14

14 Durable Medical Equipment (DME)

Medicaid authorizes supplies, appliances, and durable medical equipment (DME) to Medicaid recipients of any age living at home. A provider of these benefits must ensure the following:

- The supplies, appliances, and DME are for medical therapeutic purposes.
- The items will minimize the necessity for hospitalization, nursing facility, or other institutional care.

The attending physician is responsible for ordering the items in connection with his or her plan of treatment. The attending physician must be a licensed, active, Alabama Medicaid provider. The DME provider is responsible for delivering and setting up the equipment as well as educating the recipient in the use of the equipment.

Prior Authorization requests for coverage of durable medical equipment must be received by Medicaid's Fiscal Agent within thirty days after the equipment is dispensed. (See section 14.3.1 Authorization for Durable Medical Equipment)

NOTE:

A recipient does not have to be a Home Health Care recipient in order to receive services of this program.

Fee Schedule

DME Reimbursement rates and benefit limits for covered equipment/supplies are published on the Agency's website at the following link: http://www.medicaid.alabama.gov/CONTENT/6.0_Providers/6.6_Fee_Schedules.aspx

This DME Provider Manual is not an ALL INCLUSIVE DOCUMENT. Additional documentation may be needed upon request. The policy provisions for DME providers can be found in the *Alabama Medicaid Agency Administrative Code,* Chapter 13.

14.1 Enrollment

Medicaid's Fiscal Agent enrolls supply, appliance, and durable medical equipment providers and issues provider contracts to applicants who meet the licensure and/or certification requirements of the state of Alabama, the Code of Federal Regulations, the Alabama Medicaid Agency Administrative Code, and the Alabama Medicaid Provider Manual. A copy of the approved Medicare enrollment application is required.

Refer to Chapter 2, Becoming a Medicaid Provider, for general enrollment instructions and information. Failure to provide accurate and truthful information or intentional misrepresentation might result in action ranging from denial of application to permanent exclusion.

Re-Enrollment

Federal requirements mandate providers re-enroll periodically with the Alabama Medicaid program. Providers will be notified when they are scheduled to re-enroll. Failure to re-enroll and provide appropriate documentation to complete enrollment will result in an end-date being placed on the provider file. Once a provider file has been closed for failure to timely re-enroll, providers will have to submit a new application for enrollment using Medicaid's Provider Enrollment Web Portal.

Application Changes Process

Providers must notify Medicaid's Fiscal Agent in writing of any changes to the information contained in its application at least 30 days prior to making such changes. These changes may include, but are not limited to, changes in ownership or control, federal tax identification number, or business address changes.

Added: **Change of Ownership (CHOW) and Closures** section

Change of Ownership (CHOW) and Closures

Medicaid will mirror Medicare's Change of Ownership (CHOW) policy.
Refer to Chapter 19, Hospital for additional information on Change of Ownership.

National Provider Identifier Type and Specialty

A provider who contracts with Medicaid as a DME provider is added to the Medicaid system with the National Provider Identifier provided at the time application is made. Appropriate provider specialty codes are assigned to enable the provider to submit requests and receive reimbursement for DME related items.

NOTE:

The 10-digit NPI is required when filing a claim.

DME providers are assigned a provider type of 25 (DME) and DME providers of Durable Medical Equipment/Oxygen are assigned a specialty of 250.

Effective August 1, 2014, the Alabama Medicaid Agency DME providers will enroll/re-enroll as the following applicable provider specialties:

Specialty Name	Specialty Number	Contract Name(s)	Contract Start Date	Contract End Date
Durable Medical Equipment	250	DME		8/1/15 (for all contracts assigned prior to 8/1/14)
Prosthetic, Orthotics & Prosthesis	251	POP (adults ages 21-65 YPOP (youth ages 0-20)	8/1/14	N/A
Mastectomy Fitter	254	MSFIT	8/1/14	N/A

Specialty Name	Specialty Number	Contract Name(s)	Contract Start Date	Contract End Date
Therapeutic Shoe Fitter (TSFIT)	256	TSA: Therapeutic Shoe Fitter -Adult (ages 21-65)	8/1/14	N/A
		TSCE: Therapeutic Shoe Fitter -Child/Elderly (ages 0-20 and 66-999)		

Provider Enrollment Process

New Enrollments

New providers enrolling on or after August 1, 2014 **must** select the applicable provider specialty (all that apply) during the initial enrollment process.

Re-enrollments

Currently enrolled providers **must** select the applicable specialty (all that apply) during the annual re-enrollment process.

NOTE:

Providers may select more than one DME provider specialty; however, the required license/certification documentation must be submitted during the enrollment/re-enrollment process. The provider can only be assigned the specialty for which the appropriate supporting documentation is provided.

A POP provider does not have to select the DME specialty if not appropriate for the services provided; however, POP providers must continue to meet all DME requirements detailed in this chapter. The federal statute considers providers of Prosthetic, Orthotic & Pedorthic services DME providers/suppliers.

Reimbursement

The use of the provider specialties will ensure that the Alabama Medicaid Agency is in compliance with the various Alabama licensing boards and only reimburse DME providers for services for which they are licensed to provide. Claims submitted on or after August 1, 2015 will deny when submitted by enrolled DME providers with no assigned provider specialty.

Additionally, providers will only be reimbursed for HCPCS codes included in the assigned provider specialty type.

DME Provider Enrollment Requirements

To participate in the Alabama Medicaid Program, DME providers must meet the following requirements:

The provider shall have no felony convictions and no record of willful or grossly negligent noncompliance with Medicaid or Medicare regulations.

Physical Location Requirements

All Alabama Medicaid DME providers must maintain a physical facility on an appropriate site in accordance with all applicable federal and state regulations and/or requirements.

a. The provider's business location must be accessible to the public, Medicaid recipients, recipient's representatives and Alabama Medicaid and its agents. (The location must not be in a gated community or other area where access is restricted.)

- Location may be a “closed door” business, such as a pharmacy or supplier providing services only to recipients residing in a nursing home that complies with all applicable Federal, State, and local laws and regulations. *“Closed door” businesses must comply with all applicable federal and state regulations and/or requirements.*

b. The provider’s business must have a physical location in the state of Alabama or within a 30-mile radius of the Alabama state line. This requirement does not apply to Medicare crossover providers.

- Providers within a 30-mile radius may serve recipients only in all counties adjoining the county in which he/she has a business license and in the county where the business is physically located.
- Providers located more than 30-miles from the border may be enrolled only as follows:

  (1) For specialty equipment and supplies such as augmentative communication devices and high frequency chest wall oscillation air pulse generator systems which are not readily available in state. These providers will be reviewed on a case by case basis by the program area.

  (2) For supplies and equipment needed as the result of a transplant or unique treatment approved out of state as the result of an EPSDT referral. Suppliers will be enrolled by the Medicaid fiscal agent on a temporary basis for these situations.

  (3) Medicare cross over providers **only**

Business Signs

Maintains a permanent visible sign in plain view and posts hours of operation. If the supplier's place of business is located within a building complex, the sign must be visible at the main entrance of the building or the hours can be posted at the entrance of the supplier.

Business Telephone

Maintains a primary business telephone that is operating at the appropriate site listed under the name of the business locally or toll-free for beneficiaries.

a. Cellular phones, beepers, or pagers must not be used as the primary business telephone.

b. Calls must not be exclusively forwarded from the primary business telephone listed under the name of the business to a cellular phone, beeper, or pager during posted business hours.

c. Answering machines, answering services, facsimile machines or combination of these options must not be used exclusively as the primary business telephone during posted operating hours.

d. Answering machines and/or answering services are not acceptable as personal coverage during normal business.

Business Hours/Staffing

Providers must be open to conduct business at least 40 hours per week.

Provider’s business days/hours, Monday through Sunday, 8:00 a.m. to 8:00 p.m., are at the discretion of the provider.

Exemption(s):

- A physician DME provider who furnishes items to his/her own patient(s) as part of his/her professional service.
- A physical or occupational therapist DME provider who furnishes items to his/her own patient(s) as part of his/her professional service.

Provider's location must be accessible and staffed during posted business hours of operation.

There must be at least one person present to conduct business at the physical location. This person must be knowledgeable about the DME supplies being sold at the location.

Supplies

DME providers must have durable medical equipment, appliances or supply items stocked in the physical store location that are readily available to Medicaid recipients presenting prescriptions/orders for these items.

DME providers must display, on the location's shelves, all non-custom items for which the provider will be submitting claims to Alabama Medicaid to request reimbursement.

Displayed products must be clearly labeled, usable and readily accessible to a recipient who enters the DME location and presents a prescription/order for DME products, i.e. no expired products on the shelf, no products stored in bins on shelves.

Displayed items must be in original manufacturer's packaging, when appropriate.

Shelf location for items must be labeled, to include but not limited, item's name.

Satellite Businesses/Multiple Locations

Satellite businesses affiliated with a provider are not covered under the provider contract; therefore, no reimbursement will be made to a provider doing business at a satellite location, however, a satellite could enroll with a separate NPI.

A provider with multiple DME store locations must have completed a provider application for each store location. Each store location enrolled with Alabama Medicaid is assigned a unique Medicaid identification number.

License/Certification Requirements (Documents)

Providers should contact the applicable licensing and/or accreditation board(s) to determine the licensure requirements for each of the specialties. The appropriate documentation must be submitted during the Alabama Medicaid DME provider enrollment/re-enrollment process. If the appropriate licensure documentation is not submitted, the provider will not be assigned the selected specialty.

The provider must display, in an area accessible to recipients, customers and/patients, all licenses, certificates and permits to operate.

The chart below outlines the type of operation codes and services that can be provided by each specialty and the required license and accrediting board for each of the specialties.

Specialty Name	Specialty Number	Type of Operation Codes/Services	License/ Certification Required	License/Accreditation Board Website
DME	250	DME only "A", "B", "E" "S" and "T" HCPCS codes	HME license	Alabama Board of Home Medical Equipment (HME) Service Providers http://www.homemed.alabama.gov
Prosthetic, Orthotics & Prosthesis (POP/YPOP)	251	Prosthetic, Orthotic & Pedorthic (POP) Services only custom fabricated devices only	O&P facility license	Alabama State Board of Prosthetists and Orthotists http://www.apob.alabama.gov
Mastectomy Fitter (MSFIT)	254	Mastectomy Fitters "L" HCPCS codes (specified)	Mastectomy Fitter (MSF) license	Alabama State Board of Prosthetists and Orthotists http://www.apob.alabama.gov
		HME providers using prefabricated or off-the-shelf orthoses "L" HCPCS codes	MSF **and** HME licenses	
Therapeutic Shoe Fitter (TSFIT)	256	Therapeutic Shoe Fitters "A" HCPCS codes	Therapeutic Shoe Fitter (TSF) license	Alabama State Board of Prosthetists and Orthotists http://www.apob.alabama.gov

A copy of the following licenses/certifications must be provided, upon request, with the enrollment and/or re-enrollment processes:

License/Certifications Needed		Provider Exemptions
❒	Applicable State and Professional licenses	N/A
❒	Valid business licenses (s)	N/A
❒	Medicare Accreditation	Medicare exemptions apply
❒	Medicare Surety Bond (when applicable)	Medicare exemptions apply
❒	Medicare Surety Bond (when applicable) Effective October 1, 2010, all DME providers must have a $50,000.00 Medicaid Surety Bond for each store location. A DME supplier who provides Breast Prosthesis, Diabetic Shoes and Diabetic Shoe Inserts is **not** exempted.	DME supplier who has been a Medicaid provider for five years or longer with no record of impropriety and whose refund requests have been repaid as requested Government-operated Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) State-licensed orthotic and prosthetic personnel in private practice making custom-made orthotics and prosthetics Physicians and non-physician practitioners, as defined in section 1842(b)(18) of the Social Security Act Physical and Occupational Therapists in private practice

License/Certifications Needed		Provider Exemptions
		Providers who received $100,000 or less Medicaid payment in the past two calendar years and have been operating at this same location for at least two consecutive calendar years Pharmacy providers Phototherapy providers who only provide phototherapy services for infants Federally Qualified Health Centers

Effective June 5, 2015, out-of-state providers of home medical equipment and services provided in accordance with state or federal law or regulation to Alabama Medicaid recipients are exempt from the HME law.

Pharmacy providers are required to be enrolled with Medicare. Pharmacy providers are not required to submit copies of their Medicare Surety Bond, Medicare Accreditation nor Medicaid Surety Bond nor Home Medical Equipment (HME) License.

Prosthetic, Orthotic, and Pedorthic Providers

Durable Medical Equipment (DME) providers of Prosthetic, Orthotic, and Pedorthic devices for adults, ages 21 – 65, **must**:

- be licensed by the Alabama Board of Prosthetics, Orthotics and Pedorthics,
- be an In-State DME provider~~s~~ ONLY, and
- meet the same requirements as Durable Medical Equipment providers.

The provider is required to have a copy of their license available for auditing purposes.

Consignment Closets

Alabama Medicaid does not provide coverage for Consignment Closets. Medicaid supports recipients exercising the freedom of choice option which is to use the DME provider of their choosing.

14.2 Benefits and Limitations

This section defines durable medical equipment and provides Medicaid policy for supplying medical supplies and appliances as a DME provider.

Refer to Section 14.3 for Prior Authorization and Referral information.

Refer to Chapter 3, Verifying Recipient Eligibility, for general benefit information and limitations.

Refer to Chapter 7, Understanding Your Rights and Responsibilities as a Provider, for general criteria about Medical Necessity/ Medically Necessary Care.

Refer to the DME Fee Schedule on the Agency's website for DME reimbursement rates and benefit limits for covered equipment/supplies at the following link: http://www.medicaid.alabama.gov/CONTENT/6.0_Providers/6.6_Fee_Schedules.aspx

Benefit Limits

Medicaid covers DME items/supplies if the items/supplies are consistent with the implementation of the mandated Medicaid NCCI edits effective November 9, 2010. Refer to this link, http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Data-and-Systems/National-Correct-Coding-Initiative.html for more information regarding NCCI.

- *Medically Unlikely Edits (MUEs) define for each HCPCS / CPT code the maximum units of service (UOS) that a provider would report under most circumstances for a single beneficiary on a single date of service.*

Exceeds Benefit Limit Requests

If the prescription/order to be paid by Alabama Medicaid exceeds the maximum benefit limit established by Alabama Medicaid, the DME provider must request an override or provider authorization request for the prescribed item(s).The requests for additional units with medical documentation justifying the need must be submitted in compliance with Agency's override/prior authorization request process. If the override/prior authorization request is denied, then the item(s) above the maximum benefit limit is non-covered and the recipient can be charged as a cash recipient for the item(s) in excess of the maximum benefit limit.

NOTE:
A provider's failure or unwillingness to go through the process of obtaining an override/prior authorization does not constitute a non-covered service.

14.2.1 Durable Medical Equipment Definition

As defined by Alabama Medicaid, durable medical equipment is equipment that meets the following conditions:

- Can stand repeated use
- Serves a purpose for medical reasons
- Is appropriate and suitable for use in the home

Durable medical equipment is necessary when it is expected to make a significant contribution to the treatment of the recipient's injury or illness or for the improvement of physical condition.

The cost of the item must not be disproportionate to the therapeutic benefits or more costly than a reasonable alternative. The item must not serve the same purpose as equipment already available to the recipient.

Medicaid covers new durable medical equipment items for long term use and short term rental. Long term use is defined as the use of durable medical equipment that exceeds six months.

Short Term Rental Policy

Standard durable medical equipment (DME) items prescribed as medically necessary can be rented if needed on a short term basis. Short term is described as (6) months or less. These procedure codes will be indicated on the fee schedule with an RR for rental.

Medicaid payment for short term rental will be made under the following conditions:

1. Written order documenting estimated period of time (number of months) medical equipment will be needed
2. Documentation that establishes medical necessity for short term rental

Initial approval will consist of up to 90 days only. If recipient needs the equipment after the initial 90 day period, written documentation (including an additional PA) must be submitted that demonstrates continued medical necessity.

If equipment continues to be medically necessary longer than six months, a capped rental to purchase will be established.

Capped Rental to Purchase (requires Prior Authorization)

- Providers must submit a new Prior Authorization (PA) request for the purchase of the DME item with previous rental payments deducted from the total purchase price of the DME item.
- Providers will submit their claims with the purchase price that Medicaid has showing on the approved PA request for the purchase of the DME item.
- The requested dates of service on the new PA request for purchase of the DME item must not overlap with the dates of service on the PA request for the rental period of the DME item. Previous rental payments will be applied towards the total purchase price of the equipment.
- Reimbursement will not exceed the total purchase price of the equipment.

Providers should be aware of Medicaid policy regulating medical necessity for durable medical equipment.

14.2.2 Non-covered Items and Services

Medicaid does not cover the following types of items:

- Items of a deluxe nature
- Replacement of usable equipment
- Items for use in hospitals, nursing facilities, or other institutions
- Items for recipient's/caregiver's comfort or convenience
- Items not listed as covered by Medicaid
- Rental of equipment, with exceptions noted below:
    - For Medicaid recipient's for six months or less.

- Medicare crossovers
- Certain intravenous therapy equipment
- Short term use due to institutionalization
- Short term use due to death of a recipient
- DME items may be provided in Nursing Homes or other institutions for children through the EPSDT Program.
- Medicaid recipients may be billed for items not covered by Medicaid

Medicaid recipients may be billed for non-covered items and items covered by non-contract providers.

14.2.3 Supplying Medical Equipment Appliances and Supplies Policy

Written Prescription/Order

A written order or a signed prescription from the attending physician must be dated prior to or on the delivery date, unless a different effective date is clearly documented on the prescription/order. Otherwise, the effective date is the date of the physician signature. An effective date that is handwritten on a prescription/order and differs from the date of the physician's signature must be initialed and dated by the physician to verify the effective date.

- Verbal orders must be signed within 48 hours (two business days) of the order being issued. This prescription/order submitted to a participating supplier determines medical necessity for covered items of supplies and appliances.

