

TITLE 471 - NEBRASKA MEDICAL ASSISTANCE PROGRAM SERVICES

CHAPTER 7 - DURABLE MEDICAL EQUIPMENT, PROSTHETICS, ORTHOTICS, AND MEDICAL SUPPLIES (DMEPOS)

001. SCOPE AND AUTHORITY. These regulations govern services provided under the Medical Assistance Act, Nebraska Revised Statute (Neb. Rev. Stat.) §§ 68 901 et seq.

002. DEFINITIONS. The following definitions apply.

002.01 APPARENT LIFE-THREATENING EVENT (ALTE). Apparent life threatening events (ALTE) are episodes that are frightening to the observer and characterized by some combination of central or obstructive apnea, color change, marked change in muscle tone, choking, or gagging.

002.02 AUGMENTATIVE COMMUNICATION DEVICES. Augmentative communication devices are any modes of communication other than speech.

002.03 AUTHORIZED DURABLE MEDICAL EQUIPMENT, PROSTHETICS, ORTHOTICS, AND MEDICAL SUPPLIES (DMEPOS) PROVIDER. Providers authorized to prescribe durable medical equipment, prosthetics, orthotics, and medical supplies (DMEPOS) include physicians, nurse practitioners, clinical nurse specialists, or physician assistants.

002.04 BED-CONFINED. The client's condition is such that the client is confined to bed, although not necessarily all of the time.

002.05 CUSTOM FABRICATED. Made for a specific client from his or her individualized measurements.

002.06 CUSTOM FITTED. Substantial adjustments are made to a prefabricated item by a specially trained professional to meet the needs and unique shape of an individual client.

002.07 DURABLE MEDICAL EQUIPMENT. Equipment which:

- (A) Withstands repeated use;
- (B) Is primarily and customarily used to serve a medical purpose;
- (C) Is not useful to a person in the absence of an illness or injury; and
- (D) Is appropriate for use in the client's home.

002.08 FACILITY. A nursing facility (NF) regulated by 471 Nebraska Administrative Code (NAC) 12 or intermediate care facility for individuals with developmental disabilities (ICF/DD) regulated by 471 NAC 31.

002.09 MEDICAL SUPPLIES. Expendable or reusable supplies required for care of a medical condition in the client's home. This does not include personal care items or oral or injectable over the counter drugs and medications.

002.10 ORTHOSIS. A type of brace which either prevents or assists movement of a limb or the spine.

002.11 ORTHOTICS. Rigid or semi rigid devices which prevent or correct physical deformity or malfunction, to support a weak or deformed part of the body or eliminate motion.

002.12 PROSTHESES AND PROSTHETICS. An artificial device which replaces a missing body part lost through trauma, disease, or congenital conditions.

002.13 REGISTERED NURSE. A licensed registered nurse in the employment of a durable medical equipment, prosthetics, orthotics, and medical supplies (DMEPOS) provider.

002.14 UTILIZATION MANAGEMENT ORGANIZATION. An organization under contract with the Department to review and approve prior authorization requests.

003. PROVIDER REQUIREMENTS.

003.01 GENERAL PROVIDER REQUIREMENTS. Providers of durable medical equipment, prosthetics, orthotics, and medical supplies (DMEPOS) must comply with all applicable provider participation requirements codified in 471 NAC 2 and 3. In the event that provider participation requirements in 471 NAC 2 or 3 conflict with requirements outlined in this chapter, the individual provider participation requirements in this chapter will govern.

003.02 SERVICE SPECIFIC PROVIDER REQUIREMENTS. To participate in Medicaid, providers must be enrolled as a rental and retail supplier with the appropriate primary specialty type as outlined on the Form MC-19, Service Provider Agreement. Providers must meet any applicable state and federal laws governing the provision of their services.

004. SERVICE REQUIREMENTS.

004.01 GENERAL SERVICE REQUIREMENTS. Medicaid covers medically necessary durable medical equipment, prosthetics, orthotics, and medical supplies (DMEPOS) when prescribed by an authorized durable medical equipment, prosthetics, orthotics, and medical supplies (DMEPOS) provider.

004.01(A) MEDICAL NECESSITY. The provider must obtain written documentation from the prescribing authorized durable medical equipment, prosthetics, orthotics, and medical supplies (DMEPOS) provider which justifies the medical necessity for durable medical equipment, prosthetics, orthotics, and medical supplies (DMEPOS). The original documentation of medical necessity must be kept on file by the provider. In addition to meeting the requirements outlined in 471 NAC 1 the documentation must:

- (1) Be signed by the authorized durable medical equipment, prosthetics, orthotics, and medical supplies (DMEPOS) provider's

- own hand and dated, using the date the documentation is signed;
- (2) Specify the start date of the order;
 - (3) Include the authorized durable medical equipment, prosthetics, orthotics, and medical supplies (DMEPOS) provider's name, address, and telephone number;
 - (4) Include the diagnosis and an estimate of the total length of time the item will be needed;
 - (5) Be sufficiently detailed, including all options or additional features which will be separately billed or will require an upgraded procedure code;
 - (6) Describe the ordered item(s) using either a narrative description or a brand name and model number, including all options or additional features;
 - (7) For supplies, include appropriate information on the quantity used, frequency of change, and duration of need; and
 - (8) Include information substantiating that all Medicaid coverage criteria for the item(s) are met.

004.01(A)(i) MEDICAID CERTIFICATION OF MEDICAL NECESSITY FORMS. Use of the following Medicaid Certification of Medical Necessity (CMN) forms are required:

- (1) Form MS 78, Augmentative Communication Device Selection Report;
- (2) Form MS 79, Wheelchair and Wheelchair Seating System Selection Report; or
- (3) Form MS 80, Air Fluidized and Low Air Loss Bed Certification of Medical Necessity.

004.01(A)(ii) MEDICARE CERTIFICATION OF MEDICAL NECESSITY FORMS. Use of the following Medicare Certification of Medical Necessity (CMN) form is required: Medicare Attending Physician's Certificate of Medical Necessity for Home Oxygen form.

004.01(A)(iii) RECERTIFICATION OF MEDICAL NECESSITY. Documentation of medical necessity must be updated annually or when the authorized durable medical equipment, prosthetics, orthotics, and medical supplies (DMEPOS) provider's estimated quantity, frequency, or duration of the client's need has expired, whichever occurs first.

004.01(B) PRIOR AUTHORIZATION REQUIREMENTS. Prior authorization is required for coverage of the following items:

- (1) Augmentative communication devices with related equipment and software;
- (2) Spinal orthosis seating systems and back modules incorporated in or attached to a wheelchair base;
- (3) Transcutaneous electrical nerve stimulators (TENS);
- (4) Ultraviolet light therapy systems;
- (5) All wheelchairs and wheelchair accessories, options, and components;

- (6) Whirlpools; and
- (7) Not otherwise classified (NOC) durable medical equipment, prosthetics, orthotics, and medical supplies (DMEPOS).

004.01(B)(i) REQUESTS FOR PRIOR AUTHORIZATION. The provider will electronically submit requests for prior authorization to the Department or the appropriate utilization management organization using the standard electronic transaction or by completing and submitting Form MS 77, Request for Prior Authorization, according to the form instructions. Documentation supporting the medical necessity of the durable medical equipment, prosthetics, orthotics, and medical supplies (DMEPOS) must be submitted with each prior authorization request. The provider will receive notification from the utilization management organization on the status of the request. A copy of this document should be submitted with the payment request.

004.01(B)(ii) PRIOR AUTHORIZATION LIMITATIONS. Approved prior authorizations are valid only when:

- (1) The prior authorization is requested before the services are provided;
- (2) The client is Medicaid eligible at the time services are provided;
- (3) The provider is enrolled as a Medicaid provider in accordance with this chapter at the time the services are provided;
- (4) The Managed Care Organization (MCO) or the Department has approved the prior authorization; and
- (5) For the initial order of durable medical equipment, prosthetics, orthotics, and medical supplies (DMEPOS), a face-to-face encounter must occur within six months before or 30 days after the durable medical equipment, prosthetics, orthotics, and medical supplies (DMEPOS) order is written. The encounter must be documented and the document maintained by the authorized durable medical equipment, prosthetics, orthotics, and medical supplies (DMEPOS) provider.

004.01(C) SUPPLIES AND ACCESSORIES. Purchase or rental of durable medical equipment, prosthetics, orthotics, and medical supplies (DMEPOS) includes all items, supplies, and accessories necessary for proper and effective use of the durable medical equipment, prosthetics, orthotics, and medical supplies (DMEPOS). Additional items, supplies, and accessories are only provided for client owned durable medical equipment, prosthetics, orthotics, and medical supplies (DMEPOS).

004.01(C)(i) MAXIMUM QUANTITY FOR SUPPLIES. The maximum allowable quantity of supplies that may be dispensed is limited to a three month supply, unless otherwise specified in this chapter or in the Nebraska Medicaid Practitioner Fee Schedule.

