INDIANA HEALTH COVERAGE PROGRAMS

PROVIDER REFERENCE MODULE

Durable and Home Medical Equipment and Supplies

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Revision History

Version	Date	Reason for Revisions	Completed By
1.0	Policies and procedures as of October 1, 2015 Published: February 25, 2016	New document	FSSA and HPE
1.1	Policies and procedures as of April 1, 2016 Published: August 30, 2016	Semiannual update: • Replaced references to ADVANTAGE Health Solutions with CMCS • Updated the *Manually Priced DME, HME, and Supplies* section • Added information about continuous glucose monitors to the *Diabetic Testing Supplies* section • Revised reference to home tocolytic infusion therapy and updated the reimbursement rate for materials needed to repair PEN pumps in the *Enteral and Parenteral Nutrition Pumps for Home Infusion* section • Removed references to ThAIRapy Vest and updated the *High-Frequency Chest Wall Compression Devices (Formerly ThAIRapy Vest)* section • Updated the *Oximetry* section • Moved CPAP section and humidifier section to become subsections under *Respiratory Assistive Devices*, and updated BiPAP information in that section • Updated and reorganized the *Incontinence, Ostomy, and Urological Supplies* section • Updated and reorganized the *Osteogenic Bone Growth Stimulators* section • Updated the *Wheelchairs* section	FSSA and HPE

Version	Date	Reason for Revisions	Completed By
1.2	Policies and procedures as of April 1, 2016 (*Core*MMIS updates as of February 13, 2017) Published: April 25, 2017	• Changed Automated Voice Response (AVR) system reference to Interactive Voice Response (IVR) system • Changed Web interChange references to Provider Healthcare Portal • Added Portal instructions for billing and PA requests where needed throughout the module • Updated the *Manually Priced DME, HME, and Supplies* section: – Expanded reference to include all fee-for-service reimbursement – Updated the description for EOB 6169 • Changed the code table reference in the *Orthotic and Prosthetic Codes in the Outpatient Setting* section • Updated benefit plan information in the *Humidifiers, Nonheated or Heated* section • Updated the Customer Assistance telephone number	FSSA and HPE

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Durable and Home Medical Equipment and Supplies

Note:	*For policy information regarding coverage of durable and home medical equipment and supplies, see the Medical Policy Manual at indianamedicaid.com.*

Introduction

Indiana Administrative Code 405 IAC 5-19-2 and *Indiana Code IC 25-26-21* define durable medical equipment (DME) and home medical equipment (HME) as equipment that can withstand repeated use, is primarily and customarily used to serve a medical purpose, and generally is not useful to a member in the absence of illness or injury.

Medical supplies are items that are disposable, nonreusable, and must be replaced on a frequent basis. Providers use medical supplies primarily and customarily to serve a medical purpose, and medical supplies are generally not useful to a person in the absence of an illness or an injury.

Procedure code sets for DME providers (specialty 250) and HME providers (specialty 251) are available in *Durable and Home Medical Equipment and Supplies Codes* on the *Code Sets* page at indianamedicaid.com.

Documentation Required for Medical Supplies and Equipment

For all medical supplies and equipment, the Indiana Health Coverage Programs (IHCP) requires a written order by a physician, optometrist, or dentist. Verbal orders, communicated by the prescriber to the supplier, are permitted when appropriately documented; however, verbal orders must be followed up with written orders. Suppliers must maintain the written physician's order to support medical necessity during postpayment review. Per *405 IAC 5-25-3(a),* a physician's written order and plan of treatment are required as follows: "All Medicaid covered services other than transportation and those services provided by chiropractors, dentists, optometrists, podiatrists, and psychologists certified for private practice require a physician's written order or prescription."

According to *405 IAC 5-19-1(i)*, "Medical supplies shall be for a specific medical purpose, not incidental or general purpose usage." The IHCP has identified instances when medical supplies were dispensed in excess of medically reasonable and necessary amounts. The following information serves to clarify the IHCP standards for prescribing and dispensing medical supplies, including but not limited to items such as surgical dressings, catheters, and ostomy bags. This information does not eliminate any other IHCP requirements for DME and medical supplies at the time services are rendered.

Documentation Requirements for Prescribers of DME, HME, and Medical Supplies

For all DME and HME, a physician must make the order for the equipment or supply in writing. The written order must be maintained on file for retrospective review purposes.

A physician's signature on an order for DME, HME, or medical supplies authorizes those items to be dispensed to the patient. When writing an order for such items, the physician must consider the following questions:

- Are specific instructions, such as frequency of use, directions for use, duration of need, and so forth, listed on the order?

- Is the quantity authorized by the physician medically reasonable and necessary for the patient's medical condition?

The prescriber is also responsible for maintaining documentation in the member's medical record that supports the medical necessity of specific DME, HME, and medical supplies prescribed. To ensure that the appropriate quantity and type of item are dispensed, it is especially important that the written order be detailed. Providing a detailed written order does not eliminate the need for other IHCP requirements in effect at the time services are rendered. The written order for DME, HME, and medical supplies should include, at a minimum, the following information, when applicable:

- Patient's name
- Date ordered
- Physician's signature
- Area of body for use (for items that may be appropriate for multiple sites)
- Type and size of the product
- Quantity intended for use
- Frequency of use (for example, change dressing three times per day)
- Anticipated duration of need
- Indication of refill authorization and the number of refills
  - As needed or PRN (when necessary), refill authorization must be medically necessary and reasonable.
  - The need for long-term use must be documented in the patient's medical record.

Note:	*Orders and physician signatures may be verified retrospectively by the Family and Social Services Administration (FSSA) or the designated contractor.*

Documentation Requirements for Suppliers of DME, HME, and Medical Supplies

Suppliers are responsible for ensuring that the written order contains the necessary information to complete the order. If the physician's order lacks information necessary to accurately dispense the appropriate, specific DME, HME, and medical supplies, including type or quantity, the supplier must contact the physician's office for written clarification.

Suppliers of DME, HME, and medical supplies must maintain the prescriber's written order in the member's medical record to support medical necessity during postpayment review.

Note:	*The IHCP requires that Medicaid providers maintain medical records for a period of seven years, per 405 IAC 1-5-1(b). Services may be subject to recoupment if the physician orders are modified after the service is rendered or if orders are obtained after the provision of service.*

Prior Authorization Requirements for Medical Equipment and Supplies

Specific criteria pertaining to prior authorization (PA) for medical supplies, DME, and HME can be found in *405 IAC 5-19*. The PA requirements in this document should be used as a guideline for determining procedures requiring PA, but the *IAC* and any subsequent bulletins are the primary reference.

PA is required for all DME and HME rented or purchased with IHCP funds, except for the following items:

- Cervical collars
- Back supportive devices, such as corsets
- Hernia trusses
- Oxygen – and, for nursing facility residents, supplies and equipment for its delivery
- Parenteral infusion pumps when used in conjunction with parenteral hyperalimentation, including central venous catheters
- Eyeglasses

In accordance with *IC 12-15-21-6*, see the Fee Schedule at indianamedicaid.com to see whether a particular DME or HME item requires PA. All repairs of purchased DME and HME require PA.

Designated DME, HME, or medical supplies require that a *Medical Clearance* form be submitted with the PA request to justify medical necessity. See the *Prior Authorization* module for specific procedures and a comprehensive list of items requiring a *Medical Clearance* form. In addition, the physician must provide a written, signed prescription describing the item needed, as well as the quantity required, for the member to receive the equipment. The rendering provider, as well as the physician ordering the services or the durable medical equipment, must keep appropriate documentation on file.

PA requests for DME and HME are reviewed on a case-by-case basis, using the following criteria:

- The item must be medically necessary for the treatment of an illness or injury, or to improve the function of a body part.
- The item must be adequate for the medical need; however, items with unnecessary convenience or luxury features are not authorized.
- The anticipated period of need, plus the cost of the item, is considered in determining whether the item is rented or purchased.

Note:	*Authorization for DME, HME, and supplies is the responsibility of the managed care entity (MCE) for managed care members enrolled in the Healthy Indiana Plan (HIP), Hoosier Care Connect, or Hoosier Healthwise. For additional information about MCE authorization procedures, contact the MCE at the telephone number provided through the IHCP Interactive Voice Response (IVR) system, Provider Healthcare Portal (Portal), or 270/271 electronic transaction, or see the IHCP Quick Reference Guide at indianamedicaid.com.*

In accordance with *405 IAC 5-3-10*, PA requests can be submitted and signed by the following provider types:

- Doctor of medicine (MD)
- Doctor of osteopathy (DO)
- Dentist
- Optometrist
- Podiatrist
- Chiropractor
- Psychologist endorsed as a health service provider in psychology (HSPP)
- Home health agency (authorized agent)
- Hospital (authorized agent)
- Transportation provider (authorized agent)

The provider must approve the request by personal signature or signature stamp. Providers that are agencies, corporations, or business entities may authorize one or more representatives to sign requests for PA.

PA request forms submitted by provider types not included in the preceding list, such as DME or HME suppliers, must be signed by a physician. If a provider other than those previously listed submits the PA request via the Portal, the requester can upload an attachment documenting that the service or supply is physician-ordered. If the provider submits the PA request via 278 electronic transaction, the additional documentation must be sent by mail or fax, along with a completed *IHCP PA Update Request Form*, as described in the *Prior Authorization* module. If the attachment is not submitted at the same time as the PA request, the original request is suspended for documentation of the physician's order. Failure to submit additional documentation within 30 calendar days of the request results in denial of the request.

Out-of-state suppliers of medical equipment need to meet the criteria established in the *Out-of-State Providers* module.

The preceding procedures are intended to streamline the PA process. The IHCP Program Integrity Department evaluates provider profiles and performs retrospective reviews of services no longer requiring PA.

Notes:	*All services provided to 590 Program members with billed amounts greater than $500 per procedure require PA.* *For residents of nursing facilities and intermediate care facilities for individuals with intellectual disability (ICFs/IID), the IHCP reimburses the DME/HME items that do not require PA only through the approved per diem rate for the facility. Under no circumstances should the facility provider or any other provider bill separately for DME/HME and supply items that are included in the per diem.*

Reimbursement for DME, HME, and Medical Supplies

DME and HME reimbursement is based on Medicare fee schedules and classifications of DME.

Reimbursement for medical supplies is equal to the lower of the provider's submitted charges (usual and customary) or the Medicaid calculated allowed amount for the item. The Medicaid calculated allowed amount for an item is the amount on the statewide Fee Schedule available at indianamedicaid.com. Providers must include their usual and customary charge for each medical supply item when submitting claims for reimbursement. Providers should not use the Medicaid calculated allowed amount for their billed charge unless the Medicaid calculated allowed amount is equal to the amount that the provider charges the general public.

