



DURABLE MEDICAL EQUIPMENT

Chapter Eighteen of the Medicaid Services Manual

Issued September 1, 2010

Claims/authorizations for dates of service on or after October 1, 2015 must use the applicable ICD-10 diagnosis code that reflects the policy intent. References in this manual to ICD-9 diagnosis codes only apply to claims/authorizations with dates of service prior to October 1, 2015.

**State of Louisiana
Bureau of Health Services Financing**

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CHAPTER 18: DURABLE MEDICAL EQUIPMENT

SECTION 18.0: OVERVIEW**PAGE(S) 1**

OVERVIEW

This chapter applies to the Louisiana Medicaid Durable Medical Equipment (DME) program and contains basic information herein. Use this chapter in conjunction with Chapter 1, General Information and Administration.

Providers of DME must be enrolled in order to participate in this program. Participation is completely voluntary. However, if a provider chooses to participate, they must accept the Medicaid payment as payment in full for Medicaid covered services.

The Louisiana Medicaid DME Program covers the least costly alternative based on the **beneficiary's medical necessity** for the DME or orthotics/prosthetics device.

The DME, medical supplies, prosthetics and orthotics must be prescribed by the Medicaid beneficiary's attending physician or physician's authorized representative.

All services must be prior authorized.

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SERVICES AND LIMITATIONS

Durable Medical Equipment (DME) is covered when medical necessity criteria are met for use as part of the medical care of a beneficiary. Equipment and supplies which are payable under Louisiana Medicaid require prior authorization (PA) by the Prior Authorization Unit (PAU). Refer to section 18.5 for more information on PA.

In compliance with the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) requirements, DME items, regardless of their inclusion in this manual or on the DME fee schedule, will be considered for beneficiaries under the age of 21 based on medical necessity. A provider may submit a PA request for beneficiaries under the age of 21 for items not specified in this manual or on the DME fee schedule.

Covered Services

The covered items and services include:

1. DME;
2. Medical supplies;
3. Home dialysis supplies and equipment;
4. Therapeutic shoes;
5. Enteral nutrition, enteral/parenteral equipment and supplies;
6. Transfusion medicine; and
7. Prosthetic devices, prosthetics and orthotics.

NOTE: DME and supplies are not covered for residents in intermediate care facilities for individuals with intellectual disability (ICF/IID) and nursing facilities.

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Durable Medical Equipment and Supplies

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

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

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

Supplies must meet following criteria:

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

Providers of DME and supplies must obtain PA from the fiscal intermediary (FI).

Prosthetics and Orthotics

Louisiana Medicaid defines prosthetic and orthotics devices as leg, arm, back and neck braces, artificial legs, arms and eyes; including replacements, if required because of a change in the beneficiary's physical condition.

Providers of durable prosthetics and orthotics must obtain PA from the FI for all services. This requirement includes, but is not limited to, equipment that is rented, purchased, repaired or modified.

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Service Limitations for Nursing Facilities and Intermediate Care Facilities

The Bureau of Health Services Financing (BHSF) has instructed the PAU to deny all requests for DME and supplies for beneficiaries residing in nursing facilities and ICF/IIDs. The sole exception pertains to prosthetic and orthotic services for residents of nursing facilities. Louisiana Medicaid **will only pay** DME providers for **prosthetic and orthotic devices** supplied to residents of nursing facilities. DME providers should bill Medicaid directly for these services. Payments for prosthetic and orthotic devices are included in the payment made to ICF/IID facilities.

Edits are in place to prevent payment on claims for beneficiaries who move into an ICF/IID or nursing facility after authorization for DME or supplies have been given, but prior to the delivery date.

Non-Covered DME Services and Items

A non-covered service, item or supply is not available for reimbursement. Listed below are items and services **not** reimbursed by Medicaid through the DME program:

1. Clinically unproven equipment;
2. Comfort or convenience equipment;
3. Dentures;
4. Disposable supplies customarily provided as part of a nursing or personal care service (PCS) or a medical diagnostic or monitoring procedure;
5. Electric lifts (manual lifts are covered);
6. Emergency and non-emergency alert devices;
7. Environmental modifications (e.g. home, bathroom, ramps, etc.);
8. Equipment designed for use by a physician or trained medical personnel;
9. Experimental equipment;
10. Facilitated communications;

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11. Furniture and other items which do not serve a medical purpose;
12. Hand held showers;
13. Investigational equipment;
14. Items used for cosmetic purposes;
15. Personal comfort, convenience, or general sanitation items;
16. Physical fitness equipment;
17. Precautionary-type equipment (e.g. power generators, backup oxygen equipment provided outside of an official state and/or federally declared emergency);
18. Rehabilitation equipment;
19. Reimbursement for delivery or delivery mileage of medical supplies;
20. Routine and first aid items;
21. Safety alarms and alert systems/buttons;
22. Scooters;
23. Seat lifts and recliner lifts;
24. Standard car seats;
25. Supplies or equipment covered by Medicaid per diem rates (nursing home residents maybe approved for orthotics and prosthetics, but not for DME and supplies);
26. Televisions, telephones, video cassette recorder (VCR) machines and devices designed to produce music or provide entertainment;
27. Training equipment or self-help equipment;

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28. Van lifts;
29. Wheelchair lifts; and
30. Wheelchair ramps.

NOTE: This list is not all inclusive.

If coverage is uncertain, the provider should contact the PAU prior to dispensing the item.

Purchase versus Rental

If equipment is needed temporarily, it may be more cost effective for Medicaid to pay for the rental expenses of the equipment. Consideration will be given to:

1. Length of time the equipment is needed;
2. Total rental cost for that period of time; and
3. Purchase price of the item. If the total cost of the rental exceeds the purchase price, the equipment will be purchased rather than rented.

NOTE: Rental reimbursement – The provider cannot charge for features on equipment not medically necessary by the beneficiary's condition.

Purchasing Guidelines – Equipment

Medicaid requires that all DME supplied to eligible beneficiaries must come with a warranty from the provider that lasts a minimum of one year. Providers who make or sell prosthetic or orthotic items must provide a warranty which lasts at least 90 days from the time the item is delivered to the beneficiary. If the item fails to work during those 90 days, the manufacturer or dealer must repair or replace the item. Medicaid does not reimburse for costs associated with replacement parts or repairs to the equipment.

Medicaid reimbursement includes:

1. All elements of the manufacturer's warranty;
2. All routine or special equipment servicing, to the extent the same servicing is provided to non-Medicaid persons;

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3. All adjustments and modifications needed to make the item safe, useful and functional for the beneficiary during the entire first year (including customized wheelchairs);
4. Delivery, set-up and installation of the DME by trained and qualified provider staff, in the area of the home where the equipment will be used or the appropriate room within the home;
5. Adequate training and instruction provided to the beneficiary or the beneficiary's responsible caregiver by the provider's trained and qualified staff, in a language understood by the beneficiary or caregiver regarding the manufacturer's recommendations for the safe, sanitary, effective, and appropriate use of the item; and
6. Honoring the required one-year provider warranty for all requests or prescriptions requesting equipment repair made on or before the 366th day of service.

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

Provider Responsibilities – Rental Equipment

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

1. Ensure and maintain documentation on file that the equipment is routinely serviced and maintained by qualified provider staff, as recommended by the product manufacturer;
2. Repair, or replace all expendable parts or items, such as masks, hoses, tubing and connectors, and accessory items necessary for the effective and safe operation of the equipment;
3. Substitute similar equipment at no additional cost to Medicaid if the equipment becomes broken because of normal use while the original rental equipment is being repaired;

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4. Replace equipment that is beyond repair at no additional charge and maintain documentation of the replacement;
5. Maintain documentation that is signed and dated by both the provider and the beneficiary or beneficiary's responsible caregiver at the time of delivery, which attests to the fact that instruction has been provided by trained and qualified provider staff to the beneficiary or caregiver regarding the beneficiary's or caregiver's responsibility for cleaning the equipment and performing the general maintenance on the equipment, as recommended by the manufacturer; and
6. Maintain documentation that is signed and dated by both the provider and the beneficiary or beneficiary's responsible caregiver, which attests that the beneficiary or the caregiver was provided with the manufacturer instructions, servicing manuals, and operating guides needed for the routine service and operation of the specific type or model of equipment provided.

Limitations for Replacement of Equipment

Medicaid will **not** replace equipment that is lost, destroyed or damaged as a result of misuse, abuse, neglect, loss, or wrongful disposition of equipment by the beneficiary, the beneficiary's caregiver(s), or the provider. At a minimum, examples of equipment misuse, abuse, neglect, loss or wrongful disposition by the beneficiary, the beneficiary's caregiver, or the provider include, but are not limited to the following:

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

If equipment is stolen or destroyed in a fire, the provider must obtain, in a timely manner, a completed police or insurance report that describes the specific medical equipment that was stolen or destroyed. The police or insurance report must be submitted with the new PA request.

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Medicaid may replace equipment when the beneficiary's medical necessity changes. The provider must submit the documentation required to justify the purchase of the replacement equipment.

Equipment Maintenance and Repair

Medicaid will reimburse for the maintenance and repair of equipment only when the following conditions are met:

1. Equipment is covered by Medicaid;
2. Equipment is the personal property of the beneficiary;
3. Item is still medically necessary;
4. Equipment is used exclusively by the beneficiary;
5. No other payment source is available to pay for the needed repairs;
6. Equipment damage is not due to misuse, abuse, neglect, loss or wrongful disposition by the beneficiary, the beneficiary's caregiver, or the provider (see examples of misuse, abuse, neglect, loss or wrongful disposition under "Limitations for Replacement of Equipment" above);
7. Equipment maintenance is performed by a qualified technician;
8. Maintenance is not currently covered under a manufacturer's or provider's warranty agreement; and
9. Maintenance is not performed on a duplicate type of item already being maintained for the beneficiary during the maximum limit period.

NOTE: Refer to Section 18.2 of this chapter for specific coverage criteria.

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18.2.1 Respiratory Supplies and Equipment**18.2.1.1 Apnea Monitors**

Apnea monitors are cardio-respiratory monitoring devices capable of providing continuous or periodic two-channel monitoring of the heart rate and respiratory rate. Apnea monitors must meet current Food and Drug Administration (FDA) guidelines for products in this class. Apnea monitors must have alarm mechanisms to alert care givers of cardio-respiratory distress or other events, which require immediate intervention, and must also record and store events and provide event recording downloads or printouts of such data.

Medical Criteria for Authorization of Payment for Apnea Monitor

Home apnea monitors may be approved for rental or purchase when any of the criteria are met.

Apnea of Prematurity

Apnea of prematurity is the sudden cessation of breathing that lasts for at least 20 seconds or is accompanied by bradycardia or oxygen desaturation cyanosis in an infant younger than 37 weeks gestational age.

Apnea of Infancy

Apnea of infancy is an unexplained episode of cessation of breathing for 20 seconds or longer or a shorter respiratory pause associated with bradycardia, cyanosis, pallor, and/or marked hypotonia. The term apnea of infancy generally refers to infants with gestational age of 37 weeks or more at the onset of apnea. The Medicaid program defines bradycardia for infants as a resting heartbeat of less than 80 beats per minute at one month of age, less than 70 beats per minute at 2-3 months of age, and less than 60 beats per minute at three months of age or older.

Monitoring for subsequent siblings of Sudden Infant Death Syndrome (SIDS) victims less than eight months of age may be approved for a maximum of eight months.

Following an Apparent Life-Threatening Event

An Apparent Life-Threatening Event (ALTE) is characterized by some combination of central apnea or occasionally obstructive apnea, color change (usually cyanotic or pallid but occasionally erythematous or plethoric), and a marked change in muscle tone (usually marked limpness), choking, or gagging, which required vigorous intervention or cardiopulmonary resuscitation (CPR).

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Children requiring home oxygen therapy, central hypo-ventilator, tracheotomy, and/or home ventilator support will be considered on a case-by-case basis.

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

Apnea Monitor Initial Authorization Period for Rentals

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

Apnea Monitor Extensions after Initial Three Months

Any request for extensions after the initial three-month period must be accompanied by documented evidence obtained in the home environment of recurrence of apneic episodes (e.g., cyanosis, resuscitative measures, etc.).

Apnea monitors will not be approved beyond the initial three months without download reports or download summary information with a download report. Family non-compliance and/or physician's refusal to remove the child from the apnea monitor are not acceptable reasons for further approval of payment for rental of the apnea monitor.

Apnea Monitor Emergency Requests

An oral request may be approved in an emergency for a one-month period to avoid prolonged hospitalization. Once documentation has been received indicating medical criteria have been met, the request may be approved for an additional two months.

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18.2.1.2 Oxygen Concentrators

The attending physician, or a consultant physician who has personally examined the beneficiary at the request of the attending physician, must have seen the beneficiary within 30-60 days of prescribing oxygen therapy.

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

1. Oxygen flow rate;
2. Frequency and duration of use;
3. Estimate of the period of need; and
4. Results of a current blood gas laboratory report done at rest and at room air (performed no more than 30 days prior to the prescription) from an appropriate facility giving the arterial blood gases (ABGs) and arterial saturation. However, oxygen saturation may be determined by pulse oximetry when ABGs cannot be taken.

The following diagnostic findings support the need for oxygen therapy:

Group I

1. Current ABG with a P02 at or below 55 mm Hg, or arterial oxygen saturation at or below 88 percent or below 88 percent, taken at rest, breathing room air;
2. Current ABG with a P02 at or below 55 mm Hg, or an arterial oxygen saturation at or below 88 percent, taken during sleep; or if there is a significant drop during sleep of more than 10 mm Hg of the arterial P02, or a drop of more than five percent of the arterial oxygen saturation, and this drop is associated with symptoms or signs reasonably attributable to hypoxemia; and

Example: PO2 while awake - 75 mm HG
PO2 while asleep - 64 mm HG
Symptoms: nocturnal restlessness; and

3. Current ABG with a P02 at or below 55 mm Hg, or an arterial oxygen saturation at or below 88 percent, taken during exercise for a beneficiary who demonstrates an

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arterial P02 at or above 56mm Hg, or an arterial saturation at or below 89 percent while awake at rest. In this case, supplemental oxygen is provided during the exercise if there is evidence that use of oxygen improves the hypoxemia experienced during exercise while breathing room air.

Group II

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

Group III

Medicaid reimbursement will not be made for beneficiaries with arterial P02 levels at or above 60 mm Hg, or arterial blood saturation at or above 90 percent.

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

For beneficiaries under 21 years of age only, portable oxygen may be approved when needed for travel to and from school.

Reimbursement for Oxygen Concentrators

Payment for an oxygen concentrator also includes the cost of providing all routine maintenance and servicing, and monitoring the proper usage in the home by a respiratory therapist. At the time of the initial request for PA, the DME provider must describe a plan for routine checking and servicing of the machine and a plan for monitoring the proper usage in the home by a respiratory

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therapist as a prerequisite to authorization of purchase or rental of an oxygen concentrator from that provider.

Reimbursement will be the flat fee on file for the date of service.

Portable Oxygen

Portable oxygen equipment will be reimbursed for beneficiaries who need continuous oxygen and require portable units while in route to a doctor's office, hospital, or medically necessary appointment.

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

For beneficiaries under 21 years of age only, portable oxygen may be approved when needed for travel to and from school.

Beneficiaries may require multiple units of portable oxygen per month for medical appointments, treatment, and/or travel to and from school (for beneficiaries under 21 years of age).

In order to adhere to the Centers for Medicare and Medicaid Services (CMS) National Correct Coding Initiative (NCCI) edits, only one unit per the Healthcare Common Procedure Coding System (HCPCS) for portable oxygen contents is allowed per claim line regardless of the date(s) of service. Multiple claim lines for the HCPCS for portable oxygen contents may be billed for the same dates of service.

Portable Oxygen Concentrators

Portable oxygen concentrators may be approved for beneficiaries who meet the above criteria for portable oxygen; however, additional documentation is required. Documentation includes one or more of the below:

1. Beneficiary is:

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- a. Under the age of 21 and less costly portable oxygen options for medical appointments, medical treatment, and travel to/from school will not suffice;
or
 - b. Over the age 21 or older and requires oxygen for out of state travel for medical appointments.
2. Portable oxygen needs exceed what can be provided via less costly portable oxygen equipment.

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

Reimbursement may be based on equipment's rental or purchase price.

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18.2.1.3 High Frequency Chest Wall Oscillation Devices

High frequency chest wall oscillation devices are covered for beneficiaries who meet the following criteria.

The beneficiary must have one of the following:

1. Diagnosis of cystic fibrosis;
2. Diagnosis of bronchiectasis:
 - a. Characterized by daily productive cough for at least six continuous, months or, frequent (i.e. more than two per year) exacerbations requiring antibiotic therapy; and
 - b. Confirmed by high resolution, spiral, or standard computed tomography (CT) scan.
3. Neuromuscular Disorder; or
4. Well-documented failure of standard treatments to adequately mobilize retained secretions with all of the following:
 - a. Chest physical therapy (PT) and flutter device at least twice daily (when age appropriate);
 - b. Pattern of hospitalizations at least annually or more;
 - c. Significantly deteriorating clinical condition;
 - d. Be under the care of a pulmonologist; and
 - e. Copies of two pulmonary test results that indicate the beneficiary's condition improved with the use of the vest.

