Section (Primary Department) **Health Care Management – Utilization Management**		**SUBJECT (Document Title)** **Durable Medical Equipment – LA**	
Effective Date April 21, 2016	**Date of Last Review** ~~February 28, 2019~~March 12, 2020	**Date of Last Revision** ~~December 3, 2019~~March 12, 2020	**Dept. Approval Date** ~~December 3, 2019~~March 12, 2020
Department Approval/Signature:			

Policy applies to health plans operating in the following State(s). Applicable products noted below.

Products				
☒ **Medicaid**	☐ Arkansas	☐ Indiana	☐ Nevada	☐ Tennessee
☐ **Medicare**	☐ California	☐ Iowa	☐ New Jersey	☐ Texas
☐ **MMP/Duals**	☐ Colorado	☐ Kentucky	☐ New York – Empire	☐ Virginia
	☐ District of Columbia	☒ Louisiana	☐ New York (WNY)	☐ Washington
	☐ Florida	☐ Maryland	☐ North Carolina	☐ Wisconsin
	☐ Georgia	☐ Minnesota	☐ South Carolina	☐ West Virginia

POLICY:

Durable medical equipment (DME) is covered when medically necessary for use as part of the medical care of a member. Items and services must be:

- Primarily and customarily used to serve a medical purpose;
- Generally not useful to a person in the absence of illness or injury; and
- Appropriate for use in the home.

Covered items and services include:

- DME;
- Medical supplies;
- Home dialysis equipment and supplies;
- Therapeutic shoes;
- Parenteral and enteral nutrition, equipment, and supplies;
- Transfusion medicine; and
- Prosthetics and orthotics.

DEFINITIONS:

** Denotes terms for which Healthy Blue must use the State-developed definition.*

Durable Medical Equipment (DME)* – DME is inclusive of equipment which 1) can withstand repeated use, 2) is primarily and customarily used to serve a medical purpose, 3) generally is not useful to a person in the absence of illness or injury, and 4) is appropriate for use in the home. DME does not include disposable medical supplies[IG1][WJL2][IG3].

Medically Necessary Services* – Those health care services that are in accordance with generally accepted, evidence-based medical standards or that are considered by most physicians (or other independent licensed practitioners) within the community of their

respective professional organizations to be the standard of care. In order to be considered medically necessary, services must be: (1) deemed reasonably necessary to diagnose, correct, cure, alleviate or prevent the worsening of a condition or conditions that endanger life, cause suffering or pain or have resulted or will result in a handicap, physical deformity or malfunction; and (2) those for which no equally effective, more conservative and less costly course of treatment is available or suitable for the beneficiary. Any such services must be individualized, specific and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and neither more nor less than what the beneficiary requires at that specific point in time. ~~Although a service may be deemed medically necessary, it doesn't mean the service will~~[IG4] ~~be covered under the Medicaid Program.~~ [IG5]Services that are experimental, non-FDA approved, investigational, or cosmetic are specifically excluded from Medicaid coverage and will be deemed "not medically necessary."

Medical Supplies – Medical supplies are generally disposable, expendable, or consumable items designed for use by a single individual, including but not limited to one (1) time use items. Medical supplies include items such as catheters and diapers.

Prior Authorization – The process of determining medical necessity for specific services before they are rendered. Sometimes called prior approval, preauthorization, or precertification.

PROCEDURE:

Durable medical equipment (DME) is inclusive of equipment which can withstand repeated use. DME covered services include purchase of a device and necessary accessories, rental for a trial period, and repairs not covered by warranty (including parts, labor, and shipping). Medical necessity must be established for each service and documented, at a minimum, with the following:

- Written prescription no more than twelve (12) months old, with the printed name and the dated signature of the recipient's treating physician, the treating physician's advanced registered nurse practitioner (ARNP), or physician assistant. The prescription cannot be dated more than twenty-one (21) days after the initiation of service (date of service);
- Current hospital discharge plan with the dated signature of the recipient's treating physician, ARNP, or physician assistant that clearly describes the type of DME item or service ordered;
- Letter of Medical Necessity no more than twelve (12) months old, which includes the printed name and the dated signature of the recipient's treating physician or the treating physician's ARNP or physician assistant. Medicaid prohibits vendors from preparing sections of the letter that are to be completed by the physician or authorized prescriber. The letter of medical necessity cannot be dated more than twenty-one (21) days after the initiation of service (date of service); and
- Plan of care, if the provider is a home health agency.

All documentation of medical necessity must include the type of medical equipment, services or consumable goods ordered, including the type, quantity, frequency and length of need ordered or prescribed. Prescribed oxygen services must include rates of flow, concentration, level of frequency, duration of use, and circumstances under which oxygen is to be used. If this information is not included, a new prescription that clarifies the order is required.

Medical necessity criteria may include age of the recipient. Items exclusive to members under age twenty-one (21), Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) recipients, include disposable incontinence supplies, enteral formula, cochlear implants, and hearing aids.

NOTE: The fact that a provider has prescribed or recommended equipment, supplies or services does not, in itself, make it medically necessary or a medical necessity or a covered service.

If equipment is needed temporarily, it may be more cost effective to pay for the rental of equipment. Consideration is given to the length of time the equipment is needed, to the total rental cost for that period time, and the purchase price of the item. Equipment will be purchased, not rented, if the total cost of rental exceeds the purchase price. ~~Rental reimbursement requires prior authorization (PA). Most items are limited to a continuous ten (10) month rental cap (see below for specific item details); however[IG6][WJL7], there are some items where a shorter rental time period is authorized. This is dependent on the Fee Schedule pricing.~~Prior authorization is required for all rented equipment. Reimbursement is based on the rental price up to the maximum allowed of the particular DME. Reimbursement is dependent upon the Louisiana Medicaid DME Fee Schedule (refer to reimbursement policy *Durable Medical Equipment Rent to Purchase*[IG8]). –The provider cannot charge for features on equipment not medically required by the recipient's condition[IG9].

When rental equipment is furnished to a member the provider must:

- Ensure and maintain documentation on file that the equipment is routinely serviced and maintained by qualified provider staff, as recommended by the product manufacturer;
- Repair, or replace all expendable parts or items, such as masks, hoses, tubing and connectors, and accessory items necessary for the effective and safe operation of the equipment;
- Substitute like equipment at no additional cost to Medicaid if the equipment becomes broken because of normal use while the original rental equipment is being repaired;
- Replace equipment that is beyond repair at no additional charge and maintain documentation of the replacement;
- Maintain documentation that is signed and dated by both the provider and the recipient or recipient's responsible caregiver at the time of delivery, which attests to the fact that instruction has been provided by trained and qualified provider staff to the recipient or

caregiver regarding the recipient's or caregiver's responsibility for cleaning the equipment and performing the general maintenance on the equipment, as recommended by the manufacturer; and
- Maintain documentation that is signed and dated by both the provider and the recipient or recipient's responsible caregiver, which attests that the recipient or the caregiver was provided with the manufacturer instructions, servicing manuals, and operating guides needed for the routine service and operation of the specific type or model of equipment provided.

Medicaid requires that all DME be provided to an eligible recipient with a minimum of a one (1) year DME provider warranty. Providers who make or sell prosthetic or orthotic items must provide a warranty which lasts at least ninety (90) days, from the time the item is delivered to the recipient. If during those ninety (90) days, the item does not work, the manufacturer or dealer must repair or replace the item. Medicaid will not reimburse for replacement parts or repairs to the equipment.

Medicaid reimbursement includes:
- All elements of the manufacturer's warranty;
- All routine or special equipment servicing, to the extent the same servicing is provided to non-Medicaid persons;
- All adjustments and modifications needed to make the item safe, useful and functional for the recipient during the entire first year (including customized wheelchairs);
- Delivery, set-up and installation of the DME by trained and qualified provider staff, in the area of the home where the equipment will be used or the appropriate room within the home;
- Adequate training and instruction provided to the recipient or the recipient's responsible caregiver by the provider's trained and qualified staff, in a language understood by the recipient or caregiver regarding the manufacturer's recommendations for the safe, sanitary, effective, and appropriate use of the item; and
- Honoring the required one-year provider warranty for all requests or prescriptions requesting equipment repair made on or before the 366th day of service.

Providers cannot disregard a recipient's requests for warranty equipment repairs or modifications and may not delay needed repairs or modifications, otherwise permitted by DME policy, until the provider's or manufacturer's warranty has expired.

Maintenance and repair may be reimbursed when the following conditions are met:
- Equipment is covered by Medicaid;
- Equipment is the personal property of the recipient;
- Item is still medically necessary;
- The equipment is used exclusively by the recipient;

- No other payment source is available to pay for the needed repairs;
- Equipment damage is not due to misuse, abuse, neglect, loss or wrongful disposition by the recipient, the recipient's caregiver, or the provider;
- Equipment maintenance is performed by a qualified technician;
- Maintenance is not currently covered under a manufacturer's or provider's warranty agreement; and
- Maintenance is not performed on a duplicate type of item already being maintained for the recipient during the maximum limit period.

If equipment is lost, stolen, or destroyed in a fire, the provider must obtain and submit, in a timely manner, a completed police or insurance report describing the specific medical equipment which was stolen or destroyed. The police or insurance report must be submitted with a new PA request (refer to *Lost, Stolen, or Destroyed Durable Medical Equipment Policy and Procedure*).

Replacement of equipment that is damaged as a result of misuse, abuse, neglect, or wrongful disposition by the member, the member's caregiver, or the provider is **not covered**. Examples include but are not limited to:

- Failure to clean and maintain the equipment as recommended by the equipment manufacturer;
- Failure to store the equipment in a secure and covered area when not in use; and
- Loss, destruction or damage to the equipment caused by malicious, intentional or negligent acts of the member, the member's caregiver, or the provider.

Purchase or repair of high-cost DME greater than $3,000 (or as defined by the health plan) must undergo Medical Director review (refer to *High Cost DME, Prosthetic or Orthotic Purchases Policy and Procedure*).

Healthy Blue shall make eighty percent (80%) of standard DME and supply authorizations within two (2) business days of obtaining appropriate medical information. All standard service authorization determinations shall be made no later than fourteen (14) calendar days following receipt of the request for service. The authorization decision may be extended up to fourteen (14) additional calendar days if the member request the extension, or Healthy Blue justifies a need for additional information and how the extension is in the member's interest.

In the event a provider indicates, or Healthy Blue determines, that the standard service authorization timeframe could seriously jeopardize the member's life or health or ability to attain, maintain, or regain maximum function, Healthy Blue shall make an expedited authorization decision and provide notice as expeditiously as the member's health condition requires, but no later than seventy-two (72) hours after receipt of the request for service. Healthy Blue may extend the seventy-two (72) hour time period by up to fourteen (14) calendar

days if the member or Healthy Blue justifies a need for additional information and how the extension is in the member's best interest. A request is considered an emergency if a delay in obtaining the medical equipment or supplies would be life-threatening to the recipient.

Healthy Blue shall make retrospective review determinations within thirty (30) calendar days of obtaining appropriate medical information, but in no instance later than one hundred eighty (180) days from the date of service.

Healthy Blue shall notify the provider verbally or as expeditiously as the member's health condition requires but no greater than one (1) business day from making the initial determination, and shall provide documented confirmation of such notification to the provider within two (2) business days of making the determination.

NOTE: Where State or Federal time standards differ from the National Committee Quality Assurance (NCQA) time standards, the more stringent time standard applies.

Healthy Blue cannot subsequently retract an authorization approval after services have been provided or reduce payment for an item or service furnished in reliance upon previous service approval, unless the approval was based upon a material omission or misrepresentation about the member's health condition made by the provider.

In the event an enrollee entering Healthy Blue is actively receiving Medicaid covered DME, prosthetics, orthotics, and supplies at the time of enrollment, whether such services were provided by another MCO or Medicaid Fee-For-Service (FFS), Healthy Blue shall be responsible for the costs of continuation of these services, without any form of PA and without regard to whether such services are being provided by contract or non-contract providers. Continuation of such services shall be provided for up to ninety (90) calendar days or until the enrollee may be reasonably transferred (within the timeframe specified in the Contract) without disruption, whichever is less.

Healthy Blue shall also honor any PA for DME, prosthetics, orthotics and supplies issued while the enrollee was enrolled in another MCO or the Medicaid FFS program for a period of ninety (90) calendar days after the member's enrollment in Healthy Blue.

SPECIFIC COVERAGE CRITERIA:

The list below of covered and non-covered services is not all-inclusive (refer to the *Louisiana Medicaid Fee Schedule* and the *Medicaid Services Manual* for additional coverage information).

Ambulatory Equipment

Ambulatory equipment and aids are devices related to or adapted for walking and mobility.

- **Canes and Crutches**
  Eligible: All members where DME is a covered benefit
  PA Requirement: PA is not required
  Benefit Description: Requests for canes (wooden or metal), quad canes (four-prong), and all types of crutches may be approved if the recipient's condition impairs ambulation and there is a potential for ambulation.

- **Enhancement Accessories**
  Eligible: Non-covered
  PA Requirement: Item is **not covered**
  Benefit Description: Enhancement accessories of walkers, canes and crutches are not medically necessary. An enhancement accessory does not contribute significantly to the therapeutic function of the walker, cane or crutch. It may include, but is not limited to style, color, hand operated brakes (other than those described for heavy duty, multiple braking system, variable wheel resistance walker), seat attachments, tray attachments, or baskets (or equivalent).

- **Arm Rests**
  Eligible: All members where DME is a covered benefit
  PA Requirement: PA is required ~~and reimbursement is limited to a ten (10) month rental~~
  Benefit Description: Armrest attachments are considered medically necessary when the recipient's ability to grip is impaired.

- **Leg Extensions**
  Eligible: All members where DME is a covered benefit
  PA Requirement: PA is not required
  Benefit Description: Leg extensions are considered medically necessary for recipients six (6) feet tall or more.

- **Walking Belts**
  Eligible: Non-covered
  PA Requirement: Item is **not covered**
  Benefit Description: Medicaid does not consider walking belts used to support and guide the recipient in walking as medically necessary because they are not primarily medical in nature and are normally used by persons who do not have a disease or injury.