Manually Priced DME, HME, and Supplies

Most Healthcare Common Procedure Coding System (HCPCS) codes specific to particular DME services, equipment, and supplies are reimbursed using the maximum fee pricing methodology. However, several DME and HME service, equipment, and supply HCPCS codes that are nonspecific (with descriptions such as "unspecified," "unclassified," and "miscellaneous") are manually priced. An example of a manually priced HCPCS code is E1399 – *Durable medical equipment, not otherwise specified*.

Reimbursement for DME and HME is based on Medicare's established fee schedule, if available. For codes for which Medicare does not have an established rate and the procedure code remains manually priced, a rate may be established using acquisition cost information. Reimbursement is 75% of the manufacturer's suggested retail price (MSRP). This methodology applies to all fee-for-service (FFS) claims, including Medicare crossover and Medicare Replacement Plan claims. Providers are required to submit documentation of the MSRP with their claims for these codes. See *Procedure Codes that Require Attachments* on the *Code Sets* page at indianamedicaid.com.

The following are considered acceptable documentation of the MSRP:

- Manufacturer's invoice showing MSRP, suggested retail price, or retail price
- Quote from the manufacturer showing the MSRP, suggested retail price, or retail price
- Manufacturer's catalog page showing MSRP, suggested retail price, or retail price (the publication date of the catalog must clearly show on the documentation)
- MSRP pricing from the manufacturer's website (the manufacturer's web address must be visible on printed documentation from its website)

Documentation of MSRP must clearly come from the manufacturer of the DME or supply item. Claims on which the provider has handwritten the MSRP or modified the MSRP documentation will be denied with EOB 6169 – *The MSRP documentation submitted with the claims is not acceptable for adjudication*. *The provider can resubmit the claim with proper documentation.*

If billing for an item that has no MSRP, the provider should submit a cost invoice with the following notation: "MSRP is not available for the product billed." When this note appears on a cost invoice, the IHCP will contact the manufacturer directly to confirm that there is no MSRP for the product being billed. Manually priced medical supply and DME procedure codes that have no MSRP will be reimbursed at the provider's cost plus 20%, in accordance with *405 IAC 5-19-3(c)* and *405 IAC 5-19-1(k)*. If the manufacturer informs the IHCP that an MSRP is available for the product, the detail being reviewed will be denied with explanation of benefits (EOB) 6126 – *The IHCP has verified with the manufacturer that MSRP pricing is available. Please resubmit the claim with the proper documentation*.

Note:	*A cost invoice is an itemized bill issued directly from the supplier to the provider, listing the goods supplied and stating the amount of money due to the supplier. If the cost invoice contains more than one item, providers must identify on each attachment which item corresponds to the procedure code and amount identified on the claim.*

Providers that create or manufacture custom-molded items specific to an individual member's needs, such as a custom-molded seating system produced in house, must submit a cost invoice for processing the claim. The item should be identified as "custom" in the description field on the attached invoice.

The documentation submitted with each claim may be monitored or subject to a postpayment review; therefore, the MSRP documentation provided from the manufacturer must match the manufacturer's cost invoice. Providers must not bill more than their usual and customary charge for any item.

When providers request PA for miscellaneous services, they must include an itemized list of materials in the PA request. For any item providers identify under a miscellaneous code, they must identify a specific number of units for billing purposes and claim adjudication.

Coverage and Billing for DME, HME, and Medical Supplies

For Hoosier Healthwise Package C, the IHCP covers medical supplies and equipment, including prosthetic devices, implants, and hearing aids, when medically necessary. Pursuant to *407 IAC 3-6-1(b)*, the benefit limit on DME for Package C members is a maximum benefit of $2,000 per year, or $5,000 per lifetime.

This benefit limit does not include eyeglasses or medical supplies. Members can purchase or rent the equipment, depending on which is more cost-efficient.

The IHCP does not reimburse claims for medical supplies, nonmedical supplies, or routine DME and HME items for members residing in long-term care (LTC) facilities. LTC facilities include nursing facilities, ICFs/IID, and community residential facilities for the developmentally disabled (CRFs/DD). The IHCP policy stipulates that providers cannot bill the IHCP directly for medical supplies, nonmedical supplies, or routine DME or HME items provided to an IHCP member residing in an LTC facility. This policy also pertains to food supplements, nutritional supplements, and infant formulas (except for medically necessary infant formula, as outlined in the *Food Supplements, Nutritional Supplements, and Infant Formulas* section) of this document. The facility *per diem* rate includes the costs for these services, and the medical supplier or DME or HME company should bill the LTC facility directly for such services.

For further information, see *405 IAC 5-13-3* and *405 IAC 5-31-4*. Providers that bill the IHCP using HCPCS codes for medical supplies, nonmedical supplies, or routine DME items for members residing in LTC facilities receive a denial with EOB code 2034 – *Medical and nonmedical supplies and routine DME items are covered in the per diem rate paid to the long term care facility and may not be billed separately to the IHCP*.

All durable and disposable items and medical supplies necessary for the effective performance of a patient's dialysis are included in the composite rate for renal dialysis; therefore, these items should not be billed separately. See the *Renal Dialysis Services* module for details.

Repair and Replacement

Provisions related to the repair of purchased DME or HME and replacement of DME or HME items are outlined in *405 IAC 5-19-4* and *405 IAC 5-19-5*. The rules are summarized as follows:

- Repair of purchased DME/HME may require PA based on the HCPCS codes billed.
- The IHCP does not pay for repair of equipment still under warranty.
- The IHCP does not authorize payment for repair necessitated by member misuse or abuse, whether intentional or unintentional. The provider must obtain documentation from the member stating the member understands the service is not covered by IHCP, and the member will assume responsibility for the repairs.
- Repairs for rental equipment are the responsibility of the rental provider.
- The IHCP does not cover payment for maintenance charges of properly functioning equipment.
- Repair costs for DME or HME included in an LTC facility's *per diem* rate are not separately reimbursable.
- The IHCP does not authorize replacement of large DME or HME items more than once every five years per member. The IHCP allows more frequent replacement only if there is a change in the member's medical needs, documented in writing, significant enough to warrant a different type of equipment.

Providers should use HCPCS code E1399 – *Durable medical equipment, not otherwise specified* to bill DME items and materials that do not have a specific HCPCS code available. DME and HME providers should bill labor costs associated with servicing and repairs with HCPCS code K0739 – *Repair or nonroutine service for durable medical equipment other than oxygen equipment requiring the skill of a technician, labor component, per 15 minutes*. Providers must attach a materials and labor itemization to the claim when submitting it for payment.

Rental versus Purchase

Providers should base their decision to rent or purchase DME or HME on the least expensive option available for the anticipated period of need. DME or HME items purchased with IHCP funds become the property of the FSSA. Providers must notify the local county office of the FSSA Division of Family Resources (DFR) to make arrangements to return the equipment when a member no longer needs the equipment.

For items that the FSSA has identified as requiring frequent or substantial servicing, reimbursement is limited to rentals only and not for a purchase of the item. See the *Items Requiring Frequent or Substantial Servicing* section of this document for more information.

Used DME Not Reimbursed by Medicaid

The IHCP does not reimburse for used DME, except for the following:

- A4638 – *Replacement battery for patient-owned ear pulse generator, each*
- A7046 – *Water chamber for humidifier, used with positive airway pressure device, replacement, each*

A new item placed with a member initially as a rental item will be considered a new item by the FSSA at the time of purchase. A used DME item placed with a member initially as a rental item will be replaced by the supplier with a new item before being purchased by the FSSA.

Customized Items

The IHCP defines custom equipment as equipment uniquely constructed or substantially modified to meet the specific needs of an individual patient. For example, the IHCP would consider a customized wheelchair, billed using code E1399, as a customized item. Due to the unique aspects, providers cannot group these items with similar items for purposes of payment.

Suppliers must submit documentation of the costs of the item, including the cost of labor and types of materials used in customizing the item. They must attach a materials and labor itemization and a manufacturer's cost invoice to the claim when submitted for payment. The IHCP reviews each item on the invoice when calculating the reimbursement amount for all customized items. The IHCP reimburses the materials needed for repair at 20% above the manufacturer's cost to the provider.

The IHCP considers the following factors when reviewing PA requests for customized equipment:

- The costs and changes for construction of the item can vary widely from one patient to another. Some items, while individually constructed, may have standard costs and charges. Providers can most often identify and bill these items using existing HCPCS codes, and the items are not considered custom equipment.
- A wheelchair assembled by a supplier or ordered from a manufacturer that makes available special features, modifications, or components cannot be considered a customized wheelchair. The HCPCS contains many different codes to categorize wheelchairs. The IHCP may make additional payment for modifications such as attachments to convert a wheelchair to a one-arm drive, brake extensions, wheelchair hand rims, and antitipping devices.

Capped Rental Items

The IHCP limits certain procedure codes to 15 months of continuous rental. The IHCP defines continuous rental as rental without interruption for a period of more than 60 days. A change in provider **does not** constitute an interruption in the rental period. See the *Procedure Codes for DME/HME Capped Rental Items* table in *Durable and Home Medical Equipment and Supplies Codes* on the *Code Sets* page at indianamedicaid.com.

Providers should bill DME and HME rentals on the professional claim (*CMS-1500* claim form, 837P electronic transaction, or Portal professional claim). The IHCP handles claims submitted for the rental of DME and HME in the following manner:

- The allowed charge is the lower of the IHCP rental fee schedule amount or the actual submitted charge.
- The IHCP pays claims for capped DME/HME until the number of rental payments made to date reaches the capped rental number of 15 months.
- The IHCP evaluates requests for approval of DME/HME capped rental items for documentation of long-term need. In long-term situations, the IHCP may make a decision to purchase the item.
- The procedure codes listed in the *Procedure Codes for DME/HME Capped Rental Items* table are subject to the 15-month capped rental period. The IHCP denies claims submitted using these procedure codes with rentals in excess of 15 months.

The use of a piece of equipment during a rental period may be interrupted; however, if the patient resumes use of the equipment within 60 days of the last payment, the original 15-month period remains active. If the interruption period exceeds the 60-day period, and the interruption reasons are justified, providers must submit a new PA request to begin a new 15-month rental period. The supplier must document the reason for the greater-than-60-day break in the rental period on the *IHCP Prior Authorization Request Form*, Portal PA request, or 278 electronic transaction. Justification for a break in the rental period more than 60 days may include the following:

- Change in medical necessity
- Hospitalization
- Nursing facility stay

Unless the IHCP receives a new PA requesting a new rental period, the original 15-month period remains active. A change in the provider does not result in a new 15-month rental period. If a member becomes inactive for a period of more than 60 days, the IHCP requires a new PA to resume services.