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18.2.1.4 Peak Flow Meters and Mucus Clearance (Flutter) Devices

Portable, manual type peak flow meters can be covered for beneficiaries with asthma when prescribed for the measurement of lung function as part of an effective asthma management program and prior authorization (PA) is required.

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

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18.2.1.5 Pulse Oximeter

Pulse oximeter are a covered service for Early and Periodic Screening, Diagnostic and Treatment (EPSDT) eligible individuals who are already approved for supplemental home oxygen systems and/or vent dependent and whose blood saturation levels fluctuate (submit supporting blood saturation levels), thus requiring continuous or intermittent monitoring to adjust oxygen delivery.

This item is usually approved for a purchase for vent dependent and oxygen dependent beneficiaries. Other diagnoses are usually approved for rental for six months, then recertification is required for purchase.

Eligibility Criteria

A non-recording/alarming pulse oximeter is covered when one of the following apply. The beneficiary:

1. Is dependent on a ventilator with supplemental oxygen;
2. Has a tracheostomy, on oxygen, and requires monitoring of O₂ saturation as determined by the physician;
3. Requires supplemental oxygen and has unstable saturations; and
4. Is on supplemental oxygen and weaning is in process.

A recording/alarming pulse oximeter is covered when **all** of the following apply:

1. Beneficiary's condition meets one of the criteria for a non-recording/alarming oximeter;
2. Recording/alarming oximeter is being ordered by the physician to monitor the beneficiary during a specific event such as a weaning attempt from oxygen or ventilator; and
3. Feeding times for an infant, or other times for which the physician needs documentation of the beneficiary's blood oxygen saturation.

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18.2.1.6 Oxygen Probes

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

1. Disposable oxygen probes are limited to four per month;
2. Replacement oxygen probes are limited to one every six months; and
3. Oxygen probes and tape cannot be billed with pulse oximeter equipment in the same month of service.

NOTE: Billing of probes and equipment in the same month will result in denial.

Durable medical equipment (DME) providers must ensure that the prescription specifically indicates whether replacement or disposable oxygen probes are being prescribed for the beneficiary.

Billing for Oxygen Probes

DME providers must use the appropriate Healthcare Common Procedure Coding System (HCPCS) code and modifier on the durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) fee schedule on www.lamedicaid.com to request PA for these supplies. The rate on file for the HCPCS code includes reimbursement for the tape. The 'U5' modifier (oxygen probe for use with oximeter device, disposable) must be submitted with the PA request and claim for disposable pulse oximeter probes. Failure to submit the modifier with both will result in denial. A modifier should not be used when billing for a replacement oxygen probe.

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18.2.1.7 Ventilator Assist Devices**Bi-Level Positive Airway Pressure**

The following policy guidelines apply to all ventilator assist devices:

1. All equipment needs, including emergency equipment, must be prior authorized. The Prior Authorization Unit (PAU) will act on emergency requests and give a decision within two working days. If not an emergency, the PAU will act on written requests and give a decision within 25 days. Unless the physician can clearly justify purchase of the equipment, a rental trial period of up to three months can be requested to have an adequate trial period to document appropriateness;
2. Other equipment, such as low pressure alarms, must be separately documented to show medical necessity. Low pressure alarms will be approved for beneficiaries who are ventilator dependent or at risk for a life threatening event. Pulse oximetry, due to its technology limitations, is not reimbursable for home use;
3. These guidelines exist to assist the physician and the fiscal intermediary (FI) to efficiently approve most applications but allow physicians to request consideration for beneficiaries which for unique reasons fall outside criteria. All medical providers are expected to preserve pertinent information which may periodically be surveyed to evaluate these criteria in the future;
4. Non-disposable, reusable supplies should be prescribed, if appropriate, for medical care and economical reasons. Periodic exacerbations may increase supply needs, therefore, an extra prescription should be written. The prescription should be written out “As needed” and **not** by using the acronym “prn” so it can be used anytime during a several month span; and
5. The use of oxygen must be considered for those beneficiaries where these devices fail to adequately improve the beneficiary’s condition. There must be documentation of satisfactory clinical improvement such that mechanical ventilation through a tracheotomy tube is justifiably avoided.

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Continuous Positive Airway Pressure

A continuous positive airway pressure (CPAP) machine is used to treat beneficiaries who have moderate to severe obstructive sleep apnea (OSA).

OSA is a disorder that is characterized by obstructive apneas, hypopneas, and/or respiratory effort-related arousals (RERAs) caused by repetitive complete or partial collapse of the upper airway during sleep.

Polysomnography (PSG) and Home Sleep Apnea Tests (HSAT) are diagnostic methods utilized to confirm the presence of sleep apnea.

PSG is a test used to diagnose sleep-related breathing disorders and other sleep disorders. According to the American Academy of Sleep Medicine (AASM), during a PSG, assessment usually includes the sleep stages, respiratory effort, airflow, snoring, end-tidal carbon dioxide, oxygen saturation, and electrocardiogram (EKG), among other potential measures. PSG includes continuous and simultaneous monitoring and recording.

It may be performed as either a full-night study for diagnostic purposes only or as a split-night study to diagnose and initiate treatment evaluation.

Apnea is defined as the cessation of airflow for at least 10 seconds documented on a PSG.

Hypopnea is defined as an abnormal respiratory event lasting at least 20 seconds associated with at least a 30 percent reduction in thoracoabdominal movement or airflow as compared to baseline, and with at least a four percent decrease in oxygen saturation.

The apnea-hypopnea index (AHI) is defined as the average number of episodes of apnea and hypopnea per hour and must be based on a minimum of two hours of sleep without the use of a positive airway pressure device, reported by PSG using actual recorded hours of sleep (i.e., the AHI may not be extrapolated or projected).

A HSAT is a simplified, unattended test that can be done in the home setting as an alternative to PSG. HSAT utilizes a portable device to identify and measure the severity of sleep apnea. It involves monitoring fewer physiological parameters than PSG during sleep at home.

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HSAT should be used:

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

Criteria for Adults

A single level CPAP device is covered if the beneficiary has a diagnosis of OSA, documented by an attended facility-based PSG or a home-based HSAT and meets either of the following criteria:

1. The AHI is greater than or equal to 15 events per hour; or
2. The AHI is from five to 14 events per hour with documented symptoms of:
 - a. Excessive daytime sleepiness, impaired cognition, mood disorders, or insomnia; or
 - b. Hypertension, ischemic heart disease, or history of stroke.

For the purpose of this policy, PSG studies may not be performed by a Durable Medical Equipment (DME) provider.

For the purpose of this policy, PSG studies may be performed in a facility based sleep study laboratory, in the home, or in a mobile facility. Sleep study labs must be qualified providers of Medicare or Medicaid services and comply with all applicable state regulatory requirements.

Pediatric Criteria (Under 21 years of Age)

A single level CPAP device is covered if the beneficiary has a diagnosis of OSA documented by an attended, facility-based PSG and there is:

1. Documentation of physical exam (including airway) and of any other medical condition, which may be correctable (e.g., tonsillectomy and/or adenoidectomy) prior to the institution of assisted ventilation;

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2. Documentation of how sleep disturbance reduces the quality of life and affects the activities of daily living (ADL);
3. Prescription by a physician with training and expertise in pediatric respiratory sleep disorders;
4. Documentation of the medical diagnosis, which is known to cause respiratory/sleep disorders;
5. Sleep or respiratory study documenting two or more of the following:
 - a. Oxygen saturation of less than 90 percent pulse oximetry or partial pressure of transcutaneous or arterial of less than 60 mm. Hg.;
 - b. Carbon dioxide greater than 55 mm. Hg. By end tidal, transcutaneous, arterial, or capillary blood measurement; and
 - c. Apnea of 10 to 20 seconds duration on the average of one per hour.
6. A follow up plan should be submitted identifying the responsible physician or facility, giving data collected to demonstrate the success or failure of intervention, and showing a visit within the first month of use and a second assessment within the first three months of use;
7. Indication of a responsible, committed home environment and of caregivers properly trained in appropriate respiratory care; and
8. A written plan for home health follow up care.

Humidifiers

Humidifiers are covered if CPAP, bi-level positive airway pressure (BIPAP), or oxygen therapy has been prescribed for use in connection with medically necessary DME for purposes of moisturizing the oxygen. Humidifiers are used to prevent dry mouth, stuffy, congested, or runny nose and dry, burning, itching, or bleeding nose.

Heated and non-heated humidification for use with positive airway pressure system devices requires prior authorization (PA). Documentation of medical necessity including the diagnosis and expected outcome must be submitted with the request for PA. Non-heated humidifiers are

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sufficient for beneficiaries that did not have any particular problems with sinus or dryness prior to going on CPAP.

Non-heated humidifiers make a noticeable difference by allowing a beneficiary to sleep longer before awaking due to dryness or sleep through the entire night. They are usually smaller, lighter and less expensive than heaters. The process of evaporation lowers the temperature of the air reaching the beneficiary. Most beneficiaries using non-heated humidifiers without symptoms do not need to use it year around as they tend to get enough humidification whenever their home air conditioning or heater is not on. The effectiveness of a non-heated humidifier is related to its size. Larger non-heated humidifiers are more effective.

If beneficiaries dry out most nights on CPAP or have a history of sinus troubles prior to CPAP, they will benefit from a heated humidifier. Heated humidifiers can warm the air to whatever temperature the user is most comfortable. The warmer the air, the more moisture it carries. A heated humidifier delivers air of the temperature the beneficiary prefers in addition to humidification.

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18.2.1.8 Nebulizers

Nebulizers are reimbursed for purchase of the machine only. Medications for use with the nebulizer are reimbursed through the Pharmacy program.

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18.2.1.9 Tracheostomy Care Supplies

Tracheostomy care supplies are covered for beneficiaries following an open surgical tracheostomy.

Tracheostomy care or cleaning starter kits may be covered for a maximum of two weeks postoperative of an open surgical tracheostomy and must contain the following:

1. Plastic tray;
2. Basin;
3. Pair of sterile gloves;
4. Tube brush;
5. Pipe cleaners;
6. Pre-cut tracheostomy dressing;
7. Roll of gauze;
8. 4 inch x 4 inch sponges;
9. Cotton-tip applicators; and
10. One-half inch twill tape.

Tracheostomy care kits for an established tracheostomy may be covered for routine care. One care kit per day is considered normal usage. Additional kits may be considered only with medical necessity documentation.

Tracheostomy care kits for established tracheostomies are expected to contain the following:

1. Tube brush;
2. Pipe cleaners;

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3. Cotton-tip applicators;
4. One-half inch twill tape;
5. 4 inch x 4 inch sponges; and
6. Pair of sterile gloves.

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

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18.2.1.10 Suction Pumps

Purchase of a respiratory suction pump may be considered for beneficiaries who have difficulty raising and clearing secretions secondary to:

1. Cancer or surgery of the throat or mouth;
2. Dysfunction of the swallowing muscles;
3. Beneficiary is in an unconscious or obtunded state; or
4. Tracheostomy.

Suction machines may be considered only if the machine specified is medically required and appropriate for home use without technical or professional supervision.

Accessories and supplies may be considered when they are medically necessary and used with a medically necessary suction pump.

Sterile suction catheters are considered to be medically necessary only for tracheostomy suctioning.

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18.2.2 Intraocular Lens

Refer to Chapter 25 - [Hospital Services Provider Manual](#), Section 25.3, for coverage of an intraocular lens (IOL) under the Durable Medical Equipment (DME) program when implanted during, or subsequent to, cataract extraction surgery performed on an outpatient basis.

DME providers should use the most appropriate Healthcare Common Procedure Coding System (HCPCS) code based on industry standards when billing for the IOL.

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18.2.3 Artificial Eyes

An artificial eye is approved if an eyeball is removed and replacement is necessary to maintain the contour of the face.

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18.2.4 Artificial Larynxes

An artificial larynx is approved only if the larynx is removed and the beneficiary is unable to use an esophageal voice. Repairs and batteries are included.

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18.2.5 Augmentative and Alternative Communication Devices

Augmentative and alternative communication (AAC) devices are electronic or non-electronic aids, devices, or systems that assist a beneficiary to overcome or ameliorate (reduce to the maximum degree possible) the communication limitations that preclude or interfere with meaningful participation in current and projected medically necessary daily activities. Examples of AAC devices include the following:

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

NOTE: Meaningful participation refers to effective and efficient communication of messages in any form the beneficiary chooses.

Speech-Language Pathologist

A speech-language pathologist is an individual who has one of the following:

1. A certificate of clinical competence in speech-language pathology from the American Speech-Language Hearing Association;
2. Completed the equivalent educational requirements and work experience necessary for the certificate; or
3. Completed the academic program and is acquiring supervised work experience to qualify for the certificate.

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General Provisions

Consideration shall be given for Medicaid reimbursement for AAC devices for beneficiaries of all ages if the device is considered medically necessary, the beneficiary has the ability to physically and mentally use a device and its accessories, and if criteria are met as listed below.

The following medically necessary conditions shall be established for beneficiaries who/whose:

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

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

1. The cause of the beneficiary's impairment or disability (e.g., congenital, developmental, or acquired), or the beneficiary's age at the onset of the impairment or disability, are irrelevant considerations in the determination of medical need;
2. Beneficiary participation in other services or programs (e.g., school, early intervention services, adult services programs, employment) is irrelevant to medical necessity determination for AAC devices;
3. No cognitive, language, literacy, prior treatment, or other similar prerequisites must be satisfied by a beneficiary in advance of a request for AAC devices; and
4. The unavailability of an AAC device, component, or accessory for rental will not serve as the basis for denying a prior authorization (PA) request for that device, component or accessory.

Assessment/Evaluation

1. An assessment or evaluation of the beneficiary's functioning and communication limitations that preclude or interfere with meaningful participation in current and projected daily activities must be completed by a speech-language pathologist with input from other health professionals, (e.g., occupational therapists and rehabilitation engineers) based on the recommendation of the speech-language pathologist and a physician's prescription, as appropriate;
2. Requests for AAC devices must include a description of the speech-language pathologist's qualifications, including a description of the speech-language pathologist's AAC services training and experience; and
3. An assessment (augmentative and alternative communication evaluation) must include the following information about the beneficiary:
 - a. Identifying information:
 - i. Name;
 - ii. Medicaid identification (ID) number;

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- iii. Date of the assessment;
 - iv. Medical and neurological diagnoses (primary, secondary, tertiary);
 - v. Significant medical history;
 - vi. Mental or cognitive status; and
 - vii. Educational level and goals.
- b. Sensory status:
- i. Vision and hearing screening (no more than one year prior to AAC evaluation);
 - ii. If vision screening is failed, a complete vision evaluation;
 - iii. If hearing screening is failed, a complete hearing evaluation; and
 - iv. Description of how vision, hearing, tactile, and/or receptive communication impairments or disabilities affected expressive communication.
- c. Postural, mobility and motor status:
- i. Gross motor assessment;
 - ii. Fine motor assessment;
 - iii. Optimal positioning;
 - iv. Integration of mobility with AAC devices; and
 - v. Beneficiary's access methods (and options) for AAC devices.

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- d. Current speech, language and expressive communication status:
 - i. Identification and description of the beneficiary's expressive or receptive (language comprehension) communication impairment diagnosis;
 - ii. Speech skills and prognosis;
 - iii. Language skills and prognosis;
 - iv. Communication behaviors and interaction skills (i.e., styles and patterns);
 - v. Functional communication assessment, including ecological inventory;
 - vi. Indication of past treatment, if any; and
 - vii. Description of current communication strategies, including use of an AAC device, if any.

NOTE: If an AAC device is currently used, describe the device, when and by whom it was previously purchased, and why it is no longer adequate for communication needs.

