INDIANA HEALTH COVERAGE PROGRAMS

PROVIDER REFERENCE MODULE

Durable and Home Medical Equipment and Supplies

LIBRARY REFERENCE NUMBER: PROMOD00024
PUBLISHED: APRIL 23, 2024
POLICIES AND PROCEDURES AS OF NOV. 20, 2023
VERSION: 6.0

Revision History

Version	Date	Reason for Revisions	Completed By
1.0	Policies and procedures as of Oct. 1, 2015 Published: Feb. 25, 2016	New document	FSSA and HPE
1.1	Policies and procedures as of April 1, 2016 Published: Aug. 30, 2016	Scheduled update	FSSA and HPE
1.2	Policies and procedures as of April 1, 2016 (*Core*MMIS updates as of Feb. 13, 2017) Published: April 25, 2017	*Core*MMIS update	FSSA and HPE
2.0	Policies and procedures as of June 1, 2017 Published: Oct. 3, 2017	Scheduled update	FSSA and DXC
3.0	Policies and procedures as of May 1, 2018 Published: May 7, 2019	Scheduled update	FSSA and DXC
4.0	Policies and procedures as of Dec. 1, 2020 Published: March 11, 2021	Scheduled update	FSSA and Gainwell
5.0	Policies and procedures as of June 1, 2022 Published: Oct. 27, 2022	Scheduled update	FSSA and Gainwell
6.0	Policies and procedures as of Nov. 20, 2023 Published: April 23, 2024	Scheduled update: • Reorganized and edited text as needed for clarity • Removed references to Gainwell as the FFS PA contractor • Added notes throughout regarding new MSRP and cost invoice requirements • Updated provider enrollment information in the *Introduction* section • Updated the *Written Orders Required for Medical Equipment and Supplies* section, and updated references to allowable ordering practitioners throughout the module • Updated the *Prior Authorization Requirements for Medical Equipment and Supplies* section • Added note to the *Equipment and Supplies for Members in Long-Term Care Facilities* section regarding standard wheelchairs	FSSA and Gainwell

Version	Date	Reason for Revisions	Completed By
		• Clarified information in the *Repair and Servicing* section • Updated the *Customized Items* section • Updated the *Medical Supplies* section • Added the *Breast Milk* section • Updated the *Breast Milk Storage Bags* section • Added the *Car Seats and Car Beds* section • Added note about pharmacy billing in the *Diabetes Testing Supplies* section and updated the following subsections: – *Quantity Limits for Diabetes Testing Supplies* – *Preferred Diabetes Supply List* • Updated the *Enteral and Parenteral Nutrition* section and subsection • Updated calendar year to rolling 12-month period in the *Incontinence, Ostomy and Urological Supplies* section • Added procedure code references in the NPWT *Supplies* section • Updated the *Oxygen and Home Oxygen Equipment* section and subsections • Updated the form needed in the *Parenteral and Enteral Nutrition Pumps for Home Infusion* section • Updated the *Respiratory Assist Devices* section and subsections • Updated the *Transcutaneous Electrical Nerve Stimulator* section • Updated the *Wheelchairs* section	

Table of Contents

Durable and Home Medical Equipment and Supplies

> *Note: The information in this module applies to durable and home medical equipment and supplies provided under the Indiana Health Coverage Programs (IHCP) **fee-for-service (FFS)** delivery system. For information about services provided through the **managed care** delivery system – including Healthy Indiana Plan (HIP), Hoosier Care Connect or Hoosier Healthwise services – providers must contact the member's managed care entity (MCE) or refer to the MCE provider manual. MCE contact information is included in the IHCP Quick Reference Guide at in.gov/medicaid/providers.*
>
> *For updates to information in this module, see IHCP Bulletins at in.gov/medicaid/providers.*

Introduction

Indiana Administrative Code 405 IAC 5-19-2 defines **durable medical equipment (DME)** 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.

Indiana Code IC 25-26-21-2 defines **home medical equipment (HME)** as equipment that is prescribed by a healthcare provider; sustains, restores or supplants a vital bodily function; and is technologically sophisticated and requires individualized adjustment or regular maintenance. HME does not include walkers, ambulatory aids, commodes or any HME that the Indiana board of pharmacy specifies not to be regulated.

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.

DME and HME suppliers, as well as donor milk banks, can enroll in the Indiana Health Coverage Programs (IHCP) under provider type 25. Pharmacies (provider type 24) can also add a DME and/or HME specialty to their enrollment; see the *Provider Enrollment* and *Pharmacy Services* modules for more information.

IHCP reimbursement for DME providers (specialty 250), HME providers (specialty 251) and donor milk banks (specialty 252) is limited to designated procedure codes only. For a list of codes covered for each specialty, see *Durable and Home Medical Equipment and Supplies Codes*, accessible from the *Code Sets* page at in.gov/medicaid/providers.

Written Orders Required for Medical Equipment and Supplies

The IHCP requires a written order for all medical equipment and supplies, as follows:

- DME must be ordered in writing by an IHCP-enrolled physician, nurse practitioner, clinical nurse specialist, certified nurse midwife or physician assistant.
- Medical supplies must be ordered in writing by an IHCP-enrolled physician, dentist, nurse practitioner, clinical nurse specialist, certified nurse midwife or physician assistant.

- Prosthetic devices must be ordered in writing by an IHCP-enrolled physician, optometrist, or dentist
- Optical supplies must be prescribed by an IHCP-enrolled ophthalmologist or optometrist.
- Donor milk services must be ordered in writing by an IHCP-enrolled licensed medical practitioner (such as a physician, physician assistant or advanced practice registered nurse [APRN])

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 order to support medical necessity in the event of a postpayment review.

Both the rendering (or supplying) provider and the provider ordering the services or equipment must keep appropriate documentation on file.

Documentation Requirements for Prescribers of DME, HME and Medical Supplies

The prescribing practitioner's signature on an order for DME, HME or medical supplies authorizes those items to be dispensed to the member. When writing an order for such items, the prescribing practitioner 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 prescriber 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
- Prescriber'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" (PRN) 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 prescriber's 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 prescriber'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 prescriber'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 in the event of a postpayment review.

> *Note: The IHCP requires that Medicaid providers maintain medical records for a period of seven years, per 405 IAC 1-1.4-2(b). Services may be subject to recoupment if the written 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 DME, HME and medical supplies 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 many DME and HME rented or purchased with IHCP funds. To determine whether a particular item requires PA, see the Professional or Outpatient Fee Schedule, accessible from the *IHCP Fee Schedules* page at in.gov/medicaid/providers. All repairs of purchased DME and HME require PA.

All PA requests for medical equipment or supplies must include a written, signed prescription, as described in the *Written Orders Required for Medical Equipment and Supplies* section and subsections. If a prescription signed by a physician (or other allowable prescriber, if applicable) is not submitted along with the PA request, the request is suspended for documentation of the signed order. Failure to submit the additional documentation within 30 calendar days of the request results in denial of the request.

In addition, designated DME, HME or medical supplies require that a medical clearance form also be submitted with the PA request to justify medical necessity. See the *Prior Authorization* module for more information, including and a list of items requiring a medical clearance form.

The IHCP PA contractor reviews requests for DME and HME on a case-by-case basis, using the following criteria:

- The item must be medically necessary, as defined in *405 IAC 5-2-17*, for the treatment of an illness or injury, or to improve the member's functional level.
- 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 approved for rental or purchase. This decision will be made by the PA contractor based on the least expensive option available to meet the member's needs.

For additional PA criteria for specific items, see the appropriate subsection under the *Additional Information for Specific DME, HME and Supplies* section.

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 FSSA Program Integrity staff evaluates provider profiles and performs retrospective reviews of services that do not require PA.

> *Note: 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 disabilities (ICFs/IID), the IHCP reimburses the DME or 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 or HME and supply items that are included in the per diem.*

Certification of Medical Necessity for Medical Equipment and Supplies Used for Home Health Services

A face-to-face encounter between the member and a qualified treating practitioner in accordance with *Code of Federal Regulations 42 CFR 440.70(f)* is required for initial certification of medical necessity of home health services, as described in the *Home Health Services* module.

In accordance with *42 CFR 440.70(f),* documentation of the face-to-face encounter is required for IHCP coverage of home health services, including certain medical equipment and supplies as home health services. For the IHCP to cover the following equipment, the face-to-face visit must occur and be recorded no more than six months before the start of services:

- Compression devices
- Decubitus care equipment
- Hospital beds and accessories
- Humidifiers, compressors, nebulizers
- Infusion supplies
- Monitoring devices
- Nerve stimulators and devices
- Oxygen and related respiratory equipment
- Patient lifts
- Speech generating devices
- Traction equipment
- Ultraviolet light devices
- Wheelchairs and wheelchair accessories
- Whirlpool equipment

Reimbursement for DME, HME and Medical Supplies

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

IHCP 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 Professional and Outpatient Fee Schedules, accessible from the *IHCP Fee Schedules* page at in.gov/medicaid/providers. 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.

To comply with Section 1903(i)(27) of the *Social Security Act* (also known as the *21st Century Cures Act*), the IHCP calculates rates for select DME and medical supply procedure codes using the lowest non-zero Indiana Medicare Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) fee schedule amount or (if applicable) competitive bidding single payment amount. When both a DMEPOS fee schedule amount and a competitive bid single payment amount are available for an item covered by the Act, the IHCP will use the lower of those rates. No procedure codes subject to the Act have a single payment amount in the Round 2021 competitive bid program. As a result, only the DMEPOS fee schedule will be used to set rates for codes subject to the Act for the foreseeable future. Rates for procedure codes subject to the Act will be updated each calendar year, and the IHCP fee schedules will be updated for any Healthcare Common Procedure Coding System (HCPCS) codes for which the rate changes.

Manually Priced DME, HME and Supplies

Most 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 Advantage Plan claims. Providers are required to submit documentation of the MSRP with their claims for these codes. See *Procedure Codes That Require Attachments*, accessible from the *Code Sets* page at in.gov/medicaid/providers.

> *Note: Effective for dates of service on or after Jan. 7, 2024, the MSRP or cost invoice must be the most current MSRP or cost invoice, and can be no older than two years old.*

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/cost invoice submitted with the claim 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**." 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)*.

> *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 that providers bill using a miscellaneous code, they must identify a specific number of units for billing purposes and claim adjudication.

Equipment and Supplies for Members in Long-Term Care Facilities

The IHCP does not reimburse claims for equipment and supplies included in the facility *per diem* rate for members residing in long-term care (LTC) facilities, which include nursing facilities and ICFs/IID (including community residential facilities for the developmentally disabled [CRFs/DD] and group homes).

Equipment and supplies that are included in the facility *per diem* rate and not separately reimbursable include the following:

- Medical supplies
- Nonmedical supplies
- Routine DME and HME items
- Food supplements
- Nutritional supplements
- Infant formulas (except for medically necessary infant formula, as outlined in the *Food Supplements, Nutritional Supplements and Infant Formulas* section)

For a list of HCPCS codes for items that are included in the LTC facility *per diem* rate, see the *LTC DME Per Diem Table*, accessible from the *Long-Term Care DME Per Diem Table* page at in.gov/medicaid/providers.

> *Note: Standard wheelchairs are included in the LTC facility's per diem reimbursement rate paid by the IHCP, and the IHCP reimburses for wheelchairs outside of this per diem only when the wheelchair is "customized," as defined in the Customized Items section. For additional information, see the note in the Wheelchairs section regarding LTC facility reimbursement.*

The medical supplier or DME/HME company should bill the LTC facility directly for equipment and supplies that are included in the facility *per diem* rate. Providers that bill the IHCP using a HCPCS code listed on the *LTC DME Per Diem Table* for a member residing in an LTC facility receive a denial with EOB code 2034 – *Medical and non-medical 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*.

For further information, see *405 IAC 5-13-3* and *405 IAC 5-31-4*.

Equipment and Supplies Related to Renal Dialysis

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.

Coverage and Billing for DME, HME and Medical Supplies

The following sections provide general IHCP coverage and billing information for FFS claims for DME, HME and medical supplies. Providers should bill all DME, HME and medical supplies on the professional claim (*CMS-1500* claim form, IHCP Provider Healthcare Portal professional claim or 837P electronic transaction) – with certain exceptions for pharmacy providers (as described in the *Pharmacy Services* module) and for certain devices provided in outpatient facilities (as described in the *Orthotic and Prosthetic Devices in the Outpatient Setting* section).

> *Note: For Hoosier Healthwise Package C, the IHCP covers medical supplies and equipment – including prosthetic devices, implants and hearing aids – when medically necessary. Pursuant to 405 IAC 13-5-1, 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.*

All medical equipment and supplies must be ordered in writing by an appropriate IHCP-enrolled practitioner, as described in the *Written Orders Required for Medical Equipment and Supplies* section. For reimbursement, claims from DME and HME providers must include the National Provider Identifier (NPI) of the ordering provider. For more information, see *Section 8: Ordering, Prescribing or Referring Provider Requirements* of the *Claim Submission and Processing* module.

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. Refer to the Professional Fee Schedule, accessible from the *IHCP Fee Schedules* page at in.gov/medicaid/providers, to determine whether modifier RR (for rental item) or NU (for new purchase) is appropriate for a given DME or HME code.