Capped rental items are also subject to replacement or servicing when certain criteria are met. The IHCP does not authorize replacement of capped rental items more often than once every five years per member, unless there is a change in the member's medical needs, documented in writing, significant enough to warrant a different type of equipment.

At the end of the 15-month rental period, the IHCP considers the DME/HME equipment purchased, and, in accordance with *405 IAC 5-19-8*, the equipment becomes the property of the FSSA. During the capped rental period, the equipment supplier must supply and service the item for as long as the member continues to need it, at no additional charge to the IHCP. However, subject to prior authorization parameters, for repairs not covered by warranty, the IHCP does not reimburse more frequently than six months after the 15th month and every six months thereafter, for as long as the equipment is medically necessary.

The IHCP makes no payment for rental for any month the patient is in an institution that does not qualify as his or her home or is outside the United States for an entire month. However, if the patient is at home on the first day of a rental month, the IHCP may make payment for the entire rental month. Similarly, if a member returns an item of rental equipment to the supplier before the end of a payment month, the IHCP may make payment for the entire rental month.

Items Requiring Frequent or Substantial Servicing

For items requiring frequent or substantial servicing, the IHCP reimburses providers for rental payments only, as long as the equipment is deemed medically necessary. The IHCP denies claims for the purchase of these items. As noted in *405 IAC 5-19-4*, repair of rental items is the responsibility of the rental provider.

For a list of equipment and supplies requiring frequent or substantial servicing that are available on a rental basis, see the *Procedure Codes for Equipment and Supplies Classified by the IHCP as Requiring Frequent and Substantial Servicing* table in *Durable and Home Medical Equipment and Supplies Codes* on the *Code Sets* page at indianamedicaid.com. The IHCP denies these codes if providers bill them as a purchase. This list is not all-inclusive.

Drug-Related Medical Supplies and Medical Devices

Some drug-related medical supplies and medical devices are reimbursed on a fee-for-service (FFS) basis for Hoosier Healthwise members. See *Durable and Home Medical Equipment and Supplies Codes* on the *Code Sets* page at indianamedicaid.com for a list of drug-related medical supplies and medical devices that are paid for by the FFS medical benefit for all Hoosier Healthwise health plan members. Providers should submit these claims to Hewlett Packard Enterprise using the professional claim (*CMS-1500* claim form or electronic equivalent). Services must be provided by an IHCP-enrolled pharmacy or DME provider. This list is subject to change. Providers will be notified via an IHCP provider bulletin or other formal communication at least 30 calendar days prior to the change.

Only the drug-related medical supplies and medical devices in the *Drug-Related Medical Supplies and Medical Devices Reimbursed as Fee-for-Service* table are reimbursable by the FFS medical benefit. The Hoosier Healthwise health plans remain responsible for the following services:

- Medical supplies and medical devices not included in *Drug-Related Medical Supplies and Medical Devices Reimbursed as Fee-for-Service* table
- Physician-administered drugs billed by entities other than IHCP-enrolled pharmacy providers
- DME
- Enteral or oral nutritional supplements

Orthotic and Prosthetic Codes in the Outpatient Setting

The IHCP allows separate reimbursement of specific orthotic and prosthetic codes when rendered in the outpatient setting. These codes will be linked with revenue code 274 – *Medical/Surgical Supplies and Devices-Prosthetic/Orthotic Devices* for reimbursement as a stand-alone procedure. When services are provided in conjunction with treatment-room services, these codes may be billed with revenue code 274 for separate reimbursement. These codes will not be separately reimbursable when services are provided on the same day as a surgical service.

For the list of orthotic and prosthetic codes linked to revenue code 274, see *Revenue Codes Linked to Specific Procedure Codes* on the *Code Sets* page at indianamedicaid.com.

Medical and Surgical Supplies

The IHCP covers some, but not all, medical supplies. To the extent that the IHCP covers a medical supply item, it is a *reimbursable* service only when medically necessary. A physician or a dentist must prescribe all medical supplies and must document the need for such items. Covered medical supplies include, but are not limited to, antiseptics and solutions, bandages and dressing supplies, gauze pads, catheters, incontinence supplies, irrigation supplies, diabetic supplies, ostomy supplies, and respiratory and tracheotomy supplies.

When providers include medical supplies in LTC facility reimbursement (nursing facilities, group homes, ICFs/IID), or otherwise include them as part of reimbursement for a medical or surgical procedure, LTC providers must **always** include them as part of their nursing facility *per diem*. Under no circumstances should a pharmacy, LTC facility, or any other provider separately bill such supplies to the program. This requirement includes all covered medical supplies that are included in the LTC provider's *per diem* rate, even if the LTC facility does not include the cost of medical supplies in its cost report.

The IHCP does not reimburse for medical supplies provided in quantities greater than a one-month supply for each calendar month, except when the manufacturer packages those supplies only in larger quantities or when the member is a Medicare beneficiary and Medicare allows reimbursement for a larger quantity. Medical supplies must be for a specific medical purpose, not for incidental or general-purpose usage.

Covered sterile water products are billable with a National Drug Code (NDC) on the pharmacy claim form, which is located under the Pharmacy Services quick link at indianamedicaid.com. All covered sterile water products, with the exception of those required for compounded prescriptions, are included in the nursing home *per diem* and are, therefore, not separately reimbursable for LTC claims.

The IHCP requires providers to submit claims for medical supplies on the professional claim (*CMS-1500* claim form or electronic equivalent), using HCPCS procedure codes. Providers should send all claims for medical supplies to Hewlett Packard Enterprise. The IHCP denies all claims submitted on the pharmacy claim type, using NDCs, Health Related Item (HRI) codes, Universal Package Codes (UPCs), or Product Identification Numbers (PINs).

Additional Information for Specific DME, HME, and Supplies

The following sections contain special billing, coding, and coverage information for select DME and HME items. For information about implantable DME, see the *Surgical Services* module.

Augmentative and Alternative Communication Devices

An augmentative and alternative communication (AAC) device is a device or system that compensates for the loss or impairment of speech function due to a congenital condition, an acquired disability, or a progressive neurological disease. The term includes only equipment used for communication, such as electronic devices.

Coverage, Prior Authorization, and Reimbursement

The IHCP reimburses for a communication device if a medical doctor or a doctor of osteopathy orders the device in writing.

The IHCP requires PA for a communication device. Requesting practitioners must include medical necessity documentation within, or attached to, the PA request. As part of the PA request, providers must submit a speech pathologist's clinical evaluation, substantiating the medical necessity for the communication device.

The IHCP grants authorization of reimbursement for a communication device only when the provider sends the following:

- Documentation to substantiate that the member demonstrates sufficient mental and physical ability to benefit from the use of the system
- Documentation to substantiate that, in the absence of a communication device, people outside the member's communication environment cannot effectively understand the member
- Documentation to substantiate that the provider reasonably expects that the member's medical condition will necessitate use of the device for at least two years
- Documentation that identifies all communication devices that would meet the member's communication needs, taking into account the physical and cognitive strengths and weaknesses of the member and the member's communication environment
- Documentation noting the recommended least expensive communication device
- Documentation that the intended use of a computer or computerized device is to compensate for the member's loss or impairment of communication function (in cases where the provider requests authorization for a computer or computerized device)

Trial Period

The IHCP does not require a trial period for AAC devices, but the speech-language pathologist who conducts the AAC evaluation may recommend a trial period.

The IHCP approves PA for rental of an AAC device for a trial use period when the speech and language pathologist prepares a request that includes the following information:

- Duration of the trial period
- Examination of the AAC device during the trial period, including all the necessary components, such as mounting device, software, and switches or access control mechanism
- Identification of the AAC services provider that will assist the member during the trial period
- Identification of the AAC services provider that will assess the trial period
- Evaluation criteria specific to the member, used to determine the success or failure of the trial period
- Extension of trial periods and provision of different AAC devices when requested by the speech and language pathologist responsible for evaluating the trial use period

Rental versus Purchase

The IHCP contractor determines whether to rent or purchase an approved AAC device based on the least expensive option to meet the member's needs. The IHCP denies no AAC device to an eligible member solely because it is not available for rental.

Repair and Replacement

The IHCP does not authorize replacement of an AAC device more often than once every five years per member, unless a documented change in the member's medical needs arises and is significant enough to warrant a different type of equipment.

Rehabilitation Engineering

Subject to PA, the IHCP covers rehabilitation engineering service necessary to mount or make adjustments to a communication device. The IHCP also covers speech therapy services as medically necessary to aid the member in the effective use of a communication device, subject to *405 IAC 5-19* and *405 IAC 5-22*.

Automatic External Defibrillators and Wearable Cardioverter Defibrillators

The IHCP covers two types of automatic external defibrillators (AEDs) with PA for individual use: the stand-alone model referred to as an AED and the wearable cardioverter defibrillator (WCD):

- E0617 – *External defibrillator with integrated electrocardiogram analysis*
- K0606 – *Automatic external defibrillator, with integrated electrocardiogram analysis, garment type*

The AED (E0617) is similar to a manual defibrillator, except the AED detects and analyzes heart rhythms automatically. Various manufacturers make the AED devices. Each device uses a battery pack and electrode defibrillator pads, and the initial supplies are usually included with the device.

The WCD (K0606) consists of a vest-like or garment-like device worn under a patient's clothing that holds a monitor, electrodes, a battery, and a small alarm module. To avoid improper defibrillation, the monitor is designed to automatically sense abnormal heart rhythms and deliver electrical therapy through the electrodes after alerting the patient. Nonwearable components include a battery charger, a computer modem, a modem cable, a computer cable, WCDNET, and the diagnostic test. WCDNET is a secure, web-based data storage and retrieval system that allows the physician to access the patient's electrocardiogram (ECG) data stored by the WCD monitor. The physician uses the diagnostic tester to program the WCD to identify specific heart rates and rhythms for data storage. Additional components included with the WCD are a second battery to be used when the first is charging and an extra garment for use when the first is being cleaned.

The AED and WCD are indicated for members who normally are candidates for an implanted cardioverter defibrillator (ICD), but for whom an ICD is contraindicated or needs to be removed. Members use these devices for an average time of approximately two to three months, although some members awaiting transplant have used the device for more than one year.

Factors in Choosing the AED or WCD

Table 1 lists examples of factors that providers may consider when choosing which defibrillator is most appropriate for the member.

Both the AED and the WCD are capped rental items.

