Department of HUMAN SERVICES

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Employees' Manual, Title 8
Medicaid Appendix

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MedEquip Manual TRANSMITTAL NO. 20-1

ISSUED BY: Iowa Medicaid Enterprise

SUBJECT: ***Medical Equipment and Supply Dealer***, Chapter III, ***Provider-Specific Policies***, Title pages 1 and 2, Contents Overview page 1, Contents pages 1 and 2, and pages 1-47, revised.

Summary

The Medical Equipment and Supply Dealer manual is revised to:

- Revise language.
- Revise information relating to wheelchairs and scooters.
- Small changes to make formatting consistent throughout.

Date Effective

Upon receipt.

Material Superseded

This material replaces the following pages from the ***Medical Equipment and Supply Dealer*** manual:

Page	Date
Chapter III	
Title Page 1 and 2	
Contents Overview	May 1, 2014
Contents Page 1 and 2	May 1, 2014
1-47	May 1, 2014

Additional Information

The updated provider manual containing the revised pages can be found at: http://dhs.iowa.gov/sites/default/files/MedEquip.pdf

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@dhs.state.ia.us.

Medical Equipment and Supply Dealer

Provider Manual

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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 the Iowa Medicaid Enterprise (IME) 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 into 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 breast pumps, 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. Prior authorization is required for the following items:

- Automated medication dispensers
- Diabetic equipment and supply items produced by a manufacturer that does not have a current rebate agreement with the Department when a rebate agreement is in effect for the item

- Enteral products, feeding pumps, and supplies
- External insulin infusion pumps
- Oral nutritional products
- Patient lift, non-standard
- Power wheelchair attendant control
- Rehab shower commode chair
- Reimbursement over an established fee schedule amount
- Safety beds
- Speech generating devices (augmentative communication systems)
- Ventilator, back-up
- Vest airway clearance systems

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 in order for the equipment to be covered under Medicaid. With the exception of items listed, durable medical equipment is not provided in a hospital, nursing facility, or intermediate care facility for intellectual disability.

a. 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. IME 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 your responsibility to track the number of rental payments and discontinue billing beyond the 100 percent point.

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.

b. 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 with regard to 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.

c. 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" includes replacement of whole components, parts, or systems, such as seating systems that are worn out or broken and cannot otherwise be repaired, as long as 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.

d. **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* require prior authorization. Documentation from a physician, physical therapist or occupational therapist must indicate that the member:

- Is unable to stand for the duration of a shower, or get in and out of a bathtub, and
- Needs upper body support while sitting or toileting.

A tilt-in-space chair is covered when the documentation indicates a need for safety reasons or pressure relief.

e. Bed Pans and Urinals

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

f. 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 of the following conditions are met:

- An immediate change in position is necessary to avert a life-threatening situation, and
- The change cannot be accomplished by the use of 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 of the following conditions are met:

- There is a diagnosis-related cognitive or communication impairment such as traumatic brain injury, cerebral palsy, seizure disorder, developmental delay with cognitive impairment, or severe behavioral disorder that results in risk for safety, and
- There is evidence of mobility that puts the member at risk for injury.
- The documentation submitted supports that the bed request is appropriate to meet the member's needs.

The following documentation must be submitted with the request for prior authorization:

- Prescription from the practitioner that includes a diagnosis.
- Documentation (more than just a statement) that details cognitive or communication impairment.
- Evidence of risk for injury due to mobility, such as climbing out of bed (more than just standing at the side of the bed).
- Documentation that less costly alternatives have been tried and were unsuccessful, or are contraindicated. Less costly alternatives may include putting a mattress on the floor, padding added to regular and hospital beds, lining of cribs, medications, or helmets.
- When the bed will be used, what the time periods in bed are, and how the member will be monitored.
- Identification by relationship of all caregivers providing care to the member.
- Documentation of the sleep/wake pattern and response to awakening.

- For members with a behavior disorder, a copy of the behavioral management plan. (Coverage differs from Medicare.)
- A plan for random and ongoing reviews that ensures appropriate use of the bed.

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.

g. 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, one unit equals one day, and supplies are included. There is a seven-day coverage limit. (Coverage differs from Medicare.)

h. 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.

i. Canes

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

j. Chairs, Seat Lifts*

Prior authorization is not required for seat lift chairs. A combination lift chair and mechanism is 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.

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

When the mechanism is covered by Medicare, bill the chair component to Medicaid using procedure code E0627 with the "CG" modifier after Medicare has paid the claim for the mechanism. The Medicare EOB and documentation of medical necessity are not required with the Medicaid claim when Medicare has paid for the mechanism.

