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Medicaid Appendix
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Durable Medical Equipment Manual Transmittal No. 25-1

ISSUED BY: Division of Medical Services

SUBJECT: **Durable Medical Equipment**, Chapter III., **Provider-Specific Policies,** Title Page 1, Table of Contents Page i, Title Page 2, Contents Page 1 and 2, and pages 1-43, new.

Summary

The Durable Medical Equipment Provider Manual is created to provide information and policies relating to durable medical equipment, supplies, and prosthetic devices.

Effective Date

Immediately.

Material Superseded

None.

Additional Information

The updated provider manual containing the revised pages can be found at: https://hhs.iowa.gov/media/15903

If any portion of this manual is not clear, please contact the Iowa Medicaid Enterprise Provider Services Unit at 800-338-7909 or locally (in Des Moines) at 515-256-4609, or email at imeproviderservices@hhs.iowa.gov.

Durable Medical Equipment Provider Manual

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III. Provider-Specific Policies

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Chapter III. Provider-Specific Policies

A. Dealers Eligible to Participate

All dealers of durable medical equipment, supplies, and prosthetic devices in Iowa or in other states are eligible to participate in the Iowa Medicaid Program.

B. Coverage of Services

Payment is made for items of durable medical equipment, supplies, and prosthetic devices subject to the following requirements. Unless otherwise stated, Medicaid follows Medicare coverage criteria and documentation requirements.

NOTE: An **asterisk** (*) identifies those items where Medicaid criteria are different.

1. Medically Necessary Services

Durable medical equipment, supplies, and prosthetic devices must be required by the member because of the member's medical condition. The item shall be necessary and reasonable, as determined by Iowa Medicaid medical staff.

An item is **necessary** when it can be expected to make a meaningful contribution to the treatment of a specific illness, injury, or to the improvement in function of a malformed body member.

A prescription from a physician (Doctor of Medicine, osteopathy, or podiatry) physician assistant or advanced registered nurse practitioner is required to establish medical necessity. The prescription shall state the:

- Member's name,
- Diagnosis,
- Prognosis,
- Item or items to be dispensed,
- Length of time the item is to be required, and
- Include the signature of the prescriber and the signature date.

Although an item may be necessary, it must also be a **reasonable** expenditure for the Medicaid program. The following considerations enter the determination of reasonableness:

- Whether the expense of the item is clearly disproportionate to the therapeutic benefits which could ordinarily be derived from its use;

- Whether the expense of the item is substantially more costly than a medically appropriate and realistically feasible alternative plan of care; and
- Whether the item serves, essentially, the same purpose as an item already available to the member.

Non-medical items are not covered. These include, but are not limited to:

- Physical fitness equipment, such as exercise bikes or weights.
- First-aid or precautionary equipment, such as preset portable oxygen units.
- Self-help devices, such as safety grab bars and raised toilet seats.
- Training equipment, such as speech-teaching machines or Braille-training texts.
- Equipment that basically serves functions of comfort or convenience or that is primarily for the convenience of a person caring for the member, such as elevators, stairway elevators, and ramps.
- Equipment used for environmental control or to enhance the environmental setting, such as room heaters, air conditioners, humidifiers, dehumidifiers, and electric air cleaners.
- Convenience items, such as eating utensils or sharp disposal containers.

2. Prior Authorization*

When Medicaid **requires** an item or service to have prior authorization, providers must submit a request for prior authorization to Medicaid before billing. A list of DME that requires prior authorization can be found here. Some DME has Clinical Advisory Committee (CAC) criteria in place. A list of current CAC criteria can be found here.

NOTE: With the exception of items listed in Services to Members in a Medical Facility, medical equipment is not separately payable for members in nursing facilities. Prior authorization does not override this policy.

3. Durable Medical Equipment

Durable medical equipment (DME) is equipment that:

- Can withstand repeated use, and
- Is appropriate for use in the home, and
- Is primarily and customarily used to serve a medical purpose, and
- Is generally not useful to a person in the absence of an illness or injury.

All elements of this definition of durable medical equipment must be satisfied for the equipment to be covered under Medicaid. Except for items listed, durable medical equipment is not provided in a hospital, nursing facility, or intermediate care facility for intellectual disability.

a. New Equipment

For new equipment, the modifier NU (new durable medical equipment purchase) must be used. This indicates that the member has been furnished with a new never used piece of equipment.

For all codes requiring the NU modifier, please refer to https://med.noridianmedicare.com/web/jddme/fees-news/fee-schedules

b. Rental Equipment

Consideration is given to rental or purchase based on the price of the item and the length of time it would be required. Iowa Medicaid shall make the decision on rental or purchase based on the most reasonable method to provide the equipment.

EXCEPTION: Ventilators and oxygen systems are maintained on a rental basis for the duration of use.

Bill rental equipment monthly with a monthly date span and one unit of service.

EXCEPTION: Wound vacs, drug infusion pumps, and oxygen in nursing facilities should be billed on a daily basis, with one unit equals one day.

When the equipment is rented for less than a full month, the “KR” modifier in addition to the “RR” modifier should be used. The number of units should be the number of days the item was rented.

All supplies and accessories are included in the fee for rental and cannot be billed separately.

If the member has a permanent or long-term diagnosis for which equipment is provided, the item should be billed as purchased and not rented on a monthly basis.

When the length of need for equipment is undetermined, the equipment may be rented up to 100 percent of the purchase allowance or ten months.

At the point that total rent paid equals 100 percent of the purchase allowance or ten months, the member is considered to own the item, and no further rental payments are made. It is the providers responsibility to track the number of rental payments and discontinue billing beyond the 100 percent point or ten months.

Payment may be made for the purchase of an item even though rental payments may have been made for prior months. It may be necessary to rent the item for a time to establish that it meets the identified need before the purchase.

When a decision is made to purchase after renting an item, the **full** rental allowance is applied to the purchase allowance.

A deposit may not be charged by a provider to a Medicaid member or any other person on behalf of a Medicaid member for rental of medical equipment.

c. Used Equipment

Consider used equipment when it can meet the needs of the member. “Used equipment” is any equipment that has been purchased or rented by another party before the current purchase or rental transaction. Payment is 80 percent of the purchase allowance.

To supply used equipment, you must:

- Offer the member the same warranty that is offered to buyers of new equipment regarding the equipment’s functional capabilities,
- Certify that the used equipment has been reconditioned as necessary and is in good working order, and
- Certify that the reasonable service and repair expenses will not exceed those for comparable new equipment.

If a procedure code for used equipment is listed, use the available code. If there is no code listed for the used item, give a complete description of the item, stating that the equipment is used. Add modifier “UE” to the procedure code to designate used equipment.

d. Repair and Replacement*

Payment is made for necessary repair, maintenance, and supplies for member-owned equipment, including members who are in a nursing facility.

"Repair and maintenance" include the replacement of whole components, parts, or systems, such as seating systems that are worn out or broken and cannot otherwise be repaired, if the cost does not exceed two-thirds the cost of a new item. The age of the item and history of repairs are considered in determining whether to repair or replace an item.

Replacement of member-owned equipment, components, parts, or systems due to a change in size or condition of the member is not payable for members in nursing facilities.

When like-for-like replacement parts necessitate billing the miscellaneous procedure code K0108 or E1399, the "RB" modifier should be used. No payment is made for repairs covered under warranty. No payment is made for repairs, maintenance, or supplies when the member is renting the item. Rental of medical equipment while member-owned equipment is being repaired is a payable service. Procedure code K0462, temporary replacement for member-owned equipment being repaired should be billed. One unit equals one day.

Labor is paid in addition to repairs or non-routine service for member-owned equipment, orthotics, and prosthetics when the skill of a technician is required. Fifteen minutes equals one unit of repair service.

Replacement of member-owned equipment is covered in cases of loss or irreparable damage or when required because of a change in the member's condition. Loss of expensive items must be reported to the police and any third-party insurance coverage.