- **Walkers and Walker Accessories**
  Eligible: All members where DME is a covered benefit
  PA Requirement: PA is not required
  Benefit Description: A standard walker and related accessories are covered when prescribed by a physician for a recipient with a medical condition that impairs ambulation,

the recipient has a potential for ambulation, and the recipient has a need for greater stability and security than can be provided by a cane or crutches.

Walker **exclusions** and **non-covered** items include:

- Walker with an enclosed frame (i.e., a folding wheeled walker with a frame completely surrounding the recipient and an attached seat in the back);
- Walking belts; and
- Enhanced accessories (i.e. style, color, hand operated brakes (other than those described above for heavy duty), multiple braking system, variable wheel resistance walker), seat attachments, tray attachments, or baskets (or equivalent).

- **Wheeled Walker**
  Eligible: All members where DME is a covered benefit
  PA Requirement: PA is not required
  Benefit Description: A wheeled walker may be fixed height or adjustable height and may include glide-type brakes (or equivalent). The wheels may be fixed or swivel. A wheeled walker shall be approved only if the recipient is unable to use a standard walker due to severe neurological disorders, debilitating medical condition that may prohibit the use of a standard walker or limited use of one hand. The request must contain supporting documentation from the prescribing physician which substantiates the need for a wheeled walker rather than a standard walker.

- **Heavy Duty Walker**
  Eligible: All members where DME is a covered benefit
  PA Requirement: PA is required for some items
  Benefit Description: A heavy-duty walker may be approved for recipients who meet the criteria for a standard walker and weigh more than three hundred (300) pounds.

- **Heavy Duty, Multiple Braking System, Variable Wheel Resistance Walker**
  Eligible: All members where DME is a covered benefit
  PA Requirement: PA is required ~~and reimbursement is limited to a ten (10) month rental~~
  Benefit Description: A heavy duty, multiple braking system, variable wheel resistance walker is a four-wheeled, adjustable height, folding walker that has all of the following characteristics:
  - Capable of supporting recipients weighing more than 350 pounds;
  - Can be set so that either one or both brakes can lock the wheels;
  - Hand operated brakes that cause the wheels to lock when the hand levers are released;
  - Adjust so the recipient can control the pressure of each hand brake;
  - Additional braking mechanism on the front crossbar; and a minimum of two wheels have brakes that can be independently set through tension adjustability to provide varying resistance.

A heavy duty, multiple braking system, variable wheel resistance walker is considered medically necessary for recipients who weigh greater than three hundred fifty (350) pounds, meet coverage criteria for a standard walker, and are unable to use a standard walker due to a severe neurological disorder or other condition causing the restricted use of one hand. Obesity alone is not considered a medically necessary indication for this walker.

- **Standard Wheelchairs**
  Eligible: All members where DME is a covered benefit
  PA Requirement: PA is required ~~and reimbursement is limited to a ten (10) month rental~~
  Benefit Description: Wheelchairs are approved only when the recipient is confined to a bed, chair or room. The request should indicate the recipient's ability to walk unassisted and whether the request is for a first chair or replacement chair. Standard wheelchairs require documentation of medical necessity. Standard wheelchair attachments include: foot rests, brakes, and arm rests.

- **Motorized and/or Custom Motorized Wheelchairs**
  Eligible: All members where DME is a covered benefit
  PA Requirement: PA is required
  Benefit Description: The term motorized shall have the same meaning as power, electric or any means of propulsion other than manual. A motorized wheelchair must be medically necessary. The recipient must meet all of the following criteria in order to be considered for a motorized wheelchair:
  - The recipient is not functionally ambulatory. Not functionally ambulatory means the recipient's ability to ambulate is limited such that without use of a wheelchair, he/she would otherwise be generally bed or chair confined;
  - The recipient is unable to operate a wheelchair manually due to severe weakness of the upper extremities due to a congenital or acquired neurological or muscular disease/condition or is unable to propel any type of manual wheelchair because of other documented health problems; and
  - The recipient is capable of safely operating the controls for a motorized wheelchair and can adapt to or be trained to use a motorized wheelchair effectively.

  All wheelchairs and modifications are subject to PA. Only one (1) wheelchair may be requested at a time. Backup chairs, either motorized or manual, will be **denied** as not medically necessary. In addition to the required documentation needed for all PA requests, motorized wheelchair requests must include:
  - A physician's prescription for a motorized wheelchair;
  - Medical documentation from a physician is required to support the provisions set forth regarding recipient criteria as noted above; and
  - A seating evaluation performed, signed and dated by the physical therapist or

occupational therapist that performed the seating evaluation. The seating evaluation shall:

- Indicate the appropriateness of the specific wheelchair requested and all modifications and/or attachments to the specific wheelchair and its ability to meet the recipient's long term medical needs. Options that are primarily beneficial in allowing the recipient to perform leisure or recreational activities are **not covered**;
- Include the dated signature of the physician who prescribed the motorized wheelchair is medically necessary; and
- The recipient's diagnosis or condition is such that a motorized wheelchair is medically necessary; and
- He or she has seen the seating evaluation and motorized wheelchair recommendation.

o Documentation indicating that the recipient is capable of safely operating the controls for a motorized wheelchair and can adapt to or be trained to use the motorized wheelchair effectively. It is not sufficient for a Medicaid provider of motorized wheelchairs to indicate that a recipient is capable of safely operating the controls for a motorized wheelchair and can adapt to or be trained to use it effectively. Such documentation shall include:

- A signed and dated statement from the recipient's physician, physical therapist that he/she has determined that the recipient has the cognitive, motor and perceptual abilities needed to safely operate the controls of a motorized wheelchair. This statement must be verified by the notes and recommendation of the physician, physical therapist or occupational therapist making such statement; and
- A signed and dated statement from the recipient's physician or physical therapist that he or she has determined that the recipient can adapt to or be trained to use the motorized wheelchair effectively. This statement must be verified by the notes and recommendation of the physician, physical therapist or occupational therapist making such statement.

Request for repairs to motorized wheelchairs will be considered for basic repairs only. Basic repairs are those which are requested to repair an existing component of the recipient's current motorized wheelchair.

Requests for modifications or reconstruction of the recipient's current motorized wheelchair shall not be considered basic repairs. Requests for modifications or reconstruction of the recipient's current motorized wheelchair must be submitted in accordance with PA criteria. Modifications or reconstruction will be **denied** if it is more cost-effective to provide a new motorized wheelchair.

All repairs and modifications of motorized wheelchairs must be completed within one (1) month, unless there is a justifiable reason for a dely. Rental of a manual wheelchair may be

prior authorized on a monthly basis as a temporary replacement, if necessary, when the recipient's motorized wheelchair is being repaired or modified.

Apnea Monitors

Eligible: All members where DME is a covered benefit

PA Requirement: PA is required ~~and reimbursement is limited to an eight (8) month rental~~ ~~[IG10][WJL11]~~

Benefit Description: Apnea monitors are cardio-respiratory monitoring devices capable of providing continuous or periodic two-channel monitoring of the heart rate and respiratory rate. Apnea monitors must have alarm mechanisms to alert care givers of cardio-respiratory distress or other events which require immediate intervention, and must also record and store events and provide event recording downloads or printouts of such data. Home apnea monitors may be approved for rental or purchase when any of the criteria are met and under the following guidelines:

- **Apnea of Prematurity** – Apnea of prematurity is the sudden cessation of breathing that lasts for at least twenty (20) seconds or is accompanied by bradycardia or oxygen desaturation cyanosis in an infant younger than thirty-seven (37) weeks gestational age.
- **Apnea of Infancy** – Apnea of infancy is an unexplained episode of cessation of breathing for twenty (20) seconds or longer or a shorter respiratory pause associated with bradycardia, cyanosis, pallor, and/or marked hypotonia. The term apnea of infancy generally refers to infants with gestational age of thirty-seven (37) weeks or more at the onset of apnea. The Medicaid Program defines bradycardia for infants as a resting heartbeat of less than eighty (80) beats per minute at one (1) month of age, less than seventy (70) beats per minute at two to three (2-3) months of age, and less than sixty (60) beats per minute at three (3) months of age or older. Monitoring for subsequent siblings of Sudden Infant Death Syndrome (SIDS) victims less than eight (8) months of age may be approved for a maximum of eight (8) months.
- **Following an Apparent Life-Threatening Event** – An Apparent Life-Threatening Event (ALTE) is characterized by some combination of central apnea or occasionally obstructive apnea, color change (usually cyanotic or pallid but occasionally erythematous or plethoric), and a marked change in muscle tone (usually marked limpness), choking, or gagging, which required vigorous intervention or cardiopulmonary resuscitation (CPR). Children requiring home oxygen therapy, central hypo-ventilator, tracheotomy, and/or home ventilator support will be considered on a case-by-case basis. Approval following apneic episodes resistant to treatment, such as Ondine's Curse, shall be considered on a case-by-case basis.

Apnea Monitor Initial Authorization Period for Rentals – Authorization of payment for rental of an apnea monitor may be approved for the initial three (3) months without download reports or download summary information with download report, based on clinical data supporting medical necessity. The initial three (3) month rental includes all apnea monitor initial set up supplies – belt, leads and electrodes.

Apnea Monitor Extensions after Initial Three (3) Months – Any request for extensions after the initial three (3) month period must be accompanied by documented evidence obtained in the home environment of recurrence of apneic episodes (e.g., cyanosis, resuscitative measures, etc.). Apnea monitors will not be approved beyond the initial three (3) months without download reports or download summary information with a download report. Family non-compliance and/or physician's refusal to remove the child from the apnea monitor are not acceptable reasons for further approval of payment for rental of the apnea monitor.

Apnea Monitor Emergency Requests – An oral request may be approved in an emergency for a one (1) month period to avoid prolonged hospitalization. Once documentation has been received indicating medical criteria have been met, the request may be approved for an additional two (2) months.

Artificial Eyes
Eligible: All members where DME is a covered benefit
PA Requirement: PA is not required
Benefit Description: An artificial eye is approved if an eyeball is removed and replacement is necessary to maintain the contour of the face.

Artificial Larynxes
Eligible: All members where DME is a covered benefit
PA Requirement: PA is not required
Benefit Description: An artificial larynx is approved only if the larynx is removed and the recipient is unable to use an esophageal voice. Repairs and batteries are included.

Augmentative and Alternative Communication (ACC) Devices
Eligible: All members where DME is a covered benefit
PA Requirement: PA is required
Benefit Description: Augmentative and Alternative Communication (AAC) Devices are electronic or non-electronic aids, devices, or systems that assist a recipient to overcome or ameliorate (reduce to the maximum degree possible) the communication limitations that preclude or interfere with meaningful participation in current and projected medically necessary daily activities. Meaningful participation refers to effective and efficient communication of messages in any form the recipient chooses. Examples of AAC devices include:

- Communication boards or books, speech amplifiers, and electronic devices that produce speech and/or written output;
- Devices that are constructed for use as communication devices as well as systems that may include a computer, when the primary use of the computer serves as the recipient's communication device; and
- Related components and accessories, including software programs, symbol sets, overlays,

mounting devices, switches, cables and connectors, auditory, visual, and tactile output devices, printers, and necessary supplies, such as rechargeable batteries.

Consideration shall be given for Medicaid reimbursement for AAC devices for recipients of all ages if the device is considered medically necessary, the recipient has the ability to physically and mentally use a device and its accessories, and if criteria are met as listed below. The following medically necessary conditions shall be established for recipients who/whose:

- Have a diagnosis of a significant expressive or receptive (language comprehension) communication impairment or disability;
- Impairment or disability either temporarily or permanently causes communication limitations that preclude or interfere with the recipient's meaningful participation in current and projected daily activities; and
- Had a speech language pathologist (and other health professional, as appropriate):
  - Perform an assessment and submit a report pursuant to the criteria set forth in Assessment/Evaluation (see Assessment/Evaluation below);
  - Recommend speech language pathology treatment in the form of ACC devices and services;
  - Document the mental and physical ability of a recipient to use, or learn to use a recommended AAC device and accessories for effective and efficient communication;
  - Prepare a speech language pathology treatment plan that describes the specific components of the AAC devices and the required amount, duration, and scope of the AAC services that will overcome or ameliorate communication limitations as earlier described; and
- Requested AAC devices constitute the least costly, equally effective form of treatment that will overcome or ameliorate communication limitations as earlier described.

The following are additional general principles relating to medical necessity determinations for AAC devices:

- The cause of the recipient's impairment or disability (e.g., congenital, developmental, or acquired), or the recipient's age at the onset of the impairment or disability, are irrelevant considerations in the determination of medical need;
- Recipient participation in other services or programs (e.g., school, early intervention services, adult services programs, employment) is irrelevant to medical necessity determination for AAC devices;
- No cognitive, language, literacy, prior treatment, or other similar prerequisites must be satisfied by a recipient in advance of a request for AAC devices; and
- The unavailability of an AAC device, component, or accessory for rental will not serve as the basis for denying a prior authorization (PA) request for that device, component or accessory.

AAC device assessments and evaluations:

- An assessment or evaluation of the recipient's functioning and communication limitations

that preclude or interfere with meaningful participation in current and projected daily activities must be completed by a speech language pathologist with input from other health professionals, (e.g., occupational therapists and rehabilitation engineers) based on the recommendation of the speech language pathologist and a physician's prescription, as appropriate;

- Requests for AAC devices must include a description of the speech language pathologist's qualifications, including a description of the speech-language pathologist's AAC services training and experience; and
- An assessment (augmentative and alternative communication evaluation) must include the following information about the recipient:
  - Identifying information:
    - Name;
    - Medicaid identification number;
    - Date of the assessment;
    - Medical and neurological diagnoses (primary, secondary, tertiary);
    - Significant medical history;
    - Mental or cognitive status; and
    - Educational level and goals.
  - Sensory Status:
    - Vision and hearing screening (no more than one year prior to AAC evaluation);
    - If vision screening is failed, a complete vision evaluation;
    - If hearing screening is failed, a complete hearing evaluation; and
    - Description of how vision, hearing, tactile, and/or receptive communication impairments or disabilities affect expressive communication.
  - Postural, Mobility and Motor Status:
    - Gross motor assessment;
    - Fine motor assessment;
    - Optimal positioning;
    - Integration of mobility with AAC devices; and
    - Recipient's access methods (and options) for AAC devices.
  - Current speech, language and expressive communication status:
    - Identification and description of the recipient's expressive or receptive (language comprehension) communication impairment diagnosis;
    - Speech skills and prognosis;
    - Language skills and prognosis;
    - Communication behaviors and interaction skills (i.e., styles and patterns);
    - Functional communication assessment, including ecological inventory;
    - Indication of past treatment, if any; and
    - Description of current communication strategies, including use of an AAC device, if any.
  - **NOTE:** If an AAC device is currently used, describe the device, when and by whom it was

previously purchased, and why it is no longer adequate for communication needs).