004.01(D) MULTIPLE OR DUPLICATE ITEMS. Medicaid does not cover purchase, rental or repair of multiple durable medical equipment,

prosthetics, orthotics, and medical supplies (DMEPOS) used for the same or similar purposes. Medicaid does not cover back up equipment. Back up equipment may be supplied by the provider, but the provider may not bill Medicaid.

004.01(E) REPLACEMENT. Replacement of Medicaid covered durable medical equipment, prosthetics, orthotics, and medical supplies (DMEPOS) items owned by the client is covered if needed due to change in the client's medical condition, wear, loss, or irreparable damage.

004.01(F) REPAIR. Medicaid covers repairs required for the effective use of Medicaid covered durable medical equipment, prosthetics, orthotics, and medical supplies (DMEPOS) when the item is owned by the client and the client meets the coverage criteria for the item. Repairs must meet the following requirements:

- (1) The cost must not exceed 80 percent of the Medicaid allowable purchase price for the item;
- (2) All manufacturers and provider warranties must be pursued; and
- (3) The provider must indicate if the item is owned by the client.

004.01(F)(i) EXCEPTION. Damage to durable medical equipment, prosthetics, orthotics, and medical supplies (DMEPOS) items, due to misuse by the client or caregivers, will require a prior authorization request be submitted to either the Managed Care Organization (MCO) or the Department before repair work begins.

004.01(F)(ii) RENTAL DURING REPAIR. Medicaid covers rental of covered durable medical equipment, prosthetics, orthotics, and medical supplies (DMEPOS) for a maximum of three months during which time the client owned equipment is being repaired. If the provider's usual business practice is to provide loaner equipment at no charge, the provider will not bill Medicaid for rental during that period.

004.01(G) SUPPLIES AND ACCESSORIES FOR DURABLE MEDICAL EQUIPMENT, PROSTHETICS, ORTHOTICS, AND MEDICAL SUPPLIES (DMEPOS). Items required for the proper functioning and effective use of Medicaid eligible durable medical equipment, prosthetics, orthotics, and medical supplies (DMEPOS) are covered. Supplies and accessories for rented Medicaid durable medical equipment, prosthetics, orthotics, and medical supplies (DMEPOS) are included in the Medicaid allowable payment unless stated.

004.01(H) RENTAL. Items with a purchase price under one hundred fifty (\$150) may be purchased rather than rented, unless the authorized durable medical equipment, prosthetics, orthotics, and medical supplies (DMEPOS) provider's estimated duration of need is less than six months. Items with a purchase price of one hundred fifty (\$150) or greater must be rented, unless the authorized durable medical equipment, prosthetics, orthotics, and medical supplies (DMEPOS) provider's estimated duration of need is 12 months or greater. The Department is

not responsible for lost, stolen, or damaged rental items.

004.01(H)(i) RENTAL OPTION TO PURCHASE. All rentals must provide an option to purchase the durable medical equipment, prosthetics, orthotics, and medical supplies (DMEPOS) item, and meet the following criteria:

- (1) Providers will cease submitting payment requests for rental items when the Medicaid allowable is reached or after 12 monthly rental payments, whichever comes first;
- (2) When converting a rental item to purchase before 12 months of rental, all rental monies paid to the provider will be applied to the Medicaid allowable purchase price; and
- (3) When the conversion to purchase is completed, the item becomes the property of the client.

004.01(H)(ii) EXCEPTIONS. The following items remain the property of the provider, and may be rented on a monthly basis:

- (1) Oxygen delivery equipment;
- (2) Ventilators;
- (3) Air fluidized bed units;
- (4) Apnea monitors;
- (5) Compressors, including air power sources for equipment which is not self-contained or cylinder driven;
- (6) Low air loss bed units; and
- (7) Oximeters.

004.01(I) USED EQUIPMENT. The durable medical equipment, prosthetics, orthotics, and medical supplies (DMEPOS) provider must ensure that used durable medical equipment, prosthetics, orthotics, and medical supplies (DMEPOS) items meet the same standard of quality as new durable medical equipment, prosthetics, orthotics, and medical supplies (DMEPOS) items, and must provide comparable warranty, servicing and return policies as those which are available with new durable medical equipment, prosthetics, orthotics, and medical supplies (DMEPOS).

004.01(J) SERVICES PROVIDED FOR CLIENTS ENROLLED IN NEBRASKA MEDICAID MANAGED CARE. See 471 NAC 1.

004.01(K) HEALTH CHECK SERVICES. See 471 NAC 33.

004.01(L) DOCUMENTATION REQUIREMENTS. In addition to all other documentation requirements outlined in this chapter, the provider must:

- (i) Maintain documentation which substantiates all conditions for coverage are met; and
- (ii) Maintain documentation that states the client or caregiver is capable of being trained to use the particular device prescribed in an appropriate manner.

004.02 COVERED SERVICES.

004.02(A) COVERED SERVICES FOR CLIENTS RESIDING IN NURSING FACILITY (NF) OR INTERMEDIATE CARE FACILITY FOR INDIVIDUALS WITH DEVELOPMENTAL DISABILITIES (ICF/DD). Medicaid will reimburse durable medical equipment, prosthetics, orthotics, and medical supplies (DMEPOS) providers directly for the following items for clients residing in nursing facility (NF) or intermediate care facility for individuals with developmental disabilities (ICF/DD):

- (1) Orthotics, including lower and upper limb, foot, and spinal, as defined in this chapter;
- (2) Prosthetics, including breast, eye, and lower and upper limb, as defined in this chapter; and
- (3) All other items, necessary for the care of clients residing in nursing facility (NF) or intermediate care facility for individuals with developmental disabilities (ICF/DD), are included in payments to the facility and cannot be billed directly by a durable medical equipment, prosthetics, orthotics, and medical supplies (DMEPOS) provider.

004.02(A)(i) COVERED SERVICES REIMBURSED DIRECTLY TO NURSING FACILITIES (NF) OR INTERMEDIATE CARE FACILITY FOR INDIVIDUALS WITH DEVELOPMENTAL DISABILITIES (ICF/DD). The following items will be reimbursed directly to the nursing facility (NF) or intermediate care facility for individuals with developmental disabilities (ICF/DD):

- (1) Air fluidized beds;
- (2) Non-standard wheelchairs;
- (3) Wheelchair accessories, options, and components;
- (4) Power operated vehicles; and
- (5) Negative pressure wound therapy.

004.02(A)(ii) TRANSFER OR DISCHARGE. At the time of the client's transfer or discharge, the following items specifically purchased for and used by the client will be transferred with the client:

- (1) Any non-standard wheelchair and wheelchair accessories, options, and components;
- (2) Augmentative communication devices with related equipment and software;
- (3) Supports; and
- (4) Custom fitted or custom fabricated items.

004.02(B) SERVICES PROVIDED TO HOSPITAL PATIENTS. Medicaid covers durable medical equipment, prosthetics, orthotics, and medical supplies (DMEPOS), including fittings, provided to hospital patients, as defined in 471 NAC 10. Payment is not made separately to the durable medical equipment, prosthetics, orthotics, and medical supplies (DMEPOS) provider. In the event a customized wheelchair for primary use in other

than the hospital setting is needed for training purposes while the client is a hospital inpatient, the non hospital supplier or provider may deliver the wheelchair to the client during the inpatient stay and bill Medicaid. This exception does not apply to other items provided for use in the hospital setting.

004.02(C) AIR FLUIDIZED AND LOW AIR LOSS BED UNITS. Air fluidized and low air loss bed units are covered on a rental basis for active healing and treatment to assure progressive and consistent wound healing occurs.

004.02(C)(i) DOCUMENTATION PRIOR TO PLACEMENT. The following conditions must be met and documented prior to placement of an air fluidized or low air loss bed unit:

- (1) Comprehensive client assessment and evaluation by the authorized durable medical equipment, prosthetics, orthotics, and medical supplies (DMEPOS) provider has occurred;
- (2) Treatment has been tried without success;
- (3) Caregiver training on use of the bed by a registered nurse employed by the provider has occurred; and
- (4) Initial dietary consult has occurred, which includes recommended caloric intake and serum albumin level at or near the time of placement.

004.02(C)(ii) DOCUMENTATION DURING USAGE. The following conditions must be met and documented during use of air fluidized or low air loss bed units:

- (1) A trained adult caregiver is available to assist the client with activities of daily living, fluid balance, skin care, repositioning, recognition, and management of altered mental status, dietary needs, prescribed treatments and management and support of the bed;
- (2) Wound healing must begin within 14 days of placement on the bed unit. If progressive, consistent wound healing ceases during use of the bed, a new wound healing care plan must be reestablished within 14 days;
- (3) The client must remain on the bed unit at all times except for a maximum of one hour per day and when receiving medical treatment;
- (4) On-site client evaluation and wound care consultation by a registered nurse occurs weekly;
- (5) Changes in the client's status, treatment, and diet is monitored and documented; and
- (6) A written plan of care must be established within four weeks of placement of the bed unit. The plan of care must address skin care, pressure reducing devices and protocol, and dietary needs after use of bed unit has been discontinued.