- e. Communication needs inventory:
 - i. Description of beneficiary's current and projected communication needs;
 - ii. Communication partners and tasks including partners' communication abilities limitations, if any; and
 - iii. Communication environments and constraints which affect AAC device selection and/or features (e.g., verbal and/or visual output and/or feedback; distance communication needs).
- f. Summary of communication limitations:

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- i. Description of the communication limitations that preclude or interfere with meaningful participation in current and projected daily activities (i.e., why the beneficiary's current communication skills and behaviors prevent meaningful participation in the beneficiary's current and projected daily activities).
- g. AAC devices assessment components:
 - i. Vocabulary requirements;
 - ii. Representational system(s);
 - iii. Display organization and features;
 - iv. Rate enhancement techniques;
 - v. Message characteristics, speech synthesis, printed output, display characteristics, feedback, auditory and visual output;
 - vi. Access techniques and strategies; and
 - vii. Portability and durability concerns, if any.
- h. Identification of AAC devices considered for beneficiaries:
 - i. Identification of the significant characteristics and features of the AAC devices considered for the beneficiary; and
 - ii. Identification of the cost of the AAC devices considered for the beneficiary (including all required components, accessories, peripherals and supplies as appropriate).
- i. AAC device recommendation:
 - i. Identification of the requested AAC devices including all required components, accessories, software, peripheral devices, supplies and the device vendor;

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- ii. Identification of the beneficiary and communication partner's AAC devices preference, if any;
 - iii. Assessment of the beneficiary's ability (physically and mentally) to use, or to learn to use, the recommended AAC device and accessories for effective and efficient communication; and
 - iv. Justification stating why the recommended AAC device (including description of the significant characteristics, features and accessories) is better able to overcome or ameliorate the communication limitations that preclude or interfere with the beneficiary's meaningful participation in current and projected daily activities as compared to the other AAC devices considered; and justification stating why the recommended AAC device (including description of the significant characteristics, features and accessories) is the least costly, equally effective, alternative form of treatment to overcome or ameliorate the communication limitations that preclude or interfere with the beneficiary's meaningful participation in current and projected daily activities.
- j. Treatment plan and follow up:
- i. Description of short term communication goals (e.g., six months);
 - ii. Description of long term communication goals (e.g., one year);
 - iii. Assessment criteria to measure beneficiary's progress toward achieving short and long term communication goals;
 - iv. Description of amount, duration and scope of AAC services required for the beneficiary to achieve short and long term communication goals; and
 - v. Identification and experience of AAC service provider responsible for training (these service providers may include, e.g.: speech-language pathologists, occupational therapists, rehabilitation engineers, the beneficiary's parents, teachers and other service providers).

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- k. Summary of alternative funding source for AAC devices:
 - i. Description of availability or lack of availability, of purchase of AAC device through other funding sources.

Trial Use Periods

In instances where the appropriateness of a specific AAC device is not clear, a trial use period for an AAC device may be recommended (although it is not required) by the speech-language pathologist who conducts the AAC evaluation.

PA for rental of AAC devices shall be approved for trial use periods when the speech-language pathologist prepares a request that includes, but is not limited to:

- 1. The characteristics of the beneficiary's communication limitations;
- 2. Lack of familiarity with a specific AAC device; and
- 3. Whether there are sufficient AAC services to support the beneficiary's use of the AAC device, or other factors.

If the speech-language pathologist seeks a trial use period, they must prepare a trial use period request that includes the following information:

- 1. The duration of the trial period;
- 2. The speech-language pathologist information and the beneficiary information as required in the Assessment Evaluation;
- 3. The AAC device to be examined during the trial period, including all the necessary components (e.g., mounting device, software, switches, or access control mechanism);
- 4. The identification of the AAC services provider(s) who will assist the beneficiary during the trial period;
- 5. The identification of the AAC services provider(s) who will assess the trial period; and

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6. The evaluation criteria, specific to the beneficiary that will be used to determine the success or failure of the trial period.

Trial use period requests must include Medicaid funding for the rental of all necessary components and accessories of the AAC device. If an accessory is necessary for rental, but the communication device is available for rental for trial use, Medicaid may consider the purchase of the accessory for the trial use of the communication device.

Trial periods may be extended and/or different AAC devices provided, when requested by the speech-language pathologist responsible for evaluating the trial use period.

Results of trial use periods must be included with any subsequent request for PA of the AAC device purchase. Recommendations for the purchase of an AAC device, as a result of a trial use period of the device, must clearly indicate the beneficiary's ability to use the device during the trial period.

Repairs

Medicaid will cover repairs to keep AAC devices, accessories, and other system components in working condition. Medicaid coverage for repairs will include the cost of parts, labor, and shipping, when not otherwise available without charge pursuant to a manufacturer's warranty.

Providers of AAC devices are expected to comply with the Louisiana New Assistive Devices Warranty Act, La. R.S. § 51:2762 – 51:2767.

One of the provisions of this law is that all persons who make, sell, or lease assistive devices, including AAC devices, must provide those who buy or lease the equipment with a warranty which lasts at least one year from the time the equipment is delivered to the beneficiary. If, during the warranty period, the equipment does not work, the manufacturer or dealer must make an attempt to repair the equipment.

Medicaid additionally requires providers to provide the beneficiary with a comparable, alternate AAC device while repairing the beneficiary's device during a warranty period. Medicaid coverage may be provided for the rental of an alternate AAC device during a repair period after expiration of the warranty. Medicaid will not cover repairs, or rental of a loaner device, when repairs are made during a warranty period.

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When a device is received by the provider for the purpose of repair, the provider will conduct an assessment of the device to determine whether it can be repaired, and if so, prepare a written estimate of the parts, labor, and total cost of the repair, as well as the effectiveness (i.e., estimated durability) of the repair. If the manufacturer or provider concludes that the device is not repairable and a replacement device is needed, written notice will be provided to the beneficiary.

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

Replacement or Modification

Modification or replacement of AAC devices will be covered by Medicaid subject to the following limitations:

1. Requests for modification or replacement of AAC devices and/or accessories may be considered for coverage after the expiration of three or more years from the date of purchase of the current device and accessories in use;
2. Requests for modification or replacement require PA and must include the recommendation of the speech-language pathologist;
3. Requests for replacements of AAC devices may be submitted for identical or different devices;
4. Requests for replacements of identical AAC devices must be accompanied by a statement from the provider that the current device cannot be repaired or that replacement will be more cost effective than repair of the current device. Data must be provided about the following:
 - a. Age;
 - b. Repair history, including:
 - i. Frequency;

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- ii. Duration; and
 - iii. Cost.
 - c. Repair projections (estimated durability of repairs).
5. Requests for modification or replacement of AAC devices with different devices must include the following additional information:
- a. A significant change has occurred in the beneficiary's expressive communication, impairments, and/or communication limitations. Modification or replacement requests due to a change in the beneficiary's circumstances must be supported by a new assessment of communication limitations by a speech-language pathologist, and may be submitted at any time;
 - b. Even though there has been no significant change in the beneficiary's communication limitations, there has been a significant change in the features or abilities of available AAC devices (i.e., a technological change) that will overcome or permit an even greater amelioration of the beneficiary's communication limitations as compared to the current AAC device. A detailed description of all AAC device changes and the purpose of the changes must be provided with the results of a re-evaluation by a speech-language pathologist; or
 - c. Requests for replacements of AAC devices due to loss or damage (either for identical or different devices) must include a complete explanation of the cause of the loss or damage and a plan to prevent the recurrence of the loss or damage.

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18.2.6 Bath and Toileting Aids

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

Elevated Toilet Seats

An elevated toilet seat may be considered when a beneficiary is unable to go from a sitting to a standing position without assistance.

Bath or Shower Chairs

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

Safety Guardrails

Safety guardrails may be considered for beneficiaries who are unable to stand up in the tub or get out of the tub without assistance.

Footrest for Use with Toilet

A footrest for a toilet may be considered when the beneficiary's feet cannot touch the floor and it is needed for balance and support.

Commode Chairs

A commode chair may be considered when the beneficiary is physically incapable of utilizing regular toilet facilities.

An extra wide/heavy duty commode chair is covered for a beneficiary weighing 300 pounds or more. If the beneficiary weighs less than 300 pounds but the basic coverage criteria for a commode chair are met, payment will be based on the least costly medically appropriate alternative.

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A request for payment of a mobile commode chair will be denied as not medically necessary if basic coverage criteria for a commode chair are met. Payment will be based on the least costly medically appropriate alternative stationary commode chair.

Commode Chairs with Detachable Arms

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

Urinals (Hospital Type) and Bed Pans

Urinals (hospital type) and bed pans may be considered if the beneficiary is capable of using them and is confined to bed.

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18.2.7 Environmental Modifications or Repairs

Environmental modifications are activities of a major and largely non-recurring nature to improve the safety, sanitation and adaptability of a beneficiary's home. Installation of equipment is not covered.

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18.2.8 Batteries

Batteries are covered for artificial larynxes, insulin pumps, electric wheelchairs and cochlear implants.

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18.2.9 Blood Pressure Devices

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

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

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

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18.2.10 Breast Milk and Supplies**18.2.10.1 Donor Human Milk**

Donor human milk is covered outpatient for use by medically vulnerable infants.

Eligibility Criteria

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

1. Beneficiary is less than 12 months of age with one or more of the following conditions:
 - a. Post-surgical nutrition;
 - b. Organ transplantation;
 - c. Renal disease;
 - d. Short gut syndrome;
 - e. Malabsorption syndrome;
 - f. Feeding or formula intolerance;
 - g. Failure to thrive;
 - h. Inborn errors of metabolism;
 - i. Immunologic disorders;
 - j. Congenital heart disease (CHD) or other congenital anomalies; or
 - k. Neonatal abstinence syndrome.
2. Beneficiary's caregiver is medically or physically unable to produce breast milk at all or in sufficient quantities, is unable to participate in breastfeeding despite optimal lactation support, or has a contraindication to breastfeeding; or the beneficiary is medically or physically unable to receive caregiver breast milk or participate in breastfeeding;

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3. Beneficiary's caregiver has received education on donor human milk, including the risks and benefits; and
4. A bank accredited by, and in good standing with, the Human Milk Banking Association of North America supplied the donor human milk.

NOTE: Out-of-state DME providers enrolled only to supply donor human milk will not be limited to billing only crossover claims.

Reimbursement

Prescriptions for donor human milk must include the following:

1. Number of prescribed calories per ounce;
2. Total ounces prescribed per day;
3. Total number of weeks donor human milk is required;
4. Total allowable refills; and
5. Reason for prescribing donor human milk, including beneficiary's diagnoses.

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

Providers should review Chapter 25: Hospital Services Provider Manual for policy regarding coverage of donor human milk in an inpatient hospital setting.

18.2.10.2 Electric Breast Pumps

An electric breast pump is a mechanical device powered by batteries or electricity used by nursing mothers to extract milk from their breasts. Medicaid considers personal use, double, and electric breast pumps a coverable item for nursing mothers. A new breast pump is covered for each viable

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pregnancy. The breast pump may be obtained at the gestational age of 32 weeks to expectant mothers who meet the criteria and intend to breastfeed their infant.

PA is not required for a breast pump. Electric breast pumps are subject to post payment medical review. Providers must submit all required documentation along with a hard copy claim to the Department's FI. Failure to provide required documentation, or documentation that fails to establish medical necessity, may result in recoupment of the payment for the device.

All of the following documentation is required:

1. Prescription from the prescribing physician for the electric breast pump;
2. Education/training on breastfeeding with the prescribing physician, licensed breastfeeding practitioner or healthcare professional;
3. Louisiana Medicaid has not purchased a breast pump within the past three years for the same delivery; and
4. Completed Fillable Electric Breast Pump Request Form signed by the prescribing physician and the mother or their authorized representative.

NOTE: The Electric Breast Pump Request Form can be found in Appendix I of this Provider Manual or at the following link https://www.lamedicaid.com/provweb1/Forms/Electric_Breast_Pump_Request_Form_and_Instructions.pdf.

NOTE: Single, manual, and hospital-grade breast pumps are not covered items under Louisiana Medicaid.

Equipment Criteria

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

1. Have an adjustable suction pressure rate with either written instructions or an automatic mechanism to prevent a suction greater than 250 mm Hg;
2. Be adaptable for simultaneous pumping of both breasts (double-collection);
3. Automatically cycle with an adjustable variable cycling rate, typically 30 to 60 or more cycles per minute;

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4. Include a battery option and adapter to be used as an alternate power source when electricity is not immediately available;
5. Breast shields (flanges) that are adjustable and flexible, or flanges that are available in several different sizes if rigid, including larger sizes;
6. Accessories necessary for pumping two breasts simultaneously for electric pumps;
7. At least two collection bottles with spill-proof standard size caps, that are bisphenol-A (BPA) and di(2-ethylhexyl) phthalate (DEHP)-free; and
8. Accessories and supplies must be compatible with the pump provided. Materials must be of durable quality for withstanding repeated boiling, washing, and pumping use.

Replacement Criteria

Medicaid will allow replacement of a breast pump older than three years and after expiration of manufacturer's warranty. Equipment replacement and warranty are subject to the policy in Section 18.1 of this provider manual.

Electric Breast Pump Supplies

Electric breast pump supplies will be available to the nursing mother once every 180 days. DME providers must obtain PA for replacement supplies. The PA request must include the Fillable Electric Breast Pump Request Form.

18.2.10.3 Human Milk Storage Bags

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

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18.2.11 Enteral Nutrition

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

Enteral nutritional therapy is considered reasonable and necessary when medical documentation, such as hospital records and clinical findings, support an independent conclusion the beneficiary has a permanently inoperative internal body organ or function which does not allow absorption of sufficient nutrients to maintain weight and strength commensurate with the beneficiary's general condition. For purposes of this policy, permanent means an indefinite period of more than one month.

Prescriptions for enteral feedings must be for an average of at least 750 calories per day over the prescribed period and must constitute at least 70 percent of the daily caloric intake to be considered for coverage by Medicaid. Coverage of prescribed feedings of less than an average of 750 calories per day may only be considered with additional physician documentation and justification of the reason for prescribing less than an average of 750 calories per day. Baby food and other regular grocery products that can be used with an enteral system are not covered.

All requests must include the following information:

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

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

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

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

Enteral Infusion Pump

A standard enteral infusion pump will be approved only with documented evidence the pump is medically necessary and that syringe or gravity feedings are not satisfactory due to complications such as aspiration, diarrhea, dumping syndrome, etc.

Medicaid will pay for the rental of a standard enteral infusion pump and accessories. Medicaid can pay for repairs not covered by the warranty or lease agreement.

Hyperalimentation - Intradialytic Parenteral Nutrition Therapy

Intradialytic parenteral nutrition therapy (IDPN) is considered for prior authorization (PA) when a gastrointestinal disease or condition is present and is the cause of the beneficiary's inability to sufficiently absorb enough nutrients to maintain their weight and strength. Authorization will not be considered for beneficiaries who only have renal failure or insufficiency and an associated poor appetite or failure to thrive.

Request must include the following information:

1. Documentation that the beneficiary has an inability to sufficiently maintain their weight and strength without the intravenous (IV) nutrition therapy;
2. Documentation that adequate nutrition cannot be made possible by dietary adjustment, oral supplements, or enteral nutrition (tube or non-tube fed); and
3. Documentation that a clinically significant gastrointestinal disease or conditions that have resulted in the beneficiary's malnutrition due to the inability of the

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gastrointestinal (GI) tract to sufficiently absorb enough nutrients. A diagnosis alone is not sufficient to determine coverage.

Enteral Formula Coverage for Beneficiaries with Inborn Errors of Metabolism

This policy applies to beneficiaries with known or suspected inborn errors of metabolism served by the Office of Public Health (OPH) Genetic Disease program.

Louisiana Medicaid covers and considers medically necessary enteral formulas for beneficiaries of all ages without PA when the beneficiary has a diagnosis of an inborn error of metabolism made by a physician board certified in medical genetics or an advanced practice registered nurse (APRN) collaborating with, or a physician assistant supervised by, a physician board certified in medical genetics.

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

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18.2.12 Total Parenteral Nutrition Equipment and Supplies

An infusion pump is used to deliver nutritional requirements intravenously. Infusion pumps are covered for the delivery of parenteral nutrition for those beneficiaries who cannot absorb nutrients by the gastrointestinal tract.

Only one pump (ambulatory or stationary) will be covered at any one time. Additional pumps will be denied as not medically necessary.

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

An intravenous (IV) pole is a device to suspend fluid to be administered by gravity or pump. An IV pole will be covered when a beneficiary is receiving parenteral fluids and the beneficiary is not using an ambulatory infusion pump.

Infusion pumps, ambulatory and stationary, are indicated for the administration of parenteral medication in the home when parenteral administration of the medication in the home is reasonable and medically necessary, and an infusion pump is necessary to safely administer the medication.

An external ambulatory infusion pump is a small portable electrical device that is used to deliver parenteral medication. It is designed to be carried or worn by the beneficiary.

Prior Authorization Requirements

Requests for prior authorization (PA) of total parenteral nutrition (TPN) equipment and supplies are submitted on the PA-01 and must include documentation to establish medical necessity for TPN services. The documentation must confirm that the member meets the TPN medical necessity criteria outlined in the *Pharmacy Benefits Management Services Provider Manual*, Section 37.5.10 –Total Parenteral Nutrition of the pharmacy provider manual.

NOTE: Refer to the *Pharmacy Benefits Management Services Provider Manual* for coverage of TPN formula.

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18.2.13 Binders and Supports**18.2.13.1 Abdominal Binder and Hernia Supports****Abdominal Binders**

Abdominal binders may be approved with documentation of medical necessity.

Hernia Supports

Hernia supports may be approved with documentation of medical necessity.

