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COMMONWEALTH of VIRGINIA
DEPARTMENT OF MEDICAL ASSISTANCE SERVICES
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To: Medallion 4.0 and CCC Plus Managed Care Organizations

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Subject: MCO Services Delivery Flexibilities related to COVID-19

This memo sets out the Agency's initial guidance on the flexibilities available to providers in light of the public health emergency presented by the COVID-19 virus. These flexibilities include expanded telehealth coverage, as well as the waiver of certain program requirements, including specified service authorizations and prescription drug limitations. DMAS is also waiving specific provider requirements, as set out below. These flexibilities are relevant to the delivery of covered services related to COVID-19 detection and treatment, as well as maximizing access to care and minimizing viral spread through community contact.

Please note that the policy changes set out in this memo are in effect during the public crisis, as set out in the Governor's Emergency Declaration. This is a rapidly emerging situation and the Agency is moving quickly to address all aspects having an impact on both members and providers. Additional changes are forthcoming; DMAS is negotiating with its federal partners to authorize new flexibilities which the Agency will announce as they are approved. Providers are encouraged to frequently access the Agency's website to check the central COVID-19 response page for both FAQ's and guidance regarding new flexibilities as they are implemented. For additional questions about this memo or other

COVID-19 related issues, the agency has created a centralized point of access for submission at http://dmas.virginia.gov/contactforms/#/general

The guidance offered in this memo is directed to clarify claims processing rules that would apply to all DMAS-covered members regardless of whether the member's primary carrier is delivering Medicare or Commercial insurance benefits in coordination with the Medicaid and FAMIS benefit programs. Please share this memo with all operations/system configuration, care coordination, network/provider relations and customer service staff who work with the Medallion 4.0 and Commonwealth Coordination Care (CCC) Plus benefit plans and/or populations. All Department of Medical Assistance Services (DMAS) contracted health plans will need to ensure that claims configurations, and front line member and provider response staff training materials and staff messaging match this guidance by March 25, 2020. For the items and services that are not reimbursed using the same procedure codes as defined in the DMAS provider memo dated March 19, 2020 the contractors must ensure that network providers are given guidance on how to utilize and access the services in accord with DMAS program guidance.

All MCO benefit management structures should be assessed and adapted to allow the service provision requirements and flexibilities as defined in the DMAS memo dated March 19, 2020 and any subsequent memo related to the current and future ongoing management of COVID-19.

Billing for COVID-19 Testing
Testing is available through the Division of Consolidated Laboratory Services (State Laboratory) and from other private laboratories. For testing at DCLS, patients must meet certain clinical and epidemiologic criteria, and testing will be approved by the Virginia Department of Health. Further information on testing can be found on VDH's website. VDH approval is not required for testing at private laboratories.

VDH-enrolled clinical laboratories and health care facilities may bill DMAS for medically necessary, clinically appropriate COVID-19 lab tests using HCPCS Code U0001 (CDC testing laboratories to test patients for SARS-CoV-2, $35.91) and U0002 (non-CDC testing for SARS-CoV, $51.31) with effective dates of service on or after February 4, 2020. DMAS' fee-for-service billing system has been updated to accept the new codes and service authorization is not required. Laboratories will need to be Clinical Laboratory Improvement Amendments (CLIA) certified. DMAS is following the Center for Medicare and Medicaid Services (CMS) guidance for these two services. All Medicaid Managed Care Plans (MCOs) and Medicaid fee for service (FFS) cover COVID-19 testing.

Billing for COVID-19 Related Services
DMAS covers medically necessary services to treat or alleviate symptoms related to COVID-19. The CDC has provided Official Coding Guidelines for health care encounters and deaths related to COVID-19. All Medicaid Managed Care Plans (MCOs) and Medicaid fee for service (FFS) cover medically necessary services to treat or alleviate symptoms related to COVID-19.

Coverage of Targeted Services Delivered Via Telehealth
In order to maximize access to medically necessary services during the current public health emergency, DMAS is expanding coverage of telehealth as a method of service delivery. This is an initial policy

memo; the agency is working as quickly as possible to leverage additional needed flexibilities in this area; for example, in the area of remote patient monitoring. Medicaid MCOs may offer additional flexibilities.

"Telehealth services" means the use of telecommunications and information technology to provide access to health assessments, diagnosis, intervention, consultation, supervision, and information across distance for both medical and behavioral health services. Telehealth services includes the use of such technologies as interactive and secure medical tablets, remote patient monitoring, and store-and-forward technologies. When delivering services via telehealth, providers are required to adhere to the same standards of clinical practice and record keeping that apply to other covered services.

