician, and<br>II. There is a signed order from the treating physician for the monitor and supplies and the physician maintains records documenting the need for the prescribed treating frequency<br>III. The patient or the patient's primary caregiver has successfully completed or is scheduled to receive training in the use of the monitor, test strips, and lancing device, and<br>IV. The patient or the patient's primary caregiver is capable of using the test results to assure the patient's appropriate glycemic control, and<br>V. The monitor is designed for home use. VI.<br>Quantities allowed:<br>One test daily for non-insulin dependent<br>3 tests daily for insulin dependent<br>All other quantities require explanation & medical documentation<br><br>**Medi-Cal:**<br><br>*PHARMACY BENEFIT*<br><br>The physician must verify in writing that the patient meets the following criteria:<br>I. The patient is an insulin dependant diabetic<br>II. The patient has poor diabetic control, as demonstrated by widely fluctuating blood sugars, frequent insulin reactions or episodes of ketosis<br>III. The patient or the patient's primary caregiver is capable of being trained to use the monitor to assist in the control of their diabetes |
| **Cane/Quad Cane**<br>**E 0100**<br>**E 0105** | **Y** | **Y** | **Medicare:**<br>Medicare will cover a cane for patients with ambulation impairment, however, if patient has had or will have other mobility related equipment care must be taken not to provide too many devices or they will be denied as same or similar (i.e., cane, quad cane, walker, hemi walker, rolling walker & wheelchairs - same or similar guidelines allow for one item per five years<br><br>Exception: Change in medical condition<br><br>**Medi-Cal:**<br>Physician's prescription required. |

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| **Commode**<br>**E 0161, E 0163**<br>**E 0164, E 0165**<br>**E 0166, E 0168** | **Y** | **Y** | **Medicare:**<br>A commode is covered when the patient is incapable of using regular toilet facilities because the patient is a) room confined, b) confined to a floor of the home where there are no toilet facilities, or c) living in a home without toilet facilities.<br>An extra wide/heavy duty commode (E0168) is covered only when the patient weighs more than 300 pounds.<br>A commode chair with detachable arms (E0165) is covered if the patient has a disease process that requires side transfer or if the patient has a body configuration that requires extra width.<br>CAUTION: Patients who have a walker, cane, crutches, or a wheelchair on file with Medicare are considered ambulatory. Commode may be denied unless additional explanation is provided by M.D.<br>A mobile commode (E0164 or E0166) is considered NOT medically necessary by Medicare.<br>Raised toilet seats/high johns are not covered by Medicare.<br><br>**Medi-Cal:**<br>Raised toilet seats, toilet rails and high johns require physician's ℞ |
| **CPM Machine**<br>**E 0935**<br>**Continuous Passive Motion Device** | **Y** | **Y** | **Medicare:**<br>A CPM is a covered benefit for total knee replacement patients only unless there is a revision of a major component of a previously performed total knee replacement. Underlying diagnosis must be stated. CPM Therapy must be initiated within 48 hours of surgery (either in-patient or at home) and is payable for a maximum of 21 days following set up<br>INCLUDING any in-patient therapy days. Discharge summary must include CPM settings, Date of Surgery, Date of Hospital Discharge and Date CPM initially set up.<br><br>**Medi-Cal:**<br>A TAR is required. Documentation requirements are the same as Medicare. |
| **CPAP Machine**<br>**E 0601**<br>**Continuous Positive Airway Pressure** | **Y** | **Y** | **Medicare:**<br>A CPAP device is covered if the patient has a diagnosis of obstructive sleep apnea (OSA) Dx: G47.33 documented by sleep study performed in a qualified sleep lab (in home or mobile lab studies are prohibited) that meets either of the following criteria:<br>I. The AHI (Apnea Hypopnea Index) is greater than or equal 15 events per hour, or<br>II. The AHI is between 5 and 14 events per hour with documented symptoms of:<br>A. Excessive daytime sleepiness, impaired cognition, mood disorders, or insomnia, or,<br>B. Hypertension, ischemic heart disease, or a history of stroke<br>For coverage beyond the first three months of therapy the supplier must obtain a statement of compliance from either the physician or the beneficiary and a compliance download from CPAP machine. |

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| | | | The statement must be signed and dated no sooner than the 31st day following the onset of CPAP therapy, nor later than the 90th day, for uninterrupted payment.<br><br>**Medi-Cal:**<br>A TAR is required. Follow Medicare guidelines. |
| **CPAP & BiPAP Supplies** (see codes in description) | **Y** | **Y** | **Medicare:**<br>A4604 Tubing w/integrated heating element — 1 per 3 months<br>A7027 Combination Mask — 1 per 3 months<br>A7028 Oral Cushion — 2 per month<br>A7029 Nasal Pillows — 2 per month<br>A7030 Full Face Mask — 1 per 3 months<br>A7031 Face Mask Interface replacement For full face mask — 1 per month<br>A7032 Cushion for use on nasal mask interface — 2 per month<br>A7033 Pillow for use on nasal type interface — 2 per month<br>A7034 Nasal Interface, mask or cannula type With or without head strap — 1 per 3 months<br>A7035 Headgear — 1 per 6 months<br>A7036 Chinstrap — 1 per 6 months<br>A7037 Tubing — 1 per 3 months<br>A7038 Filter, disposable type — 2 per month<br>A7039 Filter, non-disposable type — 1 per 6 months<br>A7046 Water Chamber for humidifier — 1 per 6 months<br><br>**Medi-Cal:**<br>All supplies require a TAR. |
| **Crutches E0110-E0116** | **Y** | **Y** | **Medicare:**<br>All of the following criteria must be met:<br>I. Patient must have a mobility related diagnosis that impairs ability to perform Mobility Related Activities of Daily Living (MRADL) in the home, and<br>II. The patient is able to safely use crutches in the home, and<br>III. The functional mobility deficit can be resolved by the use of a cane or crutch. Multiple types of equipment (i.e., cane, crutch, walker) will be denied as same or similar since their use is for MRADL in the home.<br><br>**Medi-Cal:**<br>Physician's prescription required. |