Medicaid considers a prescription to be valid for the dispensing of supplies for a period of twelve months. After the twelve month period of time, the recipient must be reevaluated by the attending physician to determine medical necessity for continued dispensing of medical supplies.

A prescription/order is considered to be outdated by Medicaid when it is presented to the DME provider/ Medicaid's Fiscal Agent past ninety days from the date it was written.

EPSDT/Patient 1st Referral

An EPSDT/PT 1st referral may be submitted as an order when written according to practice guidelines and state/federal law and must include the date and signature of the provider, the item(s) ordered and the recipient's name. The EPSDT/PT 1st referral form may be considered the physician's order as long as the above noted guidelines are met. If the prescription/order is from the recipient's primary medical provider (PMP), a separate PT1st referral is not necessary. However, an EPSDT referral is **still required** as the referral provides the screening date and other additional information.

NOTE:

Signature Requirements for Referrals: Effective May 16, 2012:

For hard copy referrals, the printed, typed, or stamped name of the primary care physician with an original signature of the physician or designee is required. **Stamped or copied signatures will not be accepted**. For electronic referrals, provider certification is made via standardized electronic signature protocol.

Upon receipt of the prescription/order, the DME provider must:

- Verify Medicaid eligibility by checking the recipient's Medicaid number and verifying that number using AVRS, Medicaid's Web portal (interactive, real time), Provider Electronic Solutions or the Provider Assistance Center at Medicaid's Fiscal Agent. Recipient's eligibility must be verified on a monthly basis. Alabama Medicaid will not reimburse providers for items supplied to recipients in months where recipients have no eligibility.
- Obtain necessary referrals and prior authorization (EPSDT, Patient 1st, etc.)
- Collect the appropriate copayment amount
- Furnish the covered item(s) as prescribed
- Retain the prescriptions/orders and all medical documentation in patient's file
- Submit the proper claim form to Medicaid's Fiscal Agent

By submitting the proper claim form, the Agency expects the following:

- The provider agrees to accept as payment in full the amount paid by Medicaid for covered services.
- The provider (or their staff) advises each patient, prior to services being rendered, when Medicaid payment will not be accepted and the patient will be responsible for the bill.
- The fact that Medicaid payment will not be accepted must be recorded in the patient's record.

The provider may not bill the recipient for an item for which an override/ prior authorization was denied due to provider error or failure/unwillingness to complete the process of obtaining an override/prior authorization.

14.2.4 Warranty, Maintenance, Replacement, and Delivery

Warranty

All standard durable medical equipment must have a provider's warranty of a minimum of one year; this may include the manufacturer's warranty. If the provider supplies equipment that is not covered under a warranty, the provider is responsible for repairs, replacements and maintenance for the first year. The warranty begins on the date of delivery (date of service) to the recipient. The original warranty must be given to the recipient and the provider must keep a copy of the original warranty for audit review by Medicaid. Medicaid may request a copy of the warranty. In the event the supplying provider does not honor the mandatory one year warranty and does not repair the durable medical equipment when needed, the Agency may impose penalties, to include but not limited to deducting the total cost of the repairs from a check write of the supplying provider, recoupment of reimbursement paid to the provider for the equipment, and termination of the provider's contract.

Maintenance and Replacement

Medicaid covers repair and replacement of standard durable medical equipment. These services, in most cases, must be prior approved by Medicaid. The request for repair/ replacement of equipment and appropriate documentation (includes PA when applicable) justifying the need for replacement must be submitted electronically to Medicaid's Fiscal Agent and kept in the recipient's file.

Requests for replacement/repair of items that are covered by Medicaid which are outside the normal benefit limits, due to damage beyond repair or other extenuating circumstances must be submitted to the DME Unit for review and consideration. Request for repair/replacement due to extenuating circumstances should be mailed to, Alabama Medicaid Agency, 501 Dexter Ave., DME Unit, Montgomery AL, 36103.

Cases suggesting malicious damage, neglect, or wrongful misuse of the equipment will be investigated by Alabama Medicaid. (Providers **must** document the reason for replacement and/or repair). Requests for equipment repair/replacement will be denied if such circumstances are confirmed. Payment for repair/replacement of equipment which has been denied by Medicaid would be the responsibility of the recipient/caregiver.

Repairs

K0739 repair or no routine service for durable medical equipment other than oxygen equipment requiring the skill of a technician, labor component, per 15 minutes.

Effective January 1, 2015, the RB Modifier for Repair(s) for all wheelchair (manual or power) accessories procedure codes will allow a DME repair not exceeding $1000.00 dollars per day to bypass the need for prior authorization (PA). This may expedite the repair process which will be beneficial to Medicaid adult recipients, and providers. This process will not apply to recipients ages 0-20. This process will not override the current limitation audits for each of the procedure codes. For example, if the recipient has already received the yearly limit for a specific procedure code (e.g., 2 per calendar year), the provider will have to submit a PA for the repair even if it is less than the threshold amount of $1000.00 dollars.

Effective February 1, 2012, the allowable units for K0739 are 12 per repair. However, providers must continue to submit justification with the PA request for when submitting claims for more than four units. The request will be reviewed by Medicaid or its designee. The PA letter, in the Analyst Remarks section, will state the total units approved.

Replacement

E1399 - durable medical equipment, miscellaneous

Replacement parts are reimbursed based on the procedure code and fee schedule pricing. In situations where there are no procedure codes or fee schedule reimbursement for the repair item(s), the provider must submit an itemized list of the needed repair items with invoice pricing for each item. Alabama Medicaid will reimburse for these repair items based on provider's invoice price plus 20%.

No prior authorization is needed for replacement of DME items that did not initially require a prior authorization such as nebulizers.

Providers should submit their usual and customary charges for the service.

Replacement Equipment Due to Loss (Disasters, Fire, Theft, etc.)

Alabama Medicaid covers replacement equipment due to loss by disasters. Claims of this type must be submitted electronically (with the PA when applicable) to Medicaid's Fiscal Agent for processing. Provider must file these claims with the appropriate procedure code and **Modifier CR**. The provider must keep all documentation (fire report, theft report, etc.) in the recipient's file. (The date of the report must be within 30 days of the date of loss/event.) These claims will be monitored by Alabama Medicaid's DME Unit on a quarterly basis.

Delivery

Upon furnishing durable medical equipment/supplies, the supplier must:

1. Obtain a signature indicating that the equipment/supplies have been received by the recipient. This requirement applies to all dispensing methods. If the recipient is unable to sign for the equipment/supply items, the supplier should verify the identity of the person signing for the items, i.e. relative, home health worker, neighbor. (Refer to Rule 560-X-1-.18: Provider/Recipient Signature on Claim Forms.) The signature will indicate receipt of specified equipment/supplies and quantities of equipment/supplies provided by the supplier.
2. Document that the recipient was provided the necessary information and instructions on how to use Medicaid-covered items safely and effectively.
3. Retain all forms and documentation in the supplier's patient record.

Automatic Refills

The use of automatic refills is not allowed by the Medicaid Agency. If it is determined through provider audits that Medicaid has reimbursed the provider for excessive amounts of durable medical equipment/supplies, the amount paid for the excessive supply will be recouped.

Custom Made Items Ordered But Not Furnished

If custom made item(s) are ordered but not furnished, contact Alabama Medicaid's DME Unit prior to submitting a claim for the item(s). Failure to contact the Agency (within one year of the date ordered) prior to claim submission may result in no payment and/or recoupment for work relating to item(s), items and/or materials paid to the provider.

NOTE:

For valid procedure codes and modifiers, refer to Appendix P, Durable Medicaid Equipment (DME) Procedure Codes and Modifiers.

14.2.5 Walkers

E0140 Walker, with Trunk Support, Adjustable or Fixed Height, any Type (Specialty Walkers)

A specialty walker is a tool for disabled children with special needs who may require additional support to maintain balance or stability while walking. Walkers are height adjustable and should be set at a height that is comfortable for the user, but will allow the user to maintain a slight bend in their arms. The front two legs of the walker may or may not have wheels attached depending on the strength and abilities of the person using it.

Medicaid will cover specialty walkers for children under the age of 21 with an EPSDT referral.

Documentation

The attending physician must prescribe the specialty walker as medically necessary. The medical documentation justifying the need must accompany the prior authorization request. Documentation must also include an evaluation by the recipient's physician or a physical therapist.

Providers must submit the recipient's width and height for specialty walkers (E0140). Individuals approved for these walkers must be fitted and measured by the DME Company providing the service. Providers must submit invoice pricing and Medicaid will reimburse at provider's invoice price plus 20%.

Effective for dates of service on or after **July 1, 2014**, Alabama Medicaid will no longer require a prior authorization for procedure code(s) E0148 and E0149. All appropriate documentation must be kept in the recipient's file and will be monitored by Alabama Medicaid.

E0148 Heavy Duty Walkers without wheels rigid or folding, any type each

E0149 Heavy Duty Walkers wheeled, rigid or folding, any type, each

E0168 Extra Wide Heavy Duty Stationary Commode Chair

Medicaid will approve E0148 and E0149 to accommodate weight capacities greater than 250 pounds and E0168 for weight capacities greater than 300 pounds.

Prior Authorization

The extra wide and/or heavy duty commode chairs and the stationary or mobile with or without arms will require prior authorization. (See Section 14.3.1 Authorization for Durable Medical Equipment.)

Documentation

Providers must submit recipient's weight, width, and depth for the commode chairs, and weight width and height for the walkers. A physician's prescription/order and medical documentation must be submitted justifying the need for the equipment.

14.2.6 Respiratory Suction Pumps

E0600 Suction Pump, Home Model, Portable

A portable or stationary home model respiratory suction pump is an electric aspirator designed for oropharyngeal and tracheal suction.

Prior Authorization

This procedure code requires prior authorization. (See Section 14.3.1 Authorization for Durable Medical Equipment.)

Documentation

A physician must prescribe a suction pump as medically necessary for the equipment to qualify for Medicaid reimbursement. The recipient must be unable to clear the airway of secretions by coughing secondary to one of the following conditions:

- Cancer or surgery of the throat
- Paralysis of the swallowing muscles
- Tracheostomy
- Comatose or semi-comatose condition

The suction device must be appropriate for home use without technical or professional supervision. Individuals using the suction apparatus must be sufficiently trained to adequately, appropriately, and safely use the device.

This equipment may be purchased for any qualified Medicaid recipient who meets the above criteria. The information submitted must include documentation that the recipient meets the above medical criteria.

14.2.7 Insulin Devices and Supplies

Home Blood Glucose Monitor

E0607 Home blood glucose monitors, monitor replacement batteries, calibrator solution/chips, and spring powered lancet devices must be prescribed as medically necessary by the primary physician.

Documentation

To be considered for coverage Medicaid beneficiaries must be diagnosed as having either Type 1, Type 2, gestational diabetes, or receiving Total Parenteral Nutrition. Alabama Medicaid will reimburse covered diabetic supplies for Medicaid recipients that were diabetics prior to the pregnancy and for pregnancy related-diabetes. Reimbursement for these diabetic supplies will promote health and safety of mother and baby.

Prior Authorization

E0607 does not require prior authorization.

Home Blood Glucose Monitor with Integrated Voice Synthesizer

E2100 Blood glucose monitors with integrated voice synthesizers are covered when the patient meets the same requirements (listed above) as a regular glucometer in addition to the requirements below.

Prior Authorization

This procedure code requires prior authorization. (See Section 14.3.1 Authorization for Durable Medical Equipment.)

Documentation

The patient's physician certifies that the patient has a visual impairment (20/200 or worse) severe enough to require use of this special monitoring system.

The recipient's optometrist/ophthalmologist must certify the degree and type of visual impairment.

For procedure code E2100 to be dispensed, a written statement that the recipient requesting a glucometer with voice synthesizer is capable of using the equipment in the home setting, and is not dependent upon a caregiver for blood glucose testing. (If the recipient is dependent upon a caregiver, the caregiver's need for a glucometer with a voice synthesizer must be justified.)

Medical documentation justifying medical necessity must be in the recipient's file. Documentation in the recipient's file must also include certification that the recipient or their caregiver is receiving, or has received, diabetes education and training on the use of the glucose monitor, strips and lancets in the appropriately prescribed manner in the home.

The following supplies are also available for recipients who are eligible for the home blood glucose monitor:

Home Glucose Monitor Supplies

A4233 Replacement battery, Alkaline, other than J cell

A4234 Replacement battery, Alkaline, J cell

A4235 Replacement battery, Lithium

A4236 Replacement battery, Silver Oxide

A4256 Normal, low and high calibrator solution/chips

A4258 Spring-powered device for lancet, each

Supplies

Providers dispensing diabetic supplies must have the recipient's prescription/order on file from the primary care physician. A valid prescription/order will contain the frequency for daily blood sugar testing. Providers must ensure that diabetic supplies are dispensed based on the daily frequency of blood sugar testing indicated on the recipient's prescription/order.

It is the provider's responsibility to ensure that the recipient does not have an excessive supply of strips/lancets. If it is determined through provider audits that Medicaid has reimbursed the provider for excessive amounts of strips/lancets, the amount paid for the excessive supply will be recouped.

If recipients require additional strips or lancets above the Medicaid established limits, providers must submit a request to the Medical and Quality Review Unit at the Alabama Medicaid Agency for review and approval. The request must include the following:

1. Prescription/order,
2. number of times the recipient is testing per day,
3. documentation informing if recipient is insulin or non-insulin dependent,
4. two A1C or blood sugar test readings, and
5. for non-insulin dependent Type II diabetes, peer reviewed literature justifying the need for additional supplies.

If approval is granted, the Medical and Quality Review Unit will notify the DME Unit. Providers will also be notified of the approval and for these additional supplies, instructed to submit a clean CMS 1500 claim form with a short memo to Alabama Medicaid's DME Unit. The memo (with copy of approval notification attached) should state that the recipient has been approved for additional units and request Medicaid to override the maximum unit requirement and force payment of the claim.

A4250 - Urine test or reagent strips or tablets (100 tablets or strips), will be limited to one box of 100 count every month.

Non-Insulin Dependent Recipients:

Claims for **non-insulin** dependent recipients **must** be filed **with the procedure code WITHOUT** using a modifier.

A4253 – Blood glucose test or reagent strips for home blood glucose monitor, per box of 50, will be limited to **two** boxes every three months (providers may bill these strips two boxes in a one month period).

A4259 – lancets, per box of 100, will be limited to **one** box every three months.

Insulin Dependent Recipients

Claims for insulin dependent recipients **must** be filed **WITH the procedure code and MODIFIER U6**

A4253 (U6) - Blood glucose test or reagent strips for home blood glucose monitor, per box of 50 will be limited to **three** boxes per month for insulin dependent recipients age **21 and above.**

A4253 (U6) - Blood glucose test or reagent strips for home blood glucose monitor, per box of 50 will be limited to **four** boxes every month for insulin dependent recipients age **0 – 20.**

A4259 (U6) - Lancets, per box of 100 will be limited to two boxes per month for insulin dependent diabetics regardless of age.

Recipients with Gestational Diabetes:

Effective March 1, 2012, DME diabetic testing supplies claims billed for recipients with Gestational Diabetes must contain a diagnosis code in the range of 64880 through 64884 for ICD-9, O24410 through O24439 and O99810 through O99815 for ICD-10.

A4259 – Lancets, per box 100, will be limited to two per calendar month
A4253 – Blood glucose test or regent strips for home blood glucose monitor, per box of 50, will be limited to four per calendar month.

These claims will be processed electronically by Medicaid's Fiscal Agent. All documentation must be kept in the recipient's file and will be monitored by Alabama Medicaid on a quarterly basis.

NOTE:

Recipients who were diagnosed with diabetes prior to the pregnancy are eligible to receive diabetic equipment/supplies.

External Ambulatory Infusion Pump and Supplies (E0784)

An external ambulatory infusion pump is a small portable battery device worn on a belt around the waist and attached to a needle or catheter designed to deliver measured amounts of insulin through injection over a period of time.

The external ambulatory infusion is approved by the Alabama Medicaid Agency for use in delivering continuous or intermittent insulin therapy on an outpatient basis when determined to be appropriate medically necessary treatment, and must be prior authorized.

E0784 External Ambulatory Infusion Pump will be a capped rental item for twelve months. At the end of the twelve month period the item is considered to be a purchased item for the recipient paid in full by Medicaid. Any maintenance/repair cost would be subject to an EPSDT screening and referral and a prior authorization as addressed under current Medicaid policy.

A9274 External ambulatory insulin delivery system, disposable, each, includes all supplies and accessories is approved by the Alabama Medicaid Agency effective August 1, 2014, for use in delivering continuous or intermittent insulin therapy on an outpatient basis when determined to be appropriate medically necessary treatment.

All of the following criteria must be met in determining medical necessity for the insulin pump

1. Patient must be Medicaid eligible, less than 21 years of age, and EPSDT eligible.
2. Patient must have a documented* diagnosis of insulin dependent diabetes mellitus (IDDM, also known as type 1).
3. A board certified endocrinologist must have evaluated the patient and ordered the insulin pump.

4. Patient must have been on a program of multiple daily injections (MDI) of insulin (i.e., at least three injections per day) for at least six months prior to initiation of the insulin pump. Supporting documentation* must be submitted.
5. Patient has documented frequency of glucose self-testing (i.e. patient "logs") an average of at least four times per day during the three months prior to initiation of the insulin pump. Patient must include six consecutive weeks' worth of logs within the three months prior to the prior authorization request.
6. Patient and/or caregiver must be capable, physically and intellectually, of operating the pump. Patient/caregiver must demonstrate ability and commitment to comply with regimen of pump care, diet, exercise, medications, and glucose testing at least four times a day. Supporting documentation* must be submitted.
7. Education on insulin pump MUST have been conducted prior to prior authorization request, and each the patient, caregiver if child, and educator signed to document* their understanding.
8. Documentation* of active and past recipient compliance with medications and diet, appointments, and other treatment recommendations must be provided.