If the equipment is rented, the IHCP allows monthly rental payments until the rental price equals the purchase price. At that point, the IHCP considers the equipment purchased. If equipment is purchased, either initially or at any time before the monthly rental payments have reached the purchase price, the purchase is reimbursed in a lump sum, minus any previous rental payments. In accordance with *405 IAC 5-19-8*, DME or HME purchased with IHCP funds becomes the property of the FSSA. DME or HME purchased by the IHCP that are no longer needed by a member may be required to be returned to the local county office of the FSSA Division of Family Resources (DFR).

For DME and HME with capped rental periods, the IHCP considers the equipment purchased after a member reaches the end of the capped rental period. See the *Capped Rental Items* section for more information.

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 for more information.

The IHCP makes no payment for rental for any month the member is in an institution that does not qualify as the member's home or is outside the United States for an entire month. However, if the member is at home on at least one 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 (available on a rental basis only), 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*, accessible from the *Code Sets* page at in.gov/medicaid/providers. The IHCP denies these codes if providers bill them as a purchase.

Capped Rental Items

The IHCP limits certain DME and HME items to a set number of months of continuous rental. The IHCP defines continuous rental as rental without an interruption lasting more than 60 days. A change in provider **does not** constitute an interruption in the rental period. For procedure codes subject to a capped rental period, see *Durable and Home Medical Equipment and Supplies Codes*, accessible from the *Code Sets* page at in.gov/medicaid/providers.

For capped rental items that are subject to the *21st Century Cures Act*, the capped rental period is either **six months** or **10 months**, depending on the type of item. For capped rental items that are not subject to the Act, the capped rental period is **15 months**.

For HCPCS codes subject to the Act that are designated as capped rental items by Medicare but for which Medicare does not have a purchase rate, the IHCP will establish a purchase rate. Additionally, for codes subject to the Act, the IHCP will follow Medicare reimbursement methodology for supplies provided to members during the capped rental period. During the capped rental period, supplies provided to members will be separately reimbursable and may be billed to the IHCP.

The IHCP handles claims submitted for these capped rental items in the following manner:

- The allowed charge is the lower of the rental amount on the IHCP fee schedule or the actual submitted charge.
- The IHCP pays claims for the rental of these items until the number of rental payments made to date reaches the capped rental number of months.
- Claims for rental of these items for more than the allowed number of months of continuous rental are denied.
- The IHCP evaluates requests for approval of these items for documentation of long-term need. In long-term situations, the IHCP may make a decision to purchase the item.

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 (even if it is with a different provider), the original rental period remains active. If the interruption exceeds the 60-day period, and the interruption reasons are justified, providers must submit a new PA request to begin a new rental period. The reason for the greater-than-60-day break in the rental period must be documented on the new PA request. 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 request justifying the new rental period, the original rental period remains active. 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.
- Subject to PA parameters, for repairs not covered by warranty, the IHCP does not reimburse more frequently than six months after the end of the capped rental period and every six months thereafter, for as long as the equipment is medically necessary.

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. At the end of the rental period, the IHCP considers the DME or HME equipment to be purchased, and, in accordance with *405 IAC 5-19-8*, the equipment becomes the property of the FSSA.

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.

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*.

Repair and Servicing

The IHCP reimburses for labor costs associated with the repair and servicing of DME or HME. All repairs of purchased DME or HME require PA.

Repairs of prosthetic and orthotic devices, hearing aids, and augmentative communication devices should be billed using the appropriate repair codes for those devices. For all other DME or HME, providers should bill labor costs associated with servicing and repairs using 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. The IHCP reimburses the materials needed for repair at 20% above the manufacturer's cost to the provider (or 75% of the MSRP).

> *Note: Effective for dates of service on or after Jan. 7, 2024, the MSRP or cost invoice must be the most current MSRP or cost invoice, and can be no older than two years old.*

The IHCP will not pay for labor for the repair of DME or HME under the following circumstances:

- 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 that the member understands the service is not covered by IHCP and the member will assume responsibility for the repairs.
- The IHCP does not cover payment for maintenance charges of properly functioning equipment.

- For rental equipment, repairs are the responsibility of the rental provider.
- For DME or HME included in an LTC facility's per diem rate, repair costs are also not separately reimbursable.

In addition, the IHCP reimburses for tasks considered to be labor or nonroutine servicing of DME or HME. The IHCP will not reimburse for the following types of services:

- Evaluation of a member for a wheelchair or seating system
- Patient education in the use and care of DME or HME
- Measurement of patient for DME or HME
- Initial assembly of DME or HME

Replacement

The IHCP reimburses for the replacement of medically necessary DME or HME under the following circumstances:

- **Irreparable damage or wear:** The IHCP does not authorize replacement of large DME or HME items (such as custom/special wheelchairs, hospital beds and lifts) more than once every five years per member, unless there is a change in the member's medical needs.
- **Change in the member's condition that requires a change in equipment:** These changes must be documented by the member's qualified practitioner, and a request must be sent to the PA contractor demonstrating a significant change warranting new equipment.
- **Loss of the item from theft, fire or natural disaster:**
  - If the equipment being replaced does not require PA and does not have a limit restriction, the provider may directly bill for the item. The provider should maintain documentation in the member's records to support the reason for replacement. This documentation would be subject to postpayment review.
  - If the item requires PA, the provider must submit a new PA request for the item, including an explanation that the item was lost due to theft, fire or natural disaster. The provider should maintain documentation in the member's records to support the reason for replacement. This documentation is subject to postpayment review.
  - If the item has a limit restriction, whether or not the DME item requires PA, the provider should submit a PA request for a replacement item with an explanation that the original item was lost due to theft, fire or natural disaster. The provider should maintain documentation in the member's records to support the reason for replacement. This documentation would be subject to postpayment review.

Customized Items

Following the definition of customized item in *42 CFR Section 414.224*, the IHCP defines custom items as equipment uniquely constructed or substantially modified to meet the specific needs of an individual patient according to the description and orders of a qualified practitioner, and be so different from another item used for the same purpose that the two items cannot be grouped together for pricing purposes.

For example, a "customized" wheelchair could be a wheelchair that is custom fabricated or substantially modified so that it can meet the needs of wheelchair-confined, conjoined twins facing each other. This wheelchair is unique and cannot be grouped with any other wheelchair used for the same purpose. It is a one-of a-kind item, fabricated to meet specific needs. Customized or specialized wheelchairs are reimbursed using HCPCS code E1399 – *Durable medical equipment, miscellaneous*. E1399 should only be used in the event that there is no other appropriate and specific DME code available for the item.

Customized items require prior authorization. For PA approval, the qualified practitioner's order accompanying the PA request must indicate the specifics about the member's physical condition that requires a customized item.

> *Note: For prosthetic devices, after the basic prosthesis is approved, all customizing features are exempt from PA requirements.*

Due to the unique aspects, providers cannot group these items with similar items for purposes of payment. The costs and charges for construction of the item can vary widely from one patient to another. Suppliers must submit documentation of the costs of the item, including the cost of labor and types of materials used in customizing the item. The claim must include an attachment itemizing all materials and labor, with the MSRP or cost invoice amount for each component. The IHCP reviews each item on the MSRP or invoice when calculating the reimbursement amount for all customized items. Manually priced items are reimbursed at 75% of MSRP or 120% of cost invoice amount.

> *Note: Effective for dates of service on or after Jan. 7, 2024, the MSRP or cost invoice must be the most current MSRP or cost invoice, and can be no older than two years old.*

The following are examples of items **that do not meet the definition** or are **not** considered customized items:

- Items that are individually constructed but have standard costs and charges and can be billed using existing HCPCS codes
- A wheelchair that is ordered in individual parts from one or multiple manufacturers and assembled by a supplier
- A wheelchair that is ordered from a manufacturer that makes available special features, modifications or components
- Items that are measured, assembled, fitted or adapted in consideration of a patient's body size, weight, disability, period of need or intended use (that is, custom-fitted items)
- Items assembled by a supplier or ordered from a manufacturer that makes available customized features, modification or components for wheelchairs intended for an individual patient's use in accordance with instructions from the patient's physician

Modifications to DME

The IHCP may make additional payment for modifications to DME. Examples of modifications to wheelchairs after their assembly include attachments to convert a wheelchair to a one-arm drive, brake extensions, wheelchair hand rims and antitipping devices.

Routine Maintenance

Payment for routine maintenance of properly functioning equipment is not covered by the IHCP. Routine maintenance includes services – such as testing, cleaning, regulating and checking equipment – that do not require a technician's skill.

Orthotic and Prosthetic Devices in the Outpatient Setting

Treatment room services are reimbursed at a flat rate that includes most drugs, injections and supplies. However, the IHCP allows separate reimbursement for specific orthotic and prosthetic codes when rendered in conjunction with treatment-room services and billed with revenue code 274 – *Medical/Surgical Supplies and Devices-Prosthetic/Orthotic Devices* on the outpatient claim. These codes are not separately reimbursable when services are provided on the same day as a surgical service.

For the list of applicable orthotic and prosthetic codes, see *Revenue Codes Linked to Specific Procedure Codes*, accessible from the *Code Sets* page at in.gov/medicaid/providers. For additional information about outpatient billing, see the *Outpatient Facility Services* module.

Consumable DME and HME Supplies

When billing for consumable DME or HME supplies that are to be consumed over an established time period, providers must enter the span dates for the consumption time period – rather than the date the items are delivered – as the dates of service on the claim.

Further, the span dates on the claim must correspond to the amount of supplies provided. For example, if a 30-day supply of an item is provided, the dates of service on the claim must be the span dates from day 1 through day 30.

Claims for consumable DME or HME supplies must be submitted for processing after the span dates have passed. Claims submitted with future dates of service cannot be adjudicated and will deny.

Medical Supplies

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 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, dentist, nurse practitioner, clinical nurse specialist, certified nurse midwife or physician assistant must prescribe all medical supplies and must document the need for such items. Medical supplies must be for a specific medical purpose, not for incidental or general-purpose usage. Covered medical supplies include, but are not limited to, antiseptics and solutions, bandages and dressing supplies, gauze pads, catheters, incontinence supplies, irrigation supplies, diabetes supplies, ostomy supplies, and respiratory and tracheotomy supplies.

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.

> *Note: LTC providers (nursing facilities, group homes and ICFs/IID) must **always** include medical supplies as part of their LTC facility per diem, even if the LTC facility does not include the cost of medical supplies in its cost report. Under no circumstances should a pharmacy, LTC facility or any other provider separately bill such supplies to the IHCP. See the Equipment and Supplies for Members in Long-Term Care Facilities section for more information.*

The IHCP requires all providers (including pharmacies) to submit FFS claims for most medical supplies on the **professional claim** (*CMS-1500* claim form or electronic equivalent), using HCPCS procedure codes, and to submit these claims to the IHCP fiscal agent, Gainwell Technologies. As **exceptions** to this rule, pharmacy providers must bill FFS claims for the following medical supplies as point-of-sale (POS) **pharmacy claims** submitted to the FFS pharmacy benefit manager, Optum Rx:

- Designated glucose monitoring products from the Preferred Diabetes Supply List (PDSL), as described in the *Pharmacy Services* module
- Other diabetes supplies
- Holding chambers for inhaled medications

- Covered sterile water products (Note that 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.)

For all other medical supplies, the IHCP denies claims submitted on the pharmacy claim type, using National Drug Codes (NDCs), unique device identifiers (UDIs), Health Related Item (HRI) codes, universal product codes (UPCs) or product identification numbers (PINs).

> *Note: The IHCP does not allow the billing of procedure code A9274 (External ambulatory insulin delivery system, disposable, each, includes all supplies and accessories) on a professional claim for the following items:*
>
> - *Omnipod and Omnipod Dash disposable insulin delivery pods*
> - *V-Go disposable insulin delivery devices*
>
> *These items must be billed through the pharmacy benefit. However, providers may bill A9274 on a professional claim form for the rental or purchase of the Omnipod Personal Diabetes Manager.*

Additional Information for Specific DME, HME and Supplies

The following sections contain special billing, coding and coverage information for select DME, HME and medical supplies. 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 (electronic or nonelectronic) 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.

The IHCP requires PA for an AAC device. The IHCP reimburses for an AAC device, with prior authorization, if a medical doctor or a doctor of osteopathy orders the device in writing.

The IHCP grants authorization for an AAC device only when the documentation presented substantiates all the following:

- The member has demonstrated sufficient mental and physical capabilities to benefit from the use of the device.
- In the absence of a communication device, the member cannot effectively make himself or herself understood by others in the member's communication environment.

> *Note: The lack of previous AAC device requests or usage will not be considered a reason for denial.*

- The provider reasonably expects that the member's medical condition will necessitate use of the device for at least two years.
- The device will be used to compensate for the loss or impairment of communication function.

Requesting practitioners must include the following with the PA request:

- Medical necessity documentation
- A speech-language pathologist's clinical evaluation, substantiating the medical necessity for the communication device
- 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
- Recommendation for the least expensive communication device

> *Note: Providers can use the Augmentative Communication System Selection Form to submit this required information along with the PA request. The form is available on the Forms page at in.gov/medicaid/providers.*

The IHCP determines whether to rent or purchase an approved AAC device based on the least expensive option to meet the member's needs. The IHCP does not deny any AAC device to an eligible member solely because it is not available for rental.

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-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
- If applicable, a notation indicating that the request is for an extension of a trial period or provision of a different device when requested by the speech-language pathologist responsible for evaluating the trial use period

The IHCP does not authorize replacement of an AAC device more often than once every five years per member, except as described in the *Replacement* section.

