

**Government Business Division  
Policies and Procedures**

<b>Section (Primary Department)</b> Health Care Management - Utilization Management		<b>SUBJECT (Document Title)</b> Durable Medical Equipment - LA	
<b>Effective Date</b> April 21, 2016	<b>Date of Last Review</b> <del>March 05, 2024</del> February 07, 2025	<b>Date of Last Revision</b> <del>March 05, 2024</del> February 07, 2025	<b>Dept. Approval Date</b> <del>March 05, 2024</del> February 07, 2025
<b>Department Approval/Signature:</b>			

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

<b>Products</b>	<input type="checkbox"/> Arkansas	<input type="checkbox"/> Iowa	<input type="checkbox"/> Nevada	<input type="checkbox"/> Tennessee
<input checked="" type="checkbox"/> Medicaid/CHIP	<input type="checkbox"/> California	<input type="checkbox"/> Kentucky	<input type="checkbox"/> New Jersey	<input type="checkbox"/> Texas
<input type="checkbox"/> Medicare/SNP	<input type="checkbox"/> Colorado	<input checked="" type="checkbox"/> Louisiana	<input type="checkbox"/> New York	<input type="checkbox"/> Virginia
<input type="checkbox"/> Duals	<input type="checkbox"/> District of Columbia	<input type="checkbox"/> Maryland	<input type="checkbox"/> New York (WNY)	<input type="checkbox"/> Washington
	<input type="checkbox"/> Florida	<input type="checkbox"/> Minnesota	<input type="checkbox"/> North Carolina	<input type="checkbox"/> West Virginia
	<input type="checkbox"/> Georgia	<input type="checkbox"/> Missouri	<input type="checkbox"/> Ohio	<input type="checkbox"/> Wisconsin
	<input type="checkbox"/> Indiana	<input type="checkbox"/> Nebraska	<input type="checkbox"/> South Carolina	

**POLICY:**

Durable medical equipment is furnished by a supplier or a home health agency and is equipment that meets the following criteria:

- Can withstand repeated use;
- Is primarily and customarily used to serve a medical purpose;
- Generally, is not useful to a beneficiary in the absence of an illness or injury; and
- Is appropriate for use in the home.

Supplies, including but not limited to one time use supplies, are also covered under the DME Program when medical necessity criteria are met for use as part of the medical care of a beneficiary. Supplies must meet following criteria:

- Is primarily and customarily used to serve a medical purpose;
- Generally, is not useful to a beneficiary in the absence of an illness or injury; and
- Is appropriate for use in the home.

Covered items and services include:

- DME;
- Medical supplies;
- Home dialysis equipment and supplies;
- Therapeutic shoes;
- Enteral nutrition, enteral/parenteral equipment and supplies; Transfusion medicine; and
- Prosthetic devices, prosthetics and orthotics.

Prior authorization (PA) is an integral part of the DME program. PA requests should include the following:

- Completed precertification request form;
- Medical information from the physician;

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- Written prescription no more than twelve (12) months old from a licensed physician or physician's representative;
- Diagnosis related to the request;
- Length of time that the supplies or equipment will be needed;
- Other medical information to support the need for the requested item;
- Statement as to whether the beneficiary's age and circumstances indicate that they can adapt to or be trained to use the item effectively;
- Plan of care (POC) that includes a training program when any supplies or equipment requires skill and knowledge to use; and
- Any other pertinent information, such as measurements.

Healthy Blue covers the least costly alternative based on the beneficiary's medical necessity for the DME or orthotics/prosthetics device. In adhering to Early and Periodic Screening, Diagnosis and Treatment (EPSDT) requirements, DME items whether or not listed in this policy or on the DME Fee Schedule will be considered for beneficiaries under the age of twenty-one (21) based on medical necessity

**DEFINITIONS:**

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

**Durable Medical Equipment (DME)\*, Prosthesis, Orthosis, and certain supplies (DMEPOS) –** DME is inclusive of equipment which 1) can withstand repeated use, 2) is primarily and customarily used to serve a medical purpose, 3) generally is not useful to a person in the absence of illness or injury, and 4) is appropriate for use in the home. POS is inclusive of prosthesis, orthotics, and certain supplies. Certain supplies are those medical supplies that are of an expendable nature, such as catheters and diapers.

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

**Medically Necessary Services\*** – Those health care services that are in accordance with generally accepted, evidence-based medical standards or that are considered by most physicians (or other independent licensed practitioners) within the community of their respective professional organizations to be the standard of care. In order to be considered medically necessary, services must be: (1) deemed reasonably necessary to diagnose, correct, cure, alleviate or prevent the worsening of a condition or conditions that endanger life, cause suffering or pain or have resulted or will result in a handicap, physical deformity or malfunction; and (2) those for which no equally effective, more conservative and less costly course of treatment is available or suitable for the beneficiary. Any such services must be

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individualized, specific and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and neither more nor less than what the beneficiary requires at that specific point in time. Although a service may be deemed medically necessary, it does not mean the service will be covered by Healthy Blue. Services that are experimental, non-FDA approved, investigational, or cosmetic are specifically excluded from Medicaid coverage and will be deemed “not medically necessary.”

**Prior Authorization (PA)** – The process of determining medical necessity for specific services before they are rendered. PA is also referred to as prospective review, prior approval, preauthorization, or precertification.

**PROCEDURE:**

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

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

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

Medical necessity criteria may include age of the recipient. Items exclusive to members under age twenty-one (21), Early and Periodic Screening, Diagnosis, and Treatment (EPSDT)

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recipients, include disposable incontinence supplies, enteral formula, cochlear implants, and hearing aids.

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

### **Equipment Rental**

If equipment is needed temporarily, it may be more cost effective to pay for the rental of equipment. Consideration is given to the length of time the equipment is needed, to the total rental cost for that period of time, and the purchase price of the item. Equipment will be purchased, not rented, if the total cost of rental exceeds the purchase price. The provider cannot charge for features on equipment not medically required by the recipient's condition.

Reimbursement is based on the rental price up to the maximum allowed of the particular DME. The item is considered purchased once the purchase price has been met. Pricing and reimbursement are dependent upon the Fee Schedule (refer to reimbursement policy *Durable Medical Equipment Rent to Purchase*). There may be instances in which a particular item may be considered for direct purchase on a case-by-case basis. Healthy Blue does not allow reimbursement for used equipment (modifier UE). Used equipment cannot be sold to a recipient; however, rental equipment may be provided.

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

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

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provided.

**Equipment Purchasing Guidelines**

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

Medicaid reimbursement includes:

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

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

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

**Equipment Maintenance, Repair, and Replacement**

Maintenance and repair may be reimbursed when the following conditions are met:

- Equipment is covered by Medicaid;
- Equipment is the personal property of the recipient;
- Item is still medically necessary;
- The equipment is used exclusively by the recipient;
- No other payment source is available to pay for the needed repairs;

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- Equipment damage is not due to misuse, abuse, neglect, loss or wrongful disposition by the recipient, the recipient’s caregiver, or the provider;
- Equipment maintenance is performed by a qualified technician;
- Maintenance is not currently covered under a manufacturer’s or provider’s warranty agreement; and
- Maintenance is not performed on a duplicate type of item already being maintained for the recipient during the maximum limit period.

Healthy Blue may replace equipment when the member’s medical necessity changes. The provider must submit the documentation required to justify the purchase of the replacement equipment.

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

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

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

**DME Service Authorization**

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

In the event a provider indicates, or Healthy Blue determines, that the standard service authorization timeframe could seriously jeopardize the member’s life or health or ability to attain, maintain, or regain maximum function, Healthy Blue shall make an expedited<sup>[LA1]</sup><sup>[KS2]</sup><sup>[LA3]</sup> authorization decision and provide notice as expeditiously as the member’s health condition requires, but no later than seventy-two (72) hours after receipt of the request for service. Healthy Blue may extend the seventy-two (72) hour time period by up

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to fourteen (14) calendar days if the member or Healthy Blue justifies a need for additional information and how the extension is in the member's best interest. A request is considered an emergency if a delay in obtaining the medical equipment, or supplies would be life-threatening to the recipient.

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

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

**NOTE:** Where State or Federal time standards differ from the National Committee Quality Assurance (NCQA) time standards, the more stringent time standard applies<sup>IG4</sup><sup>KS5</sup><sup>LA6</sup>.

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

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

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

**SPECIFIC COVERAGE CRITERIA:**

The list below of covered and non-covered services is not all-inclusive.

**Abdominal Binder and Hernia Supports**

**Eligible:** All members where DME is a covered benefit

**Benefit Description:** Abdominal binders and hernia supports may be approved with

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documentation of medical necessity.

**Ambulatory Equipment**

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

- **Canes and Crutches**

**Eligible:** All members where DME is a covered benefit

**Benefit Description:** Requests for canes (wooden or metal), quad canes (four-prong), and all types of crutches may be approved if the recipient's condition impairs ambulation and there is a potential for ambulation.

- **Enhancement Accessories**

**Eligible:** Non-covered

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

- **Arm Rests**

**Eligible:** All members where DME is a covered benefit

**Benefit Description:** Reimbursement is limited to a ten (10) month rental. Armrest attachments are considered medically necessary when the recipient's ability to grip is impaired.

- **Leg Extensions**

**Eligible:** All members where DME is a covered benefit

**Benefit Description:** Leg extensions are considered medically necessary for recipients six (6) feet tall or more.

- **Walking Belts**

**Eligible:** Non-covered

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

- **Walkers and Walker Accessories**

**Eligible:** All members where DME is a covered benefit

**Benefit Description:** A standard walker and related accessories are covered when prescribed by a physician for a recipient with a medical condition that impairs ambulation, the recipient has a potential for ambulation, and the recipient has a need for greater stability and security than can be provided by a cane or crutches.

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

- Walker with an enclosed frame;



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- Walking belts; and
- Enhanced accessories (i.e., style, color, hand operated brakes (other than those described above for heavy duty), multiple braking system, variable wheel resistance walker), seat attachments, tray attachments, or baskets (or equivalent).

A walker with enclosed frame is a folding wheeled walker with a frame completely surrounding the beneficiary and an attached seat in the back. Walkers with enclosed frames are not considered medically necessary because their medical necessity compared to a standard folding wheeled walker has not been established.

- **Wheeled Walker**

**Eligible:** All members where DME is a covered benefit

**Benefit Description:** A wheeled walker may be fixed height or adjustable height and may include glide-type brakes (or equivalent). The wheels may be fixed or swivel. A wheeled walker shall be approved only if the recipient is unable to use a standard walker due to severe neurological disorders, debilitating medical condition that may prohibit the use of a standard walker or limited use of one hand. The request must contain supporting documentation from the prescribing physician which substantiates the need for a wheeled walker rather than a standard walker.

- **Heavy Duty Walker**

**Eligible:** All members where DME is a covered benefit

**Benefit Description:** A heavy-duty walker may be approved for recipients who meet the criteria for a standard walker and weigh more than three hundred (300) pounds.

- **Heavy Duty, Multiple Braking System, Variable Wheel Resistance Walker**

**Eligible:** All members where DME is a covered benefit

**Benefit Description:** Reimbursement is limited to a ten (10) month rental. A heavy duty, multiple braking system, variable wheel resistance walker is a four-wheeled, adjustable height, folding walker that has all of the following characteristics:

- Capable of supporting recipients weighing more than 350 pounds;
- Can be set so that either one or both brakes can lock the wheels;
- Hand operated brakes that cause the wheels to lock when the hand levers are released;
- Adjust so the recipient can control the pressure of each hand brake;
- Additional braking mechanism on the front crossbar; and a minimum of two (2) wheels have brakes that can be independently set through tension adjustability to provide varying resistance.

