

(c) When the purchase price of a DME item is \$300.00 or more, prior authorization shall be required for purchase or rental, as described in Appendix A, incorporated herein by reference, except as described in (e) below.

(d) When the purchase price for medical supplies is \$100.00 or more, prior authorization is required as described in Appendix A, incorporated herein by reference.

(e) Certain DME items and medical supplies require prior authorization regardless of purchase price, indicated in Appendix A, incorporated herein by reference.

(f) All medical supplies and DME items purchased or rented for use by nursing facility residents require prior authorization. Items included in the NF's per diem are not covered (see N.J.A.C. 10:59-1.4).

(g) Medicare/Medicaid claims do not require prior authorization (See N.J.A.C. 10:59-1.9).

Amended by R.2001 d.64, effective February 20, 2001.
See: 32 N.J.R. 4098(a), 33 N.J.R. 661(c).

Case Notes

Digital scale for applicant with morbid obesity was not an item for which Medicaid funds were available. R.S. v. Division of Medical Assistance, 95 N.J.A.R.2d (DMA) 65.

Medical necessity authorized purchase of thermal scan thermometer with Medicaid funds for severely retarded child. C.F. v. Division of Medical Assistance, 95 N.J.A.R.2d (DMA) 45.

10:59-1.7 Policy considerations for purchase, rental and repair of DME

(a) Medical suppliers may request payment for medical supply services only after the supply/equipment has been delivered to the beneficiary (see N.J.A.C. 10:49-9.5). All requests for payment shall be submitted timely, in accordance with N.J.A.C. 10:49-7.2.

(b) For durable medical equipment requiring prior authorization (PA), decisions regarding rental or purchase rest with the Division of Medical Assistance and Health Services.

1. Durable medical equipment may be rented when, in the judgment of the Medicaid program, the medical need for the equipment is of such a duration that rental of the equipment is more economically practical than authorizing its purchase.

(c) When durable medical equipment is authorized and purchased on behalf of a Medicaid beneficiary, ownership of such equipment will vest with the Division of Medical Assistance and Health Services. The beneficiary will be granted a possessory interest for as long as the beneficiary requires use of the equipment.

(d) Durable medical equipment items may be repaired and suppliers reimbursed for replacement parts and/or labor charges when, in the judgement of the Medicaid Program,

the medical need for the item will continue to exist for a period of time and repair is more economical than purchase.

(e) Repair costs related to rented DME shall be the responsibility of the provider and shall be considered a component of the Medicaid rental payment.

(f) Reimbursement for repairs, including parts and labor charges, will not be authorized for durable medical equipment under warranty. For purchased DME, reimbursement for the cost of repairs shall be limited to repairs not covered by a manufacturer's warranty.

(g) Reimbursement by the Medicaid program shall be limited to services billed by HCPCS codes followed by the appropriate following modifier(s).

1. NU refers to the purchase of medical supplies, new DME and/or services;
2. UE refers to the purchase of used DME; and
3. RR refers to the daily or monthly rental of DME.

Amended by R.2001 d.64, effective February 20, 2001.
See: 32 N.J.R. 4098(a), 33 N.J.R. 661(c).

In (a) and (c) substituted "beneficiary" for "recipient"; and in (b), recodified former i as 1.

10:59-1.8 Basis of reimbursement for medical supplies and DME

(a) Payment for purchase of medical supplies or DME shall be based on the following methods:

1. If there is no Medicaid Fee schedule, reimbursement shall be based on the lesser of the provider's usual and customary charge to the general public or a calculated maximum fee allowance equal to 130 percent of a supplier's invoice cost or 80 percent of the manufacturer's price list for supplies and equipment priced by report.

i. The invoice shall include the supplier as the addressee, item description, quantity, and cost.

ii. The manufacturer's price list shall include a manufacturer's name, item description, and suggested retail price per unit or package, and a notation by a supplier indicating the number of units per package, if not described by a manufacturer.

2. If there is a Medicaid Fee schedule, reimbursement shall be based on the lesser of the provider's usual and customary charge to the general public; or the Medicaid maximum fee allowance assigned by the Division.