*Documentation may include notes from the patient chart and/or pharmacy printouts (to support medication compliance history

One or more of the following criteria must also be met with supporting documentation:

1. Two elevated glycosylated hemoglobin levels (HbA1c> 7.0%) within a 120-day time
span, while on multiple daily injections of insulin.
2. History of severe glycemic excursions (commonly associated with brittle diabetes, hypoglycemic unawareness, nocturnal hypoglycemia, extreme insulin sensitivity and/or very low insulin requirements).
3. Widely fluctuating blood glucose levels before mealtime (i.e., pre-prandial blood glucose level consistently exceeds 140 mg/dL).
4. Dawn phenomenon with fasting blood sugars frequently exceeding 200 mg/dl.

Approved Diagnoses

Approval will be given for only the following type 1 diabetes mellitus diagnosis codes, if above criteria is met:

Diagnosis	Version	Diagnosis	Version	Diagnosis	Version	Diagnosis	Version
250.51	9	E10.36	0	E11.339	0	E13.29	0
250.53	9	E10.39	0	E11.341	0	E13.311	0
250.61	9	E10.40	0	E11.349	0	E13.319	0
250.63	9	E10.41	0	E11.351	0	E13.321	0
250.71	9	E10.42	0	E11.359	0	E13.329	0
250.73	9	E10.43	0	E11.36	0	E13.331	0
250.81	9	E10.44	0	E11.39	0	E13.339	0
250.83	9	E10.49	0	E11.40	0	E13.341	0
250.91	9	E10.51	0	E11.41	0	E13.349	0

Diagnosis	Version	Diagnosis	Version	Diagnosis	Version	Diagnosis	Version
250.93	9	E10.52	0	E11.42	0	E13.351	0
250.01	9	E10.59	0	E11.43	0	E13.359	0
250.03	9	E10.610	0	E11.44	0	E13.36	0
250.11	9	E10.618	0	E11.49	0	E13.39	0
250.13	9	E10.620	0	E11.51	0	E13.40	0
250.21	9	E10.621	0	E11.52	0	E13.41	0
250.23	9	E10.622	0	E11.59	0	E13.42	0
250.31	9	E10.628	0	E11.610	0	E13.43	0
250.33	9	E10.630	0	E11.618	0	E13.44	0
250.41	9	E10.638	0	E11.620	0	E13.49	0
250.43	9	E10.641	0	E11.621	0	E13.51	0
E10.10	0	E10.649	0	E11.622	0	E13.52	0
E10.11	0	E10.65	0	E11.628	0	E13.59	0
E10.21	0	E10.69	0	E11.630	0	E13.610	0
E10.22	0	E10.8	0	E11.638	0	E13.618	0
E10.29	0	E10.9	0	E11.641	0	E13.620	0
E10.311	0	E11.00	0	E11.649	0	E13.621	0
E10.319	0	E11.01	0	E11.65	0	E13.622	0
E10.321	0	E11.21	0	E11.69	0	E13.628	0
E10.329	0	E11.22	0	E11.8	0	E13.630	0
E10.331	0	E11.29	0	E13.00	0	E13.638	0
E10.339	0	E11.311	0	E13.01	0	E13.641	0
E10.341	0	E11.319	0	E13.10	0	E13.649	0
E10.349	0	E11.321	0	E13.11	0	E13.65	0
E10.351	0	E11.329	0	E13.21	0	E13.69	0
E10.359	0	E11.331	0	E13.22	0	E13.8	0

Supplies Procedure Codes

E0784, A4221, A4232, A4230, A9274

Maximum yearly limits apply to each of the procedure codes indicated above. Requests for replacement of E0784 will be limited to once every five years based on a review of submitted documentation requested.

External Ambulatory Insulin Infusion Pump Checklist

The criteria checklist must accompany the prior authorization form. The checklist is located on the Alabama Medicaid website at the link below.

http://www.medicaid.alabama.gov/CONTENT/4.0_Programs/4.3.0_LTC/4.3.3.1_Durable_Medical_Equipment.aspx

The prescribing practitioner's signature is required to certify the patient meets criteria, treatment is supervised, and supporting documentation is attached to the request.

Alabama Medicaid will reimburse for supplies in quantities prescribed as medically necessary by the physician.

A4221 - Supplies for maintenance of drug infusion catheter per week, (list drug separately). Includes all necessary supplies for one week for quantity needed (up to three units) by the recipient for that week.

For dates of service on or after January 1, 2014, Alabama Medicaid will no longer reimburse for the below listed procedure codes when billed in combination with procedure code A4221-Supplies for Maintenance of Drug Infusion Catheter, Per Week:

A4244	A4245	A4246	A4247	A4450
A4452	A4455	A4927	A4930	A6216
A6230	A6250	A6257	A6258	A6259
A6266	A6403	A6404	J1642	

A4230 - Infusion set for external insulin pump, non-needle cannula type, will be limited to 30 units per two calendar months per recipient

A4230 (U6) - Infusion set for external insulin pump, non-needle cannula type will be limited to 70***** units per two calendar months per recipient. (Payment for this quantity will also require use of the appropriate diagnosis code listed in the table above **and** U6 modifier.)

A4232 - Syringe with needle for external insulin pump, sterile, 3cc will be limited to 30 units per two calendar months per recipient

A4232 (U6) - Syringe with needle for external insulin pump, sterile, 3cc will be limited to 70***** units per two calendar months per recipient. (Payment for this quantity will also require use of the appropriate diagnosis listed in the table above **and** U6 modifier.)

A9274 – External ambulatory insulin delivery system, disposable, each, includes all supplies and accessories.

*****The maximum number of units with or without a modifier is 70. Example: If 30 units are billed without U6 modifier, then 40 is maximum number of units billable with the U6 modifier during any two calendar months.

NOTE:

Procedure codes A4362 and A5121 may not be billed on the same date of service as A4414 or A4415. Procedure code A5063 may not be billed on the same date of service as A5052.

14.2.8 Hospital Bed

A physician must prescribe a hospital bed as medically necessary in order for a recipient to qualify for a hospital bed. These procedure codes require prior authorization. (See Section 14.3.1 Authorization for Durable Medical Equipment.)

Documentation

The recipient must meet one of the following conditions:

1. Recipient positioning of the body not feasible on an ordinary bed.
2. Recipient has medical conditions that require head of bed elevation.
3. Recipient requires medical equipment which can only be attached to the hospital bed.

At least one of the criteria listed above must be met as well as any of the following for coverage of variable height hospital bed:

1. Recipient has medical condition or injuries to lower extremities and the variable height feature allows recipient to ambulate by placing feet on the floor while sitting on edge of bed.
2. Recipient's medical condition is such that they are unable to transfer from bed to wheelchair without assistance**.**
3. Severely debilitating diseases and conditions require the need of the variable height bed to allow recipient to ambulate or transfer.

Heavy Duty

This equipment may be purchased for any qualified Medicaid recipient who meets the above criteria.

E0303 Medicaid covers hospital beds (E0303) heavy duty, extra wide, with any type side rails, with mattress to accommodate weight capacities greater than 350 pounds, but less than 600 pounds.

E0304 Medicaid covers hospital beds (E0304) extra heavy duty, extra wide, with any type side rails, with mattress to accommodate weight capacities greater than 600 pounds. Medicaid will reimburse providers at invoice cost plus 20% for procedure code E0304.

E1399 Replacement mattresses for the heavy duty, extra wide bed or the extra heavy duty bed can be obtained using procedure code E1399.

Prior Authorization

Medicaid will use the established prior authorization criteria for these hospital beds, but will add the weight, width and length requirements. DME providers will ensure that accurate/correct weight, height and length measurement are included with these requests.

If hospital bed is medically necessary and is needed for six months or less, the equipment will be rented. This policy is applicable for all Medicaid recipients. If the equipment continues to be medically necessary and is needed longer than six months another PA request and prescription/order must be submitted documenting the need. If approval is granted a capped rental will be established and previous rental payments will be applied towards the total purchase price of the equipment. Reimbursement will not exceed the total purchase price.

14.2.9 Hospital Bed Accessories

Hospital bed accessories must be prescribed as medically necessary, require prior authorization (in most cases) and medical documentation must be submitted justifying the need.

Prior Authorization

E0275, **E0276,** and **E0621** do not require prior authorization.

NOTE:
For benefit limits refer to the DME Fee Schedule.

Mattress Replacement

E0271: Mattress, innerspring

E0272: Mattress, foam rubber

To qualify for Medicaid reimbursement of a mattress replacement, a physician must prescribe the equipment as medically necessary. This procedure code requires prior authorization. (See Section 14.3.1 Authorization for Durable Medical Equipment.)

Documentation

An eligible recipient must meet the following medical criteria:

- The patient has a safe and adequate hospital bed in his home
- Documentation must be submitted showing the mattress in use is damaged and inadequate to meet the patient's medical needs.

Bed Side Rails

E0305: Bedside rails, half-length

E0310: Bedside rails, full length

A physician must prescribe bedside rails as medically necessary in order for a recipient to qualify for Medicaid reimbursement. This procedure code requires prior authorization. (See Section 14.3.1 Authorization for Durable Medical Equipment.)

Documentation

The recipient must be bed confined and have one or more of the following conditions:

- Disorientation
- Positioning problem
- Vertigo
- Seizure disorder

Recipient Hydraulic Lift With Seat or Sling (E0630)

Electric Patient Lifts with Seat or Sling (E0635)

Recipient hydraulic lifts will be considered for Medicaid payment when prescribed as medically necessary by a physician. This procedure code requires prior authorization. (See Section 14.3.1 Authorization for Durable Medical Equipment.)

Documentation

An eligible recipient must meet the following medical criteria:

- Documentation must indicate the recipient has, or is highly susceptible to decubitus ulcers, and/or:
- The recipient must be essentially bed confined and would require the assistance of more than one person to transfer from bed to chair or wheelchair or commode without a lift.

Medicaid covers electric patient lifts with seat or sling (E0635) to accommodate weight capacities greater than 450 pounds.

Prior Authorization

Medicaid will use the established prior authorization criteria for these electric patient lifts, but will add the weight and width requirements. Individuals approved for these electric lifts must be fitted and measured by the Durable Medical Equipment Company providing these services.

Medicaid will reimburse provider at invoice cost plus 20% for these patient electric lifts (E0635).

E0910 Trapeze Bar, AKA Recipient Helper, Attached to Bed with Grab Bar

To qualify for Medicaid reimbursement of a trapeze bar, the physician must prescribe the equipment as medically necessary for the recipient. This procedure code requires prior authorization. (See Section 14.3.1 Authorization for Durable Medical Equipment.)

Documentation

The recipient must be essentially bed confined and must meet the following documented conditions:

- The recipient must have positioning problems. Documentation must show that the recipient has physical/mental capability of using the equipment for repositioning.
- The recipient must have difficulty getting in and out of bed independently.

E0911: Medicaid covers Trapeze Bar (E0911), heavy duty for patient weight capacity greater than 250 pounds, Attached to Bed with Grab Bar.

E0912: Medicaid covers Trapeze Bar (E0912), heavy duty, for patient weight capacity greater than 250 pounds, Freestanding, complete with Grab Bar.

Prior Authorization

Medicaid will use the established prior authorization criteria for these trapeze bars, but will add the weight requirements. Individuals approved for these trapeze bars must weigh over 250 pounds. Medicaid will reimburse providers at invoice cost plus 20% for procedure code E0912.

NOTE:

For benefit limits refer to the DME Fee Schedule.

14.2.10 Pediatric Bed/Crib

E0300: Pediatric crib, hospital grade, fully enclosed; can have side rails that extend more than 24 inches above the mattress (includes sleep safe type beds)

E0316: Safety enclosure frame/canopy for use with hospital bed, any type
The purchase of a safety enclosure frame, canopy or bubble top may be a benefit when the protective crib top or bubble top is for safety use. It is not considered a benefit when it is used as a restraint or for the convenience of family or caregivers.

E0328: Hospital bed, pediatric manual, 360 degree side enclosures, top of headboard, footboard and side rails up to 24 inches above the spring, includes mattress *(Does not include sleep safe type beds)*

E0329: Hospital bed, pediatric electric or semi-electric, 360 degree side enclosures, top of headboard, footboard and side rails up to 24 inches above the spring, includes mattress *(Does not include sleep safe type beds)*

A pediatric hospital bed or pediatric crib is defined as a fully enclosed with all of the following features:

- Allows adjustment for the head and foot of the bed (manual or semi-electric)
- Headboard
- Footboard
- Mattress
- Side rails of any type (A side rail is defined as a hinged or removable rail, board or panel)
- A bed with side rails that extends 24 inches or less above the mattress is considered a pediatric hospital bed (E0328 or E0329)
- A bed with side rails that extends more than 24 inches above the mattress is considered a pediatric crib (E0300)

Pediatric hospital beds and/or pediatric cribs that do not have all of these features will not be considered for prior authorization and will not be covered through Alabama Medicaid's DME Program.

E1399: Enclosed bed manufactured as a unit (does not include sleep safe bed types)

An enclosed bed is considered medically necessary when the recipient is cognitively impaired and mobile if his/her unrestricted mobility has resulted in documented injuries sustained as a result of wandering unsupervised. Even then, it must be shown that other, less costly methods have been attempted and have failed to effectively treat the problem. Generally, such confinement is not medically necessary nor the least costly way of managing seizures or behaviors such as head banging, rocking, etc. Issues of sensory deprivation and the potential for overuse must be addressed in this process.

Providers must submit documentation to support that the bed/crib system has been approved by the Food and Drug Administration (FDA). ***Enclosed bed systems that are not FDA approved are not covered by Alabama Medicaid.***

Documentation

Medicaid coverage is available for pediatric beds provided the beds are medically necessary and the criteria listed below are met:

1. Diagnosis of one of the following:
    - Brain Injury
    - Moderate to severe cerebral palsy
    - Seizure disorder with daily seizure activity
    - Developmental disability
    - Severe behavioral disorder
    - Documentation of the specific risk from unrestricted mobility including
        - Tonic-clonic type seizures
        - Uncontrolled perpetual movement related to diagnosis
        - Self-injurious behavior
2. Providers must submit documentation to support that the bed/crib systems accommodates child's weight &/or height, and;
3. Less costly alternatives have been tried and rejected. Physician and guardians must attest to the alternative use trials. If no alternative therapies attempted, documentation must explain why. Prescribing physician will be required to submit attestation document.

    Documentation of alternative therapies used shall include the following information:

    - Date(s) used
    - Duration of Use
    - Name of Equipment used
    - Results of use
        - Number of injuries
        - Type of injuries

4. Written monitoring plan approved by the ordering and all treating practitioners which includes, at a minimum, the following information?
    - Time frame/situations for when the bed will be used
    - Methods for monitoring the recipient at specified time intervals
    - Strategies for meeting all of recipient's needs while using the enclosed bed (including eating, hydration, skin care, toileting, and general safety)
    - Identification, by relationship, of all caregivers providing care to the recipient
    - An explanation of how any medical conditions (e.g., seizures) will be managed while the recipient is in the enclosed bed

Medicaid coverage of pediatric beds

If the pediatric bed is medically necessary and is needed for six months or less, the equipment will be rented. If the equipment continues to be medically necessary and is needed longer than six months a capped rental is established, previous rental payments will be applied towards the total purchase price of the equipment. Reimbursement will not exceed the total purchase price (fee schedule) of the equipment. *The PA will govern this process.*

14.2.11 Power Reducing Support Surfaces

Group 1

Group 1 pressure reducing support surfaces are covered for the entire Medicaid population.

Group 1 pressure reducing support surfaces include:

- **E0181**: Powered Pressure Reducing Mattress Overlay/Pad, Alternating With Pump Includes Heavy Duty,
- **E0185**: Gel/Gel-Like Pressure Pad For Mattress,
- **E0182**: Pump For Alternating Pressure Pad, Replacement Only, and
- **A4640**: Replacement Pad for Use With Medically Necessary Alternating Pressure Pad Owned By Patient. (A4640 will be considered for Medicaid payment when prescribed as medically necessary by a physician.)

The gel/gel like pad for mattress (E0185), the pump for alternating pressure pad, replacement only (E0182) and the replacement pad for alternating pressure pad owned by the patient (A4640) are purchased items because they are not considered reusable

Documentation

Medical documentation must be submitted with the prior authorization request justifying the need.

Group 2

Group 2 pressure reducing support surfaces include **E0277**: Powered Pressure-Reducing Air Mattress. **Procedure code E0277 is only covered for children up to the age of 21 through the EPSDT Program.**

Initial approval of the powered pressure-reducing air mattress (E0277) will consist of up to 90 days. If the primary physician documents that the equipment continues to be medically necessary longer than 6 months, a 10 month capped rental to purchase is established, and previous rental payments will be applied towards the total purchase price of the equipment. Rental payments include delivery, in service for caregiver, maintenance, repair and supplies if applicable. Medicaid's reimbursement will not exceed the total purchase price of the equipment.

Continued use of the Group 2 support surface is considered medically necessary until the ulcer is healed or, if healing does not continue, there is documentation in the medical record to show that the use of the Group 2 support surface is medically necessary for wound management.

Prior Authorization: Group 1 and Group 2 power reducing support surfaces require prior authorization.

Effective October 1, 2013, replacement pad for alternating pressure pad (A4640), powered pressure reducing mattress overlay pad/alternating with pump, heavy duty (E0181) and gel mattress overlay (E0185) will only require an initial PA approval. **After the initial approval, these items will be considered purchased and owned by the patient.**

14.2.12 E0570 Nebulizer

The nebulizer is a covered service in the DME program for all recipients. The nebulizer can be provided only if it can be used properly and safely in the home. A physician must prescribe it as medically necessary.

This equipment may be purchased for any qualified Medicaid recipient based on the criteria listed below. Supporting documentation must be retained in supplier's recipient file. Medical information intended to demonstrate compliance with coverage criteria may be included on the prescription/order but must be supported by information contained in the medical record. Supporting documentation, in addition to a prescription/order, may include but not limited to the physician's office records, records from hospitals, nursing facilities, home health agencies, other healthcare professionals, etc.

