Medicaid Services Manual
Transmittal Letter

April 30, 2024

To: Custodians of Medicaid Services Manual

From: Casey Angres
Chief of Division Compliance

Subject: Medicaid Services Manual Changes
Chapter 1300 – DME, Prosthetics, Orthotics, and Supplies

**Background And Explanation**

Revisions to Medicaid Services Manual (MSM) Chapter 1300 – DME, Prosthetics, Orthotics, and Supplies are being proposed.

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

Entities Financially Affected: Provider Type (PT) Durable Medical Equipment (DME) (PT 33).

Financial Impact on Local Government: Unknown at this time.

These changes are effective May 1, 2024.

| Material Transmitted | Material Superseded |
|---|---|
| MTL OL<br>MSM Chapter 1300 – DME Disposable Supplies and Supplements | MTL 27/15, 08/16, 07/17, 07/18, 09/20,<br>MSM Chapter 1300 – DME Disposable Supplies and Supplements |

| Manual Section | Section Title | Background and Explanation of Policy Changes, Clarifications and Updates |
|---|---|---|
| **1303.1(A)(4-5)** | **Durable Medical Equipment, Prosthetic Devices, Orthotic Devices, Disposable Medical Supplies (Dmepos) Program** | Medical necessity, duplicate services, and direction for deluxe definition were updated. |
| **1303.1(B)(9)** | | Added proof of teaching to be included in the recipient's record. |

| Manual Section | Section Title | Background and Explanation of Policy Changes, Clarifications and Updates |
|---|---|---|
| **1303.1(C)(6)** | | Added examples of misuse or neglect of equipment. |
| **1303.2(A)(1)(a)** | **Documentation Requirements** | Updated the acceptable timeframe of required face-to-face encounter to six months. |
| **1303.2(A)(3)** | | Added required contents to submitting an invoice. |
| **1303.2(B)(2-3)** | | Added verbiage of required documentation to be included in recipient file. |
| **1303.3** | **Rental and Purchase Options** | Clarified modifier requirements and recipient choice of rental or purchase of equipment. |
| **1303.4(A)(1)(c)** | **Prior Authorization** | Removed fax and mail option to submit prior authorizations. |
| **1303.4(A)(1)(e)** | | Reworded physician order requirements to support medical necessity. |
| **1303.4(A)(6)(a)(1)(b)** | | Removed fax option and added electronic. |
| **1303.5(A)** | **Dispensing and Delivery of DMEPOS** | Reworded quantity limits and solicitation not allowed. |
| **1303.5(B)(2)** | | Clarified delivery method 2 – not mail order. |
| **1303.5(B)(2)(b)** | | Verbiage adding delivery address and HCPCs code. |
| **1303.9(C)** | **DME at Institutional Facility (IF)** | Clarified language to match custom features and place of delivery on a claim. |
| **Appendix A(1)** | **Non-Covered Services** | Added verbiage from other areas of policy regarding comfort/convenience, clarified coverage exception policy and added electronic written request. |
| **Appendix A(2)(A)** | | Added verbiage from other areas of policy regarding comfort/convenience, clarified coverage exception policy and added electronic written request. |
| **Appendix B** | **Introduction** | Added verbiage that is within main body of policy. |

| Manual Section | Section Title | Background and Explanation of Policy Changes, Clarifications and Updates |
|---|---|---|
| | **Cardioverter Defibrillator** | New coverage added for wearable cardioverter defibrillator. |
| | **Communication Devices** | Clarified language that Speech Language Pathologists cannot be employed by the DME provider and added a trial period for communication devices to ensure proper equipment. |
| | **Diabetic Supplies** | Infusion supply codes updated. |
| | **Disposable Supplies** | Removed limits and added billing guide reference. |
| | **Mobility Assistive Equipment (MAE)** | Gait trainer codes added and a note who can provide trial and medical necessity information.<br><br>Added EPSDT verbiage for positioning seats for persons with special orthopedic needs to meet medical necessity.<br><br>Added verbiage regarding duplicate service if services in other programs.<br><br>Added language for elevating leg rest clarification. |
| | **Orthotic and Prosthetic Devices** | Added EPSDT verbiage for Cranial Remolding Orthotic Devices. |
| | **Respiratory Services** | Bi-PAP and CPAP sleep study for hospital discharge clarified. Removed reference to MSRP invoice. Removed reference to arterial blood gas for Group II. Added verbiage for Pickwickian Syndrome added. Spelled out compliance for continued use.<br><br>Added verbiage for Non-invasive Ventilator qualifications. |

# 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 where normal life activities take place, is covered by the DHCFP and NCU for eligible recipients. New equipment, repairs or replacement requires medical documentation and are 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 (including all parts to build a product) 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. Any DMEPOS products and services within other DHCFP programs that meet the same medical purpose will be processed as duplicate.

   For purposes of this Chapter, a covered service or item meets the definition of medical necessity if each of the following criteria have been satisfied:

   a. All qualifications of medical necessity outlined in Medicaid Services Manual (MSM) Chapter 100, section 103.1;

   b. It is the least costly alternative that is equally effective and safe to address the recipient's medical needs; and

   c. It is not provided as a convenience to the recipient, caregiver, or provider.

5. Deluxe equipment (definition or clarification of deluxe can be located within the DME billing guide found at www.medicaid.nv.gov) will not be authorized when it is determined that 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/Resources/Rates/RatesCostContainmentMain.

10. The DHCFP does not reimburse for items that are the same or similar to items that the recipient has already acquired or has access to 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 DMEPOS provider must adhere to all Federal Rules and Regulations applicable to their provider type including, but not limited to, 42 CFR Part 440 for enrollment. i.e. not limited to: storefront, background checks, etc.

5. 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.

6. The provider is responsible for ensuring the equipment is appropriate for the recipient and the recipient's location of normal life activities prior to billing the DHCFP.