For members who do not have Medicare coverage, bill procedure code E0627 to Medicaid with the documentation listed below. 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.

k. 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.

l. 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.

m. 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 one of the following conditions exists:

- There is a chronic, non-healing wound or ulcer with lack of healing for at least the previous 30 days despite standard wound therapy. The therapy is to include the application of moist topical dressings, debridement, and the maintenance of adequate nutritional status. In addition, the wound has been measured (length, width, and depth) and evaluated on a weekly basis to document no change.
- There is a traumatic or surgical wound that is in need of accelerated formation of granulation tissue (exposed bone, tendons, vessels, etc.) and the member has co-morbidities (diabetes mellitus, vascular disease, etc.) that will not allow the normal healing process.

Wound vac systems are not covered under the following conditions: (This list may not be all-inclusive.)

- A medical professional is not supervising, measuring, or assessing the wound or ulcer
- Wound healing has progressed to the point where the wound vac is no longer necessary
- The depth of the wound is 1 cm or less
- The member cannot tolerate the use of the wound vac
- Necrotic tissue is present in the wound
- There is active bleeding in the wound or current anticoagulant therapy
- The dimensions of the wound have not significantly changed from one monthly evaluation to the next
- The member is noncompliant

"Chronic wounds" are defined as wounds that have gone through the repair process without producing satisfactory anatomic and functional integrity. Chronic wounds could include:

- Pressure ulcers
- Venous ulcers
- Diabetic ulcers
- Surgical and traumatic wounds
- Any other wound where the healing process is compromised

For purposes of this policy, "medical professional" may be a physician, physician's assistant, registered nurse (RN or ARNP), licensed practical nurse, or physical therapist. The medical professional is responsible for evaluation and management of the therapy that includes:

- Initial evaluation,
- Ongoing assessment, and
- Continuous monitoring to support the continuation of the therapy.

Documentation after the first month must show wound measurements of the month before and current wound measurements.

Payment is on a rental basis only. One unit equals one day. A prior authorization is recommended but is not required.

n. 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.

See also Blood Pressure Monitors.

o. 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.

p. 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.

q. 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.

r. 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.

s. 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.

t. 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.

u. Neuromuscular Stimulators and Supplies

Neuromuscular stimulators and supplies are covered for scoliosis.

v. 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.

w. 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

When random 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.

x. 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.

y. Peak Flow Meters

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

z. Pneumatic Appliances and Accessories

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

aa. Respiratory Equipment and Accessories*

Respiratory assist devices are covered when prescribed because the member's ability to breathe is severely impaired. 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 intermittent positive pressure breathing **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, 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.

Vest airway clearance systems require prior authorization and must be prescribed by the member's physician. There must be a medical diagnosis related to a lung disorder and documentation of **each** of the following:

- Pulmonary function tests prior to initiation of the vest demonstrate an overall significant decrease of lung function,

  NOTE: If pulmonary function tests are not applicable, the reason must be documented.
- The member resides in an independent living situation or has a medical condition that precludes the caregiver from administering traditional chest physiotherapy, or chest physiotherapy has not been effective,
- Treatment by flutter device failed or is contraindicated,
- Treatment by intrapulmonary percussive ventilation failed or is contraindicated,
- All other less costly alternatives have been tried and failed.

If all the criteria are met, a trial period of three months will be authorized.

At the end of the trial period, a usage log detailing at least 67 percent compliance of the original prescription and a re-evaluation by the physician regarding the effectiveness of the vest must be submitted to extend the authorization or consider purchase approval.

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.

bb. Speech-Generating Device

Speech-generating devices (augmentative communication systems) 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.

Personal computers (iPads, tablets) and software are not dedicated communication devices and, therefore, are not covered. 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 IME 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.

cc. Standers

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.

dd. Suction Machines

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

ee. 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.

ff. 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.

gg. Traction Equipment and Accessories

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

hh. Urinary Collection Devices and Accessories

Urinary collection devices and accessories are covered when prescribed because of urinary incontinence or urinary retention. If the limits are exceeded, the SC modifier must be used with documentation of the medical necessity submitted with the claim.

ii. Ventilators

A secondary, or back-up, ventilator requires prior authorization. Approval shall be granted in accordance with Medicare criteria.

jj. Walkers

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

Posture control walkers or Kaye reverse walkers (E1399) 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* (E8000, E8001, E8002) 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.

kk. Wheelchairs and Scooters

Wheelchairs, wheelchair accessories, and wheelchair modifications are covered when they are medically necessary for mobility within the home, nursing facility, or intermediate care facility. Wheelchairs are defined as:

(1) Standard manual wheelchairs

Coverage of a standard manual wheelchair includes the following:

- Complete set of tires/wheels and casters, any type;
- Hand rims with or without projections;
- Weight-specific components required by the patient-weight capacity of the wheelchair;
- Elevating leg rest, lower extension tube and upper hanger bracket;
- Armrest (detachable, non-adjustable or adjustable) with or without arm pad;
- Footrest (swing away, detachable), including lower extension tube(s) and upper hanger bracket;
- Standard size footplates;

- Wheelchair bearings;
- Caster fork, replacement only; and
- 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, and footrest assembly).