Replacement equipment must be supported by the prescription of the physician, current to within six months, and documentation supporting the medical necessity for the member to have the equipment.

Due to the potential for changes in the member's health conditions over time, mobility equipment provided as a replacement must be the appropriate form of mobility for the member at the time it is lost, damaged beyond repair, or outgrown.

If the replacement equipment is a manual wheelchair, power wheelchair, or Power Operating Vehicle (POV) and it has been six months or more since Medicaid provided payment for the equipment, the member must have a mobility re-evaluation.

e. Bath Equipment

Bath and shower chairs are covered for members who are:

- Unable to safely stand for the duration of a shower, or
- Get in and out of a bathtub due to a medical condition, and
- Need upper body support while sitting.

Bath transfer benches are covered for members who are unable to safely transfer in and out of a bathtub due to a medical condition.

Shower commode chairs* requires prior authorization. CAC criteria is available for shower commode chairs and can be found here.

f. Bed Pans and Urinals

Bedpans and urinals are covered when prescribed for a member who is bed confined.

g. Beds and Accessories

Hospital beds and mattresses are covered when prescribed for a member:

- Who is bed-confined, or
- Whose condition:
  - Necessitates positioning the body in a way that is not feasible in an ordinary bed, or
  - Requires attachments that could not be used on an ordinary bed.

Variable height hi-lo hospital beds are covered when additional documentation shows a medical condition that necessitates the variable height feature.

Semi-electric hospital beds are covered when additional documentation shows that all the following conditions are met:

- An immediate change in position is necessary to avert a life-threatening situation, and
- The change cannot be accomplished using the bed side rails, trapeze, or the assistance of a caregiver, and
- The member is alert and capable of effecting this change by operating the controls in a safe manner, and
- Documentation shows the medical condition that necessitates the electric variable height feature.

The semi-electric feature is not reimbursable when it is used for the convenience of the caregiver.

Total electric hospital beds* are covered if the medical need for a semi-electric bed is met **and** the need for height adjustment is required to meet the member's desire to remain independent in transfers. Documentation of the ability to transfer from a physical therapist or occupational therapist is required. Electric beds are **not** covered to assist the caregiver.

Safety beds* require prior authorization and are covered when all the CAC criteria is met. A safety bed is designed to keep the user safe from falling out or injuring themselves because of being in bed or during sleep. Safety beds, for purposes of this criteria, do not include hospital beds or institutional beds, but do include enclosed beds and adaptive beds when used for safety purposes. CAC criteria can be found here.

Mattresses are covered when medically necessary. Mattresses cannot be billed separately with a hospital bed.

Bed side rails* are covered when prescribed for a member who is bed-confined or disoriented. Side rails cannot be billed separately **in addition to** a hospital bed.

Fracture frames are covered when prescribed for a member with an orthopedic impairment that prevents ambulation.

Trapeze bars and accessories are covered when prescribed for a member who is bed-confined, has the ability to use the equipment, and has a need to sit up because of a respiratory condition or a need to change body position for specified medical reasons, or to get in and out of bed.

Used hospital beds are covered according to the same criteria as new hospital beds. Use the UE modifier on the applicable code.

h. Bilirubin Lights*

A phototherapy (bilirubin) light with photometer is covered for home use when prescribed for short-term treatment of hyperbilirubinemia and this is the only reason hospitalization or frequent outpatient treatment would be required. For daily rental, 1 unit equals 1 day, and supplies are included. (Coverage differs from Medicare.)

i. Blood Pressure Monitors*

Blood pressure monitors are covered when ordered for a condition or disease that warrants in-home monitoring daily to at least weekly and recording with review by the physician on a regular basis. Examples include polycystic renal disease, renal failure, cardiac defects, and medications that create hypertension or hypotension.

Monitors are also covered when prescribed for any member who has end-stage renal disease, and the equipment is appropriate for home use.

j. Canes

Canes are covered when prescribed for a member whose condition impairs ambulation. White canes for the blind are **not** covered.

k. Chairs, Seat Lifts

Prior authorization is not required for seat lift chairs. A combination lift chair and mechanism are covered when:

- The chair is prescribed for a member with severe arthritis of the hip or knee, muscular dystrophy, or other neuromuscular disease, *and*
- The member can benefit therapeutically from use of the device, *and*
- The alternative would be chair or bed confinement, *and*
- A caregiver is not available to provide assistance as needed, *and*
- The member is completely incapable of standing up from a regular armchair or any chair in the member's home.
- The member can ambulate household distances in order to perform activities of daily living.
- Seat lift chairs are not covered for members who require a wheelchair in order to perform activities of daily living.
- CAC criteria is available for power seat elevation and can be found here.

Lifts that have a spring-release mechanism with a sudden catapult-like motion are **excluded** from coverage.

When the mechanism (motor) is covered by Medicare, providers may bill the chair component to Medicaid using procedure code E0627 with the "CG" modifier after Medicare has paid the claim for the mechanism. Documentation of medical necessity is not required with the Medicaid claim when Medicare has paid for the mechanism. **The Medicare EOB is not required to be attached to the claim to follow guidelines for Medicare dual eligible members as long as lift chairs are considered non-covered by Medicare.**

Additionally, while lift chairs are considered non-covered by Medicare, lift chairs are exempt from Informational Letter 2157 for Medicare dual eligible members.

For members who do not have Medicare coverage:

Bill procedure code E0627 to Medicaid with the documentation listed below. Modifier NU, UE, or RR is required for CPT E0627, and the claim is not payable without one of the required modifiers. Documentation submitted with the claims must include:

- A completed form **CMS-849, Certificate of Medical Necessity—Seat Lift Mechanisms**.
- A physical therapy, occupational therapy, or physician evaluation, if there is any question regarding the member's ability to ambulate or rise from any chair in the home. Example: Member owns a wheelchair.

l. Commodes and Accessories

Commodes and accessories are covered if the member is confined to bed or room (meaning that the member's condition is such that leaving the room is medically contraindicated or physically impractical). The accessibility of toilet facilities generally is not a factor. However, confinement to the member's home may be equated to room confinement when the home has no toilet facilities.

Payment may also be made if a member's medical condition confines the member to a specific floor of the member's home and there is no bathroom located on that floor.

Extra wide commodes are covered when the member's weight is more than 300 pounds, or the width of a standard commode is not adequate.

m. Crutches

All types of crutches are covered when prescribed for a member whose condition impairs ambulation.

Replacement items are payable for member-owned equipment only.

n. Decubitus and Wound Care Equipment

Decubitus and wound care equipment are covered when prescribed for a member who is highly susceptible to decubitus ulcers. The prescribing physician must supervise its use in connection with the course of treatment.

Wound vac systems (negative pressure wound therapy)* are covered for home use when CAC criteria is met. CAC criteria can be found here.

o. Dialysis Equipment

Dialysis equipment and supplies are covered when prescribed for a member who has end-stage renal disease, and the equipment is appropriate for home use.

Dialysis water-purification systems are covered when prescribed and necessary to render water used for dialysis chemically and organically safe.

Deionizer water-purification systems are covered when prescribed and necessary to soften water entering a reverse-osmosis unit when the quality of water is less than that required for the unit's proper functioning. The softener need not be built into the reverse-osmosis unit but must be an integral part of the dialysis system.

p. Enuresis Alarm Systems

Bed wetting alarm devices are covered when:

- The member is five years of age or older, and
- The member has experienced bed-wetting an average of three nights per week for the last three months, and
- The member has no daytime wetting, and
- Urinary tract infection, endocrine problems, neurological dysfunction, anatomic abnormalities, etc. and psychological stressors have been ruled out, and
- A licensed health care provider has prescribed the device.

q. Hand-Held Inhaler Accessories

Spacer units (inspirease, aerochamber) with and without masks are covered. A replacement mouthpiece is covered for member-owned equipment when medically necessary.

r. Heating Equipment

Heat lamps are covered when the member's medical condition is one for which the application of heat in the form of a heat lamp is therapeutically effective. The heat lamp cannot duplicate equipment or resources already available to the member (i.e., sunlight and warm moist heat).