A heavy duty, multiple braking system, variable wheel resistance walker is considered medically necessary for recipients who weigh greater than three hundred fifty (350) pounds, meet coverage criteria for a standard walker, and are unable to use a standard walker due to a severe neurological disorder or other condition causing the restricted use

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of one hand. Obesity alone is not considered a medically necessary indication for this walker.

- **Standard Wheelchairs/Custom Manual Wheelchairs**

**Eligible:** All members where DME is a covered benefit

**Benefit Description:** Reimbursement is limited to a ten (10) month rental. Wheelchairs are approved only when the recipient is confined to a bed, chair, or room. The request should indicate the recipient's ability to walk unassisted and whether the request is for a first chair or replacement chair. Standard wheelchairs require documentation of medical necessity. Standard wheelchair attachments include: footrests, brakes, and arm rests.

A custom manual wheelchair is constructed to the specific body measurements and medical needs of the beneficiary. General criteria for a custom manual wheelchair includes inability to walk and propel a standard wheelchair. In addition to the required documentation needed for all PA requests, PA requests for a custom manual wheelchair must include:

- Physician prescription for a custom manual wheelchair that includes:
  - Documentation the beneficiary is unable to propel a standard wheelchair; and
  - Diagnosis or limitations to justify the need for a custom manual wheelchair; and
- Medical justification for the requested wheelchair and ALL modifications.

- **Motorized and/or Custom Motorized Wheelchairs**

**Eligible:** All members where DME is a covered benefit

**Benefit Description:** The term motorized shall have the same meaning as power, electric or any means of propulsion other than manual. A motorized wheelchair must be medically necessary. A motorized wheelchair is covered if the recipient's condition is such that the requirement for a motorized wheelchair is long term (at least six months). The recipient must meet all of the following criteria in order to be considered for a motorized wheelchair:

- The recipient is not functionally ambulatory. 'Not functionally ambulatory' means the recipient's ability to ambulate is limited such that without use of a wheelchair, he/she would otherwise be generally bed or chair confined;
- The recipient is unable to operate a wheelchair manually due to severe weakness of the upper extremities due to a congenital or acquired neurological or muscular disease/condition or is unable to propel any type of manual wheelchair because of other documented health problems; and
- The recipient is capable of safely operating the controls for a motorized wheelchair and can adapt to or be trained to use a motorized wheelchair effectively.
- All wheelchairs and modifications are subject to PA. Only one (1) wheelchair may be requested at a time. Backup chairs, either motorized or manual, will be **denied** as not medically necessary. In addition to the required documentation needed for all PA requests, motorized wheelchair requests must include: A physician's prescription for a

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motorized wheelchair;

- Medical documentation from a physician and/or physical/occupational therapist is required to support the provisions set forth regarding recipient criteria as noted above; and
- Seating evaluation performed, signed, and dated by the physical therapist or occupational therapist that performed the seating evaluation. The seating evaluation shall:
  - Indicate the appropriateness of the specific wheelchair requested and all modifications and/or attachments to the specific wheelchair and its ability to meet the recipient's long-term medical needs. Options that are primarily beneficial in allowing the recipient to perform leisure or recreational activities are **not covered**;
  - Include the dated signature of the physician who prescribed the motorized wheelchair is medically necessary; and
  - The recipient's diagnosis or condition is such that a motorized wheelchair is medically necessary; and
  - He or she has seen the seating evaluation and motorized wheelchair recommendation.
- Documentation indicating that the recipient is capable of safely operating the controls for a motorized wheelchair and can adapt to or be trained to use the motorized wheelchair effectively. It is not sufficient for a Medicaid provider of motorized wheelchairs to indicate that a recipient is capable of safely operating the controls for a motorized wheelchair and can adapt to or be trained to use it effectively. Such documentation shall include:
  - A signed and dated statement from the recipient's physician, physical therapist that he/she has determined that the recipient has the cognitive, motor and perceptual abilities needed to safely operate the controls of a motorized wheelchair. This statement must be verified by the notes and recommendation of the physician, physical therapist or occupational therapist making such statement; and
  - A signed and dated statement from the recipient's physician or physical therapist that he or she has determined that the recipient can adapt to or be trained to use the motorized wheelchair effectively. This statement must be verified by the notes and recommendation of the physician, physical therapist or occupational therapist making such statement.

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

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

All repairs and modifications of wheelchairs must be completed within one (1) month, unless there is a justifiable reason for a delay. Rental of a manual wheelchair may be prior authorized on a monthly basis as a temporary replacement, if necessary, when the recipient's wheelchair is being repaired or modified.

**Apnea Monitors**

**Eligible:** All members where DME is a covered benefit

**Benefit Description:** Reimbursement is limited to an eight (8) month rental. Apnea monitors are cardio-respiratory monitoring devices capable of providing continuous or periodic two-channel monitoring of the heart rate and respiratory rate. Apnea monitors must meet current Food and Drug Administration (FDA) guidelines for products in this class. Apnea monitors must have alarm mechanisms to alert care givers of cardio-respiratory distress or other events which require immediate intervention and must also record and store events and provide event recording downloads or printouts of such data. Home apnea monitors may be approved for rental or purchase when any of the criteria are met and under the following guidelines:

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

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home ventilator support will be considered on a case-by-case basis. Approval following apneic episodes resistant to treatment, such as Ondine's Curse, shall be considered on a case-by-case basis.

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

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

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

**Artificial Eyes**

**Eligible:** All members where DME is a covered benefit

**Benefit Description:** An artificial eye is approved if an eyeball is removed, and replacement is necessary to maintain the contour of the face.

**Artificial Larynxes**

**Eligible:** All members where DME is a covered benefit

**Benefit Description:** An artificial larynx is approved only if the larynx is removed, and the recipient is unable to use an esophageal voice. Repairs and batteries are included.

**Augmentative and Alternative Communication (ACC) Devices**

**Eligible:** All members where DME is a covered benefit

**Benefit Description:** Augmentative and Alternative Communication (AAC) Devices are electronic or non-electronic aids, devices, or systems that assist a recipient to overcome or ameliorate (reduce to the maximum degree possible) the communication limitations that preclude or interfere with meaningful participation in current and projected medically necessary daily activities. Meaningful participation refers to effective and efficient communication of messages in any form the recipient chooses.

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Examples of AAC devices include:

- Communication boards or books, speech amplifiers, and electronic devices that produce speech and/or written output;
- Devices that are constructed for use as communication devices as well as systems that may include a computer, when the primary use of the computer serves as the recipient's communication device; and
- Related components and accessories, including software programs, symbol sets, overlays, mounting devices, switches, cables and connectors, auditory, visual, and tactile output devices, printers, and necessary supplies, such as rechargeable batteries.

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

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

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

- The cause of the recipient's impairment or disability (e.g., congenital, developmental, or acquired), or the recipient's age at the onset of the impairment or disability, are irrelevant considerations in the determination of medical need;
- Recipient participation in other services or programs (e.g., school, early intervention services, adult services programs, employment) is irrelevant to medical necessity determination for AAC devices;

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- No cognitive, language, literacy, prior treatment, or other similar prerequisites must be satisfied by a recipient in advance of a request for AAC devices; and
- The unavailability of an AAC device, component, or accessory for rental will not serve as the basis for denying a prior authorization (PA) request for that device, component, or accessory.

AAC device assessments and evaluations:

- An assessment or evaluation of the recipient's functioning and communication limitations that preclude or interfere with meaningful participation in current and projected daily activities must be completed by a speech language pathologist with input from other health professionals, (e.g., occupational therapists and rehabilitation engineers) based on the recommendation of the speech language pathologist and a physician's prescription, as appropriate;
- Requests for AAC devices must include a description of the speech language pathologist's qualifications, including a description of the speech-language pathologist's AAC services training and experience; and
- An assessment (augmentative and alternative communication evaluation) must include the following information about the recipient:
  - Identifying information:
    - Name;
    - Medicaid identification number;
    - Date of the assessment;
    - Medical and neurological diagnoses (primary, secondary, tertiary);
    - Significant medical history;
    - Mental or cognitive status; and
    - Educational level and goals.
  - Sensory Status:
    - Vision and hearing screening (no more than one year prior to AAC evaluation);
    - If vision screening is failed, a complete vision evaluation;
    - If hearing screening is failed, a complete hearing evaluation; and
    - Description of how vision, hearing, tactile, and/or receptive communication impairments or disabilities affect expressive communication.
  - Postural, Mobility and Motor Status:
    - Gross motor assessment;
    - Fine motor assessment;
    - Optimal positioning;
    - Integration of mobility with AAC devices; and
    - Recipient's access methods (and options) for AAC devices.
  - Current speech, language and expressive communication status:
    - Identification and description of the recipient's expressive or receptive (language

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- comprehension) communication impairment diagnosis;
- Speech skills and prognosis;
- Language skills and prognosis;
- Communication behaviors and interaction skills (i.e., styles and patterns);
- Functional communication assessment, including ecological inventory;
- Indication of past treatment, if any; and
- Description of current communication strategies, including use of an AAC device, if any.
- **NOTE:** If an AAC device is currently used, describe the device, when and by whom it was previously purchased, and why it is no longer adequate for communication needs).
- Communication Needs Inventory:
  - Description of recipient's current and projected communication needs
  - Communication partners and tasks including partners' communication abilities limitations, if any; and
  - Communication environments and constraints which affect AAC device selection and/or features (e.g., verbal and/or visual output and/or feedback; distance communication needs).
- Summary of Communication Limitations:
  - Description of the communication limitations that preclude or interfere with meaningful participation in current and projected daily activities (i.e., why the recipient's current communication skills and behaviors prevent meaningful participation in the recipient's current and projected daily activities).
- AAC Devices Assessment Components:
  - Vocabulary requirements;
  - Representational system(s);
  - Display organization and features;
  - Rate enhancement techniques;
  - Message characteristics, speech synthesis, printed output, display characteristics, feedback, auditory and visual output;
  - Access techniques and strategies; and
  - Portability and durability concerns, if any.
- Identification of AAC Devices Considered for Recipients:
  - Identification of the significant characteristics and features of the AAC devices considered for the recipient; and
  - Identification of the cost of the AAC devices considered for the recipient (including all required components, accessories, peripherals and supplies as appropriate).
- AAC Device Recommendation:
  - Identification of the requested AAC devices including all required components, accessories, software, peripheral devices, supplies and the device vendor;
  - Identification of the recipient and communication partner's AAC devices



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preference, if any;

- Assessment of the recipient's ability (physically and mentally) to use, or to learn to use, the recommended AAC device and accessories for effective and efficient communication; and
- Justification stating why the recommended AAC device (including description of the significant characteristics, features and accessories) is better able to overcome or ameliorate the communication limitations that preclude or interfere with the recipient's meaningful participation in current and projected daily activities as compared to the other AAC devices considered; and justification stating why the recommended AAC device (including description of the significant characteristics, features and accessories) is the least costly, equally effective, alternative form of treatment to overcome or ameliorate the communication limitations that preclude or interfere with the recipient's meaningful participation in current and projected daily activities.
- Treatment Plan and Follow Up:
  - Description of short-term communication goals (e.g., 6 months);
  - Description of long-term communication goals (e.g., one year);
  - Assessment criteria to measure recipient's progress toward achieving short- and long-term communication goals;
  - Description of amount, duration, and scope of AAC services required for the recipient to achieve short- and long-term communication goals; and
  - Identification and experience of AAC service provider responsible for training (these service providers may include, e.g.: speech language pathologists, occupational therapists, rehabilitation engineers, the recipient's parents, teachers and other service providers).
- Summary of Alternative Funding Source for AAC Device:
  - Description of availability or lack of availability, of purchase of AAC device through other funding sources.