- Communication Needs Inventory:
  - Description of recipient's current and projected communication needs
  - Communication partners and tasks including partners' communication abilities limitations, if any; and
  - Communication environments and constraints which affect AAC device selection and/or features (e.g., verbal and/or visual output and/or feedback; distance communication needs).
- Summary of Communication Limitations:
  - Description of the communication limitations that preclude or interfere with meaningful participation in current and projected daily activities (i.e., why the recipient's current communication skills and behaviors prevent meaningful participation in the recipient's current and projected daily activities).
- AAC Devices Assessment Components:
  - Vocabulary requirements;
  - Representational system(s);
  - Display organization and features;
  - Rate enhancement techniques;
  - Message characteristics, speech synthesis, printed output, display characteristics, feedback, auditory and visual output;
  - Access techniques and strategies; and
  - Portability and durability concerns, if any.
- Identification of AAC Devices Considered for Recipients:
  - Identification of the significant characteristics and features of the AAC devices considered for the recipient; and
  - Identification of the cost of the AAC devices considered for the recipient (including all required components, accessories, peripherals and supplies as appropriate).
- AAC Device Recommendation:
  - Identification of the requested AAC devices including all required components, accessories, software, peripheral devices, supplies and the device vendor;
  - Identification of the recipient and communication partner's AAC devices preference, if any;
  - Assessment of the recipient's ability (physically and mentally) to use, or to learn to use, the recommended AAC device and accessories for effective and efficient communication; and
  - Justification stating why the recommended AAC device (including description of the significant characteristics, features and accessories) is better able to overcome or ameliorate the communication limitations that preclude or interfere with the recipient's meaningful participation in current and projected daily activities as compared to the other AAC devices considered; and justification stating why the recommended AAC device (including description of the significant characteristics,

features and accessories) is the least costly, equally effective, alternative form of treatment to overcome or ameliorate the communication limitations that preclude or interfere with the recipient's meaningful participation in current and projected daily activities.

- Treatment Plan and Follow Up:
  - Description of short term communication goals (e.g., 6 months);
  - Description of long term communication goals (e.g., one year);
  - Assessment criteria to measure recipient's progress toward achieving short and long term communication goals;
  - Description of amount, duration and scope of AAC services required for the recipient to achieve short and long term communication goals; and
  - Identification and experience of AAC service provider responsible for training (these service providers may include, e.g.: speech language pathologists, occupational therapists, rehabilitation engineers, the recipient's parents, teachers and other service providers).
- Summary of Alternative Funding Source for AAC Device:
  - Description of availability or lack of availability, of purchase of AAC device through other funding sources.

In instances where the appropriateness of a specific AAC device is not clear, a trial use period for an AAC device may be recommended (although it is not required) by the speech-language pathologist who conducts the AAC evaluation. PA for rental of AAC devices shall be approved for trial use periods when the speech-language pathologist prepares a request that includes, but is not limited to:

- The characteristics of the recipient's communication limitations;
- Lack of familiarity with a specific AAC device;
- Whether there are sufficient AAC services to support the recipient's use of the AAC device, or other factors;
- The duration of the trial period;
- The speech-language pathologist information and the recipient information as required in the Assessment Evaluation;
- The AAC device to be examined during the trial period, including all the necessary components (e.g., mounting device, software, switches, or access control mechanism);
- The identification of the AAC services provider(s) who will assist the recipient during the trial period;
- The identification of the AAC services provider(s) who will assess the trial period; and
- The evaluation criteria, specific to the recipient that will be used to determine the success or failure of the trial period.

Trial periods may be extended and/or different AAC devices provided, when requested by the speech-language pathologist responsible for evaluating the trial use period. Results of trial use

periods must be included with any subsequent request for prior authorization of the AAC device purchase. Recommendations for the purchase of an AAC device, as a result of a trial use period of the device, must clearly indicate the recipient's ability to use the device during the trial period.

Medicaid covers repairs to keep AAC devices, accessories, and other system components in working condition. Coverage for repairs includes the cost of parts, labor, and shipping, when not otherwise available without charge pursuant to a manufacturer's warranty. Providers who make, sell, or lease assistive devices, including AAC devices, must provide those who buy or lease the equipment with a warranty which lasts at least one year from the time the equipment is delivered to the recipient. If, during the warranty period, the equipment does not work, the manufacturer or dealer must make an attempt to repair the equipment. Medicaid additionally requires providers to provide the recipient with a comparable, alternate AAC device while repairing the recipient's device during a warranty period. Medicaid coverage may be provided for the rental of an alternate AAC device during a repair period after expiration of the warranty. Medicaid will not cover repairs, or rental of a loaner device, when repairs are made during a warranty period.

Coverage for repairs greater than $300.00 must be accompanied by a statement from the speech-language pathologist that indicates whether there have been any significant changes in the sensory status (e.g., vision, hearing, tactile); postural, mobility or motor status; speech, language, and expressive communication status; or any other communication need or limitation of the recipient as earlier described and whether the device remains recommended for recipient's use.

Modification or replacement of AAC devices are covered subject to the following limitations:

- Requests for modification or replacement of AAC devices and/or accessories may be considered for coverage after the expiration of three (3) or more years from the date of purchase of the current device and accessories in use;
- Requests for modification or replacement require PA and must include the recommendation of the speech-language pathologist;
- Requests for replacements of AAC devices may be submitted for identical or different devices;
- Requests for replacements of identical AAC devices must be accompanied by a statement from the provider that the current device cannot be repaired or that replacement will be more cost effective than repair of the current device. Data must be provided about the following:
  - Age;
  - Repair history;
    - Frequency;
    - Duration;

    - Cost; and
  - Repair projections (estimated durability of repairs).
- Requests for modification or replacement of AAC devices with different devices must include the following additional information:
  - A significant change has occurred in the recipient's expressive communication, impairments, and/or communication limitations. Modification or replacement requests due to a change in the recipient's circumstances must be supported by a new assessment of communication limitations by a speech-language pathologist, and may be submitted at any time; or
  - Even though there has been no significant change in the recipient's communication limitations, there has been a significant change in the features or abilities of available AAC devices (i.e., a technological change) that will overcome or permit an even greater amelioration of the recipient's communication limitations as compared to the current AAC device. A detailed description of all AAC device changes and the purpose of the changes must be provided with the results of a re-evaluation by a speech-language pathologist.
  - Requests for replacements of AAC devices due to loss or damage (either for identical or different devices) must include a complete explanation of the cause of the loss or damage and a plan to prevent the recurrence of the loss or damage.

Bath and Toileting Aids

Bathroom and toileting aids are devices used to assist recipients who are unable to use standard facilities.

NOTE: Installation of equipment and environmental modifications or repairs are **not covered**.

- **Bath or Shower Chairs**
  Eligible: All members where DME is a covered benefit
  PA Requirement: PA is not required
  Benefit Description: Bath or shower chairs may be considered only for severe incapacitating problems due to neurological, physiological, or cognitive disorders that impair the recipient's balance, coordination, or physical strength needed to safely sit or stand while bathing or showering.

- **Commode Chair**
  Eligible: All members where DME is a covered benefit
  PA Requirement: PA is not required
  Benefit Description: A commode chair may be considered when the recipient is physically incapable of utilizing regular toilet facilities. An extra wide/heavy duty commode chair is covered for a recipient weighing three hundred (300) pounds or more. A commode chair with detachable arms may be considered if this feature is necessary to facilitate transferring

the recipient, or if the recipient has a body configuration that requires extra width.

- **Elevated Toilet Seats**
  Eligible: All members where DME is a covered benefit
  PA Requirement: PA is not required
  Benefit Description: An elevated toilet seat may be considered when a recipient is unable to go from a sitting to a standing position without assistance.

- **Footrest for Use with Toilet**
  Eligible: All members where DME is a covered benefit
  PA Requirement: PA is required
  Benefit Description: A Footrest for use with a toilet may be considered when the recipient's feet cannot touch the floor and it is needed for balance and support.

- **Hospital Type Urinals and Bed Pans**
  Eligible: All members where DME is a covered benefit
  PA Requirement: PA is not required
  Benefit Description: Urinals (Hospital Type) and bed pans may be considered if the recipient is capable of using them and is confined to bed.

- **Safety Guardrails**
  Eligible: All members where DME is a covered benefit
  PA Requirement: PA is required
  Benefit Description: Safety guardrails may be considered for recipients who are unable to stand up in the tub or get out of the tub without assistance.

Batteries
Eligible: All members where DME is a covered benefit
PA Requirement: PA is required for some battery types
Benefit Description: Batteries are covered for artificial larynxes, insulin pumps, electric wheelchairs and cochlear implants.

Blood Pressure Devices
Eligible: Only covered for recipients receiving hemodialysis in the home setting or under age twenty-one (21) where DME is a covered benefit
PA Requirement: PA is required
Benefit Description: Hypertension or hypotension is reviewed for recipients under age twenty-one (21). Electronic blood pressure devices may be considered for recipients under the age of twenty-one (21), based on medical necessity.

Bras, Surgical Mastectomy

Eligible: All members where DME is a covered benefit
PA Requirement: PA is required
Benefit Description: Surgical mastectomy bras are approved only if one (1) or both of the recipient's breasts have been removed. After a mastectomy, two (2) bras may be approved. If the breasts are removed in separate surgeries, two (2) more bras may be approved following the second surgery. Replacements may be approved after a reasonable length of time.

Breast or Mammary Prostheses
Eligible: All members where DME is a covered benefit
PA Requirement: PA is required
Benefit Description: A breast or mammary prosthesis is approved only after breast removal. If one breast is removed, one prosthesis may be approved. Replacement of prosthesis may be approved if medical need is established and documented.

Breast Pumps
Eligible: All members where DME is a covered benefit
PA Requirement: PA is not required
Benefit Description: Double electric breast pumps (E0603) are covered without PA for pregnant women who are planning to breastfeed or post-partum women who are already breastfeeding. Coverage extends only to personal-use, double electric breast pumps. Hospital grade, manual, or single breast pumps are **not covered**.

Nursing mothers are eligible for one (1) electric breast pump per delivery, and replacement within a three (3) year period. Medicaid allows for replacement of a breast pump older than three (3) years and after expiration of the manufacturer's warranty. Appropriate breast pump supplies require a prescription and are covered once every one hundred eighty (180) days. The billable codes for breast pump supplies are listed below:

- A4281 – Tubing for breast pump, replacement
- A4282 – Adapter for breast pump, replacement
- A4283 – Cap for breast pump bottle, replacement
- A4284 – Breast shield and splash protector
- A4285 – Polycarbonate bottle replacement
- A4286 – Locking ring for breast pump, replacement

Recipients must present a prescription for the breast pump and documentation of delivery date to a DME provider. DME providers are required to obtain the Electric Breast Pump Request form signed by the patient at the point of sale. Providers should submit the completed form with the claim.

Electric breast pumps dispensed to Medicaid recipients must meet, at a minimum, the criteria below:

- Have an adjustable suction pressure rate with either written instructions or an automatic mechanism to prevent a suction greater than 250 mm Hg;
- Be adaptable for simultaneous pumping of both breasts (double-collection);
- Automatically cycle with an adjustable variable cycling rate, typically 30 to 60 or more cycles per minute;
- Include a battery option and adapter to be used as an alternate power source when electricity is not immediately available;
- Breast shields (flanges) that are adjustable and flexible, or flanges that are available in several different sizes if rigid, including larger sizes;
- All accessories necessary for pumping two (2) breasts simultaneously for electric pumps;
- At least two (2) collection bottles with spill-proof standard size caps, that are bisphenol-A (BPA) and diethylhexyl phthalate (DEHP) free; and
- Accessories and supplies must be compatible with the pump provided. Materials must be of durable quality for withstanding repeated boiling, washing and pumping use.

Burn Garments and Stockings or Abdominal Binder and Hernia Supports
Eligible: All members where DME is a covered benefit
PA Requirement: PA is required
Benefit Description: Coverage includes custom ordered/fitted compression garments (e.g., stocking/burn garment/gradient pressure aid garment/sleeve) and pneumatic compressors and appliances. Burn garments and stockings are approved only for severe burns and major vascular problems. Abdominal binder and hernia supports may be approved with documentation of medical necessity.

Catheters
Eligible: All members where DME is a covered benefit
PA Requirement: PA is required
Benefit Description: Catheters are approved only if the recipient's medical condition necessitates the use of a catheter.

Cochlear Implants
Eligible: Members one through twenty (1-20) where DME is a covered benefit
PA Requirement: PA is required. All aspects of the cochlear device (preoperative speech and language evaluation, implantation, device, repairs, supplies, therapy) must be prior authorized.
Benefit Description: Unilateral or bilateral cochlear implants are only available to recipients under twenty-one (21) years of age with profound-to-total bilateral sensorineural hearing loss who meet the medical and social criteria listed below. Simultaneous bilateral cochlear implantation must be considered when it is determined that a unilateral cochlear implant with a hearing aid in the contralateral ear will not result in a binaural benefit.

Only one (1) device per lifetime per year per eligible recipient shall be reimbursed unless the

device fails or is damaged beyond repair, in which case reimbursement for another device and re-implantation will be considered.

