MEDICAID SERVICES MANUAL
TRANSMITTAL LETTER

June 11, 2015

TO: CUSTODIANS OF MEDICAID SERVICES MANUAL

FROM: TAMMY MOFFITT, CHIEF OF PROGRAM INTEGRITY

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

## BACKGROUND AND EXPLANATION

Revisions to Medicaid Services Manual (MSM) Chapter 1300 are being proposed to update timeframes for Continuous Positive Airway Pressure device (CPAP) and Bi-level Positive Airway Pressure device (Bi-PAP) that were changed to match Medicare's timeframes and expanded sleep study requirements to include titrate and diagnostic. Definition added for misuse and specific items were added to reflect which are non-covered by Nevada Medicaid.

These changes are effective July 1, 2015.

| MATERIAL TRANSMITTED | MATERIAL SUPERSEDED |
|---|---|
| MTL 13/15<br>CHAPTER 1300 – DME, DISPOSABLE SUPPLIES AND SUPPLEMENTS | MTL 20/13, 35/10<br>CHAPTER 1300 – DME, DISPOSABLE SUPPLIES AND SUPPLEMENTS |

| Manual Section | Section Title | Background and Explanation of Policy Changes, Clarifications and Updates |
|---|---|---|
| **1302** | **Definitions** | Added definition of misuse for clarification. |
| **1303.1.B.6** | **Provider Responsibility** | Added language that it is the provider's responsibility to provide a manufacturer's invoice for certain items where a rate has not been established. |
| **1303.3.a.4.b** | **Rent-to-Purchase Option** | Removed reference to fee schedule for rent to purchase equipment and added Nevada Medicaid. |
| **1303.3.a.4.d** | **Rental and Purchase Options** | Added in Section 1303. |
| **1303.3.a.5.a** | **Rental Only** | Removed reference to fee schedule for rent and |

| Manual Section | Section Title | Background and Explanation of Policy Changes, Clarifications and Updates |
|---|---|---|
| | **Option** | added Nevada Medicaid. |
| **1303.3.b.1.a** | **Purchase** | Added by Nevada Medicaid. |
| **1303.3.b.2.a** | | Removed reference to fee schedule with a purchase option for used equipment and added Nevada Medicaid. |
| **1303.6.B.1.a** | **Replacement** | Reference to definition added. |
| **Appendix A** | **Non-Covered Services** | Added Miscellaneous section and erectile dysfunction equipment and supplies. |
| **Appendix B** | **Miscellaneous Policy Statements** | Removed reference of RR modifier when an item is only available as a rental as the use of this modifier is not exclusive to rental items only. |
| **Appendix B** | **Communication Devices** | Added tablets as item non-covered for Augmentative Communication Devices. |
| **Appendix B** | **Respiratory Services** | Expanded sleep study requirement to specify diagnostic and titrated sleep studies for BiPAP. |
| **Appendix B** | | Reporting timeframes for Bi-level Positive Airway Pressure device (BiPAP) to match Medicare's 31st to 91 days compliance proof. |
| **Appendix B** | | Reporting timeframes for Continuous Positive Airway Pressure device (CPAP) to match Medicare's 31st to 91days compliance proof. |
| **Appendix B** | | Expanded sleep study requirement to specify diagnostic and titrated sleep studies for CPAP. |

DIVISION OF HEALTH CARE FINANCING AND POLICY

MEDICAID SERVICES MANUAL
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# 1300 INTRODUCTION

Durable Medical Equipment, Prosthetics, Orthotics and Disposable Medical Supplies (DMEPOS) 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 Division of Health Care Financing and Policy (DHCFP) in collaboration with the Quality Improvement Organization (QIO)-like vendor for exceptional cases where medical need is adequately documented.

Products must have received approval from the federal Food and Drug Administration (FDA) and be consistent with the approved use. Products or usage considered experimental or investigational are not covered services. Consideration may be made on a case-by-case basis for items approved by FDA as a Humanitarian Device Exemption (HDE) under the Safe Medical Device Act of 1990 and as defined by FDA. That is, a device that is intended to benefit patients by treating or diagnosing a disease or condition that affects fewer than 4,000 individuals in the United States per year.

All Medicaid policies and requirements (such as prior authorization, etc.) are the same for Nevada Check Up (NCU), except as indicated in the NCU Manual Chapter 1000. Reference Medicaid Services Manual (MSM) Chapter 100 – Medicaid Program, Addendums Chapter, and MSM Definitions for further information.

1301 AUTHORITY

The Division of Health Care Financing and Policy (DHCFP) covers Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) as a mandatory program under Title XIX of the Social Security Act (SSA).

The citations denoting the amount, duration and scope of services can be found in 42 Code of Federal Regulations (CFR), Part 440, Sections 70 and 230, Section 1902 (a)(10)(d) of the Title XIX of the Social Security Act, 42 United States Code (USC), Title 42, Chapter 7, Section 1396a and 1397jj, and Nevada Revised Statutes (NRS) 422.2356.

Reference Title XIX State Plan §Attachment 3.1-A Page 2h and 3c, §Attachment 4.19-B page 1b and page 2.

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 reusable, 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”.

MEDICAL DOCUMENTATION

For the purposes of obtaining DMEPOS through Nevada Medicaid and Nevada Check Up (NCU), medical documentation used to support medical necessity is part of a medical record which is completed, signed and dated by a licensed medical professional. Clinical reports or assessments required to support medical necessity must be from a licensed/certified professional performing within their scope of practice. Information used as medical documentation cannot be compiled or composed by the recipient, their relatives or representatives.

MISUSE

To use in a manner in which an item is not intended, excessive use, or to use incorrectly.

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:

a. Artificially replace a missing portion of the body;

b. Prevent or correct physical deformity or malfunction; or

c. 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 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 orthotic 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 the Division of Health Care Financing and Policy (DHCFP) and Nevada Check Up (NCU) for eligible recipients. Equipment repairs, or replacement requires medical documentation and is subject to limitations of model, cost and frequency, which are deemed reasonable by the program.

3. Disposable medical supplies are covered by the DHCFP 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, disability 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 are based on medical necessity outside of the DMEPOS Program or that is considered under the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Healthy Kids Program.

8. Refer to Appendix B of this Chapter, for Coverage and Limitation Policies regarding 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/Ratesunit.htm.

10. The DHCFP 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. All documentation must be submitted with a prior authorization 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 following website at: https://www.medicaid.nv.gov.

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 the DHCFP.

6. The provider is responsible for providing a manufacturer's invoice for certain items, where no rate has been established.

7. The DMEPOS provider must comply with additional requirements as specified throughout this Chapter and its Appendices, Medicaid Services Manual (MSM) Chapter 100, the Provider Type (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 misuse, 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. Failure to return rented equipment could result in a recipient's financial responsibility for the retail price of the rented equipment, even if the equipment is lost/stolen, the recipient has moved, or they are no longer eligible for Nevada Medicaid/NCU.

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.

In accordance with the Patient Protection and Affordable Care Act (PPACA) (The Affordable Care Act) of 2010 (Public Law 111-148), all orders for DMEPOS items, whether verbal or written, must be incidental to a physician-documented face-to-face encounter between the recipient and the prescribing physician/practitioner (as allowed by The Act) within 30 days prior to the start date of the order. The encounter must be relevant to the need for the prescribed DMEPOS.

Refer to Appendix B of this Chapter for additional order requirements on specific products.

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 the DHCFP (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 online to the DME MAC Jurisdiction D Supplier Manual, Chapter 3 – Documentation Requirements, for a current listing of those items at: https://www.noridianmedicare.com/dme/news/manual/chapter3.html

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 the DHCFP.

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 must 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. Signature includes computer signature and pen and ink, no signature stamps allowed.

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. The detailed description of the item(s) may be completed by an employee of the ordering physician/practitioner; however, the prescriber 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 DMEPOS 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, unless documented with a shorter length of time).

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 recipient's 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 must 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 must 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 payer, for all items requiring an ADMC (refer online to the DME MAC Jurisdiction D, Supplier Manual, Chapter 9). The ADMC determination must be submitted to the Quality Improvement Organization (QIO)-like vendor at the same time the prior authorization is submitted.

B. PROVIDER RESPONSIBILITY

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

2. The provider must maintain records at the physical location of their business for each item billed to, and paid by, the DHCFP 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 RENTAL AND PURCHASE OPTIONS

Items identified in the DMEPOS Fee Schedule with a rental and purchase option require prior authorization to determine if the recipient's needs justify rental or purchase based on the item prescribed, the individual's anticipated length of need and prognosis (as determined by the prescriber) and cost effectiveness to the DHCFP and NCU.

a. RENTAL

1. In addition to all other requirements and qualifications for specific products, if the DMEPOS Fee Schedule allows a rental option, a device may be rented when:

a. the anticipated length of need (per physician's/practitioner's order) is short term (six months or less) and rental would be more cost effective than purchase;

b. a temporary trial period is required for the item according to Medicaid's policy;

c. the item is only available as a rental per the DMEPOS Fee Schedule; or

d. a temporary rental is needed while a recipient-owned like item is being repaired.

2. During a rental period, rental rates include all supplies and accessories necessary to render the equipment useable and safe, delivery and set up services, education and training for recipient and family, routine maintenance and servicing (such as testing, cleaning, regulating and checking equipment), repairs, non-routine maintenance and servicing (such as breaking down sealed components and performing tests which require specialized equipment and skills of a technician), and replacement of items. These services are the responsibility of the owner, the DMEPOS supplier.

3. Throughout any rental period, there must be an active physician's/practitioner's order for ongoing use, the prior authorization effective dates are still applicable, and there is a continued medical need for the item. The DMEPOS supplier must contact the recipient or their representative within five business days prior to each billing cycle to verify the rented item is still medically necessary, in working condition, and being used by the recipient (contact does not include system generated correspondence). Verification must be documented and maintained in the DMEPOS supplier's records and be accessible for audits.

4. Rent-to-Purchase Option:

a. The DHCFP allows rental of certain DMEPOS items up to the provider's Usual and Customary Charge (UCC) for purchase, or the maximum Medicaid allowable purchase price of the item; whichever is less.

b. Unless the item is identified by Nevada Medicaid as a rental only, once the total cumulative rental payments have reached the lower of UCC or maximum Medicaid allowable purchase rate, the item is considered purchased in full and recipient-owned.

c. The provider shall automatically transfer the title for the equipment to the recipient. Providers are not to submit prior authorization to transfer titles. Providers are also not to submit prior authorizations coded as a purchase after the lower of UCC or Medicaid allowable purchase rate is reached. No rental or purchase payments will be made for the remaining reasonable useful lifetime of the device (usually not less than five years (60 months)). The provider's records must include the date the title was transferred to the recipient.

d. When an item was new at the time of issuance, and it is later determined the recipient will need the item long term, rental payments will be applied

toward the total purchase rate (either the provider's UCC or the Medicaid allowable). Refer to "Purchase Used Equipment Option" in Section 1303.

e. Equipment that was not new at the time of issuance, such as items from the provider/supplier rental fleet, supplied as a temporary short term rental item must be replaced with new equipment as soon as it is identified the recipient will need the device long term (no later than in the sixth month of rental). Payments made on rental fleet-type items will not be applied to the purchase price of a new item. Purchase or transfer of titles to recipients when the used equipment is from a rental fleet is not allowed.

f. For this option, non-routine maintenance and servicing or repairs may be covered for service dates after the item is owned by the recipient; no sooner than the month following the last rental month.

5. Rental Only Option:

a. Certain items are identified by Nevada Medicaid as a rental only. For these items, a monthly rental will be allowed as long as the recipient continues to meet all qualifications and requirements, and the recipient continues to use the device.

b. For this option, the DMEPOS supplier retains ownership of the equipment, regardless of the length of rental. As the owner, the DMEPOS supplier is responsible to ensure the equipment remains in safe working condition for the reasonable useful lifetime of the device. The rental rates include all supplies and accessories, repairs including routine and non-routine maintenance and servicing, and replacement of items when needed.

b. PURCHASE

1. Purchase New Equipment Option:

a. Certain products are identified by Nevada Medicaid in the DMEPOS Fee Schedule with a purchase option for new equipment, or can only be purchased, such as disposable supplies and custom-made items which can only be used by that recipient. These will be considered for purchase when, in addition to all other requirements and qualifications for a specific item/device:

1. the anticipated length of need (per physician's order) is long term (more than six months); and

2. the provider will be supplying a new device/item to the recipient; or

3. the item is only available for purchase.

2. Purchase Used Equipment Option:

a. Certain products are identified by Nevada Medicaid with a purchase option for used equipment. When an item was new at the time it was dispensed to a recipient for rental purposes, and prior to billing the third month of rental, it is determined the item will be needed indefinitely, the DHCFP may purchase the item for the recipient for ongoing use. The DHCFP does not purchase used equipment from the provider's inventory of rental items used for re-issuance to same or multiple persons over time (rental fleets, etc.).

b. The DHCFP will only purchase used equipment when, in addition to all other requirements and qualifications for the item:

1. the recipient meets the criteria for purchase of new equipment;

2. the item was new when placed in the recipient's use and has been used for less than three months; and

3. the item is currently being used by the same recipient during a trial period and it has been determined the length of need will now be indefinite.

c. A prior authorization must be submitted to request purchase of a used item, with all supportive medical documentation to show the date the item was initially issued to the recipient and that the recipient continues to have an ongoing need for the item.