7. The provider is responsible for providing a manufacturer's suggested retail pricing (MSRP) invoice for certain items, where no rate has been established.

8. 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.

9. The provider is responsible for teaching ~~to teach~~ the recipient, caregivers or authorized representative(s) about the operation, proper use, maintenance requirements, ~~and~~ any unacceptable use of the medical equipment and proof of the documented teachings provided, all to be included in the recipient's records.

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, non-usable or shortens the lifetime of the item (i.e.: using power mobility devices as a form of transportation, leaving equipment out in the weather, not properly charging power equipment etc.).~~;~~

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 as required by CMS, whether verbal or written, must be incidental/relevant to the treating physician-documented face-to-face encounter between the recipient and the prescribing physician/practitioner (as allowed by The Act) no more than six months ~~within 30 - 60 days~~ prior to the approved PA start date ~~of the order/script~~. The encounter must be clearly documented and relevant to the need for the prescribed DMEPOS.

Refer to Appendix B of this Chapter for additional order/documentation 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://med/noridianmedicare.com/web/jddme/education/supplier-manual

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 the most current appropriate diagnosis code(s) (ICD), 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~~ recipient'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 invoice for each item supplied. The warranty information must also be included. This may be completed by the provider/supplier but can also be documented by the physician.

3. INVOICE

All requirements below must be met when submitting an invoice.

a. Itemized bill listing Manufacturer's Cost or Manufacturer's Suggested Retail Price (MSRP) invoice for the DME item~~s~~.

b. Name and address of the manufacturer providing item.

c. Invoice number, date and identification of the equipment utilizing the Healthcare Common Procedure Coding system (HCPCs) code, including any miscellaneous HCPCs codes, if appropriate.

d. Name, address, and National Provider Identifier (NPI) of the DME provider submitting the invoice.

e. Cannot be older than six months prior to the date of authorization request.

~~3.~~4. 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.~~5. 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.~~6. 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, proof of any recipient/prescriber training as required in this chapter, choice of rental or purchase option, and warranty information given to the recipient.

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 claims for DMEPOS items, complaints, and resolution accounts filed.~~for DMEPOS items~~.

## 1303.3 RENTAL AND PURCHASE OPTIONS

Items identified in the DMEPOS Fee Schedule with an RR modifier for rental and an NU modifier for purchase (for some items to purchase no modifier may be listed on the fee schedule) option may 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. Recipients must be given the option of rental or purchase when policy allows. If a Nevada Medicaid rate has not been assigned, a cost or an MSRP invoice is ~~are~~ required to be submitted with the prior authorization (PA) request or claim, if a PA is not already required for that item.

### 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)

b. The DHCFP will only purchase 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 rented piece of equipment 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 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 p~~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 that entails clear coverage qualification and medical necessity for the specific equipment/supplies. ~~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 for locations in which normal life activities take place. 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: https://med.noridianmedicare.com/web/jddme. 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 the most current appropriate diagnosis code(s)/ICD 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. 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.

b. Usage Evaluation – For Continuing Use of Bi-Level and Continuous Positive Airway Pressure (BIPAP and CPAP) Devices use the form, FA-1A found on the QIO-like vendor's website. This form may be completed and submitted for continuing usage of BIPAP or CPAP devices.

c. Mobility Assessment for Mobility Devices, Wheelchair Accessories and Seating Systems, form FA-1B found on the QIO-like vendor's website. This form must be submitted for all mobility devices, wheelchair accessories and seating systems. The Clinical Assessment must be completed and signed by the treating physician.

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 additional information on the below 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.

1. 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.

a. The provider may request a peer-to-peer review within 10 days of the date of decision via phone contact to the QIO-like vendor.

b. The provider may request consideration of the denial by submitting additional medical documentation and requesting a reconsideration electronically ~~in writing via fax~~ within 30 days of denial.

c. If a reconsideration is not appropriate or is also denied, the recipient may be entitled to request a hearing within 90 days from the date of decision. Refer to MSM Chapter 3100 – Hearings.

B. COVERAGE AND LIMITATIONS

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 and not listed quantity limits~~, 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 ONLY to verify a re-order and not for solicitation.

### 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 (DOS) 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 (this is not considered mail order):

   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, delivery address, quantity, detailed description of the item(s) delivered, HCPCs code, brand

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. custom fabricated molded seating systems etc.) needed for the recipient's permanent, full-time use, 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. Place of service must reflect the actual place of delivery.

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.

APPENDIX A

NON-COVERED SERVICES

1. The DHCFP's DMEPOS program does not cover items if they ~~either~~ do not meet the definition of durable medical equipment, prosthetic, orthotic or disposable medical supplies. A request for convenience or comfort of a recipient or their caregiver is not a consideration of medical necessity and is non-covered. Items that ~~; or~~ are not considered primarily medical in nature; or are not FDA approved or the approved use by the FDA are ~~is~~ also not applicable when determining coverage under the DME program.

   Note: If a provider prescribes, orders and/or recommends a service or supply this does not, of itself, make it an eligible benefit.

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)) 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: http://dhcfp.nv.gov/Resources/Rates/FeeSchedules/.

   ~~1.~~A. The DHCFP is required to have a process and criteria for seeking modifications or exceptions to established coverage policies. Administrative exceptions are ~~This process is~~ available to recipients on a case-by-case basis for DMEPOS items excluded from the DMEPOS Fee Schedule~~.~~ with electronic written request via the QIO like vendor~~Because a provider prescribes, orders and/or recommends a service or supply does not, of itself, make it an eligible benefit~~.

      ~~2.~~1. Consideration will be made on a case-by-case basis using the following criteria:

         ~~1.~~a. 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 and MSM Chapter Addendum;

         ~~2.~~b. 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.~~c. 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.

~~c.~~d. Review chapter and fee schedule for coverage. If not located under this provider type but possibly might be covered under other programs i.e.: EPSDT, nursing home, etc. please review the coverage criteria and fee schedule for that specific provider type.

