NEBRASKA DEPARTMENT OF HEALTH AND HUMAN SERVICES
NOTICE OF PUBLIC HEARING

May 31, 2023
10:00 a.m. Central Time
Nebraska State Office Building – Lower Level
Meadowlark Conference Room
301 Centennial Mall South, Lincoln, Nebraska
Phone call information: 888-820-1398; Participant code: 3213662#

The purpose of this hearing is to receive comments on proposed changes to Title 471, Chapter 7 of the Nebraska Administrative Code (NAC) – *Durable Medical Equipment, Prosthetics, Orthotics, and Medical Supplies (DMEPOS).* The proposed changes set the regulations' scope and authority; update definitions; expand prescription authority; update provider requirements; update service requirements for covered and non-covered services; add glucose monitors as a covered service; update billing and payment requirements; remove unnecessary and outdated language; remove duplicate statutory language from the regulations; update formatting; and restructure the regulatory chapter.

Authority for these regulations is found in Neb. Rev. Stat. § 81-3117(7).

In order to encourage participation in this public hearing, a phone conference line will be set up for any member of the public to call in and provide oral comments. Interested persons may provide verbal comments by participating via phone conference line by calling 888-820-1398; Participant code: 3213662#.

Interested persons may attend the hearing and provide verbal or written comments, or mail, fax or email written comments, no later than the day of the hearing to: DHHS Legal Services, PO Box 95026, Lincoln, NE 68509-5026, (402) 742-2382 (fax) or dhhs.regulations@nebraska.gov, respectively.

A copy of the proposed changes is available online at http://www.sos.ne.gov, or by contacting DHHS at the mailing address or email above, or by phone at (402) 471-8417. The fiscal impact statement for these proposed changes may be obtained at the office of the Secretary of State, Regulations Division, 1201 N Street, Suite 120, Lincoln, NE 68508, or by calling (402) 471-2385.

Auxiliary aids or reasonable accommodations needed to participate in a hearing can be requested by calling (402) 471-8417. Individuals who are deaf or hard of hearing may call DHHS via the Nebraska Relay System at 711 or (800) 833-7352 TDD at least 2 weeks prior to the hearing.

FISCAL IMPACT STATEMENT

Agency: Department of Health and Human Services	
Title: 471	Prepared by: Erin Noble
Chapter: 7	Date prepared: 3-1-2023
Subject: Durable Medical Equipment, Prosthetics, Orthotics, and Medical Supplies (DMEPOS)	Telephone: 531-530-7154

Type of Fiscal Impact:

	State Agency	Political Sub.	Regulated Public
No Fiscal Impact	(☐)	(☒)	(☒)
Increased Costs	(☒)	(☐)	(☐)
Decreased Costs	(☐)	(☐)	(☐)
Increased Revenue	(☐)	(☐)	(☐)
Decreased Revenue	(☐)	(☐)	(☐)
Indeterminable	(☐)	(☐)	(☐)

Provide an Estimated Cost & Description of Impact:

State Agency:

The estimated cost of the proposed changes for Fiscal Year 2022-2023 is $888,872 in state funds. The estimate for Fiscal Year 2023-2024 is $1,804,293. These costs are due to the addition of coverage for continuous glucose monitors. The full fiscal note is available at https://nebraskalegislature.gov/FloorDocs/107/PDF/FN/LB698_20220315-084420.pdf

Political Subdivision: N/A.

Regulated Public: N/A.

If indeterminable, explain why: N/A.

TITLE 471 NEBRASKA MEDICAL ASSISTANCE PROGRAM SERVICES

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

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

002. DEFINITIONS. The following definitions apply.

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

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

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

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

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

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

002.07 DURABLE MEDICAL EQUIPMENT. Equipment which:

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

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

002.09 MEDICAL SUPPLIES. Expendable or reusable supplies required for care of a medical condition in the client's home. This does not include personal care items or oral or injectable over-the-counter drugs and medications.002.10 ORTHOSIS. A type of brace which either prevents or assists movement of a limb or the spine.

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

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

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

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

003. PROVIDER REQUIREMENTS.

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

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

004. SERVICE REQUIREMENTS.

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

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

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

004.01(A)(i) MEDICAID CERTIFICATION OF MEDICAL NECESSITY FORMS. Use of the following Medicaid Certification of Medical Necessity (CMN) forms are required:
(1) Form MS-78, Augmentative Communication Device Selection Report;
(2) Form MS-79, Wheelchair and Wheelchair Seating System Selection Report; or
(3) Form MS-80, Air Fluidized and Low Air Loss Bed Certification of Medical Necessity.

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

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

004.01(B) PRIOR AUTHORIZATION REQUIREMENTS. Prior authorization is required for coverage of the following items:
(1) Augmentative communication devices with related equipment and software;
(2) Spinal orthosis seating systems and back modules incorporated in or attached to a wheelchair base;
(3) Transcutaneous electrical nerve stimulators (TENS);
(4) Ultraviolet light therapy systems;
(5) All wheelchairs and wheelchair accessories, options, and components;
(6) Whirlpools; and
(7) Not otherwise classified (NOC) durable medical equipment, prosthetics, orthotics, and medical supplies (DMEPOS).

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

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

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

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

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

004.01(D) MULTIPLE OR DUPLICATE ITEMS. Medicaid does not cover purchase, rental or repair of multiple durable medical equipment, prosthetics, orthotics, and medical supplies (DMEPOS) used for the same or similar purposes. Medicaid does not cover back-up equipment. Back-up equipment may be supplied by the provider, but the provider may not bill Medicaid.

004.01(E) REPLACEMENT. Replacement of Medicaid-covered durable medical equipment, prosthetics, orthotics, and medical supplies (DMEPOS) items owned by the

client is covered if needed due to change in the client's medical condition, wear, loss, or irreparable damage.

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

(1) The cost must not exceed 80 percent of the Medicaid allowable purchase price for the item;

(2) All manufacturers and provider warranties must be pursued; and

(3) The provider must indicate if the item is owned by the client.

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

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

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

004.01(H) RENTAL. Items with a purchase price under one hundred fifty ($150) may be purchased rather than rented, unless the authorized durable medical equipment, prosthetics, orthotics, and medical supplies (DMEPOS) provider’s estimated duration of need is less than six months. Items with a purchase price of one hundred fifty ($150) or greater must be rented, unless the authorized durable medical equipment, prosthetics, orthotics, and medical supplies (DMEPOS) provider’s estimated duration of need is 12 months or greater. The Department is not responsible for lost, stolen, or damaged rental items.

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

(1) Providers will cease submitting payment requests for rental items when the Medicaid allowable is reached or after 12 monthly rental payments, whichever comes first;

(2) When converting a rental item to purchase before 12 months of rental, all rental monies paid to the provider will be applied to the Medicaid allowable purchase price; and

(3) When the conversion to purchase is completed, the item becomes the property of the client.

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

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

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

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

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

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

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

004.02 COVERED SERVICES.

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

(1) Orthotics, including lower and upper limb, foot, and spinal, as defined in this chapter;
(2) Prosthetics, including breast, eye, and lower and upper limb, as defined in this chapter; and
(3) All other items, necessary for the care of clients residing in nursing facility (NF) or intermediate care facility for individuals with developmental disabilities (ICF/DD),

(4) are included in payments to the facility and cannot be billed directly by a durable medical equipment, prosthetics, orthotics, and medical supplies (DMEPOS) provider.

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

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

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

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

004.02(B) SERVICES PROVIDED TO HOSPITAL PATIENTS. Medicaid covers durable medical equipment, prosthetics, orthotics, and medical supplies (DMEPOS), including fittings, provided to hospital patients, as defined in 471 NAC 10. Payment is not made separately to the durable medical equipment, prosthetics, orthotics, and medical supplies (DMEPOS) provider. In the event a customized wheelchair for primary use in other than the hospital setting is needed for training purposes while the client is a hospital inpatient, the non-hospital supplier or provider may deliver the wheelchair to the client during the inpatient stay and bill Medicaid. This exception does not apply to other items provided for use in the hospital setting.

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

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

(1) Comprehensive client assessment and evaluation by the authorized durable medical equipment, prosthetics, orthotics, and medical supplies (DMEPOS) provider has occurred;
(2) Treatment has been tried without success;
(3) Caregiver training on use of the bed by a registered nurse employed by the provider has occurred; and

(4) Initial dietary consult has occurred, which includes recommended caloric intake and serum albumin level at or near the time of placement.

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

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

004.02(C)(iii) ADDITIONAL DOCUMENTATION REQUIREMENTS. Form MS-80, Air Fluidized and Low Air Loss Bed Certification of Medical Necessity, must be completed on a monthly basis by a registered nurse, signed by the authorized durable medical equipment, prosthetics, orthotics, and medical supplies (DMEPOS) provider and kept on file with the provider and submitted to the health plans upon request.

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

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

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

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

(1) History and physical assessment by the infant's authorized durable medical equipment, prosthetics, orthotics, and medical supplies (DMEPOS) provider; and

(2) Parent or caregiver have successfully completed training on use of the equipment and any other authorized durable medical equipment, prosthetics, orthotics, and medical supplies (DMEPOS) provider recommended training.

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

(1) The number of apnea episodes during the previous two-month period of use;

(2) Tests and results of tests performed during the previous two-month period of use;

(3) Estimated additional length of time the monitor will be needed; and

(4) Any additional pertinent information the authorized durable medical equipment, prosthetics, orthotics, and medical supplies (DMEPOS) provider may wish to provide.

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

(i) Bath and toilet rails;

(ii) Raised toilet seats;

(iii) Tub stools and benches;

(iv) Transfer tub benches and attachments; and

(v) Bath support chairs.

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

(i) Disorientation;

(ii) Vertigo; or

(iii) A neurological disorder resulting in convulsive seizures.

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

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

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

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

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

(a) Voice synthesizers;
(b) Automatic timers; and
(c) Specially designed arrangements of supplies and materials to enable clients with visual impairments to use the equipment without assistance.

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

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

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

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

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

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

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

(1) Infant or neonate with abnormal weight loss;
(2) Hyperbilirubinemia;

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

004.02(L)(ii) LONG TERM RENTAL. Long term rental of breast pumps is covered for up to six months, with one additional six month period in the following instances:
(1) Congenital abnormality of the infant that impedes the infant's ability to suck or swallow;
(2) Neurologic abnormality of the infant;
(3) Prematurity; or
(4) Latch difficulties.

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

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

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

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

004.02(P)(i) EVALUATION. A licensed speech-language pathologist must evaluate the client's communication needs. The evaluation must identify the client's:
(1) Medical diagnosis:
(2) Speech-language diagnosis;
(3) Physical status;
(4) Communication abilities;
(5) Vision and hearing acuity; and
(6) Other skills required for use of the specific device selected.

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

MS-78 is submitted with the request for prior authorization. Documentation from the speech-language pathologist must show that the device meets the client's communication needs, the client has the ability to use the device and the device meets the functional communication goals established by the speech-language pathologist.

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

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

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

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

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

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

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

004.02(U) ELECTROMYOGRAPHY BIODFEEDBACK DEVICES. Electromyography biofeedback devices are covered for muscle re-education of specific muscle groups or for treating pathological muscle spasm, or weakness.

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

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

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

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

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

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

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

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

004.02(Y) FOOT ORTHOSES. Foot orthoses are covered when required to support a weak or deformed foot or leg, or to restrict or eliminate motion in a foot or leg. Coverage of orthopedic shoes is limited to one pair in a one-year period, except when documentation indicates excessive wear or size change is necessary due to growth.

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

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

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

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

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

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

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

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

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

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

(1) Diabetes team evaluation summary, which addresses:
(a) Diagnosis;
(b) Complications and compounding issues;
(c) Failure of adequate blood glucose control in spite of demonstrated compliance with multiple daily injections;
(d) Hemoglobin (Hgb) A_{1c} levels; and
(e) Patient's ability and motivation to use the pump; and
(2) Treatment plan, which includes:
(a) Inpatient initiation of continuous subcutaneous insulin infusion (CSII) pump or rationale for outpatient initiation with all policies and procedures involved;
(b) Client and family diabetes education plan; and

(c) Monitoring plan post-initiation of continuous subcutaneous insulin infusion (CSII) pump.

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

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

004.02(GG)(i) DOCUMENTATION REQUIREMENTS. Documentation must verify:
(1) The home can accommodate the lift:
(2) The caregiver is able and willing to use the equipment; and
(3) The client can tolerate using the equipment.

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

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

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

004.02(KK) NEBULIZERS AND COMPRESSORS. Medicaid provides coverage of nebulizers and compressors in the following situations:
(1) When the client's ability to breathe is severely impaired;
(2) To administer aerosol therapy when a metered dose inhaler is not adequate or appropriate;
(3) When required for use in connection with durable medical equipment, prosthetics, orthotics, and medical supplies (DMEPOS) for purposes of moisturizing oxygen; or
(4) For clients who require heated nebulizers with tracheostomies.

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

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

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

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

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

(i) Non-union of long bone fractures lasting six or more months;

(ii) Failed fusion lasting six or more months without healing of the fusion; and

(iii) Congenital pseudo arthrosis.

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

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

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

004.02(OO)(i) DOCUMENTATION REQUIREMENTS. A monthly updated certification of medical necessity is required when the oximeter is required for evaluation and regulation of home oxygen therapy. The documentation submitted by the authorized durable medical equipment, prosthetics, orthotics, and medical supplies (DMEPOS) provider must specify the client's medical condition which substantiates the need for in-home use of oximeter, estimated length of need for monitoring and frequency of monitoring required.

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

(1) The authorized durable medical equipment, prosthetics, orthotics, and medical supplies (DMEPOS) provider has determined that the client suffers severe lung disease or hypoxia-related symptoms that might be expected to improve with oxygen therapy;

(2) The client's blood gas levels indicate the need for oxygen therapy; and

(3) The client has appropriately tried other alternative treatment measures without complete success.

004.02(PP)(i) STATIONARY AND PORTABLE SYSTEM RENTAL. When both a stationary and portable system is being rented, the Medicaid allowable for all contents

is included in the Medicaid allowable for the stationary system. Stationary contents are covered only when the client owns the gaseous or liquid stationary system. Portable contents are covered only when the client uses a portable system only.