## 1303.4 PRIOR AUTHORIZATION

A. Prior authorization is a review conducted by the Quality Improvement Organization (QIO)-like vendor's medical professionals who review the prior authorization form and any additional information submitted to evaluate medical necessity, appropriateness, location of service, and compliance with the DHCFP's policy, prior to delivery of service. Reference the MSM, Chapter 100 and the general Billing Manual for detailed information on prior authorizations and Medicaid eligibility for all providers at: http://www.medicaid.nv.gov/providers/BillingInfo.aspx.

1. Submission:

   a. Prior authorizations 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 of this section applies.

   b. A prior authorization is required for most durable medical equipment, prosthetics, orthotics, and oxygen.

   c. A Medicaid provider may submit the prior authorization electronically using the QIO-like vendor's on-line prior authorization system or may fax or mail the prior authorization to the QIO-like vendor. For more information, refer to the prior authorization section posted at: https://www.medicaid.nv.gov.

   d. Requestors must submit a prior authorization 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 prior authorization 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 prior authorization request, regardless of mode of submission.

   f. Unless otherwise stated in policy, a prior authorization 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 previously, for reviewing the prior authorization, 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 the 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 prior authorization.

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, the DHCFP may defer to 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 (POC).

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

3. Prior Authorization 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. Prior Authorization 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 prior authorization 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 prior authorization 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 1303.4(a.)(1.) and (2.).

5. DMEPOS Specific Prior Authorization Forms:

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

a. All Forms and Form Release Memorandums or instructions may be accessed at the DHCFP's website: https://dhcfp.nv.gov/index/htm. The instructions provide detailed guidance on form completion requirements.

b. Specific DME prior authorization forms are found on the QIO-like vendor's website: https://www.medicaid.nv.gov/providers/forms/forms.aspx. All DMEPOS items that require prior authorization must be requested on these forms and submitted electronically, by fax or by 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 use the form, found on the QIO-like vendor's website. This form may 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 prior authorization 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 physician. For specific information on time limits and an explanation of each, refer to the general Billing Manual for all providers at: https://www.medicaid.nv.gov/providers/billinginfo.aspx.

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 MSM Chapter 3100 – Hearings.

B. COVERAGE AND LIMITATIONS

1. Coverage and limitations are explained throughout this Chapter, including its appendices. Appendix B details coverage qualifications, prior authorization 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), and rates. Codes are updated yearly. Codes not included in the fee schedule after the yearly update are considered non-covered.

C. PROVIDER RESPONSIBILITY

1. The requesting DME provider (supplier) and the prescribing physician/practitioner must work collaboratively to accurately and timely complete and submit prior authorization 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 prior authorization. Refer to the prior authorization section of the general Billing Manual for all providers at: https://www.medicaid.nv.gov/providers/billinginfo.aspx for detailed information on form completion and submission/transmission of prior authorization requests.

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 a 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 Physical Therapy (PT), Occupational Therapy (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. 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 documentation 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 include the signature and the signature date which must match the date the DMEPOS item was received by the recipient or their authorized representative to verify the DMEPOS item was received.

b. 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.

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

d. Without the 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 REPAIR, REPLACEMENT AND WARRANTY OF EQUIPMENT

### A. REPAIR

1. Repair means to fix or mend a non-functioning part of equipment and to return damaged or worn equipment back to a safe operating condition. Repair of an item may be appropriate when the anticipated lifetime of the base equipment (usually not less than five years) has not been exceeded and repair of the item is more cost effective than replacement.

2. Reimbursement to the provider may be made for repairs of recipient-owned medically necessary equipment. Medical documentation by the prescribing practitioner must be submitted to support the recipient's ongoing medical necessity for the item needing repair. Additionally the prior authorization must substantiate the absence of misuse, negligence, malicious involvement or wrongful disposition

on the part of the recipient, their legal representative, or their caregivers. It must indicate the equipment was being used appropriately in a manner prescribed or recommended. The prior authorization and claim must include HCPCS modifier RB for all DMEPOS parts furnished as part of the repair.

3. If a recipient-owned piece of medically necessary equipment requires repairs that will take more than a day and the recipient needs the device while the repairs are being performed, the provider must submit a prior authorization to request temporary (up to one month) rental of an equivalent item which can meet the recipient's basic medical needs while the recipient-owned item is being repaired.

4. Repairs to equipment owned or rented by a DMEPOS provider or an institutional facility in which the recipient is receiving services will not be covered by Nevada Medicaid or NCU.

5. Repair HCPCS codes are not to be used for: routine serving, cleaning, installation, delivery, set-up, travel necessary to make a repair, or for services covered by warranty as these costs are included in the cost of the item.

6. A re-manufactured part with a warranty used to make a repair is considered used equipment and must be billed as such, using the HCPCS modifier UE.

B. REPLACEMENT

1. Replacement of recipient-owned equipment refers to the provision of an identical or nearly identical item. Replacement may be considered on a case–by–case basis when prior authorization request substantiates the need for the replacement and is a result of either:

   a. Irreparable Wear: due to significant deterioration sustained from day-to-day use over time and a specific event (as indicated below) cannot be identified. Replacement of equipment due to irreparable wear takes into consideration the useful lifetime of the equipment which is usually not less than five years. The prior authorization must substantiate the absence of negligence and/or malicious involvement on the part of the recipient, their legal representative, or their caregiver, and that the equipment was being used appropriately. Intentional utilization of DME in a manner not prescribed or recommended, such as an excessive form of transportation may be reason for denial of equipment replacement - see misuse listed in Definitions of this chapter.

   b. Irreparable Damage: due to a specific accident or natural disaster (e.g., fire, flood) which resulted in irreparable damage or loss. These requests may be

considered only when the prior authorization request includes a copy of a police or fire report, documentation from Federal Emergency Management Agency (FEMA), the American Red Cross or a newspaper article that indicates the recipient's residence was affected by the disaster. Police or fire reports will only be considered if filed/dated within ten business days of the loss. The prior authorization must substantiate the absence of negligence and/or malicious involvement on the part of the recipient, their legal representative or their caregiver, and that the equipment was being used appropriately. The prior authorization and claim must include HCPCS modifier code RA for all DMEPOS provided as a replacement. Nevada Medicaid and NCU are payers of last resource and would be secondary to any insurance claim/reimbursement. Reference MSM Chapter 100 – Medicaid Program.

2. Replacement of any recipient-owned item, regardless of how it was originally acquired, requires a new physician's/practitioner's order and the recipient must meet current qualifications for the item. Any assessment(s) necessary to support medical necessity must have been completed within six months of the date of request.

3. Lost or stolen DMEPOS resulting from failure to maintain possession or properly secure the item is not covered by Nevada Medicaid or NCU.

C. WARRANTY

1. The purchase of many items includes a product warranty by the manufacturer and/or the DMEPOS provider. Any service (item or labor) covered by warranty cannot be billed to Nevada Medicaid or NCU, the recipient, or their representative.

2. The requesting provider must obtain verification that any repairs or replacement items being requested are not covered under the existing warranty. This documentation must be submitted with the prior authorization.

1303.7 SECTION RESERVED FOR FUTURE USE

1303.8 SECTION RESERVED FOR FUTURE USE

1303.9 DME AT INSTITUTIONAL FACILITY (IF)

A. The DHCFP'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 Orthotics

Prosthetics and Orthotics: 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. The DHCFP 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 prior authorization 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 QIO-like vendor 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 the Division of Health Care Financing and Policy (DHCFP) Medicaid Services Manual (MSM), Chapter 3100 for the Medicaid Hearings process.

APPENDIX A

NON-COVERED SERVICES

1. The Division of Health Care Financing and Policy's (DHCFP'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 DVD players

- **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)

Thermometers and 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

- **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
  Trays
  Stair lifts
  Switches

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

- **Miscellaneous:**
  Erectile Dysfunction equipment and supplies

2. The DHCFP 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)). The DHCFP has an approved list of covered DMEPOS items. The Provider Type 33 – DMEPOS Fee Schedule is available on the DHCFP website at: https://dhcfp.nv.gov/ratesunit.htm.

   a. The DHCFP 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 Section 1302 – the Addendum Medicaid Services Manual (MSM) Definitions;

      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.

**Policy: INTRODUCTION AND GENERAL INFORMATION**

**Introduction**

1. Appendix B is a supplement to the main body of Chapter 1300 and provides: specific coverage qualifications, forms and documentation requirements, and miscellaneous policies related to specific items of durable medical equipment, prosthetic devices, orthotic devices, or disposable medical supplies (DMEPOS).
2. For DMEPOS where coverage and limitations have not been addressed in this Chapter, its Appendices, or the DMEPOS Fee Schedule, the Division of Health Care Financing and Policy (DHCFP) may defer to the Durable Medical Equipment Medicare Administrative Contractor (DME MAC) Jurisdiction D, Local Coverage Determinations (LCD) and Policy Articles for coverage and limitations information. This information is available at https://www.noridianmedicare.com.

| QUALIFICATIONS | FORMS AND DOCUMENTATION REQUIREMENTS | MISCELLANEOUS POLICY STATEMENTS |
|---|---|---|
| 1. Qualifications identified for each specific item listed within this Appendix must all be met for coverage by the DHCFP.<br>2. If all qualifications are not met, refer to Appendix A for other possible coverage options. | 1. Refer to the Documentation section and/or the Prior Authorization section in Chapter 1300 for detailed requirements for each type of form. Additional form completion requirements are found in the Form Release Memorandums or Instructions on the QIO-like vendor's website at: http://www.medicaid.nv.gov/providers/forms/forms.aspx<br>2. All documentation, reports, evaluations and testing must support medical necessity as specified under the Qualifications section. Requirements must be met for each specific item listed within this Appendix and as specified for that item.<br>a. Physician's/Practitioner's Order / Prescription.<br>b. Prior authorization form (when indicated) - Durable Medical Equipment Prior Authorization Forms are available on the QIO-like vendor's website at the above link. There are specific forms for certain items of DMEPOS. Refer to policies to determine if a specific form is required. Prior authorization is required to exceed program limitations.<br>c. All services provided in an institutional facility require a prior authorization.<br>d. Detailed Product Description.<br>e. Proof of Delivery.<br>f. Additional Miscellaneous Medical Records.<br>g. Manufacturer's Invoice for certain items, especially where the DHCFP rate has not been established. | Refer to the main body of Chapter 1300 for general DMEPOS policies.<br>1. For all items, documentation must support all criteria in the Qualifications section, as specified in each category.<br>2. Providers must submit an approved prior authorization and claim using the most appropriate available HCPCS code and may not unbundle items included in the HCPCS code description.<br>3. Rented devices are to be considered purchased by the DHCFP once the purchase price has been reached. The exception to this is when the item is only available as a rental. Refer to main body of Chapter 1300.<br>4. Inclusion of a HCPCS code in this Appendix is not an indication of coverage. Refer to the DMEPOS Fee Schedule and Appendix A. |

| **Policy: BATHING AND TOILETING AIDS** | | | |
|---|---|---|---|
| **EQUIPMENT OR ITEM** | **QUALIFICATIONS** | **FORMS AND DOCUMENTATION REQUIREMENTS** | **MISCELLANEOUS POLICY STATEMENTS** |
| **Commodes-standard**<br>**Commode pail**<br>**Toilet Safety Frame-(versaframe)**<br>**Raised Toilet Seat**<br>**Bed Pan-plastic**<br>**Urinal** | 1. Medical evidence/ documentation recipient is physically incapable of utilizing regular toilet facilities; and<br>2. Recipient has a supporting diagnosis. | 1. Physician's/Practitioner's Order / Prescription. | |
| **Shower Chairs (with back and without back)**<br>**Tub Transfer Bench (padded and non-padded)** | 1. Recipient shows medical evidence/ documentation of incapability to utilize regular bathing facilities; and<br>2. Recipient has a supporting diagnosis. | 1. Physician's/Practitioner's Order / Prescription. | |

**Policy: BEDS (HOSPITAL) AND ACCESSORIES**

| EQUIPMENT OR ITEM | QUALIFICATIONS | FORMS AND DOCUMENTATION REQUIREMENTS | MISCELLANEOUS POLICY STATEMENTS |
|---|---|---|---|
| **Manual Beds**<br>**Semi-Electric Beds**<br>**Full-Electric Beds** | Medical evidence/documentation showing:<br>1. Recipient requires positioning of the body in ways not feasible with an ordinary bed due to a medical condition lasting at least one month;<br>2. Alleviation of pain due to positioning of the body;<br>3. Elevation of the head more than 30 degrees due to a medical condition, i.e.: Congestive Heart Failure (CHF); or<br>4. Requires frequent or immediate change in positioning. | 1. Prescription and/or MD signed Prior Authorization Form.<br>2. Medical documentation supporting qualifying factors. | |
| **Trapeze Bars** | 1. Medical evidence/documentation recipient needs assistance to sit up due to respiratory conditions, change body positions, or to assist in transfers in/out of bed. | 1. Prescription and/or MD signed Prior Authorization Form.<br>2. Medical documentation supporting qualifying factors. | |
| **Lifts and Lift Slings** | 1. Medical evidence/documentation showing the recipient requires more than one person in assisting in transfers from bed/bath, bed/commode, or bed/chair.<br>2. Must have an environment able to accommodate equipment.<br>3. Capable caregiver to assist with transfers. | 1. Prescription and/or MD signed Prior Authorization Form.<br>2. Medical documentation supporting qualifying factors. | |
| **Group 1 Support Surfaces** | Recipient must meet the following criteria:<br>1. Completely immobile (recipient cannot make changes in body position without assistance);<br>2. Limited mobility (recipient cannot independently make changes in body position significant enough to alleviate pressure); or<br>3. Any stage pressure ulcer on the trunk or pelvis; and | 1. Prescription and/or MD signed PA Form.<br>2. Medical documentation supporting qualifying factors. | Product needs to be adequate enough to prevent the recipient from bottoming out. |