Table 1 – Defibrillator Factors

Factors for Choosing AED (E0617)	Factors for Choosing WCD (K0606)
Inability to wear a WCD vest due to obesity	Lack of assistant who can operate an AED
Skin irritation from wearing electrodes 24 hours per day	Frequency that the member is away from home
Limited or lack of mobility	Mobility of the member
Availability of an assistant to operate the AED	Frequently unstable heart rhythms

Prior Authorization Requirements for the AED or WCD

The IHCP covers an AED or a WCD under the same PA criteria, based on the physician's clinical assessment of the member's medical needs. The AED or the WCD is covered for members in two circumstances, as described in Table 2.

Claims for defibrillators for other indications will be denied as not medically necessary. The IHCP will not purchase both an AED and a WCD for the same member, nor rent an AED and a WCD simultaneously for the same member.

Table 2 – Prior Authorization Criteria for AED or WCD

Members must meet either both criteria A and B or criterion C	
Criteria	**Description**
A	The member has one of the following conditions (1–5):
	1. A documented episode of cardiac arrest due to ventricular fibrillation, not due to a transient or reversible cause [1]
	2. A sustained, lasting 30 seconds or longer, ventricular tachyarrhythmia, either spontaneous or induced during an electrophysiologic (EP) study, not associated with acute myocardial infarction[2], and not due to a transient or reversible cause
	3. Familial or inherited conditions with a high risk of life-threatening ventricular tachyarrythmias, such as long QT syndrome or hypertrophic cardiomyopathy
	4. Coronary artery disease with a documented prior myocardial infarction, with a measured left ventricular ejection fraction[2] less than or equal to 0.35, and inducible, sustained ventricular tachycardia (VT) or ventricular fibrillation (VF) during an EP study. To meet this criterion, both (a) and (b) must occur: a) The myocardial infarction must have occurred more than four weeks prior to the external defibrillator prescription. b) The EP test must have been performed more than four weeks after the qualifying myocardial infarction.
	5. Documented prior myocardial infarction and a measured left ventricular ejection fraction less than or equal to 0.30; and a QRS duration of greater than 120 milliseconds. Members must not have any of the following: a) New York Heart Association classification IV b) Cardiogenic shock or symptomatic hypotension while in a stable baseline rhythm c) A coronary artery bypass graft (CABG) or percutaneous transluminal coronary angioplasty (PTCA) within the past three months d) An enzyme-positive myocardial infarction (MI) within the past month e) Clinical symptoms or findings that make them candidates for coronary revascularization f) Irreversible brain damage from pre-existing cerebral disease g) Any disease, other than cardiac disease (for example, cancer, uremia, liver failure), associated with a likelihood of survival of less than one year
B	Implantation surgery is contraindicated.
C	A previously implanted defibrillator now requires removal.

[1] *Transient or reversible causes include conditions such as drug toxicity, severe hypoxia, acidosis, hypocalcemia, hyperkalemia, systemic infections, and myocarditis (not all-inclusive).*

[2] *Myocardial infarctions must be documented by elevated cardiac enzymes or Q-waves on an electrocardiogram. Ejection fractions must be measured by angiography, radionuclide scanning, or echocardiography.*

Prior Authorization Criteria for Accessories K0607–K0609

The IHCP bases PA criteria for accessories on the estimated average life expectancies of the accessories. Both the AED (E0617) and the WCD (K0606) use replacement batteries (K0607) and replacement electrodes (K0609). In addition, the WCD also uses a replacement garment (K0608).

PA criteria for each accessory follows:

- K0607 – *Replacement battery for automated external defibrillator, garment type only, each*
  - The member must currently be renting or have purchased an AED (E0617) or WCD (K0606).
  - The battery being replaced must be at least 11 months old or completely discharged.
- K0608 – *Replacement garment for use with automated external defibrillator, each* (only for WCD)
  - The member must currently be renting or have purchased a WCD (K0606).
  - The garment must be damaged or worn beyond repair and have been in use at least five months.
- K0609 – *Replacement electrodes for use with automated external defibrillator, garment type only, each*
  - The member must currently be renting or have purchased an AED (E0617) or WCD (K0606).
  - The electrodes being replaced must have been used for at least 22 months, or the provider must prove that the equipment is broken or damaged beyond repair.

Casting Supplies

The IHCP allows reimbursement for cast supplies in conjunction with the initial fracture care service. The IHCP also allows cast supplies when billed in conjunction with the application of a cast, strap, or splint, when billing Current Procedural Terminology (CPT®[1]) codes 29000 through 29799, when applied initially, without restorative fracture care, or when applied as a replacement when restorative care has been previously provided.

Continuous Passive Motion Device

The following information outlines the billing parameters for a continuous passive motion (CPM) device:

- PA is not required.
- One unit of service equals one day.

For CPM devices, providers should bill using the appropriate HCPCS procedure code (E0935 – *Continuous passive motion exercise device for use on knee only* or E0936 – *Continuous passive motion exercise device for use other than knee*) and must append the modifier RR.

Cranial Remolding Orthosis

The IHCP considers HCPCS code S1040 for cranial remolding orthosis to be medically necessary for members aged 4 months to 24 months with benign positional plagiocephaly, plagiocephaly with torticollis, brachycephaly, dolichocephaly, or scaphocephaly due to conditions such as in utero or intra partum molding, premature or multiple births, and supine positioning. A pediatrician, general surgeon with a specialty in pediatrics, pediatric surgeon, craniofacial surgeon, or craniofacial anomalies team member must sign the prescription for the cranial remolding orthosis. The prescribing physician must document the medical necessity and prior authorization criteria in the patient's chart. The DME or HME supplier may submit the PA request, but the request must be signed by the prescribing physician (or, if the DME or HME supplier submits the PA request electronically, the signed physician's order must be submitted as an attachment to the request).

For the cranial remolding orthosis to be considered for approval for IHCP members between 4 months and 24 months of age, providers must submit documentation that shows the member received a minimum of a two-month trial of aggressive repositioning and stretching exercises recommended by the American Academy of Pediatrics and has failed to improve.

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[1] *CPT is copyright 2016 American Medical Association. All rights reserved. CPT is a registered trademark of the American Medical Association.*

Exercise should include at least four of the following activities:

- Alternating back and side sleeping
- Supervising "tummy time"
- Rearranging the crib relative to the primary light source
- Limiting time spent in a supine position
- Limiting time in strollers, carriers, and swings
- Rotating activity
- Exercising neck motion

The member must meet one of the following criteria:

- Moderate to severe positional plagiocephaly, with or without torticollis, documented by an anthropometric asymmetry greater than 6 mm in the measurement of the cranial base, cranial vault, or orbitotragial depth
- Brachycephaly documented by a cephalic index 2 standard deviations above or below the mean (approximately 78%)
- Scaphocephy or dolichochaly in premature or breech infants with a cephalic index significantly less than 78%
- Further correction or asymmetry for members after surgical treatment of craniosynostosis, considered on a case-by-case basis
- Moderate to severe residual plagiocephaly after surgical correction of plagiocephaly
  - The pediatric neurosurgeon or craniofacial surgeon who performed the corrective procedure must provide documentation of medical necessity.

The IHCP considers treatment for approval on a case-by-case basis for members aged 12 months to 24 months with severe plagiocephaly and who are considered to have a reasonable likelihood of continued skull growth. A pediatric neurosurgeon, craniofacial surgeon, or craniofacial anomalies team member must provide documentation of medical necessity. The member must have a documented trial of repositioning and stretching exercises, as described previously, to be considered for approval.

The following are contraindications to receiving cranial remolding orthosis:

- Members older than 24 months old
- Unmanaged hydrocephalus
- Craniosynostosis

Diabetic Testing Supplies

Reimbursement is not available for medical supplies, including diabetic supplies, dispensed in quantities greater than a one-month supply for each calendar month, except when packaged by the manufacturer only in larger quantities or when the member is a Medicare beneficiary and Medicare allows reimbursement for a larger quantity.

The IHCP accepts Medicare crossover claims for diabetic test strip procedure codes with dates of service that span 90 days. The affected procedure codes are included in the *Procedure Codes for Diabetic Testing Supplies* table in *Durable and Home Medical Equipment and Supplies Codes* on the *Code Sets* page at indianamedicaid.com.

HCPCS procedure codes A4253 – *Blood glucose test or reagent strips for home blood glucose monitor, per 50 strips* and A4259 – *Lancets, per box of 100* have a maximum quantity limitation:

- Providers are permitted to bill up to four units of A4253 (200 strips) per month. Additional units of A4253 will be denied unless PA is obtained.
- Providers are permitted to bill up to two units of A4259 (200 lancets) per month. Additional units of A4259 will be denied unless PA is obtained.

The following PA criteria are required for additional units of A4253 or A4259:

- A signed statement of medical necessity
- A clear medical recommendation of the number of additional units required to meet the patient's medical need
- A hemoglobin A1C test dated within 90 days prior to the request for additional units

To align with current IHCP policy, the following are exceptions to the National Correct Coding Initiative (NCCI) Medically Unlikely Edit (MUE) unit limit:

- A4253 – *Blood glucose test or reagent strips for home blood glucose monitor, per 50 strips*: The MUE unit limit is two, and IHCP policy allows four units (200 test strips) per month.
- A4259 – *Lancets, per box of 100*. The MUE unit limit is one, and the IHCP policy allows two units (200 lancets) per month.

The FSSA chose Abbott Diabetes Care and Roche Diagnostics as preferred vendors to supply blood glucose monitors and diabetic test strips for all Indiana Medicaid and Healthy Indiana Plan members.

The following Preferred Diabetic Supply List (PDSL), Table 3, is for professional claims (*CMS-1500* claim form or electronic equivalent), including all batch and professional Medicare crossover claims. This information does not apply to other diabetic supplies, including but not limited to syringes, pen needles, lancets, lancing devices, alcohol swabs, control solutions, ketone strips, or blood ketone test strips. Claims for blood glucose monitors and diabetic test strips are priced according to the Fee Schedule available at indianamedicaid.com.