Age Group	***Purchase or Rental Requirements***
Children 0-18	**Purchases** require documentation of one episode of severe respiratory distress associated with one of the following diagnoses: • Asthma • Reactive Airway Disease • Cystic Fibrosis • Bronchiectasis • Bronchospasm • HIV, Pneumocystosis, or complications of organ transplants or; • first time episodes associated with one of the above diagnoses.
Recipients 19 years of age and above	**Purchases** require medical records documentation of one of the following diagnoses: • Asthma • Bronchiectasis • Cystic Fibrosis • Chronic Obstructive Pulmonary Disease or Emphysema • HIV, Pneumocystosis, or complications of organ transplants • Acute complications of pneumonia • Recipients with a diagnosis of asthma must have documentation of one of the following: • The recipient has had a failed trial of at least four weeks of inhaled or oral anti-inflammatory drugs and inhaled bronchodilators. • The recipient is a moderate or severe asthmatic whose rescue treatment with MDIs is insufficient to prevent hospitalizations or emergency room visits (2 or more ER visits for asthma or 1 or more hospitalizations in the past 12 months).
Children and recipients 19 years of age and above	**Purchases** may be approved to deliver medications that can be administered only by aerosol (i.e. Pulmozyme for cystic fibrosis) and administered as an alternative to intravenous administration of those drugs (for example, nebulized tobramycin, colistin, or gentamicin).

14.2.13 Iron Chelation Therapy Equipment

Documentation

Iron Chelation Therapy equipment will be considered for Medicaid payment when prescribed as medically necessary by a physician for an eligible recipient who meets the following criteria:

- Documentation must be submitted indicating the recipient has been diagnosed as having Sickle Cell Disease.

Prior Authorization

This procedure code requires prior authorization. (See Section 14.3.1 Authorization for Durable Medical Equipment.) This includes the Auto-Syringe Infusion Pump for Iron Chelation Therapy **(E0779),** Supplies for the infusion pump **(A4222)** and the Auto-Infusion Pump Repair for Iron Chelation Therapy (**E1399** & **K0739**).

Iron Chelation Therapy equipment will be purchased for any qualified Medicaid recipient who meets the above criteria. The information submitted must include documentation that the recipient meets the above criteria.

14.2.14 Augmentative Communication Devices

Augmentative Communication Devices (ACDs) are defined as portable electronic or non-electronic aids, devices, or systems for the purpose of assisting a Medicaid eligible recipient to overcome or improve severe expressive speech-language impairments/limitations due to medical conditions in which speech is not expected to be restored. These devices also enable the recipient to communicate effectively.

These impairments include but are not limited to apraxia of speech, dysarthria, and cognitive communication disabilities. ACDs are reusable equipment items that must be a necessary part of the treatment plan consistent with the diagnosis, condition or injury, and not furnished for the convenience of the recipient or his family. Medicaid will not provide reimbursement for ACDs prescribed or intended primarily for vocational, social, or academic development/enhancement.

E2500 Speech generating device digitized speech using pre-recorded messages, less than or equal to eight minutes recording time.

E2502 Speech generating device, digitized speech using pre-recorded messages greater than 8 minutes, but less than or equal to 20 minutes recording time.

E2504 Speech generating device, digitized speech using pre-recorded messages greater than 20 minutes, but less than or equal to 40 minutes recording time.

E2506 Speech generating device, digitized speech using pre-recorded messages greater than 40 minutes recording time.

E2508 Speech generating device, synthesized speech requiring message formulation by spelling and access by physical contact with the device.

E2510 Speech generating device, synthesized speech permitting multiple methods of message formulation and access by physical contact with the device.

E2511 Speech generating software program, for personal computer or personal digital assistant.

E2512 Accessory for speech generating device**,** mounting system.

E2599 Accessory for speech generating device not otherwise classified.

V5336 Repair modification of augmentative communication system or device (excludes adaptive hearing aid).

Scope of services includes the following elements:

- Screening and evaluation
- ACD, subject to limitations
- Training on use of equipment

These are inclusive in the allowable charge and may not be billed separately.

Candidacy Criteria

Candidates must meet the following criteria:

Age	*Candidacy Criteria*
Under age 21	• EPSDT referral by Medicaid enrolled EPSDT provider. • Referral must be within one year of application for ACD. The EPSDT provider must obtain a referral from the Patient 1st Primary Medical Provider where applicable • Medical condition which impairs ability to communicate • Evaluation required by qualified, experienced professional • Physician prescription/order to be obtained after the evaluation and based on documentation contained in evaluation.
Adults, age 21+	• Referral from a primary care physician (Patient 1st PMP where applicable). • Referral must be within one year of application for ACD • Medical condition which impairs ability to communicate Evaluation by required qualified experienced professionals • Physician prescription/order to be obtained after the evaluation and based on documentation provided in the evaluation.

Evaluation Criteria

Qualified interdisciplinary professionals must evaluate the candidate. Qualified interdisciplinary professionals include:

A. Interdisciplinary professionals include a speech-language pathologist and a physician.

1. Qualifications for a speech-language pathologist include:
   - Master's degree from accredited institution
   - Certificate of Clinical Competence in speech/language pathology from the American Speech, Language, and Hearing Association
   - Alabama license in speech/language pathology
   - No financial or other affiliation with a vendor, manufacturer or manufacturer's representative of ACDs
   - Current continuing education in the area of Augmentative Communication
2. A Physician must possess the following qualifications:
   - Be a doctor of medicine or osteopathy legally authorized to practice medicine and surgery by the state in which the doctor performs such functions; and

- Have no financial or other affiliations with vendors, manufacturers, or other manufacturer's representative of ACDs.

B. Interdisciplinary professionals should also include, but may not be limited to, a physical therapist, social worker, and/or occupational therapist.

1. A physical therapist must possess the following qualifications:
   - Bachelor's degree in Physical Therapy from accredited institution
   - Alabama license in Physical Therapy
   - No financial or other affiliation with a vendor, manufacturer or manufacturer's representative of ACDs
2. A social worker must possess the following qualifications:
   - Bachelor's degree from accredited institution
   - Alabama license in Social Work
   - No financial or other affiliation with a vendor, manufacturer or manufacturer's representative of ACDs
3. An occupational therapist must possess the following qualifications:
   - Bachelor's degree in Occupational Therapy from accredited institution
   - Alabama license in Occupational Therapy
   - No financial or other affiliation with a vendor, manufacturer or manufacturer's representative of ACDs

Prior Authorization

ACDs and services are available only through the Alabama Medicaid prior authorization process. Requests for authorization must be submitted to Medicaid for review. Documentation must support that the client is mentally, physically and emotionally capable of operating/using an ACD. The request must include documentation regarding the medical evaluation by the physician and recipient information.

Medical examination by a physician is required to assess the need for an ACD to replace or support the recipient's capacity to communicate. The examination should cover:

- Status of respiration
- Hearing
- Vision
- Head control
- Trunk stability
- Arm movement
- Ambulation
- Seating/positioning
- Ability to access the device

The evaluation must be conducted within 90 days of the request for an ACD.

Providers should utilize the Augmentative Communication Device Evaluation Form on the website at this link, http://medicaid.alabama.gov/documents/5.0_Resources/5.4_Forms_Library/5.4.1 Billing/5.4.1_FILLABLE_ACD_Eval_Report_Form_3-29-11.pdf.

Medicaid requires the following recipient information with the prior authorization request:

Topic	***Information required for the PA***
Identifying information	• Name • Medicaid recipient number • Date(s) of Assessment • Medical diagnosis (primary, secondary, tertiary) • Relevant medical history
Sensory status (As observed by physician)	• Vision • Hearing • Description of how vision, hearing, tactile and/or receptive communication impairments affect expressive communication (e.g., sensory integration, visual discrimination)
Postural, Mobility & Motor Status	• Motor status • Optimal positioning • Integration of mobility with ACD • Recipient's access methods (and options) for ACD
Development Status	• Information on the recipient's intellectual/cognitive/development status • Determination of learning style (e.g., behavior, activity level)
Family/Caregiver and Community Support Systems	A detailed description identifying caregivers and support, the extent of their participation in assisting the recipient with use of the ACD, and their understanding of the use and their expectations
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 • Communication behaviors and interaction skills (i.e. styles and patterns) • Description of current communication strategies, including use of an ACD, if any • Previous treatment of communication problems
Communication Needs Inventory	• Description of recipient's current and projected (for example, within 5 years) speech-language needs • Communication partners and tasks, including partner's communication abilities and limitations, if any • Communication environments and constraints which affect ACD selection and/or features
Summary of Recipient Limitations	Description of the communication limitations
ACD Assessment Components	Justification for and use to be made of each component and accessory requested
Identification of the ACDs Considered for Recipient-Must Include at Least Three (3)	• Identification of the significant characteristics and features of the ACDs considered for the recipient • Identification of the cost of the ACDs considered for the recipient (including all required components, accessories, peripherals, and supplies, as appropriate) • Identification of manufacturer • Justification stating why a device is the least costly, equally effective alternative form of treatment for recipient • Medical justification of device preference, if any

Topic	*Information required for the PA*
Treatment Plan & Follow Up	• Description of short term and long term therapy goals • Assessment criteria to measure the recipient's progress toward achieving short and long term communication goals • Expected outcomes and description of how device will contribute to these outcomes • Training plan to maximize use of ACD
Additional Documentation	• Documentation of recipient's trial use of equipment including amount of time, location, analysis of ability to use • Documentation of qualifications of speech language pathologists and other professionals submitting portions of evaluation. Physicians are exempt from this requirement. • Signed statement that submitting professionals have no financial or other affiliation with manufacturer, vendor, or sales representative of ACDs. One statement signed by all professionals will suffice.

NOTE:

Medicaid reserves the right to request additional information and/or evaluations by appropriate professionals.

Limits

ACDs including components and accessories will be modified or replaced only under the following circumstances:

- Medical Change: Upon the request of recipient if a significant medical change occurs in the recipient's condition that significantly alters the effectiveness of the device.
- Age of Equipment: ACDs outside the manufacturer's or other applicable warranty that do not operate to capacity will be repaired. At such time as repair is no longer cost effective, replacement of identical or comparable component or components will be made upon the request of the recipient. Full documentation of the history of the service, maintenance, and repair of the device must accompany such request.
- Technological Advances: No replacements or modifications will be approved based on technological advances unless the new technology would meet a significant medical need of the recipient which is currently unmet by present device.

All requests for replacement or modification as outlined above require a new evaluation and complete documentation. If new equipment is approved, old equipment must be returned.

Other Information

Topic	*Required for the PA*
Invoice	The prior authorization request and the manufacturer's invoice must be forwarded to Medicaid's Fiscal Agent Prior Authorization department.
Trial Period	No communication components will be approved unless the client has used the equipment and demonstrated an ability to use the equipment. Prior authorization for rental may be obtained for a trial period. This demonstrated ability can be documented through periodic use of sample/demonstration equipment. Adequate supporting documentation must accompany the request. Prior authorizations for rental of ACD device E2510 may be approved for a four (4) week trial period of usage by the recipient. The manufacturer must agree to this trial period. Medicaid will reimburse the manufacturer for the dollar amount authorized by the Agency for the four (4) week trial period. This amount will be deducted from the total purchase price of the ACD device.
Repair	Repairs are covered only to the extent not covered by manufacturers' warranty. Repairs must be prior approved and billed using procedure code V5336. Battery replacement is not considered repair but does require prior authorization using procedure code E2599.
Loss/Damage	Replacement of identical components due to loss or damage must be prior approved. These requests will be considered only if the loss or damage is not the result of misuse, neglect, or malicious acts by the users.
Component / Accessory Limits	No components or accessories will be approved that are not medically required. Examples of non-covered items include but are not limited to the following: • Printers • Modems • Service contracts • Office/business software • Software intended for academic purposes • Workstations • Any accessory that is not medically required.

The ACD device must be tailored to meet each individual recipient's needs. Therefore, a recipient may need to try more than one device until one is suitable to meet their needs is identified. The Medicaid Agency will allow rental of the device, on a week to week basis, for a maximum one month with a maximum rental cap amount. The amount paid for this rental will be deducted from the total purchase price of the ACD device. The procedure code for one month rental of this device is E2510 (RR).

14.2.15 Wheelchairs

To qualify for Medicaid reimbursement of a wheelchair, the physician must prescribe the equipment as medically necessary for the recipient. These procedure codes require prior authorization. (See Section 14.3.1 Authorization for Durable Medical Equipment.)

Documentation

The recipient must be essentially bed confined and must meet the following documented conditions:

- The recipient must be essentially chair confined or bed/chair confined.
- The wheelchair is expected to increase mobility and independence.

Effective October 1, 2011, Medicaid's Motorized/Power Wheelchair Assessment Form 384 must be completed with all prior authorization requests for **Manual Wheelchairs** with additional accessories for adults. This form must be completed an Alabama licensed Physical Therapist (PT) or Occupational Therapist (OT) who has experience and training in mobility evaluations and is employed by a Medicaid enrolled hospital outpatient department. This form is located on the Agency's website at www.medicaid.alabama.gov.

Standard Wheelchair

A standard wheelchair should be requested unless documentation supports the need for any variation from the standard wheelchair. An example of this variation is an obese recipient who requires the wide heavy-duty wheelchair (E1093). For a list of valid wheelchair procedure codes, refer Appendix P, Durable Medical Equipment (DME) Procedure Codes and Modifiers.

Heavy Duty Wheelchairs

K0007 Medicaid reimburses Durable Medical Equipment providers for Extra Heavy Duty Wheelchairs. These wheelchairs accommodate weight capacities up to 600 lbs. Medicaid covers these wheelchairs as a purchase by using HCPCS code K0007.

K0009 Medicaid covers the 'Other manual wheelchair/base' (K0009) to accommodate weight capacity of 600 pounds or greater. Medicaid will reimburse for procedure code K0009 at provider's invoice price plus 20%.

Medicaid will require weight, width and depth specification for procedure codes K0007 and K0009.

K0108 The 'Wheelchair component or accessory not otherwise specified' for the wheelchair will be covered using procedure code K0108. The established prior authorization criteria for these specified codes will be used.

NOTE:

The provider must ensure that the wheelchair is adequate to meet the recipient's need. For instance, providers should obtain measurements of obese recipients to ascertain body width for issuance of a properly fitted wheelchair.

This equipment may be purchased for any qualified Medicaid recipient who meets the above criteria. This equipment may also be rented for any eligible Medicaid recipient. The information submitted must include documentation that the recipient meets the above medical criteria.

Motorized/Power Wheelchairs

The Alabama Medicaid Agency covers motorized/power wheelchairs for the entire Medicaid population. To qualify for motorized/power wheelchairs an individual must meet full Medicaid financial eligibility and established medical criteria. All requests for motorized/power wheelchairs are subject to Medicaid Prior authorization provisions established by the Alabama Medicaid Agency. The patient must meet criteria applicable to manual wheelchairs pursuant to the Alabama Medicaid Agency Administrative Code Rule No. 560-X-13-.17.

HCPCS K0813 through K0816, K0820 through K0831, K0835 through K0843, K0848 through K0864, K0868 through K0871, K0877 through K0880, K0884 through K0886, K0890, K0891, and K0898 will be used as appropriate for related motorized wheelchairs.

Providers must use an appropriate code for power/custom manual wheelchairs and accessories if one is available. If there is no appropriate code then the provider can use K0108. All prior authorization requests submitted using procedure code K0108 will be reviewed to ensure that there is not another code available.

Documentation

The attending physician must provide documentation that a manual wheelchair cannot meet the individual's medical needs, and the patient requires the motorized/power wheelchair for six (6) months or longer.

Prior Authorization

The following is the process for obtaining prior approval of a motorized/power wheelchair and accessories:

- The attending physician must provide the patient with a prescription/order for the motorized/power wheelchair.
- The attending physician must provide medical documentation that describes the medical reason(s) why a motorized/power wheelchair is medically necessary. The medical documentation should also include diagnoses, assessment of medical needs, and a plan of care.
- The patient must choose a Durable Medical Equipment (DME) provider that will provide the wheelchair.
- The DME provider should arrange to have the Alabama Medicaid Agency **Motorized/Power Wheelchair Assessment Form 384** completed by an Alabama licensed physical therapist or occupational therapist who is employed by a Medicaid enrolled hospital outpatient department (unless otherwise approved by Alabama Medicaid). (This form is located on the Agency's website: www.medicaid.alabama.gov.) The Form 384 is considered outdated by Medicaid when it is presented to the DME provider/ Medicaid's Fiscal Agent past 90 days from the date the PT evaluation was completed. If the Form 384 was received timely for the initial request but the PA is denied and the Form 384 becomes outdated, the provider should submit an amendment in the form of a memo or letter with the reconsideration documents. The amendment should verify that there have been no significant change(s) to the recipient's condition since the completion of the evaluation and that the requested wheelchair and accessories are still appropriate to meet the recipient's mobility needs. **The physical therapist's evaluation is paid separately and is not the responsibility of the DME provider.** Reimbursement is only available for physical therapists and occupational therapists employed by a Medicaid enrolled hospital through the hospital outpatient department. An occupational therapist (OT) or a physical therapist (PT) not employed by a Medicaid enrolled hospital may perform the wheelchair assessment without any reimbursement from the Alabama Medicaid Agency. The OT/PT performing the wheelchair assessment may not be employed with the DME Company or contracted with the DME Company requesting the physical therapy evaluation. If it is determined that the OT/PT is affiliated with the

DME Company, and the OT/PT will be penalized and referred to the Alabama Medicaid Fraud Control Unit.

- The DME provider must complete the Alabama Medicaid Agency **Prior Authorization Form 342**. This form may be submitted electronically or hard copy. If form 342 is submitted electronically, all attachments which include medical documentation from the physician and a completed Form 384 must be sent to Medicaid's Fiscal Agent along with a copy of the prior authorization response which providers receive after their initial electronic PA submission. This information may be mailed to HPE, Prior Authorization Unit, P. O. Box 244032, Montgomery, Alabama 36124-4032 or faxed to (334) 215-4298 within 48 hours of the electronic PA submission.