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

(1) An arterial partial pressure of oxygen (PO2) at or below 55 millimeters of mercury (mm Hg), or an arterial oxygen saturation at or below 88 percent, taken:
  (a) At rest;
  (b) During sleep for a client who demonstrates an arterial partial pressure of oxygen (PO2) at or above 56 millimeters of mercury (mm Hg);
    (i) An arterial oxygen saturation at or above 89 percent, while awake; or
    (ii) A greater than normal fall in oxygen level during sleep:
      (1) A decrease in arterial partial pressure of oxygen (PO2) more than 10 millimeter of mercury (mm Hg); or
      (2) A decrease in arterial oxygen saturation more than five percent associated with symptoms or signs reasonably attributable to hypoxemia. In either of these cases, coverage is provided only for nocturnal use of oxygen; or
  (c) During exercise:
    (i) For a client who demonstrates an arterial partial pressure of oxygen (PO2) at or above 56 millimeters of mercury (mm Hg); or
    (ii) An arterial oxygen saturation at or above 89 percent, during the day while at rest. In this case, supplemental oxygen is provided for during exercise if it is documented that the use of oxygen improves the hypoxemia which was demonstrated during exercise when the client was breathing without assistance; or
(2) An arterial partial pressure of oxygen (PO2) of 56 to 59 millimeter of mercury (mm Hg); or an arterial blood oxygen saturation of 89 percent if any of the following are documented:
  (a) Dependent edema suggesting congestive heart failure;
  (b) Pulmonary hypertension or cor pulmonale, determined by measurement of pulmonary artery pressure, gated blood pool scan, echocardiogram, "P" pulmonale of electrocardiogram; or
  (c) Erythrocythemia with a hematocrit greater than 56 percent.

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

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

(c) or her supervision or when performed by a qualified provider or supplier of laboratory services.

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

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

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

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

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

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

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

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

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

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

(1) History and physical assessment by the infant's authorized durable medical equipment, prosthetics, orthotics, and medical supplies (DMEPOS) provider has occurred;
(2) Required laboratory studies have been performed, including, complete blood count (CBC), blood type on mother and infant, direct Coombs, direct and indirect bilirubin;
(3) The authorized durable medical equipment, prosthetics, orthotics, and medical supplies (DMEPOS) provider certifies that the parent or caregiver is capable of administering home phototherapy;
(4) Parent or caregiver has successfully completed training on use of the equipment; and
(5) Equipment must be delivered and set up within four hours of discharge from the hospital or notification of the provider, whichever is more appropriate. There must be a 24-hour per day repair and replacement service available.

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

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

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

004.02(XX) POWER-OPERATED VEHICLE (POV). A power-operated vehicle (POV) is covered instead of a standard wheelchair when all of the following criteria are met:
(1) The client has a diagnosed medical condition which impairs their ability to walk;
(2) The client requires a power-operated vehicle (POV) for the purpose of:
  (a) Increasing their independence with mobility, resulting in significant difference in their ability to perform major life activities; or
  (b) Providing assisted mobility for clients who show no means of safe independent mobility;
(3) The client has significant limitation of limb function such that the client is not able to propel a manual wheelchair. Compared to their use of a manual wheelchair, the client's use of a power-operated vehicle (POV) must result in a significant improvement in independent mobility and ability to perform major life activities; and
(4) The client has demonstrated, through a trial period with a similar power-operated vehicle (POV):
  (a) The ability to safely and independently operate the controls of a power-operated vehicle (POV);
  (b) The ability to transfer safely in and out of a power-operated vehicle (POV); and
  (c) Adequate trunk stability to be able to safely ride in the power-operated vehicle (POV).

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

(1) Justify the type of wheelchair seating system; and

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

(a) Physical;

(b) Functional;

(c) Cognitive issues;

(d) Accessibility; and

(e) Cost effectiveness of equipment.

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

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

(1) Completely immobile;

(2) Limited mobility;

(3) Any stage pressure ulcer on the trunk or pelvis; or

(4) Pressure reducing cushions are covered for clients with or highly susceptible to decubiti.

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

(1) Impaired nutritional status;

(2) Fecal or urinary incontinence;

(3) Altered sensory perception; or

(4) Compromised circulatory status.

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

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

(1) Education of the client and caregiver on the prevention and management of decubiti;

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

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

004.02(ZZ)(i) ADDITIONAL CRITERIA. Coverage is limited to seat lifts which:
(1) Provide smooth transition in movement of the client;
(2) Can be controlled by the client; and
(3) Effectively assist a client in standing up and sitting down without other assistance.

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

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

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

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

004.02(BBB) SPINAL ORTHOSES. Spinal orthoses are covered for clients who require a wheelchair seating system for one of the following reasons:
(1) Supporting the client in a position that minimizes the development or progression of
musculoskeletal impairment;
(2) Relieving pressure; or

(3) Providing support in a position that improves the client's ability to perform functional activities.

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

(1) Justifies the type of wheelchair seating system; and

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

(a) Physical;

(b) Functional;

(c) Cognitive issues;

(d) Accessibility; and

(e) Cost effectiveness of equipment.

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

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

(i) Cancer or surgery of the throat or mouth;

(ii) Dysfunction of the swallowing muscles;

(iii) Unconsciousness or obtunded state; or

(iv) Tracheostomy.

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

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

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

004.02(GGG) TRANSCUTANEOUS ELECTRICAL NERVE STIMULATORS (TENS). Transcutaneous electrical nerve stimulators are covered for clients with chronic, intractable pain, or acute post-operative pain. The presumed etiology of the pain must be

a type which is accepted as responding to transcutaneous electrical nerve stimulators (TENS) therapy.

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

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

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

004.02(GGG)(ii)(1) ADDITIONAL DOCUMENTATION REQUIREMENTS. Authorized durable medical equipment, prosthetics, orthotics, and medical supplies (DMEPOS) provider approval is required for use of four leads with the transcutaneous electrical nerve stimulator (TENS) unit. The documentation must include why two leads are insufficient to meet the client's needs. Authorized durable medical equipment, prosthetics, orthotics, and medical supplies (DMEPOS) provider approval is required for a conductive garment for use with a transcutaneous electrical nerve stimulator (TENS) unit.

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

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

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

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

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

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

(1) Comprehensive client assessment and evaluation by the authorized durable medical equipment, prosthetics, orthotics, and medical supplies (DMEPOS) provider has occurred;
(2) The client has successfully completed training on the use of the equipment;
(3) The client is at high risk for preterm labor and delivery and must be a candidate for tocolytic therapy. Others at high risk for preterm labor and delivery may be covered upon approval by Medicaid through written communication from the client's authorized durable medical equipment, prosthetics, orthotics, and medical supplies (DMEPOS) provider;
(4) The pregnancy must be greater than 20 weeks gestation; and
(5) The client must have one of the following medical conditions:
    (a) Recent preterm labor with hospitalization and discharge on tocolytic therapy;
    (b) Multiple gestations;
    (c) History of preterm delivery;
    (d) Anomalies of the uterus;
    (e) Incompetent cervix;
    (f) Previous cone biopsy;
    (g) Polyhydramnios; or
    (h) Diethylstilbestrol exposure.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

004.03 NON-COVERED SERVICES.

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

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

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

(i) Air cleaners and purifiers;
(ii) Air conditioners;
(iii) Bed baths;
(iv) Bed lifters;
(v) Beds or lounge;
(vi) Beds oscillating;
(vii) Bed tables;
(viii) Bed boards;
(ix) Braille teaching texts;
(x) Carafes;
(xi) Cradles;
(xii) Dehumidifiers, room, or central heating type;
(xiii) Elevators;
(xiv) Emesis basins;
(xv) Enuresis alarms;
(xvi) Environmental control equipment;
(xvii) Exercise equipment;
(xviii) Heating and cooling plants or equipment;
(xix) Humidifiers, room, or central heating type;

(xx) Hypodermic jet pressure injectors for insulin;
(xxi) Lifts or wheelchair equipment;
(xxii) Massage devices;
(xxiii) Mattress and pillow covers;
(xiv) Medical identification items;
(xv) Pillows;
(xvi) Restraints;
(xvii) Sauna baths;
(xviii) Sheets, disposable or reusable;
(xxix) Shower attachments, handheld;
(xxx) Speech teaching machines;
(xxxi) Stairway elevators:
(xxii) Telephone arms; or
(xxxiii) Whirlpool pumps, portable.

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

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

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

(i) Angina pectoris in the absence of hypoxemia;
(ii) Dyspnea without cor pulmonale or evidence of hypoxemia;
(iii) Severe peripheral vascular disease resulting in clinically evident desaturation in one
or more extremities;
(iv) Terminal illness that does not affect the lungs; and
(v) Items that are considered precautionary and not therapeutic nature including:
(1) Spare tanks of oxygen;
(2) Emergency oxygen inhalators; and
(3) Preset portable oxygen delivery unit where flow rate is not adjustable.

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

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

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

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

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

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

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

005.01 BILLING.

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

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

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

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

(1) Bill for rental only while the item continues to be medically necessary and appropriately used by the client;

(2) Rental items not used by the client for more than a one month period, during inpatient hospitalization, may not be billed to Medicaid. The provider is responsible for determining whether the item continues to be used by the client;

(3) Bill rental on a monthly basis unless the item is used for less than a one-month period. When billing for monthly rental, the unit of service "1" indicates a one-month rental period. The provider will use the appropriate procedure code modifier when billing for monthly rental. The beginning rental date for each month will be the day of the month on which the item was initially provided. A monthly rental period is not necessarily a calendar month or a standard number

(4) of days. The monthly billing period begins the day of rental and extends to the day prior to the corresponding numerical day the following month. When rental equipment is needed at any time by the client for less than a one-month rental period, the rental is paid on a daily pro-rated basis. The provider will use the appropriate procedure code modifier when billing for daily rental. The unit of service must reflect the number of days the item was actually used; and

(5) When billing for rental items, indicate both from and to dates of service and the initial rental date.

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

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

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

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

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

005.02 PAYMENT.

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

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

(1) The provider's submitted charge; or

(2) The allowable amount for that procedure code in the Nebraska Medicaid Practitioner Fee Schedule in effect for that date of service.

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

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

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

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

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

005.02(B)(iv) AIR FLUIDIZED AND LOW AIR LOSS BED UNITS. Medicaid rental payment includes:

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

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

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

(1) Phototherapy unit and all supplies, accessories, and services necessary for proper functioning and effective use of the therapy;
(2) A minimum of one daily visit to the home by a licensed or certified health care professional is required. The daily visits must include:
    (a) A brief home assessment; and
    (b) Collection and delivery of blood specimens for bilirubin testing when ordered by the authorized durable medical equipment, prosthetics, orthotics, and medical supplies (DMEPOS) provider to be collected in the home. The authorized durable medical equipment, prosthetics, orthotics, and medical supplies (DMEPOS) provider must be informed by the provider that this service is available. An outside agency or laboratory with whom the provider contracts for collection and delivery of blood specimens may not bill Medicaid directly since payment is included in the daily rental payment. Daily home visits must occur for home assessment even if the blood collection is done outside the home; and

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

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

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

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

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

CHAPTER 7-000 DURABLE MEDICAL EQUIPMENT, PROSTHETICS, ORTHOTICS AND MEDICAL SUPPLIES (DMEPOS)

7-001 Standards for Participation: To participate in Medicaid, providers shall be enrolled as a DMEPOS Provider or a Facility Provider. DMEPOS and facility providers participating in Medicaid shall meet any applicable state and federal laws governing the provision of their services.

Medicaid does not generally enroll hospitals, physicians, and other licensed practitioners as providers of durable medical equipment, medical supplies, orthotics and prosthetics.

Medicaid enrolls as providers of DMEPOS only those providers who are involved in the direct provision of services or items to the client.

7-002 Covered Services: Medicaid covers medically necessary DMEPOS which meet program guidelines when prescribed by a physician.

7-002.01 Services Provided for Clients Enrolled in Nebraska Medicaid Managed Care: Certain Medicaid clients are required to participate in Managed Care. See 471-000-122 for a listing of the plans.

7-002.01A Nebraska Medicaid Managed Care Plans: Plans are required to provide, at a minimum, coverage of services as described in this Chapter. The prior authorization requirements, payment limitations, and billing instructions outlined in this Chapter do not apply to services provided to clients enrolled in a Managed Care plan. Services provided to clients enrolled in a Managed Care plan are not billed to Medicaid. The provider shall provide services only under arrangement with the Managed Care plan.

7-003 Non-Covered Services: Medicaid does not cover items which primarily serve the following purposes: personal comfort, convenience, education, hygiene, safety, cosmetic, and new equipment of unproven value, and equipment of questionable current usefulness or therapeutic value.

This Chapter's coverage index, although not intended to be all inclusive, specifies items which are generally not covered by Medicaid (see 471 NAC 7-013).

7-004 Definitions: Medicaid uses the following definitions -

Bed-confined: The client's condition is so severe that the client is essentially confined to bed, although not necessarily 100 percent of the time.Remains in section 2 as modified

Client: An individual who has been determined eligible for the Nebraska Medicaid Program.

Custom fabricated: Made for a specific client from his/her individualized measurements and/or pattern. Remains in section 2 as modified

Custom fitted: Substantial adjustments are made to a prefabricated item by a specially trained professional to meet the needs and/or unique shape of an individual client. Casting or molding techniques are not used in fabrication. Remains in section 2 as modified

Durable Medical Equipment: Equipment which -

1. Withstands repeated use;
2. Is primarily and customarily used to serve a medical purpose;
3. Generally is not useful to a person in the absence of an illness or injury; and
4. Is appropriate for use in the client's home.

Facility: In this Chapter refers to any nursing facility (471 NAC 12) or ICF/DD (471 NAC 31) currently enrolled as Medicaid providers. Remains in section 2 as modified

Homebound: The client's condition is such that there exists a normal inability to leave home, that leaving home requires a considerable and taxing effort by the individual, and that absences from home are infrequent or of relatively short duration or are attributable to the need to receive medical treatment.