**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 |
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| 1. Qualifications identified for each specific item listed within this Appendix must all be met for coverage by the DHCFP.<br>2. All requests must meet the definition of DME per CMS.<br>3. All DME must be primarily medical in nature.<br>~~2.~~4. All DMEPOS products (including all parts to build a product) 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 medical needs. Items intended to meet the same medical need as other services will be processed as duplicate.<br>~~3.~~5. 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 Suggested Retail Price (MSRP) Invoice (to determine pricing) for certain items, 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 deemed as a rental only by the DHCFP. Refer to main body of Chapter 1300 and the DMEPOS Fee Schedule.<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, and billing guides.<br>5. The DHCFP will not reimburse providers who supply DMEPOS prior to PA approval except in certain situations, such as retro eligibility. |

Policy: **CARDIOVERTER DEFIBRILLATOR**

| EQUIPMENT OR ITEM | QUALIFICATIONS | FORMS AND DOCUMENTATION REQUIREMENTS | MISCELLANEOUS POLICY STATEMENTS |
|---|---|---|---|
| Wearable Cardioverter defibrillator (WCD) vest **(K0606)**<br><br>**Supplies:**<br>**K0607** (Replacement battery for automated external defibrillator, garment type only), **K0608** (Replacement garment for use with automated external defibrillator, each) and **K0609** (Replacement electrodes for use with the automated external defibrillator, garment type only) | A WCD may be covered as interim treatment for recipients at high risk of sudden cardiac death (SCD) who have one at least one of the following:<br>1. A documented episode of ventricular fibrillation or a sustained, ventricular tachyarrhythmia. These dysrhythmias may be spontaneous; and/or must be reproducible during an electrophysiologic (EP) study but<br>a. may not be due to a transient or reversible cause,<br>b. not within the first 48 hours of an acute myocardial infarction,<br>c. not within the first 72 hours post coronary bypass and,<br>d. not within 5 days of a transplant<br>2. Familial or inherited conditions with a high risk of life-threatening ventricular tachyarrhythmia such as long QT syndrome or hypertrophic cardiomyopathy<br>3. A documented prior myocardial infarction, dilated cardiomyopathy, endomyocardial eosinophilic disease, endocardial fibroelastosis, or alcoholic cardiomyopathy and a measured left ventricular ejection fraction less than or equal to 0.35; or<br>4. A previously implanted defibrillator that malfunctioned due to an infection, or inflammatory reaction due to cardiac valve prosthesis. | 1. The provider and ordering practitioner have explored any less costly medically appropriate alternatives with the recipient. If the alternatives are not adequate for the recipient, the ordering practitioner is required to provide clear documentation explaining the decision.<br>2. The ordering practitioner of the wearable defibrillator is a cardiologist and experienced in the management of patients at risk for SCD. | 1. Initial evaluation will be for the first three months only.<br>2. Subsequent evaluations may be allowed if the recipient is compliant with the treating physician's order of usage, and if medically necessary, up to 10 months to be considered recipient owned. Failure of the recipient to be consistently using the K0606 device per the treating physician's order by the time of the re-evaluation would represent non-compliant utilization for the intended purpose and expectations of this therapy. This would constitute reason to deny continued coverage.<br>3. Supplies are only purchased after K0606 is recipient owned.<br><br>Non-Covered Indications<br><br>The WCD is considered investigational, not medically necessary, medically contraindicated, and not covered for all other indications unless listed as covered in this policy. This includes but is not limited to, the following:<br>1. Patients with a history of an acute myocardial infarction within 30 days and no other indications that would result in the WCD being determined as medically necessary for the recipient.<br>2. Patients with drug-refractory class IV congestive heart failure (CHF) who are not candidates for heart transplantation.<br>3. Patients with a history of psychiatric disorders that interfere with the necessary care and follow-up.<br>4. Patients in whom a reversible triggering factor (by drug therapy, definitive therapy, ablation) for VT/VF can be definitely identified, such as ventricular tachyarrhythmias in evolving acute myocardial infarction or electrolyte abnormalities. |

Policy: **CARDIOVERTER DEFIBRILLATOR**

| EQUIPMENT OR ITEM | QUALIFICATIONS | FORMS AND DOCUMENTATION REQUIREMENTS | MISCELLANEOUS POLICY STATEMENTS |
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| (continued) | Continued coverage for K0606 device beyond the first three months of therapy:<br>1. Recipients covered for the first three months for a K0606 device must be re-evaluated to establish the medical necessity of continued coverage need beyond the first three months based on above criteria documented by the treating physician.<br>2. There must be documentation in the recipient's medical record about the progress of relevant symptoms and recipient compliance of usage of the device matching the treating physician's order up to that time. | | 5. Patients with terminal illnesses or other disease processes that clearly and severely limit the patient's life expectancy.* |

**Policy: COMMUNICATION DEVICES**

| EQUIPMENT OR ITEM | QUALIFICATIONS | FORMS AND DOCUMENTATION REQUIREMENTS | MISCELLANEOUS POLICY STATEMENTS |
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| **Speech Generating Device (SGD)** *(also known as Augmentative Communication Device (ACD) or Augmentative and Alternative Communication (AAC) Device* **(E2500 – E2510)**<br><br>**Digitized Speech Devices: (E2500, E2502, E2504, E2506)**<br><br>**Synthesized Speech Devices: (E2508, E2510)** | 1. A dedicated speech generating device (SGD) may be covered when it is medically necessary to restore the function of speech to an individual with a functional disability caused by a long term (lasting more than one year) and severe speech impairment; and<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) (not employed by the DME provider) 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, | 1. For all items, documentation must support all criteria in the Qualifications section.<br>2. Providers must submit prior authorizations and claims 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).<br>6. Expected lifespan of SGD E2500-E2510 or E2511 is considered 60 months and are limited accordingly.<br>**Note: A trial period of three months may be required to ensure appropriate item.** ~~Replacement equipment may be authorized prior to the 60 months based on medical necessity~~. |