(2) Standard manual wheelchair accessories

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

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

(3) Standard power wheelchair

Coverage of a standard power wheelchair requires prior authorization and includes the following:

- Lap belt or safety belt;
- Battery charger, single mode;
- Complete set of tires/wheels and casters, any type;
- Leg rests (fixed, swing away, or detachable non-elevation leg rests with or without calf pad);
- Footrests/foot platform (fixed, swing away, detachable footrests or a foot platform without angle adjustment, single adjustable footplate);
- Armrests (fixed, swing away, detachable non-adjustable height armrests with arm pad provided);
- Any weight-specific components (braces, bars, upholstery, brackets, motors, gears, etc.) as required by patient-weight capacity of the wheelchair;

- 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;
- 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;
- Non-expandable controller or standard proportional joystick (integrated or remote); and
- 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, and footrest assembly).

(4) Standard power wheelchair accessories

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

- Shoulder harness/straps or chest straps/vest;
- Elevating leg rest;
- Angle adjustable footplates;
- Adjustable height armrests; and
- Expandable controller or nonstandard joystick (i.e., non-proportional or mini, compact or short throw proportional, or other alternative control device).

(5) Customized items

Customized items are payable with a prior authorization, in accordance with 42 CFR §414.224.

An ICF/ID is considered as a home for members who reside in one. 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
- Whether this is the first wheelchair or a replacement wheelchair
- For a replacement wheelchair, why the original chair is being replaced

A power wheelchair **attendant control** requires prior authorization. Approval shall be granted when the member has a power wheelchair and:

- Has a sip-n-puff attachment, or
- The documentation demonstrates that the member has difficulty operating the wheelchair in tight spaces, or
- The documentation demonstrates that the member becomes fatigued.

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).

(6) Wheelchair repair*

Wheelchair repair (K0739) 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.

(7) Specialized car seats*

Specialized car seats (T5001) 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. Prosthetic Devices

"Prosthetic devices" mean replacement, corrective, or supportive devices to:

- Artificially replace a missing portion of the body,
- Prevent or correct a physical deformity or malfunction, or
- Support a weak or deformed part of the body.

Prosthetic devices must be prescribed by a physician (doctor of medicine, osteopathy, or podiatry) within the scope of practice as defined by state law.

Prosthetic devices are covered even if the member's condition may change sometime in the future. Prosthetic devices are **not** covered when dispensed to a member before the member undergoes a procedure that makes the use of the device necessary.

a. Nutritional Products and Supplies

Enteral nutrition and supplies 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.

The basis of payment for nutritional therapy supplies is the least expensive method of delivery that is reasonable and medically necessary based on the documentation submitted. Prior authorization may be granted for up to one year for persons who have chronic conditions.

The prior authorization form and the claim form must show one unit per month for the infusion pump rental and one unit per day for the supply kits. Enteral product units must indicate the number of calorie units (1 unit equals 100 calories) needed for the total request.

Enteral nutrition products, oral nutrition products, and supplies should be dispensed in no more than a one-month quantity.

Daily **enteral nutrition** therapy is considered reasonable and necessary when the member has:

- A metabolic or digestive disorder that prevents the member from obtaining the necessary nutritional value from usual foods in any form and cannot be managed by avoidance of certain food products, or
- Severe pathology of the body that will not allow ingestion or absorption of sufficient nutrients from regular food to maintain weight and strength commensurate with the member's general condition.

Obtain prior authorization for enteral nutrition therapy before submitting claims for the nutritional products and the administration supplies. Submit the following documentation with form 470-0829, *Request for Prior Authorization*.

- Form 470-4210, *Certification of Enteral Nutrition*.
- 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/hr, blood glucose fluctuations, circulatory overload, jejunostomy tube used for feeding, or lipid based formula).

  In addition, Medicaid considers whether home health services are available to the member.
- For children under age five, a statement indicating eligibility for the WIC program has been denied or the amount of enteral products provided by WIC.