ICF/DD: Intermediate Care Facility for Individuals with Developmental Disabilities and Persons with Related Conditions (formerly known as ICF/MR's). This is inclusive of ICF/IIDICF/IID services defined in CFR 440.150.

Medical Supplies: Expendable or specified reusable supplies required for care of a medical condition in the client's home. This does not include personal care items (e.g., deodorants, talcum powders, bath powders, soaps, dentifrices, eye washes, contact solutions, etc.) or oral or injectable over-the-counter drugs and medications. Remains in section 2 as modified

Molded to patient: Direct molding on the involved portion of a client's body. This material is ultimately used in the device being fabricated.

Molded to patient model: A process in which an impression is made of the specified body part. This impression is used to make a positive model (usually plaster) of the body part. The orthosis is then custom fabricated and/or fitted using this model.

Orthotics: Rigid or semi-rigid devices to prevent or correct physical deformity or malfunction, to support a weak or deformed part of the body, or eliminate motion in a diseased or injured part of the body. Remains in section 2 as modified

Prosthetics: Devices to replace a missing body part. Remains in section 2 as modified

7-005 Services for Clients Residing in Nursing Facilities and Intermediate Care Facilities for Individuals with Developmental Disabilities and Persons with Related Conditions (ICF/DD's): Medicaid reimburses DMEPOS providers for only the following items for clients residing in nursing facilities and ICF/DD's, if the client's condition meets the coverage criteria for the item as outlined in 471 NAC 7-013. The DMEPOS provider shall follow any prior authorization requirements outlined in this chapter. Remains in section 4 as modified

1. Orthoses (lower and upper limb, foot, and spinal) as defined in this Chapter; and
2. Prostheses (breast, eye, lower and upper limb) as defined in this Chapter.

Remains in section 4 as modified

Air fluidized beds, non-standard wheelchairs and wheelchair accessories, options, and components, including power operated vehicles, and negative pressure wound therapy (wound VAC) will be reimbursed separately to the nursing facility or ICF/DD according to the maximum allowable rate on the durable medical equipment and supplies fee schedule found at 471-000-507.Remains in section 4 as modified

All other items necessary for the care of clients residing in nursing facilities or ICF/DD's are included in payments to the facility and cannot be billed directly by a DMEPOS provider to Medicaid. Remains in section 4 as modified

At the time of the client's transfer or discharge, the following items specifically purchased for and used by the client shall be transferred with the client:

1. Any non-standard wheelchair and wheelchair accessories, options, and components, including power operated vehicles;
2. Augmentative communication devices with related equipment and software;
3. Supports (e.g. trusses and compression stockings with related components); and
4. Custom fitted and/or custom fabricated items.

7-006 Services Provided to Hospital Patients: Hospital patients are defined as registered inpatients and outpatients of a hospital, including a rehabilitation hospital, for the primary purpose of receiving medical services. DMEPOS (including fittings) provided to hospital patients may be provided directly by the hospital or under arrangements with a non-hospital supplier/provider. Payment is made to the hospital according to the Medicaid reimbursement methodology for hospital services. Payment is not made separately to the DMEPOS provider. EXCEPTION: In the event a customized wheelchair for primary use in OTHER than the hospital setting is needed for training purposes while the client is a hospital inpatient, the non-hospital supplier/provider may deliver the wheelchair to the client during the inpatient stay and bill Medicaid. This exception does not apply to other items provided for use in the hospital setting. Remains in section 4 as modified

7-007 Documentation of Medical Necessity: The provider shall obtain written documentation from the prescribing physician which justifies the medical necessity for durable medical equipment, medical supplies, orthotics and prosthetics and related services provided. The original documentation of medical necessity must be kept on file by the provider. The documentation must -

1. Be signed by the physician's own hand (stamps or other substitutes may not be used) and dated, using the date the documentation is signed;
2. Specify the start date of the order if the item is provided before the date the documentation is signed;
3. Include the physician's name, address and telephone number;
4. Include the diagnosis and/or condition necessitating the item(s) and an estimate of the total length of time the item will be needed (in months or years). The estimated total length of time the item will be needed must be completed by the physician or physician's office staff;
5. Be sufficiently detailed, including all options or additional features which will be separately billed or will require an upgraded procedure code;
6. Describe the ordered item(s) using either a narrative description or a brand name/model number, including all options or additional features (this may be completed by someone other than the physician, but the physician must review the order and sign and date it to indicate agreement);
7. For supplies provided on a periodic basis, include appropriate information on the quantity used, frequency of change and duration of need (PRN or "as needed" may not be used); and
8. Include information substantiating that all Medicaid coverage criteria for the item(s) are met.

7-007.01 Medicaid Certification of Medical Necessity Forms: Use of the following Medicaid Certification of Medical Necessity (CMN) forms is required. Form examples and completion instructions are included in the Medicaid Provider Handbook -

Form MS-78, "Augmentative Communication Device Selection Report"
Form MS-79, "Wheelchair and Wheelchair Seating System Selection Report"
Form MS-80, "Air Fluidized and Low Air Loss Bed Certification of Medical Necessity"

Remains in section 4 as modified

7-007.02 Medicare Certification of Medical Necessity Forms: Use of Medicare CMN forms, when a specific Medicaid CMN form does not exist, is strongly encouraged. When using Medicare CNM forms, Medicare completion instructions apply. Use of the following Medicare CMN form is required -

Medicare "Attending Physician's Certificate of Medical Necessity for Home Oxygen" form (latest revised edition)

7-007.03 Recertification of Medical Necessity: Documentation of medical necessity must be updated annually or when the physician's estimated quantity, frequency or duration of the client's need has expired, whichever occurs first, unless otherwise specified in this Chapter's coverage index. Remains in section 4 as modified

7-007.04 Second Opinion: Medicaid may request a second opinion to document medical necessity.

7-008 Prior Authorization

7-008.01 Prior Authorization Requirements: Prior authorization is required for payment of rental and purchase of the items listed below. Note: Prior authorization by Medicaid is not required for payment of Medicare or other primary insurance coinsurance and deductible. Prior authorizations are not required for clients residing in a NF or ICF/DD.

1. Augmentative communication devices with related equipment and software;
2. Spinal orthosis seating systems and back modules incorporated in or attached to a wheelchair base;
3. Transcutaneous electrical nerve stimulators (TENS);
4. Ultraviolet cabinets;
5. Non-standard wheelchairs and wheelchair accessories, options, and components, including power operated vehicles;
6. Whirlpools;
7. NOC (not otherwise classified) durable medical equipment – ONLY when the purchase price of the item exceeds $500; and
8. Any item for a client whose condition does not meet the Medicaid coverage criteria for the item.

Remains in section 4 as modified

7-008.02 Requests for Prior Authorization: The provider shall submit requests for Medicaid prior authorization electronically using the standard electronic Health Care Services Review – Request for Review and Response transaction (ASC X12N 278) (see Standard Electronic Transaction Instructions at 471-000-50) or by completing and submitting a clear reproduction of Form MS-77 according to the form instructions. Remains in section 4 as modified

A full-sized copy of Form MS-77 is included in the Medicaid Provider Handbook (see 471-000-206 for an example of the form and completion instructions).

The provider shall submit the documentation of medical necessity as outlined in 471 NAC 7-007 with each prior authorization request.

The Medicaid Division shall review the prior authorization request and documentation. The Department will notify the provider of the coverage decision on Form MS-77, "Prior Authorization Request", or the standard electronic Health Care Services Review – Request for Review and Response transaction (ASC X12N 278) or if additional information is needed, the specific information will be requested.

7-008.03 Prior Authorization Limitations: Approved prior authorizations are valid only if -

1. The client is Medicaid-eligible at the time services are provided. It is the responsibility of the provider to verify the client's Medicaid eligibility for the date of services;
2. The client's condition meets the Medicaid coverage criteria for the item at the time of purchase or for the duration of the rental period;
3. For rentals, the item is used appropriately by the client for the duration of the rental period;
4. The client's living arrangement does not change. Movement to a nursing facility, ICF-DD or hospital may invalidate an approved prior authorization;
5. The client is not enrolled in a Nebraska Medicaid Managed Care Plan at the time the service is rendered; and
6. All other Medicaid policies are followed.

Remains in section 4 as modified

7-009 (Reserved)

7-010 General Coverage Requirements and Limitations:

7-010.01 Coverage Criteria: Criteria for Medicaid coverage of some DMEPOS is outlined in this Chapter's coverage index (see 471 NAC 7-013). Items not specifically listed may not be covered by Medicaid. In order to be covered by Medicaid, the client's condition must meet the coverage criteria for the specific item. Documentation which substantiates that the client's condition meets the coverage criteria must be on file with the provider (see 471 NAC 7-007 for documentation of medical necessity requirements).

Exception: Some items of equipment may be covered under certain conditions even though they do not meet the exact definition of durable medical equipment. These items may be approved only by the appropriate staff of the Medicaid Division. To be covered, the equipment must prevent frequent hospitalizations or institutionalization, or serve a therapeutic purpose in an individual case. Use of these items must be included in the physician's course of treatment and be supervised by him/her.

7-010.02 (Reserved)

7-010.03 Maximum Quantity for Supplies: The maximum allowable quantity of supplies that may be dispensed is limited to a three (3) month supply, unless otherwise specified in this Chapter's coverage index (see 471 NAC 7-013). Providers may not bill for supplies dispensed in advance and may only bill at the end of the three (3) month period, or at the end of each month.
Remains in section 4 as modified

7-010.04 Multiple or Duplicate Items: Medicaid does not cover purchase, rental or repair of multiple or duplicate durable medical equipment, orthotics or prosthetics used for the same or similar purposes (e.g., power and manual wheelchairs, two nebulizers for use at different locations, etc.) Medicaid does not cover back-up equipment. Back-up equipment may be supplied by the provider, but the provider may not bill Medicaid. Remains in section 4 as modified

7-010.05 Replacement: Replacement of medically necessary, Medicaid-covered DMEPOS owned by the client is covered if needed due to change in the client's medical condition, wear, loss, irreparable damage, except for malicious damage, culpable neglect or wrongful disposition. Replacement required due to malicious damage, or culpable neglect, or wrongful disposition should be referred to the Medicaid Division for review. Remains in section 4 as modified

7-010.06 Repair: Medicaid covers repair required for the effective use of durable medical equipment, orthotics, and prosthetics when -

1. The item is covered by Medicaid;
2. The client's condition meets the coverage criteria for the item; and
3. The item is owned by the client.

Remains in section 4 as modified

The cost of the repair may not exceed 80% of the Medicaid allowable purchase price for the item. Payment for labor charges is covered only in conjunction with repair. All manufacturer and provider warranties must be pursued. Repairs required due to malicious damage or culpable neglect should be referred to the Medicaid Division for review. Remains in section 4 as modified

Medicaid covers rental of covered durable medical equipment for a maximum of three (3) months during which time the client-owned equipment is being repaired. If at any time the provider's usual business practice is to provide loaner equipment at no charge, the provider shall not bill Medicaid for rental during that period.

When billing for repair of durable medical equipment, the provider shall indicate if the item repaired is client owned.

7-010.07 Orthoses and Prostheses: Medicaid payment for orthoses and prostheses includes -

1. Evaluation;
2. Fitting;
3. Cost of parts and labor;
4. Repairs due to normal wear and tear for a minimum of 90 days from the date dispensed; and
5. Adjustments made when fitting and for a minimum of 90 days from the date dispensed when the adjustments are NOT necessitated by changes in the client's medical condition (e.g., residual limb) or the client's functional abilities.

Orthotic/prosthetic evaluations are reimbursable only when no device, orthosis, prosthesis, part, repair or adjustment is provided.

Remains in section 5 as modified

7-010.08 Supplies/Accessories for Durable Medical Equipment: Supplies and accessories required for the proper functioning and effective use of durable medical equipment are covered when -

1. The equipment is covered by Medicaid;
2. The client's condition meets the coverage criteria for the equipment; and
3. The equipment is owned by the client.

Supplies and accessories for rented durable medical equipment are generally included in the Medicaid rental payment, unless specifically allowed as outlined in this Chapter's coverage index.

7-010.09 Rental: The following requirements apply to items provided on a rental basis. If the provider is unable to meet these requirements, the Department may select another provider.

7-010.09A Rental/Purchase Decision: Items with a purchase price under $150 may be purchased rather than rented, unless the physician's estimated duration of need is less than 6 months. Items with a purchase price of $150 or greater must be rented, unless the physician's estimated duration of need is 12 months or greater.

7-010.09B Rental Option to Purchase: All rentals, except those listed below, must carry an option to purchase the item. THE PROVIDER SHALL CEASE ALL BILLING FOR RENTAL when rental payments reach the provider's purchase price or after 12 monthly rental payments, whichever occurs first. Upon conversion to purchase, the item becomes the property of the client. Remain in section 4 as modified

When converting a rental item to purchase before 12 months of rental, all rental paid or authorized shall be applied toward the Medicaid allowable purchase price. When converting from rental to purchase before 12 months of rental, the provider shall use the appropriate procedure code modifier and list the initial rental date and purchase on or with the claim. Remain in section 4 as modified

The following items are exempt from the rental/purchase option, remain the property of the provider, and may be rented on a monthly basis -

1. Oxygen delivery equipment; and
2. Ventilators.

Remain in section 4 as modified

The following items are exempt from the rental/purchase option. After 12 monthly rental payments, the item will be paid on a monthly "maintenance" basis and will remain the property of the provider. Providers shall use the appropriate procedure code modifier when billing for monthly "maintenance" -

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

Remains in section 4 as modified

Other items may be exempt from the rental/purchase option if approved by the Medicaid Division.

