MEDICAID SERVICES MANUAL
TRANSMITTAL LETTER

September 14, 2010

TO: CUSTODIANS OF MEDICAID SERVICES MANUAL

FROM: MARTA E. STAGLIANO, CHIEF, COMPLIANCE Hirschmann for M. Stagliano

SUBJECT: MEDICAID SERVICES MANUAL CHANGES
CHAPTER 1300 – DME, DISPOSABLE SUPPLIES AND SUPPLEMENTS

BACKGROUND AND EXPLANATION

The Medicaid Services Manual (MSM), Chapter 1300, DME, Disposable Supplies and Supplements is being revised to complete its reorganization and improve the flow of information for readers. A new section was added at the beginning of the Chapter which clarifies the DMEPOS program, provider responsibilities, and recipient responsibilities. Clarification was added to Appendix A Non-Covered Services, and added disposable gloves to the list of non-covered items.

Throughout the chapter, grammar, punctuation, and capitalization changes were made, duplications removed, acronyms used and standardized, and language reworded for clarity. Renumbering and re-arranging of sections was necessary.

These policy changes are effective September 15, 2010.

MATERIAL TRANSMITTED	MATERIAL SUPERSEDED
MTL 35/10 CHAPTER 1300 – DME, DISPOSABLE SUPPLIES AND SUPPLEMENTS	MTL 11/08, 33/09 CHAPTER 1300 – DME, DISPOSABLE SUPPLIES AND SUPPLEMENTS

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
1302	**Definitions**	Removed numbering
1303	**DMEPOS Program**	Created new section which incorporates prior sections 1303.8, 1303.13, and 1303.14. Added clarification of the DMEPOS program, new requirements for provider enrollment, and clarified responsibilities of the provider and recipient.

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
1303.2	**Documentation Requirements**	Added clarification to the contents and timelines for physician/practitioner's orders. Eliminated reference to signature stamps as they are no longer allowed. Prior 1303.2 section titled Dispensing/Duration of Orders combined with section 1303.3 titled Delivery of DME and Supplies moved to section 1303.5.
1303.3	**Reserved**	Reserved for future use
1303.4	**Prior Authorization**	Changed outdated reference from Statistical Analysis Durable Medical Equipment Regional Carrier (SADMERC) to Medicare Pricing, Data Analysis and Coding (PDAC) contractor.
1303.5	**Dispensing and Delivery of DMEPOS**	Relocated from 1303.2 Dispensing/Duration of Orders. Relocated from 1303.3 Delivery of DME and Supplies. Prior 1303.5 section titled Replacement of Equipment moved to section 1303.6.
1303.8	**Reserved**	Section reserved for future use.
1303.9	**DME at Institutional Facility**	Eliminated outdated reference to 1303.11, invalid/closed HCPCS code K0115. Changed PAR to PA.
1303.13	**Reserved**	Section reserved for future use.
1303.14	**Reserved**	Section reserved for future use.
1303.15	**Utilization Control**	Corrected unit name from Medicaid Verification Section to Medicaid Program Integrity Section.
1305	**References and Cross References**	Updated contact information.
Appendix A	**Non-Covered Services**	Added Disposable gloves (non-sterile and sterile) to list.

DIVISION OF HEALTH CARE FINANCING AND POLICY

MEDICAID SERVICES MANUAL
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DME, DISPOSABLE SUPPLIES AND SUPPLEMENTS

1300 INTRODUCTION

Durable Medical Equipment (DME), Orthosis, Prosthesis, Disposable Medical Supplies, Nutritional Supplements and Hearing Aids are a covered benefit for Nevada Medicaid recipients. All items are subject to program's criteria and reimbursement restrictions as outlined throughout this chapter. Nevada Medicaid covers standard medical equipment that meets the basic medical need of the recipient. Items classified as educational or rehabilitative by nature are not covered by provider type 33. Administrative authorization for additional services may be made by the Quality Improvement Organization for exceptional cases where medical need is adequately documented.

All Medicaid policies and requirements (such as prior authorization, etc.) are the same for Nevada Check Up (NCU), with the exception of the four areas where Medicaid and NCU policies differ as documented in the NCU Manual Chapter 1000.

1301 AUTHORITY

Nevada Medicaid covers Durable Medical Equipment as an optional program under Title XIX of the Social Security Act (SSA).

Reference State Plan §Attachment 3.1-A Page 3 and 3a, §Attachment 4.19-B page 2.

Section 1833 (e) of SSA.

42 USC Section 1395 (1) (c).

1302 DEFINITIONS

ANKLE-FOOT ORTHOSES

Ankle-foot orthoses extend well above the ankle (usually to near the top of the calf) and are fastened around the lower leg above the ankle. These features distinguish them from foot orthotics, which are shoe inserts that do not extend above the ankle.

CUSTOM FABRICATED ORTHOSIS

Custom fabricated orthosis is one which is individually made for a specific patient starting with basic materials including, but not limited to, plastic, metal, leather, or cloth in the form of sheets, parts, etc. It involves substantial work such as cutting, bending, molding, sewing, etc. It may involve the incorporation of some prefabricated components. It involves more than trimming, bending, or making other modifications to a substantially prefabricated item.

DISPOSABLE MEDICAL SUPPLIES

Disposable medical supplies are those items which are not reuseable, and are primarily and customarily used to serve a medical purpose, and generally are not useful to a person in the absence of an illness or injury.

DURABLE MEDICAL EQUIPMENT (DME)

DME is defined as equipment which can withstand repeated use, and is primarily and customarily used to serve a medical purpose, and generally is not useful to a person in the absence of illness or injury and is appropriate for use in the home.

DURABLE MEDICAL EQUIPMENT MEDICARE ADMINISTRATIVE CONTRACTOR (DME MAC)

The Centers for Medicare and Medicaid Services (CMS) utilize four insurance companies to process durable medical equipment, prosthetic, orthotic, and disposable medical supply claims for Medicare in four distinct jurisdictions. Nevada is in Jurisdiction D. This was formerly referred to as Durable Medical Equipment Regional Carrier (DMERC).

DURABLE MEDICAL EQUIPMENT, PROSTHETICS, ORTHOTICS, AND SUPPLIES (DMEPOS)

Aggregate term used under the Medicare program and by some Medicaid programs, which incorporates all durable medical equipment, prosthetics, orthotics, and disposable medical supplies. The acronym is pronounced “demipose”.

MOLDED TO PATIENT MODEL ORTHOSIS

A molded-to-patient-model orthosis is a particular type of custom fabricated orthosis in which an impression of the specific body part is made (by means of a plaster cast, CAD-CAM technology, etc.) and this impression is then used to make a positive model (of plaster or other material) of the body part. The orthosis is then molded on this positive model.

ORTHOSIS

An orthosis (brace) is a rigid or semi-rigid device which is used for the purpose of supporting a weak or deformed body member or restricting or eliminating motion in a diseased or injured part of the body. An orthosis can be either prefabricated or custom-fabricated.

PREFABRICATED ORTHOSIS

Pre-fabricated orthosis is one which is manufactured in quantity without a specific patient in mind. A prefabricated orthosis may be trimmed, bent, molded (with or without heat), or otherwise modified for use by a specific patient (i.e., custom fitted). An orthosis that is assembled from prefabricated components is considered prefabricated. Any orthosis that does not meet the definition of a custom-fabricated orthosis is considered prefabricated.

PROSTHETIC DEVICES

Prosthetic devices are replacement, corrective, or supportive devices prescribed by a physician (or other licensed practitioner of the healing arts within the scope of his practice as defined by state law) to – (1) Artificially replace a missing portion of the body; or (2) Prevent or correct physical deformity or malfunction; or (3) Support a weak or deformed portion of the body. (as defined by CFR at 42 CFR 440.120(c)). For Nevada Medicaid's DMEPOS program purposes, dentures and eyeglasses are not included as a prosthetic device.

SPEECH GENERATING DEVICE (SGD)

SGDs, also commonly known as "Augmentative and Alternative Communication" (AAC) devices are electronic aids, devices, or systems that correct expressive communication disabilities that preclude an individual from meaningfully participating in activities of daily living. SGDs are covered as DME. Requests for SGDs must provide the information required in Appendix B to this Chapter of the Medicaid Services Manual (MSM).

1303 POLICY

1303.1 DURABLE MEDICAL EQUIPMENT, PROSTHETIC DEVICES, ORTHOTIC DEVICES, DISPOSABLE MEDICAL SUPPLIES (DMEPOS) PROGRAM

A. GENERAL INFORMATION

1. DMEPOS Program coverage areas include DMEPOS, parenteral and enteral nutrition (PEN), medical foods and oxygen and oxygen equipment; all of which must meet the definition of durable medical equipment, a prosthetic device, an orthortic device, or disposable medical supply.

2. Durable Medical Equipment (DME) of a medical nature, needed as a result of a medical condition, and which lasts a considerable time without significant deterioration and appropriate for use within the home, is covered by Nevada Medicaid and Nevada Check Up (NCU) for eligible recipients. Supplying equipment, repairs, or replacement requires medical documentation and may be subject to limitations of model, cost and frequency, which are deemed reasonable by the program.

3. Disposable medical supplies are covered by Nevada Medicaid and NCU for eligible recipients only if they are necessary for the treatment of a medical condition and would not generally be useful to a person in the absence of an illness or injury.

4. All DMEPOS products and services must be medically necessary, safe and appropriate for the course and severity of the condition, using the least costly and equally effective alternative to meet the recipient's medical needs.

5. Deluxe equipment will not be authorized when it is determined a standard model will meet the basic medical needs of the recipient. The recipient must have a medical need for each component of the item(s) requested. This includes accessory items and features not included in the standard models of the product.

6. Equipment which the program determines is principally for education or rehabilitation will not be approved.

7. Refer to Appendix A of this Chapter for non-covered services, and for special coverage considerations that may be based on medical necessity outside of the DMEPOS Program or that may be considered under the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Healthy Kids Program.

8. Refer to Appendix B of this Chapter for DMEPOS Coverage and Limitation Policies for specific coverage information, qualifications, documentation requirements, and miscellaneous information.

9. Refer to the Provider Type 33 DMEPOS Fee Schedule for specific item coverage under the DMEPOS program. Access http://dhcfp.nv.gov/Ratesunity.htm. This schedule provides prior authorization requirements, rates, and limitations.

10. Nevada Medicaid does not reimburse for items that are the same or similar to items that the recipient has already acquired, such as but not limited to back-up equipment, unless allowed in the specific policy for that item. Duplicate items intended to be used within the same span of time are not considered medically necessary.

11. Individuals deemed eligible for Nevada Medicaid or NCU and who have ownership of existing equipment from any prior resource must continue using that equipment. Existing equipment, regardless of who purchased it, must be identified, including the estimated date of purchase or age of equipment, and medical documentation showing evidence of need for replacement must be submitted with a prior authorization (PA) request.

12. Some items not covered under the DMEPOS Program may be covered under other Medicaid programs such as Pharmacy, Audiology, or Ocular programs. Additional resources may be available through other agencies or through waiver programs for items not covered under the DMEPOS Program or by the Medicaid State Plan.

B. PROVIDER RESPONSIBILITY

1. All DMEPOS providers must be licensed through the Nevada State Board of Pharmacy (BOP) as a Medical Device, Equipment, and Gases (MDEG) supplier, with the exception of a pharmacy that has a Nevada State Board of Pharmacy license and provides DMEPOS. Once licensed, providers must maintain compliance with all Nevada BOP licensing requirements. Reference Medicaid Services Manual (MSM) Chapter 100 – Medicaid Program for further information on enrollment and provider responsibilities. Also refer to the Enrollment Checklist posted on the QIO-like website at https://nevada.fhsc.com.

2. Suppliers of products covered under the Medicare Part B program are required to be enrolled in the Medicare Part B program in order to provide those services to Medicare and Medicaid dually eligible recipients. This includes obtaining and maintaining the Centers of Medicare and Medicaid Services (CMS) required accreditation and surety bond.

3. Potential providers who are not enrolled with the Medicare Part B program and who will not be supplying products covered under the Medicare Part B program to individuals eligible for Medicare are required to provide a statement on/with their application that requests a waiver of the requirements for Medicare Part B enrollment. This statement must indicate that they do not service Medicare-eligible individuals and include a listing of the products they plan to supply.

4. A Medicaid-contracted DMEPOS provider may be reimbursed for services rendered to Medicaid eligible recipients when provided in accordance with established policies, guidelines and timeframes.

5. The provider is responsible for ensuring the equipment is appropriate for the recipient and the recipient's residence prior to billing Medicaid.

6. The DMEPOS provider must comply with additional requirements as specified throughout this Chapter and its Appendices, MSM Chapter 100, the PT 33 DMEPOS Fee Schedule, the Provider Billing Manual, and DMEPOS Billing Guidelines.

C. RECIPIENT RESPONSIBILITY

The eligible Nevada Medicaid or NCU recipient and/or their authorized representative will:

1. Make and keep appointments necessary for securing medical services/equipment;

2. Present current verification of Nevada Medicaid or NCU eligibility;

3. Present any forms or identification necessary to utilize other health insurance coverage;

4. Contact and return to the provider of services/equipment for any necessary adjustment within the time allotted for such adjustments;

5. Maintain the equipment provided by routinely cleaning and caring for the devices according to user information and supplier's guidance. Provide safe, secure storage for item(s) when not in use to protect item(s) from loss or theft;

6. Not abuse or neglect purchased or rented item(s) in a way that renders the item(s) unsafe or non-usable;

7. Return all rented equipment to the DMEPOS provider when no longer being used, or upon the DME provider's request; and

8. Comply with additional requirements as specified throughout this Chapter and its Appendices and MSM Chapter 100.

1303.2 DOCUMENTATION REQUIREMENTS

A. Supplier/provider records must substantiate the medical necessity for all DMEPOS items dispensed to recipients. The following describes the requirements for specific types of documentation associated with DMEPOS.

1. ORDERS / PRESCRIPTIONS

a. All DME items, prosthetics, orthotics, or disposable supplies (POS) dispensed must have an order/prescription from the treating physician or practitioner, (To determine included practitioners, refer to MSM, Chapter 600 – Physician's Services), such as a Physician's Assistant (PA), or Advanced Practitioner of Nursing (APN), when within their scope of practice and in accordance with federal and state laws governing that entity, prior to dispensing the item.

General standards of care/practice mandate that if an order is not clear, a clarification of the order must be obtained from the ordering practitioner prior to acting on it.

b. Verbal Orders:

1. Verbal orders from the prescribing physician/practitioner may be accepted for DMEPOS items that do not require Prior Authorization by Nevada Medicaid (except when Medicare is primary and Medicaid co-payment will be requested, and Medicare requires a written order for that item prior to delivery). Refer to DME MAC Supplier Manual, Chapter 3 – Documentation Requirements for a current listing of those items.

2. The verbal dispensing order must include:

a. A description of the item;

b. The recipient's name;

c. The physician's name;

d. The start date and length of need of the order; and

e. Additional information sufficient to allow appropriate dispensing of the item.

3. Suppliers must maintain written documentation of the verbal order and, if the verbal order is used for dispensing the item, the supplier must obtain a detailed written order prior to billing Medicaid.

c. Written Orders:

1. Written orders are acceptable for all transactions involving DMEPOS and must be obtained prior to submitting a prior authorization for any DMEPOS items. Written orders may take the form of a photocopy, facsimile image, electronically maintained, or original "pen-and-ink" document.

2. All written orders must, at a minimum:

a. Clearly specify the start date of the order;

b. Include the length of need;

c. Be sufficiently detailed, including all options or additional features that are needed to meet the recipient's needs. The description can be either a narrative description (e.g., lightweight wheelchair base) or a brand name/model number; and

d. Be signed and dated by the treating physician/practitioner.

3. Certain items require additional elements in the written orders, as follows:

a. If the written order is for supplies that will be provided on a periodic basis, the written order must include appropriate information on the quantity used, frequency of change, and duration of need. (For example, an order for surgical dressings might specify one 4x4-hydrocolloid dressing that is changed one to two times per week for one month or until the ulcer heals).

b. If the written order is for an item such as, but not limited to, enteral formula, oxygen, etc., the order must specify the name of the product, concentration (if applicable), dosage,

frequency and route of administration, and duration of infusion (if applicable).

c. Custom-fabricated items must be clearly indicated on the written order that has been signed and dated by the prescribing physician/practitioner.

4. There are additional specifications for orders for certain items, such as, but not limited to, Power Mobility Devices (PMDs). Refer to Appendix B for details.

5. Someone other than the physician may complete the detailed description of the item. However, the ordering physician/practitioner must review the detailed description and personally indicate agreement by signing and dating the order.

6. Medical necessity information (such as an ICD-9 diagnosis code, narrative description of the recipient's condition, abilities, and limitations) is not in itself considered to be part of the order although it may be put on the same document as the order.

d. New Orders Are Required When:

1. There is a change in the order of a specific DMEPOS item;

2. There is a change in the resident's condition that warrants a change in the order, a change in the treating physician/practitioner, or DME supplier;

3. An item is replaced for any reason; or

4. An ongoing unchanged order continues to be medically necessary one year after the original order (orders are only valid for up to one year).

2. DETAILED PRODUCT DESCRIPTION

The detailed product description must contain the Healthcare Common Procedure Coding System (HCPCS) code, manufacturer, make and model, and the provider's/supplier's usual and customary charge for each item supplied. The warranty information must also be included. This may be completed by the provider/supplier but must also be signed and dated by the physician.