Electric heat pads are covered when the member's medical condition is one for which the application of heat in the form of a heating pad is therapeutically effective and other means of applying heat are not appropriate. Information submitted must indicate why other resources cannot be used.

s. Helmets*

Protective helmets are covered when documentation indicates:

- The member is prone to seizures, or
- The member is prone to falling due to a neurological or neuromuscular disorder.

t. Infusion Pumps

Ambulatory infusion pumps and supplies* are covered when prescribed for iron poisoning, chemotherapy, morphine for intractable pain, or antibiotic therapy. The documentation must indicate:

- The drug being infused
- The number of days used
- The medical justification for use of a pump versus gravity infusion

1 unit equals 1 day. (Coverage differs from Medicare)

IV poles are covered on a rental basis short term and purchased long term.

u. Monitor Equipment*

Apnea monitors are rental only and are covered when prescribed for:

- Infants under one year of age with tracheotomies
- Children up to two years of age with bronchopulmonary dysplasia who:
  - Have a tracheotomy;
  - Require supplemental oxygen, continuously or for a specific activity such as feeding; and

- Would require prolongation of their hospitalization (for monitoring) if home monitoring were unavailable.

- Young children past the age of one with:
  - Documentation that indicates a sibling died of sudden infant death syndrome (SIDS) between the ages of one and two, and
  - Signed physician documentation indicating:
    - The medical necessity, and
    - The date of interpretation of the last abnormal pneumogram within the previous six months.
- Infants who are considered high risk for SIDS with:
  - Documentation of the date of the last apneic episode or the date and results of the last pneumogram, and
  - A statement from the physician indicating the medical necessity to continue monitoring.

Apnea monitor **installation** is covered one time only when:

- The dealer goes into the home to set up the monitor, and
- Instructs the family in its use, and
- It is the practice of the dealer to make such a charge to the general public.

One pair of electrodes and one pair of lead wires are allowed per month for the apnea monitor. Identify the items and quantity of each in the description box on the claim form.

Rental of pneumogram equipment for testing is included in the fee for circadian respiratory pattern recording, 12 to 24 hours when a home pneumoradiogram is performed.

v. Neuromuscular Stimulators and Supplies

Neuromuscular stimulators and supplies are covered for scoliosis.

w. Osteogenesis Stimulators

Non-spinal osteogenesis stimulators are covered for the following indications:

- Non-union of long-bone fractures
- Nonunion is considered to exist only after three or more months have elapsed without healing of the fracture.

- Failed fusion exists after nine months or more
- Congenital pseudoarthroses

Spinal osteogenesis stimulators are covered for the following indications:

- Failed spinal fusion where a minimum of nine months has elapsed since surgery
- Following a multilevel spinal fusion surgery
- Following spinal fusion surgery where there is a history of a previously failed spinal fusion at the same site

Ultrasonic osteogenesis stimulators are covered when all of the following conditions are met:

- Non-union of a fracture, and
- The fracture is other than the skull or vertebrae, and
- The fracture is not tumor related.

x. Oxygen*

Medicaid coverage of home oxygen and oxygen equipment under the durable medical equipment benefit is considered reasonable and necessary only for members with significant hypoxemia, as defined by Medicare.

EXCEPTION: Oxygen for children through three years of age is covered when prescribed. Significant hypoxemia is not required for these children. A pulse oximeter reading must be obtained at one year of age and two years of age and documented in the provider record.

A qualifying **Certificate of Medical Necessity for Oxygen, form CMS-484**, or a reasonable facsimile is required according to Medicare criteria when:

- Oxygen is initially provided prior to submitting the claim.
- A recertification is required.
- The certification is revised.

All of the following information is required to be documented in the provider record:

- A diagnosis of the disease requiring use of oxygen
- The flow rate
- The type of system ordered, i.e., cylinder gas, liquid gas, or concentrator
- A specific estimate of the frequency and duration of use (“Oxygen PRN” or “oxygen as needed” **is not** acceptable)

If the member's condition or the need for oxygen services changes, the attending physician must adjust the medical documentation accordingly.

Payment for oxygen therapy is based on the premise that the reasonable charge for oxygen is no more than the least costly form of delivery, unless other forms were documented as medically necessary.

Medicaid payment is made for the rental of equipment only. All accessories, contents, and disposable supplies related to the oxygen delivery system, servicing and repairing of equipment are included in the Medicaid payment.

(1). Oxygen Contents

Oxygen contents codes E0441 – E0444 are covered **only** for member-owned systems.

(2). Oxygen Delivery Equipment

Medicaid payment is made for the rental of equipment only. All accessories, contents, supplies, servicing and repairs are included in the payment for the equipment. Oxygen equipment accessory items are separately payable **only** when the member owns the equipment.

Members may be provided with a **portable oxygen system** to complement a stationary oxygen system, or to be used by itself. Include with your claim:

- Documentation from the physician (MD or DO) of the medical necessity for portable oxygen
- A list of the specific activities that require the member to use portable oxygen

Medicaid does not cover a second oxygen system when used as a backup for oxygen concentrators or as a standby in case of emergency.

Stationary Oxygen Systems

To document ongoing usage, maintain a log of meter or clock readings for each member. Update readings every four to six weeks. You may take readings during normal maintenance service calls. These logs are subject to review by Medicaid personnel.

All oxygen concentrator codes have the allowance for disposable supplies computed in Medicaid's allowance for use of any oxygen concentrator.

Monthly maintenance and replacement of filters are not considered repairs.

(3). Oxygen in a Nursing Facility*

Oxygen systems and contents for Medicaid residents of a nursing facility are not covered unless the member has a medical need for oxygen for 12 or more hours per day for at least 30 days or more. Payment will be made when all of the following requirements and conditions have been met:

- A physician's prescription documents that a resident of a nursing facility requires oxygen for 12 hours per day or more.
- The oxygen provider and the physician must both keep a qualifying Medicare form **CMS-484, Certificate of Medical Necessity for Oxygen**, or a reasonable facsimile, in their files.

  Documentation must contain the following:

  - The number of hours oxygen is required per day ("PRN" is not covered.)
  - The diagnosis of the disease requiring continuous oxygen
  - The prognosis
  - The length of time the oxygen will be needed
  - The oxygen flow rate and concentration
  - The type of system ordered (cylinder gas, liquid gas, or concentrator)
  - A specific estimate of the frequency and duration of use
  - The initial, periodic, and ending reading on the time meter clock on each concentrator and the dates of each reading

The oxygen provider must maintain logs of oxygen use. The nursing facility must document oxygen use in its records according to 441 Iowa Administrative Code 78.10(2)(1)(3).

When post payment review of the oxygen log and the nursing facility records fails to support that an average of 12 hours per day of oxygen was provided over a 30-day period, the overpayment will be recouped. Oxygen that does not meet this criterion is the responsibility of the nursing facility.

(4). Oximeter*

Documentation of the member's hypoxemia conditions must be maintained in the provider's records. Oximeter probes are included in the rental.

(5). Respiratory Therapists

Respiratory therapist services are **not covered** under the provisions for coverage of oxygen services as durable medical equipment. The durable medical equipment benefit provides for coverage of home use of oxygen and oxygen equipment but does not include a professional component in the delivery of such service.

y. Patient Lifts

Patient lifts are covered when prescribed for a member who is bed-confined and requires periodic movement to affect improvement or to retard deterioration in the member's condition. Documentation must include the member's height, weight, diagnoses, and caregivers available.

A non-standard patient lift, such as a portable, ceiling or electric lifter requires prior authorization. Approval shall be granted when the member meets the criteria for a patient lift and a standard lifter (Hoyer type) will not work.