**Policy: BEDS (HOSPITAL) AND ACCESSORIES**

| EQUIPMENT OR ITEM | QUALIFICATIONS | FORMS AND DOCUMENTATION REQUIREMENTS | MISCELLANEOUS POLICY STATEMENTS |
|---|---|---|---|
| | a) At least one of the following:<br>i) Impaired nutritional status;<br>ii) Fecal or urinary incontinence;<br>iii) Altered sensory perception;<br>iv) Compromised circulatory status. | | |
| **Pressure Pad For Mattress: Non-Powered Pressure Reducing Mattress Overlays** | (E0185) Gel/gel-like mattress overlay, with gel layer 2 inches or greater.<br>(E0197) Air mattress overlay interconnected air cells having a cell height of 3 inches or greater that are inflated with an air pump.<br>(E0198) Water mattress overlay with a filled height of 3 inches or greater.<br>(E0199) Foam mattress overlay with base thickness of 2 inches or greater and a peak height of 3 inches or greater if it is a convoluted overlay (egg-crate) or an overall height of at least 3 inches if it is a non-convoluted overlay. Foam with a density and other qualities that provide adequate pressure reduction, and durable waterproof cover.<br>1. Recipient must meet group 1 support surfaces criteria for qualification. | 1. Prescription and/or MD signed Prior Authorization Form.<br>2. Medical documentation supporting qualifying factors. | |
| **Non-Powered Pressure Reducing Mattress** | (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.<br>(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 on a hospital bed frame.<br>1. Recipient must meet group 1 support surfaces criteria for qualification. | 1. Prescription and/or MD signed Prior Authorization Form.<br>2. Medical documentation supporting qualifying factors. | |

**Policy: BEDS (HOSPITAL) AND ACCESSORIES**

| EQUIPMENT OR ITEM | QUALIFICATIONS | FORMS AND DOCUMENTATION REQUIREMENTS | MISCELLANEOUS POLICY STATEMENTS |
|---|---|---|---|
| **Powered Pressure Reducing Mattress Overlay Systems** | (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.<br>Recipient must meet group 1 support surfaces criteria for qualification. | 1. Prescription and/or MD signed Prior Authorization Form.<br>2. Medical documentation supporting qualifying factors. | |
| **Group 2 Support Surfaces** | Recipient must meet the following criteria:<br>1. Multiple stage II pressure ulcers located on the trunk or pelvis;<br>2. Recipient 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.<br>a. Treatment includes patient/caregiver education, regular assessment by a licensed healthcare practitioner, appropriate turning and positioning, appropriate wound care, appropriate management of moisture/incontinence, nutritional assessment and intervention consistent with the overall plan of care; and<br>3. Ulcers have worsened or remained the same over the past month; <u>OR</u><br>4. Large or multiple stage III or IV pressure ulcer(s) on the trunk or pelvis; <u>OR</u><br>5. Recent myocutaneous flap or skin graft for a pressure ulcer on the trunk or pelvis (surgery | 1. Prescription and/or MD signed Prior Authorization Form.<br>2. Medical documentation supporting qualifying factors. | |

**Policy: BEDS (HOSPITAL) AND ACCESSORIES**

| EQUIPMENT OR ITEM | QUALIFICATIONS | FORMS AND DOCUMENTATION REQUIREMENTS | MISCELLANEOUS POLICY STATEMENTS |
|---|---|---|---|
| (continued)<br>**Group 2 Support Surfaces** | within the past 60 days); and<br>6. Recipient 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). | | |
| **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.<br>(E0193) Describes a semi-electric or total electric hospital bed with a fully integrated powered pressure reducing mattress which has all the characteristics previously defined.<br>1. Recipient must meet criteria for Group 2 support surfaces. | 1. Prescription and/or MD signed Prior Authorization Form.<br>2. Medical documentation supporting qualifying factors. | |
| **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 prevents 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.<br>1. Recipient must meet criteria for Group 2 support surfaces. | 1. Prescription and/or MD signed Prior Authorization Form.<br>2. Medical documentation supporting qualifying factors. | |

| Policy: BEDS (HOSPITAL) AND ACCESSORIES | | | |
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| **EQUIPMENT OR ITEM** | **QUALIFICATIONS** | **FORMS AND DOCUMENTATION REQUIREMENTS** | **MISCELLANEOUS POLICY STATEMENTS** |
| **Powered Pressure Reducing Mattress Overlay** | (E0372) Low air loss, powered flotation 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 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.<br>1. Recipient must meet criteria for Group 2 support surfaces. | 1. Prescription and/or MD signed Prior Authorization Form.<br>2. Medical documentation supporting qualifying factors. | |
| **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 prevents 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.<br>1. Recipient must meet criteria for Group 2 support surfaces. | 1. Prescription and/or MD signed Prior Authorization Form.<br>2. Medical documentation supporting qualifying factors. | |

**Policy: BEDS (HOSPITAL) AND ACCESSORIES**

| EQUIPMENT OR ITEM | QUALIFICATIONS | FORMS AND DOCUMENTATION REQUIREMENTS | MISCELLANEOUS POLICY STATEMENTS |
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| **Group 3 Air-fluidized Bed** | (E0194) Device employing the circulation of filtered air through silicone coated ceramic beads creating the characteristics of fluid.<br>1. Recipient has a stage III (full thickness tissue loss) or stage IV (deep tissue destruction) pressure sore;<br>2. Is bedridden or chair bound as a result of severely limited mobility;<br>3. In the absence of an air fluidized bed, the recipient would require institutionalization;<br>4. Ordered in writing by recipient'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;<br>5. Conservative treatment must have been at least one month in duration without progression toward wound healing. Treatment should include:<br>a. Frequent repositioning of recipient (usually every 2 hours);<br>b. Use of group 2 support surface;<br>c. Necessary treatment to resolve any wound infection;<br>d. Optimization of nutrition status to promote wound healing;<br>e. Debridement by any means, including wet-to-dry gauze dressings to remove devitalized tissue from the wound bed;<br>f. Maintenance of a clean, moist bed of granulation tissue with appropriate moist dressings protected by an occlusive covering while the wound heals; | 1. Prescription and/or MD signed Prior Authorization Form.<br>2. Medical documentation supporting qualifying factors. | |

| **Policy: BEDS (HOSPITAL) AND ACCESSORIES** | | | |
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| **EQUIPMENT OR ITEM** | **QUALIFICATIONS** | **FORMS AND DOCUMENTATION REQUIREMENTS** | **MISCELLANEOUS POLICY STATEMENTS** |
| (continued)<br>**Group 3 Air-fluidized Bed** | g. Education of the recipient and caregiver on the prevention and management of pressure ulcers;<br>h. Assessment by a physician, nurse, or other licensed healthcare practitioner at least weekly; and<br>i. Appropriate management of moisture / incontinence.<br>6. Trained adult caregiver is available to assist the recipient 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;<br>7. A physician directs the home treatment regimen, and reevaluates and recertifies the need for the air-fluidized bed on a monthly basis; and<br>8. All other equipment has been considered and ruled out. | | |

**Policy: COMMUNICATION DEVICES**

| EQUIPMENT OR ITEM | QUALIFICATIONS | FORMS AND DOCUMENTATION REQUIREMENTS | MISCELLANEOUS POLICY STATEMENTS |
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| **Speech Generating Device (SGD)**<br>*(also known as Augmentative Communication Device (ACD) or Augmentative and Alternative Communication (AAC) Device*<br>**(E2500 – E2510)**<br><br>**Digitized Speech Devices:**<br>**(E2500, E2502, E2504, E2506)**<br><br>**Synthesized Speech Devices:**<br>**(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<br>2. When **all** of the following are met:<br>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;<br>b. The recipient's medical condition is one resulting in a long term (lasting more than one year) and severe expressive speech impairment;<br>c. The recipient's speaking needs cannot be met using natural communication methods;<br>d. Other forms of treatment have been considered and ruled out;<br>e. The recipient's speech impairment will benefit from the device ordered; and<br>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.<br>2. Prior Authorization.<br>3. Detailed Product Description.<br>4. Additional Miscellaneous Medical Records (if needed); and:<br>5. Speech and Language Pathologist (SLP)'s formal written evaluation which includes, at a minimum, all of the following:<br>a. Current communication impairment, including the type, severity, language skills, cognitive ability, and anticipated course of the impairment;<br>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;<br>c. A description of the functional communication goals expected to be achieved and treatment options;<br>d. Rationale for selection of a specific device and any accessories;<br>e. Demonstration that the recipient possesses a treatment plan that includes a training schedule for the selected device;<br>f. The cognitive and physical abilities to effectively use the selected device and any accessories to communicate; and<br>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. | 1. For all items, documentation must support all criteria in the Qualifications section.<br>2. Providers must submit prior authorization and claim using the most appropriate available HCPCS code and may not unbundle items included in the HCPCS code description.<br>3. Codes E2500 – E2510 perform the same essential function - speech generation and may not be issued in conjunction with E2511.<br>4. Code E2511 – SGD software program for Personal Computers (PC) or Personal Digital Assistant (PDA) may not be issued in conjunction with E2500 – E2510.<br>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), tablets or other devices that are not dedicated SGDs do not meet the definition of durable medical equipment (DME) and are therefore non-covered.<br>6. Expected lifespan of SGD E2500-E2510 or E2511 is 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.<br>7. Refer to section 1303.4 for exceptions to |

**Policy: COMMUNICATION DEVICES**

| EQUIPMENT OR ITEM | QUALIFICATIONS | FORMS AND DOCUMENTATION REQUIREMENTS | MISCELLANEOUS POLICY STATEMENTS |
|---|---|---|---|
| (continued)<br>**Speech Generating Device (SGD)** | | h. For a subsequent upgrade to a previously issued SGD, documentation must support the medical necessity regarding the functional benefit to the recipient of the upgrade compared to the initially provided SGD.<br>i. SLP evaluations and recommendations should consider recipient's needs both at present and over the useful lifespan of the device being recommended.<br>6. Prior authorizations 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.<br>7. Prior authorizations for digitized speech output SGDs with static displays must identify the symbol set that will be used to operate the device.<br>8. For all products and accessories, the Manufacturer's Invoice which includes: name of product, make, model, HCPCS code, and cost. | quantity and frequency limitations. Refer to section 1303.6 for policy regarding lost, stolen, or damaged equipment.<br>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.<br>9. Non-integrated keyboards provided with an SGD are not separately reimbursable.<br>10. One symbol set may be billed separately using code E2599.<br><u>Device Descriptions</u>:<br>1. Digitized speech devices, sometimes referred to as devices with "whole message" speech output, utilize words or phrases that have been recorded by an individual other than the SGD user for playback upon command of the SGD user.<br>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.<br>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 |

| **Policy: COMMUNICATION DEVICES** | | | |
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| **EQUIPMENT OR ITEM** | **QUALIFICATIONS** | **FORMS AND DOCUMENTATION REQUIREMENTS** | **MISCELLANEOUS POLICY STATEMENTS** |
| (continued)<br>**Speech Generating Device (SGD)** | | | speech formulation and device access.<br>4. E2508 devices require that the user make physical contact with a keyboard, touch screen or other display containing letters.<br>5. E2510 devices permit the user multiple methods of message formulation and multiple methods of device access.<br>a. 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.<br>b. 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 previously described 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. | 1. As previously described for SGD. | |

**Policy: COMMUNICATION DEVICES**

| EQUIPMENT OR ITEM | QUALIFICATIONS | FORMS AND DOCUMENTATION REQUIREMENTS | MISCELLANEOUS POLICY STATEMENTS |
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| **Speech Generating Software Programs for Personal Computer (PC) or Personal Digital Assistant (PDA) (E2511)** | 1. All of the previously described qualifications for a Speech Generating Device are met; and<br>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). | 1. As previously described 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.<br>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.<br>3. Repairs to, or replacement of recipient-owned equipment (PC and PDA) is not reimbursable. |
| **Access Device (E2599)**<br><br>*(such as, but not limited to: optical head pointers, joysticks, switches and scanning devices)* | 1. All of the previously described qualifications for a Speech Generating Device (SGD) are met; and<br>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. | 1. An access device enables the selection of letters, words or symbols via direct or indirect selection techniques.<br>2. 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 previously described qualifications for a Speech Generating Device (SGD) are met; and<br>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. | |

| Policy: COMMUNICATION DEVICES | | | |
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| **EQUIPMENT OR ITEM** | **QUALIFICATIONS** | **FORMS AND DOCUMENTATION REQUIREMENTS** | **MISCELLANEOUS POLICY STATEMENTS** |
| **SGD Mounting Systems (E2512)** | 1. All of the previously described qualifications for a Speech Generating Device are met; and<br>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. | |
| **SGD Batteries, Battery Chargers, and AC Adapters** | 1. All of the previously described qualifications for a Speech Generating Device are met; and<br>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. | | |
| **SGD Carrying Case** | 1. All of the previously described qualifications for a Speech Generating Device are met; and<br>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<br>3. Replacement is needed to protect a medically necessary device due to wear and tear; no more frequently than 1 unit per calendar year. | | |