7-010.09C Rental Payment: Payment for rental includes -

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

Remains in section 5 as modified

7-010.09D Rental Billing Procedures:

1. Providers shall bill for rental only while the item continues to be medically necessary and appropriately used by the client;
2. Rental items not used by the client for more than a one month period (e.g., during inpatient hospitalization) may not be billed to Medicaid. The provider is responsible for determining whether the item continues to be used by the client; and
3. The provider shall bill rental on a monthly basis unless the item is used for less than a one-month period. When billing for monthly rental, the unit of service "1" indicates a one-month rental period. The provider shall use the appropriate procedure code modifier when billing for monthly rental. The beginning rental date for each month shall be the day of the month on which the item was initially provided. A monthly rental period is not necessarily a calendar month or a standard number of days (e.g., 28, 30, 31). Examples of monthly rental periods are –

Remains in section 5 as modified

January 5 - February 4
March 20 - April 19
June 15 - July 14

When rental equipment is needed at any time by the client for less than a one-month rental period, the rental is paid on a daily pro-rated basis. The provider shall use the appropriate procedure code modifier when billing for daily rental. The unit of service must reflect the number of days the item was actually used.

4. When billing for rental items, the provider shall indicate both "from" and "to" dates of service and the initial rental date.

7-010.09E Rental Delivery and Setup: If the client no longer requires rental equipment during the first month rental period and the rental item required delivery and set-up (e.g., oxygen delivery equipment, hospital bed, etc.), the provider may bill for "equipment set-up" in addition to the daily pro-rated rental fee for the days the equipment was actually used. Delivery and set-up charges may not be billed for client instruction on use of equipment or for equipment that is generally covered or customarily provided for a period of less than one month (e.g., home phototherapy services, CPM devices, etc.).

7-010.09F Loss/Damage of Rental Items: The Department is not responsible for lost, stolen, or damaged rental items.

7-010.10 Used Equipment: Used equipment is any equipment that has been purchased or rented by someone before the current purchase transaction. Used equipment also includes equipment that has been used under circumstances where there has been no commercial transaction (e.g., equipment used for trial periods or as a demonstrator). The provider must assure that used equipment meets the same standard of quality as new equipment and must provide comparable warranty, servicing and return policies available with new equipment.

Remains in section 4 as modified

When billing for used equipment, the provider shall use the appropriate procedure code modifier.

7-010.11 HEALTH CHECK (EPSDT) Treatment Services: Services not covered under Medicaid but defined in Section 1905(a) of the Social Security Act must meet the conditions of items 1 through 8 listed in the definition of "Treatment Services" in 471 NAC 33-001.04. These services must be prior authorized by the Medicaid Division.

7-011 Payment Methodology: Medicaid pays for covered durable medical equipment, medical supplies, orthotics and prosthetics, at the lower of -

1. The provider's submitted charge; or
2. The allowable amount for that procedure code in the Nebraska Medicaid Practitioner Fee Schedule in effect for that date of service. The allowable amount is indicated in the fee schedule as -
   a. The unit value multiplied by the conversion factor;
   b. The invoice cost (indicated as "IC" in the fee schedule);
   c. The maximum allowable dollar amount; or
   d. The reasonable charge for the procedure as determined by the Medicaid Division (indicated as "RNE" - rate not established - in the fee schedule). A copy of the purchase invoice showing the provider's actual cost for an item may be requested and used for pricing.

Remains in section 5 as modified

7-011.01 Revisions of the Fee Schedule: The Department may adjust the fee schedule to -

1. Comply with changes in state or federal requirements;
2. Comply with changes in national standard code sets, such as HCPCS and CPT;
3. Establish an initial allowable amount for a new procedure or a procedure which was previously identified as "RNE" or "BR" based on information that was not available when the fee schedule was established for the current year; and
4. Adjust the allowable amount when the Medicaid Division determines that the current allowable amount is -
   a. Not appropriate for the service provided; or
   b. Based on errors in data or calculation.

Providers may access information on fee schedules and changes in fee schedules on the DHHS Website under Provider Information page links.

7-011.02 Medicare/Medicaid Crossover Claims: For payment of Medicare/Medicaid crossover claims, see 471 NAC 3-004. Remains in section 5 as modified

7-012 Billing Requirements: Providers shall bill the Department on the appropriate claim form or electronic format (see Claim Submission Table at 471-000-49).

Any item billed to Medicaid must actually be dispensed or directly supplied by the provider that bills for the item. This does not preclude a provider from contracting with billing agents. Remains in section 5 as modified

The provider or the provider's authorized agent shall submit the provider's usual and customary charge for each procedure code listed on the claim. Any discount offered to the public must be reflected in the provider's submitted charge, except discounts for cash payment at the time of sale.

7-012.01 Procedure Codes and Modifiers: The provider shall bill the Department using the appropriate HCPCS procedure codes and modifiers. Remains in section 5 as modified

HCPCS procedure codes used by Medicaid are listed in the Nebraska Medicaid Practitioner Fee Schedule (see 471-000-507).

7-013 Coverage Index

Note: HCPCS procedure codes used by Medicaid are listed in the Nebraska Medicaid Practitioner Fee Schedule (see 471-000-507).

Description	Coverage Criteria
AIR CLEANERS/PURIFIERS.....	Not covered environmental control equipment; not primarily medical in nature.
AIR CONDITIONERS.....	Not covered environmental control equipment; not primarily medical in nature.
AIR FLUIDIZED and LOW AIR LOSS BED UNITS	Covered on a rental basis for - 1. A maximum period of 20 weeks for active healing and treatment of stage III (full thickness tissue loss) or stage IV (deep tissue destruction) decubiti located on the trunk or pelvis, while progressive, consistent wound healing occurs; or 2. A maximum period of eight weeks from the date of surgery for post-operative healing of major skin grafts or myocutaneous flaps on the trunk or pelvis. The client must be placed on the bed unit immediately after the surgical procedure. (Note: The supplier does not bill Medicaid for services provided while the client is a hospital patient (see 471 NAC 7-006). Note: Medicaid does not cover air fluidized beds for prevention of decubiti or pain control. Note: Air powered mattress overlays or mattress replacements are not covered. The following conditions must be met and documented prior to placement of an air fluidized or low air loss bed unit - 1. Comprehensive client assessment and evaluation by the attending physician has occurred; 2. Conservative treatment has been tried without success; 3. Caregiver training on use of the bed by a registered nurse employed by the provider has occurred; and 4. Initial dietary consult has occurred, which includes recommended caloric intake and serum albumin level at or near the time of placement.

The following conditions must be met and documented during use of air fluidized or low air loss bed units -

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

Remains in section 4 as modified

Payment: Medicaid rental payment includes -

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

Documentation: See 471 NAC 7-007 for documentation of medical necessity requirements. The provider must have documentation on file that substantiates that all requirements for coverage are met. Form MS-80 "Air Fluidized and Low Air Loss Bed Certification of Medical Necessity" must be completed on a monthly basis by a registered nurse employed by the provider and signed by the ordering physician and kept on file with the provider. (See 471-000-209 for form and completion instructions.)

Remains in section 4 as modified

APNEA MONITORS..... Covered on a rental basis for infants (birth through completion of one year of age) that meet one of the following criteria -

1. Infants with one or more apparent life-threatening events (ALTE's) requiring mouth-to-mouth resuscitation or vigorous stimulation. ALTE is defined as an episode that is frightening to the observer and characterized by some combination of apnea (central of occasionally obstructive), color change (usually cyanotic or pallid but occasionally erythematous or plethoric), marked change in muscle tone (usually limpness), choking or gagging. In some cases, the observer fears the infant has died;
2. Symptomatic preterm infants;
3. Siblings of one or more SIDS victims; or
4. Infants with certain diseases or conditions, such as central hyperventilation, bronchopulmonary dysplasia, infants with tracheostomies, infants with substance-abusing mothers, or infants with less severe ALTE's.

Remains in section 4 as modified

Criteria for discontinuing apnea monitoring must be based on the infant's clinical condition. A monitor may be discontinued when ALTE infants have had two- three months free of significant alarms or apnea requiring vigorous stimulation or resuscitation. Evaluating the infant's ability to tolerate stress (e.g., immunizations, illness) during this time is advisable.
Remains in section 4 as modified

Pneumocardiograms are covered for diagnostic/ evaluation purposes and when required to determine when the infant may be removed from the monitor. Payment does not include analysis and interpretation. This service must be billed by the physician performing the service. Remains in section 4 as modified

Note: Medicaid does not cover monitors that do not use rechargeable batteries.

The following conditions must be met prior to initiation of home apnea monitoring -

1. History and physical assessment by the infant's attending physician; and
2. Parent/caregiver have successfully completed training on use of the equipment and any other physician recommended training (e.g., infant resuscitation and stimulation).

Remains in section 4 as modified

Payment: Medicaid rental payment includes complete parent/caregiver training on use of the equipment and record keeping. Medicaid does not make separate payment for remote alarms. When provided, payment for a remote alarm is included in the monitor rental payment. Remains in section 5 as modified

Supplies/Accessories: Apnea monitor supplies are covered for use with rented and client-owned apnea monitors. For rented apnea monitors, the apnea monitor supplies must be billed on the same claim as the apnea monitor rental.

Documentation: See 471 NAC 7-007 for documentation of medical necessity requirements. The provider must have documentation on file that substantiates that all conditions for coverage are met. Apnea monitor rental exceeding two months requires a physician's narrative report of client progress to be kept on file with the provider. A new progress report is required every two months. The report must include -

1. The number of apnea episodes during the previous two-month period of use;
2. Tests and results of tests performed during the previous two-month period of use;
3. Estimated additional length of time the monitor will be needed; and
4. Any additional pertinent information the physician may wish to provide.

Remains in section 3 as modified

BATH and TOILET AIDS..... The following bath and toilet aids are covered for clients with severe conditions which justify use of the item: bath/toilet rails, raised toilet seats, tub stools and benches, transfer tub benches and attachments, and bath support chairs. Remains in section 3 as modified

Bathtub patient lifts and rehabilitation shower chairs are covered for clients with severe conditions who, without use of the equipment, would be unable to bathe or shower. The client must be unable to use a stationary tub stool or bench, rails and/or similar equipment. Remains in section 3 as modified

Note: Bed baths and shower attachments (e.g., hand-held shower attachments, faucet adapters, etc.) are not covered.

Documentation: See 471 NAC 7-007 for documentation of medical necessity requirements.

BED BATHS ..... Not covered-hygienic equipment; not primarily medical in nature.

BED LIFTERS..... Not covered-not primarily medical in nature.

BED SIDE RAILS..... Covered for clients who are at risk for injury due to one of the following conditions –

1. Disorientation;
2. Vertigo; or
3. A neurological disorder resulting in convulsive seizures.

Remains in section 4 as modified

Bed side rails are also covered when an integral part of, or an accessory to, a hospital bed. Remains in section 4 as modified

Documentation: See 471 NAC 7-007 for documentation of medical necessity requirements.

(See also HOSPITAL BED ACCESSORIES.)

BED TABLES, ANY TYPE ..... Not covered-convenience item; not primarily medical in nature.

BED WEDGES..... Covered for clients that require the head of the bed to be elevated more than 30 degrees most of the time due to congestive heart failure, chronic pulmonary disease or problems with aspiration. Standard bed pillows must have been tried and failed. Remains in section 4 as modified

Documentation: See 471 NAC 7-007 for documentation of medical necessity requirements.

BEDBOARDS ..... Not covered-not primarily medical in nature.

BEDPANS and URINALS ..... Covered for clients who are bed-confined. Remains in section 4 as modified

Documentation: See 471 NAC 7-007 for documentation of medical necessity requirements.

BEDS, HOSPITAL ..... See HOSPITAL BEDS.

BEDS, LOUNGE (MANUAL OR POWER)..... Not covered-not a hospital bed; comfort or convenience item; not primarily medical in nature.

BEDS, OSCILLATING..... Not covered-institutional equipment; inappropriate for home use.

BIOFEEDBACK DEVICES..... See ELECTROMYOGRAPHY (EMG) BIOFEEDBACK DEVICES.

BLOOD GLUCOSE MONITORS ..... Covered for clients that meet all of the following conditions -

1. The client is diabetic (includes non-insulin treated diabetes and gestational diabetes);
2. The client's physician states that the client is capable of being trained to use the particular device prescribed in an appropriate manner. In some cases, the client may not be able to perform this function, but a responsible individual can be trained to use the equipment and monitor the client to assure that the intended effect is achieved. This is permissible if this information is properly documented by the client's physician; and
3. The device is designed for home rather than clinical use.

Remains in section 4 as modified

Blood glucose monitors with such features as voice synthesizers, automatic timers, and specially designed arrangements of supplies and materials to enable clients with visual impairments to use the equipment without assistance are covered when the following conditions are met –Remains in section 4 as modified

1. The client and device meet the three conditions listed above for coverage of standard blood glucose monitors; and
2. The client's physician certifies that the client has a visual impairment severe enough to require use of this special monitoring system.

Remains in section 4 as modified

Supplies/Accessories: Supplies necessary for effective use and proper functioning of a blood glucose monitor are covered for use with rented and client-owned monitors for clients whose condition meets the criteria for coverage of the monitor.

Documentation: See 471 NAC 7-007 for documentation of medical necessity requirements. Use of the Medicare CMN form is strongly encouraged.

BLOOD PRESSURE MONITORS ..... Covered for clients with hypertension whose condition must be self-monitored at home. An electronic blood pressure monitor is covered only if the client is unable to use a standard cuff and stethoscope due to conditions such as poor eyesight or hearing, arthritis, or other physical disability.Remains in section 4 as modified

Note: Blood pressure monitors required for renal dialysis are payable ONLY to approved renal dialysis facilities. (See DIALYSIS EQUIPMENT AND SUPPLIES.)

Supplies/Accessories: Payment for purchase and rental of a blood pressure monitor includes all accessories necessary for proper functioning and effective use of the monitor. Accessories are payable only as replacement for use with client-owned monitors for clients whose condition meets the criteria for coverage of the monitor.

Documentation: See 471 NAC 7-007 for documentation of medical necessity requirements. The documentation must specify the cuff size, that the physician will be monitoring its use in connection with the client's continuing course of treatment, and that the client or caregiver will be instructed in use of the equipment by the physician, physician's office staff or other qualified health professional. Remains in section 4 as modified

BONE GROWTH STIMULATORS ..... See OSTEOGENESIS STIMULATORS.