**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 codes:<br>Diabetes Mellitus<br>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 three injections per day), with frequent self-adjustments of insulin doses for at least six months prior to request for the insulin pump.<br>5. Documented frequency of glucose self-testing is an average of at least four times per day during the two months prior to starting the insulin pump.<br>6. Glycosylated hemoglobin level (HbA1C) > 7.0%<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 four times per day) with multiple injections.<br>2. Recipient has been on a program of multiple injections of insulin (at least three times per day) with frequent self- adjustment of insulin doses at least six 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 HbA1C level (within last 60 days).<br>b. Signed narrative from the physician documenting the recipient's compliance. | 1. External ambulatory infusion pump recipients with Gestational Diabetes who~~m~~ do not meet conditions one through six 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><br>A4224 - Supplies for insulin infusion catheter (per/week)<br>A4225 - Supplies for external infusion pump-syringe type cartridge (each)<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~~<br><br>Note: Available under DHCFP Pharmacy Program, billed through point of sale (POS). |

**Policy: DISPOSABLE SUPPLIES**

| EQUIPMENT OR ITEM | QUALIFICATIONS | FORMS AND DOCUMENTATION REQUIREMENTS | MISCELLANEOUS POLICY STATEMENTS |
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| **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 six 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 (listed in the billing guide~~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 |

| Policy: MOBILITY ASSISTIVE EQUIPMENT (MAE) | | | |
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| **EQUIPMENT OR ITEM** | **QUALIFICATIONS** | **FORMS AND DOCUMENTATION REQUIREMENTS** | **MISCELLANEOUS POLICY STATEMENTS** |
| (continued)<br>**Walkers**<br><br>**Walker Accessories** | 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 a functional mobility deficit that can be sufficiently resolved with use of a walker.<br>1. 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. | | 1. Walker accessory items may be provided as replacement items for recipient-owned MAE. When the walker HCPCS description includes the accessory item, these items cannot be billed separately with the initial purchase. |
| **Gait Trainers:**<br><br>**E8000**<br>**E8001**<br>**E8002** | 1. EPSDT only.<br>2. Mobility Assistive Device for moderate to maximum support for walking.<br>3. Functional mobility deficit cannot be resolved using a walker. | 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.<br>3. Must demonstrate the capability of independently walking with the use of a gait trainer.<br>**Note**: Trial and medical necessity must come from the prescribing physician or physical or occupational therapist that specializes in mobility.<br>4. An MSRP Invoice if there is no rate established by the DHCFP. | Note: Rehab equipment and physical/ occupational therapy equipment for home use is not covered under the DME benefit. Please review policies applicable to therapies and rehabilitation. |
| **POSITIONING SEAT FOR PERSONS WITH SPECIAL ORTHOPEDIC NEEDS**<br>**T5001** | EPSDT only<br>**Adaptive Car Seats**<br><br>1. The recipient's diagnosis(es)/clinical condition(s) support the need for a specialized vehicle positioning seat due to decreased seated postural control that would immediately result in an adverse medical outcome. | 1. Complete valid Physician's/Practitioner's Order/Prescription.<br>2. Ordering practitioner clinical that discusses the medical necessity for the requested equipment.<br>3. Complete qualified health care professional evaluation that meets the following criteria: | 1. Duplication of services/equipment will not be approved.<br>2. Deluxe equipment will not be approved if there are less costly alternatives.<br>3. Products must have received approval from the federal Food and Drug Administration (FDA) and be consistent with the approved use. |

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

| EQUIPMENT OR ITEM | QUALIFICATIONS | FORMS AND DOCUMENTATION REQUIREMENTS | MISCELLANEOUS POLICY STATEMENTS |
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| | 2. A commercially available vehicle positioning seat has been trialed and demonstrated to not meet recipient's medical needs.<br>3. The recipient can only be safely transported in a specialized vehicle positioning seat.<br>4. If the recipient has a mobility base, the recipient cannot be transported in a motor vehicle in the mobility base (for example, the recipient's primary caregiver does not drive an adaptive van equipped to transport the recipient in the mobility base).<br>5. The growth capacity of the positioning seat will accommodate the recipient growth.<br>6. The positioning seat and components and/or accessories (if necessary) comply with federal safety standards.<br><br>In addition to submitting the information required with all PA requests for positioning seats, providers are required to also submit **all** of the following information with a PA request for a positioning seat for motor vehicle use:<br>1. Description of how the recipient is currently transported in a motor vehicle and<br>2. Accessibility of the recipient's primary caregiver's vehicle.<br><br>**Activity/Feeder/Corner Chairs**<br>In addition to submitting the information required with all PA requests for positioning seats, providers are required to also submit **all** of the following information with a PA request for a positioning seat for home use:<br>1. Accessibility of the recipient's residence. | a. Is performed by a licensed physician, physician's assistant, occupational therapist, or physical therapist.<br>b. Includes detailed assessments in the relevant areas that pertain to the specific CRT (complex rehabilitation technology) service requested.<br>c. Uses body structure and function and/or activity components of the International Classification of Functioning model to provide justification for recipient specific needs for each requested line item.<br>d. Includes a signed statement from the qualified health care professional who is writing the evaluation indicating that they do not have a financial relationship with the CRT supplier requesting the durable medical equipment.<br><br>4. A complete CRT professional evaluation that meets the following criteria:<br>a. Is performed by a qualified CRT professional.<br>b. Includes a copy of the certification as defined in §DHS 101.03 (28m).<br>c. Indicates the qualified CRT professional performing the CRT evaluation was present at the recipient's CRT clinical evaluation or indicates that documentation of coordination has been submitted with the CRT clinical evaluation performed by the qualified health care professional. | 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 the FDA as a Humanitarian Device Exemption (HDE) under the Safe Medical Device Act of 1990 and as defined by the 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. |

