MSA MEDICAL SERVICES ADMINISTRATION

Bulletin

Michigan Department of Community Health

Distribution: Medical Suppliers 03-05

Issued: November 1, 2003

Subject: Revision of Chapter III

Effective: January 1, 2004

Programs Affected: Medicaid and Children's Special Health Care Services

The purpose of this bulletin is to transmit a revised Medicaid Medical Suppliers Provider Manual, Chapter III that will be implemented effective for dates of service on and after January 1, 2004. The revisions include elimination of the prior authorization requirement for specific services, and clarification of standards of coverage and documentation requirements.

The attached Chapter is formatted into two main sections. Section 1 is a program overview, and Section 2 is the coverage conditions and requirements for specific items or services. (Please note the following: a pulse oximeter will now be reimbursed as a capped rental item. Any oximeter that has already been rented for longer than 10 months will be considered purchased.) The bulletin also provides information regarding procedure code changes effective January 1, 2004 and implemented due to these policy revisions.

The format of the chapter is new. The Michigan Department of Community Health (MDCH) is in the process of updating all provider manuals with the goal of creating a single, all-inclusive manual that will be updated annually, distributed via compact disc, and also be available through the internet. (The Department will continue the current process of issuing paper policy bulletins throughout the year as needed.) The new manual will allow the user to locate information through word searches and have internal links between related sections.

During the updating of the manuals/chapters, some information is being relocated to different areas. The MSA-1653-B Prior Authorization Form will be located in the Forms Appendix along with other required MDCH forms. Until the Forms Appendix is issued, providers may access forms on the MDCH website. Important MDCH telephone contact information will be located in the Directory Appendix. The wheelchair accessory reimbursement methodology chart and the enteral formulae chart will be found at the same MDCH website location as the Medical Supplier database.

HCPCS Code Additions and Deletions

Effective January 1, 2004, new Program coverage will be implemented for the HCPCS* codes listed in Table 1. Table 2 lists current HCPCS codes that are being replaced by other HCPCS codes effective January 1, 2004.

Table 1: HCPCS Additions

HCPCS CODE	SHORT DESCRIPTION	COMMENTS
A5500	Diab shoe for density insert	
A5503	Diabetic shoe w/roller/rockr	
A5504	Diabetic shoe with wedge	
A5505	Diab shoe w/metatarsal bar	
A5506	Diabetic shoe w/off set heel	
A5507	Modification diabetic shoe	Prior authorization required
B4199	Parenteral sol > 100gm prote	Prior authorization required except for specified diagnoses (555.0, 555.1, 560.9, 569.81, 577.0, 577.1, 577.2, 579.3)
L1843	Knee upright w/resistance	
L1902	AFO ankle gauntlet	
L2112	AFO tibial fracture soft	
L2114	AFO tib fx semi-rigid	
L3170	Foot plastic heel stabilizer	
L3224	Woman's shoe oxford brace	
L3225	Man's shoe oxford brace	
L3257	Orth foot add charge split s	
L3760	EO with joint, prefabricated	
L3807	WHFO, no joint, prefabricated	
L3810	WHFO thumb abduction bar	
L3890	Torsion mechanism wrist/elbo	
L3907	WHFO wrst gauntlt thmb spica	Prior authorization required
L3962	Rigid EO wo joints	
S1040	Cranial remolding orthosis	Prior authorization required except for specified diagnosis 754.0

Table 2: HCPCS Deletions

HCPCS CODE	SHORT DESCRIPTION	COMMENTS
A4221	Maint drug infus cath per wk	Replaced by S5498, S5501, or S5502
A4300	Cath impl vasc access portal	Replaced by S5520
S8101	Spacer with mask	Use A4627
S8433	Skin support/breast prosth	Use A4280

* HCPCS (Health Care Financing Administration) Common Procedure Coding System

Manual Maintenance

Effective January 1, 2004, replace the current Chapter III with the attached revised version.

Effective January 1, 2004, the following Medicaid Bulletins are obsolete and should be removed from your manual:

MS 01-08, MS 01-05, MS 01-03, MS 01-01, MS 00-04, MS 00-01, MS 99-03, MS 99-02, MS 99-01, MS 98-01, MS 97-05, MS 97-04, MS 97-03, MS 96-03, MS 96-02

This bulletin may be discarded after manual maintenance is completed.

Questions

Any questions regarding this bulletin should be directed to: Provider Support, Department of Community Health, P.O. Box 30731, Lansing, Michigan 48909-8232, or e-mail at ProviderSupport@michigan.gov. When you submit an e-mail, be sure to include your name, affiliation, and a phone number so you may be contacted if necessary. Providers may phone toll free: 1-800-292-2550.

Approved

Paul Reinhart, Director
Medical Services Administration

MEDICAL SUPPLIERS

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SECTION 1 – PROGRAM OVERVIEW

The primary objective of the Medicaid Program is to ensure that medically necessary services are made available to those who would not otherwise have the financial resources to purchase them.

The primary objective of the Children's Special Health Care Services (CSHCS) Program is to ensure that CSHCS beneficiaries receive medically necessary services that relate to the CSHCS qualifying diagnosis.

This chapter describes policy coverage for the Medicaid Fee for Service (FFS) population and the CSHCS Fee for Service (FFS) Population (Basic Health Plan). Throughout the chapter, use of the terms Medicaid and MDCH will include both the Medicaid and CSHCS Programs unless otherwise noted.

Medicaid covers the least costly alternative that meets the beneficiary's medical need.

Below are common terms used throughout this chapter:

Medical Supplies	Medical supplies are those items that are required for medical management of the beneficiary, are disposable or have a limited life expectancy, and can be used in the beneficiary's home. Examples are: hypodermic syringes/needles, ostomy supplies, and dressings necessary for the medical management of the beneficiary. Medical supplies are items covered to: ▪ Treat a medical condition. ▪ Prevent unnecessary hospitalization or institutionalization. ▪ Support Durable Medical Equipment (DME) used by the beneficiary in the home.
Durable Medical Equipment (DME)	DME are those items that can stand repeated use, are primarily and customarily used to serve a medical purpose, are not useful to a person in the absence of illness or injury, and can be used in the beneficiary's home. Examples are: hospital beds, wheelchairs, and ventilators. DME is a benefit for beneficiaries when: ▪ It is medically and functionally necessary to meet the needs of the beneficiary. ▪ It may prevent frequent hospitalization or institutionalization. ▪ It is life sustaining.
Orthotics	Orthotics assist in correcting or strengthening a congenital or acquired physical anomaly, or malfunctioning portion of the body. Orthotics are a benefit to: ▪ Improve and/or restore the beneficiary's functional level. ▪ Prevent or reduce contractures. ▪ Facilitate healing or prevent further injury.
Prosthetics	Prosthetics artificially replace a portion of the body to prevent or correct a physical anomaly or malfunctioning portion of the body. Prosthetics are a benefit to: ▪ Improve and/or restore the beneficiary's functional level. ▪ Enable a beneficiary to ambulate or transfer.

1.1 Provider Types

Services provided must be appropriate for the specified provider types according to the Medical Assistance Provider Enrollment Agreement (DCH-1625). (Refer to Forms Appendix for additional information.) The provider types and the services they may provide are as follows:

Provider Type 85: Orthotist and Prosthetist	▪ Prefabricated, custom-fitted and custom fabricated orthoses and prostheses ▪ Medical supplies related to orthotics and prosthetics (e.g., stump sox, etc.) ▪ Shoes
Provider Type 87: Medical Supplier	▪ Durable medical equipment (including oxygen) ▪ Medical supplies ▪ Prefabricated and specific custom-fitted orthoses (custom-fitting may only include simple or minor intervention) ▪ Shoes
Provider Type 88: Shoe Store	▪ Shoes, selected shoe inserts and additions

1.2 Medical Suppliers / DME / Prosthetics and Orthotics Database

For specifics regarding the Health Care Financing Administration Common Procedure Coding System (HCPCS) codes used to denote covered services, refer to the Medical Suppliers/DME/Prosthetics and Orthotics Database on the MDCH website, hereafter referred to as the Medical Supplier Database. (Refer to Directory Appendix for contact information.) The database includes the HCPCS codes, short description, designated modifiers, quantity limits, prior authorization (PA) indicator, fee screens, International Classification of Diseases, Clinical Modification (ICD-9-CM) codes, and whether the item may be billed by a medical supplier if the beneficiary resides in a nursing facility. If there is no established procedure code that adequately describes the item, use the appropriate Not Otherwise Classified (NOC) HCPCS procedure code.

1.3 Place of Service

Medicaid covers medical supplies, durable medical equipment, orthotics, and prosthetics for use in the beneficiary's place of residence except for skilled nursing or nursing facility.

For residents in a skilled nursing or nursing facility, most medical supplies and/or DME are considered as part of the facility's per diem rate. The following items are exempt from the per diem rate and may be billed by the Medical Supplier:

- Air-fluidized beds.
- Bariatric beds.
- Custom-made wheelchairs may be covered when standard DME does not meet the functional needs of the beneficiary, is required for independence, if it can only be used by the specific beneficiary. (If purchased by Medicaid, the equipment becomes the property of the beneficiary.)
- Gaseous oxygen and equipment if required by the beneficiary for frequent or prolonged use (eight or more hours of use on a daily basis).

- Orthotics and Prosthetics.
- Parenteral nutrition, including all supplies, equipment, and solutions.
- Powered air flotation bed (low air loss therapy).
- Selected surgical dressings. (Refer to the Medical Supplier Database for specific procedure codes.)
- Shoes and Additional Components.

To determine the acceptable place of service codes allowed for billing purposes, refer to the Billing and Reimbursement for Professionals Chapter of this manual.

In an outpatient facility, all equipment and services required for treatment during an emergency room or clinic visit are included in the reimbursement to the hospital (e.g., cervical collar, air cast).

In an inpatient hospital setting, services provided as part of the hospital care and treatment would be part of the DRG payment to the hospital (e.g., cervical collar or cast). Items provided to be used after discharge and delivered to the hospital to facilitate discharge may be reimbursed to the medical supplier (e.g., oyxgen, walker, wheelchair).

1.4 AGE LIMITATIONS

Coverage may be different based on the beneficiary's age. For specifics of HCPCS codes and age parameters, refer the to Coverage Conditions and Requirements Section of this chapter and the Medical Supplier Database.

1.5 MEDICAL NECESSITY

Services are covered if they are the most cost-effective treatment available and meet the Standards of Coverage stated in the Coverage Conditions and Requirements Section of this chapter.

A service is determined to be medically necessary if prescribed by a physician and it is:

- Within applicable federal and state laws, rules, regulations, and MDCH promulgated policies.
- Medically appropriate and necessary to treat a specific medical diagnosis or medical condition, or functional need.
- Within accepted medical standards; practice guidelines related to type, frequency, and duration of treatment; and within scope of current medical practice.
- Inappropriate to use a nonmedical item.
- The most cost effective treatment available.

1.5.A. PRESCRIPTION REQUIREMENTS

A prescription must contain all of the following:

- Beneficiary's name;
- Date of birth (DOB);

- Beneficiary ID number or Social Security Number (SSN) (if known);
- Prescribing physician's name, address, and telephone number;
- Prescribing physician's signature (a stamped or co-signature will not be accepted);
- The date the prescription was written;
- The specific item prescribed;
- The amount and length of time that the item is needed; and
- Date of order if different from the physician's signature date.

The prescription must meet the following timeframes:

- For medical supplies, refills may be allowed up to one year from the original physician's signature date on the prescription.
- For oxygen, ventilators, and other long-term use, up to one year from the original physician signature date.
- For purchase of DME, the original physician signature date must be within the last 180 days.
- For orthotics and prosthetics, the original physician signature date for an initial service must be within the last 60 days. For replacement of an orthosis or prosthesis, the physician signature date must be within the last 180 days.

A new prescription will be required when there is a change in the beneficiary's condition causing a change in the item or the frequency of its use.

The provider may complete a detailed description of the item with applicable HCPCS procedure codes, but the treating physician must review this description and personally sign and date the order to indicate agreement. The provider may not change or modify a prescription, certificate of medical necessity (CMN), or any other physician or health care practitioner's signed documentation.

For beneficiaries eligible for CSHCS coverage only, the following additional requirements apply:

- The prescription must be related to the CSHCS qualifying diagnosis. (Providers must verify this information by referring to the beneficiary's eligibility letter received from CSHCS.)
- A physician subspecialist must sign the prescription if it is stated as required by the CSHCS Program in the Coverage Conditions and Requirements Section of this chapter.

MDCH reserves the right to request additional documentation from a specialist for any beneficiary and related service on a case-by-case basis if necessary to determine coverage of the service.

1.5.B. DOCUMENTATION

The Coverage Conditions and Requirements Section of this chapter specifies the documentation requirements for individual service areas. Additional information other than what is required on the prescription may be required. To provide this information, Medicaid accepts a certificate of medical necessity (CMNs will be mandatory for electronic PA), a letter or a copy of applicable medical record. The prescribing physician must sign all documentation and the documentation (if a letter or applicable medical records) must state the beneficiary's name, DOB and ID number (if known) or SSN (if known).

1.5.C. CERTIFICATE OF MEDICAL NECESSITY (CMN) REQUIREMENTS

A CMN must contain all of the following:

- Beneficiary's name and address;
- Date of Birth (DOB);
- Beneficiary ID number (if initiated by the Provider) or SSN;
- Prescribing physician's signature, date of signature, telephone number;
- The supplier's name and address;
- The expected start date of the service (if different from the prescription date);
- A complete description of the item;
- The amount and length of time the item is needed;
- Beneficiary's diagnosis; and
- The medical necessity of the item.

For specifics, refer to the Coverage Conditions and Requirements Section of this chapter.

MDCH will accept a CMN initiated by a medical supplier, orthotist or prosthetist. However, only the beneficiary identifier fields and the areas detailing the description of the item with applicable HCPCS procedure codes are to be completed by the provider. The physician must complete the CMN by writing the medical reason or necessity for the specific item being requested. A medical supplier, orthotist, or prosthetist may not alter or write the medical reason or necessity for the item requested.

Additional documentation (including the CMN) must be current and within the timeframe stated under Documentation for each item in the Coverage Conditions and Requirements Section of this chapter.

1.6 DOCUMENTATION IN BENEFICIARY FILE

The supplier must maintain all required documentation for the specific service in the beneficiary's file for six years. For audit purposes, the supplier's records or beneficiary's medical record must contain the prescription and required documentation that substantiates the medical necessity of the item supplied. In addition to the prescription and any applicable documentation required, the provider must maintain on file:

- Equipment use logs or other provider required documentation as stated in the Coverage Conditions and Requirements Section of this chapter under Documentation for the item.
- For items purchased, proof of purchase (e.g., delivery slips, sales slips, vouchers).
- For items rented, set-up slips and pick-up slips with signature of beneficiary or legal representative, and maintenance records.
- For items shipped directly to beneficiary, date of delivery must be maintained in the records with delivery slip. Please note that it is the provider's responsibility to replace a service for which the beneficiary states was not received without additional cost to MDCH or beneficiary.
- Proof of education and instruction to beneficiary and/or caregiver regarding the proper usage of equipment and/or supplies when applicable (e.g., delivery slip signed by beneficiary).

1.7 PRIOR AUTHORIZATION (PA)

Prior authorization (PA) is required for certain items before the item is provided to the beneficiary or, in the case of custom-made DME or prosthetic/orthotic appliances, before the item is ordered. To determine if a specific service requires PA, refer to the Coverage Conditions and Requirements Section of this chapter and/or the Medical Supplier Database on the MDCH website.

PA will be required in the following situations:

- Services that exceed quantity/frequency limits or established fee screen.
- Medical need for an item beyond MDCH's Standards of Coverage.
- Use of a Not Otherwise Classified (NOC) code.
- More costly service for which a less costly alternative may exist.
- Procedures indicating PA is required on the Medical Supplier Database.

1.7.A. PRIOR AUTHORIZATION (PA) FORM

Requests for PA must be submitted on the Special Services Prior Approval-Request/Authorization form (MSA-1653B). (Refer to the Forms Appendix for a copy of the PA form and completion instructions.) In addition, medical documentation (e.g., prescription, CMN, letter or other) must accompany the form. The information on the PA request form must be:

- Typed – All information must be clearly typed in the designated boxes of the form.
- Complete – The provider must provide the specific HCPCS code and the HCPCS code description. If the service falls under a NOC code, a complete description of the service and/or specific materials and labor time, if applicable. The prescription must be submitted with the request. (Refer to the Coverage Conditions and Requirements Section of this chapter for additional information.)

PA request forms and attached documentation may be mailed or faxed to the MDCH Review and Evaluation Division. (Refer to Directory Appendix for contact information.)

Instructions for the electronic submission of PA requests and the HIPAA 278 transaction code set are available on the MDCH website.

1.7.B. EMERGENCY PRIOR AUTHORIZATION (PA)

A provider may contact MDCH to obtain a verbal PA when the prescribing physician has indicated that it is medically necessary to provide the service within a 24-hour time period.

To obtain a verbal PA, the provider may call or fax a request. If the provider chooses to use a PA form to request a verbal authorization, "verbal PA request" must be in Box 37 along with the physician's name and phone number. (Refer to Directory Appendix for contact information.)

If an emergency service is required during nonworking hours (i.e., after 4:00 p.m., weekends, and State of Michigan holidays), the provider must contact the Review and Evaluation Division on the next available working day.

The following steps must still be completed before an actual PA number is issued for billing purposes:

- Submission of the PA request (MSA-1653B) to MDCH within 30 days of the verbal authorization. (Include the date of the verbal authorization in Box 37.)
- Submission of the supporting documentation (e.g., prescription and CMN, physician letter, or applicable medical record).

The PA number will not be given for billing MDCH and the provider will not be reimbursed if:

- The beneficiary was not eligible when the service was provided.
- A completed PA request (MSA-1653B) is not received within 30 days of the verbal authorization.
- Required prescription and documentation is not received.
- The prescription and/or documentation are not signed within 30 days of the effective date.
- The prescription and/or documentation are not received within 30 days of the date of service (DOS).
- The medical need for the service is different than what was verbally given and does not fall within the Standards of Coverage.

Verbal authorization does not guarantee payment or eligibility.

1.7.C. Retroactive Prior Authorization (PA)

Services provided before PA is requested will not be covered unless the beneficiary was not eligible on the DOS and the eligibility was made retroactive. If MDCH's record does not show that retroactive eligibility was provided, then the request for retroactive PA will be denied.

1.7.D. Beneficiary Eligibility

Approval of a service on the MSA-1653-B confirms that the service is authorized for the beneficiary. The approval does not guarantee that the beneficiary is eligible for Medicaid. If the beneficiary is not eligible on the DOS, or is enrolled in a Medicaid Health Plan (MHP) and the provider orders or delivers the service, MDCH will not reimburse the provider. To assure payment, the provider must verify eligibility prior to ordering or delivering the service. (Refer to the Eligibility Chapter of this manual for additional information.)

When equipment is prior authorized (if required) and ordered, but not delivered before the loss of eligibility, MDCH will pay for the service if the product is delivered within 30 days after the loss of eligibility.

1.7.E. Changes in Enrollment (FFS/MHP/SHP)

When beneficiaries change enrollment status (e.g., from managed care to FFS or FFS to managed care), the following applies:

- When custom-made equipment, prosthetic or orthotic, is ordered for a beneficiary during a hospital stay but not delivered until discharge and enrollment changes, the payment must be made by the party responsible for the hospital stay.
- When a custom-made, fit, or modified service is prior authorized and ordered by the provider before a change of enrollment, the party that authorized the service is responsible for payment. This responsibility only applies if the service is delivered within 30 days of the change of eligibility.

This policy does not apply to prefabricated, mass-produced, or ready-made items that can be used by a person other than for whom it is ordered. It also excludes rental items, all expendable/disposable medical supplies, or any item that does not require a length of time (days or weeks) to special order for a specific person.

1.7.F. Age Parameters

Some services are only covered if the beneficiary is under the age of 21. For specifics regarding PA requirements and coverage, refer to the Medical Supplier Database on the MDCH website or the Coverage Conditions and Requirements Section of this chapter.