During the COVID-19 national emergency and effective immediately, the Office of Civil Rights at the Department of Health and Human Services "will not impose penalties for noncompliance with the regulatory requirements under the HIPAA Rules against covered health care providers in connection with the good faith provision of telehealth during the COVID-19 nationwide public health emergency." This applies to telehealth provided for any reason and does not have to be related to diagnosis and treatment of COVID-19. The full notice and related guidance on acceptable applications can be found here.

DMAS will reimburse for Medicaid-covered services delivered via telehealth where the following conditions are met:

- To the extent feasible under the circumstances, providers must assure the same rights to confidentiality and security as provided in face-to-face services. Providers must ensure the patient's informed consent to the use of telehealth and advise members of any relevant privacy considerations.
- DMAS is waiving the requirement that services delivered via telehealth (real-time, two-way communications) must utilize both audio and visual connection. DMAS is allowing the use of audio connections in addition to audio-visual connections.
- DMAS is waiving the requirement that provider staff must be with the patient at the originating site in order to bill DMAS for the originating site facility fee. These "telepresenters" shall not be required for payment of the originating site fee. Telehealth in the home is discussed more fully below, but no originating site fee shall be paid for telehealth in the home.
- Providers shall submit claims for telehealth services using the appropriate CPT or HCPCS code for the professional service delivered. In some cases, there are existing codes available for certain specifically telehealth-focused services. In others, such as behavioral health, please see the service specific section below for guidance. During the initial phase of the emergency, the Agency will permit providers who have not previously billed for telehealth delivery to bill for covered services delivered via telehealth (including audio and audio-visual) using their usual place of service code as the delivery location, but must document in the member's record the alternative location used and that the service was delivered via telehealth.
- Providers are asked to update their systems and procedures as soon as possible to enable the use of modifiers (GT or GQ) or telehealth POS (02) when billing for services delivered via telehealth. DMAS will require the use of these codes after the initial phase of the emergency is over. Additional information will be included in a future memo.

- Providers using telehealth POS (02) or modifiers for telehealth services covered under the prior policy shall continue to use the modifier GT (via interactive audio and video telecommunications system) or GQ (via synchronous telecommunications system), or POS code (02) when billing for services delivered via telehealth.
- Both services delivered via telehealth and billed using telehealth modifiers, and services delivered via telehealth and billed without modifiers will be reimbursed at the same rate as the analogous service provided face-to-face.
- Providers shall maintain appropriate documentation to support medical necessity for the service delivery model chosen, as well as to support medical necessity for the ongoing delivery of the service through that model of care.

Home as Originating Site
During the current emergency, DMAS will allow the home as the originating site. This is particularly important for members who are quarantined, those who are diagnosed with or demonstrating symptoms of COVID-19, or those who are at high risk of serious illness from COVID-19. Clinicians shall use clinical judgment when determining the appropriate use of home as the originating site. No originating site fee shall be paid for telehealth in the home.

Telehealth in the Delivery of Behavioral Health Services
DMAS will allow for telehealth (including telephonic) delivery of all behavioral health services with several exceptions. Services that will be allowable via telehealth include:

- Care coordination, case management, and peer services
- Service needs assessments (including the Comprehensive Needs Assessment and the IACCT assessment in mental health and the Multidimensional Assessment in ARTS) and all treatment planning activities
- Outpatient psychiatric services
- Community mental health and rehabilitation services
- Addiction Recovery and Treatment Services

The per diem rates for therapeutic group homes, psychiatric residential treatment facilities, and inpatient psychiatric hospitalization will not be billable through telehealth; however, within these services, activities including assessments, therapies (individual, group, family), care coordination, team meetings, and treatment planning are allowable via telehealth.

As stated above in the general guidance and until otherwise notified, behavioral health providers delivering services via telehealth (including telephonic communications) shall simply bill and submit a claim as they normally would in their regular practice. The Place of Service (POS) that the provider usually bills should remain the same and no modifiers shall be necessary in order to minimize systems errors during this critical time. Providers shall maintain appropriate documentation to indicate the mode of delivery and to support medical necessity for the ongoing delivery of the service through that model of care. As noted above in the general guidance, providers should move to systems changes to allow Place of Service Codes (02) to reflect telehealth delivery as this will be required at a future date.