| Policy: MOBILITY ASSISTIVE EQUIPMENT (MAE) | | | |
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| **EQUIPMENT OR ITEM** | **QUALIFICATIONS** | **FORMS AND DOCUMENTATION REQUIREMENTS** | **MISCELLANEOUS POLICY STATEMENTS** |
| | 2. All commercially available or special adaptive equipment or items owned and/or used by the recipient in all environments regardless of the pay source of that equipment; and<br>3. The recipient's current or anticipated use of a mobility base. | 5. Assessments that are completed in-person, signed and dated, and include details of the following areas:<br>a. Current equipment the recipient may be using (such as the equipment's make, model, and age).<br>b. Projected life expectancy of the current and proposed CRT item.<br>c. Recipient's home or setting for accessibility using the Durable Medical Equipment Home Accessibility Report, F-02891 (08/2022).<br>d. Transportation method, including the make and model of vehicle, if applicable.<br>e. Cost-effectiveness of the requested service compared to a similar service and the reason the comparable service would not meet the recipient's needs, if applicable.<br>f. Other specific models ruled out and why they would not meet medical needs.<br>6. Signed and dated statement asserting that the qualified CRT professional will provide appropriate training to the recipient and will maintain adequate documentation of the training provided.<br>7. The recipient's current age, height, and weight, as well as the source and date of the height and weight record.<br>8. Clinical documentation of the recipient's functional status that includes the following:<br>a. Ambulation status, including what ambulation aids are used (if any).<br>b. Transfer performance.<br>c. Head and trunk stability.<br>d. Sitting and standing balance. | |

| Policy: MOBILITY ASSISTIVE EQUIPMENT (MAE) | | | |
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| **EQUIPMENT OR ITEM** | **QUALIFICATIONS** | **FORMS AND DOCUMENTATION REQUIREMENTS** | **MISCELLANEOUS POLICY STATEMENTS** |
| | | e. Sitting and standing endurance.<br>9. Clinical documentation of the recipient's diagnosis(es) and/or all other medical conditions, including complications of the following:<br>a. Airway<br>b. Skin integrity<br>c. Circulation<br>d. Behavior, if applicable<br>10. Description of the recipient's current equipment and the reason the existing equipment no longer meets the recipient's medical needs, including adaptations or modifications to commercially available items.<br>11. Manufacturer product information/ order form, including the make, model, size, height and weight user limits, and growth capacity of the positioning seat.<br>12. A cost or MSRP Invoice if there is no rate established by the DHCFP. | |
| **Wheelchairs** *(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>The recipient must have a medical need for, and the requested item must be suitable for use in the home and other locations the recipient is likely to encounter in their normal life activities, in accordance with 42 CFR | All from MAE General Qualification section; 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 in MSM Chapter 1300.<br>2. An MSRP Invoice if there is no rate established by the DHCFP. | 1. Medicaid allows only one wheelchair at a time. Backup chairs are denied as a duplicate benefit.<br>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 |

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

| EQUIPMENT OR ITEM | QUALIFICATIONS | FORMS AND DOCUMENTATION REQUIREMENTS | MISCELLANEOUS POLICY STATEMENTS |
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| **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;<br>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; | 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.<br>2. An MSRP Invoice if there is no rate established by the DHCFP. | See also General Information and Coverage and Limitations that may include items desired for reasons other than medical necessity:<br>1. Any DMEPOS or services within other DHCFP programs that meet the same medical purpose may be duplicative.<br>2. An option/accessory that is primarily to allow the recipient to perform leisure or recreational activities.<br>3. Electronic interface used to control lights or other electrical devices.<br>4. Power seat elevation feature and power standing feature.<br>5. Non-medically necessary power wheelchair features may include, 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 are considered duplicative and contradictory as one option indicates recipient's ability to operate safely and the other indicates it is not safe for the recipient to operate. |

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

| EQUIPMENT OR ITEM | QUALIFICATIONS | FORMS AND DOCUMENTATION REQUIREMENTS | MISCELLANEOUS POLICY STATEMENTS |
|---|---|---|---|
| **Power Tilt and/or Recline Seating Systems: (E1002-E1010, E1012)**<br><br>**Power Seating System** *(tilt only, recline only, or combination tilt and recline – with or without power elevating leg rests)* | 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.<br><br>3. Power Elevating Leg rests:<br>(E1010) may be considered medically necessary if:<br>a. The recipient has significant lower extremity edema that requires having an elevating leg rest; or<br>b. The recipient meets the criteria for and has a reclining back on the wheelchair.<br>AND the following is noted:<br>a. The patient is unable to use upper extremities to elevate leg rests independently, and<br>b. The recipient is left alone for periods of two or more hours during the day or does not have someone readily available to assist with needed positioning such as in a work or school setting.<br><br>Center Mount Power Elevating leg rest/Platform:<br>(E1012) may be considered medically necessary if criteria for E1010 are met AND at least one of the following: | | |

| Policy: MOBILITY ASSISTIVE EQUIPMENT (MAE) | | | |
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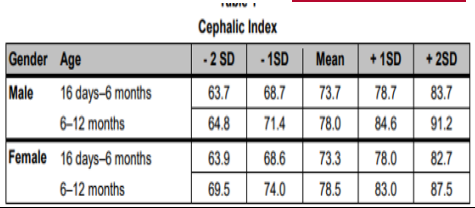
| **EQUIPMENT OR ITEM** | **QUALIFICATIONS** | **FORMS AND DOCUMENTATION REQUIREMENTS** | **MISCELLANEOUS POLICY STATEMENTS** |
| | a. The recipient has a musculoskeletal condition such as contracture or the presence of a cast or brace which prevents 90 degree flexion at the knee.<br>b. The recipient's feet are too close together to use individual foot plates (this might be because they have insufficient hip range (not enough abduction). OR<br>c. The recipient is a bariatric recipient, and they are wider at the knees than at the hips, and their legs are too wide to fit in between the hinge points of the standard power elevated leg rest. | | |
| **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)** *(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. | | |