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

- The characteristics of the recipient's communication limitations;
- Lack of familiarity with a specific AAC device;
- Whether there are sufficient AAC services to support the recipient's use of the AAC device, or other factors;
- The duration of the trial period;

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- The speech-language pathologist information and the recipient information as required in the Assessment Evaluation;
- The AAC device to be examined during the trial period, including all the necessary components (e.g., mounting device, software, switches, or access control mechanism);
- The identification of the AAC services provider(s) who will assist the recipient during the trial period;
- The identification of the AAC services provider(s) who will assess the trial period; and
- The evaluation criteria, specific to the recipient that will be used to determine the success or failure of the trial period.

Trial periods may be extended and/or different AAC devices provided, when requested by the speech-language pathologist responsible for evaluating the trial use period. Results of trial use periods must be included with any subsequent request for prior authorization of the AAC device purchase. Recommendations for the purchase of an AAC device, as a result of a trial use period of the device, must clearly indicate the recipient's ability to use the device during the trial period.

Medicaid covers repairs to keep AAC devices, accessories, and other system components in working condition. Coverage for repairs includes the cost of parts, labor, and shipping, when not otherwise available without charge pursuant to a manufacturer's warranty. Providers who make, sell, or lease assistive devices, including AAC devices, must provide those who buy or lease the equipment with a warranty which lasts at least one (1) year from the time the equipment is delivered to the recipient. If, during the warranty period, the equipment does not work, the manufacturer or dealer must make an attempt to repair the equipment. Medicaid additionally requires providers to provide the recipient with a comparable, alternate AAC device while repairing the recipient's device during a warranty period. Medicaid coverage may be provided for the rental of an alternate AAC device during a repair period after expiration of the warranty. Medicaid will not cover repairs, or rental of a loaner device, when repairs are made during a warranty period.

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

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

- Requests for modification or replacement of AAC devices and/or accessories may be considered for coverage after the expiration of three (3) or more years from the date of

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- purchase of the current device and accessories in use;
- Requests for modification or replacement require PA and must include the recommendation of the speech-language pathologist;
- Requests for replacements of AAC devices may be submitted for identical or different devices;
- Requests for replacements of identical AAC devices must be accompanied by a statement from the provider that the current device cannot be repaired or that replacement will be more cost effective than repair of the current device. Data must be provided about the following:
  - Age;
  - Repair history;
    - Frequency;
    - Duration;
    - Cost; and
  - Repair projections (estimated durability of repairs).
- Requests for modification or replacement of AAC devices with different devices must include the following additional information:
  - A significant change has occurred in the recipient's expressive communication, impairments, and/or communication limitations. Modification or replacement requests due to a change in the recipient's circumstances must be supported by a new assessment of communication limitations by a speech-language pathologist, and may be submitted at any time; or
  - Even though there has been no significant change in the recipient's communication limitations, there has been a significant change in the features or abilities of available AAC devices (i.e., a technological change) that will overcome or permit an even greater amelioration of the recipient's communication limitations as compared to the current AAC device. A detailed description of all AAC device changes and the purpose of the changes must be provided with the results of a re-evaluation by a speech-language pathologist.
  - Requests for replacements of AAC devices due to loss or damage (either for identical or different devices) must include a complete explanation of the cause of the loss or damage and a plan to prevent the recurrence of the loss or damage.

**Bath and Toileting Aids**

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

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

- **Bath or Shower Chairs**

**Eligible:** All members where DME is a covered benefit

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**Benefit Description:** Bath or shower chairs may be considered only for severe incapacitating problems due to neurological, physiological, or cognitive disorders that impair the recipient's balance, coordination, or physical strength needed to safely sit or stand while bathing or showering.

- **Commode Chair**

**Eligible:** All members where DME is a covered benefit

**Benefit Description:** A commode chair may be considered when the recipient is physically incapable of utilizing regular toilet facilities. An extra wide/heavy duty commode chair is covered for a recipient weighing three hundred (300) pounds or more. If the recipient weighs less than 300 pounds but the basic coverage criteria for a commode chair are met, payment will be based on the least costly medically appropriate alternative. A request for payment of a mobile commode chair will be denied as not medically necessary if basic coverage criteria for a commode chair are met. Payment will be based on the least costly medically appropriate alternative stationary commode chair.

A commode chair with detachable arms may be considered if this feature is necessary to facilitate transferring the recipient, or if the recipient has a body configuration that requires extra width. If these additional criteria are not met but the basic coverage criteria for a commode chair are met, reimbursement will be authorized based on the least costly medically appropriate alternative.

- **Elevated Toilet Seats**

**Eligible:** All members where DME is a covered benefit

**Benefit Description:** An elevated toilet seat may be considered when a recipient is unable to go from a sitting to a standing position without assistance.

- **Footrest for Use with Toilet**

**Eligible:** All members where DME is a covered benefit

**Benefit Description:** A Footrest for use with a toilet may be considered when the recipient's feet cannot touch the floor and it is needed for balance and support.

- **Hospital Type Urinals and Bed Pans**

**Eligible:** All members where DME is a covered benefit

**Benefit Description:** Urinals (hospital type) and bed pans may be considered if the recipient is capable of using them and is confined to bed.

- **Safety Guardrails**

**Eligible:** All members where DME is a covered benefit

**Benefit Description:** Safety guardrails may be considered for recipients who are unable to stand up in the tub or get out of the tub without assistance.

**Batteries**

**Eligible:** All members where DME is a covered benefit

**Benefit Description:** Batteries are covered for artificial larynxes, insulin pumps, electric wheelchairs and cochlear implants.

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**Blood Pressure Devices**

**Benefit Description:** Blood pressure devices are covered for beneficiaries who meet one of the below criteria:

- Beneficiaries receiving hemodialysis in the home setting;
- Pregnant beneficiaries with a diagnosis of chronic hypertension; and
- Beneficiaries under the age of 21 years diagnosed with hypertension or hypotension.

Only electronic blood pressure devices may be approved for beneficiaries under the age of 21 years and for those who are pregnant. Documentation of medical necessity is required.

**Bras, Surgical Mastectomy**

**Eligible:** All members where DME is a covered benefit

**Benefit Description:** Surgical mastectomy bras are approved only if one (1) or both of the recipient's breasts have been removed. After a mastectomy, two (2) bras may be approved. If the breasts are removed in separate surgeries, two (2) more bras may be approved following the second surgery. Replacements may be approved after a reasonable length of time.

**Breast or Mammary Prostheses**

**Eligible:** All members where DME is a covered benefit

**Benefit Description:** A breast or mammary prosthesis is approved only after breast removal. If one breast is removed, one prosthesis may be approved. Replacement of prosthesis may be approved if medical need is established and documented.

**Breast Pumps**

**Eligible:** All members where DME is a covered benefit

**Benefit Description:** Double electric breast pumps (E0603) are covered without PA for pregnant women who are planning to breastfeed or post-partum women who are already breastfeeding. Coverage extends only to personal-use, double electric breast pumps. Hospital grade, manual, or single breast pumps are **not covered**.

An electric breast pump is a mechanical device powered by batteries or electricity used by nursing mothers to extract milk from their breasts. Healthy Blue considers personal use, double, and electric breast pumps a coverable item for nursing mothers. A new breast pump is covered for each viable pregnancy. The breast pump may be obtained at the gestational age of 32 weeks to expectant mothers who meet the criteria and intend to breastfeed their infant. PA is not required; however, electric breast pumps are subject to post-payment medical review. Providers must submit all required documentation. Failure to provide required documentation, or ~~if the~~ documentation ~~submitted that~~ fails to establish medical necessity, ~~will~~may result in recoupment of the payment for the device.

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All of the following documentation is required:

- A prescription from the prescribing physician for the electric breast pump;
- Education/training on breastfeeding with the prescribing physician, licensed breastfeeding practitioner or healthcare professional;
- Healthy Blue has not purchased a breast pump within the past three (3) years for the same delivery; and
- Completed *Electric Breast Pump Request Form* signed by the prescribing physician and the mother or her authorized representative.

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

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

Healthy Blue will allow replacement of a breast pump older than three (3) years and after expiration of manufacturer's warranty. [Equipment replacement and warranty are subject to the policy in Section 18.2 of the DME provider manual.](#) Electric breast pump supplies will be available to the nursing mother once every 180 days. DME providers must obtain PA for replacement supplies. The PA request must include the Fillable Electric Breast Pump Request Form.

### **Burn Garments and Stockings**

**Eligible:** All members where DME is a covered benefit

**Benefit Description:** Burn garments and stockings are approved only for severe burns and major vascular problems.

### **Catheters**

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**Eligible:** All members where DME is a covered benefit

**Benefit Description:** Catheters are approved only if the recipient's medical condition necessitates the use of a catheter.

**Cochlear Implants**

**Eligible:** Members one through twenty (1-20) years of age (EPSDT eligible only) where DME is a covered benefit

**Benefit Description:** Unilateral or bilateral cochlear implants are covered when deemed medically necessary for the treatment of severe-to-profound, bilateral sensorineural hearing loss in enrollees under 21 years of age. Any implant must be used in accordance with Food and Drug Administration (FDA) guidelines. All aspects of the cochlear device (preoperative speech and language evaluation, implantation, device, repairs, supplies, therapy) must be prior authorized. Only one (1) cochlear implant per lifetime, per ear, per eligible beneficiary shall be reimbursed unless the implant fails or is damaged beyond repair, in which case reimbursement for another implant and re-implantation will be considered.

Eligibility Criteria – Only beneficiaries under 21 years of age with severe-to-profound bilateral sensorineural hearing loss, who meet the eligibility criteria, qualify for cochlear implants. The beneficiaries must meet the criteria for the cochlear implant as outlined in *Chapter 5, Professional Services Provider Manual*, in addition to having an approved prior authorization for the surgical procedure.

Healthy Blue requires a multidisciplinary implant team to collaborate on determining eligibility and providing care that includes, at minimum: a fellowship-trained pediatric otolaryngologist or fellowship-trained otologist, an audiologist, and a speech-language pathologist.

An audiological evaluation must find:

- Severe-to-profound hearing loss determined through the use of an age-appropriate combination of behavioral and physiological measures; and
- Limited or no functional benefit achieved after a sufficient trial of hearing aid amplification.

A medical evaluation must include:

- Medical history;
- Physical examination verifying the candidate has intact tympanic membrane(s), is free of active ear disease, and has no contraindication for surgery under general anesthesia;
- Verification of receipt of all recommended immunizations;
- Verification of accessible cochlear anatomy that is suitable to implantation, as confirmed by imaging studies (computed tomography (CT) and/or magnetic resonance imagery (MRI)), when necessary; and
- Verification of auditory nerve integrity, as confirmed by electrical promontory stimulation, when necessary.

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For bilateral cochlear implants, an audiologic and medical evaluation must determine that a unilateral cochlear implant plus hearing aid in the contralateral ear will not result in binaural benefit for the enrollee.

Non-audiological evaluations must include:

- Speech and language evaluation to determine enrollee’s level of communicative ability; and
- Psychological and/or social work evaluation, as needed.  
Pre-operative counseling must be provided to the enrollee, if age appropriate, and the enrollee’s caregiver and must provide:
- Information on implant components and function; risks, limitations, and potential benefits of implantation; the surgical procedure; and postoperative follow-up schedule;
- Appropriate post-implant expectations, including being prepared and willing to participate in pre- and post- implant assessment and rehabilitation programs; and
- Information about alternative communication methods to cochlear implants.

Prior Authorization and Reimbursement – All aspects of the cochlear implant (preoperative evaluation, implantation, implant, repairs, supplies, therapy) must be prior authorized.

- The request to perform surgery must come from the multidisciplinary team consisting of, at minimum, a fellowship-trained pediatric otolaryngologist or fellowship-trained otologist, an audiologist, and a speech-language pathologist.
- Reimbursement for each implant will not be authorized until the surgical procedure has been approved.
- When the implantation procedure is performed in the hospital setting, Healthy Blue shall reimburse the hospital for the device(s) in addition to the hospital payment.