1.7.G. Reimbursement Amounts

Most items have established fee screens that are published in the Medical Suppliers Database. The approved reimbursement amount of the fees for NOC codes, and all

codes without established fee screens, will be indicated on the authorized PA request. The provider must provide a manufacturer's invoice or other documentation that states the acquisition cost for the service on the PA request form. If the provider is requesting reimbursement for labor, the specific time must be stated on the request form.

1.7.H. BILLING AUTHORIZED SERVICES

After an authorization is issued, the information (e.g., PA number, procedure code, modifier, and quantity) that was approved on the authorization must match the information on the invoice. (Refer to the Billing and Reimbursement for Professionals Chapter of this manual for complete billing instructions.)

1.7.I. HOSPITAL DISCHARGE WAIVER SERVICES

Hospital Discharge Waiver Services are DME items rented for the beneficiary in which the PA requirement is waived for up to the first three months after hospital discharge. If the beneficiary still requires these items after three months from hospital discharge, the PA requirement would still apply.

These items are as follows: HCPCS codes E0163, E0165, E0176, E0180, E0255, E0256, E0260, E0292, E0293, E0565, E0619, E0630, E0910, E0940, K0001, K0002, K0003, K0004, K0016, K0028, K0048 and K0079

1.8 DURABLE MEDICAL EQUIPMENT (DME)

1.8.A. STANDARD AND CUSTOM-MODIFIED VERSUS CUSTOM-MADE EQUIPMENT

Standard, custom-modified, or custom-made equipment must be medically necessary and meet the medical need and/or functional need of the beneficiary.

- Custom-modified or custom-fitted refers to modifications to a standard item to meet functional needs of a beneficiary by using prefabricated parts (e.g., addition of a strap to a standard item) based on the measurement of the specific beneficiary.
- Custom-made equipment is fabricated to meet the beneficiary's specific medical and/or functional need. The item cannot be used by another beneficiary and conforms to individual measurements, body castings and/or moldings. It incorporates minimal use of prefabricated components, with the majority of the device being fabricated specifically for the beneficiary.

MDCH will consider coverage of custom-made equipment when a standard or custom-modified item (commercially available) will not meet the medical and/or functional needs of the user. All custom-made equipment requires PA. Once the custom-made equipment is purchased, it becomes the property of the beneficiary.

1.8.B. PAYMENT RULES: RENTAL AND/OR PURCHASE

Generally, equipment will be purchased when a beneficiary requires the equipment for an extended period of time. For prior authorized services, the PA consultant may change the authorization request from a rental to a purchase or a purchase to a rental based on

the documentation submitted. If DME items are purchased, the provider must indicate whether the DME item provided is new or used as appropriate. The provider should refer to the Payment Rules described in the Coverage Conditions and Requirements Section of this chapter for MDCH's policy on specific services.

Purchase (New or Used) - Items may be purchased if they are inexpensive accessories for other DME equipment or the equipment itself will be used for an extended period of time.	To be reimbursed for **new** equipment, the provider must: ▪ Adhere to all aspects of the manufacturer's warranty, including all routine servicing, ▪ Deliver, set-up and install the equipment in the home, if applicable, ▪ Instruct the beneficiary or caregiver in the use and general care of the item, and ▪ Complete all adjustments and/or modifications needed to make the item functional.
	To be reimbursed for **used** equipment, the provider must: ▪ Ensure that the used equipment is fully serviced and in good operating condition, ▪ Include all routine servicing for the equipment into the purchase price of the item for a minimum of one year, ▪ Instruct the beneficiary or caregiver in the use and general care of the item, and ▪ Not allow the cost of its maintenance to exceed the cost of new equipment.
Rental - The rental payment includes routine servicing and all necessary repairs or replacements to make the rented item functional.	**Rental Only** – Items that require regular and ongoing servicing/maintenance would be rented for the duration indicated by the physician's order. Examples are oxygen, apnea monitors, and volume ventilators.
	Capped Rental – Items rented until purchase price is reached. For Medicaid, items may be rented for a maximum period of 10 months. If the provider has been reimbursed for 10 months of rental, the item is considered purchased. (If used equipment is issued to the beneficiary, the usual and customary charge reported to Medicaid must accurately reflect that the item is used.)
	Converting Rental to Purchase – The majority of DME items can be rented as a capped rental for up to a maximum of 10 months. If the purchase of an item is requested after an initial rental period has occurred, the provider must subtract the amount already paid for the rental item from the total purchase price.

1.8.C. REPAIRS AND REPLACEMENT PARTS

Repairs and the replacement of component parts for DME owned by the beneficiary are reimbursable if MDCH purchased the item. If MDCH did not reimburse for the original item, it must be medically necessary, meet the Standards of Coverage detailed in this chapter, and prescription and documentation requirements must be met as if MDCH were being asked to purchase.

For purchased items, all conditions of the warranty must be followed prior to requesting any repairs or replacement parts. Routine periodic servicing, such as cleaning, testing, regulating, and checking of equipment, is also included in the cost of the equipment. If equipment is found to be defective or not operating properly, it must be removed from service and cannot be placed into use again until it is brought up to manufacturer's operating standards and specifications. It is the responsibility of the provider to supply

loaner equipment while the beneficiary-owned item is being serviced at no charge to MDCH. For audit purposes, all suppliers must maintain protocols and records defining how the maintenance of equipment is to be achieved.

MDCH will consider reimbursement for a replacement when it is more costly to repair than replace. When submitting a PA request for a replacement, the provider must provide a statement regarding the cost to repair the service versus replacement.

Repairs and the replacement of component parts for DME do not apply to an item that is currently being reimbursed by MDCH as a rental.

Repair of DME involving the replacement of a component part includes the cost of the part and the labor associated with its removal, replacement and finishing. The RP modifier is required.

For a repair in which no specific HCPCS code is appropriate, report HCPCS code E1340 (for the labor charge) and HCPCS code E1399 (for the replacement part). For wheelchairs, HCPCS code K0108 is to be used in place of HCPCS code E1399. RP modifier is reported for these codes. PA is required. The provider must provide a manufacturer's invoice or other documentation that states the acquisition cost for the service with the PA request form. If the provider is requesting reimbursement for labor, the specific time must be stated on the request form.

The replacement of a DME item will be considered when a significant change in the patient's condition has occurred or the item cannot be restored to a serviceable condition. Replacement of DME for youth will be evaluated on an individual basis due to the expected growth pattern. MDCH will not replace an item due to damage to the item as a result of misuse or abuse by the beneficiary or the caregiver. If damage to an item is the result of theft or car accident, attempts should be made to collect the full or partial payment from the third party's insurance company, if applicable. A copy of the police or fire report must be submitted with the PA request form.

The provider may not provide or substitute a service of lesser quality or provide a different brand or type than what was authorized through PA or would fall under the HCPCS code description to accommodate Medicaid fee screens.

The provider may not add additional component HCPCS codes or bill for a more complex code (e.g., custom versus prefabricated) to increase the amount of reimbursement. The provider may not bill for a HCPCS code describing a custom-made service in lieu of the availability of a code to cover a prefabricated item.

1.9 PROSTHETICS AND ORTHOTICS (P&O)

For custom-made prosthetics and orthotics (P&O), MDCH reserves the right to request a recommendation from an appropriate physician subspecialist, physical therapist (PT) or occupational therapist's (OT) evaluation when necessary to determine the functional and/or medical need for the item requested.

1.9.A. NONCUSTOM VERSUS CUSTOM-MADE

Noncustom orthotics are prefabricated, available off the shelf for use, require basic measurements, and could include simple or minor custom fitting if necessary. Any delivery or service charges, fitting and preparatory procedures are considered part of the total purchase charge. Custom-made P&O require measurements, fitting, casting or recasting, or molding to allow the appliance to meet the specific functional needs of the beneficiary. It may involve the incorporation of some prefabricated components. Adding prefabricated components to a prefabricated item is not considered custom-made. Selection of the procedure code should be based on the service provided. Custom codes should not be used for prefabricated services.

All orthotist and prosthetist providers (Type 85) must have facility accreditation through the American Board for Certification in Orthotics and Prosthetics, Inc. (ABC) in order to furnish and bill for custom-made P&O appliances. Providers must maintain their ABC accreditation and be able to provide proof upon request. Any provider currently enrolled as a Type 87 with proof of ABC facility accreditation must re-enroll as a Type 85 in order to furnish custom-made P&O items. Provider Type 87 providers must only bill specific prefabricated and custom-fitted orthotics that may include simple or minor intervention.

Medicaid will continue to consider coverage of these services when provided by other types of practitioners in which the service is within their scope of current medical practice.

1.9.B. HCPCS MODIFIERS - LEFT AND RIGHT SIDE OF THE BODY

The LT or RT modifiers must be reported for orthoses and prostheses to designate either the left or right side of the body if applicable. The frequency limits are based on the individual item being replaced. If the same code is used bilaterally on the same date of service, the items LT and RT must be entered on the same line of the claim listing the appropriate combined quantities. To determine whether a procedure code requires the LT or RT modifier, refer to the Medical Supplier Database on the MDCH website. (Refer to Directory Appendix for contact information.)

The provider may not provide or substitute a service of lesser quality or provide a different brand or type than what was authorized through PA or items that would fall under the HCPCS code description to accommodate the Medicaid fee screens.

The provider may not add additional component HCPCS codes or bill for a more complex code (e.g., custom versus prefabricated) to increase the amount of reimbursement. The provider may not bill for a HCPCS code describing a custom-made service in lieu of the availability of a code to cover a prefabricated item.

1.9.C. ADJUSTMENTS, REPLACEMENTS AND REPAIRS

Adjustments related to the delivery of orthoses are considered as part of the purchase price and are not separately reimbursable up to 90 days following placement. Providers are still responsible for the replacement, modification, and adjustment of any orthotic or prosthetic item that they placed but was not fitted properly. It is expected that the

provider will adjust the device if possible before billing the program for modifications or replacements when there is unexpected growth spurt, substantial weight loss or gain, or post surgery.

Replacement of a component part of an orthosis includes the cost of the part and the labor associated with its removal, replacement and finishing. The RP modifier is required.

For a **repair** in which no specific HCPCS code is appropriate, bill for the actual time it takes to repair or adjust the device and for the minor materials used. Report the labor charge by using HCPCS code L4205 (for orthoses) or HCPCS code L7520 (for prostheses). For minor materials used in repairing the item, report HCPCS code L4210 (for orthoses) or HCPCS code L7510 (for prostheses). No "RP" modifier should be reported with these procedure codes. MDCH will cover the acquisition cost of material, not the provider's charge.

1.10 NONCOVERED SERVICES

Services that are not covered by Medicaid include, but are not limited to:

- Adaptive equipment (e.g., rocker knife, swivel spoon, etc.)
- Air conditioner
- Air purifier
- Enteral formulae to accommodate psychological or behavioral conditions, food preferences, allergies, loss of appetite, or noncompliance with a specialized diet
- Environmental Control Units
- Equipment not used or not used properly by the beneficiary
- Exam tables/massage tables
- Exercise equipment (e.g., tricycles, exercise bikes, weights, mat/mat tables, etc.)
- Generators
- Heating pads
- Home modifications
- Hot tubs
- House/room humidifier
- Insulin pumps for the purpose of solving problems of beneficiary noncompliance
- Items used solely for the purpose of restraining the beneficiary for behavioral or other reasons
- Lift chairs, reclining chairs, vibrating chairs
- More than one pair of shoes on the same date of service
- New equipment when current equipment can be modified to accommodate growth
- Nutritional formulae representing "only" a liquid form of food

- Nutritional puddings/bars
- Over-the-counter shoe inserts
- Portable oxygen, when oxygen is ordered to be used at night only
- Power tilt-in-space or reclining wheelchairs for a long-term care resident because there is limited staffing
- Pressure gradient garments for maternity-related edema
- Prosthetic appliances for a beneficiary with a potential functional level of K0
- Regular or dietetic foods (e.g., Slimfast, Carnation Instant Breakfast, etc.)
- School items (e.g., computers, writing aids, book holder, mouse emulator, etc.)
- Second wheelchairs for beneficiary preference or convenience
- Sensory devices (e.g., games, toys, etc.)
- Sports drinks/juices
- Stair lifts
- Standard infant/toddler formulae
- Therapy modalities (bolsters, physio-rolls, therapy balls, jett mobile)
- Thickeners for foods or liquids (e.g., Thick – it)
- Toothettes
- Transcutaneous Nerve Stimulator when prescribed for headaches, visceral abdominal pain, pelvic pain, or temporal mandibular joint (TMJ) pain
- Ultrasonic osteogenesis stimulators
- Weight loss or "light" products
- Wheelchair lifts or ramps for home or vehicle (all types)
- Wheelchair accessories (e.g., horns, lights, bags, special colors, etc.)
- Wigs for hair loss

For specific procedure codes that are not covered, refer to the Medical Supplier Database on the MDCH website or the Coverage Conditions and Requirements Section of this chapter.

1.11 CHARGING THE BENEFICIARY

The provider may not charge the beneficiary for failure to provide sufficient documentation to support coverage or failure to obtain PA. The provider may charge the beneficiary if the beneficiary waives his right to PA. The provider must maintain on file a document that demonstrates that the beneficiary knew and understood that the waiver of PA would result in the beneficiary's responsibility for payment. In addition, the provider may not charge the beneficiary any co-payments (unless permitted by Medicaid) or charges above the Medicaid allowable amount.

SECTION 2 – COVERAGE CONDITIONS AND REQUIREMENTS

2.1 APNEA MONITOR

Definition	An apnea monitor measures both heart rate and respirations and meets all of the Equipment Control Regulatory Industry (ECRI) Standards for home monitors.
Standards of Coverage	**A Newborn Infant Following Hospital Discharge –** Units are covered for a newborn infant up to three months following hospital discharge if one of the following diagnoses or medical conditions applies: ▪ Apnea of newborn ▪ Apnea of prematurity ▪ Apparent life threatening event (ALTE) ▪ Sibling of Sudden Infant Death Syndrome (SIDS) ▪ Bronchopulmonary Dysplasia
	A Sibling of Sudden Infant Death Syndrome (SIDS) Following Hospital Discharge – ▪ Units are covered for up to one month past the age of the sibling who died from SIDS; or ▪ Up to three months past the age of the sibling who died if the child was a twin of the beneficiary being monitored.
	An Acute Respiratory Illness - Short-term coverage of a unit (up to two months) is a benefit when the beneficiary has a respiratory illness/diagnosis such as Pertussis, Respiratory Syncytial Virus (RSV), or Pneumonia.
	As a Diagnostic Tool - Short-term coverage of a unit (up to three months) used as a diagnostic tool is a benefit if the infant is under three months of age at set up, and the parent and/or guardian reports suspected events.
	Beneficiaries with Tracheostomy – Units are generally not covered for beneficiaries who have a tracheostomy. Units may be considered for coverage only if, after careful evaluation of current treatment plan and equipment already in the home, the beneficiary's medical needs are still not met. Documentation explaining the medical need must be submitted with a detailed plan of management.
	Beneficiaries who are Ventilator Dependent - Units are considered to be included in the ventilator reimbursement to function as a "back up" alarm for the ventilator low-pressure alarm.

Noncovered Conditions	Units are not covered for the following diagnoses/medical conditions unless documentation justifies medical necessity and usage meets the established Standards of Coverage above: ▪ Chromosomal abnormalities ▪ Congenital heart defects with or without arrythymias ▪ Cerebral palsy ▪ Asymptomatic prematurity ▪ Developmental delay/mental retardation ▪ Seizure disorder ▪ Hydrocephaly with or without Arnold-Chiari Syndrome ▪ Irreversible terminal conditions ▪ Distant family history of SIDS (other than immediate sibling)
Documentation	The documentation must be less than 30 days old and include all of the following: ▪ A statement from an appropriate subspecialist trained in the treatment of apnea (i.e., apnea clinic, neonatalogist, pediatric intensivist, pediatric pulmonologist, or neurologist) medically substantiating the continued need for the unit. ▪ Download interpretation of the monitor data documenting continued apnea or bradycardia events. ▪ For a sibling of SIDS, the age of the sibling at death.
PA Requirements	PA is not required for any of the following if the Standards of Coverage are met: ▪ Up to three months usage for newborn infants following a hospital discharge. ▪ Up to three months usage for siblings of SIDS following a hospital discharge. ▪ Used up to two months due to a respiratory illness (e.g., Pertussis, Respiratory Syncytial Virus (SV), or Pneumonia). ▪ Used up to 3 months as a diagnostic tool.
	PA is required for either of the following: ▪ Continuation of the monitor beyond the initial two or three months. ▪ For other diagnosis/medical conditions or applications not indicated in the Standards of Coverage.
Payment Rules	An Apnea Monitor is considered a **rental only** item and includes all of the following: ▪ All accessories needed to use the unit (e.g., electrodes, lead wires, belts, cables, etc.). ▪ Education on the proper use and care of the equipment. ▪ Routine servicing and all necessary repairs or replacements to make the unit functional. ▪ Periodic downloading/interpretation of recorded data.

2.2 Bi-Level Positive Airway Pressure (BIPAP) Device

Definition	The BIPAP device delivers a noninvasive positive air pressure into the upper airway to assist spontaneous respiratory efforts. The device has two pressure levels (one for breathing in and one for breathing out).
Standards of Coverage	A BIPAP device **without the backup rate feature** may be covered for the following conditions for up to four months: ▪ For Obstructive Sleep Apnea (OSA), if the sleep study (polysomnogram) performed in an accredited Sleep Center or Sleep Laboratory documents the following: ➢ Continuous airway pressure of 13-15 cm water does not adequately control/eliminate obstructive/hypopnic events; or ➢ The beneficiary cannot tolerate continuous positive airway pressures of greater than or equal to 12 cm water, in addition to evidence that the sleep lab has worked with the beneficiary to try different application devices, ramp times, relaxation techniques, etc. ▪ For respiratory failure if there are lab values (i.e., arterial blood gas [ABG], venous blood gas [VBG] or capillary blood gas) indicating respiratory failure and follow-up lab values documenting improvement with the use of a BIPAP. ▪ For a diagnosis/medical condition for which a CPAP is inappropriate for use (e.g., cardiomyopathy, corpulmonale, primary pulmonary hypertension, left ventricular hypertrophy, etc.).
	A BIPAP device **with the backup rate feature** may be covered if the beneficiary requires the backup feature due to insufficient spontaneous respiratory efforts (e.g., inadequate negative respiratory force due to central apena, neuromuscular diseases such as muscular dystrophy, etc.).
Documentation	Documentation must be less than 90 days old and include: ▪ Diagnosis related to the need for BIPAP. ▪ BIPAP settings and number of hours per day used. ▪ Other medical conditions ruling out the appropriate use of a CPAP if present (e.g., cardiomegaly, left ventricular hypertrophy, primary pulmonary hypertension, etc.). ▪ For diagnosis of OSA, results of a sleep study (polysomnogram) including CPAP/BIPAP titration. ▪ For diagnosis of respiratory failure, test results substantiating the condition (e.g., ABG, VBG, or capillary gas values) as well as test results showing improvement on BIPAP. ▪ Negative inspiratory force measurement, if appropriate. For continued coverage beyond the initial four months, the following additional information must be provided: ▪ Medical statement indicating beneficiary is stable and the BIPAP device settings are adequate. ▪ Documentation of beneficiary compliance through the review of equipment use logs.
PA Requirements	PA is required for all BIPAP requests.

Payment Rules	BIPAP units are considered a **capped rental** item and are inclusive of all of the following: ▪ All accessories needed to use the unit (e.g., tubing, application devices, chinstrap, headgear, humidifier, etc.). ▪ Education on the proper use and care of the equipment. ▪ Routine servicing and all necessary repairs or replacements to make the unit functional.