3. PROOF OF DELIVERY (POD)

A POD is a supplier's delivery receipt, which is dated and timed.

NOTE: Item(s) ordered must be delivered within 120 days of the date of the order.

4. ADDITIONAL MISCELLANEOUS MEDICAL RECORDS

The provider's recipient medical records must contain sufficient documentation of the recipient's medical condition to substantiate the necessity for the type and quantity of items ordered and the frequency of the use or replacement. The information should include the recipient's diagnosis and other pertinent information, including but not limited to: duration of recipient's condition, clinical course (deteriorating or improving), prognosis, nature and extent of functional limitations, other therapeutic interventions and results, past experience with related items, etc. The records may include physician's office records, hospital, nursing home or home health records, records from other professionals including but not limited to: nursing, physical and occupational therapists, prosthetists and orthotists, although medical necessity for item(s) requested must be stated by the prescribing physician/practitioner.

5. ADVANCED DETERMINATION OF MEDICARE COVERAGE (ADMC)

When Medicare is the primary payor, for all items requiring an ADMC (refer to DME MAC Supplier Manual, Chapter 9), the ADMC determination must be submitted to the QIO-like vendor at the time the PA is submitted.

B. PROVIDER RESPONSIBILITY

1. The provider must obtain the required documentation in a timely manner as described under each section above.

2. The provider must maintain records at the physical location of their business for each item billed to, and paid by, Nevada Medicaid for at least six years from the Remittance Advice (RA) date. At a minimum, this includes the original signed order/prescription, all supporting medical documentation, and proof of delivery.

3. The provider must maintain records in a readily accessible location and, for audit and investigation purposes, to make available upon request by Medicaid staff or its contractors, all supporting information related to prior authorizations, dispensed items, and/or paid clams for DMEPOS items.

1303.3 RESERVED FOR FUTURE USE

1303.4 PRIOR AUTHORIZATION

A. Prior Authorization (PA) is a review conducted by the QIO-like vendor's medical professionals who review the PA form and any additional information submitted to evaluate medical necessity, appropriateness, location of service, and compliance with Medicaid's policy, prior to delivery of service. Reference the MSM, Chapter 100 and the general Billing Manual for all providers posted at https://nevada.fhsc.com/providers/billinginfo.asp for detailed information on Prior Authorization and when Medicaid eligibility is determined retroactively.

1. Submission:

a. Must be completed and submitted by a current Medicaid provider (requestor), and the approval must be received, prior to delivery of services. The exception to this is if the recipient is determined eligible for Medicaid retroactively or if number four below applies.

b. A PA is required for most non-disposable durable medical equipment, prosthetics, orthotics, and oxygen. To determine the PA requirements for specific items, refer to the Provider Type 33 Fee Schedule posted at http://dhcfp.nv.gov/RatesUnit.htm.

c. A Medicaid provider may submit the PA electronically using the QIO-like vendor's on-line PA system (OPAS) or may fax or mail the PA to the QIO-like vendor. For more information, refer to the Prior Authorization section posted at https://nevada.fhsc.com/providers/priorauth/priorauth.asp.

d. Requestors must submit a PA with the most appropriate HCPCS code available and may not unbundle items included in the HCPCS code description. If an item has a designated code available, the miscellaneous code cannot be used. Providers may contact the Medicare Pricing, Data Analysis and Coding (PDAC) contractor, or the DME MAC for guidance on correct coding.

e. Documentation requirements are the same regardless of which mode of submission is used (e.g. the on-line PA system, faxed, or mailed). Documentation submitted for consideration of the request must include the physician's order and must clearly support coverage qualifications and recipient's medical need for the equipment. Failure to provide all of the supporting medical documentation in its entirety, and within the required

timeframes, will result in a denial of the PA request, regardless of mode of submission.

f. Unless otherwise stated in policy, a PA may be submitted to request authorization to exceed established quantity limitations when the medical documentation supports medical necessity for the increased quantity or frequency.

2. Review Consideration:

a. In addition to the specifications mentioned above for reviewing the PA, products and services must be medically necessary, safe and appropriate for the course and severity of the condition using the least costly equally effective alternative to meet the recipient's needs.

b. The recipient must have a medical need for, and requested item must be suitable for use within the home. Consideration will also be based on the recipient's additional use of the item for the conditions in each of the environments the recipient is likely to encounter in their daily routines, such as, but not limited to: attending school, work, and shopping. This information must be included in the supportive documentation submitted with the PA.

c. For durable medical equipment, prosthetics, orthotics, and disposable medical supplies and appliances where coverage and limitation policies have not been established within this Chapter or its Appendices, Nevada Medicaid may defer to Durable Medical Equipment Medicare Administrative Contractor (DME MAC) Jurisdiction D, Local Coverage Determination (LCD) and policy articles for coverage and limitation criteria. These can be accessed at http://www.noridianmedicare.com/dme. The item must meet the definition of durable medical equipment, prosthetic, orthotic, or disposable medical supply and must be necessary to meet the medical needs of the recipient, and must be part of the prescribing physician's/practitioner's plan of care.

d. Nevada Medicaid has the option of requesting an Independent Medical Evaluation (IME) to determine the recipient's limitations and abilities to support medical necessity.

3. PA Requirements for Third Party Liability (TPL) and Medicare Crossovers:

a. Refer to MSM, Chapter 100, for more information on TPL, and Medicare Crossovers and the requirements for securing Prior Authorizations.

4. PA Emergency Situations:

   a. In an emergency situation, when an order is received by the supplier after the QIO-like vendor working hours or over weekends or State holidays, dispensing of a 72-hour supply of those DMEPOS items that require PA will be allowed only when:

      1. A delay of 24 hours of treatment could result in very severe pain, loss of life or limb, loss of eyesight or hearing, injury to self, or bodily harm to others; and

      2. The treating physician/practitioner indicates a diagnosis/ICD-9 code on the prescription that supports the use of the emergency policy.

   b. The provider/supplier must submit the PA the next business day with all required supportive documentation. The documentation must include proof of the date and time the order was received by the supplier and documentation to support both a.1. and a.2. above.

5. DMEPOS Specific PA Forms:

   All forms must be completed and submitted by a current Medicaid provider. Forms used must be the most current version.

   a. Forms and Form Release Memorandums or instructions may be accessed at the Division's website https://nevada.fhsc.com/providers/forms/forms.asp. The instructions provide detailed guidance on form completion requirements.

   b. DME PA, form found on the QIO-like vendor's website: All DMEPOS items requiring prior authorization must be requested on this form and submitted via the OPAS, Fax, or mail to the QIO-like vendor for approval.

   c. Usage Evaluation – For Continuing Use of Bi-Level and Continuous Positive Airway Pressure (BIPAP and CPAP) Devices, form found on the QIO-like vendor's website: This form must be completed and submitted for continuing usage of BIPAP or CPAP devices.

   d. Mobility Assessment for Mobility Devices, Wheelchair Accessories and Seating Systems, form found on the QIO-like vendor's website: This form must be submitted for all mobility devices, wheelchair accessories and seating systems.

6. Denied Prior Authorization Requests:

a. There are various processing levels associated with PA requests which do not support medical necessity. These may include, but are not limited to: a contact to the provider by the QIO-like vendor, a system generated technical denial, a system generated denial or reduction of services, a provider-requested reconsideration, a provider-requested peer-to-peer review with the physicians. For specific information on time limits and an explanation of each, refer to the general Billing Manual for all providers posted at http://nevada.fhsc.com/providers/billinginfor.asp.

b. If a prior authorization request is denied or reduced, the provider and recipient will be sent a Notice of Decision (NOD) with a citation/reason to provide a general explanation of the denial. The provider may request consideration of the denial by submitting additional supportive information and requesting a "Reconsideration" in writing.

c. If a reconsideration is not appropriate or is also denied, the recipient may be entitled to request an appeal or hearing. Refer to Section 1304 of this Chapter and Chapter 3100 – Hearings.

B. COVERAGE AND LIMITATIONS

1. Coverage and limitations are explained throughout this Chapter, including its appendices. Appendix B details coverage qualifications, PA documentation requirements, and limitations for specific items.

2. Refer to the Nevada Medicaid Provider Type 33 – DME Fee Schedule posted at http://dhcfp.nv.gov/RatesUnit.htm for covered services. The Fee Schedule identifies covered services/items (listed in alpha-numeric order according to HCPCS code), rates, PA requirements, and limitations.

C. PROVIDER RESPONSIBILITY

1. The requesting DME provider and the prescribing physician/practitioner must work collaboratively to accurately and timely complete and submit PA requests, including all supportive documentation in order to ensure the item(s) being requested is/are the most appropriate to meet the recipient's medical needs. This must be done prior to dispensing any DMEPOS item requiring a PA. Refer to the Prior Authorization section of the general Billing Manual for all providers at https://nevada.fhsc.com/providers/billinginfo.asp for detailed information on form completion and submission/transmission of PA request.

2. In the event additional information is requested by the QIO-like vendor, the provider should submit the requested information within established time limits, and/or review the notice of decision to determine the reason for denial, make any necessary corrections, continue to work collaboratively with the prescribing physician/practitioner to obtain medical justification, and/or when appropriate, request Reconsideration by providing additional supportive information to justify the medical need for the equipment. Refer to the general Billing Manual for all providers for details on denied requests.

D. RECIPIENT RESPONSIBILITY

1. The recipient and/or their representative must accurately represent their needs in relationship to obtaining medical equipment.

2. The recipient must attend appointments with PT, OT, and/or physician/ practitioners for the purpose of evaluation for DMEPOS, and with DME providers for adjustments and servicing of equipment.

3. The recipient and/or representative must provide the written order/prescription from the physician/practitioner. If assistance is needed to obtain DMEPOS, the recipient or their authorized representative should contact the local Nevada Medicaid District Office Care Coordination unit for assistance. Contact numbers are provided in Section 1305 of this chapter. The exception to this is if the ordering physician/practitioner submits the information directly to the DME provider/supplier on behalf of the recipient.

4. The recipient and/or their authorized representative must present proof of identity and provide documentation of Medicaid coverage and any form of identification necessary to utilize other health insurance coverage.

1303.5 DISPENSING AND DELIVERY OF DMEPOS

A. Dispensing/Duration of Orders

Medical supply orders must be dispensed at a monthly interval. DMEPOS is dispensed according to the physician's orders, subject to coverage limitations. The physician's order for medical supplies is valid up to one year. Suppliers may not ship items on a regular, monthly basis without an indication from the recipient, family member, or authorized representative that the supply is needed. Documentation of this need must be kept on file. It is acceptable for the supplier to contact the recipient to verify a re-order.

B. Delivery of DMEPOS

1. Delivery Method 1. Supplier delivering items directly to the recipient or authorized representative:

   a. The delivery receipt must be signed and dated by the recipient or authorized representative to verify the DMEPOS item was received.

   b. The date of the signature on the delivery receipt must be the date the DMEPOS item was received by the recipient or their authorized representative.

   c. The delivery receipt must include the recipient's name, quantity, a detailed description of the item(s) delivered, brand name, make and model, serial number (if applicable), and date and time of delivery.

   d. The date of service on the claim must be the date the DMEPOS item was received by the recipient or their authorized representative. An exception to this would be when an item must be billed using a date span and the quantity dispensed crosses over into the next month.

2. Delivery Method 2. Suppliers utilizing a delivery/shipping service to deliver items:

   a. Acceptable POD includes the delivery/shipping service's delivery receipt and the supplier's shipping invoice (Bill of Lading (BOL or BL)).

   b. The supplier's BOL must include the recipient's name, quantity, detailed description of the item(s) delivered, brand name, make and model, serial number (if applicable), date and time of delivery/shipment, and delivery service package identification number associated with recipient's package(s).

   c. The delivery/shipping service delivery receipt (POD) must reference the recipient's package(s), deliver address, and the corresponding package identification number given by the delivery service.

   d. Without the delivery/shipping service delivery receipt (POD) that identifies each individual package with a unique identification number and delivery address, the item will be denied and any overpayment will be recouped.

1303.6 REPLACEMENT OF EQUIPMENT

Lost, damaged, or stolen equipment replacement requests must be submitted on a prior authorization request form. The request must substantially support the absence of negligence and malicious involvement on the part of the recipient. Replacement is not considered a Medicaid benefit, but substantiated requests will be considered on a case–by–case basis for an administrative exception to the non–replacement policy. For example, if a recipient can produce a copy of a police report or other evidence which absolves them of responsibility for the loss, Medicaid may make an administrative exception to replace essential durable medical equipment.

1303.7 SECTION RESERVED FOR FUTURE USE

1303.8 SECTION RESERVED FOR FUTURE USE

1303.9 DME AT INSTITUTIONAL FACILITY (IF)

A. Nevada Medicaid's hospital and nursing facility rates for an inpatient stay are all inclusive and cover all items needed by the patient during the length of stay. This includes all:

1. Disposable supplies;
2. Wound care supplies;
3. Urological supplies;
4. Respiratory supplies;
5. Metabolic, Nutritional and Temperature supplies;
6. Endocrine supplies;
7. Fluid and Electrolyte supplies;
8. Dental supplies;
9. Emollient supplies; and
10. Supplements.

B. Prosthetics and Orthosis

Prosthetics and Orthosis: Are included in the all inclusive per-diem if provided to a patient during an inpatient hospital prior to discharge and the patient uses item for medically necessary inpatient treatment or rehabilitation. (e.g., after spinal surgery).

C. DME that cannot be utilized by another recipient due to its unique custom features (e.g. seating system), are not part of the institution's inclusive rate.

1. All DME must be prior authorized for exception to inclusive facility rates.

2. Hospital and nursing facility patients may be approved for wheelchairs in preparation for discharge. Nevada Medicaid may approve power chairs one month in advance of discharge. Physician documentation to substantiate discharge date may be required.

3. Specialized or custom-made items, which will be needed by the patient upon discharge may be requested during the inpatient stay. However, approval of the items may be restricted to delivery to the patient at the time of discharge to his home or other place of residence. Providers of requested items will be paid directly only if the required PA has been approved. Facilities will not be paid for items supplied by another provider.

1303.10 SECTION RESERVED FOR FUTURE USE

1303.11 SECTION RESERVED FOR FUTURE USE

1303.12 SECTION RESERVED FOR FUTURE USE

1303.13 SECTION RESERVED FOR FUTURE USE

1303.14 SECTION RESERVED FOR FUTURE USE

1303.15 UTILIZATION CONTROL

A. Pre-Service

The coverage, limitations and exclusions outlined in this chapter constitute pre-service controls on over-utilization.

B. Pre-Payment

The fiscal agent will screen each claim for existence and/or application of prior resources, correct coding of services, and appropriate authorization form. In addition, each claim will be screened for accuracy in computation and compliance with published procedures.

C. Post-Payment

All providers offering services to Medicaid recipients are subject to post-payment review. The Medicaid Program Integrity Section is responsible for review of any improper, abusive, or fraudulent practices. Definition of abuse and the sanctions to be imposed are delineated in the Nevada MSM, Chapter 100.

1304 HEARINGS

Please reference Nevada Medicaid Services Manual, Chapter 3100 for the Medicaid Hearings process.

1305 REFERENCES AND CROSS REFERENCES

1305.1 MANUALS

A. Medicaid Services Manuals:

Chapter 100 Medicaid Program
Chapter 500 Nursing Facilities (NF)
Chapter 700 Rates
Chapter 1100 Ocular
Chapter 1200 Pharmacy
Chapter 1500 Healthy Kids (EPSDT)
Chapter 1600 Intermediate Care Facility for the Mentally Retarded (ICF/MR)
Chapter 2000 Audiology
Chapter 3100 Hearings (for Medicaid Recipients)
Chapter 3200 Hospice
Chapter 3300 Program Integrity
Chapter 3600 Managed Care Organization

B. Nevada Check Up Manual:

Chapter 1000 Nevada Check Up Program

1305.2 FORMS

A. CMS 1500 Claim Form is available from business form companies.

B. Prior Authorization (PA) forms, both electronic and hard copies are available to providers by accessing either the Division of Health Care Financing and Policy website or the QIO-like vendor's website.

- Durable Medical Equipment PA, form found on the QIO-like vendor's website;
- Usage Evaluation for Bi-PAP and CPAP, form found on the QIO-like vendor's website;
- Mobility Assessment for Mobility Devices, Wheelchair Accessories, and Seating Systems form found on the QIO-like vendor's website.