Table 3 – Preferred Diabetic Supply List

Blood Glucose Monitor	Corresponding Test Strip
FreeStyle Lite System Kit	FreeStyle Lite Test Strips
FreeStyle Freedom Lite System Kit	FreeStyle Lite Test Strips
FreeStyle InsuLinx Meter	FreeStyle InsuLinx Test Strips
Precision Xtra Meter	Precision Xtra Test Strips
ACCU-CHEK Aviva Care Kit	ACCU-CHEK Aviva/ACCU-CHEK Aviva Plus
ACCU-CHEK Nano Smartview Meter	ACCU-CHEK Smartview Test Strips

Professional claims (including Medicare crossover claims) for blood glucose monitors and diabetic test strips must be submitted to the Hewlett Packard Enterprise FFS medical benefit for all Healthy Indiana Plan and Hoosier Care Connect members. See the *Drug-Related Medical Supplies and Medical Devices Reimbursed as Fee-for-Service* table in *Durable and Home Medical Equipment and Supplies Codes* on the *Code Sets* page at indianamedicaid.com for a list of drug-related medical supplies and medical devices that are paid for by the FFS medical benefit for all Hoosier Healthwise members.

Claims for procedure codes E0607 – *Home blood glucose monitor* and A4253 – *Blood glucose test or reagent strips for home blood glucose monitor, per 50 strips* require the 11-digit National Drug Code (NDC) or NDC and modifier, depending on the vendor of the product being dispensed. If the NDC is missing, invalid, not in the proper format, or does not correspond with the procedure code and modifier provided, claims will be denied. This requirement includes Medicare crossover claims.

The modifiers NU (indicating a new product) and RR (indicating a rental product) are not used for E0607, E0607 U1, A4253, or A4253 U1 for supplies that are on the PDSL. Medicare crossover claims require the appropriate modifier, and non-Medicare third-party liability (TPL) claims for nonpreferred PDSL require the U1 modifier.

Claims billed for an NDC included on the PDSL will not require the addition of modifier U1. If modifier U1 is included with a **preferred** blood glucose monitor or diabetic test strip NDC, the claim will be denied. Claims billed for a blood glucose monitor or diabetic test strip not listed in Table 3 will require the addition of modifier U1, along with the NDC and appropriate procedure code. Claims billed for an NDC not on the PDSL will be denied.

Blood glucose monitors and diabetic test strips not included on the PDSL require PA. The FSSA advises prescribers to prescribe only the products listed on the PDSL, which eliminates the need to obtain prior authorization for the product. Prescribers may also write the prescription in a generic version ("Blood glucose monitor and/or diabetic test strips") to allow the pharmacy or DME provider to dispense the blood glucose monitor or diabetic test strip product included on the PDSL. If a member has a unique circumstance that requires the use of a product not listed on the PDSL, the prescriber must obtain prior authorization. Prior authorization will be granted for members based on medical necessity.

Continuous glucose monitors are FDA-approved devices used to record ongoing glucose levels in interstitial fluid. Continuous glucose monitoring provides information about glucose fluctuations that might not otherwise be obtained with traditional testing methods. The IHCP reimburses for use of short-term continuous glucose monitoring (95250 and 95251) and long-term continuous glucose monitoring (A9276, A9277, and A9278) for adults and children (age 7 and above) when the service is considered medically necessary. The codes for long-term continuous glucose monitoring require MSRP documentation (or a cost invoice, if no MSRP is available for the item) be submitted with the claim.

Enteral and Parenteral Nutrition Pumps for Home Infusion

Enteral therapy may include enteral feeding within or by way of the intestine, or enteral tube feeding that includes the provision of nutritional requirements through a tube into the stomach or small intestine. *Parenteral therapy* includes any route other than the alimentary canal (such as intravenous, subcutaneous, intramuscular, or mucosal), and total parenteral nutrition (TPN).

The following three provider types may bill for parenteral and enteral therapy when provided in a member's home:

- HME and DME medical supply dealers
- Home health agencies
- Pharmacies

Providers must bill separately for the components for home infusion and enteral therapy. HME providers bill all supplies and formulas used for home infusion and enteral therapy on the professional claim (*CMS-1500* claim form or electronic equivalent) using the appropriate HCPCS codes. Home health agencies bill services provided by a registered nurse (RN), licensed practical nurse (LPN), or home health aide on the institutional claim (*UB-04* claim form or electronic equivalent) using the appropriate HCPCS codes for services provided.

Providers can bill parenteral and enteral services and therapies received by dual-eligible members (Medicare and Traditional Medicaid) to Medicare and the IHCP as crossovers or Medicare Replacement Plans. The provider must submit these services on the institutional claim (*UB-04* claim form or electronic equivalent).

The IHCP does not routinely use HCPCS S codes when other national codes are available for the same services. The IHCP does not reimburse HCPCS S codes for home infusion therapy and enteral therapy (prior to March 16, 2016, providers could bill S9349 – *Home tocolytic infusion therapy*). Providers must separately bill the appropriate national codes, using the proper billing format, to receive reimbursement for services described in HCPCS S codes for home therapy, including home infusion and enteral therapy.

Parenteral and enteral nutrition (PEN) pumps are not in the capped rental fee schedule category; however, the payment policies are similar. The IHCP makes no more than 15 monthly rental payments, just as with the capped rental. At the end of the 15-month rental period, the pump becomes the property of the IHCP. If there is medical necessity for rental of the pump past the 15-month rental limit, the supplier is entitled to periodic servicing payments.

For enteral pumps, the IHCP pays no more than one-half the rental payment every six months, beginning six months after the last rental payment. For parenteral pumps, the IHCP pays no more than one-half the rental payment every three months, beginning three months after the last rental payment. The supplier should keep written proof of servicing of enteral and parenteral pumps on file.

PEN pumps include HCPCS codes B9000, B9002, B9004, and B9006. The IHCP requires the *Certification of Medical Necessity: Parenteral and Enteral Nutrition* for all PEN pumps. Providers must submit a copy of the Certification of Medical Necessity (CMN) with the initial, and each subsequent, PA request for enteral nutrition items.

The IHCP does not require PA for the total parenteral nutrition or infusion pumps when used in conjunction with parenteral hyperalimentation, including central venous catheters.

Necessary servicing of pumps may include repairs that require specialized testing equipment not available to the member or nursing home. The IHCP pays for only actual servicing. However, providers must obtain prior authorization for reimbursement for repair or servicing not covered by warranty. When requesting PA for repair services, providers must include an itemized list of materials and labor with the PA request. When submitting the claim for payment, providers must attach a materials-and-labor itemization plus a manufacturer's invoice to the claim. The IHCP reimburses the materials needed for repair at 20% above the manufacturer's cost to the provider.

Durable and Home Medical Equipment and Supplies Codes on the *Code Sets* page at indianamedicaid.com includes lists of HCPCS codes for the parenteral nutrition solution, kit, and pump and for the enteral nutrition formula, kit, tubing, and pump. See the Fee Schedule at indianamedicaid.com for a comprehensive list of covered procedures. For information about enteral nutrition items, see the *Food Supplements, Nutritional Supplements, and Infant Formulas* section of this document. For information about infusion pump implantation, see the *Surgical Services* module.

Eyeglasses and Lenses

See the *Vision Services* module for information on eyeglasses and lenses.

Food Supplements, Nutritional Supplements, and Infant Formulas

Per *405 IAC 5-24-9*, food supplements, nutritional supplements, and infant formulas are covered only when no other means of nutrition is feasible or reasonable. Prior authorization for these items is required. Approval is subject to the following criteria:

- The feasibility or reasonableness of other means of nutrition, as documented by the requesting practitioner, and as determined by the office's contractor on a case-by-case basis.
- Authorization is not granted when convenience of the member or the member's caretaker is the primary reason for the request for the service.
- Coverage is not available in cases of routine or ordinary nutritional needs.
- Coverage is not available in cases in which the item is to be used for other than nutritional purposes.
- Hyperalimentation and total parenteral nutritional products do not require prior authorization. These products may be separately billed to Medicaid for residents of LTC facilities.

Providers must coordinate with the appropriate entity when seeking approval for Medicaid coverage of infant formula. If the eligible member is assigned to Traditional Medicaid (FFS Full Medicaid or FFS Package A – Standard Plan) on the date of service, Cooperative Managed Care Services (CMCS) is responsible for processing the required PA. Information about obtaining PA through CMCS can be found in the *Prior Authorization* module or on the *Prior Authorization* page at indianamedicaid.com.

For members enrolled in HIP, Hoosier Care Connect, and Hoosier Healthwise managed care programs on the date of service, the member's managed care entity (MCE) is responsible for approving Medicaid coverage of the infant formula. Each MCE has developed its own policy and procedure for how medical necessity for infant formula must be documented and approval obtained. See the *IHCP Quick Reference Guide* at indianamedicaid.com for contact information.

While the member is awaiting authorization, the Women, Infants and Children (WIC) program will provide a supplemental amount of exempt infant formula or medical food. Pursuant to *Code of Federal Regulations 7 CFR 246.10(d)(1)(iii)* and *246.10(d)(1)(iv)*, to receive this WIC benefit, members must obtain documentation of a qualifying condition from a healthcare professional licensed to write medical prescriptions. Please note that members should be referred to WIC only as a secondary provider. Medicaid becomes the primary provider after approval as a covered benefit is granted.

Enteral Nutrition

The IHCP requires PA for enteral nutrition. The IHCP requires a CMN for enteral nutrition and allows someone other than the ordering physician to complete the CMN. However, the ordering physician must review for the accuracy of the information, sign, and date the CMN to indicate agreement. Providers should photocopy CMN forms, because the contractor does not supply this form as a routine item. Providers must submit a copy of the CMN with each PA request (including the initial request) for enteral nutrition items.

After the initial PA of enteral nutrition items, the IHCP requires subsequent PA after three, nine, and eighteen months of therapy to document the member's continued need for therapy. After two years, the IHCP determines the need for further PA on a case-by-case basis. If the member does not medically require enteral nutrition services for two consecutive months, the IHCP requires a new PA, and the required extension schedule starts again.

For the initial PA or extensions of initial PA, providers must include additional documentation to support medical necessity of the following orders:

- The need for special nutrients
- The need for total caloric intake less than 20 cal/kg/day or greater than 35 cal/kg/day
- The need for a pump

See *Durable and Home Medical Equipment and Supplies Codes* on the *Code Sets* page at indianamedicaid.com for a list of HCPCS codes for the enteral nutrition formula, kit, tubing, and pump.

Food Thickener, HCPCS Code B4100

The IHCP covers food thickener (B4100 – *Food thickener, administered orally, per oz*), when ordered by a physician, based on medical necessity, and subject to prior authorization. According to the Health Insurance Portability and Accountability Act (HIPAA), only drugs and biologics may be reported on the pharmacy claim with an NDC. Nutritional supplements are not considered drugs or biologics and, therefore, should not be billed on a pharmacy claim. Bill nutritional supplements using the appropriate HCPCS procedure code on the professional claim (*CMS-1500* claim form or electronic equivalent).