18.2.13.2 Lumbar Orthosis and Truss Supports

Lumbar orthosis and truss supports may be approved with documentation of medical necessity.

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18.2.14 Support Garments**18.2.14.1 Support Hose**

Support hose are approved only for severe incapacitating vascular problems, such as:

1. Acute thrombophlebitis;
2. Massive venous stasis; or
3. Pulmonary embolism.

18.2.14.2 Surgical Mastectomy Bras

Surgical mastectomy bras are approved only if one or both of the beneficiary's breasts have been removed. After a mastectomy, two bras may be approved. If the breasts are removed in separate surgeries, two more bras may be approved following the second surgery.

Replacements may be approved after a reasonable length of time.

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18.2.15 Hearing Aids

Hearing aids are only provided to eligible beneficiaries under 21 years of age (Early and Periodic Screening, Diagnostic and Treatment (EPSDT) eligibles) and approved only when there is a significant hearing loss documented by audiometric data from both an ear specialist (otologist) and a hearing aid provider.

A hearing loss greater than 20 decibels average hearing level in the range 250-2000 hz is considered significant.

Reimbursement is at the flat fee on file for the date of service. Hearing aids must have a two-year warranty and should normally be expected to last at least three years before replacement.

Repair and batteries do not require prior authorization (PA).

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18.2.16 Cochlear Implant (Early and Periodic Screening, Diagnostic and Treatment - Only)

Reimbursement is available for cochlear implants for Medicaid beneficiaries with severe-to-profound bilateral sensorineural hearing loss.

Only beneficiaries under 21 years of age, who meet the eligibility criteria, qualify for cochlear implants. Please refer to Chapter 5, Professional Services Provider Manual for eligibility criteria.

Only one cochlear implant per lifetime, per ear, per eligible beneficiary shall be reimbursed unless the implant fails or is damaged beyond repair, in which case reimbursement for another implant and re-implantation will be considered.

Covered Expenses

The following expenses related to the maintenance of each cochlear implant device will be covered if prior authorized:

1. All costs for upgrades and repairs to the component parts of the implant; and
2. All costs for cords and batteries.

Cochlear Implant Device Criteria

The beneficiaries must meet the criteria for the cochlear implant as outlined in Chapter 5, Professional Services Provider Manual, in addition to having an approved prior authorization (PA) for the surgical procedure.

Non-Covered Expenses of Cochlear Device(s)

The following items are non-covered expenses:

1. Service contracts and/or extended warranties; and
2. Insurance to protect against loss and theft.

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Prior Authorization for Cochlear Implant(s)

All aspects of the cochlear implant (preoperative evaluation, implantation, implant, repairs, supplies, therapy) must be prior authorized. The request to perform surgery must come from the multidisciplinary team (MDT) consisting of, at minimum, a fellowship-trained pediatric otolaryngologist or fellowship-trained otologist, an audiologist, and a speech-language pathologist.

NOTE: Reimbursement for each implant will not be authorized until the surgical procedure has been approved.

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18.2.17 Dialysis Equipment and Supplies

Dialysis equipment and supplies are approved only if the beneficiary is under treatment for chronic renal disease and is trained in the use of the equipment.

All requests must have:

1. The diagnosis and prognosis;
2. Any other pertinent medical and social data;
3. The date the beneficiary was first dialyzed;
4. A statement from the facility that the beneficiary is capable of operating the equipment;
5. A statement from the equipment provider for home dialysis verifying that the beneficiary has been trained to use the dialysis equipment;
6. The name of the provider;
7. A prescription for the machine and the supplies; and
8. Frequency of dialysis.

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18.2.18 Baclofen Therapy

Consideration shall be given for Medicaid reimbursement for implantation of an intrathecal baclofen therapy (IBT) infusion pump if the treatment is considered medically necessary; the candidate is 4 years of age or older with a body mass sufficient to support the implanted system, and any one or more of the criteria as described below apply.

Inclusive criteria for candidates with spasticity of cerebral origin:

1. There is severe spasticity of cerebral origin with no more than mild athetosis;
2. The injury is older than one year;
3. There has been a drop in Ashworth scale of one or more;
4. Spasticity of cerebral origin is resistant to conservative management; and
5. The candidate has a positive response to test dose of Intrathecal Baclofen.

Inclusive criteria for candidates with spasticity of spinal cord origin:

1. Spasticity of spinal cord origin that is resistant to oral antispasmodics or side effects unacceptable in effective doses;
2. There has been a drop in Ashworth scale of two or more; or
3. The candidate has a positive response to test dose of Intrathecal Baclofen.

Caution should be exercised when considering IBT infusion pump implantation for candidates who: have a history of autonomic dysreflexia, suffer from psychotic disorders, have other implanted devices, or utilize spasticity to increase function such as in posture, balance and locomotion.

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Exclusion Criteria

Consideration for an implantation of an IBT infusion pump shall not be made if the candidate:

1. Fails to meet any of the inclusion criteria;
2. Is pregnant, or refuses or fails to use adequate methods of birth control;
3. Has a severely impaired renal or hepatic function;
4. Has a traumatic brain injury of less than one year pre-existent to the date of the screening dose;
5. Has a history of hypersensitivity to oral baclofen;
6. Has a systemic or localized infection which could infect the implanted pump; or
7. Does not respond positively to a 50, 75 or 100 mcg Intrathecal bolus of Lioresal during the screening trial procedure.

Diagnoses Covered

The following diagnoses are considered appropriate for IBT treatment and infusion pump implantation:

1. Meningitis;
2. Encephalitis;
3. Dystonia;
4. Multiple sclerosis;
5. Spastic hemiplegia;
6. Infantile cerebral palsy;
7. Other specified paralytic syndromes;

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8. Acute, but ill-defined, cerebrovascular disease;
9. Closed fracture of base of skull;
10. Open fracture of base of skull;
11. Closed skull fracture;
12. Fracture of vertebral column with spinal cord injury;
13. Intracranial injury of other and unspecified nature; and
14. Spinal cord injury without spinal bone injury.

Prior Authorization for Intrathecal Baclofen Therapy

Prior authorization (PA) for chronic infusion of IBT must be requested after the screening trial procedure has been completed, but **prior** to pump implantation.

The request to initiate chronic infusion must come from the multidisciplinary team (MDT) that evaluates the beneficiary. This MDT must be made up of a neurosurgeon or an orthopedic surgeon, a psychiatrist and/or neurologist, the beneficiary's attending physician, a nurse, a social worker and allied professionals (physical therapist, occupational therapist, etc.).

These professionals must have expertise in the evaluation, management and treatment of spasticity of cerebral and spinal cord origin and shall have undergone training in infusion therapy and pump implantation by a recognized product supplier with expertise in Intrathecal Baclofen.

The following documentation must be submitted in one package by the MDT:

1. A recent history with documentation of assessments in the following areas:
 - a. Medical and physical;
 - b. Neurological;
 - c. Functional; and
 - d. Psychosocial.

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2. Ashworth scores taken before and after the administration of IBT test dose(s); and
3. Documentation of any other findings about the beneficiary's condition which would be of interest to or would assist the Medical Review team in making a decision regarding the beneficiary's need for chronic infusion, i.e., a video tape of the trial dosage.

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18.2.19 Ambulatory Equipment**18.2.19.1 Canes and Crutches**

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

18.2.19.2 Walkers and Walker Accessories

A standard walker and related accessories are covered if all of the following criteria are met:

1. Prescribed by a physician for a beneficiary with a medical condition that impairs ambulation;
2. Beneficiary has a potential for ambulation; and
3. Beneficiary has a need for greater stability and security than can be provided by a cane or crutches.

Wheeled Walker

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

Heavy Duty Walker

A heavy-duty walker may be approved for beneficiaries who meet the criteria for a standard walker and weigh more than 300 pounds.

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Heavy Duty, Multiple Braking System, Variable Wheel Resistance Walker

A heavy duty, multiple braking system, variable wheel resistance walker is a four-wheeled, adjustable height, folding walker that has all of the following characteristics:

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

A heavy duty, multiple braking system, variable wheel resistance walker is considered medically necessary for beneficiaries who weigh greater than 350 pounds, meet coverage criteria for a standard walker, and are unable to use a standard walker due to a severe neurological disorder or other condition causing the restricted use of one hand. Obesity alone is not considered a medically necessary indication for this walker.

Leg Extensions

Leg extensions are considered medically necessary for beneficiaries six feet tall or taller.

Arm Rests

Arm rest attachments are considered medically necessary when the beneficiary's ability to grip is impaired.

Non-Covered Walker Items

1. Walker with enclosed frame;

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

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

Enhancement Accessories

Medicaid considers enhancement accessories of walkers, canes and crutches not medically necessary. An enhancement accessory does not contribute significantly to the therapeutic function of the walker, cane or crutch. It may include, but is not limited to style, color, hand operated brakes (other than those described in the section above on heavy duty, multiple braking system, variable wheel resistance walker), seat attachments, tray attachments, or baskets (or equivalent).

Walking Belts

Medicaid does not consider walking belts used to support and guide the beneficiary in walking as medically necessary because they are not primarily medical in nature and are normally used by persons who do not have a disease or injury.

18.2.19.3 Wheelchairs

Wheelchairs are approved only when the beneficiary is confined to a bed, chair or room. All requests for a custom manual or power wheelchair require submission of a completed **Custom Wheelchair** form.

Standard Wheelchairs

The request should indicate the beneficiary's ability to walk unassisted without the use of an appropriate fitted cane or walker and whether the request is for a first chair or replacement chair. Standard wheelchairs require documentation of medical necessity.

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Prior authorization (PA) will be made for only one wheelchair at a time. Backup chairs, either motorized or manual, will be denied as not medically necessary.

Standard Wheelchair Attachments

1. Foot rests;
2. Brakes; and
3. Arm rests.

Custom Manual Wheelchairs

A custom manual wheelchair is constructed to the specific body measurements and medical needs of the beneficiary. General criteria for a custom manual wheelchair includes inability to walk and propel a standard wheelchair.

In addition to the required documentation needed for all PA requests, PA requests for a custom manual wheelchair must include:

1. Completed PA-01 form or the electronic PA demographics on ePA;
2. Physician prescription for a custom manual wheelchair that includes:
 - a. Documentation the beneficiary is unable to propel a standard wheelchair; and
 - b. Diagnosis or limitations to justify the need for a custom manual wheelchair; and
3. **Custom Wheelchair** form with medical justification for the requested wheelchair and **ALL** modifications. All medical justification must be documented on the form. Indicating, “*See attached*” in a field on the form is not sufficient. Attaching documentation to the form without completing the fields on the form related to that documentation may result in denial of the PA.

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Custom Motorized Wheelchairs

The term *motorized* shall have the same meaning as power, electric or any means of propulsion other than manual. A motorized wheelchair must be medically necessary.

A motorized wheelchair is covered if the beneficiary's condition is such that the requirement for a motorized wheelchair is long term (at least six months).

The beneficiary must meet all of the following criteria in order to be considered for a motorized wheelchair:

1. Is not functionally ambulatory. 'Not functionally ambulatory' means the beneficiary's ability to ambulate is limited such that without use of a wheelchair, they would otherwise be generally bed or chair confined;
2. Unable to operate a wheelchair manually due to severe weakness of the upper extremities due to a congenital or acquired neurological or muscular disease/condition or is unable to propel any type of manual wheelchair because of other documented health problems; and
3. Capable of safely and independently operating the controls for a motorized wheelchair and can adapt to or be trained to use a motorized wheelchair effectively.

Wheelchair Prior Authorization

All wheelchairs and modifications required to meet the needs of a particular beneficiary are subject to PA. The PA request must include documentation on the **Custom Wheelchair** form of medical justification for the requested wheelchair and modification. PA will be made for only one wheelchair at a time. Backup chairs, either motorized or manual, will be denied as not medically necessary.

In addition to the required documentation needed for all PA requests, PA requests for motorized wheelchair must include:

1. Completed PA-01 form or the electronic PA demographics on ePA;
2. Physician's prescription for a motorized wheelchair;

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

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recommendation of the physician, physical therapist or occupational therapist making such statement.

Wheelchair Repairs and Modifications

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

Requests for modifications or reconstruction of the beneficiary's current wheelchair shall not be considered basic repairs. Requests for modifications or reconstruction of the beneficiary's current wheelchair must be submitted in accordance with PA criteria and submitted on the Repair Form for **Custom Wheelchairs**.

Modifications, repairs, or reconstruction will be denied if it is more cost effective to provide a new wheelchair.

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

18.2.19.4 Standing Frames

A standing frame (also known as a stander, standing aid, standing device) is assistive technology that can be used by a person who relies on a wheelchair for mobility. A standing frame provides alternative positioning to sitting in a wheelchair by supporting the person in the standing position.

Specific Criteria

The criteria to be considered for a standing frame include, but are not limited to, the following; the beneficiary must:

1. Be at a high risk for lower extremity contractures that cannot be improved with other interventions (stretching, medications, serial casting, splinting, and modalities);
2. Be able to tolerate a standing or upright position on the foot and ankle;

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3. Be non-ambulatory or is unable to stand due to conditions such as, but not limited to, neuromuscular or congenital disorders, including acquired skeletal abnormalities;
4. Have tried more cost effective alternatives and still requires a stander;
5. Not have a walker or gait trainer and it is not anticipated they will require one;
6. Have demonstrated improved mobility, function and physiologic symptoms or has maintained status with the use of the requested stander and is able to follow a home standing program with the use of the requested stander; and
7. Use the equipment for personal use only. The equipment will not be used at school.

Exclusion Criteria

Non-coverage of the standing frame includes, but is not limited to the following:

1. Beneficiary has complete paralysis of the lower extremities;
2. There is no expected improvement in mobility or maintenance of function;
3. Anticipated functional benefits of standing can be achieved through less-costly alternatives;
4. Mobile (dynamic) stander – either self-propelled standers or standers with powered mobility;
5. Active stander – allows movement of the arms and legs in a standing position;
6. In beneficiaries with syncope, orthostatic hypotension, postural tachycardia syndrome, osteogenesis imperfecta, osteoporosis, and other brittle bone diseases, and hip subluxation;
7. Beneficiary with hip and knee flexion contractures of more than 20 degrees; and
8. Beneficiary who has a gait trainer or ambulatory device.

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Documentation Requirements

The following documentation must be submitted to support the medical necessity for this equipment:

1. PA – (PA-01 Form);
2. Physician prescription;
3. State of Louisiana Medicaid Standing Frame Evaluation (BHSF-SF-Form 1) completed by a Louisiana State License Physician and Physical or Occupational Therapist in its entirety. (See Appendix G); and
4. Original Manufacture price.

18.2.19.5 Strollers of a Therapeutic Type

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

18.2 19.6 Special Needs Car Seat

A special needs car seat is designed for safe transport of the moderately to severely disabled child.

A special needs car seat is covered when all of the following criteria apply:

1. Special needs car seat must be medically necessary and appropriate. The physician must submit a full description of the beneficiary's postural condition including head and trunk control and height and weight. Weight must be between 20-105 pounds;
2. Beneficiary's condition is of such severity that they cannot be safely transported using a standard car seat, car seat belts, or modified vest travel restraints;
3. There is expected long-term need for the car seat; and
4. Special needs car seat must accommodate at least 36 months growth.

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If applicable, the car seat must be equipped with leg extensions to allow for growth over the 36-month period. Consideration must be given to the manufacturers' weight limitations.

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18.2.20 Diabetic Supplies and Equipment

Insulin pumps requiring tubing and supplies are covered through the durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) program. All reservoirs and canisters will be covered through the DMEPOS program. All other diabetic supplies and equipment are covered through the Louisiana Medicaid Pharmacy program.

Continuous Subcutaneous Insulin External Infusion Pumps

A continuous subcutaneous insulin external infusion pump is a portable insulin pump. It is about the size and weight of a small pager. The pump delivers a continuous basal infusion of insulin. Insulin pumps can be automatically programmed for multiple basal rates over a 24-hour time period. This can be useful for such situations as nocturnal hypoglycemia, the dawn phenomenon, and to assist with tight glycemic control.

Before meals or at other times (e.g., hyperglycemia after unanticipated caloric intake), the pump can be set to deliver a bolus of insulin, similar to taking an injection of pre-meal regular insulin for someone using multiple daily injections.

Payment for a continuous subcutaneous insulin external infusion pump and related supplies will be authorized for treatment of Type I diabetes. **Beneficiaries must meet either Criterion A or B as follows:**

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

1. Glycosylated hemoglobin level (HbA1c) greater than 7.0 percent;
2. History of recurring hypoglycemia;
3. Wide fluctuations in blood glucose levels (regardless of A1C);
4. Demonstrated microvascular complications;

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5. Recurrent severe hypoglycemia;
6. Suboptimal diabetes control (A1C exceeds target range for age);
7. Adolescents with eating disorders;
8. Pregnant adolescents;
9. Ketosis-prone individual;
10. Competitive athletes; and
11. Extreme sensitivity to insulin in younger children.