1. Ceiling Track Lifts and/or Electric Patient Lifts

   Ceiling track lifts and/or electric patient lifts have CAC criteria that the member must meet. The CAC criteria can be found here.

z. Peak Flow Meters

Coverage for peak flow meters is limited to one device every six months.

aa. Pneumatic Appliances and Accessories

Pneumatic appliances and accessories are covered when prescribed for a member who has intractable edema of the extremities.

1. Pneumatic Compression Devices

   Pneumatic compression devices are a treatment option for patients with lymphedema who have failed conservative measures. They require prior authorization and have CAC criteria that can be found here.

bb. Respiratory Equipment and Accessories*

Respiratory assist devices are covered when prescribed due to impairment of the member's ability to breathe. A three-month successful trial on a rental basis is required before purchase. Payments made for the rental period must be applied towards the purchase of the equipment.

Nasal continuous positive airway pressure (**CPAP**) device is covered when the member has a diagnosis of sleep apnea.

Intermittent assist device with a bi-level positive airway pressure **(Bi-Pap)** device is covered when physician documentation indicates a failed trial on CPAP or test results indicate that only a Bi-Pap unit will meet the medical needs of the member.

Intermittent assist device with a bi-level positive airway pressure spontaneous timed **(Bi-Pap ST)** device is covered according to Medicare criteria and is rental only.

All types of **IPPB** machines are covered.

A home model, electric or pneumatic **percussor** is covered (for purchase only) when:

- Prescribed for mobilizing respiratory tract secretions in patients with chronic obstruction lung disease, chronic bronchitis, or emphysema, cystic fibrosis, neuromuscular conditions with impaired cough, bronchiectasis or ciliary dyskinesia, and
- The member or operator of powered percussor has received appropriate training by a physician or therapist, and
- No one competent to administer manual therapy is available, and
- Medical necessity for **long-term** chest therapy is indicated.

Nebulizers are covered when the member requires aerosol medication therapy because of a chronic respiratory condition. Rental may be allowed for acute conditions where the ability to breathe is severely impaired.

Inhalation accessories are covered separately **only** for member-owned equipment.

Vaporizers are covered when prescribed for a member who has a chronic severe respiratory impairment that would benefit from the use of a vaporizer.

High Frequency Chest Wall Oscillation

High-frequency chest wall oscillation (HFCWO) is a form of chest physical therapy in which an inflatable vest is attached to a machine that vibrates it at high frequency. The vest vibrates the chest to loosen and thin mucus. The loosened secretions may require another intervention to be cleared from the airway.

Medical equipment and supplies needed for HFCWO treatment are considered medically necessary when CAC criteria is met. CAC criteria can be found here.

A stationary or portable **volume ventilator** is covered when prescribed and determined the type of equipment specified is medically required and appropriate for **home** use without technical or professional supervision. Payment is for rental only.

cc. Augmentative Communication Systems (Speech-Generating Device)

Augmentative communication systems (speech-generating devices) are covered for persons unable to communicate their basic needs through oral speech or manual sign language. Coverage is allowed for members in nursing facilities, intermediate care facilities for intellectual disability (ICF/ID), and private homes.

Prior to the approval of the speech-generating device, the member needs a formal evaluation of their cognitive and language abilities by a speech-language pathologist (SLP). The formal written evaluation must include, at a minimum, ALL elements within the CAC criteria.

Speech generating devices require prior authorization. In addition to the **Request for Prior Authorization**, you must also complete and submit form **470-2145, Augmentative Communication System Selection**.

Providers are asked to photocopy the sample as needed. No supply of the form is printed for ordering.

Information requested on form 470-2145 includes a medical history, diagnosis, and prognosis completed by a physician. In addition, a speech or language pathologist needs to describe current functional abilities in the following areas:

- Communication skills
- Motor status
- Sensory status
- Cognitive status
- Social and emotional status
- Language status

Also needed from the speech or language pathologist is information on:

- Educational ability and needs
- Vocational potential
- Anticipated duration of need
- Prognosis regarding oral communication skills
- Prognosis with a particular device
- Recommendations

The Iowa HHS speech pathology consultant will evaluate each request. A minimum one-month trial period is required for all devices. During this time, the member should have access to the device daily and use it in a variety of communication situations.

Previous communication device use, cognitive level, and age of the member are considered in determining whether the trial period is adequate. Reimbursement for the rental of the equipment for up to three months for a trial period is available.

Payment is made for the most cost-effective item which meets basic communication needs commensurate with the person’s cognitive and language abilities. Separate payment is not allowed for the initial evaluation by the speech therapist to determine need.

Communication device carrying cases are covered when necessary to protect the device.

Communication device wheelchair attachments require prior authorization and are covered when necessary for persons who use a wheelchair.

Repairs for augmentative communication devices are covered in accordance with the repair policy. See Repair and Replacement. Requests for reimbursement should include a simple description of the repair, the need for the repair, and ongoing use of the device.

dd. Gait Trainer/Standers

Gait trainers are wheeled devices that assist a person who is unable to walk independently to learn or relearn to walk safely and efficiently as part of gait training. Gait trainers are intended for children or adults with physical disabilities to provide the opportunity to improve walking ability.

Standers may require a three-month trial rental period before consideration for purchase. Sit-to-stand, mobile and tri-standers must have supporting documentation for these features. A request for prior authorization is recommended but not required.

Pediatric or adult gait trainer will be considered medically necessary when ALL of the CAC criteria is met. CAC criteria can be found here.

ee. Suction Machines

Suction machines are covered when prescribed, medically necessary, and appropriate for home use without technical or professional supervision.

ff. Transcutaneous Electrical Nerve Stimulators (TENS)

Tens are covered when:

- Prescribed for the relief of acute post-operative pain, or chronic intractable pain, **and**
- Documentation shows that other forms of treatment have been attempted and were ineffective.

TENS unit supplies are separately payable only for member-owned equipment. Coverage includes four leads per month and disposable patches.

gg. Thermometers*

Basal thermometers are covered for family planning purposes only. Oral or rectal thermometers are covered for members under 21 years of age when prescribed by a physician.

hh. Traction Equipment and Accessories

Traction equipment and accessories are covered when prescribed for a member who has an orthopedic impairment that necessitates the equipment.

ii. Urinary Collection Devices and Accessories

Urinary collection devices and accessories are covered when prescribed because of urinary incontinence or urinary retention.

Amounts that exceed the allowed quantities are covered when medically necessary.

If a provider has determined that it is medically necessary for a member to receive units above the maximum, the claim should be submitted electronically using the Attachment Control Number (ACN) and the submission of supporting documentation via the Iowa Medicaid Portal Access (IMPA).

Documentation of medical necessity must be included. The first page of documentation should indicate a review is needed due to units exceeding the allowed maximum.

Claims with supporting documentation will suspend to the Quality Improvement Organization (QIO) to review for medical necessity of units billed. Only quantities that are determined to be medically necessary will be reviewed for reimbursement.

jj. Ventilators

Ventilators shall be maintained on a rental basis for the duration of use. A secondary, or back-up, ventilator requires prior authorization. Approval shall be granted in accordance with Medicare criteria.

Providers should append the TM modifier to all back vent claims to ensure correct claims processing.

kk. Walkers

Walkers are covered when prescribed for a member whose condition impairs ambulation.

- **Posture control walkers or Kaye reverse walkers** are covered when prescribed for a member whose condition impairs ambulation and whose diagnosis indicates that posture or gait control is a problem, e.g., cerebral palsy.
- **Pediatric gait trainer walkers*** are covered for children through 12 years of age who need upper and lower body support to walk due to developmental delay in gross and fine motor skills relating to a neurological or neuromuscular disease.
- **Gait trainer walkers** for members 13 years of age and older should be billed using procedure code E1399. A three-month trial rental period before purchase may be appropriate if there is concern about the member's continued use of the walker.

Pediatric or adult gait trainer will be considered medically necessary when ALL of the CAC criteria is met. CAC criteria can be found here.