2.3 BLOOD GLUCOSE MONITORING EQUIPMENT AND SUPPLIES

Definition	Blood glucose monitoring supplies and equipment are defined as those items necessary to monitor blood glucose levels. The equipment and supplies include, but are not limited to, blood glucose monitors, testing strips, lancets, and calibrator solution/chips.
Standards of Coverage	A home blood glucose monitor and related supplies may be covered when an insulin dependent beneficiary has been diagnosed with either hypoglycemia or hyperglycemia and it is medically necessary to monitor fluctuations of blood glucose levels on a daily basis.
Documentation	Documentation must be less than 90 days old and include all of the following: ▪ Diagnosis/condition related to the need for the blood glucose monitoring. ▪ Items to be dispensed. ▪ Quantity of items to be dispensed for one month's usage. ▪ Frequency of testing. ▪ For beneficiaries under 21, treatment plan for treating abnormal blood glucose levels (if pediatric endocrinologist did not order the monitor/supplies). **For CSHCS beneficiaries**, a prescription from a Pediatric Endocrinologist is required.
PA Requirements	PA is not required when the Standards of Coverage are met and the beneficiary has one of the following diagnoses: ▪ Diabetes Mellitus Without Mention of Complications ▪ Diabetes With Ketoacidosis ▪ Diabetes With Hyperosmolarity ▪ Diabetes With Other Coma ▪ Diabetes With Renal Manifestations ▪ Diabetes With Opthalmic Manifestations ▪ Diabetes With Neurological Manifestations ▪ Diabetes With Peripheral Circulatory Disorders ▪ Diabetes With Other Specified Manifestations ▪ Diabetes With Unspecified Complication ▪ Diabetes Mellitus Complicating Pregnancy

	PA is required for: ▪ Home glucose monitors with special features such as voice synthesis. ▪ Medical need not within the Standards of Coverage and/or a diagnosis that has not been removed from PA. ▪ Replacement within three years.
Payment Rules	All items (including the monitor) are considered **purchase only** items. To report date of service (DOS) for blood glucose test or reagent strips, lancets, and normal, low and high calibrator solution, use a span date in the "From" and "To" fields, not to exceed one month.

2.4 BLOOD PRESSURE MONITORING

Definition	Blood pressure monitoring includes manual and automatic blood pressure units.
Standards of Coverage	A manual blood pressure unit may be covered for a beneficiary under the age of 21 when: ▪ Daily titration of medications is required for renal disease. ▪ A cardiovascular condition is present that affects blood pressure (e.g., congenital heart disease). ▪ A brain lesion or cancer tumor is present that affects blood pressure. ▪ A medication regimen is present that affects blood pressure.
	Coverage for beneficiaries age 21 and over with uncontrolled blood pressure when one of the following is present: ▪ Fluctuation in blood pressure as a result of renal disease. ▪ Medications are titrated based on blood pressure readings.
	Automatic Blood Pressure Monitor is covered when: ▪ Standards of coverage for a manual unit have been met. ▪ Beneficiary is age 11 or over. ▪ Economic alternatives such as a manual blood pressure unit have either been tried or ruled out prior to requesting authorization of an automatic blood pressure monitor.
Documentation	The documentation must be less than 30 days old and include: ▪ Diagnosis/medical condition pertaining to the need for the blood pressure monitor. ▪ Complete physician's treatment plan, including current blood pressure medications, frequency of checks, and specific patient protocol in case of an abnormal reading. ▪ The medical reason a manual blood pressure unit cannot be used for beneficiaries over the age of ten years. ▪ Prescription from a pediatric nephrologist when daily titration of medications is required for renal disease (**required for coverage under CSHCS**).
PA Requirements	PA is required for all blood pressure units.
Payment Rules	A blood pressure monitor is considered a **purchase only** item**.**

2.5 BREAST PUMP

Definition	A hospital grade electric breast pump is heavy duty, piston-operated, and is capable of being used frequently on a daily basis.
Standards of Coverage	A hospital grade electric breast pump may only be covered for a beneficiary with a Neonatal Intensive Care Unit (NICU) infant, up to three months of age, when one of the following applies: ▪ The infant has a severe feeding problem secondary to cleft lip and/or palate. ▪ The infant has a severe feeding problem due to oral motor dysfunction, secondary to pre-maturity. ▪ The infant is hospitalized resulting in a physical separation of the mother and infant. For continued coverage beyond the initial three months, additional documentation must be provided.
Documentation	Documentation must be less than 30 days old and include: ▪ Diagnosis/medical condition of the infant relating to the need for a breast pump. ▪ Infant's age (gestational age, if premature). ▪ Mother's discharge date. ▪ Anticipated duration of need.
PA Requirements	PA is not required when the Standards of Coverage are met. PA is required for coverage beyond three months.
Payment Rules	A breast pump is considered a **rental only** item and is inclusive of the following: ▪ All related accessories necessary to use the equipment (To obtain additional reimbursement for the initial breast pump kit, report the "KH" modifier with HCPCS code E0604 for the first month of rental only). ▪ Education on the proper use and care of the equipment. ▪ Routine servicing and all necessary repairs or replacements to make the unit functional. The rental pump may be billed using the infant's Medicaid ID number if the need for the hospital grade pump meets the standards of coverage and the mother loses Medicaid eligibility.

2.6 CANES AND CRUTCHES

Definition	Canes or crutches include, but are not limited to, adjustable or fixed canes, quad or three prong canes, forearm crutches and under arm crutches.
Standards of Coverage	Canes or crutches are covered if: ▪ The diagnosis/medical condition results in instability in ambulation or inability to ambulate. ▪ The beneficiary requires the stability of a cane or crutch to ambulate.

Documentation	Documentation must be less than 180 days old and include the following: ▪ Diagnosis/medical condition related to instability or inability to ambulate. ▪ Type of item requested. ▪ Medical reason for replacement (when appropriate).
PA Requirements	PA is not required when Standards of Coverage are met.
	PA is required when: ▪ The beneficiary is over the age of 21, and replacement is required within five years. ▪ The beneficiary is under the age of 21, and replacement is required within one year. For replacement of pads, handgrips or tips, the provider may call for a verbal authorization. The provider must provide acquisition cost supported by a manufacturer's invoice. A prescription is not required if the program has covered the cane and/or crutch. The original prescription for the item must be kept on file.
Payment Rules	Canes and crutches are considered **purchase only** items.

2.7 CHILDREN'S PRODUCTS

Definition	Children's products that may be considered for coverage include, but are not limited to, equipment that is used in the home or vehicle by children under age 21 for the purposes of positioning, safety during activities of daily living, or assisted mobility. Examples of these items include: bath supports, specialized car seats, corner chairs, dynamic standers, feeder seats, gait trainers, pediatric walkers, positioning commodes, side lyers, standers, and toileting supports.
Standards of Coverage	Children's products are covered if one or more of the following applies: ▪ Beneficiary is unable to independently maintain a seated position. ▪ Beneficiary cannot stand and/or ambulate without the aid of an assistive device. ▪ Beneficiary has physical anomalies that require support to allow a functional position or prevent further disability.
Documentation	Documentation must be less than 180 days old and include all of the following: ▪ Diagnosis appropriate for the equipment requested. ▪ Any adaptive or assistive devices currently used in the home. ▪ Reason economic alternatives cannot be used, if applicable. ▪ Statement of functional need from an appropriate pediatric subspecialist, occupational, or physical therapist.
PA Requirements	PA is required for all requests.
Payment Rules	All children's products are considered **purchase only** items**.**

2.8 COMMODES

Definition	A commode is a chair with an enclosed pan or pail that may be stationary or mobile, with fixed or removable arms, a seat lift, and footrest.

Standards of Coverage	A **standard commode** may be covered if the beneficiary is unable to safely use home toileting facilities, is confined to a single room, or is confined to one level of the home in which no toileting facilities are available.
	A **heavy-duty commode** may be covered for a beneficiary weighing 300 pounds or greater and the beneficiary is unable to safely use home toileting facilities, is confined to a single room, or is confined to one level of the home in which no toileting facilities are available.
	A **shower commode chair** may be covered if required to enable the beneficiary to shower independently or with assistance in the home setting and there are no economic alternatives available.
Documentation	Documentation must be less than 180 days old and include: ▪ Diagnosis appropriate for the equipment requested ▪ Functional limitations requiring the equipment. ▪ Weight (if a heavy-duty commode is required). ▪ Discharge date from hospital, if applicable.
PA Requirements	PA is not required for any of the following if the Standards of Coverage are met: ▪ Up to Three Months Following Hospital Discharge **-** rental of a stationary commode chair with fixed arms (or) stationary commode chair with detachable arms for a diagnosis not already removed from PA. ▪ For the purchase or rental of a stationary, mobile, extra wide, or heavy duty commode chair with fixed or detachable arms for the following diagnoses: ➢ Amyotrophic Lateral Sclerosis ➢ Multiple Sclerosis ➢ Cerebral Palsy, Unspecified ➢ Congenital and Progressive Hereditary Muscular Dystrophy ➢ Fracture Of Vertebral Column With Spinal Cord Injury (cervical and dorsal) ▪ Replacement of pail or pan for use with commode chair.
	PA is required for the following: ▪ Medical need beyond the Standards of Coverage. ▪ Commodes with footrests and/or seat mechanisms. ▪ Continued coverage after the three-month rental following hospital discharge for a diagnosis not removed from PA. ▪ Replacement is required within five years, if the beneficiary is over 21. ▪ Replacement is required within two years if the beneficiary is under 21.
Payment Rules	A commode may be considered a **capped rental** or **purchase** item. Reimbursement for all commodes includes pail/pan and accessories (except footrest). If unit is billed as a capped rental, the rental payment would be inclusive of the following: ▪ Education on the proper use and care of the equipment. ▪ Routine servicing and all necessary repairs or replacement to make the unit functional.

2.9 COMPRESSOR (LARGE VOLUME)

Definition	A compressor is an electrical device that provides humidity to a tracheostomy and is capable of continuous operation.
Standards of Coverage	A compressor is covered to provide humidity for a tracheostomy.
Documentation	Documentation must be less than 90 days old and include all of the following: ▪ Diagnosis/medical condition related to the need for the equipment. ▪ Specific unit requested.
PA Requirements	PA is not required for rental of a large volume compressor if the Standards of Coverage are met and documentation details one of the following diagnoses: ▪ Artificial Opening Status – Tracheostomy. ▪ Attention to Artificial Openings – Tracheostomy.
	PA is required for: ▪ Purchase of a large volume compressor (if not rented for 10 months). ▪ Medical need beyond the Standards of Coverage. ▪ Replacement within five years.
Payment Rules	A unit may be considered a **capped rental** item or **purchased** item. If unit is billed as a capped rental, the rental payment would be inclusive of the following: ▪ All accessories needed to use the equipment. ▪ Education on the proper use and care of the equipment. ▪ Routine servicing and all necessary repairs or replacements to make the unit functional.

2.10 CONTINUOUS POSITIVE AIRWAY PRESSURE (CPAP) DEVICE

Definition	The CPAP device delivers a noninvasive positive air pressure into the upper airway to assist spontaneous respiratory efforts.
Standards of Coverage	A CPAP device may be covered for Obstructive Sleep Apnea (OSA) if a sleep study (polysomnogram) performed in an accredited Sleep Center or Sleep Laboratory documents the following: ▪ Apnea-Hypopnea Index (AHI) documents a minimum of 15 events per hour, or ▪ AHI documents five to 14 events per hour with related symptoms such as: ➢ Excessive daytime sleepiness, impaired cognition, mood disorders; and/or ➢ Hypertension, ischemic heart disease or history of stroke, or morbid obesity. For beneficiaries under the age of 21 only, tracheomalacia, tracheostomy complications or other anomalies of larynx, trachea, and bronchus may be covered when a particular CPAP setting improved and maintained airway patency and oxygenation.

Documentation	Documentation must be less than 90 days old and include: ▪ Diagnosis and/or medical condition related to the need for the CPAP device. ▪ A copy of the sleep study (polysomnogram) for a diagnosis of OSA. The recorded sleep study must contain at least two hours of recorded sleep and the AHI must be calculated using actual recorded hours of sleep. ▪ For continued coverage beyond the initial four months, documentation must substantiate that the beneficiary has been compliant with the use of the CPAP and the device continues to be effective in treating the condition. If a unit log is maintained, the information must be submitted. ▪ Prescription from an appropriate pediatric subspecialist is required **for coverage under CSHCS Program.**
PA Requirements	PA is not required if the Standards of Coverage are met and: ▪ The beneficiary is over the age of 21 and has one of the following diagnoses: ➢ Tracheostomy Complications ➢ Tracheomalacia ➢ Other Anomalies Of Larynx, Trachea, and Bronchus ➢ Insomnia With Sleep Apnea ➢ Hypersomnia With Sleep Apnea ➢ Other And Unspecified Sleep Apnea ▪ For unobstructive sleep apnea, use diagnosis description of other and unspecified sleep apnea. ▪ The beneficiary is under the age of 21, has one of the above diagnoses, and the device is prescribed by the appropriate pediatric subspecialist.
	PA is required for: ▪ Medical need beyond the Standards of Coverage. ▪ Replacement within five years. PA is given for the initial four months and then for the final six months.
Payment Rules	A CPAP device is considered a **capped rental** item and is inclusive of the following: ▪ All accessories needed to use the unit (e.g., tubing, application devices, filters, chinstrap, headgear, humidifier, etc.). ▪ Education on the proper use and care of the equipment. ▪ Routine servicing and all necessary repairs or replacements to make the unit functional. After the first 10 months of use, necessary repairs and/or replacements of accessories are separately reimbursable. (Replacement parts for the full CPAP mask should be considered prior to replacement of the entire mask.)

2.11 DIABETIC SHOES AND INSERTS

Definition	Diabetic shoes, inserts and related modifications include, but are not limited to, depth inlay shoes, multi-density inserts, roller or rocker bottoms, wedges, metatarsal bar, and off-set heel.
Standards of Coverage	Diabetic Shoes, inserts, and/or modifications may be covered for individuals who have, due to complications with diabetes mellitus, one of the following conditions: ▪ History of previous foot ulcerations or pre-ulcerative calluses. ▪ Established peripheral neuropathy or sensory impairment. ▪ Peripheral Vascular Disease with an ankle brachial index at rest of 0.5 or less following exercise. ▪ Loss of a toe or portion of the foot due to amputation arising from diabetes. A **custom-molded diabetic shoe** is covered only if the depth shoe cannot accommodate a foot anomaly. **Inserts** are covered if the beneficiary requires a depth shoe or custom-molded diabetic shoe. For a depth shoe, three inserts would be separately reimbursable in addition to the noncustomized one included with the shoe. For a custom-molded shoe, two inserts would be separately reimbursable. Modifications to custom-molded or depth shoe may be covered instead of an additional insert.
Documentation	Documentation must be less than 30 days old and include all of the following: ▪ Diagnosis/medical condition related to the service requested. ▪ Medical reasons for specific shoe type and/or modification.
PA Requirements	PA is not required for the following inserts if the Standards of Coverage are met: ▪ Multiple density insert, direct formed, molded to foot with external heat source. ▪ Multiple density insert, direct formed, compression molded to patient's foot without external heat source. ▪ Multiple density insert, custom fabricated and custom-molded from model of patient's foot. ▪ Depth inlay shoes. ▪ Modifications if an additional insert is not provided.
	PA is required for: ▪ Medical need beyond the Standards of Coverage. ▪ Replacement within one year. ▪ Quantity beyond established limits. ▪ Custom-made shoes and other inserts not included above.
Payment Rules	All items are considered **purchase only**.

2.12 ENCLOSED BED SYSTEMS

Definition	An Enclosed Bed System includes the mattress, bed frame, and enclosure as one unit.
Standards of Coverage	An Enclosed Bed System may be covered if the following applies: ▪ There is a diagnosis/medical condition (e.g., seizure activity) which could result in injury in a standard bed, crib, or hospital bed; and ▪ There are no economic alternatives to adequately meet the beneficiary's needs.
Documentation	The documentation must be less than six months old and include: ▪ Diagnosis/medical condition requiring use of the bed and any special features (if applicable). ▪ Safety issues resulting from the medical condition and related to the need for an Enclosed Bed System. ▪ Other products or safety methods already tried without success, (e.g., bumper pads/rails). ▪ Type of bed requested. ▪ Type of special features requested, if applicable.
Noncovered Conditions	Enclosed Bed Systems are not covered when the purpose is to restrain the beneficiary due to behavioral conditions, caregiver need or convenience, etc.
PA Requirements	PA is required for all Enclosed Bed Systems.
Payment Rules	The Enclosed Bed System is considered a **purchase only** item. For Youth Beds, refer to the Hospital Beds portion of this chapter.

2.13 ENTERAL NUTRITION

Enteral nutrition is the nutrition administered by tube or orally into the gastrointestinal tract. Seven enteral formulae HCPCS categories have been defined for oral and tube feeding use, and the formulae in each main category possess similar characteristics. Each list is not all-inclusive nor are all the enteral formulae generally equivalent within a specific category. The categories are provided as a guideline for medical suppliers when the prescriber has ordered an enteral formula using the brand name. For products not listed, the provider may contact the Statistical Analysis DME Regional Carrier (SADMERC) for a coding determination or refer to the Enteral Product Classification List on the SADMERC web site. (Refer to the Directory Appendix for contact information.) If none of the classifications are appropriate, the NOC code should be used. For more information regarding specific enteral formulae products listed under each main category, refer to the Medical Supplier Database on the MDCH website.

2.13.A. ENTERAL NUTRITION (ADMINISTERED ORALLY)

Standards of Coverage	Enteral nutrition (administered orally) may be covered for beneficiaries under the age of 21 when: ▪ A chronic medical condition exists resulting in nutritional deficiencies and a three-month trial is required to prevent gastric tube placement. ▪ Supplementation to regular diet or meal replacement is required, and the beneficiary's weight to height ratio has fallen below the fifth percentile on standard growth grids. ▪ Physician documentation details low percentage increase in growth pattern or trend directly related to the nutritional intake and associated diagnosis/medical condition. **For CSHCS coverage**, a nutritionist or appropriate subspecialist must indicate that long-term enteral supplementation is required to eliminate serious impact on growth and development.
	For beneficiaries age 21 and over: ▪ The beneficiary must have a medical condition that requires the unique composition of the formulae nutrients that the beneficiary is unable to obtain from food. ▪ The nutritional composition of the formulae represents an integral part of treatment of the specified diagnosis/medical condition. ▪ The beneficiary has experienced significant weight loss.
Documentation	Documentation must be less than 30 days old and include: ▪ Specific diagnosis/medical condition related to the beneficiary's inability to take or eat food. ▪ Duration of need. ▪ Amount of calories needed per day. ▪ Current height and weight, as well as change over time. (For beneficiaries under 21, weight to height ratio.) ▪ Specific prescription identifying levels of individual nutrient(s) that is required in increased or restricted amounts. ▪ List of economic alternatives that have been tried. ▪ Current laboratory values for albumin or total protein (for beneficiaries age 21 and over only). For continued use beyond three to six months, **the CSHCS Program requires** a report from a nutritionist or appropriate pediatric subspecialist.
PA Requirements	PA is required for all enteral formulae for oral administration.

2.13.B. ENTERAL NUTRITION (ADMINISTERED BY TUBE)

Standards of Coverage	Enteral formulae are covered when the diagnosis/medical condition requires placement of a gastric tube and nutrition is administered by syringe, gravity, or pump.

Documentation	Documentation must be less than 30 days old and include: ▪ Specific diagnosis/medical condition requiring tube feeding. ▪ Duration of treatment. ▪ Amount needed per day. ▪ If a pump is required, the medical reason why syringe or gravity method could not be used.
PA Requirements	PA is not required for standard formulae for enteral tube feedings provided up to the program's established quantity limits per month. (Applies only to specific enteral formulae and related supplies and equipment. Refer to the Medical Supplier Database on the MDCH website for additional information.)
	PA is required for the following: ▪ All specialized enteral formulae requests for tube feedings. ▪ Over-quantity requests for standard formulae enteral tube feedings. ▪ Medical need beyond Standards of Coverage.

2.13.C. ENTERAL NUTRITION PAYMENT RULES

When billing for enteral formulae (administered orally or by tube), the appropriate formulae HCPCS code should be billed on a monthly basis with total calories used (divided by 100) as the unit amount. (To calculate the appropriate number of caloric units, combine total calories of all cans to be used and divide by 100.) Medicaid will reimburse for a maximum quantity of up to 900 units for any combination of approved formulae.