OR

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

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

Updated fasting C-peptide testing requirement:

1. Insulinopenia (defined as fasting C-peptide level less than or equal to 110 percent of the lower limit of normal of the laboratory's measurement method); and
2. Fasting C-peptide levels will only be considered valid with a concurrently obtained fasting glucose of less than 225 mg/dl.

NOTE: Levels only need to be documented once in the medical record.

The pump must be ordered by a physician who has familiarity with continuous subcutaneous insulin infusion (CSII) and who works closely with a team of nurses, diabetes educators, and

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dietitians who are knowledgeable in the use of CSII; the follow-up care of the beneficiary must be managed by a physician meeting these same requirements.

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18.2.21 Orthotics and Prosthetics**18.2.21.1 Orthotic Devices**

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

1. Complete description of special type brace;
2. Beneficiary's mental and physical ability to use the device;
3. Whether the device is a replacement;
4. Whether training is indicated; and
5. Plan of training, when indicated.

18.2.21.2 Orthopedic Shoes and Corrections

Orthopedic shoes and corrections may be approved only when:

1. Needed to protect gains from surgery or casting (qualifies as an emergency prior authorization (PA));
2. Medically necessary to prevent clinical deterioration of the foot as with beneficiaries with severe diabetes;
3. Medically necessary to prevent clinical deterioration of the foot as with beneficiaries with severe peripheral vascular disease; or
4. Attached to braces.

Shoes for Diabetics

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

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1. Documents that the beneficiary has diabetes;
2. Certifies that the beneficiary is being treated under a comprehensive plan of care (POC) for their diabetes and that they need therapeutic shoes; and
3. Documents that the beneficiary has one or more of the following conditions:
 - a. Previous amputation of the foot or part of the foot due to complications that resulted from diabetes;
 - b. History of previous foot ulceration;
 - c. Pre-ulcerative callus formation, or peripheral neuropathy with a history of callus formation;
 - d. Foot deformity; or
 - e. Poor circulation.

Shoe Lifts

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

Reimbursement

Because Medicare requires that the beneficiary either has diabetes with peripheral complications or the shoe must always be attached to braces, Medicaid will allow PA for consideration of payment when Medicare's criteria are not met. The provider must use a GY modifier when submitting the PA request for consideration or the claim for payment.

NOTE: Cables are not considered braces and therefore are not covered.

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Shoes for Minor Orthopedic Problem

Payment will not be made for shoes to correct minor orthopedic problems such as pes planus, metatarsus adductus, and internal tibial torsion.

18.2.21.3 Prosthetic Devices

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

1. Whether the request is for the first prosthesis or a replacement;
2. The mental and physical ability of the beneficiary to use the device; and
3. Whether training is required for a replacement.

A plan of training shall always be a part of a first request for prosthesis.

18.2.21.4 Traction Equipment

Traction equipment is approved only if the beneficiary has significant orthopedic impairment which prevents ambulation. Cervical traction collars are considered under orthotic devices.

18.2.21.5 Breast or Mammary Prostheses

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

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18.2.22 Disposable Incontinence Products

The products below are covered for beneficiaries aged 4 years of age through 20 years of age when specifically prescribed by the beneficiary's physician and specific criteria are met as described below.

Diapers

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

Pull-on Briefs

There is presence of a medical condition resulting in permanent bowel/bladder incontinence and the beneficiary has cognitive and physical ability to assist in their toileting needs.

Liners/Guards

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

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

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

Documentation Requirements

The prescription request form for disposable incontinence products may be completed, or a physician's prescription can be submitted along with the required documentation as listed below.

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Documentation must reflect the beneficiary's current condition and include the following:

1. Diagnosis (specific ICD-10-CM or its successor) of condition causing incontinence (primary and secondary diagnosis);
2. Item to be dispensed;
3. Duration of need (physician must provide);
4. Size;
5. Quantity of item and anticipated frequency the item requires replacement; and
6. Description of mobility/limitations.

To avoid unnecessary delays and need for reconsideration, care should be taken to use the correct Healthcare Common Procedure Coding System (HCPCS) codes located on the durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) fee schedule located on www.lamedicaid.com.

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

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

The "Prescription Request Form for Disposable Incontinence Supplies" collects this information. (See Appendix D for form).

Prior Authorization Requirements for Incontinence Supplies

Prior authorization (PA) is required for all disposable incontinence supplies. The PA requests shall meet all previously defined criteria for:

1. Eligible beneficiary;

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2. Eligible provider;
3. Covered product; and
4. Documentation requirements.

Quantity Limitations

Disposable incontinence supplies are limited to eight per day. Additional supporting documentation is required for requests that exceed the established limit.

Dispensing

Only a one-month supply may be dispensed at any time as initiated by the beneficiary. Allowable amounts may preclude the purchase of some products. The rate has been established so that the majority of products on the market are obtainable. Providers should always request authorization for the appropriate product for the beneficiary's current needs.

Providers must provide at the minimum, a moderate absorbency product that will accommodate a majority of the Medicaid beneficiary's incontinence needs. Supplying a larger quantity of inferior products is not an acceptable practice.

For beneficiaries requesting a combination of incontinence supplies, the total quantity shall not exceed the established limit absent approval of extraordinary needs.

Because payment cannot exceed the number of units prior authorized, providers who choose to have incontinent supplies shipped directly from the manufacturer to the beneficiary's home shall be responsible for any excess over the number of supplies approved by the PA.

Catheters

Catheters are approved only if the beneficiary's medical condition necessitates the use of a catheter.

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18.2.23 Hospital Beds and Patient Lifts**18.2.23.1 Hospital Beds**

Standard hospital beds are approved if the beneficiary is confined to a bed and their condition necessitates positioning the body in a way that is not possible in an ordinary bed. Elevation of the head/upper body less than 30 degrees does not usually require the use of a hospital bed.

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

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

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

Hospital Beds, Fixed and Variable Height

A fixed height hospital bed is one with manual head and leg elevation adjustments but no height adjustment. A variable height hospital bed is one with manual height adjustment and manual head and leg elevation adjustments.

In addition to the required documentation for PA requests as described under Hospital Beds above, the request must also include that the beneficiary has a condition that requires special attachments (such as a trapeze, foot board, or traction equipment) that cannot be fixed and used on an ordinary home bed.

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Furthermore, requests for a variable height bed must document that the beneficiary requires a bed height different than a fixed height hospital bed to permit safe transfers to a chair or for adequate bed care.

Hospital Bed, Semi-Electric

A semi-electric hospital bed is one with manual height adjustment and electric head and leg elevation adjustments.

In addition to the required documentation as previously listed under Hospital Beds, the PA request must document that the beneficiary requires a bed height different than a fixed height hospital bed to permit safe transfers to a chair or for adequate bed care. The PA request must also include that the beneficiary is alone for extended periods of time, requires frequent and immediate changes in body position and can operate the bed controls independently.

Hospital Bed, Total Electric

A total electric hospital bed is one with electric height adjustment and electric head and leg elevation adjustments.

In addition to the required documentation as previously listed under Hospital Beds, the PA request must document that the beneficiary requires a bed height different than a fixed height hospital bed to permit safe transfers to a chair or for adequate bed care. The PA request must also include that the beneficiary is alone for extended periods of time, requires frequent and immediate changes in body position and can operate the bed controls independently.

Documentation submitted on the PA request must also indicate one of the following:

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

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Hospital Bed Mattresses

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

Egg-Crate Mattresses & Alternating Air Pressure Mattresses/Pads

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

The PA request must include:

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

Sheepskins

Sheepskins are approved if the beneficiary's skin condition necessitates use.

Side Rails

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

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Hospital Bed, Pediatric

A pediatric hospital bed allows for the manual, semi-electric, or fully electric adjustment to the head and leg elevation. A pediatric hospital bed is:

1. One with a full side rail (360 degrees, up to 24 inches high above the mattress) enclosure; and
2. May be manual, semi-electric, or total electric.

Specific Criteria**Hospital Bed, Pediatric without Safety Enclosure**

A pediatric hospital bed without an added safety enclosure is covered when **all** of the following criteria are met.

The beneficiary must:

1. Be under 21 years of age;
2. Meet the criteria for a hospital bed. (See Hospital Bed Criteria in this section);
3. Have a medical condition that prevents the use of a standard size hospital bed and is best met by a pediatric sized hospital bed;
4. Have a medical condition that requires positioning of the body ordered by the physician so that the head of the bed elevation is greater than 30 degrees, or have documented problems with aspirations; and
5. Have a medical condition that is expected to last greater than six months which requires positioning of the body in ways that are not feasible with an ordinary bed, or hospital bed.

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In addition, the following criteria must be met:

1. The desired medical benefit is not attainable by the use of an ordinary bed. All alternative methods have been tried and failed;
2. An ordinary bed cannot be modified or adapted by commercially available items to meet the medical needs; and
3. Pillows and wedges must have been considered and ruled out.

Hospital Bed, Pediatric with Safety Enclosure

A pediatric hospital bed with an added safety enclosure is covered when **all** of the following criteria are met. The absence of a pediatric hospital bed with safety enclosure would result in the beneficiary being institutionalized.

The beneficiary must:

1. Be under 21 years of age;
2. Have one of the following diagnoses: brain injury, moderate to severe cerebral palsy, seizure disorder (with daily seizure activity taking anti-seizure medication), developmental disability, or severe behavior disorder (this list is not all inclusive);
3. Meet the criteria for a hospital bed. (See Hospital Bed Criteria in this section);
4. Have a medical condition that puts them at risk for falling off of or seriously injuring themselves while in an ordinary bed, standard size hospital bed, or a pediatric sized hospital bed;
5. Have a history of behavior involving unsafe mobility (climbing out of bed - more than standing at the side of the bed) that puts the beneficiary at risk for serious injury while in an ordinary bed, standard hospital bed, or pediatric hospital bed;
6. Be cognitively impaired and have communication impairments. The beneficiary is mobile and their unrestricted mobility has resulted in documented injuries; and

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7. Have tried less costly alternatives which were unsuccessful, including any of the following (not all inclusive):
 - a. Rail protectors;
 - b. Medications to address seizures and/or behaviors;
 - c. Helmets for head banging;
 - d. Baby monitors and bed alarm systems;
 - e. Behavior modification strategies;
 - f. Removal of safety hazards and installation of child protection devices (e.g. baby gate, safety door knob) in the beneficiary's room;
 - g. Placement of mattress on the floor; and
 - h. Physical and environmental factors for behavior have been eliminated. These include, but are not limited to, hunger, thirst, toileting, pain, restlessness, fatigue due to sleep deprivation, acute physical illness, temperature, noise levels, lighting, medication side effects, over/under stimulation or a change in caregivers or routine.

Exclusion Criteria

Non-coverage of the pediatric hospital bed includes, but is not limited to the following:

1. Lack of caregiver monitoring of beneficiary's safety;
2. The safety enclosure frames are used as a restraint or for the convenience of family or caregiver;
3. An ordinary bed, typically sold as furniture, which consists of a frame, box spring, and mattress;

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4. Institutional type hospital beds (e.g. oscillating beds, spring-base beds, circulating beds, continuous lateral rotation beds, and Stryker frame beds);
5. Enclosed beds for beneficiaries with 24-hour care from caregivers who are required to be awake and actively caring for the child;
6. Enclosed bed systems that are not approved by the Food and Drug Administration (FDA) (e.g. Vail Enclosure Bed, Posey Bed Enclosure System); and
7. The hospital beds where manufacturer is not registered and cleared to market with the FDA.

Documentation Requirements

The following documentation must be submitted to support the medical necessity for this equipment:

1. PA form – (PA-01 Form);
2. Physician prescription;
3. Louisiana Medicaid Pediatric Hospital Bed Evaluation (BHSF-PHB-Form 1) completed by a Louisiana State licensed physician and physical or occupational therapist in its entirety (see Appendix G); and
4. Original manufacturer's price.

18.2.23.2 Patient Lifts

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

1. Beneficiary is confined to bed, chair or room and is unable to transfer or unable to achieve needed movement with or without assistance;
2. Caregiver is unable without the use of a lift to provide periodic movement necessary to arrest or retard deterioration in the beneficiary's condition, thus affecting improvement in rehabilitation; and

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3. Caregiver is unable to transfer beneficiary from chair to bed or bath (or vice versa) e.g., because of beneficiary's size or weight.

Medicaid covers hydraulic lifts. **Electric lifts are not covered.**

Lift Slings

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

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18.2.24 Trapeze Bar

Trapeze bars are approved if the beneficiary requires assistance to sit up in bed because of a respiratory condition or a need to change body position for other medical reasons.

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18.2.25 Electrical Stimulators**18.2.25.1 Osteogenic Bone Growth Stimulators**

Osteogenic bone growth stimulators are used to augment bone repair associated with either a healing fracture or bone fusion. Medicaid coverage is limited to reimbursement for electrical and ultrasonic non-invasive types of bone growth stimulators. Medicaid will not provide reimbursement for invasive types of bone growth stimulators.

This item has not been approved by the U.S. Food and Drug Administration (FDA) for rental. Therefore, Medicaid will not approve payment for an osteogenic bone growth stimulator as a rental device.

Non-Spinal Non-Invasive Electrical Stimulators

Non-spinal non-invasive electrical bone growth stimulators may be considered under the following circumstances:

1. Failure of long bone fractures to heal. A period of six months from the initial date of treatment must elapse before failure is considered to have occurred;
2. Failure of long bone fusions (a period of nine months from the initial date of treatment must elapse before failure is considered to have occurred); or
3. Treatment of congenital pseudoarthroses. There is no minimal time requirement after the diagnosis.

Non-Spinal Non-Invasive Ultrasonic Stimulators

Non-Spinal non-invasive ultrasonic bone growth stimulators may be considered under the following circumstances:

1. Failure of a non-union fracture to heal. A period of 90 days following treatment has occurred;
2. Documentation consists of two sets of radiographs, one before treatment and the second occurring 90 days after treatment; and

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3. Radiographs shall include multiple views and be accompanied by a written interpretation by a physician stating that there has been no clinically significant evidence of the fracture healing between the two sets of radiographs.

Spinal Non-Invasive Electrical Stimulators

Spinal non-invasive electrical bone growth stimulators may be considered:

1. When a minimum of nine months has elapsed since the beneficiary had fusion surgery which resulted in a failed spinal fusion;
2. When there is a history of a previously failed spinal fusion at the same site following spinal fusion surgery (meaning more than nine months has elapsed since fusion surgery was performed at the same level which is being fused again). As long as nine months has passed since the failed fusion surgery, this repeated fusion attempt requires no minimum passage of time for the application of the device; or
3. Following a multi-level spinal fusion (i.e., involving three or more contiguous vertebrae, such as L3-L5 or L4-S1). There is no minimum requirement for application after surgery.

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18.2.25.2 Vagus Nerve Stimulators

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

Criteria for Beneficiary Selection

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

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

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physician must document this opinion clearly in the request for prior authorization (PA).

Exclusion Criteria

Regardless of the criteria for beneficiary selection, **authorization for VNS implantation shall not be given if the beneficiary has one or more of the following criteria:**

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

Place of Service Restriction

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

Prior Authorization

PA for implantation of the VNS shall be requested after the beneficiary evaluation has been completed but prior to stimulator implantation.

This request to initiate implantation shall come from the multidisciplinary team (MDT) that evaluates the beneficiary. The MDT should be comprised of the following:

1. A surgeon who has been trained and is familiar with the carotid sheath;
2. A psychiatrist or neurologist;
3. The beneficiary's attending physician;

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4. A nurse;
5. A social worker; and
6. Allied health professionals (physical therapist, occupational therapist, etc.).

These professionals shall have expertise in the evaluation, management, and treatment of epilepsy and have undergone VNS implantation training by a nationally recognized product supplier with expertise in VNS.

The following documentation shall be labeled and submitted in one package by the MDT:

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

Billing for the Cost of the Vagus Nerve Stimulator

The VNS is reimbursable by the Medicaid program; however, reimbursement of the device is dependent upon approval of the surgeon to perform the procedure. Hospitals should confirm the surgeon has received an authorization for the procedure prior to submitting the claim. Hospitals shall submit the appropriate Healthcare Common Procedure Coding System (HCPCS) code for the VNS generator and VNS leads, to the fiscal intermediary (FI) on a CMS-1500 claim form with the acronym "DME" written in red on the top of the form. The claim will pend to the FI's medical review department for review of the surgeon's approved PA request. If the surgeon's request is

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approved, the hospital claim will be allowed to process for payment. If there is no valid authorization, the hospital claim will deny with edit 191 (PA required).

Subsequent Implants and Battery Replacement

Battery replacement and subsequent implants require PA. In order to be considered, the request must contain documentation demonstrating the benefits of the original VNS transplant.

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18.2.26 Intravenous Therapy and Administrative Supplies

Intravenous (IV) therapy is a way of taking medicine so that it flows straight into the bloodstream.