Gloves

Documentation of medical need is required for all gloves, nonsterile and sterile. The supplier must maintain a signed physician's order in the patient record, with a start and stop date, frequency of treatment, and type of treatment that makes the gloves medically necessary. Documentation must indicate the reason the physician ordered the gloves as part of the plan of care. Physicians must renew their orders at least every 12 months to ensure ongoing need for gloves.

A4927 – Nonsterile Gloves, per 100

Nonsterile gloves are reimbursed only when used by the patient, family, or other nonpaid caregiver. Providers cannot bill the IHCP for any amount that exceeds their usual and customary charge to the general public. Providers should use partial units to bill nonsterile gloves individually in the units field of the professional claim. The partial unit is billed by entering the appropriate decimal indicator for the number of gloves used. For example, two gloves are billed as 0.02; 40 gloves are billed as 0.40.

One unit of A4927 equals 100 nonsterile gloves. Per IHCP guidelines, code A4927 is limited to five units (500 gloves) per month. Nonsterile gloves are reimbursable only when used by the patient, family, or other nonpaid caregiver.

Examples of a medical need for a nonsterile glove include, but are not limited to, the following uses:

- A bowel program requiring manual evacuation
- An ostomy care program
- A wound care program

Note:	*The IHCP does not separately reimburse providers for nonsterile gloves supplied for ESRD and dialysis services. Payment for gloves is included in the payment for dialysis services.* *Payment for gloves is included in the nursing facility per diem rate; therefore, gloves are not separately billable by the nursing facility or another provider.*

A4930 – Sterile Gloves, per Pair

Sterile gloves are reimbursable, when medically necessary, using procedure code A4930 – *Gloves, sterile, per pair*. Sterile gloves are often included in sterile procedure kits, such as catheter insertion kits and suture removal kits. Items in these kits are not billed separately.

Hearing Aids

See the *Audiology Services* module for information about hearing aids.

High-Frequency Chest Wall Compression Devices (Formerly ThAIRapy Vest)

A high-frequency chest wall oscillation system is a mechanical device that uses a vest and a generator to assist in loosening bronchial secretions and clearing the airway. All requests for this DME device require PA with an appropriate clinical summary and physician prescription.

High-frequency chest wall compression devices include but are not limited to the following:

- The Vest® Airway Clearance System, formerly known as ThAIRapy Vest or ABI vest (Hill-Rom Services, Inc.)
- MedPulse® Respiratory Vest System and SmartVest® Airway Clearance System (Electromed Inc.)
- The inCourage® System (RespirTech, Inc.)

The IHCP requires a three-month rental of a high-frequency chest wall oscillation system before purchase of the equipment is covered or reimbursable. At the end of three months, documentation that the system has been used on a regular basis is required. Medical records must indicate the patient's compliance and tolerance before the IHCP will approve the purchase.

The three-month rental prior to purchasing pertains only to the generator system (E0483). Reimbursement for the system vest (A7025) and hose (A7026) replacements are purchase only.

Incontinence, Ostomy, and Urological Supplies

The IHCP covers incontinence supplies for members three years old or older. The following restrictions apply:

- A maximum of $162.50 is allowed per member per month for all incontinence supplies.
- A maximum of $1,950 is allowed per member, per rolling 12-month period for all incontinence supplies. Providers may supply such services to an IHCP member only in 30-day increments. Although a physician may write an order for a longer period of time, providers may provide each member with only a 30-day supply at a time.

Contracted Vendor Requirement

FFS members, including those in the Traditional Medicaid program, are required to obtain incontinence, ostomy, and urological supplies – including diapers, underpads, ostomy bags, and gloves – through mail order from one of the following IHCP-contracted providers:

- **Binson's Home Health Care Centers**
  binsons.com
  Telephone: 1-888-217-9610
- **J&B Medical Supply Company**
  jandbmedical.com
  Telephone: 1-866-674-5850

FFS claims for supplies from noncontracted vendors will be systematically denied. Noncontracted vendors and other caregivers should encourage members who require incontinence, ostomy, and urological supplies to contact one of the two contracted vendors to obtain supplies.

Members enrolled in the 590 Program, Medical Review Team (MRT), First Steps, Preadmission Screening and Resident Review (PASRR), LTC, or a managed care program are excluded from this policy requirement.

Products with uses sometimes unrelated to incontinence, ostomy, or urological conditions are not affected by the IHCP-contracted vendor requirement. IHCP members may purchase the following supplies from any appropriate IHCP-enrolled supplier. The following procedure codes are billable by all appropriate providers:

- A4364 (adhesive liquid)
- A4456 (adhesive remover wipes)
- A4402 (lubricant)
- A4450 and A4452 (tape)
- A4455 (adhesive remover)
- A4927 (gloves)
- A5120, A5121, and A5122 (skin barrier)

For a list of procedure codes for incontinence, ostomy, and urological supplies that must be purchased from a contracted vendor for FFS coverage, see the *Incontinence, Ostomy, and Urological Supplies Available Only through Contracted Vendors for Fee-for-Service Members* table in *Durable and Home Medical Equipment and Supplies Codes* on the *Code Sets* page at indianamedicaid.com.

Members with Medicare

IHCP members with Medicare or other third-party insurance must follow the guidelines of Medicare or their primary insurance plan to receive reimbursement for incontinence, ostomy, and urological supplies. Crossover claims and claims with a third-party payment amount indicated for these supplies are not affected by the IHCP-contracted-vendor requirement, as long as Medicare or the primary carrier provided coverage for the product and coverage was in effect on the date of service.

Before supplying these products to FFS IHCP members, providers must verify the member's Medicare or primary carrier eligibility and product coverage for the date of service. If coverage under Medicare or the primary carrier does not apply to the date or type of service, the claims will be subject to IHCP policy requiring these supplies to be provided by one of the two contracted vendors. If Medicare or the primary carrier does not cover this type of service, the claim is processed following Medicaid rules, as though Medicaid is primary. In this case, claims from a noncontracted vendor are denied.

Nursing Assessments Required

Members are required to participate in a nursing assessment to determine the appropriate products, brands, and quantities of incontinence, ostomy, or urological products needed. All nursing assessments must be performed by a licensed nurse who is employed by the supplying provider.

Prior Authorization for Incontinence Products

PA is not required for the reimbursement of incontinence supplies unless they are supplied by an out-of-state provider or the member is using high-end incontinence products. Prior authorization for high-end incontinence products will be granted based on medical necessity. The following information must be submitted to determine medical necessity:

- Member has sampled all applicable products from the two vendors.
- Member has submitted documentation indicating why the products sampled were not appropriate (for example, leakage, skin breakdown, and so on).

High-end incontinence products (HCPCS T-codes indicated by an asterisk on the *Incontinence, Ostomy, and Urological Supplies Available Only through Contracted Vendors for Fee-for-Service Members* table in *Durable and Home Medical Equipment and Supplies Codes* on the *Code Sets* page at indianamedicaid.com) require PA based on medical necessity. Claims for these procedure codes must include the U9 modifier to process correctly.

Documentation Required for All Incontinence Supplies

The IHCP requires documentation of medical necessity for all incontinence supplies. The physician should maintain documentation of the medical necessity for the supplies in the patient's record. The supplier must maintain a signed physician's order in the IHCP member's record for audit purposes. The order must include a start and stop date, and a detailed list of the incontinence supplies ordered.

Providers must renew the physician's order annually, at minimum. For example, an order written on February 15, 2015, is effective for a maximum of 12 months, through February 14, 2016. The supplier must obtain a new order to cover dates of service starting February 15, 2016 and continuing through February 14, 2017. The supplier must have a current order to initiate or continue the provision of supplies to an IHCP member.

In addition to the signed physician's order, the supplier must maintain documentation of proof of delivery. Documentation must include the date of delivery, address of delivery, and signature of the IHCP member, caregiver, or family member who received the supplies.

Incontinence Supplies for Group Homes, Intermediate Care Facilities for the Intellectually Disabled, and Long-Term Care Facility Residents

The IHCP reimburses incontinence supplies for members residing in group homes, ICFs/IID, and LTC facilities through the *per diem* rate for the facility, and the facility or any other provider cannot bill separately for these supplies.

Orthopedic or Therapeutic Footwear

See the *Podiatry Services* module for information about reimbursement for orthopedic footwear, orthopedic shoe additions, and corrective features built into shoes, such as heels, lifts, wedges, arch supports, and inserts.

Osteogenic Bone Growth Stimulators

The IHCP provides reimbursement for four different osteogenic bone-growth stimulators when the service is considered medically necessary and provided in compliance with all IHCP guidelines, including obtaining prior authorization.

IHCP policy states that the diagnosis of a nonunion fracture must meet the following criteria:

- Serial radiographs must confirm that the fracture healing has ceased for three or more months before starting treatment with an osteogenic stimulator.
- Serial radiographs must include a minimum of two sets of radiographs, each including multiple views of the fracture site separated by a minimum of 90 days.

The IHCP excludes nonunions of the skull and vertebrae, and those that are tumor-related, from coverage.

The IHCP does not cover treatment for fresh fractures or nonunion associated with osteomyelitis.

Noninvasive Stimulators – E0747 and E0748

The IHCP covers noninvasive stimulator devices only for the following indications:

- Nonunion of long bone fractures
- Congenital pseudoarthroses
- As an adjunct to spinal fusion surgery for patients at high risk of pseudarthrosis due to previously failed spinal fusion at the same site, or for those undergoing multiple-level fusion (a fusion involving three or more vertebrae)

Invasive or Implantable Stimulator – E0749

The IHCP covers the implantable or invasive stimulator for the following indications:

- Nonunion of long bone fractures
- As an adjunct to spinal fusion surgery for patients at high risk of pseudarthrosis due to previously failed spinal fusion at the same site, or for those undergoing multiple-level fusion (a fusion involving three or more vertebrae)

Ultrasound Stimulator – E0760

The IHCP covers the ultrasound stimulator for the following indications:

- Nonunion of a fracture documented by a minimum of two sets of radiographs obtained before starting treatment with the ultrasound stimulator, separated by a minimum of 90 days, each including multiple views of the fracture site, and with a written interpretation by a physician stating that there has been no clinically significant evidence of the fracture healing between two sets of radiographs
- Not concurrent use with other noninvasive osteogenic devices

Oximetry

Oximetry for oxygen saturation is performed with an oximeter device that can be appropriately billed with HCPCS code E0445 – *Oximeter device for measuring blood oxygen levels noninvasively*.

Noninvasive pulse oximeters (E0445) are classified as capped rental items under the IHCP. The device is available for rental using the RR modifier or purchase using the NU modifier. Rental of noninvasive pulse oximeters includes all cords, batteries, alarms, sensors, probes, printers, and all supplies.