Please Note: All program-specific guidance for COVID-19 service flexibilities is located in the Medicaid Memo on COVID-19 Flexibilities dated March 19, 2020.

Face-to-Face Service Delivery Guidance for all DMAS-Covered Services:
DMAS is issuing the following recommendations to assist agencies, health care organizations, and providers, and to assure that members continue to receive necessary interventions.

- All providers shall limit the amount of face-to-face contacts with members. If a provider, member, caregiver, and or anyone in home or facility is experiencing symptoms of a medical illness, all face-to-face contact shall be minimized or avoided.
- All face-to-face requirements including assessments, reassessments, and service delivery are waived for all members residing in the community, with the exception of instances when there is concern for the member's health safety and welfare. Face-to-face meetings shall be replaced with phone calls with members and/or documentation from providers.
- Existing face-to-face requirements continue to apply in cases where there is a compelling concern for the member's health, safety and welfare based on the professional judgement of licensed staff.

Requirements for Member Co-payments (Applicable across MCOs and FFS)
All member co-pays have been suspended, effective March 13, 2020. No co-pays will be collected from any Medicaid or FAMIS member in order to encourage all members to seek needed medical care and treatment.

Pharmacy Benefit Changes in Response to COVID 19
Effectively immediately, the Fee-for-Service (FFS) and Medicaid managed care health plans will

1) Suspend all drug co-payments for Medicaid, FAMIS and FAMIS Moms members,
2) Cover a maximum of a 90 day supply for all drugs **excluding** Schedule II drugs. In Virginia, Schedule II drugs include most opioids, amphetamines, methylphenidate, etc. A complete list of Schedule II drugs can be found at https://law.lis.virginia.gov/vacode/title54.1/chapter34/section54.1-3448/ .
3) Suspend refill to soon edits for all drugs prescribed for 34 days or less. Drugs dispensed for 90 days will be subject to a 75% refill to soon edit. Patients will only be able to get a subsequent 90 day supply of drugs after 75% of the prescription has been used (approximately day 68).
4) Federal and state law prohibit the early refilling of Schedule II drugs except in the case of an emergency. Pharmacists should refer to Virginia Board of Pharmacy's guidance for emergency fill procedures.

Pharmacists and prescribers must continue to comply with all applicable state and federal laws and regulations related to the prescribing and dispensing of controlled substances. Pharmacists are encouraged to review the Virginia Board of Pharmacy's **Emergency Provisions for Pharmacists During the COVID-19 Declared Emergency** for additional guidance.

Waiving Service Authorization Requirements on Select Services
Providers are required to submit for service authorization review: 1) any new request for services; and 2) requests for changes in services such as increase or decrease.

Please see Attachment B for a full list of services for which service authorization is being extended or waived.

Please note that DME providers may deliver up to a 2-month supply at a time (60 days) during the response to the COVID-19 pandemic. DME providers are instructed to bill in monthly increments with the anniversary date (30 days at a time). Providers will be required to keep records of patient/caregiver contact to determine the appropriate need for supplies during each 60-day period if it is determined a second 60-day supply period is needed. Providers are also required to maintain the normal delivery ticket documentation and proof of delivery.

Suspension of Out-of-Network Requirements

For Out-of-Network services, the MCOs shall relax out of network authorization requirements as appropriate and pay the Medicaid fee schedule, in order to expedite needed care for members.

Medallion 4.0 and CCC Plus Managed Care Programs
During the emergency DMAS requires for all MCO's to ensure that claims systems and benefit management rules are aligned with the most current DMAS Memoranda on the COVID-19 service delivery flexibilities. Please refer to the Medicaid Memo posted on March 19, 2020 for up to date more guidance. MCOs may, at their discretion, allow additional enhanced delivery flexibilities within their provider network.

- Member and Provider Communications
  The department requires copies of all provider and member communions addressing the COVID 19 crisis. Please send that information to
  CCC Plus-CCCPlusMCOs@dmas.virginia.gov
  Medallion 4.0-Managedcarehelp@dmas.virginia.gov

- Daily Update:
  The department is requesting that the plans each morning by 10 am send a daily update of any COVID updates including known complications, concerns, staffing or location changes. In addition, plans should be on a daily call with DMAS team members at 3 pm

- Weekly reports/Crisis Updates
  The department will be requesting weekly reports about testing and treatment so that we can provide that information to HHR as needed.