004.02(C)(iii) ADDITIONAL DOCUMENTATION REQUIREMENTS. Form MS 80, Air Fluidized and Low Air Loss Bed Certification of Medical

Necessity, must be completed on a monthly basis by a registered nurse, signed by the authorized durable medical equipment, prosthetics, orthotics, and medical supplies (DMEPOS) provider and kept on file with the provider and submitted to the health plans upon request.

004.02(D) APNEA MONITORS. Apnea monitors are covered on a rental basis for infants up to one year of age who meet at least one of the following criteria:

- (1) Infants with one or more apparent life-threatening events (ALTEs) requiring mouth to mouth resuscitation or vigorous stimulation;
- (2) Symptomatic preterm infants;
- (3) Siblings of one or more sudden infant death syndrome (SIDS) victims; or
- (4) Infants with certain diseases or conditions, such as central hyperventilation, bronchopulmonary dysplasia, infants with tracheostomies, infants with substance abusing mothers, or infants with less severe apparent life-threatening events (ALTEs).

004.02(D)(i) ADDITIONAL CRITERIA. Criteria for discontinuing apnea monitoring must be based on the infant's clinical condition. A monitor may be discontinued when apparent life-threatening event (ALTE) infants have had two to three months free of significant alarms or apnea requiring vigorous stimulation or resuscitation. Pneumocardiograms are covered for diagnostic or evaluation purposes and when required to determine when the infant may be removed from the monitor. Payment does not include analysis and interpretation.

004.02(D)(ii) COVERAGE CONDITIONS. The following conditions must be met prior to initiation of home apnea monitoring:

- (1) History and physical assessment by the infant's authorized durable medical equipment, prosthetics, orthotics, and medical supplies (DMEPOS) provider; and
- (2) Parent or caregiver have successfully completed training on use of the equipment and any other authorized durable medical equipment, prosthetics, orthotics, and medical supplies (DMEPOS) provider recommended training.

004.02(D)(iii) DOCUMENTATION REQUIREMENTS. Apnea monitor rental exceeding two months requires an authorized durable medical equipment, prosthetics, orthotics, and medical supplies (DMEPOS) provider's narrative report of client progress to be kept on file with the provider. A progress report is required every two months, and must include:

- (1) The number of apnea episodes during the previous two month period of use;
- (2) Tests and results of tests performed during the previous two month period of use;

- (3) Estimated additional length of time the monitor will be needed; and
- (4) Any additional pertinent information the authorized durable medical equipment, prosthetics, orthotics, and medical supplies (DMEPOS) provider may wish to provide.

004.02(E) BATH AND TOILET AIDS. Bathtub patient lifts and rehabilitation shower chairs are covered for clients with severe conditions who, without use of the equipment, would be unable to bathe or shower. The client must be unable to use a stationary tub stool or bench, rails, or similar equipment. Covered bath and toilet aids include the following durable medical equipment, prosthetics, orthotics, and medical supplies (DMEPOS):

- (i) Bath and toilet rails;
- (ii) Raised toilet seats;
- (iii) Tub stools and benches;
- (iv) Transfer tub benches and attachments; and
- (v) Bath support chairs.

004.02(F) BED SIDE RAILS. Bed side rails are covered for clients who are at risk for injury due to one of the following conditions:

- (i) Disorientation;
- (ii) Vertigo; or
- (iii) A neurological disorder resulting in convulsive seizures.

004.02(G) BED WEDGES. Bed wedges are covered for clients that require the head of the bed to be elevated more than 30 degrees due to congestive heart failure, chronic pulmonary disease, or problems with aspiration. Standard bed pillows must have been tried and failed.

004.02(H) BEDPANS AND URINALS. Bedpans and urinals are covered for clients who are determined by their authorized durable medical equipment, prosthetics, orthotics, and medical supplies (DMEPOS) provider to be bed confined.

004.02(I) BLOOD GLUCOSE MONITORS. Blood glucose monitors are covered for clients with insulin-treated diabetes, non-insulin-treated diabetes, and gestational diabetes.

004.02(I)(i) DOCUMENTATION REQUIREMENTS. The authorized durable medical equipment, prosthetics, orthotics, and medical supplies (DMEPOS) provider must retain documentation stating the client or caregiver is capable of being trained to use the particular device prescribed in an appropriate manner.

004.02(I)(ii) ADDITIONAL FEATURES. Medicaid covers blood glucose monitors with additional features such as:

- (a) Voice synthesizers;
- (b) Automatic timers; and

(c) Specially designed arrangements of supplies and materials to enable clients with visual impairments to use the equipment without assistance.

004.02(I)(ii)(1) DOCUMENTATION REQUIREMENTS. An authorized durable medical equipment, prosthetics, orthotics, and medical supplies (DMEPOS) provider must certify the client has a visual impairment and requires use of a blood glucose monitor with additional features. The certification must identify the additional features are necessary.

004.02(J) BLOOD PRESSURE MONITORS. Blood pressure monitors are covered for clients with a hypertension diagnosis that must be self monitored at home. An electronic blood pressure monitor is covered only if the client is unable to use a standard cuff and stethoscope due to medical conditions.

004.02(J)(i) ACCESSORIES. Accessories are covered only as replacement for use with client owned monitors for clients whose condition meets the criteria for coverage of the monitor.

004.02(J)(ii) DOCUMENTATION REQUIREMENTS. The documentation must specify the cuff size, that the authorized durable medical equipment, prosthetics, orthotics, and medical supplies (DMEPOS) provider will be monitoring its use in connection with the client's continuing course of treatment, and that the client or caregiver will be instructed in use of the equipment by the authorized durable medical equipment, prosthetics, orthotics, and medical supplies (DMEPOS) provider, their office staff, or other qualified health professional.

004.02(K) EXTERNAL BREAST PROSTHESES AND SUPPLIES. Breast prostheses and supplies are covered for clients who have had a mastectomy.

004.02(L) BREAST PUMPS. Breast pumps are covered for clients who are breast feeding if one or more of the following conditions are met for either short term or long term rental. Hospital grade breast pumps are covered only on a rental basis.

004.02(L)(i) SHORT TERM RENTAL. Short term rental of breast pumps for up to two months is covered in the following instances:

- (1) Infant or neonate with abnormal weight loss;
- (2) Hyperbilirubinemia;
- (3) Inadequate milk supply;
- (4) Mastitis;
- (5) Acutely ill infant;
- (6) Infant food allergy;
- (7) Medical condition of mother that precludes feeding infant at breast; or
- (8) Maternal post-partum complications.

004.02(L)(ii) LONG TERM RENTAL. Long term rental of breast pumps is covered for up to six months, with one additional six month period in the following instances:

- (1) Congenital abnormality of the infant that impedes the infant's ability to suck or swallow;
- (2) Neurologic abnormality of the infant;
- (3) Prematurity; or
- (4) Latch difficulties.

004.02(M) CANES AND CRUTCHES. Canes and crutches are covered for clients with conditions that impair ambulation.

004.02(N) CAR SEATS. Car seats are covered for clients age 20 and younger with physical disabilities when required for positioning during transportation when standard seat belts and car seats are not appropriate.

004.02(O) COMMODES. Commodes are covered for clients who are confined to bed, to a room or to a home without accessible bathroom facilities. A commode chair with detachable arms is covered when medically necessary.

004.02(P) COMMUNICATION DEVICES, AUGMENTATIVE. Communication devices are covered for clients who are unable to use natural oral speech as a primary means of communication. Non portable devices may be covered only if required for visual enhancement or accommodated by a portable device. The specific device recommended and all accessories required for use of the device must be identified and medically necessary. Communication boards, dedicated speech-generating devices, and related accessories are durable medical equipment (DME). Artificial larynx, voice amplification, and related devices are prostheses.

004.02(P)(i) EVALUATION. A licensed speech-language pathologist must evaluate the client's communication needs. The evaluation must identify the client's:

- (1) Medical diagnosis;
- (2) Speech-language diagnosis;
- (3) Physical status;
- (4) Communication abilities;
- (5) Vision and hearing acuity; and
- (6) Other skills required for use of the specific device selected.

004.02(P)(ii) DOCUMENTATION REQUIREMENTS. Form MS-78, Augmentative Communication Device Selection Report, must be completed and signed by the evaluating speech language pathologist and the authorized durable medical equipment, prosthetics, orthotics, and medical supplies (DMEPOS) provider. Form MS 78 is submitted with the request for prior authorization.

Documentation from the speech-language pathologist must show that the device meets the client's communication needs, the client has the ability to use the device and the device meets the functional communication goals established by the speech-language pathologist.

004.02(P)(ii)(1) TRIAL PERIOD. The provider must maintain documentation showing the results of the selected device during a trial period lasting a minimum of one month.

004.02(Q) CONTINUOUS GLUCOSE MONITORS (CGM). Continuous glucose monitors (CGM) are covered for eligible beneficiaries who have Diabetes mellitus, use multiple daily doses of insulin or are on an insulin pump, are being assessed at least every six months by the healthcare practitioner for this condition, and for whom the treatment is medically indicated and appropriate. The continuous glucose monitor (CGM) is used for diagnostic and therapeutic purposes when medically necessary. The initial authorization period for the therapeutic continuous glucose monitor (CGM) is six months and the renewal authorization period is 12 months. For therapeutic continuous glucose monitors (CGM), beneficiaries must be able to hear and view the continuous glucose monitor (CGM) alerts and respond accordingly or have a caregiver who is able to do so.