**Policy: DIABETIC SERVICES**

| EQUIPMENT OR ITEM | QUALIFICATIONS | FORMS AND DOCUMENTATION REQUIREMENTS | MISCELLANEOUS POLICY STATEMENTS |
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| **External Ambulatory Infusion Pump, Insulin (E0784)** | Covered ICD-9 codes:<br>250-250.93 Diabetes Mellitus<br>648.0 Diabetes Mellitus<br>648.8 Gestational Diabetes<br><br>All of the following conditions must be met:<br>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.<br>2. Recipient has completed a comprehensive diabetic education program within the last year.<br>3. Recipient is motivated to achieve and maintain improved glycemic control.<br>4. Recipient has been on a program of multiple daily injections of insulin (e.g., at least 3 injections per day), with frequent self-adjustments of insulin doses for at least 6 months prior to request for the insulin pump.<br>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.<br>6. Glycosylated hemoglobin level (HbA1C) > 7.0%<br><br>In addition, one or more of the following indications must be present:<br>1. History of recurring hypoglycemia;<br>2. Wide fluctuations in blood glucose before mealtime (e.g., preprandial blood glucose level commonly exceeds 140 mg/dl;<br>3. Dawn phenomenon with fasting blood sugars frequently >200 ml/dl; | 1. A prescription from a physician who manages recipients with insulin pumps and who works closely with a team including nurses, diabetes educators, and dietitians.<br>2. Prior authorization is required for the insulin pump with all of the following documentation:<br>a. Certification of Diabetic Education Class with first time request.<br>b. Signed statement from the physician acknowledging medical necessity and the following:<br>1. Recipient is motivated to achieve and maintain improved glycolic control, indicated by showing documented finger sticks (at least 4 times per day) with multiple injections.<br>2. Recipient has been on a program of multiple injections of insulin (at least 3 times per day) with frequent self-adjustment of insulin doses at least 6 months prior to initiation of the insulin pump.<br>3. Cognitive ability to operate pump and calculate insulin dosages.<br>3. Qualifying lab results per qualifications.<br>4. Physician current history and physical including one or more of the additional indications listed in the qualification column.<br>5. Documentation requirements for recipients using the insulin pump prior to Medicaid eligibility requires a PA with the following documentation:<br>a. A current HbA1C level.<br>b. Signed narrative from the physician documenting the recipient's compliance and ability to self adjust the insulin pump | 1. External ambulatory infusion pump recipients with Gestational Diabetes whom do not meet conditions 1 through 6 but do meet qualifications under Gestational Diabetes approval of the insulin pump will be on a rental basis until the end of the pregnancy.<br>2. Insulin Pump-related Supplies through the DMEPOS program:<br>E0784 - External Ambulatory Infusion pump, Insulin<br>A4230 - Infusion set for external pump, non-needle cannula type<br>A4231 - Infusion set for external pump, needle type<br>A4232 - Syringe with needle for external insulin pump, sterile, 3cc |

| Policy: DIABETIC SERVICES | | | |
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| **EQUIPMENT OR ITEM** | **QUALIFICATIONS** | **FORMS AND DOCUMENTATION REQUIREMENTS** | **MISCELLANEOUS POLICY STATEMENTS** |
| (continued)<br>**External Ambulatory Infusion Pump, Insulin (E0784)** | 4. Extreme insulin sensitivity; or<br>5. Gestational diabetes or when pregnancy occurs or is anticipated within 3 months in a previously diagnosed diabetic with ANY of the following indications:<br>a. Erratic blood sugars in spite of maximal recipient compliance and split dosing; or<br>b. Other evidence that adequate control is not being achieved.<br>Qualifications for recipients on the external ambulatory infusion pump prior to Medicaid eligibility:<br>1. Current Glycosylated hemoglobin level (HbA1C).<br>2. Recipient has been compliant with using the insulin pump and has the ability of self-adjusting the insulin pump according to glucose levels. | according to glucose levels. | |
| **Diabetic Equipment and Supplies** | | 1. Physician's/Practitioner's Order / Prescription | 1. Diabetic shoes, fitting, and Modification A5500 – A5507, A5512 – A5513<br>2. Diabetic equipment and supplies, such as Glucometers, Test strips, Lancet Device and Lancets, Insulin syringes for self-injection are not covered under the DHCFP's DME program. These supplies are covered under the DHCFP's pharmacy program and must be billed through the Point of Sale (POS). Refer to MSM Chapter 1200, Pharmacy Services. |

**Policy: DISPOSABLE SUPPLIES**

| EQUIPMENT OR ITEM | QUALIFICATIONS | FORMS AND DOCUMENTATION REQUIREMENTS | MISCELLANEOUS POLICY STATEMENTS |
|---|---|---|---|
| **Disposable Incontinent Supplies** | 1. Disposable briefs/diapers, pull-ons/protective underwear, liners/ shields/ guards/ pads/ undergarments, and underpads may be covered for individuals age four 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.<br>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.<br>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.<br>4. Recipients with waist size greater than 60 inches may be considered for Bariatric size briefs/diapers.<br>5. Individuals under four 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 practitioner. | 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:<br>a. Diagnosis of medical condition causing incontinence with a diagnosis of urinary and/or bowel incontinence;<br>b. The specific item (diaper/brief, pull-on, liner/ shield/ guard/ pad, underpads) and the order must specify the recipient's measurements for the ordered item;<br>c. Frequency of replacement and/or changes needed and monthly quantity of each item to be dispensed;<br>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.<br>2. Documentation of other interventions tried or currently in progress to treat or ameliorate the incontinence.<br>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.<br>4. Prior authorization is always required for code T4543, Bariatric size brief/diapers, or to exceed established quantity limitations, or for ages less than four years old. | 1. Use of diapers and related products for individuals under the age of four years are considered age appropriate and are non-covered, unless the individual meets the qualifications and the order was a result of an Early and Periodic Screening, Diagnosis and Treatment (EPSDT) screening. These would require prior authorization.<br>2. Refer to the DMEPOS Fee Schedule. Prior authorization may be submitted to exceed established limits for these products when medical documentation clearly indicates a greater quantity is medically necessary.<br>3. 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 prior authorization and may be in addition to diapers, briefs, pull-ons, or protective underwear.<br>4. Gloves, sterile or non-sterile and disposable wipes/washcloths are not considered medically necessary for use with incontinence care and are non-covered.<br>5. Underpads used for tube feedings or other procedures not related to incontinence are non-covered as these would be considered convenience items |

| **Policy: DISPOSABLE SUPPLIES** | | | |
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| **EQUIPMENT OR ITEM** | **QUALIFICATIONS** | **FORMS AND DOCUMENTATION REQUIREMENTS** | **MISCELLANEOUS POLICY STATEMENTS** |
| (continued)<br>**Disposable Incontinent Supplies** | | | and not medically necessary.<br>6. Any products used for menses are non-covered.<br>Failure of the provider to maintain required documentation could result in post-payment recoupment of monies paid. |

**Policy: MOBILITY ASSISTIVE EQUIPMENT (MAE)**

| EQUIPMENT OR ITEM | QUALIFICATIONS | FORMS AND DOCUMENTATION REQUIREMENTS | MISCELLANEOUS POLICY STATEMENTS |
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| **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 further in this appendix that must be met. Items may be covered if all of the following qualifications are met:<br>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.<br>**Note:** A mobility limitation is one that:<br>a. Prevents the recipient from accomplishing the MRADL entirely;<br>b. Places the recipient at reasonably determined heightened risk of morbidity or mortality secondary to the attempts to perform an MRADL; or<br>c. Prevents the recipient from completing the mobility-related Activities of Daily Living (ADL) within a reasonable time frame.<br>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 Prior Authorization 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 on the following website: https://www.medicaid.nv.gov/providers/forms/forms.aspx<br>Each specific item may also have additional form requirements and specifications listed further that must be met.<br>1. Physician's/Practitioner's Order/Prescription.<br>2. Prior authorization, forms 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.<br>**Note**: For items that require prior authorization and have a rate or Usual and Customary Charge (UCC) of less than $500.00, use the DME Prior Authorization, Form FH-1; for items with a rate or UCC of $500.00 or more, the Mobility Assessment and Prior Authorization Form, FA-1B is required.<br>3. Detailed Product Description.<br>4. Proof of Delivery.<br>5. Additional Miscellaneous Medical Records. | Refer to the main body of MSM Chapter 1300 for general DMEPOS policies. The comments/ policy statements identified in this "general information" section pertain to all MAE items.<br>1. For all MAE items, documentation must support all criteria in the Qualifications section, as specified in each category.<br>a. All rented mobility devices are to be considered purchased by the DHCFP once the purchase price is reached.<br>b. Providers must submit prior authorization and claim with the most appropriate HCPCS code and may not unbundle items included in the HCPCS code description.<br>c. Inclusion of a HCPCS code in this policy section is not an indication of coverage. Refer to the DMEPOS Fee Schedule.<br>d. The recipient must have a medical need within the home for the requested item. In addition, consideration will include:<br>1. recipient's medical needs;<br>2. use of the item; and<br>3. the conditions in each of the environments the recipient is likely to encounter in their daily routines, such as, but not limited to:<br>a. attending school;<br>b. work; and<br>c. shopping.<br>This information must be included in the |

| Policy: MOBILITY ASSISTIVE EQUIPMENT (MAE) | | | |
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| **EQUIPMENT OR ITEM** | **QUALIFICATIONS** | **FORMS AND DOCUMENTATION REQUIREMENTS** | **MISCELLANEOUS POLICY STATEMENTS** |
| (continued)<br>**MAE General Information**<br>***(pertains to all items in this policy section)*** | | | supportive documentation submitted with the prior authorization. |
| **Canes and Crutches**<br><br>**Cane Accessories**<br><br>**Crutch Accessories** | 1. The MAE General Qualifications are met and the recipient:<br>a. has a medical condition causing impaired ambulation and there is a potential for ambulation;<br>b. is able to safely use the cane or crutches; and<br>c. has functional mobility deficit that can be sufficiently resolved by use of the item. | 1. Physician's/Practitioner's Order/Prescription. | 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. The MAE General Qualifications are met and the recipient:<br>a. has a below-the-knee injury and/or surgery causing impaired ambulation and there is a potential for ambulation;<br>b. is medically unable to safely use a cane(s), standard crutches, a walker, or a wheelchair;<br>c. has functional mobility deficit that can be sufficiently resolved by use of the item; and<br>d. (self) or care giver is not requesting the device for convenience. | 1. Physician's/Practitioner's Order/Prescription.<br>2. Prior Authorization.<br>3. The additional medical documentation by the prescribing physician/practitioner, submitted with the prior authorization, 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**<br><br>**Walker Accessories** | 1. If the MAE General Qualifications are met, a standard walker may be covered if the recipient:<br>a. is *unable* to safely use appropriately fitted canes or crutches to resolve functional mobility deficits; and<br>b. is *able* to safely use the walker; and<br>c. has functional mobility deficit that can be | 1. Physician's/Practitioner's Order/Prescription.<br>2. Prior Authorization, when indicated.<br>3. A heavy duty walker requires a prior authorization to verify weight. | All from General Information Miscellaneous Policy Statement section; and<br>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 |

**Policy: MOBILITY ASSISTIVE EQUIPMENT (MAE)**

| EQUIPMENT OR ITEM | QUALIFICATIONS | FORMS AND DOCUMENTATION REQUIREMENTS | MISCELLANEOUS POLICY STATEMENTS |
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| (continued)<br>**Walkers**<br><br>**Walker Accessories** | sufficiently resolved with use of a walker.<br>2. In addition to #1 and #2 in the MAE General Information Qualification section and #1 of this section, a heavy duty walker may be covered if the recipient's weight is greater than 300 pounds. | | be billed separately with the initial purchase. |
| **Gait Trainers** | 1. Authorization will be given for recipients under 18 years of age only.<br>2. And as a Mobility Assistive Device only.<br>3. Recipient is unable to utilize a standard or reverse walker as a result of truncal weakness, spasticity and/or balance issues. | 1. Physician's/Practitioner's Order/Prescription.<br>2. Prior authorization documenting recipient's inability to utilize a standard or reverse walker and how the gait trainer will meet the recipient's needs. | 1. Not allowed if used as rehab equipment. |
| **Wheelchairs**<br>*(pertains to all wheelchair types – manual and power)* | 1. In addition to the MAE General Qualification section, 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<br>2. The recipient meets the specific qualifications listed further in this section for the type of wheelchair being requested.<br>3. 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. | All from MAE General Qualification section; and<br><br>1. Mobility Assessment, form found on the QIO-like vendor's website (refer to detailed requirements in Form Instructions at: https://www.medicaid.nv.gov/providers/forms/forms.aspx and in MSM Chapter 1300. | 1. Medicaid allows only one wheelchair at a time. Backup chairs are denied as not medically necessary.<br>2. 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, provider/supplier must submit a copy of the ADMC written decision by Medicare with the prior authorization.<br>3. Reimbursement for all wheelchair codes includes all labor charges involved in the assembly of the wheelchair and all covered additions or modifications. Reimbursement |