Preoperative Evaluation – If prior authorized, Healthy Blue shall reimburse for preoperative evaluation services (i.e., evaluation of speech, language, voice, communication, auditory processing, and/or audiologic/aural rehabilitation) even when the enrollee may not subsequently receive an implant.

Implants, Equipment, Repairs, and Replacements –

- At the time of surgery, Healthy Blue makes reimbursement to the hospital for both the implant and the per diem. Refer to the *Inpatient Hospital Services* section of the *MCO Manual* for specific information.
- The following expenses related to the maintenance of each cochlear implant device will be covered if prior authorized:
  - All costs for upgrades and repairs to the component parts of the implant; and
  - All costs for cords and batteries.
- Healthy Blue shall cover other necessary equipment, repairs, and replacements according to the *Durable Medical Equipment Provider Manual* chapter of the *Medicaid Services Manual*.



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- The following items are non-covered expenses:
  - Service contracts and/or extended warranties; and
  - Insurance to protect against loss and theft.

Implantation Procedure, Postoperative Rehabilitative Costs, and Subsequent Therapy – The cochlear implant surgery must be prior authorized. The PA must include documentation of supporting audiological, medical, and non-audiological evaluations, and documentation of preoperative counseling. Healthy Blue covers the cochlear implant surgery as well as postoperative aural rehabilitation by an audiologist and subsequent speech, language, and hearing therapy.

Re-performance of the Implantation Surgery – Re-performance of cochlear implant surgery because of infection, extrusion, or other reasons must be prior authorized. Documentation explaining the reason the initial cochlear implant surgery must be repeated and the request for re-performance should be submitted simultaneously to Healthy Blue for review.

Post-Operative Programming – Healthy Blue covers cochlear implant post-operative programming and diagnostic analysis services.

**Diabetic Supplies and Equipment**

[Only insulin pumps](#) requiring tubing and supplies are covered through the durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) program. [All reservoirs and canisters will be covered through the DMEPOS program.](#) All other diabetic supplies and equipment are covered through the Healthy Blue Pharmacy program.

**NOTE:** In accordance with La. R.S. 46:450.8, Louisiana Medicaid will reimburse continuous glucose monitors and other diabetic supplies as a pharmacy benefit starting October 28, 2023. Effective with dates of service on or after October 28, 2023, the following diabetic supplies will be reimbursed as a pharmacy benefit as well as a durable medical equipment (DME) service. For dates of service on or after December 1, 2023, diabetic supplies and equipment will be reimbursed as a pharmacy benefit only. Durable medical equipment (DME) claims will deny after December 1, 2023.

- Diabetes glucose meters
- Diabetic test strips
- Continuous glucose meters
- Transmitters and sensors
- External insulin pumps (e.g., CeQur Simplicity, Omnipod and V-Go)
- Control solution
- Ketone test strips
- Lancets and devices
- Pen needles
- Re-usable insulin pens

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- Syringes

~~\*Cannulas and reservoirs will remain a DME benefit.~~

Preferred products and prior authorization criteria for continuous glucose monitors are posted on the Diabetic Supplies Preferred Drug List.

Select diabetic supplies will be subject to a quantity limit.

- **Continuous Subcutaneous Insulin External Infusion Pumps**

**Eligible:** Members with Type I diabetes where DME is a covered benefit

**Benefit Description:** Reimbursement is limited to a ten (10) month rental. A continuous subcutaneous insulin external infusion pump is a portable insulin pump. It is about the size and weight of a small pager. The pump delivers a continuous basal infusion of insulin. Insulin pumps can be automatically programmed for multiple basal rates over a twenty-four (24) hour period. This can be useful for such situations as nocturnal hypoglycemia, the dawn phenomenon, and to assist with tight glycemc control.

Continuous Subcutaneous Insulin External Infusion Pumps that require tubing are billed via the DME program. Only insulin pumps that appear on the Preferred Drug List (PDL) are billed through the pharmacy. Healthy Blue receives a weekly drug file that contains the NDCs covered as a pharmacy benefit. The Pharmacy program uses the NDC to bill for this equipment while the DME program uses the HCPCS code for billing of this equipment.

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

Criterion A – The recipient has completed a comprehensive diabetes education program and, for at least six months prior to initiation of the insulin pump, has been on a program of multiple daily injections of insulin (at least three (3) injections per day) with frequent self-adjustments of insulin dosages ~~for at least six (6) months prior to initiation of the insulin pump;~~ and has documented an average frequency of glucose self-testing ~~an average~~ of at least four (4) times per day during the two (2) months prior to initiation of the insulin pump; and meets two (2) or more of the following criteria while on the multiple daily injection regimen:

- Has a glycosylated hemoglobin level (HbA1c) greater than 7.0 percent;
- Has a history of recurring hypoglycemia;
- Has wide fluctuations in blood glucose levels (regardless of A1C);
- Demonstrated microvascular complications;
- Recurrent severe hypoglycemia;
- Suboptimal diabetes control (A1C exceeds target range for age);
- Adolescents with eating disorders;

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- Pregnant adolescents;
- Ketosis-prone individuals;
- Competitive athletes; and
- Extreme sensitivity to insulin in younger children.

OR

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

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

Updated fasting C-peptide testing requirement:

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

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

**Dialysis Equipment and Supplies**

**Eligible:** All members where DME is a covered benefit

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

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

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- Frequency of dialysis.

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

**Disposable (Elastomeric) Infusion Pumps**

Disposable (Elastomeric) infusion pumps are specialized infusion devices that may be covered when one of more of the following criteria are met:

- Device will be used for short-term antibiotic infusion therapy (less than 30-day duration);
- Device is expected to increase beneficiary compliance with antibiotic therapy;
- Caregiver cannot administer the antibiotic by pump;
- To avoid hospitalization of an immuno-compromised beneficiary, which may increase the risk of further infection; or
- Outside of antibiotic therapy, the beneficiary has no need for hospitalization.

Disposable (Elastomeric) Infusion Pumps are not covered when the antibiotic being administered:

- Is not considered medically necessary to the treatment of the beneficiary's illness;
- Is used for pain management;
- Exceeds the frequency or duration ordered by the physician;
- Is a chemotherapeutic agent; or
- Is not FDA-approved.

Prior authorization (PA) is required for disposable infusion pumps and intravenous supplies (IV) supplies. The following standards will be considered when determining medical necessity of IV supplies for use with disposable (Elastomeric) infusion pumps:

- The aseptic technique is acceptable for IV catheter insertion and site care;
- Nonsterile gloves are acceptable for the insertion of a peripheral IV catheter and for changing any IV site dressing;
- Sterile technique may be medically necessary. Examples of medical necessity include, but are not limited to, a beneficiary who is immuno-compromised;
- Peripheral IV site is rotated at least weekly, but no more frequently than every 72 hours;
- IV administration set (with or without dial flow regulator), extension set (with or without dial flow regulator), and any add-on devices are changed every 72 hours; or
- One IV access catheter is used per insertion.

Requests for disposable (Elastomeric) infusion pumps must include the following:

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- [Information on the underlying diagnosis or condition;](#)
- [Physician's order and documentation supporting medical necessity; and](#)
- [Name of the antibiotic, dosage, the duration of therapy, and the frequency of administration.](#)

**Disposable Incontinence Products**

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

A physician's prescription can be submitted along with the required documentation as listed below. Documentation must reflect the recipient's current condition and include the following:

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

Disposable incontinence supplies are **limited to eight (8) per day**. Only a one-month supply may be dispensed at any time as initiated by the recipient. Additional supporting documentation is required for requests that exceed the established limit.

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

- Description of mental status/level of orientation;
- Description of current supportive services; and
- Additional supporting diagnosis to justify increased need for supplies.

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

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

- **Diapers**  
**Eligible:** Members four through twenty (4-20) where DME is a covered benefit

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**Benefit Description:** The individual has a medical condition resulting in permanent bowel/bladder incontinence, and the individual would not benefit from or has failed a bowel/bladder training program when appropriate for the medical condition.

- **Pull-On Briefs**

**Eligible:** Members four through twenty (4-20) where DME is a covered benefit

**Benefit Description:** There is presence of a medical condition resulting in permanent bowel/bladder incontinence and the recipient has cognitive and physical ability to assist in [his/hers/their](#) toileting needs.

- **Liners/Guards**

**Eligible:** Members four through twenty (4-20) where DME is a covered benefit

**Benefit Description:** Liners/guards may be approved if they are cost-effective in reducing the amount of other incontinence supplies needed.

**Donor Human Milk**

**Eligible:** Certain medically vulnerable infants

**Benefit Description:** Donor human milk is covered outpatient for use by medically vulnerable infants.

Donor human milk is considered medically necessary when the following criteria are met:

- The member is less than 12 months of age with one or more of the following conditions:
  - Post-surgical nutrition;
  - Organ transplantation;
  - Renal disease;
  - Short gut syndrome;
  - Malabsorption syndrome;
  - Feeding or formula intolerance;
  - Failure to thrive;
  - Inborn errors of metabolism;
  - Immunologic disorders;
  - Congenital heart disease or other congenital anomalies; or
  - Neonatal abstinence syndrome.
- The member's caregiver is medically or physically unable to produce breast milk at all or in sufficient quantities, is unable to participate in breastfeeding despite optimal lactation support, or has a contraindication to breastfeeding; or the beneficiary is medically or physically unable to receive caregiver breast milk or participate in breastfeeding; and
- The member's caregiver has received education on donor human milk, including the risks and benefits; and
- A bank accredited by, and in good standing with, the Human Milk Banking Association of North America supplied the donor human milk.

Prescriptions for donor human milk must include the following:

- Number of prescribed calories per ounce;

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- Total ounces prescribed per day;
- Total number of weeks donor human milk is required;
- Total allowable refills; and
- Reason for prescribing donor human milk, including beneficiary's diagnoses.

Prior authorization is not required for donor human milk. Donor human milk is, however, subject to post payment medical review. The DME provider must submit a prescription containing all required documentation along with a hard copy claim to the department's fiscal intermediary. Failure to provide required documentation, or ~~if the~~ documentation ~~submitted that~~ fails to establish medical necessity, will result in recoupment of the payment for the donor human milk.

**Human Milk Storage Bags**

Human milk storage bags are designed to safely store and protect expressed human milk for feeding a child. Medicaid covers 100 human milk storage bags per month for lactating members. The Medicaid reimbursement rate on file covers a one month supply of storage bags.

**Enteral and Parenteral Nutrition**

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

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

- **Enteral Nutrition Therapy**

**Eligible:** All members where DME is a covered benefit

**Benefit Description:** Enteral therapy or oral nutritional supplements may be provided safely and effectively in the home by non-professional persons who have undergone special training. Healthy Blue will not pay for any services furnished by non-physician professionals. Enteral nutritional therapy is considered reasonable and necessary for a recipient when medical documentation, such as hospital records and clinical findings, support an independent conclusion that the recipient has a permanently inoperative internal body organ or function which does not allow absorption of sufficient nutrients to maintain weight and strength commensurate with ~~his/her~~ the beneficiary's general condition. For purposes of this policy, permanent means an indefinite period of more than one (1) month.

Prescriptions for enteral feedings must be for an average of at least 750 calories per day over the prescribed period and must constitute at least seventy percent (70%) of the daily

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caloric intake to be considered for coverage by Medicaid. Coverage of prescribed feedings of less than an average of 750 calories per day may only be considered with additional physician documentation and justification of the reason for prescribing less than an average of 750 calories per day.

All requests must include the following information:

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

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

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

Enteral feedings can only be provided for the most economic package equivalent in calories and ingredient content to the needs of the recipient as established by medical documentation. The physician(s) must document the reason for prescribing a formula including the beneficiary's diagnoses.

Approved requests shall be reviewed at periodic intervals not to exceed six (6) months. Approval may be granted for up to six (6) months at a time. Healthy Blue, however, will pay for no more than one (1) month's supply of enteral nutrients at any one time.