Providers should refer to the following chart for additional assistance:

Formulae	100 calories = 1 unit (u)	6 (8 oz) cans a day	1 month = 30 days	6 months = 180 days	$5.00 cost/8 oz liquid or packet or can
Standard @ 250 calories/8 oz	250 cals/100 =2.5 units	2.5 u x 6 = 15 units a day	15 u x 30 = 450 units a month	15 x 180=2700 units for 6 months	$5.00 ÷ 2.5 u = $2.00 per unit
Caloric Dense @ 355 calories/8 oz	355 cals/100 =3.55 units	3.55 u x 6= 21 units a day	21 u x 30 = 630 units a month	21 u x 180 = 3780 units for 6 months	$5.00 ÷ 3.55 u = $1.41 per unit
Powder, 1 package = 150 calories	150 cals/100 = 1.5 units	1.5 u x 6 = 9 units a day	9 u x 30 = 270 units a month	9 u x 180 =1620 units for 6 months	$5.00 ÷ 1.5 u = $3.33 per unit
Powder, 1# can = 112 oz when mixed @ 20 calories/oz* = 2240 calories for the entire can (* can vary with physician orders)	2240 cals/100 = 22.4 units		6 cans per month = 22.4 x 6 = 134 units a month	134 u x 6 months = 804 units for 6 months	$5.00 ÷ 22.4 u = $0.30 per unit

The necessary equipment and supply code for enteral tube feedings should be billed up to specified quantity limits. Feeding bags, anchoring devices, syringes, drain sponges, cotton tip applicators, tape, adaptors, and connectors used in conjunction with a gastrostomy or enterostomy tube are included in the supply kit codes and should not be billed separately.

Dietary formulae for oral feedings may be obtained from either a medical supplier (Provider Type 87) or a pharmacy (Provider Type 50).

Dietary formulae for tube feedings are covered only through the medical supplier (Provider Type 87).

2.14 External Infusion (Insulin) Pump and Related Supplies

Definition	Insulin pumps deliver a constant and continuous infusion of insulin, driven by mechanical force, into the subcutaneous space via a needle or soft cannula.
Standards of Coverage	Insulin pumps are covered when other methods to control blood glucose levels have been ineffective and one of the following applies: ▪ Blood glucose levels demonstrate poor glycemic control despite monitoring at least four times per day and multiple daily insulin injections with a persistently elevated gylcosylated hemoglobin level greater than seven percent. ▪ There is a history of severe gylcemic excursions, brittle diabetes, hypogylcemic/hyperglycemic reaction, nocturnal hypoglycemia, any extreme insulin sensitivity, and/or very low insulin requirements. ▪ There is evidence of the "dawn" phenomenon where fasting blood glucose level often exceeds 200 mg/dl.
Documentation	Documentation must be less than 90 days old and include: ▪ Diagnoses/medical condition pertaining to the need for the pump. ▪ Lab values of blood glucose levels. ▪ Medical history documenting the need for the pump. ▪ Any medical complications experienced by the beneficiary related to the need for blood glucose monitoring. **CSHCS requires** a prescription from an appropriate pediatric subspecialist.
PA Requirements	PA is not required if the Standards of Coverage are met, and: ▪ The beneficiary is over the age of 16 and has one of the diagnoses indicated below: ➢ Diabetes With Ketoacidosis ➢ Diabetes With Hyperosmolarity ➢ Diabetes With Other Coma ➢ Diabetes With Renal Manifestations ➢ Diabetes With Ophthalmic Manifestations ➢ Diabetes With Neurological Manifestations ➢ Diabetes With Peripheral Circulatory Disorders

	➢ Diabetes With Other Specified Manifestations ➢ Diabetes With Unspecified Complication ➢ Diabetes Mellitus Complicating Pregnancy ▪ The beneficiary is under the age of 16, has one of the diagnoses above, and the pump is ordered by a pediatric endocrinologist.
	PA is required for the following: ▪ Medical need beyond the Standards of Coverage. ▪ Diagnoses/conditions other than those listed above. ▪ Replacement of pump within five years.
Payment Rules	Insulin pumps are considered a **purchase only** item. The purchase payment is inclusive and includes of all of the following: ▪ A 30-day trial period at no cost to the Program or the beneficiary prior to purchase of device. ▪ Comprehensive care coordination, including a plan for follow-up monitoring by the physician after installation of the pump.

2.15 HIGH FREQUENCY CHEST WALL OSCILLATION (HFCWO) DEVICE

Definition	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. The air-pulse generator rapidly inflates and deflates the vest, gently compressing and releasing the chest wall to create mini-coughs that dislodge mucus from the bronchial walls, increase mobilization, and move it along toward central airways.
Standards of Coverage	A HFCWO system may be covered up to 4 months for the following: ▪ Diagnosis of Cystic Fibrosis. ▪ All other treatment modalities have not been effective.
Documentation	Documentation must be less than 180 days old and include: ▪ Diagnosis pertaining to the need for this unit. ▪ Severity of condition (e.g., frequency of hospitalizations, pulmonary function tests, etc.). ▪ Current treatment modalities and others already tried. ▪ Plan of care by the attending Cystic Fibrosis (CF) Center specialist substantiating need for the device is **required under the CSHCS Program**. ▪ For continuation beyond the initial four months, the following information must be provided: ➢ Documentation of client compliance through the review of equipment use logs; and ➢ Medical statement from a CF Center Specialist substantiating the continued effectiveness of the vest is **required under the CSHCS program.**

PA Requirements	PA is required for all requests.
Payment Rules	The HFCWO system chest compression generator system is considered a **capped rental** item and is inclusive of the following: ▪ All accessories necessary to use the equipment except for the vest itself. This may be separately reimbursed during the initial rental period. ▪ Education on the proper use and care of the equipment ▪ Routine servicing and all necessary repairs and replacements to make the equipment functional.

2.16 HOME INTRAVENOUS INFUSION THERAPY

Definition	Intravenous infusion therapy, administered in the home, is medicine injected directly into a vein.
Standards of Coverage	Coverage of home infusion therapy, its expected course, and duration of treatment is based on the plan of care prescribed by the physician. Only the days involving active infusion will be considered for payment. The medical supplier facilitating the administration of home infusion therapy must: ▪ Be accredited through the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) or other appropriate accrediting body. ▪ Maintain logs detailing proper equipment maintenance consistent with manufacturer's requirements. ▪ Provide education and training to the beneficiary or caregiver related to proper care techniques. ▪ Provide comprehensive care coordination involving the pharmacist, nurses, physician or any other infusion therapy professional.
Documentation	Documentation must be less than 30 days old and include the following: ▪ Diagnosis appropriate for specified therapy. ▪ Dosage, frequency, route and duration of medication/medications being infused.
	Documentation for **antibiotic, antiviral and/or antifungal therapies** must include at least one of the following test results to support the diagnosis: ▪ Positive culture from appropriate site (e.g., a blood culture for diagnosis of sepsis, wound culture for diagnosis osteomyelitis, etc.). ▪ Bone scan showing osteomyelitis. ▪ X-ray showing osteomyelitis or abscess. ▪ ECHO/ultrasound showing endocarditis. ▪ Vegetations or abscess. ▪ CT or MRI scan showing osteomyelitis or abscess. ▪ Minimum of three of the following: ➢ Fever of 101° F or more, pain, warmth, redness, edema in affected area.

	➢ Elevated C-reactive protein. ➢ Elevated white blood cell count. ➢ Elevated sedimentation rate (ESR). ➢ A trial course of oral antibiotic therapy with no improvement, or worsening of symptoms. For the diagnoses of cellulitis, pneumonia, urinary tract infection, and otitis media, documentation must indicate a failure of oral antibiotic therapy, unless a culture shows bacteria that is not sensitive to oral antibiotic medications available. This does not apply to cystic fibrosis pneumonia; PA is not needed with a positive sputum culture or a history of positive sputum cultures.
	Documentation for **electrolyte replacement therapy (condition unrelated to hydration status)** must include a copy of the appropriate abnormal laboratory level (e.g., low potassium level for diagnosis hypokalemia, etc.).
	Documentation for **steroid therapy** must indicate exacerbation of multiple sclerosis or diagnosis related to transplant rejections.
	Documentation for **chemotherapy and pain management therapy** must include a cancer diagnosis and a copy of the treatment protocol to which the beneficiary has been assigned.
	Documentation for **hydration therapy for hyperemesis gravidarium** must include laboratory results indicating current dehydration level, estimated delivery date, and must address a trial of anti-emetics.
	Documentation for **gammaglobulin therapy** must include abnormal IGG, IGM, IGA or IGE levels prior to the beneficiary receiving an IVIG. If beneficiary has been receiving IVIG infusion therapy in an outpatient or physician office setting, these laboratory tests may not be current.
	Documentation for **iron overload therapy** must indicate a diagnosis of Sickle Cell Anemia and support the need for the requested therapy.
	Documentation for **factor products** must indicate a clotting disorder diagnosis and support the need for requested therapy.
	The provider must keep **verification of equipment maintenance** on file that includes: ▪ Name of the manufacturer. ▪ Dates the equipment was checked for proper use, care and function according to the manufacturer's requirements.
PA Requirements	PA is not required for specific HCPCS "S" codes if all of the following apply: ▪ Standards of Coverage are met. ▪ Beneficiary is age five or older. ▪ Medical need for the therapy is related to one of the diagnoses/conditions that do not require PA. (For details regarding covered HCPCS "S" codes, PA requirements and related ICD-9-CM diagnosis exception codes ranges and quantity limits, refer to the Medical Supplier Database on the MDCH website.)

	PA is required for the following: ▪ Medical need beyond the Standards of Coverage. ▪ The beneficiary is under the age of five. ▪ Infusion days exceed the established Medicaid limits.
Payment Rules	Reimbursement for the HCPCS "S" codes related to home intravenous infusion therapy is calculated on a per diem basis as defined by the code descriptions. Costs included within the per diem rate: ▪ All infusion related supplies and equipment, such as the infusion pump, needles, syringes, gauze, sterile tubing, catheters, etc. (For pump-related infusion, the per diem rate payment includes routine servicing and all necessary repairs or replacements to make the rented DME functional.) ▪ The compounding of medications compliant with standards of pharmaceutical practice, including a medication profile set-up with recommendations of dosage or medication changes if needed. ▪ Patient educational activities related to receiving home infusion therapy and the coordination of care with physicians, nurses and other caregivers. Costs not associated with the per diem rate: ▪ Medications (drugs) must be billed as pharmacy services. ▪ Nursing visits are covered through a Home Health Agency. ▪ PICC and Midline insertion procedures and associated supplies may be billed separately.
	HCPCS "S" codes must be reported as a daily rate by reporting the total number of days used as units unless otherwise noted. Routine catheter care is included within the daily rate for the active infusion. If multiple drugs are being administered concurrently for the same therapy, report modifier "SH" for two drugs or "SJ" for three or more drugs. If multiple therapies are needed, more than one therapy code may be reported. For chemotherapy and pain management, the specific HCPCS code will designate either continuous or intermittent administration. If the therapy is provided without interruption for 24 hours or more, report the continuous therapy code. For less than 24 hours of therapy, use the intermittent code. For antibiotic, antiviral, or antifungal therapy, report the code that best describes the frequency of administration. Only one therapy code of this series may be reported on the same date of service. If multiple drugs are administered, report modifier "SH" or "SJ".

2.17 HOME UTERINE ACTIVITY MONITOR (HUAM)

Definition	A home uterine activity monitor (HUAM) is used to record the frequency of uterine contractions for the purpose of predicting pre-term delivery. The monitor is worn on a belt, records the uterine contractions that are transmitted across modem lines to a central monitoring office that contacts the physician's office for interpretation.

Standards of Coverage	A HUAM may be covered for up to 90 days in the home setting for a beneficiary at high risk for pre-term delivery during the 24th through the 36th gestational week, and one of the following medical conditions applies: ▪ Pre-term labor on tocolytics. ▪ History of pre-term labor or delivery in previous pregnancies. ▪ Incompetent cervix (cerclage).
Documentation	Documentation must be less than 90 days old and include: ▪ Diagnosis and/or medical condition pertaining to the need for the monitor. ▪ Expected date of birth. ▪ Last day of the 36th week of gestation. ▪ Involvement with a regional perinatal center.
PA Requirements	PA is required for all monitors.
Payment Rules	A HUAM is a **rental only** item and is inclusive of the following: ▪ The monitor and other related supplies required to use the equipment properly. ▪ Education on proper use and care of the equipment. ▪ Routine servicing and all necessary repairs or replacements to make the unit functional. ▪ Periodic downloading and interpretation of the data. ▪ Perinatal nursing services related to oversight of the use of the monitor. To provide a HUAM, the medical supplier must complete a special enrollment process by completing the Medical Assistance Provider Enrollment Agreement (DCH-1625) and the Home Uterine Activity Monitor Agreement (DCH-1152) and sending them to the MDCH Provider Enrollment Unit. (Refer to Directory Appendix for contact information.)

2.18 HOSPITAL BEDS

Definition	A hospital bed has a special construction, consisting of a frame and an innerspring mattress, with a head and/or leg elevation adjustment mechanism for the purpose of repositioning.
Standards of Coverage	A standard hospital bed may be covered if: ▪ The diagnosis/medical condition requires a specific elevation or positioning of the body not possible with a standard bed (elevation of 30 degrees or greater). ▪ The body requires positioning in a hospital bed to alleviate pain.

	For other beds, the above Standards of Coverage must be met, and one of the following applies: ▪ **Variable height hospital bed** may be covered if different heights are medically necessary for assisting beneficiary transfers from the chair, wheelchair or standing position. ▪ **Heavy-duty extra wide hospital bed** may be covered if a beneficiary weighs more than 350 pounds but does not exceed 600 pounds. ▪ **Extra heavy-duty bed** may be covered if a beneficiary weighs more than 600 pounds. ▪ A **fully electric hospital bed** may be covered when frequent and/or immediate changes in body position are required and there is no caregiver. ▪ A **youth bed** may be covered if the beneficiary is under the age of 21 and the bed is required to have crib style side rails.
	Hospital Bed Accessories ▪ The **trapeze bar** may be covered when required by the beneficiary to assist with transfers or frequent changes in body position. ▪ **Side rails** are covered when required for safety. ▪ A **replacement innerspring** mattress or foam rubber mattress may be covered for replacement when the beneficiary owns the bed.
Noncovered Items	Youth beds are not covered for the sole purpose of age appropriateness.
Documentation	Documentation must be less than 90 days old and include the following: ▪ Diagnosis/medical condition related to the service requested. ▪ Medical and/or functional reasons for the specific type of hospital bed and/or accessory. ▪ Any alternatives tried or ruled out.
PA Requirements	PA is not required if the Standards of Coverage are met and the following applies: ▪ For fixed height, variable height, semi-electric beds, side rail, and trapeze for one of the following diagnoses/medical conditions: ➢ Multiple Sclerosis ➢ Infantile Cerebral Palsy ➢ Congenital or Hereditary Progressive Muscular Dystrophy ➢ Fracture of the Cervical or Dorsal Areas (open or closed) ▪ For up to three months, for hospital discharge, for procedure codes E0255, E0256, E0260, E0292, E0293, E0910, E0940 when required for diagnoses not removed from PA.

	PA is required for: ▪ Medical need beyond the Standards of Coverage. ▪ Full electric beds or any other hospital beds and/or accessories requiring PA as specified in the Medical Supplier Database. ▪ Replacement of a fixed height, variable height, or semi-electric bed and/or accessory within eight years.
Payment Rules	A bed may be a **capped rental** or **purchase** item. If unit is billed as a capped rental, the rental payment would be inclusive of the following: ▪ All accessories needed to use the equipment, except for trapezes, side rails, and mattresses where appropriate. ▪ Education on the proper use and care of the equipment. ▪ Routine servicing and all necessary repairs or replacements to make the unit functional.

2.19 INCONTINENT SUPPLIES

Definition	Incontinent supplies are items used to assist individuals with the inability to control excretory functions. The type of coverage for incontinent supplies may be dependent on the success or failure of a bowel/bladder training program. A bowel/bladder training program is defined as instruction offered to the beneficiary to facilitate: ▪ Independent care of bodily functions through proper toilet training. ▪ Appropriate self-catheter care to decrease risk of urinary infections and/or avoid bladder distention. ▪ Proper techniques related to routine bowel evacuation.
Standards of Coverage	**Diapers, incontinent pants, liners, and belted/unbelted undergarments without sides** are covered for individuals age three or older if both of the following applies: ▪ A medical condition resulting in incontinence and there is no response to a bowel/bladder training program. ▪ The medical condition being treated results in incontinence, and beneficiary would not benefit from or has failed a bowel/bladder training program. **Pull-on briefs** are covered for an initial six-month period if all of the following conditions apply: ▪ Presence of a medical condition causing bowel/bladder incontinence. ▪ Beneficiary is actively participating in a bowel/bladder training program and demonstrating definitive progress. **Continued Coverage for Pull-On Briefs:** Pull-on briefs are considered a short-term transitional product to be used as a training item. For continued coverage beyond the initial six months, a reassessment must be completed every six months detailing definitive progress being made in the bowel/bladder training. Documentation of the reassessment must be kept in the beneficiary's file.

	Incontinent wipes are covered when necessary to maintain cleanliness outside of the home. **Intermittent catheters** are covered when catherization is required due to severe bladder dysfunction. **Hydrophilic-coated intermittent catheters** are considered for individuals that have Mitrofanoff stomas, partial stricture or small, tortuous urethras. **Disposable underpads** are covered for beneficiaries of all ages with a medical condition resulting in incontinence.
Documentation	Documentation must be less than 30 days old and include the following: ▪ Diagnosis of condition causing incontinence (primary & secondary diagnosis). ▪ Item to be dispensed. ▪ Duration of need. ▪ Quantity of item and anticipated frequency the item requires replacement. ▪ For pull-up briefs, a six-month reassessment is required.
PA Requirements	PA is required for: ▪ Hydrophilic type urinary catheters. (Use HCPCS A4649 and describe type of catheter requested on the PA request for additional reimbursement to be considered). ▪ For usage over the established quantities.
	PA is not required for all other incontinent items unless usage exceeds established quantity limitations.
Payment Rules	**Volume Purchase Agreement** - Through a competitive bid process, the State of Michigan has contracted with a volume purchase contractor for selected incontinent supplies for beneficiaries enrolled in the Medicaid FFS, the CSHCS FFS or Basic Health Plan Programs and the Adult Benefit Waiver (ABW).
	Beneficiaries Exempt from the MDCH Volume Purchase Contract - Based on dual eligibility, specific beneficiaries may be exempt from obtaining services from the MDCH Volume Purchase Contractor as described below: ▪ Beneficiaries dually enrolled in Medicaid and Medicare are not required to obtain products from the contractor but may choose to obtain products from the contractor or any other medical supplier enrolled in Medicaid. ▪ Beneficiaries enrolled in a MHP or CSHCS Special Health Plan (SHP) will receive coverage of these products through the medical supplier contracted by the health plan. This medical supplier could be the Contractor if negotiated by the MHP or SHP. ▪ Beneficiaries enrolled in either a commercial FFS plan or HMO if its coverage includes incontinence supplies are expected to follow the primary payer's rules first. If these products are not covered by the plan, the beneficiary must obtain these items though the MDCH Volume Purchase Contractor.

Services Covered Through the Contract

The following list details the selected incontinent supply items that must be obtained from the MDCH Volume Purchase Contractor for Medicaid and CSHCS Programs.