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| (continued)<br>**Wheelchairs** *(pertains to all wheelchair types – manual and power)* | | | also includes support, such as emergency services, delivery, set-up education, and on-going assistance with use of the wheelchair.<br>4. For all wheelchairs (manual or power) recipient weight capacity is:<br>Standard Duty = 300 lbs or less;<br>Heavy Duty = 301-450 lbs;<br>Very Heavy Duty = 451 – 600 lbs;<br>Extra Heavy Duty = 601 lbs or more. |
| **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;<br>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;<br>3. The recipient's weight is within the established weight limitations of the wheelchair that is requested/provided;<br>4. The recipient will use it on a regular basis in the home;<br>5. The recipient or their caregiver has not expressed an unwillingness to use the manual wheelchair that is provided in the home; and<br>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, | | |

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| (continued)<br>**Manual – *Standard* Adult size** | 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 Wheelchair;<br>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<br>3. Recipient has not mastered age appropriate sensory and motor development requirements (e.g., two years old is unable to ambulate/walk).<br>4. Stroller-type pediatric wheelchair devices, rigid or folding, will be considered only when:<br>a. classified by the DME Pricing, Data Analysis, and Coding (PDAC) contractor as pediatric wheelchairs, when all of the previous criteria are met;<br>b. 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<br>c. 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 requirements from the Forms/Documentation section under "Wheelchairs", plus:<br>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 the DME Pricing, Data Analysis and Coding (PDAC) contractor as medical devices, will be denied as not primarily medical in nature.<br>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. |

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| **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:<br>a. cannot self-propel in a standard wheelchair; and<br>b. the recipient can and does self-propel in a lightweight wheelchair. | | |
| **High Strength Lightweight Wheelchair (K0004)** | 1. May be covered when a recipient:<br>a. self-propels the wheelchair while engaging in frequent activities that cannot be performed in a standard or lightweight wheelchair; and/or<br>b. requires a seat width, depth, or height that cannot be accommodated in a standard, lightweight or hemi-wheelchair, and spends at least two hours per day in the wheelchair.<br>**Note:** This type of wheelchair is rarely medically necessary if the expected duration of need is less than three months (e.g., post-operative recovery). | | |
| **Ultra-light-weight Wheelchair (K0005)** | 1. May be determined for coverage on an individual consideration basis, as follows:<br>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<br>b. Recipient must have a medical need for anticipated future adaptations of the | 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. | |

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| (continued) **Ultra-light-weight Wheelchair (K0005)** | wheelchair that can only be accommodated by the K0005 device. | 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. | | |
| **Power Mobility Devices (PMDs)** *(pertains to all POVs and PWCs below)* | 1. May be covered if the recipient meets all previously described 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;<br>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<br>3. The recipient meets the additional qualifications for the specific device requested, as indicated further in this section. | 1. Additional Documentation Requirements for a Power Mobility Device or Power Wheelchair:<br>a. Orders: The physician/ practitioner's order must contain all of the following components:<br>1. Recipient's name.<br>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.<br>3. Pertinent diagnosis/conditions that relate to the need for the power device.<br>4. Length of need.<br>5. Physician/practitioner's signature.<br>b. Order must be received by the provider within 45 days after the completion of the Mobility Assessment.<br>2. Mobility Assessment, form found on the QIO-like vendor's website (refer to detailed requirements in Form Instructions at: https://www.medicaid.nv.gov/providers/forms/forms.aspx and in MSM Chapter 1300 – Prior Authorization section. | 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 months. The item may be approved for rental if all qualifications are met.<br>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.<br>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- |

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| **EQUIPMENT OR ITEM** | **QUALIFICATIONS** | **FORMS AND DOCUMENTATION REQUIREMENTS** | **MISCELLANEOUS POLICY STATEMENTS** |
| (continued)<br>**Power Mobility Devices (PMDs)**<br>*(pertains to all POVs and PWCs below)* | | 3. Additional supporting documentation may include the Medicare-required Face-to-Face evaluation/examination. | Face examination was completed. |
| **Power Operated Vehicle (POV)** | 1. The recipient is able to:<br>a. safely transfer to and from the POV;<br>b. operate the tiller steering system; and<br>c. maintain postural stability and position while operating the POV in the home;<br>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;<br>3. The recipient's home provides adequate access between rooms, maneuvering space, and surfaces for use of the POV that is requested/provided;<br>4. Use of a POV will significantly improve the recipient's ability to participate in MRADLs;<br>5. The recipient will use it on a regular basis in the home;<br>6. The recipient or their caregiver has not expressed an unwillingness to use the POV that is provided in the home;<br>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;<br>8. The recipient's weight is within the established weight limitations of the POV that is requested/provided; and<br>9. Documented outcome of the Mobility Assessment for the recipient determines this to be the most appropriate device for their needs. | | |

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| **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;<br>2. Recipient *does not have* sufficient strength, postural stability, or other physical or mental capabilities needed to safely operate a POV in the home;<br>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;<br>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;<br>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;<br>Use of a power wheelchair will significantly improve the recipient's ability to participate in MRADLs;<br>6. Recipient will use it on a regular basis in the home;<br>7. Recipient or their caregiver has not expressed an unwillingness to use the power wheelchair that is requested/provided in the home;<br>8. 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; | | |

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| | and<br>9. 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<br>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) |

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| **Group 1, 2, or 3 PWC "Standard"** | 1. As previously stated for Power Wheelchairs. No additional qualifications. | | |
| **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<br>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<br>2. The recipient meets the qualifications for a power tilt and/or recline seating system with three or more actuators; or<br>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<br>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<br>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.<br>1. The recipient must meet the qualifications for | As listed previously; 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 | |

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| (continued)<br>**Group 4 PWC "Any Power Option"** | a Group 1, Group 2, or Group 3 PWC with the same power option being requested for the Group 4 PWC.<br>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. | recipient's medical needs. | |
| **Group 5 Pediatric PWC "Single Power Option"** | 1. Same as Group 2 Single Power Option qualifications; and<br>2. The recipient is expected to grow in height. | | |
| **Wheelchair Options, Accessories, and Seating Systems** | 1. Options and accessories for wheelchairs may be covered if:<br>a. The recipient meets the wheelchair qualifications as indicated previously, and has either a manual or power wheelchair;<br>b. The device is an appropriate option/accessory for the type of chair the individual has;<br>c. The option/accessory itself is medically necessary, as determined through the Mobility Assessment, form found on the QIO-like vendor's website;<br>d. When the option/accessory is not a required component of the mobility device at the time of initial dispensing;<br>e. The option/accessory is not covered under an existing warranty; and<br>f. As indicated for each specific item listed further in this section.<br>2. All wheelchair seating system items in this category may be covered if:<br>a. The recipient meets the wheelchair qualifications as indicated above, and has either a manual or power wheelchair; | For all items under this heading: all from General Information section above; and<br><br>1. Mobility Assessment, form found on the QIO-like vendor's website (refer to detailed requirements in Form Instructions at: https://www.medicaid.nv.gov/providers/forms/forms.aspx and MSM Chapter 1300 - Prior Authorization section. | See also General Information; Coverage and Limitations; and Non-covered Services:<br>1. An option/accessory that is beneficial primarily in allowing the recipient to perform leisure or recreational activities.<br>2. Electronic interface used to control lights or other electrical devices is not primarily medical in nature.<br>3. Power seat elevation feature and power standing feature are not primarily medical in nature.<br>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. |

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| (continued) **Wheelchair Options, Accessories, and Seating Systems** | b. The item is appropriate for the type of chair the individual has;<br>c. The item itself is medically necessary, as determined through the Mobility Assessment, form found on the QIO-like vendor's website;<br>d. When the item is not a required component of the mobility device at the time of initial dispensing;<br>e. The item is not covered under an existing warranty; and<br>f. As indicated for each specific item further. | | |
| **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 two 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 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:<br>a. The recipient has a musculoskeletal condition or the presence of a cast or brace which prevents 90 degree flexion at the knee;<br>b. The recipient has significant edema of the lower extremities that requires having an | | |

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| **EQUIPMENT OR ITEM** | **QUALIFICATIONS** | **FORMS AND DOCUMENTATION REQUIREMENTS** | **MISCELLANEOUS POLICY STATEMENTS** |
| (continued)<br>**Footrest / Legrest Elevating Legrests (E0990, K0046, K0047, K0053, K0195)** | a. elevating legrest; or<br>2. The recipient meets the qualifications for and has a reclining back on the wheelchair. | | |
| **Hardware Swingaway, Retractable, 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). | | |
| **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. |
| **Manual Fully Reclining Back option (E1226)** | 1. May be covered if the recipient has one or more of the following conditions:<br>a. The recipient is at high risk for development of a pressure ulcer and is unable to perform a functional weight shift; or<br>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**<br><br>**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. | | |

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| **Power Tilt and/or Recline Seating Systems: (E1002-E1010)**<br>**Power Seating System**<br>*(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<br>a. The recipient is at high risk for development of a pressure ulcer and is unable to perform a functional weight shift;<br>b. The recipient utilizes intermittent catheterization for bladder management and is unable to independently transfer from the wheelchair to bed; or<br>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 MAE qualifications 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)**<br>*(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. | | |
| **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 year. | | |

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| **EQUIPMENT OR ITEM** | **QUALIFICATIONS** | **FORMS AND DOCUMENTATION REQUIREMENTS** | **MISCELLANEOUS POLICY STATEMENTS** |
| **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. | | |
| **Seating Systems (wheelchair):** | As listed for Wheelchair Options, Accessories and Seating Systems. | For all items under this heading: all from MAE General Information; and<br>1. Mobility Assessment, form found on the QIO-like vendor's website (refer to detailed requirements in Form Instructions at: https://www.medicaid.nv.gov/providers/forms/forms.aspx and MSM Chapter 1300 - Prior Authorization section. | All from MAE General Information; and<br>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.<br>2. Coverage and Limitations/Non-Covered as not medically necessary:<br>a. Powered seat cushion (E2610) (effectiveness has not been established).<br>b. A seat or back cushion provided for a transport chair.<br>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 DME Pricing, Data Analysis and Coding (PDAC) contractor. |
| **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. |

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| **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<br>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<br>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. | | |
| **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:<br>a. Current or past history of a pressure ulcer on the area of contact with the seating surface; or<br>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 | | |

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| **EQUIPMENT OR ITEM** | **QUALIFICATIONS** | **FORMS AND DOCUMENTATION REQUIREMENTS** | **MISCELLANEOUS POLICY STATEMENTS** |
| (continued)<br>**Skin Protection Seat Cushion (E2603, E2604, K0734, K0735) (Pre-fabricated)** | 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:<br>a. Has a manual or power wheelchair with a sling/solid seat/back; and<br>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). | | |
| **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 previously. | | |

**Policy: NUTRITIONAL SERVICES**

| EQUIPMENT OR ITEM | QUALIFICATIONS | FORMS AND DOCUMENTATION REQUIREMENTS | MISCELLANEOUS POLICY STATEMENTS |
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| **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.<br><br>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.<br>2. The recipient must have:<br>a. A condition involving the small intestine and/or its exocrine glands which significantly impairs the absorption of nutrients; or<br>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. Physician's/Practitioner's Order / Prescription<br>2. All TPN services require prior authorization. Medical coverage will be determined by the DHCFP QIO-like vendor.<br>3. A new authorization would be required when:<br>a. Nutrients billed with a different code are ordered;<br>b. The number of days per week administered is increased or decreased; or<br>c. Parenteral nutrition services are resumed when they are not required for two consecutive months.<br>4. 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 and B9006)** | 1. Infusion pumps (B9004 and B9006) 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. | | |

