14

14 Durable Medical Equipment (DME), Supplies, Appliances, Prosthetics, Orthotics and Pedorthics (POP)

Medicaid authorizes DME, supplies, appliances, and POP to Medicaid recipients of any age living at home. Participating providers (also referred to as "all providers mentioned in this chapter" or "provider") are those Home Health Agencies, pharmacies, DME, supply, appliance and POP suppliers contracted with Medicaid for this program. A provider of these benefits must ensure the following:

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

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

Prior Authorization (PA) requests for coverage of DME must be received by Medicaid's PA contractor within 30 days after the equipment is dispensed. (See section 14.3.1 Authorization for Durable Medical Equipment)

Deleted: ~~Fiscal Agent~~
Added: PA contractor

NOTE:

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

Fee Schedule

DME Reimbursement rates and benefit limits for covered equipment and supplies are published on Medicaid's website at the following link:
http://medicaid.alabama.gov/content/Gated/7.3G_Fee_Schedules.aspx

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

14.1 Enrollment

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

Refer to Chapter 2, Becoming a Medicaid Provider, for general enrollment instructions and information. Failure to provide accurate and truthful information or intentional

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misrepresentation might result in action ranging from denial of application to permanent exclusion.

Re-Validation

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

Application Changes Process

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

Change of Ownership (CHOW) and Closures

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

National Provider Identifier (NPI) Type and Specialty

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

NOTE:

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

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

Effective August 1, 2014, Medicaid DME providers will enroll or re-validate as the following applicable provider specialties:

Specialty Name	Specialty Number	Contract Name(s)	Contract Start Date	Contract End Date
Durable Medical Equipment	250	DME		8/1/15 (for all contracts assigned prior to 8/1/14)
Prosthetic, Orthotics & Pedorthics	251	POP (adults ages 21-65	8/1/14	N/A
		YPOP (youth ages 0-20)		
Mastectomy Fitter	254	MSFIT	8/1/14	N/A
Therapeutic Shoe Fitter (TSFIT)	256	TSA: Therapeutic Shoe Fitter -Adult (ages 21-65)	8/1/14	N/A
		TSCE: Therapeutic Shoe Fitter -Child/Elderly (ages 0-20 and 66-999)		

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Provider Enrollment Process

New Enrollments

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

Re-validations

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

NOTE:

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

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

Reimbursement

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

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

DME Provider Enrollment Requirements

To participate in Medicaid providers shall have no felony convictions and no record of willful or grossly negligent noncompliance with Medicaid or Medicare regulations.

Physical Location Requirements

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

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

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

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

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- Out-of state bordering DME providers, located within 30 miles of the border, may be enrolled as a regular Medicaid DME provider.
- Providers located more than 30-miles from the border may be enrolled only as follows:

  (1) for specialty equipment and supplies such as augmentative communication devices, automatic external defibrillators, high frequency chest wall oscillation air pulse generator systems which are not readily available in state; or

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

Business Signs

All providers mentioned in this chapter must maintain a permanent visible sign in plain view and post hours of operation. If the provider's place of business is located within a building complex, the sign must be visible at the main entrance of the building and the hours can be posted at the entrance of the provider.

Business Telephone

A provider must maintain a primary business telephone listed under the name of the business in a local directory or a toll free number available through directory assistance. The primary business telephone number must be kept updated with the Agency's fiscal agent. The exclusive use of a beeper, answering machine, answering service or cell phone during posted business hours is prohibited.

Business Hours and Staffing

All providers mentioned in this chapter must remain open to the public for a minimum of **30** hours per week during normal business hours except physicians, physical and occupational therapists or a provider working with custom made orthotics and prosthetics.

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

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

Supplies

Providers (as related to the provider specialty) must have DME, appliances or supply items stocked in the physical store location that are readily available to Medicaid recipients presenting prescriptions or orders for these items.

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

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

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

Shelf location for items must be labeled to include at minimum, the item's name.

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Satellite Businesses and Multiple Locations

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

A provider with multiple store locations must have completed a provider application for each location. Each store location enrolled with Medicaid is assigned a unique Medicaid Identification Number.

License and Certification Requirements (Documents)

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

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

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

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

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

License/Certifications Needed		Provider Exemptions
❒	Applicable State and Professional licenses	N/A
❒	Valid business license(s)	N/A
❒	Medicare Accreditation	Medicare exemptions apply
❒	Medicare Surety Bond (when applicable)	Medicare exemptions apply

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License/Certifications Needed		Provider Exemptions
❒	Medicaid Surety Bond (when applicable) Effective October 1, 2010, all participating providers are required to have a $50,000 Surety Bond for each NPI unless the provider meets an exemption. A provider who supplies Breast Prosthesis, Diabetic Shoes and Diabetic Shoe Inserts is **not** exempted.	A DME supplier who has been a Medicaid provider for five years or longer with no record of impropriety, and whose refund requests have been repaid as requested; or A government-operated DME, Prosthetics, Orthotics and Supplies (DMEPOS) provider; or A state-licensed orthotic and prosthetic personnel in private practice making custom-made orthotics and prosthetics; or Are physicians and non-physician practitioners, as defined in section 1842(b)(18) of the Social Security Act; or Are physical and occupational therapists in private practice; or Are providers who received $100,000 or less Medicaid payment in the past two calendar years and have been operating at the same location for at least two consecutive calendar years; or Are pharmacy providers; or Are phototherapy providers who only provide phototherapy services for infants; or Are Federally Qualified Health Centers.

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

Pharmacy providers are required to be enrolled with Medicare. Pharmacy providers are **not** required to submit copies of Medicare or Medicaid Surety Bonds, Medicare Accreditation or HME License.

Prosthetic, Orthotic, and Pedorthic (POP) Providers

Basic level prosthetics, orthotics and pedorthics are covered benefits to Medicaid eligible recipients up to age 65 in a non-institutional and institutional setting. POP providers, **must**:

- be licensed by the Alabama Board of Prosthetics, Orthotics and Pedorthics,
- be an in-state provider ONLY, and
- meet the same requirements as other DME providers.

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

Consignment Closets

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

14.2 Benefits and Limitations

This section defines DME and provides Medicaid policy for supplying products.

Refer to Section 14.3 of this chapter for PA and Referral Requirements.

Refer to Chapter 3 of the Provider Manual, Verifying Recipient Eligibility, for general benefit information and limitations.

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

Refer to the DME Fee Schedule on Medicaid's website for reimbursement rates and benefit limits for covered equipment and supplies at the following link:
http://medicaid.alabama.gov/content/Gated/7.3G_Fee_Schedules.aspx

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Benefit Limits

Medicaid covers items and supplies if the items and supplies are consistent with the implementation of the mandated Medicaid NCCI edits effective November 9, 2010. Refer to this link, https://www.medicaid.gov/medicaid/program-integrity/national-correct-coding-initiative-medicaid/index.html for more information regarding NCCI.

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

Exceeds Benefit Limit Requests

If the prescription or order to be paid by Medicaid exceeds the maximum benefit limit established by Medicaid, the provider must request an override or provider authorization request for the prescribed item(s).The requests for additional units with documentation justifying medical necessity must be submitted in compliance with Medicaid's override or PA request process. If the override or PA request is denied, the item(s) above the maximum benefit limit is not covered and the recipient may be charged as a cash recipient for the item(s) in excess of the maximum benefit limit.

NOTE:

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

14.2.1 Definitions

As defined by Medicaid, DME is equipment:

- that can stand repeated use;
- is primarily and customarily used to serve a medical purpose;
- generally is not useful to a person in the absence of an illness or injury; and
- is appropriate for use in the home.

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

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

Medicaid covers the purchase of DME items for long term use. Long term use is defined as the use of DME which exceeds six months. Medicaid covers the rental of DME items for six months or less.

Short Term Rental Policy

Standard DME items prescribed as medically necessary can be rented if needed on a short term basis. Short term is described as six months or less. Applicable procedure codes are indicated on the fee schedule with an RR for rental.

Medicaid does allow short term rentals of reclining wheelchairs for up to 3 months following a surgical procedure, other procedures or casting.

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Medicaid payment for short term rental will be made when the following documentation is submitted:

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

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

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

Capped Rental to Purchase (requires PA)

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

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

14.2.2 Non-covered Items and Services

Non-covered items and services include, but are not limited to:

- Items of a deluxe nature
- Replacement of usable equipment
- Items for use in hospitals, nursing facilities, or other institutions. However, DME items may be provided in nursing homes or other institutions for children through the EPSDT Program.
- Items for the patient or patient's caregiver's comfort or convenience
- Items not listed as covered by Medicaid
- Rental of equipment, with the following exceptions:
    - Rental for six months or less, or
    - Medicare crossovers, or
    - Certain intravenous therapy equipment, or
    - Short term use due to institutionalization, or
    - Short term use due to death of a recipient.
    - Negative Pressure Wound Pump are not covered in the home setting.

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

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14.2.3 Method of Requesting DME, Supplies, Appliances and POP Requirements for Placing the Initial Written Prescription/Order and the Required Face-to-Face Visit for Initiating Certain Medical Supplies, Equipment, and Appliances

In accordance with 42 C.F.R. § 440.70, the authorized practitioner who develops the recipient's written plan of care ("the ordering practitioner") is required to sign and place the initial prescription or order for certain medical supplies, equipment, and appliances. Subsequent written prescriptions/orders for refills, ancillary supplies, repairs or services, or re-certifications do not require the ordering practitioner's signature or an additional face-to-face visit.

Either an enrolled physician or one of the following authorized non-physician practitioners (NPP) may both conduct and document the clinical findings from the required face-to-face visit and write the initial written prescription or order for certain medical supplies, equipment, and appliances:

1. Certified registered nurse practitioners (CRNP) or clinical nurse specialists (CNS) working under a collaboration agreement under Alabama law with the ordering physician;
2. Physician assistants (PA) under the supervision of the ordering physician; or
3. Attending acute or post-acute physicians, if recipients are admitted to home health services immediately after discharge from an acute or post-acute stay.

The required face-to-face visit for the initial written prescription or order for certain medical supplies, equipment, and appliances must be related to the primary reason why the recipients require the certain medical supplies, equipment, and appliances and must occur no more than 6 months prior to the start of services. The required face-to-face visit may be conducted using telehealth systems.

The ordering practitioner is also required to review the recipient's written plan of care annually to determine the recipient's continued need for all medical supplies, equipment, and appliances.

Not all initial written prescriptions or orders for medical supplies, equipment, and appliances require a face-to-face visit be conducted. The face-to-face visit requirement is limited only to the certain medical supplies, equipment, and appliances that are also subject to a face-to-face requirement under the Medicare DME program as "Specific Covered Items" in 42 C.F.R. 410.38(g).

The following link from CMS provides a list of the DME codes for Specific Covered Items that are subject to the face-to-face visit requirements under the Medicare DME program: https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Medical-Review/Master-List

All wheelchair base codes (manual and power) require a face-to-face visit.

The ordering practitioner is also required to review the recipient's written plan of care annually to determine the recipient's continued need for all medical supplies, equipment, and appliances.

DME providers are also required to maintain all such written or electronic documentation in the recipient's medical records.

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Refer to Chapter 17—Home Health for more information on the requirements for placing the initial written prescription/order for home health services.