Coverage of cochlear implants includes, but is not limited to, the following:

- Implantation of device;
- Preoperative speech and language evaluation;
- Postoperative rehabilitative costs (only to be provided by the audiologist);
- Subsequent speech, language, and hearing therapy;
- Speech processor repairs, batteries, and headset cords;
- Replacement of the external speech processor if lost, stolen or irreparably damaged. Upgrade for cosmetic or technological advances in the hardware shall not qualify as a reason for replacement; and
- Post-operative programming and diagnostic analysis.

The following expenses related to the maintenance of the cochlear device(s) are **non-covered** and are the responsibility of either the recipient or his family or caregiver(s):

- All costs for service contracts and/or extended warranties; and
- All costs for insurance to protect against loss and theft.

The following criteria applies to cochlear implant recipients:

- Have a profound bilateral sensorineural hearing loss which is a pure tone average of 1,000, 2,000 and 4,000 Hz of 90dB HL or greater;
- Be a profoundly deaf child, age one (1) year or older, or be a post-linguistically deafened adult through the age of twenty (20) years;
- Receive no significant benefit from hearing aids as validated by the cochlear implant team;
- Have high motivation to be part of the hearing community as validated by the cochlear implant team;
- Had no responses obtained to auditory brainstem response, otoacoustic emission (OAE) testing, or any other special testing that would be required to determine that the hearing loss is valid and severe enough to qualify for cochlear implantation.
- Had radiologic studies that demonstrate no intracranial anomalies or malformations which would contraindicate implantation of the receiver-stimulator or the electrode array;
- Have no medical contraindications for undergoing implant surgery or post-implant rehabilitation; and
- Show that the candidate and his/her family are well-motivated, possess appropriate post-implant expectations and are prepared and willing to participate in and cooperate with pre- and post-implementation assessment and rehabilitation programs as recommended by the implant team and in conjunction with Federal Drug Administration (FDA) guidelines.

Additional age-specific criteria for children one (1) year through nine (9) years:

- Appropriate tests were administered and no significant benefit from a hearing aid was

obtained in the best aided condition measured by age-appropriate speech perception materials.

Additional age-specific criteria for children ages ten (10) through seventeen (17) years:

- Appropriate tests were administered and no significant benefit from a hearing aid was obtained in the best aided condition measured by age-appropriate speech perception materials;
- Has received consistent exposure to effective auditory or phonological stimulation in conjunction with oral method of education and auditory training;
- Utilizes spoken language as the primary mode of communication through either an oral/aural (re)habilitation program or total communications educational program with significant oral/aural training; and
- Has at least six (6) months experience with hearing aids or vibrotactile device except in the case of meningitis (in which case the six (6) month period will be reduced to three (3) months).

Additional age-specific criteria for children ages ten (10) through seventeen (17) years:

- Is post-linguistically deafened with severe to profound bilateral sensorineural hearing loss which is pure tone average of 1000, 2000, and 4000 Hz of 90dB HL or greater;
- Has obtained no significant benefit from a hearing aid obtained in the best aided condition for speech/sentence recognition material;
- Has received consistent exposure to effective auditory or phonological stimulation or auditory communication;
- Utilizes spoken language as the primary mode of communication through either an oral/aural (re)habilitation program or a total communications educational program with significant oral/aural training; and
- Has at least six (6) months experience with hearing aids or vibrotactile device except in the case of meningitis in which case three (3) months experience will be required.

The request to perform surgery must come from the multidisciplinary team which assessed the recipient's disability and determined the recipient to be a possible candidate for implantation. The multidisciplinary team must consist of:

- A surgeon/otologist;
- An audiologist;
- A speech/language pathologist,
- A psychiatrist, and
- An educator of the deaf with experience in oral/auditory instruction.

Diabetic Supplies and Equipment

Diabetic supplies and equipment are designed to treat and manage diabetes. Items including glucometers, insulin pumps, and supplies for insulin pumps (other than the insulin itself) are

covered through the DME Program.

- **Glucometer**
  Eligible: All members where DME is a covered benefit
  PA Requirement: Request/purchase is done through the Pharmacy Program
  Benefit Description: Glucose monitors are provided to Medicaid eligible recipients who are insulin-dependent or insulin-requiring, or have a diagnosis of gestational diabetes. The prescription or letter for the blood glucose monitor must state that:
  - The recipient is an insulin-dependent or insulin-requiring diabetic, or the recipient's diagnosis is gestational diabetes; and
  - The recipient or someone on his/her behalf can be trained to use the monitor correctly.

  The following diabetic supplies are provided by pharmacies:
  - Disposable insulin syringes;
  - Blood glucose monitoring strips;
  - Urine ketone monitoring strips;
  - Auto-lancet devices; and
  - Auto-lancets.

  A prescription for disposable syringes must contain the prescribing physician's written statement that the recipient is insulin-dependent or insulin-requiring.

  NOTE: DME and supplies are **not covered** for residents in ICF/DD and nursing facilities. Glucometers are covered in nursing facility per diem rates.

- **Continuous Glucose Monitoring (CGM) Devices**
  Eligible: Members with Type I diabetes where DME is a covered benefit
  PA Requirement: PA is required
  Benefit Description: Continuous glucose monitoring (CGM) devices are covered for long-term use. CGM systems automatically take glucose measurements at regular intervals throughout the day and night and translate the readings into dynamic data, generating glucose direction and rate of change reports.

  CGM devices require PA and the recipient must meet one (1) of the following eligibility criteria:
  - Diagnosis of Type I diabetes with recurrent, unexplained, severe hypoglycemia (glucose levels less than 50 milligrams per deciliter), or impaired hypoglycemia awareness that puts the recipient at risk; or
  - Pregnant recipient with poorly controlled Type 1 diabetes evident by recurrent, unexplained hypoglycemic episodes, hypoglycemic unawareness or postprandial hyperglycemia, or recurrent diabetic ketoacidosis.

The following are CGM limitations and exclusions:

- Sensors (A9276) are limited to four (4) per month, and one (1) sensor has a seven (7) day life span;
- Transmitters (A9277) are limited to one (1) per three (3) months, or two (2) per six (6) months;
- Receivers (A9278) are limited to one (1) per three (3) years;
- Testing strips are covered under the Pharmacy Program; and
- Short-term CGM use is **not covered**.

- **Continuous Subcutaneous Insulin External Infusion Pumps**
  Eligible: Members with Type I diabetes where DME is a covered benefit
  PA Requirement: PA is required ~~and reimbursement is limited to a ten (10) month rental~~
  Benefit Description: A continuous subcutaneous insulin external infusion pump is a portable insulin pump. It is about the size and weight of a small pager. The pump delivers a continuous basal infusion of insulin. Insulin pumps can be automatically programmed for multiple basal rates over a twenty-four (24) hour period. This can be useful for such situations as nocturnal hypoglycemia, the dawn phenomenon, and to assist with tight glycemic control.

  Authorization for a continuous subcutaneous insulin external infusion pump and related supplies is made for treatment of Type I diabetes. Recipients must meet either criterion A or B as follows:

  Criterion A – The recipient has completed a comprehensive diabetes education program and has been on a program of multiple daily injections of insulin (at least three (3) injections per day) with frequent self-adjustments of insulin dose for at least six (6) months prior to initiation of the insulin pump; and has documented frequency of glucose self-testing an average of at least four (4) times per day during the two (2) months prior to initiation of the insulin pump; and meets two (2) or more of the following criteria while on the multiple daily injection regimen:
  - Has a glycosylated hemoglobin level (HbAlc) greater than 7.0 percent;
  - Has a history of recurring hypoglycemia;
  - Has wide fluctuations in blood glucose levels (regardless of A1C);
  - Demonstrated microvascular complications;
  - Recurrent severe hypoglycemia;
  - Suboptimal diabetes control (A1C exceeds target range for age);
  - Adolescents with eating disorders;
  - Pregnant adolescents;
  - Ketosis-prone individuals;
  - Competitive athletes; and

- Extreme sensitivity to insulin in younger children.

OR

Criterion B – The recipient with Type I diabetes has been on a pump prior to enrollment in Medicaid and has documented frequency of glucose self-testing an average of at least four (4) times per day during the month prior to Medicaid enrollment.

In addition to meeting criterion A or B above, the recipient with diabetes must be insulinopenic per the updated fasting C-peptide testing requirement, **or** must be autoantibody positive (e.g. islet cell autoantibodies (ICA), glutamic acid decarboxylase (GAD65), the 40K fragment of tyrosine phosphatase (IA2), insulin autoantibodies (IAA), or zinc transporter 8 autoantibodies (ZnT8).

Updated fasting C-peptide testing requirement:
- Insulinopenia (defined as fasting C-peptide level less than or equal to 110 percent of the lower limit of normal of the laboratory's measurement method)
- Fasting C-peptide levels will only be considered valid with a concurrently obtained fasting glucose less than 225 mg/dl
- **NOTE:** Levels only need to be documented once in the medical record.

The pump must be ordered by and follow-up care of the recipient must be managed by a physician who has familiarity with continuous subcutaneous insulin infusion (CSII) and who works closely with a team of nurses, diabetes educators and dietitians who are knowledgeable in the use of CSII.

Continuous subcutaneous insulin external infusion pump **exclusions and non-covered** items include:
- Continuous subcutaneous insulin external infusion pumps shall be denied as not medically necessary for all Type II diabetics, including insulin requiring Type II diabetics.
- Insulin for the continuous subcutaneous insulin external infusion pumps must be obtained through the Pharmacy Program and is not covered by the DME Program.
- Replacement of a currently functioning insulin pump for the sole purpose of receiving the most recent insulin pump technology is not covered as this is not medically necessary.
- Additional software or hardware required for downloading data to a device such as a personal computer, smart phone, or tablet to aid in self-management of diabetes mellitus is not covered.

Dialysis Equipment and Supplies
Eligible: All members where DME is a covered benefit

PA Requirement: PA is required
Benefit Description: Dialysis equipment and supplies are approved only if the recipient is under treatment for chronic renal disease and is trained in the use of the equipment. All requests must include:

- The diagnosis and prognosis;
- Any other pertinent medical and social data;
- The date the recipient was first dialyzed'
- A statement from the facility that the recipient is capable of operating the equipment;
- A statement from the equipment provider verifying that the recipient has been trained to use the dialysis equipment;
- The name of the provider;
- A prescription for the machine and the supplies; and
- Frequency of dialysis.

NOTE: Blood pressure devices are covered for recipients receiving hemodialysis in the home setting. Syringes and needles are covered for dialysis purposes when used to inject heparin into the dialysis system. Insulin syringes are **not covered** by the DME Program, but are covered by the Pharmacy Program.

Disposable Incontinence Products (T4521-T4535 and T4543)
The products below are covered for recipients ages four through twenty (4-20) years when specifically prescribed by the recipient's physician and specific criteria are met as described below.

The Medicaid Prescription Request Form for Disposable Incontinence Products may be completed, or a physician's prescription can be submitted along with the required documentation as listed below. Documentation must reflect the recipient's current condition and include the following:

- Diagnosis (specific ICD-10-CM code) of condition causing incontinence (primary and secondary diagnosis);
- Item to be dispensed;
- Duration of need (physician must provide);
- Size;
- Quantity of item and anticipated frequency the item requires replacement; and
- Description of mobility/limitations.

Disposable incontinence supplies are **limited to eight (8) per day**. Additional supporting documentation is required for requests that exceed the established limit.

Documentation for extraordinary needs must include all of the above and:

- Description of mental status/level of orientation;

- Description of current supportive services; and
- Additional supporting diagnosis to justify increased need for supplies.

Recipients, who have a diagnosis of nocturnal incontinence, including those who do not have a problem in the daytime but are not able to wake up to go to the bathroom at night, may qualify to receive a diaper or pull-up for nighttime use.

NOTE: Permanent loss of bladder and/or bowel control is defined as a condition that is not expected to be medically or surgically corrected and that is of long and indefinite duration.

- **Diapers**
  Eligible: Members four through twenty (4-20) where DME is a covered benefit
  PA Requirement: PA is required
  Benefit Description: The individual has a medical condition resulting in permanent bowel/bladder incontinence, and the individual would not benefit from or has failed a bowel/bladder training program when appropriate for the medical condition.

- **Pull-On Briefs**
  Eligible: Members four through twenty (4-20) where DME is a covered benefit
  PA Requirement: PA is required
  Benefit Description: There is presence of a medical condition resulting in permanent bowel/bladder incontinence and the recipient has cognitive and physical ability to assist in his/her toileting needs.

- **Liners/Guards**
  Eligible: Members four through twenty (4-20) where DME is a covered benefit
  PA Requirement: PA is required
  Benefit Description: Liners/guards may be approved if they are cost-effective in reducing the amount of other incontinence supplies needed.

Enteral and Parenteral Nutrition

Enteral therapy, parenteral therapy, or oral nutritional supplements may be provided safely and effectively in the home by non-professional persons who have undergone special training. Medicaid will not pay for any services furnished by non-physician professionals.

NOTE: Syringes are not separately reimbursable for enteral and parenteral therapy, as these items are included in the supply kits.

- **Enteral Nutrition Therapy**
  Eligible: Members under twenty-one (21) where DME is a covered benefit
  PA Requirement: PA is required

Benefit Description: Enteral nutritional therapy is considered reasonable and necessary for a recipient when medical documentation, such as hospital records and clinical findings, support an independent conclusion that the recipient has a permanently inoperative internal body organ or function which does not allow absorption of sufficient nutrients to maintain weight and strength commensurate with his/her general condition. For purposes of this policy, permanent means an indefinite period of more than one (1) month.

Prescriptions for enteral feedings must be for an average of at least 750 calories per day over the prescribed period and must constitute at least seventy percent (70%) of the daily caloric intake to be considered for coverage by Medicaid. Coverage of prescribed feedings of less than an average of 750 calories per day may only be considered with additional physician documentation and justification of the reason for prescribing less than an average of 750 calories per day. All requests must include the following information:

- Name of the nutrient product or nutrient category;
- Number of calories prescribed by enteral feeding per day (100 calories equals one (1) unit) and whether the prescribed amount constitutes seventy percent (70%) or more of the daily caloric intake;
- Frequency of administration per day;
- Method of administration (oral or, if tube, whether syringe, gravity, or pump fed);
- Route of administration, if tube fed (i.e. nasogastric, jejunostomy, gastrostomy, percutaneous enteral gastrostomy, or naso-intestinal tube); and
- Reason for use of a pump, if prescribed.