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- PA requests for a power wheelchair must provide documentation that the recipient is able to independently use the requested item, either through a trial of the equipment (strongly recommended), or information to substantiate this ability. Information may be documented on the Wheelchair/ Seating Evaluation Form (Form 384).
- Alabama Medicaid Agency or designated contractor may request additional information to support the appropriateness of this request. Additionally, a request for a trial may be required to determine if the recipient(s) can independently operate the wheelchair.
- The DME provider must ensure that the prior authorization request for the motorized/power wheelchair includes the product's model number, product name the name of the manufacturer. Providers must submit an itemized list of wheelchair/wheelchair accessory codes and pricing with the prior authorization request.

Effective July 1, 2009, prior authorization requests for wheelchairs received will no longer require providers to submit signed delivery tickets for wheelchairs to Alabama Medicaid before the prior authorization (PA) request is placed in an approved status in the Alabama Medicaid Interchange PA System. ***However, a signed delivery ticket must be in the recipient's record for auditing purposes.*** If a recipient's record is audited and there is no signed delivery ticket showing proof of delivery of the wheelchair, Alabama Medicaid will recoup all monies paid for the wheelchair.

Requests for EPSDT-referred specialized wheelchair systems

Medicaid uses Medicare-based allowables for EPSDT-referred wheelchair systems. If no Medicare price is available, reimbursement rates established by Medicaid for EPSDT-referred wheelchair systems are based on a discount from Manufacturers Suggested Retail Price (MSRP) instead of a "cost-plus" basis.

Providers are required to submit available MSRPs from three manufacturers for wheelchair systems (excluding seating system and add-on products) appropriate for the individual's medical needs.

Requests submitted with fewer than three prices from different manufacturers must contain documentation supporting the appropriateness and reasonableness of requested equipment for a follow-up review by Medicaid professional staff. Provider must document non-availability of required MSRPs to justify not sending in three prices.

The established rate will be based on the MSRP minus the following discounts:

- Manual Wheelchair Systems - 20% discount from MSRP
- Power Wheelchair Systems - 15% discount from MSRP
- Ancillary (add-on) products - 20% discount from MSRP

Effective May 1, 2011, and thereafter, DME providers will no longer submit PA request for custom wheelchairs and custom wheelchair accessories for children age 0-20 using procedure code E1220. DME providers will be required to use valid procedure codes, from the DME Fee Schedule, when submitting prior authorization requests for custom wheelchairs and custom wheelchair accessories for children age 0-20, whenever possible. DME providers may use procedure code K0108 (wheelchair component or accessory, not otherwise specified), for wheelchair accessories that have no valid procedure code listed on the DME Fee Schedule.

Complex Rehabilitation Technology (CRT) Category

Effective October 1, 2012, Alabama Medicaid provides recognition for individually configured complex rehabilitation technology (CRT) products and services for complex needs patients under the age of 21. These HCPCS codes include complex rehabilitation power wheelchairs, highly configurable manual wheelchairs, adaptive seating and positioning systems, and other specialized equipment such as standing frames and gait trainers. Refer to Appendix P, Durable Medical Equipment (DME) Procedure Codes and Modifiers, for applicable CRT procedure codes.

Wheelchair Repairs

Suppliers providing motorized/power wheelchairs or subsequent repairs/replacement parts to recipients must have at least one employee with certification from Rehabilitation Engineering and assistive Technology Society of North America (RESNA) or registered with the National Registry of Rehab Technology Suppliers (NRRTS). The NRRTS or RESNA certified professional must have direct in person involvement in the wheelchair selection for the patient. RESNA certifications must be updated every two years. NRRTS certifications must be updated annually. If the NRRTS or-RESNA's certification is found not to be current, Alabama Medicaid's Prior Authorization Contractor will deny the PA request for the wheelchair. For information regarding certification through RESNA call (703) 524-6686, extension 314.

Prior Authorization

Repairs and/or replacement of parts for motorized/power wheelchairs will require prior authorization by the Alabama Medicaid Agency. Prior authorization may be granted for repairs and replacement parts for motorized/power wheelchairs not previously paid for by Medicaid and those prior authorized through the EPSDT program. Wheelchair repairs and replacement parts for motorized/power wheelchairs may be covered using the appropriate HCPCS code listed in Section 14.5.3 under Wheelchair Accessories.

- Home/environmental and vehicle adaption's, equipment and modifications for wheelchair accessibility are not covered.

Reimbursement may be made for up to one month for a rental of a wheelchair using procedure code K0462 while patient owned wheelchair is being repaired. When submitting prior authorization (PA) request for loaner wheelchairs providers must submit the appropriate procedure code for the loaner wheelchair dispensed. Alabama Medicaid will then establish the monthly rental at 80% of Medicare's allowable price for the wheelchair code. If loaner wheelchair is not needed for the entire month the wheelchair rental fee will be prorated on a daily basis. When submitting the claim to Medicaid's Fiscal Agent for payment, providers must bill using procedure code K0462 with the Medicaid established rate as it appears on the PA approval form.

14.2.16 Wheelchair Low Pressure and Positioning Equalization Pad

E2603 Skin protection wheelchair seat cushion, width less than 22 in, any depth

E2604 Skin protection wheelchair seat cushion, width 22 in or greater, any depth

To qualify for Medicaid reimbursement of a low pressure equalization pad, the equipment must be prescribed as medically necessary for the recipient by the physician. These procedure codes require prior authorization. (See Section 14.3.1 Authorization for Durable Medical Equipment.)

Documentation

To qualify for Medicaid reimbursement or a Low Pressure and Positioning Equalization Pad for a wheelchair, the recipient must meet the following **documented** criteria:

- A licensed physician must prescribe the equipment as medically necessary.
- Recipient must have decubitus ulcer or skin breakdown.
- Recipient must be essentially bed/wheelchair confined.

This equipment may be purchased for any qualified Medicaid recipient who meets the above criteria. This equipment may also be rented for any recipient under the age of 21 who is referred through the EPSDT Program. The information submitted must include documentation that the recipient meets the above medical criteria.

K0108

Medicaid also reimburses Durable Medical Equipment providers for the ROHO Cushions for the Extra Heavy Duty Wheelchair. This wheelchair cushion is covered as a purchase through Medicaid using Medicare's procedure code K0108. This HCPCS code may be used to cover wheelchair cushions for obese individuals who could not use HCPCS codes E2603 and E2604.

NOTE:
Medicaid will use the established prior authorization criteria for the Extra Heavy Duty Wheelchair and ROHO Cushion, but we will add weight, width and depth specifications. Individuals approved for these items must be fitted and measured for wheelchair and cushion by the Durable Medical Equipment Company providing these services.

14.2.17 Oxygen

Oxygen is necessary for life. When we breathe in, oxygen enters the lung and goes into the blood. When the lungs cannot transfer enough oxygen into the blood to sustain life, an oxygen program may be necessary.

NOTE:

Include a copy of the Oxygen Certification Form (Form 360) with oxygen requests. This form is used for initial certification, recertification, and changes in the oxygen prescription/order. This form must be filled out, signed and dated by the ordering physician.

Prior Authorization

Oxygen therapy is a covered service for the entire Medicaid population based on medical necessity and requires prior authorization. (See section 14.3.1 Authorization for Durable Medical Equipment) The DME provider will be notified in writing of the assigned effective date and additional justification requirements if applicable.

In order to receive a prior authorization number, Forms 360 and 342 must be completed and submitted to Medicaid's Fiscal Agent. Oxygen therapy is based on the degree of desaturation and/or hypoxemia. **Oxygen will not be approved for PRN use only.**

Documentation

To assess patient's need for oxygen therapy, the following criteria must be met:

a. The medical diagnosis must indicate a chronic debilitating medical condition, with evidence that other forms of treatment (such as medical and physical therapy directed at secretions, bronchospasm and infection) were tried without success, and that continuous oxygen therapy is required.

b. Recipients must meet the following criteria:

   i. Adults with a current **ABG** with a **PO2 at or below 59 mm Hg** or an **oxygen saturation at or below 89 percent**, taken at rest, breathing room air. If the attending physician certifies that an ABG procedure is unsafe for a patient, an oximetry for SaO2 may be performed instead. Pulse oximetry readings on adults will be considered only in unusual circumstances. Should pulse oximetry be performed, the prescribing physician must document why oximetry reading is necessary instead of arterial blood gas.

   ii. Recipients 20 years old or less with **a SaO2 level:**

      - **For ages birth through three years, equal to or less than 94%**
      - **For ages four and above equal to or less than 89%**

c. The physician must have seen the recipient and obtained the ABG or SaO2 **within 6 months** of prescribing oxygen therapy. Submission of a copy of a report from inpatient or outpatient hospital or emergency room setting will also meet this requirement. Prescriptions/orders for oxygen therapy must include **all of the following**:

   i. type of oxygen equipment

   ii. oxygen flow rate or concentration level

iii. frequency and duration of use

iv. estimate of the period of need

v. circumstances under which oxygen is to be used

d. Medical necessity initial approval is an approval for no more than three months. To renew approval, ABG or oximetry is required within the third month of the initial approval period. Approval for up to 12 months will be granted at this time if resulting pO2 values or SaO2 levels continue to meet criteria. If ABG or oximetry is not obtained within the third month of the initial approval period or in the case of a subsequent recertification requests within 6 months prior to the end of the current certification period, approval will be granted beginning with the date of the qualifying ABG or oximetry reading.

e. Criteria for equipment reimbursement

i. Oxygen concentrators will be considered for users requiring one or more tanks per month of compressed gas (stationary unit). Prior approval requests will automatically be subjected to a review to determine if a concentrator will be most cost effective.

ii. Reimbursement will be made for portable O2 only in gaseous form. Medicaid will cover portable oxygen for limited uses such as physician visits or trips to the hospital. This **must** be stated as such on the medical necessity or prior approval request. Portable systems that are used on a standby basis only will not be approved. **Only one portable system (E0431) consisting of one tank and up to four refills (E0443) per month will be approved based on a review of submitted medical justification.** An example of justification for refills includes, but is not limited to, multiple weekly visits for radiation or chemotherapy.

iii. **E1392:** A portable oxygen concentrator may be approved if the reimbursement is more cost effective than a tank and multiple refills. The portable oxygen concentrator must accommodate the oxygen flow rate prescribed for the recipient and the time needed for portable oxygen, e.g. medical appointments.

- If a recipient requires more than one refill (E0443), the provider must submit justification as to why the portable concentrator does not meet recipient's needs. If not documented, the recipient must be provided a portable concentrator.

Medicaid will reimburse for only one stationary system.

iv. **For initial certification for oxygen the DME supplier, and its employees, may not perform the ABG study or oximetry analysis used to determine medical necessity**.

v. Effective January 1, 2005 for recertification for oxygen only following qualifying sleep study which allows for approval of nocturnal oxygen, the DME supplier may perform the oximetry analysis to determine continued medical necessity for recipients receiving nocturnal oxygen only. A printed download of the oximetry results must be submitted with a prior authorization request. Handwritten results will not be accepted.

NOTE:

There are no restrictions related to oxygen flow rate and eligibility for oxygen coverage. The restriction is related **only** to the procedure codes covered.

Only one portable system consisting of one tank and up to four refills per month will be approved based on a review of submitted medical justification.

At initial certification for continuous oxygen an ABG or O2Sat is acceptable. For initial certification of nocturnal oxygen a sleep study is required. At recertification for continuous oxygen an ABG or O2 Sat is acceptable. For recertification of nocturnal oxygen an overnight oximetry reading is acceptable.

14.2.18 Pulse Oximeter

E0445: Pulse oximetry is a non-invasive method of determining blood oxygen saturation levels to assist with determining the amount of supplemental oxygen needed by the patient.

Pulse oximeters are a covered service for EPSDT eligible individuals who are already approved for supplemental home oxygen systems and whose blood saturation levels fluctuate, thus requiring continuous or intermittent monitoring to adjust oxygen delivery.

Prior Authorization

This procedure code requires prior authorization. (See Section 14.3.1 Authorization for Durable Medical Equipment)

To receive prior authorization, submit a written request to include, but not limited to, all the following requirements:

- A completed Form 342 with required supportive documentation
- Copy of EPSDT form/referral
- Copy of prior approval form for home oxygen (Form 360)

The use of home pulse oximetry, for pediatric patients, is considered medically appropriate if one of the following criteria in documentation requirements A is met in addition to the documentation requirements in B:

Documentation Requirements A:

1. Patient is ventilator dependent with supplemental oxygen required; or
2. Patient has a tracheostomy and is dependent on supplemental oxygen; or
3. Patient requires supplemental oxygen per Alabama Medicaid criteria (see below) and has unstable saturations[1]; or
4. [1]Patient is on supplemental oxygen and weaning is in process; or

[1]Unstable saturations are documented desaturations which require adjustments in the supplemental oxygen flow rates to maintain saturation values. This should be documented to have occurred at least once in a 60 day period immediately preceding the request for certification/recertification.

5. Patient is diagnosed with a serious respiratory diagnosis and requires short term[2] oximetry to rule out hypoxemia and/or to determine the need for supplemental oxygen.

Documentation Requirements B:

The following documentation is required:

1. **Pulse oximetry evaluations**. To qualify, from birth through three years must have a SaO2 equal to or less than 94%. Recipients age four and above must have a SaO2 equal to or less than 89%. Conditions under which lab results were obtained must be specified. When multiple pulse oximetry readings are obtained the qualifying desaturations must occur for five or more minutes (cumulative desaturation time) to qualify. Pulse oximetry evaluations are acceptable when ordered by the attending physician, and performed under his/her supervision, or when performed by a qualified provider or supplier of laboratory services. **A DME supplier is not a qualified provider of lab services.**
2. **Plan of Care.** A plan of care updated within 30 days of request must be submitted to include, at a minimum, plans for training the family or caregiver: The training plan shall provide specific instructions on appropriate responses for different scenarios, i.e., what to do when O2 sats are below 89%.

Initial approval will consist of up to 90 days only. For requests secondary to the need to determine the appropriateness of home oxygen liter flow rates, to rule out hypoxemia and/or to determine the need for supplemental oxygen, approval will be granted for up to 30 days only. Renewal may be requested for patients already approved for oxygen coverage by the Alabama Medicaid Agency. Documentation may also include written or printed results of pulse oximetry readings obtained within the last month with documentation of condition(s) present when readings were obtained. Renewal may be granted for up to a seven-month period for patients receiving oxygen coverage through Alabama Medicaid.

Qualifying Diagnoses:

Lung disease, including but not limited to interstitial lung disease, cancer of the lung, cystic fibrosis bronchiectasis.

- Hypoxia related symptoms/conditions, such as pulmonary hypertension
- Recurrent CHF secondary to cor pulmonale
- Erythrocytosis
- Sickle cell disease
- Severe Asthma
- Hypoplastic heart disease
- Suspected sleep apnea or nocturnal hypoxia
- Other diagnoses with medical justification

Medicaid Coverage for Pulse Oximeter

The Pulse Oximeter must be an electric desk top model with battery backup, alarm systems, memory and have the capacity to print downloaded oximeter

[2]Short-term is defined as monitoring/evaluation for up to 30 days. “Spot oximetry” is not covered under this policy.

readings. Downloads for each month of the most current certification period are required for all recertification requests. Recertification is required until the recipient no longer meets criteria or the device is removed from the home. If the pulse oximeter is no longer medically necessary (criteria no longer met), the oximeter will be returned to the supplier and may be rented to another client who meets criteria for pulse oximeter.

This device will be rented for up to three months during the initial certification period. If this device is needed beyond the initial certification period, the equipment will then become a rental to purchase item for an additional seven month period. The monthly payment will include delivery, in-service for the caregiver, maintenance, repair, supplies and 24-hour service calls. After the ten month rental period, the equipment is paid in full and no additional payment will be made by Alabama Medicaid. The pulse oximeter will be considered to be owned by the recipient.

Medicaid will pay for repair of the pulse oximeter after the initial 10 months only to the extent not covered by the manufacturer's warranty. Repairs must be prior authorized and the necessary documentation to substantiate the need for repairs must be submitted to Medicaid's Fiscal Agent who will forward this information to Medicaid's Prior Authorization Unit. In addition, one reusable probe per recipient per year will be allowed after the initial 10 months capped rental period.

Limitations

Diagnoses not covered:

- Shortness of breath without evidence of hypoxemia
- Peripheral Vascular Disease
- Terminal illnesses not affecting the lungs, such as cancer not affecting the lungs or heart disease with any evidence of heart failure or pulmonary involvement.

Pulse oximeter requests for renewal will not be approved after the initial monitoring/evaluation period for those recipients not meeting criteria for oxygen coverage. Spot oximetry readings are non-covered service under the DME program.

14.2.19 Pulse Oximeter Supplies

Supplies for the Pulse Oximeter will only be paid for by Medicaid after completion of the ten month rental period.

A4606 - non disposable probe

A4606 – disposable probe

NOTE:
When requesting disposable probes medical documentation must be submitted justifying the need for disposable probes. The documentation must show why a disposable probe is medically necessary.

14.2.20 Volume Ventilator – Stationary or Portable (E0450, E0461-R) and Pressure Ventilator – (E0463, E0464-R)

Volume Ventilators are stationary or portable, with backup rate feature, and used with non-invasive interface or invasive interface (e.g., tracheostomy tube). Non-invasive volume ventilators are laptop sized, designed for homecare and allows maximum mobility.

Pressure ventilators weigh about 12.4 pounds which enables the user to be mobile and contain pressure control, pressure support and flow triggering features. These devices decrease the work of breathing while increasing patient comfort.