Oximetry determination should be billed using the appropriate CPT code. IHCP reimbursement for noninvasive pulse oximetry determination is available using the following CPT codes:

- 94760 – *Non-invasive ear or pulse oximetry for oxygen saturation; single determination*
- 94761 – *Non-invasive ear or pulse oximetry for oxygen saturation; multiple determinations*
- 94762 – *Non-invasive ear or pulse oximetry for oxygen saturation; by continuous overnight monitoring*

Reimbursement of codes 94760, 94761, and 94762 includes the physician interpretation of the oximetry results and any related equipment. Noninvasive pulse oximetry is not separately reimbursable during a pneumogram.

For CPT code 94762, one unit of service equals one day. Use this code for billing oximetry service on a daily basis, up to and including a maximum of eight units of service per month. If a member requires more than eight units per month, the device can be rented and billed using E0445 RR, instead of CPT code

94762. Purchase of an oximetry system, E0445 NU, is appropriate for an expected long-term need where the cost to purchase the system is less than the expected monthly rental charges.

PA is not required for noninvasive pulse oximetry.

Oxygen and Home Oxygen Equipment

Oxygen and oxygen equipment reimbursement includes the system for furnishing oxygen, the vessels that store the oxygen, the tubing and administration sets that allow the safe delivery of the oxygen, and the oxygen contents. The oxygen and oxygen equipment classification does not fall under capped rental guidelines. Prior authorization based on medical necessity is required.

Only rented oxygen systems (HCPCS codes E0424, E0431, E0434, E0439, E1390, E1405, and E1406) are reimbursable.

The IHCP includes oxygen contents (HCPCS codes E0441 through E0444) in the rental allowance. Oxygen contents are separately reimbursable only when a third-party has purchased an oxygen system, or the IHCP or third party has rented or purchased a portable oxygen system.

The IHCP also includes accessories – including but not limited to cannulas, masks, and tubing (HCPCS codes A4615, A4616, A4619, A4620, A7525, and A7526) – in the allowance for rented systems. The IHCP does not allow separate billing of these items unless they are used with a **purchased** oxygen system. Spare tanks of oxygen and emergency oxygen inhalators are denied as medically unnecessary, because they are considered precautionary and not therapeutic in nature.

For all oxygen codes, one unit equals one month. Providers must indicate one month of service on the professional claim by entering a **1** in the units field for the service billed.

The facility, pharmacy, or other provider cannot bill the IHCP for oxygen, oxygen equipment, or supplies for oxygen delivery for the usual care and treatment of members in LTC facilities. The IHCP reimburses for these in the facility *per diem* rate. The IHCP requires PA for nonstandard equipment and associated repair costs. Providers can bill separately for these. Facilities cannot require members to purchase or rent such equipment with the member's personal funds.

Prior Authorization Requirements

PA is required for oxygen concentrators, except when used for nursing facility residents certified by a physician as needing oxygen therapy.

For members receiving oxygen services in a home setting, the IHCP requires PA for all oxygen and associated equipment and supplies, including concentrators and portable liquid oxygen equipment. The ordering physician must complete, sign, and date a certification of medical necessity (CMN) and submit it with the PA request for members receiving service at home. The IHCP accepts the same CMN for oxygen currently accepted by Medicare. Providers must keep the CMN or *CMS 484.2* on file. Providers should use this form for initial PA, subsequent PA extensions, and changes in the prescriptions. The IHCP does not require a separate order because the order information is incorporated in the CMN. Providers should photocopy CMN forms because the contractor does not supply this form as a routine item.

Note:	*For managed care members enrolled in HIP, Hoosier Care Connect, or Hoosier Healthwise, contact the appropriate MCE for PA information.*

The IHCP requires PA renewals at least annually. Providers should submit a new PA and CMN whenever there is a change in the oxygen prescription, such as an increase or decrease in oxygen flow rate or different equipment ordered, or if there is a change in the attending physician. In addition, the IHCP may require subsequent extensions in individual cases. For more information on obtaining PA, see the *Prior Authorization* module.

The IHCP uses Medicare's coverage criteria and medical policy to determine medical necessity for prior approval. The following coverage and payment rules apply to oxygen therapy when supplied for members in the home setting following an inpatient stay.

The IHCP requires recertification three months after initial certification for inpatients in the following cases:

- For inpatient members whose arterial PO_2 (oxygen partial pressure) was 56 mm Hg or greater or whose oxygen saturation was 89% or greater on the initial certification
- For inpatient members whose physician's initial estimate of length of need for oxygen was one to three months
- If the first situation applies, repeat testing must be performed between the 61st and the 90th days of home oxygen therapy

For members for whom the IHCP does not require recertification at three months, the IHCP requires recertification at 12 months after the initial certification.

The IHCP requires initial certification and three-month recertification when the initial PO_2 is 56 mm Hg or greater or oxygen saturation is 89% or greater. Documentation must include the results of a recently performed arterial blood gas (ABG) or oximetry test. The IHCP does not require retesting for recertification at 12 months, but providers must include on the form the results of the most recent ABG or oximetry test representing the patient's chronic stable state. The form must specify whether tests were performed while on room air or on oxygen, and specify the amount. The form must specify whether the patient was at rest, sleeping, or exercising when the test was performed.

Home Oxygen Therapy Coverage and Payment Rules

The IHCP covers home oxygen therapy only for patients with significant hypoxemia in the chronic stable state, provided the following are met:

- The attending physician has determined that the patient has a severe lung disease or hypoxia-related symptoms that might be expected to improve with oxygen.
- The patient's blood gas levels indicate the need for oxygen therapy.
- The physician has tried or considered alternative treatment measures and has deemed them clinically ineffective.

Note:	*The IHCP accepts transcutaneous oximetry in lieu of arterial or capillary blood gases for oxygen monitoring. A physician or provider other than a DME supplier, certified to conduct such tests, must conduct the measurement of these tests. The IHCP does not extend this prohibition to tests conducted by a hospital that may also be furnishing home oxygen therapy to the patient directly or through an associated organization.*

The patient needs to meet the criteria in one of the following categories to receive approval of home oxygen therapy:

Group I Criteria – The patient meets the criteria with any of the following:

- An arterial PO_2 at or below 55 mm Hg or an arterial oxygen saturation at or below 88%, taken at rest.
- The IHCP provides coverage only for nocturnal use of oxygen in the following cases:
  - The patient demonstrates an arterial PO_2 at or below 55 mm Hg or an arterial oxygen saturation at or below 88% taken during sleep, and the patient demonstrates an arterial PO_2 at or above 56 mm Hg or an arterial oxygen saturation at or above 89% while awake.

  - The patient demonstrates a greater than normal fall in oxygen level during sleep, a decrease in arterial PO_2 more than 10 mm Hg, or a decrease in arterial oxygen saturation of more than 5%, associated with symptoms or signs reasonably attributable to hypoxemia, such as cor pulmonale, P pulmonale on EKG, documented pulmonary hypertension, and erythrocytosis.

- The IHCP provides coverage only during exercise if the patient demonstrates an arterial PO_2 at or below 55 mm Hg or an arterial oxygen saturation at or below 88% (taken during exercise) and an arterial PO_2 at or above 56 mm Hg or an arterial oxygen saturation at or above 89% (taken during the day while at rest). In this case, the IHCP provides supplemental oxygen during exercise if it is documented that the use of oxygen improves the hypoxemia that was demonstrated during exercise when the patient was breathing room air.

Group II Criteria – The patient meets the criteria when the patient demonstrates an arterial PO_2 of 56 to 59 mm Hg or an arterial blood oxygen saturation of 89% and any of the following:

- Dependent edema suggesting congestive heart failure
- Pulmonary hypertension or cor pulmonale, determined by measurement of pulmonary artery pressure, gated blood pool scan, echocardiogram, or P pulmonale on EKG, P wave greater than 3 mm in standard leads II, III, or AVF
- Erythrocythemia with a hematocrit greater than 56%

Group III Criteria – The IHCP requires additional documentation to substantiate use of oxygen when the patient demonstrates an arterial PO_2 level at or above 60 mm Hg or arterial blood oxygen saturation at or above 90%. Providers should ensure that additional documentation appears on the PA request or an attached form, indicating the type, frequency, and severity of incidents or episodes. Examples include, but are not limited to, the following:

- Apnea conditions
- Bronchopulmonary dysplasia
- Cerebral palsy
- Cyanotic congenital heart disease
- Episodic attacks of acute and severe asthma
- Intermittent cyanosis or dyspnea documented by clinical observation
- Intermittent upper airway obstruction
- Neuromuscular disorders extensive enough to affect pharyngeal and chest muscles, and that clinically interfere with normal breathing
- Severe recurrent attacks of epilepsy
- Significant intellectual disability with repetitive episodes of respiratory difficulties
- Tracheal laryngeal malacia

The IHCP may give PA to patients who fall into Group III for three, six, or twelve months, depending on the medical necessity demonstrated in the documentation provided. If PA is not waived based on one of the preceding criteria, the IHCP determines whether to require retesting using ABG or transcutaneous oximetry readings when and if authorization is granted. Providers must include such results, or the results of the latest ABG or oximetry readings, on the CMN form when submitted with the new PA request.

Portable Oxygen Systems

The IHCP covers a portable oxygen system if the patient is mobile within the home.

The IHCP does not reimburse for spare tanks of oxygen or emergency oxygen inhalators, as they are considered medically unnecessary because they are precautionary and not therapeutic in nature.

The IHCP does not cover respiratory therapists' services under the DME benefit.

Nebulizer with Compressor

The IHCP does not require PA for a nebulizer with compressor. Billing units for this DME are as follows:

- For purchase, one unit equals one nebulizer
- For rental, one unit equals one month

The procedure code and modifiers for nebulizers are E0570 NU – *Purchase* and E0570 RR – *Rental.*

Phototherapy (Bilirubin Light)

PA is not required for phototherapy. Use the following parameters for phototherapy billing:

- One unit of service equals one day.
- This service is limited to 15 units per lifetime of the member.
- Use procedure code E0202 RR (rental) when billing for phototherapy.

Pneumatic Artificial Voicing Systems

The IHCP reimburses for a pneumatic artificial voice system or artificial larynx, subject to PA. The IHCP grants PA only when the provider sends the following:

- Documentation to substantiate that the member demonstrates sufficient mental and physical ability to benefit from the use of the system
- Documentation to substantiate that the member demonstrates sufficient articulation and language skills to benefit from the use of the system

When a provider supplies a pneumatic artificial voice system or an artificial larynx to a member on an inpatient basis, the attendant costs fall under the established *per diem* rate for the hospital or LTC facility. The provider should not bill separately for attendant costs.