**NOTE:** Healthy Blue is responsible for ensuring coordination between the Women, Infant, and Children (WIC) Program and MCO providers. Coordination shall include referral of potentially eligible women, infants and children and reporting of appropriate medical information to the WIC Program. WIC may be able to provide infant formula, among other items and services to women, infants, and children up to age five (5). An individual who is eligible for Medicaid is automatically income eligible for WIC benefits.

- **Enteral Infusion Pump**

**Eligible:** All members where DME is a covered benefit



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**Benefit Description:** A standard enteral infusion pump will be approved only with documented evidence that the pump is medically necessary, and that syringe or gravity feedings are not satisfactory due to complications such as aspiration, diarrhea, dumping syndrome, etc. Healthy Blue will pay for the rental of a standard enteral infusion pump and accessories, and repairs not covered by the warranty or lease agreement.

- **Hyperalimentation – Intradialytic Parenteral Nutrition (IDPN) Therapy**

**Eligible:** All members where DME is a covered benefit

**Benefit Description:** Reimbursement is limited to a ten (10) month rental. Intradialytic parenteral nutrition (IDPN) therapy is considered for PA when a gastrointestinal disease or condition is present and is the cause of the recipient’s inability to sufficiently absorb enough nutrients to maintain their weight and strength.

Authorization will not be considered for recipients who only have renal failure or insufficiency and an associated poor appetite or failure to thrive. Request must include the following information:

- Documentation that the recipient has an inability to sufficiently maintain their weight and strength without the IV nutrition therapy;
- Documentation that adequate nutrition cannot be made possible by dietary adjustment, oral supplements, or enteral nutrition (tube or non-tube fed); and
- Documentation that a clinically significant gastrointestinal disease or conditions that have resulted in the recipient’s malnutrition due to the inability of the GI tract to sufficiently absorb enough nutrients. A diagnosis alone is not sufficient to determine coverage.

- **Enteral Formula Coverage for Beneficiaries with Inborn Errors of Metabolism**

**Eligible:** Beneficiaries with known or suspected inborn errors of metabolism served by the Office of Public Health Genetic Diseases Program

**Benefit Description:** Healthy Blue covers and considers medically necessary enteral formulas for beneficiaries of all ages without PA when the beneficiary has a diagnosis of an inborn error of metabolism made by a physician board certified in medical genetics or an advanced practice registered nurse collaborating with, or a physician assistant supervised by, a physician board certified in medical genetics.

Enteral formulas are also covered and considered medically necessary without PA if a beneficiary is suspected of having an inborn error of metabolism, pending the results of a definitive evaluation, when such enteral formula is needed to prevent morbidity. In this case, the enteral formula does not need to be ordered by a specialist. To provide documentation of medical necessity, the Genetic Disease Program must maintain a completed Request for Enteral Formula for Inborn Errors of Metabolism order form “in the beneficiary’s record which is signed and dated by the appropriate ordering provider. Claims for enteral formula are subject to post-payment review and non-compliance with

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this policy may result in recoupment of overpayments.

- **Total Parenteral Nutrition Equipment and Supplies**

An infusion pump is used to deliver nutritional requirements intravenously. Infusion pumps are covered for the delivery of parenteral nutrition for those beneficiaries who cannot absorb nutrients by the gastrointestinal tract. Only one pump (ambulatory or stationary) will be covered at any one time. Additional pumps will be denied as not medically necessary.

- An external ambulatory infusion pump is a small portable electrical device that is used to deliver parenteral nutrition. It is designed to be carried or worn by the beneficiary; or
- A stationary infusion pump is an electrical device, which serves the same purpose as an ambulatory pump, but is larger and typically mounted on a pole.

An intravenous (IV) pole is a device to suspend fluid to be administered by gravity or pump. An IV pole will be covered when a beneficiary is receiving parenteral fluids, and the beneficiary is not using an ambulatory infusion pump. Infusion pumps, ambulatory and stationary, are indicated for the administration of parenteral medication in the home when parenteral administration of the medication in the home is reasonable and medically necessary, and an infusion pump is necessary to safely administer the medication. An external ambulatory infusion pump is a small portable electrical device that is used to deliver parenteral medication. It is designed to be carried or worn by the beneficiary.

Note: TPN formula is a pharmacy benefit

**Environmental Modifications or Repairs**

**Eligible:** Non-covered

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

**Hearing Aids**

**Eligible:** Members under twenty-one (21) where DME is a covered benefit (EPSDT eligible only)

**Benefit Description:** Hearing aids are only provided to eligible recipients under the age of twenty-one (21) and approved only when there is a significant hearing loss documented by audiometric data from both an ear specialist (otologist) and a hearing aid provider. A hearing loss greater than 20 decibels average hearing level in the range 250-2000 Hz is considered significant.

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Reimbursement is the flat fee on file for the date of service. Hearing aids must have a two (2) year warranty and should normally be expected to last at least three (3) years before replacement. Repair and batteries do not require PA.

**Hospital Beds and Mattresses**

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

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

- **Hospital Beds**

**Eligible:** All members where DME is a covered benefit

**Benefit Description:** Reimbursement is limited to a ten (10) month rental. Standard hospital beds are approved if the recipient is confined to a bed and their condition necessitates positioning the body in a way that is not possible in an ordinary bed. Elevation of the head/upper body less than thirty (30) degrees does not usually require the use of a hospital bed.

PA requests for all covered hospital beds (as described in this section) must include the following:

- The recipient requires positioning of the body in ways not feasible with an ordinary bed due to a medical condition that is expected to last for at least one month;
- The recipient 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; and
- The recipient has a condition that requires special attachments (such as a trapeze, foot board, or traction equipment) that cannot be fixed and used on an ordinary home bed.

NOTE: More specific criteria may apply as described for each covered hospital bed type

- **Hospital Beds, Fixed and Variable Height**

**Eligible:** All members where DME is a covered benefit

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**Benefit Description:** Reimbursement is limited to a ten (10) month rental. A fixed height hospital bed is one with manual head and leg elevation adjustments but no height adjustment. A variable height hospital bed is one with manual height adjustment and manual head and leg elevation adjustments. To be eligible, the recipient must have a condition that requires special attachments (such as a trapeze, foot board, or traction equipment) that cannot be fixed and used on an ordinary home bed. Furthermore, requests for a variable height bed must document that the recipient requires a bed height different than a fixed height hospital bed to permit safe transfers to a chair or for adequate bed care.

- **Hospital Beds, Semi-Electric**

**Eligible:** All members where DME is a covered benefit

**Benefit Description:** Reimbursement is limited to a ten (10) month rental. A semi-electric hospital bed is one with manual height adjustment and electric head and leg elevation adjustments. The recipient must require a bed height different than a fixed height hospital bed to permit safe transfers to a chair or for adequate bed care. The PA request must also include that the recipient is alone for extended periods of time, requires frequent and immediate changes in body position and can operate the bed controls independently.

- **Hospital Beds, Total Electric**

**Eligible:** All members where DME is a covered benefit

**Benefit Description:** Reimbursement is limited to a ten (10) month rental. A total electric hospital bed is one with electric height adjustment and electric head and leg elevation adjustments. Requests must document that the recipient requires a bed height different than a fixed height hospital bed to permit safe transfers to a chair or for adequate bed care. The PA request must also include that the recipient is alone for extended periods of time, requires frequent and immediate changes in body position and can operate the bed controls independently. Documentation must also indicate one (1) of the following:

- The recipient has tried multiple means of transfer and can only transfer with a total electric bed; or
- The recipient has a care giver with a documented medical condition stating an inability to use a crank on a semi-electric bed.

- **Hospital Beds, Pediatric**

**Eligible:** All members where DME is a covered benefit

**Benefit Description:** Reimbursement is limited to a ten (10) month rental. Pediatric hospital beds allow for manual, semi-electric, or fully electric adjustment to the head and

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leg elevations. A pediatric hospital bed is one with a full side rail (360 degrees, up to 24 inches high above the mattress) enclosure. Specific criteria must be met for pediatric beds with or without safety enclosures.

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

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

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

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

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

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

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

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

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

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- **Hospital Bed Mattresses**

**Eligible:** All members where DME is a covered benefit

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

- **Egg-Crate Mattresses and Alternating Air Pressure Mattresses/Pads**

**Eligible:** All members where DME is a covered benefit

**Benefit Description:** Egg-crate mattresses and alternating pressure mattresses/pads are devices used to relieve pressure and prevent the occurrence of decubitus ulcers. The pads include: gel, air, dry and water pressure pads for mattresses, and mattress-size pads.

Requests must include:

- Documentation on the lesions, the recipient's condition, positioning, nutritional status (including serum albumen and total protein levels with the initial request), and detailed descriptions of prior treatments used and the outcomes of the treatments;
- Documentation showing the presence of stage three (3) or stage four (4) decubitus ulcers affecting at least two (2) pressure bearing surfaces; and
- For subsequent PA requests, documentation must show signs of healing. The presence of new decubitus must be explained and may be a basis for denial without extenuating circumstances.

- **Sheepskins**

**Eligible:** All members where DME is a covered benefit

**Benefit Description:** Sheepskins are approved if the recipient's skin condition necessitates use.

- **Side Rails**

**Eligible:** All members where DME is a covered benefit

**Benefit Description:** Side rails for beds other than hospital beds are approved only if the recipient's medical condition necessitates use of rails on a regular bed.

**High Frequency Chest Wall Oscillation Device**

**Eligible:** All members where DME is a covered benefit

**Benefit Description:** High frequency chest wall oscillation devices are covered for recipients who meet the following criteria. The recipient must have one (1) of the following:

- A neuromuscular disorder;
- A diagnosis of cystic fibrosis;
- A diagnosis of bronchiectasis; or
  - Characterized by daily productive cough for at least six (6) continuous, months or, frequent (i.e., more than two (2) per year) exacerbations requiring antibiotic therapy;

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and

- Confirmed by high resolution, spiral, or standard CT scan.
- Well-documented failure of standard treatments to adequately mobilize retained secretions with all of the following:
  - Chest physical therapy and flutter device at least twice daily (when age appropriate);
  - A pattern of hospitalizations at least annually or more;
  - Significantly deteriorating clinical condition;
  - Be under the care of a pulmonologist; and
  - Copies of two (2) pulmonary test results that indicate the recipient's condition improved with the use of the vest.

**Intraocular Lens Implants (IOL)**

**Eligible:** All members where DME is a covered benefit

**Benefit Description:** An Intraocular Lens (IOL) is covered under the DME program when implanted during, or subsequent to, cataract extraction surgery performed on an outpatient basis.

Intraocular lens (IOL) may be billed separately by the hospital if the hospital provides the device. Only one (1) provider may bill for the IOL. Payment for the IOL is a flat fee-for-service.

Medicaid will pay for IOLs implanted during or subsequent to cataract extraction surgery performed on an outpatient basis. Lenses will be covered under the DME program. When billing on an outpatient basis, claims must be submitted by the provider who actually supplies the lens. Providers are required to submit separate claim forms for the surgery and for the lens.

If billing as an inpatient, the charges for the lens must be included on the inpatient claim.

**Intrathecal Baclofen Therapy (ITB)**

**Eligible:** All members where DME is a covered benefit

**Benefit Description:** Surgical implantation of a programmable infusion pump for the delivery of intrathecal baclofen (ITB) therapy is covered for individuals four (4) years of age or older with a body mass sufficient to support the implanted system, and any one (1) or more of the criteria as described below is met:

- Inclusive criteria for candidates with spasticity of cerebral origin:
  - There is severe spasticity of cerebral origin with no more than mild athetosis;
  - The injury is older than one (1) year;
  - There has been a drop in Ashworth scale of one (1) or more;
  - Spasticity of cerebral origin is resistant to conservative management; or



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- The candidate has a positive response to test dose of ITB.
- Inclusive criteria for candidates with spasticity of spinal cord origin:
  - Spasticity of spinal cord origin that is resistant to oral antispasmodics or side effects unacceptable in effective doses;
  - There has been a drop in Ashworth scale of two (2) or more; or
  - The candidate has a positive response to test dose of ITB.