004.02(R) CONTINUOUS PASSIVE MOTION. Continuous passive motion devices are covered for clients who have received a total knee replacement. Coverage is limited to the first three weeks following surgery.

004.02(R)(i) DOCUMENTATION. The provider must retain documentation showing the device was provided to the client within two days following surgery.

004.02(S) CONTINUOUS POSITIVE AIRWAY PRESSURE SYSTEMS (CPAP). Continuous positive airway pressure systems (CPAP) are covered for clients with moderate or severe obstructive sleep apnea for whom surgery is a likely alternative to continuous positive airway pressure systems (CPAP). Intermittent assist devices with a continuous positive airway pressure systems (CPAP) are covered for clients who, after trial use with continuous positive airway pressure systems (CPAP), cannot tolerate use of continuous positive airway pressure systems (CPAP) without the intermittent assist devices. Humidifiers for use with continuous airway pressure systems (CPAP) are covered for clients who require supplemental humidification with continuous airway pressure systems (CPAP).

004.02(S)(i) DOCUMENTATION REQUIREMENTS. The provider must maintain documentation showing authorized durable medical equipment, prosthetics, orthotics, and medical supplies (DMEPOS) provider approval of intermittent assist devices and humidifiers.

004.02(T) DRESSINGS. Dressings are covered for clients that require treatment of a wound or surgical incision.

004.02(U) ELECTROMYOGRAPHY BIODFEEDBACK DEVICES.

Electromyography biofeedback devices are covered for muscle re education of specific muscle groups or for treating pathological muscle spasm, or weakness.

004.02(V) ENTERAL AND PARENTERAL NUTRITION, AND NUTRITIONAL SUPPLEMENTS. Enteral nutritional supplements are covered for clients with normal gastrointestinal absorptive capacity who, due to permanent or temporary non-function or disease of the structures which normally permit food to reach the small bowel and requires tube feeding to provide sufficient nutrients.

004.02(V)(i) PARENTERAL NUTRITION. Parenteral nutritional supplements are covered for clients with disease of the gastrointestinal tract which prevents absorption of sufficient nutrients. No more than one month supply of parenteral nutrients, equipment, or supplies may be provided in advance.

004.02(V)(ii) NUTRITIONAL SUPPLEMENTS. Nutritional supplements are covered for clients who require nutritional supplementation to maintain weight and strength commensurate with the client's general condition.

004.02(V)(iii) CLIENTS ELIGIBLE FOR SUPPLEMENTAL FEEDING AND NUTRITION PROGRAM. Clients eligible for Supplemental Feeding and Nutrition Program for Women, Infants, and Children (WIC), enteral nutrients are covered if the product is not covered by Women, Infants, and Children (WIC) or to the extent the quantity required exceed the maximum quantity provided by Women, Infants, and Children (WIC).

004.02(V)(iv) DOCUMENTATION REQUIREMENTS. Authorized durable medical equipment, prosthetics, orthotics, and medical supplies (DMEPOS) provider approval must be documented for:

- (1) Use of a pump; and
- (2) Clients age 20 and younger with special delivery needs.

004.02(W) EYE PROSTHESES. Eye prostheses are covered for clients with absence or shrinkage of an eye due to birth defect, trauma, or surgical removal.

004.02(X) FAMILY PLANNING SUPPLIES. Prescribed family planning supplies are covered when medically necessary and required to prevent or delay pregnancy.

004.02(Y) FOOT ORTHOSES. Foot orthoses are covered when required to support a weak or deformed foot or leg, or to restrict or eliminate motion

in a foot or leg. Coverage of orthopedic shoes is limited to one pair in a one-year period, except when documentation indicates excessive wear or size change is necessary due to growth.

004.02(Z) HEARING AID BATTERIES. Hearing aid batteries are covered for clients who use hearing aids.

004.02(AA) HEAT AND COLD APPLICATION DEVICES. Heat and cold application devices are covered for clients with medical conditions requiring heat or cold therapy.

004.02(BB) HOSPITAL BEDS. Fixed height, variable height, and semi-electric hospital beds are covered for clients who:

- (1) Require positioning of the body due to a medical condition or pain which is expected to last at least one month;
- (2) Require the head of the bed to be elevated most of the time, due to a medical condition;
- (3) Require equipment which can only be attached to a hospital bed;
- (4) Require a bed height different from the height provided by a fixed height bed in order to permit transfer to a chair, wheelchair, or standing position; or
- (5) Require frequent changes in body position.

004.02(BB)(i) SUPPLIES AND ACCESSORIES. Medicaid covers supplies and accessories including:

- (1) An innerspring or foam rubber mattress;
- (2) Side rails;
- (3) Trapeze bar; and
- (4) Bed cradle.

004.02(CC) IMPOTENCE TREATMENT DEVICES. Impotence treatment devices are covered for clients with organic impotence and without conditions that contraindicate use of the device.

004.02(DD) INCONTINENCE APPLIANCES AND CARE SUPPLIES. Incontinence appliances and care supplies are covered for clients without control over bladder or bowel function. Incontinence diapers or briefs and liners are not covered for clients under age three.

004.02(EE) INSULIN INFUSION PUMPS, EXTERNAL. External continuous subcutaneous insulin infusion (CSII) pumps are covered for clients with conditions which require administration of parenteral medication when reasonable and necessary.

004.02(EE)(i) DOCUMENTATION REQUIREMENTS. The provider will obtain written documentation from the prescribing authorized durable medical equipment, prosthetics, orthotics, and medical supplies (DMEPOS) provider which includes at minimum, the following:

(1) Diabetes team evaluation summary, which addresses:

- (a) Diagnosis;
- (b) Complications and compounding issues;
- (c) Failure of adequate blood glucose control in spite of demonstrated compliance with multiple daily injections;
- (d) Hemoglobin (Hgb) A1c levels; and
- (e) Patient's ability and motivation to use the pump; and

(2) Treatment plan, which includes:

- (a) Inpatient initiation of continuous subcutaneous insulin infusion (CSII) pump or rationale for outpatient initiation with all policies and procedures involved;
- (b) Client and family diabetes education plan; and
- (c) Monitoring plan post-initiation of continuous subcutaneous insulin infusion (CSII) pump.

004.02(FF) INTERMITTENT POSITIVE PRESSURE BREATHING (IPPB) MACHINES. Intermittent positive pressure breathing (IPPB) machines are covered for clients who require respiratory therapy treatment for hypoventilation.

004.02(GG) PATIENT LIFTS. Patient lifts are covered for clients when assistance is required for transfers in the residence.

004.02(GG)(i) DOCUMENTATION REQUIREMENTS. Documentation must verify:

- (1) The home can accommodate the lift;
- (2) The caregiver is able and willing to use the equipment; and
- (3) The client can tolerate using the equipment.

004.02(HH) LOWER AND UPPER LIMB ORTHOSES. Lower and upper limb orthoses are covered when required to support a weak or deformed arm or segments of the lower or upper limb.

004.02(II) LOWER AND UPPER LIMB PROSTHESES. Medicaid covers lower and upper limb prostheses for clients to replace a missing body part.

004.02(JJ) MEDICAL AND SURGICAL SUPPLIES. Medical and surgical supplies are covered for clients who require home treatment of a specific medical condition, protection or support of a wound, surgical incision, or diseased or injured body part.

004.02(KK) NEBULIZERS AND COMPRESSORS. Medicaid provides coverage of nebulizers and compressors in the following situations:

- (1) When the client's ability to breathe is severely impaired;
- (2) To administer aerosol therapy when a metered dose inhaler is not adequate or appropriate;

- (3) When required for use in connection with durable medical equipment, prosthetics, orthotics, and medical supplies (DMEPOS) for purposes of moisturizing oxygen; or
- (4) For clients who require heated nebulizers with tracheostomies.

004.02(KK)(i) DOCUMENTATION REQUIREMENTS. Authorized durable medical equipment, prosthetics, orthotics, and medical supplies (DMEPOS) provider approval must be documented for portable compressors with internal battery features and ultrasonic nebulizers when other means of nebulization is ineffective.

004.02(LL) NEUROMUSCULAR ELECTRICAL STIMULATORS (NMES). Neuromuscular electrical stimulators (NMES) are covered for treatment of disuse atrophy where nerve supply to the muscle is intact, including brain, spinal cord and peripheral nerves, and other non neurological reasons for disuse are causing atrophy.

004.02(LL)(i) SUPPLIES AND ACCESSORIES. Supplies and accessories for rented neuromuscular electrical stimulators (NMES) units, the lead wires, and supplies must be billed on the same claim as the neuromuscular electrical stimulators (NMES) rental.

004.02(LL)(ii) DOCUMENTATION REQUIREMENTS. Authorized durable medical equipment, prosthetics, orthotics, and medical supplies (DMEPOS) provider approval must be documented for a conductive garment.