Prior Authorization

The procedure code requires prior authorization. (See Section 14.3.1 Authorization for Durable Medical Equipment)

Documentation

Volume ventilator and pressure ventilators are covered for children with an EPSDT screening when prescribed by a physician as medically necessary:

The recipient must meet the following conditions:

- Medically dependent on a ventilator for life support at least 6 hours a day
- Dependent for at least 30 consecutive days (or the maximum number of days authorized under the State Plan, whichever is less) as an inpatient in one or more hospitals, NFs, or ICFs/IID;
- Except for the availability of respiratory care services (ventilator equipment) would require respiratory care as an inpatient in a hospital, NF, or ICF/IID and would be eligible to have payment made for inpatient care under the state plan.
- Adequate social support services to be cared for at home are available.
- Receives services under the direction of a physician who is familiar with the technical and medical components of home ventilator support, and who has medically determined that in-home care is safe and feasible for the individual without continuous technical or professional supervision. (Reference 42 CFR Section 440.185 Respiratory care for ventilator-dependent individuals.)

and

Patient has at least one or more of the following conditions:

a. Chronic respiratory failure

b. Spinal cord injury

c. Chronic pulmonary disorders

d. Neuromuscular disorders, or

e. Other neurological disorders and thoracic restrictive diseases.

Initial approval will be allowed for up to 12 months based on the EPSDT screening.

Subsequent approvals will require documentation from the physician which substantiates that the recipient continues to meet the medical criteria and indicate the recipient's overall condition has not improved sufficiently.

The ventilator will be reimbursed as a monthly rental item. The monthly rental includes delivery, in-service for caregiver, maintenance, a backup ventilator, back up battery, all medically necessary supplies, and repairs and on call service as necessary. Recertification is required until the recipient no longer meets the criteria or the device is removed from the home. If the ventilator is no longer medically necessary (i.e., the criteria is no longer met) it will be returned to the supplier.

14.2.21 Continuous Positive Airway Pressure (CPAP) Device

Supplies for CPAP Device - A7030, A7031, A7032, A7033, A7034, A7035, A7036, A7037, A7038, A7039, A7044 and A7046

E0601 The Continuous Positive Airflow Pressure (CPAP) devices are designed to deliver slightly pressurized air to keep the throat open during the night. The device itself weighs about five pounds and fits on a bedside table. A mask containing tubing connects to the device and fits over the nose. Air is delivered by a mask covering the nose or through prongs that fit inside the nose. In addition, the machine supplies a steady stream of air through the tubes and applies sufficient air pressure to prevent tissues in the airway from collapsing during sleep when a person inhales.

Prior Authorization

CPAP therapy is covered through the EPSDT Program for children up to the age of 21 and requires prior authorization.

Documentation

Diagnosis must be documented by a sleep study performed by a registered or approved sleep laboratory. CPAP therapy is considered medically appropriate if the conditions listed below are met and the documentation requirements listed below are submitted:

A physician either specializing in pulmonary, neurology or a board certified sleep specialist must document that the recipient meets the following conditions:

1. Patient is diagnosed with obstructive sleep apnea, upper airway resistance syndrome, or mixed sleep apnea; and

2. The diagnosis is supported by associated signs and syndromes of craniofacial malformations, neuromuscular disorders, cardiopulmonary or metabolic disorders, morbid obesity or adenotonsillar hypertrophy, tracheomalacia, tracheostomy complications or other anomalies of the larynx, trachea and bronchus that can be documented to improve and maintain airway patency and oxygenation through the use of CPAP.

The following documentation must be submitted:

1. A sleep study must be done within six months of prescribing CPAP therapy; and

2. The sleep study results recorded for at least 360 minutes or 6 hours. A sleep study is acceptable for patients less than six months old if the duration of the sleep study is 240 minutes or 4 hours.

Medicaid will approve the CPAP based on the EPSDT Screening.

Recertification

To renew approval, physician must submit documentation indicating that the recipient's overall condition has not changed and that CPAP is still medically necessary. Documentation of patient compliance with treatment is required and can be substantiated with smart card downloads in order to continue to be covered. The patient must use the device at least four (4) hours per night, 50% of all nights or it will no longer be covered. CPAP may be restarted (by the pulmonologist, or neurologist, or board certified sleep specialist) if indicated. However, if therapy is restarted then the physician must reassess patient compliance again in three months. If patient is still noncompliant, then therapy is no longer covered... In addition, for continued coverage a repeat sleep study is required if the last study was conducted more than 2 years ago.

Reimbursement

Effective January 1, 2013, the CPAP will be a capped rental to purchase item. The equipment can be rented for up to 3 months. After 3 months, if the recipient continues to meet criteria and must continue on the CPAP, the CPAP machine will transition to a purchase, with the total rental payments during the first 3 months and a subsequent one month payment equaling the purchase rate. No additional payment will be made by Alabama Medicaid on the CPAP machine and the machine will be considered to be owned by the recipient. The monthly payment will include delivery, in-service for the caregiver, maintenance, repair and supplies. Alabama Medicaid will not reimburse separately for procedure codes A7030, A7034, A7037 and A7038 during the CPAP's four month capped rental period. Recertification is required after the initial three months until the recipient no longer meets the criteria, the device is removed from the home, or the device becomes a purchased item for the recipient. If the CPAP is determined not be medically necessary (i.e., the criteria is no longer met) and if the total rental amount paid is less than the established purchased price the device will be returned to the supplier.

Billable Modifiers for CPAP

PAs submitted for dates of service on or after January 1, 2013 must comply with the following instructions:

LL modifier - Submitted for CPAP initial three (3) months approval

No modifier - Submitted for final payment (starts benefit limit count)

RA modifier - Submitted for replacement of machine only, within the 8-year period

(Replacement has to be prior approved by Agency as directed by policy.)

RR modifier was terminated for Medicaid claims effective December 31, 2012

(Accepted for cross-over claims only, after December 31, 2012)

CPAP Restarts

Alabama Medicaid will only reimburse for one CPAP restart within a consecutive twelve (12) month period for recipients who did not meet the Agency's compliance criteria after the start of the initial PA approval.

A CPAP restart is defined as a new request for oxygen therapy via CPAP after compliance has not been met by the recipient following the initial approval of three (3) months trial therapy.

To restart CPAP therapy, the pulmonologist, neurologist, or a board certified sleep medicine specialist must submit documentation indicating that the recipient's overall condition has not improved and that the CPAP is still medically necessary for the recipient's condition. If criteria are met, the recipient will be approved for another three (3) month trial.

At the end of the restart, the recipient will keep the CPAP and the provider will submit a PA for final payment of the CPAP machine. No additional payment will be made by Alabama Medicaid on the CPAP machine and the machine will be considered to be owned by the recipient.

NOTE:

Upon initial approval of the CPAP device, recipients may need to try more than one mask to maximize effectiveness of the device. Trial of various masks will be considered as covered in the rent to purchase price and no additional reimbursement is available.

14.2.22 Bilateral Positive Airway Pressure (BI-PAP) Device

Supplies for BI-PAP Device - A7030, A7031, A7032, A7033, A7034, A7035, A7036, A7037, A7038, A7039, A7044, A7046, E0550, E0561, and E0565

E0470, **E0471, E0472:** The Bilateral Positive Airway Pressure (BI-PAP) devices are designed to deliver pressured air to keep the throat open during the night. A mask containing tubing connects to the device and fits over the nose. The machine supplies two levels of pressure through the tube, one for inhaling and one for exhaling. In addition, the machine applies sufficient air pressure to prevent tissues in the airway from collapsing during sleep when a person exhales.

Prior Authorization

The BI-PAP device is covered for children under the age of 21 through the EPSDT screening Program and requires prior authorization.

Documentation

BI-PAP therapy is considered medically appropriate if the following criteria are met in addition to the documentation requirements:

A. A sleep study with subsequent failure on CPAP therapy is required for patients prescribed therapy for obstructive sleep apnea syndrome, or mixed sleep apnea unless the patient is 5 years of age or younger.

B. The prescribing physician, either specializing in pulmonary, neurology or board certified sleep specialist, must document that the recipient has one of the following diagnosis:

   1. Patient is diagnosed with central or obstructive sleep apnea, (sleep study required) or
   2. Patient is diagnosed with upper airway resistance syndrome, (sleep study required) or
   3. Patient is diagnosed with mixed sleep apnea, (sleep study required) or

4. Patient is diagnosed with a neuromuscular disease (examples include muscular dystrophies, myopathies, and spinal cord injuries), respiratory insufficiency or restrictive lung disease from wall deformities (sleep study not required)

The following documentation is required if a sleep study was indicated:

1. The sleep study must be done within 6 months of prescribing BIPAP Therapy.
2. The results of a sleep study recorded for at least 360 minutes or 6 hours must be submitted. A sleep study is acceptable for patients less than six months old if the duration of the sleep study is 240 minutes or 4 hours.

Initial approval will consist of 90 days of therapy. To renew approval, a statement is needed from the physician indicating that the recipients overall condition has not changed and that BIPAP is still medically indicated. Documentation of patient compliance with treatment is required. Patient must use the device at least 50% of sleep time. For continued coverage, a repeat sleep study is required if the last study was conducted more than 2 years ago.

Reimbursement

The BI-PAP will be a capped rental item. The equipment will be rented for up to 10 months with the total rental payments equal to purchase price. At the end of the 10 month rental period the item is considered to be a purchased item for the recipient paid in full by Medicaid. The monthly rental payment will include delivery, in-service for the caregiver, maintenance, repair and all supplies. Recertification is required until the recipient no longer meets criteria, the device is removed from the home, or the device becomes a purchased item for the recipient. If BI-PAP is determined not to be medically necessary and if the total rental amount paid is less than the established purchased price the device will be returned to the supplier. Supplies and repairs for BI-PAP are only covered after the 10 month rent to purchase period. Supplies and repairs for the BI-PAP are covered through prior authorization. Supplies will be covered up to the maximum allowed units for the specified timeframe as indicated on the DME fee schedule. BI-PAP devices will be limited to one per recipient every eight years.

Effective January 1, 2014, DME Providers submitting PAs for dates of service on or after January 1, 2014:

- Will no longer be reimbursed for the BI-PAP and the humidifier devices separately when billed on the same date of service.
- Will no longer be reimbursed for humidifier devices as a continuous rental when billed with BI-PAP procedure codes E0470, E0471 & E0472.

Billable Modifiers for BI-PAP

PAs submitted for dates of service on or after January 1, 2014 must comply with the following instructions:

LL modifier - Submitted for BI-PAP's

- initial three month trial period and
- next six months

No modifier - Submitted for the final month (totaling 10 months capped)

RA modifier - Submitted for replacement of machine only, within the 8-year period.

(Replacement has to be prior approved by Agency as directed by policy.)

NOTE:

Upon initial approval of the BI-PAP device recipients may need to try more than one mask to maximize effectiveness of the device. Trial of various masks will be considered as covered in the rent to purchase price and no additional reimbursement is available.

14.2.23 Home Phototherapy

E0202: Home phototherapy is a covered service in the DME Program for neonatal jaundice, is frequently used for management of physiologic hyperbilirubinemia. The infant is exposed to continuous ultraviolet light via a lamp used in the home for a prescribed period of time. The ultra violet light helps to reduce elevated bilirubin levels which can cause brain damage.

Prior authorization for Home Phototherapy for the first four (4) consecutive days of therapy is no longer a requirement.

If more than four (4) consecutive days of therapy are needed, requests for additional days must be submitted with medical documentation justifying the need to the Clinical Services & Support Division Medical Quality and Review Unit at the Alabama Medicaid Agency for review and approval. If approval is granted, the Clinical Services & Support Division Medical Quality and Review Unit will notify the Provider with billing instructions.

The use of Home phototherapy for children under age 21 is considered medically appropriate if all of the following criteria are met:

1. The infant is term (37 weeks of gestation or greater), older than forty-eight hours and otherwise healthy; and
2. The serum bilirubin levels> 12; and
3. The serum bilirubin level is not due to a primary liver disorder; and
4. The diagnostic evaluation (described below) is negative; and
5. The infants' bilirubin concentrations as listed below indicate consideration of phototherapy

AGE, HOURS	Consider phototherapy when total serum bilirubin is:
25-48	Greater than 12 (170)
49-72	Greater than 15 (260)
Greater than 72	Greater than 17 (290)

NOTE: These are recommendations for phototherapy for inpatient and outpatient use

NOTE:

An EPSDT screening is not required.

Diagnostic evaluation

Prior to therapy, a diagnostic evaluation should include:

- History and physical examination;
- Hemoglobin concentration or hematocrit;
- WBC count and differential count;
- Blood smear for red cell morphology and platelets;
- Reticulocyte count
- Total and direct-reacting bilirubin concentration
- Maternal and infant blood typing and Coombs test; and
- Urinalysis includes a test for reducing substances.

Documentation

Documentation from the attending physician should indicate the duration of treatment, frequency of use per day and the maximum number of days for home phototherapy. A registered nurse with active license must perform home visits for professional services associated with phototherapy. Providers must submit written verification to the Medicaid agency which includes the nurse's name and license number with an effective date and expiration date for the nurse's license. The provider must assure that the parent or caregiver receives education for the safe and effective use of the home phototherapy equipment. The procedure code (E0202) used for phototherapy includes a global fee per day for equipment, nurse visits, and collection of lab work.

NOTE:
A skilled nursing visit may not be billed in the Home Health program for this service.

14.2.24 High Frequency Chest Wall Oscillation Air Pulse Generator System (Includes Hoses and Vest)

E0483 A high frequency chest wall oscillation (HFCWO) system is an airway clearance device consisting of an inflatable vest connected by two tubes to a small air-pulse generator that is easy to transport. Request for the HFCWO must be received by Medicaid's Fiscal Agent within thirty calendar days after the equipment is dispensed.

Prior Authorization

This procedure code requires prior authorization. (See Section 14.3.1 Authorization for Durable Medical Equipment)

Documentation

The recipient must meet the following conditions:

The HFCWO is covered for EPSDT referred recipients when prescribed as medically necessary by a physician and all of the following criteria are met:

1. The patient has had two or more hospitalizations or episodes of home intravenous antibiotic therapy for acute pulmonary exacerbations during the previous twelve months; and
2. The FEV1 (forced expiratory flow in one second) is less than 80% of predicted value or FVC (forced vital capacity) is less than 50% of the predicted value; and

3. There is a prescribed need for chest physiotherapy at least twice daily; and
4. There is a well-documented failure of other forms of chest physiotherapy which have been demonstrated in the literature to be efficacious, including hand percussion, mechanical percussion, and Positive Expiratory Pressure (PEP) device. The evidence must show that these have been tried in good faith and been shown to have failed prior to approval of the vest; and
5. The patient does not have a caretaker available or capable of assisting with hand percussion, then a trial of hand percussion would not be a necessary prerequisite, but such patients would still need to in good faith complete a trial of mechanical percussion and the use of the PEP device.

NOTE:

The qualifying diagnosis for the HFCWO system is Cystic Fibrosis (277.00, 277.02 for ICD-9 and E84.9, E84.0 for ICD-10).

Medicaid Coverage for the HFCWO (Capped Rental)

The initial rental approval will consist of up to 90 days. A monthly rate will be paid to the provider for the first three months. The rental period will allow the patient to demonstrate compliance with the device. At the end of the 90 days, documentation (requires an additional PA) is required that demonstrates recipients usage and compliance levels. If patient compliance is shown in the first three month rental period, in the fourth month, the device will transition to a purchase, with the total rental payments during the first three months payment and subsequent one month payment equaling the purchase rate.

The rental will include all accessories necessary to use the equipment, education on the proper use and care of the equipment as well as routine servicing, necessary repairs and replacements for optimum performance of the equipment. The monthly payment will include delivery, in-service for the caregiver, maintenance and repair. After the device is purchased no additional cost will be incurred by the Medicaid Agency because the device (the inflatable vest, generator and hoses) is covered under lifetime warranty and the responsibility of the manufacturer or supplier to provide maintenance or replace the device.

Recertification is required until the recipient no longer meets the criteria, the device is removed from the home, or the device is purchased. If the HFCWO is determined not to be medically necessary (i.e., the criteria is no longer met) the HFCWO will be returned to the supplier if the total rental amount paid is less than the established purchase price.

Percussor Electric or Pneumatic

Chest percussors, electric or pneumatic, are used to mobilize secretions in the lungs. Chest percussions may be performed by striking the chest with cupped hands or with a mechanical hand held unit. An electric percussor is a vibrator that produces relatively course movements to the chest wall to mobilize respiratory tract secretions and stimulate the cough mechanism.

(See section 14.3.1 Authorization for Durable Medical Equipment)

The percussor is considered medically necessary for patients with excessive mucus production and difficulty clearing secretions if the following criteria are met:

- Must be an EPSDT Medicaid eligible individual; and
- Patient has a chronic lung condition of cystic fibrosis or bronchiectasis; and
- Other means of chest physiotherapy such as hand percussion and postural drainage have been used and failed; and
- No caregiver available or caregiver is not capable of performing manual therapy; and
- Clinical documentation indicates that manual therapy has been used and does not mobilize respiratory tract or the patient cannot tolerate postural drainage

14.2.25 Incontinence Products (Disposable Diapers)

T4521 Adult-sized incontinence product, diaper, small

T4522 Adult-sized incontinence product, diaper, medium

T4523 Adult-sized incontinence product, diaper, large

T4524 Adult-sized incontinence product, diaper extra large

T4529 Child-sized incontinence product, diaper small/medium

T4530 Child-sized incontinence product, large

T4543 Adult-size incontinence brief/diaper, above extra-large (bariatric)

Prior Authorization

These procedure codes for disposable diapers require prior authorization. (See Section 14.3.1 Authorization for Durable Medical Equipment)

Documentation

Medicaid will consider payment of disposable diapers when referred as medically necessary from an EPSDT screening and the criteria below are met:

1. Recipient must be at least 3 years old;
2. Patient must be non-ambulatory or minimally ambulatory; and
3. Patient must be medically at risk for skin breakdown, which is defined as meeting at least two of the following:

    a. Unable to control bowel or bladder functions,

    b. Unable to utilize regular toilet facilities due to medical condition

    c. Unable to physically turn self or reposition self,

    d. Unable to transfer self from bed to chair or wheelchair without assistance.