ITB is used for the treatment of severe spasticity of the spinal cord or of cerebral origin. The following diagnoses are considered appropriate for ITB treatment and infusion pump implantation:

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

Caution should be exercised when considering ITB infusion pump implantation for candidates who:

- Have a history of autonomic dysreflexia;
- Suffer from psychotic disorders;
- Have other implanted devices; or
- Utilize spasticity to increase function such as in posture, balance and locomotion.

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

- Fails to meet any of the inclusion criteria;
- Is pregnant, or refuses or fails to use adequate methods of birth control;
- Has a severely impaired renal or hepatic function;
- Has a traumatic brain injury of less than one (1) year pre-existent to the date of the screening dose;
- Has a history of hypersensitivity to oral baclofen;
- Has a systemic or localized infection which could infect the implanted pump; or

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- Does not respond positively to a 50, 75, or 100 mcg intrathecal bolus of baclofen during the screening trial procedure.

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

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

The following documentation must be submitted by the multidisciplinary team:

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

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

When the implantation procedure is performed in the hospital setting, Healthy Blue shall reimburse the hospital for the pump in addition to the hospital reimbursement.

**Intravenous (IV) Therapy and Administrative Supplies**

**Eligible:** All members where DME is a covered benefit

**Benefit Description:** IV pole reimbursement is limited to a ten (10) month rental. Intravenous (IV) therapy or intravenous therapy is a way of taking medicine so that it flows straight into the bloodstream. IV medicines are given through flexible plastic tubes that are inserted into a vein, usually in the arm or the chest. Medication that is given through an IV may be given with

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a syringe as a single dose (push), from a bag that is attached to the end of the tube (gravity infusion) or with a pump.

IV medication is used instead of medicine that is taken by mouth (oral) when:

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

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

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

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

**Lumbar Orthosis and Truss Supports**

**Eligible:** All members where DME is a covered benefit

**Benefit Description:** Lumbar orthosis and truss supports may be approved with documentation of medical necessity.

**Patient Lifts and Slings**

**Eligible:** All members where DME is a covered benefit

**Benefit Description:** Lifts are approved only if all of the following conditions are met:

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

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

- **Lift Slings**

**Eligible:** All members where DME is a covered benefit

**Benefit Description:** Lift slings or seats, either canvas or nylon, are considered part of the lift and are only covered as replacement items.

**Nebulizers**

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**Eligible:** All members where DME is a covered benefit

**Benefit Description:** Nebulizers are reimbursed for purchase only. Medications for use with the nebulizer are reimbursed through the Pharmacy Program, not DME.

**Orthopedic Shoes and Corrections**

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

- **Orthopedic Shoes and Corrections**

**Eligible:** All members where DME is a covered benefit

**Benefit Description:** Orthopedic shoes and corrections may be approved only when:

- Needed to protect gains from surgery or casting (qualifies as an emergency PA);
- Medically necessary to prevent clinical deterioration of the foot as with recipients with severe diabetes;
- Medically necessary to prevent clinical deterioration of the foot as with recipients with severe peripheral vascular disease; or
- Attached to braces.

- **Diabetic Shoes**

**Eligible:** All members where DME is a covered benefit

**Benefit Description:** Special shoes and corrections are covered for diabetics. Coverage is provided for extra-depth or custom molded shoes, as well as inserts or modifications, when the physician:

- Documents that the recipient has diabetes;
- Certifies that the recipient is being treated under a comprehensive plan of care for [his/hers/their](#) diabetes and that he/she needs therapeutic shoes; and
- Documents that the recipient has one or more of the following conditions:
  - Previous amputation of the foot or part of the foot due to complications that resulted from diabetes;
  - History of previous foot ulceration;
  - Pre-ulcerative callus formation, or peripheral neuropathy with a history of callus formation;
  - Foot deformity; or
  - Poor circulation.

- **Shoe Lifts**

**Eligible:** All members where DME is a covered benefit

**Benefit Description:** Shoe lifts are covered only if the lift needed is greater than one-half (½) inch. Inserts are only covered for shoes which are attached to braces, or when there is sufficient documentation from the treating physician to justify medical coverage without the attachments to braces.

Because Medicare requires that the recipient either has diabetes with peripheral complications or the shoe must always be attached to braces, Medicaid will allow PA for

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consideration of payment when Medicare's criteria are not met. The provider must use a GY modifier when submitting the PA request for consideration or the claim for payment.

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

- **Shoes for Minor Orthopedic Problems**

**Eligible:** Non-covered

**Benefit Description:** Item is **not covered**. Payment will not be made for shoes to correct minor orthopedic problems such as pes planus, metatarsus adductus, and internal tibial torsion.

**Orthotic Devices**

**Eligible:** All members where DME is a covered benefit

**Benefit Description:** Orthotic devices include leg braces, neck braces, knee braces and supports, spinal supports, splints, brace attachments and repairs. The request for approval should include the following:

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

**Osteogenesis Stimulators**

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

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

- **Osteogenic Bone Growth Stimulators**

**Eligible:** All members where DME is a covered benefit

**Benefit Description:** Purchase only. Osteogenic bone growth stimulators are used to augment bone repair associated with either a healing fracture or bone fusion. Medicaid coverage is limited to reimbursement for electrical and ultrasonic non-invasive types of bone growth stimulators.

- **Non-Spinal Non-Invasive Electrical Stimulators**

**Eligible:** All members where DME is a covered benefit

**Benefit Description:** Purchase only. Non-spinal non-invasive electrical bone growth stimulators may be considered under the following circumstances:

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- The failure of long bone fractures to heal. A period of six (6) months from the initial date of treatment must elapse before failure is considered to have occurred;
- The failure of long bone fusions (a period of nine (9) months from the initial date of treatment must elapse before failure is considered to have occurred); or
- The treatment of congenital pseudoarthroses. There is no minimal time requirement after the diagnosis.
- **Non-Spinal Non-Invasive Ultrasonic Stimulators**  
**Eligible:** All members where DME is a covered benefit  
**Benefit Description:** Purchase only. Non-spinal non-invasive ultrasonic bone growth stimulators may be considered under the following circumstances:
  - The failure of a non-union fracture to heal. A period of ninety (90) days following treatment has occurred;
  - Documentation consists of two (2) sets of radiographs, one before treatment and the second occurring ninety (90) days after treatment; and
  - The radiographs shall include multiple views and be accompanied by a written interpretation by a physician stating that there has been no clinically significant evidence of the fracture healing between the two (2) sets of radiographs.
- **Spinal Non-Invasive Electrical Stimulators**  
**Eligible:** All members where DME is a covered benefit  
**Benefit Description:** Purchase only. Spinal non-invasive electrical bone growth stimulators may be considered:
  - When a minimum of nine (9) months has elapsed since the recipient had fusion surgery which resulted in a failed spinal fusion;
  - When there is a history of a previously failed spinal fusion at the same site following spinal fusion surgery (meaning more than nine months has elapsed since fusion surgery was performed at the same level which is being fused again). As long as nine (9) months has passed since the failed fusion surgery, this repeated fusion attempt requires no minimum passage of time for the application of the device;
  - Following a multi-level spinal fusion (i.e., involving three or more contiguous vertebrae, such as L3-L5 or L4-S1). There is no minimum requirement for application after surgery.

**Oxygen Concentrators**

**Eligible:** All members where DME is a covered benefit

**Benefit Description:** Reimbursement is limited to a ten (10) month rental. The attending physician, or consultant physician who has personally examined the recipient at the request of the attending physician, must have seen the recipient within thirty to sixty (30-60) days of prescribing oxygen therapy.

Initial requests for oxygen concentrators must include a prescription which is signed and dated by the treating physician and which includes:

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

The following diagnostic findings support the need for oxygen therapy:

**Group I:**

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

**Group II:**

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

**Group III:**

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

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Reimbursement- Payment for an oxygen concentrator also includes the cost of providing all routine maintenance and servicing and monitoring the proper usage in the home by a respiratory therapist. At the time of the initial request for PA, the DME provider must describe a plan for routine checking and servicing of the machine and a plan for monitoring the proper usage in the home by a respiratory therapist as a prerequisite to authorization of purchase or rental of an oxygen concentrator from that provider. Reimbursement will be the flat fee on file for the date of service.

- **Portable Oxygen**

**Eligible:** All members where DME is a covered benefit

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

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

- Members may require multiple units of portable oxygen refills within the same month, if medically justified. Examples of justification for refills include, but are not limited to, multiple visits for radiation or chemotherapy as well as travel to and from school for beneficiaries under 21 years of age.
- To comply with the CMS National Correct Coding Initiative (NCCI) edits, only 1 unit per Healthcare Common Procedure Coding System (HCPCS) code for portable oxygen contents is allowed per claim line regardless of the date(s) of service. Multiple claim lines for the HCPCS code for portable oxygen contents may be billed for the same dates of service.

- **Portable Oxygen Concentrators**

Portable oxygen concentrators may be approved for recipients who meet the above criteria for portable oxygen; however, additional documentation is required.

Documentation includes one or more of the below:

- Beneficiary is:
  - Under the age of 21 and less costly portable oxygen options for medical appointments, medical treatment, and travel to/from school will not suffice; or
  - Over the age 21 or older and requires oxygen for out of state travel for medical appointments.



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- Portable oxygen needs exceed what can be provided via less costly portable oxygen equipment.

The beneficiary's treating physician must submit documentation of medical necessity, as well as the anticipated number of medical visits per month with the prior authorization request. If the beneficiary is under the age of 21, documentation of the mileage the beneficiary travels to/from school must be provided including the home and school address. Portable oxygen concentrators will not be approved to be used on a standby basis only. Reimbursement may be based on equipment's rental or purchase price.

- **Peak Flow Meters and Mucus Clearance (Flutter) Devices**

**Eligible:** All members where DME is a covered benefit

**Benefit Description:** Portable, manual type peak flow meters can be covered for recipients with asthma when prescribed for the measurement of lung function as part of an effective asthma management program and PA is required.

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

- **Pulse Oximeter and Oxygen Probes**

**Eligible:** Members under twenty-one (21) where DME is a covered benefit (EPSDT eligible only) and already approved for a supplement home oxygen system and/or ventilator dependent

**Benefit Description:** Pulse Oximeter is a covered service for EPSDT eligible individuals who are already approved for supplemental home oxygen systems and/or ventilator dependent and whose blood saturation levels fluctuate (submit supporting blood saturation levels), thus requiring continuous or intermittent monitoring to adjust oxygen delivery.

The following criteria for coverage apply to pulse oximeter:

This item is usually approved for a purchase for vent-dependent and oxygen-dependent recipients. Other diagnoses are usually approved for rental for six (6) months, then recertification is required for purchase.

A non-recording/alarming pulse oximeter is covered when one (1) of the following apply:

- The beneficiary is dependent on a ventilator with supplemental oxygen;
- The beneficiary has a tracheostomy, on oxygen, and requires monitoring of O2 saturation as determined by the physician;
- The beneficiary requires supplemental oxygen and has unstable saturations; or

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

Prior authorization is required for coverage of supplies related to pulse oximeters include oxygen probes and tape. Probes and tape are included in the rate on file for pulse oximeter equipment rental. For purchased equipment, coverage for oxygen probes and tape have the following limitations:

- Disposable oxygen probes are limited to four (4) per month.
- Replacement oxygen probes are limited to one (1) every six (6) months.
- Oxygen probes and tape cannot be billed with pulse oximeter equipment in the same month of service.
- **NOTE:** Billing of probes and equipment in the same month will result in denial.