Pneumograms

Providers should bill pneumograms using CPT code 94772 – *Circadian respiratory pattern recording (pediatric pneumogram), 12-24 hour continuous recording, infant*. CPT code 94772 includes technical and professional components of service. Providers should use modifier TC when billing only the technical component, or modifier 26 when billing only the professional component.

The IHCP does not require PA for pneumograms. The IHCP considers one pneumogram, with any number of channels, to be one unit. The IHCP does not separately reimburse for oximetry during a pneumogram because oximetry is included in the pneumogram reimbursement.

Prosthetic Devices

The IHCP reimburses for prosthetic devices under the following conditions:

- A physician, optometrist, or dentist must order all prosthetic devices in writing.
- When the basic prosthesis is approved, all customizing features are exempt from PA. The IHCP does not cover prosthetic devices dispensed for purely cosmetic reasons.

The IHCP allows separate reimbursement of specific prosthetic codes when rendered in the outpatient setting. See the *Orthotic and Prosthetic Codes in the Outpatient Setting* section of this document for details.

Respiratory Assistive Devices – Continuous Positive Airway Pressure (CPAP) and Bi-Level Positive Airway Pressure (BiPAP)

The IHCP covers three types of respiratory assist devices (RADs) for eligible members who meet specific medical criteria:

- Continuous positive airway pressure (CPAP) devices (E0601)
- Bi-level positive airway pressure (BiPAP) devices with a backup rate feature (E0471)
- BiPAP devices without a backup rate feature (E0470)

When the RAD (CPAP or BiPAP) is owned by the member, the IHCP reimburses RAD accessories according to specific limitations. Otherwise, the cost of the accessories is included in the rental reimbursement rate for the device. See *Durable and Home Medical Equipment and Supplies Codes* on the *Code Sets* page at indianamedicaid.com for a list of procedure codes for RAD accessories. For information about humidifiers used with a RAD device, see the *Humidifiers, Nonheated or Heated* subsection.

Bi-Level Positive Airway Pressure (BiPAP)

The IHCP provides reimbursement for BiPAP without backup rate (E0470) or BiPAP with backup rate (E0471) for members that meet specified criteria.

Coverage will be considered when the physician's documentation includes a statement that the member is experiencing symptoms of sleep-associated hypoventilation, such as daytime hypersomnolence, excessive fatigue, morning headache, cognitive dysfunction, or dyspnea. Medical necessity must be documented, and specific criteria outlined in the *Medical Policy Manual* must also be met.

BiPAP devices will also be covered for members with clinical disorder groups characterized as follows, when specific criteria outlined in the *Medical Policy Manual* are met:

- Restrictive thoracic disorders (progressive neuromuscular diseases or severe thoracic cage abnormalities)
- Severe chronic obstructive pulmonary disease (COPD)
- Central sleep apnea (CSA)
- Obstructive sleep apnea (OSA) – E0470 only

Continuous Positive Airway Pressure (CPAP)

The IHCP reimburses for CPAP systems for members meeting one of the following criteria:

- A diagnosis of obstructive sleep apnea (OSA) with an apnea-hypopnea index (AHI) or respiratory disturbance index (RDI) equal to or greater than 15 events per hour, documented in a recorded polysomnography
- A diagnosis of OSA with an AHI or RDI from 5 to 14 events per hour documented in a recorded polysomnography with documented symptoms of excessive daytime sleepiness, impaired cognition, mood disorders, insomnia or hypertension, ischemic heart disease, or history of stroke
- A diagnosis of moderate or severe OSA in a member for whom surgery is a likely alternative to CPAP

Copies of the member's sleep lab evaluation, including a polysomnography, must be retained in the physician's record.

Humidifiers, Nonheated or Heated

The IHCP covers a nonheated (E0561) or a heated (E0562) humidifier for use with a BiPAP device (E0470 and E0471) or a CPAP system (E0601), when ordered by a physician, based on medical necessity, and subject to prior authorization.

The IHCP considers humidifiers E0561 and E0562 for use with a BiPAP or CPAP system for reimbursement only when physician documentation supports the medical necessity of the humidifier. Documentation must indicate that the member is suffering from nosebleeds, extreme dryness of the upper airways, or other conditions that interfere with compliance or use of the BiPAP or CPAP system, and that the humidifier could improve this condition.

HCPCS codes E0561 and E0562 are single-patient-use devices, categorized as inexpensive and routinely purchased items available to members with Full Medicaid or Package A – Standard Plan. The IHCP covers rental temporarily for crossover and Medicare Replacement Plan claims only, and no longer requires a rental trial period before purchase of nonheated or heated humidifiers.

Trend Event Monitoring and Apnea Monitors

Providers should use HCPCS code E0618 when a member requires an apnea monitor without a recording feature. For trend event monitoring with an apnea monitor that has recording features, use HCPCS code E0619 for the actual monitor, and use the appropriate CPT code for monitoring, recording, transmission, and interpretation to bill for these services. See the *Procedure Codes for Trend Event Monitoring and Apnea Monitors* table in *Durable and Home Medical Equipment and Supplies Codes* on the *Code Sets* page at indianamedicaid.com.

Wheelchairs

The IHCP covers the purchase of a nonmotorized wheelchair or motorized wheelchair, subject to prior authorization review.

Requests for both nonmotorized wheelchairs and for similar motorized vehicles require that the provider submits a medical clearance with the PA request. The appropriate IHCP medical clearance forms are available for download from the *Forms* page at indianamedicaid.com. The requesting physician is required to sign both the PA request and medical clearance form.

Motorized Wheelchairs

Providers should determine the most appropriate HCPCS code to use, based on the Wheelchair Product Classification List published by Medicare's Statistical Analysis Durable Medical Equipment Regional Carrier (SADMERC). This listing itemizes the manufacturers and specific power wheelchair models and details the exact HCPCS code associated with each product and model type.

Providers cannot bill separately for programmable electronic systems, which come standard on the specific motorized or power wheelchair model provided, as the total reimbursement for the motorized or power wheelchair with programmable electronics is an all-inclusive rate. The IHCP allows separate reimbursement only for programmable electronic system upgrades, determined to be medically necessary for the patient, made on motorized/power wheelchair bases. Any such upgrades must have PA, and providers must bill the service under HCPCS code K0108 with a KA modifier. Providers must bill the wheelchair base with HCPCS code K0014 (covered only for certain programs). For claims submission, providers must attach a cost invoice or retail price invoice to document the cost or price of the wheelchair base and the upgraded electronic system. The IHCP allows separate reimbursement only if an electronic system is an upgrade to a system that comes standard on a specific wheelchair model.

Certain patients may need adaptive switch controls (such as a sip and puff), and patients with degenerative diseases whose prognosis could worsen in the future may need additional drive controls and programming not available on the basic one-drive electronic system. In these instances, a physiatrist must confirm the medical necessity to support the need for the programmable electronic system upgrade, and the physician must document medical necessity in the patient record as well as on a completed IHCP medical clearance form for motorized/power wheelchairs.

Reimbursement of the universal headrest plates are subject to the following PA criteria:

- The IHCP covers universal headrest plates when the initial headrest ordered for a new wheelchair does not meet the member's needs upon the first or subsequent fittings. On the PA request, the provider must document the brand name and model of the original headrest, and include an explanation of why the headrest did not meet the member's needs. In addition, the provider must indicate the brand name and model of the subsequent headrest that will be used on the wheelchair.
- The IHCP covers universal headrest plates for a used wheelchair if the member's condition changes and the wheelchair back is not predrilled for the headrest. The provider must provide documentation of the medical necessity for the headrest.
- The IHCP covers replacement universal headrest plates with documentation of an explanation for the replacement (for example, the plate is damaged due to high tone or spasticity of the patient).

The IHCP does not cover universal headrest plates for the initial headrest ordered for use on a new wheelchair. The wheelchair back should be predrilled to accommodate the headrest initially ordered with the wheelchair. Providers should direct questions to Customer Assistance at 1-800-457-4585.

The IHCP covers motorized wheelchairs only when the member is enrolled in a school, sheltered workshop, or work setting, or if the member is left alone for a significant period of time. Providers must document that the member can safely operate the vehicle and that the member does not have the upper extremity function necessary to operate a manual wheelchair.

Nonmotorized Wheelchairs

The IHCP includes standard nonmotorized wheelchairs in the *per diem* rate for LTC facilities, per *405 IAC 5-13-3-4* and *405 IAC 5-13-3-7*. Requests for prior authorization of a custom wheelchair for a member in an LTC facility should be submitted to CMCS or to the appropriate MCE for approval only if there is a medical necessity for the custom wheelchair. For example, if the member's diagnosis requires sitting in a particular upright position due to a breathing difficulty, the member may need a customized wheelchair. Providers must follow the normal PA process, using IHCP medical clearance forms and the *IHCP Prior Authorization Request Form*, the Portal PA request, or 278 electronic transaction.

LTC members receive 24-hour care in a nursing facility. This care includes safety, propulsion, and evaluation of the member for skin breakdown, and following an active plan of care to prevent and treat decubitus ulcers. Therefore, providers should not request custom wheelchairs for the sole purpose of providing safety, preventing decubitus ulcers, allowing self-propulsion, or providing restraint.

Wheelchair Power Seating

The IHCP has determined the following HCPCS codes to be medically necessary items:

- E1002, E1003, E1004, E1005, E1006, E1007, and E1008 for power seating systems
- E1010 and E1012 RR (rental only) for power-elevating leg rests
- E2310 and E2311 for electric connectors

With prior authorization, the IHCP covers these HCPCS codes as inexpensive and routinely purchased items for rental or purchase.

Wheelchair Seat Cushions

The IHCP covers codes for general and custom wheelchair seat cushions (E2601–E2609) and for adjustable seat cushions (E2622–E2625).

General and custom cushions (E2601–E2609) are purchase-only items. Providers must attach the NU modifier when billing E2601–E2609. Adjustable seat cushions (E2622–E2625) are covered as new (NU) or rental (RR) items. The adjustable cushions do not have to be listed on the SADMERC classification list to be reimbursed by the IHCP.

Wheelchair Accessories

Providers must use HCPCS code E1028 – *Wheelchair accessory, manual swingaway, retractable or removable mounting hardware for joystick, other control interface or positioning accessory* for PA and billing for universal headrest plates.

The IHCP denies requests for approval of the universal headrest plate using HCPCS code E1399 – *Durable medical equipment, miscellaneous for appropriate coding*. Providers should submit their usual and customary charge using HCPCS code E1028.