14.2.26 Apnea Monitor

E0619: The apnea monitor is a covered service with prior authorization in the DME program for EPSDT referred recipients. The apnea monitor can be provided only if it can be used properly and safely in the home and if it has been prescribed as medically necessary by a physician.

Prior Authorization

This procedure code requires prior authorization. (See Section 14.3.1 Authorization for Durable Medical Equipment)

Documentation

To qualify for the placement of an apnea monitor and Medicaid reimbursement for the monitor, the recipient must meet/have documentation of **at least one** of the following (Infants are defined as less than or equal 12 months of age):

- Apnea that lasts 20 or more seconds that is associated with baby's color changing to pale, purplish or blue, bradycardia (heart rate below 80 beats per minute), baby choking or gagging that requires mouth-to-mouth resuscitation or vigorous stimulation documented by medical personnel (documented pathologic apnea).
- Pre-term infants with periods of pathologic apnea
- Sibling of SIDS victim
- Infants with neurological conditions that cause central hypoventilation
- Infants or children less than two years of age with new tracheostomies (tracheostomy within the last 60 days)

The following must also be included:

- Documentation from the physician with a patient specific plan of care, proposed evaluation and intervention to include length of time of use each day, anticipated reevaluation visits/intervals, additional therapeutic interventions appropriate for diagnosis/cause of apnea
- Documentation of counseling to parents must include the understanding that monitoring cannot guarantee survival
- Documentation of parental training and demonstration of proficiency in CPR and resuscitation methods. The staff providing CPR training must have a license/certification to provide such training.
    - It is the DME provider's responsibility to ensure that parents provide them with documentation of CPR training.
    - It is not the provider's responsibility to provide CPR training to the parents.

Approval is for three (3) months only.

Renewal criteria **must** include the following:

- A copy of nightly monitor strips or monthly download is required as documentation of pathologic apnea or bradycardia for the past three months.
- A letter from the physician with patient-specific plan of care to justify the medical necessity for continued use of monitor at **each** recertification period.

Discontinuation Criteria include:

- Apparent Life-Threatening Event (ALTE) infants that have had two to three months free of significant alarms or apnea.
- The provider must check for recipient compliance (i.e. documentation via download monthly or through nightly strips). The monitor will be discontinued with documentation of non-compliance. Non-compliance is defined as failure to use the monitor at least 80% of each certification period.
- Sibling of SIDS victim who is greater than six months of age
- Tracheostomy recipients greater than two years of age

NOTE:

A caregiver trained and capable of performing Cardiopulmonary Resuscitation (CPR) must be available in the home. Documentation must be provided.

When submitting a prior approval request for Medicaid's authorization of an apnea monitor for a sibling of a SIDS victim, use the diagnosis code V201 for ICD-9 and Z76.2 for ICD-10. DME providers should use V201 or Z76.2 only for a recipient who is a sibling of a SIDS victim. Do not use diagnosis code 7980. The clinical statement on PA Form 342 must include documentation from the physician supporting the recipient's diagnosis of 'Sibling of SIDS victim.'

14.2.27 Enteral Nutrition Equipment and Supplies

B4034, B4036 (EPSDT only)

A4213, B4035, B4081, B4082, B4087, B4088, B9002, B9998 (entire Medicaid population)

Prior Authorization

Prior authorization requests are required for most Enteral Nutrition Equipment and Supplies. Prior authorization requests must be submitted with verification that all medical criteria have been met. (See Section 14.3.1 Authorization for Durable Medical Equipment)

Documentation

Enteral nutrition equipment and supplies are covered for children under the age of 21 with an EPSDT Screening and Referral.

Recipients age 21 and above (with noted limitations) qualify based on medical necessity and prior authorization when the following criteria are met:

The recipient meets the following criteria for enteral nutrition:

a. Recipient is < age 21 and record supports that > than 50 % of need is met by specialized nutrition; **OR**

b. Recipient is > age 21 and record supports 100 % of need is met by specialized nutrition and provided by tube feedings **AND** must submit documentation from the attending physician to support that the recipient cannot tolerate bolus feeding and requires enteral nutrition by pump.

Enteral nutrition for adults 21 years of age and above is provided through bolus feeds using procedure code A4213

14.2.28 Total Parenteral Nutrition (TPN) Pump and Supplies

B4224: (Parenteral administration kit; per day) is to be used with TPN Therapy.

B4220: (Parenteral nutrition supply kit; premix, per day) or B4222 (Parenteral nutrition supply kit; homemix, per day) may be used in conjunction with B4224. However, at no time should both B4220 and B4222 be billed on the same date of service with procedure code B4224.

Prior Authorization

TPN pumps (B9004, B9006) are provided for all Medicaid recipients and require prior authorization.

TPN supplies (E0776, B4224, B4220 and B4222) do not require prior authorization.

Documentation

All TPN supplies are provided to Medicaid recipients based on medical necessity when the following criteria are met:

1. The recipient meets the criteria for total parenteral nutrition (TPN)
   a. Recipient < age 21 and record supports that > than 50 % of need is met by specialized nutrition, or
   b. Recipient > age 21 and record supports 100 % of need is met by specialized nutrition.
2. The recipient cannot be sustained through oral feedings and must rely on enteral nutrition therapy which is administered by some form of intravenous therapy.
3. Verification that the criteria have been met must accompany the PA request.

E0776: If procedure code E0776 (IV Pole) is needed for a period of more than six months this is considered long term and should be billed as a purchased item. Procedure code E0776 may be rented short term for up to six months or less.

14.2.29 Home Infusion Therapy Services Equipment and Supplies

Home Infusion Therapy **(**HIT**)** includes administration of medication and nutrients and the associated supplies, provided to Medicaid recipients residing in a private residence. Infusion therapy is a procedure that involves the insertion of a catheter into a blood vessel providing a painless way of drawing blood, delivering drugs and nutrients into a patient's bloodstream over a period of weeks, months or even years. Common uses for intravenous therapy are intravenous antibiotic treatment, chemotherapy, hydration and pain management therapy.

HIT components can be provided and billed by enrolled DME Pharmacies and Durable Medical Equipment (DME) Infusion providers only as described in the HIT policy. DME Home Infusion providers must be accredited by a nationally recognized accrediting body in order to be reimbursed for home infusion therapy services. Providers must submit sufficient proof of accreditation during initial provider enrollment and re-enrollment process.

Documentation

HIT must be prescribed by the attending physician as a medically necessary health care service. The physician's orders must clearly document the starting date for care, expected duration of therapy, the amount and types of services required. If the recipient requires multiple drug therapies, the therapies must be provided by the same agency. The medication administration record and or the nursing documentation should coincide with the billing based on the time of completion and discontinued use of the drug that required the need for durable medical supplies. The recipient's record must have medical documentation justifying medical necessity.

HIT services billed using the S codes include, antibiotic, antiviral or antifungal therapy (S9500; S9501, S9502, S9503 and S9504), hydration therapy (S9373), chemotherapy (S9330), pain management therapy (S9326), specialty infusion therapies such as anti-coagulant (S9336), antiemetic (S9351), catheter care (S5498, S5501), and catheter insertion (S5520 and S5521). These "S" codes include administrative services, professional pharmacy services, care coordination **and all necessary supplies and equipment (including pump)**. Drugs and nursing visits are billed separately.

Prior Authorization

The "S" codes listed in this paragraph **do not** require prior authorization.

Catheter Care

S5498 (1 unit; limited to 31 units per month; must be billed 1 unit per day)

Home Infusion Therapy, Catheter Care/ Maintenance, simple (single lumen), includes administrative services, professional pharmacy services, care coordination, **and all necessary supplies and equipment** (drugs and nursing visits coded separately)

S5501 (1 unit; limited to 31 units per month; must be billed 1 unit per day)

Home Infusion Therapy, Catheter Care/ Maintenance, complex (more than one lumen), includes administrative services, professional pharmacy services, care coordination, **and all necessary supplies and equipment** (drugs and nursing visits coded separately)

S5520 (1 unit; limited to 5 units per month; must be billed 1 unit per day)

Home Infusion Therapy, **all supplies** (including catheter) necessary for peripherally inserted central venous catheter (PICC) line insertion

S5521 (1 unit; limited to 5 units per month; must be billed 1 unit per day)

Home Infusion Therapy, **all supplies** (including catheter) necessary for a midline catheter insertion

The catheter dressing supplies may be reported separately when used as a stand-alone therapy, or during days not covered under another infusion therapy reimbursement rate. PICC line, Port-A-Cath or MediPort dressing supplies including the anchor device is allowed as a separate charge if there is no other therapy in the last 30 days in the home.

Pain Management

S9326 (limited to 31 units per month; must be billed 1 unit per day)

Home Infusion Therapy, continuous (24 hours or more) pain management infusion, includes administrative services, professional pharmacy services, care coordination, **and all necessary supplies and equipment** (drugs and nursing visits coded separately)

Pain management therapy is considered medically necessary when used to administer opioid drugs (e.g., morphine) and/or clonidine intrathecally for treatment of severe chronic intractable pain in persons who have proven unresponsive to less invasive medical therapy. The recipient's record must have medical documentation justifying medical necessity:

Chemotherapy

S9330 (1 unit; limited to 31 units per month; must be billed 1 unit per day)

Home Infusion Therapy, continuous (24 hours or more) chemotherapy infusion includes administrative services, professional pharmacy services, care coordination, **and all necessary supplies and equipment** (drugs and nursing visits coded separately)

The recipient's record must have medical documentation justifying medical necessity.

Anticoagulant Therapy

S9336 (1 unit; limited to 31 units per month; must be billed 1 unit per day)

Home Infusion Therapy, continuous anticoagulant infusion therapy (e.g., heparin), includes administrative services, professional pharmacy services, care coordination, **and all necessary supplies and equipment** (drugs and nursing visits coded separately)

Antibiotic, Antiviral or Antifungal Therapy

Effective for dates of service on or after June 1, 2014, DME Provider(s) billing for Antibiotic, Antiviral or Antifungal Therapy procedure code(s) S9500, S9501, S9502, S9503 and S9504 must bill with the "SQ" modifier. **S9500** (1 unit; limited to 31 units per month; must be billed 1 unit per day)

Home Infusion Therapy, antibiotic, antiviral, or antifungal therapy; once every 24 hours; includes administrative services, professional pharmacy services, care coordination, **and all necessary supplies and equipment** (drugs and nursing visits coded separately),

S9501 (1 unit; limited to 31 units per month; must be billed 1 unit per day)

Home Infusion Therapy, antibiotic, antiviral**,** or antifungal therapy; once every 12 hours; includes administrative services, professional pharmacy services, care coordination, **and all necessary supplies and equipment** (drugs and nursing visits coded separately)

S9502 (1 unit; limited to 31 units per month; must be billed 1 unit per day)

Home Infusion Therapy, antibiotic, antiviral**,** or antifungal therapy; once every 8 hours; includes administrative services, professional pharmacy services, care coordination, **and all necessary supplies and equipment** (drugs and nursing visits coded separately)

S9503 (1 unit; limited to 31 units per month; must be billed 1 unit per day)

Home Infusion Therapy, antibiotic, antiviral, or antifungal therapy; once every 6 hours; includes administrative services, professional pharmacy services, care coordination, **and all necessary supplies and equipment** (drugs and nursing visits coded separately)

S9504 (1 unit; limited to 31 units per month; must be billed 1 unit per day)

Home Infusion Therapy, antibiotic, antiviral, or antifungal therapy; once every 4 hours; includes administrative services, professional pharmacy services, care coordination, **and all necessary supplies and equipment** (drugs and nursing visits coded separately)

Intravenous Immune Globulin (IVIG) Therapy

Effective for dates of service on or after June 1, 2014, Intravenous Immune Globulin (IVIG) Therapy must be billed with a diagnosis code in the range from 279.00 through 279.06, 279.10, 279.2 and 279.12 for ICD-9, and for ICD-10 bill D80.0 through D80.5, D81.0, D82.0, D83.1, and D83.8 with procedure code; S9500, S9502, S9503, S9504 or S9338.

The following procedure codes must be used to bill for Intravenous Immune Globulin (IVIG) therapy:

S9500 (1 unit: limited to 31 units per month; must be billed 1 unit per day)
S9502 (1 unit: limited to 31 units per month; must be billed 1 unit per day)
S9503 (1 unit: limited to 31 units per month; must be billed 1 unit per day)
S9504 (1 unit: limited to 31 units per month; must be billed 1 unit per day)
S9338 (1 unit; limited to 31 units per month; must be billed 1 unit per day)

In addition, the derivative must be administered in the home of the recipient and the physician must determine that it is medically necessary. This service includes administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment. Drugs and nursing visits are to be coded separately.

Prior Authorization
If the recipient does not have one of the required diagnoses or the units exceed the allowable amount, the provider must obtain prior authorization. See Section 14.3.1 Authorization for Durable Medical Equipment)

Hydration Therapy

S9373 (1 unit; limited to 31 units per month; must be billed 1 unit per day)

Home Infusion Therapy, hydration therapy includes administrative services, professional pharmacy services, care coordination, **and all necessary supplies and equipment** (drugs and nursing visits coded separately), (do not use with hydration therapy codes S9374-S9377 using daily volume scales),

Hydration therapy is considered medically necessary for recipients who become dehydrated due to illness, surgery, or accident. Dehydration occurs when patients are losing necessary fluids at a rate faster than they are retaining fluids. The recipient's record must have medical documentation justifying medical necessity.

Anti-emetic

S9351 (1 unit; limited to 31 units per month; must be billed 1 unit per day)
Home Infusion Therapy, continuous or intermittent anti-emetic infusion therapy; includes administrative services, professional pharmacy services, care coordination, **and all necessary supplies and equipment** (drugs and nursing visits coded separately)

Anti-emetic therapy is typically used to treat motion sickness and the side effects of opioids analgesics, general anesthetics and chemotherapy directed against cancer. The anti-emetic assists the recipient in preventing or alleviating irretractable nausea and vomiting. The recipient's record must have medical documentation justifying medical necessity.

S9347 (1 unit; limited to 31 units per month; must be billed 1 unit per day)
Home Infusion Therapy, uninterrupted, long-term, controlled rate Intravenous or subcutaneous infusion therapy (e.g. epoprostenol); includes administrative services, professional pharmacy services, care coordination, **and all necessary supplies and equipment** (drugs and nursing visits coded separately).

S9490 (1 unit; limited to 31 units per month; must be billed 1 unit per day)
Home Infusion Therapy, corticosteroid infusion; includes administrative services, professional pharmacy services, care coordination, **and all necessary supplies and equipment** (drugs and nursing visits coded separately).

Home Infusion Otherwise Classified (S9379)

Home Infusion Therapy, infusion therapy not otherwise classified; includes administrative services, professional pharmacy services, care coordination, **and all necessary supplies and equipmen**t (drugs and nursing visits coded separately)
Anticipating that new infusion therapies will be developed or that a current therapy has been overlooked, the Clinical Services & Support Division Medical and Quality Review Unit will consider authorization of other therapies on an individual basis. These special requests will require peer reviewed medical literature documentation and medical review.

Prior Authorization

This procedure code requires prior authorization. (See Section 14.3.1 Authorization for Durable Medical Equipment)

Limitations

Drugs and nursing visits for home infusion are coded separately.

14.2.30 Prosthetic, Orthotic and Pedorthic Devices

Prosthetic, orthotic and pedorthic devices are covered for children up to the age of 21 through the EPSDT Program. Unless specified on the DME Fee schedule, these devices DO NOT REQUIRE PRIOR AUTHORIZATION. For items to be covered recipients must meet eligibility requirements, the devices must be reasonable and necessary to improve the functioning of a malformed body member or replace an absent body member, and meet all other applicable Medicaid statutory and regulatory requirements.

Basic level prosthetic, orthotics and pedorthic devices prescribed as medically necessary by the primary care physician are provided for adults ages 21-65 in institutional and non-institutional settings. All requests for prosthetic, orthotic and pedorthic devices for adults do not require prior authorization.

The provider must be practicing as a Prosthetic, Orthotic or Pedorthic Practitioner in the State of Alabama at an accredited facility. Providers must keep a copy of the written prescription/order from the primary physician for the prosthetic or orthotic device in the recipient's file. The provider must also have in the recipient's file documentation of the education and follow-ups provided to the recipient of the use of the prosthetic and orthotic device.

A prosthetic device is an artificial substitute that replaces all or part of a body organ, or replaces all or part of the function of a permanently inoperative, absent or malfunctioning body part. Lower limb prostheses may include a number of components, such as prosthetic feet, ankles, knees, endoskeletal knee-shin systems, limb-ankle prostheses, socket insertions and suspensions. Pedorthic is the making and fitting of shoes and other foot support products to alleviate and prevent foot injury and disease.

Orthotic devices are fabricated, fitted and/or modified devices to correct or compensate for a neuro-musculoskeletal disorder or acquired condition (in other words braces for the body, excluding teeth). The orthotic device may be custom fabricated and fitted, prefabricated custom fitted or off-the-shelf if prefabricated and fitted.

For Medicaid to approve lower limb prosthesis medical documentation must be maintained in the supplier's recipient file substantiating that prosthesis is essential in order for the recipient to ambulate and that the recipient is motivated to ambulate.

For Medicaid to approve an orthotic device medical documentation must be maintained in the supplier's recipient file to show that the device supports or aligns movable parts of the body, prevent or correct deformities, or improve functioning.

For Medicaid to approve Therapeutic Shoes for diabetes medical documentation must be maintained in the supplier's recipient file showing that the recipient has diabetes mellitus and other medical conditions justifying the need.