1305.3 PROVIDER RESOURCES / CONTACTS

A. Provider Relations, help desk, general information, and provider training

Magellan Medicaid Administration Inc.
Customer Service Center
P.O. Box 30042
Reno, NV 89520-3042
Toll Free within Nevada (877) NEV-FHSC (638-3472)
Website: http://nevada.fhsc.com/

B. Prior Authorization (PA) contact

Magellan Medicaid Administration Inc. – Health Care Management (HCM)
Prior Authorization Unit
Nevada Medicaid and Nevada Check Up
4300 Cox Road
Glen Allen, VA 23060
Phone: 1-800-525-2395 Fax: 1-866-480-9903
Online Prior Authorization System (OPAS)
https://hcm.fhsc.com

C. Pharmacy Point of Sale (POS) Department

Magellan Medicaid Administration Inc.
Nevada Medicaid Paper Claims Processing Unit
PO Box C-85042
Richmond, VA 23261-5042
(800) 884-3238

D. Eligibility Verification

Automated Response System (ARS)
Recipient eligibility, recent payments, claim status, prior authorization information, service limit information, and prescriber ID verification via phone.
Telephone: 1-800-942-6511
Electronic Verification System (EVS)
Log onto EVS at https://nevada.fhsc.com/ (then select EVS)

E. State policy inquiries or Fair Hearing requests

Nevada Medicaid Central Office
1100 E William Street, Suite 101

Carson City, NV 89701
(775)684-3600
Website: http://dhcfp.nv.gov
Email: techhelp@dhcfp.nv.gov

F. Nevada Medicaid District Offices and Care Coordination Staff

- Carson City (775) 684-3651
- Elko (775) 753-1191
- Las Vegas (702) 668-4200
- Reno (775) 687-1900

APPENDIX A

NON-COVERED SERVICES

1. Nevada Medicaid's Durable Medical Equipment, Prosthetics, Orthotics, and Disposable Supplies (DMEPOS) program does not cover the following items as they either do not meet the definition of durable medical equipment, prosthetic, orthotic, or disposable medical supplies; or are not considered primarily medical in nature. This list is not all-inclusive and may be revised periodically:

- **Equipment used for physical fitness or personal recreation, such as but not limited to:**
  Bicycles/tricycles
  Electronic devices primarily designed for entertainment
  Exercise equipment
  Hot tubs or Jacuzzis
  Personal computers
  Playground equipment (swings, jungle gyms, tunnels, parachutes, obstacle courses)
  Printers
  Pulse tachometers
  Swimming equipment (such as earplugs)
  Tape recorders
  Tennis/gym shoes
  Video recorders; or

- **Personal care or hygiene products, such as but not limited to:**
  Car Seats
  Dental care supplies (toothbrushes, toothpaste, dental floss and toothettes)
  Disposable gloves (non-sterile and sterile)
  Disposable wipes (includes baby wipes and attends-type wash cloths)
  Enuresis or bed-wetting alarms
  Feeding instruments – tableware and/or baby bottles
  First aid products
  Foam cushion pads
  Food - table foods (with exception of medical foods as defined in Appendix B)
  Glasses (magnifying or reading)
  Heat and massage aids
  Ice packs (disposable)
  Massage devices
  Medical alert bracelets/jewelry
  Menses products
  Scales (bathroom, kitchen, food, or diet)
  Strollers (exception: pediatric wheelchair type classified as a medical device by SADMERC, with a HCPCS code)
  Thermometer covers

- **Household items, such as but not limited to:**
  Air conditioners (includes swamp coolers)
  Appliances (microwave, cutting boards or other adaptive equipment for cooking, cleaning, etc.)
  Food blenders
  Furniture
  High chairs
  Humidifiers or dehumidifiers (room type or central)
  Lift chairs
  Orthopedic mattresses
  Overbed tables
  Safety/Canopy Beds
  Telephones (and related items: answering machines, telephone alert systems, or telephone arms)
  Vaporizers
  Waterbeds; or

- **Household equipment and supplies/Home or Vehicle modification equipment, such as but not limited to:**
  Ceiling fans
  Elevators
  Home security systems
  Intercom monitors
  Medical alert systems
  Motorized lifts for vehicle
  Power door openers
  Ramps or wheelchair ramps
  Stair lifts
  Switches; or

- **Environmental products such as but not limited to:**
  Air filters
  Conditioners
  Hypoallergenic bedding and linens
  Purifiers

2. Nevada Medicaid has the authority to establish reasonable standards, consistent with the objectives of the Medicaid statute, for determining the extent of such coverage (42 U.S.C. § 1396 (a) (17)) based on such criteria as medical necessity or utilization control (42 CFR 440.230 (d)). Nevada Medicaid has an approved list of covered DMEPOS items identifying prior authorization requirements and service limitations. The Provider Type 33 – DMEPOS Fee Schedule is available on the DHCFP website at http://dhcfp.nv.gov/.

   a. Nevada Medicaid is required to have a process and criteria for seeking modifications or exceptions to established coverage policies. This process is available to recipients on a case-by-

case basis for DMEPOS items excluded from the DMEPOS Fee Schedule. Because a provider prescribes, orders, and/or recommends a service or supply does not, of itself, make it an eligible benefit.

b. Consideration will be made on a case-by-case basis using the following criteria:

1. The item must meet the definition of durable medical equipment, prosthetic, orthotic, or disposable medical supply as defined in MSM Chapter 100 and Chapter 1300;

2. The prescribing physician/practitioner must submit supporting documentation identifying the individual's specific medical needs that meet the standard definition of medical necessity as defined in MSM Chapter 100 (e.g. physical assessment indicating the limitations to be ameliorated by the use of the item(s), peer review documentation indicating this is an accepted standard of care within Nevada's medical community); and

3. The prescribing physician/practitioner must document that other items have been used and were found ineffective. The requested item(s) must be the most cost-effective alternative, medically necessary service, provided at the most appropriate level to meet the medical needs of the recipient, that it is reasonable and accessible to the recipient.

For durable medical equipment, prosthetics, orthotics, and supplies where coverage and limitations have not been addressed in this Chapter, or its Appendices, Nevada Medicaid may defer to the Durable Medicaid Equipment Medicare Administrative Contractor (DME MAC) Jurisdiction D, Local Coverage Determinations (LCD) for coverage and limitation criteria. https://www.noridianmedicare.com.

EQUIPMENT	QUALIFICATIONS	FORMS REQUIRED	COMMENTS
RESPIRATORY EQUIPMENT - OXYGEN			
Concentrators Portables Regulators 02 Carts Disposable O2 Supplies Tubing Cannulas O2 Masks Humidifiers	Arterial blood gases or an ear oximetry reporting: 1. PO2 Level of 60 mmHG or less on room air, OR 2. 80 mmHG or less on O2, OR 3. O2 Sat level of 89% or less, AND 4. Medical Necessity 5. Must list conditions of study (rest, sleeping, exercising, room air, on oxygen) CHILDREN: 92% or less room air sat, at rest *Liquid oxygen and related equipment are non-covered Medicaid services unless recipient does not have electrical utilities at residence. Reimbursement will be only for stationary at the same rate of concentrator.*	➢ Oximetry spot check or overnight tape results ➢ Medical documentation supporting qualifying factors ➢ Prescription and/or MD signed PA/CMN Form	Oximetry test must be performed by a physician or qualified laboratory. O2 sats will not be accepted from an oxygen supplier. O2 sats must be performed within 60 days of requested dates of service.

EQUIPMENT	QUALIFICATIONS	FORMS REQUIRED	COMMENTS
RESPIRATORY EQUIPMENT THERAPY			
EO483 High Frequency Chest Wall Oscillation Air- Pulse Generator System (Rental and the initial purchase includes hose and vest) Replacement Items: A7025- High Frequency Chest Wall Oscillation Systems Vest, for the use with recipient owned equipment A7026- High Frequency Chest Wall Oscillation System Hose, for use with recipient owned equipment	FDA-approved high frequency chest compression (HFCC) device (vest coupled to a pneumatic compressor) is a covered benefit for recipients who meet all of the following qualifications: 1. Documented medical justification for the need and length of time the HCFF system will be utilized; and 2. Recipient must have one of the following diagnoses which causes excessive, tenacious secretions and impairs ability to clear secretions: a. Cystic fibrosis, or b. Chronic bronchiectasis, or c. Chronic neuromuscular disorder with prior history of pneumonia or other significant worsening of pulmonary functioning; AND 3. Well-documented failure of other methods, or inability to use other airway clearance therapies including chest physical therapy (CPT), flutter valve, etc. to adequately mobilize retained secretions; and 4. Documentation of physician's treatment plan that includes external manipulation of the thorax at least daily to release retained secretions; and 5. Documented evidence that recipient is having difficulty with secretion clearance, or presence of atelectasis caused by mucus plugging confirmed by high resolution, spiral, or standard CT scan; and 6. Age greater than 2 years; and 7. Recipient and caregiver cannot adequately perform the needed bronchial drainage treatment (such as having more than one child requiring CPT or a valid medical reason that prohibits the CPT). Recipients who have a documented diagnosis, other than those listed under item 2 above, which causes excessive, tenacious secretions and impairs ability to clear secretions may be reviewed on a case by case basis to determine Medical Necessity (e.g. not experimental or investigational). For consideration, the recipient must meet the following qualifications: 1. Recipient meets above qualifications 1 through 7, excluding item 2; and 2. Documented evidence of a recent prior history of pneumonia or other significant worsening pulmonary functioning. Qualification for Continued Use Continued coverage of the HFCC device beyond the three-month trial of therapy requires documentation date no sooner than the 61st day, but not later than 120 days after initiating therapy in one of the following formats: 1. The treating physician submits documentation to include the effectiveness of treatment, recipient's compliance and tolerance of the therapy; or	1. Physician's order/prescription. 2. Completed PA form. 3. Physician's assessment to include the diagnosis for treatment. Clearly defined medical need for airway clearance as evidenced by retained secretions, prior history of pneumonia or other significant worsening pulmonary function, presence of actelectasis caused by mucus plugging by report. 4. Documented failure of CPT, type used, frequency, duration of use and outcomes. 5. Current medications, route of administration, dosage, and frequency. 6. Diagnostic studies such as high resolution, spiral, or standard CT scan. 7. Number of times per day recipient requires CPT. 8. Age of recipient. 9. Identify primary caregiver and the caregiver availability. 10. The prescribing physician will need to submit periodic follow-up reports.	Disease conditions such as: cystic fibrosis (CF), bronchiectasis, and immotile cilia syndrome can lead to abnormal airway clearance which is a source of increased sputum production, often purulent and tenacious; chest physiotherapy (CPT) becomes necessary. In conditions such as CF, excessive tenacious secretions necessitate routine CPT to prevent airway obstruction leading to secondary infection, the principal cause of morbidity and mortality. The standard method of CPT is manual percussion and postural drainage. In the home setting, CPT is administered to the recipient by a trained adult one to three times a day for 20 - 30 minutes per session. FDA approved HFCC (oscillating devices) have been utilized as an alternative to conventional manual chest physical therapy to promote the clearance of respiratory secretions in patients with impaired ability to cough or otherwise expel them on their own. For purchase to be considered a three month trial period on a rental basis is required. After the trial period and receipt of the follow up documentation showing evidence of compliance and effectiveness the HFCC device may be approved for purchase. **Not Medically Necessary** 1. When the criteria in this policy are not met. 2. Recipient receiving duplication of services. Nevada Medicaid will not reimburse for providers for bronchial drainage performed by a therapist or other heath care professional while the recipient has the bronchial drainage vest (i.e., home health services where a physical therapist, nurse, and/or aide is performing CPT and postural drainage).

EQUIPMENT	QUALIFICATIONS	FORMS REQUIRED	COMMENTS
	2. Report via monthly usage meter checks documenting use at least 67% of prescribed frequency.		3. Recipients who has contraindication of external manipulation of the thorax as defined by American Association of Respiratory Care (AARC) contained in their clinical practice guidelines for Postural Drainage Therapy which include, but is not limited to: a. unstable head or neck injury • active hemorrhage with hemodynamic instability • subcutaneous emphysema • spinal fusion or spinal anesthesia • recent skin grafts or flaps on the thorax • burns, open wounds • skin infections of the thorax • recently placed Tran venous pacemaker or subcutaneous pacemaker • suspected pulmonary tuberculosis • lung contusion • bronchospasm • osteomyelitis of the ribs • osteoporosis • coagulopathy • complaint of significant chest wall pain The QIO-like vendor will provide authorization to include the 61st through 120 days if medically necessary.

EQUIPMENT	QUALIFICATIONS	FORMS REQUIRED	COMMENTS
CPAP (E0601)	A single level continuous positive airway pressure (CPAP) device (E0601) is covered if the patient has a diagnosis of obstructive sleep apnea (OSA) documented by an attended, facility-based polysomnogram and meets either of the following criteria (1 or 2): 1. The AHI is ≥ 15 events per hour, or 2. The AHI is from 5 to 14 events per hour with documented symptoms of: a. Excessive daytime sleepiness, impaired cognition, mood disorders, or insomnia, or b. Hypertension, ischemic heart disease, or history of stroke. 3. The AHI must be calculated based on a minimum of 2 hours of recorded sleep and must be calculated using actual recorded hours of sleep (i.e., the AHI may not be an extrapolated or a projected calculation). Continued coverage of an E0601 device beyond the first three months of therapy requires that, no sooner than the 61st day but no later than 120 days after initiating therapy, the supplier ascertain from either the recipient or the treating physician that the recipient is continuing to use the CPAP device. Continued use is defined as an average of 4 hours per 24 hour period. Medicaid has made a form found on the QIO-like vendor's website "Usage Evaluation" available for your use; this can be accessed on the First Health website https://nevada.fhsc.com, select "Provider" tab then "Form". It is not mandatory that this form be used. The supplier can not provide answers to any of the information, as it must be obtained from the recipient, caregiver, spouse, or attending physician. Information should include: 1. Number of hours a day the machine is used. 2. Number of months using machine. 3. Will they continue to use the machine in the future? 4. Identify who has answered the information (can not be the suppler).	➢ Manufacturer's Invoice (purchased equipment) ➢ Sleep Study ➢ Medical documentation supporting qualifying factors. ➢ Prescription and/or MD signed PA/CMN Form	Rental will be for 3 mos. Further approval requires letter of compliance, completed form found on the QIO-like vendor's website from recipient or follow up notes with physician. CPAP will be purchased at that time.
(E0470) BIPAP 'S' w/o back up (E0471) BIPAP 'ST' w/back up rate	For a E0470 or E0471 respiratory assist device to be covered, the treating physician must fully document in the patient's medical record symptoms characteristic of sleep-associated hypoventilation, such as daytime hypersomnolence, excessive fatigue, morning headache, cognitive dysfunction, dyspnea, etc. A respiratory assist device (E0470, E0471) used to administer NPPRA therapy is covered for those patients with clinical disorder groups characterized as (I) restrictive thoracic disorders (i.e., progressive neuromuscular diseases or severe thoracic cage abnormalities), (II) severe chronic obstructive pulmonary disease (COPD), (III) central sleep apnea (CSA), or (IV) obstructive sleep apnea (OSA) (E0470 only) and who also meet the following criteria: 1. Restrictive Thoracic Disorders:	➢ Manufacturer's Invoice (purchased equipment) ➢ Sleep Study ➢ Prescription and/or MD signed PA/CMN Form ➢ Medical documentation supporting qualifying factors	Rental will be for 3 mos. Further approval requires letter of compliance or completed form found on the QIO-like vendor's website and follow up notes with physician. BIPAP will be purchased at that time.

EQUIPMENT	QUALIFICATIONS	FORMS REQUIRED	COMMENTS
(E0470) BIPAP 'S' w/o back up (E0471) BIPAP 'ST' w/back up rate (cont'd)	a. There is documentation in the patient's medical record of a progressive neuromuscular disease (for example, amyotrophic lateral sclerosis) or a severe thoracic cage abnormality (for example, post-thoracoplasty for TB), and b. An arterial blood gas $PaCO_2$, done while awake and breathing the patient's usual FIO_2 is $\geq$ 45 mm Hg, or c. Sleep oximetry demonstrates oxygen saturation $\leq$ 88% for at least five continuous minutes, done while breathing the patient's usual FIO_2 , or, d. For a progressive neuromuscular disease (**only**), maximal inspiratory pressure is < 60 cm H20 or forced vital capacity is < 50% predicted, and e. Chronic obstructive pulmonary disease does not contribute significantly to the patient's pulmonary limitation. If all above criteria are met, either a E0470 or E0471 device (based upon the judgment of the treating physician) will be covered for patients within this group of conditions for the first three months of NPPRA therapy (see below for continued coverage after the initial three months). If all of the above criteria are not met, then E0470 or E0471 and related accessories will be denied as not medically necessary. 2. Severe COPD: a. An arterial blood gas $PaCO_2$, done while awake and breathing the patient's usual FIO_2 , is $\geq$ 52 mm Hg, and b. Sleep oximetry demonstrates oxygen saturation $\leq$ 88% for at least five continuous minutes, done while breathing oxygen at 2 LPM or the patient's usual FIO_2 (whichever is higher), and c. An arterial blood gas $PaCO_2$, done while awake and breathing the patient's usual FIO_2 , is $\geq$ 52 mm Hg, and d. Prior to initiating therapy, OSA (and treatment with CPAP) has been considered and ruled out. If all of the above criteria for patients with COPD are met, a E0470 device will be covered for the first three months of NPPRA therapy (see below for continued coverage after the initial three months). A E0471 device will not be covered for a patient with COPD during the first two months, because therapy with a E0470 device with proper adjustments of the device's settings and patient accommodation to its use will usually result in sufficient improvement without the need of a back-up rate. (See below for coverage of a E0471 device for COPD after 2 month's use of a E0470 device.) If all of the above criteria are not met, E0470 and related accessories will be denied as not medically necessary. If E0471 is billed, even if the criteria for a E0470 device are met, since the E0471 is in a different payment category than E0470 and a least costly medically appropriate alternative payment cannot be made, it will be denied as not medically necessary. 3. Central Sleep Apnea, i.e., apnea not due to airway obstruction: Prior to initiating therapy, a complete facility-based, attended polysomnogram must be performed documenting the following: a. The diagnosis of central sleep apnea (CSA), and b. The exclusion of obstructive sleep apnea (OSA) as the predominant cause of sleep-associated hypoventila-tion, and c. The ruling out of CPAP as effective therapy if OSA is a component of the sleep-associated hypoventilation, and d. Oxygen saturation $\leq$ 88% for at least five continuous minutes, done while breathing the patient's usual FIO_2 , and		