HCPCS Code	Nomenclature
A4310	Insert Tray W/O Bag/Cath
A4311	Catheter W/O Bag 2-Way Latex
A4312	Cath W/O Bag 2-Way Silicone
A4314	Cath W/Drainage 2-Way Latex
A4315	Cath W/Drainage 2-Way Silicone
A4320	Irrigation Tray
A4322	Irrigation Syringe
A4324	Male Ext Cath W/Adh Coating
A4325	Male Ext Cath W/Adh Strip
A4326	Male External Catheter
A4328	Female Urinary Collection Pouch
A4330	Perianal Fecal Collection Pouch
A4331	Extension Drainage Tubing
A4333	Urinary Cath Anchor Device
A4334	Urinary Cath Leg Strap
***A4335	Incontinence Supply
A4338	Indwelling Catheter Latex
A4340	Indwelling Catheter, Speciality Type
A4344	Cath Indw Foley 2-Way Silicone
A4351	Straight Tip Urine Catheter
A4352	Coude Tip Urinary Catheter

HCPCS Code	Nomenclature
A4357	Bedside Drainage Bag
A4358	Urinary Leg Bag Or Abdomen Bag
A4521	Adult Size Diaper, Small Size
A4522	Adult Size Diaper, Medium Size
A4523	Adult Size Diaper, Large Size
A4524	Adult Size Diaper, Extra Large Size
A4525	Adult Size Brief, Small Size
A4526	Adult Size Brief, Medium Size
A4527	Adult Size Brief, Large Size
A4528	Adult Size Brief, Extra Large Size
A4529	Child Size Diaper, Small/Medium Size
A4530	Child Size Diaper, Large Size
A4531	Child Size Brief, Small/Medium Size
A4532	Child Size Brief, Large Size
A4533	Youth Size Diaper
A4534	Youth Size Brief
A4535	Disposable Incont Liner/Shield
A4536	Prot Underwear, Washable, Any Size
A4554	Disposable Underpads
A5112	Urinary Leg Bag; Latex
T1500	Diaper/Incont Pant, Reusable/Washable

***Use HCPCS code A4335 only to report belted/unbelted undergarment w/o sides. PA is not required up to the established quantity limit of 150 per month.

Quantity Limitations Based on Combination of Items Used

Diapers and Pull-on Briefs - For a beneficiary using both diapers and pull-on briefs, the combined total quantity of these items cannot exceed 300 per month. (The maximum amount of pull-on briefs is 150 per month even if the beneficiary is not using diapers.)

Diapers of Different Sizes - For a beneficiary using a combination of different sized diapers, the total quantity must not exceed 300 per month.

2.20 LIFTS (HYDRAULIC AND ELECTRIC)

Definition	Lifts include, but are not limited to, hydraulic and electric, and accessories include slings and/or seats.
Standards of Coverage	A standard **hydraulic lift** may be covered when the beneficiary requires assistance in transfers, provision of the lift will allow the beneficiary to be transferred safely, and one of the two conditions stated below are met: ▪ The beneficiary requires a one-person assist but the weight or size of the beneficiary prohibits safe transfers or could cause harm to the caregiver. ▪ The beneficiary requires a two-person assist and there are not two caregivers in the home. An **electric lift** may be covered when the above Standards of Coverage are met and the hydraulic lift cannot be used safely or when the beneficiary's medical condition results in increased tone (e.g., spasticity).
Documentation	Documentation must be less than 90 days old and include the following: ▪ Diagnosis/condition requiring use of the lift. ▪ Functional level of assistance required to complete activities of daily living (ADLs). ▪ Type of transfer required. ▪ Weight and height of the beneficiary. ▪ Type of lift requested. ▪ An occupational or physical therapy evaluation and recommendation. ▪ Number of caregivers in the home and number of hours during the 24-hour period that each caregiver is present.
PA Requirements	PA is not required if Standards of Coverage are met for**:** ▪ Hydraulic lifts ▪ Replacement slings or seats
	PA is required for: ▪ Electric lifts ▪ Replacement within ten years
Payment Rules	A lift may be a **capped rental** or **purchase** item. If unit is billed as a capped rental, the rental payment would be inclusive of the following: ▪ All accessories needed to use the equipment. ▪ Education on the proper use and care of the equipment. ▪ Routine servicing and all necessary repairs or replacements to make the unit functional.

2.21 MECHANICAL IN-EXSUFFLATION DEVICE

Definition	A mechanical in-exsufflation device is a portable electric device that utilizes a blower and a valve to alternately apply a positive and then a rapid negative pressure to an individual's airway to assist the person to cough more effectively.
Standards of Coverage	A mechanical in-exsufflation device may be covered for up to four months if the following applies: ▪ Diagnosis of respiratory failure due to neuromuscular deficits. ▪ Beneficiary is unable to cough or clear secretions effectively due to reduced peak expiratory force. ▪ Other treatment modalities have not been effective (e.g., inhalers, PEP mask therapy, or flutter devices). For coverage beyond four months, continued use of a mechanical in-exsufflation device may be covered when there is continued effectiveness.
Documentation	Documentation must be less than 180 days old and include the following: ▪ Diagnosis/medical condition related to the service requested. ▪ Current treatment modalities and any others already tried. ▪ Documentation of beneficiary's ability to use. ▪ Plan of care from a pulmonologist substantiating need for this device is **required under the CSHCS program.** For coverage beyond the first four months, a medical statement substantiating continued effectiveness is required.
PA Requirements	PA is required for all requests.
Payment Rules	A mechanical in-exsufflation device is a **capped rental** item and is inclusive of the following: ▪ All accessories needed to use the unit (e.g., circuits, filters etc.). ▪ Education on the proper use and care of the equipment. ▪ Routine servicing and all necessary repairs or replacements to make the unit functional.

2.22 NEBULIZER

Definition	A nebulizer is a powered device that allows a medication to be changed from a liquid to a mist so it may be effectively inhaled into the lungs. Types of nebulizers include, but are not limited to, standard and ultrasonic.

Standards of Coverage	A **standard nebulizer** device may be covered if: ▪ The beneficiary has a diagnosis related to an obstructive airway disease (e.g., asthma, bronchopulmonary dysplasia, chronic obstructive pulmonary disease [COPD], etc.). ▪ The physician has already considered use of a metered dose inhaler and it was insufficient to meet the needs of the beneficiary. An **ultrasonic nebulizer** is covered when a standard nebulizer is ineffective.
Documentation	Documentation must be less than 90 days old and include the following: ▪ Diagnosis/condition requiring use of the nebulizer. ▪ Medications prescribed. ▪ Frequency of administration. ▪ Medical reason economic alternatives are ineffective. ▪ For an ultrasonic nebulizer, pulmonary function testing done after use of a standard nebulizer and after use of an ultrasonic nebulizer showing the ultrasonic is more efficacious.
PA Requirements	PA is not required if Standards of Coverage are met for standard nebulizer and associated accessories up to established quantity limits
	PA is required for: ▪ Ultrasonic nebulizer. ▪ Replacement of standard nebulizer within five years. ▪ When the Standards of Coverage are not met.
Payment Rules	A nebulizer is considered either a **capped rental** or **purchase** item. Accessories are separately reimbursable. If unit is billed as a capped rental, the rental payment would be inclusive of the following: ▪ Education on the proper use and care of the equipment ▪ Routine servicing and all necessary repairs or replacements to make the unit functional

2.23 NEGATIVE PRESSURE WOUND THERAPY (PUMP AND ACCESSORIES)

Definition	Negative pressure wound therapy (NPWT) utilizes a sub-atmospheric (negative) pressure technique to reduce edema, increase localized blood flow and granulation tissue formation, and remove exudates from the wound. The NPWT pump must be able to apply pressure intermittently or continuously in a range from 25 – 125 mm HG and accommodate multiple wounds.

Standards of Coverage	Negative pressure wound therapy is covered for short-term therapy (seven to 14 days) if one of the following conditions applies and failure of several less expensive treatment modalities has occurred: ▪ Stage III or IV pressure ulcer(s) - ➢ Beneficiary has been part of a comprehensive ulcer management program (e.g., appropriately turned and positioned, appropriately managed for either moisture or incontinence, received adequate nutritional support, etc.) for at least the last 30 days. ➢ Beneficiary has used either a Group 2 or 3 Support Surface for at least the last 30 days. ▪ Diabetic Ulcers - Beneficiary has been on a comprehensive diabetic management program. ▪ Venous stasis ulcers - ➢ Compression bandages have been applied consistently. ➢ Mobility and leg elevation have been encouraged. ▪ Dehisced incisions or traumatic wounds - Wound care clinical protocols have been ineffective.
Documentation	All documentation, except wound measurements, must be less than 30 days old. Documentation of wound measurements must be less than seven days old and include the following: ▪ Evaluation, care and wound measurements by a licensed medical professional. ▪ All previous dressings tried. ▪ Debridement of necrotic tissue, if applicable. ▪ Evaluation and provision of adequate nutritional status. ▪ Appropriate turning/repositioning schedule. ▪ Incontinence management, if applicable. ▪ Appropriate pressure reduction addressed if wound is pressure related.
Continued Coverage	For continued coverage beyond the initial seven to 14 days, documentation must be submitted detailing updated wound measurements and substantiate continued effectiveness.
PA Requirements	PA is required for all requests.
Payment Rules	A negative pressure wound therapy pump is a **rental only** service. Payment for the pump is considered as a daily rental rate by reporting total number of days used as units. The canister and dressing set are considered **purchase** items and may be separately reimbursed from the pump code.

2.24 ORTHOPEDIC FOOTWEAR

Definition	Orthopedic footwear may include, but is not limited to, orthopedic shoes, surgical boots, removable inserts, Thomas heels, and lifts.

Standards of Coverage	**Orthopedic shoes and inserts** may be covered if any of the following applies: ▪ Required to accommodate a leg length discrepancy of ¼ inch or greater, or a size discrepancy between both feet of one size or greater. ▪ Required to accommodate needs related to a partial foot prosthesis, clubfoot, or plantar fascitis. ▪ Required to accommodate a brace (extra depth only are covered). **Surgical Boots or Shoes** may be covered to facilitate healing following foot surgery, trauma or a fracture.
Noncovered Items	Shoes and inserts are noncovered for the conditions of: ▪ Pes Planus or Talipes Planus (flat foot) ▪ Adductus metatarsus ▪ Calcaneus Valgus ▪ Hallux Valgus Standard shoes are also noncovered.
Documentation	Documentation must be less than 60 days old and include the following: ▪ Diagnosis/medical condition related to the service requested. ▪ Medical reasons for specific shoe type and/or modification. ▪ Functional need of the beneficiary. ▪ Reason for replacement, such as growth or medical change. **CSHCS requires** a prescription from an appropriate pediatric subspecialist.
PA Requirements	PA is not required for the following items if the Standards of Coverage are met: ▪ Surgical boots or shoes. ▪ Shoe modifications, such as lifts, heel wedges, or metatarsal bar wedges up to established quantity limits. ▪ Orthopedic shoe to accommodate a brace. ▪ Orthopedic shoes and inserts when the following medical conditions are present: ➢ Plantar Fascial Fibromatosis ➢ Unequal Leg Length (Acquired) ➢ Talipes Ezuinovarus (Clubfoot) ➢ Longitudinal Deficiency of Lower Limb, Not Elsewhere Classified ➢ Unilateral, without Mention of Complication (Partial Foot Amputation) ➢ Unilateral, Complicated (Partial Foot Amputation) ➢ Bilateral, without Mention of Complication (Partial Foot Amputation) ➢ Bilateral, Complicated (Partial Foot Amputation)

	PA is required for: ▪ All other medical conditions related to the need for orthopedic shoes and inserts not listed above. ▪ All orthopedic shoes and inserts if established quantity limits are exceeded. ▪ Medical need beyond the Standards of Care. ▪ For beneficiaries under the age of 21, replacement within six months. ▪ For beneficiaries over the age of 21, replacement within one year.
Payment Rules	These are **purchase only** items.

2.25 ORTHOTICS (CERVICAL)

Definition	Cervical orthotics include, but are not limited to, cervical collars and cranial helmets.
Standards of Coverage	**Cervical collars** may be covered to facilitate healing and/or restrict mobility for the following indications: ▪ Pre- and post-surgery ▪ Pre- and post-cervical fusion ▪ Cervical trauma ▪ Post-fractures
	Cervical helmets may be covered to prevent head injury for beneficiaries with medical conditions effecting balance that predisposes them to fall. For the medical condition of plagiocephaly, a **custom fabricated cranial remolding orthosis** is covered and must include the following: ▪ Proper measurements, including topography, casting, etc. ▪ The use of a FDA approved helmet. ▪ All necessary follow-up visits, including fitting and adjustments for 18 months after placement.
Documentation	Documentation must be less than 60 days old and include the following: ▪ Diagnosis/medical condition related to the service requested. ▪ Medical reasons for appliance requested. ▪ Functional needs of the beneficiary. ▪ Reason for replacement, such as growth or medical change. ▪ Prescription from an appropriate pediatric subspecialist is **required under the CSHCS program.** For repairs, a copy of the physician's prescription at the time of original placement and itemization of materials used to repair appliance or rationale for related labor costs must be documented.

PA Requirements	PA is not required when the Standards of Coverage are met for: ▪ Cervical collars. ▪ Nonmolded cranial helmets. ▪ Molded cranial helmets for a beneficiary under the age of one year with diagnosis of plagiocephaly when prescribed by an appropriate pediatric subspecialist. ▪ Repairs as follows: ➢ The total repair cost equals one hour of labor or less ➢ The cost of minor parts equals $50 or less
	PA is required for: ▪ Custom molded cranial helmets for conditions other than plagiocephaly. ▪ Replacement of a cranial nonmolded helmet or cervical collar within one year. ▪ Repair costs exceed the maximum limits as stated above.
Payment Rules	These are covered as **purchase only** items.

2.26 ORTHOTICS (LOWER EXTREMITY)

Definition	Lower extremity orthotics include, but are not limited to, hip, below knee, above knee, knee, ankle, and foot orthoses, etc.
Standards of Coverage	Lower extremity orthotics are covered to: ▪ Facilitate healing following surgery of a lower extremity. ▪ Support weak muscles due to neurological conditions. ▪ Improve function due to a congenital paralytic syndrome (i.e., Muscular Dystrophy).
Documentation	Documentation must be less than 60 days old and include the following: ▪ Diagnosis/medical condition related to the service requested. ▪ Medical reasons for appliance requested, including current functional level. ▪ A physical therapy evaluation may be required on a case-by-case basis when PA is required. ▪ Reason for replacement, such as growth or medical change. ▪ Prescription from an appropriate pediatric subspecialist is **required under the CSHCS program.** ▪ Medical justification for each additional component required. For repairs, a new prescription is not required if the original orthotic was covered by MDCH. A copy of the original prescription for the orthotic and itemization of materials used to repair appliance and rationale for related labor costs must be documented.

PA Requirements	PA is not required for the following if the Standards of Coverage are met: ▪ Fracture orthosis for fractures. ▪ Hip orthosis for Legg Perthes. ▪ Prefabricated knee appliances. ▪ Custom fabricated knee orthosis for Old Disruption of Anterior Cruciate Ligament. ▪ Prefabricated ankle foot orthosis (AFO) and knee ankle foot orthosis (KAFO). ▪ Custom fabricated plastic AFOs if up to four additional components with the base code as indicated in the Medical Supplier Database (add-ons include: double action joints, t-strap or malleolar pad, varus/valgus modification and soft interface). ▪ Custom fabricated metal AFOs if up to six additional components with the base code as indicated in the Medical Supplier Database (add-ons include: double action joints, noncorrosive finish, t-strap or malleolar pad, extended steel shank, long tongue stirrup and growth extensions). Shoes are not considered an add-on and would be considered in addition to the other items. ▪ Custom fabricated plastic KAFOs if up to eight additional components with the base code as indicated in the Medical Supplier Database (add-ons include: double action joints, t-strap or malleolus pad, drop lock, varus/valgus modification, noncorrosive finish, knee cap, soft interface and growth extensions). ▪ Custom fabricated metal KAFOs if up to eight additional components with the base code as indicated in the Medical Supplier Database (add-ons include: double action joints, t-strap or malleolus pad, drop lock, growth extensions, noncorrosive finish, knee cap, extended steel shank and long tongue stirrup). Shoes are not considered an add-on and would be considered in addition to the other items. If other add-on items are not listed above or a greater number of components are medically necessary, PA is required for the entire appliance. Additional components are not covered simply to add reimbursement value to the appliance. For **repairs**, up to two episodes per year, as follows: ▪ The total repair cost equals one hour of labor or less. ▪ The cost of minor parts equals $50 or less.
	PA is required for: ▪ Custom fabricated knee orthoses for all other diagnoses/medical conditions. ▪ Hip Knee Ankle Foot Orthosis (HKAFOs) for all other diagnoses/medical conditions. ▪ Fracture orthosis for all other diagnoses/medical conditions. ▪ Other base codes or additional codes indicated as requiring PA in the Medical Supplier Database. ▪ Repair costs exceed the maximum limits as stated above. ▪ Replacement within six months for a beneficiary under the age of 21. ▪ Replacement within two years for a beneficiary over the age of 21.
Payment Rules	These are covered as **purchase only** items.

2.27 ORTHOTICS (SPINAL)

Definition	Spinal orthotics include, but are not limited to, cervical, thoracic, lumbar, sacral, spinal, thoracic mid belt lumbar sacral, and sacroiliac orthotics.
Standards of Coverage	Spinal orthotics are covered to: ▪ Facilitate healing following a spinal injury. ▪ Arrest or correct the curvature of the spine or spondylothesis greater than grade 1. ▪ Support weak spinal muscles due to atrophy and/or a deformed spine. ▪ Facilitate healing following spinal surgery.
Documentation	Documentation must be less than 60 days old and include the following: ▪ Diagnosis/medical condition related to the service requested. ▪ Medical reasons for appliance. ▪ Functional needs of the beneficiary. ▪ Reason for replacement, such as growth or medical change. ▪ Prescription from an appropriate pediatric subspecialist is **required under the CSHCS program.** For **repairs**, a new prescription is not required if the original orthotic was covered by MDCH. A copy of the original prescription for the orthotic and itemization of materials used to repair appliance and rationale for related labor costs must be documented.
PA Requirements	PA is not required for the following if the Standards of Coverage are met: ▪ Prefabricated thoracic-lumbar-sacral orthosis (TLSOs) ▪ Prefabricated lumbar sacral orthosis (LSOs) ▪ Prefabricated sacroiliac supports ▪ Cervical-Thoracic-Lumbar-Sacral Orthosis (CTLSOs) for the treatment of curvature of the spine ▪ Custom fabricated TLSOs, LSOs, and sacroiliac supports for the Base code and up to three additional components indicated on the database and with one of the following diagnoses: ➢ Neurofibromatosis, Type 1 ➢ Scoliosis (and Kyphoscoliosis), Idiopathic ➢ Progressive Infantile Idiopathic Scoliosis ➢ Curvature of Spine (Scoliosis) ** ➢ Certain Congenital Musculoskeletal Deformities of the Spine ➢ Spondylolisthesis **Curvature of the spine (scoliosis) must be listed in conjunction with the other conditions of Charcot-Marie-Tooth Disease or Neurofibromatosis to not require PA. ▪ For **repairs**, up to two episodes per year, as follows: ➢ The total repair cost equals one hour of labor or less. ➢ The cost of minor parts equals $50 or less.

	PA is required for: ▪ Diagnosis/medical conditions not removed from PA. ▪ Repair costs exceed the maximum limits as stated above. ▪ Replacement within one year for a beneficiary under the age of 21, from the original service date. ▪ Replacement within two years for a beneficiary over the age of 21, from the original service date.
Payment Rules	These are covered as **purchase only** items.

2.28 ORTHOTICS (UPPER EXTREMITY)

Definition	Upper extremity orthotics includes, but are not limited to, shoulder, elbow, wrist, and hand orthotics.
Standards of Coverage	Upper extremity orthoses are covered: ▪ Following an acute cerebral vascular accident. ▪ To support weak muscles due to a neuromuscular condition. ▪ Facilitate healing immediately following surgery. ▪ Improve function due to a congenital paralytic syndrome (e.g., Muscular Dystrophy).
Documentation	Documentation must be less than 60 days old and include the following: ▪ Diagnosis/medical condition related to the service requested. ▪ Medical reasons for appliance requested. ▪ Functional needs of the beneficiary. ▪ Reason for replacement such as growth or medical change. ▪ Prescription from an appropriate pediatric subspecialist is **required under the CSHCS program.** For **repairs**, a new prescription is not required if the original orthotic was covered by MDCH. A copy of the original prescription for the orthotic and itemization of materials used to repair appliance and rationale for related labor costs must be documented.
PA Requirements	PA is not required for the following if the Standards of Coverage are met: ▪ Prefabricated shoulder orthosis (SOs), elbow orthoses (EOs) and shoulder-wrist-hand orthosis (SEWHOs). ▪ Custom fabricated SOs, EOs and SEWHOs if the base code and up to two additional components are needed. ▪ Prefabricated upper extremity fracture orthosis if the treatment is related to a fracture related condition. ▪ Custom fabricated upper extremity fracture orthosis if the base code and up to two additional components are needed. ▪ Prefabricated wrist-hand-finger orthosis (WHFOs) and hand-finger orthoses (HFOs).