II. Wheelchairs and Scooters

Wheelchairs, accessories, and modifications are covered when they are medically necessary for mobility within the home, nursing facility or intermediate care facility, intellectually disabled (ICD/IF). An ICF/ID is considered as a home for members who resided in one.

Strollers and wheelchairs are primarily mobility devices but are occasionally needed to assure the safety of an individual who is otherwise ambulatory. These criteria will not apply when a deficit in age-appropriate ambulation exists. In that case, the request should be evaluated based on the mobility needs of the member, using the appropriate mobility-related criteria. Strollers and wheelchairs may be medically necessary for safety is the criteria within the CAC criteria is met. The CAC criteria can be found here.

Mobility related device purchase CAC criteria can be found here.

Wheelchairs are defined as:

1. **Standard manual wheelchairs.** Coverage of a standard manual wheelchair includes the following:
   a. Completed set of tires/wheels and casters, any type;
   b. Hand rims with or without projections;

c. Weight-specific components required by the patient-weight capacity of the wheelchair;

d. Elevating leg rest, lower extension tube and upper hanger bracket;

e. Armrest (detachable), including lower extension tube(s) and upper hanger bracket;

f. Footrests (swing away, detachable), including lower extension tube(s) and upper hanger bracket;

g. Standard size footplates;

h. Wheelchair bearings;

i. Caster fork, replacement only; and

j. All labor chargers involved in the assembly of the wheelchair including, but not limited to:

- front caster assembly
- rear wheel assembly
- ratchet assembly
- wheel lock assembly

2. **Standard manual wheelchair accessories** that are separately billable and require prior authorization include the following:

a. Headrest extensions;
b. One-arm drive attachments;
c. Positioning accessories;
d. Specialized skin protection seat and back cushions; and
e. Anti-rollback devices

3. **Standard power wheelchair**. Coverage of a standard power wheelchairs requires prior authorization and includes the following:

a. Lap belt or safety belt;

b. Battery charger, single mode;

c. Complete set of tires/wheels and casters, any type;

d. Leg rests (fixed, swing away, or detachable non-elevation leg rests with or without calf pad);

e. Footrests/foot platform fixed, swing away, detachable footrests or a foot platform without angel adjustment, single adjustable footplate);

f. Armrests (fixed, swing away, detachable non-adjustable height armrests with arm pad provided);

g. Any weight-specific components (braces, bars, upholstery, brackets, motors, gears, etc.) as required by patient-weight capacity of the wheelchair;

h. Any seat width and depth. For power wheelchairs with a sling/solid seat/back, the following may be billed separately:

- For standard duty, seat width and/or depth greater than 20 inches;
- For heavy duty, seat width and/or depth greater than 22 inches;
- For very heavy duty, seat width and/or depth greater than 24 inches.

EXCEPTION: For extra heavy duty, there is no separate billing.

i. Any back width. For power wheelchairs with a sling/solid seat/back, the following may be billed separately:

- For standard duty, seat width and/or depth greater than 20 inches;
- For heavy duty, seat width and/or depth greater than 22 inches;
- For very heavy duty, seat width and/or depth greater than 24 inches.

EXCEPTION: For extra heavy duty, there is no separate billing.

j. Non-expandable controller or standard proportional joystick (integrate or remote); and

k. All labor charges involved in the assembly of the wheelchair including, but not limited to:

- front caster assembly
- rear wheel assembly
- ratchet assembly
- wheel lock assembly
- footrest assembly

4. **Standard power wheelchair accessories** that are billed separately and require a prior authorization include the following:

a. Shoulder harness/straps or chest straps/vest:

b. Elevating leg rest;

c. Angle adjustable footplates;

d. Adjustable height armrests; and

e. Expandable controller or nonstandard joystick (i.e., non-proportional or mini, compact or short throw proportional, or other alternative control device).

f. Power wheelchair attendant controls may be considered medically necessary when the member meets CAC criteria. CAC criteria can be found here.

Documentation submitted must include all of the following:

- Prescription from the member's physician
- The member's present condition warranting each particular feature or type of wheelchair
- The member's place of residence
- Caregiver availability
- Current physical therapy or occupational therapy evaluation if the physician's evaluation regarding mobility is not descriptive or complete
- Indicate if this is initial wheelchair or a replacement wheelchair
- For a replacement of wheelchair, include explanation for why the original chair is being replaced

Wheelchairs may be covered for children in school who have limited ambulation. Pertinent sections of the child's Individual Education Plan (IEP) must be included with the claim or prior authorization request to determine coverage.

Replacement will not be considered unless the cost of repairs exceeds two-thirds the cost of replacement. An itemized list of repair parts and costs must be included to support replacement. Like parts are replaced with like parts. For example: A manual elevating leg rest will be replaced with the same, not a replacement power elevating leg rest.

K0739 for labor should not be billed for assessment and fitting with initial purchase of the chair.

Prior authorization may be requested but is not required. Claims submitted without prior authorization must include supporting documentation.

All accessories are included in the reimbursement of the POV HCPCS code and cannot be billed separately (gel batteries, seating, flat free inserts, oxygen holder).

Some accessories are included in the manual wheelchair and power wheelchair HCPCS codes and cannot be billed separately.

The member's home and community environment must be considered when providing the appropriate mobility equipment (e.g., mobility device does not fit within each room of the member's home, or it cannot be transported).

Wheelchair repair* is covered for member-owned equipment, 1 unit equals 15 minutes. If the member is in a nursing facility, Medicaid will replace parts with the exact same part. If new accessories are being requested due to change in condition or size of the member, accessories will be denied, as they are the responsibility of the facility. Wheelchair repairs do not require a physician order.

Specialized car seats* are covered for children up to 130 pounds in weight when special positioning is required for safe transportation and there is not a way to transport the member in the member's wheelchair in the vehicle. (Coverage differs from Medicare.)

4. Nutritional Products and Supplies

Enteral nutrition and supplies do not require prior authorization. They are considered a prosthetic and are separately payable for nursing facility and intermediate care facility for intellectual disability (ICF/ID) residents when delivered via a gastrostomy or jejunostomy tube.

Enteral feeding pumps also require prior authorization. Separate payment for the pump is not allowed when the nursing facility owns the pump. Medicaid follows Medicare criteria for enteral feeding pumps.

CAC criteria for Nutritional Products and Supplies can be found here.

Submit the following documentation with the **Request for Prior Authorization, form 470-0829**.

- Form 470-4210, .
- Documentation of the medical necessity for an **enteral pump**, if applicable. Pumps are not covered for the convenience of the caregiver.
- The medical reasons for not using a roller-clamp-controlled gravity feeding set must be identified (e.g., gravity feeding unsatisfactory due to reflux or aspiration, severe diarrhea, dumping syndrome, administration rate less than 100 ml/hour, blood glucose fluctuations, circulatory overload, jejunostomy tube used for feeding, or lipid-based formula).
- Use the "BO" modifier for nutritional products administered orally.

RELiZORB is a single-use, point-of-care digestive enzyme cartridge that connects in-line with existing enteral pump feed sets and pump extension sets. It is designed to mimic the action of pancreatic lipase for use in adults and pediatric patients 5 years of age and older receiving enteral tube feedings

RELiZORB® may be considered medically necessary if criteria within the CAC criteria are met. CAC criteria can be found here.

Food thickener* requires prior authorization and is not covered for members in a nursing facility or intermediate care facility for intellectual disability. The initial request for prior authorization must include the results of a swallow study that shows the member either has aspiration or has increased risk of aspiration. When prior authorization has been granted, subsequent requests for continuation do not need to include the results of a current swallow study unless the amount needed has changed. Example: A change from nectar to honey consistency.

Medical foods* require prior authorization and are covered when medically necessary for the treatment of a specific medical diagnosis. Medical foods that do not have a National Drug Classification (NDC) number are not covered. CAC criteria for medical foods can be found here.

Daily **parenteral nutrition** therapy is considered reasonable and necessary for a member with severe pathology of the alimentary tract that does not allow absorption of sufficient nutrients to maintain weight and strength commensurate with the member's general condition.