BRAILLE TEACHING TEXTS ..... Not covered-education equipment; not primarily medical in nature.

BREAST PROSTHESES (EXTERNAL) and SUPPLIES .... Covered for clients who have had a mastectomy. Remains in section 4 as modified

Documentation: See 471 NAC 7-007 for documentation of medical necessity requirements.

BREAST PUMPS..... Covered for clients who are breast feeding if one of the conditions listed below for short term or long term rental are met. Hospital grade breast pumps are covered only on a rental basis.Remains in section 4 as modified

SHORT TERM RENTAL (up to 2 months)

1. Infant/neonate with abnormal weight loss
2. Hyperbilirubinemia
3. Inadequate milk supply
4. Mastitis
5. Acutely ill infant
6. Infant food allergy (to maintain milk supply for a limited period until off the offending foods)
7. Medical condition of mother that precludes feeding infant at breast (examples include, but not limited to: mom on radioactive compound or other medication short term)
8. Maternal post-partum complications (examples but not limited to: excessive fluids during delivery, maternal blood loss, D&C)

Remains in section 4 as modified

LONG TERM RENTAL (up to 6 months, with one additional 6 month period if medically necessary)

1. Congenital abnormality of the infant (examples, but not limited to: cleft lip/palate, Down syndrome, other syndrome with poor suck/swallow, abnormal anatomy, congenital heart disease)
2. Neurologic abnormality of the infant (examples, but not limited to: low tone, poor suck/swallow reflex)
3. Prematurity (less than 37 weeks gestation)
4. Latch difficulties

Remains in section 4 as modified

Supplies/Accessories: During rental of a breast pump, supplies and accessories necessary for proper functioning and effective use of the pump are included in the rental allowance. For the purchase of a pump, the allowance includes supplies and accessories needed for one month. Accessories and supplies are payable only as a replacement for use with client-owned pumps for clients whose condition meets the criteria for coverage of the pump.

Documentation: See 471 NAC 7-007 for documentation of medical necessity requirements.

CANES and CRUTCHES..... Covered for clients with conditions that impair ambulation.

Note: A white cane for use by a blind person is considered an identifying and self-help device rather than an item which makes a meaningful contribution to the treatment of an illness or injury and is therefore not covered.

Supplies/Accessories: Payment for purchase and rental of canes and crutches includes all accessories necessary for proper functioning and effective use of the item. Accessories such as tips, handgrips, etc., are payable only as replacement for use with client-owned canes or crutches for clients whose condition meets the criteria for coverage of the item.

Documentation: See 471 NAC 7-007 for documentation of medical necessity requirements.

CAR SEATS ..... Positioning seats approved for use in vehicles are covered for clients age 20 and younger with physical disabilities when required for positioning during transportation when standard seat belts or infant car seats are not appropriate. Remains in section 4 as modified

Documentation: See 471 NAC 7-007 for documentation of medical necessity requirements.

CARAFES..... Not covered-convenience item; not primarily medical in nature.

COMMODES ..... Covered for clients who are confined to bed or room or confined to home in which there are no bathroom facilities on that floor or bathroom facilities are inaccessible.

A commode chair with detachable arms is covered only if medically necessary, such as for obesity or paraplegia.

Remains in section 4 as modified

Supplies/Accessories: Payment for purchase and rental of a commode includes all accessories necessary for proper functioning and effective use of the commode. Accessories such as a commode pail or pan are payable only as replacement for use with client-owned commodes whose condition meets the criteria for coverage of the monitor.

Documentation: See 471 NAC 7-007 for documentation of medical necessity requirements.

COMMUNICATION DEVICES, AUGMENTATIVE.....

Covered for clients who are unable to use natural oral speech as a primary means of communication. The specific device requested must be appropriate for use by the client and the client must demonstrate the abilities or potential abilities to use the device selected. Client/family/ environment must support the use of the device. Remains in section 4 as modified

Coverage is limited to portable devices needed to supplement, aid or serve as an alternative to natural speech for clients with severe expressive communication disorders. Non-portable devices may be covered only if required for visual enhancement or physical access needs that cannot be accommodated by a portable device.

An evaluation of the client's communication needs by a qualified professional speech pathologist is required. A background and experience in augmentative communication is recommended.

A qualified professional speech pathologist must -

1. Have been granted a certificate of clinical competence from the American Speech and Hearing Association or have completed the equivalent educational requirements and work experience needed for the certificate or have completed the academic program and is acquiring supervised work experience to qualify for the certificate; and
2. If practicing in Nebraska, be licensed by the Nebraska Department of Health and Human Services or be certified by the Nebraska Department of Education; or
3. If practicing outside Nebraska, meet that state's requirements for participation in the Medicaid Program.

The evaluation must address the client's medical diagnosis, speech-language diagnosis, physical status, communication abilities, vision and hearing acuity, cognitive, neuromotor, language and other skills or potential required for use of the specific device selected. The specific device recommended, along with all accessories required for use of the device must be identified and the selection justified.

A trial period with the device selected may be required. A maximum of three months rental may be approved for rental of devices not subsequently purchased. (See 471 NAC 7-010.08 for rental requirements.)

When an augmentative communication device with related equipment and software is no longer needed or when a replacement device is requested, it is strongly encouraged that augmentative communication devices with related equipment and software purchased with Medicaid funds be donated to a regional or facility-based "equipment pool".

Communication boards, dedicated speech-generating devices (medical in nature) and related accessories are DME. Artificial larynx, voice amplification, and related devices are prostheses.

Documentation: See 471 NAC 7-007 for documentation of medical necessity requirements. Form MS-78, "Augmentative Communication Device Selection Report", must be completed and signed by the evaluating speech-language pathologist and the ordering physician. Form MS-78 is submitted with the request for prior authorization.

COMPRESSORS..... See NEBULIZERS and COMPRESSORS.

CONTINUOUS PASSIVE MOTION (CPM) DEVICES..... Covered for clients who have received a total knee replacement. To qualify for coverage, use of the device must commence within two days following surgery. Coverage is limited to that portion of the three-week period following surgery during which the device is used in the client's home. Remains in section 4 as modified

Accessories/Supplies: Payment for rental of CPM devices includes all accessories necessary for proper functioning and effective use of the device.

Documentation: See 471 NAC 7-007 for documentation of medical necessity requirements.

CONTINUOUS POSITIVE AIRWAY PRESSURE SYSTEMS (CPAP)..... Covered for clients with moderate or severe obstructive sleep apnea for whom surgery is a likely alternative to CPAP. Remains in section 4 as modified

Intermittent assist devices with CPAP are covered for clients that after trial use with CPAP cannot tolerate use of CPAP without intermittent assist devices. Remains in section 4 as modified

Humidifiers for use with CPAP are covered for clients that require supplemental humidification with CPAP. Remains in section 4 as modified

Supplies/Accessories: Supplies and accessories necessary for effective use and proper functioning of CPAP devices are covered for use with rented and client-owned devices for clients whose condition meets the criteria for coverage of the device.

Documentation: See 471 NAC 7-007 for documentation of medical necessity requirements. Use of Medicare CMN form is strongly encouraged.

CRADLES, ANY TYPE ..... Not covered-not primarily medical in nature.

CRUTCHES ..... See CANES and CRUTCHES.

DEHUMIDIFIERS, ROOM OR CENTRAL HEATING SYSTEM TYPES ..... Not covered-environmental control equipment; not primarily medical in nature.

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

DIATHERMY MACHINES, STANDARD and PULSED WAVE TYPES..... Not covered-inappropriate for home use.

DRESSINGS..... Covered for clients that require treatment of a wound or surgical incision.Remains in sections 4 as modified

Note: Skin/wound cleaners are not covered.

Documentation: See 471 NAC 7-007 for documentation of medical necessity requirements.

ELECTRICAL NERVE STIMULATORS ..... See NEUROMUSCULAR ELECTRICAL STIMULATORS; TRANSCUTANEOUS ELECTRICAL NERVE STIMULATORS.

ELECTROMYOGRAPHY (EMG) BIOFEEDBACK DEVICES	Covered for muscle re-education of specific muscle groups or for treating pathological muscle spasm, or weakness, when more conventional treatments (heat, cold, massage, exercise, support) have not been successful. This therapy is not covered for psychosomatic conditions, or for psychiatric conditions. Remains in section 4 as modified Supplies/Accessories: Payment for purchase and rental of a EMG biofeedback device includes all accessories necessary for proper functioning and effective use of the device. Accessories are payable only as replacement for use with client-owned devices for clients whose condition meets the criteria for coverage of the device. Documentation: See 471 NAC 7-007 for documentation of medical necessity requirements.
ELEVATORS	Not covered-convenience item; not primarily medical in nature.
EMESIS BASINS	Not covered-convenience item; not primarily medical in nature.
ENTERAL NUTRITION	Covered for clients with normal gastrointestinal (G.I.) absorptive capacity who, due to permanent or temporary nonfunction or disease of the structures that normally permit food to reach the small bowel, requires tube feedings to provide sufficient nutrients to maintain weight and strength commensurate with the client's overall health status. Note: Permanent impairment is not required for coverage. Remains in section 4 as modified Coverage includes enteral nutrients, infusion pumps, feeding supply kits, and nasogastric/gastrostomy/jejunostomy tubes. Enteral feeding supply kits include all the necessary supplies (excluding the tubing) for the enteral patient using the syringe, gravity, or pump method of nutrient administration.

No more than one month supply of enteral nutrients, equipment or supplies may be provided in advance.

If a pump is ordered, there must be documentation to justify its use (e.g., gravity feeding is not satisfactory due to reflux and/or aspiration, severe diarrhea, dumping syndrome, administration rate less than 100 ml/hr, blood glucose fluctuations, circulatory overload).

Note: Disposable drug delivery systems (elastomer infusion pumps) and infusion controller devices are not covered.

Note: For clients eligible for the Supplemental Feeding and Nutrition Program for Women, Infants and Children (WIC), enteral nutrients are covered if the product is not covered by WIC or if the quantity required exceeds the maximum quantity provided by WIC.

Documentation: See 471 NAC 7-007 for documentation of medical necessity requirements. Use of the Medicare CMN form is strongly encouraged.

(See also NUTRITIONAL SUPPLEMENTS; PARENTERAL NUTRITION.)

ENURESIS ALARMS ..... Not covered-not primarily medical in nature.

ENVIRONMENTAL CONTROL EQUIPMENT..... Not covered-not primarily medical in nature.

ESOPHAGEAL DILATORS..... Not covered-physician instrument.

EXERCISE EQUIPMENT..... Not covered-not primarily medical in nature.
(includes exercise bicycles, Moore wheel, treadmills, weights)

EYE PROSTHESES ..... Covered for clients with absence or shrinkage of an eye due to birth defect, trauma or surgical removal. Remains in section 4 as modified

Documentation: See 471 NAC 7-007 for documentation of medical necessity requirements.

FAMILY PLANNING SUPPLIES ..... Covered when required to prevent or delay pregnancy.

Documentation: See 471 NAC 7-007 for documentation of medical necessity requirements.

FOOT ORTHOSES
(orthopedic shoes, shoe modifications, transfers)..... Covered when required to support a weak or deformed body member or to restrict or eliminate motion in a diseased or injured part of the body. Remains in secton 4 as modified

Orthopedic shoes and shoe corrections are not covered for flexible or congenital flat feet. Coverage of orthopedic shoes is limited to one pair at the time of purchase. Except when documentation indicates excessive wear or size change necessary due to growth, only one pair of orthopedic shoes is covered in a one year period.

Documentation: See 471 NAC 7-007 for documentation of medical necessity requirements.

HEARING AID BATTERIES..... Covered for clients that use hearing aids. Remains in section 4 as modified

Note: For policy regarding NMAP coverage of hearing aids, see 471 NAC 8-000.

Documentation: See 471 NAC 7-007 for documentation of medical necessity requirements.

HEAT/COLD APPLICATION DEVICES..... Covered for clients with medical conditions for which the application of heat or cold is therapeutic. Remains in section 4 as modified

Documentation: See 471 NAC 7-007 for documentation of medical necessity requirements.

(See also PARAFFIN BATH UNITS.)

HEATING and COOLING PLANTS/EQUIPMENT ..... Not covered environmental control equipment; not primarily medical in nature.

HOSPITAL BEDS ..... A fixed height hospital bed is one with manual head and leg elevation adjustments, but no height adjustments. A fixed height hospital bed is covered for clients whose condition meets one of the following criteria:

1. Requires positioning of the body in ways not feasible with an ordinary bed due to a medical condition which is expected to last at least one month. Elevation of the head/upper body less than 30 degrees does not usually require use of a hospital bed;
2. Requires, for the alleviation of pain, positioning of the body in ways not feasible with an ordinary bed;
3. Requires the head of the bed to be elevated more than 30 degrees most of the time due to congestive heart failure, chronic pulmonary disease or problems with aspiration. Pillows or wedges must have been tried and failed; or
4. Requires traction equipment which can only be attached to a hospital bed.

Remains in section 4 as modified

A variable height hospital bed is one with manual height adjustment and with manual head and leg elevation adjustments. A variable height hospital bed is covered if the client's condition meets the criteria for coverage of a fixed height hospital bed and the client also requires a bed height different from that provided by fixed height hospital bed in order to permit transfers to chair, wheelchair or standing position.

A semi-electric hospital bed is one with manual height adjustment and with electric head and leg elevation adjustments. A semi-electric hospital bed is covered if the client's condition meets the criteria for coverage of a fixed height hospital bed and the client also requires frequent changes in body position and/or has an immediate need for a change in body position.

Note: A total electric bed is one with electric height adjustment and with electric head and leg elevation adjustments. An electric bed height adjustment feature is not covered; it is a convenience feature. If the documentation supports a lower level bed, payment is based on the allowable for the least costly alternative.

Supplies/Accessories: An innerspring or foam rubber mattress is covered when an integral part of, an accessory to or as a replacement for a medically necessary hospital bed owned by the client.

Side rails are covered when an integral part of, or an accessory to, a medically necessary hospital bed if the client's condition requires bed side rails. (See also BED SIDE RAILS.)