Subject to PA, the IHCP covers rehabilitation engineering service necessary to mount or make adjustments to an AAC 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) for individual use:

- The stand-alone model (referred to simply as an AED), billed with HCPCS code E0617 – *External defibrillator with integrated electrocardiogram analysis*
- The wearable cardioverter defibrillator (WCD), billed with HCPCS code K0606 – *Automatic external defibrillator, with integrated electrocardiogram analysis, garment type*

These devices are similar to a manual defibrillator, except that they detect and analyze heart rhythms automatically. AEDs and WCDs are indicated for members who normally are candidates for an implanted cardioverter defibrillator (ICD), but for whom ICDs are contraindicated or need to be removed.

Various manufacturers make the AED and WCD devices. Each device uses a battery pack and electrode defibrillator pads, and the initial supplies are usually included with the device. The WCD 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. Nonwearable components include a battery charger, a computer modem, a modem cable, a computer cable, a WCDNET data storage and retrieval system, and the diagnostic tester. 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.

Both the AED and the WCD are capped rental items (see the *Capped Rental Items* section). 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.

Prior Authorization for the AED and WCD Devices

Prior authorization is required for the AED and the WCD. The IHCP follows nationally recognized care guidelines when determining medical necessity for AEDs and WCDs..

Prior Authorization for AED and WCD Accessories

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

PA criteria for each accessory follows:

- For replacement batteries:
  - The member must currently be renting or have purchased an AED or WCD.
  - The battery being replaced must be at least 11 months old or completely discharged.
- For replacement electrodes:
  - The member must currently rent or have purchased an AED or the WCD.
  - The electrodes being replaced must have been used for at least 22 months, or it must be proven that the equipment is broken or damaged beyond repair.
- For replacement garment (only for WCD):
  - The member must currently rent or have purchased a WCD.
  - The garment must be damaged or worn beyond repair and must have been in use at least five months.

Breast Milk

Effective Nov. 1, 2022, the IHCP enrolls donor milk banks to process, store and distribute breast milk. For reimbursement, providers bill HCPCS code T2101 – *Human breast milk processing, storage and distribution only*.

Prior authorization is required for up to 5,000 ounces of milk. PA criteria include the following:

- The donor milk service requires a written order from a licensed medical practitioner (such as a physician, physician assistant or advanced practice registered nurse [APRN]).
- The infant's mother is medically or physically unable to produce maternal breast milk or to produce it in sufficient quantities to meet the infant's needs, or the maternal breast milk is contraindicated.

- The milk must be determined medically necessary for the infant by the following requirements:
  - For infants with an adjusted age or chronologic age up to 6 months as applicable, at least one of the following must apply:
    - Birth weight below 1,500 grams
    - Presence of a congenital or acquired condition that increases risk for development of necrotizing enterocolitis
    - Presence of congenital heart disease
    - Infant on list to receive an organ transplant or already has received one
    - Presence of congenital or acquired condition for which use of human milk confers a clear medical advantage beyond the generally accepted human milk advantage regarding absorption and immunological protection
  - For infants with an adjusted age or chronologic age 6 months through 12 months as applicable, at least one of the following must apply:
    - Birth weight below 1,500 grams with a long-term feeding or gastrointestinal condition that has arisen as a complication related to prematurity
    - Infant on list to receive an organ transplant or already has received one
    - Presence of congenital or acquired condition for which use of human milk confers a clear medical advantage beyond the generally accepted human milk advantage regarding absorption and immunological protection

For information about requirements to become a milk donor bank, see the *Provider Enrollment* module.

Breast Milk Storage Bags

The IHCP covers the HCPCS code K1005 – *Disposable collection and storage bag for breast milk, any size, any type, each*. Eligible members may receive a maximum of 200 bags per calendar month to assist with breast feeding.

> *Note: For dates of service on and after Jan. 1, 2024, HCPCS code A4287 replaces K1005 for billing this item.*

Prior authorization is not required, but members must meet all the following criteria for medical necessity:

- The member recently delivered a baby, and a physician has ordered or recommended mother's breast milk for the infant.
- Documentation in medical record indicates there is the potential for adequate milk production.
- Documentation in medical record indicates there is a long-term need for, and planned use of, a breast pump to obtain a milk supply for the infant.
- The member is capable of being trained to use a breast pump, as indicated by the physician or provider.
- Current or expected physical separation of mother and infant (such as illness, hospitalization or work) would make breastfeeding difficult or there is difficulty with "latch on" due to physical, emotional or developmental problems of the mother or infant.

Car Seats and Car Beds

Effective Aug. 19, 2022, the IHCP covers specialized car seats and car beds as DME using HCPCS code E1399 – *Durable Medical Equipment, miscellaneous*. Prior authorization is required.

Indications to determine the medical necessity for specialized car seats and car beds must include one of the following:

- The member has significant limb spasticity, muscle flaccidity or spinal deformity that prevents safe use of a normal car seat.
- The member has had a special evaluation conducted by an independent occupational or physical therapist supporting the specific needs for the customized car seat or car bed.
- The specialized car seat or car bed is to be used for the member to promote safe transfers that cannot be accomplished through other means.

This DME should be replaced as required to meet the member's growing needs. Replacements are covered only when the current car seat or car bed no longer meets the need of the member (such as outgrowing the item) or when the item was involved in an accident making it unsafe to use.

See the *Customized Items* section for information regarding billing and reimbursement of customized equipment such as specialized car seats and car beds.

Casting Supplies

The IHCP allows reimbursement for cast supplies in conjunction with the initial fracture care service. The IHCP also allows cast supplies in the following situations:

- 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
- When applied as a replacement when restorative care has been previously provided

Continuous Passive Motion Device

Prior authorization is not required for the continuous passive motion (CPM) device. Providers should bill for the CPM device using the appropriate HCPCS procedure code along with modifier RR:

- E0935 – *Continuous passive motion exercise device for use on knee only*
- E0936 – *Continuous passive motion exercise device for use other than knee*

One unit of service equals one day.

Cranial Remolding Orthosis

The IHCP provides coverage, with prior authorization, for cranial remolding orthosis (HCPCS code S1040) for members aged 4 months to 24 months with qualifying medical conditions, including plagiocephaly, brachycephaly, scaphocephaly or dolichocephaly.

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 other prior authorization criteria in the patient's chart.

This item is separately reimbursable for outpatient claims, as described in the *Orthotic and Prosthetic Devices in the Outpatient Setting* section.

Indications

The IHCP considers approval for the cranial remolding orthosis when the following criteria are met:

- The members is between 4 months and 24 months of age.
- The provider submits documentation showing that 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. 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 meets one of the following medical 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
    - 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.
  - Brachycephaly documented by a cephalic index two 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%
  - Asymmetry or the need for further correction 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

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.

Contraindications

The following are contraindications to receiving cranial remolding orthosis:

- Members older than 24 months of age
- Unmanaged hydrocephalus
- Craniosynostosis

Custom Tracheostomy Tubes

A custom tracheostomy tube is a device on which the manufacturer is required to make substantive customization or modification to meet a specific member's medical needs. The IHCP covers custom tracheostomy tubes, with prior authorization. Authorization of custom tracheostomy tubes requires clinical documentation supporting the medical appropriateness and a statement from the prescribing practitioner explaining why a standard or off-the-shelf tracheostomy tube will not meet the member's medical needs.

Custom tracheostomy tubes are billed with HCPCS code S8189 – *Tracheostomy supply, not otherwise classified*. A cost invoice must be submitted with the claim.

> *Note: Effective for dates of service on or after Jan. 7, 2024, the MSRP or cost invoice must be the most current MSRP or cost invoice, and can be no older than two years old.*

Diabetes Testing Supplies

The IHCP covers diabetes testing supplies, subject to the limits and requirements outlined in the following sections.

> *Note: Pharmacies (provider type 24), including those enrolled with DME specialty 250, must bill for diabetes testing supplies via the point-of-sale (POS) pharmacy claim, as described in the Pharmacy Services module. The billing information in this section, including information about procedure codes (which are used on medical claims), is not applicable to pharmacy providers.*

Quantity Limits for Diabetes Testing Supplies

Reimbursement is not available for medical supplies, including diabetes 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 with dates of service that span 90 days for diabetes test strips and continuous glucose monitor supplies and accessories. For affected procedure codes, see *Durable and Home Medical Equipment and Supplies Codes*, accessible from the Code Sets page at in.gov/medicaid/providers.

HCPCS procedure codes for test strips and lancets have maximum quantity limitations as follows:

- A4253 – *Blood glucose test or reagent strips for home blood glucose monitor, per 50 strips*
  - 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.
- A4259 – *Lancets, per box of 100*
  - 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

Preferred Diabetes Supply List

The FSSA selects certain preferred vendors to supply diabetes glucose monitoring products for members of all IHCP programs. The Preferred Diabetes Supply List (PDSL) can be found on the Optum Rx Indiana Medicaid website, accessible from the *Pharmacy Services* page at in.gov/medicaid/provider. From the Optum Rx Indiana Medicaid website, select the PDSL under the Preferred Products tab.

> *Note: Ancillary diabetes supply products (such as syringes, pen needles, lancets, lancing devices, alcohol swabs, control solutions, ketone strips and blood ketone test strips) are not subject to PDSL limitations.*

Diabetes glucose monitoring products that are not included on the PDSL require prior authorization. The FSSA advises prescribers to prescribe only the products listed on the PDSL, which eliminates the need to obtain PA for the product. Prescribers may also write the prescription in a generic version ("Blood glucose monitor and/or diabetes test strips" or "continuous glucose monitor and/or sensors") to allow the pharmacy or DME provider to dispense the diabetes glucose monitoring products 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.

The procedure codes that are subject to the PDSL can be found in *Durable and Home Medicaid Equipment and Supplies Codes*, accessible from the *Code Sets* page at in.gov/medicaid/providers.

Claims for the procedure codes subject to the PDSL require the entire vendor-specific National Drug Code (NDC) (for products labeled before Sept. 24, 2023) or unique device identifier (UDI) of the product being dispensed. If the NDC/UDI code is missing, invalid, not in the proper format, or does not correspond with the procedure code and modifier provided, the claim will be denied. This requirement includes Medicare crossover claims.

> *Note: The U.S. Food and Drug Administration (FDA) has instituted regulations impacting the use of NDCs in medical devices such as diabetes glucose monitoring products. Diabetes glucose monitoring products manufactured and labeled on or after Sept. 24, 2023, will no longer use NDC numbers for product identification. Instead, manufacturers will begin to use unique device identifiers (UDIs) for those items (see the Unique Device Identification System (UDI System) page at fda.gov). UDIs for most diabetes glucose monitoring products will be similar, if not identical to previously used NDCs. Current NDCs/UDI for PDSL products are included on the Preferred Diabetes Supply List.*

For procedure codes subject to the PDSL, if the NDC/UDI code entered is **not** one that the PDSL lists for that procedure code, modifier U1 must be included to indicate that the nonpreferred item has been prior authorized.

> *Note: Medicare crossover claims do not require prior authorization from the IHCP; therefore, the modifier U1 requirement for nonpreferred items does not apply to those claims. Instead, Medicare crossover claims for diabetes glucose monitoring products require the appropriate modifier as listed on the Medicare fee schedule.*
> *Non-Medicare third-party liability (TPL) claims for nonpreferred diabetes glucose monitoring products do require the U1 modifier, just as Medicaid-primary claims do.*

Claims for preferred diabetes glucose monitoring products (those with an NDC/UDI that appears on the PDSL) do **not** require the addition of modifier U1. If modifier U1 is included with an NDC/UDI code that is listed on the PDSL, the claim will be denied.

Diabetes glucose monitoring products are priced according to the Professional Fee Schedule, accessible from the *IHCP Fee Schedules* page at in.gov/medicaid/providers.

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*, the IHCP provides coverage for food supplements, nutritional supplements and infant formulas when no other means of nutrition is feasible or reasonable. Coverage is not available in cases of routine or ordinary nutritional needs. Coverage is also not available in cases in which the item is to be used for other than nutritional purposes.

In a long-term care (LTC) facility, costs for these products, when used either for nutritional supplementation or as the sole source of nutrition for the resident, are included in the facility's established per diem rate. When these products are furnished to an LTC facility resident, they are not separately reimbursable by the IHCP and should not be billed separately to the IHCP by either the LTC facility or another provider furnishing the products. The exception is parenteral hyperalimentation and total parenteral nutritional (TPN) products, which may be separately billed to the IHCP for residents of LTC facilities.

Prior authorization is required for all food supplements, nutritional supplements and infant formulas, with the exception of parenteral hyperalimentation and TPN products. The PA determination is made on a case-by-case basis, taking into consideration the feasibility or reasonableness of other means of nutrition, as documented by the requesting practitioner. Authorization is not granted when convenience of the member or the member's caretaker is the primary reason for the request for the service.

Food supplements, nutritional supplements and infant formulas should be billed on the professional claim (*CMS-1500* claim form or electronic equivalent), using the appropriate HCPCS procedure code, or as an outpatient claim on the *UB-04* claim form or electronic equivalent, along with the appropriate revenue code. These items should **not** be billed on the pharmacy claim.

Food Thickener

The IHCP covers food thickener, when ordered by a physician, based on medical necessity, and subject to prior authorization.