004.02(MM) OSTEOGENIC STIMULATORS. Osteogenic stimulators are covered for clients with at least one of the following indications:

- (i) Non-union of long bone fractures lasting six or more months;
- (ii) Failed fusion lasting six or more months without healing of the fusion; and
- (iii) Congenital pseudo arthrosis.

004.02(NN) OSTOMY SUPPLIES. Ostomy supplies are covered for clients with an ostomy.

004.02(NN)(i) DOCUMENTATION REQUIREMENTS. Authorized durable medical equipment, prosthetics, orthotics, and medical supplies (DMEPOS) provider approval must be documented for skin moisturizers, protectants, and sealants for clients with ostomies.

004.02(OO) OXIMETERS, EAR, AND PULSE. Oximeters are covered on a rental basis for clients who require a minimum of daily monitoring of arterial blood oxygen saturation levels for evaluation and regulation of home oxygen therapy. Coverage for other indications will be determined on a case-by-case basis.

004.02(OO)(i) DOCUMENTATION REQUIREMENTS. A monthly updated certification of medical necessity is required when the oximeter is required for evaluation and regulation of home oxygen therapy. The

documentation submitted by the authorized durable medical equipment, prosthetics, orthotics, and medical supplies (DMEPOS) provider must specify the client's medical condition which substantiates the need for in-home use of oximeter, estimated length of need for monitoring and frequency of monitoring required.

004.02(PP) OXYGEN AND OXYGEN EQUIPMENT. Portable oxygen systems alone or to complement a stationary oxygen system will be covered if the client is mobile within the residence. Oxygen and oxygen equipment are covered for clients with significant hypoxemia in the chronic stable state, when the following conditions are met:

- (1) The authorized durable medical equipment, prosthetics, orthotics, and medical supplies (DMEPOS) provider has determined that the client suffers severe lung disease or hypoxia related symptoms that might be expected to improve with oxygen therapy;
- (2) The client's blood gas levels indicate the need for oxygen therapy; and
- (3) The client has appropriately tried other alternative treatment measures without complete success.

004.02(PP)(i) STATIONARY AND PORTABLE SYSTEM RENTAL. When both a stationary and portable system is being rented, the Medicaid allowable for all contents is included in the Medicaid allowable for the stationary system. Stationary contents are covered only when the client owns the gaseous or liquid stationary system. Portable contents are covered only when the client uses a portable system only.

004.02(PP)(ii) OXYGEN THERAPY. Oxygen therapy is covered for clients with significant hypoxemia evidenced by the following:

- (1) An arterial partial pressure of oxygen (PO₂) at or below 55 millimeters of mercury (mm Hg), or an arterial oxygen saturation at or below 88 percent, taken:
 - (a) At rest;
 - (b) During sleep for a client who demonstrates an arterial partial pressure of oxygen (PO₂) at or above 56 millimeters of mercury (mm Hg);
 - (i) An arterial oxygen saturation at or above 89 percent, while awake; or
 - (ii) A greater than normal fall in oxygen level during sleep:
- (1) A decrease in arterial partial pressure of oxygen (PO₂) more than 10 millimeter of mercury (mm Hg); or
- (2) A decrease in arterial oxygen saturation more than five percent associated with symptoms or signs reasonably attributable to hypoxemia. In either of these cases, coverage is provided only for nocturnal use of

oxygen; or

(c) During exercise:

- (i) For a client who demonstrates an arterial partial pressure of oxygen (PO₂) at or above 56 millimeters of mercury (mm Hg); or
- (ii) An arterial oxygen saturation at or above 89 percent, during the day while at rest. In this case, supplemental oxygen is provided for during exercise if it is documented that the use of oxygen improves the hypoxemia which was demonstrated during exercise when the client was breathing without assistance; or

(2) An arterial partial pressure of oxygen (PO₂) of 56 to 59 millimeter of mercury (mm Hg); or an arterial blood oxygen saturation of 89 percent if any of the following are documented:

- (a) Dependent edema suggesting congestive heart failure;
- (b) Pulmonary hypertension or cor pulmonale, determined by measurement of pulmonary artery pressure, gated blood pool scan, echocardiogram, "P" pulmonale of electrocardiogram; or
- (c) Erythrocythemia with a hematocrit greater than 56 percent.

004.02(PP)(iii) DOCUMENTATION REQUIREMENTS. The authorized durable medical equipment, prosthetics, orthotics, and medical supplies (DMEPOS) provider must provide documentation that shows the conditions outlined in this chapter have been met. Documentation for oxygen therapy must include:

- (a) The results of a blood gas study that has been ordered and evaluated by the authorized durable medical equipment, prosthetics, orthotics, and medical supplies (DMEPOS) provider; or
- (b) A measurement of pulse arterial oxygen saturation when ordered and evaluated by the authorized durable medical equipment, prosthetics, orthotics, and medical supplies (DMEPOS) provider and performed under his or her supervision or when performed by a qualified provider or supplier of laboratory services.

004.02(PP)(iii)(1) ADDITIONAL DOCUMENTATION REQUIREMENTS. A durable medical equipment, prosthetics, orthotics, and medical supplies (DMEPOS) supplier is not considered a qualified provider or supplier of laboratory services for purposes of these guidelines. When a client's initial certification for oxygen is approved based on an arterial partial pressure of oxygen (PO₂) of 56 millimeter of mercury (mm Hg) or greater or an oxygen saturation of 89 percent or greater, retesting between the 61st and 90th day of home oxygen therapy is required in order to

establish continued medical necessity.

004.02(QQ) PACEMAKER MONITORS, SELF-CONTAINED. Pacemaker monitors are covered for clients with cardiac pacemakers.

004.02(RR) PARAFFIN BATH UNITS, PORTABLE. Paraffin bath units are covered for clients who have undergone a successful trial period of paraffin therapy.

004.02(RR)(i) DOCUMENTATION REQUIREMENTS. The authorized durable medical equipment, prosthetics, orthotics, and medical supplies (DMEPOS) provider must provide documentation of successful trial period of paraffin therapy.

004.02(SS) PEAK FLOW METERS. Peak flow meters are covered for clients with chronic asthma.

004.02(TT) PERCUSSORS. Percussors are covered for mobilizing respiratory tract secretions in clients with cystic fibrosis, chronic obstructive lung disease, chronic bronchitis, or emphysema.

004.02(TT)(i) DOCUMENTATION REQUIREMENTS. The authorized durable medical equipment, prosthetics, orthotics, and medical supplies (DMEPOS) provider must provide documentation showing the client or operator of powered percussor has received appropriate training by an authorized durable medical equipment, prosthetics, orthotics, and medical supplies (DMEPOS) provider or therapist when no one else competent to administer manual therapy is available.

004.02(UU) PHOTOTHERAPY SERVICES. Phototherapy is covered on a rental basis for infants who meet the following criteria:

- (1) Neonatal hyperbilirubinemia;
- (2) Bilirubin level at initiation of phototherapy is 14 18 milligrams (mgs) per deciliter. Home phototherapy is not covered if the bilirubin level is less than 12 milligrams (mgs) at 72 hours of age or older; or
- (3) Direct bilirubin level is less than two milligrams (mgs) per deciliter.

004.02(UU)(i) PHOTOTHERAPY HOME TREATMENT. The following conditions must be met prior to initiation of home phototherapy:

- (1) History and physical assessment by the infant's authorized durable medical equipment, prosthetics, orthotics, and medical supplies (DMEPOS) provider has occurred;
- (2) Required laboratory studies have been performed, including, complete blood count (CBC), blood type on mother and infant, direct Coombs, direct and indirect bilirubin;
- (3) The authorized durable medical equipment, prosthetics, orthotics, and medical supplies (DMEPOS) provider certifies that the parent or caregiver is capable of administering home phototherapy;

- (4) Parent or caregiver has successfully completed training on use of the equipment; and
- (5) Equipment must be delivered and set up within four hours of discharge from the hospital or notification of the provider, whichever is more appropriate. There must be a 24 hour per day repair and replacement service available.

004.02(UU)(ii) DOCUMENTATION REQUIREMENTS. An authorized durable medical equipment, prosthetics, orthotics, and medical supplies (DMEPOS) provider's narrative report outlining the client's progress and the circumstances necessitating extended therapy must be submitted with the claim when billing for home phototherapy exceeding three days.

004.02(VV) PNEUMATIC COMPRESSORS AND APPLIANCES. Pneumatic compressors and appliances are covered for clients with intractable edema of the extremities and are intended for single person use only.

004.02(WW) POSTURAL DRAINAGE BOARDS. Postural drainage boards are covered for clients with chronic pulmonary conditions.