A trapeze bar is covered for clients who need the device to sit up because of a respiratory condition, to change body position for other medical reasons, or to get in or out of bed.

A bed cradle is covered for clients with acute gouty arthritis or burns for whom it is necessary to prevent contact with the bed coverings.

Note: An overbed table is not covered since it is a convenience item and not primarily medical in nature.

Note: A bed board is not covered since it is not primarily medical in nature.

Documentation: See 471 NAC 7-007 for documentation of medical necessity requirements. Use of Medicare CMN form is strongly encouraged.

HUMIDIFIERS (ROOM OR CENTRAL HEATING TYPE)..... Not covered environmental control equipment; not primarily medical in nature. (See also VAPORIZERS.)

IMPOTENCE TREATMENT DEVICES..... Covered for clients with organic impotence and without conditions that contraindicate use of the device. Remains in section 4 as modified

Supplies/Accessories: Payment for purchase of the device includes all accessories necessary for proper functioning and effective use of the device.

Documentation: See 471 NAC 7-007 for documentation of medical necessity requirements.

INCONTINENCE APPLIANCES and CARE SUPPLIES..... Covered for clients without control over bladder or bowel function. Incontinence diapers/briefs and liners are not covered for clients under age 3. Remains in section 4 as modified

Note: Skin cleansers are not covered.

Documentation: See 471 NAC 7-007 for documentation of medical necessity requirements.

INFUSION PUMPS, EXTERNAL..... Covered for clients with conditions which require administration of parenteral medication when reasonable and necessary, and when an infusion pump is necessary to safely administer the medication. Remains in section 4 as modified

Note: Disposable drug delivery systems (elastomer infusion pumps) and infusion controller devices are not covered.

Insulin Infusion pumps, Continuous Subcutaneous (CSII): Purchase is covered on a prior authorization basis based on medical necessity. The provider shall obtain written documentation from the prescribing physician which includes at minimum, the following:

1. Diabetes Team Evaluation Summary: Letter from the prescribing physician who is part of a diabetes team; (the team must include at minimum a physician with expertise in diabetes and a diabetic health educator) must address at minimum:
   a. Diagnosis;
   b. Complications/Compounding issues;
   c. Failure of adequate blood glucose control in spite of demonstrated compliance with multiple daily injections;
   d. Hgb A_{1c} levels; and
   e. Patient's ability and motivation to use the pump.
   Remains in section 4 as modified

2. Treatment plan: A comprehensive plan of care for the client utilizing the CSII which includes:
   a. Inpatient initiation of CSII or rationale for outpatient initiation with all policies and procedures involved;
   b. Client/family diabetes education plan; and
   c. Monitoring plan post-initiation of CSII.
   Remains in section 4 as modified

Supplies/Accessories: Supplies necessary for effective use and proper functioning of an external infusion pumps are covered for use with rented and client-owned pumps for clients whose condition meets the criteria for coverage of the pump.

Note: For billing of medications administered with external infusion pumps, see 471 NAC 16-000, Pharmacy Services.

Documentation: See 471 NAC 7-007 for documentation of medical necessity requirements.

(See also ENTERAL NUTRITION; PARENTERAL NUTRITION.)

INJECTORS (hypodermic jet pressure powered devices for injection of insulin) ..... Not covered-effectiveness not adequately demonstrated.

INTERMITTENT POSITIVE PRESSURE BREATHING (IPPB) MACHINES ..... Covered for clients whose ability to breathe is severely impaired. Remains in section 4 as modified

Supplies/Accessories: Payment for purchase and rental of an IPPB machine includes all accessories necessary for proper functioning and effective use of the machine. Accessories are payable only as replacement for use with client-owned devices for clients whose condition meets the criteria for coverage of the machine.

Documentation: See 471 NAC 7-007 for documentation of medical necessity requirements.

LIFTS, PATIENT ..... Covered for clients when transfer between bed and a chair, wheelchair or commode requires the assistance of more than one person or without the use of a lift, the client would be bed confined. Remains in section 4 as modified

Documentation: See 471 NAC 7-007 for documentation of medical necessity requirements. Documentation must verify the client can use the lift and has had a successful trial, if first time user.

Prior Authorization: Prior authorization of payment is not required.

(See also BATH and TOILET AIDS; SEAT LIFT CHAIRS.)

LIFTS, WHEELCHAIR/ EQUIPMENT	Not covered-convenience item; not primarily medical in nature.
LOW AIR LOSS BED UNITS	See AIR FLUIDIZED and LOW AIR LOSS BED UNITS.
LOWER and UPPER LIMB ORTHOSES.....	Covered when required to support a weak or deformed body member or to restrict or eliminate motion in a diseased or injured part of the body. Documentation: See 471 NAC 7-007 for documentation of medical necessity requirements. Prior Authorization: Prior authorization of payment is not required.
LOWER and UPPER LIMB PROSTHESES	Covered when required to replace a missing body part. Note: Myoelectric and electronically switch controlled prosthetic devices are not covered. Documentation: See 471 NAC 7-007 for documentation of medical necessity requirements.
LYMPHEDEMA PUMPS	See PNEUMATIC COMPRESSORS.
MASSAGE DEVICES.....	Not covered-comfort item; not primarily medical in nature.
MATTRESS/PILLOW COVERS.....	Not covered-not primarily medical in nature.
MEDICAL IDENTIFICATION ITEMS	Not covered-do not serve a diagnostic or therapeutic purpose.
MEDICAL/SURGICAL SUPPLIES	Covered for clients that require home treatment of a specific medical condition, protection or support of a wound, surgical incision or diseased or injured body part. Note: Skin/wound cleansers and "ready to use" disinfectant cleaning solution are not covered. Documentation: See 471 NAC 7-007 for documentation of medical necessity requirements. (See also DRESSINGS; INCONTINENCE APPLIANCES and CARE SUPPLIES; OSTOMY SUPPLIES; TRACHEOSTOMY CARE SUPPLIES.)

NEBULIZERS and COMPRESSORS..... Covered if the client's ability to breathe is severely impaired, to administer aerosol therapy when use of a metered dose inhaler is not adequate or appropriate, or when required for use in connection with durable medical equipment for purposes of moisturizing oxygen.

Heated nebulizers are covered for clients with tracheostomies that require heated oxygen.

Portable compressors with internal battery features require specific documentation from the physician justifying the medical necessity of the portable feature.

Ultrasonic nebulizers are covered only when other means of nebulization is documented by the physician to be ineffective.

Note: For nebulizers and humidifiers for use with a flow meter or regulator, see OXYGEN and OXYGEN EQUIPMENT.

Supplies/Accessories: Supplies and accessories necessary for effective use and proper functioning of a nebulizer or compressor are covered for use with rented and client-owned equipment for clients whose condition meets the criteria for coverage of the compressor. Note: Distilled water is not covered. For billing of medications for inhalation therapy, see 471 NAC 16, Pharmacy Services.

Documentation: See 471 NAC 7-007 for documentation of medical necessity requirements.

NEUROMUSCULAR ELECTRICAL STIMULATORS (NMES)..... Covered for treatment of disuse atrophy where nerve supply to the muscle is intact, including brain, spinal cord and peripheral nerves, and other non-neurological reasons for disuse are causing atrophy. Some examples would be castings or splinting of a limb, contracture due to scarring of soft tissue as in burn lesions, and hip replacement surgery (until orthotic training begins). Note: Neuromuscular electric stimulators are not covered for treatment of scoliosis. Remains in section 4 as modified

A conductive garment for use with a NMES unit may be covered when medical necessity is sufficiently substantiated.

Supplies/Accessories: NMES supplies are covered for use with rented and client-owned NMES units for clients whose condition meets the criteria for coverage of the unit. For rented NMES units, the lead wires and supplies must be billed on the same claim as the NMES rental.

Documentation: See 471 NAC 7-007 for documentation of medical necessity requirements.

NUTRITIONAL SUPPLEMENTS ..... Covered for clients who require nutritional supplementation to maintain weight and strength commensurate with the client's general condition.

Note: Infant formula for oral nutritional supplements is covered for clients age 20 and younger only if medically necessary for special dietary needs (e.g., soy based, low iron, premature, etc.)

Note: For clients eligible for the Supplemental Feeding and Nutrition Program for Women, Infants and Children (WIC), nutritional supplements are covered if the product is not covered by WIC or if the quantity requirement exceeds the maximum quantity provided by WIC.

Documentation: See 471 NAC 7-007 for documentation of medical necessity requirements.

(See also ENTERAL NUTRITION; PARENTERAL NUTRITION.)

OCULAR PROSTHESES..... See EYE PROSTHESES.

ORTHOPEDIC SHOES..... See FOOT ORTHOSES.

ORTHOSES..... See FOOT ORTHOSES; UPPER and LOWER LIMB ORTHOSES.

OSTEOGENIC STIMULATORS (NONINVASIVE)..... Covered for client's with one of the following indications -

1. Nonunion of long bone fractures;
2. Failed fusion; and
3. Congenital pseudoarthrosis.

Nonunion of long bone fractures is considered to exist only after six or more months.

Remains in section 4 as modified

A failed fusion is considered to exist only after 6 months or more have elapsed without healing of the fusion.

Supplies/Accessories: Payment for osteogenic stimulators includes all accessories and supplies necessary for proper functioning and effective use of the device.

Documentation: See 471 NAC 7-007 for documentation of medical necessity requirements. Use of Medicare CMN form is strongly encouraged.

OSTOMY SUPPLIES..... Covered for clients with an ostomy.

Skin moisturizers, protectants and sealants are covered only if medically necessary for clients with ostomies. Remains in section 4 as modified

Note: Skin cleansers are not covered.

Documentation: See 471 NAC 7-007 for documentation of medical necessity requirements.

OVERBED TABLES..... Not covered convenience item; not primarily medical in nature.

OXIMETERS, EAR/PULSE..... Covered on a rental basis for clients who require a minimum of daily monitoring of arterial blood oxygen saturation levels for evaluation and regulation of home oxygen therapy. Coverage for other indications will be determined on a case-by-case basis. Remains in section 4 as modified

Note: In-home overnight (12 hour or similar) oximetry trend studies and other single test ("one time") oximetry testing is not covered.

Supplies/Accessories: During rental of an oximeter, supplies and accessories necessary for proper functioning and effective use of the device are included in the rental allowance.

Documentation: See 471 NAC 7-007 for documentation of medical necessity requirements. The documentation must specify -

1. The client's medical condition which substantiates the need for in-home use of oximeter;
2. The estimated length of need for monitoring; and
3. The frequency of monitoring required (e.g., continuous, daily, etc.).

A monthly updated certification of medical necessity is required when the oximeter is required for evaluation and regulation of home oxygen therapy. Remains in section 4 as modified

OXYGEN and OXYGEN EQUIPMENT..... Covered for clients with significant hypoxemia in the chronic stable state provided the following conditions are met:

1. The attending physician has determined that the client suffers severe lung disease or hypoxia-related symptoms that might be expected to improve with oxygen therapy;
2. The client's blood gas levels indicate the need for oxygen therapy; and
3. The client has appropriately tried other alternative treatment measures without complete success. Remains in section 4 as modified

Oxygen therapy is covered for clients with significant hypoxemia evidenced by any of the following:

1. An arterial PO2 at or below 55 mm Hg, or an arterial oxygen saturation at or below 88 percent, taken -
   a. at rest;
   b. during sleep for a client who demonstrates an arterial PO2 at or above 56 mm Hg, or an arterial oxygen saturation at or above 89 percent, while awake, or a greater than normal fall in oxygen level during sleep (a decrease in arterial PO2 more than 10 mm Hg, or a decrease in arterial oxygen saturation more than 5 percent) associated with symptoms or signs reasonable attributable to hypoxemia (e.g., impairment of cognitive processes and nocturnal restlessness or insomnia). In either of these cases, coverage is provided only for nocturnal use of oxygen; or

c. during exercise for a client who demonstrates an arterial PO2 at or above 56 mm Hg or an arterial oxygen saturation at or above 89 percent, during the day while at rest. In this case, supplemental oxygen is provided for during exercise if it is documented that the use of oxygen improves the hypoxemia that was demonstrated during exercise when the client was breathing room air; or

2. An arterial PO2 of 56 to 59 mm Hg or an arterial blood oxygen saturation of 89 percent if any of the following are documented -
   a. Dependent edema suggesting congestive heart failure;
   b. Pulmonary hypertension or cor pulmonale, determined by measurement of pulmonary artery pressure, gated blood pool scan, echocardiogram, "P" pulmonale of EKG (P wave greater than 3 mm in standard leads II, III, or AVF); or
   c. Erythrocythemia with a hematocrit greater than 56 percent

Remains in section 4 as modified

Oxygen therapy is not covered for -

1. Angina pectoris in the absence of hypoxemia;
2. Dyspnea without cor pulmonale or evidence of hypoxemia;
3. Severe peripheral vascular disease resulting in clinically evident desaturation in one or more extremities; and
4. Terminal illness that does not affect the lungs.

Portable oxygen systems alone or to complement a stationary oxygen system may be covered if the client is mobile within the residence. Remains in section 4 as modified

Respiratory therapists' services are not covered. The durable medical equipment benefit provides for coverage of oxygen and oxygen equipment, but does not include a professional component in the delivery of such services.

Note: The following items are not covered since they are precautionary and not therapeutic in nature -

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

Note: Piped-in oxygen delivery is not considered an acceptable delivery mode for reimbursement as durable medical equipment.

Oxygen therapy includes the oxygen contents, the system for furnishing it, the vessels that store it, and the tubing and administration sets that allow the safe delivery of oxygen.

When a both stationary and portable system is being rented, the allowable for all contents is included in the allowable for the stationary system. Stationary contents are payable only when the client owns the gaseous or liquid stationary system. Portable contents are payable only when the client uses a portable system only (either rented or owned).