(b) Payment for rental of DME will be calculated as follows:

1. If a medical equipment item has a maximum fee allowance of \$100.00 or less, the monthly rental payment will be the amount billed or 20 percent of the approved purchase price, whichever is less. Six such payments shall be deemed to be the full purchase price. No further

payments shall be made and the equipment will be considered the property of the State.

2. If a medical equipment item has an approved maximum fee allowance of more than \$100.00, the monthly rental payment will be the amount billed or 12 percent of the fee, whichever is less. Ten such payments shall be deemed to be the full purchase price and no further payments shall be made and the equipment will be considered the property of the State.

3. If the purchase of a rental item is authorized prior to the close of the maximum rental period (see N.J.A.C. 10:59-1.8(b)1 and 2), a final payment will be made which equals the difference between the sum of the prior rental payments and the maximum fee allowance.

4. If death, ineligibility, or other circumstances over which the New Jersey Medicaid Program has no control, should occur, rental fees for any medical equipment item shall terminate at the end of the month such circumstance(s) occur and no further payment will be made.

(c) Payment for replacement parts and repairs will be made as follows:

1. Reimbursement for replacement parts shall be based on the purchase policy described under N.J.A.C. 10:59-1.8(a); and

2. Reimbursement for labor charges will be the maximum fee allowance established by the Division per hour of labor provided.

10:59-1.9 Dual Medicare/Medicaid or NJ KidCare coverage

(a) When a Medicaid or NJ KidCare beneficiary also has Medicare coverage, the Medicaid and the NJ KidCare programs require that Medicare benefits be used first and to the fullest extent. Responsibility for payment by the New Jersey Medicaid or NJ KidCare program shall be limited to the unsatisfied deductible and/or coinsurance to the extent that the combined Medicare/Medicaid or Medicare/NJ KidCare payment does not exceed the Medicaid or NJ KidCare maximum allowable.

(b) In those instances where Medicare policy disallows reimbursement for an item/service under certain circumstances, for example, a special wheelchair for a NF resident, the provider shall obtain prior authorization from the Medicaid or NJ KidCare—Plan A program and submit a hard copy claim to Medicaid or NJ KidCare—Plan A with an Explanation of Benefits from Medicare attached.

(c) Medicare/Medicaid claims shall be filed timely, in accordance with N.J.A.C. 10:49-7.2.

(d) When a beneficiary is eligible for Medicare and Medicaid or Medicare and NJ KidCare coverage, a Medicare/Medicaid or Medicare/NJ KidCare claim will cross over from the Medicare DMERC Region A to the Medicaid or NJ KidCare fiscal agent. There are instances, however, where claims will not cross over from Medicare to Medicaid or NJ KidCare, for example, claims denied by Medicare or claims where the Medicaid or NJ KidCare fiscal agent is unable to match pertinent identifying data (see N.J.A.C. 10:49-7.2(d)3 for further instructions).

(e) There are situations in which Medicare coverage differs significantly from coverage considered medically necessary by the Medicaid or NJ KidCare program. In these situations, the provider may request PA from the Medicaid or NJ KidCare program prior to requesting Medicare payment.

1. The provider must request PA for the higher level of service under the procedure code assigned by the Division for "reconciliation of downgraded Medicare/Medicaid or Medicare/NJ KidCare claims."

(f) For dually eligible beneficiaries, Medicaid or NJ KidCare coverage shall be based on Medicare policy as it relates to rental and/or purchase of supplies and DME except as described in (e) above.

Amended by R.1998 d.382, effective July 20, 1998.
See: 30 N.J.R. 1255(b), 30 N.J.R. 2646(b).

In (a), inserted "to the extent that the combined Medicare/Medicaid or Medicare/NJ KidCare payment does not exceed the Medicaid or NJ KidCare maximum allowable" at the end, and inserted references to NJ KidCare and substituted beneficiary for recipient throughout the section.

10:59-1.10 Third party liability (TPL), excluding Medicare

(a) When a Medicaid beneficiary has other health insurance, the Medicaid program requires that such benefits be used first and to the fullest extent. Supplementation may be made for Medicaid covered services, but the combined total payment shall not exceed the amount payable under the Medicaid program in the absence of other coverage (see N.J.A.C. 10:49-7.3).