CCC Plus MCO Face-to-Face Requirements
The changes to the face-to-face requirements are as follows, effective March 12, 2020:

a. For CCC Plus members in nursing facilities, all face-to-face requirements including initial health risk assessments, reassessments (both scheduled and triggering), interdisciplinary care team meetings, and care planning meetings are waived. Face-to-face meetings shall be replaced with phone calls with member, family/authorized representatives, nursing facility staff and/or

documentation, e.g., copy of most recent minimum data set or other available member records. Details on how the information was obtained in lieu of the face-to-face meeting must be documented within the member's record.

b. For CCC Plus members residing in the community, with the exception of instances when there is concern for the member's health safety and welfare, all face-to-face requirements including health risk assessments, reassessments (both scheduled and triggering), interdisciplinary care team meetings, and care planning meetings are waived. Face-to-face meetings shall be replaced with phone calls with members and/or documentation from providers. This waiving of the face-to-face requirements shall be used for all CCC Plus members residing in the community where the member's health, safety and welfare is maintained by authorized services and information received by using an alternate method in lieu of the face-to-face meeting. Details on how the information was obtained in lieu of the face-to-face meeting must be documented within the member's record.

c. Existing face-to-face requirements continue to apply in cases where there is a compelling concern for the member's health, safety and welfare based on the professional judgement of licensed staff.

d. All Quality Management Reviews (QMRs) will be desk audit only. All needed materials will be requested from the provider to conduct the review. Providers will be allowed flexibility in instances where they have limited staff to submit records. DMAS will schedule a call to discuss the process for reviewing health plan findings from the desk audit reviews.

e. All face-to-face requirements to conduct the annual level of care evaluations (LOCERI) are waived. This waiving of face-to-face requirement is for both past due and currently due level of care evaluations. For CCC Plus Waiver members who have had a face-to-face health risk assessment (initial or reassessment) from October 1, 2019 through March 12, 2020, the information from this assessment may be used to submit LOCERI data in lieu of the face-to-face meeting to complete and submit the annual level of care evaluation.

Eligibility and Enrollment

Several changes are being made to Eligibility and Enrollment policies and procedures to ensure continued coverage during this emergency. The agency's priority is to ensure continued coverage and access to coverage during this time. DMAS encourages uninsured patients to apply online (www.commonhelp.virginia.gov) as the fastest way to apply for care during an emergency. However, if patients experience interruptions in coverage or need corrections to their coverage during this time, please contact the centralized contact option highlighted at the beginning of this memo.

Fair Hearings and Appeals

Member Appeals

For all appeals filed from March 12, 2020, and throughout the declaration of emergency, if the appeal is for a reduction, termination, or denial of existing services, the MCO should automatically continue

the services during the internal appeal with no financial impact to the member. This applies whether the member has requested continued coverage or not. Additionally, if a further appeal is made to DMAS after the MCOs internal appeal process has been exhausted, DMAS will automatically grant continued coverage and the MCO must continue the services during the DMAS appeal with no financial impact to the member.

DMAS is also seeking federal authority to accept client/member appeals filed during the COVID-19 emergency that miss the normal filing deadlines. DMAS expects that this authority will be granted. If so, those appeals will move forward as if the deadlines were met. MCOs should accept internal appeals filed during the emergency even if the normal deadline to file the appeal was not met.

Appeal documents such as case summaries can still be submitted through the normal methods, but electronic means will be the most reliable during the emergency. The Appeals Division fax is 804-452-5454 and e-mail is Appeals@DMAS.Virginia.Gov

Provider Appeals

Pursuant to the Governor's Declaration of a State of Emergency issued on March 12, 2020 (Executive Order 51), the DMAS Director is authorized to waive state requirements and regulations. DMAS is exercising this authority for deadlines that govern provider appeals that are specified in the Code of Virginia and DMAS' provider appeal regulations. The following changes are being made:

- Providers affected by the COVID-19 emergency can request a hardship exemption to the normal deadline to file an appeal. MCOs should accept appeals as timely filed if a hardship is indicated on the appeal request.

- All deadlines after an appeal has been filed are extended for the period of the declaration of emergency. This applies to the following informal appeal deadlines: case summary, informal-fact-finding conference (IFFC), document submission after the IFFC, and the informal appeal decision. This also applies to the following formal appeal deadlines: documentary evidence, hearing date, post-hearing briefs, recommended decision, exceptions, and the Final Agency Decision. For example, if the declaration of emergency lasts 50 days, these deadlines are extended 50 days.