IV medicines are given through flexible plastic tubes that are inserted into a vein, usually in the arm or the chest.

Medication that is given through an IV may be given with a syringe as a single dose (push), from a bag that is attached to the end of the tube (gravity infusion) or with a pump.

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

1. An oral form of the medication is not available;
2. IV medication will be more effective than oral medicine per the prescribing physician; and/or
3. Beneficiary is unable to take medication by mouth.

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

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

Syringes and Needles

Syringes and needles are covered only for IV therapy, intramuscular (IM) injections, subcutaneous (Sub Q) injections, for dialysis purposes when used to inject heparin into the dialysis system, and for wound care.

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

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NOTE: Insulin syringes are not covered in the Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) program, but are covered in the Pharmacy program. Syringes are not separately reimbursable for enteral and parenteral therapy, as these items are included in the supply kits.

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18.2.27 Wound Care Supplies

Surgical dressings, bandages, and other wound care supplies may receive prior authorization (PA) approval for three months at a time. The PA request must reflect the submitted prescription and document the factors below in order to meet criteria.

To request PA for wound care supplies, the following documentation must be provided:

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

The prescription must be updated for any extensions to be granted.

A Medicaid approved home health agency must be involved in the care of the beneficiary for consideration of approval for wound care supplies. Any routine supplies provided by the home health agency that are not covered by the Durable Medical Equipment, Prosthetics/Orthotics and Supplies (DMEPOS) Program must be provided in the skilled nursing visit rate.

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Wound Care Reimbursement

When prior authorized as medically necessary, reimbursement is manually priced. The fiscal intermediary (FI) will determine the reimbursement for manually priced durable medical equipment (DME) items based on 70 percent of the Medicare fee schedule or 70 percent of the manufacturer's suggested retail price (MSRP) amount, or billed charges, whichever is the lesser amount. If an item is not available at 70 percent of the Medicare fee schedule amount or 70 percent of the MSRP amount, the flat fee that will be utilized is the lowest cost at which the item has been determined to be widely available by analyzing usual and customary fees charged in the community.

Wound Care System

Wound care systems may be considered for reimbursement when prior authorized. A wound care system may be considered for reimbursement for beneficiaries with a Stage III or IV chronic, non-healing wound, such as a pressure, venous stasis, and diabetic ulcers, postsurgical wound dehiscence, non-adhering skin grafts, or surgical flaps required for covering such wounds.

Types of wound care systems include the following:

1. Thermal wound care system; and
2. Sealed suction wound care system.

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

NOTE: This list of covered services may not be all inclusive. (See the fee schedule located on the Louisiana Medicaid web site). Refer to the Section 18.5 for information regarding PA.

Surgical Dressings and Bandages

The below surgical dressings and bandages are approved only for wound dressing and post-operative care with documentation of medical necessity:

1. Gauze;
2. Tape;

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3. Sponges;
4. Cement; and
5. Disposable gloves.

Burn Garments and Stockings

Burn garments and stockings are approved only for severe burns and major vascular problems.

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18.2.28 Disposable (Elastomeric) Infusion Pumps

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

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

Disposable (elastomeric) infusion pumps are **not covered** when the antibiotic being administered:

1. Is not considered medically necessary to the treatment of the beneficiary's illness;
2. Is used for pain management;
3. Exceeds the frequency or duration ordered by the physician;
4. Is a chemotherapeutic agent; or
5. Is not approved by the Food and Drug Administration (FDA).

Prior authorization

Prior authorization (PA) is required for disposable infusion pumps and intravenous (IV) supplies.

Intravenous Supplies

The following standards will be considered when determining medical necessity of IV supplies for use with disposable (Elastomeric) infusion pumps:

1. The aseptic technique is acceptable for IV catheter insertion and site care;

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

Documentation Requirements

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

1. Information on the underlying diagnosis or condition;
2. Physician's order and documentation supporting medical necessity; and
3. Name of the antibiotic, dosage, the duration of therapy, and the frequency of administration.

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BENEFICIARY REQUIREMENTS

Durable medical equipment and supplies are covered for eligible beneficiaries and must be prior authorized.

It is the provider's responsibility to verify beneficiary eligibility and to maintain verification in the beneficiary's treatment record. Additionally, eligible beneficiaries under this Program must be referred by a physician, have a prescription signed by the physician and must not be institutionalized.

NOTE: Refer to the General Information and Administration, Chapter One, for more information on beneficiary eligibility.

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PROVIDER REQUIREMENTS

The following entities may enroll as providers in the Durable Medical Equipment (DME) program:

1. Businesses that supply DME and medical supplies;
2. Pharmacies that supply DME and medical supplies;
3. Home health agencies;
4. Orthopedic physician groups who supply orthotic and prosthetic devices that are not otherwise included in the physician's office visit charge; and
5. Optometrists and opticians who supply prosthetic eyes.

Businesses are defined as enterprises, commercial entities, or firms in either the private or public sector, that are concerned with providing products or services to satisfy customer requirements.

General DME Provider Enrollment Requirements

Providers must be enrolled in the Louisiana Medicaid program to participate. Participation is voluntary. The Louisiana Medicaid Provider Enrollment Application can be obtained from the Medicaid web portal. (See Appendix E for the link to the website). To enroll as a Medicaid provider, a DME and medical supply entity must meet the following criteria:

1. Be licensed by the local government agency as a business or merchant, or provide documentation from the city or county authority that no licensure is required;
2. Be licensed by the Department of Health, Medical Quality Assurance, Board of Orthotics and Prosthetics, if providing orthotics and prosthetic devices;
3. Be licensed by the Agency for Health Care Administration, Division of Health Quality Assurance, in possession of a home health equipment license;
4. Be in compliance with all applicable laws relating to qualifications or licensure; and
5. Have an in-state business location or be located not more than 50 miles from the Louisiana state line.

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Business Location Eligibility Requirements

Eligibility for initial enrollment, continued enrollment, or re-enrollment as a Medicaid DME and medical supply provider requires the provider to meet one of the criteria below:

1. Must be a DME or medical supply business currently occupying (maintains staff and business equipment at the site) and operating (accommodates ordering and allows pick-up and return of equipment/supplies at this site) from a physical business site that is located within the state of Louisiana, and that is easily accessed by Louisiana Medicaid beneficiaries and the general public it serves;

NOTE: The physical business site should, at a minimum, have identifiable and visible signage, posted operational hours, handicap accessibility, working utilities, appropriate furniture and office equipment to conduct business, fire extinguishers, telephone access, some inventory or stock available to be viewed and/or purchased by beneficiaries, and staff with knowledge to assist beneficiaries.

2. Must be a DME or medical supply business that provides sufficient proof that the business occupies and operates a DME and medical supply or medical supply business location within 50 miles of the Louisiana state line. The business must submit proof of all current city and state licenses, permits, and certifications required of DME and medical supply providers operating within the state where the DME business is physically located and provide proof that the business location can be easily accessed by Louisiana Medicaid beneficiaries and the general public it serves; or
3. If the DME business or medical supply is physically located more than 50 miles from the Louisiana state line, the business must supply DME or supplies not otherwise available from other enrolled providers located within the state. The business must also provide proof of all current and applicable licenses, permits, and certifications required of a DME or medical supply business in the state where the applicant business is physically located.

All applicants and currently enrolled DME and medical supply providers must submit proof of current accreditation as a prerequisite for enrollment, continued enrollment or reenrollment (see *Exemption from Accreditation Requirements* in this section). Proof of accreditation from one of the following Medicare deemed accreditation organizations listed below will be accepted:

1. The Joint Commission (JC);

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2. National Association of Boards of Pharmacy (NABP);
3. Board of Orthotist/Prosthetist Certification (BOC);
4. The Compliance Team, Inc.;
5. American Board for Certification in Orthotics & Prosthetics, Inc. (ABC);
6. National Board of Accreditation for Orthotic Suppliers (NBAOS);
7. Commission on Accreditation of Rehabilitation Facilities (CARF);
8. Community Health Accreditation Program (CHAP);
9. HealthCare Quality Association on Accreditation (HQAA); and
10. Accreditation Commission for Health Care, Inc.

NOTE: Web site information for the accrediting organizations can be found in Appendix E of this manual chapter.

Exemptions of Accreditation Requirements

Professionals exempted from the proof of accreditation requirement are:

1. Physicians;
2. Physician assistants;
3. Nurse practitioners (NPs);
4. Occupational therapists (OTs);
5. Speech-language pathologists;
6. Clinical nurse;
7. Certified registered nurse anesthetists (CRNAs);

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8. Certified nurse-midwives;
9. Clinical social workers;
10. Clinical psychologists;
11. Registered dietitians;
12. Nutritional professionals; and
13. Podiatrists.

Other Professionals Exempted by the LDH Secretary

1. Orthotists;
2. Prosthetists;
3. Opticians;
4. Audiologists; and
5. DME providers with a specialty of 8W (donor milk only).

Requirements for Medical Oxygen Providers and Retailers

In addition to meeting the general DME and medical supply provider requirements, oxygen providers and providers of oxygen-related equipment and services must also have a current and valid oxygen permit. Permits can be obtained by contacting the Office of Public Health (OPH), Food and Drug Program. (See Appendix E of this manual chapter for contact information).

Pharmacy providers who also provide DME and bill Medicaid for oxygen must submit copies of their OPH pharmacy permits with their provider enrollment applications.

Oxygen providers must have a licensed certified respiratory therapist (CRT), registered respiratory therapist (RRT), registered nurse (RN), or respiratory care practitioner (RCP) under contract or on staff to provide management and consumer instruction at the provider's physical DME business location or in the beneficiary's home.

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DME oxygen providers and providers of oxygen-related equipment and services must establish and implement written policies and procedures to ensure all new and used oxygen-related or respiratory equipment, including the internal filters purchased by the provider, are appropriately disinfected, sterilized, serviced, and properly stored according to manufacturer's specifications.

Prior to renting, delivering, or providing the equipment to any individual beneficiary, all licensure requirements and industry standards are applicable.

NOTE: Used equipment cannot be sold to a beneficiary; however, rental equipment may be provided.

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

If the equipment has a patient compliance hour meter, that reading must also be documented and maintained in the beneficiary's record.

Requirements for Home Health Providers and Supplies

Home health providers who wish to bill for supplies through the DME program must write a letter indicating the desire to bill supplies through the DME program and submit it along with an enrollment packet to Provider Enrollment for consideration.

It is not necessary to have a different provider number to bill supplies through the DME program, but the State must have this request letter in order to establish the provider record before supplies can be billed.

All DME policies and billing guidelines are applicable for any DME service provided.

Home health agencies often train beneficiaries (or their caregivers) to administer medications, or to use certain equipment or supplies, in their absence. As long as the home health agency is monitoring the administration and is providing home health services to the beneficiary, they can

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be provided DME covered intravenous (IV) supplies, or other home health supplies, for use in the beneficiary's home.

In situations where normal usage amounts are exceeded, the larger quantity may be approved. Documentation justifying the need for larger quantities must accompany the request for prior authorization.

The below is a list of supplies included in the reimbursement for a home health visit. These supplies cannot be billed in addition to a visit.

Reimbursable Supplies	
Adhesive tape	Paper tape
Alcohol	Self-assistive devices (long handle tongs and shoehorn stocking aide)
Alcohol preps-swab	Sharps containers
Bandage scissors	Sterile Specimen containers
Blood drawing supplies	Surgical masks
Culturettes	Tape measure, all types
Disposable gloves-non-sterile	Thermometer cover
Disposable gowns (plastic, paper)	Thermometer with holder
Disposable wash cloths	Tourniquet
Emesis basins	Tubex holder
Goggles	Vacutainer used for drawing blood
Non-sterile cotton balls, buds	Water soluble lubricant
Oral swabs/toothettes	

NOTE: This list is not all inclusive

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Documentation of Medical Necessity

Medical necessity must be established for each service and documented, at a minimum, with the following:

1. Written prescription not more than 12 months old, with the printed name and the dated signature of the beneficiary's treating physician or the treating physician's advanced registered nurse practitioner (ARNP) or physician assistant. The prescription can be received by the DME and medical supply provider before or after the DME service has been initiated, but the prescription cannot be dated more than 21 days after the initiation of service (date of service);
2. Current hospital discharge plan with the dated signature of the beneficiary's treating physician or the treating physician's ARNP or physician assistant that clearly describes the type of DME item or service ordered;
3. Letter of Medical Necessity not more than 12 months old, which includes the printed name and the dated signature of the beneficiary's treating physician or the treating physician's ARNP or physician assistant. Medicaid prohibits vendors from preparing sections of the letter of medical necessity that are to be completed by the physician or authorized prescriber. The letter of medical necessity cannot be dated more than 21 days after the initiation of service (date of service); and
4. Plan of care, if the provider is a home health agency.

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

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

Freedom of Choice

The beneficiary is allowed the freedom to choose any Medicaid-enrolled provider to supply the item(s).

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If the chosen provider will not provide the item at or below the approved cost, the beneficiary must be offered the opportunity to choose another provider if Medicaid is going to cover the item. The Department or the Prior Authorization Unit (PAU) will assist the beneficiary in locating a provider if necessary.

Delivery Arrangements and Documentation Requirements

The provider is responsible for delivery and set-up of the item if the beneficiary is physically or mentally unable to handle the arrangements themselves.

NOTE: Louisiana Medicaid does not reimburse freight or delivery charges.

Delivery documentation is a record of the beneficiary's or responsible caregiver's receipt of prescribed and medically-necessary medical supplies or DME.

Delivery documentation must be maintained in the beneficiary's file; and, at a minimum, include the following information:

1. Name of the DME and medical supply provider;
2. Provider's identification number for the DME physical location that rendered the service or equipment;
3. Address of the DME physical location that rendered the service or equipment;
4. Beneficiary's full name and 10-digit Medicaid identification number;
5. Documentation of service location that identifies whether medical equipment or supplies were received by the beneficiary or caregiver at the DME physical location or delivered directly to beneficiary's residence;
6. Date of delivery;
7. Complete description of item(s) delivered;
8. Manufacturer name of equipment delivered;
9. Model number;

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10. Serial or item number(s), where applicable;
11. Current hour meter reading(s), if applicable;
12. Oxygen tank or cylinder's contents, if applicable;
13. Clearly written statement identifying whether the equipment is new or used;
14. Signed and dated documentation of training provided to beneficiary or responsible caregiver;
15. Dated signature of DME delivery person and his professional license number, if applicable;
16. If a DME item is appropriate for shipment, the date of shipment and proof of documented delivery and receipt, such as UPS tracking document; and
17. Signature of beneficiary or responsible caregiver and date of delivery or receipt, if the information was obtained by the deliverer.

Pick-up and Return Documentation Requirements

Pick-up and return documentation must be maintained in the beneficiary's file in the following circumstances:

1. Medical equipment is being returned to the provider's DME business location by the beneficiary or responsible caregiver;
2. Equipment is no longer medically necessary and is picked up from the beneficiary's residence by the provider;
3. Equipment is no longer functioning properly and is picked up from the beneficiary's residence; and
4. Equipment picked up from the beneficiary's residence for other clearly documented reasons.

Pick-up documentation must include, at a minimum, the following information:

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1. Name of DME and medical supply provider;
2. Medicaid identification number of the DME location;
3. Address of the DME physical location that originally rendered the service or equipment;
4. Beneficiary's full name and 10-digit Medicaid identification number;
5. Complete description of item(s) picked up;
6. Manufacturer name of item(s) picked up;
7. Model and serial or item number(s) of item(s) picked up;
8. Reason the equipment is being picked up;
9. Current hour meter reading(s);
10. Description of the pick-up location that identifies whether medical equipment or supplies were returned to the DME business location or retrieved from the beneficiary's residence, etc., including the beneficiary's pick-up address;
11. Reason for the return of medical equipment to the provider's DME business location by the beneficiary or responsible caregiver, the reason for the return;
12. Date of pick up or return;
13. Dated signature of staff picking up the equipment and his professional license number, if applicable; and
14. Dated signature of beneficiary or responsible caregiver releasing the medical equipment to the provider, if the information was obtained by the deliverer.

Training Documentation Requirements

The beneficiary's record must contain documentation of the training that was provided to the beneficiary upon the receipt of prescribed medical equipment and supplies.

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Training documentation must, at a minimum, include the following information:

1. Beneficiary's name;
2. Complete description of medical equipment or item(s) received;
3. Model and serial number of item received;
4. Date of training;
5. Printed name, signature, and title of trainer;
6. Professional license number of trainer, if applicable;
7. Dated signatures of beneficiary or responsible caregiver, attesting to his understanding of information and handouts provided; and
8. Description of training handouts or brochures.

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PRIOR AUTHORIZATION

Prior authorization (PA) is an integral part of the DME program. Services within the scope of the Durable Medical Equipment (DME) Program that require prior authorization are identified on the DME-POS Fee Schedule. If DME equipment or supply is not authorized prior to the service being rendered, providers have six months after the date of service to request authorization. Providers who neglect to obtain authorization within the first six months will not receive reimbursement.