Enteral and Parenteral Nutrition

Both enteral and parenteral nutrition products require an IHCP *Durable Medical Equipment Information Form for Enteral and Parenteral Nutrition* (available on the *Forms* page at in.gov/medicaid/providers) be completed by the DME supplier and kept on file in the patient's medical records, along with a physician's signed order for the products.

The IHCP requires PA for enteral nutrition. After the initial PA of enteral nutrition items, the IHCP requires subsequent PA after three, nine and 18 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 renewal schedule starts again.

Each PA request for enteral nutrition items must include a copy of the completed IHCP *Durable Medical Equipment Information Form for Enteral and Parenteral Nutrition* and a physician's signed order. Providers must include *additional* documentation (with the initial and subsequent PA request) 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 the *Parenteral and Enteral Nutrition Pumps for Home Infusion* section)

The IHCP does not require PA for total parenteral nutrition (TPN) products when used in conjunction with parenteral hyperalimentation, including central venous catheters.

Enteral Feeding Cartridge

The IHCP covers HCPCS code B4105 – *In-line cartridge containing digestive enzyme(s) for enteral feeding, each*.

PA is required for all digestive enzyme cartridges for use with enteral tube feeding. For IHCP approval and coverage of initial requests up to three months, all the following criteria must be met:

- Diagnosis of cystic fibrosis and exocrine pancreatic insufficiency (EPI)
- Evidence of failed standard pancreatic enzyme therapy (defined as not meeting target weight gain for a minimum period of six weeks)
- Requires nightly continuous tube feedings through gastrostomy tube no less than three times weekly to achieve goal caloric intake

Each PA request for enteral nutrition items must include a copy of the completed DME information form. Providers must include *additional* documentation with the initial and subsequent PA requests to support medical necessity of the following orders:

- The need for special nutrients
- The need for a pump; see the *Parenteral and Enteral Nutrition Pumps for Home Infusion* section.

HCPCS code B4105 can be submitted on professional claims (*CMS-1500* form or electronic equivalent) and outpatient claims (*UB-04* form or electronic equivalent). Professional claims must include an attachment of the MSRP or cost invoice.

> *Note: Effective for dates of service on or after Jan. 7, 2024, the MSRP or cost invoice must be the most current MSRP or cost invoice, and can be no older than two years old.*

Infant Formula

Providers must coordinate with the appropriate entity when seeking approval for Medicaid coverage of infant formula. If the eligible member is assigned to FFS Medicaid on the date of service, the IHCP FFS nonpharmacy PA contractor is responsible for processing the required PA. Information about obtaining PA through the IHCP FFS nonpharmacy PA contractor can be found in the *Prior Authorization* module or on the *Prior Authorization* page at in.gov/medicaid/providers.

For members enrolled in HIP, Hoosier Care Connect or Hoosier Healthwise managed care programs on the date of service, the member's 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 in.gov/medicaid/providers 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. Members should be referred to WIC only as a secondary provider. Medicaid becomes the primary provider after approval as a covered benefit is granted.

Gloves

The IHCP provides coverage for sterile and nonsterile gloves for use in the home by the member, family or other nonpaid caregiver. All gloves must be ordered in writing by a physician. Sterile gloves must be used only when medical conditions necessitate them.

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. The order should reflect any changes in the plan of care in the home treatment setting. Providers must maintain records of quantities supplied. If these supplies are delivered or mailed, a record showing proof of delivery must be maintained.

The IHCP does not provide reimbursement for sterile or nonsterile gloves in the following situations:

- Gloves used in the home by a paid caregiver are noncovered.
- Gloves that are not used for a medically necessary treatment are noncovered.
- For end-stage renal disease (ESRD) and dialysis services, payment for gloves is included in the composite reimbursement rate and should not be billed separately.
- For members who reside in an LTC facility, gloves are included in the per diem reimbursement rate; therefore, gloves are not separately billable by the nursing facility or another provider.

Nonsterile Gloves

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 bill for nonsterile gloves using procedure code A4927 – *Gloves, non-sterile, per 100*. To bill nonsterile gloves individually, providers should use partial units 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.

Per IHCP guidelines, coverage is limited to 500 gloves (five units of A4927) per member per month.

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
- Exposure to blood and body fluids

Sterile Gloves

Sterile gloves are reimbursable, when medically necessary, using procedure code A4930 – *Gloves, sterile, per pair.*

Medical necessity for sterile gloves includes, but is not limited to, the following:

- Tracheostomy changes
- Wound care for specified populations, such as those who are immunosuppressed or burn victims

Sterile gloves are not separately reimbursed when they are included in sterile procedure kits, such as catheter insertion kits and suture removal kits.

Hearing Aids

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

High-Frequency Chest Oscillation Systems

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.

Prior authorization is required for all high-frequency chest wall oscillation systems. For IHCP approval and coverage, the following criteria must be met:

- A physician's order
- The physician's determination that the member requires airway clearance therapy at least once a day
- A pulmonary function study, done within 90 days of the date of the request, that demonstrates:
  - A forced expiratory volume (FEV1) 80% of predicted
  - A forced vital capacity (FVC) 50% of predicted
  - A 25% decrease on small airway score (forced expiratory flow [FEF] 25–75) over one year
- Documentation supporting that chest physiotherapy or flutter devices used twice a day have been ineffective in managing bronchial secretions
- Documentation supporting that family members and caregivers have been unable to provide effective chest therapy, or that the member is living independently or is away at school
- Risk of continued hospitalization for the member
- The member does not have a cardiac condition

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 requirement pertains only to the generator system. Reimbursement for the replacement vest and hose are purchase only.

Hospital and Specialty Beds

The IHCP provides coverage for hospital and specialty beds when they are medically necessary in a noninstitutional setting, when there is a written physician's order, and when prior authorization has been received for the bed.

The IHCP designates hospital and specialty beds according to the following definitions:

- Hospital beds
  - A *fixed-height hospital bed* is one with manual adjustment elevation for head and leg.
  - A *variable-height hospital bed* is one with manual adjustment elevation for the head, height and legs.
  - A *semi-electric hospital bed* is one with manual adjustment elevation for height and with electric elevation adjustments for the leg and head.
  - A *total-electric hospital bed* is one with electric elevation adjustments for height, head and leg.
- Specialty beds
  - An *enclosed bed* is one that is a single piece of equipment (for example, a bed and mesh canopy, or a bed with padded walls and a mattress especially designed for patients with traumatic brain injury [TBI]).
  - A *pediatric hospital bed* has higher side rails that are close together to prevent injury from falling through the rails. Pediatric hospital beds usually also have a protective covering over the rails.

Prior authorization is required for all types of hospital beds and specialty beds. The following items are required with the PA request for all hospital and specialty beds:

- A written physician's order
- A completed *Medical Clearance Form for Hospital and Specialty Beds* (available on the *Forms* page at in.gov/medicaid/providers) signed by a physician
- Documentation of medical necessity in a noninstitutional setting
- Appropriate diagnosis demonstrating medical necessity for a bed

For requirements specific to each type of bed, see the following subsections.

Hospital Beds

A hospital bed is considered medically necessary if **one or more** of the following conditions are met:

- A physician ordered positioning of the body in ways not feasible with an ordinary bed, and the order is due to a medical condition that is expected to last at least one month; elevation of the head and upper body needs to be at an angle greater than 30 degrees.
- A physician ordered positioning of the body to alleviate pain in ways that are not possible in an ordinary bed.
- A physician ordered positioning of the body in a way that requires head elevation at an angle greater than 30 degrees most of the time.
  - The need for head elevation must be related to a medical condition, such as congestive heart failure, chronic pulmonary disease or problems with aspiration.
  - Pillows or wedges must have been tried and failed.
- A physician ordered traction that requires traction equipment that can be attached only to a hospital bed.

A variable-height hospital bed is covered if, in addition to meeting one or more of the preceding criteria for a hospital bed, the physician orders a bed height different from a fixed-height hospital bed to accommodate transfers to a chair, wheelchair or standing position.

A semi-electric hospital bed is covered if, in addition to meeting one or more of the above criteria for a hospital bed, the physician orders frequent changes in body positioning or the patient has an immediate need for a change in body position.

Enclosed or Cubicle Bed

An enclosed bed or cubicle bed is considered medically necessary when **all** the following criteria are met:

- An appropriate diagnosis that could include but is not limited to the following:
  - Severe intellectual disabilities
  - Profound intellectual disabilities
  - Leukodystrophy
  - Picks disease
  - Obstructive hydrocephalus
  - Infantile cerebral palsy
  - Generalized convulsive epilepsy
  - Grand mal status epileptic
  - Anoxic brain damage
  - Convulsions
  - Intracranial injury of other and unspecified nature
- Documentation of medical necessity, including at least one of the following:
  - Daily seizure activity
  - Uncontrolled perpetual movement related to diagnosis
  - Self-injurious behavior, such as uncontrolled head banging
- Documentation of safety factors tried and failed, including but not limited to the following:
  - Chest restraints
  - Side rails
  - A mattress on the floor
  - Protective helmet
- Supporting documentation including secondary diagnoses and pertinent history, such as:
  - History of injuries or falls
  - High risk for fractures due to osteoporosis
  - At risk for hemorrhage due to thrombocytopenia
  - Frequent upper-respiratory infections or other complications related to aspiration
  - Respiratory complications related to positioning, requiring elevation of the head and upper body at an angle greater than 30 degrees
  - Requires frequent positional changes
- A signed physician's order for enclosed bed or cubicle bed
- Verification that the primary caregiver is willing and able to clean and maintain the mesh canopy per the manufacturer recommendations. IHCP will not pay for laundering of the mesh canopy.

Pediatric Hospital Bed

Pediatric hospital beds are considered medically necessary when **all** the following criteria are met:

- A diagnosis that supports medically necessity, which could include but is not limited to the following:
  - Tracheostomy
  - Gastrostomy
  - Heart failure
  - Pleural effusion, except tuberculous
  - Acute respiratory failure
  - Pulmonary insufficiency

  - Diseases of the lung
  - Diseases of trachea and bronchus
  - Respiratory distress syndrome in newborn
  - Other respiratory problems after birth
  - Other symptoms involving respiratory system and chest
- A physician's order for a multi-positional bed due to the need for frequent position changes
- A physician's order for elevation of upper body and head at an angle greater than 30 degrees
- Written documentation of why a standard crib is not appropriate and what alternative methods have been tried and failed
- Documentation of at least **one** of the following:
  - A risk for aspiration pneumonitis or gastric reflux related to disease
  - A history of aspiration pneumonitis

Incontinence, Ostomy and Urological Supplies

The IHCP covers incontinence supplies for members 3 years old or older, based on medical necessity. The following restrictions apply for FFS billing:

- A member may receive a maximum of $162.50 per month for all incontinence supplies.
- A member may receive a maximum of $1,950 per rolling 12-month period for all incontinence supplies.

Providers may supply such items to an IHCP member only in 30-day increments. Although a physician may write an order for a longer period of time, providers must provide each member with only a 30-day supply at a time, except as described in the *Incontinence Supplies Covered by Medicare or Other Primary Insurers* section.

Documentation Requirements

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 clinical documentation must include a diagnosis of incontinence. The incontinence diagnosis must also be documented on the professional claim (*CMS-1500* claim form or electronic equivalent), with information about the specific quantity and description of the supplies provided.

Incontinence supplies must be ordered in writing by a physician. The written order 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)
- Detailed list of supplies ordered (including 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 (including start and stop dates)

The supplier must maintain the signed physician's order in the IHCP member's record for audit purposes.

The physician's order must be renewed annually, at minimum. For example, an order written on Feb. 15, 2022, is effective for a maximum of 12 months, through Feb. 14, 2023. The supplier must obtain a new order to cover dates of service starting Feb. 15, 2023. 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 in the member's medical record of proof of delivery. Documentation must include the following:

- Date of delivery
- Address of delivery
- Signature of the IHCP member, caregiver or family member who received the supplies
- Specific quantity and description (such as brand, type, size and so forth) of the supplies provided

Nursing Assessment Requirements

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.

Contracted Vendor Requirements

FFS members, including those in the Traditional Medicaid program, are required to obtain incontinence, ostomy and urological supplies – including but not limited to 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: 888-217-9610
- **J&B Medical Supply Company**
  jandbmedical.com
  Telephone: 866-674-5850

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. FFS claims for these supplies from noncontracted vendors will be systematically denied, except as described in the *Incontinence Supplies Covered by Medicare or Other Primary Insurers* section.

Some products that *may* be used for incontinence, ostomy or urological conditions – such as adhesive and adhesive remover, lubricant, gloves, and skin barriers – also have other, *unrelated* uses. When these supplies are used for purposes unrelated to incontinence, ostomy or urological conditions, they are not affected by the IHCP-contracted vendor requirement and may be obtained from any appropriate IHCP-enrolled provider (including but not limited to the contracted vendors).

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*, accessible from the *Code Sets* page at in.gov/medicaid/providers.

Prior Authorization for High-End Incontinence Products

PA is **not** required for the reimbursement of incontinence supplies ***except*** in the following cases:

- The products are supplied by an out-of-state provider.
- The member is using high-end incontinence products.