	▪ For **repairs** as follows: ➢ The total repair cost equals one hour of labor or less. ➢ The cost of minor parts equals $50 or less.
	PA is required for: ▪ Custom fabricated WHFOs and HFOs. ▪ Repair costs that exceed the maximum limits as stated above. ▪ Replacement within one year for a beneficiary under the age of 21, from the original service date. ▪ Replacement within two years for a beneficiary over the age of 21, from the original service date.
Payment Rules	These are covered as **purchase only** items.

2.29 OSTEOGENSIS STIMULATORS

Definition	An Osteogensis Stimulator is a device that provides electrical stimulation to augment bone repair. A noninvasive electrical stimulator is characterized by an external power source, which is attached to a coil or electrodes placed on the skin or on a cast or brace over a fracture or fusion site. The stimulator includes, but is not limited to, the Osteogensis stimulator, electrical, noninvasive, other than spinal applications and Osteogensis stimulator, electrical, noninvasive, spinal applications.
Standards of Coverage	A **nonspinal electrical osteogensis stimulator** may be covered for up to 90 days when other treatment methods have been ineffective and when one of the following applies: ▪ There is a nonunion of a long bone fracture and radiographic evidence indicates that the fracture healing has ceased for three or more months. ▪ If there is failed fusion of a joint other than in the spine where a minimum of nine months has elapsed since the surgery. ▪ Congential Pseudoarthrosis. A **spinal electrical osteogensis stimulator** may be covered for up to 90 days when other treatment methods have been ineffective and when one of the following applies: ▪ There is a failed spinal fusion where a minimum of nine months has elapsed since the last surgery. ▪ Following multilevel (three or more vertebrae) spinal fusion surgery without internal fixation. ▪ Following spinal fusion surgery where there is a history of a previously failed spinal fusion at the same level or levels.
Documentation	Documentation must be less than 90 days old and include all of the following: ▪ Diagnosis/medical condition related to the need for the device. ▪ A minimum of two sets of radiographs, prior to placement of the device, of multiple views and at least 90 days apart. ▪ Alternative treatment methods tried and results. ▪ Other modalities still to be used (include type and location.)

PA Requirements	PA is required.
Payment Rules	Osteogenesis Stimulators are considered a **rental only** item and are inclusive of the following: ▪ All Accessories needed to use the unit (e.g., electrodes, wires, cables, etc.). ▪ Education on the proper use and care of the equipment. ▪ Routine servicing and all necessary repairs or replacement to make the unit functional.

2.30 OSTOMY SUPPLIES

Definition	Ostomy supplies are those products necessary to maintain and care for a temporary or permanent stoma and include, but are not limited to, belts, barriers, adhesive remover, filters and pouches.
Standards of Coverage	**Standard wear ostomy products** are changed daily and are covered for specified quantities when the beneficiary has an ostomy. **Extended wear ostomy products** may be covered when change is not required on a daily basis and the quantities must match manufacturers' recommendations for use.
Documentation	Documentation must be less than 90 days old and include the following: ▪ Diagnosis/medical condition. ▪ Appliance required. ▪ Quantity of item. ▪ Frequency of change. ▪ Type and location of ostomy. ▪ Condition of the skin surface surrounding the stoma.
PA Requirements	PA is not required for ostomy supplies up to established quantity limits.
	PA is required for quantities above established Program limits.
Payment Rules	These are **purchase only** items.

2.31 OXYGEN, OXYGEN EQUIPMENT AND ACCESSORIES

Definition	Oxygen therapy includes, but is not limited to, stationary compressed systems, portable gaseous systems, stationary liquid systems, portable liquid systems, and concentrators.
Standards of Coverage	Stationary oxygen equipment and accessories may be covered in the home setting for either short-term (less than six months) or long-term (six months or greater) use. **For beneficiaries under age 21**, oxygen therapy may be covered when oxygen is required during a variety of activities (e.g., sleeping, feeding, resting) and there is an oxygen saturation rate of 93 percent or below or PO2 level of 65 mm HG or below. **For beneficiaries age 21 and older,** when the beneficiary requires oxygen for continuous use (test taken while the beneficiary is at rest, breathing room air), nocturnal use (test taken while sleeping), or exercise use (test taken during exercise) and the oxygen saturation rate is 88 percent or below or the PO2 level is 55 mm HG or below.

	Once the Standards of Coverage are met, the type of equipment covered is determined by the following: ▪ Medical diagnosis or condition related to the need for oxygen. ▪ Activity level. ▪ Amount of liter flow needed. The three main types of oxygen systems are: ▪ **Compressed Oxygen System** – Used primarily for intermittent use or low liter flow requirements (less than one liter per minute). A portable unit may be authorized if activities cannot be accomplished by the use of a stationary alone. ▪ **Concentrators -** Used for higher liter flows, usually one liter or more. A portable compressed oxygen unit may be authorized if activities cannot be accomplished by the use of a concentrator alone. ▪ **Liquid Oxygen System -** Used for high liter flow requirements. Liter flow must be ordered at more than four liters per minute. In cases where liquid oxygen is inappropriate, a compressed gas or concentrator system could be covered if criteria for that unit are met.
Documentation	Documentation must be less than 30 days old and include the following: ▪ Diagnosis/medical condition appropriate for the need of oxygen. ▪ Required liter flow (e.g., two liters per minute). An order for "Oxygen PRN" or "Oxygen as Needed" does not meet this requirement. ▪ Hours used per day (e.g., eight hours a day). For intermittent use (less than eight hours per day), indicate activity or time of day. An order for "Oxygen PRN" or "Oxygen as Needed" does not meet this requirement. ▪ Duration of need (e.g., three months, six months or lifetime). ▪ Delivery system to be used (e.g., concentrator, compressed gas, liquid). ▪ Current oxygen saturation level or PO2 level. ▪ For liquid oxygen, total number of pounds required per month. ▪ A prescription from a pediatric pulmonologist, a neonatologist, a pediatrician intensivist, and/or pediatric cardiologist is **required under the CSHCS program.** **After the initial prescription for home oxygen**, a six-month follow-up prescription and/or CMN must be obtained. At this time, a new oximetry or ABG test result must be obtained to substantiate the continued need for treatment. Thereafter, a prescription is only required on an annual basis. An updated lab test is required only when there is a change in equipment need or level of oxygen usage.
	Equipment Maintenance - Verification of the proper use, care and function (e.g., verification that the equipment delivers the proper percentage of liter flow) must be performed according to the manufacturer's requirements. The following information must also be maintained in the patient's file: ▪ The name of the manufacturer. ▪ The manufacturer's requirements for verification of proper use, care and function of the equipment. ▪ The date that each equipment verification was performed.

<table>
<tr><td>PA Requirements</td><td>PA is not required for gaseous stationary, concentrators, and portable oxygen systems if the Standards of Coverage are met and the beneficiary has one of the following diagnoses:
<table>
<tr><th>Diagnosis Description</th><th>Diagnosis Description</th></tr>
<tr><td>Pulmonary Tuberculosis</td><td>Other Emphysema</td></tr>
<tr><td>Coccidioidomycosis</td><td>Bronchiectasis</td></tr>
<tr><td>Malignant Neoplasm of Trachea, Bronchus, and Lung</td><td>Chronic Airway Obstruction</td></tr>
<tr><td>Secondary Malignant Neoplasm of Respiratory and Digestive Systems</td><td>Pneumoconioses and other Lung Diseases due to External Agents</td></tr>
<tr><td>Other and Unspecified Disorders of Metabolism (Cystic Fibrosis)</td><td>Postinflammatory Pulmonary Fibrosis</td></tr>
<tr><td>Other Diseases of Blood and Blood–Forming Organs (Secondary Polycythemia, Familial Polycythemia)</td><td>Other Alveolar and Parietoalveolar Pneumonopathy</td></tr>
<tr><td>Myoneural Disorders</td><td>Pulmonary Eosenophilia</td></tr>
<tr><td>Muscular Dystrophies and other Myopathies</td><td>Tracheomalacia</td></tr>
<tr><td>Chronic Pulmonary Heart Disease</td><td>Congenital Heart Disease</td></tr>
<tr><td>Heart Failure</td><td>Bronchopulmonary Disease</td></tr>
<tr><td>Chronic Bronchitis</td><td></td></tr>
</table>
PA is not required for gaseous stationary or concentrators for the condition of obstructive sleep apnea.</td></tr>
<tr><td></td><td>PA is required for:
Oxygen required for short-term use only.
Liquid oxygen systems.
Liquid oxygen contents only.
Medical need for long-term oxygen use does not meet Standards of Coverage.</td></tr>
<tr><td>Payment Rules</td><td>All oxygen equipment is a rental only and is inclusive of the following:
All necessary accessories (e.g., regulator, tubing, mask or cannula, contents base, etc.). Stationary gaseous or liquid oxygen contents are separately payable only when the patient owns the equipment and the coverage criteria has been met.
The rental payment includes routine servicing and all necessary repairs or replacements to make the rented DME functional. The equipment should be checked according to manufacturer's specifications.</td></tr>
</table>

	Combination of Equipment Covered: ▪ Only one delivery method is covered per month (i.e., gaseous, gaseous/concentrator or liquid). ▪ A portable compressed gaseous system or liquid system will only be provided in addition to an existing stationary system, unless oxygen is needed for ambulation only. ▪ A backup cylinder is considered part of the inclusive reimbursement for the oxygen system.
	Nursing Facility Residents: ▪ For a nursing facility resident, the DME provider may bill for oxygen gas, equipment, and supplies only when used for prolonged daily use. Intermittent or infrequent use of these items is included in the nursing facility per diem rate. ▪ For a County Medical Care Facility or Hospital Long Term Care Unit, the DME provider cannot bill for oxygen gas, equipment and supplies for any resident. Frequent or prolonged use is defined as: ▪ Long-term daily basis. ▪ At least eight hours duration or more per day.

2.32 PARENTERAL NUTRITION

Definition	Parenteral nutrition is the provision of nutrition intravenously.
Standards of Coverage	Parenteral nutrition may be covered when: ▪ There is an impairment or disease of the gastrointestinal track that impairs the ability of nutrients to be digested and absorbed. ▪ Post-surgical nonabsorption from a recent massive small bowel resection leaving less than five feet of small bowel remaining beyond the ligament of Treitz or short bowel syndrome with severity that involves a net gastrointestinal fluid and electrolyte malabsorption in which the enteral losses exceed 50 percent of oral/enteral intake.
Documentation	Documentation must be less than 30 days old and include the following: ▪ Specific diagnosis related to the beneficiary's inability to take or eat regular food. ▪ Amount of nutrients needed per day. ▪ Duration of treatment. ▪ Current height, weight, and recent weight loss. ▪ Identification of levels of individual nutrient(s) that are required in increased or restricted amounts.
PA Requirements	PA is not required for parenteral equipment, supplies, and solutions when the Standards of Coverage have been met, and one of the following diagnoses exists: ▪ Noninfectious Enteritis of the Small Intestine ▪ Noninfectious Enteritis of the Large Intestine ▪ Unspecified Intestinal Obstruction

	▪ Fistula of Intestine, Excluding Rectum and Anus ▪ Acute Pancreatitis ▪ Chronic Pancreatitis ▪ Cyst And Pseudocyst of Pancreas ▪ Other and Unspecified Post-Surgical NonAbsorption
Payment Rules	Parenteral nutrition must be billed as a daily rate by reporting total number of days used as units. The parenteral lipids, the parenteral pre-mix solution, the infusion pump, supply kit, and the administration kit may be billed in combination with each other. If reporting parenteral lipids without one of the parenteral pre-mix solutions, only the pump code is separately reimbursable. The administration kit includes all items necessary for the administration of the solution (e.g., the extension sets, pump cassettes, clamps, containers, and connectors). The supply kit includes all necessary medical supplies such as dressings, tape, alcohol wipes, filters, syringes, needles, and injection caps. For Medicaid beneficiaries residing in a nursing facility, the parenteral solution, equipment and supplies may be billed by the medical supplier.

2.33 PEAK FLOW METER

Definition	A peak flow meter is a small device used to measure the air flow out of the lungs.
Standards of Coverage	A peak flow meter may be covered if the beneficiary has a diagnosis related to an obstructive airway disease (e.g., asthma, COPD).
Documentation	Documentation must be less than 90 days old and include the following: ▪ Diagnosis/condition related to the need for the meter. ▪ Frequency of use.
PA Requirements	PA is not required if the Standards of Coverage have been met.
	PA is required when: ▪ Medical need is beyond Standards of Coverage. ▪ Replacement is required within one year.
Payment Rules	This is a **purchase only** item.

2.34 PHOTOTHERAPY (BILIRUBIN) LIGHT WITH PHOTOMETER

Definition	A phototherapy light with photometer is an ultraviolet light source used to reduce bilirubin levels.
Standards of Coverage	A phototherapy light may be covered if: ▪ The beneficiary is being treated for the diagnosis of neonatal jaundice. ▪ The treatment is limited to seven consecutive days and occurs during the first 30 days of life.
Documentation	Documentation must be less than 24 hours old and include: ▪ Diagnosis/condition related to the need for the device. ▪ Duration of need.

PA Requirements	PA is not required if the Standards of Coverage are met and there is one of the following diagnoses: ▪ Optic Papillitis ▪ Hemolytic Disease due to Other and Unspecified Isoimmunization ▪ Perinatal Jaundice from Other Excessive Hemolysis ▪ Neonatal Janudice Associated with Pre-term Delivery ▪ Neonatal Jaundice due to Delayed Conjugation from Other Cases ▪ Unspecified Fetal and Neonatal Jaundice ▪ Kernicterus not due to Isoimmunization
	PA is required for: ▪ Diagnosis/medical condition other than those listed above. ▪ Medical need is beyond the Standards of Coverage.
Payment Rules	A phototherapy light with photometer is a **rental only** item, and is inclusive of the following: ▪ All accessories needed to use the unit (e.g., ultraviolet light source, a fiberoptic system with fiberoptic blanket if needed, etc.). ▪ Education on the proper use and care of the equipment. ▪ Routine servicing and all necessary repairs or replacements to make the unit functional.

2.35 PNEUMATIC COMPRESSORS AND APPLIANCES (LYMPHEDEMA PUMP)

Definition	Pneumatic compressors and appliances may be either nonsegmented or segmented, with or without calibrated gradient pressure. An integral part of treatment, along with the pneumatic compression device, is leg or arm elevation and the use of custom fabricated gradient pressure stockings or sleeves, compression bandaging, etc.
Standards of Coverage	A pneumatic compression device may be covered only as a treatment of last resort (e.g., other less intensive treatment has not been effective). A **nonsegmented device or segmented device without manual control** of the pressure in each chamber may be covered for up to 90 days for any of the following: ▪ Radical surgical procedures with removal of regional groups of lymph nodes (e.g., radical mastectomy). ▪ Post-radiation fibrosis. ▪ Metastasis of malignant tumors to regional lymph nodes with lymphatic obstruction. ▪ Scarring of lymphatic channels if: ➢ There is significant ulceration of the lower extremity(ies); and ➢ The beneficiary has received repeated, standard treatments from a physician using such methods as a compression bandage system or its equivalent.

	▪ Treatment of chronic venous insufficiency with edema and/or venous ulcers. ▪ Milroy's Disease. ▪ Congenital anomalies. ▪ Refractory lymphedema related to venous insufficiency complicated by recurrent cellulitis (scarring of the lymphatic channels). A **segmented device with calibrated gradient pressure** may be covered when there is a painful focal lesion (e.g., significant sensitive skin scar or contracture) of the extremity that requires a reduction in pressure over the affected segment.
Documentation	The Documentation must be less than 30 days old and include the following: ▪ Diagnosis/condition appropriate for the equipment requested. ▪ Location and size of the painful focal lesion(s), which necessitates the use of the device, if applicable. ▪ Length of time each lesion has been continuously present. ▪ Plan of treatment including the frequency and duration of each treatment episode and anticipated prognosis. ▪ Type of unit to be used, the necessary pressure in each chamber and why the specific features of the equipment are needed. ▪ Description of other treatments that have been tried.
Continued Use After the Initial 90 Days	For continued coverage beyond the initial 90 days, the following additional information must be provided: ▪ Bilateral limb measurements before and after the approved treatment. ▪ Results of the treatment provided.
PA Requirements	PA is required for all requests for this item.
Payment Rules	A unit may be a **capped rental** or **purchase** item. If unit is billed as a capped rental, the rental payment would be inclusive of the following: ▪ All accessories needed to use the equipment. ▪ Education on the proper use and care of the equipment. ▪ Routine servicing and all necessary repairs or replacements to make the unit functional.

2.36 PRESSURE GRADIENT PRODUCTS

Definition	Pressure gradient products include, but are not limited to, sleeves, wrist gauntlets, vests, legs, etc.
Standards of Coverage	Pressure gradient products may be covered to reduce edema, promote circulation, reduce scarring or reduce retention of fluid in the extremities due to the following conditions: ▪ Lymphedema ▪ Chronic venous insufficiency ▪ Thrombophlebitis

	▪ Burns Up to two garments may be covered when the items must be worn for 24 hours.
Documentation	Documentation must be less than 60 days old and include the following: ▪ Diagnosis of condition being treated. ▪ Item to be dispensed. ▪ Number of hours to be worn. ▪ Location and number of extremities involved.
PA Requirements	PA is not required for ready-made pressure gradient products up to established quantity limits.
	PA is required for: ▪ All custom-made products and special features such as a zipper, enclosed toe, open pubis, etc. ▪ Replacement within three months.
Payment Rules	All pressure gradient products are considered a **purchase only** item.

2.37 PROSTHETICS (LOWER EXTREMITIES)

Definition	Lower extremity prosthetics include, but are not limited to, partial foot, below knee, above knee, hip and hemi-pelvectomy prostheses.
Standards of Coverage	A **lower extremity prosthesis** may be covered to restore mobility for an beneficiary who demonstrates the ability to transfer and/or ambulate and the beneficiary's potential functional level is between the ranges of K1 through K4.
Documentation	Documentation must be less than 60 days old and include the following: ▪ Diagnosis/medical condition related to the service requested. ▪ Current functional "K" level. ▪ An occupational or physical therapy evaluation may be required on a case-by-case basis when PA is required.
PA Requirements	**Below Knee Prosthesis** ▪ PA is not required for a below knee preparatory prosthesis when the Standards of Coverage are met and it consists of a base code and the following add-ons: one test socket, insert, and/or suspension system. Socks and sheaths are not considered as add-ons and would be considered in addition to the other items. ▪ PA is not required for an exoskeletal below knee definitive prosthesis when the Standards of Coverage are met and it consists of a base code and the following add-ons: up to two test sockets, foot, insert, socket material, socket design, and/or suspension system. Socks and sheaths are not considered as add-ons and would be considered in addition to the other items. ▪ PA is not required for an endoskeletal below knee definitive prosthesis when the Standards of Coverage are met and it consists of a base code and the following add-ons: up to two test sockets, foot, insert, socket material, socket design, and/or suspension system. Socks and sheaths are not considered as add-ons and would be considered in addition to the other items.

	Above Knee Prosthesis ▪ PA is not required for an above knee preparatory prosthesis when the Standards of Coverage are met and it consists of a base code and the following add-ons: one test socket, foot, knee, socket design and/or suspension system. Socks and sheaths are not considered as add-ons and would be considered in addition to the other items. ▪ PA is not required for an exoskeletal above knee definitive prosthesis when the Standards of Coverage are met and it consists of a base code and the following add-ons: up to two test sockets, foot, knee, insert, socket material, socket design, and/or suspension system. Socks and sheaths are not considered as add-ons and would be considered in addition to the other items. Refer to the Medical Supplier Database for the specific codes removed from PA. For **repairs**, up to two episodes per year, as follows: ▪ The total repair cost equals one hour of labor or less. ▪ The cost of minor parts equals $50 or less.
	PA is required when: ▪ The Standards of Coverage are not met. ▪ Other base codes or additional codes not indicated on the Medical Supplier Database as removed from PA are required then PA is required for the entire appliance. ▪ The beneficiary is over the age of 21 and replacement is required within five years. ▪ The beneficiary is under the age of 21 and replacement is required within two years.
Payment Rules	These are **purchase only** items.