EQUIPMENT	QUALIFICATIONS	FORMS REQUIRED	COMMENTS
(E0470) BIPAP 'S' w/o back up (E0471) BIPAP 'ST' w/back up rate (cont')	e. Significant improvement of the sleep-associated hypoventilation with the use of a E0470 or E0471 device on the settings that will be prescribed for initial use at home, while breathing the patient's usual FIO_2 . If all above criteria are met, either a E0470 or E0471 device (based upon the judgment of the treating physician) will be covered for patients with documented CSA conditions for the first three months of NPPRA therapy (see below for continued coverage after the initial three months). If all of the above criteria are not met, then E0470 or E0471 and related accessories will be denied as not medically necessary. 4. Obstructive Sleep Apnea (OSA): Criteria (A) and (B) are both met: a. A complete facility-based, attended polysomnogram, has established the diagnosis of obstructive sleep apnea according to the following criteria: The apnea-hypopnea index (AHI) is ≥ 15 events per hour, or The AHI is from 5 to 14 events per hour with documented symptoms of: 1. Excessive daytime sleepiness, impaired cognition, mood disorders, or insomnia, or 2. Hypertension, ischemic heart disease, or history of stroke, and b. A single level device (E0601, Continuous Positive Airway Pressure Device, CPAP) has been tried and proven ineffective. If the above criteria is met, a E0470 device will be covered for the first three months of NPPRA therapy (see below for continued coverage after the initial three months). If E0470 is billed and these criteria are not met but the coverage criteria in the DMERC policy for Continuous Positive Airway Pressure System (CPAP) are met, payment will be based on the allowance for the least costly medically appropriate alternative, E0601. A E0471 device is not medically necessary if the primary diagnosis is OSA. If E0471 is billed, since the E0471 is in a different payment category than E0470 and E0601 and a least costly medically appropriate alternative payment cannot be made, it will be denied as not medically necessary. **Continued Coverage For E0470 And E0471 Devices Beyond First Three Months Of Therapy:** Patients covered for the first 3 months of a E0470 or E0471 device must be re-evaluated to establish the medical necessity of continued coverage beyond the first three months. While the patient may certainly need to be evaluated at earlier intervals after this therapy is initiated, the re-evaluation upon which will base a decision to continue coverage beyond this time must occur no sooner than 61 days after initiating therapy by the treating physician. Medicaid will not continue coverage for the 4th and succeeding months of NPPRA therapy until this re-evaluation has been completed. There must be documentation in the patient's medical record about the progress of relevant symptoms and patient usage of the device up to that time. Failure of the patient to be consistently using the E0470 or E0471 device for an average of 4 hours per 24 hour period by the time of the re-evaluation (on or after 61 days, but no later than 120 days, after initiation of therapy) would represent non-compliant utilization for the intended purposes and expectations of benefit of this therapy. This would constitute reason for Medicaid to deny continued coverage as not medically necessary. The following items of documentation must be obtained by the supplier of the device for continuation of coverage beyond three months:		

EQUIPMENT	QUALIFICATIONS	FORMS REQUIRED	COMMENTS
(E0470) BIPAP 'S' w/o back up (E0471) BIPAP 'ST' w/back up rate (cont')	1. a signed and dated statement completed by the treating physician no sooner than 61 days after initiating use of the device, declaring that the patient is compliantly using the device (an average of 4 hours per 24 hour period) and that the patient is benefiting from its use. Medicaid has made a form found on the QIO-like vendor's website "Usage Evaluation" available for your use; this can be accessed on the First Health website https://nevada.fhsc.com, select "Provider" tab then "form". It is not mandatory that this form be used as long as the above information is provided by the treating physician. If the above criteria are not met, continued coverage of a E0470 or E0471 device and related accessories will be denied as not medically necessary. For Group II patients (COPD) who qualified for a E0470 device, if at a time no sooner than 61 days after initial issue and compliant use of a E0470 device, the treating physician believes the patient requires a E0471 device, the E0471 device will be covered if the following criteria are met: a. an arterial blood gas $PaCO_2$, repeated no sooner than 61 days after initiation of compliant use of the E0470, done while awake and breathing the patient's usual FIO_2 , still remains $\geq$ 52 mm Hg, and b. a sleep oximetry, repeated no sooner than 61 days after initiation of compliant use of a E0470 device, and while breathing with the E0470 device, demonstrates oxygen saturation $\leq$ 88% for at least five continuous minutes, done while breathing oxygen at 2 LPM or the patient's usual FIO_2 [whichever is higher], and c. a signed and dated statement from the treating physician, completed no sooner than 61 days after initiation of the E0470 device, declaring that the patient has been compliantly using the E0470 device (an average of 4 hours per 24 hour period) but that the patient is NOT benefiting from its use. If the above criteria for a E0471 are not met, since the E0471 is in a different payment category than E0470 and a least costly medically appropriate alternative payment cannot be made, it will be denied as not medically necessary.		
Humidifiers & Supplies	1) Medical evidence/documentation patient is a new start or compliant with current positive airway pressure therapy. 2) Sleep study or equipment fitting documentation showing recommended type and sizing. 3) Quantity limited to reimbursable guidelines.	➢ Medical documentation supporting qualifying factors. ➢ Prescription and/or MD signed PA Form	Reference fee schedule for quantity limits.
Ventilators	Medical evidence/documentation supporting a related diagnosis for equipment (i.e. tracheostomy)	➢ Manufacturer's Invoice ➢ Prescription and/or MD signed PA Form	Medical Supplier must keep back up available for emergent situations for rented equipment.
Respirometers	Medical evidence/documentation supporting a related diagnosis for equipment		
Nebulizers and compressors	A small volume nebulizer (A7003, A7004, A7005) and related compressor (E0570, E0571) are covered when: a. It is medically necessary to administer beta-adrenergics, anticholinergics, corticosteroids, and cromolyn for the management of obstructive pulmonary disease (ICD-9 diagnosis codes 491.0 - 505), or b. It is medically necessary to administer gentamicin, tobramycin, amikacin, or dornase alfa to a patient with cystic fibrosis (ICD-9 diagnosis code 277.00) or	➢ Medical documentation supporting qualifying factors. 1) Prescription and/or MD signed PA Form	Reference fee schedule for quantity limits.

EQUIPMENT	QUALIFICATIONS	FORMS REQUIRED	COMMENTS
Nebulizers and compressors (cont'd)	c. It is medically necessary to administer pentamidine to patients with HIV (ICD-9 diagnosis code 042), pneumocystosis (ICD-9 diagnosis code 136.3), and complications of organ transplants (ICD-9 diagnosis codes 996.8-996.89), or d. It is medically necessary to administer mucolytics (other than dornase alpha) for persistent thick or tenacious pulmonary secretions (ICD-9 diagnosis codes 480.0-505, and 786.4). For criterion (a) to be met, the physician must have considered use of a metered dose inhaler (MDI) with and without a reservoir or spacer device and decided that, for medical reasons, it was not sufficient for the administration of needed inhalation drugs. The reason for requiring a small volume nebulizer and related compressor/generator instead of or in addition to an MDI must be documented in the patient's medical record and be available to Medicaid on request. A large volume nebulizer (A7017), related compressor (E0565 or E0572), and water or saline (K0182 or K0529) are covered when it is medically necessary to deliver humidity to a patient with thick, tenacious secretions, who has cystic fibrosis (ICD-9 diagnosis code 277.00), bronchiectasis (ICD-9 diagnosis code 494 or 748.61), a tracheostomy (ICD-9 diagnosis code V44.0 or V55.0), a tracheobronchial stent (ICD-9 diagnosis code 519.1). Combination code E0585 will be covered for the same indications. An E0565 or E0572 compressor and filtered nebulizer (A7006) are also covered when it is medically necessary to administer pentamidine to patients with HIV (ICD-9 diagnosis code 042). If a large volume nebulizer, related compressor/generator, and water or saline are used predominantly to provide room humidification it will be denied as noncovered. Small volume ultrasonic nebulizer (E0574), large volume ultrasonic nebulizer (E0575) and battery powered compressor (E0571) will be reimbursed at the least costly alternative of a pneumatic compressor (E0570).		
Apnea Monitor	An Apnea Monitor is a non-reimbursable service in conjunction with an E0454 pressure ventilator, with pressure control pressure support, and flow triggering features. 1 year qualification for at least one of: • 765.0-1 prematurity (gestational age must be listed on HCFA 1500) • 764.0-9 substantially small for gestational age • 760.71 HX of maternal alcohol abuse • 760.72 HX of maternal narcotics abuse • 760.73 HX of maternal hallucinogenic agent abuse 6 month qualification for at least one of: • 530.1 Gastro-esophageal reflux • 786.09 Abnormal pneumogram indicating desaturating apnea • 799.0 Periodic respirations • 727.9 Significant bradycardia or tachycardia of unknown or specified origin • 746.9 Congenital heart defect • 770.7 Broncho-pulmonary dysplasia or newborn respiratory distress • 770.8 Respiratory distress • 798.0 Family history of SIDS (siblings only) • 480.1 Respiratory Syncytial Virus (RSV) • 770.8 Apparent Life Threatening Episode (ALTE) with subsequent visits of physician or emergency room	➢ Medical documentation supporting qualifying factors. ➢ Prescription	➢ Program limit to one year for dx including prematurity and maternal substance abuse. ➢ Other dx limited to 6 months. ➢ Beyond stated time limit requires PA, with medical justification. ➢ Original PA not required for ICD9 codes listed under qualifications. Other dx require PA. ➢ Reference fee schedule for quantity limits.

EQUIPMENT	QUALIFICATIONS	FORMS REQUIRED	COMMENTS
Apnea Monitor (cont'd)	• 478.74 Laryngeotracheal malacia • 748.3 Tracheal stenosis • 787.2 Swallowing abnormality		
Suction Pumps	Patients who have difficulty raising and clearing secretions due to : • Cancer or surgery of the throat or mouth, or • Dysfunction of the swallowing muscles, or • Unconsciousness or abrtunded state, or • Tracheostomy (V44.0)	➢ Medical documentation supporting qualifying factors. ➢ Prescription and/or MD signed PA Form	Reference fee schedule for quantity limits.
BATHING EQUIPMENT			
Commodes-standard Commode pail Toilet Safety Frame-(versaframe) Raised Toilet Seat Bed Pan-plastic Urinal	1. Medical evidence/documentation patient is physically incapable of utilizing regular toilet facilities and 2. has a supporting diagnosis.	➢ Prescription for billing	
Shower Chairs w/back & w/o back Tub Transfer Bench Padded and Non-padded	1. Patient shows medical evidence/documentation of incapability to utilize regular bathing facilities, and 2. Has a supporting diagnosis.	➢ Prescription for billing	
BEDS & OVERLAYS			
Manual Beds Semi-Electric Beds Full-Electric Beds	Medical evidence/documentation showing: 1. Patient requires positioning of the body in ways not feasible with an ordinary bed due to a medical condition lasting at least one month, or 2. Alleviation of pain due to positioning of the body, or 3. Elevation of the head more than 30 degrees due to CHF, or 4. Requires frequent or immediate change in positioning.	➢ Medical documentation supporting qualifying factors. ➢ Prescription and/or MD signed PA Form.	
Trapeze Bars	Medical evidence/documentation patient needs assistance to sit up due to respiratory conditions, change body positions, or to assist in transfers in/out of bed.	➢ Medical documentation supporting qualifying factors. ➢ Prescription and/or MD signed PA Form.	
Lifts and Lift Slings	1. Medical evidence/documentation showing the patient requires more than one person in assisting in transfers form bed/bath, bed/commode, bed/chair. 2. Must have an environment able to accommodate equipment. 3. Capable caregiver to assist with transfers.	➢ Medical documentation supporting qualifying factors. ➢ Prescription and/or MD signed PA Form.	

Group 1 Support Surfaces	Pt must meet the following criteria: 1) Completely immobile (pt cant make changes in body position without assistance) OR 2) Limited mobility (pt cant independently make changes in body position significant enough to alleviate pressure) Or Any stage pressure ulcer on the trunk or pelvis, and a) At least one of the following: i) Impaired nutritional status ii) Fecal or urinary incontinence iii) Altered sensory perception iv) Compromised circulatory status 3) AND patient does not bottom out		
Pressure pad for mattress-non-powered pressure reducing mattress overlays	(E0185) Gel/gel-like mattress overlay, with gel layer 2 inches or greater (E0197) Air mattress overlay interconnected air cells having a cell height of 3 inches or greater that are inflated with an air pump. (E0198) Water mattress overlay with a filled height of 3 inches or greater. (E0199) Foam mattress overlay with base thickness of 2" or greater and a peak height of 3" or greater if it is a convulted overlay (eggcrate) or an overall height of at least 3 inches if is a non-convoluted overlay. Foam with a density and other qualities that provide adequate pressure reduction, and durable waterproof cover. **1) Patient must meet group 1 support surfaces criteria for qualification.**	➢ Medical documentation supporting qualifying factors. ➢ Prescription and/or MD signed PA Form.	

EQUIPMENT	QUALIFICATIONS	FORMS REQUIRED	COMMENTS
Non-powered pressure reducing mattresses	(E0184) Foam height of 5 inches or greater, and foam with a density and other qualities that provide adequate pressure reduction, and can be placed directly on a hospital bed frame (E0186, E0187, E0196) Air water or gel mattress, height of 5 inches or greater of the air, water, or gel layer (respectively), and durable, waterproof cover, and can be placed directly ona hospital bed frame. 1) **Patient must meet group 1 support surfaces criteria for qualification.**	➢ Medical documentation supporting qualifying factors. ➢ Prescription and/or MD signed PA Form.	
Powered pressure reducing mattress overlay systems	(E0180, E0181, E0182, A4640) Alternating pressure or low air loss systems; Air pump or blower which provides either sequential inflation and deflation of air cells or a low interface pressure throughout the overlay, and inflated cell height of the air cells through which air is being circulated is 2.5 inches or greater, and height of the air chambers, proximity of the air chambers to one another, frequency of air cycling (for app overlays) and air pressure provide adequate patient lift, reduce pressure and prevent bottoming out. 1. **Patient must meet group 1 support surfaces criteria for qualification.**	➢ Medical documentation supporting qualifying factors. ➢ Prescription and/or MD signed PA Form.	
Group 2 Support Surfaces	Patient must meet the following criteria: 1) Multiple stage II pressure ulcers located on the trunk or pelvis, and 2) Patient has been on a comprehensive ulcer treatment program for at least the past month which has included the use of an appropriate group 1 support surface a) Treatment includes patient/caregiver education, regular assessment by a licensed healthcare practioner, appropriate turning and positioning, appropriate wound care, appropriate management of moisture/incontenence, nurtitional assessment and intervention consistent with the overall plan of care. And, 3) Ulcers have worsened or remained the same over the past month. OR 1) Large or mulitple stage III or IV pressure ulcer(s) on the trunk or pelvis. OR 1) Recent myocutaneous flap or skin graft for a pressure ulcer on the trunk or pelvis (surgery within the past 60 days), and 2) Patient has been on a group 2 or 3 support surface immediately prior to a recent discharge from a hospital or nursing facility (discharge within the past 30 days)	➢ Medical documentation supporting qualifying factors. ➢ Prescription and/or MD signed PA Form.	
Powered pressure reducing mattress	(E0277) An air pump or blower which provides either sequential inflation and deflation of the air cells or a low interface pressure throughout the mattress, inflated cell height of the air cells through which air is being circulated is 5 inches or greater, and height of the air chambers, proximity of the air chambers to one another, frequency of air cycling (for alternating pressure mattresses), and air pressure provide adequate patient lift, reduce pressure and prevent bottoming out, and surface designed to reduce friction and shear, can be placed directly on a hospital bed frame. (E0193) Describes a semi-electric or total electric hospital bed with a fully integrated powered pressure reducing mattress which has all the characteristics defined above. **1) Patient must meet criteria for Group 2 support surfaces.**	➢ Medical documentation supporting qualifying factors. ➢ Prescription and/or MD signed PA Form.	
Non-powered pressure reducing mattress overlay	(E0371) Height and design of individual cells which provide significantly more pressure reduction than a group 1 overlay and prevent bottoming out, and total height of 3 inches or greater, and surface designed to reduce friction and shear, and documented evidence to substantiate that the product is effective for the treatment of conditions described by the coverage criteria for group 2 surfaces. **1) Patient must meet criteria for Group 2 support surfaces.**	➢ Medical documentation supporting qualifying factors. ➢ Prescription and/or MD signed PA Form.	
Powered pressure reducing mattress overlay	(E0372 (low air loss, powered floatation without low air loss, or alternating pressure) which is characterized by all of the following: Air pump or blower which provides either sequential inflation and deflation of the air cells or a low interface pressure throughout the overlay, and inflated cell height of the air cells through which air is being circulated is 3.5 inches or greater, and height of the air chambers, proximity of the air chambers to one another, frequency of air	➢ Medical documentation supporting qualifying factors.	