004.02(XX) POWER-OPERATED VEHICLE (POV). A power operated vehicle (POV) is covered instead of a standard wheelchair when all of the following criteria are met:

- (1) The client has a diagnosed medical condition which impairs their ability to walk;
- (2) The client requires a power-operated vehicle (POV) for the purpose of:

- (a) Increasing their independence with mobility, resulting in significant difference in their ability to perform major life activities; or
- (b) Providing assisted mobility for clients who show no means of safe independent mobility;

- (3) The client has significant limitation of limb function such that the client is not able to propel a manual wheelchair. Compared to their use of a manual wheelchair, the client's use of a power-operated vehicle (POV) must result in a significant improvement in independent mobility and ability to perform major life activities; and
- (4) The client has demonstrated, through a trial period with a similar power-operated vehicle (POV):

- (a) The ability to safely and independently operate the controls of a power-operated vehicle (POV);
- (b) The ability to transfer safely in and out of a power-operated vehicle (POV); and
- (c) Adequate trunk stability to be able to safely ride in the power-operated vehicle (POV).

004.02(XX)(i) DOCUMENTATION REQUIREMENTS. The authorized durable medical equipment, prosthetics, orthotics, and medical supplies (DMEPOS) provider must complete Form MS 79, Wheelchair and Wheelchair Seating System Selection Report, and must:

- (1) Justify the type of wheelchair seating system; and
- (2) Provide evidence of a coordinated assessment, which includes communication between the client, caregiver(s), authorized durable medical equipment, prosthetics, orthotics, and medical supplies (DMEPOS) provider, physical or occupational therapist, and equipment supplier. The assessment should address:

- (a) Physical;
- (b) Functional;
- (c) Cognitive issues;
- (d) Accessibility; and
- (e) Cost effectiveness of equipment.

004.02(XX)(ii) PRIOR AUTHORIZATION. All power-operated vehicles (POVs) and power-operated vehicle (POV) accessories require prior authorization before items are provided to the client.

004.02(YY) PRESSURE REDUCING SUPPORT SURFACES. Pressure reducing support surfaces are covered for clients who meet one of the following conditions:

- (1) Completely immobile;
- (2) Limited mobility;
- (3) Any stage pressure ulcer on the trunk or pelvis; or
- (4) Pressure reducing cushions are covered for clients with or highly susceptible to decubiti.

004.02(YY)(i) ADDITIONAL CRITERIA. If the client meets criteria two or three above, he or she must also meet at least one of the following criteria:

- (1) Impaired nutritional status;
- (2) Fecal or urinary incontinence;
- (3) Altered sensory perception; or
- (4) Compromised circulatory status.

004.02(YY)(ii) REPLACEMENTS. Replacements are covered when the anticipated length of need is at least one year or the original pressure reducing mattress is not supportive enough for the client.

004.02(YY)(iii) DOCUMENTATION REQUIREMENTS. The authorized durable medical equipment, prosthetics, orthotics, and medical supplies (DMEPOS) provider must provide an approved care plan.

Adherence to the care plan or treatment is not to be construed as elements for coverage criteria. Authorized durable medical equipment, prosthetics, orthotics, and medical supplies (DMEPOS) provider supervision during the use in connection with the client's course of treatment must be documented. The care plan must include the following:

- (1) Education of the client and caregiver on the prevention and management of decubiti;
- (2) Regular assessment by a licensed health healthcare practitioner;
- (3) Appropriate turning and positioning;
- (4) Appropriate wound care for stage II, III, or IV ulcer;
- (5) Moisture and incontinence control needed; and
- (6) Nutritional assessment and intervention consistent with the overall plan of care if there is impaired nutritional status.

004.02(ZZ) SEAT LIFTS. Seat lifts are covered if all of the following criteria are met:

- (1) The client must have severe arthritis of the hip or knee or have a severe neuromuscular disease;
- (2) The seat lift chair must be a part of the authorized durable medical equipment, prosthetics, orthotics, and medical supplies (DMEPOS) provider's course of treatment and be prescribed to effect improvement, or arrest or hinder deterioration in the client's condition;
- (3) The client must be completely incapable of standing up from a regular armchair or Any chair in their home; and
- (4) Once standing, the client must have the ability to ambulate.

004.02(ZZ)(i) ADDITIONAL CRITERIA. Coverage is limited to seat lifts which:

- (1) Provide smooth transition in movement of the client;
- (2) Can be controlled by the client; and
- (3) Effectively assist a client in standing up and sitting down without other assistance.

004.02(ZZ)(ii) DOCUMENTATION REQUIREMENTS. The authorized durable medical equipment, prosthetics, orthotics, and medical supplies (DMEPOS) provider must provide documentation that shows the criteria outlined in this chapter have been met.

004.02(ZZ)(iii) MEDICARE AND MEDICAID CLIENTS. For clients eligible for both Medicare and Medicaid, the seat portion of the seat lift chair will be covered by Medicaid if the seat lift mechanism has been approved by Medicare. Prior authorization of payment is not required. Documentation of Medicare coverage must be submitted on or with the Medicaid claim when billing for the chair portion.

004.02(AAA) SITZ BATHS. Sitz baths are covered for clients with infection or injury of the perineal area.

004.02(AAA)(i) DOCUMENTATION REQUIREMENTS. Documentation must have an authorized durable medical equipment, prosthetics, orthotics, and medical supplies (DMEPOS) provider ordered plan of care in the client's residence.

004.02(BBB) SPINAL ORTHOSES. Spinal orthoses are covered for clients who require a wheelchair seating system for one of the following reasons:

- (1) Supporting the client in a position that minimizes the development or progression of musculoskeletal impairment;
- (2) Relieving pressure; or
- (3) Providing support in a position that improves the client's ability to perform functional activities.

004.02(BBB)(i) DOCUMENTATION REQUIREMENTS. Documentation must be provided using Form MS 79, Wheelchair and Wheelchair Seating System Selection Report, which:

- (1) Justifies the type of wheelchair seating system; and
- (2) Provides evidence of a coordinated assessment. A coordinated assessment includes communication between the client, caregiver(s), authorized durable medical equipment, prosthetics, orthotics, and medical supplies (DMEPOS) provider, physical or occupational therapist, and equipment supplier. The assessment should address:

- (a) Physical;
- (b) Functional;
- (c) Cognitive issues;
- (d) Accessibility; and
- (e) Cost effectiveness of equipment.

004.02(BBB)(ii) PRIOR AUTHORIZATION. All wheelchair and wheelchair accessories require prior authorization before items are provided to the client.

004.02(CCC) SUCTION PUMPS. Suction pumps are covered for clients who have difficulty raising and clearing secretions caused by:

- (i) Cancer or surgery of the throat or mouth;
- (ii) Dysfunction of the swallowing muscles;
- (iii) Unconsciousness or obtunded state; or
- (iv) Tracheostomy.

004.02(DDD) SUPPORTS. Support items include elastic supports, elastic surgical stockings, slings, and trusses. Supports are covered for post-surgical clients, and clients with intractable edema of the lower

extremities or other circulatory disorders.

004.02(EEE) TRACHEOSTOMY CARE SUPPLIES. Tracheostomy care supplies are covered for clients with an open surgical tracheostomy. A tracheostomy care or cleaning starter kit is covered following an open surgical tracheostomy for a two week post operative period. An artificial larynx is covered for clients that have had a laryngectomy or whose larynx is permanently inoperable. Artificial larynx and tracheostomy speaking valves are prostheses.

004.02(FFF) TRACTION EQUIPMENT. Traction equipment is covered for clients with orthopedic impairments requiring traction equipment that prevents ambulation during the period of use. Cervical pillows are covered only when required for use with traction equipment.

004.02(GGG) TRANSCUTANEOUS ELECTRICAL NERVE STIMULATORS (TENS). Transcutaneous electrical nerve stimulators are covered for clients with chronic, intractable pain, or acute post operative pain. The presumed etiology of the pain must be a type which is accepted as responding to transcutaneous electrical nerve stimulators (TENS) therapy.

004.02(GGG)(i) ACUTE POST-OPERATIVE PAIN. For acute post operative pain, a transcutaneous electrical nerve stimulator (TENS) unit is generally covered for no more than one month following the day of surgery. Approval for more than one month will be determined on a case-by-case basis, based on the documentation provided by the authorized durable medical equipment, prosthetics, orthotics, and medical supplies (DMEPOS) provider, and submitted with the prior authorization request. A four-lead transcutaneous electrical nerve stimulator (TENS) unit may be used with either two lead or four leads, depending on the character of the patient's pain.

004.02(GGG)(ii) DOCUMENTATION REQUIREMENTS. Documentation for a transcutaneous electrical nerve stimulator (TENS) must show:

- (a) The pain is present for at least three months;
- (b) Other appropriate treatment modalities have been unsuccessful;
- (c) Names of treatment modalities and length of time each treatment modality was used;
- (d) Results of the treatment modalities;
- (e) Trial basis of one month the transcutaneous electrical nerve stimulator (TENS) unit was used;
- (f) Monitor report from the authorized durable medical equipment, prosthetics, orthotics, and medical supplies (DMEPOS) provider to determine the effectiveness of the transcutaneous electrical nerve stimulator (TENS) unit in modulating the pain; and
- (g) A reevaluation of the client at the end of the trial period which indicates:

- (i) How often the client used the transcutaneous electrical nerve stimulator (TENS) unit;
- (ii) Typical duration of use each time; and
- (iii) Results.