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

DME providers must use the appropriate HCPCS code and modifier on the DMEPOS Fee Schedule to request prior authorization for these supplies. The rate on file for the HCPCS code includes reimbursement for the tape. The U5 modifier (oxygen probe for use with oximeter device, disposable) must be submitted with the PA request and claim for disposable pulse oximeter probes. Failure to submit the modifier with both will result in denial. A modifier should not be used when billing for a replacement oxygen probe.

**Requirements for Medical Oxygen Providers and Retailers**

In addition to meeting the general DME and medical supply provider requirements, oxygen providers and providers of oxygen-related equipment and services must also have a current and valid oxygen permit. Permits can be obtained by contacting the Office of Public Health (OPH), Food and Drug Program. Pharmacy providers who also provide DME and bill Medicaid for oxygen must submit copies of their OPH pharmacy permits with their provider enrollment applications. Oxygen providers must have a licensed certified respiratory therapist (CRT), registered respiratory therapist (RRT), registered nurse (RN), or respiratory care practitioner (RCP) under contract or on staff to provide management and consumer instruction at the provider's physical DME business location or in the beneficiary's home.

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DME oxygen providers and providers of oxygen-related equipment and services must establish and implement written policies and procedures to ensure all new and used oxygen-related or respiratory equipment, including the internal filters purchased by the provider, are appropriately disinfected, sterilized, serviced, and properly stored according to manufacturer's specifications. Prior to renting, delivering, or providing the equipment to any individual beneficiary, all licensure requirements and industry standards are applicable. NOTE: Used equipment cannot be sold to a beneficiary; however, rental equipment may be provided.

Additionally, all providers of medical oxygen and oxygen-related equipment must have an updated contingency plan on file that ensures emergency oxygen, oxygen-related equipment and services will be provided to beneficiaries 24 hours a day. Providers are responsible for ensuring that medical oxygen and oxygen-related equipment are available during emergencies, if medically necessary. This may include the aftermath of a natural disaster. Healthy Blue will not reimburse providers for unused equipment and supplies retrieved after an emergency. Pickup and delivery documentation must be maintained for all equipment. The provider of DME oxygen services and oxygen-related equipment and services must maintain beneficiary records. All beneficiary records must include equipment assessments, such as oxygen concentrator hour meter readings. If the equipment has a patient compliance hour meter, that reading must also be documented and maintained in the beneficiary's record.

**Prosthetic Devices**

**Eligible:** All members where DME is a covered benefit

**Benefit Description:** Prosthetic devices include artificial limbs, body parts, sockets, suspension components, attachment, alignment and finishing. A complete description of the prosthesis is required, such as whether the device is a conventional type, above the knee or a special type.

The request should indicate the following:

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

**Special Needs Car Seat**

**Eligible:** All members where DME is a covered benefit

**Benefit Description:** A special needs car seat is designed for safe transport of the moderately to severely disabled child. A special needs car seat is covered when all of the following criteria apply:

- The special needs care seat must be medically necessary and appropriate;
- The physician must submit a full description of the recipient's postural condition including

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- head and trunk control and height and weight. Weight must be between 20-105 lbs.;
- The recipient's condition is of such severity that he/she cannot be safely transported using a standard car seat, car seat belts, or modified vest travel restraints;
  - There is expected long-term need for the car seat; and
  - The special needs care seat must accommodate at least thirty-six (36) months growth. If applicable, the car seat must be equipped with leg extensions to allow for growth over the 36-month period. Consideration must be given to the manufacturers' weight limitations.

**Strollers, Therapeutic Type**

**Eligible:** All members where DME is a covered benefit

**Benefit Description:** Strollers of a therapeutic type are approved if the recipient is confined to a bed, chair or room, or if they are needed for transportation to a medical or training facility.

**Standing Frames**

**Eligible:** All members where DME is a covered benefit

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

The recipient must:

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

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

- The recipient has complete paralysis of the lower extremities;
- When there is no expected improvement in mobility or maintenance of function;
- The anticipated functional benefits of standing can be achieved through less costly alternatives;
- In recipients with syncope, orthostatic hypotension, postural tachycardia syndrome, osteogenesis imperfecta, osteoporosis, and other brittle bone diseases, and hip subluxation;

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- In recipient's that have hip and knee flexion contractures of more than twenty (20) degrees;
- Mobile (dynamic) stander – either self-propelled standers or standers with powered mobility;
- Active stander – allows movement of the arms and legs in a standing position; and
- A stander will not be purchased for a recipient who has a gait trainer or ambulatory device.

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

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

**Suction Pumps**

**Eligible:** All members where DME is a covered benefit

**Benefit Description:** Reimbursement is limited to a ten (10) month rental. Purchase of a respiratory suction pump may be considered for recipients who have difficulty raising and clearing secretions secondary to:

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

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

**Support Hose**

**Eligible:** All members where DME is a covered benefit

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

**Surgical Dressing or Bandages**

**Eligible:** All members where DME is a covered benefit

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

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documentation of medical necessity.

**Syringes and Needles**

**Eligible:** All members where DME is a covered benefit

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

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

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

**Tracheostomy Care Supplies**

**Eligible:** All members where DME is a covered benefit

**Benefit Description:** Tracheostomy care supplies are covered for recipients following an open surgical tracheostomy. Tracheostomy care or cleaning starter kits may be covered for a maximum of two (2) weeks postoperative of an open surgical tracheostomy and must contain the following:

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

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

- Tube brush;
- Pipe cleaners;
- Cotton-tip applicators;
- One-half inch twill tape;
- 4-inch x 4-inch sponges; and

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- Pair of sterile gloves.

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

**Traction Equipment**

**Eligible:** All members where DME is a covered benefit

**Benefit Description:** Reimbursement is limited to a ten (10) month rental. Traction equipment is approved only if the recipient has significant orthopedic impairment which prevents ambulation. Cervical traction collars are considered under orthotic devices.

**Trapeze Bar**

**Eligible:** All members where DME is a covered benefit

**Benefit Description:** Reimbursement is limited to a ten (10) month rental. Trapeze bars are approved if the recipient requires assistance to sit up in bed because of a respiratory condition or a need to change body position for other medical reasons.

**Ventilator Assist Devices**

A ventilator is a medical device that supports breathing and provides a recipient with oxygen when they are unable to breathe on their own. Non-invasive ventilator assist devices are covered when medically necessary. All non-invasive and invasive ventilators must be prior authorized for a period of 12 months. Continued authorization requires documentation to support ongoing medical need and member compliance.

The following policy guidelines apply to all ventilator assist devices:

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

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- **Continuous and Bi-Level Positive Airway Pressure (CPAP and BiPAP)**

**Eligible:** All members where DME is a covered benefit

**Benefit Description:** ~~Item is precertified by AIM Specialty Health, and reimbursement is limited to a ten (10) month rental [IG13][KS14][LA15].~~ A continuous positive airway pressure (CPAP) machine is used to treat recipients who have moderate to severe obstructive sleep apnea (OSA). A respiratory cycle is defined as an inspiration, followed by expiration. Polysomnography (PSG) is the continuous and simultaneous monitoring and recording of various physiological and pathophysiological parameters of sleep with physician review, interpretation, and report. It must include sleep staging, which is defined to include a 1-4 lead electroencephalogram (EEG), and electrooculogram (EOG), and a submental electromyogram (EMG). PSG must also include at least the following additional parameters of sleep: airflow, respiratory effort, and oxygen saturation via oximetry. It may be performed as either a full-night study for diagnostic purposes only or as a split night study to diagnose and initiate treatment evaluation.

Apnea is defined as the cessation of airflow for at least ten (10) seconds documented on a polysomnogram. Hypopnea is defined as an abnormal respiratory event lasting at least twenty (20) seconds associated with at least a thirty percent (30%) reduction in thoracoabdominal movement or airflow as compared to baseline, and with at least a four percent (4%) decrease in oxygen saturation. The apnea-hypopnea index (AHI) is defined as the average number of episodes of apnea and hypopnea per hour and must be based on a minimum of two hours of sleep without the use of a positive airway pressure device, reported by PSG using actual recorded hours of sleep (i.e., the AHI may not be extrapolated or projected).

A Home Sleep Apnea Test (HSAT) is a diagnostic tool used to diagnose OSA. It is an alternative to PSG, which requires an overnight stay in a sleep lab. HSAT should be used:

- For patients who have or are suspected of having OSA and do not require more complex monitoring;
- For patients who have a high likelihood of having moderate to severe OSA; and
- For patients with uncomplicated medical histories.

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

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



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

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

- **Humidifiers**

**Eligible:** All members where DME is a covered benefit

**Benefit Description:** Reimbursement is limited to a ten (10) month rental. Humidifiers are used to prevent dry mouth, stuffy, congested, or runny nose and dry, burning, itching, or bleeding nose. Humidifiers are covered if continuous positive airway pressure (CPAP), bi-level positive airway pressure (BiPAP), or oxygen therapy has been prescribed for use in connection with medically necessary DME for purposes of moisturizing the oxygen. Heated and non-heated humidification for use with positive airway pressure system devices requires PA. Documentation of medical necessity including the diagnosis and expected outcome must be submitted.

**Vagus Nerve Stimulators (VNS)**

**Eligible:** All members where DME is a covered benefit

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

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

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

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

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

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

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

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

The following documentation shall be submitted by the multidisciplinary team:

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

Coverage of VNS includes but is not limited to:

- VNS;
- Implantation of the VNS;
- Programming of the VNS; and
- Battery replacement.

Healthy Blue restricts coverage of the surgery to implant the VNS to an outpatient hospital, unless medically contraindicated.

Healthy Blue advises hospitals to confirm that the provider performing the implantation has received an authorization for the procedure prior to submitting their claim in order to prevent denials. Healthy Blue shall reimburse for vagus nerve stimulators using HCPCS procedure code C1767 (VNS generator) and/or C1778 (VNS leads). Healthy Blue reimburses following review of the provider’s approved authorization.

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

**Wound Care Supplies**

**Eligible:** All members where DME is a covered benefit

**Benefit Description:** Surgical dressings, bandages, and other wound care supplies may receive PA approval for three (3) months at a time. The PA request must reflect the submitted prescription [and document the factors below in order to meet criteria](#). The prescription must be updated for any extensions to be granted. ~~The PA request must document the factors below in order to meet criteria.~~ [To request PA for wound care supplies, the following documentation must be provided:](#)

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

**Wound Care Systems and Supplies**

**Eligible:** All members where DME is a covered benefit

**Benefit Description:** Reimbursement is limited to a ten (10) month rental. A wound care system may be considered for ~~approval~~ [reimbursement when prior authorized](#) for recipients with a Stage III or IV chronic, non-healing wound, such as a pressure, venous stasis, and diabetic ulcers, postsurgical wound dehiscence, non-adhering skin grafts, or surgical flaps required for covering such wounds. Types of wound care systems include the following:

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

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

A [Medicaid approved](#) home health agency must be involved in the care of the beneficiary for consideration of approval for wound care supplies (i.e., surgical dressings, bandages, and other). Any routine supplies provided by the home health agency that are not covered by the DMEPOS Program must be provided in the skilled nursing visit rate.