(b) Regardless of the status of a provider's claim with other third parties, all claims for Medicaid reimbursement shall be received by the Medicaid fiscal agent within the time frames specified in N.J.A.C.10:49-7.2, Timeliness of claim submission.

(c) The Medicaid program has not established any cross-over arrangements with any third party insurer.

Amended by R.2001 d.64, effective February 20, 2001.
See: 32 N.J.R. 4098(a), 33 N.J.R. 661(c).

In (a), substituted "beneficiary" for "recipient".

10:59-1.11 Recycling durable medical equipment

(a) The New Jersey Medicaid and NJ KidCare programs shall utilize the services of a durable medical equipment (DME) recycling contractor, acting as an agent of the State, to recycle certain DME for reuse by Medicaid and NJ KidCare fee-for-service beneficiaries when such equipment is considered medically necessary.

(b) The New Jersey Medicaid and NJ KidCare fee-for-service programs shall recycle certain DME when the aggregate cost of recycling an item of DME, including costs for pickup and delivery, repairs, maintenance, tracking of DME and other directly related costs, are less than the Medicaid maximum fee allowance for the purchase of new DME.

1. Coverage and reimbursement for DME which is determined recyclable by the New Jersey Medicaid and NJ KidCare fee-for-service programs shall be limited to such equipment when this equipment is available from the DME recycling contractor.

2. Recyclable DME shall include, but not be limited to, the following:

- i. Canes, all types;
- ii. Commodes;
- iii. Communication devices;
- iv. Crutches, all types;
- v. Durable bathroom equipment;
- vi. Hospital beds, all types;
- vii. Walkers, all types;
- viii. Wheelchairs and wheelchair components.

(c) Prior to dispensing equipment determined recyclable by the State, medical suppliers shall contact the DME recycling contractor to determine the availability of recycled equipment for reuse. Reimbursement for recycling used equipment shall be limited to services provided by the recycling contractor.

(d) Claims for new DME, when such DME is readily available from the DME recycling contractor, shall be denied reimbursement by the Medicaid and NJ KidCare fee-for-service programs.

(e) Medical suppliers in receipt of used DME which is considered recyclable by the Medicaid and NJ KidCare programs shall arrange for the return of such equipment to the DME recycling contractor by contacting the contractor directly.

Repeal and New Rule, R.1999 d.176, effective June 7, 1999 (operative July 1, 1999).

See: 30 N.J.R. 4033(a), 31 N.J.R. 1506(a).
Section was "Recycling policy".

10:59-1.12 Parenteral therapy

(a) Parenteral therapy refers to the administration of a drug by the intravenous or subcutaneous route of administration.

(b) Total parenteral nutrition (TPN) means the administration of a patient's total daily nutritional needs via the parenteral route of administration.

(c) All parenteral therapy services, including total parenteral nutrition (TPN), require prior authorization (see N.J.A.C. 10:59-1.6).

(d) For parenteral therapy other than TPN, coverage through the medical supplier shall be limited to supplies and equipment. Medicaid and NJ KidCare fee-for-service maximum fee allowances for drug costs related to TPN solutions shall only be reimbursed to medical suppliers who are also licensed as providers of pharmaceutical services.

1. Coverage for all medical supplies and DME related to TPN therapy shall be based on monthly fee allowances as established by the Division (see N.J.A.C. 10:59-2.3 for monthly fee allowances and unit descriptions).

(e) All drugs related to parenteral therapy shall be covered as pharmaceutical services (see N.J.A.C. 10:51-1.11) and shall only be billed to the Division by providers of pharmaceutical services (see N.J.A.C. 10:51-1.2(d)).

1. Reimbursement of all DME base solutions and supplies related to parenteral therapy shall be based on the mode of parenteral administration.

2. Medicaid and NJ KidCare fee-for-service maximum fee allowances for parenteral therapy-related DME shall be based on all-inclusive per diem rates established by the Division (see N.J.A.C. 10:59-2.3 for daily allowances and unit descriptions). The per diem rate includes the cost of the base solution.