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| **Enteral Feeding B4150, B4152, B4153, B4154, B9002, E0776** | **Y** | **Y** | **Medicare:**<br>Enteral formulas consisting of semi-synthetic intact protein/ protein isolates, B4150 or B4152 are covered for patients being fed with a G-tube or J-tube and whose condition is considered to be permanent (minimum expected term of therapy 3 months). Specialized formulas, B4153 and B4154, must be individually justified for each patient. If medical necessity is not substantiated payment will be made for the least costly alternative, B4150. If a feeding pump, B9002, is ordered there must be documentation in the patient's medical record that justifies the use of a pump over Bolus or Gravity feeding. If there is no medical justification the pump will be denied as not medically necessary. Medicare pays for enteral feeding products based on caloric units. Daily calories as well as method of administration must be specified on the order. A CMN will be sent to the physician for completion and signature. Medicare does not cover orally administered nutritionals.<br><br>**Medi-Cal:**<br>Covers oral supplemental nutritionals with the following requirements:<br>• Prescription, Rx with the formula, direction, diagnosis and length of need.<br>• Enteral form.<br>• Chart notes.<br>• Blood labs showing Hemoglobin, Hematocrit & Albumin levels.<br>• Statement from the physicians that specifically address disorder/disease caused condition or GI system compromise/complication that impaired the patient from absorption/ingestion/digestion or full use of various regular food source to meet daily nutritional requirements. |
| **Grab Bars E0241-E0243** | **Y** | **Y** | **Medicare:**<br>Items designed to be used primarily in the bathroom are not covered by Medicare.<br>These items are considered to be for comfort/convenience and will not be paid by Medicare.<br><br>**Medi-Cal:**<br>Physician prescription required. |

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| **Hospital Beds E0250-E0266 and E0301-E0304** | **Y** | **Y** | **Medicare:**<br>A Semi-electric hospital bed (E0260, E0261, E0294, E0295) is covered if patient meets one of the above criteria and requires either frequent or immediate need for changes in body position.<br>Physician must state medical reason for bed on prescription.<br><br>I. The patient has a medical condition, which requires positioning of the body not feasible with an ordinary bed (i.e., raising of feet/legs and/or head greater than 30 degrees).<br>II. The patient has a medical condition, which requires body positioning not feasible with an ordinary bed to alleviate pain.<br>III. The patient needs the head of the bed elevated more than 30 degrees most of the time due to CHF, COPD, or aspiration. Pillows and wedges must have been considered and ruled out.<br>IV. The patient requires traction equipment, which can only be attached to a hospital bed.<br>A heavy duty, extra wide hospital bed (E0301, E0303) is covered if the patient meets one of the criteria above and patient's weight is greater than 350 pounds but does not exceed 600 pounds.<br>A Full-electric hospital bed is not a covered benefit for Medicare. Electric powered height adjustment is considered a convenience feature.<br><br>**Medi-Cal:**<br>Physician's prescription and TAR required. |
| **Incontinence Supplies - Multiple Codes** | **N** | **Y** | **Medicare:**<br>Medicare does not cover incontinence supplies as they are disposable in nature NOT durable.<br><br>**Medi-Cal:**<br>With appropriate diagnosis and physician's ℞ restrictions apply. |

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| **Low Air Loss Bed E0277-Group II Support Surface** | **Y** | **Y** | **Medicare:**<br>Group II Support Surface is covered if the patient meets:<br>1. Criterion A and B and C, or<br>2. Criterion D, or<br>3. Criterion E and F<br>A. Multiple Stage II pressure ulcers located on the trunk or pelvis (ICD.10: L89.119, L89.129 – L89.309), and<br>B. Patient has been on a comprehensive ulcer treatment program for at least the past month that has included the use of an appropriate Group I Support Surface, and<br>C. The ulcers have worsened or remained the same over the past month, or<br>D. Large or multiple Stage III or IV pressure ulcer(s) on the trunk or pelvis (ICD.10: L89.119, L89.129 – L89.309) or<br>E. Recent myocutaneous flap or skin graft or a pressure ulcer on the trunk or pelvis (surgery within the past 60 days), and<br>F. The patient has been on a Group II or III Support Surface immediately prior to a recent discharge from a hospital or nursing facility (discharge within the past 30 days).<br>Plan of care must include (every 90 days) wound evaluation, nutritional assessment, education of caregiver in turning and positioning as appropriate, wound care and incontinence management by a doctor, nurse, or other licensed professional.<br><br>**Medi-Cal:**<br>Blood Labs less than 30 days old that include Hemoglobin, Hematocrit and Albumin levels as well as a nutritional assessment and wound evaluation must be submitted with TAR. Photos of ulcer that include measurements are also required. |
| **Nebulizer E0570** | **Y** | **Y** | **Medicare:**<br>A small volume nebulizer (A7003, A7004, A7005) and related compressor E0570 are covered when:<br>It is medically necessary to deliver specified drugs for use in the treatment of COPD, Cystic Fibrosis, Broncheictasis, HIV, Pheumocystosis, Asthma, and Complications of Organ Transplants. Covered Medications are very specific.<br>Specifically covered Dx include:<br>A15.0 TB<br>B20 HIV, B59 Pneumocytosis<br>E84.0 Cystic Fibrosis<br>J12.0-J70.9 Pneumonias & other respiratory conditions<br>Q33.4 Congenital bronchiectasis<br>R09.3 Abnormal sputum<br>T86.90-T86.92 and T86.92 and T86.99 Organ Transplant complications<br><br>Ultrasonic nebulizers (E0575) and portable, battery operated nebulizers (E0571) are not considered medically necessary by Medicare and will be denied.<br><br>**Medi-Cal:**<br>Requires a TAR. Additionally, a DHS form that documents a history of ER or Clinic visits and failure to respond to metered dose inhalers for a specific reason must be completed, signed and dated by the prescribing physician. |