Prior authorization for high-end incontinence products will be granted based on medical necessity. At minimum, the following information must be submitted to determine medical necessity:

- Documentation from the member that the member has sampled all applicable products from the two vendors and indicating why the products sampled were not appropriate (for example, leakage, skin breakdown and so on).
- Documentation supporting medical necessity for the high-end ostomy supplies. The documentation must include one or more of the following:
  - Recurrent infections or skin breakdown
  - Issues the member is having with the current product (allergic reaction, redness, irritation and so on)
  - Enzymes dissolving the adhesive or causing skin breakdown
- Documentation of the actual quantity needed per month for the member and factors that affect the frequency of the change

Procedure codes for high-end incontinence products are 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*, accessible from the *Code Sets* page at in.gov/medicaid/providers. Claims for these procedure codes must include modifier U9 to process correctly (with the exception of crossover claims, as described in the following section).

Incontinence Supplies Covered by Medicare or Other Primary Insurers

IHCP members with Medicare or other third-party insurance must follow the guidelines of their primary insurance plan to receive reimbursement for incontinence, ostomy and urological supplies. Crossover claims and other claims with a third-party payment amount (including payments of $0) indicated for these supplies are not affected by the IHCP-contracted-vendor requirement or the 30-day-supply requirement, as long as the primary carrier provided coverage for the product.

In cases when the other insurance payment is zero, one of the following adjustment reason codes (ARCs) must be indicated on the IHCP claim, or the detail will deny:

- ARC 1 – Deductible Amount
- ARC 2 – Coinsurance Amount
- ARC 3 – Copayment Amount

Additionally, no prior authorization is required for crossover claims, including claims for high-end incontinence products, and the U9 modifier is not required for these items on crossover claims. This exception applies **only** to claims paid (in whole or in part) by Medicare or a Medicare Advantage Plan; IHCP prior authorization continues to be required for high-end incontinence products that were covered by a commercial TPL carrier.

Before supplying FFS IHCP members with incontinence products in a greater-than-30-day supply, or from a noncontracted vendor (for designated items), or without PA (for high-end items supplied to dually eligible members), providers must first verify the member's primary carrier eligibility and product coverage for the date of service. If coverage under the primary carrier does not apply to the date or type of service, the claim will be subject to IHCP policies requiring these products to be supplied in 30-day increments, designated supplies to be provided by one of the two contracted vendors, and PA for high-end items.

Incontinence Supplies for Long-Term Care Facility Residents

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

INR Monitoring

The IHCP covers the following home international normalized ratio (INR) monitoring services:

- G0248 – *Demonstrate use of home INR monitoring*
- G0249 – *Provide INR testing materials and equipment*
- 93792 – *Patient or caregiver training for home INR*
- 93793 – *Anticoagulation management for patients on warfarin*

Reimbursement for HCPCS codes G0248 and G0249 is limited to Medicare or Medicare Advantage Plan crossover claims only. The IHCP covers these codes only on professional (*CMS-1500* claim form or electronic equivalent) **crossover claims** or outpatient institutional (*UB-04* claim form or electronic equivalent) **crossover claims**.

Prior authorization is required for CPT codes 93792 and 93793. PA for home INR monitoring requires the following criteria be met:

- The patient must have been anticoagulated for at least three months prior to use of the home INR monitoring device.
- The patient must have undergone a face-to-face educational program on anticoagulation management and must have demonstrated the correct use of the device prior to its use in the home.
- The management plan requires documentation that the patient is correctly using the device for anticoagulation management as a condition for the continuation of home monitoring services.
- Self-testing with the device should not occur more frequently than once a week.

Negative Pressure Wound Therapy

The IHCP provides coverage for negative pressure wound therapy (NPWT), including the pump device and related supplies, in a home-care setting or an LTC facility setting. Prior authorization is required, based on the following criteria:

- The member must have a physician's order.
- The NPWT must be reasonable and medically necessary.
- The member must have one of the following conditions:
  - Stage III or IV pressure ulcer
  - Neuropathic ulcer
  - Venous or arterial insufficiency ulcer
  - Chronic (being present for at least 30 days) ulcer of mixed etiology
  - Traumatic or surgically created wound
- A complete wound-therapy program, described in the following sections, depending on the type of wound, must have been tried and failed before applying the NPWT.

Wound-Therapy Program Requirements

For all ulcers or wounds, **all** the following minimum general measures of a wound-therapy program must be addressed, applied, or considered and ruled out before applying the NPWT:

- Documentation in a patient's medical record of evaluation, care, and wound measurements by a licensed medical professional
- Application of dressings to maintain a moist wound environment

- Debridement of necrotic tissue and treatment of active infection, if present
- Evaluation of and provision for adequate nutritional status
- Ensure adequate wound perfusion

Stage III or IV Pressure Ulcers

In addition to the minimum general measures, stage III or IV pressure ulcers must also be evaluated for all the following components:

- The patient has been appropriately turned and positioned, and has a current turning and positioning plan in place.
- If the wound is on the trunk or the pelvis, the patient has used a group 2 or group 3 support surface.
- The patient's moisture and incontinence has been appropriately managed.

Neuropathic Ulcers

In addition to the minimum general measures, neuropathic ulcers must also be evaluated for all the following components:

- The patient has been on a comprehensive diabetes or other applicable disease management program.
- Reduction in pressure on a foot ulcer has been accomplished with appropriate modalities.

Venous Stasis Ulcers

In addition to the minimum general measures, venous stasis ulcers must also be evaluated for all the following components:

- Compression bandages or garments have been consistently applied.
- Leg elevation and ambulation have been encouraged.

Prior Authorization for NPWT

Prior authorization is required for reimbursement of NPWT services, including the pump device and supplies. The PA request must include a completed *Medical Clearance Form for Negative Pressure Wound Therapy* (available on the *Forms* page at in.gov/medicaid/providers), signed by the physician.

The NPWT is authorized for only four weeks at a time. To obtain PA for continued service after the initial PA of NPWT, the following documentation must be included with the request:

- Indication that a licensed medical professional has directly performed or supervised the performance of the dressing changes
- A statement from the treating physician describing the initial condition of the wound, including measurements, efforts taken to address wound care, and the changes in the wound therapy being applied to affect wound healing
- Progress and changes in the ulcer (If there is no progress in one month, or from month to month, the approval for the NPWT will be discontinued.)
- A completed NPWT medical clearance form, signed and dated by the ordering physician

Each new physician's order for continued use of NPWT requires a new PA period. If a PA is modified and authorized for less time than the physician's order had requested initially, a new PA form and updated physician's orders must be obtained before the current authorization expires.

Authorization for coverage beyond four months in a home-care setting will be given individual consideration, based on additional documentation that sets out the reason for continuing use of NPWT.

Supplies

Supplies for the NPWT must be prior authorized. The following limits apply, unless documentation is submitted indicating medical necessity for an increased amount of supplies:

- NPWT dressing sets (A6550) – No more than 15 units of dressing sets), any size, will be authorized per wound, per month. (Each dressing set equals one unit.)
- NPWT pump cannisters (A7000) – No more than 10 canisters, any size, will be authorized per wound, per month.

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 osteogenic bone-growth stimulators when the service is considered medically necessary and provided in compliance with all IHCP guidelines. Prior authorization is required for osteogenic bone-growth stimulators.

Indications

For authorization of an osteogenic bone-growth stimulator, the diagnosis of a nonunion fracture must meet the following criteria:

- Serial radiographs must have confirmed that the healing of the fracture has ceased for three or more months prior to 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.

In addition, the member must meet medical criteria specific to the type of device being requested:

- **Noninvasive electrical stimulators** are covered only for the following indications:
  - Nonunion of long bone fractures
  - Congenital pseudoarthrosis
  - As an adjunct to spinal fusion surgery for patients at high risk of pseudoarthrosis due to previously failed spinal fusion at the same site, or for those undergoing multiple-level fusions (fusions involving three or more vertebrae, such as L3–L5 or L4–S1)
- **Noninvasive ultrasonic stimulators** are covered for the following indication:
  - Written interpretation by a physician stating that there has been no clinically significant evidence of the nonunion fracture healing between the two or more sets of radiographs (each with multiple views of the fracture site, separated by at least 90 days) obtained prior to starting treatment with an osteogenic stimulator.

> *Note: The ultrasonic osteogenic stimulator may not be used concurrently with other noninvasive osteogenic devices.*

- **Implantable stimulators** – See the *Surgical Services* module for coverage requirements.

Contraindications

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.

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*.

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 or the oximeter device.

Oxygen and Home Oxygen Equipment

The IHCP covers home oxygen therapy for conditions described in this section. For members receiving oxygen services in a home setting, the IHCP requires prior authorization for all oxygen and associated equipment and supplies, including concentrators and portable liquid oxygen equipment. Oxygen coverage is determined by the results of an arterial blood gas (ABG) or oximetry test. Results of specific testing must be reviewed before coverage can be determined.

The PA request must include a completed Certificate of Medical Necessity for Oxygen form that has been reviewed, signed and dated by the ordering physician. Providers may use the IHCP *Certificate of Medical Necessity for Oxygen* form, available on the *Forms* page at in.gov/medicaid/providers, or they may use their own equivalent Certificate of Medical Necessity for Oxygen form. Providers must keep a copy of the completed form on file. Providers should use this form for initial PA, subsequent PA renewals (recertifications) and PA revisions (for changes in the prescription). The IHCP does not require a separate written order, because the order information is incorporated in the Certificate of Medical Necessity for Oxygen form.

Providers are asked to differentiate oxygen needs for a member in their medical documentation by designating them as termed or lifetime oxygen users:

- A **termed** oxygen user is designated as a member that will require only temporary oxygen support.
- A **lifetime** oxygen user is designated as a member that is not expected to recover enough over their lifetime to no longer require supplemental oxygen.

On the IHCP *Certificate of Medical Necessity for Oxygen* form, providers indicate a lifetime oxygen user in Section B, by entering **99** for the Estimated Length of Need (99=lifetime). Anything less than 99 is considered a termed oxygen user. If a provider uses their own Certificate of Medical Necessity for Oxygen form, that form must indicate whether the member is a termed or lifetime oxygen user.

The PA request itself must also indicate whether the member is a termed or lifetime oxygen user. For FFS members, the following guidance applies:

- If the request is submitted through the FFS PA contractor's provider portal, providers will have to respond to the question asking if the member will require supplemental oxygen for their lifetime. For lifetime oxygen users, the authorization must be submitted for a date-of-service range that spans 365 days . Providers are required to submit a completed Certificate of Medical Necessity for Oxygen form as an attachment to the portal request.
- If the request is submitted by phone or fax to the FFS PA contractor, providers must articulate to the customer service representative, or indicate within the faxed request, whether the member is a "lifetime" user. In addition to the phone or faxed request, providers must also submit (by mail or fax) a completed Certificate of Medical Necessity for Oxygen form.

See the *IHCP Quick Reference Guide* at in.gov/medicaid/providers for the portal link, phone and fax numbers for the FFS PA contractor, as well as for managed care contractors.

Providers are asked to keep approved authorizations for lifetime oxygen users on file in case the member changes managed care entities or Medicaid programs.

The IHCP requires PA renewals at least annually for both termed and lifetime oxygen users. See the *Recertifications* section for details.

For any member not determined to require lifetime oxygen use, providers must also submit a new PA request and updated Certificate of Medical Necessity for Oxygen form any time there is a change in the oxygen prescription, such as increase or decrease in oxygen flow rate or different equipment ordered, or if there is a change in the attending physician. See the *Revised Certifications* section for details. In addition, the IHCP may require subsequent reassessments in individual cases. For more information on obtaining PA, see the *Prior Authorization* module.

Authorization of home oxygen therapy is based on the medical criteria indicated in the following *Indications for Home Oxygen Therapy* section.

Indications for Home Oxygen Therapy

The IHCP covers home oxygen therapy for members with hypoxemia, provided the following are met:

- The treating provider has determined that the member has a severe lung disease or hypoxia-related symptoms that might be expected to improve with oxygen.
- The patient's blood gas levels (as measured by either pulse oximetry or arterial blood gas*) indicate the need for oxygen therapy.
- The provider has tried or considered alternative treatment measures and has deemed them clinically ineffective.
- The member meets the criteria in one of the category groups (Group I, II or III) as presented in the following section.

**Note: The IHCP accepts transcutaneous oximetry in lieu of arterial or capillary blood gases for oxygen monitoring. The measurement of these tests must be conducted by a physician or provider (other than a DME supplier) certified to conduct such 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.*

Initial Certification

The start date of home oxygen coverage cannot precede the date of prescription or the date of the test(s) whose results establish that the special coverage criteria are met. Testing is required within 30 days prior to the date of initial certification. If the oxygen is begun immediately following discharge from an acute care facility, the test must be within two days prior to discharge.