EQUIPMENT	QUALIFICATIONS	FORMS REQUIRED	COMMENTS
Powered pressure reducing mattress overlay (cont'd)	cycling (for alternating pressure overlays), and air pressure to provide adequate patient lift, reduce pressure and prevent bottoming out, and surface designed to reduce friction and shear. **1) Patient must meet criteria for Group 2 support surfaces.**	➢ Prescription and/or MD signed PA Form.	
Advanced Non-powered pressure reducing mattress	(E0373) Height and design of individual cells which provide significantly more pressure reduction than a group 1 mattress and prevent bottoming out, and total height of 5 inches or greater, and surface designed to reduce friction and shear, and documented evidence to substantiate that the product is effective for the treatment of conditions described by the coverage criteria for group 2 support surfaces, and can be placed directly on a hospital bed frame. **1. Patient must meet criteria for Group 2 support surfaces.**	➢ Medical documentation supporting qualifying factors. ➢ Prescription and/or MD signed PA Form.	
Group 3 Air-fluidized Bed	(E0194) Device employing the circulation of filtered air through silicone coated ceramic beads creating the characteristics of fluid. 1) Patient has a stage III (full thickness tissue loss) or stage IV (deep tissue destruction) pressure sore, and 2) Is bedridden or chair bound as a result of severely limited mobility, and 3) In the absence of an air fluidized bed, the patient would require institutionalization, and 4) Ordered in writing by patient's attending physician after comprehensive assessment and evaluation after completion of conservative treatment. Evaluation performed within one month prior to indication of therapy with air fluidized bed. a) Conservative treatment must have been at least one month in duration without progression toward wound healing. Treatment should include: b) Frequent repositioning of patient (usually every 2 hours) c) Use of group 2 support surface d) Necessary treatment to resolve any wound infection, and e) Optimization of nutrition status to promote wound healing, and f) Debridement by any means, including wet-to-dry gauze dressings, to remove devitalized tissue from the wound bed; and g) Maintenance of a clean, moist bed of granulation tissue with appropriate moist dressings protected by an occlusive covering, while the wound heals, and h) Education of the patient and caregiver on the prevention and management of pressure ulcers, and i) Assessment by a physician, nurse, or other licensed healthcare practitioner at least weekly, and j) Appropriate management of moisture/incontinence. 5) Trained adult caregiver is available to assist the patient with ADL's, fluid balance, dry skin care, repositioning, recognition and management of altered mental status, dietary needs, prescribed treatments, and management and support of the air-fluidized bed system and its problems such as leakage. 6) A physician directs the home treatment regimen, and reevaluates and recertifies the need for the air-fluidized bed on a monthly basis. All other equipment has been considered and ruled out.	➢ Medical documentation supporting qualifying factors. ➢ Prescription and/or MD signed PA Form.	
OTHER			
Home Uterine Activity Monitor	1) Patient has a current diagnosis of pre-term labor and a history of previous pre-term labor/delivery w/ pregnancies. 2) Records from physician showing pre-term labor w/uterine contractions of four or more per hour and progressive cervical changes. 3) Cervical dilation is less than four centimeters 4) Patient is ordered o bedrest or restricted activities 5) Tocolytic therapy initiated (oral, subq, IV route)	➢ Medical documentation supporting qualifying factors. ➢ PA submitted more than ten (10) days after onset of service may be denied.	Reimbursement only for days of documented telephone contact between patient and monitoring device.

Home Uterine Activity Monitor (cont'd)	6) Documentation will show there is an increase in physician/patient contact due to pre-term labor symptoms. 7) The patient is, in the opinion of the physician capable of complying with the home monitoring program. 8) Patient is not less than 24 weeks gestation or more than 37 weeks gestation.	➢ Medical documentation supporting qualifying factors. ➢ PA submitted more than ten (10) days after onset of service may be denied. ➢ Prescription and/or MD signed PA Form.	Reimbursement only for days of documented telephone contact between patient and monitoring device.
Phototherapy Unit	Bilirubin levels must be at or greater than 12.0 with bilirubin therapy on initial day of treatment. Authorization is for max of 3 days.	➢ Medical Documentation supporting qualifying factors. ➢ Prescription and/or MD signed PA Form.	
Pneumatic compression devices (used for lymphedema)	1) One or more limbs involved, and 2) Radical surgical procedure with removal of regional groups of lymph nodes (after radical mastectomy) or, 3) Post radiation fibrosis, or 4) Spread of malignant tumors to regional lymph nodes with lymphatic obstruction, or 5) Scarring of lymphatic channels, or 6) Onset of puberty (Milroy's disease) or 7) Congenital anomalies, and 8) Must be treatment of last resort with documented evidence elevation and custom fabricated gradient pressure stockings or sleeves are ineffective, and 9) Continuous oversight by treating physician (including instruction, treatment plan, fracture and duration of use ongoing monitoring and evaluation).	➢ Medical documentation supporting qualifying factors. ➢ Prescription and/or MD signed PA Form.	
Osteogenesis Stimulator	Non-spinal noninvasive electrical osteogenesis stimulator may be covered if; 1) None union of a long bone fracture after six months have elapsed without healing of the fracture, or 2) Failed fusion of a joint, other than in the spine, where a minimum of nine months have elapsed since the last surgery, or 3) Congenital pseudarthrosis *Ultrasonic osteogenic stimulators are non-covered Medicaid services.*	➢ Medical documentation supporting qualifying factors. ➢ Prescription and/or MD signed PA Form.	Rental for 20-week intervals, additional auth will be considered with medical justification.
Osteogenesis Stimulator	Spinal noninvasive electrical osteogenesis stimulator may be covered if: 1) Failed spinal fusion where a minimum of nine months have elapsed since the last surgery, or 2) Following a multilevel spinal fusion surgery involving three or more vertebrae, or 3) Following spinal fusion surgery where there is a history of a previously failed spinal fusion. *Ultrasonic osteogenic stimulators are non-covered Medicaid services.*	➢ Medical documentation supporting qualifying factors. ➢ Prescription and/or MD signed PA Form.	Rental for 20-week intervals, additional auth will be considered with medical justification.

EQUIPMENT	QUALIFICATIONS	FORMS REQUIRED	COMMENTS
Oximeter rental: E0445-**RR** device for measuring blood oxygen levels, non-invasively **Accessories** A4606-Oxygen probe for use with oximeter device, replacement	Nevada Medicaid covers short-term[1] and long-term[2] Pulse Oximetry in the home as medically necessary when one of the following criteria is met under the appropriate corresponding age requirements: **Any age determination:** 1. Recipient is dependent on both a ventilator and supplemental oxygen; or 2. Recipient has a tracheostomy and is oxygen dependent; or 3. Recipient is on supplemental oxygen and weaning is in process: or **A pediatric recipient must meet one of the following criteria**: 1. infants with chronic lung disorder (e.g. bronchopulmonary dysplasia); or 2. premature infant on active therapy for apnea; [1] less than 30 days [2] greater than 30 days	a. Prior authorization (PA); and b. Prescription by physician; and c. Documentation of recipient's medical condition, which documents the need for in-home use of an oximeter, duration of use, plans for training/instructions of family, caregiver, and/or recipient responses for decreased O_2 by the physician; and **Recertification of PA:** 1. Recertification is required until the recipient no longer meets criteria or the device is removed from the home; and Physician progress notes/narratives to substantiate the continued need to use oximeter to include family, recipient and/or caregivers responses to decreased O_2 Saturation.	Approval of Oximeter will be on a rental basis only purchase of equipment is non-reimbursable. **Oximeter testing is not a reimbursable service for DME providers.** Initial approval may be for 30 days; unless Initial documentation supports long term use then approval will be up to six months. Approval for PA recertification request will be for up to 6 months.

EQUIPMENT	QUALIFICATIONS	FORMS REQUIRED	COMMENTS
E0784 External Ambulatory Infusion Pump, Insulin	Covered ICD-9 codes 250-250.93 Diabetes Mellitus 648.0 Diabetes Mellitus 648.8 Gestational Diabetes All of the following conditions must be met: 1. Fasting serum C-peptide level that is less than or equal to 110% of the lower limit of normal of the laboratory's measurement method or as an alternative must be beta cell autoantibody positive. 2. Recipient has completed a comprehensive diabetic education program within the last year. 3. Recipient is motivated to achieve and maintain improved glycemic control. 4. Recipient has been on a program of multiple daily injections of insulin (i.e. at least 3 injections per day), with frequent self-adjustments of insulin doses for at least 6 months prior to request of the insulin pump. 5. Documented frequency of glucose self-testing is an average of at least 4 times per day during the 2 months prior to starting the insulin pump. 6. Glycosylated hemoglobin level (HbA1C) > 7.0% **In addition, one or more of the following indications must be present**: 1. History of recurring hypoglycemic; or 2. Wide fluctuations in blood glucose before mealtime (e.g. preprandial blood glucose level commonly exceeds 140 mg/dl; or 3. Dawn phenomenon with fasting blood sugars frequently >200 ml/dl; or 4. Extreme insulin sensitivity; or 5. Gestational diabetes Recipients with Gestational diabetes or when pregnancy occurs or is anticipated within 3 months in a previously diagnosed diabetic with **ANY** of the following indications: • Erratic blood sugars in spite of maximal patient compliance and split dosing; or • Other evidence that adequate control is not being achieved. **Qualifications for recipients on the external ambulatory infusion pump prior to Medicaid eligibility:** • Current Glycosylated hemoglobin level (HbA1C) • Recipient has been compliant with using the insulin pump and has the ability of self-adjusting the insulin pump according to glucose levels.	Prior authorization is required for the insulin pump with all of the following documentation: 1. A prescription from a physician who manages patients with insulin pumps and who works closely with a team including nurses, diabetes educators, and dietitians. 2. Certification of Diabetic Education Class with first time request. 3. Signed statement from the physician acknowledging medical necessity and the following: a. Recipient is motivated to achieve and maintain improved glycolic control, indicated by showing documented finger sticks (at least 4x/day) with multiple injections. b. Recipient has been on a program of multiple injections of insulin (at least 3x/day) with frequent self-adjustment of insulin doses at least 6 months prior to initiation of the insulin pump. c. Cognitive ability to operate pump and calculate insulin dosages. 4. Qualifying lab results per qualifications. 5. Physician current history and physical including one or more of the additional indications listed in the	External ambulatory infusion pump recipient with Gestational Diabetes whom do not meet conditions 1 through 6 but do meet qualifications under Gestatioanal Diabetes approval of the insulin pump will be on a rental basis until the end of the pregnancy. Diabetic Supplies through the DME program E0784-External Ambulatory Infusion pump, Insulin A4230-Infusion set for external pump, nonneedle cannula type A4231-Infusion set for external pump, needle type A4232-Syringe with needle for external insulin pump, sterile, 3cc Diabetic shoes, fitting, and Modification A5500 – A5513 Diabetic Supplies reimbursed through POS-Pharmacy Program Glucometers Test strips Lancet Device and lancets Insulin syringes for self-injection

		qualification column. Documentation requirements for recipients using the insulin pump prior to Medicaid eligibility: 1. Requires a PA with the following documentation: a. A current HbA1C level b. Signed narrative from the physician documenting the recipients' compliance and ability to self adjust the insulin pump according to glucose levels.	
Diabetic Equipment and Supplies			Diabetic equipment and supplies, such as Glucometers, Test strips, Lancet Device and Lancets, Insulin syringes for self-injection are not covered under Nevada Medicaid's DME program. These supplies are covered under Nevada Medicaid's pharmacy program and must be billed through the Point of Sale (POS). Refer to Chapter 1200, Pharmacy Services.

S9435 Medical foods for inborn errors of metabolism	Authorization of "Medical foods" will be considered for recipients under the age of 21 years as an Early and Periodic Screening, Diagnosis and Treatment Service (EPSTD) with a diagnosis of an inherited metabolic disease in which treatments are restricted and monitored diet consisting of specially formulated low-protein foods and are an established standard of care. The following inherited metabolic conditions fit the category but, are not limited to: Phenylketonuria (PKU) ICD-9 270.1 Homocystinuria ICD-9 270.4 Maple Syrup Urine Disease ICD-9 270.3 Definitions and qualifications: 1. Medical foods refer to products designed for the specific nutrition management of a disease or condition for which distinctive nutrition requirements based on recognized scientific principles are established by medical evaluation. 2. "Inherited metabolic disease" means a disease caused by an inherited abnormality of body chemistry for which testing is mandated by law. 3. Medical foods are products specially formulated or modified to have less than one gram of protein per serving. This does not include a food that is naturally low in protein. 4. Medical food is prescribed by and consumed under the direction of a physician for the dietary treatment of a qualifying metabolic disease. 5. The recipient is currently receiving comprehensive nutrition services by a physician and dietician for the dietary treatment of a qualifying metabolic disease. 6. Medical foods specifically used to meet the distinctive nutritional requirements of a qualifying metabolic disorder and not generally used by persons in the absence of a qualifying metabolic disorder. 7. Medical foods should be requested as part of an EPSDT supplement service. Medical foods are not food products readily available in the grocery stores and health food stores. For example, a child with diabetes could find a variety of foods in the grocery store to meet the child's nutritional requirements without specially formulated medical foods. 8. Approval will be limited to $2,500.00 per year unless proof of medical necessity exceeds that amount.	1. A prescription signed by the requesting physician specializing in the treatment of metabolic conditions for requested "medical foods"; and 2. A completed prior authorization form that includes; a. types of medical food (i.e., LP baking mix); and b. product line company names and product code numbers; and c. total amount (units or case) of each medical food; and d. number of servings for each product unit (number of servings per box, can or case); and e. cost per unit or case for each medical food product; and f. total cost of all products submitted; and g. Dates and duration of request 3. History and physical examination and current evaluation (within the last 6 months) which includes all existing diagnoses and medical conditions from the physician specializing in the treatment of metabolic conditions or an appropriate specialist. Documentation must include test results used in establishing the diagnosis and any other pertinent medical data/reports to justify products being requested; and	Medical foods will be approved after review of submitted documentation if found to meet the following conditions: a. Documentation supports dietary treatment of the metabolic disease or conditions mentioned in this policy for which nutritional requirements are established by medical evaluation, but does not include a natural food that is naturally low in protein; and b. Submitted supporting documentation is found to support I inherited metabolic diagnosis; and b. Approved time-frame will be for a maximum of six-months and the servicing provider can only be a Medicaid pharmacy or DME provider. Grocery stores, health food stores, and/or retail vendors <u>may not</u> be authorized as providers for medical foods.

		4. A copy of the nutritional assessment and treatment plan by a registered dietitian and/or physician specializing in nutritional assessment and treatment of metabolic conditions; and including a. Daily number of phenylalanine exchange or total protein intake for disorders requiring a protein restriction. Snack foods do not exceed 10% of total cost of foods requested; and b. Documentation that the medical food is specially formulated and necessary for specific dietary management of the metabolic disorder.	

EQUIPMENT	QUALIFICATIONS	FORMS/DOCUMENTATION REQUIRED	COMMENTS
Mobility Assistive Equipment (MAE)			
General Information ***(pertains to all items in this policy section)***	***The qualifications identified in this "general information" section must all be met for any items included in this policy section. Each specific item may also have additional qualifications listed below that must be met. Items may be covered if all of the following qualifications are met:*** 1. The recipient has a mobility limitation that significantly impairs his/her ability to participate in one or more Mobility-Related Activities of Daily Living (MRADL) performed in the home and in each of the environments the recipient is likely to encounter in their daily routines, such as but not limited to: attending school, work, and shopping. The MRADLs to be considered in this and all other statements in this policy are: toileting, grooming, bathing, dressing, eating, and transferring. **Note:** A mobility limitation is one that: a. Prevents the recipient from accomplishing the MRADL entirely; ***or*** b. Places the recipient at reasonably determined heightened risk of morbidity or mortality secondary to the attempts to perform an MRADL; ***or*** c. Prevents the recipient from completing the mobility-related activities of daily living within a reasonable time frame. 2. All required assessments, evaluations, and physician/ practitioner's orders as indicated throughout this section were completed within the required time limits.	***The forms and specifications as described in this "general information" section pertain to all MAE items. Refer to the Documentation section and/or the PA section in Chapter 1300 for detailed requirements for each type of form. Additional completion requirements are found in the Form Release Memorandums/Instructions for the Division's forms at*** https://nevada.fhsc.com/providers/forms/forms.asp ***Each specific item may also have additional form requirements and specifications listed below that must be met.*** 1. Order / Prescription 2. Prior Authorization, form found on the QIO-like vendor's website (when indicated) refer to the DMEPOS Fee Schedule to determine need for a prior authorization for each item. 3. Detailed Product Description 4. Proof of Delivery 5. Additional Miscellaneous Medical Records	***Refer to the main body of Chapter 1300 for general DMEPOS policies. The comments/policy statements identified in this "general information" section pertain to all MAE items.*** 1. For all MAE items, documentation must support all criteria in the Qualifications section, as specified in each category. 2. All rented mobility devices are to be considered purchased by Nevada Medicaid once the purchase price is reached. 3. Providers must submit PA and claim with the most appropriate HCPCS code and may not unbundle items included in the HCPCS code description. 4. Inclusion of a HCPCS code in this policy section is not an indication of coverage. Refer to the DMEPOS Fee Schedule. 5. The recipient must have a medical need within the home for the requested item. In addition, consideration will include: recipient's medical needs, use of the item, and the conditions in each of the environments the recipient is likely to encounter in their daily routines, such as, but not limited to: attending school, work, and shopping. This information must be included in the supportive documentation submitted with the PA.