A written order or a signed prescription (as defined by the Medicare Program Integrity Manual Chapter 5) signed by the ordering practitioner is required for covered items. The order or prescription must be dated prior to or on the delivery date, unless a different effective date is clearly documented. Otherwise, the effective date is the date of the physician signature. An effective date that is handwritten on a prescription or order and differs from the date of the ordering practitioner's signature must be initialed and dated by the ordering practitioner to verify the effective date.

A valid prescription or order for diabetic supplies must include the recipient's name, date and signature of the provider, frequency of blood sugar testing, number of refills and a description of each item ordered. For example, a prescription or order cannot simply list, "diabetic supplies," but must **specify** the supplies (e.g., strips, lancets, glucometer).

- Verbal orders must be signed within 48 hours (two business days) of the order being issued. This prescription or order submitted to a participating provider determines medical necessity for covered items of supplies and appliances.
- Prescriptions cannot be written with indefinite, ninety-nine (99) refill date(s) or lifetime refills. Medicaid considers a prescription to be valid for the dispensing of supplies for a period of twelve months. After the twelve month period of time, the recipient must be reevaluated by the ordering practitioner to determine medical necessity for continued dispensing of medical supplies.
- Automatic refills (the automatic refilling of a claim without recipient request prior to each fill) are not allowed. Claims found to be automatically refilled will be recouped.
- The length of need may be documented on the prescription or elsewhere in the medical documentation.
- The standard order/prescription must include the following elements:
    A. Beneficiary name
    B. Description of the item
    C. Quantity, if applicable
    D. Order date
    E. Treating practitioner name or National Provider Identifier (NPI)
    F. Treating practitioner signature.

NOTE:

ALL DME items require a prescription/medical order, including repairs. A prescription or order is considered to be outdated by Medicaid when it is presented to the provider or Medicaid's PA contractor past 90 days from the date it was written.

Deleted: ~~fiscal agent~~
Added: PA contractor

EPSDT Referral

An EPSDT referral may be submitted as an order when written according to practice guidelines and state or federal law and must include the date and signature of the provider, the item(s) ordered and the recipient name. The EPSDT Referral Form may be considered the physician's order as long as the above noted guidelines are met. However, an EPSDT referral is **still required** as the referral provides the screening date and other additional information.

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NOTE:

Signature Requirements for Referrals: Effective May 16, 2012:

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

Upon receipt of the prescription or order, the provider must:

- Verify Medicaid eligibility by using the recipient's Medicaid number using Medicaid's Automated Voice Response System, Medicaid's Web portal (interactive, real time), Provider Electronic Solutions or the Provider Assistance Center at Medicaid's Fiscal Agent. Recipient's eligibility must be verified on a monthly basis. Medicaid will not reimburse providers for items supplied to recipients in months where the recipient does not have eligibility.
- Obtain necessary referrals and PAs (EPSDT, etc.)
- Collect the appropriate copayment amount
- Furnish the covered item(s) as prescribed
- Retain the prescription or orders and all medical documentation in patient's file
- Submit the proper claim form to Medicaid's Fiscal Agent

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

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

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

14.2.4 Warranty, Maintenance, Replacement, and Delivery

Warranty

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

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the supplying provider, recoupment of reimbursement paid to the provider for the equipment, or termination of the provider's contract.

Maintenance and Replacement

Deleted: ~~fiscal agent~~
Added: PA contractor

Medicaid covers repair and replacement of DME, supplies, appliances and POP. These services, in most cases, must be prior approved by Medicaid. The request for repair or replacement and appropriate documentation (includes PA when applicable) justifying the need for replacement must be submitted electronically to Medicaid's PA contractor and kept in the recipient's file.

Requests for replacement or repair of items that are covered by Medicaid which are outside the normal benefit limits, due to damage beyond repair or other extenuating circumstances must be submitted to the prior authorization contractor for review and consideration. Request for repair or replacement due to extenuating circumstances should be submitted following the standard prior authorization process.

Medicaid will not repair or replace items that are lost, destroyed, or damaged as a result of misuse, neglect, loss, or wrongful disposition of equipment by the recipient, the recipient's caregiver(s), or the provider. Prior authorization requests for repair or replacement will be denied if such circumstances are confirmed. Payment for repair or replacement of items denied by Medicaid is the responsibility of the recipient. At a minimum, examples of misuse, neglect, loss or wrongful disposition by the recipient, recipient's caregiver, or the provider include, but are not limited to the following:

- Loss of item or related parts
- Selling or loaning item or related parts
- Damage due to weather
- Failure to store the items in a secure and covered area when not in use
- Loss, destruction or damage caused by the malicious, intentional or negligent acts

Repairs

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

Effective January 1, 2015, the RB Modifier for Repair(s) for all wheelchair (manual or power) accessory procedure codes will allow a DME repair not exceeding $1,000 per day to bypass the need for PA. This may expedite the repair process which will be beneficial to Medicaid recipients and providers. This process will not apply to recipient's ages 0-20. This process will not override the current limitation audits for each of the procedure codes. For example, if the recipient has already received the yearly limit for a specific procedure code (e.g., 2 per calendar year), the provider will have to submit a PA for the repair even if it is less than the threshold amount of $1,000.

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

Replacement

E1399 - durable medical equipment, miscellaneous

Replacement parts are reimbursed based on the procedure code and fee schedule pricing. In situations where there are no procedure codes or fee schedule

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reimbursement for the replacement item(s), the provider must submit an itemized list of the needed items with invoice pricing for each item. Alabama Medicaid will reimburse these replacement items based on the provider's invoice purchase price plus 20%. The reimbursement amount will be calculated based on the provider's **final purchase invoice**, after all discounts have been applied.

No PA is needed for replacement of DME items that did not initially require a PA such as nebulizers unless a replacement is needed within the benefit limit period (i.e., product limited to 1 every 2 years, but replacement is needed after 18 months).

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

Replacement Equipment Due to Loss

Medicaid covers replacement items due to loss by disasters, fire, theft, etc. The provider must submit the appropriate documentation (fire report, police report, etc.) with the PA (if PA is required), and keep all related documentation in the recipient's file per Medicaid's record retention policy. Provider must file these claims with the appropriate procedure code and **Modifier CR**. The date of the report must be within 30 days of the date of loss or event. These claims will be monitored by Alabama Medicaid's DME Unit on a quarterly basis.

K0462- Temporary Replacement for Patient Owned Equipment Being Repaired

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

Delivery

Upon furnishing DME, supplies, appliances and POP, the supplier must:

1. Obtain the recipient's signature or the signature of the recipient's designee. For the purposes of this chapter, designee is defined as: "Any person who can sign and accept the delivery on behalf of the recipient." The relationship of the designee should be noted on the delivery slip (i.e. spouse, power of attorney, etc.). The signature of the designee should be legible. If the signature is not legible, the name of the person should be printed on the delivery slip. This requirement applies to all dispensing and delivery methods. (Refer to Rule 560-X-1-.18: Provider/Recipient Signature on Claim Forms.)
2. Document that the recipient was provided the necessary information and instructions on how to use Medicaid-covered items safely and effectively.
3. Retain all forms and documentation in the supplier's patient record.
4. For shipped items, the date of service is the date of delivery to the recipient. For this reason, delivery tickets must indicate the date of delivery to the recipient.

Added: to the recipient
Added: to the recipient

Automatic Refills

Automatic refills are not permitted by the Medicaid Agency. Violations may result in unauthorized charges. The provider may be held liable, or Medicaid may recoup the unauthorized charges, or cancel the provider agreement.

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Custom Made Items Ordered But Not Furnished

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

NOTE:

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

For any procedure code paid at invoice plus 20%, such as E1399, the reimbursement amount will be calculated based on the provider's **final purchase invoice,** after all discounts have been applied. Billing invoices addressed to the recipient are not appropriate for reimbursement.

14.2.5 Walkers

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

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

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

Prior Authorization

E0140 requires prior authorization. (See Section 14.3.1 Authorization for Durable Medical Equipment.)

Documentation

The prescriber must prescribe the specialty walker as medically necessary. The medical documentation justifying the need must accompany the PA request. Documentation must also include an evaluation by the recipient's physician or a physical therapist (PT).

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

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

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

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

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E0168 Extra Wide Heavy Duty Stationary Commode Chair

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

Prior Authorization

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

Documentation

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

14.2.6 Respiratory Suction Pumps

E0600 Suction Pump, Home Model, Portable

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

Prior Authorization

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

Documentation

The suction pump must be prescribed as medically necessary in order to qualify for Medicaid reimbursement. The recipient must be unable to clear the airway of secretions by coughing secondary to one of the following conditions:

- Cancer or surgery of the throat or mouth
- Dysfunction of the swallowing muscles
- Tracheostomy
- Unconsciousness or obtunded state

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

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

14.2.7 Insulin Devices and Supplies

E0607 Home Blood Glucose Monitor

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

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Prior Authorization

E0607 does not require PA.

Documentation

To be considered for coverage, Medicaid beneficiaries must be diagnosed as having either type 1, type 2, gestational diabetes, or receiving Total Parenteral Nutrition. Alabama Medicaid will reimburse covered diabetic supplies for Medicaid recipients that were diabetics prior to the pregnancy and for pregnancy related-diabetes. Reimbursement for these diabetic supplies will promote health and safety of mother and baby. Alabama Medicaid does not prefer one brand of home blood glucose monitor over another. All home blood glucose monitors billable under E0607 are considered a DME benefit and must be billed as a DME claim.

E2100 Home Blood Glucose Monitor with Integrated Voice Synthesizer

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

Prior Authorization

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

Documentation

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

The patient's optometrist or ophthalmologist must certify the degree and type of visual impairment.

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

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

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

Home Glucose Monitor Supplies

A4233 Replacement battery, Alkaline, other than J cell

A4234 Replacement battery, Alkaline, J cell

A4235 Replacement battery, Lithium

A4236 Replacement battery, Silver Oxide

A4256 Normal, low and high calibrator solution/chips

A4258 Spring-powered device for lancet, each

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Supplies

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

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

If recipients require additional strips or lancets above the Medicaid established limits, providers must submit a request to the prior authorization contractor for review and approval. The request must include the following:

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

If approval is granted, providers will be notified of the approval for these additional supplies and instructed to submit a clean CMS 1500 claim form to Alabama Medicaid's DME Unit.

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

Non-Insulin Dependent Recipients

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

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

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

Insulin Dependent Recipients

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

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

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

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

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Recipients with Gestational Diabetes

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

A4259 – Lancets, per box of 100, will be limited to **two** boxes per calendar month

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

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

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

E0784 External Ambulatory Infusion Pump and Supplies

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

Prior Authorization

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

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

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

To date, the Omnipod 5 "G6" insulin pump has not been approved by the PDAC (Medicare Contractor for Pricing, Data Analysis and Coding) for billing under the existing external insulin pump and pod procedure codes, E0784 and A9274. Therefore, effective February 1, 2023, Omnipod insulin pumps and refill pods without an approved procedure code should be billed under E1399 with an SC modifier. More information on how to bill the Omnipod can be found below:

- As with other insulin pumps, the Omnipod will require a prior authorization (PA) and the current criteria for external insulin pumps/pods will be followed.
- The PA request should include the initial kit and refill pods.
- Providers must submit an invoice with each PA request and append the SC modifier on the PA request.

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- If the invoice or modifier is not submitted with the PA, the PA will be denied.
- Providers will be reimbursed final purchase invoice cost + 20%.
- Requests for the other models, with an applicable procedure code, will continue to be billed and submitted under E0784 or A9274, respectively, and reimbursed per the amount listed on the fee schedule.