2.38 PULSE OXIMETER

Definition	A pulse oximeter is a noninvasive device that measures arterial oxygen saturation levels and pulse rate. The device consists of a sensor attached to the patient's finger or ear lobe that is linked to a processing unit that delivers a read-out.
Standards of Coverage	Pulse oximeter may be covered: ▪ **For beneficiaries 21 or over** as a diagnostic tool for short-term rental (one month) if ordered for oxygen or ventilator weaning in the home ▪ **For beneficiaries under 21**: ➢ As a diagnostic tool for short-term rental (one month) when there are suspected desaturations during sleep, stress, or feeding. ➢ Up to six months with a diagnosis requiring oxygen use. ➢ Up to six months for beneficiaries with a tracheostomy.
Documentation	Documentation must be less than 90 days old and include the following: ▪ Diagnosis/medical condition related to the need for the unit. ▪ Treatment plan addressing what is to be done for abnormal readings. ▪ Current oxygen orders, if applicable.

	▪ For coverage beyond the initial six-month period, an evaluation by an appropriate subspecialist is required (e.g., pediatric pulmonologist, pediatric cardiologist, neurologist, ENT, or pediatric internist) is **required under the CSHCS program**.
PA Requirements	PA is not required when the Standards of Coverage are met, the beneficiary is under 21, and has one of the following diagnoses: ▪ Tracheostomy (Artificial Opening Status) ▪ Tracheostomy (Attention to Artificial Openings)
	PA is required: ▪ For all beneficiaries over the age of 21. ▪ When the Standards of Coverage are not met.
Payment Rules	A pulse oximeter is a **capped rental** item and is inclusive of the following: ▪ All accessories needed to use the unit (e.g., nondisposable infant or adult oximeter probes, cables, etc). ▪ Education on the proper use and care of the equipment. ▪ Routine servicing and all necessary repairs or replacements to make the unit functional. ▪ Periodic downloading of recorded data.

2.39 SPEECH GENERATING DEVICES (SGD)

Definition	A Speech Generating Device (SGD) is defined as any electric or nonelectric aid or device that replaces or enhances lost communication skills. The device must be an integral part of a treatment plan for a person with a severe communication disability who is otherwise unable to communicate basic functional needs.
Standards of Coverage	SGDs may be covered under the following conditions for beneficiaries who demonstrate the comprehension and physical skills necessary to communicate using the requested device. ▪ **Prosthetic Function -** To replace a missing body part, to prevent or correct physical deformity or malfunction, or to support a weak or deformed portion of the body. ▪ **Rehabilitative Function -** To restore communication skills to the previous functional level by providing a tool to the beneficiary. A speech-language pathologist in conjunction with other disciplines, such as occupational therapists, physical therapists, psychologists, and seating specialists as needed, must provide a thorough and systematic evaluation of the beneficiary's receptive and expressive communication abilities. Ancillary professionals must possess proper credentials (certification, license, and registration, etc., as appropriate). SGD vendors (manufacturers, distributors) may not submit assessment information or justification for any requested SGD.

	Frequency - The program will purchase new equipment only. Only one SGD will be purchased within a three-year period for beneficiaries under age 21. Only one SGD will be purchased within five years for beneficiaries age 21 and older. Exceptions may be considered in situations where there has been a recent and significant change in the beneficiary's medical or functional status relative to the beneficiary's communication skills.
	Warranty - The warranty period begins at the point when the device is in the beneficiary's home and the beneficiary has received adequate training to use his system for functional communication.
	Repairs - Repairs for augmentative communication devices (SGD) are covered after the warranty expires for no more than one SGD per beneficiary. Additionally, repair of an SGD not purchased by MDCH is covered only if the SGD is determined to be necessary to meet basic functional communication needs in accordance with the criteria for SGD coverage.
Documentation	Documentation must be within 90 days old and include: ▪ Medical diagnosis. (The medical diagnosis must directly relate to the beneficiary's communication deficit.) ▪ Specifications for the SGD. (Refer to the ACD Evaluation Form [MSA-1653-C] in the Forms Appendix.) ▪ Necessary therapy and training to allow the beneficiary to meet functional needs. All SGD evaluation documentation must be submitted using the MSA-1653-C. Documentation for modifications must indicate the changes in the beneficiary's functional or medical status that necessitate the need for modifications in the system or parts. When a current SGD needs replacement and the replacement is **identical** to the SGD previously purchased by MDCH, the documentation required is: ▪ Clinical confirmation of continued suitability by a speech-language pathologist. ▪ Clinical confirmation of ability to functionally access a SGD by a speech-language pathologist and occupational or physical therapist. ▪ Cost of the repair and the cost of replacement. When a current SGD needs replacement and the replacement is **different** than the SGD previously purchased by the program, a new SGD Evaluation must be conducted utilizing MSA-1653-C. Additional documentation required is a statement that indicates how the current system no longer meets the beneficiary's functional communication needs. A current re-evaluation is required for any device that is not identical to the device being replaced. For replacements due to loss or damage, indicate the following additional documentation: ▪ The cause of the loss or damage; and ▪ The plan to prevent recurrence of the loss or damage.
PA Requirements	The speech-language pathologist performs the functional communication assessment and SGD evaluation and initiates the PA request with a medical supplier that has a specialty enrollment with the MDCH to provide SGDs. Providers may contact the Provider Enrollment Unit at the MDCH for enrollment information. (Refer to Directory Appendix for contact information.)

	PA is required for all SGD systems. The MSA-1653-C specifies all documentation requirements and must accompany the Special Services Prior Approval – Request/Authorization (MSA-1653-B) when requesting authorization for an SGD. A copy of the physician prescription must be submitted with the request for an SGD. The prescription must be based on the evaluation of an individual's communication abilities and medical needs made by a speech-language pathologist and other evaluation team members (as appropriate).
	Modifications - All modifications and upgrades for SGDs require PA. Indicate the procedure code that defines the modifications requesting PA for modifications and upgrades.
	Repairs - For a repair, report HCPCS code E1340 (for the labor charge) and HCPCS code E1399 (for the replacement part). PA is required for all repairs. If repair charges exceed a $150.00, a speech-language pathologist, occupational therapist, or physical therapist must conduct an evaluation. A statement must be included in the evaluation indicating whether the current SGD continues to meet the beneficiary's functional needs. If the beneficiary's needs are being met with the current system, PA may be granted. Each repair must consist of a thorough assessment of the general working condition of the entire system so that frequent repairs may be avoided. If additional repairs to the system are needed, PA for those additional services must be obtained. In some cases, it may be more costly to repair the SGD than to replace it. When requesting PA for a repair, provide the cost of the repair and the cost of the replacement so that determination can be made by MDCH whether to repair or replace the device.
	Replacements - All replacements (identical, upgrades, downgrades) of an SGD require PA.
Payment Rules	**Purchase** - MDCH will purchase new equipment only. The serial number of the device purchased must be maintained on file by the vendor for audit purposes. Shipping and handling fees relating to the SGD equipment are not separately reimbursed. Reimbursement includes the charges for the SGD and all approved components. The provider's charge for an SGD must be based on the usual and customary charge. Reimbursement will be the lesser of the provider's charge and/or the Medicaid fee screen.
	Rental - MDCH will rent equipment or devices when the purchase price of the device including the component parts exceeds $9,000.00. Equipment will not be rented for a period of less than 30 days and may be rented for a maximum period of 90 days. The monthly rental reimbursement rate will be 1/10 of the maximum purchase reimbursement. The amount reimbursed for rental will be deducted from the total purchase price.

2.40 SUPPORT SURFACES – GROUP 1

Definition	Pressure Reducing Support Surfaces – Group 1 include, but are not limited to, alternating pressure pad and pump; water, air, or dry pressure mattresses; or gel or gel-like pressure pads. A Group 1 support surface must provide both a waterproof cover and adequate support to prevent the beneficiary from "bottoming out" with the use of the item.
Standards of Coverage	A Group 1 mattress overlay or mattress may be covered if one of the following applies: The beneficiary: ▪ Is completely immobile (i.e., cannot make changes in body position without assistance). ▪ Has limited mobility (i.e., cannot independently make changes in body position significant enough to alleviate pressure) with the presence of at least one of the additional conditions: ➢ Impaired nutritional status; ➢ Fecal or urinary incontinence; ➢ Altered sensory perception; or ➢ Compromised circulatory status. ▪ Has any stage pressure ulcer on the trunk or pelvis with the presence of at least one of the additional conditions: ➢ Impaired nutritional status; ➢ Fecal or urinary incontinence; ➢ Altered sensory perception; or ➢ Compromised circulatory status.
Documentation	Documentation must be less than 30 days old and include the following: ▪ Education of the beneficiary and/or caregiver on the prevention and/or management of pressure ulcers. ▪ Diagnosis/medical condition related to need for the item. ▪ Regular assessment by a nurse, physician, or other licensed healthcare practitioner. ▪ Appropriate turning and positioning. ▪ Appropriate wound care (for a Stage II, III, or IV ulcer). ▪ Appropriate management of moisture/incontinence. ▪ Wound size, stage and location (for a Stage II, III or IV ulcer). ▪ Nutritional assessment and intervention consistent with the overall plan of care.

<table>
<tr><td>PA Requirements</td><td>PA is not required for HCPCS codes A4640, E0180, E0184, E0185, E0186, E0187 or E0197 if the Standards of Coverage are met and one of the following diagnoses is present:
<table>
<tr><th>Diagnosis Description</th></tr>
<tr><td>Neurofibromatosis</td></tr>
<tr><td>Cerebral Degenerations Usually Manifested in Childhood</td></tr>
<tr><td>Parkinson’s Disease</td></tr>
<tr><td>Huntington’s Chorea</td></tr>
<tr><td>Spinocerebellar Disease</td></tr>
<tr><td>Anterior Horn Cell Disease</td></tr>
<tr><td>Multiple Sclerosis</td></tr>
<tr><td>Other Demyelinating Disease of Central Nervous System</td></tr>
<tr><td>Hemiphegia and Hemiparesis</td></tr>
<tr><td>Infantile Cerebral Palsy</td></tr>
<tr><td>Other Paralytic Syndromes</td></tr>
</table>
<table>
<tr><th>Diagnosis Description</th></tr>
<tr><td>Anoxic Brain Damage</td></tr>
<tr><td>Encephalophy, Unspecified</td></tr>
<tr><td>Compression of Brain</td></tr>
<tr><td>Cerebral Edema</td></tr>
<tr><td>Congenital or Hereditary Progressive Muscular Dystrophy, Myotonic Disorders, Familial Periodic Paralysis</td></tr>
<tr><td>Decubitus Ulcer</td></tr>
<tr><td>Spina Bifida</td></tr>
<tr><td>Other Congenital Anomalies of Nervous System</td></tr>
<tr><td>Alteration of Consciousness, coma or Transient Alteration of Awareness</td></tr>
<tr><td>Fracture of the Cervical or Dorsal Areas (open or closed)</td></tr>
<tr><td></td></tr>
</table>
PA is required for:
▪ Medical need beyond the Standards of Coverage.
▪ All other diagnoses
▪ Replacement in less than three years.</td></tr>
<tr><td>Payment Rules</td><td>A Group 1 support surface may be a capped rental or purchase depending on the specific HCPCS code. Only a single Group 1 support surface will be considered for a purchase/rental at any given time.
If unit is billed as a capped rental, the rental payment would be inclusive of the following:
▪ All accessories needed to use the equipment (e.g., pump, pad, cards, etc.).
▪ Education on the proper use and care of the equipment.
▪ Routine servicing and all necessary repairs or replacement to make the unit functional.</td></tr>
</table>

2.41 SUPPORT SURFACES – GROUP 2

Definition	Pressure Reducing Support Surfaces - Group 2 include, but are not limited to, powered air flotation beds; powered pressure-reducing air mattresses; powered air overlay for mattress, or nonpowered advance pressure reducing mattress. A Group 2 support surface must provide both a waterproof cover and adequate support to prevent the beneficiary from "bottoming out" with the use of the item.

Standards of Coverage	A Group 2 mattress support may be covered up to three months when one of the following applies: ▪ Multiple Stage II pressure ulcers are located on the trunk or pelvis and the beneficiary has participated with a comprehensive ulcer treatment program for at least the past month which has included the use of an appropriate Group 1 support surface, and the wound has worsened or had no change. ▪ Large or multiple Stage III or IV pressure ulcer(s) on the trunk or pelvis. ▪ Recent myocutaneous flap or skin graft for a pressure ulcer on the trunk or pelvis (surgery within the past 60 days) and the beneficiary has been on a Group 2 or 3 surface immediately after a recent discharge from a hospital or nursing facility (discharge within the past 30 days).
	Continued Use of a Group 2 support surface on a monthly basis may be covered for restorative purposes only when healing continues to progress. Continued use of a Group 2 support surface on a monthly basis will not be reauthorized for coverage if: ▪ The beneficiary is noncompliant with care plan; or ▪ The documentation in the medical record demonstrates that other aspects of the plan of care are not being modified to promote healing.
Documentation	Documentation must be less than 14 days old and include the following: ▪ Diagnosis/medical condition related to need for item. ▪ Size, stage and location of the ulcer. ▪ Other treatment modalities/surfaces already tried. ▪ Education of the beneficiary and caregiver on the prevention and/or management of pressure ulcers. ▪ Regular assessment by a nurse, physician, or other licensed healthcare practitioner. ▪ Appropriate turning and positioning. ▪ Current appropriate wound care (for a Stage II, III, or IV ulcer). ▪ Appropriate management of moisture/incontinence. ▪ Nutritional assessment and intervention consistent with the overall plan of care.
PA Requirements	PA is required for all Group 2 support surfaces.
Payment Rules	A Group 2 support surface may be a **capped rental** or **purchase** depending on the specific HCPCS procedure code. A powered flotation bed is a **rental only** and must be billed as a daily rate by reporting total number of days used as units. If the unit is billed as a capped rental, the rental payment would be inclusive of the following: ▪ All accessories needed to use the equipment. ▪ Education on the proper use and care of the equipment. ▪ Routine servicing and all necessary repairs or replacements to make the unit functional.

	For a power flotation bed, if use exceeds a ten-month time frame, report the "MS" modifier after six months of continued maintenance and servicing of the item. (MS - six-month maintenance and servicing fee for reasonable and necessary parts and labor that are not covered under any manufacturer or supplier warranty).

2.42 SUPPORT SURFACES – GROUP 3

Definition	Pressure Reducing Support Surfaces – Group 3 are fully integrated air fluidized beds for the purpose of alleviating pressure. The surface uses the circulation of filtered air through silicone coated ceramic beads that creates the characteristics of fluid.
Standards of Coverage	A Group 3 air-fluidized bed is covered for up to 90 days if all of the following applies: ▪ The beneficiary has a Stage III (full thickness tissue loss) or Stage IV (deep tissue destruction) pressure ulcer. ▪ The beneficiary is bedridden or chairbound as a result of severely limited mobility. ▪ The beneficiary's attending physician orders in writing an air-fluidized bed based on a comprehensive assessment and evaluation of the beneficiary after conservative treatment has been tried without success. ▪ A trained adult caregiver is available to assist the beneficiary with ADLs, fluid balance, dry skin care, repositioning, recognition and management of altered mental status, dietary needs, prescribed treatments and management of the air-fluidized bed ▪ A physician directs the home treatment regimen, and re-evaluates the need for the air-fluidized bed on a monthly basis. ▪ All other conservative treatment methods have been tried without success (e.g., Group 1 or Group 2 support surfaces).
	Continued Use of a Group 3 support surface may be covered for restorative purposes only when healing continues to progress. Continued use of a Group 3 support surface will not be reauthorized for coverage if: ▪ Beneficiary is noncompliant with care plan; or ▪ Documentation in the medical record demonstrates that other aspects of the plan of care are not being modified to promote healing.
Noncovered Conditions	Group 3 support surfaces are noncovered if: ▪ Beneficiary requires treatment with wet soaks or moist wound dressings that are not protected with an impervious covering such as plastic wrap or other occlusive material. ▪ Caregiver is unwilling or unable to provide the type of care required by the beneficiary on a air-fluidized bed. ▪ Structural support is inadequate to support the weight of the air-fluidized bed system. ▪ Electrical system is insufficient for the anticipated increase in energy consumption. ▪ Other known contraindications exist.
Documentation	Documentation must be less than 14 days old and include the following: ▪ Diagnosis/medical condition related to the need for the bed. ▪ Size, stage and location of the ulcer.

	▪ Other treatment modalities already tried. ▪ Education of the beneficiary and/or caregiver on the prevention and/or management of pressure ulcers. ▪ Monthly assessment by a nurse, physician, or other licensed healthcare practitioner. ▪ Appropriate turning and positioning. ▪ Current appropriate wound care (for a Stage II, III, or IV ulcer). ▪ Appropriate management of moisture/incontinence. ▪ Nutritional assessment and intervention consistent with the overall plan of care.
PA Requirements	PA is required for all Group 3 support surface requests.
Payment Rules	A Group 3 support surface or air fluidized bed is a **rental only** item and must be billed as a daily rate by reporting total number of days used as units. The rental payment is considered to include the following: ▪ All accessories needed to use the equipment. ▪ Education on the proper use and care of the equipment. ▪ Routine servicing and all necessary repairs or replacements to make the unit functional. If use exceeds a 10-month timeframe, report the "MS" modifier after six months of continued maintenance and servicing of the item.

2.43 SURGICAL DRESSINGS

Definition	Surgical dressings include a primary dressing (used as a protective covering applied directly to the wound or lesion) and/or a secondary dressing (used to secure a primary dressing in place). Many of the primary dressings covered by MDCH are self-adhesive and would not require a secondary dressing to be placed as well. Examples of surgical dressing are adhesive tape, roll gauze, and elastic bandages.
Standards of Coverage	Surgical dressings are covered for one or more of the following: ▪ To treat a wound or opening in the skin. ▪ To debride a wound or lesion. ▪ To treat pressure ulcers. Coverage of the quantity or type of dressing is based on: ▪ Size, stage, location and current status of the wound/lesions being treated. ▪ Number of wounds/lesions. ▪ Number of body locations involved. ▪ Frequency of dressing change.
Documentation	Documentation must be less than 30 days old and include the following: ▪ Diagnosis/medical condition related to the need for the items(s). ▪ Item to be dispensed.

	▪ Quantity of item. ▪ Anticipated frequency of dressing change. ▪ Size, stage, location, and number of wounds/lesions. For dressing requests of quantities over established limits, documentation to substantiate medical need is required.
PA Requirements	PA is required for: ▪ Collagen dressings or wound fillers. ▪ Silicone gel sheets. ▪ Composite dressings. ▪ Quantities beyond Medicaid's established limits.
	PA is not required for all other types of surgical dressings unless usage exceeds established quantity limitations.
Payment Rules	All items are considered a **purchase** up to the allowable quantities. Modifiers A1 through A9 must be reported in addition to the HCPCS code to report the appropriate number of wounds being treated. The modifiers are as follows: ▪ A1 - Dressing for one wound ▪ A2 – Dressing for two wounds ▪ A3 – Dressing for three wounds ▪ A4 – Dressing for four wounds ▪ A5 – Dressing for five wounds ▪ A6 – Dressing for six wounds ▪ A7 – Dressing for seven wounds ▪ A8 – Dressing for eight wounds ▪ A9 – Dressing for nine or more wounds Dressings related to infusion pumps, or parenteral/enteral nutrition, tracheostomy, or gastrostomy are included in either the daily rate or in established all-inclusive kit codes and are not separately reimbursable.

2.44 TRACHEOSTOMY CARE SUPPLIES

Definition	Tracheostomy care supplies include, but are not limited to, tracheostomy filters, tubes, masks, care kits, cleaning brushes, shower protectors and suction catheters.