The patient must meet the criteria in one of the following category groups:

- **Group I criteria**
  - Adult member age 21 years or older demonstrates an arterial PO_2 (oxygen partial pressure) at or below 55 mm Hg or an arterial oxygen saturation at or below 88%, taken at rest on room air unless contraindicated by a provider.
  - Pediatric member age 20 years or younger demonstrates an arterial PO_2 at or below 60 mm Hg or an arterial saturation at or below 90% taken at rest on room air unless contraindicated by a provider.
  - Infants 0 through 12 months of age with bronchopulmonary dysplasia (BPD) may have variable oxygen needs. In these cases, appropriate documentation, in the absence of qualifying arterial PO_2 or pulse oximetry oxygen saturation values, must be presented for consideration on a case-by-case basis.
  - The IHCP provides coverage **only for nocturnal use** of oxygen in the following cases:
    - For any member who demonstrates an arterial PO_2 at or below 55 mm Hg or an arterial oxygen saturation at or below 88% during sleep on room air unless contraindicated by a provider, and the member demonstrates an arterial PO_2 at or above 56 mm Hg or an arterial oxygen saturation at or above 89% while awake on room air unless contraindicated by a provider.
    - For any member who 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 impairment of cognitive processes, nocturnal restlessness or insomnia.
  - The IHCP provides coverage **only during exercise** in the following instance:
    - For any member who demonstrates an arterial PO_2 at or below 55 mm Hg or an arterial oxygen saturation at or below 88% taken during exercise on room air unless contraindicated by a provider and the member demonstrates 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 on room air unless contraindicated by a provider. In this case, the IHCP provides supplemental oxygen during exercise if it is documented that the use of oxygen improves the hypoxemia that was documented during exercise when the member was breathing room air.
  - If a member does not meet criteria based on PO_2 or arterial oxygen saturation levels, but the provider believes the member may still be in need of home oxygen, the provider may submit documentation for PA and medical necessity review.
- **Group II criteria**
  - Adult member age 21 years or older demonstrates an arterial PO_2 of 56 to 59 mm Hg or an arterial blood oxygen saturation of 89% or lower on room air unless contraindicated by a provider, **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%

– Pediatric member age 20 years or younger demonstrates:
- Cystic fibrosis complicated by severe chronic hypoxemia
- Cystic fibrosis with both mild chronic hypoxemia and dyspnea on exertion
- Bronchopulmonary dysplasia complicated by chronic hypoxemia
- Sleep-disordered breathing complicated by severe nocturnal hypoxemia who cannot tolerate positive airway pressure therapy or is awaiting surgical treatment of sleep-disordered breathing
- Sickle cell disease complicated by severe chronic hypoxemia
- Pulmonary hypertension without congenital heart disease complicated by chronic hypoxemia
- Interstitial lung disease complicated by severe chronic hypoxemia
- Interstitial lung disease with mild chronic hypoxemia and either dyspnea on exertion or desaturation during sleep or exertion

- **Group III criteria**

> *Note: The IHCP requires additional documentation to substantiate the use of oxygen for members in this group. Providers should ensure that additional documentation appears on the PA request or an attached document, indicating the type, frequency, and severity of incidents or episodes.*
>
> *The IHCP may grant PA to members who fall into Group III for three, six or 12 months, depending on the medical necessity demonstrated in the documentation provided. Providers must include such benefits, or the results of the latest ABG or oximetry readings, on the Certificate of Medical Necessity for Oxygen when submitted with the new PA request.*

– Any member who demonstrates an arterial PO_2 level at or above 60 mm Hg or an arterial blood oxygen saturation at or above 90% on room air unless contraindicated by a provider.

– Episodes 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 clinically interfere with normal breathing
- Severe recurrent attacks of epilepsy
- Significant intellectual disability with repetitive episodes of respiratory difficulties
- Tracheal laryngeal malacia
- Cluster headaches (see the *Cluster Headaches – Additional Criteria and Limits* section for additional criteria specific to this indication)
- Acute conditions causing hypoxia such as pneumonia, coronavirus disease 2019 (COVID-19) or congestive heart failure

Revised Certifications

For termed oxygen users (those not determined to require lifetime oxygen use), a revised PA with an updated Certificate of Medical Necessity for Oxygen form is necessary under any of the following circumstances:

- The prescribed maximum flow rate changes from one of the following categories to another: (a) less than 1 LPM, (b) 1-4 LPM, and (c) greater than 4 LPM. If the change is from category (a) or (b) to category (c), a repeat ABG or oximetry test with the member on 4 LPM must be performed within 30 days prior to the start of the greater-than-4-LPM flow.
- Portable oxygen is added subsequent to the initial certification of a stationary system. In this situation, there is no requirement for a repeat ABG or oximetry test unless the initial qualifying study was performed during sleep, in which case a repeat ABG must be performed while the member is at rest (awake) or during exercise on room air unless contraindicated by a provider.
- The initial certification specified an estimated length of need that is less than lifetime and the physician wants to extend the certification.
- There is a new treating provider. (No new ABG or oximetry testing is required in this situation; however, a revised Certificate of Medical Necessity for Oxygen form is still required.)

Effective Nov. 20, 2023, the preceding circumstances do **not** require submission of a new PA and Certificate of Medical Necessity for Oxygen form if there is a prior PA and Certificate of Medical Necessity for Oxygen form on file identifying the member as a **lifetime** oxygen user.

Recertifications

The circumstances and the results of testing that established the medical necessity at the start of home oxygen therapy determine the recertification schedule. The IHCP requires a new prior authorization, including a Certificate of Medical Necessity for Oxygen form, and repeat ABG or oximetry for recertification:

- Recertification is required **three months** after initial certification in the following cases:
  - For members whose arterial PO_2 was 56 mm Hg or greater or whose oxygen saturation was 89% or greater on the initial certification, and (effective Nov. 20, 2023) who are not assessed to be on lifetime oxygen need
  - For members whose physician's initial estimate of length of need for oxygen was one to three months

  Repeat ABG or oximetry testing must be performed within the previous 30 days for continuation of home oxygen therapy.
- Recertification is required **annually** for **all** members. Repeat ABG or oximetry testing must be performed within the previous six months for continuation of home oxygen therapy.

Cluster Headaches – Additional Criteria and Limits

Home oxygen therapy for the treatment of cluster headaches is considered medically necessary when the following criteria are met:

- The member has a diagnosis of cluster headaches using criteria from the International Headache Society.
- The headaches must be accompanied by at least one of the following findings:
  - Ipsilateral conjunctival injection and/or lacrimation
  - Ipsilateral nasal congestion and/or rhinorrhea
  - Ipsilateral eyelid edema
  - Ipsilateral forehead and facial sweating

  - Ipsilateral miosis and/or ptosis
  - A sense of restlessness or agitation

The following standards are followed for time-limit approvals and renewals:

- Cluster headache requiring oxygen therapy will be limited to an initial three-month consideration. A provider should be alerted that a clinical current progress note that includes frequency, duration, and intensity of headache pattern and response to oxygen therapy will be required for all renewal requests.
- If the headache pattern has decreased to a level that no longer meets criteria, a renewal will not be approved.
- If the headache pattern persists and there is clinical documentation of a positive response to oxygen therapy, an additional three-month approval will be granted.

Only a stationary gaseous oxygen system (procedure code E0424) and related contents (procedure code E0441) are covered for the treatment of cluster headaches.

Billing and Reimbursement

The IHCP reimburses liquid and gaseous oxygen systems as rental items only. The oxygen system does not fall under capped rental guidelines.

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 IHCP includes oxygen contents 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) in the allowance for rented systems. The IHCP separately reimburses for these items only when 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.

Long-Term Care Facility Considerations

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 includes reimbursement for these items in the facility *per diem* rate. If a member in an LTC facility requires nonstandard equipment, these items may be eligible for separate reimbursement. The IHCP requires PA for nonstandard equipment and associated repair costs. Facilities cannot require members to purchase or rent such equipment with the member's personal funds.

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

Parenteral and Enteral Nutrition Pumps for Home Infusion

The IHCP covers parenteral and enteral nutrition (PEN) pumps for home infusion. For all PEN pumps, the IHCP requires a completed *Durable Medical Equipment Information Form for Enteral and Parenteral Nutrition* (available on the *Forms* page at in.gov/medicaid/providers) be kept in the patient's records.

The IHCP does not require prior authorization for the PEN pumps; however, PA **is** required for enteral nutrition used with the pump. For information about parenteral and enteral nutrition items, see the *Food Supplements, Nutritional Supplements and Infant Formulas* section.

Billing and Reimbursement

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

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

Providers must bill separately for the components for parenteral and enteral home infusion therapy:

- DME, HME and pharmacy providers bill all **supplies and formulas** used for parenteral and enteral home infusion 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 dually eligible members (Medicare and Traditional Medicaid) to Medicare or Medicare Advantage Plans and to the IHCP as crossovers. The provider must submit these services on the institutional claim (*UB-04* claim form or electronic equivalent).

See the Professional and Outpatient Fee Schedules, accessible from the *IHCP Fee Schedules* page at in.gov/medicaid/providers for a comprehensive list of covered procedures.

> *Note: 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. 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.*

PEN pumps are capped rental items. The IHCP makes no more than 15 monthly rental payments; 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. See the *Capped Rental Items* section for more information.

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.

Servicing and Repairs

Necessary servicing of pumps may include repairs that require specialized testing equipment not available to the member or nursing home. The IHCP pays only for actual servicing. However, providers must obtain prior authorization for reimbursement for repair or servicing not covered by warranty. See the *Repair and Servicing* section for more information.

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 voicing system (also known as an artificial larynx), subject to PA. The IHCP grants PA only when the provider sends the following:

- Documentation substantiating that the member demonstrates sufficient mental and physical ability to benefit from the use of the system
- Documentation substantiating 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.

Prosthetic Devices

The IHCP reimburses for prosthetic devices under the following conditions:

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

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.

Myoelectric Upper-Limb Prosthetics

The IHCP covers myoelectric upper-limb prosthetics for the following procedure codes:

- L8701 – *Powered upper extremity range of motion assist device, elbow, wrist, hand with single or double upright(s), includes microprocessor, sensors, all components, and accessories, custom fabricated*
- L8702 – *Powered upper extremity range of motion assist device, elbow, wrist, hand, finger, single or double upright(s), includes microprocessor, sensors, all components and accessories, custom fabricated*

Myoelectric upper limb prosthetic components meet the definition of medical necessity when all the following criteria are met:

- Patient is age 2 years or older.
- Upper-extremity prosthesis is needed.
- Patient is a suitable candidate for myoelectric prosthesis, as indicated by all the following:
  - Unilateral transhumeral or transradial (forearm) deficiency
  - Able and willing to participate in myoelectric prosthesis training
  - Able to tolerate weight of prosthesis
  - Adequate cognitive ability to operate myoelectric prosthesis
  - Remaining proximal arm musculature containing minimum microvolt threshold to operate myoelectric prosthesis
  - No surrounding environment that precludes use of myoelectric prosthesis (such as excessive moisture or dust)
  - No underlying neuromuscular disease
- Provider or team of experts with appropriate expertise in patient's condition has evaluated patient and recommended prosthesis.
- Standard body-powered prosthesis cannot be used or has insufficient functionality to assist patient with performance of activities of daily living.

Respiratory Assist Devices

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

- Continuous positive airway pressure (CPAP) devices
- Bilevel positive airway pressure (BiPAP) devices with a backup rate feature
- BiPAP devices without a backup rate feature

Whether the RAD (CPAP or BiPAP) is owned or rented by the member, the IHCP reimburses RAD accessories separately, with specific limitations according to CMS guidelines.

For a list of procedure codes for respiratory assist devices and supplies, along with PA indicators for new and continued use, see *Durable and Home Medical Equipment and Supplies Codes*, accessible from the *Code Sets* page at in.gov/medicaid/providers.

> *Note: Effective Jan. 1, 2024, the IHCP removed PA requirements for **continued use** of certain respiratory assist devices, services and. Members with a **new** requirement for any of these items will still require an **initial** PA if the item requires PA under their current coverage plan. The information in the following sections will be updated in the next version of this module to reflect this new policy.*

For information about humidifiers used with a RAD, see the *Humidifiers Used with a Positive Pressure Airway Device* subsection.

Continuous Positive Airway Pressure (CPAP)

The IHCP reimburses for CPAP systems for members who meet one or more of the following criteria:

- A diagnosis of 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 5–14 events per hour documented in a recorded polysomnography, with one or more of the following documented symptoms of:
  - Excessive daytime sleepiness
  - impaired cognition
  - Mood disorders
  - Insomnia or hypertension
  - Ischemic heart disease
  - History of stroke
- A diagnosis of moderate or severe OSA in a member for whom surgery is a likely alternative to CPAP

CPAP devices do not require prior authorization. However, copies of the member's sleep lab evaluation, including a polysomnography, must be retained in the physician's record.

Bilevel Positive Airway Pressure (BiPAP)

The IHCP provides reimbursement for BiPAP with backup or BiPAP without backup, with prior authorization, 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.

First Three Months of Therapy

BiPAP devices are covered for the first three months of therapy for members with clinical disorders characterized in the following sections, when all listed criteria are met.

> *Note: For members under the age of 19, appropriate noninvasive testing (such as capillary blood gas and end tidal CO_2 tests) may be substituted in place of an arterial blood gas $PaCO_2$ test to meet medical criteria for all conditions. All other required criteria listed under each condition must be followed.*

Restrictive Thoracic Disorders

A BiPAP device with or without backup (based on the judgment of the treating physician) may be covered for the first three months of therapy for members with restrictive thoracic disorders if all the following criteria are met:

- One of the following conditions is documented in the member's medical record:
  - A progressive neuromuscular disease (for example, amyotrophic lateral sclerosis)
  - A severe thoracic-cage abnormality (for example, post-thoracoplasty for tuberculosis)

- One of the following measurements has been demonstrated for the member:
  - An arterial blood gas analysis, done while the member is awake and breathing the member's usual fraction of inspired oxygen (FiO_2), demonstrates $PaCO_2$ greater than or equal to 45 mm Hg.
  - Sleep oximetry, done while breathing the member's usual FiO_2, demonstrates oxygen saturation of less than or equal to 88% for at least five continuous minutes.
  - For members with a progressive neuromuscular disease only – Maximal inspiratory pressure is less than 60 cm H_2O, or forced vital capacity is less than 50% predicted.
- Chronic pulmonary disease does not contribute significantly to the member's pulmonary limitation.