- All informal fact-finding conferences and formal hearings will be conducted by telephone during the period of emergency.

Attachment A

Table of Codes for Telehealth.

CODE	DEFINITION	Provider Type/Specialty
99201 – 99205 99211-99215	Initial and subsequent E&M office visit or other outpatient visit	MD: 020/000 NP: 023/000 FQHC: 052/000 RHC: 053/000 Health Dept.: 051/000
99221-99223 99231-99233	Initial and subsequent hospital care	MD: 020/000 NP: 023/000 FQHC: 052/000 RHC: 053/000 Health Dept.: 051/000
Q3014	Telemedicine Facility Fee	MD: 020/000 NP: 023/000 FQHC: 052/000 RHC: 053/000 Health Dept.: 051/000
99304-99306 99307-99310	Initial and subsequent physician nursing home care	MD: 020/000 NP: 023/000 FQHC: 052/000 RHC: 053/000 Health Dept.: 051/000
99354-99355 99356-99357	Prolonged service office Prolonged service inpatient	MD: 020/000 NP: 023/000 FQHC: 052/000 RHC: 053/000 Health Dept.: 051/000

ATTACHMENT B

Extended Service Authorizations for the following services:

CCC Plus Waiver Services

Exend SA for 60 days		
HCPCS Code	**Mod**	**Description**
T1019		Agency directed personal care
S5126		Consumer directed personal care
S9123		EPSDT Private Duty Nursing-RN
S9124		EPSDT Private Duty Nursing-LPN
G0493		EPSDT Private Duty Nursing-Congregate-RN
G0494		EPSDT Private Duty Nursing-Congregate-LPN
T1000	U1	Private Duty Nursing
T1001	U1	Private Duty Nursing
T1002		Private Duty Nursing-RN
T1003		Private Duty Nursing-LPN
S9125	TD	Skilled Respite RN
S9125	TE	Skilled Respite LPN
T1030	TD	Private Duty Nursing-Congregate-RN
T1031	TE	Private Duty Nursing-Congregate-LPN

Durable Medical Equipment

Waive SA for 60 days		
HCPCS Code	**Description**	**Billing Unit**
	Respiratory	
A4604	Tubing with integrated heating element for use with positive airway pressure device	Each
A4608	Transtracheal oxygen catheter, each	Each
A7025	High Frequency chest wall oscillation system vest, replacement for with patient owned equipment, each	Each
A7026	High Frequency chest wall oscillation system hose, replacement for use with patient owned equipment, each	Each
A7044	Oral interface used with positive airway pressure device, each	Each

E0430	Portable Gaseous Oxygen System, purchase, Includes Regulator, flowmeter, humidifier, cannula or mask, and tubing	Each
E0433 RR	Portable liquid liquid oxygen system, rental; home liquefier used to fill portable liquid oxygn containers, includes portable containers, regulator, flowmeter, humidifer, cannula or mask and tubing, with or without supply reservior and gauge	Day
E0435	Portable liquid oxygen system, purchase, includes portable container, supply reservoir, flowmeter, humidifier, contents gauge, cannula or mask, tubing, and refill adapter	Each
E0441	Stationary oxygen contents, gaseous, 1 month supply = 1 unit	1 Unit
E0444	Portable oxygen contents, liquid, one month's suppley = 1 unit	1 Unit
E0445	Oximeter device for measuring blood oxygen levels, non-invasively	Each
E0445 RR	Oximeter device for measuring blood oxygen levels, non-invasively	Day
E0447	**Portable oxygen contents, liquid, one month's suppley = 1 unit, prescribed amount at rest or nighttime exceeds 4 liters per minute (lpm)**	**1 Unit**
E0457	Chest shell (cuirass)	Each
E0457 RR	Chest shell (cuirass)	Day
E0460	Negative pressure ventilator, portable or stationary	Each
E0461 RR	Volume ventilator, stationary or portable, with backup rate feature, used with non-invasive interface	Each
E0465	Home ventilator, any type, used with invasive interface, (e.g., tracheostomy tube)	Each
E0465 RR	Home ventilator, any type, used with invasive interface, (e.g., tracheostomy tube)	Day
E0466	Home ventilator, any type, used with non-invasive interface, (e.g., mask, chest shell)	Each
E0466 RR	Home ventilator, any type, used with non-invasive interface, (e.g., mask, chest shell)	Day
E0467	**Home Ventilator, multi-function respiratory device, also performs any or all of the additional functions of oxygen concentration, drug nebulization, aspiration, and cough stimulation, includes all accessories, components and supplies for all functions**	**Each**