Documentation: See 471 NAC 7-007 for documentation of medical necessity requirements. Use of the Medicare CMN form is required. Documentation must include the results of a blood gas study that has been ordered and evaluated by the attending physician. This will usually be in the form of a measurement of the partial pressure of oxygen (PO2) in the arterial blood. A measurement of pulse arterial oxygen saturation may also be acceptable when ordered and evaluated by the attending physician and performed under his/her supervision or when performed by a qualified provider or supplier of laboratory services. Note: A DMEPOS supplier is not considered a qualified provider or supplier of laboratory services for purposes of these guidelines. When a client's initial certification for oxygen is approved based on an arterial PO2 of 56 mm Hg or greater or an oxygen saturation of 89% or greater, retesting between the 61st and 90th day of home oxygen therapy is required in order to establish continued medical necessity.

Supplies/Accessories: Oxygen supplies/accessories (e.g., tubing, administration sets, etc.), are payable only as replacement for use with client owned delivery systems for clients whose condition meets the criteria for coverage of oxygen therapy.

Prior Authorization: Prior authorization of payment is not required.

Billing Requirements: When billing for oxygen therapy, the DMEPOS provider shall use the appropriate unit of service as described in the procedure code. Units of service should be rounded to the nearest unit of the procedure code description.

PACEMAKER MONITORS, SELF CONTAINED ..... Covered for clients with cardiac pacemakers. Remains in Section 4 as modified

Documentation: See 471 NAC 7-007 for documentation of medical necessity requirements.

PARAFFIN BATH UNITS, PORTABLE ..... Covered for clients with conditions that are expected to be relieved by long term use of this modality and who have undergone a successful trial period of paraffin therapy. Remains in section 4 as modified

Supplies/Accessories: Paraffin is covered for use with rented and client-owned paraffin bath units for clients whose condition meets the criteria for coverage of the device.

Documentation: See 471 NAC 7-007 for documentation of medical necessity requirements.

PARALLEL BARS ..... Not covered support exercise equipment; primarily for institutional use; in the home setting, other devices (e.g., walkers) available to meet client's needs.

PARENTERAL NUTRITION..... Covered for clients with severe permanent or temporary disease of the gastrointestinal tract which prevents absorption of sufficient nutrients to maintain weight and strength commensurate with the client's overall health status.

Coverage includes parenteral nutrition infusion pumps, supply and administration kits, and parenteral nutrients. Parenteral supply and administration kits include all the components necessary to administer therapy.

No more than one month supply of parenteral nutrients, equipment or supplies may be provided in advance.

Note: Disposable drug delivery systems (elastomer infusion pumps) and infusion controller devices are not covered.

Note: For clients eligible for the Supplement Feeding and Nutrition Program for Women, Infants and Children (WIC), parenteral nutrients are covered if the product is not covered by WIC or if the quantity required exceeds the maximum quantity provided by WIC.

Documentation: See 471 NAC 7-007 for documentation of medical necessity requirements.

PEAK FLOW METERS ..... Covered for clients with chronic asthma.

Documentation: See 471 NAC 7-007 for documentation of medical necessity requirements.

PERCUSSORS ..... Covered for mobilizing respiratory tract secretions in clients with cystic fibrosis, chronic obstructive lung disease, chronic bronchitis, or emphysema, when the client or operator of powered percussor has received appropriate training by a physician or therapist and no one competent to administer manual therapy is available. Remains in section 4 as modified

Documentation: See 471 NAC 7-007 for documentation of medical necessity requirements.

PHOTOTHERAPY SERVICES ... Covered on a rental basis for infants that meet the following criteria -

1. Neonatal hyperbilirubinemia is the infant's sole clinical problem;
2. The infant is greater than or equal to 37 weeks gestational age and birth weight greater than 2,270 gm (5 lbs);
3. The infant is greater than 48 hours of age;
4. Bilirubin level at initiation of phototherapy (greater than 48 hours of age) is 14-18 mgs per deciliter; and
5. Direct bilirubin level is less than 2 mgs per deciliter.

Remains in section 4 as modified

Home phototherapy is not covered if the bilirubin level is less than 12 mgs. at 72 hours of age or older.

The following conditions must be met prior to initiation of home phototherapy -

1. History and physical assessment by the infant's attending physician has occurred. If home phototherapy begins immediately upon discharge from the hospital, the newborn discharge exam will suffice;
2. Required laboratory studies have been performed, including, CBC, blood type on mother and infant, direct Coombs, direct and indirect bilirubin;
3. The physician certifies that the parent/caregiver is capable of administering home phototherapy;
4. Parent/caregiver have successfully completed training on use of the equipment; and
5. Equipment must be delivered and set up within 4 hours of discharge from the hospital or notification of provider, whichever is more appropriate. There must be a 24-hour per day repair and/or replacement service available.

Remains in section 4 as modified

At a minimum, one bilirubin level must be obtained daily while the infant is receiving home phototherapy.

Payment: Medicaid daily rental payment includes -

1. Phototherapy unit and all supplies, accessories, and services necessary for proper functioning and effective use of the therapy;
2. A minimum of one daily visit to the home by a licensed and/or certified "health care professional" is required. The daily visits must include -
   a. A brief home assessment; and
   b. Collection and delivery of blood specimens for bilirubin testing when ordered by the physician to be collected in the home. The physician must be informed by the provider that this service is available.

   An outside agency or laboratory with whom the provider contracts for collection and delivery of blood specimens may not bill Medicaid directly since payment is included in the daily rental payment. Daily home visits must occur for home assessment even if the blood collection is done outside the home.
3. Complete caregiver training on use of equipment and completion of necessary records.

Documentation: See 471 NAC 7-007 for documentation of medical necessity requirements. A physician's narrative report outlining the client's progress and the circumstances necessitating extended therapy must be submitted with the claim when billing for home phototherapy exceeding three days. Remains in section 4 as modified

Billing Requirements: The provider shall bill for home phototherapy daily rental on a single claim and indicate the total number of rental days as the units of service.

PILLOWS..... Not covered convenience item; not primarily medical in nature. (See also BED WEDGES; TRACTION EQUIPMENT.)

PNEUMATIC COMPRESSORS and APPLIANCES ..... Covered for clients with intractable edema of the extremities.

Rental of a pneumatic appliance is not covered because the item is intended for single-person use.

Remains in section 4 as modified

Documentation: See 471 NAC 7-007 for documentation of medical necessity requirements. Use of Medicare CMN form is strongly encouraged.

POSTURAL DRAINAGE BOARDS..... Covered for clients with chronic pulmonary conditions.
Remains in section 4 as modified

Documentation: See 471 NAC 7-007 for documentation of medical necessity requirements.

PRESSURE REDUCING SUPPORT SURFACES ..... Pressure reducing mattress pads/overlays are covered when the client meets one of the following criteria -

1. Completely immobile (i.e., the client cannot make changes in body position without assistance);
2. Limited mobility (i.e., the client cannot independently make changes in body position significant enough to alleviate pressure); or
3. Any stage pressure ulcer on the trunk or pelvis.

Remains in section 4 as modified

If the client meets criteria 2 or 3 above, the client must also meet at least one of the following criteria -

a. Impaired nutritional status;
b. Fecal or urinary incontinence;
c. Altered sensory perception; or
d. Compromised circulatory status.

Remains in section 4 as modified

Pressure reducing mattress replacements are covered when the client meets the coverage criteria for a pressure reducing mattress pad/overlay and -

1. Anticipated length of need is at least one year; or
2. "Bottoming out" is anticipated on a comparable pad/overlay. "Bottoming out" is the finding that the client's body will be in contact with a flat outstretched hand (palm up) that is placed underneath the support surface in various body positions.

Note: Powered mattress pads/overlays and mattress replacements, except alternating pressure pads, are not covered.

The client must also have a care plan established by the physician or other licensed healthcare practitioner directly involved in the client's care which should include the following:

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

Adherence to the care plan/treatment is not to be construed as elements for coverage criteria.

Pressure reducing cushions are covered for clients with or highly susceptible to decubiti and whose physician will be supervising its use in connection with his/her course of treatment.

Documentation: See 471 NAC 7-007 for documentation of medical necessity requirements. The client's physician must have prescribed the item for treatment must specify in the prescription that s/he will be supervising its use in connection with the client's course of treatment. Use of Medicare CMN form is strongly encouraged.

(See also AIR FLUIDIZED and LOW AIR LOSS BED UNITS.)

PROSTHESES ..... See BREAST PROSTHESES; EYE PROSTHESES; UPPER and LOWER LIMB PROSTHESES.

PULSE TACHOMETERS..... Not covered-not reasonable or necessary for monitoring pulse of client with or without a cardiac pacemaker.

REPAIR ..... See 471 NAC 7-010.06 for repair policy.

RESTRAINTS, ANY TYPE..... Not covered-not primarily medical in nature.
(including body, chest, wrist,
ankle, or for use in cars)

SAUNA BATHS..... Not covered-not primarily medical in nature.

SEAT LIFTS..... Covered if all the following criteria are met -

1. The client must have severe arthritis of the hip or knee or have a severe neuromuscular disease;
2. The seat lift chair must be a part of the physician's course of treatment and be prescribed to effect improvement, or arrest or retard deterioration in the client's condition;
3. The client must be completely incapable of standing up from a regular armchair or any chair in their home; and
4. Once standing, the client must have the ability to ambulate.

Coverage is limited to those types which operate smoothly, can be controlled by the client, and effectively assist a client in standing up and sitting down without other assistance. Excluded from coverage is the type of lift which operates by a spring release mechanism with a sudden, catapult-like motion and jolts the client from a seated to standing position.

Payment: Payment for seat lift chairs which incorporates a recliner feature along with the seat lift is limited to the amount payable for a seat lift without this feature.

Documentation: See 471 NAC 7-007 for documentation of medical necessity requirements. Use of Medicare CMN form is strongly encouraged.

Medicare/ Medicaid Clients: For clients eligible for both Medicare and Medicaid, the seat portion of the seat lift chair will be covered by if Medicaid the seat lift mechanism has been approved by Medicare. Prior authorization of payment is not required. Documentation of Medicare coverage (remittance advice or coordination of benefits) must be submitted on or with the Medicaid claim when billing for the chair portion.

SHEETS, DISPOSABLE OR REUSABLE ..... Not covered-convenience item; not primarily medical in nature.

SHOWER ATTACHMENTS, HANDHELD ..... Not covered-hygienic equipment; not primarily medical in nature.

SITZ BATHS ..... Covered for clients with infection or injury of the perineal area and use of the item is part of the physician ordered planned regimen of treatment in the client's home.

Documentation: See 471 NAC 7-007 for documentation of medical necessity requirement.

SPEECH TEACHING MACHINES ..... Not covered-education equipment; not primarily medical in nature.

SPINAL ORTHOSES ..... Covered when required to support a weak or deformed body member or to restrict or eliminate motion in a diseased or injured body part.

A seating system, back module for use with a wheelchair is covered when medically necessary for use with a medically necessary wheelchair base, for a client who has a diagnosed medical condition that impairs their ability to sit. A wheelchair seating system may be covered for the purpose of -

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

Remains in section 4 as modified

An evaluation of the client's wheelchair seating needs by a licensed physical or occupational therapist is required. Documentation must be provided using Form MS-79 "Wheelchair and Wheelchair Seating System Selection Report", and must -

1. Justify the type of wheelchair seating system; and
2. Provide evidence of a coordinated assessment. A coordinated assessment includes communication between the client, caregiver(s), physician, physical and/or occupational therapist, and equipment supplier. The assessment should address physical, functional, and cognitive issues, as well as accessibility and cost effectiveness of equipment.

Remains in section 4 as modified

Form MS-79 must be reviewed and signed by a physician involved in the client's care. Note: This evaluation will generally not be required when the diagnosis or prescribed length of need indicates the wheelchair will be required on a short-term basis only.

Documentation: See 471 NAC 7-007 for documentation of medical necessity requirements. Form MS-79, "Wheelchair and Wheelchair Seating System Selection Report" is required with all requests for prior authorization of wheelchairs, wheelchair options/accessories, and seating systems, unless the wheelchair will be required on a short term basis only. Form MS-79 must be completed by the licensed physical or occupational therapist who evaluated the client's wheelchair/seating system needs and reviewed and signed by a physician involved in the client's care. (See 471-000-208 for form and completion instructions.)

Remains in section 4 as modified

STAIRWAY ELEVATORS..... Not covered convenience item; not primarily medical in nature.

STOCKINGS, SURGICAL..... See SUPPORTS.

SUCTION PUMPS..... Covered for clients who have difficulty raising and clearing secretions secondary to -

1. Cancer or surgery of the throat or mouth;
2. Dysfunction of the swallowing muscles;
3. Unconsciousness or obtunded state; or
4. Tracheostomy.

Remains in section 4 as modified

Supplies/Accessories: Supplies and accessories necessary for effective use and proper functioning of a suction pump are covered for use with rented and client-owned suction pumps for clients whose condition meets the criteria for coverage of the pump.

Documentation: See 471 NAC 7-007 for documentation of medical necessity requirements. Use of Medicare CMN form is strongly encouraged.

(See also TRACHEOSTOMY CARE SUPPLIES.)

SUPPORTS (including elastic supports, elastic/surgical stockings, slings, trusses, etc.).... Covered for post-surgical clients, and clients with intractable edema of the lower extremities or other circulatory disorders.
Remains in section 4 as modified

Note: Support pantyhose are not covered.

Documentation: See 471 NAC 7-007 for documentation of medical necessity requirements.

TELEPHONE ALERT SYSTEMS ..... Not covered these are emergency communication systems and do not serve a diagnostic or therapeutic purpose.

TELEPHONE ARMS..... Not covered convenience item; not primarily medical in nature.

TOOTHBRUSHES ..... Not covered personal hygiene item.

TRACHEOSTOMY CARE SUPPLIES ..... Covered for clients with an open surgical tracheostomy.

A tracheostomy care or cleaning starter kit is covered following an open surgical tracheostomy for a two week post-operative period.

An artificial larynx is covered for clients that have had a laryngectomy or whose larynx is permanently inoperable.

Artificial larynx and tracheostomy speaking valves are prostheses.

Documentation: See 471 NAC 7-007 for documentation of medical necessity requirements.

Remain in section 4 as modified

TRACTION EQUIPMENT ..... Covered for clients with orthopedic impairments requiring traction equipment that prevents ambulation during the period of use.