Severe Chronic Obstructive Pulmonary Disease

A BiPAP device **without backup** may be covered for the first three months of therapy for members with chronic obstructive pulmonary disease (COPD) if all the following criteria are met:

- An arterial blood gas analysis, done while the member is awake and breathing the member's usual FiO_2, demonstrates $PaCO_2$ greater than or equal to 52 mm Hg.
- Sleep oximetry, done while the member is breathing oxygen at 2 liters per minute (LPM) or the member's usual FiO_2 (whichever is higher), demonstrates oxygen saturation less than or equal to 88% for at least five continuous minutes.
- Prior to initiating therapy, OSA and treatment with CPAP have been considered and ruled out.

A BiPAP device **with backup** will usually ***not*** be covered for a member with COPD during the first two months, because therapy with a BiPAP device without backup – with properly adjusted settings and the member's accommodation to its use – usually results in sufficient improvement without the need of a backup rate. After the first two months of therapy, a BiPAP device with backup may be covered for members with COPD if all the following criteria are met:

- Arterial blood gas analysis – repeated no sooner than 61 days after initiation of compliant use of a BiPAP device without backup and done while the member is awake and breathing the member's usual FiO_2 – demonstrates that $PaCO_2$ remains greater than or equal to 52 mm Hg.
- Sleep oximetry – repeated no sooner than 61 days after initiation of compliant use of a BiPAP device without backup and while the member is breathing oxygen at 2 LPM or the member's usual FiO_2 (whichever is higher) using the BiPAP device without backup – demonstrates oxygen saturation less than or equal to 88% for at least five continuous minutes.
- A signed and dated statement from the treating physician is completed no sooner than 61 days after the initiation of the BiPAP device without backup, declaring that the member has been compliantly using the BiPAP device without backup an average of four hours per 24-hour period, but that the member is not benefiting from its use. The statement should also say that the physician believes that the member meets the listed criteria for a BiPAP device with backup.

If the member is approved to switch to a BiPAP device with backup, a new three-month period coverage period is initiated before reevaluation is required.

Obstructive Sleep Apnea

A BiPAP device **without backup** may be covered for the first three months of therapy for members with obstructive sleep apnea (OSA) if both the following criteria are met:

- A complete facility-based, attended polysomnogram has established the diagnosis of OSA.
- A single-level device (CPAP) has been tried and proven medically ineffective.

A BiPAP device **with backup** is not medically necessary if the primary diagnosis is OSA.

Central Sleep Apnea

A BiPAP device with or without backup (based on the judgment of the treating physician) may be covered for the first three months of therapy for members with central sleep apnea (CSA) conditions if all the following criteria are met:

- A complete facility-based, attended polysomnogram, performed prior to initiating therapy, has established the diagnosis of CSA
- The ruling out of a single-level device (CPAP) as effective therapy if either CSA or OSA is a component of sleep-associated hypoventilation
- Significant improvement of the sleep-associated hypoventilation with the use of a BiPAP device (with or without backup) on the settings that will be prescribed for initial use at home, while breathing the member's usual FiO_2

Hypoventilation Syndrome

A BiPAP device **without backup** may be covered for the first three months of therapy for members with hypoventilation syndrome if all the following criteria are met:

- An initial arterial blood gas analysis, done while the member is awake and breathing the member's usual FiO_2, demonstrates $PaCO_2$ greater than or equal to 45 mm Hg.
- Spirometry shows an FEV1/FVC of greater than or equal to 70% and an FEV1 of greater than or equal to 50% of predicted.
- One of the following measurements has been demonstrated for the member:
  - An initial arterial blood gas analysis, done during sleep or immediately upon awakening, and breathing the member's prescribed FiO_2, shows the member's $PaCO_2$ worsened greater than or equal to 7 mm Hg compared to the result of the first requirement (the same test performed while the member was awake).
  - A facility-based, attended polysomnogram demonstrates oxygen saturation of less than or equal to 88% for greater than or equal to five minutes of nocturnal recording time, not caused by obstructive upper-airway events.

A BiPAP device **with backup** may be covered for the first three months of therapy if all the following criteria for members with hypoventilation syndrome are met:

- A covered BiPAP device without backup is being used.
- Spirometry shows an FEV1/FVC of greater than or equal to 70% and an FEV1 of greater than or equal to 50% of predicted.
- One of the following measurements has been demonstrated for the member:
  - An arterial blood gas $PaCO_2$, done while the member is awake and breathing the member's prescribed FiO_2, worsens greater than or equal to 7 mm Hg compared to the result of the test performed to qualify the member for the BiPAP device without backup.
  - A facility-based polysomnogram, performed while the member is using the BiPAP device without backup, demonstrates oxygen saturation of less than or equal to 88% for greater than or equal to five minutes of nocturnal recording time, not caused by obstructive upper airway events.

Continued Coverage Beyond the First Three Months of Therapy

Members covered for the first three months of using a BiPAP device (with or without backup) must be reevaluated to establish the medical necessity of continued coverage by the IHCP. While the member may need to be evaluated at earlier intervals after the initiation of therapy, the reevaluation upon which IHCP will base a decision to continue coverage beyond this time must occur within 61 to 90 days of initiating therapy.

For continued coverage beyond the first three months of therapy, the member's medical record must include documentation about the progress of relevant symptoms and the member's usage of the device up to that time. Failure of the member to consistently use the BiPAP device for an average of four hours per 24-hour period by the time of the reevaluation represents noncompliant utilization for the intended purposes and expected benefits of this therapy. This noncompliance constitutes reason for the IHCP to deny continued service as not medically necessary.

In addition, the device supplier must obtain documentation signed and dated by the treating physician no sooner than 61 days after initiating use of the device. This documentation must declare that the member is compliantly using the device an average of four hours per 24-hour period, and that the member is benefiting from its use.

Humidifiers Used With a Positive Pressure Airway Device

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

Physician documentation supporting the medical necessity of the humidifier for use with a BiPAP device or CPAP system must be included with the PA request. Documentation must indicate that the member suffers from nosebleeds, extreme dryness of the upper airways, or other conditions that interfere with compliance or use of the BiPAP or CPAP, and that the humidifier could improve this condition.

> *Note: Effective Jan. 1, 2024, the IHCP does not require PA for continued use of humidifiers for use with BiPAP or CPAP devices. Members with a new requirement for a humidifier will still require an initial PA.*

Heated and nonheated humidifiers are single-patient-use devices, categorized as inexpensive and routinely purchased items. As such, these devices are available to members **for purchase only**, except as described in the following situation. For members who are dually eligible (for Medicare and Traditional Medicaid), the IHCP does not pay for the purchase of nonheated or heated humidifiers. The IHCP covers rental, temporarily, of these items for Medicare and Medicare Advantage Plan crossover claims only.

The IHCP does not require a rental trial period before purchase of these items.

Standers

The IHCP provides reimbursement for standers considered medically necessary in noninstitutional settings.

Types of covered standers include:

- Prone
- Supine
- Vertical
- Multi-positional
- Sit-to-stand

The IHCP does not provide reimbursement for mobile standers (also known as *dynamic standers*), which have large, pneumatic wheels and allow self-propulsion in the standing position through larger areas. However, the IHCP may cover the mobility option as a reimbursable accessory for the sit-and-stand type stander, allowing the member limited mobility in a small area. See the *Additional Requirements for Sit-to-Stand Standers* subsection for coverage criteria.

Prior authorization for medical necessity is required for all standers covered by the IHCP. The PA request must specify the brand name, model number, type of stander and base price of the stander. Certain types of standers require additional documentation, as described in the following sections.

An itemized list of any additional attachments and accessories with individual prices must be included with the PA request. Trays are included in the stander's base price; upgraded trays will not be reimbursed. Certain supports and straps are included in the stander's base price; upgraded supports and straps are considered on a case-by-case basis.

All initial and subsequent PA requests for standers must include a completed *Medical Clearance Form for Standing Equipment* (available on the *Forms* page at in.gov/medicaid/providers), signed by the physician who orders the stander.

All **initial** PA requests for standers require the following items:

- A completed medical clearance form signed by the physician
- A physician's order for the stander
- A copy of a physical therapy and/or occupational therapy evaluation within the last two months, showing the patient's functional and cognitive baseline and ability to progress with therapy
- Documentation of medical necessity
- A plan of care (POC) signed by the ordering physician (see the *Plan of Care* section)

Subsequent PA requests for standers require the following items:

- A completed medical clearance form signed by the physician
- Ongoing documentation indicating progress toward goals through the 15th month or the final month

Plan of Care

The POC must include the following documentation:

- Measurable goals for therapy and training, therapy necessary to obtain a stander may be performed by a physical therapist, occupational therapist or family member who has been properly trained to perform the necessary exercises
- Estimated amount of time the member is expected to stand:
  - The member should be able to stand one hour a day or have the potential goal of standing one hour a day.
  - The member is not required to stand for one hour continuously.
- List of expected benefits from utilizing the stander as an adjunctive therapy, which may include but are not limited to the following examples:
  - Aids in the prevention of atrophy in the trunk and leg muscles
  - Improves circulation to the trunk and lower extremities
  - Prevents formation of decubitus ulcers (pressure sores) with changeable positions
  - Helps maintain bone integrity
  - Reduces swelling in the lower extremities
  - Improves range of motion
  - Improves kidney and bladder function
  - Decreases muscle spasms
  - Strengthens the cardiovascular system and builds endurance
  - Improves strength of the trunk and lower extremities
  - Prevents or decreases muscle contractures

- Lessens or prevents progressive scoliosis
- Aids normal skeletal development
- Improves bowel function

Additional Requirements for Multi-Positional Standers

When a multi-positional stander is requested, the provider must indicate the secondary complications that justify the need for a multi-positional stander. Secondary complications include but are not limited to the following examples:

- The member requires postural drainage.
- The member requires suctioning related to excessive secretions while in the stander.
- The member has a history of postural hypotension.

Additional documentation that must be included in the PA request for a multi-positional stander includes the following:

- Specific muscle groups targeted for stretching and strengthening in the stander and expected outcomes
- Specific orders indicating the proper positioning of the member in the stander

Additional Requirements for Sit-to-Stand Standers

All requests for sit-to-stand standers will be considered on a case-by-case basis. All diagnoses listed previously will be considered for sit-to-stand standers. The member must be able to perform the following:

- Maneuver from a sitting to a standing position without assistance
- Stand vertically or have the medical potential to stand vertically in the near future

Documentation of medical justification for a sit-to-stand stander must be included in the PA request. Some examples of secondary conditions that may justify the need for a sit-to-stand stander are as follows:

- Children who are not ready to stand fully upright, but are actively in transition between sitting and standing
- Highly independent youth and adults who can stand vertically and safely transfer alone
- Members who cannot stand for long periods of time due to contractures or muscle weakness
- Members with orthostatic hypotension

Children are not required to be independent to meet the criteria for sit-to-stand standers. Decisions regarding approval for children will be made on a case by case basis.

Certain sit-to-stand standers have a mobility option. The mobility option is identified by two medium sized all-terrain tires on the front of the stander and casters in the rear of the stander. Two maneuvering wheels are placed at waist level and attached to a pulley system which allows the member limited mobility in a small area. The IHCP will cover the mobility option as a reimbursable accessory. The mobility option will be approved only for members with independent capabilities and with the bilateral upper-body strength and coordination to maneuver themselves.

Transcutaneous Electrical Nerve Stimulator

All PA requests for the transcutaneous electrical nerve stimulator (TENS) unit must include a signed physician's order and a completed *Medical Clearance Form for TENS* (available on the *Forms* page at in.gov/medicaid/providers).

Trend Event Monitoring and Apnea Monitors

Providers should use HCPCS code E0618 – *Apnea monitor, without recording feature* 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 – *Apnea monitor, with recording feature* for the actual monitor and the appropriate CPT code for monitoring, recording, transmission and interpretation.

Tumor Treatment Fields (TTF) Device

The IHCP covers an electric tumor treatment fields (TTF) device, such as the Optune device, for the treatment of glioblastoma multiforme (GBM).

Prior authorization is required. All general PA criteria and requirements for documentation must be met. Additionally, all the following criteria must be met for PA consideration:

- The member has a new diagnosis of GBM.
- The member has received initial treatment with surgery (when reasonable).
- TTF therapy is initiated within seven weeks from the last dose of chemotherapy or radiotherapy.
- There is no evidence of progression by Response Assessment in Neuro-Oncology (RANO) criteria.
- The member has a Karnofsky Performance Scale (KPS) index of at least 70.
- TTF treatment will be used for an average of 18 hours per day.

The following HCPCS codes are covered:

- A4555 – *Electrode/transducer for use with electrical stimulation device used for cancer treatment, replacement only*
- E0766 RR – *Electrical stimulation device used for cancer treatment, includes all accessories, any type; Rental*

Claims for code A4555 must include an attachment of the MSRP or cost invoice.

> *Note: Effective for dates of service on or after Jan. 7, 2024, the MSRP or cost invoice must be the most current MSRP or cost invoice, and can be no older than two years old.*

Wheelchairs

The IHCP provides reimbursement for nonmotorized (manual) wheelchairs, motorized (power) wheelchairs, power operated vehicles (POVs) and wheelchair accessories when medically necessary for IHCP members. Prior authorization is required, and certain medical criteria must be met for the approval of each piece of equipment.