(f) When the beneficiary is a nursing facility resident, all parenteral therapy drugs and TPN solutions shall be billed by the Medicaid or NJ KidCare pharmacy provider that is under contract with the nursing facility to provide pharmaceutical services.

1. The contracted provider of pharmaceutical services must be licensed to provide parenteral therapy (see N.J.A.C. 10:51-1.2(d)) and approved as a medical supplier by the Division (see N.J.A.C. 10:59-1.3).

2. All costs for supplies and DME which are used for the administration of parenteral therapy and TPN solutions, shall be components of the nursing facility per diem rate and shall not be eligible for fee-for-service reimbursement from the New Jersey Medicaid or NJ KidCare programs.

Amended by R.2000 d.391, effective October 2, 2000.
See: 32 N.J.R. 2198(a), 32 N.J.R. 3568(a).

Rewrote the section.

10:59-1.13 Augmentative/alternative communication system (ACS)

(a) ACS requires prior authorization. Requests for prior authorization shall include the following:

1. A list of specialists involved in the multi-disciplinary team evaluation of the beneficiary, including, at a minimum, a speech-language pathologist, physical therapist, occupational therapist, and social worker.
2. An evaluation report by the speech-language pathologist, which shall include the following:
 - i. The communication status of the beneficiary, including relevant mental and physical disabilities;
 - ii. A list of augmentative/alternative communication devices/systems tried during the evaluation period;
 - iii. The rationale for the selection of the prescribed device/system and a description of how it will enhance functional communicative abilities;
 - iv. A certification that the beneficiary can mentally and physically benefit from the device/system and is willing to use it;
 - v. Recommendations for follow-up instruction so that maximum benefit may be obtained;
 - vi. A description of the beneficiary's gross and fine motor abilities, perceptual skills, reading skills, and cognitive abilities;
 - vii. Results of an audiometric screening and/or audiologic evaluation, as appropriate;
 - viii. A summary of past speech-language treatment;
 - ix. Results of the trial period with the device; and
 - x. A list of recommended augmentative communication devices, including all necessary accessories, prices and provider information.

(b) Follow up visits will be made by the appropriate MDO staff, at their discretion, to monitor appropriate ACS use.

(c) Reimbursement can be made for ACS rental during the trial period in accordance with the policy contained at N.J.A.C. 10:59-1.7 regarding rental of DME.

Amended by R.2001 d.64, effective February 20, 2001.

See: 32 N.J.R. 4098(a), 33 N.J.R. 661(c).

In (a), substituted "beneficiary" for "recipient" throughout.

10:59-1.14 Pressure reduction systems

(a) Pressure reduction systems include:

1. Air fluidized bed systems which employ the circulation of filtered air through silicone-coated ceramic beads creating the characteristics of fluid;

2. Powered low air loss bed systems which incorporate the use of an air-bladder system consisting of a series of interconnected adjustable air sacs designed to allow air escape to reduce support surface pressure. Air to the sacs is supplied by a separate power supply unit; and

3. Low end products which include any powered or non-powered overlay or mattress.

(b) Policies for providing and authorizing DME as described in N.J.A.C. 10:59-1.5 and 1.6 apply.

(c) Reimbursement for low end products is included in the NF's per diem, and therefore shall not be covered.

(d) Periods of Prior Authorization (PA) for air-fluidized and powered low air loss bed systems shall be limited to 30 days.

(e) Requests for PA for air fluidized and low air loss bed systems shall include the following:

1. A medical history relating to the wound which includes previous therapy and pressure relief systems utilized and found unsuccessful;
2. Physician progress notes indicating medical necessity, plan of treatment, and evaluation of response to treatment specific to the care of the wound;
3. A wound care flow sheet documenting weekly the site, size, depth and stage of the wound, noting also the presence and description of drainage or odor;
4. Laboratory values include a complete blood count and blood chemistries initially and on request thereafter;
5. A nutritional assessment by a registered dietitian initially and on request thereafter; and
6. Photographs of the site, upon permission of the beneficiary/family, after full due consideration is afforded to the beneficiary's right to privacy, dignity and confidentiality.