004.02(GGG)(ii)(1) ADDITIONAL DOCUMENTATION

REQUIREMENTS. Authorized durable medical equipment, prosthetics, orthotics, and medical supplies (DMEPOS) provider approval is required for use of four leads with the transcutaneous electrical nerve stimulator (TENS) unit. The documentation must include why two leads are insufficient to meet the client's needs. Authorized durable medical equipment, prosthetics, orthotics, and medical supplies (DMEPOS) provider approval is required for a conductive garment for use with a transcutaneous electrical nerve stimulator (TENS) unit.

004.02(HHH) TRANSFER EQUIPMENT. Transfer equipment is covered for clients who require assistance with transfer.

004.02(III) TRAPEZE EQUIPMENT. Trapeze equipment is covered for clients to:

- (i) Sit up due to a respiratory condition;
- (ii) Change body position for other medical reasons; or
- (iii) To get in or out of bed.

004.02(JJJ) ULTRAVIOLET CABINETS. Ultraviolet cabinets are covered for clients with generalized, intractable psoriasis.

004.02(JJJ)(i) DOCUMENTATION REQUIREMENTS. Documentation must justify treatment at home rather than alternative site.

004.02(KKK) UTERINE MONITORS, HOME. Home uterine monitors are covered on a rental basis for clients that meet the following criteria:

- (1) Comprehensive client assessment and evaluation by the authorized durable medical equipment, prosthetics, orthotics, and medical supplies (DMEPOS) provider has occurred;
- (2) The client has successfully completed training on the use of the equipment;
- (3) The client is at high risk for preterm labor and delivery and must be a candidate for tocolytic therapy. Others at high risk for preterm labor and delivery may be covered upon approval by Medicaid through written communication from the client's authorized durable medical equipment, prosthetics, orthotics, and medical supplies (DMEPOS) provider;
- (4) The pregnancy must be greater than 20 weeks gestation; and
- (5) The client must have one of the following medical conditions:
 - (a) Recent preterm labor with hospitalization and discharge on tocolytic therapy;

- (b) Multiple gestations;
- (c) History of preterm delivery;
- (d) Anomalies of the uterus;
- (e) Incompetent cervix;
- (f) Previous cone biopsy;
- (g) Polyhydramnios; or
- (h) Diethylstilbestrol exposure.

004.02(KKK)(i) DOCUMENTATION REQUIREMENTS. Documentation must show the treatment meets both medical necessity and the criteria outlined in this chapter.

004.02(LL) VAPORIZERS. Vaporizers are covered for clients with a respiratory illness. Coverage includes cool mist and warm mist vaporizers.

004.02(MMM) VENTILATORS. Ventilators are covered for treatment of:

- (i) Neuromuscular diseases;
- (ii) Thoracic restrictive diseases;
- (iii) Chronic respiratory failure consequent to chronic obstructive pulmonary disease; and
- (iv) Respiratory paralysis.

004.02(NNN) WALKERS. Walkers are covered for clients with conditions which impair ambulation and there is a need for greater stability and security than provided by a cane or crutches. A heavy duty, multiple braking system, variable wheel resistance walker is covered for clients who are unable to use a standard walker due to one of the following:

- (i) Obesity;
- (ii) Severe neurologic disorders; or
- (iii) Restricted use of one hand.

004.02(OOO) WHEELCHAIRS, MANUAL AND POWER. Manual and power wheelchairs are covered for clients who have a diagnosed medical condition which impairs their ability to walk. A powered wheelchair may be approved in the event the client has significant limitation of limb function which prohibits the client from being able to propel a manual wheelchair.

004.02(OOO)(i) DOCUMENTATION REQUIREMENTS. Documentation must follow the criteria outlined in this chapter.

004.02(OOO)(ii) PRIOR AUTHORIZATION. All wheelchair and wheelchair accessories require prior authorization before items are provided to the client.

004.02(PPP) WHEELCHAIR SEATING SYSTEM. Wheelchair seating systems are covered for clients who have a diagnosis which impairs their ability to sit. The wheelchair seating system may be covered for the following purposes:

- (1) Supporting the client in a position which minimizes the development or progression of musculoskeletal impairment;
- (2) Relieving pressure; or
- (3) Providing support in a position which improves the client's ability to perform functional activities.

004.02(PPP)(i) DOCUMENTATION REQUIREMENTS. Documentation must follow the criteria outlined in this chapter.

004.02(QQQ) WHEELCHAIR-RECLINING BACK OR TILT-IN-SPACE WHEELCHAIR FRAME. Tilt-in-space and reclining back wheelchairs are covered for clients with a diagnosis which impairs their ability to tolerate the fully upright sitting position for significant amounts of time. Combination power recline and tilt-in-space wheelchair frames, if unavailable in manually operated forms, are covered for clients who require both recline and tilt-in-space features.

004.02(QQQ)(i) DOCUMENTATION REQUIREMENTS. Documentation must show:

- (1) The client needs to remain in a wheelchair for purposes of mobility or other interaction with their environment;
- (2) The client requires frequent, significant adjustment of their position in the wheelchair, either to change hip angle or their sitting position relative to the ground; and
- (3) For power operation of elevating leg rests, the client has the cognitive and motor ability to operate the power required control switches and is routinely in situation where caregivers are not available to manually recline or tile them as needed.

004.02(RRR) BUILT-IN TYPE WHIRLPOOL BATH EQUIPMENT STANDARD. Covered for clients who have a condition for which the whirlpool bath is expected to provide substantial therapeutic benefit.

004.02(SSS) WOUND THERAPY NEGATIVE PRESSURE. Covered for clients with stage IV decubiti, which does not respond to usual wound dressing. This is a rental in which the provider is responsible for training the client, caregivers or facility staff and monitoring the use of the equipment.

004.02(TTT) NOT OTHERWISE CLASSIFIED (NOC) CODES. Coverage of items for which no specific procedure code exists will be determined by Medicaid on a case by case basis.

004.02(TTT)(i) DOCUMENTATION REQUIREMENTS. Manufacturer's invoice and authorized durable medical equipment, prosthetics, orthotics, and medical supplies (DMEPOS) provider approval must be submitted as a part of the Medicaid staff review.

004.03 NON-COVERED SERVICES.

004.03(A) GENERAL COVERAGE RESTRICTIONS. Medicaid does not cover durable medical equipment, prosthetics, orthotics, and medical supplies (DMEPOS) items for the following uses:

- (i) Personal comfort;
- (ii) Convenience;
- (iii) Education;
- (iv) Hygiene;
- (v) Safety;
- (iv) Cosmetic;
- (vii) New equipment of unproven value; or
- (viii) Equipment of questionable current usefulness or therapeutic value.

004.03(B) EQUIPMENT NOT PRIMARILY MEDICAL IN NATURE. Medicaid does not cover the following items because they are not primarily medical in nature:

- (i) Air cleaners and purifiers;
- (ii) Air conditioners;
- (iii) Bed baths;
- (iv) Bed lifters;
- (v) Beds or lounge;
- (vi) Beds oscillating;
- (vii) Bed tables;
- (viii) Bed boards;
- (ix) Braille teaching texts;
- (x) Carafes;
- (xi) Cradles;
- (xii) Dehumidifiers, room, or central heating type;
- (xiii) Elevators;
- (xiv) Emesis basins;
- (xv) Enuresis alarms;
- (xvi) Environmental control equipment;
- (xvii) Exercise equipment;
- (xviii) Heating and cooling plants or equipment;
- (xix) Humidifiers, room, or central heating type;
- (xx) Hypodermic jet pressure injectors for insulin;
- (xxi) Lifts or wheelchair equipment;
- (xxii) Massage devices;
- (xxiii) Mattress and pillow covers;
- (xxiv) Medical identification items;
- (xxv) Pillows;
- (xxvi) Restraints;
- (xxvii) Sauna baths;
- (xxviii) Sheets, disposable or reusable;
- (xxix) Shower attachments, handheld;
- (xxx) Speech teaching machines;
- (xxxi) Stairway elevators;
- (xxxii) Telephone arms; or
- (xxxiii) Whirlpool pumps, portable.

004.03(C) DIATHERMY MACHINES, STANDARD AND PULSED WAVE TYPES. Medicaid does not cover diathermy machines as part of the durable medical equipment, prosthetics, orthotics, and medical supplies (DMEPOS) benefit.

004.03(D) ESOPHAGEAL DILATORS. Medicaid does not cover esophageal dilators as part of the durable medical equipment, prosthetics, orthotics, and medical supplies (DMEPOS) benefit.

004.03(E) OXYGEN THERAPY. Respiratory therapist services are not covered. The durable medical equipment, prosthetics, orthotics, and medical supplies (DMEPOS) benefit provides for coverage of oxygen and oxygen equipment but does not include a professional component in the delivery of such services. Oxygen therapy is not covered for:

- (i) Angina pectoris in the absence of hypoxemia;
- (ii) Dyspnea without cor pulmonale or evidence of hypoxemia;
- (iii) Severe peripheral vascular disease resulting in clinically evident desaturation in one or more extremities;
- (iv) Terminal illness that does not affect the lungs; and
- (v) Items that are considered precautionary and not therapeutic nature including:

- (1) Spare tanks of oxygen;
- (2) Emergency oxygen inhalators; and
- (3) Preset portable oxygen delivery unit where flow rate is not adjustable.

