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1. Section Modifications

Version	Section/ Column	Modification Description	Date	SME
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26.1	2.3.3 Documentation Requirements	Updated IDAPA reference	9/12/2016	E Garibovic D Baker
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18.1	2.2.5 Covered Equipment	Updated link to coverage criteria	6/26/15	J Siroky D Baker
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16.1	2.5.1 Overview	Changed PHA Health Questionnaire information to reference current enrollment applications	2/26/15	C Brock C Taylor
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15.1	2.2.6.1 Oral, Enteral, or Parenteral Nutritional Products, Equipment, and Supplies	Updated documentation and history requirements	2/12/15	J Siroky C Taylor
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13.4	2.2.10.2. Program Limitations	Deleted bullet – All refitting, repairs, or alteration requests must have medical justification documented by the participant's attending physician.	07/01/14	J Siroky C Taylor D Baker

Version	Section/ Column	Modification Description	Date	SME
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13.2	2.2.3.1 Physician Orders	Added note about repairs	07/01/14	J Siroky C Taylor D Baker
13.1	2.2.2.2 Primary Care Case Management	Added information when referral is not required for HC or HH	07/01/14	J Siroky C Taylor D Baker
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11.2	2.2.11 PA Procedures	Updated table, DME Item for Orthotics PA requirement	3/7/14	J Siroky C Taylor
11.1	2.2.10.2 Program Limitations	Added bullet for breast pumps	3/7/14	J Siroky C Taylor
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10.3	2.3.4.5 Diagnosis Codes	Updated for ICD-10	2/21/14	L Neal
10.2	2.3.3.7 Diagnosis Codes	Updated for ICD-10	2/21/14	L Neal
10.1	2.3.2.5 Diagnosis Codes	Updated for ICD-10	2/21/14	L Neal
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9.1	2.5.3 Behavioral PHA – Tobacco Cessation	Removed section	1/24/14	A Coppinger
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5.23	2.4 Billing Policy	Added section and updated information	4/1/13	A Roy
5.22	2.3.1 Covered Equipment and Supplies (Waiver Services)	Updated for clarity	4/1/13	J Siroky
5.21	2.2.11 PA Procedures	Updated subsections for clarity	4/1/13	A Roy
5.20	2.2.10 Prosthetic/Orthotic Description	Updated subsections for clarity	4/1/13	J Siroky
5.19	2.2.9.6 Certificate of Medical Necessity	Updated for clarity	4/1/13	J Siroky
5.18	2.2.9.5 Payment Methodology	Updated for clarity	4/1/13	J Siroky
5.17	2.2.9.4 Ventilator Dependent Participants	Updated for clarity	4/1/13	J Siroky
5.16	2.2.9.3 Cluster Headaches	Updated for clarity	4/1/13	J Siroky
5.15	2.2.9 Oxygen Services	Updated for clarity		J Siroky
5.14	2.2.8 Additional Equipment and Supplies for Children	Updated for clarity	4/1/13	A Roy
5.13	2.2.7 Non-covered Equipment and Supplies	Updated for clarity	4/1/13	A Roy
5.12	2.2.6 Covered Disposable Medical Supplies	Updated for clarity	4/1/13	A Roy

Version	Section/ Column	Modification Description	Date	SME
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5.10	2.2.4 Purchase, Rental, and Warranty Policy	Updated for clarity	4/1/13	A Roy
5.9	2.2.3.1 Physician Orders	Updated for clarity	4/1/13	J Siroky
5.8	2.2.2.4 Waiver Services for Enhanced Plan	Added section	4/1/13	J Siroky
5.7	2.2.2.3 Medicare and Medicaid	Updated for clarity	4/1/13	J Siroky
5.6	2.2.2.2 Primary Care Case Management	Added section and updated HC information; added information about IMHH	4/1/13	J Siroky
5.5	2.2.2.1 Hospice Participants	Added section	4/1/13	A Roy
5.4	2.2.2. Participant Eligibility	Added section	4/1/13	A Roy
5.3	2.2.1 Program Abuse	Reorganized sections	4/1/13	A Roy
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2.1	2.2.3 Place of Service (POS) Codes	Updated with all POS codes	06/27/11	J Gillett
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1.2	2.3.4 Prior Authorization (PA) Procedures	Updated PA information	08/27/10	C Stickney
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2. Durable Medical Equipment Guidelines

2.1 Overview

Idaho Medicaid will purchase or rent medically necessary durable medical equipment (DME) and disposable medical supplies (DMS) for eligible participants residing in community settings.