Cervical pillows are covered only when required for use with traction equipment.

Remains in section 4 as modified

Supplies/Accessories: Payment for purchase and rental of traction equipment includes all accessories necessary for proper functioning and effective use of the equipment. Accessories are payable only as replacement for use with client-owned traction equipment for clients whose condition meets the criteria for the equipment.

Documentation: See 471 NAC 7-007 for documentation of medical necessity requirements.

TRANSCUTANEOUS ELECTRICAL NERVE STIMULATORS (TENS)..... Covered for clients with chronic, intractable pain or acute post-operative pain who meet the following criteria -

The presumed etiology of the pain must be a type which is accepted as responding to TENS therapy.

For chronic, intractable pain, the medical record must document the location of the pain, the duration of time the patient has had the pain and the presumed etiology of the pain. The pain must have been present for at least 3 months.

Remain in section 4 as modified

Other appropriate treatment modalities must have been tried and failed and the medical record must document what treatment modalities have been used (including the names and dosage of medication), the length of time that each type of treatment was used and the results. The TENS unit must be used by the client on a trial basis for a minimum of one month, but not to exceed two months. This trial period may not begin sooner than the end of the 3 months used to establish the existence of chronic pain. The trial period will be paid as a rental. The trial period must be monitored by the physician to determine the effectiveness of the TENS unit in modulating the pain. For coverage of a purchase, the physician must determine that the patient is likely to derive significant therapeutic benefit from continuous use of the unit over a long period of time. The physician's records must document a reevaluation of the client at the end of the trial period and must indicate how often the client used the TENS unit, the typical duration of use each time, and the results.

A TENS unit is not covered for acute pain (less than 3 months duration) other than post-operative pain. For acute post-operative pain, a TENS unit is generally covered for no more than one month following the day of surgery. Approval for more than one month will be determined on a case-by-case basis, based on the documentation provided by the attending physician and submitted with the prior authorization request. Remains in section 4 as modified

A four-lead TENS unit may be used with either 2 lead or 4 leads, depending on the character of the patient's pain. If it is ordered for use with 4 leads, the medical record must document why 2 leads are insufficient to meet the client's needs. Remains in section 4 as modified

A conductive garment for use with a TENS unit may be covered when medical necessity is sufficiently substantiated.

Supplies/Accessories: TENS supplies are covered for use with rented and client-owned TENS units for clients whose condition meets the criteria for coverage of the unit. If the TENS unit is used less than daily, the frequency of billing for the TENS supplies must be reduced proportionally. For rented TENS units, the supplies must be billed on the same claim as the TENS rental.

Documentation: See 471 NAC 7-007 for documentation of medical necessity requirements.

TRANSFER EQUIPMENT ..... Covered for clients that require assistance with transfer. Remains in section 4 as modified

Documentation: See 471 NAC 7-007 for documentation of medical necessity requirements.

(See also LIFTS, PATIENT; WHEELCHAIR OPTIONS/ ACCESSORIES.)

TRAPEZE EQUIPMENT ..... Covered when required for clients to sit up because of a respiratory condition, to change body position for other medical reasons, or to get in or out of bed. Remains in section 4 as modified

Documentation: See 471 NAC 7-007 for documentation of medical necessity requirements.

(See also HOSPITAL BED ACCESSORIES.)

ULTRAVIOLET CABINETS..... Covered for clients with generalized, intractable psoriasis. Documentation must justify treatment at home rather than alternative site (e.g., the outpatient department of a hospital). Remains in section 4 as modified

Documentation: 471 NAC 7-007 for documentation of medical necessity requirements.

URINALS ..... See BEDPANS and URINALS.

UTERINE MONITORS,
HOME..... Covered on a rental basis for clients that meet the following criteria -

1. The client is at high risk for preterm labor and delivery and must be a candidate for tocolytic therapy;
2. The pregnancy must be greater than 20 weeks gestation; and
3. The client must have one of the following medical conditions -
   a. Recent preterm labor with hospitalization and discharge on tocolytic therapy;
   b. Multiple gestations;
   c. History of preterm delivery;
   d. Anomalies of the uterus;
   e. Incompetent cervix;
   f. Previous cone biopsy;
   g. Polyhydramnios; or
   h. Diethylstilbestrol exposure.

Others at high risk for preterm labor and delivery may be covered upon approval by the Medicaid Medical Director through written communication from the client's physician (preferably in consultation with a perinatologist).

Uterine monitoring is not covered after completion of the 36th week of pregnancy.

The following conditions must be met prior to provision of uterine monitors -

1. Comprehensive client assessment and evaluation by the attending physician has occurred; and
2. Client has successfully completed training on use of equipment.

Payment: Medicaid rental payment includes all equipment, supplies and services necessary for the effective use of the monitor. This does not include medications or physician's professional services.

Documentation: See 471 NAC 7-007 for documentation of medical necessity requirements.

Billing Requirements: The provider shall indicate on the claim the condition which necessitates use of the monitor and, when billing for the final rental period, the date of discontinuation of the monitor.

VAPORIZERS, ROOM TYPE ..... Covered for clients with a respiratory illness. Coverage includes "cool-mist" and "warm-mist" vaporizers. Remains in section 4 as modified

Documentation: See 471 NAC 7-007 for documentation of medical necessity requirements.

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

1. The client has a diagnosed medical condition which impairs their ability to walk;
2. The client requires a POV for the purpose of -
   a. Increasing their independence with mobility, resulting in significant difference in their ability to perform major life activities. Major life activities are those basic activities that the average person in the general population can perform with little or no difficulty. They include, but are not limited to: caring for oneself, mobility, learning, working, performing manual tasks, breathing, seeing, and communicating; or
   b. Providing assisted mobility for clients who show no means of safe independent mobility.
3. The client has significant limitation of limb function such that the client is not able to propel a manual wheelchair. Compared to their use of a manual wheelchair, the client's use of a POV must result in a significant improvement in independent mobility and ability to perform major life activities; and
4. The client has demonstrated, through a trial period with a similar POV -
   a. the ability to safely and independently operate the controls of a POV;
   b. the ability to transfer safely in and out of a POV; and
   c. adequate trunk stability to be able to safely ride in the POV.

An evaluation of the client's wheelchair needs by a licensed physical or occupational therapist is required. Documentation must be provided using Form MS-79 "Wheelchair and Wheelchair Seating System Selection Report", and must -

1. Justify the type of POV as well as any options or accessories; and
2. Provide evidence of a coordinated assessment. A coordinated assessment includes communication between the client, caregiver(s), physician, physical and/or occupational therapist, and equipment supplier. The assessment should address physical, functional, and cognitive issues, as well as accessibility and cost effectiveness of equipment.

Form MS-79 must be reviewed and signed by a physician involved in the client's care. Note: This evaluation will generally not be required when the diagnosis or prescribed length of need indicates the POV will be required on a short-term basis only.

Documentation: See 471 NAC 7-007 for documentation of medical necessity requirements. Form MS-79, "Wheelchair and Wheelchair Seating System Selection Report" is required with all requests for prior authorization of wheelchairs, wheelchair options/accessories, and seating systems, unless the wheelchair will be required on a short term basis only. Form MS-79 must be completed by the licensed physical or occupational therapist who evaluated the client's wheelchair/seating system needs and reviewed and signed by a physician involved in the client's care. (See 471-000-208 for form and completion instructions.)

VENTILATORS ..... Covered for treatment of neuromuscular diseases, thoracic restrictive diseases, chronic respiratory failure consequent to chronic obstructive pulmonary disease and respiratory paralysis. Remains in section 4 as modified

Supplies/Accessories: Payment for rental of ventilators includes all accessories necessary for proper functioning and effective use of the device. Accessories are payable only as replacement for use with client-owned ventilators for clients whose condition meets the criteria for the device.

Documentation: See 471 NAC 7-007 for documentation of medical necessity requirements.

WALKERS ..... Covered for clients with conditions that impair ambulation and there is a need for greater stability and security than provided by a cane or crutches. Remain in section 4 as modified

A heavy duty, multiple braking system, variable wheel resistance walker is covered for clients who are unable to use a standard walker due to obesity, severe neurologic disorders, or restricted use of one hand. Remains in section 4 as modified

Supplies/Accessories: Payment for purchase and rental of walkers includes all accessories necessary for proper functioning and effective use of the item. Accessories such as tips, handgrips, etc., are payable only as replacement for use with client-owned walkers for clients whose condition meets the criteria for coverage of the item.

Documentation: See 471 NAC 7-007 for documentation of medical necessity requirements.

WHEELCHAIRS, (MANUAL and POWER) ..... A manual wheelchair is covered for clients who meet the following criteria -

1. The client has a diagnosed medical condition which impairs their ability to walk; and
2. The client requires a wheelchair for the purpose of -
   a. Increasing their independence with mobility, resulting in significant difference in their ability to perform major life activities. Major life activities are those basic activities that the average person in the general population can perform with little or no difficulty. They include, but are not limited to: caring for oneself, mobility, learning, working, performing manual tasks, breathing, seeing, and communicating; or
   b. Providing assisted mobility for clients who show no means of safe independent mobility.

A powered wheelchair is covered instead of a manual wheelchair if the client meets the criteria for a manual wheelchair and –

1. The client has significant limitation of limb function such that the client is not able to propel a manual wheelchair. Compared to their use of a manual wheelchair, the client's use of a powered wheelchair must result in a significant improvement in independent mobility and ability to perform major life activities; and
2. The client has demonstrated, through a trial period with a similar powered wheelchair, the ability to safely and independently operate the controls of a powered wheelchair.

Remains in section 4 as modified

An evaluation of the client's wheelchair needs by a licensed physical or occupational therapist is required. Documentation must be provided using Form MS-79 "Wheelchair and Wheelchair Seating System Selection Report", and must –

Remains in section 4 as modified

1. Justify the type of wheelchair as well as any options or accessories; and
2. Provide evidence of a coordinated assessment. A coordinated assessment includes communication between the client, caregiver(s), physician, physical and/or occupational therapist, and equipment supplier. The assessment should address physical, functional, and cognitive issues, as well as accessibility and cost effectiveness of equipment.

Form MS-79 must be reviewed and signed by a physician involved in the client's care. Note: This evaluation will generally not be required when the diagnosis or prescribed length of need indicates the wheelchair will be required on a short-term basis only.

Options/Accessories: Wheelchair options/accessories are covered when medically necessary for use with a medically necessary, rented or client-owned wheelchair base.

A wheelchair seating system is covered when medically necessary for use with a medically necessary wheelchair base, for a client who has a diagnosed medical condition that impairs their ability to sit. A wheelchair seating system may be covered for the purpose of -

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

Remains in section 4 as modified

A reclining back wheelchair frame is one in which the angle between the seat and the back of the frame is adjustable between 90 and 180 degrees. It may include elevating leg rests. A reclining back may be manually operated (by a caregiver) or power operated (usually by the wheelchair user).

A tilt-in-space wheelchair frame is one in which the angle between the seat and the back remain relatively fixed, but the seat and back pivot as a unit away from the fully upright position, such that the angle that both the seat and back make with the ground is able to be adjusted, usually more than 30 degrees. A tilt-in-space wheelchair frame may be manually operated (by a caregiver) or power operated (usually by the wheelchair user).

Reclining back or tilt-in-space wheelchair frames are covered for clients that -

1. Have a diagnosed medical condition which impairs their ability to tolerate the fully upright sitting position for significant amounts of time (usually greater than two hours);
2. Need to remain in a wheelchair for purposes of mobility or other interaction with their environment; and
3. Require frequent, significant adjustment of their position in the wheelchair, either to change hip angle or their sitting position relative to the ground.

Power operation of the reclining or tilt-in-space mechanism, which may include power operated elevating legrests, is covered for clients that meet the criteria for a reclining or tilt-in-space mechanism and -

1. Have the cognitive and motor ability to operate the required control switch(es); and
2. Are routinely in situations (e.g., home, community, school, work, etc.) where caregivers are not available within a reasonable time to manually recline or tilt them as needed.

Combination power recline/tilt-in-space frames, if unavailable in manually operated forms, are covered for clients that require both recline and tilt-in-space features (e.g., lack of necessary passive hip flexion for use of a standard tilt-in-space or inability to tolerate a significantly greater hip extension angle during sitting).

Documentation: See 471 NAC 7-007 for documentation of medical necessity requirements. Form MS-79, "Wheelchair and Wheelchair Seating System Selection Report" is requiredwith all requests for prior authorization of wheelchairs, wheelchair options/accessories, and seating systems, unless the wheelchair will be required on a short term basis only. Form MS-79 must be completed by the licensed physical or occupational therapist who evaluated the client's wheelchair/seating system needs and reviewed and signed by a physician involved in the client's care. (See 471-000-208 for form and completion instructions.)

(See also SPINAL ORTHOSES - Seating Systems and Back Modules; Vehicles, Power Operated.)

WHIRLPOOL BATH EQUIPMENT, STANDARD (BUILT-IN TYPE)	Covered for clients who are homebound and have a condition for which the whirlpool bath is expected to provide substantial therapeutic benefit to justify its cost. Where the client is not homebound, but has such a condition, payment is restricted to providing the services elsewhere (e.g., an outpatient department of a hospital) if that alternative is less costly. Remains in section 4 as modified Documentation: See 471 NAC 7-007 for documentation of medical necessity requirements.
WHIRLPOOL PUMPS, PORTABLE	Not covered-not primarily medical in nature; generally used for soothing or comfort purposes.
WOUND THERAPY NEGATIVE PRESSURE	Negative Pressure Wound Therapy is covered for clients with stage 4 decubiti, which does not respond to usual wound dressing. This is a rental in which the provider is responsible for training the client, caregivers or facility staff and monitoring the use of the equipment. Remains in section 4 as modified Documentation: See 471 NAC 7-007 for documentation of medical necessity requirements.
NOT OTHERWISE CLASSIFIED (NOC) CODES.....	Coverage of items for which no specific procedure code exists will be determined on a case-by-case basis. Documentation: See 471 NAC 7-007 for documentation of medical necessity requirements. Remains in section 4 as modified