E0467	**Home Ventilator, multi-function respiratory device, also performs any or all of the additional functions of oxygen concentration, drug nebulization, aspiration, and cough stimulation, includes all accessories, components and supplies for all functions**	**Day**
E0470	Respiratory Assist Device, bi-level pressure capability, w/out backup rate feature, used w/noninvasive interface e.g. nasal or facial mask.	Each
E0470 RR	Respiratory Assist Device, bi-level pressure capability, w/out backup rate feature, used w/noninvasive interface e.g. nasal or facial mask.	Day
E0471	Respiratory assist device, bi-level pressure capability, w/backup rate feature, used w/noninvasive interface, eg. Nasal or facial mask	Each
E0471 RR	Respiratory assist device, bi-level pressure capability, w/backup rate feature, used w/noninvasive interface, eg. Nasal or facial mask	Day
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)	Each
E0472 RR	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)	Day
E0480	Percussor, Electric Or Pneumatic, Home Model	Each
E0480 RR	Percussor, Electric Or Pneumatic, Home Model	Day
E0482	Cough stimulating device	Each
E0482 RR	Cough stimulating device	Day
E0483	**High frequency chest wall oscillation system, includes all accessories and supplies, each**	Each
E0483 RR	**High frequency chest wall oscillation system, includes all accessories and supplies, each**	Day
E0500	IPPB Machine, all types, w/built-in nebulization; manual or automatic valves; internal or external power source	Each
E0500 RR	IPPB Machine, all types, w/built-in nebulization; manual or automatic valves; internal or external power source	Day

E0565	Compressor, air power source for equipment which is not self contained or cylinder driven	Each
E0565 RR	Compressor, air power source for equipment which is not self contained or cylinder driven	Day
E0575	Nebulizer, Ultra-Sonic large volume	Each
E0575 RR	Nebulizer, Ultra-Sonic large volume	Day
E0601	Continuous Positive Airway Pressure (CPAP) Device	Each
E0601 RR	Continuous Positive Airway Pressure (CPAP) Device	Day
E0618	Apnea Monitor without recording feature	Each
E0619	Apnea Monitor with recording feature	Each
E1352	Oxygen accessory, flow regulator capable of positive inspiratory pressure	Each
E1353	Regulator	Each
E1355	Stand/Rack	Each
E1372	Immersion external heater for nebulizer	Each
E1372 RR	Immersion Heater For Nebulizer	Day
S8120	Oxygen contents, gaseous, 1 unit equals 1 cubic foot	Each
S8121	Oxygen contents, liquid, 1 unit equals 1 pound	Each
S8999	Resuscitation bag (for use by patient on artificial respiration during power failure or other catastrophic event)	Each
	Diabetic supplies	
S5560	Insulin delivery device, reusable pen, 1.5 ml size	Each
S5561	Insulin delivery device, reusable pen, 3 ml size	Each
	Enteral Nutrition	
B9002	Enteral Nutrition Infusion Pump, Any Type	Each
B9004	Parenteral nutrition unfusion pump, portable	Each
B9006	Parenteral nutrition unfusion pump, stationary	Each
E0791	Parenteral infusion pump, stationary, single or multichannel	Each

	Blood pressure	
A4670	Automatic Blood Pressure Monitor	Each
	Ostomy supplies	
A4387	Ostomy pouch, closed, with barrier attached, with built in convexity (one piece), each	Each
A5120	Skin Barrier Wipes or swabs, each	Each

Home Health Services *(DMAS Uses Revenue Codes-MCO's use CPT Codes)*

Home Health Services-Waive SA for 60 days		
Revenue Code	**Mod**	**Description**
0550	Skilled Nursing Assessment	
0551	Skilled Nursing Care, Follow-Up Care	
0559	Skilled Nursing Care, Comprehensive Visit	
0571	Home Health Aide Visit	
0424	Physical Therapy, Home Health Assessment	
0421	Physical Therapy, Home Health Follow-UP Visit	
0434	Occupational Therapy, Home Health Assessment	
0431	Occupational Therapy, Home Health Follow-Up Visit	
0444	Speech-Language Services, Home Health Assessment	
0441	Speech Language Services, Home Health Follow-Up Visit	
0542	Non-Emergency Transportation, Per Mile	