Enteral nutritional therapy will not be approved for temporary impairments or for convenience feeding via gastrostomy.

Baby food and other regular grocery products that~~t~~ [IG12] can be used with an enteral system are **not covered**.

Nutritional supplements given between meals to boost daily protein-caloric intake or as the mainstay of a daily nutritional plan may be covered for recipients under age twenty-one (21) where medical necessity is established. Nutritional supplements are **not covered** for recipients age twenty-one (21) and older.

Enteral feedings can only be provided for the most economic package equivalent in calories and ingredient content to the needs of the recipient as established by medical documentation. The physician(s) must document the reason for prescribing a formula higher than category I-A (B4150) or category II (B4152). This includes any formula in categories III through IV (B4153 through B4155).

NOTE: The Medicaid Program is always the payer of last resort. This means all other available resources must be utilized before Healthy Blue pays for a recipient's care. Healthy Blue shall ensure coordination with the Women, Infant, and Children (WIC) Program. WIC may be able to provide infant formula, among other items and services to women, infants, and children up to age five (5). An individual who is eligible for Medicaid is automatically income eligible for WIC benefits.

- **Enteral Infusion Pump**
  Eligible: All members where DME is a covered benefit
  PA Requirement: PA is required
  Benefit Description: A standard enteral infusion pump will be approved only with documented evidence that the pump is medically necessary and that syringe or gravity feedings are not satisfactory due to complications such as aspiration, diarrhea, dumping syndrome, etc. Medicaid will pay for the rental of a standard enteral infusion pump and accessories, and repairs not covered by the warranty or lease agreement.

- **Hyperalimitation – Intradialytic Parenteral Nutrition (IDPN) Therapy**
  Eligible: All members where DME is a covered benefit
  PA Requirement: PA is required~~ and reimbursement is limited to a ten (10) month rental~~[IG13][WJL14]
  Benefit Description: Intradialytic parenteral nutrition (IDPN) therapy is considered for PA when[IG15] a gastrointestinal disease or condition is present and is the cause of the recipient's inability to sufficiently absorb enough nutrients to maintain their weight and strength. Authorization will not be considered for recipients who only have renal failure or insufficiency and an associated poor appetite or failure to thrive. Request must include the following information:
  - Documentation that the recipient has an inability to sufficiently maintain their weight and strength without the IV nutrition therapy;
  - Documentation that adequate nutrition cannot be made possible by dietary adjustment, oral supplements, or enteral nutrition (tube or non-tube fed); and
  - Documentation that a clinically significant gastrointestinal disease or conditions that have resulted in the recipient's malnutrition due to the inability of the GI tract to sufficiently absorb enough nutrients. A diagnosis alone is not sufficient to determine coverage.

Environmental Modifications or Repairs
Eligible: Non-covered
PA Requirement: Installation of equipment is **not covered**
Benefit Description: Environmental modifications or repairs are activities of a major and largely non-recurring nature to improve the safety, sanitation and adaptability of a recipient's home.

Hearing Aids

Eligible: Members under twenty-one (21) where DME is a covered benefit
PA Requirement: Implantable hearing aids require PA and/or greater than $3,000/purchase
Benefit Description: Hearing aids are only provided to eligible recipients under the age of twenty-one (21) and approved only when there is a significant hearing loss documented by audiometric data from both an ear specialist (otologist) and a hearing aid provider. A hearing loss greater than 20 decibels average hearing level in the range 250-2000 Hz is considered significant.

Reimbursement is $553 per hearing aid. Hearing aids must have a two (2) year warranty and should normally be expected to last at least three (3) years before replacement. Repairs are reimbursed at the invoice price up to $40 per hour for labor. Repair and batteries do not require PA.

Hospital Beds and Mattresses

Hospital beds are covered for home use to care for individuals who may be confined or spend a lot of time in bed due to medical condition or illness. PA requests for all covered hospital beds must include the following:

- The recipient requires positioning of the body in ways not feasible with an ordinary bed due to a medical condition that is expected to last for at least one (1) month;
- The recipient requires the head of the bed to be elevated more than thirty (30) degrees most of the time due to congestive heart failure, chronic pulmonary disease, or problems with aspiration. Pillows or wedges must have been tried and failed; and
- The recipient has a condition that requires special attachments (such as a trapeze, foot board, or traction equipment) that cannot be fixed and used on an ordinary home bed.

- **Hospital Beds**
  Eligible: All members where DME is a covered benefit
  PA Requirement: PA is required ~~and reimbursement is limited to a ten (10) month rental~~[IG16][WJL17]
  Benefit Description: Standard hospital beds are approved if the recipient is confined to a bed and their condition necessitates positioning the body in a way that is not possible in an ordinary bed. Elevation of the head/upper body less than thirty (30) degrees does not usually require the use of a hospital bed.

- **Hospital Beds, Fixed and Variable Height**
  Eligible: All members where DME is a covered benefit
  PA Requirement: PA is required ~~and reimbursement is limited to a ten (10) month rental~~[IG18][WJL19]

Benefit Description: A fixed height hospital bed is one with manual head and leg elevation adjustments but no height adjustment. A variable height hospital bed is one with manual height adjustment and manual head and leg elevation adjustments. To be eligible, the recipient must have a condition that requires special attachments (such as a trapeze, foot board, or traction equipment) that cannot be fixed and used on an ordinary home bed. Furthermore, requests for a variable height bed must document that the recipient requires a bed height different than a fixed height hospital bed to permit safe transfers to a chair or for adequate bed care.

- **Hospital Beds, Semi-Electric**
  Eligible: All members where DME is a covered benefit
  PA Requirement: PA is required ~~and reimbursement is limited to a ten (10) month rental~~[IG20][WJL21]
  Benefit Description: A semi-electric hospital bed is one with manual height adjustment and electric head and leg elevation adjustments. The recipient must require a bed height different than a fixed height hospital bed to permit safe transfers to a chair or for adequate bed care. The PA request must also include that the recipient is alone for extended periods of time, requires frequent and immediate changes in body position and can operate the bed controls independently.

- **Hospital Beds, Total Electric**
  Eligible: All members where DME is a covered benefit
  PA Requirement: PA is required ~~and reimbursement is limited to a ten (10) month rental~~[IG22][WJL23]
  Benefit Description: A total electric hospital bed is one with electric height adjustment and electric head and leg elevation adjustments. Requests must document that the recipient requires a bed height different than a fixed height hospital bed to permit safe transfers to a chair or for adequate bed care. The PA request must also include that the recipient is alone for extended periods of time, requires frequent and immediate changes in body position and can operate the bed controls independently. Documentation must also indicate one (1) of the following:
  - The recipient has tried multiple means of transfer and can only transfer with a total electric bed; or
  - The recipient has a care giver with a documented medical condition stating an inability to use a crank on a semi-electric bed.

- **Hospital Beds, Pediatric**
  Eligible: All members where DME is a covered benefit
  PA Requirement: PA is required ~~and reimbursement is limited to a ten (10) month rental~~[IG24][WJL25]

Benefit Description: Pediatric hospital beds allow for manual, semi-electric, or fully electric adjustment to the head and leg elevations. A pediatric hospital bed is one with a full side rail (360 degrees, up to 24 inches high above the mattress) enclosure. Specific criteria must be met for pediatric beds with or without safety enclosures.

Hospital Bed, Pediatric without Safety Enclosure – A pediatric hospital bed without an added safety enclosure is covered when all of the following criteria are met. The recipient must:

- Be under twenty-one (21) years of age;
- Meet the criteria for a hospital bed;
- Have a medical condition that prevents the use of a standard size hospital bed and is best met by a pediatric sized hospital bed;
- Have a medical condition that requires positioning of the body ordered by the physician so that the head of the bed elevation is greater than 30 degrees, or have documented problems with aspirations; and
- Have a medical condition that is expected to last greater than 6 months which requires positioning of the body in ways that are not feasible with an ordinary bed, or hospital bed.
- In addition, the recipient must meet the following criteria:
  - The desired medical benefit is not attainable by the use of an ordinary bed. All alternative methods have been tried and failed;
  - An ordinary bed cannot be modified or adapted by commercially available items to meet the medical needs; and
  - Pillows and wedges must have been considered and ruled out.

Hospital Bed, Pediatric with Safety Enclosure – A pediatric hospital bed with an added safety enclosure is covered when all of the following criteria are met. The absence of a pediatric hospital bed with safety enclosure would result in the recipient being institutionalized. The recipient must:

- Be under twenty-one (21) years of age;
- Have one of the following diagnoses: brain injury, moderate to severe cerebral palsy, seizure disorder (with daily seizure activity taking anti-seizure medication), developmental disability, or severe behavior disorder (this list is not all inclusive);
- Meet the criteria for a hospital bed;
- Have a medical condition that puts him/her at risk for falling off of or seriously injuring himself/herself while in an ordinary bed, standard size hospital bed, or a pediatric sized hospital bed;
- Have a history of behavior involving unsafe mobility (climbing out of bed – more than standing at the side of the bed) that puts the recipient at risk for serious injury while in an ordinary bed, standard hospital bed, or pediatric hospital bed;
- Be cognitively impaired and have communication impairments. The recipient is mobile

and his/her unrestricted mobility has resulted in documented injuries; and

- Have tried less costly alternatives which were unsuccessful, including any of the following (not all inclusive):
  - Rail protectors;
  - Medications to address seizures and/or behaviors;
  - Helmets for head banging;
  - Baby monitors and bed alarm systems;
  - Behavior modification strategies;
  - Removal of safety hazards and installation of child protection devices (e.g., baby gate, safety door knob) in the recipient's room;
  - Placement of mattress on the floor; and
  - Physical and environmental factors for behavior have been eliminated. These include, but are not limited to, hunger, thirst, toileting, pain, restlessness, fatigue due to sleep deprivation, acute physical illness, temperature, noise levels, lighting, medication side effects, over/under stimulation or a change in caregivers or routine.

Exclusion and non-coverage of a pediatric hospital bed includes, but is not limited to the following:

- Lack of caregiver monitoring of recipient's safety;
- The safety enclosure frames are used as a restraint or for the convenience of family or caregiver;
- An ordinary bed, typically sold as furniture, which consists of a frame, box spring, and mattress;
- Institutional type hospital beds (e.g. oscillating beds, spring-base beds, circulating beds, continuous lateral rotation beds, and Stryker frame beds);
- Enclosed beds for recipients with 24-hour care from caregivers who are required to be awake and actively caring for the child;
- Enclosed bed systems that are not approved by the FDA (e.g. Vail Enclosure Bed, Posey Bed Enclosure System); and the
- Hospital beds where manufacturer is not registered and cleared to market with the FDA.

The following documentation must be submitted to support medical necessity of a pediatric hospital bed:

- Physician prescription;
- Louisiana Medicaid Pediatric Hospital Bed Evaluation completed by a Louisiana state licensed physician and physical or occupational therapist in its entirety; and
- Original manufacturer's price.

- **Hospital Beds Mattresses**
  Eligible: All members where DME is a covered benefit
  PA Requirement: PA is required

Benefit Description: Hospital bed mattresses are considered part of the hospital bed and will only be approved to replace mattresses that are no longer functional, when the recipient meets the criteria to receive a hospital bed.

- **Egg-Crate Mattresses and Alternating Air Pressure Mattresses/Pads**
  Eligible: All members where DME is a covered benefit
  PA Requirement: PA is required
  Benefit Description: Egg-crate mattresses and alternating pressure mattresses/pads are devices used to relieve pressure and prevent the occurrence of decubitus ulcers. The pads include: gel, air, dry and water pressure pads for mattresses, and mattress-size pads. Requests must include:
  - Documentation on the lesions, the recipient's condition, positioning, nutritional status (including serum albumen and total protein levels with the initial request), and detailed descriptions of prior treatments used and the outcomes of the treatments;
  - Documentation showing the presence of stage three (3) or stage four (4) decubitus ulcers affecting at least two (2) pressure bearing surfaces; and
  - For subsequent PA requests, documentation must show signs of healing. The presence of new decubitus must be explained and may be a basis for denial without extenuating circumstances.

- **Sheepskins**
  Eligible: All members where DME is a covered benefit
  PA Requirement: PA is required
  Benefit Description: Sheepskins are approved if the recipient's skin condition necessitates use.

- **Side Rails**
  Eligible: All members where DME is a covered benefit
  PA Requirement: PA is required
  Benefit Description: Side rails for beds other than hospital beds are approved only if the recipient's medical condition necessitates use of rails on a regular bed.

High Frequency Chest Wall Oscillation Device
Eligible: All members where DME is a covered benefit
PA Requirement: PA is required
Benefit Description: High frequency chest wall oscillation devices (E0483) are covered for recipients who meet the following criteria. The recipient must have one (1) of the following:
- A neuromuscular disorder;
- A diagnosis of cystic fibrosis; or
- A diagnosis of bronchiectasis;
  - Characterized by daily productive cough for at least six (6) continuous, months or,

frequent (i.e. more than two (2) per year) exacerbations requiring antibiotic therapy; and
- Confirmed by high resolution, spiral, or standard CT scan.

And must have well-documented failure of standard treatments to adequately mobilize retained secretions with all of the following:
- Chest physical therapy and flutter device at least twice daily (when age appropriate);
- A pattern of hospitalizations at least annually or more;
- Significantly deteriorating clinical condition;
- Be under the care of a pulmonologist; and
- Copies of two pulmonary test results that indicate the recipient's condition improved with the use of the vest.