Standards of Coverage	Tracheostomy care supplies are covered to support the care of a beneficiary with a tracheostomy. A tracheostomy starter kit may be covered for the four weeks following the initial tracheostomy surgery. The kit code includes the following items: Plastic tray, basin, sterile gloves, tube brush, pipe cleaners, a pre-cut tracheostomy dressing, a roll of gauze, drain sponges, cotton tip applicators, tracheostomy tube ties or twill tape. After the initial four weeks, the established tracheostomy kit may be covered. The kit code includes the following items: Tube brush, pipe cleaners, cotton tip applicators, tracheostomy tube ties or twill tape, and drain sponges.
Documentation	Documentation must be less than 90 days old and include the following: ▪ Diagnosis/medical condition. ▪ Specific items required.
PA Requirements	PA is not required when the Standards of Coverage are met and established quantity limits are not exceeded.
	PA is required when: ▪ Standards of Coverage are not met. ▪ Quantities requested exceed the established limits. ▪ Other items not part of one of the kit codes may be considered for separate reimbursement. (Refer to the Medical Supplier Database on the MDCH website for additional information.)
Payment Rules	Payment is **purchase only**. All quantities reported should reflect a 30-day supply.

2.45 TRANSCUTANEOUS ELECTRICAL NERVE STIMULATOR (TENS)

Definition	A Transcutaneous Electrical Nerve Stimulator (TENS) is a device that utilizes electrical current delivered through electrodes placed on the surface of the skin to decrease the beneficiary's perception of pain by inhibiting the transmission of afferent pain nerve impulses and/or stimulating the release of endorphins.
Standards of Coverage	A TENS unit is covered for reduction of pain for beneficiaries with either chronic, intractable pain of at least three months duration, or acute post-operative pain limited to 30 days from the date of surgery, or pain related to cancer, when: ▪ The beneficiary is able to use the TENS device. ▪ There is effective control of pain. ▪ Other treatment modalities have been ineffective.
Documentation	Documentation must be less than 30 days old and must include all of the following: ▪ Diagnosis/medical condition related to the need for a TENS (including type and location of pain). ▪ Alternative treatments for pain tried and the results. ▪ Other modalities of treatment still being used, (type and duration must be detailed).

	Continued Use after the initial 90 days - The documentation must be included with the PA request to describe the effectiveness of the treatment received. For continued coverage for chronic intractable pain, the documentation must be within 30 day old and include the following: ▪ Medication regimen, before and after use. ▪ Functional level (affected by pain) before and after use.
PA Requirements	PA is required for all requests.
Payment Rules	A TENS unit may be considered as a **capped rental**. The rental payment is inclusive of the following: ▪ All accessories needed to use the equipment (e.g., electrodes, lead wires, cables, etc). ▪ Education on the proper use and care of the equipment. ▪ Routine servicing and all necessary repairs or replacements to make the unit functional.

2.46 WALKERS

Definition	Walkers include, but are not limited to, rigid, wheeled, heavy duty, and folding.
Standards of Coverage	Walkers may be covered when the beneficiary has impaired ambulation and requires a walker for safe and independent ambulation.
Documentation	Documentation must be less than six months old and include: ▪ Diagnosis/medical condition related to the need for the service. ▪ Functional level possible with use of walker. ▪ Medical reason for type of attachment or modification, if applicable. ▪ Medical reason for heavy-duty walker (e.g., obesity, severe neurological disorder or restricted use of hands).
PA Requirements	PA is not required for standard walkers when the Standards of Coverage are met.
	PA is required for: ▪ An enclosed, framed folding walker. ▪ Heavy-duty walker. ▪ Replacement within five years. ▪ Additional attachments (e.g., arm troughs).
Payment Rules	Walkers may be a **capped rental** or **purchase** item. After the first ten months of rental, necessary repairs and/or replacements of accessories are separately reimbursable.

2.47 WHEELCHAIRS, PEDIATRIC MOBILITY ITEMS AND SEATING SYSTEMS

Definition	**A wheelchair** has special construction, consisting of a frame and wheels, with many different options, and includes, but is not limited to, standard, lightweight high strength, powered, etc. A **pediatric mobility item or stroller** has special lightweight construction, consisting of a frame and wheels, with many different options and includes, but is not limited to, transport chairs. **Seating systems** are systems to facilitate positioning in a wheelchair. These include, but are not limited to: ▪ **Standard or planar** prefabricated components or components assembled by a supplier or ordered from a manufacturer who makes available special features, modifications or components. ▪ **Contoured seating** is shaped to fit a person's body to provide support to facilitate proper posture and/or pressure relief. Contoured seating is not considered custom-made. ▪ **Custom seating** is uniquely constructed or substantially modified to meet the specific needs of an individual beneficiary. A **standing wheelchair** is a wheelchair that incorporates a standing mechanism that may be self-propelled by the user for mobility. It allows an individual to go from a seated position to a standing position with either a manual level or power switch.
Standards of Coverage Wheelchairs	**Manual wheelchairs** will be covered if the beneficiary demonstrates all of the following: ▪ Has a diagnosis/condition that indicates a lack of functional ambulatory status. ▪ Must be able to regularly use the wheelchair throughout the day. ▪ Must be able to be positioned in the chair safely and without aggravating any medical condition or causing injury. ▪ Must have a method to propel wheelchair, which may include: ➢ Ability to self-propel for at least 60 feet over hard, smooth, and carpeted surfaces. ➢ Willing, able, and reasonable caregiver to push the chair if needed. A **standard hemi-wheelchair** may be covered when a lower seat to the floor is required. A **lightweight wheelchair** may be covered when the beneficiary is unable to propel a standard wheelchair due to decreased upper extremity strength or secondary to a medical condition that affects endurance. A **heavy-duty wheelchair** may be covered if the beneficiary's weight is more than 250 pounds but does not exceed 300 pounds. An **extra heavy-duty wheelchair** is covered if the beneficiary's weight exceeds 300 pounds. A **high strength lightweight, ultra-light or an extra heavy-duty wheelchair** may be covered when required for a specific functional need.

	Back Up or Secondary Manual Wheelchair may be considered when the: ▪ Beneficiary is primarily a power wheelchair user but needs a manual wheelchair to have access to the community or independent living. ▪ Beneficiary's medical condition requires a power wheelchair that cannot accommodate public transportation and, therefore requires another transport device.
	Power Wheelchairs or Power Operated Vehicles (POV) may be covered if the beneficiary demonstrates all of the following: ▪ Lacks ability to propel a manual wheelchair or has a medical condition that would be compromised by propelling a manual one. ▪ Requires the use of a wheelchair for at least four hours throughout the day. ▪ Able to safely control a wheelchair through doorways and over thresholds up to 1½ inches.
	Wheelchair Accessory may be covered if medically necessary to meet the functional needs of the beneficiary. Specific accessories are part of the initial purchase of a wheelchair and should not be billed separately. Other accessories/modifications are considered as upgrades and would require medical justification from physician, occupational or physical therapist. Physician, occupational or physical therapist must address the status/condition of the current chair and include the brand, model, serial number and age of current chair**.**
	Standard And Custom-Modified Versus Custom-Made - Standard, custom-modified, or custom-made wheelchairs must be medically necessary and meet the intended purpose. ▪ **Custom-modified** refers to modifications to a standard wheelchair item to meet specialized needs of a beneficiary by using prefabricated parts (e.g., addition of a strap to a standard item). ▪ A **custom-made wheelchair** is fabricated to meet the functional needs of one specific person. The item is specifically made to fit one user based on direct measurements or body castings. It may involve the incorporation of some prefabricated components but the majority of the device is fabricated specifically for the user. Structural modification beyond the initial fabrication may be required to ensure the desired fit and functionality. MDCH will consider coverage of custom-made equipment when a standard or custom-modified item will not meet the medical and/or functional needs of the user.
	For beneficiaries under 21, stand-up wheel chairs may be covered if: ▪ Medical documentation supports the need for standing daily and it is ordered by a pediatric specialist. ▪ Other economic alternatives have been ineffective.
	A **pediatric mobility item (wheelchair/stroller)** may be covered for children ages three and over when: ▪ The requested item will be the primary mobility device for a child who cannot self propel a manual wheelchair or operate a power wheelchair. ▪ Diagnosis or medical condition effects resulting in the ability to ambulate. ▪ It is required as a transport device when primary wheelchair is not portable and cannot be transported.

	Standard or planar seating systems are covered when necessary to assure appropriate positioning in a wheelchair, other economic alternatives have been ineffective, and beneficiary has one of the following conditions: ▪ Postural deformities ▪ Contractures ▪ Tonal abnormalities ▪ Functional impairment ▪ Muscle weakness ▪ Pressure points ▪ Difficulties with seating balance Payment for a seating system includes all repairs and modifications for a two-year period for beneficiaries of all ages.
Standards of Coverage – Wheelchair Modifications	**Manual or Power Recline** may be covered when needed for relief of pressure on the seat and/or back and one of the following applies: ▪ History of skin breakdown or current indication of imminent skin breakdown that cannot be controlled (or has not in the past) by less costly modalities such as pressure relief cushions or manual pressure relief techniques. ▪ Has ability to tolerate a 90 – 135 degree of range of motion at the hip needed for reclining without triggering excessive abnormal tone. ▪ Is unable to tolerate an upright position in a wheelchair for long periods of time due to fatigue, shortness of breath, increased tone, or discomfort related to pressure that cannot be manually relieved. A low shear recline back is covered when the beneficiary does not have the ability to reposition himself in the chair following reclining and the shearing would result in skin breakdown.
	Tilt-in-Space function allows the seat and back of the wheelchair to move as a unit such that the angle of the back to the floor changes from approximately 90 degrees to 45 degrees or less. This change in position does not affect the hip-to-knee angle. The seat may be tilted manually or by power. The tilt-in-space modification to a wheelchair may be covered if one or more of the following apply: ▪ History of skin breakdown or current indication of skin breakdown that cannot be controlled (or has not in the past) by less costly modalities such as pressure relief cushions or manual pressure relief techniques. ▪ Excessive extensor or flexor muscle tone that is exacerbated by change in hip angle and makes positioning in any upright chair ineffective, and a reason why changing angles of position is medically necessary. ▪ Very low muscle tone that cannot maintain upright positioning against gravity, causing spinal anomalies. ▪ Beneficiary has knee contractures and has a custom-molded seating system.

	Coverage of a joint **tilt-in-space and recline modification** to a wheelchair requires medical need such as high probability of the development of hip contractures if only a tilt-in-space without recline is used. There also needs to be a medical contraindication to recline only without tilt-in-space.
	A **power driven recline mechanism or tilt-in-space** may be covered if: ▪ Beneficiary requires assistance to use a manual tilt-in-space or recline system and there are regular periods of time that the beneficiary is without assistance. ▪ Beneficiary requires assistance to use a manual tilt-in-space or recline system and is able to independently care for himself when provided a power recline or tilt-in-space modification. ▪ Beneficiary resides in a nursing facility and use of a power tilt-in-space will permit movement to a less restrictive setting.
Noncovered Items	▪ Secondary wheelchairs for beneficiary preference or convenience. ▪ Standing wheelchairs for beneficiaries over 21 years old. ▪ Coverage of power tilt-in-space or recline for a long-term care resident because there is limited staffing. ▪ Nonmedical wheelchair accessories such as horns, lights, bags, etc. ▪ New equipment when current equipment can be modified to accommodate growth.
Documentation	The documentation must be within 180 days old, and include the following: ▪ Diagnosis appropriate for the equipment requested. ▪ Occupational therapy or physical therapy evaluation and recommendation. ▪ Brand and model of requested wheelchair. ▪ If a replacement wheelchair is requested, list brand, model, serial number and age of current chair. ▪ Medical reason for add-on components or modifications if applicable. ▪ Specific medical condition (e.g., contractures, muscle strength) if seating system requested. ▪ Current ambulatory status of beneficiary (e.g., distance the individual can walk, the level of assistance required). ▪ Any adaptive or assistive devices currently used (if replacement chair is requested, list brand, model, serial number and age of current chair). ▪ Other cost-effective alternatives that have been ruled out. ▪ A pediatric subspecialist is **required under the CSHCS Program**.
PA Requirements	PA is not required for the following if Standards of Coverage are met: ▪ The rental of specific wheelchairs up to the first three months after hospital discharge. ▪ The rental of standard wheelchairs for up to three months following outpatient surgery or discharge from a rehabilitation/nursing facility if Standards of Coverage are met. ▪ Specific accessory codes. ▪ Specific pediatric mobility items if the related diagnosis/condition is one of the following:

	➢ Spinal Muscular Atrophy ➢ Motor Neuron Disease ➢ Other Anterior Horn Cell Disease ➢ Anterior Horn Cell Disease, Unspecified ➢ Hemiplegia And Hemiparesis ➢ Infantile Cerebral Palsy ➢ Other Specified Myoneural Disorders ➢ Myoneural Disorders, Unspecified ➢ Spina Bifida With Hydrocephalus ➢ Spina Bifida Without Mention of Hydrocephalus ➢ Spina Bifida (Other Congential Anomalies of Nervous System) ➢ Microcephalus ➢ Reduction Deformities of Brain ➢ Congential Hydrocephalus To verify if a specific accessory item or pediatric mobility item does not require PA, refer to the Medical Supplier Database on the MDCH website.
	PA is required for: ▪ Rental of a standard wheelchair beyond three months for hospital discharge waiver. ▪ Replacement of standard chairs beyond established timeframes. ▪ Medical need of a standard chair not defined by Standards of Coverage. ▪ Custom wheelchairs. ▪ Wheelchair modifications of tilt-in-space and/or recline (power or manual). ▪ Seating systems. ▪ Diagnosis/medical conditions not listed to bypass PA for pediatric mobility items. ▪ Medical need not within the Standards of Coverage.
Payment Rules	A wheelchair can be considered a **capped rental** or **purchase** item.
	Repairs for beneficiary owned wheelchairs are covered only after manufacturer warranty has been exhausted. It is the responsibility of the provider to supply loaner equipment while the original item is being serviced. If repair of a wheelchair not purchased by MDCH is requested, the item must be medically necessary and meet the basic Standards of Coverage. Repair of a wheelchair involving the replacement of a component part includes the cost of the part and the labor associated with its removal, replacement and finishing.
	Replacement of a wheelchair is subject to manufacturer warranty and/or cost of repairs. The replacement may also be considered when a significant change in the patient's condition has occurred or the item cannot be restored to a serviceable condition. Replacement of wheelchairs for youth will be evaluated on an individual basis due to the expected growth pattern. Based on these conditions, a wheelchair may be considered for replacement every five years for adults and every two years for children.

	For **beneficiaries residing in a nursing facility**: ▪ Standard DME is included in the facility's per diem rate. ▪ Custom-fitted or custom-fabricated DME required for the beneficiary's full time use is billable by a medical supplier. The custom-fitted or custom-made DME must offer physical/restorative function to the beneficiary and allow for independence in the nursing facility setting that is not possible with standard DME. Once the custom-fitted or custom-made equipment is purchased, it becomes the property of the beneficiary.
	Details regarding whether or not separate reimbursement may be considered for specific **wheelchair accessory codes,** when provided in conjunction with the purchase of a manual wheelchair, power wheelchair, or modification of an existing wheelchair, may be found in the Medical Supplier Database on the MDCH website.

2.48 VENTILATORS

Definition	A ventilator is a device designed to intermittently or continuously assist or control pulmonary ventilation. ▪ A negative pressure ventilator exerts negative (sub-atmospheric) pressure on the exterior chest wall. ▪ A positive pressure ventilator ventilates the lungs as the result of a positive pressure applied to the airway.
Standards of Coverage	Negative and positive pressure ventilators may be covered when there is a respiratory related diagnosis (e.g., neuromuscular disease, thoracic restrictive disease, chronic respiratory failure) and the beneficiary requires ventilator assistance.
Documentation	Documentation must be less than 90 days old and include the following: ▪ Respiratory diagnosis/medical condition related to the need for the ventilator. ▪ Type of ventilator ordered. ▪ Ventilator settings. ▪ Number of hours beneficiary is required to use the ventilator.
PA Requirements	PA is required for all ventilators.
Payment Rules	All ventilators are a **rental only** item and are inclusive of the following: ▪ All accessories needed to use the unit (e.g., circuits, water feed sets, adaptors, temperature probes, filters, heated or nonheated humidifier, oxygen analyzer, water or saline for humidifier, etc). ▪ Education on the proper use and care of the equipment. ▪ Routine servicing and all necessary repairs or replacements to make the unit functional. An additional ventilator may only be covered to allow a beneficiary access to the community. When billing more than one vent, the additional vent must be reported using a NOC code. A backup ventilator in case of a power failure is not separately reimbursable.

SECTION 3 - PRIOR AUTHORIZATION (PA) COMPLETION INSTRUCTIONS

The Special Services Prior Approval-Request/Authorization Form (MSA-1653-B) is generally self-explanatory. The following copy of the form contains special instructions, where necessary. Completion of Boxes 12 through 39 is mandatory. For complete information on required modifiers, documentation, and appropriate quantity amounts, refer to the following documents:

- Standards of Coverage portion of this chapter.
- Billing and Reimbursement for Professionals Chapter of this manual.
- Medical Supplier Database on the MDCH website.

Boxes 1. Through 10. – MDCH Use Only

Boxes 12 Through 14., 16. & 17. – Provider Name, Type, Provider ID Number, Address and Phone Number

Box 11. – MDCH Issued PA Number

Box 15. – Provider Use Only

Boxes 18. Through 23.- Enter this information and verify it through Eligibility Verification System.

Boxes 25. Through 29. – Referring Physician Name, Type (10, 11, 13), Medicaid ID Number, Phone Number and Address

Box 24 – Check "Yes" if the beneficiary resides in a nursing facility (NF). Provide NF address and phone number in **Box 37**. Check "No" if the beneficiary is not in a NF.

Box 36. –Enter the beneficiary's primary and secondary diagnoses (list both the code and description). The prescription /CMN must accompany this form.

Box 37. –Any additional remarks regarding this request should be listed in this box such as NF name, address and phone number, verbal authorization date, retroactive date of service if being requested, etc.

Box 40. – If amended, a change has been made on the form.

Box 42 –The MDCH Consultant signature

Box 41 –If No Action, returned because beneficiary is in an HMO, service does not require PA, etc. If Insufficient Data, returned for more information.

SPECIAL SERVICES

1. Control Number

CONSULTANT USE ONLY

11. Prior Authorization No.

12. Provider's Name *(Last, First, Middle Initial)* | 13. Type | 14. ID Number | 15. Provider Use Only

16. Provider's Address *(Number,* | 17. Phone Numb

18. Recipient's Name *(Last, First,* | 21. Birth Date | 22. County

23. Recipient's Address *(Number, Street, City, State, Zip)* | 24. Does Patient Reside in a Nursing Care Facility ☐ YES ☐ NO

25. Referring Physician's Name *(Last, First, Middle Initial)* | 26. Type | 27. ID Number | 28. Phone Number

29. Referring Physician's Address *(Number, Street, City, State, Zip)*

30. Line No.	31. DESCRIPTION OF SERVICE (Include brand name and model number where applicable)	32. Procedure Code	33. Quantity	34. Charge	35. Modifier
01					
02					
03					
04					
05					

36. Primary Diagnosis Description and Prescription (Quote Physician Order)

37. Remarks and/or Documentation of Medical Necessity

38. Indicate Any Other Services Provided To This Recipient During the Past Year

39. PROVIDER CERTIFICATION: The patient named above (parent if minor or authorized representative) understands the necessity to request prior approval for the services indicated in Item 31. I understand the services requested herein require prior approval and if approved and submitted on the appropriate invoice, payment and satisfaction of approved claims, statements or documents or concealment of a material fact may be prosecuted under ap

Provider Signature | Date

CONSULTANT USE ONLY

40.	41.	42.
APPROVED AS:	DISAPPROVED ☐	
PRESENTED ☐	NO ACTION ☐	
AMENDED ☐	INSUFF. DATA ☐	

Consultant Signature | Date

MSA-1653-B (Rev. 4-96) Previous edition may be used.