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| **Nebulizer Supplies - multiple codes** | **Y** | **Y** | **Medicare:**<br>A7003 Administration Set w/Small volume Pneumatic nebulizer, disposable — 2 per month<br>A7004 Small Volume Pneumatic Nebulizer Disposable — 2 per month (in addition to A7003)<br>A7005 Administration Set w/Small volume Pneumatic Nebulizer NON disposable — 1 per 3 months<br>A7006 Administration Set w/Small volume Pneumatic Nebulizer Filtered — 1 per month<br>A7013 Disposable Filter for Compressor — 2 per month<br>A7525 Tracheostomy Mask — 1 per month<br><br>**Medi-Cal:**<br>Requires prescription from prescribing physician. |
| **Ostomy Supplies Multiple Codes** | **Y** | **Y** | **Medicare:** Usual maximum quantity of supplies per month<br>A4357 (2) Bedside drainage bag<br>A4362 (20) 4x4 skin barrier<br>A4364 (4) Liquid adhesive 1 oz.<br>A4367 (1) Ostomy belt<br>A4369 (2) Liquid skin barrier 1 oz.<br>A4377 (10) Ostomy pouch drainable<br>A4381 (10) Ostomy pouch urinary<br>A4397 (4) Irrigation sleeve<br>A4402 (4) Lubricant 1 oz.<br>A4404 (10) Ostomy ring<br>A4405 (4) Barrier paste non pectin 1 oz.<br>A4406 (4) Barrier paste pectin 1 oz.<br>A4414 (20) Skin barrier w/flange w/out convex<br>A4415 (20) Skin barrier w/flange w/out convex<br>A4416 (60) Ostomy pouch w/barrier 1 pc.<br>A4417 (60) Ostomy pouch w/barrier convex<br>A4418 (60) Ostomy pouch closed<br>A4419 (60) Ostomy pouch closed 2 pc.<br>A4420 (60) Ostomy pouch closed 2 pc.<br>A4423 (60) Ostomy pouch closed 2 pc.<br>A4424 (20) Ostomy pouch drainage 1 pc.<br>A4425 (20) Ostomy pouch drainage 2 pc.<br>A4426 (20) Ostomy pouch closed 2 pc.<br>A4429 (20) Ostomy pouch urinary 1 pc.<br>A4431 (20) Ostomy pouch urinary 1 pc.<br>A4432 (20) Ostomy pouch urinary 2 pc.<br>A4433 (20) Ostomy pouch urinary 2 pc.<br>A4434 (20) Ostomy pouch urinary 2 pc.<br>A4450 (40) Tape non waterproof per 18 sq. inches<br>A4452 (40) Tape waterproof per 18 sq. inches<br>A5051 (60) Ostomy pouch closed 1 pc. w/barrier<br>A5052 (60) Ostomy pouch closed 1 pc. w/o barrier<br>A5053 (60) Ostomy pouch closed use w/faceplate |

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| **Ostomy Supplies Multiple Codes (continued)** | **Y** | **Y** | A5054 (60) Ostomy pouch closed use w/barrier/flange 2 pc.<br>A5055 (31) Stoma cap<br>A5061 (20) Ostomy pouch drainage 1 pc. w/barrier<br>A5062 (20) Ostomy pouch drainage 1 pc. w/o barrier<br>A5063 (20) Ostomy pouch drainage 2 pc. use w/barrier/flange<br>A5071 (20) Ostomy pouch urinary w/barrier 1 pc.<br>A5072 (20) Ostomy pouch urinary w/o barrier 1 pc.<br>A5073 (20) Ostomy pouch urinary use w/barrier/flange 1 pc.<br>A5081 (31) Continent device plus<br>A5082 (1) Contenent device catheter<br>A5083 (150) Contenent device assorted cover<br>A5093 (10) Convex insert<br>A5121 (20) Skin barrier solid 6x6<br>A5122 (20) Skin barrier solid 8x8<br>A5126 (20) Adhesive or non-adhesive foam disc/pad<br>A5131 (1) Appliance Cleaner 16 oz.<br>A6216 (60) Gauze 16 sq. inch<br>A4361 (3) Ostomy faceplate per 6 months<br>A4371 (10) Ostomy skin barrier powder per oz. per 6 months<br>A4398 (2) Ostomy irrigation bag per 6 months<br>A4399 (2) Ostomy irrigation cone per 6 months<br>A4455 (16) Adhesive remover per oz. per 6 months<br>A5102 (2) Bedside drainage bottle per 6 months<br>A5120 (150) Skin barrier wipes each per 6 months<br><br>**Medi-cal:**<br>Requires ℞ from prescribing physician. |
| **Overbed Table E0274** | **N** | **N** | **Medicare:**<br>This item is considered a comfort/convenience item by Medicare and is not a covered benefit.<br><br>**Medi-Cal**<br>Not a covered benefit. |