EQUIPMENT	QUALIFICATIONS	FORMS/DOCUMENTATION REQUIRED	COMMENTS
Mobility Assistive Equipment (MAE)			
CANES AND CRUTCHES **CANE ACCESSORIES** **CRUTCH ACCESSORIES**	1. In addition to the General Information Qualification section above, canes and crutches may be covered if the recipient: a. has a medical condition causing impaired ambulation and there is a potential for ambulation; ***and*** b. is able to safely use the cane or crutches; ***and*** c. the functional mobility deficit can be sufficiently resolved by use of the item.	From the General Information Forms section above, numbers 1, 3, and 4.	All from General Information Comments section; ***and*** 1. Cane and/or crutch accessory items may be provided as replacement items for recipient-owned MAE. When the cane or crutch HCPCS description includes the accessory item, these items cannot be billed separately with the initial purchase.
CRUTCH SUBSTITUTE, LOWER LEG PLATFORM, WITH OR WITHOUT WHEELS (E0118)	1. In addition to the General Information Qualification section above, a crutch substitute may be covered if: a. the recipient has a below-the-knee injury and/or surgery causing impaired ambulation and there is a potential for ambulation; ***and*** b. the recipient is medically unable to safely use a cane(s), crutches, a walker, or a wheelchair; ***and*** c. the recipient's functional mobility deficit can be sufficiently resolved by use of the item; ***and*** d. the recipient or care giver is not requesting the device for convenience.	All from General Information Forms section above; ***and*** 1. The additional medical documentation by the prescribing physician/practitioner, submitted with the PA, must indicate why the recipient is not able to use an alternative, more cost effective mobility device, such as: cane(s), crutches, walker, or a wheelchair.	
WALKERS **WALKER ACCESSORIES**	1. In addition to the General Information Qualification section above, a **standard** walker may be covered if the recipient: a. is *unable* to safely use appropriately fitted canes or crutches to resolve functional mobility deficits; ***and*** b. is *able* to safely use the walker; ***and*** c. the functional mobility deficit can be sufficiently resolved with use of a walker. 2. In addition to #1 and #2 in the General Information Qualification section above and #1 of this section, a **heavy duty** walker may be covered if the recipient's weight is greater than 300 pounds.	From the General Information Forms section above, numbers 1, 3, and 4, plus 1. A heavy duty walker requires a PA to verify weight.	All from General Information Comments section; ***and*** 1. Walker accessory items may be provided as replacement items for recipient-owned MAE. When the walker HCPCS description includes the accessory item, these items cannot be billed separately with the initial purchase.

EQUIPMENT	QUALIFICATIONS	FORMS/DOCUMENTATION REQUIRED	COMMENTS
Mobility Assistive Equipment (MAE)			
WHEELCHAIRS *(pertains to all wheelchair types – manual and power)*	1. In addition to the General Information Qualification section above, a wheelchair may be covered if the recipient's mobility limitation cannot be sufficiently resolved by the use of an appropriately fitted cane(s), crutches, or a walker; ***and*** 2. The recipient meets the specific qualifications listed below for the type of wheelchair being requested.	All from General Information section above; ***and*** 1. Mobility Assessment, form found on the QIO-like vendor's website (refer to detailed requirements in Form Instructions at https://nevada.fhsc.com/providers/forms/forms.asp and in the main Chapter 1300 section.	All from General Information section; ***and*** 1. The recipient must have a medical need for, and the requested item must be suitable for use in the home, in accordance with 42 CFR 440.70(b)(3). Consideration for prior authorization is also based on the recipient's additional use of the item for the conditions in each of the environments the recipient is likely to encounter in their daily routines. 2. Medicaid allows only one wheelchair at a time. Backup chairs are denied as not medically necessary. 3. For all Medicare/Medicaid dual eligible recipients, Medicaid is payer of last resort. Therefore, any MAE that qualifies as an Advanced Determination of Medicare Coverage (ADMC) item must be submitted to Medicare prior to requesting approval by Medicaid. After the ADMC decision is received from Medicare, the provider/ supplier must submit a copy of the ADMC written decision by Medicare with the PA request. 4. Reimbursement for all wheelchair codes includes all labor charges involved in the assembly of the wheelchair and all covered additions or modifications. Reimbursement also includes support, such as emergency services, delivery, set-up education, and on-going assistance with use of the wheelchair. 5. For all wheelchairs (manual or power) recipient weight capacity is: Standard Duty = 300 lbs or less; Heavy Duty = 301-450 lbs; Very Heavy Duty = 451 – 600 lbs; Extra Heavy Duty = 601 lbs or more.

EQUIPMENT	QUALIFICATIONS	FORMS/DOCUMENTATION REQUIRED	COMMENTS
Mobility Assistive Equipment (MAE)			
Manual – *Standard* Adult size	1. The recipient's home provides adequate access between rooms, maneuvering space, and surfaces for use of the manual wheelchair that is provided; ***and*** 2. Use of an optimally configured manual wheelchair will significantly improve the recipient's ability to participate in MRADLs. **Note:** an optimally-configured manual wheelchair is one with an appropriate wheelbase, device weight, seating options, and other appropriate non-powered accessories; ***and*** 3. The recipient's weight is within the established weight limitations of the wheelchair that is requested/provided; ***and*** 4. The recipient will use it on a regular basis in the home; ***and*** 5. The recipient or their caregiver has not expressed an unwillingness to use the manual wheelchair that is provided in the home; ***and*** 6. The recipient has sufficient upper extremity strength, function, and other physical and mental capabilities needed to safely self-propel the manual wheelchair that is provided in the home during a typical day, or the recipient has a caretaker available, willing, and able to assist in the operation of the wheelchair.		
Manual – *Standard* Pediatric Size	1. The pediatric recipient must meet the qualifications in relationship to his/her age-appropriate developmental stages and mobility limitations for all qualifications for a Manual – Standard Adult Size section above; ***and*** 2. Pediatric wheelchairs are covered only for a pediatric recipient (or an adult of very small stature). Recipient's weight cannot exceed 125 pounds; ***and*** 3. Recipient has not mastered age appropriate sensory and motor development requirements (e.g., two years old is unable to ambulate/walk). 4. Stroller-type pediatric wheelchair devices, rigid or folding, will be considered only when classified by the Statistical Analysis Durable Medical Equipment Regional Carrier (SADMERC) as pediatric wheelchairs, when all of the above criteria are met; ***and*** Due to severity of illness, injury, and/or absence of or malfunction of a body part, there is a medical need for the features of the device requested to provide for the recipient's proper alignment/positioning, transportation of the individual, and any medical devices attached to the individual; ***and*** a. a manual wheelchair would not be more beneficial to the individual's developmental needs and there is no potential for the recipient to participate in self propelling a manual wheelchair.	1. All from Forms/Documentation section under "Wheelchairs" above, plus: 2. All pediatric device requests must include the growth capabilities of the equipment requested and address how that equipment can accommodate for the recipient's growth over the 60 month period that follows approval. This information should be included on the Mobility Assessment, form found on the QIO-like vendor's website.	1. Stroller-type devices readily available without a prescription in commercial or retail stores, and which have not been coded by SADMERC as medical devices, will be denied as not primarily medical in nature. 2. Stroller-type devices used for children absent of illness, injury and/or a missing or malfunction of a body part do not meet the definition of Durable Medical Equipment (DME) and, are therefore not considered medically necessary.

EQUIPMENT	QUALIFICATIONS	FORMS/DOCUMENTATION REQUIRED	COMMENTS
Mobility Assistive Equipment (MAE)			
WHEELCHAIRS – Manual Specialty	1. May be covered if, in addition to the general qualifications for a wheelchair and a manual wheelchair, the qualifications for the following specified devices are met and determined to be medically necessary:		
Standard Hemi-Wheelchair (K0002)	1. May be covered when the recipient requires a lower seat height (17" to 18") because of short stature or to enable the recipient to place his/her feet on the ground for propulsion.		
Lightweight Wheelchair (K0003)	1. May be covered when a recipient: a. cannot self-propel in a standard wheelchair; ***and*** b. the recipient can and does self-propel in a lightweight wheelchair.		
High Strength Lightweight Wheelchair (K0004)	1. May be covered when a recipient: a. self-propels the wheelchair while engaging in frequent activities that cannot be performed in a standard or lightweight wheelchair; ***and/or*** b. requires a seat width, depth, or height that cannot be accommodated in a standard, lightweight or hemi-wheelchair, and spends at least two (2) hours per day in the wheelchair. **Note:** This type of wheelchair is rarely medically necessary if the expected duration of need is less than three (3) months (e.g., post-operative recovery).		
Ultra-light-weight Wheelchair (K0005)	1. May be determined for coverage on an individual consideration basis, as follows: a. Recipient must have a medical condition which is progressively deteriorating, or be at risk for injury due to use of another optimally-configured mobility device; ***and*** b. Recipient must have a medical need for anticipated future adaptations of the wheelchair that can only be accommodated by the K0005 device.	1. Additional documentation of the medical necessity must include a description of the recipient's routine activities, types of activities the recipient frequently encounters, and whether the recipient is fully independent in the use of the wheelchair. Describe the features of the K0005 base which are needed and not available in the K0001 - K0004 bases. This may be included in the Mobility Assessment form.	
Heavy Duty Wheelchair (K0006)	1. May be covered if the recipient weighs more than 250 pounds or has severe spasticity.		
Extra Heavy Duty Wheelchair (K0007)	1. May be covered if the recipient weighs more than 300 pounds.		

EQUIPMENT	QUALIFICATIONS	FORMS/DOCUMENTATION REQUIRED	COMMENTS
Mobility Assistive Equipment (MAE)			
POWER MOBILITY DEVICES (PMDs) *(pertains to all POVs and PWCs below)*	1. May be covered if the recipient meets all above qualifications for a wheelchair (either adult or pediatric, whichever is appropriate); and the recipient's mobility limitation cannot be sufficiently resolved by the use of an appropriately fitted cane(s), crutches, walker, or an optimally-configured manual wheelchair; ***and*** 2. The recipient does not have sufficient upper extremity strength or function needed to safely self propel an optimally configured manual wheelchair in the home to perform MRADLs during a typical day. **Note:** Limitations of strength, endurance, range of motion, coordination, presence of pain, or deformity or absence of one or both upper extremities are to be assessed in the Mobility Assessment; ***and*** 3. The recipient meets the additional qualifications for the specific device requested, as indicated below:	1. Additional Documentation Requirements for a Power Mobility Device or Power Wheelchair: a. Orders: The physician/practitioner's order must contain all of the following components: 1. Recipient's name 2. Description of the item ordered. This may be general – e.g., "power wheelchair", "power operated vehicle", or "power mobility device" – or may be more specific 3. Pertinent diagnosis/conditions that relate to the need for the power device 4. Length of need 5. Physician/practitioner's signature b. Order must be received by the supplier within 45 days after the completion of the Mobility Assessment, . 2. Mobility Assessment, form found on the QIO-like vendor's website (refer to detailed requirements in Form Instructions at https://nevada.fhsc.com/providers/forms/forms.asp and in the main Chapter 1300 – Prior Authorization section. 3. Additional supporting documentation may include the Medicare-required Face-to-Face evaluation/examination.	1. Purchase of any Power Mobility Device is not considered medically necessary when the underlying condition is reversible and the length of need is less than six (6) months. The item may be approved for rental if all qualifications are met. 2. The Mobility Assessment, and written supportive documentation must be performed by an individual who is fiscally, administratively, and contractually independent from the DME provider/supplier, and who receives no form of compensation from the billing DME provider / supplier. **Note:** The exception to this is information about whether the recipient's home can accommodate the requested equipment, which may be obtained from or documented by the DME provider/supplier. 3. Prescribing physician/practitioners may bill an additional fee using HCPCS code G0372 on the claim for the office visit (CPT 99211) during which the Medicare-required Face-to-Face examination was completed.

EQUIPMENT	QUALIFICATIONS	FORMS/DOCUMENTATION REQUIRED	COMMENTS
Mobility Assistive Equipment (MAE)			
Power Operated Vehicle (POV)	1. The recipient is able to: a. safely transfer to and from the POV; ***and*** b. operate the tiller steering system; ***and*** c. maintain postural stability and position while operating the POV in the home; ***and*** 2. The recipient's mental capabilities (e.g., cognition and judgment) and physical capabilities (e.g., vision and hearing) are sufficient for safe mobility using a POV in the home; ***and*** 3. The recipient's home provides adequate access between rooms, maneuvering space, and surfaces for use of the POV that is requested/provided; ***and*** 4. Use of a POV will significantly improve the recipient's ability to participate in MRADLs; ***and*** 5. The recipient will use it on a regular basis in the home; ***and*** 6. The recipient or their caregiver has not expressed an unwillingness to use the POV that is provided in the home; ***and*** 7. If unable to operate the POV independently, the recipient has a caretaker available, willing, and able to assist in the operation of the POV; ***and*** 8. The recipient's weight is within the established weight limitations of the POV that is requested/provided; ***and*** 9. Documented outcome of the Mobility Assessment for the recipient determines this to be the most appropriate device for their needs.		
Power Wheelchairs (PWC) - Adult	1. May be covered if the recipient's mobility limitation cannot be sufficiently resolved by the use of an appropriately fitted cane(s), crutches, walker, an optimally-configured manual wheelchair, or a POV; ***and*** 2. Recipient *does not have* sufficient strength, postural stability, or other physical or mental capabilities needed to safely operate a POV in the home; ***and*** 3. Recipient *does have* the mental and physical capabilities, or		

	has a willing and capable caregiver to safely operate the power wheelchair that is requested/provided; ***and*** 4. Recipient's home *does not* provide adequate access between rooms, maneuvering space, and surfaces for the operation of a POV with a small turning radius; ***and*** 5. Recipient's home *does* provide adequate access between rooms, maneuvering space, and surfaces for the operation of the power wheelchair that is requested/provided; ***and*** 6. Use of a power wheelchair will significantly improve the recipient's ability to participate in MRADLs; ***and*** 7. Recipient will use it on a regular basis in the home; ***and*** Recipient or their caregiver has not expressed an		
	unwillingness to use the power wheelchair that is requested/provided in the home; ***and*** a. If the recipient is not able to operate the power wheelchair independently, the recipient has a caregiver who is unable to adequately propel an optimally configured manual wheelchair, but is available, willing, and able to safely operate the power wheelchair that is provided; ***and*** 8. The recipient's weight is within the established weight limitations of the power wheelchair requested/provided.		
Power Wheelchair (PWC) – Pediatric	1. The recipient is expected to grow in height with a maximum weight of 125 pounds; ***and*** 2. The outcome of the Mobility Assessment has determined this item to be the most appropriate for the individual over the 60-month period following approval.		
Power Wheelchairs – *(listed by specific groups)*	1. Meets above qualifications for a PWC (either adult or pediatric, whichever is appropriate); ***and*** as indicated for each specific item below.		

Power Wheelchairs (PWCs) are categorized into Groups based on their performance and the following specifications table:

CHARACTERISTICS	GROUP 1	GROUP 2	GROUP 3	GROUP 4	GROUP 5
Length	<= 40"	<= 48"	<= 48"	<= 48"	<= 48"
Width	<= 24"	<= 34"	<= 34"	<= 34"	<= 28"
Minimum Obstacle Height	20mm	40mm	60mm	75mm	60mm
Minimum Top-end Speed – flat surface	3 MPH	3 MPH	4.5 MPH	6 MPH	4 MPH
Minimum Range	5 miles	7 miles	12 miles	16 miles	12 miles
Dynamic Stability Incline	6 degrees	6 degrees	7.5 degrees	9 degrees	9 degrees

Chair Accommodates	non-powered options and seating systems (recline-only, manually elevating legrests – except captain's chair)	Seating and positioning items (seat and back cushions, headrests, lateral trunk supports, lateral hip supports, medial thigh supports - except captain's chair)	Same as Group 2	Same as Group 2	Weight capacity up to 125#; and Same as Group 1and Group 2; and Adjustability for growth (minimum of 3" for width, depth, and back height adjustments)
Group 1, 2, or 3 PWC "Standard"	No additional qualifications.				

EQUIPMENT	QUALIFICATIONS	FORMS/DOCUMENTATION REQUIRED	COMMENTS
Mobility Assistive Equipment (MAE)			
Group 2 PWC "Single Power Option"	1. Recipient requires a drive control interface other than a hand or chin-operated standard proportional joystick (examples include but are not limited to head control, sip and puff, switch control); ***or*** 2. Recipient meets qualifications for a power tilt or recline seating system and the system is being used on the wheelchair.		
Group 2 PWC "Multiple Power Option"	1. Same as Group 2 Single Power Option qualifications; ***and*** 2. The recipient meets the qualifications for a power tilt and/or recline seating system with three (3) or more actuators; ***or*** 3. The recipient uses a ventilator, which is mounted on the wheelchair.		
Group 3 PWC "Single Power Option"	1. Same as Group 2 Single Power Option qualifications; ***and*** 2. The recipient's mobility limitation is due to a neurological condition, myopathy, or skeletal deformity in which the mobility limitation cannot be accommodated by a Group 2 option.		
Group 3 PWC "Multiple Power Option"	1. Same as Group 2 Multiple Power Option qualifications; ***and*** 2. The recipient's mobility limitation is due to a neurological condition, myopathy, or skeletal deformity in which the mobility limitation cannot be accommodated by a Group 2 option.		
Group 4 PWC "Any Power Option"	This group of PWC is rarely considered medically necessary due to the added features, such as increased speed, climbing ability, and travel distance which are not needed to complete MRADLs. 1. The recipient must meet the qualifications for a Group 1, Group 2, or Group 3 PWC with the same power option being requested for the Group 4 PWC. 2. The recipient must have additional medical needs and mobility limitations that cannot be accommodated by an appropriately configured Group 1, 2, or 3 PWC.	As above; ***and*** 1. Additional documentation from the prescribing physician/practitioner that specifically addresses why the Group 4 PWC and accompanying accessories are medically necessary and why a Group 1, 2, or 3 PWC with accompanying accessories will not meet the recipient's medical needs.	
Group 5 Pediatric PWC "Single Power Option"	1. Same as Group 2 Single Power Option qualifications; ***and*** 2. The recipient is expected to grow in height.		