Approved Diagnoses

Approval will be given for only the following type 1 diabetes mellitus diagnosis codes, if the below linked criteria are met:

Deleted: ~~250.51 9~~ ~~E10.36…10~~ ~~13.8 10~~
Added: E10.10 10 E10.339…10 E10.9 10

Diagnosis	Version	Diagnosis	Version	Diagnosis	Version	Diagnosis	Version
E10.10	10	E10.339	10	E10.43	10	E10.622	10
E10.11	10	E10.341	10	E10.44	10	E10.628	10
E10.21	10	E10.349	10	E10.49	10	E10.630	10
E10.22	10	E10.351	10	E10.51	10	E10.638	10
E10.29	10	E10.359	10	E10.52	10	E10.641	10
E10.311	10	E10.36	10	E10.59	10	E10.649	10
E10.319	10	E10.39	10	E10.610	10	E10.65	10
E10.321	10	E10.40	10	E10.618	10	E10.69	10
E10.329	10	E10.41	10	E10.620	10	E10.8	10
E10.331	10	E10.42	10	E10.621	10	E10.9	10

External Ambulatory Insulin Infusion Pump Criteria Checklist

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

http://medicaid.alabama.gov/content/4.0_Programs/4.3_Pharmacy-DME/4.3.12_DME.aspx

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

Supplies Procedure Codes

E0784, A4232, A4230, A9274

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

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

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

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

A4230 (U6) - Infusion set for external insulin pump, non-needle cannula type will be limited to 70* units per two calendar months per recipient. (Payment for this quantity will

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also require use of the appropriate diagnosis code listed in the table above **and** U6 modifier.)

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

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

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

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

Recertification/Renewal

For patients who have received external ambulatory insulin infusion pump equipment and supplies through Alabama Medicaid and need a Prior Authorization Renewal, an updated prescription and an attestation from the patient's prescribing provider, stating their recommendation for continued use of the insulin delivery system/pump and pods, is required.

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

Continuous Glucose Monitor (CGM)

CGMs require prior authorization (PA) and are considered medically appropriate for recipients (children and adults) under the following curcumstances:

1. Recipient is diagnosed with type 1 diabetes mellitus

OR

2. Recipient is diagnosed with type 2 diabetes mellitus or gestational diabetes **AND** is insulin-treated with multiple (three or more) daily injections of insulin

AND

3. The prescribing practitioner must evaluate the recipient within six months prior to ordering the CGM, and at least every six months thereafter, to assess diabetes control, determine medical necessity, and confirm the criteria above are met.

For recipients who have received CGM equipment and supplies through Alabama Medicaid and need a PA renewal, an updated prescription from the prescribing practitioner as well as the initial determination above must be met.

NOTE:
*Coverage for non-medical items, even when the items may be used to serve a medical purpose, such as smart devices (smart phones, tablets, personal computers, etc.) are **non-covered**. This includes smart devices used in conjunction with CGMs.*

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Alabama Medicaid does not prefer one brand of CGM over the other. ***CGM providers must be enrolled with Alabama Medicaid as a DME Supplier/Provider.*** *Please see the CGM Policy Webpage for additional billing information: https://medicaid.alabama.gov/content/4.0_Programs/4.3_Pharmacy-DME/4.3.17_CGM.aspx*

Medicaid Reimbursement for CGM:

Supplies provided for non-adjunctive, non-implanted CGM patients effective November 1, 2023 will include:

A4239 –CGM supplies and accessories (this includes sensors and transmitters)

- 1 month supply=1 billable unit by the DME provider.
- Supply allowances should not exceed one year supply except in cases where supplies are dispensed in boxed quantities (i.e., 1 box = 5 sensors). In those cases, supply allowances will be approved to cover 365 days of use or through the duration of the prescription/medical order, whichever comes first.

E2103-CGM monitor or receiver.

- All models: 1 receiver **or** monitor = 1 billable unit
- CGM receivers are limited to one every five years, require PA, and will be considered based upon the review of submitted documentation.

Final purchase (after ALL discounts are applied) invoices must be included with all PA requests.

Limitations:

Maintenance is not available after the device has been purchased. Repairs are prior authorized and the necessary documentation to substantiate the need for repairs must be submitted at the time of PA submission. The supplies are covered up to the maximum allowed units for the specified time frames (see supplies).

CGM receivers are limited to one every five tears, require PA, and will be considered based on submitted documentation. Replacement requests made within the 5-year limit period will be considered for approval when the need for replacement is due to disaster or damage and not the result of misuse, gneglect, or malicious acts by the recipient or the caregiver. This type of request must be submitted as an over the limit PA request and must be accompanied by a police report, fire report, or other appropriate documentation.

14.2.8 Hospital Bed

A physician must prescribe a hospital bed as medically necessary in order for a recipient to qualify for a hospital bed.

If a hospital bed is medically necessary and is needed for six months or less, the equipment will be rented. This policy is applicable for all Medicaid recipients. If the equipment continues to be medically necessary and is needed longer than six months another PA request and prescription or order must be submitted documenting the need. If approval is granted a capped rental will be established and previous rental payments

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will be applied towards the total purchase price of the equipment. Reimbursement will not exceed the total purchase price.

Prior Authorization

These procedure codes require PA. (See Section 14.3.1 Authorization for Durable Medical Equipment.)

Medicaid will use the established PA criteria for these hospital beds, but will add the weight requirement. DME providers will ensure that an accurate weight measurement is included with these requests.

Documentation

The recipient must meet one of the following conditions:

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

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

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

Heavy Duty

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

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

E0304 Medicaid covers hospital beds (E0304) extra heavy duty, extra wide, with any type side rails, with mattress to accommodate weight capacities greater than 600 pounds. Medicaid will reimburse providers the established CURES Act rate for E0304.

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

14.2.9 Hospital Bed Accessories

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

Prior Authorization

Most accessory codes require PA.

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E0275, **E0276,** and **E0621** do not require PA.

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

Mattress Replacement

E0271: Mattress, innerspring

E0272: Mattress, foam rubber

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

Documentation

An eligible recipient must meet the following medical criteria:

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

Bed Side Rails

E0305: Bedside rails, half-length

E0310: Bedside rails, full length

A physician must prescribe bedside rails as medically necessary in order for a recipient to qualify for Medicaid reimbursement. These procedure codes require PA. (See Section 14.3.1 Authorization for Durable Medical Equipment.)

Documentation

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

- Disorientation
- Positioning problem
- Vertigo
- Seizure disorder

Recipient Hydraulic Lift

E0630: Recipient Hydraulic Lift with Seat or Sling

E0635: Electric Patient Lifts with Seat or Sling

Recipient hydraulic lifts will be considered for Medicaid payment when prescribed as medically necessary by a physician. These procedure codes require PA. (See Section 14.3.1 Authorization for Durable Medical Equipment.)

Documentation

An eligible recipient must meet the following medical criteria:

- Documentation must indicate the recipient has, or is highly susceptible to decubitus ulcers, or

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- The recipient must be essentially bed confined and would require the assistance of more than one person to transfer from bed to chair or wheelchair or commode without a lift.

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

Prior Authorization

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

Medicaid will reimburse providers at their final purchase invoice cost plus 20% for these patient electric lifts (E0635).

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

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

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

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

Documentation

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

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

Prior Authorization

Medicaid will use the established PA criteria for these trapeze bars, but will add the weight requirements. Individuals approved for these trapeze bars must weigh over 250 pounds. Medicaid will reimburse providers the established CURES Act rate for procedure code E0912.

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

14.2.10 Pediatric Bed/Crib

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

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

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

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

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

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

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

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

Added: (CG)

NOTE:

Effective April 1, 2026, enclosed beds manufactured as a unit must be billed with the CG modifier.

Added: NOTE: Effective April 1…the CG modifier.

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

Providers must submit documentation to support that the bed or crib system has been approved by the Food and Drug Administration (FDA) and the U.S. Department of Health and Human Services as a medical device. Device registration is not equivalent or acceptable. ***Enclosed bed systems that are not FDA approved are not covered by Alabama Medicaid.***

Added: and the U.S…equivalent or acceptable

Documentation

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

1. Diagnosis of one of the following:
    - Brain Injury

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- Moderate to severe cerebral palsy
- Seizure disorder with daily seizure activity
- Developmental disability
- Severe behavioral disorder
- Documentation of the specific risk from unrestricted mobility including
    - Tonic-clonic type seizures
    - Uncontrolled perpetual movement related to diagnosis
    - Self-injurious behavior

2. Providers must submit documentation to support that the bed or crib system accommodates child's weight &/or height, and;
3. Less costly alternatives have been tried and rejected. Physician and guardians must attest to the alternative use trials. If no alternative therapies attempted, documentation must explain why. Prescribing physician will be required to submit attestation document.

    Documentation of alternative therapies used shall include the following information:

    - Date(s) used
    - Duration of Use
    - Name of Equipment used
    - Results of use
        - Number of injuries
        - Type of injuries
4. Written monitoring plan approved by the ordering and all treating practitioners which includes, at a minimum, the following information:

    - Time frame or situations for when the bed will be used
    - Methods for monitoring the recipient at specified time intervals
    - Strategies for meeting all of recipient's needs while using the enclosed bed (including eating, hydration, skin care, toileting, and general safety)
    - Identification, by relationship, of all caregivers providing care to the recipient
    - An explanation of how any medical conditions (e.g., seizures) will be managed while the recipient is in the enclosed bed

Medicaid coverage of pediatric beds

If the pediatric bed is medically necessary and is needed for six months or less, the equipment will be rented. If the equipment continues to be medically necessary and is needed longer than six months a capped rental is established, previous rental payments will be applied towards the total purchase price of the equipment. Reimbursement will not exceed the total purchase price (fee schedule) of the equipment. *The PA will govern this process.* E0328 and E0329 will be reimbursed at final purchase invoice cost + 20%.

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14.2.11 Power Reducing Support Surfaces

Prior Authorization

Group 1 and Group 2 power reducing support surfaces require PA.

Group 1

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

Group 1 pressure reducing support surfaces include:

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

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

Documentation

Medical documentation must be submitted with the PA request justifying the need.

Group 2

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

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

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

Documentation

Medical documentation must be submitted with the PA request justifying the need.

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

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14.2.12 E0570 Nebulizer

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

This equipment may be purchased for any qualified Medicaid recipient based on the criteria listed below.

Documentation

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

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

14.2.13 Iron Chelation Therapy Equipment

Prior Authorization

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

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Documentation

Iron Chelation Therapy equipment will be considered for Medicaid payment when prescribed as medically necessary by a physician for an eligible recipient who has been diagnosed as having Sickle Cell Disease.

Iron Chelation Therapy equipment will be purchased for any qualified Medicaid recipient who meets the above criteria, supported by documentation.

14.2.14 Augmentative Communication Devices

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

Added: or Speech Generating Devices (SGDs)

ACDs are reusable equipment items that must be a necessary part of the treatment plan consistent with the diagnosis, condition or injury, and not furnished for the convenience of the recipient or the recipient's family. Medicaid will not provide reimbursement for ACDs prescribed or intended primarily for vocational, social, or academic development and enhancement.

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Added: the recipient's

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

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

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

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

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

E2510 Speech generating device, synthesized speech permitting multiple methods of message formulation and multiple methods of device access.

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

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

E2599 Accessory for speech generating device not otherwise classified.