**Policy: NUTRITIONAL SERVICES**

| EQUIPMENT OR ITEM | QUALIFICATIONS | FORMS AND DOCUMENTATION REQUIREMENTS | MISCELLANEOUS POLICY STATEMENTS |
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| **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:<br>a. AIDS wasting syndrome (as indicated by a weight loss of 20 pounds or 10% of reference weight);<br>b. Carcinoma of gastrointestinal tract;<br>c. Disease of pancreas;<br>d. Dysphagia;<br>e. Failure to thrive;<br>f. Fistulas of the gastrointestinal tract;<br>g. Gastrostomy tube, artificial opening status;<br>h. Gastrostomy tube, attention to artificial opening;<br>i. Inborn errors of metabolism;<br>j. Inflammatory bowel disease;<br>k. Intestinal malabsorption;<br>l. Malabsorption;<br>m. Malnutrition;<br>n. Necrotizing enterocolitis;<br>o. Noninfectious gastroenteritis and colitis;<br>p. Pancreatitis and pancreatic insufficiency;<br>q. Radiation or chemotherapeutic enteropathy;<br>r. Short bowel syndrome; and/or<br>s. Vascular disease of the small bowel.<br>2. As a non-allergenic source of food in infants when all (e.g., soy base formulas) other food formulas are not tolerated; or<br>3. Other medical conditions with appropriate medical justification. | 1. Physician's/Practitioner's Order/ Prescription.<br>2. Prior authorization when indicated. | 1. Non-covered nutritional supplies and products:<br>a. Enteral nutrition will be denied as non-covered in situations involving temporary impairments.<br>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..<br>c. Enteral nutrition products that are administered orally and related supplies are non-covered.<br>d. Baby food and other regular grocery products that can be blenderized and used with the enteral system will be denied as non-covered.<br>2. Nutritional supplements carved out from institutional per diem if clinical coverage criteria are met. |

**Policy: NUTRITIONAL SERVICES**

| EQUIPMENT OR ITEM | QUALIFICATIONS | FORMS AND DOCUMENTATION REQUIREMENTS | MISCELLANEOUS POLICY STATEMENTS |
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| **Medical Foods for Inborn Errors of Metabolism**<br>**(S9435)** | 1. Authorization of "medical foods" will be considered for recipients under the age of 21 years as an EPSDT service with a diagnosis of an inherited metabolic disease in which treatments are restricted and a monitored diet consisting of specially formulated low-protein foods are an established standard of care. The following inherited metabolic conditions fit the category, but are not limited to:<br>Phenylketonuria (PKU) ICD-9 270.1<br>Homocystinuria ICD-9 270.4<br>Maple Syrup Urine Disease ICD-9 270.3<br>2. Definitions and qualifications:<br>a. 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.<br>b. "Inherited metabolic disease" means a disease caused by an inherited abnormality of body chemistry for which testing is mandated by law.<br>c. 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.<br>d. Medical food is prescribed by and consumed under the direction of a physician for the dietary treatment of a qualifying metabolic disease.<br>e. The recipient is currently receiving comprehensive nutrition services by a physician and dietician for the dietary | 1. A prescription signed by the requesting physician specializing in the treatment of metabolic conditions for requested "medical foods";<br>2. A completed prior authorization form that includes:<br>a. types of medical food (e.g., LP baking mix);<br>b. product line company names and product code numbers;<br>c. total amount (units or case) of each medical food;<br>d. number of servings for each product unit (number of servings per box, can or case);<br>e. cost per unit or case for each medical food product;<br>f. total cost of all products submitted; and<br>g. Dates and duration of request<br>3. History and physical examination and current evaluation (within the last six 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;<br>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:<br>a. Daily number of phenylalanine exchange | 1. Medical foods will be approved after review of submitted documentation if found to meet the following conditions:<br>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;<br>b. Submitted supporting documentation is found to support inherited metabolic diagnosis; and<br>c. 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 may not be authorized as providers for medical foods. |

| Policy: NUTRITIONAL SERVICES | | | |
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| **EQUIPMENT OR ITEM** | **QUALIFICATIONS** | **FORMS AND DOCUMENTATION REQUIREMENTS** | **MISCELLANEOUS POLICY STATEMENTS** |
| (continued)<br>**Medical Foods for Inborn Errors of Metabolism (S9435)** | treatment of a qualifying metabolic disease.<br>f. 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.<br>g. Medical foods should be requested as part of an EPSDT supplement service.<br>h. 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.<br>i. Approval will be limited to $2,500.00 per year unless proof of medical necessity exceeds that amount. | or total protein intake for disorders requiring a protein restriction. Snack foods do not exceed 10% of total cost of foods requested; and<br>b. Documentation that the medical food is specially formulated and necessary for specific dietary management of the metabolic disorder. | |

**Policy: ORTHOTIC AND PROSTHETIC DEVICES**

| EQUIPMENT OR ITEM | QUALIFICATIONS | FORMS AND DOCUMENTATION REQUIREMENTS | MISCELLANEOUS POLICY STATEMENTS |
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| **Orthotics and/or Prosthetics**<br><br>**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:<br>a. A change in the physiological condition of the recipient;<br>b. Irreparable wear of the device or a part of the device, without evidence of recipient negligence; or<br>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's/Practitioner's Order/ Prescription.<br>2. Prior authorization, when indicated. | 1. 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 recipient's condition are covered under the initial physician's order for the prosthesis for the life of the prosthesis.<br>2. Maintenance recommended by the manufacturer that must be performed by the prosthetist is a covered repair.<br>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-Related Services (inserts, arch supports, footwear, lifts, wedges, heels, and related services) – HCPCS "L" codes** | 1. Devices are covered for individuals under age 21 years when determined to be medically necessary through EPSDT screening and recommendations.<br>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.<br>2. Prior authorization is required when "L" code product rate is $250.00 or more per unit. | 1. Refer to Diabetic Services section and HCPCS "A" codes in Fee Schedule for diabetic shoe insert coverage information. |

**Policy: ORTHOTIC AND PROSTHETIC DEVICES**

| EQUIPMENT OR ITEM | QUALIFICATIONS | FORMS AND DOCUMENTATION REQUIREMENTS | MISCELLANEOUS POLICY STATEMENTS |
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| **Orthotics**<br>**Ankle-Foot Orthoses (AFO)**<br>**Knee-Ankle-Foot Orthoses (KAFO)** | 1. Appliances necessary for the straightening or correction of a deformity are covered by the DHCFP for eligible recipients.<br>2. <u>AFOs used in non-ambulatory recipients</u>: A static AFO (L4396) is covered if all of the following criteria are met:<br>a. Plantar flexion contracture of the ankle (ICD-9 diagnosis code 718.47) with dorsiflexion on passive range of motion testing of at least 10 degrees (e.g., a non-fixed contracture);<br>b. Reasonable expectation of the ability to correct the contracture;<br>c. Contracture is interfering or expected to interfere significantly with the recipient's functional abilities; and<br>d. Used as a component of a therapy program which includes active stretching of the involved muscles and/or tendons.<br>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:<br>a. The recipient could not be fit with a prefabricated AFO;<br>b. The condition necessitating the orthotic is expected to be permanent or of longstanding duration (more than six months);<br>c. There is a need to control the knee, ankle or foot in more than one place;<br>d. The recipient has a documented neurological, circulatory, or orthopedic status that requires custom fabricating over a model to prevent tissue injury; or<br>e. The recipient has a healing fracture which | 1. Physician order.<br>2. Prior Authorization.<br>3. 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.<br>2. Providers of this type of equipment are to identify each component by L-code identifiers according to the American Orthotic and Prosthetic Association. |

| **Policy: ORTHOTIC AND PROSTHETIC DEVICES** | | | |
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| **EQUIPMENT OR ITEM** | **QUALIFICATIONS** | **FORMS AND DOCUMENTATION REQUIREMENTS** | **MISCELLANEOUS POLICY STATEMENTS** |
| (continued)<br>**Orthotics**<br>**Ankle-Foot Orthoses (AFO)**<br>**Knee-Ankle-Foot Orthoses (KAFO)** | lacks normal anatomical integrity or anthropometric proportions. | | |
| **Thoracic-Lumbar-Sacral Orthoses (TLSO)**<br><br>**Lumbar-Sacral Orthoses (LSO)** | 1. TLSO or LSO are covered when it is ordered for one of the following indications:<br>a. To reduce pain by restricting mobility of the trunk;<br>b. To facilitate healing following an injury to the spine or related soft tissue;<br>c. To facilitate healing following a surgical procedure on the spine or related soft tissue; or<br>d. To otherwise support weak spinal muscles and/or a deformed spine. | | |

**Policy: ORTHOTIC AND PROSTHETIC DEVICES**

| EQUIPMENT OR ITEM | QUALIFICATIONS | FORMS AND DOCUMENTATION REQUIREMENTS | MISCELLANEOUS POLICY STATEMENTS |
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| **Prosthetic Devices** | Appliances necessary to replace a missing part by an artificial substitute are covered by the DHCFP for eligible recipients.<br>A determination of the medical necessity for certain components/additions to the prosthesis is based on the recipient's potential functional abilities.<br>1. Potential functional ability is based on the reasonable expectations of the prosthetist and treating physician, considering factors including but not limited to:<br>a. The recipient's past history (including prior prosthetic use if applicable);<br>b. The recipient's current condition including the status of the residual limb and the nature of other medical problems;<br>c. The recipient's desire to ambulate; and<br>d. Clinical assessments of recipient rehabilitation potential must be based on the following classification levels:<br><br><u>Level 0</u>: 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.<br><br><u>Level 1</u>: 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.<br><br><u>Level 2</u>: 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 | 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.<br>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. | 1. Myoelectrically controlled prostheses and related equipment are not covered by this program.<br>2. Providers of this type of equipment are to identify each component by L-code identifiers according to the American Orthotic and Prosthetic Association.<br>3. The following items are included in the reimbursement for a prosthesis and are not separately billable:<br>a. Evaluation of the residual limb and gait;<br>b. Fitting of the prosthesis;<br>c. Cost of base component parts and labor contained in HCPCS base codes;<br>d. Repairs due to normal wear or tear within 90 days of delivery;<br>e. 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. |

**Policy: ORTHOTIC AND PROSTHETIC DEVICES**

| EQUIPMENT OR ITEM | QUALIFICATIONS | FORMS AND DOCUMENTATION REQUIREMENTS | MISCELLANEOUS POLICY STATEMENTS |
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| (continued)<br>**Prosthetic Devices** | community ambulator.<br><br>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.<br><br>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.<br><br>Foot and Knee Prosthesis:<br>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.<br><br>Sockets:<br>1. Test (diagnostic) sockets for immediate prostheses (L5400-L5460) are not medically necessary.<br>2. No more than two test (diagnostic) sockets for an individual prosthesis are medically necessary without additional documentation.<br>3. No more than two of the same socket inserts (L5654-L5665) are allowed per individual prosthesis at the same time. | | |

| **Policy: OSTEOGENESIS STIMULATOR DEVICES** | | | |
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| **EQUIPMENT OR ITEM** | **QUALIFICATIONS** | **FORMS AND DOCUMENTATION REQUIREMENTS** | **MISCELLANEOUS POLICY STATEMENTS** |
| **Osteogenesis Stimulator** ***(Non-spinal Noninvasive Electrical)*** | Device may be covered if:<br>1. Non-union of a long bone fracture after six months have elapsed without healing of the fracture;<br>2. Failed fusion of a joint, other than in the spine, where a minimum of nine months have elapsed since the last surgery; or<br>3. Congenital pseudarthrosis | 1. Prescription and/or MD signed Prior Authorization Form.<br>2. Medical documentation supporting qualifying factors. | 1. Rental for 20-week intervals, additional authorization will be considered with medical justification.<br>2. Ultrasonic Osteogenic Stimulators are non-covered Medicaid services. |
| **Osteogenesis Stimulator** ***(Spinal Noninvasive Electrical)*** | Device may be covered if:<br>1. Failed spinal fusion where a minimum of nine months have elapsed since the last surgery;<br>2. Following a multilevel spinal fusion surgery involving three or more vertebrae; or<br>3. Following spinal fusion surgery where there is a history of a previously failed spinal fusion. | 1. Prescription and/or MD signed Prior Authorization Form.<br>2. Medical documentation supporting qualifying factors. | 1. Rental for 20-week intervals, additional authorization will be considered with medical justification.<br>2. Ultrasonic Osteogenic Stimulators are non-covered Medicaid services. |

| **Policy: PHOTOTHERAPY UNITS** | | | |
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| **EQUIPMENT OR ITEM** | **QUALIFICATIONS** | **FORMS AND DOCUMENTATION REQUIREMENTS** | **MISCELLANEOUS POLICY STATEMENTS** |
| **Phototherapy Unit** | 1. Bilirubin levels must be at or greater than 12.0 with bilirubin therapy on initial day of treatment.<br>2. Authorization is for a maximum of three days. | 1. Prescription and/or MD signed Prior Authorization Form.<br>2. Medical documentation supporting qualifying factors. | |

| **Policy: PNEUMATIC COMPRESSION DEVICES** | | | |
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| **EQUIPMENT OR ITEM** | **QUALIFICATIONS** | **FORMS AND DOCUMENTATION REQUIREMENTS** | **MISCELLANEOUS POLICY STATEMENTS** |
| **Pneumatic Compression Devices** ***(used for lymphedema)*** | 1. One or more limbs involved; and<br>2. Radical surgical procedure with removal of regional groups of lymph nodes (after radical mastectomy); or<br>3. Post radiation fibrosis;<br>4. Spread of malignant tumors to regional lymph nodes with lymphatic obstruction;<br>5. Scarring of lymphatic channels,<br>6. Onset of puberty (Milroy's disease); or<br>7. Congenital anomalies; and<br>8. Must be treatment of last resort with documented evidence that elevation and custom fabricated gradient pressure stockings or sleeves are ineffective; and<br>9. Continuous oversight by treating physician (including instruction, treatment plan, fracture and duration of use ongoing monitoring and evaluation). | 1. Prescription and/or MD signed Prior Authorization Form.<br>2. Medical documentation supporting qualifying factors. | |