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| **Oxygen System Stationary E1390, E1391** | **Y** | **Y** | **Medicare:**<br>Home Oxygen Therapy is covered only if all of the following conditions are met:<br>I. The treating physician has determined that the patient has severe lung disease or hypoxia-related symptoms that might be expected to improve with oxygen therapy, and<br>II. The patient's blood gas study meets the criteria stated below, and<br>III. The qualifying blood gas study was performed by a physician or by a qualified laboratory (not the supplier), and<br>IV. The qualifying blood gas study was obtained under the following conditions.<br>A. If the test was performed during an inpatient hospital stay the reported test must be the one obtained closest to, but no earlier than 2 days prior to hospital discharge date, or<br>B. If the qualifying blood gas study is NOT performed during an inpatient hospital stay, the reported test must be performed while the patient is in a chronic stable state – i.e., not during a period of acute illness.<br>V. Alternative treatment measures have been tried or considered and deemed clinically ineffective.<br>*Based upon ABG results Oxygen patients who qualify will fall into one of two categories. Recertification requirements are different for each group.*<br>Patients whose test results fall into Group I will need to be recertified after one year. Patients whose test results fall in Group II will need to be recertified after three months (ABG/O2 Sat test performed between 61st and 90th day after initial set up and delivery).<br>GROUP I = PO2 at or below 55 mmHg or O2 Sat at or below 88% taken at rest when awake or a PO2 at or below 55 mmHg or O2 Sat at or below 88% for at least 5 minutes when taken during sleep. (Other parameters apply if test taken during exercise). GROUP II – PO2 of 56-59 mmHg or an O2 Sat of 89% taken.<br>at rest when awake, during sleep or exercise (under specified parameters) AND only in the presence of one or more of the following conditions:<br>1. Dependent edema suggesting CHF<br>2. Pulmonary hypertension or cor pulmonale<br>3. Erythrocythemia with a hematocrit greater than 56%. A CMN is required for Medicare. Oxygen is NOT provided for the following conditions in the absence of qualifying blood labs: Angina Pectoris, Dyspnea without cor pulmonale or evidence of hypoxemia, severe peripheral vascular disease with clinical evidence of extremity desaturation but in the absence of systemic hypoxemia, cluster headaches, or any terminal illness not resulting in systemic hypoxemia.<br><br>**Medi-Cal:**<br>Requires a TAR and a DHS form to be completed, signed and dated. |

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| **Oxygen System Portable E0430, E0431,** | **Y** | **Y** | **Medicare:**<br>A portable oxygen system is separately payable by Medicare if the patient is mobile within the home or requires oxygen during exercise as demonstrated in an ABG performed while exercising.<br><br>**Medi-Cal:**<br>Testing guidelines are the same as Medicare |
| **Conserving Device E1399** | | | **Medicare:**<br>Not a Medicare benefit.<br><br>**Medi-Cal:**<br>The patient meets the criteria for supplemental oxygen and requires the oxygen tank to be extended in its usage, such as in extended periods of time away from home. The patient must be on a liter flow of 2. |
| **Apnea Monitor E0619** | | | **Medicare:**<br>This item is not a covered benefit.<br><br>**Medi-Cal:**<br>Use of apnea monitors are covered for patients when the patient has a diagnosis of at least one of the following:<br>• Apnea of prematurity; or,<br>• An Apparent Life Threatening event; or,<br>• A near-miss SIDS; or,<br>• The apparently normal sibling of a SIDS victim; or,<br>• A medical condition(s) for which continuous monitoring is medically necessary.<br><br>Requirements<br>As medically necessary.<br><br>Authorization for rental may be granted in increments of up to four months, both for initial and reauthorization. Authorization may be granted for one device every three years. TARs require documentations of a history and physical examination or a discharge summary, supporting the medical necessity for an apnea monitor. |

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| **Hydraulic Patient Lift E0630** | **Y** | **Y** | **Medicare:**<br>A lift is covered if transfer between bed and a chair, wheelchair, or commode requires the assistance of more than one person and, without the use of a lift, the patient would be bed confined. The sling for the lift is included in the original delivery, however, a replacement sling can be ordered (E0621) when the original sling becomes unserviceable.<br><br>**Medi-Cal:**<br>Requires a TAR and the submission of a DHS 6181 Form, completed and signed by the physician detailing the specific functional level of the patient. |
| **Pneumatic Compression Device (Lumphedema Pump) E0650, E0651, E0952** | **Y** | **Y** | **Medicare:**<br>Pneumatic Compression Devices are covered ONLY for the treatment of lymphedema or for the treatment of chronic venous insufficiency WITH venous stasis ulcers. Coverage criteria must be met or the device will be denied as not medically necessary.<br>Lymphedema: Patient must have undergone a four-week trial of conservative therapy including the use of compression sleeves or bandages, exercise and limb elevation and must also include before and after measurements indicating failure of conservative therapeutic modalities.<br>Chronic Venous Insufficiency with Venous Stasis Ulcers: Patient must have undergone a documented trial of six months of conservative therapy in which ulcerations have failed to heal. Conservative therapy must include compression sleeves or bandages, proper wound care, exercise, and limb elevation. Size and location of each ulceration on lower limb must be specified and there must be evidence of regular physician visits for conservative treatment monitoring during the six-month trial.<br><br>**Medi-Cal:**<br>Requires a TAR. Requirements and documentation follows Medicare guidelines. |

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| **Power Operated Vehicle (POV) "Scooter" E1230** | **Y** | **Y** | **Medicare:**<br>A POV is covered if all of the following criteria I-VII have been met:<br>I. The patient has a mobility limitation that significantly impairs his/her ability to participate in one or more mobility-related activities of daily living (MRADLs) such as toileting, feeding, dressing, grooming, and bathing in customary locations WITHIN the home.<br>II. The patient's mobility limitation cannot be sufficiently resolved by the use of an appropriately fitted cane or walker.<br>III. The patient does not have sufficient upper extremity function to safely self-propel an optimally configured manual wheelchair in the home to perform MRADLs during a typical day.<br>IV. The patient has sufficient strength, postural stability, and other physical and mental capabilities needed to safely operate the POV being provided INSIDE of the home.<br>V. The patient's home provides adequate access between rooms, maneuvering space, and surfaces for the operation of the POV that is being provided.<br>VI. The use of a POV will significantly improve the patient's ability to participate in MRADLs and the patient will use it on a regular basis in the home.<br>VII. The patient has not expressed an unwillingness to use the POV that is being provided in the home.<br>Additional documentation substantiating the above statements may be required by Medicare including but not limited to records documenting the patient's disease process and an evaluation of the patient's physical limitations performed by the physician, a physical therapist, or other licensed professional.<br><br>**Medi-Cal:**<br>Requires a TAR and the completion of a DHS 6181 Form by the prescribing physician. |
| **Repairs E1340 (Labor Only)** | **Y** | **Y** | **Medicare:**<br>Repairs are covered for Home Medical Equipment that is owned by the patient and was paid for by Medicare. For equipment needing repair that is owned by the patient but was paid for by another provider or paid for privately the patient must meet Medicare's documentation requirements to be eligible for Medicare to cover repair of the item. Repair claims must be submitted with make model and serial number of the item being repaired.<br><br>**Medi-Cal:**<br>Medi-Cal will make repairs to equipment that was paid for by Medi- Cal. For equipment not paid for by Medi-Cal patient must qualify for the equipment under program guidelines. Repairs under $250.00 do not require a TAR. Repairs over $250.00 require a physician's prescription and a TAR. |