IHCP reimbursement is limited to one nonmotorized wheelchair, motorized wheelchair or POV per five-year period, unless a change in the member's medical needs is documented in writing by the requesting provider. The change in medical needs must be significant enough to warrant a different type of equipment. Any wheelchair designated for use as a backup will be denied as not medically necessary.

Reimbursement for nonmotorized and motorized wheelchairs includes all labor charges involved in the assembly of the wheelchair. Reimbursement of nonmotorized wheelchairs, motorized wheelchairs and POVs also includes emergency services, delivery, setup and items covered under warranty.

For information about customized wheelchairs, see the *Customized Items* section. For information about wheelchair modifications, see the *Modifications to DME* section.

> *Note: 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. The IHCP reimburses for wheelchairs outside of this per diem only when the wheelchair is "customized," as defined in the Customized Items section. Providers can submit requests for prior authorization of a custom wheelchair for a member in an LTC facility 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.*
>
> *LTC providers must follow the normal PA process, using IHCP medical clearance forms and the IHCP Prior Authorization Request Form or electronic equivalent (the PA contractor's provider portal or the 278 electronic transaction). The ordering physician must indicate the specifics about the member's physical condition that requires a customized wheelchair.*
>
> *LTC members receive 24-hour care in a nursing facility or ICF/IID. 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.*

Standing Wheelchairs

The IHCP does not cover standing wheelchairs, because there is insufficient clinical data to support the benefits of this equipment.

Nonmotorized Wheelchairs

The IHCP reimburses for both standard and nonstandard nonmotorized adult wheelchairs, and for nonmotorized pediatric wheelchairs, when medically necessary.

PA requests for nonmotorized wheelchairs must include a completed *Medical Clearance Form for Nonmotorized Wheelchair Purchase* (available for download from the *Forms* page at in.gov/medicaid/providers). The medical clearance form must document the member's condition, mobility needs and/or prognosis to support the medical necessity for a nonmotorized wheelchair.

Unless the medical clearance form is signed by the ordering physician, a separate signed physician's order is also required.

Power Mobility Devices (PMDs)

Power mobility devices (PMDs) include motorized wheelchairs and POVs.

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

The following defined criteria must be met for a member to qualify for any PMD:

- The member must have significant mobility limitations that restrict the ability to complete one or more mobility-related activities of daily living (MRADLs), such as toileting, feeding, dressing or bathing.
- The member's mobility issues are not resolved safely with the use of a cane or walker.

- The member is unable to use a properly fitted and functioning nonmotorized wheelchair in the home, at work, at school or in the workshop to complete the MRADL for one or more of the following reasons:
  - Lack of upper body strength
  - Lack of coordination
  - Limited range of motion in upper body
  - Presence of pain that limits upper body mobility
  - Upper body physical deformity or amputations

PA requests for PMDs must include a completed *Medical Clearance Form for Motorized Wheelchair Purchase* (available for download from the *Forms* page at in.gov/medicaid/providers), signed by the ordering physician. The medical clearance form must document the medical necessity for a nonmotorized wheelchair. A separate signed order is not required in addition to this form.

Motorized Wheelchairs

Providers should determine the most appropriate HCPCS code to use for motorized wheelchairs, based on the Product Classification List published by the DME Pricing, Data Analysis and Coding (PDAC) contractor for the Centers for Medicare & Medicaid Services (CMS). This listing itemizes the manufacturers and specific motorized wheelchair models and details the exact HCPCS code associated with each product and model number.

A member who requires a motorized wheelchair is usually nonambulatory and has severe weakness of the upper extremities due to a neurologic or muscular disease or condition and would otherwise be confined to a bed or chair without the use of the motorized wheelchair. A motorized wheelchair is covered if the member's condition is such that the requirement for a motorized wheelchair is long-term (at least six months).

All IHCP members requesting a motorized wheelchair must meet the following criteria:

- The CMS-defined basic coverage criteria are met.
- The member does not qualify for a power operated vehicle (POV).
- The member is physically and mentally able to safely operate a motorized wheelchair or has a caregiver who is unable to adequately propel an optimally configured nonmotorized wheelchair, but is available and willing to operate the motorized wheelchair for the member.
- The home environment allows appropriate access with a motorized wheelchair, including maneuvering space and appropriate surfaces.
- The member does not exceed the weight limitations for the motorized wheelchair provided.
- A motorized wheelchair will significantly improve the member's ability to independently perform MRADLs.
- The member is willing to use a motorized wheelchair.
- The member is enrolled in a school, sheltered workshop or work setting, or the member is left alone for a significant period of time.

Providers cannot bill separately for programmable electronic systems that come standard on the specific motorized wheelchair model provided, as the total reimbursement for the motorized wheelchair with programmable electronics is an all-inclusive rate. The IHCP allows separate reimbursement only if an electronic system is an upgrade to a system that comes standard on a specific wheelchair model, and only when the upgrade is medically necessary. Any such upgrades must have PA.

Certain patients may need adaptive switch controls (such as a sip-and-puff controls), 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. The medical necessity supporting the need for a programmable electronic system upgrade must be included on the *Medical Clearance Form for Motorized Wheelchair Purchase*.

The following accessories and options are considered to be included in the basic equipment package for motorized wheelchairs (any exceptions must be submitted for PA consideration at the time of the wheelchair is purchased or rented):

- Lap belt or safety belt
- Battery charger
- A complete set of tires and casters, any type
- Leg rests
- Leg rest/leg rest platform
- Arm rest
- Weight specific components, such as braces, bars, upholstery, brackets, motors or gears, mandated by additional patient weight
- Any seat width and depth
- Any back width
- Controller and input devices for non-expandable and standard proportional joystick

The following services are allowed outside the basic equipment package for all motorized wheelchairs in **groups 1 through 5**, with PA and only if medical necessity criteria are met. Any services billed outside the basic equipment package must be submitted on the same claim for the same date of service:

- Adjustable height arm rests
- Shoulder harness/straps or chest/straps/vest
- Elevating leg rests
- An expandable controller
- Nonstandard joystick, that is, non-proportional or mini, compact or short-throw proportional

Similarly, the following services are allowed outside the basic equipment package for all motorized wheelchairs in **groups 3, 4 and 5**, with PA and only if medical necessity criteria are met. Any services billed outside the basic equipment package must be submitted on the same day claim for the same date of service:

- Angle adjustable foot plates
- Motorized wheelchairs with a sling/solid seat/back:
  - Standard duty, seat width and/or depth greater than 20 inches
  - Heavy duty, seat width and/or depth greater than 22 inches
  - Very heavy duty, seat width and/or depth greater than 24 inches
- Motorized wheelchairs with a sling/solid seat/back:
  - Standard duty, back width greater than 20 inches
  - Heavy duty, back width greater than 22 inches
  - Very heavy duty, back width greater than 24 inches

- Nonstandard seat and back will only be provided if the IHCP member's physical dimensions are provided and require the additional seat width and depth. PA and medical necessity criteria are required.

Motorized Wheelchairs – Single-Power Option

For **groups 2 and 5** single-power-option motorized wheelchairs, **one** of the following additional criteria must apply:

- The member requires a drive control interface other than a hand or chin operated standard proportional joystick (such as head control, sip and puff, switch control, and so forth)
- The member meets the requirements for a power tilt or power recline seating system, and the system is being used on the wheelchair.

For **groups 3 and 4** single-power-option motorized wheelchairs, the following additional criteria apply:

- The member has mobility limitations due to a neurological condition, myopathy or congenital skeletal deformity.
- And **one** of the following additional criteria:
  - The member requires a drive control interface other than a hand or chin operated standard proportional joystick (such as, head control, sip and puff, switch control, and so forth).
  - The member meets the requirements for a power tilt or power recline seating system, and the system is being used on the wheelchair.

Motorized Wheelchairs – Multiple Power Option

Groups 2 and 5 multiple-power-option motorized wheelchairs require any **two** of the follow three criteria:

- The member uses a ventilator that is mounted to the wheelchair.
- The member requires a drive control interface other than a hand or chin operated standard proportional joystick (such as, head control, sip and puff, switch control, and so forth)
- The member meets the requirements for a power tilt or power recline seating system and the system is being used on the wheelchair.

For **groups 3 and 4** multiple-power-option motorized wheelchairs, the following criteria apply:

- The member has mobility limitations due to a neurological condition, myopathy or congenital skeletal deformity.
- And any **two** of the following three criteria:
  - The member uses a ventilator that is mounted to the wheelchair.
  - The member requires a drive control interface other than a hand or chin operated standard proportional joystick (such as, head control, sip and puff, switch control, and so forth)
  - The member meets the requirements for a power tilt or power recline seating system and the system is being used on the wheelchair.

Motorized Wheelchairs – No Power Option

For no-power option **groups 3 and 4** motorized wheelchairs, the IHCP member must have mobility limitations due to a neurological condition, myopathy or congenital skeletal deformity.

Power-Operated Vehicles

The IHCP will reimburse for a POV, such as scooters, for members who are unable to operate nonmotorized wheelchairs and who have adequate trunk stability to safely operate the vehicle. A POV should be considered when the member does not require the full support or features that are provided by power wheelchairs. POVs are not covered by the IHCP when they are needed for use outside the home only, or to allow the member to perform leisure or recreational activities. Therefore, POVs that are designed, by size and features, primarily for outdoor use, will be denied as not medically necessary.

The prior authorization criteria for all POVs are as follows:

- The CMS defined basic coverage criteria are met.
- The member has the ability to safely transfer to and from the POV.
- The member has the ability to operate the tiller-steering system.
- The member has the ability to maintain proper body position and stability while operating the POV.
- The member has the physical and mental capability to safely operate a POV.
- The home environment allows appropriate access with a POV, including maneuvering space and appropriate surfaces.
- The patient does not exceed the weight limitations for the POV provided.
- A POV will significantly improve the IHCP member's ability to independently perform MRADL.
- All accessories and options for a POV are included in the initial reimbursement rate of the POV, including but not limited to the following:
  - Lap or safety belt
  - Battery or batteries required for operation
  - Battery charger, single mode
  - Complete set of tires
  - Weight appropriate upholstery and seating system
  - Tiller steering
  - Non-expandable controller with proportional response to input
  - All accessories needed for the safe operation of the POV

A completed *Medical Clearance Form Motorized Wheelchair Purchase* must be submitted with the PA request form that documents the member's condition, mobility needs and/or prognosis to support the medical necessity for a POV. Documentation must indicate the member's condition that renders them unable to operate a nonmotorized wheelchair. Documentation must also indicate the member is capable of safely operating a POV, can transfer in and out of a POV, and has adequate trunk stability to safely ride in and operate the POV.

Wheelchair Accessories

The IHCP covers medically necessary wheelchair accessories. Prior authorization is required, and certain medical criteria must be met for the approval of each piece of equipment. The following sections provide details about coverage and PA criteria for specified wheelchair accessories.

See the *Motorized Wheelchairs* section for information about accessories and options included in, or allowed outside of, the basic equipment package for motorized wheelchairs.

Universal Headrest Plate

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*. Providers should submit their usual and customary charge using HCPCS code E1028.

Reimbursement of 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.
- 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).

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 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.

Elevating Leg Rests

The IHCP covers elevated leg rests if the member meets the following criteria:

- Documentation of musculoskeletal condition or the presence of a cast or brace which prevents 90° flexion at the knee
- Documentation of significant edema of the lower extremities
- Evidence that the member meets the criteria for and has a reclining back on the wheelchair

The provider must provide documentation that the member meets the preceding criteria.

Power Tilt and/or Recline Seating System

All three of the following criteria must be met to be reimbursed for a power tilt or recline seating system, or the combination of a power tilt and recline seating system:

- The member must qualify for a power wheelchair that accommodates a power tilt and/or recline seating system.
- The member had an evaluation that was performed by a licensed/certified medical professional, such as a physical or occupational therapist, or a physician who has specific training and experience in rehabilitation wheelchair evaluations. These professionals must document the medical necessity for the device and its special features in the patient's home, work, school or workshop. The physical or occupational therapist or physician may have no financial relationship with the supplier.

- The provider must substantiate and document that the member meets one of the following in addition to the preceding two criteria:
  - The member is unable to perform a functional weight shift and is therefore at high risk of developing pressure ulcers.
  - The member uses intermittent catheterization for bladder management and is unable to transfer independently from the wheelchair to the bed.
  - The seating system will be used to manage increased tone and spasticity.

Push-Rim Activated Power Assist Device

The IHCP covers HCPCS code E0986 – *Manual wheelchair accessory, push-rim activated power assist system*.

The IHCP covers push-rim activated power assist devices for manual wheelchairs when medically necessary. All the following criteria must be met:

- Coverage criteria pertaining to specific wheelchair type are met.
- The individual has one of the following, relevant to the assessment of upper extremity function:
  - Limitations of strength, endurance, range of motion or coordination
  - Presence of pain or deformity
  - Absence of one or both upper extremities
- The individual has been self-propelling in a manual wheelchair for at least one year.
- The individual has had a specialty evaluation that:
  - Was performed by a licensed/certified medical professional, such as a physical therapist or occupational therapist, or practitioner who has had specific training and experience in rehabilitation wheelchair evaluation.
  - Documents the need for the device in the individual's home.