Intrathecal Baclofen Therapy (ITB)
Eligible: All members where DME is a covered benefit
PA Requirement: PA is required and dependent upon approval of the surgeon to perform the procedure
Benefit Description: Surgical implantation of a programmable infusion pump for the delivery of intrathecal baclofen (ITB) therapy is covered for individuals four (4) years of age or older with a body mass sufficient to support the implanted system, and any one (1) or more of the criteria as described below apply.
- Inclusive criteria for candidates with spasticity of cerebral origin:
  - There is severe spasticity of cerebral origin with no more than mild athetosis;
  - The injury is older than one (1) year;
  - There has been a drop in Ashworth scale of one (1) or more;
  - Spasticity of cerebral origin is resistant to conservative management; or
  - The candidate has a positive response to test dose of ITB.
- Inclusive criteria for candidates with spasticity of spinal cord origin:
  - Spasticity of spinal cord origin that is resistant to oral antispasmodics or side effects unacceptable in effective doses;
  - There has been a drop in Ashworth scale of two (2) or more; or
  - The candidate has a positive response to test dose of ITB.

ITB is used for the treatment of severe spasticity of the spinal cord or of cerebral origin. The following diagnoses are considered appropriate for ITB treatment and infusion pump implantation:
- Meningitis;
- Encephalitis;
- Dystonia;
- Multiple sclerosis;
- Spastic hemiplegia;

- Infantile cerebral palsy;
- Other specified paralytic syndromes;
- Acute, but ill-defined, cerebrovascular disease;
- Closed fracture of base of skull;
- Open fracture of base of skull;
- Closed skull fracture;
- Fracture of vertebral column with spinal cord injury;
- Intracranial injury of other and unspecified nature; or
- Spinal cord injury without evidence of spinal bone injury.

Caution should be exercised when considering ITB infusion pump implantation for candidates who: have a history of autonomic dysreflexia; suffer from psychotic disorders; have other implanted devices; or utilize spasticity to increase function such as in posture, balance and locomotion.

The following candidates are **excluded** from receiving ITB:

- Fails to meet any of the inclusion criteria;
- Is pregnant, or refuses or fails to use adequate methods of birth control;
- Has a severely impaired renal or hepatic function;
- Has a traumatic brain injury of less than one (1) year pre-existent to the date of the screening dose;
- Has a history of hypersensitivity to oral baclofen;
- Has a systemic or localized infection which could infect the implanted pump; or
- Does not respond positively to a 50, 75, or 100 mcg intrathecal bolus of baclofen during the screening trial procedure.

PA for chronic infusion of ITB must be requested after the screening trial procedure has been completed, but prior to pump implantation. The request to initiate chronic infusion must come from the multidisciplinary team that evaluates the recipient. These professionals must have expertise in the evaluation, management and treatment of spasticity of cerebral and spinal cord origin and shall have undergone training in infusion therapy and pump implantation by a recognized product supplier with expertise in ITB. This multidisciplinary team must be:

- A neurosurgeon or an orthopedic surgeon;
- A psychiatrist and/or neurologist;
- The recipient's attending physician;
- A nurse;
- A social worker; and
- An allied professionals (physical therapist, occupational therapist, etc.).

The following documentation must be submitted by the multidisciplinary team:

- A recent history with documentation of assessments in the following areas:
  - Medical and physical;
  - Neurological;
  - Functional; and
  - Psychosocial.
- Ashworth scores taken before and after the administration of ITB test dose(s); and
- Documentation of any other findings about the recipient's condition which would be of interest to or would assist the medical review team in making a decision regarding the recipient's need for chronic infusion (i.e., a video tape of the trial dosage).

Healthy Blue shall cover outpatient bolus injections given to candidates for the ITB infusion treatment if medically necessary even if the member fails the screening trial procedure.

Intravenous (IV) Therapy and Administrative Supplies
Eligible: All members where DME is a covered benefit
PA Requirement: PA is required~~; IV pole reimbursement is limited to a ten (10) month rental~~
Benefit Description: Intravenous (IV) therapy or intravenous therapy is a way of taking medicine so that it flows straight into the bloodstream. IV medicines are given through flexible plastic tubes that are inserted into a vein, usually in the arm or the chest. Medication that is given through an IV may be given with a syringe as a single dose (push), from a bag that is attached to the end of the tube (gravity infusion) or with a pump.
IV medication is used instead of medicine that is taken by mouth (oral) when:

- The medicine needed is not available in oral form;
- The doctor feels that IV medication will be more effective than oral medicine; and/or
- Recipient is unable to take medication by mouth.

Some of the different devices that are used to give IV medicines are:

- Cannulas;
- Central lines, (Hickman's catheter);
- Peripheral Intravenous Central Catheter (PICC) lines; and
- Portacaths® (Infuse-a-port®, Mediport®).

NOTE: Syringes and needles are covered for IV therapy. Documentation must show that a home health agency is administering and/or monitoring the administration of IV therapy provided in the home in order for these supplies to be approved.

Lumbar Orthosis and Truss Supports
Eligible: All members where DME is a covered benefit
PA Requirement: PA is required for some items
Benefit Description: Lumbar orthosis and truss supports may be approved with documentation of medical necessity.

Patient Lifts
Eligible: All members where DME is a covered benefit
PA Requirement: PA is required
Benefit Description: Lifts are approved only if all of the following conditions are met:

- If the recipient is confined to bed, chair or room and is unable to transfer or unable to achieve needed movement with or without assistance;
- If the caregiver is unable without the use of a lift to provide periodic movement necessary to arrest or retard deterioration in the recipient's condition, thus affecting improvement in rehabilitation; and
- When the caregiver is unable to transfer recipient from chair to bed or bath (or vice versa) e.g., because of recipient's size or weight.

NOTE: Medicaid covers manual or hydraulic lifts. Electric lifts are **not covered**.

Lift Slings
Eligible: All members where DME is a covered benefit
PA Requirement: PA is required
Benefit Description: Lift slings or seats, either canvas or nylon, are considered part of the lift and are only covered as replacement items.

Nebulizers
Eligible: All members where DME is a covered benefit
PA Requirement: PA is not required
Benefit Description: Nebulizers are reimbursed for purchase only. A diagnosis of asthma, COPD, or other respiratory condition must be supplied. Medications for use with the nebulizer are reimbursed through the Pharmacy Program, not DME.

Orthopedic Shoes and Corrections
Orthopedic shoes and corrections improve mobility and treat many different types of ailments.

- **Orthopedic Shoes and Corrections**
  Eligible: All members where DME is a covered benefit
  PA Requirement: PA is not required
  Benefit Description: Orthopedic shoes and corrections may be approved only when:
  - Needed to protect gains from surgery or casting (qualifies as an emergency PA);
  - Medically necessary to prevent clinical deterioration of the foot as with recipients with severe diabetes;
  - Medically necessary to prevent clinical deterioration of the foot as with recipients with severe peripheral vascular disease; or
  - Attached to braces.

- **Diabetic Shoes**
  Eligible: All members where DME is a covered benefit
  PA Requirement: PA is not required
  Benefit Description: Special shoes and corrections are covered for diabetics. Coverage is provided for extra-depth or custom molded shoes, as well as inserts or modifications, when the physician:
  - Documents that the recipient has diabetes;
  - Certifies that the recipient is being treated under a comprehensive plan of care for his/her diabetes and that he/she needs therapeutic shoes; and
  - Documents that the recipient has one or more of the following conditions:
    - Previous amputation of the foot or part of the foot due to complications that resulted from diabetes;
    - History of previous foot ulceration;
    - Pre-ulcerative callus formation, or peripheral neuropathy with a history of callus formation;
    - Foot deformity; or
    - Poor circulation.

- **Shoe Lifts**
  Eligible: All members where DME is a covered benefit
  PA Requirement: PA is not required
  Benefit Description: Shoe lifts are covered only if the lift needed is greater than 1/2 inch. Inserts are only covered for shoes which are attached to braces, or when there is sufficient documentation from the treating physician to justify medical coverage without the attachments to braces.

  Because Medicare requires that the recipient either has diabetes with peripheral complications or the shoe must always be attached to braces, Medicaid will allow PA for consideration of payment when Medicare's criteria are not met. The provider must use a GY modifier when submitting the PA request for consideration or the claim for payment.

  NOTE: Cables are not considered braces. Cables are **not covered**.

- **Shoes for Minor Orthopedic Problems**
  Eligible: Non-covered
  PA Requirement: Item is **not covered**
  Benefit Description: Payment will not be made for shoes to correct minor orthopedic problems such as pes planus, metatarsus adductus, and internal tibial torsion.

Orthotic Devices

Eligible: All members where DME is a covered benefit
PA Requirement: PA is required for some items
Benefit Description: Orthotic devices include leg braces, neck braces, knee braces and supports, spinal supports, splints, brace attachments and repairs. The request for approval should include the following:

- A complete description of special type brace;
- The recipients mental and physical ability to use the device;
- Whether the device is a replacement;
- Whether training is indicated; and
- The plan of training, when indicated.

Osteogenesis Stimulators

An osteogenic stimulator is a medial tool used to stimulate the natural repair of broken or fractured bones and enhance the body's bone healing process.

NOTE: Medicaid will not provide approval or reimbursement for invasive types of bone growth stimulators. This item has not been approved by FDA for rental. Therefore, Medicaid will not approve payment for an osteogenic bone growth stimulator as a rental device.

- **Osteogenic Bone Growth Stimulators**
  Eligible: All members where DME is a covered benefit
  PA Requirement: PA is required (purchase only)
  Benefit Description: Osteogenic bone growth stimulators are used to augment bone repair associated with either a healing fracture or bone fusion. Medicaid coverage is limited to reimbursement for electrical and ultrasonic non-invasive types of bone growth stimulators.

- **Non-sSpinal**[IG26] **Non-iInvasive**[IG27] **Electrical Stimulators**
  Eligible: All members where DME is a covered benefit
  PA Requirement: PA is required (purchase only)
  Benefit Description: Non-spinal non-invasive electrical bone growth stimulators may be considered under the following circumstances:
  - The failure of long bone fractures to heal. A period of six (6) months from the initial date of treatment must elapse before failure is considered to have occurred;
  - The failure of long bone fusions (a period of nine (9) months from the initial date of treatment must elapse before failure is considered to have occurred); or
  - The treatment of congenital pseudoarthroses. There is no minimal time requirement after the diagnosis.

- **Non-Spinal Non-Invasive Ultrasonic Stimulators**
  Eligible: All members where DME is a covered benefit
  PA Requirement: PA is required (purchase only)

Benefit Description: Non-spinal non-invasive ultrasonic bone growth stimulators may be considered under the following circumstances:

- The failure of a non-union fracture to heal. A period of ninety (90) days following treatment has occurred;
- Documentation consists of two (2) sets of radiographs, one before treatment and the second occurring ninety (90) days after treatment; and
- The radiographs shall include multiple views and be accompanied by a written interpretation by a physician stating that there has been no clinically significant evidence of the fracture healing between the two (2) sets of radiographs.

- **Spinal Non-Invasive Electrical Stimulators**
  Eligible: All members where DME is a covered benefit
  PA Requirement: PA is required (purchase only)
  Benefit Description: Spinal non-invasive electrical bone growth stimulators may be considered:
  - When a minimum of nine (9) months has elapsed since the recipient had fusion surgery which resulted in a failed spinal fusion;
  - When there is a history of a previously failed spinal fusion at the same site following spinal fusion surgery (meaning more than nine months has elapsed since fusion surgery was performed at the same level which is being fused again). As long as nine (9) months has passed since the failed fusion surgery, this repeated fusion attempt requires no minimum passage of time for the application of the device;
  - Following a multi-level spinal fusion (i.e., involving three or more contiguous vertebrae, such as L3-L5 or L4-S1). There is no minimum requirement for application after surgery.

Oxygen Therapy

Temporary or long-term supplemental oxygen at home may help relieve symptoms of many conditions and improve quality of life.

- **Oxygen Concentrators**
  Eligible: All members where DME is a covered benefit
  PA Requirement: PA is required~~ and reimbursement is limited to a ten (10) month rental~~[JG28][WJL29]
  Benefit Description: The attending physician, or consultant physician who has personally examined the recipient at the request of the attending physician, must have seen the recipient within thirty to sixty (30-60) days of prescribing oxygen therapy.

  Initial requests for oxygen concentrators must include a prescription which is signed and dated by the treating physician and which includes:
  - The oxygen flow rate;
  - The frequency and duration of use;

- An estimate of the period of need; and
- The results of a current blood gas laboratory report done at rest and at room air (performed no more than thirty (30) days prior to the prescription) from an appropriate facility giving the arterial blood gases (ABGs) and arterial saturation. However, oxygen saturation may be determined by pulse oximetry when ABGs cannot be taken.

The following diagnostic findings support the need for oxygen therapy:

Group I

- A current ABG with a P02 at or below 55 mmHg, or arterial oxygen saturation at or below 88 percent or below 88 percent, taken at rest, breathing room air.
- A current ABG with a P02 at or below 55 mmHg, or an arterial oxygen saturation at or below 88 percent, taken during sleep; or if there is a significant drop during sleep of more than 10 mmHg of the arterial P02, or a drop of more than 5 percent of the arterial oxygen saturation, and this drop is associated with symptoms or signs reasonably attributable to hypoxemia.
- A current ABG with a P02 at or below 55 mmHg, or an arterial oxygen saturation at or below 88 percent, taken during exercise for a recipient who demonstrates an arterial P02 at or above 56 mmHg, or an arterial saturation at or below 89 percent while awake at rest. In this case, supplemental oxygen is provided during the exercise if there is evidence that use of oxygen improves the hypoxemia experienced during exercise while breathing room air.

Group II

- Coverage is available for recipients whose current arterial P02 is 56-59 mmHg or whose arterial blood oxygen saturation is 89 percent, if there is evidence of:
  - Dependent edema suggesting congestive heart failure (CHF) (documentation from the physician must indicate the degree of edema and if it is associated with CHF);
  - "P" pulmonale on a current electrocardiogram (EKG) (documentation from the physician must indicate if the AP@ wave on an EKG taken within the last thirty (30) days was greater than 3 mm in standard leads II, III of AVF); or
  - Erythrocythemia with a current hematocrit greater than 56 percent.