| | MEDICARE | MEDICAL | |
|---|---|---|---|
| **Negative Pressure Wound Therapy** | | | **Medicare:**<br>A Negative Pressure Wound Therapy pump and supplies are covered when criterion A or B is met:<br>A.Ulcers and wounds in the home setting: The beneficiary has a chronic Stage III or IV pressure ulcer, neuropathic ulcer, venous or arterial insufficiency ulcer or a chronic (being present for at least 30 days) ulcer of mixed etiology. A complete wound therapy program described by criterion 1 and criterion 2,3, or 4 as applicable depending on the type of the wound, must have been tried or considered and ruled our prior to application of NPWT.<br><br>1. For all ulcers or wounds, the following components of a wound therapy program must include a minimum of all of the following general measures, which should either be addressed, applied, or considered and ruled out prior to application of NPWT:<br>a. Documentation in the beneficiary's medical record of evaluation, care, and wound measurements by a licensed medical professional, and<br>b. Application of dressings to maintain a moist wound environment, and<br>c. Debridement of necrotic tissue if present, and<br>d. Evaluation of and provision for adequate nutrition<br>2. For Stage III or IV pressure ulcers:<br>a. The beneficiary has been appropriately turned and positioned, and<br>b. The beneficiary has used a group 2 or 3 support surface for pressure ulcers on the posterior trunk or pelvis (see LCD on support surfaces), and<br>c. The beneficiary's moisture and incontinence have been appropriately managed<br>3. For neuropathic (for example, diabetic) ulcers:<br>a. The beneficiary has been on a comprehensive diabetic management program, and<br>b. Reduction in pressure on a foot ulcer has been accomplished with appropriate modalities<br>4. For venous insufficiency ulcers:<br><br>a. Compression bandages and/or garments applied<br><br>b. Leg elevation and ambulation encouraged |

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|---|---|---|---|
| **Negative Pressure Wound Therapy continued** | | | B. Ulcers and Wounds Encountered in an Inpatient Setting:<br>1. An ulcer or wound (described under A above) is encountered in the inpatient setting and, after wound treatments described under A-1 through A-4 have been tried or considered and ruled out, NPWT is initiated because it is considered in the judgment of the treating physician, the best available treatment option.<br>2. The beneficiary has complications of a surgically created wound (for example, dehiscence) or a traumatic wound (for example, pre-operative flap or graft) where there is documentation of the medical necessity for accelerated formation of granulation tissue which cannot be achieved by other available topical wound treatments (for example, other conditions of the beneficiary that will not allow for healing times achievable with other topical wound treatments).<br>**MEDICAL**<br>Requires TAR, submit documents per Medicare guidelines. |
| **Suction Machine E0600** | **Y** | **Y** | **Medicare:**<br>Use of a respiratory suction pump is covered for patients who have difficulty raising and clearing secretions secondary to:<br>A) Cancer or surgery of the throat or mouth<br>B) Dysfunction of the swallowing muscles<br>C) Unconsciousness or obtunded state<br>D) Tracheostomy<br>Accessories and supplies are covered and are separately payable when they are medically necessary and used with a medically necessary pump in a covered setting. Sterile suction catheters (A4624) are medically necessary only for tracheostomy suctioning. No more than three catheters per day are covered for trach suctioning. When a catheter is used for oropharyngeal suctioning it can be reused if properly cleaned and disinfected therefore no more than three per week are covered for this type of use.<br>**Medi-Cal:**<br>Requires a TAR and physician's prescription. |
| **Surgical Dressings/wound care Multiple codes** | **Y** | **N** | **Medicare:**<br>Dressings are covered for all wounds that have been surgically created or medically treated. Dressings are not covered for bumps/ scrapes/minor cuts. A detailed written order must accompany the Rx.<br>There are many codes for wound care supplies. Please call for codes & utilization guidelines. |
| **Tub Chair with and without Back E0245** | **N** | **Y** | **Medicare:**<br>Equipment designed primarily for use in the bathroom is not a Medicare benefit.<br>**Medi-Cal:**<br>Physician prescription required. |
| **Transfer Tub Bench, Padded or Non-Padded E0247** | **N** | **Y** | **Medicare:**<br>Equipment designed primarily for use in the bathroom is not a Medicare benefit.<br>**Medi-Cal:**<br>Physician prescription required. |