DME is equipment defined as follows.

- Other than prosthetics or orthotics, which can withstand repeated use.
- Primarily used to serve a medical purpose.
- Generally not useful to a person in the absence of an illness or injury.
- Appropriate for use in the home.
- Reasonable and necessary for the treatment of an illness or injury.

DMS refers to medically necessary items which have a limited life expectancy and are consumable, expendable, disposable, or nondurable.

2.2 DME and DMS for Participants Residing in Facilities

General Information

Items that are customized for a specific participant, such as prosthetics and orthotics, may be billed separately to Medicaid unless the participant is a resident of a skilled nursing facility.

When a PA for DME is required, the provider must obtain the PA prior to delivering the item even if the participant has other third party insurance. The only exception is when the primary insurance is Medicare. Additional information about Medicaid and Medicare DME guidelines is available online at <https://www.noridianmedicare.com/> or <http://www.dme.idaho.gov>.

Hospital, Skilled Nursing Facility

While a participant is a resident of a hospital or skilled nursing facility, DME providers may not bill for DME or DMS.

ICF/ID (Intermediate Care Facility for Intellectually Disabled)

While a participant is a resident of an ICF/ID facility, items such as non-sterile gloves, incontinence supplies, and all other medical supplies used to save labor or linen are included in the *per diem* payment and are billed directly to the facility. Specialized wheelchairs are separately payable for participants in ICF/ID facilities

Exceptions to this include:

- Items that are customized to meet a specific participant's need and cannot be altered to be useful to another resident cost effectively.
- Wheelchairs for participants who need specialized wheelchair and seating systems and cannot be altered to be useful to another resident cost effectively.
- Authorized repairs related to a chair or seating system that is specialized to meet a specific participant's needs.

To determine if a participant is residing in an ICF/ID, providers may consult a list of Idaho ICF/ID facilities found at:

<http://healthandwelfare.idaho.gov/Portals/0/Medical/LicensingCertification/AlphaICF.pdf>.

Assisted Living Facility

While a participant is a resident of an Assisted Living Facility, basic supplies such as non-sterile gloves are included in the *per diem* payment, and are billed directly to the facility. A list of Residential Care Assisted Living Facilities can be found at <http://www.healthandwelfare.idaho.gov/Medical/LicensingCertification/StateOnlyPrograms/AssistedLiving/tabid/273/Default.aspx>.

2.3 General Policy

When billing for medical equipment and supplies, the provider must bill with a DME provider number.

This section covers all Medicaid services provided by the following Supplier provider types and specialties.

- Optometric Supplies
- Pharmacy – Clinic
- Pharmacy – Community / Retail
- Pharmacy – Institutional
- Pharmacy – Specialty
- Pharmacy – Mail Order
- Pharmacy – Institutional
- Durable Medical Equipment & Medical Supplies – Oxygen Equipment & Supplies
- Durable Medical Equipment & Medical Supplies – Parenteral & Enteral Nutrition
- Durable Medical Equipment & Medical Supplies
- Durable Medical Equipment & Medical Supplies – Dialysis Equipment & Supplies
- Pharmacy DME – All pharmacy DME providers must be registered with the Board of Pharmacy (*IDAPA 27.01.01*)
- Pharmacy – Home Infusion Therapy
- Prosthetic/Orthotic Supplier
- Non-Pharmacy Dispensing Site
- Contractor-Home Modifications
- Emergency Response System Companies
- Assistive Technology Supplier
- Contractor-Home Modifications
- Home Delivered Meals
- PHA-Weight Management
- PHA-Tobacco Cessation

2.3.1 Program Abuse

Providers are required to follow all state and federal regulations related to Medicaid including, but not limited to, the rules in *IDAPA 16.03.09 Medicaid Basic Plan Benefits*, *IDAPA 16.03.10 Medicaid Enhanced Plan Benefits*, and *IDAPA 16.05.07 The Investigation and Enforcement of Fraud, Abuse, and Misconduct*.