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

Scope of services includes the following elements:

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

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

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Candidacy Criteria

Candidates must meet the following criteria:

Deleted: ~~EPSDT~~
Added: rendering
Added: EPSDT
Deleted: ~~professional~~
Added: speech language pathologist and prescribing provider
Deleted: ~~and based on~~
Added: written based on the information and
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Added: provided
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Deleted: ~~experienced professionals~~
Added: speech language pathologist and prescribing provider

Age	*Candidacy Criteria*
Under age 21	• EPSDT referral by Medicaid enrolled EPSDT provider. • Referral must be within one year of application for ACD • The rendering provider must obtain a referral from the referring EPSDT provider • Medical condition which impairs ability to communicate • Evaluation required by qualified, experienced speech language pathologist and prescribing provider • Prescription or order to be obtained after the evaluation, written based on the information and documentation provided in the evaluation
Adults, age 21+	• Referral must be within one year of application for ACD • Medical condition which impairs ability to communicate Evaluation by required qualified speech language pathologist and prescribing provider • Prescription or order to be obtained after the evaluation and based on documentation provided in the evaluation.

Evaluation Criteria

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

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

B. Interdisciplinary professionals should also include, but may not be limited to, a physical therapist, social worker, and/or occupational therapist.
   1. A physical therapist must possess the following qualifications:
      - Bachelor's degree in Physical Therapy from accredited institution;
      - Alabama license in Physical Therapy; and
      - No financial or other affiliation with a vendor, manufacturer or manufacturer's representative of ACDs.

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

Prior Authorization

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

Deleted: ~~services~~
Added: associated accessories
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Added: PA contractor

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

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

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

The speech language pathologist and prescribing provider should utilize the Augmentative Communication Device Evaluation Form.

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Added: The speech language..and prescribing provider
Deleted: ~~on the website at this link.~~

http://www.medicaid.alabama.gov/documents/9.0_Resources/9.4_Forms_Library/9.4.14_PA_Forms/9.4.14_PA_Form_480_ACD_Eval_Report_FILLABLE_3-29-11.pdf

Medicaid requires the following recipient information with the PA request:

Topic	***Information required for the PA***
Identifying information	• Name • Medicaid recipient number • Date(s) of Assessment • Medical diagnosis (primary, secondary, tertiary) • Relevant medical history

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

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Topic	*Information required for the PA*
Additional Documentation	• Documentation of recipient's trial use of equipment including amount of time, location, analysis of ability to use • Documentation of qualifications of speech language pathologists and other professionals submitting portions of evaluation. Physicians are exempt from this requirement. • Signed statement that submitting professionals have no financial or other affiliation with manufacturer, vendor, or sales representative of ACDs. One statement signed by all professionals will suffice.

NOTE:

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

Limits

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

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

All requests for replacement or modification as outlined above require a new evaluation and complete documentation.

Other Information

Topic	*Required for the PA*
Invoice	The PA request and the **manufacturer's invoice** must be submitted to the PA record using the PA barcode coversheet.
Trial Period	No communication components will be approved unless the client has used the equipment and demonstrated an ability to use the equipment. PA for rental may be obtained for a trial period. This demonstrated ability can be documented through periodic use of sample/demonstration equipment. Adequate supporting documentation must accompany the request. PAs for rental of ACD device E2510 may be approved for a four week trial period of usage by the recipient. The manufacturer must agree to this trial period. Medicaid will reimburse the manufacturer for the dollar amount authorized by Medicaid for the four (4) week trial period. This amount will be deducted from the total purchase price of the ACD device.
Repair	Repairs are covered only to the extent not covered by manufacturers' warranty. Repairs must be prior approved and billed using procedure code V5336. Battery replacement is not considered repair but does require PA using procedure code E2599.

Deleted: ~~forwarded to Medicaid's…Agent PA department~~
Added: submitted to the…PA barcode coversheet

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Topic	*Required for the PA*
Loss/Damage	Replacement of identical components due to loss or damage must be prior approved. These requests will be considered only if the loss or damage is not the result of misuse, neglect, or malicious acts by the users.
Component / Accessory Limits	No components or accessories will be approved that are not medically required. Examples of non-covered items include but are not limited to the following: • Printers • Modems • Service contracts • Office/business software • Software intended for academic purposes • Workstations • Any accessory that is not medically required.

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

14.2.15 Wheelchairs

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

Documentation

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

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

Limitation and Exclusions

- Within the seven year period, Medicaid will not repair or replace equipment that is lost, destroyed, or damaged as a result of misuse, neglect, loss or wrongful disposition of equipment by the recipient, the recipient's caregiver(s), or the provider. At a minimum, example of equipment misuses, neglect, loss or wrongful disposition by the recipient, recipient's caregiver, or the provider include, but are not limited to the following:
    a. Loss of wheelchair or parts.
    b. Selling or loaning wheelchair or parts.
    c. Damage due to weather.
    d. Failure to store the wheelchair in a secure and covered area when not in use.
    e. Use on public roadways where the speed limit is greater than 25 miles per hour.
    f. Loss, destruction or damage caused by the malicious, intentional or negligent acts.

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Patient Education

- Provider is responsible for patient education and documentation of appropriate usage of wheelchair. Patient education shall include, but not be limited to, proper storage, usage on or off public roadways, battery life, cleaning, warranty, etc.
- Documentation of patient education and understanding by both the servicing provider and the recipient or caregiver shall be kept in the patient file for the life of the wheelchair.

Effective August 1, 2017, Medicaid's annual limit for manual or power/motorized wheelchairs is one every five years for children ages 0-20, and one every seven years for adults ages 21 and older.

Effective July 1, 2017, Medicaid's **Wheelchair Modification/Repair Form 386** will be **mandatory** for prior authorizations submitted July 1. 2017 and after for all requested wheelchair modification or repairs requiring a PA. This form must be completed signed and dated by an Alabama-licensed Physical Therapist (PT) or Occupational Therapist (OT), **if** a PT/OT assessment was required for the modification to address changing/growing the seating; changing drive controls; adding a power function or power assist, etc. The PT/OT should have experience and training in mobility evaluations and must be employed by a Medicaid-enrolled hospital outpatient department. The form may read, "See Letter of medical necessity," which may be attached to the form. Otherwise, justification may be provided by the repair technician or provider ATP/SMS on the form. The form should be dated and have the printed name and signature of the provider. This form is located on Medicaid's website at www.medicaid.alabama.gov.

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

NOTE:

All wheelchair PT/OT assessments must be conducted in-person by the same professional who signs the form. Telehealth/Virtual assessments are not accepted for wheelchair related PT/OT assessments included in both the Form 386 and the Form 384 referenced above. The PT/OT who signs the applicable assessment form must be the provider who conducted all observations, tests, and measurements.

Standard Wheelchair

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

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HCPCS E1050 through E1200 and K0005 will be used as appropriate for standard wheelchairs.

Heavy Duty Wheelchairs

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

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

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

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

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

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

Motorized/Power Wheelchairs

Medicaid covers motorized or power wheelchairs for the entire Medicaid population. To qualify for motorized or power wheelchairs an individual must meet full Medicaid financial eligibility and established medical criteria. All requests for motorized or power wheelchairs are subject to Medicaid PA provisions established by Medicaid. The patient must meet criteria applicable to manual wheelchairs pursuant to the Alabama Medicaid Agency Administrative Code Rule No. 560-X-13-.17. **HCPCS K0813 through K0816, K0820 through K0831, K0835 through K0843, K0848 through K0864, K0868 through K0871, K0877 through K0880, K0884 through K0886, K0890, K0891, and K0898 will be used as appropriate for related motorized wheelchairs.**

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

Providers should submit K0108 for a "growth kit," after ensuring the manufacturer does not provide a growth kit free of charge. A statement that the provider verified the information about the growth kit should also be submitted.

Documentation

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

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Prior Authorization

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

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

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- This form must be completed (i.e. written or typed) by an Alabama licensed physical therapist or occupational therapist employed by an enrolled hospital through the hospital outpatient department. *(For clarification: The use of a scribe is highly discouraged unless needed in extenuating circumstances such as physical limitation by evaluating therapist. If scribe is used, attestation statement along with reason for use of scribe should be provided).*
- If Form 384 was received timely for the initial request but the PA is denied and Form 384 becomes outdated, the OT or PT can submit an amendment in the form of a memo or letter with the reconsideration documents or the OT or PT can sign, date, and attest at the bottom of Form 384 that there have been no significant change(s). The amendment and/or signature should verify that there have been no significant change(s) to the recipient's condition since the completion of the evaluation and that the requested wheelchair and accessories are still appropriate

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to meet the recipient's mobility needs. **The PT's evaluation is paid separately and is not the responsibility of the DME provider.**

- Reimbursement is only available for physical therapists and occupational therapists employed by a Medicaid enrolled hospital through the hospital outpatient department. An OT or PT not employed by a Medicaid enrolled hospital may perform the wheelchair assessment without any reimbursement from Medicaid. The OT or PT performing the wheelchair assessment should not be employed with the DME Company or contracted by the DME Company requesting the physical therapy evaluation. If it is determined that the OT or PT is affiliated with the DME Company the OT or PT will be penalized and referred to the Alabama Medicaid Fraud Control Unit.
- The DME provider must submit the PA request electronically. Refer to Chapter 4, Obtaining Prior Authorization, about PA submissions and electronic upload of supporting documentation.
- PA requests for a power wheelchair must provide documentation that the recipient is able to independently use the requested item, either through a trial of the equipment (strongly recommended), or information to substantiate this ability. Information may be documented on the Motorized/Power Wheelchair Assessment Form (Form 384).
- Alabama Medicaid Agency or designated contractor may request additional information to support the appropriateness of this request. Additionally, a request for a trial may be required to determine if the recipient can independently operate the wheelchair.
- The DME provider must ensure that the PA request for the motorized or power wheelchair includes the product's model number, product name the name of the manufacturer. Providers must submit an itemized list of wheelchair, wheelchair accessory codes and pricing with the PA request.

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

Criteria required for providing ALL Power Wheelchair Groups

Suppliers providing power wheelchairs and/or power operated vehicles to recipients must have at least one employee with certification from Rehabilitation Engineering and Assistive technology Society of North America (RESNA) registered with the National Registry of Rehab Technology Suppliers (NRRTS) or Assistive Technology Professional (ATP) certificate.

As an alternate, a supplier shall be certified as a Certified Rehab Technology Supplier (ATS) from Rehabilitation Engineering and Assistive Technology Society of North American (RESNA). Only suppliers who are certified may participate. For information regarding certification through RESNA call (703) 524-6686 or www.RESNA.org.

1. The beneficiary requires a power wheelchair for mobility and to perform mobility related activities of daily living (MRADL) in the home and/or community settings; and

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2. The beneficiary's mobility limitation is due to a neurological condition, myopathy, congenital skeletal deformity, or similar medically, functionally limiting condition; and
3. The beneficiary has had a specialty evaluation that was performed by a licensed/certified medical professional, such as a Physical Therapist (PT), Occupational Therapist (OT), or physician who has specific training and experience in rehabilitation wheelchair evaluations that documents the medical necessity for the wheelchair and its special features. The PT, OT or physician may have no financial relationship with the supplier; and
4. The wheelchair is provided by a supplier that employs a RESNA-certified Assistive Technology Professional (ATP) who specializes in wheelchairs and who has direct, in-person involvement in the wheelchair selection for the beneficiary.

Clinical Criteria Specific to Group Options:

Group I: Operates in accommodated environments only, traversing low level surfaces with minimal environmental barriers. Recipient with good postural stability, unable to operate a Tiller steering, and cannot independently transfer from POV. Indoor use mainly, no power seating needed.