| | MEDICARE | MEDI CAL | |
|---|---|---|---|
| **Urinal**<br>**E0325, E0326** | **Y** | **Y** | **Medicare:**<br>Covered if patient is bed confined. May not be covered if patient has a bedside commode.<br><br>**Medi-Cal:**<br>Physician's prescription required |
| **Walker**<br>**E0135, E0143, E0147** | **Y** | **Y** | **Medicare:**<br>If patient's ability to walk is limited a walker can be provided in conjunction with a wheelchair IF the walker is being used either for transferring in and out of the wheelchair or for gait therapy.<br>Physician must specify on prescription FWW (Front Wheeled Walker) or PUW (Pick Up Walker). Heavy-duty, four wheeled walkers with brakes and a seat are covered ONLY if the patient has a progressive neurological condition OR hemiparesis. The patient MUST be ambulatory (no wheelchair currently in use) to qualify for a four wheeled walker with brakes. For patients who have had a wheelchair in the recent past a physician's statement detailing the patient's improved condition and ambulation ability must be included with order for the four wheeled walker.<br><br>**Medi-Cal:**<br>Physician's prescription required. TAR required for Heavy Duty Four Wheeled Walker with Brakes. (E0147). |

| | | | |
|---|---|---|---|
| **Wheelchairs (Manual) K0001, K0002, K0003, K0004, K0006, K0007** | | | **Medicare:**<br>A Manual Wheelchair is covered if the following Criteria I-V are all met<br>AND either VI or VII are met.<br>I. The patient has a mobility limitation that significantly impairs his/her ability to participate in one or more mobility-related activities of daily living (MRADLs) such as toileting, feeding, dressing, grooming, and bathing in customary locations in the home, and<br>II. The patient's mobility limitation cannot be sufficiently resolved with an appropriately fitted cane or walker, and<br>III. The patient's home provides adequate access between rooms, maneuvering space, and surfaces for use of the manual wheelchair that is provided, and<br>IV. Use of a manual wheelchair will significantly improve the patient's ability to participate in MRADLs and the patient will use it on a regular basis in the home, and<br>V. The patient has not expressed an unwillingness to use the manual wheelchair that is being provided, in the home, and<br>VI. The patient has sufficient upper extremity function and other physical and mental capabilities needed to safely self-propel the manual wheelchair that is provided in the home during a typical day, OR<br>VII. The patient has a caregiver who is available, willing, and able to provide assistance with the wheelchair.<br>K0002 Standard Hemi Height Wheelchair: is covered when the patient needs a lower height due to short stature or to enable the patient to place his/her feet on the ground for propulsion.<br>K0003 Lightweight Wheelchair: is covered when a patient cannot self-propel in a standard wheelchair in the home AND the patient can and does self-propel in a lightweight wheelchair. Caregiver strength and ability to move a lightweight wheelchair vs. standard weight wheelchair is primarily convenience in nature and not a consideration in providing a lightweight wheelchair.<br>K0004 High Strength Lightweight Wheelchair: is covered if the patient self-propels in the wheelchair while engaging in frequent activities in the home that cannot be performed in a standard or lightweight wheelchair OR the patient requires a seat width, depth, or height that cannot be accommodated in a standard, lightweight or hemi-height wheelchair and spends at least two hours per day in the wheelchair.<br>K0006 Heavy Duty Wheelchair: is covered if the patient weighs more than 250 pounds or has a diagnosis that indicates severe spasticity.<br>K0007 Extra Heavy Duty Wheelchair: is covered if the patient weighs more than 300 pounds.<br><br>**Medi-Cal:**<br>Requires a TAR and the submission of a DHS 6181 Form completed, signed and dated by the physician. |

**Wheelchairs (Power)**
**K0823, K0824**

**Medicare:**

A Power Wheelchair is covered if all of the following criteria I-VII have been met:

I. The patient has a mobility limitation that significantly impairs his/her ability to participate in one or more mobility-related activities of daily living (MRADLs) such as toileting, feeding, dressing, grooming, and bathing in customary locations WITHIN the home.

II. The patient's mobility limitation cannot be sufficiently resolved by the use of an appropriately fitted cane or walker.

III. The patient does not have sufficient upper extremity function to safely self-propel and optimally configured manual wheelchair in the home to perform MRADLs during a typical day.

IV. The patient does NOT have sufficient upper extremity strength or postural stability necessary to safely operate a POV inside of the home.

V. The patient's home provides adequate access between rooms, maneuvering space, and surfaces for the operation of the Power Wheelchair that is to be provided.

VI. The use of the Power Wheelchair will significantly improve the patient's ability to participate in MRADLs and the patient will use it on a regular basis in the home.

VII. The patient has not expressed an unwillingness to use the Power Wheelchair that is to be provided in the home.

Additional documentation substantiating the above statements may be required by Medicare including but not limited to records documenting the patient's disease process and an evaluation of the patient's physical limitations performed by the physician, a physical therapist, or other licensed professional.

CAUTION: Although Medicare is well aware of use outside of the home for all wheelchair types, their only concern is use within the home for MRADLS.

Community use should not be mentioned on or orders for Medicare beneficiaries when prescribing a wheelchair.

**Medi-Cal:**

Requires a TAR and the completion of a DHS 6181 Form by the prescribing physician.