| Policy: NUTRITIONAL SERVICES | | | |
|---|---|---|---|
| **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** |
| **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. Adjustments, routine periodic servicing (testing, cleaning and checking) to a prosthesis needed for 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 prosthetic.<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. |
| **Cranial Remolding Orthotic Devices**<br><br>**Cranial remolding orthosis, pediatric, ridged, with soft interface material, custom fabricated, includes fitting and adjustment(s)**<br>**HCPCS S1040** | **EPSDT ONLY:**<br>Medically necessary for either of the following two diagnosis:<br>1. Craniosynostosis following surgical correction, or<br>2. Treatment of cranial asymmetry in infants 3-18 months of age with severe non-synostotic cranial positional asymmetry (plagiocephaly or brachycephaly).<br><br>ALL of the following criteria must be present in infants with non-synostotic positional cranial asymmetry: | 1. Physician's/Practitioner's Order/Prescription<br>2. Prior authorization.<br>3. Indication within prior authorization documents referencing EPSDT.<br>4. If applicable, therapy notes reflecting repositioning and stretching therapy.<br>~~3.~~5. Anthropometric measurements. | To meet criteria for a cranial remolding orthotic device, Cranial vault anthropometric measurements must show at least one of the following:<br><br>1. Asymmetry discrepancy of 10mm or more in one of the following anthropometric measurements:<br>a. Cranial vault, or<br>b. Skull base, or<br>c. Orbit tragal depth. |

**Policy: ORTHOTIC AND PROSTHETIC DEVICES**

| EQUIPMENT OR ITEM | QUALIFICATIONS | FORMS AND DOCUMENTATION REQUIREMENTS | MISCELLANEOUS POLICY STATEMENTS |
|---|---|---|---|
| | 1. Infant is 18 months of age or younger.<br>2. Severe asymmetry is present with or without torticollis.<br>3. For children less than 6 months of age, there must be documentation clearly noted in the medical records that medical personnel have instructed caregivers in appropriate positional therapies and that those therapies have been administered for at least two months without improvement, or there must be documentation of a comorbid diagnosis or delay in diagnosis that prevents the completion of a trial of conservative therapy. | | OR<br><br>2. A cephalic index (CI), head with times 100 divided by head length, of two or more standard deviations above or below the mean for age and gender.<br><br>Table located from www.aetna.com<br>  |
| **Orthotics**<br>**Ankle-Foot Orthoses (AFO)**<br><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. AFOs used in non-ambulatory recipients:<br>A static AFO (L4396) is covered if all of the following criteria are met:<br>a. Plantar flexion contracture of the ankle 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. AFO/KAFOs used in ambulatory recipients: | 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. |

Cephalic Index

| Gender | Age | - 2 SD | - 1SD | Mean | + 1SD | + 2SD |
|---|---|---|---|---|---|---|
| Male | 16 days–6 months | 63.7 | 68.7 | 73.7 | 78.7 | 83.7 |
| | 6–12 months | 64.8 | 71.4 | 78.0 | 84.6 | 91.2 |
| Female | 16 days–6 months | 63.9 | 68.6 | 73.3 | 78.0 | 82.7 |
| | 6–12 months | 69.5 | 74.0 | 78.5 | 83.0 | 87.5 |

**Policy: RESPIRATORY SERVICES**

| EQUIPMENT OR ITEM | QUALIFICATIONS | FORMS AND DOCUMENTATION REQUIREMENTS | MISCELLANEOUS POLICY STATEMENTS |
|---|---|---|---|
| **Apnea Monitor** | 1. One-year qualification for at least one of:<br>a. Prematurity (gestational age must be listed on CMS 1500);<br>b. Substantially small for gestational age;<br>c. HX of maternal alcohol abuse;<br>d. HX of maternal narcotics abuse; and/or<br>e. HX of maternal hallucinogenic agent abuse.<br>2. Six-month qualification for at least one of:<br>a. Gastro-esophageal reflux;<br>b. Abnormal pneumogram indicating desaturating apnea;<br>c. Periodic respirations;<br>d. Significant bradycardia or tachycardia of unknown or specified origin;<br>e. Congenital heart defect;<br>f. Bronchopulmonary dysplasia or newborn respiratory distress;<br>g. Respiratory distress;<br>h. Family history of SIDS (siblings only);<br>i. Respiratory Syncytial Virus (RSV);<br>j. Apparent Life-Threatening Episode (ALTE) with subsequent visits to physician or emergency room;<br>k. Laryngotracheal malacia;<br>l. Tracheal stenosis; and/or<br>m. 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. An Apnea Monitor is a non-reimbursable service in conjunction with a pressure ventilator, with pressure control pressure support and flow triggering features. |
| **Bi-Level Positive Airway Pressure (BiPAP) Device**<br><br>**BiPAP "S" (E0470) (without back u)**<br><br>**BiPAP "ST" (E0471) (with back up)** | 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. | | **Exception:** To discharge from a hospital setting for the initial rental period a sleep study is not required. |

**Policy: RESPIRATORY SERVICES**

| EQUIPMENT OR ITEM | QUALIFICATIONS | FORMS AND DOCUMENTATION REQUIREMENTS | MISCELLANEOUS POLICY STATEMENTS |
|---|---|---|---|
| **(continued)**<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)** | 2. 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. Refer to specific documentation requirements specified in the Qualifications section for each scenario.<br>~~5. MSRPs Invoice is required when no rate is established by the DHCFP.~~ | 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>3. BiPAP replacement requires proof of compliance or medical necessity.<br>**<u>Note</u>**: The BiPAP will be rented until the purchase price is reached; this includes the initial three-month rental period. |