(f) Coverage for air fluidized and low air loss bed systems shall be limited to the following conditions:

1. The beneficiary has two stage III (full-thickness tissue loss) pressure sores or a stage IV (deep tissue destruction) pressure sore which involves two of the following sites: hips, buttocks, or sacrum; and
2. The beneficiary is bedridden or chairbound as a result of severely limited mobility; and
3. The beneficiary is receiving maximal medical/nursing care, previously instituted conservative treatment has been unsuccessful and all other alternative equipment has been considered and ruled out.

4. If the beneficiary has coexisting risk factors (such as vascular irregularities, nutritional depletion, diabetes or immune suppression), they must present post-operatively with a posterior or lateral flap or graft site requiring short-term therapy until the operative site is viable.

(g) Coverage for conditions other than those described in (e) above may be considered on an individual basis by the MDO.

Amended by R.2001 d.64, effective February 20, 2001.
See: 32 N.J.R. 4098(a), 33 N.J.R. 661(c).

In (e)6 and (f), substituted "beneficiary" for "recipient" throughout.

10:59-1.15 Apnea monitor

(a) Apnea monitors shall require prior authorization (PA) for initial certification and subsequent recertification.

1. To obtain authorization, providers shall complete the "Home Apnea Monitor Certification" form FD-287 which requires the prescriber's signature. The FD-287 may be used in lieu of a prescription by suppliers.

(b) Coverage of apnea monitors shall be limited to use by infants not otherwise monitored for the same purpose by another device.

(c) Reimbursement for apnea monitors is included in the NF's per diem, and shall not be covered separately.

(d) Suppliers shall provide a properly functioning monitor in an environment that assures its safe and effective use.

(e) Apnea monitors shall be reimbursed on a monthly rental basis. The rental payment shall include, but not be limited to, belt lead wires, electrodes, patient connecting cable, and battery, if appropriate.

istration (HCFA) for physician and non-physician services which are not in CPT-4.

2. LEVEL III CODES (Narratives found in N.J.A.C. 10:59-2.3) are assigned by the Division to be used for those services not identified by CPT-4 codes or HCFA-assigned codes. Level III codes identify services unique to New Jersey.

(b) The responsibilities of the provider of durable medical equipment (DME) and medical supply services for rendering services and requesting reimbursement are listed at N.J.A.C. 10:59-1.

Amended by R.2001 d.64, effective February 20, 2001.
See: 32 N.J.R. 4098(a), 33 N.J.R. 661(c).

10:59-2.2 Elements of HCPCS Coding System which require the attention of the provider

(a) The list of HCPCS procedure codes in N.J.A.C. 10:55-2.4 is arranged in tabular form with specific information for each code given under columns with the titles "HCPCS Code", "Description", and "Maximum Fee Allowance".

(b) The column titled "Maximum Fee Allowance" indicates the maximum amount of reimbursement or the following symbol:

1. "B.R." (By Report) is listed instead of a dollar amount. It means that additional information will be required in order to properly evaluate the service. Attach a copy of the provider's invoice or manufacturer's price list to the claim form.

(c) Services and procedures may be modified under certain circumstances. When applicable, the modifying circumstances should be identified by the addition of alphabetic and/or numeric characters at the end of the HCPCS procedure code. The New Jersey Medicaid program's recognized modifier codes for medical supply services are as follows:

1. "NU" Purchase of new Durable Medical Equipment (DME)
2. "UE" Purchase of used DME
3. "RR" DME rental service

SUBCHAPTER 2. HCFA COMMON PROCEDURE CODING SYSTEM (HCPCS)

10:59-2.1 Introduction

(a) The New Jersey Medicaid Program utilizes the Health Care Financing Administration's (HCFA) Common Procedure Coding System (HCPCS). HCPCS follows the American Medical Association's Physicians' Current Procedural Terminology—4th Edition (CPT-4) architecture, employing a five-position code and as many as two 2-position modifiers. Unlike the CPT-4 numeric design, the HCFA assigned codes and modifiers contain alphabetic characters. HCPCS was developed as a three-level coding system. Level I codes are not applicable to medical supplies and durable medical equipment. The level II and Level III codes are as follows:

1. LEVEL II CODES (Narratives found at N.J.A.C. 10:59-2.3) are assigned by Health Care Financing Admin-

10:59-2.3 HCPCS procedure codes and maximum fee allowance schedule for medical supplies and durable medical equipment

HCPCS Code	Description	Maximum Fee Allowance
A4206	Syringe with needle, sterile 1cc	B.R.
A4207	Syringe with needle, sterile 2cc	B.R.
A4208	Syringe with needle, sterile 3cc	B.R.
A4209	Syringe with needle, sterile 5cc or greater	B.R.
A4210	Needle-free injection device	B.R.
A4211	Supplies for self-administered injections	B.R.
A4212	Huber-type needle, each	B.R.
A4213	Syringe, sterile, 20cc or greater	B.R.
A4214	Sterile saline or water, 30 cc vial	0.81/vial

HCPCS Code	Description	Maximum Fee Allowance	HCPCS Code	Description	Maximum Fee Allowance
A4215	Needles only, sterile, any size	B.R.			
A4230	Infusion set for external insulin pump, non-needle, cannula type	B.R.			
A4231	Infusion set for external insulin pump, needle type	B.R.	A4356	Irrigation through a three-way indwelling foley catheter	37.03
A4232	Syringe with needle for external insulin pump, sterile 3 cc	B.R.	A4357	External urethral clamp or compression device (not to be used for catheter clamp)	7.94
A4244	Alcohol or peroxide, per pint	B.R.			
A4245	Alcohol wipes, per box	B.R.	A4358	Bedside drainage bag, day or night, with or without anti-reflux device, with or without tube	7.12
A4246	Betadine or Phisohex solution, per pint	B.R.			
A4247	Betadine or iodine swabs/wipes, per box	B.R.	A4359	Urinary leg bag; vinyl, with or without tube	27.00
A4250	Urine test or reagent strips or tablets (100 tablets or strips)	B.R.	A4361	Urinary suspensory without leg bag	6.20
A4253	Blood glucose test or reagent strips for home blood glucomitor, per 50 strips	B.R.	A4362	Ostomy face plate	5.03
A4256	Normal, low and high calibrator solution/chips	B.R.	A4363	Skin barrier; solid, 4" x 4" or equivalent; each	4.07
A4258	Spring powered device for lancet, each	B.R.	A4364	Skin barrier; liquid (spray, brush, etc.) powder or paste; per oz.	4.58
A4259	Lancets, per box	B.R.			
A4265	Paraffin	B.R.			
A4300	Implantable vascular access portal/catheter (venous, arterial, epidural or peritoneal)	B.R.	A4367	Adhesive for ostomy or catheter; liquid (for example, spray or brush) cement, powder or paste; any composition (for example, silicone, latex); per oz.	6.86
A4305	Disposable drug delivery system, flow rate of 50 ml or greater per hour	B.R.	A4397	Ostomy belt	4.50
A4306	Disposable drug delivery system, flow rate of 5 ml or less per hour	B.R.	A4398	Irrigation supplies; sleeve	2.25
A4310	Insertion tray without drainage bag and without catheter (accessories only)	6.61	A4399	Irrigation supplies; bag	11.25
A4311	Insertion tray without drainage bag with indwelling catheter, foley type, two-way latex with coating (teflon, silicone, silicone elastomer or hydrophilic, etc.)	8.34	A4400	Irrigation supplies; cone/catheter	24.61
A4312	Insertion tray without drainage bag with indwelling catheter, foley type, two-way, all silicone	8.34	A4402	Ostomy irrigation set	1.08
A4313	Insertion tray without drainage bag with indwelling catheter, foley type, three-way, for continuous irrigation	8.34	A4404	Lubricant	1.22
A4314	Insertion tray with drainage bag with indwelling catheter, foley type, two-way latex with coating (teflon, silicone, silicone elastomer or hydrophilic, etc.)	15.46	A4421	Ostomy rings	B.R.
A4315	Insertion tray with drainage bag with indwelling catheter, foley type, two-way, all silicone	15.46	A4454	Not otherwise classified ostomy supplies; ureterostomy supplies	B.R.