Group II: Operates in accommodated environments for longer distances/travel, however, limited. Can operate joystick, unlikely to require changes to steering mechanisms, power seat option.

Groups III-V: Operates in accommodated environments and non-accommodated environments for extended distances, traversing threshold and curbs ~2" in height. Have very specialized needs and seating systems. Operates joystick or alternative control, such as head control, sip and puff, switch control etc. Allows modifications to seating configuration. Groups are differentiated by the level of environmental, medical, and functional needs.

Requests for EPSDT-referred specialized wheelchair systems

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

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

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

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

- Manual Wheelchair Systems - 20% discount from MSRP
- Power Wheelchair Systems - 15% discount from MSRP
- Ancillary (add-on) products:
- Electronic ancillary products – 15% discount from MSRP
- Non-electronic ancillary products – 20% discount from MSRP

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

Procedure code E2300 (Power Seat Elevation Systrem) has replaced procedure code E2298 effective April 1, 2024. Prior Authorization remains a requirement and limit remains one (1) per two (2) calendar years.

Complex Rehabilitation Technology (CRT) Category

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

Wheelchair Repairs

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

Prior Authorization

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

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

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14.2.16 Wheelchair Low Pressure and Positioning Equalization Pad

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

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

To qualify for Medicaid reimbursement of a low pressure equalization pad, the equipment must be prescribed as medically necessary for the recipient by the physician.

Prior Authorization

The above listed procedure codes require PA. (See Section 14.3.1 Authorization for Durable Medical Equipment.)

Documentation

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

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

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

K0108

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

NOTE:
Medicaid will use the established PA criteria for the Extra Heavy Duty Wheelchair and ROHO Cushion, but will add weight, width and depth specifications. Individuals approved for these items must be fitted and measured for wheelchair and cushion by the DME company providing these services.

14.2.17 Oxygen

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

NOTE:
Beginning 11/1/2020 and continuing until a time determined by the Alabama Medicaid Agency, oxygen saturation measurements will not be required.

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

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Added: PA contractor

if it is being used as the prescription.-A DME supplier representative may sign and date the form if the DME provider is submitting both the prescription signed by the prescriber AND Form 360 to Medicaid's PA contractor for prior authorization review.

Prior Authorization

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

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In order to receive a PA number, the Form 360 must be completed and submitted to Medicaid's PA contractor. Oxygen therapy is based on the degree of desaturation or hypoxemia.

Documentation

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

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

b. Recipients must meet the following criteria:

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

ii. An adult with an arterial PO2 at or below 55mmHg, or an oxygen saturation at or below 88%, for at least five minutes during sleep for a recipient who demonstrates an arterial PO2 above 59mm Hg or an O2 saturation at or above 90% while awake. The five minutes do not have be consecutive.

iii. A decrease in arterial PO2 more than 10mm Hg, or a decrease in O2 saturation more than five percent from the baseline saturation, for at least five minutes taken during sleep associated with symptoms (e.g., impairment of cognitive processes and nocturnal restlessness or insomnia, or signs (e.g. cor pulmonale, "P" pulmonale on EKG, documented pulmonary hypertension and erythrocytosis) reasonably attributed to hypoxemia.

iv. An arterial PO2 at or below 55mmHg or an O2 saturation at or below 88%, taken during activity for a recipient who demonstrates an O2 saturation at or above 90% during the day while at rest.

v. Recipients 20 years old or younger with **a SaO2 level:**

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

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

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requirement. Prescriptions or orders for oxygen therapy must include **all of the following**:

i. type of oxygen equipment

ii. oxygen flow rate or concentration level

iii. frequency and duration of use

iv. estimate of the period of need

v. circumstances under which oxygen is to be used

d. Medical necessity initial approval is for no more than twelve months. To renew approval, ABG or oximetry is required within six months prior to the end of the initial approval period. Approval for up to 12 months will be granted at this time if resulting PO2 values or SaO2 levels continue to meet criteria. If ABG or oximetry is not obtained timely before the end of the initial approval period, approval for a renewal will be granted beginning with the date of the qualifying ABG or oximetry reading.

e. Criteria for equipment reimbursement

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

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

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

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

iv. The DME supplier, and its employees, may not perform the ABG study or oximetry analysis used to determine medical necessity for recipients receiving nocturnal oxygen only. The provider cannot perform the oxygen saturation reading for recipients receiving oxygen 24 hours per day.

v. For recertification, the DME supplier may perform the oximetry analysis to determine continued medical necessity for recipients receiving nocturnal oxygen only. A printed download of the oximetry

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results must be submitted with a PA request. Handwritten results will not be accepted.

NOTE:

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

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

14.2.18 Pulse Oximeter

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

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

Prior Authorization

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

To receive a PA, submit an electronic request to include, but is not limited to, all of the following requirements:

- Required supporting documentation;
- Copy of EPSDT form or referral; and
- Copy of prior approval form for home oxygen (Form 360).

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

Documentation Requirements A:

1. Patient is ventilator dependent with supplemental oxygen required; or
2. Patient has a tracheostomy and is dependent on supplemental oxygen; or
3. Patient requires supplemental oxygen per Alabama Medicaid criteria (see below) and has unstable saturations[1]; or
4. [1]Patient is on supplemental oxygen and weaning is in process; or
5. Patient is diagnosed with a serious respiratory diagnosis and requires short term[2] oximetry to rule out hypoxemia or to determine the need for supplemental oxygen.

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

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

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Documentation Requirements B:

The following documentation is required:

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

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

Qualifying Diagnoses:

- Lung disease, including but not limited to interstitial lung disease, cancer of the lung and cystic fibrosis bronchiectasis
- Hypoxia related symptoms/conditions, such as pulmonary hypertension
- Recurrent CHF secondary to cor pulmonale
- Erythrocytosis
- Sickle cell disease
- Severe Asthma
- Hypoplastic heart disease
- Suspected sleep apnea or nocturnal hypoxia
- Other diagnoses with medical justification

Coverage Information

The Pulse Oximeter must be an electric desk top model with battery backup, alarm systems, memory and have the capacity to print downloaded oximeter readings. Downloads for each month of the most current certification period are required for all recertification requests. Recertification is required until the recipient no longer meets criteria or the device is removed from the home. If the pulse oximeter is no longer medically necessary (criteria no longer met), the oximeter will be returned to the supplier and may be rented to another client who meets criteria for pulse oximeter.

This device will be rented for up to three months during the initial certification period. If this device is needed beyond the initial certification period, the equipment will then become a rent to purchase item for an additional seven month period. The monthly

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payment will include delivery, in-service for the caregiver, maintenance, repair, supplies and 24-hour service calls. After the ten month rental period, the equipment is paid in full and no additional payment will be made by Alabama Medicaid. The pulse oximeter will be considered to be owned by the recipient.

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

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Added: PA contractor

Limitations

Diagnoses not covered:

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

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

14.2.19 Pulse Oximeter Supplies

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

A4606 - non disposable probe

A4606 – disposable probe

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

14.2.20 Volume Ventilator

E0465-(R)- Home ventilator, any type used with invasive interface, (e.g., tracheostomy tube)

E0466-(R)- Home ventilator, any type, used with non-invasive interface, (e.g., mask, chest shell)

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

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

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

Documentation

Volume ventilator and pressure ventilators are covered for children (ages 0 to 20) with an EPSDT screening when prescribed by a physician as medically necessary:

The recipient must meet **all** of the following conditions:

- Medically dependent on a ventilator for life support at least 6 hours a day
- Dependent for at least 30 consecutive days and medical documentation from the recipient's primary prescribing provider indicates long-term dependency on ventilator support;
- Except for the availability of respiratory care services (ventilator equipment) would require respiratory care as an inpatient in a hospital, NF, ICF, or IID and would be eligible to have payment made for inpatient care under the state plan.
- Adequate social support services to be cared for at home are available.
- Receives services under the direction of a physician who is familiar with the technical and medical components of home ventilator support, and who has medically determined that in-home care is safe and feasible for the individual without continuous technical or professional supervision. (Reference 42 CFR Section 440.185 Respiratory care for ventilator-dependent individuals.)

AND

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

a. Chronic respiratory failure,
b. Spinal cord injury,
c. Chronic pulmonary disorders,
d. Neuromuscular disorders, or
e. Other neurological disorders and thoracic restrictive diseases.

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

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

Medicaid will provide coverage for the use of volume and pressure ventilators for recipients aged 21 and older if all the following medical necessity criteria are met:

1. Patient is medically dependent on ventilator for life support at least 6 hours in a 24-hour period;
2. Patient labs indicate arterial blood gases (ABGs)with pCO_2 >50 (hypercapnia) and pO_2 <55 (hypoxemia) on the most recent hospital admission or within past 12 months;
3. Patient has adequate social support services to be cared fofr at home;
4. Patient receuves services under the direction of a physician familiar with technology and medical components of home ventilator support and has medically determined in-home care is safe and feasible for the patient;

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AND

Adult recipient must have at least one or more of the following:

1. Chronic respiratory failure due to chronic obstructive pulmonary disease (COPD) with acute exacerbations with hypercapnia ($pCO_2 > 50$) and hypoxemia (pO_2 <55) on ABGs.
2. Spinal cord injury such as quadriplegia.
3. Chronic pulmonary disorder such as pulmonary hypertension from congestive heart failure,
4. Neuomuscular disorder such as muscular dystrophies, myopathy.
5. Othe neurological disorders.
6. Thoaracic restrictive disease from chest wall deformities, scoliosis.
7. Obesity hypoventilation syndrome.

Initial approval will be approved for a 3-month rental period. Recertification must include documentation from the prescribing provider substantiating that the patient continues to meet criteria, documentation must indicate recipient's overall condition with any hospitalizations and ED visits, and must document patient compliance with use of NIV, etc.

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

14.2.21 Continuous Positive Airway Pressure (CPAP) Device

E0601 Continuous Positive Airflow Pressure (CPAP) devices are designed to deliver slightly pressurized air to keep the throat open during the night. The device itself weighs about five pounds and fits on a bedside table. A mask containing tubing connects to the device and fits over the nose. Air is delivered by a mask covering the nose or through prongs that fit inside the nose. In addition, the machine supplies a steady stream of air through the tubes and applies sufficient air pressure to prevent tissues in the airway from collapsing during sleep when a person inhales.2

Prior Authorization

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

Documentation

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

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

1. Recipient is diagnosed with obstructive sleep apnea, upper airway resistance syndrome, or mixed sleep apnea; and
2. Adenotonsillectomy has been unsuccessful in relieving OSA; or
3. Adenotonsillar tissue is minimal, or

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4. Adenotonsillectomy is inappropriate based on OSA being attributable to another underlying cause (e.g., septum deviations, facial abnormalities (craniofacial syndromes), obesity, cardiopulmonary or metabolic disorders, tracheomalacia, tracheostomy complications or other anomalies of the larynx, trachea and bronchus; or when adenotonsillectomy is contraindicated.

The following documentation also must be submitted:

1. A sleep study must be done within six months of prescribing CPAP therapy; and
2. The sleep study results are recorded for at least 360 minutes or six hours. A sleep study is acceptable for patients less than six months old if the duration of the sleep study is 240 minutes or four hours.

Medicaid will approve the CPAP based on the EPSDT Screening.