Group III

- Medicaid reimbursement will not be made for recipients with arterial P02 levels at or above 60 mmHg, or arterial blood saturation at or above 90 percent.

Payment for an oxygen concentrator also includes the cost of providing all routine maintenance and servicing, and monitoring the proper usage in the home by a respiratory therapist. At the time of the initial request for PA, the DME provider must describe a plan for routine checking and servicing of the machine and a plan for monitoring the proper

usage in the home by a respiratory therapist as a prerequisite to authorization of purchase or rental of an oxygen concentrator from that provider. Reimbursement will be the flat fee on file for the date of service.

- **Portable Oxygen**
  Eligible: All members where DME is a covered benefit
  PA Requirement: PA is required
  Benefit Description: Portable oxygen equipment will be reimbursed for recipients who need continuous oxygen and require portable units while enroute to a doctor's office, hospital, or medically necessary appointment. For recipients under age twenty-one (21) only, portable oxygen may be approved when needed for travel to and from school.

  Documentation of medical necessity as well as the anticipated number of visits per month needed must be submitted by the recipient's treating physician with the prior authorization request. Portable systems will not be approved to be used on a standby basis only. Units will be authorized per month based on review of submitted medical justification. An example of justification for refills includes, but is not limited to, multiple weekly visits for radiation or chemotherapy.

  NOTE: One (1) unit of portable oxygen gaseous contents (E0443) is equal to one (1) month's supply.

- **Peak Flow Meters and Mucus Clearance (Flutter) Devices**
  Eligible: All members where DME is a covered benefit
  PA Requirement: PA is required
  Benefit Description: Portable, manual type peak flow meters can be covered for recipients with asthma when prescribed for the measurement of lung function as part of an effective asthma management program and PA is required.

  Coverage of small, hand held mucus clearance (flutter) devices is provided when prescribed for recipients with lung diseases or conditions producing retained secretions, such as Chronic Obstructive Pulmonary Disease and Cystic Fibrosis, to facilitate the removal of mucus from the lungs and must be prior authorized.

- **Pulse Oximeter**
  Eligible: Members under twenty-one (21) where DME is a covered benefit and already approved for a supplement home oxygen system and/or ventilator dependent
  PA Requirement: PA is required
  Benefit Description: Pulse Oximeter (E0445) are a covered service for EPSDT eligible individuals who are already approved for supplemental home oxygen systems and/or ventilator dependent and whose blood saturation levels fluctuate (submit supporting blood

saturation levels), thus requiring continuous or intermittent monitoring to adjust oxygen delivery.

The following criteria for coverage apply to pulse oximeter:
This item is usually approved for a purchase for vent-dependent and oxygen-dependent recipients. Other diagnoses are usually approved for rental for six (6) months, then recertification is required for purchase.

A non-recording/alarming pulse oximeter is covered when one (1) of the following apply:
- The beneficiary is dependent on a ventilator with supplemental oxygen;
- The beneficiary has a tracheostomy, on oxygen, and requires monitoring of O2 saturation as determined by the physician;
- The beneficiary requires supplemental oxygen and has unstable saturations; or
- The beneficiary is on supplemental oxygen and weaning is in process.

A recording/alarming pulse oximeter is covered when all of the following apply:
- The beneficiary's condition meets one of the criteria for a non-recording/alarming oximeter;
- The recording/alarming oximeter is being ordered by the physician to monitor the beneficiary during a specific event such as a weaning attempt from oxygen or ventilator; and
- Feeding times for an infant, or other times for which the physician needs documentation of the recipient's blood oxygen saturation.

Prior authorization is required for coverage of supplies related to pulse oximeters include oxygen probes and tape. Probes and tape are included in the rate on file for pulse oximeter equipment rental. For purchased equipment, coverage for oxygen probes and tape have the following limitations:
- Disposable oxygen probes are limited to four (4) per month.
- Replacement oxygen probes are limited to one (1) every six (6) months.
- Oxygen probes and tape cannot be billed with pulse oximeter equipment in the same month of service.
- **NOTE:** Billing of probes and equipment in the same month will result in denial.

DME providers must ensure that the prescription specifically indicates whether replacement or disposable oxygen probes are being prescribed for the recipient.

DME providers must use the appropriate HCPCS code and modifier on the DMEPOS Fee Schedule to request prior authorization for these supplies. The rate on file for the HCPCS code includes reimbursement for the tape. The ‘U5’ modifier (Oxygen probe for use with oximeter device, disposable) must be submitted with the PA request and claim for

disposable pulse oximeter probes. Failure to submit the modifier with both will result in denial. A modifier should not be used when billing for a replacement oxygen probe.

E0445: Oximeter device is limited to one (1) per year.
A4606: Replacements oxygen probe (without modifier) is limited to one (1) per 6 months.
A4606: Disposable oxygen probe (with modifier U5) is limited to four (4) per month.

Prosthetic Devices
Eligible: All members where DME is a covered benefit
PA Requirement: PA is required for some items
Benefit Description: Prosthetic devices include artificial limbs, body parts, sockets, suspension components, attachment, alignment and finishing. A complete description of the prosthesis is required, such as whether the device is a conventional type, above the knee or a special type. The request should indicate the following:

- Whether the request is for the first prosthesis or a replacement;
- The mental and physical ability of the recipient to use the device; and
- Whether training is required for a replacement.
- **NOTE:** A plan of training shall always be a part of a first request for prosthesis.

Special Needs Car Seat
Eligible: All members where DME is a covered benefit
PA Requirement: PA is required
Benefit Description: A special needs car seat is designed for safe transport of the moderately to severely disabled child. A special needs car seat is covered when all of the following criteria apply:

- The special needs care seat must be medically necessary and appropriate;
- The physician must submit a full description of the recipient's postural condition including head and trunk control and height and weight. Weight must be between 20-105 lbs.;
- The recipient's condition is of such severity that he/she cannot be safely transported using a standard car seat, car seat belts, or modified vest travel restraints;
- There is expected long-term need for the car seat; and
- The special needs care seat must accommodate at least thirty-six (36) months growth.

Strollers, Therapeutic Type
Eligible: All members where DME is a covered benefit
PA Requirement: PA is required
Benefit Description: Strollers of a therapeutic type are approved if the recipient is confined to a bed, chair or room, or if they are needed for transportation to a medical or training facility.

Standing Frames
Eligible: All members where DME is a covered benefit

PA Requirement: PA is required
Benefit Description: A standing frame (also known as a stander, standing aid, standing device) is assistive technology that can be used by a person who relies on a wheelchair for mobility. A standing frame provides alternative positioning to sitting in a wheelchair by supporting the person in the standing position. The criteria to be considered for a standing frame include, but are not limited to, the following. The recipient must:

- Be at a high risk for lower extremity contractures that cannot be improved with other interventions (stretching, medications, serial casting, splinting, and modalities);
- Be able to tolerate a standing or upright position on the foot and ankle;
- Be non-ambulatory or is unable to stand due to conditions such as, but not limited to, neuromuscular or congenital disorders, including acquired skeletal abnormalities;
- Have tried more cost effective alternatives and still requires a stander;
- Not have a walker or gait trainer and it is not anticipated they will require one;
- Have demonstrated improved mobility, function and physiologic symptoms or has maintained status with the use of the requested stander and is able to follow a home standing program with the use of the requested stander; and
- Use the equipment for personal use only. The equipment will not be used at school.

Exclusions and **non-coverage** of standing frame include, but is not limited to the following:

- The recipient has complete paralysis of the lower extremities;
- When there is no expected improvement in mobility or maintenance of function;
- The anticipated functional benefits of standing can be achieved through less costly alternatives;
- In recipients with syncope, orthostatic hypotension, postural tachycardia syndrome, osteogenesis imperfecta, osteoporosis, and other brittle bone diseases, and hip subluxation;
- In recipient's that have hip and knee flexion contractures of more than 20 degrees;
- Mobile (dynamic) stander – either self-propelled standers or standers with powered mobility;
- Active stander – allows movement of the arms and legs in a standing position; and
- A stander will not be purchased for a recipient who has a gait trainer or ambulatory device.

The following documentation must be submitted to support the medical necessity of a standing frame:

- Physician prescription;
- State of Louisiana Medicaid Standing Frame Evaluation completed by a Louisiana state licensed physician and physical or occupational therapist in its entirety; and
- Original manufacture price.

Suction Pumps
Eligible: All members where DME is a covered benefit

PA Requirement: PA is required~~ and reimbursement is limited to a ten (10) month rental~~[JG30][WJL31]

Benefit Description: Purchase of a respiratory suction pump may be considered for recipients who have difficulty raising and clearing secretions secondary to:

- Cancer or surgery of the throat or mouth;
- Dysfunction of the swallowing muscles;
- Recipient is in an unconscious or obtunded state; or
- Tracheostomy.

Suction machines may be considered only if the machine specified is medically required and appropriate for home use without technical or professional supervision. Accessories and supplies may be considered when they are medically necessary and used with a medically necessary suction pump. Sterile suction catheters are considered to be medically necessary only for tracheostomy suctioning.

Support Hose

Eligible: All members where DME is a covered benefit

PA Requirement: PA is required

Benefit Description: Support hose are approved only for severe incapacitating vascular problems, such as acute thrombophlebitis, massive venous stasis, or pulmonary embolism.

Surgical Dressing or Bandages

Eligible: All members where DME is a covered benefit

PA Requirement: PA is required

Benefit Description: Surgical dressings and bandages (e.g., gauze, tape, sponges, cement and disposable gloves) are approved only for wound dressing and post-operative care with documentation of medical necessity.

Syringes and Needles

Eligible: All members where DME is a covered benefit

PA Requirement: PA is not required

Benefit Description: Syringes and needles are covered only for intravenous (IV) therapy, intramuscular (IM) injections, sub-coetaneous (Sub Q) injections, for dialysis purposes when used to inject heparin into the dialysis system, and for wound care.

Documentation must show that a home health agency is administering and/or monitoring the administration of IV therapy provided in the home in order for these supplies to be approved.

NOTE: Insulin syringes are **not covered** in the DME Program, but are covered in the Pharmacy Program. Syringes are not separately reimbursable for enteral and parenteral therapy, as these items are included in the supply kits.

Tracheostomy Care Supplies
Eligible: All members where DME is a covered benefit
PA Requirement: PA is required
Benefit Description: Tracheostomy care supplies are covered for recipients following an open surgical tracheostomy. Tracheostomy care or cleaning starter kits may be covered for a maximum of two (2) weeks postoperative of an open surgical tracheostomy and must contain the following:

- Plastic tray;
- Basin;
- Pair of sterile gloves;
- Tube brush;
- Pipe cleaners;
- Pre-cut tracheostomy dressing;
- Roll of gauze;
- 4 inch x 4 inch sponges;
- Cotton-tip applicators; and
- One-half inch twill tape.

Tracheostomy care kits for an established tracheostomy may be covered for routine care. One (1) care kit per day is considered normal usage. Additional kits may be considered only with medical necessity documentation. Tracheostomy care kits for established tracheostomies are expected to contain the following:

- Tube brush;
- Pipe cleaners;
- Cotton-tip applicators;
- One-half inch twill tape;
- 4 inch x 4 inch sponges; and
- Pair of sterile gloves.

NOTE: Sterile suction catheters are considered medically necessary only for tracheostomy suctioning.

Traction Equipment
Eligible: All members where DME is a covered benefit
PA Requirement: PA is required ~~and reimbursement is limited to a ten (10) month rental~~
Benefit Description: Traction equipment is approved only if the recipient has significant orthopedic impairment which prevents ambulation. Cervical traction collars are considered under orthotic devices.

Trapeze Bar

Eligible: All members where DME is a covered benefit
PA Requirement: PA is required ~~and reimbursement is limited to a ten (10) month rental~~
Benefit Description: Trapeze bars are approved if the recipient requires assistance to sit up in bed because of a respiratory condition or a need to change body position for other medical reasons.

Ventilator Assist Devices

A ventilator is a medical device that supports breathing and provides a recipient with oxygen when they are unable to breathe on their own. Non-invasive ventilator assist devices are covered when medically necessary. Continued authorization requires documentation to support ongoing medical need and member compliance.

The following policy guidelines apply to all ventilator assist devices:

- All equipment needs, including emergency equipment, must be prior authorized.
- Unless the physician can clearly justify purchase of the equipment, a rental trial period of up to three (3) months can be requested to have an adequate trial period to document appropriateness.
- Other equipment, such as low pressure alarms, must be separately documented to show medical necessity. Low pressure alarms will be approved for recipients who are ventilator dependent or at risk for a life threatening event.
- Pulse oximetry, due to its technology limitations, is not reimbursable for home use, with the exception of EPSDT recipients approved for a supplement home oxygen system and/or are ventilator dependent.
- Non-disposable, reusable supplies should be prescribed, if appropriate, for medical care and economical reasons. Periodic exacerbations may increase supply needs, therefore, an extra prescription should be written out “as needed.”
- The use of oxygen must be considered for those recipients where these devices fail to adequately improve the recipient’s condition. There must be documentation of satisfactory clinical improvement such that mechanical ventilation through a tracheotomy tube is justifiably avoided.

- **Continuous and Bi-Level Positive Airway Pressure (CPAP and BiPAP)**
  Eligible: All members where DME is a covered benefit
  PA Requirement: Item is precertified by AIM Specialty Health; PA is required ~~and reimbursement is limited to a ten (10) month rental~~
  Benefit Description: A continuous positive airway pressure (CPAP) machine is used to treat recipients who have moderate to severe obstructive sleep apnea. Apnea is defined as the cessation of airflow for at least ten (10) seconds documented on a polysomnogram. Hypopnea is defined as an abnormal respiratory event lasting at least twenty (20) seconds associated with at least a 30 percent reduction in thoracoabdominal movement or airflow as compared to baseline, and with at least a 4 percent decrease in oxygen saturation.