| DESCRIPTION- MEDICAL BASED | CODE | RENTAL/SALE | QUANTITY |
|---|---|---|---|
| BED | | | |
| BED-SEMI ELECTRIC | E0295 | RENTAL | 1 |
| MATTRESS | E0271 | RENTAL | 1 |
| FULL RAILS/HALF RAILS | E0310/E0305 | RENTAL | 1 |
| LOW AIR LOSS | E0277 | DAILY | 31 |
| WHEELCHAIRS | | | |
| STANDARD | K0001 | RENTAL | 1 |
| LIGHTWEIGHT | K0003 | RENTAL | 1 |
| PEDIATRIC | K0004 | RENTAL | 1 |
| TRANSPORT | E1038 | RENTAL | 1 |
| RECLINING WC NEEDS ALL BOLD HCPCS | K0001 | RENTAL | 1 |
| RECLINING BACK | E1226 | RENTAL | 1 |
| ANTI TIPPERS | E0971 | RENTAL | 2 |
| HEEL LOOP | E0951 | RENTAL | 2 |
| ELEVATED LEG REST | K0195 | RENTAL | 2 |
| ELEVATED LEG REST | K0195 | RENTAL | 2 |
| POWER WHEELCHAIR | K0823 | RENTAL | 1 |
| BATERRIES PWR WC | E2365 | SALE | 2 |
| OXYGEN | | | |
| CONCENTRATOR | E1390 | RENTAL | 1 |
| PORTABLE SYSTEM | E0431 | RENTAL | 1 |
| OXYGEN CONTENTS | E0443 | SALE | 1 |
| M6/CONSERVING DEVICE | E1399 | RENTAL | 1 |
| HYDRAULIC LIFT | E0630 | RENTAL | 1 |
| SUCTION UNIT | E0600 | RENTAL | 1 |
| CPM<br>(21 DAYS RENTAL ONLY) | E0935 | DAILY | 21 |
| BREAST PUMP | | | |
| SINGLE USE | E0603 | SALE | 1 |
| NEGATIVE PRESSURE WOUND THERAPY | E2402 | RENTAL | 1 |
| CANISTER | A7000 | | |
| DRESSINGS | A6550 | SALE | 15 |
| COUGH ASSIST DEVICE | E0482 | RENTAL OR SALE | 1 |
| INTERFACE MASK | A7020 | SALE | 1 |

ANY QUANTITY ABOVE MEDICARE/MEDICAL GUIDELINES REQUIRES AN AUTHORIZATION

| DESCRIPTION- MEDICAL BASED | CODE | RENTAL/SALE | QUANTITY |
|---|---|---|---|
| ENTERAL DME | | | |
| ENTERAL PUMP | B9002 | RENTAL | 1 |
| IV POLE | E0776 | RENTAL | 1 |
| | | | |
| ENTERAL PUMP FEEDING KIT | | | |
| ENTERAL PUMP FEEDING BAGS | B4035 | SALE | 31 |
| GRAVITY BAGS | B4036 | SALE | 31 |
| SYRINGES | A4322 | SALE | 31 |
| GLOVES | A4927 | SALE | 100 |
| ALCOHOL PREP WIPES | A4245 | SALE | 100 |
| 4X4 GAUZE | A6402 | SALE | 50 |
| TAPE | A4450 | SALE | 80 |
| G-TUBE | B4087 | SALE | 1 |
| G-TUBE LOW PROFILE | B4088 | SALE | 1 |
| EXTENSIONS | B9998 | SALE | 5 |
| **FORMULA** | DEPENDING ON ITEM | SALE | |
| | | | |
| CPAP | E0601 | RENTAL | 1 |
| BIPAP | E0470 | RENTAL | 1 |
| HUMIDIFIER | E0562 | SALE | 1 |
| | | | |
| FULL FACE MASK | A7030 | SALE | 1/3 MO |
| NASAL MASK | A7034 | SALE | 1/3 MO |
| HEADGEAR | A7035 | SALE | 1/6 MO |
| TUBING | A7037 | SALE | 1/3 MO |
| FILTER | A7038 | SALE | 2/ MO |
| WATER CHAMBER | A7046 | SALE | 1/6 MO |
| | | | |
| COMMODE | E0163 | SALE | 1 |
| DROP ARM COMMODE | E0165 | SALE | 1 |
| FRONT WHEELED WALKER | E0143 | SALE | 1 |
| | | | |
| 4 WHEELED WALKER WITH SEAT | E0143 E0156 | SALE | 1 |
| HEAVY DUTY FRONT WHEELED WALKER | E0149 | SALE | 1 |
| HEAVY DUTY 4 WHEELED WALKER | E0149 E0156 | SALE | 1 |
| | | | |
| NEBULIZER | E0570 | SALE | 1 |
| | | | |
| SINGLE POINT CANE | E0100 | SALE | 1 |
| QUAD CANE | E0105 | SALE | 1 |
| | | | |
| CRUTCHES | E0114 | SALE | 1 |
| | | | |
| SHOWER CHAIR | E0245 | SALE | 1 |
| | | | |
| OSTOMY SUPPLIES | BY ITEM # | SALE | |
| | | | |
| UROLOGICAL SUPPLIES | BY ITEM # | SALE | |
| | | | |
| WOUND CARE SUPPLIES | BY ITEM # | SALE | |
| | | | |
| INCONTINENCE PRODUCTS<br>$165 ALLOWABLE PER MONTH | *ONLY MEDICAL COVERS* | | |

| ITEM AND DESCRIPTION | HCPC CODE | QTY PER MONTH | 2 OR MORE PRODUCTS |
|---|---|---|---|
| **PEDIATRIC DIAPER SM & MED | T4529 | 200 | 200 |
| **PEDIATRIC DIAPER LARGE | T4530 | 200 | 200 |
| **PEDIATRIC PULL ON SM & MED | T4531 | | |
| **PEDIATRIC PULL ON LARGE | T4532 | | |
| DIAPER/BRIEF YOUTH | T4533 | 200 | |
| DIAPER/BRIEF SMALL | T4521 | 200 | |
| DIAPER/BRIEF MEDIUM | T4522 | 192 | |
| DIAPER/BRIEF LARGE | T4523 | 216 | |
| DIAPER/BRIEF X-LARGE | T4524 | | |
| **DIAPER/BRIEF BARIATRIC | T4543 | 192 | 200 |
| **PULL UP DIAPER YOUTH PULL UP | T4534 | 200 | |
| DIAPER SMALL | T4525 | 120 | |
| PULL UP DIAPER MEDIUM | T4526 | 120 | |
| PULL UP DIAPER LARGE | T4527 | 120 | |
| PULL UP DIAPER X-LARGE | T4528 | | |
| PULL UP DIAPER XX-LARGE | T4544 | 120 | |
| REUSABLE UNDERWEAR SIZE SM TO XXXXL | T4536 | 2 | |
| UNDERGARMENTS | T4535 | 180 | 300 |
| LIGHT SHIELDS/LINERS | T4535 | 180 | 300 |
| MODERATE SHIELD/LINERS | T4535 | 180 | 300 |
| HEAVY CAPACITY SHIELD/LINERS | T4535 | 180 | 300 |
| DISPOSABLE UNDERPADS/TUCKS | T4541 | 120 | |
| **BREATHABLE UNDERPADS *FOR LOW AIR LOSS MATTRESS | A4554 | PER AUTH | |
| REUSABLE UNDERPADS | T4537 | 2 PER YEAR | |
| CREAMS & WASH COVERED FOR UNDER 21 YEARS OLD CREAMS & WASH NOT INCLUDED ON THE $165 PER MONTH | | | |
| INCONTINENCE CREAMS | A6250 | 540GM/MON | 2 PER MNTH |
| INCONTINENCE WASH | A4335 | 960ML/MON | 2 PER MNTH |
| MISCELLANEOUS INCNT PRIDUCTS | A4520 | | |