004.03(F) PARALLEL BARS. Medicaid does not cover parallel bars as part of the durable medical equipment, prosthetics, orthotics, and medical supplies (DMEPOS) benefit. Parallel bars are primarily intended for institutional use, not in a home setting.

004.03(G) PRESSURE REDUCING SUPPORT SERVICES. Medicaid does not cover powered mattress pads or overlays and mattress replacements, except alternating pressure pads, as part of the durable medical equipment, prosthetics, orthotics, and medical supplies (DMEPOS) benefit.

004.03(H) PULSE TACHOMETERS. Medicaid does not cover pulse tachometers as part of the durable medical equipment, prosthetics, orthotics, and medical supplies (DMEPOS) benefit when they are not reasonable or necessary for monitoring pulse of client with or without a cardiac pacemaker.

004.03(I) SEAT LIFTS. Excluded from coverage is the type of lift which operates by a spring release mechanism with a sudden, catapult like motion, and jolts the client from a seated to standing position.

004.03(J) TELEPHONE ALERT SYSTEMS. Medicaid does not cover emergency communication systems that do not serve a diagnostic or

therapeutic purpose.

004.02(K) TOOTHBRUSHES. Medicaid does not cover personal hygiene items including toothbrushes.

005. BILLING AND PAYMENT FOR DURABLE MEDICAL EQUIPMENT, PROSTHETICS, ORTHOTICS, AND MEDICAL SUPPLIES (DMEPOS)

005.01 BILLING.

005.01(A) GENERAL BILLING REQUIREMENTS. Providers must comply with all applicable billing requirements codified in 471 NAC 3. In the event that individual billing requirements in 471 NAC 3 conflict with billing requirements outlined in this chapter, the individual billing requirements in this chapter will govern.

005.01(B) SPECIFIC BILLING REQUIREMENTS. Providers must bill the Department on the appropriate claim form or electronic format. Any item billed to Medicaid must actually be dispensed or directly supplied by the provider that bills for the item. This does not preclude a provider from contracting with billing agents. Providers may not bill for durable medical equipment, prosthetics, orthotics, and medical supplies (DMEPOS) dispensed in advance.

005.01(B)(i) PROCEDURE CODES AND MODIFIERS. The provider will bill the Department using the Healthcare Common Procedure Coding System (HCPCS) and Current Procedural Terminology (CPT) procedure codes and modifiers.

005.01(B)(ii) RENTAL BILLING PROCEDURES. Providers must use the following rental billing procedures:

- (1) Bill for rental only while the item continues to be medically necessary and appropriately used by the client;
- (2) Rental items not used by the client for more than a one month period, during inpatient hospitalization, may not be billed to Medicaid. The provider is responsible for determining whether the item continues to be used by the client;
- (3) Bill rental on a monthly basis unless the item is used for less than a one month period. When billing for monthly rental, the unit of service "1" indicates a one month rental period. The provider will use the appropriate procedure code modifier when billing for monthly rental. The beginning rental date for each month will be the day of the month on which the item was initially provided. A monthly rental period is not necessarily a calendar month or a standard number of days. The monthly billing period begins the day of rental and extends to the day prior to the corresponding numerical day the following month. When rental equipment is needed at any time by the client for less than a one month rental period, the rental is paid on a daily pro rated basis. The provider will use the appropriate procedure code modifier when billing for daily rental. The unit of service

must reflect the number of days the item was actually used; and
(4) When billing for rental items, indicate both from and to dates of service and the initial rental date.

005.01(B)(iii) USED ITEMS. When billing for used durable medical equipment, prosthetics, orthotics, and medical supplies (DMEPOS) items, the provider must use the used equipment (UE) procedure code modifier.

005.01(B)(iv) APNEA MONITOR SUPPLIES. Apnea monitor supplies are covered for use with rented and client owned apnea monitors. For rented apnea monitors, the apnea monitor supplies must be billed on the same claim as the apnea monitor rental.

005.01(B)(v) HOME PHOTOTHERAPY. The provider must bill for home phototherapy daily rental on a single claim and indicate the total number of rental days as the units of service.

005.01(B)(vi) UTERINE MONITORS, HOME. The provider must indicate on the claim the condition which necessitates use of the monitor and, when billing for the final rental period, the date of discontinuation of the monitor.

005.01(B)(vii) OXYGEN THERAPY. When billing for oxygen therapy, the durable medical equipment, prosthetics, orthotics, and medical supplies (DMEPOS) provider must use the appropriate unit of service as described in the procedure code. Units of service should be rounded to the nearest unit of the procedure code description.

005.02 PAYMENT.

005.02(A) GENERAL PAYMENT REQUIREMENTS. Medicaid will reimburse the provider for services rendered in accordance with the applicable payment regulations codified in 471 NAC 3. In the event that individual payment regulations in 471 NAC 3 conflict with payment regulations outlined in this chapter, the individual payment regulations in this chapter will govern.

005.02(B) SPECIFIC PAYMENT REQUIREMENTS. Medicaid pays for covered durable medical equipment, prosthetics, orthotics, and medical supplies (DMEPOS) at the lower of:

- (1) The provider's submitted charge; or
- (2) The allowable amount for that procedure code in the Nebraska Medicaid Practitioner Fee Schedule in effect for that date of service.

005.02(B)(i) MEDICARE AND MEDICAID CROSSOVER CLAIMS. Information on payment of Medicare and Medicaid crossover claims is found in 471 NAC 3.

005.02(B)(ii) ORTHOSES AND PROSTHESES. Medicaid payment for orthoses and prostheses includes:

- (1) Evaluations only when no device, orthosis, prosthesis, part, repair, or adjustment is provided;
- (2) Fitting;
- (3) Cost of parts and labor;
- (4) Repairs due to normal wear and tear for a minimum of 90 days from the date dispensed; and
- (5) Adjustments made when fitting and for a minimum of 90 days from the date dispensed when the adjustments are not necessitated by changes in the client's medical condition or the client's functional abilities.

005.02(B)(iii) RENTAL PAYMENT. Payment for rental includes:

- (1) All necessary repair and replacement parts; and
- (2) All accessories and supplies necessary for the effective use of the equipment, unless specifically allowed as outlined in the coverage criteria for the item.

005.02(B)(iv) AIR FLUIDIZED AND LOW AIR LOSS BED UNITS.

Medicaid rental payment includes:

- (1) Air fluidized or low air loss bed unit and all accessories and services necessary for proper functioning and effective use of the bed;
- (2) Weekly on site client evaluation and wound care consultation by a registered nurse employed by the provider, with 24 hour per day availability; and
- (3) Complete caregiver training on use of equipment, wound care, and prevention.

005.02(B)(v) APNEA MONITORS. Medicaid rental payment includes complete parent or caregiver training on use of the equipment and record keeping. Medicaid does not make separate payment for remote alarms. When provided, payment for a remote alarm is included in the monitor rental payment.

005.02(B)(vi) HOME PHOTOTHERAPY PAYMENT. Medicaid daily rental payment includes:

- (1) Phototherapy unit and all supplies, accessories, and services necessary for proper functioning and effective use of the therapy;
- (2) A minimum of one daily visit to the home by a licensed or certified health care professional is required. The daily visits must include:
 - (a) A brief home assessment; and
 - (b) Collection and delivery of blood specimens for bilirubin testing when ordered by the authorized durable medical equipment, prosthetics, orthotics, and medical supplies (DMEPOS) provider to be collected in the home. The

authorized durable medical equipment, prosthetics, orthotics, and medical supplies (DMEPOS) provider must be informed by the provider that this service is available. An outside agency or laboratory with whom the provider contracts for collection and delivery of blood specimens may not bill Medicaid directly since payment is included in the daily rental payment. Daily home visits must occur for home assessment even if the blood collection is done outside the home; and

(3) Complete caregiver training on use of equipment and completion of necessary records.

005.02(B)(vii) RATE NOT ESTABLISHED CODES. For rate not established (RNE) codes on the Nebraska Medicaid Practitioner Fee Schedule, payment will be determined based on manufacturer's invoice cost.

005.02(B)(viii) SEAT LIFTS. Payment for seat lift chairs which incorporates a recliner feature along with the seat lift is limited to the amount payable for a seat lift without this feature.

005.02(B)(ix) UTERINE MONITORS, HOME. Medicaid rental payment includes all equipment, supplies, and services necessary for the effective use of the monitor. This does not include medications or authorized durable medical equipment, prosthetics, orthotics, and medical supplies (DMEPOS) provider's professional services.

005.02(B)(x) DIALYSIS EQUIPMENT AND SUPPLIES. Medicaid reimburses for dialysis systems, related supplies, and equipment only to approved renal dialysis facilities under the Medicare Method I composite rate payment methodology. Payment cannot be made to suppliers, pharmacies, or home health agencies for dialysis systems, related supplies, and equipment.