Requests for Prior Authorization

Providers may submit requests for prior authorization of DME equipment/supplies by completion of the Louisiana Request for Prior Authorization Form, the PA-01 (see Appendix A of this manual chapter). No other form or substitute will be accepted. Completed requests must be sent to the Prior Authorization Unit (PAU). Requests may be mailed, faxed or submitted through electronic PA (e-PA). The preferred method is e-PA.

Electronic Prior Authorization (e-PA)

Electronic-PA is a web application that provides a secure web based tool for providers to submit prior authorization requests and to view the status of previously submitted requests. For more information regarding e-PA visit the Louisiana Medicaid web site or call the PAU (see Appendix E for the website and contact information).

NOTE: Emergency requests cannot be submitted via e-PA.

Routine Requests

All routine PA request packets should include the following:

1. Completed PA-01 form;
2. Medical information from the physician;
3. Written prescription from a licensed physician or physician's representative;
4. Diagnosis related to the request;
5. Length of time that the supplies or equipment will be needed;
6. Other medical information to support the need for the requested item;

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7. Statement as to whether the beneficiary's age and circumstances indicate that they can adapt to or be trained to use the item effectively;
8. Plan of Care (POC) that includes a training program when any supplies or equipment requires skill and knowledge to use; and
9. Any other pertinent information, such as measurements.

Mail the completed PA packet to the PAU.

Providers are required to release equipment upon approval from the PAU and verification of eligibility.

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

Emergency Requests

Louisiana Medicaid has provisions and procedures in place for emergency situations. A request is considered an emergency if a delay in obtaining the medical equipment or supplies would be life-threatening to the beneficiary. In an emergency, telephone or verbal requests shall be permitted. (See Appendix E for contact information).

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

1. Apnea monitors;
2. Breathing equipment;
3. Enteral therapy;
4. Parenteral therapy (must be provided by a pharmacy);
5. Suction pumps; and
6. Wheelchair rentals for post-operative needs.

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

1. The beneficiary's name, age and 13-digit identification number or card control number (CCN);

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2. Treating physician's name;
3. Diagnosis;
4. Time period needed for the item;
5. Complete description of the item(s) requested;
6. Reason that the request is a medical emergency; and
7. Cost of the item.

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

Emergency Hospital Discharge Request

The provider should contact the PAU immediately and follow the emergency request procedures for beneficiaries pending discharge. Prior authorization will be approved for a one-month supply only. Separate requests are required for ongoing services.

NOTE: Discharge from a Nursing Facility would not be considered for Emergency Request.

Nursing Facility Discharge

Nursing facility discharges are not considered emergency requests. The provider shall submit the request as soon as notification of the discharge plan is received to avoid delays.

The provider shall contact the PAU immediately when notified of a beneficiary pending discharge from a nursing home. The provider must have documentation of the expected discharge date for the beneficiary from the facility. The prior authorization request must be faxed to the fiscal intermediary and not sent via the Electronic-PA. The coversheet should be labeled, "Pending Discharge" and include the expected discharge date.

NOTE: Submission of the PA via the electronic-PA will result in automatic denial based on system editing.

The prior authorization request will be reviewed and the provider notified of the determination.

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Medicare Part B Beneficiaries

If the request for medical equipment and supplies is covered by Medicare and the beneficiary is enrolled in Medicare Part B, no prior authorization is required; however, Medicare **must** be billed prior to billing Medicaid.

If the item is not covered by Medicare, the request will be processed as if it were being processed for non-Medicare beneficiaries.

Federal law and regulations require states to institute policies and procedures to ensure that Medicaid beneficiaries use all other resources available to the beneficiary prior to payment by Medicaid.

NOTE: Refer to Sections 18.6 of this chapter and Chapter One, General Information and Administration for more information on third party liability (TPL).

Prior Authorization Determination Time Limits

Prior authorization requests submitted to the PAU for the purchase of supplies or the purchase, rental or repair of equipment shall be processed no later than 25 days from the receipt date. Failure to make a timely determination shall result in an automatic approval.

Date of Service Change for Prior Authorization

It is a requirement of Medicaid that providers **not bill for durable medical equipment, services, supplies, prosthetics, or orthotics until the services have been rendered or the items have been delivered or shipped** to the beneficiary. It is also a requirement that the date of service and the date of delivery is the same date in order for a claim to be paid.

When requesting authorization of payment for these items or services, the provider should request authorization on the actual date of the service, delivery, or shipment of the item, or if not known, the provider should request a span date of sufficient duration to allow for authorization by the PAU and delivery of the service or item. This will prevent unnecessary denial of payment on the claim.

In the event a provider needs to change the date of service to match the date of delivery, a reconsideration request must be submitted to the PAU. A copy of the delivery ticket must be attached if the delivery of the service or item has already been made.

Requests for adjustments to dates of service must be sent in writing to the PAU and should always include the reason for the adjustment and documentation of the delivery date. Telephone requests are not allowed for the change.

The guidelines as described below should be followed and considered in requesting a change in the dates of service:

CHAPTER 18: DURABLE MEDICAL EQUIPMENT

SECTION 18.5: PRIOR AUTHORIZATION**PAGE(S) 6**

1. A telephone authorization has been obtained for DME services to be provided after a beneficiary's discharge from a hospital facility. If the discharge was delayed beyond the anticipated date of discharge and service, a date of service may be adjusted at the provider's request to reflect the actual discharge date as the date of service;
2. A change in providers after PA is approved for services may justify a change in the "thru" or end date of services for the old provider's PA file;
3. When a delay in the delivery of an item after prior authorization by the FI, is justified as unavoidable by the provider. The date of service would be adjusted to match the delivery date. The provider must document the reason for the delay and the actual date of delivery (documented with a delivery ticket);
4. An adjustment of the date of service may only be considered if the date of delivery is within six months of the original, anticipated date of service that was entered onto the PA file when the request was approved. Any delays of delivery longer than six months after the date of service on the PA file cannot be considered for a date of service adjustment;
5. Delays by the provider in submissions of a claim for payment, not involving a justified delay in delivery, cannot be considered by the PAU as a reason for changing the date of service on the PA file. Any delays by the provider in submitting a claim after delivery, which result in a problem in meeting the timely filing deadlines, can be considered only for resolution through the established procedures for an override of the timely filing limits for claims;
6. If a provider is approved for a service and is able to deliver the approved item at an earlier time than the anticipated date of service that was entered on the PA file, the provider may ask that the date of service be adjusted to an earlier date to match their earlier delivery date. The provider must send documentation (copy of the delivery ticket) with the request; and
7. The provider is allowed to wait to deliver until prior authorization has been approved; however, the item must be delivered before the claim can be submitted.

NOTE: It is a violation of federal and state Medicaid policy to bill for a service that has not been delivered but has been ordered.

Please remember that information on DME claims (not prior authorization request) cannot be changed after submittal.

CHAPTER 18: DURABLE MEDICAL EQUIPMENT

SECTION 18.5: PRIOR AUTHORIZATION**PAGE(S) 6**

The PA system was designed to act on an original request with the receipt of medical information or a request for extension of services which is considered a “new” request and must contain all necessary information in order for the PAU to approve the service. This includes the original/current diagnosis, an up-to-date prescription and other pertinent documentation to support that the services, supplies, and equipment are ongoing.

Requests that are submitted noting the diagnosis is a lifetime condition or includes a reference to previously submitted information will not be approved. The prescription date shown in field 9 of the request for prior authorization (PA-01 form) should fall within 60 days of the initial request or re-request (continuation).

CHAPTER 18: DURABLE MEDICAL EQUIPMENT

SECTION 18.6: CLAIMS RELATED INFORMATION**PAGE(S) 2**

CLAIMS RELATED INFORMATION

DME services are billed to Medicaid on the most current CMS-1500 claim form. Providers are strongly encouraged to file claims via electronic data interchange (EDI). Electronic claims must be HIPAA compliant. The benefits of electronic submission include the following:

1. Increased cash flow;
2. Improved claim control;
3. Decrease in time for receipt of payment;
4. Improved claim reporting; and
5. Reduction of errors through pre-editing of claims information.

Hard copy claims may be mailed to the fiscal intermediary (FI). However, submitting claims electronically is the preferred method. (See Appendix E for contact information)

Refer to Appendix B for sample claim forms, adjustment and void form and instructions as related to DME.

Mandatory items on the CMS-1500 are indicated by **underlining and/or an asterisk (*)**. Claims submitted with missing or invalid information in these fields will be returned unprocessed with a rejection letter listing the reason(s) the claims are being returned. Such claims cannot be processed until corrected and resubmitted. Completed and corrected DME claim forms should be mailed to the fiscal intermediary (FI). (See Appendix E for contact information).

Reimbursement

Louisiana Medicaid reimburses DME providers based on rates published in fee schedules. These rates are uniform statewide and by provider type. According to this type of reimbursement methodology, the provider is paid the lower of the billed charges or the Medicaid rate published in the applicable fee schedule.

CHAPTER 18: DURABLE MEDICAL EQUIPMENT

SECTION 18.6: CLAIMS RELATED INFORMATION**PAGE(S) 2**

When services or products do not have an established reimbursement amount, the claim is manually reviewed to determine an appropriate reimbursement. DME and expendable supplies are subject to manual pricing by analyzing such factors as invoiced costs to providers, comparative prices of the providers manufacturer's suggested retail prices and negotiated rates based on an accumulation of data from private insurers as to their allowable reimbursement for these types of equipment and supplies.

When Louisiana Medicaid requires documentation of the physician's order, supporting documentation must accompany the claim in order to be considered for reimbursement.

Third Party Liability

Enrolled providers must determine if beneficiaries are covered by a third party. If a beneficiary is covered by a third party, providers must bill the third party prior to billing Medicaid. Medicaid is payer of last resort. Refer to General Information and Administration, Chapter One for more information on third party liability (TPL).

**STATE OF LOUISIANA
DEPARTMENT OF HEALTH
Bureau of Health Services Financing Medical Assistance Program
REQUEST FOR PRIOR AUTHORIZATION**

CONTINUATION OF SERVICES _____YES _____NO

(15) PROVIDER SIGNATURE: *Connie David* (16) DATE OF REQUEST: 08/13/2009

Instructions for Completing Prior Authorization Form (PA-01)

NOTE: ONLY THE FIELDS LISTED BELOW ARE TO BE COMPLETED BY THE PROVIDER OF SERVICE. ALL OTHER FIELDS ARE TO BE USED BY THE PRIOR AUTHORIZATION DEPARTMENT AT UNISYS.

- | | |
|----------------------|--|
| FIELD NO. 1 | CHECK THE APPROPRIATE BLOCK TO INDICATE THE TYPE OF PRIOR AUTHORIZATION REQUESTED. |
| FIELD NO. 2 | ENTER BENEFICIARY'S 13-DIGIT MEDICAID ID NUMBER OR THE 16-DIGIT CCN NUMBER. |
| FIELD NO. 3 | ENTER THE BENEFICIARY'S SOCIAL SECURITY NUMBER. |
| FIELD NO. 4 | ENTER THE BENEFICIARY'S LAST NAME, FIRST NAME AND MIDDLE INITIAL AS IT APPEARS ON THEIR MEDICAID CARD. |
| FIELD NO. 5 | ENTER THE BENEFICIARY'S DATE OF BIRTH IN MMDDYYYY FORMAT (MM=MONTH, DD=DAY, YYYY=YEAR). |
| FIELD NO. 6 | ENTER THE PROVIDER'S 7-DIGIT MEDICAID NUMBER. IF ASSOCIATED WITH A GROUP, ENTER THE ATTENDING PROVIDER NUMBER ONLY. |
| FIELD NO. 7 | ENTER THE BEGINNING AND ENDING DATES OF SERVICE IN MMDDYYYY FORMAT (MM=MONTH, DD=DAY, YYYY=YEAR). |
| FIELD NO. 8 | ENTER THE NUMERIC ICD9-DIAGNOSIS CODE (PRIMARY & SECONDARY) AND THE CORRESPONDING DESCRIPTION. |
| FIELD NO. 9 | ENTER THE DAY THE PRESCRIPTION, DOCTOR'S ORDERS WAS WRITTEN IN MMDDYYYY FORMAT (MM=MONTH, DD=DAY, YYYY=YEAR). |
| FIELD NO. 10 | ENTER THE NAME OF THE BENEFICIARY'S ATTENDING PHYSICIAN PRESCRIBING THE SERVICES. |
| FIELD NO. 11 | ENTER THE HCPCS / PROCEDURE CODE. |
| FIELD NO. 11A | ENTER THE CORRESPONDING MODIFIERS (WHEN APPROPRIATE). |
| FIELD NO. 11B | ENTER THE 11 DIGIT NDC CODE THAT CORRESPONDS WITH THE HCPC FORMULA CODE, OR THE CORRESPONDING DESCRIPTION FOR EACH PROCEDURE REQUESTED. |
| FIELD NO. 11C | ENTER THE NUMBER OF UNITS REQUESTED FOR EACH INDIVIDUAL HCPC/ PROCEDURE. |
| FIELD NO. 11D | ENTER THE REQUESTED CHARGES FOR EACH INDIVIDUAL HCPC/ PROCEDURE WHEN APPROPRIATE FOR THE REQUESTED HCPC/ PROCEDURE. |
| FIELD NO. 12 | ENTER THE LOCATION FOR ALL SERVICES RENDERED. |
| FIELD NO. 13 | ENTER THE NAME, MAILING ADDRESS AND TELEPHONE NUMBER OF THE PROVIDER OF SERVICE. |
| FIELD NO. 14 | ENTER THE NAME, MAILING ADDRESS AND TELEPHONE NUMBER OF THE BENEFICIARY'S CASE MANAGER , IF AVAILABLE |
| FIELD NO. 15 | PROVIDER/AUTHORIZED SIGNATURE IS REQUIRED. YOUR REQUEST WILL NOT BE ACCEPTED IF NOT SIGNED. IF USING A STAMPED SIGNATURE, IT MUST BE INITIALED BY AUTHORIZED PERSONNEL. |
| FIELD NO. 16 | DATE IS REQUIRED. YOUR REQUEST WILL NOT BE ACCEPTED IF FIELD IS NOT DATED. |

IF YOU HAVE ANY QUESTIONS CONCERNING THE PRIOR AUTHORIZATION PROCESS, PLEASE CONTACT THE PRIOR AUTHORIZATION DEPARTMENT AT UNISYS:

PRIOR AUTHORIZATION TOLL-FREE NO.: 1-800-488-6334

PRIOR AUTHORIZATION UNIT NO.: 1- 225-928-5263

PRIOR AUTHORIZATION FAX NO.: 1-225-929-6803

CHAPTER 18: DURABLE MEDICAL EQUIPMENT

APPENDIX B – CLAIMS FILING

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CLAIMS FILING

Hard copy billing of Durable Medical Equipment (DME) services are billed on the paper CMS-1500 (02/12) claim form or electronically on the 837P Professional transaction. Instructions in this appendix are for completing the CMS-1500; however, the same information is required when billing claims electronically. Items to be completed are listed as **required**, **situational** or **optional**.

Required information must be entered in order for the claim to process. Claims submitted with missing or invalid information in these fields will be returned unprocessed to the provider with a rejection letter listing the reason(s) the claims are being returned, or will be denied through the system. These claims cannot be processed until corrected and resubmitted by the provider.

Situational information may be required, but only in certain circumstances as detailed in the instructions that follow.

Paper claims should be submitted to:

Gainwell Technologies
P.O. Box 91020
Baton Rouge, LA 70821

NOTE: Electronic claims submission is the preferred method for billing. (See the Electronic Data Interchange (EDI) Specifications located on the Louisiana Medicaid web site at www.lamedicaid.com, directory link “Health Insurance Portability and Accountability Act (HIPAA) Information Center”, sub-link “5010v of the Electronic Transactions” – 837P Professional Guide.

This appendix includes the following:

1. Instructions for completing the CMS-1500 claim form and samples of completed CMS-1500 claim forms; and
2. Instructions for adjusting/voiding a claim and samples of adjusted CMS-1500 claim forms.

CMS-1500 (02/12) INSTRUCTIONS FOR DME SERVICES

Please click the following link to access “CMS-1500 (02/12) Instructions for DME Services”:
https://www.lamedicaid.com/Provweb1/billing_information/CMS_1500_DME.pdf.

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APPENDIX B – CLAIMS FILING

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ADJUSTING/VOIDING CLAIMS

An adjustment or void may be submitted electronically or by using the CMS-1500 (02/12) form.

Only a paid claim can be adjusted or voided. Denied claims must be corrected and resubmitted – not adjusted or voided.

Only one claim line can be adjusted or voided on each adjustment/void form.

For those claims where multiple services are billed and paid by service line, a separate adjustment/void form is required for each claim line if more than one claim line on a multiple line claim form must be adjusted or voided.