**Policy: PREGNANCY-RELATED EQUIPMENT**

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

**Policy: PREGNANCY-RELATED EQUIPMENT**

| EQUIPMENT OR ITEM | QUALIFICATIONS | FORMS AND DOCUMENTATION REQUIREMENTS | MISCELLANEOUS POLICY STATEMENTS |
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| **Home Uterine Activity Monitor** | 1. Recipient has a current diagnosis of pre-term labor and a history of previous pre-term labor/delivery with pregnancies.<br>2. Records from physician showing pre-term labor with uterine contractions of four or more per hour and progressive cervical changes.<br>3. Cervical dilation is less than four centimeters.<br>4. Recipient is ordered on bedrest or restricted activities.<br>5. Tocolytic therapy initiated (oral, subcutaneous, or intravenous route).<br>6. Documentation will show there is an increase in physician/patient contact due to pre-term labor symptoms.<br>7. The recipient is, in the opinion of the physician, capable of complying with the home monitoring program.<br>8. Recipient is not less than 24 weeks gestation or more than 37 weeks gestation. | 1. Prescription and/or MD signed Prior Authorization Form.<br>2. Prior Authorization Note: Prior authorization submitted more than ten days after onset of service may be denied.<br>3. Medical documentation supporting qualifying factors | 1. Reimbursement only for days of documented telephone contact between recipient/physician and monitoring device. |

**Policy: RESPIRATORY SERVICES**

| EQUIPMENT OR ITEM | QUALIFICATIONS | FORMS AND DOCUMENTATION REQUIREMENTS | MISCELLANEOUS POLICY STATEMENTS |
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| **Apnea Monitor** | 1. One year qualification for at least one of:<br>a. 765.0-1 prematurity (gestational age must be listed on CMS 1500);<br>b. 764.0-9 Substantially small for gestational age;<br>c. 760.71 HX of maternal alcohol abuse;<br>d. 760.72 HX of maternal narcotics abuse; and/or<br>e. 760.73 HX of maternal hallucinogenic agent abuse.<br>2. Six month qualification for at least one of:<br>a. 530.1 Gastro-esophageal reflux;<br>b. 786.09 Abnormal pneumogram indicating desaturating apnea;<br>c. 799.0 Periodic respirations;<br>d. 727.9 Significant bradycardia or tachycardia of unknown or specified origin;<br>e. 746.9 Congenital heart defect;<br>f. 770.7 Bronchopulmonary dysplasia or newborn respiratory distress;<br>g. 770.8 Respiratory distress;<br>h. 798.0 Family history of SIDS (siblings only);<br>i. 480.1 Respiratory Syncytial Virus (RSV);<br>j. 770.8 Apparent Life Threatening Episode (ALTE) with subsequent visits to physician or emergency room;<br>k. 478.74 Laryngeotracheal malacia;<br>l. 748.3 Tracheal stenosis; and/or<br>m. 787.2 Swallowing abnormality. | 1. Prescription and/or MD signed Prior Authorization Form.<br>2. Medical documentation supporting qualifying factors. | 1. Program limit to one year for diagnoses including prematurity and maternal substance abuse.<br>2. Other diagnoses limited to six months.<br>3. Beyond stated time limit requires prior authorization with medical justification.<br>4. Original prior authorization not required for ICD-9 codes listed under qualifications. Other diagnoses require prior authorization.<br>5. Reference DMEPOS PT 33 Fee Schedule for quantity limits.<br>6. An Apnea Monitor is a non-reimbursable service in conjunction with an E0463 or E0464 pressure ventilator, with pressure control pressure support, and flow triggering features. |

**Policy: RESPIRATORY SERVICES**

| EQUIPMENT OR ITEM | QUALIFICATIONS | FORMS AND DOCUMENTATION REQUIREMENTS | MISCELLANEOUS POLICY STATEMENTS |
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| **Bi-Level Positive Airway Pressure (BiPAP) Device**<br><br>**BiPAP 'S' (E0470) (without back up)**<br><br>**BiPAP 'ST' (E0471) (with back up rate)**<br><br>**Bi-Level Positive Airway Pressure (BiPAP) Device**<br><br>**BiPAP 'S' (E0470)** ***(without back up)***<br><br>**BiPAP 'ST' (E0471)** ***(with back up rate)*** | 1. For an E0470 or E0471 Respiratory Assist Device (RAD) to be covered, the treating physician must fully document in the recipient's medical record symptoms characteristic of sleep-associated hypoventilation, such as daytime hypersomnolence, excessive fatigue, morning headache, cognitive dysfunction, dyspnea, etc.<br>A RAD (E0470, E0471) used to administer Noninvasive Positive Pressure Respiratory Assistance (NPPRA) therapy is covered for those recipients with clinical disorder groups characterized as (Group I) restrictive thoracic disorders (e.g., progressive neuromuscular diseases or severe thoracic cage abnormalities), (Group II) severe chronic obstructive pulmonary disease (COPD), (Group III) central sleep apnea (CSA), or (Group IV) obstructive sleep apnea (OSA) (E0470 only) and who also meet the following criteria:<br><u>Group I: Restrictive Thoracic Disorders:</u><br>a. There is documentation in the recipient's medical record of a progressive neuromuscular disease (e.g., amyotrophic lateral sclerosis) or a severe thoracic cage abnormality (e.g., post-thoracoplasty for TB); and<br>b. An arterial blood gas PaCO2 , done while awake and breathing the recipient's usual FIO2 is > 45 mm Hg; or<br>c. Sleep oximetry demonstrates oxygen saturation < 88% for at least five continuous minutes, done while breathing the recipient's usual FIO2; or | 1. Prescription and/or MD signed Prior Authorization/CMN Form.<br>2. Sleep Study (Diagnostic and Titrated sleep studies).<br>3. Medical documentation supporting qualifying factors.<br>4. Manufacturer's Invoice (purchased equipment).<br>5. Refer to specific documentation requirements specified in the Qualifications section for each scenario. | 1. The initial rental will be for three months.<br>2. Further approval requires:<br>a. A letter of compliance from the recipient; or<br>b. A completed form found on the QIO-like vendor's website; or<br>c. Follow up notes from physician documenting compliance with the BiPAP; or<br>d. A readout/printout from the BiPAP supplier documenting regular usage of the BiPAP.<br><br>The BiPAP will be rented until the purchase price is reached, this includes the initial three month rental period. |

| **Policy: RESPIRATORY SERVICES** | | | |
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| **EQUIPMENT OR ITEM** | **QUALIFICATIONS** | **FORMS AND DOCUMENTATION REQUIREMENTS** | **MISCELLANEOUS POLICY STATEMENTS** |
| (continued)<br>**BiPAP 'ST' (E0471)**<br>***(with back up rate)*** | d. For a progressive neuromuscular disease (**only**), maximal inspiratory pressure is < 60 cm H20 or forced vital capacity is < 50% predicted; and<br>e. Chronic obstructive pulmonary disease does not contribute significantly to the recipient's pulmonary limitation.<br>3. If all previously described criteria are met, either an E0470 or E0471 device (based upon the judgment of the treating physician) will be covered for recipients within this group of conditions for the first three months of NPPRA therapy (see continued coverage after the initial three months). If all of the previously described criteria are not met, then E0470 or E0471 and related accessories will be denied as not medically necessary.<br><u>Group II: Severe COPD</u>:<br>a. An arterial blood gas $PaCO_2$ done while awake and breathing the recipient's usual $FIO_2$ is $\geq$ 52 mm Hg; and<br>b. Sleep oximetry demonstrates oxygen saturation $\leq$ 88% for at least five continuous minutes, done while breathing oxygen at 2 LPM or the recipient's usual $FIO_2$ (whichever is higher);<br>c. An arterial blood gas $PaCO_2$, done while awake and breathing the recipient's usual $FIO_2$, is $\geq$ 52 mm Hg; and<br>d. Prior to initiating therapy, OSA (and treatment with CPAP) has been considered and ruled out. | | |

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| (continued)<br>**Bi-Level Positive Airway Pressure (BiPAP) Device**<br><br>**BiPAP 'S' (E0470)**<br>***(without back up)***<br><br>**BiPAP 'ST' (E0471)**<br>***(with back up rate)*** | 4. If all of the previously described criteria for recipients with COPD are met, an E0470 device will be covered for the first three months of NPPRA therapy (see Continued Coverage). An E0471 device will not be covered for a recipient with COPD during the first two months, because therapy with a E0470 device with proper adjustments of the device's settings and recipient accommodation to its use will usually result in sufficient improvement without the need of a back-up rate. (See further in this section for coverage of an E0471 device for COPD after two month's use of an E0470 device).<br>5. If all of the previously described criteria are not met, E0470 and related accessories will be denied as not medically necessary. If E0471 is billed, even if the criteria for an 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.<br><u>Group III: Central Sleep Apnea (e.g., apnea not due to airway obstruction)</u>:<br>Prior to initiating therapy, a complete facility-based, attended polysomnogram must be performed documenting the following:<br>a. The diagnosis of central sleep apnea (CSA);<br>b. The exclusion of obstructive sleep apnea (OSA) as the predominant cause of sleep-associated hypoventilation;<br>c. The ruling out of CPAP as effective therapy if OSA is a component of the sleep-associated hypoventilation; and | | |

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| | d. Oxygen saturation ≤ 88% for at least five continuous minutes, done while breathing the recipient's usual $FIO_2$; and<br>e. Significant improvement of the sleep-associated hypoventilation with the use of an E0470 or E0471 device on the settings that will be prescribed for initial use at home, while breathing the recipient's usual $FIO_2$.<br>6. If all previously described criteria are met, either an E0470 or E0471 device (based upon the judgment of the treating physician) will be covered for recipients with documented CSA conditions for the first three months of NPPRA therapy (see Continued Coverage). If all of the previously described criteria are not met, then E0470 or E0471 and related accessories will be denied as not medically necessary.<br>Group IV: Obstructive Sleep Apnea (OSA):<br>Criteria (a) and (b) are both met:<br>a. A complete facility-based, attended polysomnogram has established the diagnosis of obstructive sleep apnea according to the following criteria:<br>1. The apnea-hypopnea index (AHI) is ≥ 15 events per hour; or<br>2. The AHI is from 5 to 14 events per hour with documented symptoms of:<br>a. Excessive daytime sleepiness, impaired cognition, mood disorders, or insomnia; or<br>b. Hypertension, ischemic heart disease, or history of stroke; and | | |

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| (continued)<br>**Bi-Level Positive Airway Pressure (BiPAP) Device**<br><br>**BiPAP 'S' (E0470)**<br>***(without back up)***<br><br>**BiPAP 'ST' (E0471)**<br>***(with back up rate)*** | b. A single level device E0601, Continuous Positive Airway Pressure (CPAP) device has been tried and proven ineffective.<br>7. If the previously described criteria is met, an E0470 device will be covered for the first three months of NPPRA therapy (see Continued Coverage). If E0470 is billed and these criteria are not met but the coverage criteria in the DMEMAC LCD and/or Policy Articles for Continuous Positive Airway Pressure System (CPAP) are met, payment will be based on the allowance for the least costly medically appropriate alternative, E0601.<br>8. An 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.<br><br>Continued Coverage For E0470 And E0471 Devices Beyond First Three Months Of Therapy:<br>1. Recipients covered for the first three months for an E0470 or E0471 device must be re-evaluated to establish the medical necessity of continued coverage beyond the first three months. While the recipient 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 | | |

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| (continued)<br>**Bi-Level Positive Airway Pressure (BiPAP) Device**<br><br>**BiPAP 'S' (E0470)**<br>***(without back up)***<br><br>**BiPAP 'ST' (E0471)**<br>***(with back up rate)*** | the treating physician. Medicaid will not continue coverage for the fourth and succeeding months of NPPRA therapy until this re-evaluation has been completed.<br>2. There must be documentation in the recipient's medical record about the progress of relevant symptoms and recipient usage of the device up to that time. Failure of the recipient to be consistently using the E0470 or E0471 device for an average of four hours per 24 hour period by the time of the re-evaluation (on or after the 31st day, but no later than 91 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 to deny continued coverage as not medically necessary.<br>3. The following items of documentation must be obtained by the supplier of the device for continuation of coverage beyond three months: a signed and dated statement completed by the treating physician no sooner than 61 days after initiating use of the device,<br>declaring that the recipient is compliantly using the device (an average of four hours per 24 hour period) and that the recipient is benefiting from its use. A "Usage Evaluation" form FH-1A, found on the QIO-like vendor's website is available for use at:<br>https://www.medicaid.nv.gov/,<br>select "Provider" then "Forms". It is not mandatory that this form be used as long as the above information is provided by the treating physician. | | |