EQUIPMENT	QUALIFICATIONS	FORMS/DOCUMENTATION REQUIRED	COMMENTS
Mobility Assistive Equipment (MAE)			
WHEELCHAIR OPTIONS and ACCESSORIES	1. Options and accessories for wheelchairs may be covered if: a. The recipient meets the wheelchair qualifications as indicated above, and has either a manual or power wheelchair; ***and*** b. The device is an appropriate option/accessory for the type of chair the individual has; ***and*** c. The option/accessory itself is medically necessary, as determined through the Mobility Assessment, form found on the QIO-like vendor's website; ***and*** d. When the option/accessory is not a required component of the mobility device at the time of initial dispensing; ***and*** e. The option/accessory is not covered under an existing warranty; ***and*** f. As indicated for each specific item below:	For all items under this heading: all from General Information section above; ***and*** 1. Mobility Assessment, form found on the QIO-like vendor's website (refer to detailed requirements in Form Instructions at https://nevada.fhsc.com/providers/forms/forms.asp and Chapter 1300 - Prior Authorization section.	All from General Information section; ***and*** Limitations/Non-covered: 1. An option/accessory that is beneficial primarily in allowing the recipient to perform leisure or recreational activities. 2. Electronic interface used to control lights or other electrical devices is not primarily medical in nature. 3. Power seat elevation feature and power standing feature are not primarily medical in nature. 4. Non-medically necessary power wheelchair features including but not limited to: stair climbing (A9270), electronic balance (A9270), ability to balance on two wheels (A9270), remote operation (A9270), an attendant control (E2331) provided in addition to a patient-operated drive control system.
Anti-rollback Device (E0974)	1. May be covered if the recipient propels himself/herself and needs the device because of ramps which enable the individual to gain access to and from or within the home.		
Arm of Chair Adjustable Arm Height Option (E0973, K0017, K0018, K0020)	1. May be covered if the recipient requires an arm height that is different than that available using nonadjustable arms and the recipient spends at least 2 hours per day in the wheelchair.		
Arm Trough (E2209)	1. May be covered if recipient has quadriplegia, hemiplegia, or uncontrolled arm movements.		
Batteries / Chargers	1. Up to two (2) batteries (E2361, E2363, E2365, E2371, K0731, and K0733) at any one time are allowed if required for a power wheelchair.		1. Replacements only when not covered under warranty.
Footrest / Legrest Elevating Legrests (E0990, K0046, K0047, K0053, K0195)	1. May be covered if: a. The recipient has a musculoskeletal condition or the presence of a cast or brace which prevents 90 degree flexion at the knee; ***or*** b. The recipient has significant edema of the lower extremities that requires having an elevating legrest; ***or*** 2. The recipient meets the qualifications for and has a reclining back on the wheelchair.		

EQUIPMENT	QUALIFICATIONS	FORMS/DOCUMENTATION REQUIRED	COMMENTS
Mobility Assistive Equipment (MAE)			
Hardware - Swingaway, Retractable, or Removable for Joystick, Other Control Interface, or Positioning Accessory (E1028)	1. May be covered if recipient needs to move the component out of the way to perform a slide transfer to a bed or chair, or to enable performance of MRADLs, unless the hardware is included in the allowance for the item (such as E2325, a sip and puff interface).		
Manual Fully Reclining Back option (E1226)	1. May be covered if the recipient has one or more of the following conditions: a. The recipient is at high risk for development of a pressure ulcer and is unable to perform a functional weight shift; ***or*** b. The recipient utilizes intermittent catheterization for bladder management and is unable to independently transfer from the wheelchair to the bed.		
Non-Standard Seat Frame Dimensions **A Non-Standard Seat Width and/or Depth for a manual wheelchair (E2201-E2204)**	1. May be covered only if the recipient's dimensions justify the need.		
Power Tilt and/or Recline Seating Systems: (E1002-E1010) **Power Seating System** – *(tilt only, recline only, or combination tilt and recline – with or without power elevating legrests)*	1. May be covered if the recipient meets the criteria for a power wheelchair and the outcome of the Mobility Assessment, form found on the QIO-like vendor's website has determined the specific feature to be medically necessary; ***and*** a. The recipient is at high risk for development of a pressure ulcer and is unable to perform a functional weight shift; ***or*** b. The recipient utilizes intermittent catheterization for bladder management and is unable to independently transfer from the wheelchair to bed; ***or*** 2. The power seating system is needed to manage increased tone or spasticity.		
Power Wheelchair Drive Control Systems **An Attendant Control (E2331)**	1. May be covered in place of a patient-operated drive control system if recipient meets qualifications above for a wheelchair, is unable to operate a manual or power wheelchair and has a caregiver who is unable to operate a manual wheelchair but is able to operate a power wheelchair.		
Power Wheelchair Electronic Interface (E2351) *(to allow a Speech Generating Device to be operated by the PWC control interface)*	1. May be covered if the recipient meets the criteria for, and has a covered speech generating device.		

EQUIPMENT	QUALIFICATIONS	FORMS/DOCUMENTATION REQUIRED	COMMENTS
Mobility Assistive Equipment (MAE)			
Push-Rim Activated Power Assistive Device (E0986) for a manual wheelchair	1. May be covered if the recipient meets all qualifications for a power mobility device; and the recipient has been self-propelling in a manual wheelchair for at least one (1) year.		
Safety Belt / Pelvic Strap (E0978)	1. May be covered if the recipient has weak upper body muscles, upper body instability or muscle spasticity which requires use of this item for proper positioning.		
WHEELCHAIR SEATING **Wheelchair Seating Systems**	1. All items in this category may be covered if: a. The recipient meets the wheelchair qualifications as indicated above, and has either a manual or power wheelchair; ***and*** b. The item is appropriate for the type of chair the individual has; ***and*** c. The item itself is medically necessary, as determined through the Mobility Assessment, form found on the QIO-like vendor's website; ***and*** d. When the item is not a required component of the mobility device at the time of initial dispensing; ***and*** e. The item is not covered under an existing warranty; ***and*** f. As indicated for each specific item below:	For all items under this heading: all from General Information section above; ***and*** 1. Mobility Assessment, form found on the QIO-like vendor's website (refer to detailed requirements in Form Instructions at https://nevada.fhsc.com/providers/forms/forms.asp and Chapter 1300 - Prior Authorization section.	All from General Information section; ***and*** 1. All seating and positioning devices/ material and included components must meet the requirements of CMS and as set forth in the DME MAC Local Coverage Determination (LCD) – L15670 (or more current) and related Policy Articles at the time of dispensing. 2. Limitations/Non-Covered as not medically necessary: a. Powered seat cushion (E2610) (effectiveness has not been established). b. A seat or back cushion provided for a transport chair. c. A prefabricated seat cushion, a prefabricated positioning back cushion, or a brand name custom fabricated seat or back cushion which has not received a written coding verification from the SADMERC.
General Use Seat Cushion (E2601, E2602) and Wheelchair Back Cushion (E2611, E2612) (Pre-fabricated)	1. May be covered if the recipient has a manual or power wheelchair with a sling/solid seat/back.		1. General use seat cushion or wheelchair back cushion for a POV or a PWC with a captain's chair seat is not medically necessary.

EQUIPMENT	QUALIFICATIONS	FORMS/DOCUMENTATION REQUIRED	COMMENTS
Mobility Assistive Equipment (MAE)			
Custom Fabricated Seat Cushion (E2609)	1. May be covered if the recipient meets all qualifications for a prefabricated skin protection seat cushion or positioning seat cushion; ***and*** 2. The documentation and Mobility Assessment form clearly explains why a prefabricated seating system is not sufficient to meet the recipient's seating and positioning needs.		
Custom Fabricated Back Cushion (E2617)	1. May be covered if the recipient meets all qualifications for a prefabricated positioning back cushion; ***and*** 2. The documentation and Mobility Assessment form clearly explains why a prefabricated seating system is not sufficient to meet the recipient's seating and positioning needs.		
Headrest (E0955)	1. May be covered when the recipient has a manual tilt-in-space, manual semi or fully reclining back on a manual wheelchair, a manual fully reclining back on a power wheelchair, or power tilt and/or recline power seating system.		1. A headrest for a POV or a power wheelchair with a captain's chair seat is non-covered as not medically necessary.
Skin Protection Seat Cushion (E2603, E2604, K0734, K0735) (Pre-fabricated)	1. May be covered for a recipient who has a manual or power wheelchair with a sling/solid seat/back; ***and*** either of the following: a. Current or past history of a pressure ulcer on the area of contact with the seating surface; ***or*** b. Absent or impaired sensation in the area of contact with the seating surface or inability to carry out a functional weight shift due to one of the following diagnoses: spinal cord injury resulting in quadriplegia or paraplegia (344.00-344.1), other spinal cord disease (336.0-336.3), multiple sclerosis (340), other demyelinating disease (341.0-341.9), cerebral palsy (343.0-343.9), anterior horn cell diseases including amyotrophic lateral sclerosis (335.0-335.21, 335.23-335.9), post polio paralysis (138), traumatic brain injury resulting in quadriplegia (344.09), spina bifida (741.00-741.93), childhood cerebral degeneration (330.0-330.9), Alzheimer's disease (331.0), or Parkinson's disease (332.0).		
Positioning Seat Cushion (E2605, E2606), Positioning Back Cushion (E2613-E2616, E2620, E2621) and/or Positioning Accessory (E0955-E0957, E0960)	1. May be covered for a recipient who: a. Has a manual or power wheelchair with a sling/solid seat/back; ***and*** b. Has any significant postural asymmetries that are due to one of the diagnoses listed in Skin Protection Seat Cushion qualification 1.b. above, or to one of the following diagnoses: monoplegia of the lower limb (344.30-344.32, 438.40-438.42) or hemiplegia (342.00-342.92, 438.20-438.22) due to stroke, traumatic brain injury, or other etiology, muscular dystrophy (359.0, 359.1), torsion dystonias (333.4, 333.6, 333.71), spinocerebellar disease (334.0-334.9).		

EQUIPMENT	QUALIFICATIONS	FORMS/DOCUMENTATION REQUIRED	COMMENTS
Mobility Assistive Equipment (MAE)			
Combination Skin Protection and Positioning Seat Cushion (E2607, E2608, K0736, K0737)	1. May be covered for a recipient who meets the qualifications for both a **Skin Protection Seat Cushion** and a **Positioning Seat Cushion** as indicated above.		

Policy # 12: SPEECH GENERATING DEVICE

EQUIPMENT OR ITEM	QUALIFICATIONS	FORMS AND DOCUMENTATION REQUIREMENTS	MISCELLANEOUS COMMENTS/ STATEMENTS
SPEECH GENERATING DEVICE (SGD) *(also known as Augmentative Communication Device (ACD) or Augmentative and Alternative Communication (AAC) Device* (E2500 – E2510) **Digitized Speech Devices:** (E2500, E2502, E2504, E2506) **Synthesized Speech Devices:** (E2508, E2510)	1. A dedicated speech generating device (SGD) may be covered when it is medically necessary to restore the function of speech to an individual with a functional disability caused by a long term (lasting more than one year) and severe speech impairment; ***and*** 2. When **all** of the following are met: a. The recipient has had a formal written evaluation of their cognitive and communication abilities by a speech-language pathologist (SLP) which contains all of the items specified in the Forms/Documentation column; ***and*** b. The recipient's medical condition is one resulting in a long term (lasting more than one year) and severe expressive speech impairment; ***and*** c. The recipient's speaking needs cannot be met using natural communication methods; ***and*** d. Other forms of treatment have been considered and ruled out; ***and*** e. The recipient's speech impairment will benefit from the device ordered; ***and*** f. A copy of the SLP's written evaluation and recommendation was forwarded to the recipient's treating physician/practitioner and the prescribing physician/practitioner agreed with, and ordered the specific device and accessories as recommended.	1. Physician's/Practitioner's Order / Prescription 2. Prior Authorization (PA) 3. Detailed Product Description 4. Additional Miscellaneous Medical Records (if needed), ***and*:** 5. Speech and Language Pathologist (SLP)'s formal written evaluation which includes, at a minimum, all of the following: a. Current communication impairment, including the type, severity, language skills, cognitive ability, and anticipated course of the impairment; ***and*** b. An assessment of whether the recipient's daily communication needs could be met using other natural modes of communication or with low-technology devices; ***and*** c. A description of the functional communication goals expected to be achieved and treatment options; d. Rationale for selection of a specific device and any accessories; ***and*** e. Demonstration that the recipient possesses a treatment plan that includes a training schedule for the selected device; ***and*** f. The cognitive and physical abilities to effectively use the selected device and any accessories to communicate; ***and*** g. An attestation statement from the SLP performing the recipient evaluation and/or recommending the product(s) indicating they are not an employee of, and have no financial relationship with the supplier/manufacturer of the SGD. h. For a subsequent upgrade to a previously	1. For all items, documentation must support all criteria in the Qualifications section. 2. Providers must submit PA and claim using the most appropriate available HCPCS code and may not unbundle items included in the HCPCS code description. 3. Codes E2500 – E2510 perform the same essential function - speech generation and may not be issued in conjunction with E2511. 4. Code E2511 – SGD software program for Personal Computers (PC) or Personal Digital Assistant (PDA) may not be issued in conjunction with E2500 – E2510. 5. Computer-based and PDA-based AAC devices/speech generating devices are covered when they have been modified to run only AAC software and will not be reimbursed in conjunction with another SGD. Laptop computers, desktop computers, personal digital assistants (PDAs) or other devices that are not dedicated SGDs do not meet the definition of durable medical equipment (DME) and are therefore non-covered. 6. Expected lifespan of SGD E2500-E2510 or E2511 is

(continued) **SPEECH GENERATING DEVICE (SGD)**		issued SGD, documentation must support the medical necessity regarding the functional benefit to the recipient of the upgrade compared to the initially provided SGD. i. SLP evaluations and recommendations should consider recipient's needs both at present and over the useful lifespan of the device being recommended. 6. PAs for synthesized speech output SGDs and digitized speech output SGDs with dynamic displays must include the software required for operation of the device. Any requests for supplemental software for a synthesized speech output SGD must be established as specifically medically necessary. 7. PAs for digitized speech output SGDs with static displays must identify the symbol set that will be used to operate the device. 8. For all products and accessories, the Manufacturer's Invoice which includes: name of product, make, model, HCPCS code, and cost.	considered 60 months and are limited accordingly. Replacement equipment may be authorized prior to the 60 months based on medical necessity. The recipient's condition and product performance will be taken into review. 7. Refer to section 1303.4 for exceptions to quantity and frequency limitations. Refer to section 1303.5 for policy regarding lost, stolen, or damaged equipment. 8. Reimbursement for codes E2500, E2502, E2504, E2506, E2508 and E2510 is intended to include all applicable software programs (whether they are on the device when shipped by the manufacturer or added by the supplier prior to delivery) necessary to render the device operational, batteries, battery chargers and AC adapters, and a carrying case. These items may not be billed separately at the time of initial issuance. 9. Non-integrated keyboards provided with an SGD are not separately reimbursable. 10. One symbol set may be billed separately using code E2599. <u>Device Descriptions</u>: 1. Digitized speech devices, sometimes referred to as devices with "whole message" speech output, utilize words or phrases

(continued) **SPEECH GENERATING DEVICE (SGD)**			that have been recorded by an individual other than the SGD user for playback upon command of the SGD user. 2. Synthesized speech devices translate a user's input into device-generated speech. Users of synthesized speech SGDs are not limited to pre-recorded messages but rather can independently create messages as their communication needs dictate. 3. Devices that have the capability to generate both digitized and synthesized speech are coded as E2508 or E2510, depending on the method of synthesized speech formulation and device access. 4. E2508 devices require that the user make physical contact with a keyboard, touch screen or other display containing letters. 5. E2510 devices permit the user multiple methods of message formulation and multiple methods of device access. Multiple methods of message formulation must include the capability for message selection by two or more of the following methods: letters, words, pictures or symbols. Multiple methods of access must include the capability to access the device by two or more of the following: direct physical contact with a

			keyboard or touch screen, indirect selection techniques with a specialized access device such as a joystick, head mouse, optical head pointer, switch, light pointer, infrared pointer, scanning device, or Morse Code.
SPEECH GENERATING DEVICE (SGD) ACCESSORIES (E2599)	1. Accessories (E2599) for E2500 – E2510 may be covered if the basic coverage qualifications above for the base device are met and medical necessity for each accessory is clearly documented in the formal evaluation by the SLP and ordered by the physician/practitioner.	As above for SGD.	
Speech Generating Software Programs for Personal Computer (PC) or Personal Digital Assistant (PDA) (E2511)	1. All of the above qualifications for a Speech Generating Device are met; ***and*** 2. The recipient currently owns the PC or PDA to which the software will be applied to enable the device to function as a Speech Generating Device (SGD).	As above for SGD.	1. Installation of the software program or technical support that enables a recipient-owned laptop computer, desktop computer or PDA to function as an SGD is included in the cost of the software program, therefore is not separately reimbursable. 2. Medically necessary upgrades to speech generating devices and/or software programs may be reimbursed 60 months after the month of initial issuance of the device. 3. Repairs to, or replacement of recipient-owned equipment (PC and PDA) is not reimbursable.
Access Device (E2599) *(such as, but not limited to: optical head pointers, joysticks, switches and scanning devices)*	1. All of the above qualifications for a Speech Generating Device (SGD) are met; ***and*** 2. The access device has been determined to be medically necessary.	1. Documentation by a licensed medical professional, such as a physician, speech-language pathologist, or physical therapist, which supports the medical necessity for the requested access device.	3. An access device enables the selection of letters, words or symbols via direct or indirect selection techniques. 4. Any components such as software programs, interfaces, cables, adapters, interconnects or switches necessary for the access

			device to interface with the SGD should be included in the charge for the access device itself and is therefore not separately reimbursable.
Electronic Components (E2599)	1. All of the above qualifications for a Speech Generating Device (SGD) are met; ***and*** 2. The electronic components are necessary to allow the SGD to be operated by the drive control interface of a power wheelchair.	1. Documentation must include that the recipient requires the use of a power wheelchair, and must address the recipient's ability to operate the SGD from the power wheelchair.	
Mounting Systems (E2512)	1. All of the above qualifications for a Speech Generating Device are met; and 2. The accessories are needed to place the SGD, switches or other access devices within the reach of the recipient.	1. Documentation supporting medical necessity for the mounting system and that the recipient has a medical need for, and owns the device to which the SGD is to be mounted.	
Batteries, Battery Chargers, and AC Adapters	1. All of the above qualifications for a Speech Generating Device are met; and 2. The accessories are needed to replace an SGD battery, a battery charger, or AC adapter that was provided with initial issuance of the SGD and is no longer functioning.		
Carrying Case	1. All of the above qualifications for a Speech Generating Device are met; and 2. A carrying case may be paid separately with the initial issuance of an SGD when it would be charged separately to the general public or to the primary insurer; or 3. Replacement is needed to protect a medically necessary device due to wear and tear; no more frequently than 1 unit per calendar year.		