The provider should complete the information on the **adjustment** exactly as it appeared on the original claim, **changing only the item(s) that was in error and noting the reason for the change in the space provided on the claim.**

If a paid claim is being voided, the provider must enter all the information on the **void** from the original claim exactly as it appeared on the original claim. After a voided claim has appeared on the Remittance Advice (RA), a corrected claim may be resubmitted (if applicable).

Only the paid claim's most recently approved internal control number (ICN) can be adjusted or voided; thus:

1. If the claim has been successfully adjusted previously, the most current ICN (the ICN of the adjustment) must be used to further adjust the claim or to void the claim; and
2. If the claim has been successfully voided previously, the claim must be resubmitted as an original claim. The ICN of the voided claim is no longer active in claims history.

If a paid claim must be adjusted, almost all data can be corrected through an adjustment, with the exception of the Provider Identification (ID) Number and the Beneficiary/Patient ID Number. **Claims paid to an incorrect provider number or for the wrong Medicaid beneficiary cannot be adjusted. They must be voided and corrected claims submitted.**

CHAPTER 18: DURABLE MEDICAL EQUIPMENT

APPENDIX B – CLAIMS FILING

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Adjustments/Voids Appearing on the Remittance Advice

When an Adjustment/Void Form has been processed, it will appear on the RA under *Adjustment or Voided Claim*. The adjustment or void will appear first. The original claim line will appear in the section directly beneath the Adjustment/Void section.

The approved adjustment will replace the approved original and will be listed under the "Adjustment" section on the RA. The original payment will be taken back on the same RA and appear in the "Previously Paid" column.

When the void claim is approved, it will be listed under the "Void" column of the RA.

An Adjustment/Void will generate credit and debit entries which appear in the Remittance Summary on the last page of the RA.

Sample forms are on the following pages

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APPENDIX B – CLAIMS FILING

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SAMPLE DME CLAIM FORM ADJUSTMENT WITH ICD-10 DIAGNOSIS CODE
(DATES OF SERVICE ON OR AFTER 10/01/15)

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

DME

Mail To:
Gainwell Technologies
P.O. Box
91020
Dallas, Texas 75291

<input type="checkbox"/> PICA											
1. MEDICARE <input type="checkbox"/> MEDICAID <input checked="" type="checkbox"/> TRICARE <input type="checkbox"/> CHAMPVA <input type="checkbox"/> RESERVE HEALTH PLAN <input type="checkbox"/> FECA <input type="checkbox"/> OTHER <input type="checkbox"/>											
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) LOU, JANNIE											
3. PATIENT'S BIRTH DATE MM DD YY 06 11 00 SEX M <input type="checkbox"/> F <input checked="" type="checkbox"/>											
4. INSURED'S NAME (Last Name, First Name, Middle Initial)											
5. PATIENT'S ADDRESS (No., Street)											
6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>											
7. INSURED'S ADDRESS (No., Street)											
8. RESERVED FOR NUCC USE											
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)											
10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (Current or Previous) YES <input type="checkbox"/> NO <input type="checkbox"/>											
11. INSURED'S POLICY GROUP OR FECA NUMBER											
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE (I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefit to either myself or to my designated representative.) SIGNED: _____ DATE: _____											
13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE (I authorize payment of medical benefits to the undersigned physician or supplier for services deemed necessary.) SIGNED: _____ DATE: _____											
14. DATE OF CURRENT ILLNESS, INJURY, OR PREGNANCY (LMP) MM DD YY QUAL: _____											
15. OTHER DATE MM DD YY QUAL: _____											
16. NAME OF REFERRING PROVIDER OR OTHER SOURCE DN: JOHN DOE, MD											
17a. 1234567 17b. NPI 1234567890											
18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY											
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)											
20. OUTSIDE LAB? YES <input type="checkbox"/> NO <input type="checkbox"/> \$ CHARGES											
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY: Please A-L to service line below (24E) A. G809 E. Z931 C. _____ D. _____ F. _____ G. _____ H. _____ I. _____ J. _____ K. _____ L. _____											
22. RESUBMISSION CODE A 02 ORIGINAL REF. NO. 6259012345600											
23. PRIOR AUTHORIZATION NUMBER 612345678											
24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY B. PLACE OF SERVICE C. D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) E. DIAGNOSIS F. G. DAYS OF UNITS H. I. ID. QUAL J. RENDERING PROVIDER ID. #											
1 09 08 16 09 08 16 12 A4322 AB 90.00 30 NPI											
2											
3											
4											
5											
6											
25. FEDERAL TAX I.D. NUMBER SIGN. EIN 26. PATIENT'S ACCOUNT NO. 1234 27. ACCEPT ASSIGNMENT? (For prior claims, see back) YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> 28. TOTAL CHARGE \$ 90.00 29. AMOUNT PAID \$ 30. Rev'd for NUCC Use											
31. SIGNATURE OF PHYSICIAN OR SUPPLIER (Including degrees or credentials) (I certify that the statements on the reverse apply to this bill and are made a part thereof.) IMA BILLER SIGNED: _____ DATE: 9/12/16											
32. SERVICE FACILITY LOCATION INFORMATION a. NPI b. 1326547895 c. 1987654											
33. BILLING PROVIDER INFO & PH# (800) 233-3333 XYZ DURABLE MEDICAL SERVICES 700 MAIN ST ANY TOWN, LA 70000											

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CHAPTER 18: DURABLE MEDICAL EQUIPMENT

APPENDIX B – CLAIMS FILING

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Sample of a Claim Form



HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA										PICA																																																	
1. MEDICARE (Medicare#) <input type="checkbox"/> MEDICAID (Medicaid#) <input type="checkbox"/> TRICARE (ID#/DoD#) <input type="checkbox"/> CHAMPVA (Member ID#) <input type="checkbox"/> GROUP HEALTH PLAN (ID#) <input type="checkbox"/> FECA BLK LUNG (ID#) <input type="checkbox"/> OTHER (ID#) <input type="checkbox"/>										1a. INSURED'S I.D. NUMBER (For Program in Item 1)																																																	
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)										3. PATIENT'S BIRTH DATE MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/>										4. INSURED'S NAME (Last Name, First Name, Middle Initial)																																							
5. PATIENT'S ADDRESS (No., Street)										6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>										7. INSURED'S ADDRESS (No., Street)																																							
CITY STATE										CITY STATE										CITY STATE																																							
ZIP CODE TELEPHONE (Include Area Code) ()										8. RESERVED FOR NUCC USE										ZIP CODE TELEPHONE (Include Area Code) ()																																							
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)										10. IS PATIENT'S CONDITION RELATED TO:										11. INSURED'S POLICY GROUP OR FECA NUMBER																																							
a. OTHER INSURED'S POLICY OR GROUP NUMBER										a. EMPLOYMENT? (Current or Previous) YES <input type="checkbox"/> NO <input type="checkbox"/>										a. INSURED'S DATE OF BIRTH MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/>																																							
b. RESERVED FOR NUCC USE										b. AUTO ACCIDENT? YES <input type="checkbox"/> NO <input type="checkbox"/> PLACE (State) _____										b. OTHER CLAIM ID (Designated by NUCC)																																							
c. RESERVED FOR NUCC USE										c. OTHER ACCIDENT? YES <input type="checkbox"/> NO <input type="checkbox"/>										c. INSURANCE PLAN NAME OR PROGRAM NAME																																							
d. INSURANCE PLAN NAME OR PROGRAM NAME										10d. CLAIM CODES (Designated by NUCC)										d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES <input type="checkbox"/> NO <input type="checkbox"/> If yes, complete items 9, 9a, and 9d.																																							
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.										13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.																																																	
SIGNED _____ DATE _____										SIGNED _____																																																	
14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL. _____										15. OTHER DATE MM DD YY QUAL. _____										16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY																																							
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE										17a. _____ 17b. NPI _____										18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY																																							
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)										20. OUTSIDE LAB? YES <input type="checkbox"/> NO <input type="checkbox"/> \$ CHARGES _____										21. PRIOR AUTHORIZATION NUMBER																																							
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind. _____										22. RESUBMISSION CODE _____ ORIGINAL REF. NO. _____										23. PRIOR AUTHORIZATION NUMBER																																							
24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY B. PLACE OF SERVICE C. EMG D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER E. DIAGNOSIS POINTER F. \$ CHARGES G. DAYS ON Plan H. EPST/Plan I. ID. QUAL. J. RENDERING PROVIDER ID. #																																																											
1																																																											
2																																																											
3																																																											
4																																																											
5																																																											
6																																																											
25. FEDERAL TAX I.D. NUMBER SBN EIN <input type="checkbox"/> <input type="checkbox"/>										26. PATIENT'S ACCOUNT NO.										27. ACCEPT ASSIGNMENT? (For gov. claims, see back) YES <input type="checkbox"/> NO <input type="checkbox"/>										28. TOTAL CHARGE \$										29. AMOUNT PAID \$										30. Reserved for NUCC Use									
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)										32. SERVICE FACILITY LOCATION INFORMATION										33. BILLING PROVIDER INFO & PH # ()																																							
SIGNED _____ DATE _____										a. NPI b. _____										a. NPI b. _____																																							

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CHAPTER 18: DURABLE MEDICAL EQUIPMENT

APPENDIX C: RESERVED

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CHAPTER 18: DURABLE MEDICAL EQUIPMENT

**APPENDIX D: REQUEST FORM FOR DISPOSABLE INCONTINENCE
PRODUCTS****PAGE(S) 1**

REQUEST FORM FOR DISPOSABLE INCONTINENCE PRODUCTS

A copy of the “State of Louisiana – Louisiana Department of Health (LDH) – Medicaid Request for Disposable Incontinence Products” form must be used with all prior authorization (PA) requests for incontinence products. A copy of the form can be downloaded here: https://www.lamedicaid.com/Provweb1/Forms/Form_DIP1.pdf.

CHAPTER 18: DURABLE MEDICAL EQUIPMENT**APPENDIX E: CONTACT/REFERRAL INFORMATION****PAGE(S) 4****CONTACT INFORMATION****Gainwell Technologies**

TYPE OF ASSISTANCE	CONTACT INFORMATION
e-CDI technical support	Gainwell Technology (877) 598-8753 (Toll Free) (225) 216-6303
Electronic Media Interchange (EDI) Electronic Claims testing and assistance	P.O. Box 91025 Baton Rouge, LA 70898 Phone: (225) 216-6000 Fax: (225) 216-6335
Pre-Certification Unit (Hospital) Pre-certification issues and forms	P.O. 14849 Baton Rouge, LA 70809-4849 Phone: (800) 877-0666 Fax: (800) 717-4329
Pharmacy Point of Sale (POS)	P.O. Box 91019 Baton Rouge, LA 70821 Phone: (800) 648-0790 (Toll Free) Phone: (225) 216-6381 (Local) <i>*After hours, please call REVS</i>
Prior Authorization Unit (PAU)	Gainwell Technology – PAU P.O. Box 14919 Baton Rouge, LA 70898-4919 (800) 488-6334
Provider Enrollment Unit (PEU)	Gainwell Technology – PEU P. O. Box 80159 Baton Rouge, LA 70898-0159 (225) 216-6370 (225) 216-6392 Fax
Provider Relations Unit	Gainwell Technology – Provider Relations Unit P. O. Box 91024 Baton Rouge, LA 70821 Phone: (225) 924-5040 or (800) 473-2783 Fax: (225) 216-6334
Recipient Eligibility Verification (REVS)	Phone: (800) 766-6323 (Toll Free) Phone: (225) 216-7387 (Local)

CHAPTER 18: DURABLE MEDICAL EQUIPMENT**APPENDIX E: CONTACT/REFERRAL INFORMATION****PAGE(S) 4****Louisiana Department of Health (LDH)**

TYPE OF ASSISTANCE	CONTACT INFORMATION
General Medicaid Hotline Louisiana Medicaid Website	(888) 342-6207 (Toll Free) www.lamedicaid.com
Health Standards Section (HHS)	P.O. Box 3767 Baton Rouge, LA 70821 Phone: (225) 342-0128 Fax: (225) 5292
Louisiana Children's Health Insurance Program (LaCHIP)	(225) 342-0555 (Local) (877) 252-2447 (Toll Free) http://ldh.la.gov/index.cfm/page/222
Office of Aging and Adult Services (OAAS)	P.O. Box 2031 Baton Rouge, LA 70821 Phone: (866) 758-5038 Fax: (225) 219-0202 E-mail: MedWeb@la.gov http://ldh.la.gov/index.cfm/subhome/12
Office for Citizens with Developmental Disabilities (OCDD)	628 N. Fourth Street Baton Rouge, LA 70802 Phone: (225) 342-0095 (Local) Phone: (866) 783-5553 (Toll-free) E-mail: ocddinfo@la.gov http://ldh.la.gov/index.cfm/subhome/11
Rate Setting and Audit Hospital Services	P.O. Box 91030 Baton Rouge, LA 70821 Phone: 225-342-0127 Fax: 225-342-9462
Office of Public Health (OPH) Food and Drug Program	Phone: (225) 342-7516
Beneficiary Assistance for Authorized Services	Phone: (888) 342-6207 (Toll Free)
Recovery and Premium Assistance Third-Party Liability (TPL) Recovery, Trauma	P.O. Box 3588 Baton Rouge, LA 70821 Phone: (225) 342-1376 Fax: (225) 342-5292

CHAPTER 18: DURABLE MEDICAL EQUIPMENT**APPENDIX E: CONTACT/REFERRAL INFORMATION** **PAGE(S) 4****Fraud Hotline**

TYPE OF ASSISTANCE	CONTACT INFORMATION
To report fraud	Program Integrity (PI) Section P.O. Box 91030 Baton Rouge, LA 70821-9030 Fraud and Abuse Hotline: (800) 488-2917 Fax: (225) 219-4155 http://ldh.la.gov/index.cfm/page/219

Appeals

TYPE OF ASSISTANCE	CONTACT INFORMATION
To file an appeal	Division of Administrative Law (DAL) - Health and Hospitals Section Post Office Box 4189 Baton Rouge, LA 70821-4189 (225) 342-0443 (225) 219-9823 (Fax)

Other Helpful Contact Information:

TYPE OF ASSISTANCE	CONTACT INFORMATION
Centers for Medicare and Medicaid Services (CMS) OASIS, CMS-485 Form	www.cms.hhs.gov
Governor's Office of Homeland Security and Emergency Preparedness (GOSHEP)	http://gohsep.la.gov

ACCREDITATION ORGANIZATIONS (DME)	
Accreditation Commission for Health Care, Inc.	www.achc.org/
American Board for Certification in Orthotics, Prosthetics & Pedorthics, Inc. (ABC)	www.abcop.org
Board of Certification/Accreditation, International (BOC)	www.bocusa.org

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ACCREDITATION ORGANIZATIONS (DME)	
Commission on Accreditation of Rehabilitation Facilities (CARF)	www.carf.org
Community Health Accreditation Program (CHAP)	www.chapinc.org
Healthcare Quality Association on Accreditation (HQAA)	www.hqaa.org
National Association of Boards of Pharmacy (NABP)	www.nabp.net
The Compliance Team, Inc.	www.thecomplianeteam.org
The Joint Commission (JC)	www.jointcommission.org

CHAPTER 18: DURABLE MEDICAL EQUIPMENT

APPENDIX F: COVERED SERVICES/CODES

PAGE(S) 1

BILLING CODES

Information on the covered services, procedure codes and the current rates is available here:
http://www.lamedicaid.com/provweb1/fee_schedules/DME_Index.htm

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APPENDIX G: STANDING FRAME EVALUATION FORM PAGE(S) 1

STANDING FRAME EVALUATION FORM

A copy of the “State of Louisiana – Louisiana Department of Health (LDH) – Medicaid Standing Frame Evaluation” form must be used with all prior authorization (PA) requests for a standing frame. A copy of the form can be downloaded here: <http://www.lamedicaid.com/provweb1/Forms/PAforms.htm>.

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APPENDIX H: PEDIATRIC HOSPITAL BED EVALUATION FORM**PAGE(S) 1**

PEDIATRIC HOSPITAL BED EVALUATION FORM

A copy of the “State of Louisiana – Louisiana Department of Health (LDH) – Medicaid Pediatric Hospital Bed Evaluation” form must be used with all prior authorization (PA) requests for a pediatric hospital bed. A copy of the form can be downloaded here: <http://www.lamedicaid.com/provweb1/Forms/PAforms.htm>.

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APPENDIX I: ELECTRIC BREAST PUMP REQUEST FORM PAGE(S) 1

ELECTRIC BREAST PUMP REQUEST FORM

A copy of the “State of Louisiana – Louisiana Department of Health (LDH) – Electric Breast Pump Request” form must be completed prior to dispensing a double-electric breast pump. The form must be submitted with required documentation for retrospective review to Gainwell Technologies. A copy of the form can be downloaded here: www.lamedicaid.com/provweb1/Forms/Electric_Breast_Pump_Request_Form_and_Instructions.pdf