Since the alimentary tract of such a member does not function adequately, this therapy is administered via an intravenous catheter placed during a hospitalization. The member and other caregivers are trained in the care of the intravenous catheter and administration of the care of the intravenous catheter and administration of the solution.

Parenteral nutrition does not require a prior authorization.

B9998 must include a description of 12-inch extension set, 24-inch extension set, or decompression tubes.

5. Orthotics

a. Orthopedic Shoes*, Therapeutic Shoes for Diabetics, Accessories, and Modifications

Medicaid coverage of **orthopedic shoes**, accessories, and modifications differs from Medicare. Orthopedic shoes, inserts, arch supports, and modifications are covered when:

- A written prescription by a Doctor of Medicine, podiatry or osteopathy includes the date, diagnosis, reason the orthopedic shoes are needed, probable duration of need, and specific description of any modification the shoes must include, **and**
- The diagnosis indicates an orthopedic, neuromuscular, vascular, or insensate foot condition (a diagnosis of flat feet is **not** covered.)

A **single orthopedic shoe not attached to a brace** is covered when the second shoe is attached to a brace.

Therapeutic shoes for persons with diabetes are covered according to Medicare criteria. The appropriate HCPCS "A" code should be billed for therapeutic shoes for diabetics with one unit as one shoe.

Orthopedic shoes, therapeutic shoes for diabetics, and inserts are limited as follows:

- Two pair of custom-molded shoes (which include inserts provided with these shoes) per member are allowed in a rolling 12-month period unless documentation of change in size or evidence of excessive wear is submitted. Two additional pairs of inserts for custom-molded shoes are allowed in a rolling 12-month period.
- Only two pairs of depth shoes per member are allowed in a rolling 12-month period unless documentation of change in size, condition or evidence of excessive wear is submitted. Three pairs of inserts in addition to the non-customized removable inserts provided with depth shoes are allowed in a rolling 12-month period.
- The "GD" modifier should be used when billing for more than the normal quantities in a 12-month period.

EXCEPTION: When required for participation in school sport activities, **athletic shoes** (T1999) for school age children under age 21 are allowed in addition to orthopedic shoes.

A **"custom" shoe** is one that is made for a specific person. A shoe with only a pre-molded or molded to patient model removable insert is not a custom shoe.

An off-the-shelf shoe that has been modified with attachments, such as arch supports, lifts, edges and heels, specific to the member is a custom shoe. Inserts and attachments may be billed separately in addition to the code for the shoe when a custom shoe is provided.

Custom-molded shoes are shoes that:

- Are constructed over a positive model of the member's foot, and
- Are made of leather or other suitable material of equal quality, and
- Have some form of closure such as laces or Velcro, and
- Have inserts that can be altered or replaced as the member's condition warrants.

Custom-molded shoes, inserts, and modifications are allowed only for members with a foot deformity that cannot be accommodated by a depth shoe. The nature and severity of the deformity must be well documented in the supplier's records.

If there is insufficient justification for a custom-molded shoe but the general coverage criteria are met, payment will be based on the allowance for the depth shoe.

"Depth shoes" are shoes that meet all of the following requirements:

- Have a full length, heal-to-toe filler that when removed provides a minimum of 3/16" of additional depth used to accommodate custom-molded or customized inserts.
- Are made from leather or other suitable material of equal quality. Have some form of shoe closure.
- Are available in full and half sizes with a minimum of three widths so that the sole is graded to the size width of the upper portions of the shoe according to the American standard sizing schedule or its equivalent.

Metatarsal bars are exterior bars that are placed behind the metatarsal heads in order to remove pressure from the metatarsal heads. The bars are of various shapes, heights, and construction depending on the exact purpose.

Offset heel is a heel flanged at its base either in the middle, to the side, or a combination, that is then extended upward to the shoe in order to stabilize extreme positions of the hind foot.

Rigid rocker bottoms are exterior elevations with apex position for 51 percent to 75 percent distance measured from the back end of the heel. The apex is a narrowed or pointed end of an anatomical structure. The apex must be positioned behind the metatarsal heads and tapering off sharply to the front tip of the sole.

Apex height helps to eliminate pressure at the metatarsal heads. The steel in the shoe ensures rigidity. The heel of the shoe tapers off in the back in order to cause the heel to strike in the middle of the heel.

Roller bottoms (sole or bar) are the same as rocker bottoms, but the heel is tapered from the apex to the front tip of the sole.

Wedges (posting) are either of hind foot, fore foot, or both and may be in the middle or to the side. The function is to shift or transfer weight bearing upon standing or during ambulation to the opposite side for added support, stabilization, equalized weight distribution, or balance.

Plaster impression foot orthotics are covered when they:

- Are constructed of more than one layer of a material that is soft enough and firm enough to hold an impression during use, and
- Are molded to the member's foot or made over a model of the foot.

Molded digital orthotics are covered.

b. Orthotic Devices

Orthotic devices are covered when prescribed for the purpose of:

- Supporting a weak or deformed body member, or
- Preventing or correcting a physical deformity or malfunction, or
- Restricting or eliminating motion in a diseased or injured part of the body.

1. Custom Knee Orthotics may be medically necessary when the CAC criteria is met. CAC criteria can be found here.
2. Cranial Orthotics may be medically necessary when the CAC criteria is met. CAC criteria can be found here. Cranial orthotic devices require prior authorization.

c. Prosthetics

- **Breast prostheses** are covered, including mastectomy bras, sleeves, and forms.

- **Electronic speech aids** are covered for members who have had a laryngectomy or whose larynx is permanently inoperative.
- **Prosthetic eyes** are covered.
- **Fitting charges** are included in the fee.
- **Tracheotomy speaking valves**, e.g. Passey Muire, are limited to one every four months.

6. Medical Supplies

"Medical supplies" are nondurable items consumed in the process of giving medical care. They include nebulizers, gauze, bandages, sterile pads, adhesive tape, and sterile absorbent cotton but do not include food or drugs.

Medical supplies are payable for a specific medical purpose. Supplies that are provided on a recurring basis should not automatically be dispensed. The Medicaid member, health care practitioner, or caretaker must request the supplies to be dispensed. Documentation of each request must be maintained in the provider's files.

Do not dispense medical supplies at any one time in quantities exceeding a three-month supply.

EXCEPTION: Oral nutritional products, enteral nutrition products, and supplies should be dispensed only in no more than a one-month quantity.

Documentation of medical necessity for the additional quantity must be submitted with the claim.

A limited variety of supplies is approved for payment for members receiving care in a nursing facility or an intermediate care facility for intellectual disability. See Services to Members in a Medical Facility.

a. Diabetic Equipment and Supplies

Diabetic equipment and supplies, including needles and syringes, blood glucose test strips and diabetic urine test supplies are covered when prescribed for use in the control of a diabetic condition. Items that are considered convenience items are **not** covered.

Diabetic supplies are covered as follows.

Code	Description	Limit Effective 3/1/2025
A4206	Syringe with needle, sterile, 1 cc or less, each	200/month
A4208	Syringe with needle, sterile 3 cc, each	100/month
A4209	Syringe with needle, sterile 5 cc or greater, each	100/month
A4212	Non-coring needle or stylet with or without catheter	10/month
A4213	Syringe, sterile, 20 cc or greater, each	150/month
A4215	Needle, sterile, any size, each	200/month
A4232	Syringe with needle for external insulin pump, sterile, 3 cc	20/month

Amounts that exceed the allowed quantities are covered when medically necessary.

If a provider has determined that it is medically necessary for a member to receive units above the maximum, the claim should be submitted electronically using the Attachment Control Number (ACN) and the submission of supporting documentation via the Iowa Medicaid Portal Access (IMPA).

Documentation of medical necessity must be included. The first page of documentation should indicate a review is needed due to units exceeding the allowed maximum.

Claims with supporting documentation will suspend to the Quality Improvement Organization (QIO) to review for medical necessity of units billed. Only quantities that are determined to be medically necessary will be reviewed for reimbursement.