Medical equipment and supply items used by or provided to an individual other than the participant for which the items were ordered is prohibited.

Idaho Medicaid has no obligation to repair or replace any piece of durable medical equipment or supply that has been damaged, defaced, lost, or destroyed as a result of neglect, abuse, or misuse of the item.

Program rules and regulations are strictly enforced and violators are subject to penalties for program fraud and abuse.

2.3.2 Participant Eligibility

Providers must check eligibility to validate coverage as some restrictive programs may not include the DME and/or supplies that are billed.

2.3.2.1 Hospice Participants

If a participant is receiving hospice services, the hospice agency is responsible for any DME and supplies that are necessary for the palliation and management of the participant's terminal illness. Hospice agencies often provide incontinent and other DME supplies for participants residing in an assisted living facility. DME providers should review the hospice supply list available from either the facility or the hospice agency. Hospice agencies often also cover some DME items for those residing in skilled nursing facilities and ICF/IDs.

2.3.2.2 Primary Care Case Management

Healthy Connections (HC)

Effective 2/1/16, a referral from the HC physician is not required for DME. For more information, see [General Provider and Participant Information](#).

2.3.2.3 Medicare and Medicaid

Providers must enroll with the Idaho Medicaid Program separately from Medicare. If the participant is dually eligible for Medicare and Medicaid, Medicare must be billed first. Claims submitted electronically to Medicare through the DME MACs are crossed over to Medicaid. Consult the [General Billing Instructions](#) for more information.

For a dually eligible participant (who is eligible for both Medicare and Medicaid), Idaho Medicaid can only reimburse the Medicaid portion of the payment for equipment and supplies when providers are fully compliant with all Medicare regulations and policies.

2.3.2.4 Waiver Services for Enhanced Plan

Waiver services are covered for Medicaid Enhanced Plan participants who are also on the Waiver Program. These are services beyond the scope of the Idaho Medicaid State Plan.

2.3.3 Documentation Requirements

The vendor is required to obtain all medical necessity documentation prior to billing for DME and supplies.

Note: Documentation must be kept on file for five years after the date of service.

Documentation must include all of the following:

- The participant's medical diagnosis and description of the current medical condition that makes the equipment or supplies medically necessary.
- Estimation of the time period (dates) the medical equipment or supply item will be needed, and the frequency of use. As needed (PRN) orders will not be accepted without instructions on how/when the medical equipment or supplies will be used.
- For medical supplies, the description and quantity of the supply needed per month.
- A full description of the medical equipment requested. All modifications or additions to basic equipment must be documented in the attending physician's prescription.

- The original physician's dated signature ordering the equipment and supplies and verifying that all of the above information is accurate and correct is required before billing. Stamped signatures and dates are not acceptable for billing Idaho Medicaid.
- Medical necessity documentation as required by *IDAPA 16.03.09*. These rules are available online at <http://adminrules.idaho.gov/rules/current/16/0309.pdf>.

2.3.3.1 Physician Orders

Detailed Written Orders

Detailed written orders are required for all DME, prosthetic, orthotic, and medical supplies prior to submitting a claim. All orders must clearly specify the start date. If the written order is for supplies that will be provided on a periodic basis, the written order should include appropriate information on the quantity used, frequency, and duration of need.

The written order must be sufficiently detailed, including all options or additional features that will be separately billed or that will require an upgraded code. If the supply is a drug, the order must specify the name of the drug, concentration, dosage, frequency, and duration of use. The treating physician/midlevel practitioner must complete/review the detailed description and personally sign and date the order. If the provider does not have an order that has been both signed and dated by the treating physician/midlevel practitioner before billing Medicaid, the claim is not valid.

***Note:** A physician order for equipment repairs is not required if the equipment was originally purchased by Medicaid. If the equipment is not an item covered by Medicaid, Idaho Medicaid is not responsible for repairs.*

Verbal/Preliminary Order

Except for the excluded items listed below, providers may dispense DME, prosthetic, orthotic, and medical supplies based on a verbal or preliminary written order from the treating physician/midlevel practitioner.