Reimbursement

Effective August 1, 2022, the CPAP will be considered a purchased item. No additional payment will be made by Alabama Medicaid on the CPAP machine and the machine will be considered to be owned by the recipient. The purchase payment will include delivery, in-service for the caregiver, maintenance and repair.

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

Effective March 6, 2020, CPAP and humidifier devices (heated and non-heated) billed on the same date of service will be reimbursed separately. Effective August 1, 2022, the humidifier will be reimbursed as a purchase when billed with a CPAP.

NOTE:

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

14.2.22 Bilateral Positive Airway Pressure (BI-PAP) Device

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

Prior Authorization

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

Documentation

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

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

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

1. Patient is diagnosed with central or obstructive sleep apnea, (sleep study required),
2. Patient is diagnosed with upper airway resistance syndrome, (sleep study required),
3. Patient is diagnosed with mixed sleep apnea, (sleep study required), or
4. Patient is diagnosed with a neuromuscular disease (examples include muscular dystrophies, myopathies, and spinal cord injuries), respiratory insufficiency or restrictive lung disease from wall deformities (sleep study not required)

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

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

Initial approval will be considered a purchased item for any qualified Medicaid recipient who meets the above criteria. The information submitted must include documentation that the recipient meets the above medical criteria. After initial approval, BIPAPs will be considered purchased and owned by the recipient.

Reimbursement

Effective July 1, 2022, the BIPAP will be considered a purchased item. No additional payment will be made by Alabama Medicaid on the BIPAP machine and the machine will be considered to be owned by the recipient. The purchase payment will include delivery, in-service for the caregiver, maintenance, and repairs. Supplies will be covered up to the maximum allowed units for the specified timeframe as indicated on the DME fee schedule. BI-PAP devices will be limited to one per recipient every eight years.

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

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

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

NOTE:

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

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14.2.23 Home Phototherapy

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

Prior authorization

PA for Home Phototherapy for the first four consecutive days of therapy is no longer a requirement.

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

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

1. The infant is term (37 weeks of gestation or greater), older than 48 hours and otherwise healthy;
2. The serum bilirubin levels > 12;
3. The serum bilirubin level is not due to a primary liver disorder;
4. The diagnostic evaluation (described below) is negative; and
5. The infants' bilirubin concentrations as listed below indicate consideration of phototherapy

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

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

NOTE:
An EPSDT screening is not required.

Diagnostic evaluation

Prior to therapy, a diagnostic evaluation should include:

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

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Documentation

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

NOTE:

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

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

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

Deleted: ~~Fiscal Agent~~
Added: PA contractor

Prior Authorization

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

Documentation

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

1. The patient has had two or more hospitalizations or episodes of home intravenous antibiotic therapy for acute pulmonary exacerbations during the previous twelve months; and
2. The FEV1 (forced expiratory flow in one second) is less than 80% of predicted value or FVC (forced vital capacity) is less than 50% of the predicted value; and
3. There is a prescribed need for chest physiotherapy at least twice daily; and
4. There is a well-documented failure of other forms of chest physiotherapy which have been demonstrated in the literature to be efficacious, including hand percussion, mechanical percussion, and Positive Expiratory Pressure (PEP) device. The evidence must show that these have been tried in good faith and been shown to have failed prior to approval of the vest; and
5. The patient does not have a caretaker available or capable of assisting with hand percussion, then a trial of hand percussion would not be a necessary prerequisite, but such patients would still need to in good faith complete a trial of mechanical percussion and the use of the PEP device.

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NOTE:

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

Medicaid Coverage for the HFCWO (Capped Rental)

The initial rental approval will consist of up to 90 days. A monthly rate will be paid to the provider for the first three months. The rental period will allow the patient to demonstrate compliance with the device. At the end of the 90 days, documentation (requires an additional PA) is required that demonstrates recipients usage and compliance levels. The device must have been used at least 67% of the time. If patient compliance is shown in the first three month rental period, in the fourth month, the device will transition to a purchase, with the total rental payments during the first three months payment and subsequent one month payment equaling the purchase rate. The first three months payment should be billed with the RR modifier. The final purchase payment should not be billed with a modifier.

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

Recertification is required until the recipient no longer meets the criteria, the device is removed from the home, or the device is purchased. Recertification criteria submitted should include a current prescription, documentation of continuing medical necessity, compliance and that the recipient's respiratory status is stable or improving. If the HFCWO is determined not to be medically necessary (i.e., the criteria are no longer met) the HFCWO will be returned to the supplier if the total rental amount paid is less than the established purchase price.

Percussor Electric or Pneumatic

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

(See section 14.3.1 Authorization for Durable Medical Equipment)

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

- Must be an EPSDT Medicaid eligible individual;
- Patient has a chronic lung condition of cystic fibrosis or bronchiectasis;
- Other means of chest physiotherapy such as hand percussion and postural drainage have been used and failed;
- No caregiver available or caregiver is not capable of performing manual therapy; and

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- Clinical documentation indicates that manual therapy has been used and does not mobilize respiratory tract or the patient cannot tolerate postural drainage.

14.2.25 Incontinence Products and Supplies (Disposable Diapers)

Medicaid will consider payment of disposable diapers as a personal comfort item if EPSDT referred and/or the patient is currently enrolled in the ID and/or LAH Waiver Special Waiver Program.

Prior Authorization

The applicable procedure codes for disposable diapers require PA. (See Section 14.3.1 Authorization for Durable Medical Equipment)

Documentation

Medicaid will consider payment for incontinence supplies (diapers **OR** pullups) when referred as medically necessary with an EPSDT screening **AND** the following criteria are met:

1. Recipients between the ages of 3 and 20 years old must meet one of the following:
    a. At least 3 years old if non-ambulatory;
    b. **OR** at least 3 years old if minimally or fully ambulatory **AND** medically at risk for skin breakdown, which is defined as meeting at least two of the following:
        i. Unable to control bowel or bladder functions;
        ii. Unable to utilize regular toilet facilities due to medical condition;
        iii. Unable to physically turn or reposition self independently;
        iv. Unable to transfer self from bed to chair or wheelchair independently.
    c. **OR** at least 3 years old if minimally or fully ambulatory **AND** unable to assist in his/her toileting needs due to mental status, a cognitive disability, or a developmental disability.
        i. Documentation must be recipient specific and detailed to include the following:
            a. How the cognitive, developmental, or behavioral diagnosis/disability affects or inhibits independent toileting.
            b. Documentation of failed caregiver led toilet training **OR** therapy led toilet training.

Form letters will ***NOT* be accepted for medical necessity documentation.**

NOTE: Minimal ambulation requires moderate to maximum assistance to ambulate 10 feet or more. Moderate assistance means the recipient has to be physically assisted by at least one other person to ambulate 10 feet or more. Maximum assistance means that the recipient requires two or more persons to support them to ambulate 10 or more feet. Either of these may require a cane or walker in addition to the physical support provided by another person(s).

Limitations:

Diapers

The number of units (a unit = 1 diaper) will be determined based upon the size of the disposable diaper. The maximum units are as follows:

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T4521	Adult-sized incontinence product, diaper, small	180 units per month
T4522	Adult-sized incontinence product, diaper, medium	180 units per month
T4523	Adult-sized incontinence product, diaper, large	150 units per month
T4524	Adult-sized incontinence product, diaper extra large	150 units per month
T4529	Child-sized incontinence product, diaper small/medium	210 units per month
T4530	Child-sized incontinence product, large	210 units per month
T4533	Youth-sized incontinence product, brief/diaper	210 units per month
T4543	Adult-size incontinence brief/diaper, above extra-large	150 units per month

Pullups

All pullups have a limit of 150 units (1 unit = 1 pullup) per month.

T4525 Adult sized disposable pull-on incontinence underwear, small
T4526 Adult sized disposable pull-on incontinence underwear, medium
T4527 Adult sized disposable pull-on incontinence underwear, large
T4528 Adult sized disposable pull-on incontinence underwear, x-large
T4531 Pediatric sized disposable pull-on incontinence underwear, small/medium
T4532 Pediatric sized disposable pull-on incontinence underwear, large
T4534 Youth sized disposable pull-on incontinence underwear

Recipients cannot receive both diapers and pullups in the same benefit period. If there is a current PA for diapers, it must be end-dated *prior to* approving a PA for pullups and vice versa.

Exceptions:

EPSDT recipients may receive name brand diapers at an increased reimbursement rate. The following procedure codes **with an SC modifier** should be used when approving PAs for name brand diapers:

T4521	Adult-sized incontinence product, diaper, small	120 units per month
T4522	Adult-sized incontinence product, diaper, medium	120 units per month
T4523	Adult-sized incontinence product, diaper, large	120 units per month
T4524	Adult-sized incontinence product, diaper, extra-large	120 units per month
T4530	Child-sized incontinence product, diaper, large	120 units per month
T4533	Youth-sized incontinence product, brief/diaper, each	120 units per month

If a change in modifier is needed, the current prior authorization should be end-dated and a new prior authorization with the updated modifier should be submitted.

Special Waiver Patients:

ID and LAH Waiver patients are also able to receive the following items:

A4553 Non-disposable under pads, all sizes
A4554 Disposable under pads, all sizes
A4927 Non-sterile gloves
A9286 Any hygienic item, device (i.e. Baby wipes)

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T4535 Disposable liner/shield/pad

T4545 Incontinence disposable penile wrap

14.2.26 Apnea Monitor

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

Prior Authorization

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

Documentation

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

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

The following must also be included:

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

Approval is for three months only.

Renewal criteria **must** include the following:

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

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Discontinuation Criteria include:

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

NOTE:

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

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

14.2.27 Enteral Nutrition Equipment and Supplies

B4034, B4036 (EPSDT only)

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

Prior Authorization

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

Documentation

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

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

The recipient meets the following criteria for enteral nutrition:

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

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

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

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14.2.28 Total Parenteral Nutrition (TPN) Pump and Supplies

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

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

Prior Authorization

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

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

Documentation

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

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

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

14.2.29 Home Infusion Therapy Services Equipment and Supplies

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

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

Documentation

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

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required the need for durable medical supplies. The recipient's record must have medical documentation justifying medical necessity.

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

Prior Authorization

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

Catheter Care

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

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

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

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

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

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

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

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

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

Pain Management

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

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

Pain management therapy is considered medically necessary when used to administer opioid drugs (e.g., morphine) and/or clonidine intrathecally for treatment of severe chronic intractable pain in persons who have proven unresponsive to less invasive

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

Chemotherapy

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

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

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

Anticoagulant Therapy

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

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

Antibiotic, Antiviral or Antifungal Therapy

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

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

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

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

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

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

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

Home Infusion Therapy, antibiotic, antiviral, or antifungal therapy; once every 6 hours; includes administrative services, professional pharmacy services, care coordination,

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and all necessary supplies and equipment (drugs and nursing visits coded separately)

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

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

Intravenous Immune Globulin (IVIG) Therapy

Effective for dates of service on or after June 1, 2014, Intravenous Immune Globulin (IVIG) Therapy must be billed with a diagnosis code in the range from 279.00 through 279.06, 279.10, 279.2 and 279.12 for ICD-9, and for ICD-10 bill D80.0 through D80.5, D81.0 through D81.2, D81.6 through D81.7, D81.89 through D81.9, D82.0; D83.0 through D83.2; D83.8 through D83.9 and G61.0 with procedure codes : S9500, S9502, S9503, S9504 or S9338. For non-covered diagnosis codes, a prior authorization and peer reviewed medical literature can be submitted and will be reviewed for medical neccessity.