Criteria for Adults – A single-level CPAP device is covered if the recipient has a diagnosis of obstructive sleep apnea (OSA) documented by an attended, facility-based polysomnogram and meets either of the following criteria:

- Apnea-hypopnea index (AHI) greater than or equal to fifteen (15) events per hour; or,
- AHI is from five to fourteen (5-14) events per hour with documented symptoms of:
  - Excessive daytime sleepiness, impaired cognition, mood disorders, or insomnia; or
    - Hypertension, ischemic heart disease, or history of stroke.

Pediatric Criteria – A single-level CPAP device is covered for a recipient under age twenty-one (21) with a diagnosis of OSA documented by an attended, facility-based polysomnogram and there is:

- Documentation of physical exam (including airway) and of any other medical condition, which may be correctable (e.g., tonsillectomy and/or adenoidectomy) prior to the institution of assisted ventilation;
- Documentation of how sleep disturbance reduces the quality of life and affects the activities of daily living;
- Prescription by a physician with training and expertise in pediatric respiratory sleep disorders;
- Documentation of the medical diagnosis, which is known to cause respiratory/sleep disorders;
- Sleep or respiratory study documenting two (2) or more of the following:
  - Oxygen saturation of less than 90 percent pulse oximetry or partial pressure of transcutaneous or arterial of less than 60 mmHg;
  - Carbon dioxide greater than 55 mmHg by end tidal, transcutaneous, arterial, or capillary blood measurement; and
  - Apnea of 10 to 20 seconds duration on the average of one (1) per hour.
- A follow up plan should be submitted identifying the responsible physician or facility, giving data collected to demonstrate the success or failure of intervention, and showing a visit within the first month of use and a second assessment within the first three (3) months of use;
- Indication of a responsible, committed home environment and of caregivers properly trained in appropriate respiratory care; and
- A written plan for home health follow up care.

- **Humidifiers**
  Eligible: All members where DME is a covered benefit
  PA Requirement: PA is required for some items ~~and reimbursement is limited to a ten (10) month rental~~
  Benefit Description: Humidifiers are used to prevent dry mouth, stuffy, congested, or runny nose and dry, burning, itching, or bleeding nose. Humidifiers are covered if continuous

positive airway pressure (CPAP), bi-level positive airway pressure (BiPAP), or oxygen therapy has been prescribed for use in connection with medically necessary DME for purposes of moisturizing the oxygen. Heated and non-heated humidification for use with positive airway pressure system devices requires PA. Documentation of medical necessity including the diagnosis and expected outcome must be submitted.

Vagus Nerve Stimulators (VNS)

Eligible: All members where DME is a covered benefit

PA Requirement: PA is required and dependent upon approval of the surgeon to perform the procedure

Benefit Description: Consideration shall be given for Medicaid reimbursement for implantation of the vagus nerve stimulator (VNS) if the treatment is considered medically necessary, the recipient meets the published criteria, and the recipient has a diagnosis of medically intractable epilepsy.

The following criteria are used to determine recipient eligibility and approval of the VNS:

- Partial epilepsy confirmed and classified according to the International League Against Epilepsy (ILAE) classification. The recipient may also have associated generalized seizures, such as tonic, tonic-clonic, or atonic. The VNS may have efficacy in primary generalized epilepsy as well;
- Age twelve (12) years or greater, although case by case consideration may be given to younger children who meet all other criteria and have sufficient body mass to support the implanted system;
- Seizures refractory to medical anti-epilepsy treatment, with adequately documented trials of appropriate standard and newer anti-epilepsy drugs or documentation of recipient's inability to tolerate these medications;
- Recipient has undergone surgical evaluation and is considered not to be an optimal candidate for epilepsy surgery;
- Recipient is experiencing at least four (4) to six (6) identifiable partial onset seizures each month. Recipient must have had a diagnosis of intractable epilepsy for at least two (2) years. The two (2) year period may be waived if waiting would be seriously harmful to the recipient;
- Recipient must have undergone quality of life (QOL) measurements. The choice of instruments used for the QOL measurements must assess quantifiable measures of daily life in addition to the occurrence of seizures; and
- In the expert opinion of the treating physician, there must be reason to believe that quality of life will improve as a result of implantation of the VNS. This improvement should occur in addition to the benefit of seizure frequency reduction. The treating physician must document this opinion clearly in the request for PA.

Regardless of the criteria for recipient selection, authorization for VNS implantation shall not be given if the recipient has one (1) or more of the following criteria:

- Psychogenic seizures or other non-epileptic seizures;
- Insufficient body mass to support the implanted system;
- Systemic or localized infections that could infect the implanted system; or
- A progressive disorder contraindicated to VNS implantation, e.g., malignant brain neoplasm, Rasmussen's encephalitis, Landau-Kleffner syndrome and progressive metabolic and degenerative disorders.

Surgery to implant the VNS is restricted to an outpatient hospital, unless medically contraindicated. If it is medically necessary for the recipient to be hospitalized, the hospital must obtain pre-certification for the stay as well as obtain PA to perform the surgery and purchase the device.

PA for implantation of the VNS shall be requested after the recipient evaluation has been completed but prior to stimulator implantation. This request to initiate implantation shall come from the multi-disciplinary team that evaluates the recipient. These professionals shall have expertise in the evaluation, management, and treatment of epilepsy and have undergone VNS implantation training by a nationally recognized product supplier with expertise in VNS. The multi-disciplinary team should be comprised of the following:

- A surgeon who has been trained and is familiar with the carotid sheath;
- A psychiatrist or neurologist;
- The recipient's attending physician;
- A nurse;
- A social worker; and
- Allied health professionals (physical therapist, occupational therapist, etc.).

The following documentation shall be submitted by the multidisciplinary team:

- A recent history with documentation of assessments in the following areas:
  - Medical and physical including a history of prior drug experience;
  - Neurological information about seizure type and epilepsy syndrome diagnosis, and the results of EEG and/or video EEG monitoring;
  - Functional and psychosocial assessment;
  - Result of evaluation of epilepsy surgery; and
- Documentation of any other findings about the recipient's condition which would be of interest to or would assist the Medical Review team in making a decision regarding the medical necessity for recipient implantation.

Coverage of VNS includes but is not limited to:

- VNS;
- Implantation of the VNS;
- Programming of the VNS; and

- Battery replacement.

NOTE: VNS device reimbursement is dependent upon approval of the surgeon to perform the procedure. Battery replacement and subsequent implants require PA. In order to be considered, the request must contain documentation demonstrating the benefits of the original VNS transplant.

Wearable Cardioverter Defibrillator (WCD)
Eligible: All members where DME is a covered benefit
PA Requirement: PA is required and is limited to rental only
Benefit Description: The ZOLL Life Vest wearable cardioverter defibrillator (WCD) is an external device that is intended to perform the same tasks as an implantable cardioverter defibrillator (ICD), without requiring invasive procedures. The device is designed for use by adult patients, eighteen (18) years of age or older, twenty-four (24) hours a day to monitor and treat ventricular fibrillation and ventricular tachycardia, life-threatening arrhythmias that require immediate treatment. This vest-like medical device, worn under clothing, is the first cardioverter defibrillator that can be worn outside the body rather than require surgical implantation in the chest. PA is required to ensure medical necessity of the WCD and that the WCD will not be used for experimental or investigational purposes.

Wound Care Supplies
Eligible: All members where DME is a covered benefit
PA Requirement: PA is required
Benefit Description: Surgical dressings, bandages, and other wound care supplies may receive PA approval for three (3) months at a time. The PA request must reflect the submitted prescription. The prescription must be updated for any extensions to be granted. The PA request must document the factors below in order to meet criteria:

- Accurate diagnostic information pertaining to the underlying diagnosis/condition as well as any other medical diagnoses/conditions, to include the recipient's overall health status;
- Appropriate medical history related to the current wound;
- Wound measurements to include length, width and depth, any tunneling and/or undermining;
- Wound color, drainage (type and amount) and odor, if present;
- The prescribed wound care regimen, to include frequency, duration and supplies needed;
- Treatment for infection, if present;
- The recipient's use of a pressure reducing mattress and/or cushion, when appropriate; and
- Whether or not a home health agency is involved in the care.

Wound Care Systems
Eligible: All members where DME is a covered benefit
PA Requirement: PA is required ~~and reimbursement is limited to a ten (10) month rental~~

Benefit Description: A wound care system may be considered for approval for recipients with a Stage III or IV chronic, non-healing wound, such as a pressure, venous stasis, and diabetic ulcers, postsurgical wound dehiscence, non-adhering skin grafts, or surgical flaps required for covering such wounds. Types of wound care systems include the following:

- Thermal wound care system; and
- Sealed suction wound care system.

Portable hyperbaric oxygen chambers that are placed directly over the wound and provide higher concentrations of oxygen to the damaged tissue are **not covered**.

EXCLUSIONS:

DME and supplies are **not covered** for residents in Intermediate Care Facilities for the Developmentally Disabled (ICF/DD) and nursing facilities, with the exception of prosthetic and orthotic services for residents of nursing facilities. Nursing facility residents may be approved for prosthetics and orthotics, but no other DME or supplies. Payments for prosthetic and orthotic devices are included in the payments made to ICF/DD facilities, therefore are not covered for ICF/DD residents.

Non-covered DME items and services include (the below list is not all-inclusive):

- Clinically unproven equipment
- Comfort or convenience equipment
- Dentures
- Disposable supplies customarily provided as part of a nursing or personal care service or a medical diagnostic or monitoring procedure
- DME and supplies for residents in ICF/DD and nursing facilities.
- Electric lifts (manual lifts are covered)
- Emergency and non-emergency alert devices
- Environmental modifications (e.g., home, bathroom, ramps, etc.)
- Equipment designed for use by a physician or trained medical personnel
- Experimental equipment
- Facilitated communications (FC)
- Furniture and other items which do not serve a medical purpose
- Handheld showers
- Investigational equipment
- Items used for cosmetic purposes
- Personal comfort, convenience or general sanitation items
- Physical fitness equipment

- Precautionary-type equipment (e.g., power generators, backup oxygen equipment)
- Rehabilitation equipment
- Reimbursement for delivery or delivery mileage of medical supplies
- Replacement of equipment that is damaged as a result of misuse, abuse, neglect, or wrongful disposition of equipment by the member, the member's caregiver, or the provider
- Routine and first aid items
- Safety alarms and alert systems/buttons
- Scooters
- Seat lifts and recliner lifts
- Supplies or equipment covered by Medicaid per diem rates (nursing home residents may be approved for orthotics and prosthetics, but not for DME and supplies)
- Standard car seats
- Televisions, telephones, VCR machines and devices designed to produce music or provide entertainment
- Training equipment or self-help equipment
- Van lifts
- Wheelchair Lifts
- Wheelchair Ramps

Below is a list of supplies included in the reimbursement for a home health visit. These supplies cannot be billed in addition to a home health visit. This list is not all-inclusive:

- Adhesive tape
- Alcohol
- Alcohol prep-swab
- Bandage scissors
- Blood drawing supplies
- Culturettes
- Disposable gloves, non-sterile
- Disposable gowns, paper or plastic
- Disposable wash cloths
- Emesis basins
- Googles
- Non-sterile cotton ball, buds
- Oral swabs/toothettes
- Paper tape
- Self-assistive devices (e.g., long handle tongs and shoehorn aide)
- Sharp containers
- Sterile specimen containers
- Surgical masks
- Tape measure, all types
- Thermometer cover
- Thermometer with holder
- Tourniquet
- Tubex holder
- Vacutainer used for drawing blood
- Water soluble lubricant

Healthy Blue shall ensure that physicians and all other professionals abide by the professional guidelines set forth by their certifying and licensing agencies in addition to complying with Louisiana Medicaid regulations.

In general, services that are not approved by the Food and Drug Administration or services that

are experimental, investigational, or cosmetic are excluded from Medicaid coverage and will be deemed not medically necessary.

REFERENCES:

Associates Performing Utilization Review – LA
CFR Title 42
Clinical Criteria for Utilization Management Decisions – Core Process
Clinical Information for Utilization Review – LA
Continuity of Care – LA
Durable Medical Equipment Provider Manual
Durable Medical Equipment Rent to Purchase[IG32]
Health Care Management Denial – LA
Health Plan Advisory 13-12
Health Plan Advisory 14-5
Health Plan Advisory 14-11
Health Plan Advisory 14-15
Health Plan Advisory 16-2
Health Plan Advisory 18-8
Health Plan Advisory 18-15
Health Plan Advisory 18-16
Health Plan Advisory 19-4
High Cost DME, Prosthetic or Orthotic Purchases
Informational Bulletin 19-10
Lost, Stolen or Destroyed Durable Medical Equipment
Louisiana State Contract
NCQA Accreditation Standards and Guidelines
Out of Area, Out-of-Network Care – LA
Out-of-Network Authorization Process
Precertification of Requested Services – LA
Sleep Management Program
Women, Infant, and Children (WIC) – LA

RESPONSIBLE DEPARTMENTS:

Primary Department:
Health Care Management – Utilization Management

Secondary Department(s):
Claims

Section (Primary Department)	**SUBJECT (Document Title)**
Health Care Management – Utilization Management	**Durable Medical Equipment – LA**

EXCEPTIONS:

None

REVISION HISTORY:

Review Date	Changes
04/21/2016	• New
06/14/2016	• Off cycle edits • Update to table under Diabetic Shoes and Cochlear Implants
05/18/2017	• For annual review • Minor change under Continuous Subcutaneous Insulin External Infusion Pumps section • Reference section updated
10/13/2017	• Off cycle review • AGP references changed to Healthy Blue • Minor change to procedure section under Osteogenic Bone Grown Stimulator
04/20/2018	• For annual review • No changes
01/09/2019	• Off cycle review • Removed table format • Updated coverage of Breast Pumps and Continuous Glucose Monitoring Devices
02/28/2019	• Off cycle review/ Early annual review • Edits to procedure section
07/26/2019	• Off cycle review • Updated Procedure
09/25/2019	• Off-cycle Review • Updated Pulse Oximeter section under Procedure
~~12/03/2019~~03/12/2020	• Annual ~~Off cycle~~ review • New LA Emergency Contract Revisions • Edits to policy, definitions, procedure, exclusions, and reference sections • Claims added as a secondary department