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| (continued)<br>**Bi-Level Positive Airway Pressure (BiPAP) Device**<br><br>**BiPAP 'S' (E0470)**<br>***(without back up)***<br><br>**BiPAP 'ST' (E0471)**<br>***(with back up rate)*** | 4. If the above criteria are not met, continued coverage of an E0470 or E0471 device and related accessories will be denied as not medically necessary.<br>5. For Group II (COPD) recipients who qualified for an E0470 device, if at a time no sooner than 61 days after initial issue and compliant use of an E0470 device, the treating physician believes the recipient requires an E0471 device, the E0471 device will be covered if the following criteria are met:<br>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 recipient's usual $FIO_2$, still remains $\geq$ 52 mm Hg;<br>b. a sleep oximetry, repeated no sooner than 61 days after initiation of compliant use of an E0470 device, and while breathing with the E0470 device, demonstrates oxygen saturation < 88% for at least five continuous minutes, done while breathing oxygen at 2 LPM or the recipient's usual $FIO_2$ (whichever is higher); and<br>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 recipient has been compliantly using the E0470 device (an average of four hours per 24 hour period) but that the recipient is NOT benefiting from its use.<br>6. If the above criteria for an E0471 are not met, since the E0471 is in a different payment category than E0470 and a least costly medically appropriate alternative payment | | |

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| (continued)<br>**Bi-Level Positive Airway Pressure (BiPAP) Device**<br><br>**BiPAP 'S' (E0470)**<br>***(without back up)***<br><br>**BiPAP 'ST' (E0471)**<br>***(with back up rate)*** | cannot be made, it will be denied as not medically necessary. | | |
| **Continuous Positive Airway Pressure Device**<br>**CPAP (E0601)** | 1. A single level continuous positive airway pressure (CPAP) device (E0601) is covered if the recipient has a diagnosis of obstructive sleep apnea (OSA) documented by an attended, facility-based polysomnogram and meets either of the following criteria (a or b):<br>a. The AHI is ≥ 15 events per hour; or<br>b. The AHI is from 5 to 14 events per hour with documented symptoms of:<br>1. Excessive daytime sleepiness, impaired cognition, mood disorders, or insomnia; or<br>2. Hypertension, ischemic heart disease, or history of stroke.<br>Note: 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 (e.g., the AHI may not be an extrapolated or a projected calculation).<br>2. Continued coverage of an E0601 device beyond the first three months of therapy requires that, no sooner than the 31st day but no later than 91 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 | 1. Prescription and/or MD signed Prior Authorization/CMN Form.<br>2. Sleep Study (Diagnostic and Titrated sleep studies).<br>3. Medical documentation supporting qualifying factors.<br>4. Manufacturer's Invoice (purchased equipment).<br>5. Refer to specific documentation requirements specified in the Qualifications section for each scenario. | 1. The initial rental will be for three months.<br>2. Further approval requires:<br>a. letter of compliance from the recipient; or<br>b. a completed form found on the QIO-like vendor's website; or<br>c. follow up notes from physician documenting compliance with the CPAP; or<br>d. a readout/printout from the CPAP supplier documenting regular usage of the CPAP.<br><br>The CPAP will be rented until the purchase price is reached, this includes the initial three month rental period. |

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| (continued)<br>**Continuous Positive Airway Pressure Device**<br>**CPAP (E0601)** | use is defined as an average of four hours per 24 hour period.<br><br>A "Usage Evaluation" form FH-1A, found on the QIO-like vendor's website is available for use at: https://www.medicaid.nv.gov/, select "Provider" then "Forms". It is not mandatory that this form be used as long as the previously listed is provided by the treating physician.<br><br>The supplier cannot provide answers to any of the information, as it must be obtained from the recipient, caregiver, spouse, or attending physician. Information should include:<br>a. Number of hours a day the machine is used.<br>b. Number of months using machine.<br>c. Will the recipient continue to use the machine in the future?<br>Identify who has answered the information (cannot be the supplier). | | |

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| **High Frequency Chest Wall Oscillation Air-Pulse Generator System (E0483)**<br><br>**(Rental and the initial purchase includes hose and vest)**<br><br>**Replacement Items:**<br><br>**High Frequency Chest Wall Oscillation Systems Vest, for the use with recipient owned equipment (A7025)**<br><br>**High Frequency Chest Wall Oscillation System Hose, for use with recipient owned equipment (A7026)** | 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:<br>1. Documented medical justification for the need and length of time the HFCC system will be utilized; and<br>2. Recipient must have one of the following diagnoses which causes excessive, tenacious secretions and impairs ability to clear secretions:<br>a. Cystic fibrosis;<br>b. Chronic bronchiectasis; or<br>c. Chronic neuromuscular disorder with prior history of pneumonia or other significant worsening of pulmonary functioning;<br>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;<br>4. Documentation of physician's treatment plan that includes external manipulation of the thorax at least daily to release retained secretions;<br>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;<br>6. Age greater than 2 years; and<br>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). | 1. Physician's order/prescription.<br>2. Completed prior authorization form.<br>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 atelectasis caused by mucus plugging by report.<br>4. Documented failure of CPT, type used, frequency, duration of use and outcomes.<br>5. Current medications, route of administration, dosage, and frequency.<br>6. Diagnostic studies such as high resolution, spiral, or standard CT scan.<br>7. Number of times per day recipient requires CPT.<br>8. Age of recipient.<br>9. Identify primary caregiver and the caregiver availability.<br>10. The prescribing physician will need to submit periodic follow-up reports. | 1. 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.<br>2. 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.<br>3. 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.<br>4. 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.<br>5. The QIO-like vendor will provide authorization to include the 61st through 120 days if medically necessary.<br>**Not Medically Necessary** |

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| (continued)<br>**High Frequency Chest Wall Oscillation Air-Pulse Generator System (E0483)**<br><br>**(Rental and the initial purchase includes hose and vest)**<br><br>**Replacement Items:**<br><br>**High Frequency Chest Wall Oscillation Systems Vest, for the use with recipient owned equipment (A7025)**<br><br>**High Frequency Chest Wall Oscillation System Hose, for use with recipient owned equipment (A7026)** | Recipients who have a documented diagnosis, other than those listed under item 2, 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:<br>1. Recipient meets qualifications 1 through 7, excluding item 2; and<br>2. Documented evidence of a recent prior history of pneumonia or other significant worsening pulmonary functioning.<br><br>**Qualifications for Continued Use**<br><br>Continued coverage of the HFCC device beyond the three-month trial of therapy requires documentation dated no sooner than the 61st day, but not later than 120 days after initiating therapy in one of the following formats:<br>1. The treating physician submits documentation to include the effectiveness of treatment, recipient's compliance and tolerance of the therapy; or<br>2. Report via monthly usage meter checks documenting use at least 67% of prescribed frequency. | | 1. When the criteria in this policy are not met.<br>2. Recipient receiving duplication of services.<br>3. The DHCFP will not reimburse providers for bronchial drainage performed by a therapist or other health care professional while the recipient has the bronchial drainage vest (e.g., home health services where a physical therapist, nurse, and/or aide is performing CPT and postural drainage).<br>4. Recipients who have 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 are not limited to:<br>a. unstable head or neck injury;<br>b. active hemorrhage with hemodynamic instability;<br>c. subcutaneous emphysema;<br>d. spinal fusion or spinal anesthesia;<br>e. recent skin grafts or flaps on the thorax;<br>f. burns, open wounds;<br>g. skin infections of the thorax;<br>h. recently placed trans-venous pacemaker or subcutaneous pacemaker;<br>i. suspected pulmonary tuberculosis;<br>j. lung contusion;<br>k. bronchospasm;<br>l. osteomyelitis of the ribs;<br>m. osteoporosis; |

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| (continued)<br>**High Frequency Chest Wall Oscillation Air-Pulse Generator System (E0483)**<br><br>**(Rental and the initial purchase includes hose and vest)**<br><br>**Replacement Items:**<br><br>**High Frequency Chest Wall Oscillation Systems Vest, for the use with recipient owned equipment (A7025)**<br><br>**High Frequency Chest Wall Oscillation System Hose, for use with recipient owned equipment (A7026)** | | | n. coagulopathy; and/or<br>o. complaint of significant chest wall pain. |
| **Humidifiers and Supplies** | 1. Medical evidence/documentation recipient is a new start or compliant with current positive airway pressure therapy.<br>2. Sleep study or equipment fitting documentation showing recommended type and sizing.<br>3. Quantity limited to reimbursable guidelines. | 1. Prescription and/or MD signed Prior Authorization Form<br>2. Medical documentation supporting qualifying factors. | 1. Reference DMEPOS PT 33 fee schedule. |

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| **Nebulizers and Compressors** | 1. A small volume nebulizer (A7003, A7004, A7005) and related compressor (E0570, E0571) are covered when:<br>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);<br>b. It is medically necessary to administer gentamicin, tobramycin, amikacin, or dornase alfa to a recipient with cystic fibrosis (ICD-9 diagnosis code 277.00);<br>c. It is medically necessary to administer pentamidine to recipients 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<br>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).<br>Note: 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 recipient's medical record and be available to Medicaid on request.<br>2. A large volume nebulizer (A7017), related compressor (E0565 or E0572), and water or | 1. Prescription and/or MD signed Prior Authorization Form.<br>2. Medical documentation supporting qualifying factors. | 1. Reference DMEPOS PT 33 fee schedule.<br>2. Small volume ultrasonic nebulizer (E0574) and large volume ultrasonic nebulizer (E0575) will be reimbursed at the least costly alternative of a pneumatic compressor (E0570). |

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| (continued)<br>**Nebulizers and Compressors** | saline (A7018 or A4216) are covered when it is medically necessary to deliver humidity to a recipient 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 recipients 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 non-covered. | | |

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| **Oximeter Rental:**<br>**E0445-RR device for measuring blood oxygen levels, non-invasive**<br><br>**Accessories:**<br>**Oxygen probe (A4606) for use with oximeter device, replacement** | 1. The DHCFP 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:<br>a. Any age determination:<br>1. Recipient is dependent on both a ventilator and supplemental oxygen;<br>2. Recipient has a tracheostomy and is oxygen dependent; or<br>3. Recipient is on supplemental oxygen and weaning is in process.<br>b. A pediatric recipient must meet one of the following criteria:<br>1. Infants with chronic lung disorder (e.g., bronchopulmonary dysplasia); or<br>2. Premature infant on active therapy for apnea.<br><br>[1] less than 30 days<br>[2] greater than 30 days | 1. Prescription by physician;<br>2. Prior authorization; and<br>3. Documentation by the physician 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 $O_2$; and<br><br>**Recertification of Prior Authorization:**<br>1. Recertification is required until the recipient no longer meets criteria or the device is removed from the home; and<br>2. Physician progress notes/narratives to substantiate the continued need to use the oximeter for decreased $O_2$ saturations. Allowable notations to include family, recipient and/or caregivers responses. | 1. Approval of Oximeter will be on a rental basis only; purchase of equipment is non-reimbursable.<br>2. Initial approval may be for 30 days; unless initial documentation supports long term use then approval will be up to six months.<br>3. Approval for prior authorization recertification request will be for up to six months.<br>4. Oximeter testing is not a reimbursable service for DME providers. |
| **Oxygen ($O_2$):**<br>**Concentrators**<br>**Portables**<br>**Regulators**<br>**$O_2$ Carts**<br><br>**Oxygen Supplies:**<br>**Tubing**<br>**Cannulas**<br>**$O_2$ Masks**<br>**Humidifiers** | 1. Arterial blood gases or an ear oximetry reporting:<br>a. $PO_2$ Level of 60 mmHG or less on room air; or<br>b. 80 mmHG or less on $O_2$; or<br>c. $O_2$ saturation (sat) level of 89% or less; and<br>d. Medical Necessity;<br>e. Must list conditions of study (rest, sleeping, exercising, room air, on oxygen).<br>2. CHILDREN: 92% or less room air saturation, at rest.<br>3. $O_2$ sats must be performed within 60 days of requested dates of service. | 1. Prescription and/or MD signed Prior Authorization/CMN Form.<br>2. Oximetry spot check or overnight tape results<br>3. Medical documentation supporting qualifying factors. | 1. Oximetry test must be performed by a physician or qualified laboratory. $O_2$ saturations (sats) will not be accepted from an oxygen supplier.<br>2. 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 as concentrator. |

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| **Respirometers** | 1. Medical evidence/documentation supporting a related diagnosis for equipment. | | |
| **Suction Pumps** | 1. Recipients who have difficulty raising and clearing secretions due to:<br>a. Cancer or surgery of the throat or mouth;<br>b. Dysfunction of the swallowing muscles;<br>c. Unconsciousness or obtunded state; or<br>d. Tracheostomy (V44.0). | 1. Prescription and/or MD signed Prior Authorization Form.<br>2. Medical documentation supporting qualifying factors. | 1. Reference DMEPOS PT 33 Fee Schedule for quantity limits. |
| **Ventilators** | 1. Medical evidence/documentation supporting a related diagnosis for equipment (e.g., tracheostomy). | 1. Prescription and/or MD signed Prior Authorization Form.<br>2. Medical documentation supporting qualifying factors.<br>3. Manufacturer's Invoice. | 1. Medical Supplier must keep back up inventory available for rented equipment in emergent situations. Reimbursement for a back up ventilator provided in the recipient's home will only be allowed if it is medically prohibitive for a provider to respond in an emergent situation such as a recipient being on 24 hour ventilation support. |