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**EXCLUSIONS:**

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

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

- Clinically unproven equipment
- Comfort or convenience equipment
- Dentures
- Disposable supplies customarily provided as part of a nursing or personal care service or a medical diagnostic or monitoring procedure
- DME and supplies for residents in ICF/DD and nursing facilities
- Electric lifts (manual lifts are covered)
- Emergency and non-emergency alert devices
- Environmental modifications (e.g., home, bathroom, ramps, etc.)
- Equipment designed for use by a physician or trained medical personnel
- Experimental equipment
- Facilitated communications (FC)
- Furniture and other items which do not serve a medical purpose
- Handheld showers
- Investigational equipment
- Items used for cosmetic purposes
- Personal comfort, convenience, or general sanitation items
- Physical fitness equipment
- Precautionary-type equipment (e.g., power generators, backup oxygen equipment [provided outside of an official state and/or federally declared emergency](#))
- Rehabilitation equipment
- Reimbursement for delivery or delivery mileage of medical supplies
- Replacement of equipment that is damaged as a result of misuse, abuse, neglect, or wrongful disposition of equipment by the member, the member's caregiver, or the provider
- Routine and first aid items
- Safety alarms and alert systems/buttons
- Scooters
- Seat lifts and recliner lifts
- Standard car seats

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- Supplies or equipment covered by Medicaid per diem rates (nursing home residents may be approved for orthotics and prosthetics, but not for DME and supplies)
- Televisions, telephones, VCR machines and devices designed to produce music or provide entertainment
- Training equipment or self-help equipment
- Van lifts
- Wheelchair Lifts
- Wheelchair Ramps

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

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

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

In general, services that are not approved by the Food and Drug Administration or services that are experimental, investigational, or cosmetic are excluded from Medicaid coverage and will be deemed not medically necessary.

**REFERENCES:**

- ~~Associates Performing Utilization Review – LA~~
- CFR Title 42
- Clinical Criteria for Utilization Management Decisions – Core Process

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- ~~Clinical Information for Utilization Review—LA~~
- Continuity of Care – LA
- Durable Medical Equipment Rent to Purchase
- Health Care Management Denial – LA
- ~~High Cost DME, Prosthetic or Orthotic Purchases~~
- Home Health Services- LA
- Lost, Stolen or Destroyed Durable Medical Equipment
- Louisiana Medicaid Durable Medical Equipment Provider Manual
- Louisiana Medicaid Managed Care Organization (MCO) Manual
- Louisiana Medicaid Professional Services Provider Manual
- Louisiana State Contract
- Managed Care Organization (MCO) Manual – LA
- NCQA Accreditation Standards and Guidelines
- Out of Area, Out-of-Network Care – LA
- Out-of-Network Authorization Process
- ~~Precertification of Requested Services—LA~~
- Sleep Management Program
- Utilization Management- LA
- Women, Infant, and Children (WIC) – LA

**RESPONSIBLE DEPARTMENTS:**

**Primary Department:**

Health Care Management – Utilization Management

**Secondary Department(s):**

Claims

Medicaid Quality and Accreditation

**EXCEPTIONS:**

In adhering to EPSDT requirements, DME items whether or not listed or on the DME fee schedule will be considered for recipients under the age of twenty (21) based on medical

necessity. A provider may submit a PA request for recipients under the age of twenty-one (21) for items not listed or on the DME fee schedule.

It is a requirement of Medicaid that providers not bill for DME, services, supplies, prosthetics, or orthotics until the services have been rendered or the items have been delivered or shipped to the beneficiary. It is also a requirement that the date of service and the date of delivery is the same date for a claim to be paid. It is a violation of federal and state Medicaid

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policy to bill for a service that has not been delivered but has been ordered.

When requesting authorization of payment for these items or services, the provider should request authorization on the actual date of the service, delivery, or shipment of the item, or if not known, the provider should request a span date of sufficient duration to allow for authorization by Healthy Blue and delivery of the service or item.

It is the responsibility of the provider to verify eligibility on a monthly basis. PA only approves the existence of medical necessity, not beneficiary eligibility.

Healthy Blue has provisions in place for emergency situations. A request is considered an emergency if a delay in obtaining the medical equipment, or supplies would be life-threatening to the beneficiary. In an emergency, telephone or verbal requests shall be permitted.

The items listed below are some examples of medical equipment and supplies considered for emergency approval. However, other equipment will be considered on a case-by-case basis:

- Apnea monitors;
- Breathing equipment;
- Enteral therapy;
- Medical oxygen;
- Parenteral therapy (must be provided by a pharmacy);
- Suction pumps; and
- Wheelchair rentals for post-operative needs

The providers of emergency items must contact Healthy Blue immediately by telephone and provide the following information:

- The beneficiary's name, date of birth, and ID number;
- Ordering physician and servicing provider's information;
- Diagnosis;
- Time period needed for item;
- Complete description of the item(s) requested including CPT code(s); and
- Reason that the request is a medical emergency

A decision will generally be made by Healthy Blue within 24 hours, but in no case later than the business day following the date the completed request is received. Healthy Blue will contact the provider by telephone with a decision. If approved, the item shall be supplied upon the verbal approval. Healthy Blue will follow up with written confirmation of the decision.

When -Healthy Blue requires documentation of the physician's order, supporting



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documentation must accompany the claim to be considered for reimbursement.

If the request for medical equipment and supplies is covered by Medicare and the beneficiary is enrolled in Medicare Part B, no prior authorization is required; however, Medicare must be billed prior to billing Medicaid. If the item is not covered by Medicare, the request will be processed as if it were being processed for non-Medicare beneficiaries.

Pursuant to federal and state law, the Medicaid Program is intended to be the payer of last resort. Federal law and regulations require states to institute policies and procedures to ensure that Medicaid beneficiaries use all other resources available to the beneficiary prior to payment by Medicaid.

**REVISION HISTORY:**

Review Date	Changes
04/21/2016	<ul style="list-style-type: none"> <li>• New</li> </ul>
06/14/2016	<ul style="list-style-type: none"> <li>• Off cycle edits</li> <li>• Update to table under Diabetic Shoes and Cochlear Implants</li> </ul>
05/18/2017	<ul style="list-style-type: none"> <li>• For annual review</li> <li>• Minor change under Continuous Subcutaneous Insulin External Infusion Pumps section</li> <li>• Reference section updated</li> </ul>
10/13/2017	<ul style="list-style-type: none"> <li>• Off cycle review</li> <li>• AGP references changed to Healthy Blue</li> <li>• Minor change to procedure section under Osteogenic Bone Grown Stimulator</li> </ul>
04/20/2018	<ul style="list-style-type: none"> <li>• For annual review</li> <li>• No changes</li> </ul>
01/09/2019	<ul style="list-style-type: none"> <li>• Off cycle review</li> <li>• Removed table format</li> <li>• Updated coverage of Breast Pumps and Continuous Glucose Monitoring Devices</li> </ul>
02/28/2019	<ul style="list-style-type: none"> <li>• Off cycle review/ Early annual review</li> <li>• Edits to procedure section</li> </ul>
07/26/2019	<ul style="list-style-type: none"> <li>• Off cycle review</li> <li>• Updated Procedure</li> </ul>
09/25/2019	<ul style="list-style-type: none"> <li>• Off cycle Review</li> <li>• Updated Pulse Oximeter section under Procedure</li> </ul>
03/12/2020	<ul style="list-style-type: none"> <li>• Annual review</li> <li>• New LA Emergency Contract Revisions</li> </ul>

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Review Date	Changes
	<ul style="list-style-type: none"> <li>Edits to policy, definitions, procedure, exclusions, and reference sections</li> <li>Claims added as a secondary department</li> </ul>
05/14/2021	<ul style="list-style-type: none"> <li>Annual Review</li> <li>Edits throughout to align with current versions of the Contract, MCO Manual, and DME Provider Manual</li> <li>Policy, Procedure, and References updated</li> <li>Added exceptions</li> </ul>
11/10/2021	<ul style="list-style-type: none"> <li>Off-cycle review</li> <li>Policy updated to include and reflect LDH changes to Cochlear Implants (Action Alert #37556 effective 1/26/2022), CGM clarification (provided via email 11/1/2021), and Enteral Formula Coverage for Beneficiaries with Inborn Errors of Metabolism criteria (DME Provider Manual revised/issued 6/9/2021).</li> </ul>
04/01/2022	<ul style="list-style-type: none"> <li>Annual Review</li> <li>Policy updated to include and reflect LDH coverage of Human Milk Storage Bags (Action Alert #39752-IB 22-8)</li> </ul>
08/24/2022	<ul style="list-style-type: none"> <li>Off-Cycle Review</li> <li>Alphabetized definitions and DME Definition updated to align with Contract</li> <li>Procedure updated to include and reflect LDH coverage criteria for Continuous Glucose Monitoring Devices (LDH IB 22-23) Effective 08/01/2022.</li> <li>Procedure updated to include and reflect LDH authorization criteria for Non-invasive and Invasive Ventilators (LDH IB 22-25) Effective 09/01/2022.</li> </ul>
10/24/2022	<ul style="list-style-type: none"> <li>Off-Cycle Review</li> <li>Edits throughout to align with Model Contract Readiness Review</li> <li>Updated policy, definitions for Medically Necessary Services and Prior Authorization, and procedure sections</li> </ul>
11/08/2022	<ul style="list-style-type: none"> <li>Off-Cycle Review</li> <li>Updated procedure to align with LDH Information Bulletin 22-35 (Action Alert #44024): Human Donor Milk Outpatient Coverage</li> </ul>
03/22/2023	<ul style="list-style-type: none"> <li>Annual Review</li> <li>Update to Donor Human Milk to align with #44024-Informational Bulletin 22-35: Human Donor Milk Outpatient Coverage</li> <li>Update Enteral Nutrition Therapy description to align with LDH DME Provider Manual</li> <li>Update Portable Oxygen to align with LDH DME Provider Manual and</li> </ul>

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Review Date	Changes
	<p>Alert#46159 - LA-IB 23-3</p> <ul style="list-style-type: none"> <li>• Minor grammatical updates to definitions and exceptions</li> <li>• Updated procedure sections</li> </ul>
08/02/2023	<ul style="list-style-type: none"> <li>• Off-Cycle Review</li> <li>• Exceptions section updated</li> <li>• Update to Diabetic Supplies and Equipment to align with Alert #47890- Informational Bulletin 23-11</li> <li>• Update to Procedure sections to align with most current LDH DME Provider Manual and MCO Manual</li> </ul>
10/02/2023	<ul style="list-style-type: none"> <li>• Off-Cycle Review</li> <li>• Procedure section updated - Update to Diabetic Supplies and Equipment section to align with LDH Alert #49186- Informational Bulletin 23-11 Revision</li> </ul>
03/05/2024	<ul style="list-style-type: none"> <li>• Annual Review</li> <li>• Update to Diabetic Supplies and Equipment section to align with LDH Alerts #49940/50192/51084</li> <li>• Portable Oxygen Concentrator criteria added per LDH DME Provider Manual Revision Log (11/27/2023)</li> <li>• Update to Breast Pump Coverage section to align with LDH Alert #51989 and LDH DME Provider Manual revisions on 3/18/2024</li> <li>• Medicaid Quality and Accreditation department added as a secondary department</li> <li>• Policy, Definitions, Procedure, Exceptions and References sections language updated</li> </ul>
<a href="#">10/08/2024</a> <a href="#">02/07/2025</a>	<ul style="list-style-type: none"> <li>• <a href="#">Annual Review</a></li> <li>• <a href="#">Updated Procedure, References, and Exceptionsexclusions sections</a></li> <li>• <a href="#">Revisions made throughout policy to incorporate gender inclusive language per DME Provider Manual revisions on 3/08/24 and 3/18/24</a></li> <li>• <a href="#">Update to the Breast Milk and Supplies section and the Diabetic Supplies and Equipment section to align with LDH DME Provider Manual revisions on 3/18/24</a></li> <li>• <a href="#">Update to add Disposable Elastometric Infusion Pumps section to align with LDH Alert #55040 (IB 24-34)</a></li> <li>• <a href="#">Update to the Oxygen Equipment and Supplies section to align with LDH Alert #55529 IB 24-41 and to align with DME Provider Manual revisions on 10/8/24</a></li> <li>• <a href="#">Update to the Ventilator Assist Devices section to add At Home Sleep Apnea Test criteria per DME Provider Manual revision on 2/4/25</a></li> </ul>

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Review Date	Changes
	<ul style="list-style-type: none"><li>• <a href="#">Removed retired policies from References and added Home Health Services- LA and Utilization Management- LA policies</a></li><li>• <a href="#">Edits made to Exceptions section</a></li></ul>