**Policy: RESPIRATORY SERVICES**

| EQUIPMENT OR ITEM | QUALIFICATIONS | FORMS AND DOCUMENTATION REQUIREMENTS | MISCELLANEOUS POLICY STATEMENTS |
|---|---|---|---|
| (continued)<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)*** | 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 (COPD) 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>Group II: Severe COPD:<br>a. An arterial blood gas $PaCO_2$ done while awake and breathing the recipient's usual $FIO_2$ is ≥ 52 mm Hg; and<br>b. Sleep oximetry 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);<br>~~c. An arterial blood gas $PaCO_2$, done while awake and breathing the recipient's usual $FIO_2$, is ≥ 52 mm Hg; and~~<br>~~d.~~c. Prior to initiating therapy, OSA (and treatment with CPAP) has been considered and ruled out. | | |

**Policy: RESPIRATORY SERVICES**

| EQUIPMENT OR ITEM | QUALIFICATIONS | FORMS AND DOCUMENTATION REQUIREMENTS | MISCELLANEOUS POLICY STATEMENTS |
|---|---|---|---|
| (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><br>Group III: Obesity hypoventilation syndrome (also known as Pickwickian Syndrome)<br><br>1. BMI greater than 30; and one of the below three:<br>a. An initial arterial blood gas PaCO2, done while awake and breathing the recipient's prescribed FIO2, is greater than or equal to 45 mmHg, or<br>b. Asleep PaCO2 increase of at least 10 mmHg from baseline awake value and at | | |

**Policy: RESPIRATORY SERVICES**

| EQUIPMENT OR ITEM | QUALIFICATIONS | FORMS AND DOCUMENTATION REQUIREMENTS | MISCELLANEOUS POLICY STATEMENTS |
|---|---|---|---|
| (continued)<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)*** | least 50 mmHg for at least 10 minutes sleep time, or<br>c. Asleep PCO2 55 mmHg or more for at least 10 minutes.<br><br>Group ~~III~~IV: Central Sleep Apnea (e.g., apnea not due to airway obstruction):<br>Prior to initiating therapy, a complete 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<br>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. | | |

| Policy: RESPIRATORY SERVICES | | | |
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| **EQUIPMENT OR ITEM** | **QUALIFICATIONS** | **FORMS AND DOCUMENTATION REQUIREMENTS** | **MISCELLANEOUS POLICY STATEMENTS** |
| (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)*** | Group ~~I~~V: Obstructive Sleep Apnea (OSA):<br>Criteria (a) and (b) are both met:<br>a. A complete 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 five 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 | | |
| tinued)<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)*** | c. 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 | | |

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| | 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 the~~61~~ 31st day ~~days~~ after initiating therapy by the treating physician. Medicaid will not continue coverage for the fourth and succeeding months of NPPRA therapy until this re-evaluation has been completed. | | |
| (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)*** | 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 4 hours per 24-hour period for 70% of nights during a consecutive 30-day period (i.e.: 21 out of 30 nights) 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 | | |

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| | treating physician no sooner than ~~61~~ 31 days after initiating use of the device, declaring that the recipient is compliantly using the device ~~(~~an average of ~~four~~ 4 hours per 24-hour period~~)~~ for 70% of nights during a consecutive 30-day period (~~ie~~i.e.: 21 out of 30 nights).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: https://www.medicaid.nv.gov/, 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. | | |
| (continued)<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)*** | 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 the 31st ~~61~~ day~~s~~ 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 31 ~~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 31 ~~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 | | |

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| | treating physician, completed no sooner than 31 ~~61~~ days after initiation of the E0470 device, declaring that the recipient has been compliantly using the E0470 device 4 hours per 24-hour period for 70% of nights during a consecutive 30-day period (ie:21 out of 30 nights).~~(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 | | |
| (continued)<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)*** | medically appropriate alternative payment cannot be made, it will be denied as not medically necessary. | | |
| **Continuous Positive Airway Pressure Device 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 complete 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 five 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 two hours of recorded sleep and must be calculated using actual recorded hours of sleep | 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. MSRP Invoice is required when no rate is established by the DHCFP.<br>5. Refer to specific documentation requirements specified in the Qualifications section for each scenario.<br><br>**Exception:** To discharge from a hospital setting for the initial rental period a sleep study is not required. | 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>3. CPAP replacement requires proof of compliance or medical necessity.<br>**Note**: The CPAP will be rented until the purchase price is reached; this includes the initial three-month rental period. |

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| | (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 | | |
| (continued)<br>**Continuous Positive Airway Pressure Device CPAP (E0601)** | the CPAP device. Continued use is defined as an average of 4 hours per 24-hour period or 70% of nights during a consecutive 30-day period (i.e.:21 out of 30 nights). 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). | | |
| **High Frequency Chest Wall Oscillation Air-Pulse Generator System (E0483)** | 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 | 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 | 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 |

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| | | 2. Medical documentation supporting qualifying factors.<br>3. MSRP Invoice is required when no rate is established by the DHCFP. | for a backup 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. |

**Policy: RESPIRATORY SERVICES**

| EQUIPMENT OR ITEM | QUALIFICATIONS | FORMS AND DOCUMENTATION REQUIREMENTS | MISCELLANEOUS POLICY STATEMENTS |
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| Non-invasive ventilator (NIV)(E0466) | 1. For a Non-invasive ventilator (NIV) (E0466) to be covered:<br>a. The treating physician must fully document in the recipient's medical record all rationale for NIV.<br>b. Recipient must have demonstrated failure of bilevel positive airway pressure (BPAP) to improve hypercapnia and/or oxygen saturation level. (this B-PAP trial must be provided along with all supportive clinical documents).<br><br>**Note:** PaCO2 levels may not normalize even with adequate response to Bi-PAP therapy. Failure to normalize PaCO2 levels alone is not considered a therapeutic failure of Bi-PAP). AVAPS mode is available on Bi-level PAP devices coded E0471. A non-invasive ventilator (E0466) is not considered medically necessary when the sole purpose of the home ventilator is to function as a respiratory assistance device (RAD) including continuous positive airway pressure (CPAP), auto-titrating PAP (APAP), bilevel | | 1. The initial rental will be for 3 months.<br>2. Continued use of noninvasive home ventilators after the initial three-month certification period is considered medically necessary when all the following are met:<br>a. Medical records document improvement in relevant signs or symptoms due to use of the device; and<br>b. The device is used for at least an average of 4 hours per 24-hour period or 70% of nights out of a consecutive 30-day period (ie: 21 nights out of 30 nights) based on a download of compliance from the device; and<br>c. None of the following contraindications:<br>1. FIO2 requirement > 0.40;<br>2. PEEP > 10 cm H2O; |