A4316	Insertion tray with drainage bag with indwelling catheter, foley type, three-way, for continuous irrigation	15.46	A4455	Tape, all types, all sizes	B.R.
A4320	Irrigation tray for bladder irrigation with bulb or piston syringe	5.00	A4460	Adhesive remover or solvent (for tape, cement or other adhesive)	B.R.
A4322	Irrigation syringe, bulb or piston	2.50	A4465	Elastic bandage, per roll (for example, compression bandage)	B.R.
A4323	Sterile saline irrigation solution, 1000 ml.	8.00	A4470	Nonelastic binder for extremity	B.R.
A4326	Male external catheter; specialty type (for example, inflatable or faceplate, each)	B.R.	A4480	Gravlee jet washer	B.R.
A4327	Female external urinary collection device; metal cup, each	B.R.	A4550	Vabra aspirator	B.R.
A4328	Female external urinary collection device; pouch	10.00	A4554	Surgical trays	B.R.
A4329	External catheter starter set, male/female, includes catheters/urinary collection device, bag/pouch and accessories (tubing, clamps, etc.), 7 day supply	39.95	A4556	Disposable underpads, all sizes (for example, Chux's), each	0.31
A4330	Perianal fecal collection pouch with adhesive	B.R.	A4557	Electrodes (for example, apnea monitor)	B.R.
A4335	Incontinence supply; miscellaneous	B.R.	A4558	Lead wires (for example, apnea monitor)	B.R.
A4338	Indwelling catheter; foley type, two-way latex with coating (such as teflon, silicone, silicone elastomer, or hydrophilic)	8.14	A4560	Conductive paste or gel	B.R.
A4340	Indwelling catheter; specialty type, (such as coude, mushroom or wing)	10.00	A4565	Pessary	20.94
A4344	Indwelling catheter, foley type, two-way, all silicone	15.52	A4570	Slings	B.R.
A4346	Indwelling catheter, foley type, three-way for continuous irrigation	15.00	A4572	Splint	B.R.
A4347	Male external catheter with or without adhesive, with or without anti-reflux device; per dozen	17.29	A4575	Rib belt	B.R.
A4351	Intermittent urinary catheter; straight tip	5.00	A4581	Topical hyperbaric oxygen chamber, disposable	B.R.
A4352	Intermittent urinary catheter; coude (curved) tip	5.00	A4595	Supplies, Risser jacket	B.R.
A4354	Insertion tray with drainage bag, without catheter	9.00	A4611	TENS supplies, 2 lead, per month	B.R.
A4355	Irrigation tubing set for continuous bladder	6.86	A4612	Battery, heavy duty; replacement for patient-owned ventilator	180.00
			A4613	Battery cables; replacement for patient-owned ventilator	44.00
			A4614	Battery charger; replacement for patient-owned ventilator	B.R.
			A4615	Peak expiratory flow rate meter, hand held	B.R.
			A4616	Cannula, nasal	7.50
			A4617	Tubing (oxygen), per foot	B.R.
			A4618	Mouthpiece	5.00
			A4619	Breathing circuits	9.15
			A4620	Face tent	10.00
			A4621	Variable concentration mask	10.00
			A4622	Tracheostomy mask or collar	10.17
			A4623	Tracheostomy or laryngectomy tube	75.00
			A4624	Tracheostomy, inner cannula (replacement only)	6.00
			A4625	Tracheostomy, care or cleaning starter kit	2.00
			A4626	Tracheal suction catheter, any type, each	8.00
			A4627	Tracheostomy care or cleaning starter kit	3.00
			A4628	Tracheostomy cleaning brush, each	B.R.
			A4629	Spacer, bag or reservoir, with or without mask, for use with metered dose inhaler	B.R.
			A4630	Oropharyngeal suction catheter, each	B.R.
			A4631	Tracheostomy care kit for established tracheostomy	B.R.
				Replacement batteries for medically necessary TENS, owned by patient	B.R.
				Replacement batteries for medically necessary electronic wheelchair, owned	B.R.