14.2.31 Adult Prosthetic, Orthotic and Pedorthic Devices Covered For Medicaid Recipients age 21

Lower Limb Prostheses Codes – L5301, L5321, L5620, L5624, L5629, L5631, L5649, L5650, L5655, L5685, L5695, L5700, L5701, L5704, L5705, L5812, L5850, L5910,L5940, L5950, L5962, L5964, L5972, L5974, L5920

Prosthetic related Supplies Codes - L8400, L8410, L8420, L8430, L8470, L8480

Prosthetic related supply codes are covered if a recipient is an amputee, has a prosthetic leg, and these supplies are necessary for the function of the prosthetic.

Orthotic Basic Codes – L1930, L1960, L1970, L1990, L2020, L2405 Ankle-foot orthoses (AFO) codes L1930, L1960, L1970, L1990 and knee-ankle foot orthoses (KAFO) codes L2020 and L2405 are covered for ambulatory recipients with weakness or deformity of the foot and ankle, which requires stabilization for medical reasons, and have the potential to benefit functionally. Knee-ankle foot orthoses (KAFO) are primarily covered for ambulatory recipients that require additional knee stability and would not benefit from the AFO.

Therapeutic Shoe Codes for Diabetes – A5500, A5513, A5501

Addition To Lower Extremity Orthosis: Shoe-Ankle-Shin-Knee- L2220

Additions General - L2795

Additions: Socket Variations - L5651, L5652

Additions: Socket Insert and Suspensions – L5671, L5673, L5679

Additions: Endoskeltal Knee-Shin System - L5986

Prosthetic Socks: L8440, L8460

Wrist-Hand-Finger Orthosis – L3807

Orthosis Devices Spinal – L0472, L0458

Transfer or Replacement – L3610

Orthotic Devices-Spinal – L0172

Thoracic – L0486

Cervical-Thoracic-Lumbar-Sacral Orthosis (CTLSO) – L0628 must be billed with a CG modifier for age 21-65, L0630, L0640

Additions To Spinal Orthosis – L0984

14.2.32 External Breast Prostheses

(1) External breast prostheses following mastectomy for breast cancer are covered for all Medicaid-eligible recipients meeting the criteria.

(2) Coverage is available for the external breast prostheses when all of the following criteria are met:
(a) Recipient must be eligible for Medicaid on the date of service for provision of prostheses;

(b) The applicable International Classification of Diseases 10th Revision, Clinical Modification (ICD-10-CM) diagnosis code which indicates carcinoma or malignant neoplasm of the breast must be provided.

(c) Effective January 1, 2013, Alabama Medicaid will no longer require prior authorizations (PAs) for external breast prostheses for artificial breast substitutes covered under the Durable Medical Equipment program. The appropriate procedure codes are billed as indicated below:

Procedure Code	Description	Limits
L8000	Breast prosthesis, mastectomy bra Maximum of 4 on initial request	6/year
L8015	External breast prosthesis garment, with mastectomy form	2/year
L8020	Breast prosthesis, mastectomy form	**
L8030	Breast prosthesis, silicone or equal	**
L8035	Custom breast prosthesis, post mastectomy, molded to patient model	
L8039	Breast prosthesis, not otherwise classified Evaluated on a case-by-case basis with submission of pricing information and medical documentation	

Limited to two of **L8020 or **L8030** per year, or one **L8020** and one **L8030** per year.

(3) Maximum calendar year limits apply to each of the procedures as indicated above.

(4) Durable Medical Equipment (DME) providers of external breast prostheses devices for adults must be enrolled as an Alabama Medicaid Agency (AMA) provider and Mastectomy Fitters must be licensed by the Alabama Board of Prosthetics, Orthotics and Pedorthics.

For reimbursement rates and benefit limits for the Prosthetic, Orthotic and Pedorthic procedure codes, refer to the DME fee schedule.

14.2.33 Controlled Dose Drug Inhalation System (K0730)

Alabama Medicaid covers K0730. This code is a 10 month capped rental to purchase item and at the end of the 10 month rental period the device will be a purchased item for the recipient.

Prior Authorization

This procedure code does not require prior authorization.

Documentation

The drug delivery system will only be covered for eligible Medicaid recipients currently receiving the drug Ventavis. Alabama Medicaid must currently be reimbursing for this drug for these recipients. Providers will be required to submit claims with one of the following diagnosis codes 415.0, 416.0, and 416.8 for the controlled dose inhalation drug delivery system. If it is determined through provider audits that providers are not billing procedure code K0730 in accordance with Medicaid's policy guidelines, Medicaid payments for this service will be recouped.

Repairs

Repairs for this system will be covered using procedure code E1399. All repair cost must be submitted with itemized provider invoice cost. Repairs will be reimbursed at provider's cost plus 20%.

14.2.34 Tracheostomy Supplies

Alabama Medicaid covers tracheostomy supplies for eligible Medicaid recipients when prescribed as medically necessary by the physician.

A4605 Tracheal suction catheter, closed system, each (delee)

A7008 Large volume nebulizer, disposable, prefilled, used with aerosol compressor (neb adapters)

A7010 Corrugated tubing, disposable, used with large volume nebulizer, 100ft (aerosol tubing)

A7012 Water collection device, used with large volume nebulizer (drain bag)

A9900 Miscellaneous DME supply, accessory, and/or service component of another HCPCS code (suction machine bacteria filters)

S8999 Resuscitation bag (for use by patient on artificial respiration during power failure or other catastrophic event (resuscitation bags)

Prior Authorization

The above listed supplies do not require prior authorization but there are quantity restrictions. See DME Fee Schedule for quantity restrictions.

The following procedure codes require PA:

A7509 Filter holder and integrated filter housing, and adhesive, for use as a tracheostoma heat moisture exchange system.

S8189 Tracheostomy supply, not otherwise classified will be used to bill for the customized/specialty trachs.

E1399 Peep valves and respiguard filters will be billed using miscellaneous code E1399. Any other trach supply items requested must be submitted using miscellaneous procedure code E1399. Medical documentation and provider's invoice must be submitted for review and approval. Medicaid will reimburse these trach supplies at provider's invoice price plus 20%.

14.2.35 Transfer Boards

E0705 Medicaid will consider coverage of transfer boards when prescribed as medically necessary by the recipient's primary care physician. Transfer boards will be approved for Medicaid eligible recipients with medical conditions that limit their ability to transfer from a wheelchair to a bed, chair, toilet, etc. Medical documentation should indicate that the recipient is immobile and requires assistance.

14.2.36 Special Ostomy Supplies

A4221 Special ostomy supplies should be submitted using procedure code A4421 with an SC modifier.

Prior Authorization

Special ostomy supplies will require prior authorization (PA). All PA requests will be approved based on the submitted quantity limitations prescribed by the physician and medical documentation justifying the need. Special ostomy supplies will be reimbursed at provider's invoice price plus 20% and will pay from the approved price listed on the PA file.

14.2.37 Adaptive Strollers, Equipment and Accessories

E1035 Adaptive strollers, equipment and accessories are covered items in the DME program for Medicaid eligible children under the age of 21 through the EPSDT program who meet criteria. Medicaid will reimburse providers at provider's invoice price plus 20%.

14.2.38 Enuresis Alarm

S8270 The enuresis alarm is covered through the DME Program for recipient's age 5 years up to age 21. Providers should submit their claims for the enuresis alarm using procedure code S8270 and should bill their usual and customary charge for reimbursement.

The American Academy of Family Physicians (AAFP) published recommendation for treatment of enuresis stating there are two first line therapies, enuresis alarm and desmopressin. Providers are encouraged to prescribe the enuresis alarm as a first line and cost effective therapy.

14.3 Prior Authorization and Referral Requirements

Certain DME requires prior authorization. Please refer to DME Fee Schedule on the Agency's website (www.medicaid.alabama.gov) for an inclusive listing of DME items that require prior authorization from Medicaid. Payment will not be made for these procedures unless the prior authorization request is received within **thirty calendar days** after the service is provided.

Prior authorization requests for supplies, appliances and DME must include medical records to support the medical necessity of the requested item(s). **Checklists are not sufficient medical documentation.**

NOTE:
Prior authorization is not a guarantee of payment. The authorization number does not guarantee recipient eligibility at the time the equipment is dispensed. The provider is responsible for verifying recipient's eligibility.

When filing claims for recipients enrolled in the Patient 1st Program, refer to Chapter 39 to determine whether your services require a referral from the Primary Medical Provider (PMP).

All requests for prior approval should be initiated and signed by the attending physician and must document medical necessity. Requests may be sent electronically using the Medicaid's Fiscal Agent software or mailed in hardcopy to the Prior Authorization Unit, P.O. Box 244032, Montgomery, Alabama 36124-4032. The Agency's PA Contractor will approve or deny the request. Medicaid's Fiscal Agent will return any requests containing missing or invalid information. Please see Chapter 4, Obtaining Prior Authorization, for additional information.

Procedures for changing rendering providers

1. Obtain a written statement from the initial rendering provider indicating that they are aware and agree with the decision of the recipient to change providers and that the approved PA may be cancelled.

2. Confirm this decision with the recipient by having the new provider submit a written statement that they will now be submitting a PA request on the patient's behalf and have the patient sign that they agree and understand.

3. Cancel the approved PA request in the system.

4. Review the new providers request and approve or deny.

14.3.1 Authorization for Durable Medical Equipment

Provider must have a prescription/order on file from the attending physician that a specific covered item of durable medical equipment is medically necessary for use in the recipient's home prior to completing the Alabama Prior Review and Authorization Request, Form 342. The physician may also fax the prescription/order to the provider of the recipient's choice. The provider must submit the appropriate Alabama Medicaid Prior Review and Authorization Request Form 342 and any other pertinent medical information to the Medicaid Fiscal agent. The Fiscal Agent will assign a prior authorization tracking number and transmit the request to Medicaid Agency's Prior Authorization Approval designee for review.

Prior authorization requests for purchase, rental, or re-certification of DME must be received by Medicaid's fiscal agent within **thirty calendar days** of the signature date the equipment was dispensed. Prior authorization requests that are received by Medicaid's Fiscal Agent and rejected due to incorrect information will not be considered received timely unless resubmitted correctly within thirty days of the dispensed date.

Medicaid will review the request and assign a status of approved, denied, or pending. Providers are sent approval letters indicating the ten-digit PA number that should be referenced on the claim form for billing. Providers and recipients will be notified on denied requests. Providers will be notified of approved requests.

If a prior authorization (PA) request is assigned an approved status by Alabama Medicaid, only the approved procedure code(s), without alteration(s), can be dispensed to the recipient. If the procedure code on Form 342 (DME Prior Authorization) is incorrect, then the procedure code must be cancelled using Form 471 (Prior Authorization Change Request) and a new PA submitted for the correct procedure code, However, upon the provider's request, Alabama Medicaid or its designee may approve the replacement of the correct procedure code to the current PA **only** if the previously submitted documentation verifies the correct procedure code.

All prior requests returned to the DME provider by Medicaid or its designee for additional medical information, if resubmitted, must contain the following:

Prior authorization requests that are lacking necessary information (EPSDT screening, referrals, required attachment) will be denied and the reason(s) noted in the PA letter under, “Analyst Remarks Request for reconsideration of a denied PA must be received by the fiscal agent within 30 days of the date of the denial letter.

All prior requests denied by Medicaid or its designee for additional medical information, if resubmitted for reconsideration, must contain the following:

(a) The PA denial letter

(b) The EPSDT Referral/PMP (Primary Managed Care Provider) Form, if applicable,

(c) All necessary documentation to justify medical necessity,

(d) Current prescription/order,

(e) Providers are encouraged to write the PA number on each page of documents submitted for reconsideration.

Prior Authorization Forms: For a hardcopy request, the provider or authorized representative must personally sign the form in the appropriate area or place his/her initials next to a typewritten or stamped signature to certify that the requested service, equipment, or supply is medically indicated and is reasonable and necessary for the treatment of the patient, and that a physician signed order or prescription/order is on file (if applicable). For electronic requests, provider certification will be made via standardized electronic signature protocol.

DME Review Criteria

Medicaid reviews all DME prior authorization requests for the following:

- Medicaid eligibility
- Medicare eligibility
- Medical necessity
- Therapeutic purpose for use of equipment in the recipient’s home

Although equipment prescribed by the physician may be on the list of covered items, Medicaid will determine to what extent it would be reasonable for Medicaid reimbursement. Equipment may be authorized when it is expected to make a significant contribution to the treatment of the recipient’s injury or illness or to improve his physical condition. Equipment will be denied if it is disproportionate to the therapeutic benefits or more costly than a reasonable alternative.

In the event Medicaid receives an authorization form from more than one provider prescribing the same item for a recipient, Medicaid will consider the authorization form received first.

NOTE:

For information on submitting Electronic PA Requests Requiring Attachments refer to Chapter 4, section 4.2.1 (Submitting PAs Using Provider Electronic Solutions) of the Alabama Medicaid Provider Manual.

Disposition of Equipment

The recipient or caregiver should contact the Alabama Medicaid Agency, DME Program, when the need for the equipment no longer exists. The DME provider should not take back equipment from recipients or caregivers that were purchased by Medicaid. The provider should have the recipient or caregiver call the DME Program at 1 (800) 362-1504 when the equipment is no longer being used or needed.

14.3.2 Program Referrals

Refer to the Provider Manual's Appendix A, Well Child Checkup (EPSDT) for billing instructions regarding program referrals.

EPSDT Referrals

The Omnibus Budget Reconciliation Act of 1989 expanded the scope of the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Program for Medicaid recipients under age 21. Effective October 1, 1990, Medicaid began prior authorizing certain approved medical supplies, appliances, and durable medical equipment prescribed as a result of an EPSDT screening to treat or improve a defect, an illness, or a condition.

Patient 1st Referrals

When filing claims for recipients enrolled in the Patient 1st program, refer to Chapter 39, Patient 1st Billing Manual to determine whether your services require a referral from the Primary Medical Provider (PMP).

Suppliers requesting approvals for medical items must provide Medicaid with an expected date of delivery.

For medical items approved based on medical necessity, Medicaid will indicate the time frame allowed for providers to dispense equipment on the approval letter.

When a provider is unable to dispense equipment within the time frame specified on the approval letter, an extension may be requested with written justification as to the specific reason(s) why the equipment cannot be supplied in a timely manner. All requests for extensions (Form 471: Prior Authorization Change Request) must be submitted to Medicaid's Medical and Quality Review Unit prior to the expiration date indicated on the approval letter. Medicaid will cancel approvals for medical items that are not dispensed in a timely manner when there is no justifiable reason for delay.

The Medicaid screening provider and recipient will be notified when an approved request for equipment is canceled due to provider noncompliance and the recipient will be referred to other Medicaid providers to obtain medical items.

14.4 Cost-Sharing (Copayment)

Medicaid recipients are required to pay and suppliers are required to collect the designated copay amount for the rental/purchase of services, supplies, appliances, and equipment, including crossovers. The copayment does not apply to services provided for pregnant women, recipients less than 18 years of age, emergencies, surgical fees, and family planning. Native American Indians that present an "active user letter" issued by Indian health Services (IHS) will be exempt from the Medicaid required copayment.

The Medicaid DME Program requires copayment at the following rates:

Item	*Copay Amount*
Durable Medical Equipment, including crossovers	$3.90 for items costing $50.01 or more $2.60 for items costing $25.01-$50.00 $1.30 for items costing $10.01-$25.00
Supplies and Appliances, including crossovers	$3.90 for items costing $50.01 or more $2.60 for items costing $25.01-$50.00 $1.30 for items costing $10.01-$25.00 $0.65 for items costing $10.00 or less
Iron Infusion Pump Repair	$ 3.90 for each Prior Authorization (PA) Number

The provider may not deny services to any eligible Medicaid recipient because of the recipient's inability to pay the cost-sharing amount imposed.

14.5 Completing the Claim Form

To enhance the effectiveness and efficiency of Medicaid processing, providers should bill Medicaid claims electronically.

DME providers who bill Medicaid claims electronically receive the following benefits:

- Quicker claim processing turnaround
- Immediate claim correction
- Enhanced online adjustment functions
- Improved access to eligibility information

Refer to Appendix B, Electronic Media Claims Guidelines, for more information about electronic filing.

NOTE:

When filing a claim on paper, a CMS-1500 claim form is required. Medicare-related claims must be filed on the Medical Medicaid/Medicare-related Claim Form.

Refer to Chapter 5, Filing Claims, for general claims filing information and instructions.

14.5.1 Time Limit for Filing Claims

Medicaid requires all claims for DME to be filed within one year of the date of service. Refer to Section 5.1.5, Filing Limits, for more information regarding timely filing limits and exceptions.

14.5.2 Diagnosis Codes

Effective June 1, 2008 DME providers may no longer bill using diagnosis code V729 on hard copy and electronically submitted claims. Providers will now be required to bill with specific diagnosis codes.

NOTE:

ICD-9 codes should be used for claims submitted with dates of service prior to or equal to 09/30/2015.

ICD-10 codes should be used for claims submitted with dates of service on/after 10/01/2015.

14.5.3 Procedure Codes and Modifiers

The medical supplies and appliances listed in Appendix P are available to eligible Medicaid recipients for use in their homes as prescribed by the attending physician and dispensed by a Medicaid contract provider.

For a complete listing of procedure codes and modifiers refer to Appendix P: Durable Medical Equipment (DME) Procedure Codes and Modifiers.

14.5.4 Place of Service Codes

The following place of service code applies when filing claims for DME:

POS	*Description*
12	Home

14.5.5 Required Attachments

To enhance the effectiveness and efficiency of Medicaid processing, your attachments should be limited to claims with third party denials.

NOTE:

When an attachment is required, a hard copy CMS-1500 claim form must be submitted.

Refer to Section 5.8, Required Attachments, for more information on attachments.

14.6 For More Information

This section contains a cross-reference to other relevant sections in the manual.

Resource	Where to Find It
CMS-1500 Claim Filing Instructions	Chapter 5
Medical Necessity/Medically Necessary Care	Chapter 7
Electronic Media Claims (EMC) Submission Guidelines	Appendix B
AVRS Quick Reference Guide	Appendix L
Alabama Medicaid Contact Information	Appendix N
DME Procedure Codes and Modifiers	Appendix P