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| | positive airway pressure (BPAP, BiPAP, AVAPS) or adaptive servo-ventilation (ASV).<br><br>NV Medicaid considers NIV to be medically necessary for the following indications when criteria are met:<br>1. Restrictive Thoracic Disorders<br>2. Severe COPD, and<br>3. Obesity hypoventilation syndrome (also known as the Pickwickian Syndrome)<br><br>**NOTE**: Overlap syndromes (presence of more than one condition, such as COPD and sleep apnea), and pediatric respiratory failure cases require secondary medical review by a physician.<br><br>**Criteria for Restrictive Thoracic disorders (all four of the below criteria must be met):**<br><br>**1.** Documentation of a neuromuscular disease (ex. amyotrophic lateral sclerosis, muscular dystrophy, progressive neuromuscular disorder with respiratory muscle weakness) or a severe thoracic cage abnormality (ex. post-thoracoplasty for tuberculosis or severe kyphoscoliosis) and both of the following (a. and b.):<br>a. One of the following:<br>1. An arterial blood gas partial pressure of carbon dioxide (PaCO2) was measured while awake and breathing room air or on prescribed oxygen with a measurement of: PaCO2 ≥ 45 mm Hg; or<br>2. Sleep Oximetry demonstrates O2 saturation ≤88% for at least 5 mins while breathing **prescribed** O2; and<br>b. If neuromuscular disease is present, maximal inspiratory pressure is < -60 cm H20, or forced vital capacity is < 50% predicted; and | | 3. Need for continuous invasive monitoring.<br><br>**Note:** The NIV will be rented until the purchase price is reached; this includes the initial 3-month rental period. |

2. Respiratory failure has failed to improve with an adequate trial of bilevel positive airway pressure (Bi-PAP), as evidenced by one of the following:
   a. Intolerance to Bi-PAP, or
   b. Worsening dyspnea, hemodynamic instability, or unresponsive hypoxemia; or
   c. Signs of respiratory failure, including tachypnea (respiratory rate >24/min) and respiratory acidosis (e.g., pH<7.35)

**(Note:** PaCO2 levels may not normalize even with adequate response to Bi-PAP therapy. Failure to normalize PaCO2 levels alone is not considered a therapeutic failure of Bi-PAP),

3. Chronic obstructive pulmonary disease (COPD) does not contribute significantly to the pulmonary limitation; and
4. None of the following contraindications:
   a. FIO2 requirement > 0.40;
   b. Positive-end expiratory pressure (PEEP) > 10 cm H2O;
   c. Need for continuous invasive monitoring in adult patients.

**Criteria for Severe COPD (all four of the below criteria must be met):**

1. An arterial blood gas PaCO2 measurement was done while awake *and* breathing at baseline and prescribed FIO2, which is greater than or equal to 52 mm Hg; and
2. Prior to initiating therapy, sleep apnea and treatment with a continuous positive airway pressure device (CPAP) has been considered and ruled out.

**(Note**: Formal sleep testing is not required if the medical record demonstrates that sleep apnea (Obstructive Sleep Apnea (OSA), CSA and/or Comp

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| | SA) is not the predominant cause of awake hypercapnia or nocturnal arterial oxygen desaturation; and<br><br>3. Respiratory failure has failed to improve with an adequate trial of Bi-PAP (trial must be included in the clinical provided), as evidenced by *one* of the following:<br><br>**(Note**: PaCO2 levels may not normalize even with adequate response to Bi-PAP therapy. Failure to normalize PaCO2 levels alone is not considered a therapeutic failure of Bi-PAP);<br><br>a. Intolerance to Bi-PAP, or<br>b. Worsening dyspnea, hemodynamic instability, or unresponsive hypoxemia; **or**<br>c. Signs of respiratory failure: include tachypnea (respiratory rate >24/min) and respiratory acidosis (e.g., pH <7.35), and<br><br>**4.** None of the following contraindications:<br>a. FIO2 requirement > 0.40;<br>b. PEEP > 10 cm H2O;<br>c. Need for continuous invasive monitoring.<br><br>**Criteria for obesity hypoventilation syndrome (all four of the below criteria must be met):**<br><br>1. BMI greater than 30; and<br>2. An initial arterial blood gas PaCO2, done while awake and breathing the recipient's prescribed FIO2, is greater than or equal to 45 mm Hg; and<br>3. Respiratory failure has failed to improve with an adequate trial of Bi-PAP (trial must be included in the clinical provided), as evidenced by *one* of the following**:**<br><br>**(Note:** PaCO2 levels may not normalize even with adequate response to Bi-PAP therapy. Failure to | | |

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| | normalize PaCO2 levels alone is not considered a therapeutic failure of Bi-PAP);<br><br>a. Intolerance to Bi-PAP, or<br>b. Worsening dyspnea, hemodynamic instability, or unresponsive hypoxemia; **or**<br>c. Signs of respiratory failure: include tachypnea (respiratory rate >24/min) and respiratory acidosis (e.g., pH<7.35), and<br>4. None of the following contraindications:<br>a. FIO2 requirement > 0.40;<br>b. PEEP > 10 cm H2O;<br>**c.** Need for continuous invasive monitoring. | | |