NUTRITION AND RELATED SERVICES			
EQUIPMENT	**QUALIFICATIONS**	**FORMS REQUIRED**	**COMMENTS**
PARENTERAL NUTRITION	1. Total Parenteral Nutrition (TPN) is covered for a recipient with permanent, severe pathology of the alimentary tract which does not allow absorption of sufficient nutrients to maintain weight and strength commensurate with the recipient's general condition. Permanence does not require a determination that there is no possibility that the recipient's condition may improve sometime in the future. If the judgment of the attending physician, substantiated in the medical record, is that the condition is of long and indefinite duration (ordinarily at least 3 months), the test of permanence is considered met. 2. The recipient must have: a. A condition involving the small intestine and/or its exocrine glands which significantly impairs the absorption of nutrients; or b. Disease of the stomach and/or intestine which is a motility disorder and impairs the ability of nutrients to be transported through the gastrointestinal (GI) system.	1. All TPN services require Prior Authorization. Medical coverage will be determined by the Nevada Medicaid QIO-like organization. 2. A new authorization would be required when: a. Nutrients billed with a different code are ordered; or b. The number of days per week administered is increased or decreased; or c. Parenteral nutrition services are resumed when they are not required for two (2) consecutive months. 3. There must be objective evidence supporting the clinical diagnosis.	1. Parenteral nutrition will be denied as non-covered in situations involving temporary impairments.
Infusion pumps Equipment and Supplies: (B9004-B9006)	1. Infusion pumps (B9004-B9906) are covered for recipients in whom parenteral nutrition is covered.		1. Only one pump (stationary or portable) will be covered at any one time. Additional pumps will be denied as not medically necessary.
Supply Kit, (B4220 or B4222) Administration Kit	1. If the coverage requirements for parenteral nutrition are met, one supply kit (B4220 or B4222) and one administration kit will be covered for each day that parenteral nutrition is administered, if such kits are medically necessary and used.		

NUTRITION AND RELATED SERVICES			
EQUIPMENT	**QUALIFICATIONS**	**FORMS REQUIRED**	**COMMENTS**
ENTERAL NUTRITION	1. Enteral Equipment and Supplies are a Medicaid program benefit that requires a prior authorization. The following diagnoses and conditions are acceptable for medical coverage based on severity and the QIO-like vendor determination: a. Necrotizing enterocolitis, b. Malnutrition, c. Noninfectious gastroenteritis and colitis, d. Disease of pancreas, e. Intestinal malabsorption f. Failure to thrive, g. Dysphagia h. Gastrostomy tube, artificial opening status i. Gastrostomy tube, attention to artificial opening, j. Inflammatory bowel disease, k. Carcinoma of gastrointestinal tract, l. Short bowel syndrome, m. Fistulas of the gastrointestinal tract, n. Pancreatitis and pancreatic insufficiency, o. Vascular disease of the small bowel, p. Radiation or chemotherapeutic enteropathy, q. Malabsorption, r. AIDS wasting syndrome (as indicated by a weight loss of 20 pounds or 10% of reference weight), s. Inborn errors of metabolism, 2. As a non-allergenic source of food in infants when all (e.g., soy base formulas) other food formulas are not tolerated; or 3. Other medical conditions with appropriate medical justification.		1. Non-covered nutritional supplies and products: a. Enteral nutrition will be denied as non-covered in situations involving temporary impairments; b. Enteral nutrition is non-covered for recipients with a functioning gastrointestinal tract whose need for enteral nutrition is due to reasons such as anorexia or nausea associated with mood disorder, end-stage disease, etc.; c. Enteral nutrition products that are administered orally and related supplies are non-covered; d. Baby food and other regular grocery products that can be blenderized and used with the enteral system will be denied as non-covered. 2. Nutritional Supplements – Carved out from institutional per diem if clinical coverage criteria are met.

ORTHOTIC AND PROSTHETIC DEVICES			
EQUIPMENT	**QUALIFICATIONS**	**FORMS REQUIRED**	**COMMENTS**
Orthotics and/or Prosthetics Adjustments, Repairs and Component Replacements.	1. Replacement of a prosthesis, prosthetic component or orthosis is covered if the treating physician orders a replacement device or part because of any of the following: a. A change in the physiological condition of the recipient; *or* b. Irreparable wear of the device or a part of the device, without evidence of recipient negligence; *or* c. The condition of the device or part of the device requires repairs and the cost of such repairs would be more than 60% of the cost of a replacement device or of the part being replaced.	1. Physician order and PA	1. Adjustments, Repairs and Component Replacement for Orthosis and Prosthesis; Routine periodic servicing such as testing, cleaning, and checking is non-covered. Adjustments to a prosthesis required by wear or by a change in the recipients condition are covered under the initial physician's order for the prosthesis for the life of the prosthesis. 2. Maintenance recommended by the manufacturer that must be performed by the prosthetist is a covered repair. 3. Repairs are covered when necessary to make the prosthesis functional. The cost of the repairs must not exceed the cost for a replacement.
Orthopedic Shoe (inserts, arch supports, footwear, lifts, wedges, heels, and related services)	1. Devices are covered for individuals under age 21 years when determined to be medically necessary through EPSDT screening and recommendations. 2. A surgical boot/shoe or Plastazote sandal may be covered for individuals of any age when ordered and determined to be medically necessary.	1. Physician's order 2. PA is required when product rate is $250.00 or more per unit.	
Orthotics Ankle-Foot Orthosis (AFO) Knee-Ankle-Foot Orthosis (KAFO)	1. Appliances necessary for the straightening or correction of a deformity are covered by Nevada Medicaid for eligible recipients. 2. <u>AFOs used in non-ambulatory recipients</u>: A static AFO (L4396) is covered if all of the following criteria are met: a. Plantar flexion contracture of the ankle (ICD9 diagnosis code 718.47) with dorsiflexion on passive range of motion testing of at least 10 degrees (i.e., a non-fixed contracture); b. Reasonable expectation of the ability to correct the	1. Physician order and PA 2. Original orthotics, adjustments, repairs, replacement of parts or an entire orthosis require medical documentation and may be subject to limitations of costs and frequency which are deemed reasonable by the program.	1. Orthotics include, but may not be limited to: braces, orthopedic shoes, elastic stockings, back supports/ corsets, splints, and garments for treating burn patients. 2. Providers of this type of equipment are to identify each component by L-code identifiers according to the American Orthotic and Prosthetic Association.

	contracture; c. Contracture is interfering or expected to interfere significantly with the recipient's functional abilities; *and* d. Used as a component of a therapy program which includes active stretching of the involved muscles and/or tendons. 3. <u>AFO/KAFOs used in ambulatory recipients:</u> A molded-to-patient-model, or custom-fabricated are covered for ambulatory recipients if the following are met: a. The recipient could not be fit with a prefabricated AFO; *or* b. The condition necessitating the orthotic is expected to be permanent or of longstanding duration (more than six months); *or* c. There is a need to control the knee, ankle or foot in more than one place; *or* d. The recipient has a documented neurological, circulatory, or orthopedic status that requires custom fabricating over a model to prevent tissue injury; *or* e. The recipient has a healing fracture which lacks normal anatomical integrity or anthropometric proportions.		
<u>Thoracic-Lumbar-Sacral Orthoses (TLSO)</u> <u>Lumbar-Sacral Orthoses (LSO)</u>	1. TLSO or LSO are covered when it is ordered for one (1) of the following indications: a. To reduce pain by restricting mobility of the trunk; *or* b. To facilitate healing following an injury to the spine or related soft tissues; *or* c. To facilitate healing following a surgical procedure on the spine or related soft tissue; *or* d. To otherwise support weak spinal muscles and/or a deformed spine.		

ORTHOTIC AND PROSTHETIC DEVICES			
EQUIPMENT	**QUALIFICATIONS**	**FORMS REQUIRED**	**COMMENTS**
PROSTHETIC DEVICES	Appliances necessary to replace a missing part by an artificial substitute are covered by Nevada Medicaid for eligible recipients. A determination of the medical necessity for certain components/additions to the prosthesis is based on the recipient's potential functional abilities. 1. Potential functional ability is based on the reasonable expectations of the prosthetist and treating physician, considering factors including but not limited to: a. The recipient's past history (including prior prosthetic use if applicable); *and* b. The recipient's current condition including the status of the residual limb and the nature of other medical problems; *and* c. The recipient's desire to ambulate. d. Clinical assessments of recipient rehabilitation potential must be based on the following classification levels: Level 0: Does not have the ability or potential to ambulate or transfer safely with or without assistance and a prosthesis does not enhance their quality of life or mobility. Level 1: Has the ability or potential to use a prosthesis for transfers or ambulation on level surfaces at fixed cadence. Typical of the limited and unlimited household ambulatory. Level 2: Has the ability or potential for ambulation with the ability to traverse low level environmental barriers such as curbs, stairs or uneven surfaces. Typical of the limited community ambulator.	1. Initial prosthetics, adjustments for which payment is to be made, repairs, replacement of parts, or an entire prosthetic device require medical documentation and may be subject to limitations of cost and frequency which are deemed reasonable by the program. 2. Sufficient clinical documentation of functional need for the technology or design feature of a given type of prosthesis is required to be retained in the physician's or prosthetist's files and must be available for Medicaid review.	Myoelectrically controlled prostheses and related equipment are not covered by this program. Providers of this type of equipment are to identify each component by L-code identifiers according to the American Orthotic and Prosthetic Association. The following items are included in the reimbursement for a prosthesis and are not separately billable: 1. Evaluation of the residual limb and gait; 2. Fitting of the prosthesis; 3. Cost of base component parts and labor contained in HCPCS base codes; 4. Repairs due to normal wear or tear within 90 days of delivery; 5. Adjustments of the prosthesis or the prosthetic component made when fitting the prosthesis or component and for 90 days from the date of delivery when the adjustments are not necessitated by changes in the residual limb or the recipient's functional abilities.

ORTHOTIC AND PROSTHETIC DEVICES			
EQUIPMENT	**QUALIFICATIONS**	**FORMS REQUIRED**	**COMMENTS**
(continued) Prosthetic Devices	Level 3: Has the ability or potential for ambulation with variable cadence. Typical for the community ambulatory who has the ability to traverse most environmental barriers and may have vocational, therapeutic or exercise activity that demands prosthetic utilization beyond simple locomotion. Level 4: Has the ability or potential for prosthetic ambulation that exceeds basic ambulation skills, exhibiting high impact, stress, or energy levels. Typical of the prosthetic demands of the child, active adult, or athlete. Services billed for this functional level are non-covered by Medicaid. Foot and Knee Prosthesis: Foot and knee prosthesis coverage will be based on medical necessity by the QIO-like vendor. The recipient's functional level will be taken into consideration. Sockets: 1. Test (diagnostic) sockets for immediate prostheses (L5400-L5460) are not medically necessary. 2. No more than 2 test (diagnostic) sockets for an individual prosthesis are medically necessary without additional documentation. 3. No more than 2 of the same socket inserts (L5654-L5665) are allowed per individual prosthesis at the same time.		

DISPOSABLE INCONTINENT SUPPLIES

EQUIPMENT	QUALIFICATIONS	FORMS REQUIRED	COMMENTS
DISPOSABLE INCONTINENT SUPPLIES	1. Disposable briefs/diapers, pull-ons/protective underwear, liners/ shields/ guards/ pads/ undergarments, and underpads may be covered for individuals age 4 years and older with a medical diagnosis (1) of a neurological or neuromuscular disorder or other diagnosis of a medical condition that causes urinary or bowel incontinence, and (2) a diagnosis of urinary and/or bowel incontinence. 2. Diagnoses must be supported by medical documentation which includes other recent (within past 6 months) interventions used to treat or ameliorate the incontinence, such as but not limited to a bowel and bladder training/retraining program, other toileting programs, exercise and strengthening regimens. 3. The individual's weight, waist/girth measurements, and belt-to-belt measurements must be consistent with manufacture's recommendations for the sizing of their products. 4. Recipients with waist size greater than 60 inches may be considered for Bariatric size briefs/diapers. 5. Individuals under 4 years of age must have a diagnosis of Human Immune Deficiency Virus (HIV) positive or Acquired Immune Deficiency Syndrome (AIDS) with an accompanying gastrointestinal abnormality causing frequent or intractable diarrhea which is documented by the prescribing practioner.	1. A physician's order. In addition to other requirements for written orders, the prescriber must indicate on the written order all of the following: a. Diagnosis of medical condition causing incontinence with a diagnosis of urinary and/or bowel incontinence; b. The specific item (diaper/brief, pull-on, liner/ shield/ guard/ pads, underpads) and the order must specify the recipient's measurements for the ordered item; c. Frequency of replacement and/or changes needed and monthly quantity of each item to be dispensed; d. The size of the item to be dispensed including the individual's current weight, waist/girth and belt to belt measurements to support the size of product needed. The size of the product supplied must be consistent with the manufacturer's recommendation for their product. 2. Documentation of other interventions tried or currently in progress to treat or ameliorate the incontinence. 3. Documentation must be included in the medical record and must be part of the treatment plan for the individual. The supplier must retain copies of all supporting documentation for audits.	1. Use of diapers and related products for individuals under the age of 4 years are considered age appropriate and are non-covered, unless the individual meets the qualifications and the order was a result of an EPSDT screening. These would require Prior Authorization. 2. PA is required for code T4543, Bariatric size brief/diapers. 3. Refer to the DMEPOS Fee Schedule for additional product limitations and PA requirements. PA may be submitted to exceed established limits for these products when medical documentation clearly indicates a greater quantity is medically necessary. 4. Use of multiple types of briefs, diapers, pull-ons, or protective underwear in any size combination cannot exceed the maximum limit either 100 units or 186 units per month depending on the item without PA. Liners, shields, guards, pads, and underpads in any combination cannot exceed the maximum limit of 100 units per month without PA and may be in addition to diapers, briefs, pull-ons, or protective underwear. 5. Gloves, sterile or non-sterile and disposable wipes/washcloths are not considered medically necessary for use with incontinence care and are non-covered. 6. Underpads used for tube feedings or other procedures not related to incontinence are non-covered as these would be considered convenience items and not medically necessary.

			7. Any products used for menses are non-covered. 8. Failure of the provider to maintain required documentation could result in post-payment recoupment of monies paid.

HOME-BASED TERBUTALINE INFUSION PUMP THERAPY			
EQUIPMENT	**QUALIFICATIONS**	**FORMS REQUIRED**	**COMMENTS**
Home-Based (outpatient) Terbutaline Infusion Pump Therapy	Terbutaline infusion pump therapy is a covered benefit when the following conditions are met: 1. The recipient is at high risk for preterm labor and delivery based on one or a combination of factors: a. Current diagnosis of preterm labor with uterine contractions of four or more per hour and progressive cervical change. b. Cervical dilatation is less than four centimeters. c. History of preterm labor/delivery with previous pregnancies. 2. The recipient is currently or has recently been under treatment to prevent preterm labor with a combination of the following methods: a. Bed rest or restricted activity. b. Oral tocolytic therapy (document ineffectiveness). c. Increased office visits or phone contact for counseling. d. Hospitalization. 3. Appropriate alternative treatment has been tried and was not successful or was contraindicated. 4. Physician states recipient is capable of complying with home Terbutaline infusion pump therapy. 5. Recipient is not less than 20 weeks gestation or more than 37 weeks gestation. 6. Fetus is alive and well with an estimated weight of less than 2,500 grams. 7. Costs associated with Terbutaline infusion pump therapy do not exceed $240/day.	1. Requires a prior authorization 2. Medical records from physician must be submitted to substantiate all qualifications. 3. PA will not be processed without medical records to substantiate request.	