Examples of conditions that do **not** justify approval of enteral nutrition therapy are:

- Weight-loss diets
- Wired-shut jaws
- Diabetic diets
- Milk or food allergies for members five years of age and older

- The use of enteral products for convenience reasons when regular food in pureed form would meet the medical need of the member
- Nutritional supplementation to boost calorie or protein intake in the absence of severe pathology of the body

Oral supplementation* of a regular diet requires prior authorization and is reimbursable when a member:

- Is unable to ingest or absorb sufficient nutrients from regular food due to a metabolic, digestive, or psychological disorder or pathology, and
- Documentation to support the fact that 51 percent or more of the daily caloric intake is provided by the supplement. Oral supplementation may also be allowed when otherwise determined medically necessary in accordance with evidence-based guidelines for treatment of the member's condition. Such conditions include:
  - Acquired immunodeficiency syndrome (AIDS)
  - Burns
  - Cancer
  - Failure to thrive syndrome
  - Problems with the kidney, liver, lungs, pancreas or stomach
  - Prolonged infections
  - Prolonged vomiting
  - Surgery
  - Trauma

Use the "BO" modifier for nutritional products administered orally.

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.

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.

Enteral supplies* are covered as follows. Items with an * below require prior authorization.

Description	**Normal Quantity**
Syringe feeding kit*	1 unit per day
Pump feeding kit*	1 unit per day
Gravity feeding kit*	1 unit per day
Standard gastrostomy or jejunostomy tube	1 unit per 3 months
Low profile button kits	1 unit per 3 months
12-inch extension set	1 unit (1 case of 5 per month)
24-inch extension set	1 unit (1 case of 5 per month)
Bard decompression tube	2 per month

Amounts that exceed the normal quantities listed above are covered when medically necessary. The claim must include documentation of the medical necessity. The code must be billed with the "GD" modifier for "medically necessary units exceed the norm."

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

b. 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.

c. 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.

Continuous passive motion device is covered only when prescribed and initiated within two days of total knee replacement surgery. Documentation submitted must show the date of knee replacement surgery and the date the device was initiated. Up to 21 days of rental are allowed.

Cranial orthotic devices are covered when medical documentation submitted with the claim supports that either of the following condition exists:

- The device is medically necessary for the post-surgical treatment of synostic plagiocephaly.
- Photographic evidence supports the medical necessity for treatment of moderate to severe non-synostotic positional plagiocephaly and all of the following conditions exist:
  - The child is 12 weeks of age, but less than 36 weeks of age, and has failed to respond to a two-month trial of repositioning therapy, or
  - The child is 36 weeks of age, but less than 108 weeks of age, and
  - There is documentation of either of the following criteria:
    - Cephalic index of at least two standard deviations above the mean for the appropriate gender and age, or
    - Asymmetry of 12 millimeters or more in one of the following measures:
      - Cranial vault
      - Skull base
      - Orbitotragial depth

Cranial orthotic devices do not require prior authorization.

d. 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.

5. 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.

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: Blood glucose test strips, A4273, are defined in HCPCS as 50 strips for one unit. If a member was provided with 25 test strips, A4253 with the "CC" modifier should be billed. The number of units would be 25.

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. Non-preferred items require prior authorization and are approved when medically necessary. Items that are considered convenience items are **not** covered.

Diabetic supplies are covered as follows.

Description	Normal Quantity
Blood glucose test or reagent strips	6 units per month (1 unit equals 50 strips)
Urine glucose test strips	3 units per month (1 unit equals 100 strips)
Lancets	4 units per month (1 unit equals 100 lancets)
Needles	500 units per month (1 unit equals 1 needle)

Home blood glucose monitors and supplies are covered when the member meets all of 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 IME Pharmacy Unit is required.

Reusable insulin pens* are allowed through DME 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.

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 are 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. The "GD" modifier cannot be used with reusable underpads. 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

The "GD" modifier for "normal quantities exceeded" should be used when quantities billed have exceeded limits and the documentation supports the medical necessity. The documentation should be submitted with the claim.

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. One battery equals one 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.

6. 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 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 https://secureapp.dhs.state.ia.us/MedicaidFeeSched/X12.xml 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 Human Services according to the Medicare reimbursement method.

Payment for supplies with no established Medicare fee is at the average wholesale pricing less 10 percent. Payment for items with no established Medicaid fee, Medicare fee, or average wholesale price is the manufacturer's suggested retail price less 15 percent.

Payments for items with no average wholesale price, Medicare or Medicaid fee, or manufacturer's suggested retail price is at the dealer cost on the invoice plus 10 percent. The actual invoice from the manufacturer for the item provided must be submitted with the claim. Catalog pages or printouts supplied by the provider are not considered invoices.

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.

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
EP	Items or services provided as a result of a Care for Kids (EPSDT) examination
FP	Family planning related item or service
GD	Normal quantities exceeded
KR	Rental period less than one month
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*.

The Billing Manual can be located online at: http://www.dhs.state.ia.us/policyanalysis/PolicyManualPages/Manual_Documents/Provman/all-iv.pdf.