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

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

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

Prior Authorization

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

Hydration Therapy

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

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

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

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Anti-emetic Therapy

S9351 (1 unit; limited to 31 units per month; must be billed 1 unit per day)

Home Infusion Therapy, continuous or intermittent anti-emetic infusion therapy; includes administrative services, professional pharmacy services, care coordination, **and all necessary supplies and equipment** (drugs and nursing visits coded separately)

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

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

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

Home Infusion Otherwise Classified (S9379)

Home Infusion Therapy, infusion therapy not otherwise classified; includes administrative services, professional pharmacy services, care coordination, **and all necessary supplies and equipmen**t (drugs and nursing visits coded separately)

Anticipating that new infusion therapies will be developed or that a current therapy has been overlooked, the Clinical Services & Support Division Medical and Quality Review Unit will consider authorization of other therapies on an individual basis. These special requests will require peer reviewed medical literature documentation and medical review.

Prior Authorization

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

Limitations

Drugs and nursing visits for home infusion are coded separately.

14.2.30 Cough Stimulating Devices (E0482)

Medicaid will provide coverage of the Cough Stimulating Devices for children under the age of 21 through the EPSDT program if all of the following criteria are met:

1. Patient has a neuromuscular disease such as polio, multiple sclerosis, quadriplegia or significant impairment of chest wall and/or diaphragmatic movement such that it results in an inability to clear retained secretions **AND**

2. Patient is cognitively intact, or has a caregiver who is capable, physically and intellectually of operating the CSD effectively.

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Limitations

- The Cough Stimulating Device will be covered as a capped rental item. The initial rental approval will consist of up to 6 months before purchase of the equipment under the 10-month capped rental plan.
- At the end of the 6-month period, the physician must submit documentation of continued medical necessity, evidence of recipient/caregiver compliance an improved diseased management since beginning use of the cough-stimulating device as indicated by few infections requiring antibiotics and fewer hospitalizations. A new prior authorization (PA) must be submitted at the end of the six months period.
- If approval is granted for an additional 4 months, the equipment becomes a capped rental item. At the end of the 10-month period the device is considered to be a purchased item paid for in full by Medicaid. Any maintenance or repair cost would be subject to an EPSDT screening and referral and a PA.

14.2.31 Prosthetic, Orthotic and Pedorthic Devices

Basic level prosthetics, orthotics and pedorthics are covered benefits to Medicaid eligible recipients up to age 65 in a non-institutional and institutional setting. Children below the age of 21 are covered through the EPSDT Program.

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

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

Prior Authorization

Unless specified on the DME Fee schedule, these devices DO NOT REQUIRE PA.

Documentation

For items to be covered recipients must meet eligibility requirements, the devices must be reasonable and necessary to improve the functioning of a malformed body member or replace an absent body member and meet all other applicable Medicaid statutory and regulatory requirements.

The provider must be practicing as a prosthetic, orthotic or pedorthic practitioner in the State of Alabama at an accredited facility. Providers must keep a copy of the written and signed prescription or order from the primary physician for the prosthetic or orthotic device in the recipient's file for a period of three years plus the current year. The provider must also have documentation of the education and follow-up provided to the recipient of the use of the prosthetic and orthotic device in the recipient's file.

Coverage Information

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

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

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

Refer to the DME Fee Schedule on the Alabama Medicaid website for Prosthetic, Orthotic, and Pedorthic reimbursement rates and benefit limits.

14.2.32 Prosthetic, Orthotic and Pedorthic Devices Covered for Medicaid Recipients aged 21 and above

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

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

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

Orthotic Basic Codes – L1930, L1960, L1970, L1990, L2020, L2405
Ankle-foot orthoses (AFO) codes L1930, L1960, L1970, L1990 and knee-ankle foot orthoses (KAFO) codes L2020 and L2405 are covered for ambulatory recipients with weakness or deformity of the foot and ankle, which requires stabilization for medical reasons, and have the potential to benefit functionally. Knee-ankle foot orthoses (KAFO) are primarily covered for ambulatory recipients that require additional knee stability and would not benefit from the AFO. L4361 is covered for all recipients with a valid and current prescription without a prior authorization.

Pneumatic and/or Vacuum Walking Boot – L4361
Therapeutic Shoe Codes for Diabetes – A5500, A5513, A5501
Addition to Lower Extremity Orthosis, Shoe-Ankle-Shin-Knee- L2220
Additions General - L2795
Additions, Socket Variations - L5651, L5652
Additions, Socket Insert and Suspensions – L5671, L5673, L5679
Additions, Endoskeletal Knee-Shin System - L5986
Prosthetic Socks: L8440, L8460
Wrist-Hand-Finger Orthosis – L3807
Orthosis Devices Spinal – L0472, L0458
Transfer or Replacement – L3610
Orthotic Devices, Spinal – L0172
Thoracic – L0486
Cervical-Thoracic-Lumbar-Sacral Orthosis (CTLSO) – L0628 must be billed with a CG modifier for age 21-65, L0630, L0640
Additions to Spinal Orthosis – L0984

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14.2.33 External Breast Prostheses

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

(2) Coverage is available for the external breast prostheses when all of the following criteria are met:

(a) Recipient must be eligible for Medicaid on the date of service for provision of prostheses.

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

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

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

Limited to two of **L8020 or **L8030** per year, or one **L8020** and one **L8030** per year.
(3) Maximum calendar year limits apply to each of the procedures as indicated above.

(4) Providers of external breast prostheses devices for adults must be enrolled as a Medicaid provider and Mastectomy Fitters must be licensed by the Alabama Board of Prosthetics, Orthotics and Pedorthics.

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

14.2.34 Controlled Dose Drug Inhalation System (K0730)

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

Prior Authorization

This procedure code does not require PA.

Documentation

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

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billing procedure code K0730 in accordance with Medicaid's policy guidelines, Medicaid payments for this service will be recouped.

Repairs

Repairs for this system will be covered using procedure code E1399. All repair cost must be submitted with itemized provider purchase invoice cost. Repairs will be reimbursed at provider's purchase invoice cost plus 20%. The reimbursement amount will be calculated based on the provider's **final purchase invoice** after all discounts have been applied.

14.2.35 Tracheostomy Supplies

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

A4605 Tracheal suction catheter, closed system, each

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

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

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

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

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

Prior Authorization

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

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

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

E1399 Peep valves and Respigard filters will be billed using miscellaneous code E1399. Any other trach supply items requested must be submitted using miscellaneous procedure code E1399. Medical documentation and provider's invoice must be submitted for review and approval. Medicaid will reimburse these trach supplies at provider's purchase invoice price plus 20%. The reimbursement amount will be calculated based on the provider's **final purchase invoice** after all discounts have been applied.

14.2.36 Transfer Boards

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

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14.2.37 Special Ostomy Supplies

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

Prior Authorization

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

Effective for dates of service on or after April 1, 2023, Alabama Medicaid Agency will cover the below ostomy supply procedure codes. The procedure codes listed below will be subject to maximum allowed units per year. For reimbursement rates and benefit limits, refer to the DME Fee Schedule.

Procedure code	Procedure code description	Maximum allowed units
A4407	Ext wear ost sknbarr <=4SQ"	2 units per week/104 units per year
A4409	Ost skin barr convex <=4 SQ I	2 units per week/104 units per year
A4408	Ext wear ost skn barr >4SQ"	2 units per week/104 units per year
A4410	Ost skn barr extnd >4 SQ	2 units per week/104 units per year
A5056	1 pc ost pouch w filter	2 units per week/104 units per year
A5057	1 pc ost pou w built-in conv	2 units per week/104 units per year
A4425	Ost pch drain for barrier fl	2 units per week/104 units per year
A4391	Urinary pouch w ex wear barr	2 units per week/104 units per year
A4393	Urine pch w ex wear bar conv	2 units per week/104 units per year
A4428	Urine ost pouch w faucet/tap	2 units per week/104 units per year
A4430	Ost urine pch w b/bltin conv	2 units per week/104 units per year
A4416	Ost pch clsd w barrier/filtr	3 units per week/156 units per year
A4419	Ost pch for bar w flange.flt	3 units per week/156 units per year
A4406	Pectin based ostomy paste	3 units per week/156 units per year
A4413	2 pc drainable ost pouch	2 units per week/104 units per year
A4424	Ost pch drain w bar & filter	2 units per week/104 units per year
A4432	OS pch urine w bar/fange/tap	2 units per week/104 units per year
A4435	1pc ost pch drain hgh output	2 units per week/104 units per year
A5073	Urinary pouch on barr w/flng	2 units per week/104 units per year
A4371	Skin barrier powder per oz	2 units per year
A4396	Peristomal hernia support blt	2 units per year

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14.2.38 Adaptive Strollers, Equipment and Accessories

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

Enuresis Alarm

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

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

14.2.39 Urinary Catheters

Effective January 1, 2023, A4351, A4352, A4353, and A4349 will be limited to 180 catheters per calendar month for all ages. No prior authorization is required.

For each episode of covered catheterization, Medicaid will cover:

- Intermittent urinary catheter straight tip (A4351); or
- Intermittent urinary catheter coude (curved) tip (A4352)
- Intermittent urinary catheter, with insertion supplies (A4353)
- Male external catheter with or without adhesive, disposable, each (A4349).

14.2.40 External Ambulatory Chemotherapy Infusion Pump

An external ambulatory chemotherapy infusion pump is a small portable battery or electrical device worn on a belt around the waist and attached to a needle or catheter designed to deliver measured amounts of chemotherapeutic agents through injection over a period of time. E0781 is used for an external ambulatory infusion pump that is provided in an outpatient cancer facility and the patient takes home to continue administration of chemotherapy.

Coverage Policy for Adults and Children (Defined through EPSDT as 20 years old and younger):
Medicaid will consider payment for an external ambulatory infusion pump when referred as medically necessary and all of the criteria below are met:

1. The patient must have a documented diagnosis of any unspecified cancerous tumor where this disease is unresectable or where the beneficiary refuses surgical excision of the tumor. Anticancer chemotherapy drugs used in these conditions are not required to meet the criteria.
2. A board-certified specialist in Oncology (CSO) must have evaluated the patient and ordered the infusion pump.
(Reviewer: Check for notes in patient chart for initial assessment and order of pump by CSO. Follow up/other documentation may be by local physician.)

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3. Patient or caregiver must be capable, physically and intellectually, of operating the pump. Patient/caregiver must demonstrate ability and commitment to comply with regimen of pump care and medications.
(Reviewer: Check for physician attestation, notes in patient chart. Education on infusion pump MUST have been conducted prior to prior authorization request, and each the patient, caregiver if child, and educator signed to document their understanding.)

Checklist must be submitted and signed by physician or CSO.

Limitations:
E0781 - External Ambulatory Chemotherapy Infusion Pump will be rented on a monthly basis. The pump will be reimbursed at a monthly rental rate based on the CURES rate listed on the fee schedule.

14.2.41 Cranial Orthoses

S1040 Cranial orthoses involve an adjustable helmet or band that progressively mold the shape of the infant cranium by applying corrective forces to prominences while leaving room for growth in the adjacent flattened areas.

Coverage Information:
Use of an adjustable cranial orthosis may be considered medically necessary following cranial vault remodeling surgery for synostosis. Synostotic deformities associated with functional deficits are addressed by surgical remodeling of the cranial vault. Use of an adjustable cranial orthosis for synostosis in the absence of cranial vault remodeling surgery is considered not medically
necessary.