** BILLED WITH INVOICE (NO ALLOWABLES LISTED ON FORMULARY)

ANY QUANTITY ABOVE MEDICARE/MEDICAL GUIDELINES REQUIRES AN AUTHORIZATION

| DESCRIPTION- COMMERCIAL/SENIOR | CODE | RENTAL/SALE | QUANTITY |
|---|---|---|---|
| BED | E0260 | RENTAL | 1 |
| LOW AIR LOSS | E0277 | RENTAL | 1 |
| WHEELCHAIR | | | |
| STANDARD | K0001 | RENTAL | 1 |
| LIGHTWEIGHT | K0003 | RENTAL | 1 |
| PEDIATRIC TRANSPORT | K0004 | RENTAL | 1 |
| | E1038 | RENTAL | 1 |
| RECLINING WC NEEDS ALL BOLD HCPCS | K0001 | RENTAL | 1 |
| RECLINING BACK | E1226 | RENTAL | 1 |
| ANTI TIPPERS | E0971 | RENTAL | 2 |
| HEEL LOOP | E0951 | RENTAL | 2 |
| ELEVATED LEG REST | K0195 | RENTAL | 2 |
| ELEVATED LEG REST | K0195 | RENTAL | 2 |
| POWER WHEELCHAIR | K0823 | RENTAL | 1 |
| BATERRIES PWR WC | E2365 | SALE | 2 |
| OXYGEN | | | |
| CONCENTRATOR | E1390 | RENTAL | 1 |
| PORTABLE SYSTEM | E0431 | RENTAL | 1 |
| OXYGEN CONTENTS | E0443 | SALE | 1 |
| E CART | E1355 | RENTAL | 1 |
| M6/CONSERVING DEVICE | E1399 | RENTAL | 1 |
| HYDRAULIC LIFT | E0630 | RENTAL | 1 |
| SUCTION UNIT | E0600 | RENTAL | 1 |
| CPM | | | |
| (21 DAYS RENTAL ONLY) | E0935 | DAILY | 21 |
| BREAST PUMP | | | |
| SINGLE USE | E0603 | SALE | 1 |
| NEGATIVE PRESSURE WOUND THERAPY | E2402 | RENTAL | 1 |
| CANISTER | A7000 | SALE | 10 |
| DRESSINGS | A6550 | SALE | 15 |
| COUGH ASSIST DEVICE | E0482 | RENTAL OR SALE | 1 |
| INTERFACE MASK | A7020 | SALE | 1 |
| ENTERAL | | | |
| ENTERAL PUMP | B9002 | RENTAL | 1 |
| IV POLE | E0776 | RENTAL | 1 |

| DESCRIPTION- COMMERCIAL/SENIOR | CODE | RENTAL/SALE | QUANTITY |
|---|---|---|---|
| ENTERAL PUMP FEEDING KITS | | | |
| ENTERAL PUMP FEEDING KIT | B4035 | SALE | 31 |
| SYRINGE/BOLUS FED | B4034 | SALE | 31 |
| GRAVITY | B4036 | SALE | 31 |
| G-TUBE | B4087 | SALE | 1 |
| G-TUBE LOW PROFILE | B4088 | SALE | 1 |
| EXTENSIONS | B9998 | SALE | 5 |
| **FORMULA** | DEPENDING ON ITEM | SALE | |
| CPAP | E0601 | RENTAL | 1 |
| BIPAP | E0470 | RENTAL | 1 |
| HUMIDIFIER | E0562 | SALE | 1 |
| FULL FACE MASK | A7030 | SALE | 1/3 MO |
| NASAL MASK | A7034 | SALE | 1/3 MO |
| HEADGEAR | A7035 | SALE | 1/6 MO |
| TUBING | A7037 | SALE | 1/3 MO |
| FILTER | A7038 | SALE | 2/ MO |
| WATER CHAMBER | A7046 | SALE | 1/ 6 MO |
| COMMODE | E0163 | SALE | 1 |
| FRONT WHEELED WALKER | E0143 | SALE | 1 |
| 4 WHEELED WALKER WITH SEAT | E0143 E0156 | SALE | 1 |
| HEAVY DUTY FRONT WHEELED WALKER | E0149 | SALE | 1 |
| HEAVY DUTY 4 WHEELED WALKER | E0149 E0156 | SALE | 1 |
| NEBULIZER | E0570 | SALE | 1 |
| SINGLE POINT CANE | E0100 | SALE | 1 |
| QUAD CANE | E0105 | SALE | 1 |
| CRUTCHES | E0114 | SALE | 1 |
| OSTOMY SUPPLIES | BY ITEM # | SALE | |
| UROLOGICAL SUPPLIES | BY ITEM # | SALE | |
| WOUND CARE SUPPLIES | BY ITEM # | SALE | |