Home blood glucose monitors and supplies are covered when the member meets all the following criteria:

- The member is diabetic, and
- The device is designed for home rather than clinical use, and
- The member's physician states that the member is capable of being trained to use the particular device prescribed in an appropriate manner.

If the member is not able to perform this function, a responsible family member can be trained to use the equipment and monitor to ensure that the intended effect is achieved. The record must contain proper documentation by the member's physician.

Home blood glucose monitors with special features such as voice synthesizers, automatic timers, and specially designed arrangements of supplies and materials are covered when all of the following conditions are met:

- The member and the device meet the conditions listed for coverage of standard home blood glucose monitors, **and**
- The member can use the equipment without assistance, **and**
- The member's physician certifies that the member has a visual impairment severe enough to require use of this special monitoring system. The degree and type of visual impairment must be specified.

Disposable insulin pens may be covered as a medication under the pharmacy program. Prior authorization from the Iowa Medicaid Pharmacy Unit is required.

Reusable insulin pens * are allowed through Durable Medical Equipment once every six months when documentation submitted with the claim indicates that:

- The member's visual or motor skills are impaired to such that they cannot accurately draw up their own insulin, **and**
- There is no caregiver available to provide assistance. **Insulin, insulin cartridges, and insulin pens** must be **billed on a pharmacy claim**.

External insulin infusion pumps* require prior authorization and are covered according to Medicare criteria. Additionally, a request for rental may be submitted for members who have pregnancy induced diabetes.

Supplies* for a member-owned insulin pump do not require a prior authorization. If the quantities allowed are exceeded documentation of the medical necessity must be submitted with the claim.

Continuous Glucose Monitoring (CGMs) Prior authorization is required every six months. Approved if medical necessity met per CAC criteria. CAC criteria can be found here.

b. Diapers and Disposable Underpads*

Diapers, briefs, panty liners, and disposable underpads (e.g., Chux) are covered when:

- They are prescribed and determined to be appropriate for a member who has lost control over bowel or bladder function, *and*
- A bowel or bladder training program was not successful, *and*
- The member is three years of age or older. (Coverage differs from Medicare.)

Requesting a prior authorization cannot override the criteria above.

Incontinence products are not covered for stress, urge, or overflow incontinence.

"Briefs" and panty liners are covered when the criteria for diapers are met (lost control over bowel or bladder function, bowel bladder training program was not successful, over four years of age).

Disposable underpads may be used simultaneously with diapers or briefs if warranted by the member's medical condition. Examples include When needed for nighttime use, for non-ambulatory members, when frequent changing is not available.

The following table indicates the maximum units that can be provided in a 90-day period when no other incontinence products are used. For example, a member may receive 1,080 diapers in a 90-day period when this member does not also use liners or pull-ons. If a member uses diapers and pull-ons, these maximum units do not apply.

Category	Description	Codes	Maximum Units
A	Diaper/brief	T4521 T4522 T4523 T4524 T4529 T4530 T4533 T4543	1,080 per 90-day supply
B	Liner/shield/guard/pad	T4535	450 per 90-day supply
C	Pull-on	T4525 T4526 T4527 T4528 T4531 T4532 T4534	450 per 90-day supply
D	Disposable underpads	A4554	600 per 90-day supply
E	Reusable underpads	T4537 T4540	48 per 12 months

The following table indicates the maximum units that can be provided in a 90-day period when a combination of incontinence products is used.

Category Combinations	Maximum Combined Total per 90 Days	Individual Maximums Within Combined Maximum
A and B	1,080	Category B = 450 maximum
B and C	450	N/A
A and C	1,080	Category C = 450 maximum
A and B and C	1,080	Category B and C = combined maximum of 450
A and D	1,260	Category A = 1,080 maximum Category D = 180 maximum
B or C with D	630	Category B or C = 450 maximum Category D = 180 maximum
E (T4537 & 4540)	48	48 maximum

A maximum of 48 reusable bed pads and chair pads, codes T4537 and T4540, are allowed per year in addition to the individual or combined disposable product maximums above. Reusable underpads are washable and therefore should not be necessary in additional quantities.

When more than the normal limits are medically necessary, documentation, including the failure of other modalities or treatments and a description of the member's medical condition related to the incontinence, must be maintained in the provider's records. Examples of such situations include:

- Prescribed diuretics
- Bowel medications
- History of skin problems

Amounts that exceed the allowed quantities are covered when medically necessary.

If a provider has determined that it is medically necessary for a member to receive units above the maximum, the claim should be submitted electronically using the Attachment Control Number (ACN) and the submission of supporting documentation via the Iowa Medicaid Portal Access (IMPA).

Documentation of medical necessity must be included. The first page of documentation should indicate a review is needed due to units exceeding the allowed maximum.

Claims with supporting documentation will suspend to the Quality Improvement Organization (QIO) to review for medical necessity of units billed. Only quantities that are determined to be medically necessary will be reviewed for reimbursement.

c. Dressings and Surgical Supplies

Dressings are covered when prescribed to be used for the therapeutic and protective covering for a wound or surgical incision, considered necessary for the proper treatment of a diseased or injured body part, and used as a protective wrapping and support.

Surgical supplies are covered when medically necessary.

d. Enema Supplies

Enema supplies are covered when prescribed for medicinal purposes.

e. Family Planning*

Basal thermometers are covered for family planning purposes only. Diaphragms for contraceptive use are covered.

f. Hearing Aid Batteries*

Hearing aid batteries are covered for members with hearing aids. Up to 30 batteries *per aid* are covered in a 90-day period. 1 battery equals 1 unit of service.

g. Irrigation Solutions

Sterile or saline **water** is covered. **Catheter irrigation solutions** are covered when prescribed for use with medically necessary urinary equipment.

h. IV Supplies

IV supplies are covered when prescribed for home antibiotic or parenteral therapy.

i. Ostomy Supplies and Accessories

Ostomy supplies and accessories are covered when medically necessary. One unit per day of regular wear or three units per month of extended wear are allowed. If the limits are exceeded, documentation of the medical necessity must be submitted with the claim.

j. Support Stockings*

Support stockings are **not** considered an orthotic and are **not** covered in nursing facilities.

Anti-embolism surgical stockings (i.e., Ted hose) are covered when prescribed for post-surgical members.

Graduated compression stockings (i.e., Jobst) are covered when prescribed for members with intractable edema of the lower extremities as well as other circulatory disorders.

Custom-made gradient compression stockings are covered only when prescribed for members whose measurements exceed manufactured sizes. The manufacturer must be identified on the claim. The invoice should be attached for pricing. The member's measurements should be included.

7. Services to Members in a Medical Facility

No payment is made to medical suppliers for medical supplies or durable medical equipment for members receiving inpatient or outpatient care in a hospital.

No payment is made for medical supplies or durable medical equipment for members for whom the facility is receiving skilled nursing care payment, except for orthotic and prosthetic services, orthopedic shoes, and therapeutic shoes for diabetics.

No payment is made for durable medical equipment or supplies for members in an intermediate care facility for intellectual disability or a facility receiving nursing facility payments, except for the following:

- Catheter (indwelling Foley)
- Colostomy and ileostomy appliances
- Colostomy and ileostomy care dressings, liquid adhesive, and adhesive tape
- Diabetic supplies (disposable or retractable needles and syringes, test-tape, clinitest tablets, and clinistix)
- Disposable catheterization trays or sets (sterile)
- Disposable bladder irrigation trays or sets (sterile)
- Disposable saline enemas (sodium phosphate type, for example)
- Hearing aid batteries
- Orthotic and prosthetic services, including augmentative communication devices
- Orthopedic shoes
- Repair of member-owned equipment
- Oxygen services (See Oxygen.) Oxygen services for residents in an ICF/ID are included in the per diem and are not payable separately.
- Therapeutic shoes for diabetics
- Wheelchairs for members in an intermediate care facility for intellectual disability

- Wheelchairs for members in a nursing facility are only covered when the wheelchair is a customized wheelchair. A customized wheelchair is one that is designed, assembled, modified, or constructed for the specific member in whole or in part, based on the member's condition, measurements, and needs. The member's condition must necessitate the regular use of a wheelchair on a long-term basis to enable independent mobility within the facility. **NOTE:** A prior authorization is required.