Documentation:
The following criteria must be met for prior approval of cranial orthses:
1. The practitioner must sign and date the order/prescription to indicate the type of cranial orthoses and the medical reason(s) for its use, **and**
2. The documentation should indicate the recipient had a cranial vault remodeling surgery.

Reimbursement:
The agency will reimburse cranial orthoses as an all-inclusive service, including the helmet, fittings, monthly helmet adjustments, anatomical scans, and payment to the required licensed personnel that perform the adjustments and scans. Providers will be reimbursed their final purchase invoice costs, which should not exceed a reimbursement amount of $3,000.

Limitations:
Cranial orthotic helmets are limited to (2) per lifetime.

14.2.42 INR Prothombin Home Monitoring

Use of International Normalized ratio (INR) allows physicians to determine the level of anticoagulation in a patient independent of the laboratory reagents used. The INR is the ratio of the patient's prothrombin time compared to the mean prothrombin time for a group of normal individuals. By using this monitoring system in the home, patients with mechanical heart valves on Warfarin/Coumadin therapy who require frequent prothrombin time monitoring are able to check the prothrombin time at home. The associated prothrombin time self-monitoring procedure codes are listed below.

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Coverage
Medicaid will cover the use of home prothrombin time INR monitoring for anticoagulation management for patients with mechanical heart valves on Warfarin (Coumadin). The monitor and the home testing must be prescribed by a physician and the following patient requirements must be met:

- Must have been anticoagulated for at least three months prior to the use of the home INR device,
- Must undergo an educational program on anticoagulation management and the use of the device prior to its use in the home, and
- Self-testing with the device is limited to a frequency of once per week.

G0248: Demonstration at initial use of home INR monitoring for patient with mechanical heart valve(s) who meets Medicare coverage criteria, under the direction of a physician, includes demonstration use and care of the INR monitor, obtaining at least one blood sample, provision of instructions for reporting home INR test results and documentation of a patient ability to perform testing.

G0249: Provision of test materials and equipment for home INR monitoring to patient with mechanical heart valve(s) who meet Medicare coverage criteria. Includes provision of materials for use in the home and reporting of test results to physician; per 4 tests.

Limitations

- Medicaid will not cover home INR monitoring for patients with porcine valves.
- Procedure codes G0249 will be limited to one billing per month.
- Procedure code G0249 will be reimbursed at provider's final purchase invoice cost + 20%. The authorized dollar amount will be entered on the approved Prior Authorization.
- Procedure code G0248 will be limited to once per calendar year.
- Home INR monitoring services are limited to patients with the Diagnosis Code V43.3 (organ or tissue replaced by other means; heart valve).

14.2.43 Driveline Management Trays (LVAD Kits)

Driveline management trays are only covered for recipients who have been diagnosed with heart failure and, subsequently, had to have a left ventricular asssist device implanted. All the following criteria must be met with supporting documentation:

- The recipient must be eligible for Medicaid.
- Driveline management tray supplies must be prescribed by the attending physician as a medically necessary health care service to correct or improve a defect or medical condition.
- The Prescribing practitioner must sign and date the written order for the driveline management tray supplies.
- Documentation in the recipient's medical record must indicate if the recipient had a recent hospitalization for a left ventricular assist device (LVAD) transpant that is expected to remain in place until the recipient's heart recovers.
- Documentation in the recipient's medical record must indicate the device will remain in place perpetually.

Limitations

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- Driveline management trays are only covered for patients who have been diagnosed with heart failure and, subsequently, had to have a LVAD device implanted.
- Driveline management trays are limited to three (3) kits per week in non-infected patients, and seven (7) to infected patients.
- Medical record documentation of LVAD implant.
- Prior authorizations should be request at the time of the procedure.

Procedure Code(s)

- Q0508 – The reimbursement amount will be calculated based on the provider's Final paid (after all discounts have been applied) invoice amount plus 20%.

14.2.44 Miscellaneous/Unspecified Procedure Codes

Ocassionally, recipients are prescribed products/services that do not have CMS established procedure codes. Miscellaneous and unspecified procedure codes are intended for use when the product or service requested does not meet the requirements of a current CMS established procedure code. These procedure codes are reimbursed based on the provider's final purchase invoice (cost less any discounts received) plus 20%.

- **E1399** is intended to be used only for general DME products that do not fit into any existing procedure code description.
- **K0108** is intended to be used only for **wheelchair components and/or accessories** for which there is no CMS established procedure code. Please see section 14.2.15 for more information.
- **B9998** is intended to be used only for **enteral supplies** for which there is no CMS established procedure code. Please see section 14.2.27 for more information.

Considerations

DME reimbursement rates and benefit limits for covered products/services are updated quarterly and published to the Alabama Medicaid website at the following link: http://medicaid.alabama.gov/content/Gated/7.3G_Fee_Schedules.aspx

Limitations

Miscellaneous/unspecified procedure codes are not to be used in the absence of coverage for a product/service with a CMS established procedure code.

If coverage is desired for a newly established CMS procedure code, the Alabama Medicaid dossier submission form should be completed and submitted by utilizing the following link: https://medicaid.alabama.gov/documents/4.0_Programs/4.3_Pharmacy-DME/4.3.12_DME/4.3.12_DME_AL_Medicaid_Dossier_Packet_Fillable.pdf

14.3 Prior Authorization and Referral Requirements

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

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

NOTE:

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

When filing claims for recipients enrolled in the ACHN Program, refer to Chapter 40 to determine whether your services require a referral from the PCP.

Deleted: the
Deleted: fiscal agent software
Added: provider web portal
Deleted: Fiscal Agent
Added: PA contractor
Deleted: return any requests…or invalid information
Added: deny any PA…to request reconsideration

All requests for prior approval should be initiated and signed by the prescriber and must document medical necessity. Requests may be sent electronically using Medicaid's provider web portal. Medicaid's PA Contractor will approve or deny the request. Medicaid's PA contractor will deny any PA that is missing information or has incorrect information. Additional documentation may be submitted within 14 calendar days to request reconsideration. Please see Chapter 4, Obtaining Prior Authorization, for additional information.

Procedures for changing rendering providers

1. Obtain a written statement from the initial rendering provider indicating that they are aware and agree with the decision of the recipient to change providers and that the approved PA may be cancelled.
2. Confirm this decision with the recipient by having the new provider submit a written statement that they will now be submitting a PA request on the patient's behalf and have the patient sign that they agree and understand.
3. Cancel the approved PA request in the system.
4. Review the new providers request and approve or deny.

14.3.1 Authorization for Durable Medical Equipment

Deleted: physician
Added: prescriber
Deleted: fiscal agent
Added: PA contractor through the fiscal agent software.
Deleted: designee
Added: contractor

Provider must have a prescription or order on file from the prescriber that a specific covered item of durable medical equipment is medically necessary for use in the recipient's home prior to submitting the PA request electronically. The prescriber may also fax the prescription or order to the provider of the recipient's choice. The provider must submit pertinent medical information to the Medicaid PA contractor through the fiscal agent software. Refer to Chapter 4, Obtaining Prior Authorization, for information about the PA process. The fiscal agent will assign a PA tracking number and transmit the request to Medicaid's PA contractor for review.

Deleted: fiscal agent
Added: PA contractor
Deleted: fiscal agent
Added: PA contractor
Deleted: thirty
Added: fourteen
Deleted: of the dispensed
Added: from the denial
Added: NOTE: Documentation uploaded…should be submitted.

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

NOTE:

Documentation uploaded after the 14 day reconsideration period or after the PA has been placed in denied status will not be reviewed. Instead, a new PA request should be submitted.

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

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

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

PA requests that are lacking necessary information (EPSDT screening, referrals, required attachment) will be denied and the reason(s) noted in the PA letter under, "Analyst Remarks Request for reconsideration of a denied PA must be received by the PA contractor within 14 days of the date of the denial letter.

All prior requests denied by Medicaid or its designee for additional medical information, if resubmitted for reconsideration, must contain the following the specific documentation noted on the PA decision letter under "Analyst's Remarks."

DME Review Criteria

Medicaid reviews all DME PA requests for the following:

- Medicaid eligibility
- Medicare eligibility
- Medical necessity - **All medical necessity letters should be specific to the recipient and include all relevant medical diagnoses, limitations, and/or disabilities. FORM LETTERS ARE NOT ACCEPTABLE.**
- Therapeutic purpose for use of equipment in the recipient's home

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

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

NOTE:

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

Disposition of Equipment

DME Providers should not repossess any DME equipment or supplies with a purchase claim reimbursed by Alabama Medicaid.

Added: or
Deleted: ~~or~~ ~~pending~~
Added: approved and
Deleted: ~~Providers will be…of approved requests.~~

Deleted: ~~fiscal agent~~
Added: PA contractor
Deleted: ~~30~~
Added: 14

Deleted: ~~PA Forms: For…electronic signature protocol.~~

Deleted: ~~physician~~
Added: prescriber

Deleted: ~~an authorization form~~
Added: a prior authorization
Deleted: ~~authorization form~~
Added: prior authorization

Deleted: ~~The recipient or…used or needed.~~
Added: DME Providers should…by Alabama Medicaid.

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Added: In-home monthly rental…on February 1st.

In-home monthly rental DME equipment should not be repossessed for any period already reimbursed by Medicaid unless the recipient requests repossession, the DME provider has verified the recipient's date of death, or the DME provider reverses the paid claim.

EXAMPLE: If a claim is submitted with a date of service of January 1st and there isn't a claim adjustment made, a recipient request for repossession received, or a verified date of death for the recipient, then the earliest date of repossession would be the first of the following month on February 1st.

14.3.2 Program Referrals

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

EPSDT Referrals

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

ACHN Referrals

When filing claims for recipients enrolled in the ACHN program, refer to Chapter 40, ACHN Billing Manual to determine whether your services require a referral from the PMP.

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

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

When a provider is unable to dispense equipment within the time frame specified on the approval letter, an extension may be requested with written justification as to the specific reason(s) why the equipment cannot be supplied in a timely manner. All requests for extensions (Form 471: Prior Authorization Change Request) must be submitted to Medicaid's Medical and Quality Review contractor, prior to the expiration date indicated on the approval letter. Refer to Chapter 4, Obtaining Prior Authorization for information about the Form 471. Medicaid will cancel approvals for medical items that are not dispensed in a timely manner when there is no justifiable reason for delay.

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

14.4 Cost-Sharing (Copayment)

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

The Medicaid DME Program requires copayment at the following rates:

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

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

14.5 Completing the Claim Form

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

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

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

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

NOTE:

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

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

14.5.1 Time Limit for Filing Claims

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

14.5.2 Diagnosis Codes

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

NOTE:

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

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

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14.5.3 Procedure Codes and Modifiers

Deleted: ~~contract~~
Added: enrolled

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

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

14.5.4 Place of Service Codes

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

POS	*Description*
12	Home

14.5.5 Required Attachments

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

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

Refer to Section 5.7, Required Attachments. For more information on attachments.

14.6 For More Information

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

Resource	Where to Find It
Obtaining Prior Authorization	Chapter 4
CMS-1500 Claim Filing Instructions	Chapter 5
Medical Necessity/Medically Necessary Care	Chapter 7
Electronic Media Claims (EMC) Submission Guidelines	Appendix B
AVRS Quick Reference Guide	Appendix L
Alabama Medicaid Contact Information	Appendix N
DME Procedure Codes and Modifiers	Appendix P

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