For members in nursing facilities who have member-owned equipment, replacement of components, parts, or systems for the equipment is allowed as long as:

- The cost does not exceed two-thirds the cost of a new item, and
- The replacement is not due to change in size or condition of the member.

C. Basis of Payment

The basis of payment for most items is a fee schedule. The fee schedule amount is the maximum payment allowed.

Click here to view the fee schedule for Medical Equipment and Supply Dealers.

For those services and items furnished both under Part B of Medicare and under Medicaid, the fee shall be the lowest charge recognized under Medicare.

For those services and items furnished only under Medicaid, the fee shall be the lowest charge determined by the Iowa Department of Health and Human Services according to the Medicare reimbursement method.

The payment methodology for Durable Medical Equipment (DME) and Medical Supply codes that are listed as "by-report" payment is based on Manufacturer's Suggested Retail Price (MSRP) less 15%. If MSRP is not available, payment is based on invoice, cost plus 10%.

The payment methodology for Enteral Nutrition codes that are listed as "by-report" is based on AWP less 10%. If AWP is not available, payment is based on Manufacturer's Suggested Retail Price (MSRP) less 15%. If MSRP is not available, payment is based on invoice, cost plus 10%.

The payment methodology for other procedure codes that are listed as "by-report" is based on comparison of procedure codes of similar description and complexity. If there is no procedure code of similar description and complexity, then Provider Cost Audit (PCA) is contacted to assist with developing a fee.

Rentals: Modifier “KR” should be billed for equipment rental when the rental period is less than one month. Example: A standard wheelchair, procedure code K0001, was rented for six weeks. The first month would be billed as K0001-RR with one unit for the month. The remaining two weeks would be billed with K0001-RR and KR with 14 units for the 14 days.

Providers are encouraged to use the Medical Supplies fee schedule to determine which procedure codes are considered rentals, denoted by “RR” in the “Proc Mod” column for the “KR” modifier.

Suppliers who elect to bill for partial months should enter the date of service the rental period begins in the "From" field and the ending rental date of service in the "To" field of the HCFA-1500 claim form for each partial month of billing. The modifier "RR," indicating rental, and any other applicable modifiers must also be appended to the claim line for the partial month rental item(s).

Exceeding Allowed Limits: When the quantity of a supply provided differs from the quantity in the HCPCS definition, the “CC” modifier should be billed with the actual number of individual items provided as the units. Example: One unit of blood glucose test strips, procedure code A4253, is defined in HCPCS as 50 strips. If a member was provided with 25 strips, A4253 with the “CC” modifier should be billed. The number of units would be 25 for the actual quantity provided.

HCPCS code descriptions should be used to determine which codes are appropriate for the “CC” modifier

Date Span Billing: Durable Medical Equipment (DME) rental and medical supplies are required to bill dates of service in the following manner:

- Rental Items – The Iowa Medicaid payment system will not allow for future dates of service. **All claims must be filed post-service; meaning once services are rendered**.
- Codes paid at a monthly rental rate should be billed as one unit per line with the date range for the preceding month.
- If the Medicaid Medically Unlikely Edit (MUE) is less than the units being billed, please see IL 22262 for direction.
- Codes paid at a daily rental rate should be billed with the date range for the preceding month. The number of units billed should reflect the total number of days within that rental period.
    - Daily rental should not include more than 31 units to reflect the number of days in the month.

- If a member's month-to-month eligibility changes in the middle of a date span for daily rental, the units should be consistent with eligibility dates.
- Purchase Items – Purchased items cannot not be billed with a future date span.

Please note: the "from" date on DME claims should equal the date of anticipated need (not delivery date) and is the date for eligibility purposes in processing the claim. Iowa Medicaid would also like to make providers aware that Iowa Medicaid billing policy varies from that of Medicare. Due to programming limitations in the Medicaid claims payment system Medicaid requires that the "from" date of service be the anticipated date the supplies will be needed. Iowa Medicaid does follow Medicare policy regarding contact with the member and delivery date prior to the anticipated need. The maximum number of days for the member contact prior to delivery is 14 calendar days. The delivery date should be no sooner than 10 calendar days prior to the end of usage for the current product.

Billing Examples

All rental or purchased DME item claims must be retrospective.

Correct Billing for Monthly Rentals				
Line	From Date of Service	To Date of Service	Proc Code	Units of Service
1	1/1/2023	1/31/2023	E0250	1
1	1/15/2023	2/14/2023	E0570	1

Correct Billing for Partial Month Rental				
Line	From Date of Service	To Date of Service	Proc Code	Units of Service
1	1/1/2023	1/31/2023	K0001- RR	1
2	2/1/2023	2/14/2023	K0001- KR	14

Correct Billing for Daily Rental				
Line	From Date of Service	To Date of Service	Proc Code	Units of Service
1	1/1/2023	1/31/2023	E0936	31
1	2/1/2023	2/14/2023	E0936	14

Correct Billing for 90-Day Supply Purchase				
Line	From Date of Service	To Date of Service	Proc Code	Units of Service
1	3/1/2023	5/29/2023	A4253	6
1	3/1/2023	5/29/2023	A4259	3
All claims must be filed after services are rendered				

Payment for used equipment is 80 percent of the purchase allowance.

The amount payable is based on the least expensive item that meets the member's medical needs. Payment is not approved for duplicate items. No allowance is made for delivery, freight, postage, or other provider operating expenses for durable medical equipment, prosthetic devices, or sickroom supplies.

For selected medical services, supplies, and equipment, including equipment servicing, which in the judgment of the Secretary of the U.S. Department of Health and Human Services generally do not vary significantly in quality from one provider to another, the fee for payments shall be the lowest price for which such devices are widely and consistently available in a locality.

Reimbursement over the established fee schedule amount for bariatric equipment, pediatric equipment, specialized medical equipment, supply or other requires prior authorization. Approval shall be granted when the item is medically necessary and:

- Meets the definition of a code in the current HCPCS, and
- Has an established Medicaid fee schedule amount that is inadequate to cover the provider's cost to obtain the item.

D. Procedure Codes and Nomenclature

Claims submitted without a procedure code are denied. Medicaid recognizes Medicare's National Level II Healthcare Common Procedure Coding System (HCPCS). However, all HCPCS codes are not covered.

The provider is responsible for selecting the code that best describes the item dispensed. Refer coverage questions to the Provider Services Unit.

Iowa Health and Human Services Provider Services

Toll Free: 800-338-7909

Des Moines Area: 515-256-4609

Modifiers

Place the following modifiers after the five-position procedure code as appropriate:

Modifier	Description
BO	Oral administration of nutritional product
CC	Supply quantity differs from that in the HCPCS definition
CG	Chair component for a seat lift chair
DD	Powdered enteral nutrition product
EP	Items or services provided as a result of a Care for Kids (EPSDT) examination
FP	Family planning related item or service
KR	Rental period less than one month
NU	New equipment

RB	Like for like replacement
RR	Rental equipment
SC	Sometimes covered by Medicare
UC	Telephone translation service
UE	Used equipment

E. Billing Policies and Claim Form and Instructions

Claims for Medical Equipment and Supply Dealers are billed on federal form **CMS-1500, Health Insurance Claim Form**.

Click here to view a sample of the CMS-1500.

Click here to view billing instructions for the CMS-1500.

Refer to Chapter IV. Billing Iowa Medicaid for claim form instructions, all billing procedures, and a guide to reading the Iowa Medicaid Remittance Advice statement.

The Billing Manual can be located online at: Medicaid Provider Policy Manuals | Health & Human Services