***Note:** A detailed written order that is signed and dated by the physician/midlevel practitioner must be obtained **prior to billing** Idaho Medicaid.*

At a minimum, the verbal or preliminary order must include the following information:

- Description of the item
- Participant's name
- Physician's name
- Start date of the order

Providers must maintain copies of the preliminary written order or written documentation of the verbal order along with the detailed written order. This documentation must be available to Idaho Medicaid or its agent(s) immediately upon request. If the provider does not have at least the verbal or written preliminary order from the treating physician/midlevel practitioner before dispensing an item, that item is not payable. The term "order" or "written order" in all other Medicaid documentation means "detailed written order" unless otherwise specified.

The following items are excluded from verbal/preliminary orders and always require a detailed written order prior to delivery.

- Any items for which Medicaid requires prior authorization
- Pressure reducing pads
- Mattress overlays
- Mattresses
- Beds
- Seat-lift chairs

For items excluded from verbal/preliminary orders, the provider must have received a detailed written order that has been both signed and dated by the treating physician/midlevel practitioner **prior** to dispensing the item.

If a provider bills for any item without a detailed written order, or if there was no appropriate verbal/preliminary order prior to dispensing the item, Medicaid can deny or recoup any dollars paid for the item.

2.3.4 Purchase, Rental, and Warranty Policy

2.3.4.1 DME Rent/Purchase Decision

Rental payments (continuous or intermittent) will be applied toward the purchase price of the equipment. The equipment will be considered purchased after the tenth (10th) monthly rental payment, except those items such as oxygen and ventilators that are continuous rental.

The Department of Health and Welfare may choose to continue to rent certain equipment without purchasing it. The total monthly rental cost shall not exceed one-tenth of the total purchase price of the item.

Monthly rental payments include supplies, when so designated in the DME MAC Supplier Manual, and a full service warranty. Supplies, routine maintenance, repair, and replacement are the responsibility of the DME provider during the warranty period and for continuous rental equipment.

2.3.4.2 Warranty Requirements

Payment will not be made for the cost of materials covered under the manufacturer's warranty. If the warranty period has expired, the provider must have documented on file the date of purchase and warranty period. Medicaid requires the following warranty periods:

- The power drive of a wheelchair will have a one-year warranty.
- An ultra-light or high strength lightweight wheelchair will have a lifetime warranty on the frame and cross-braces.
- All other wheelchairs will have a one-year warranty.
- All electrical components and new or replacement parts will have a six-month warranty.
- Any other DME not defined will have a one-year warranty period.

If the manufacturer denies the warranty due to user misuse/abuse, this information must be supplied when requesting approval for repair or replacement.

2.3.5 Covered Equipment

Medical equipment for purchase must be new when dispensed unless authorized by DHW as used. This includes equipment that is issued as "rent-to-purchase." It does not apply to short-term rental equipment.

Idaho Medicaid follows Medicare criteria when those criteria are available in the DMAC manual or are part of a local or national coverage determination (LCD or NCD). Medicare coverage criteria can be found at <https://med.noridianmedicare.com/web/jddme/policies>. When there are no Medicare criteria available, the Department may establish criteria. Many items are covered only when prior authorized.

A number of the items listed below may require PA. Providers should verify the actual procedure code that is listed in the fee schedule on the Department's website (www.dme.idaho.gov) to make sure the specific item does not require PA.

All DME items covered by Medicaid are listed in the fee schedule and are covered when medically necessary and the least costly means of meeting the participant's medical need.

Note: Lift devices provided under the waiver program require PA.

2.3.6 Covered Disposable Medical Supplies

No more than a one-month supply of necessary medical supplies can be dispensed per calendar month. The physician's order must indicate the type and quantity or frequency of use.

For all DMS and prosthetic and orthotic items that are provided on a recurring basis, providers are required to have contact with the participant or caregiver/designee prior to dispensing a new supply of items. The provider must contact the participant within 14 calendar days prior to the delivery, and the participant must request a refill of supplies before they are dispensed. This is done to ensure the refilled item remains necessary and existing supplies are approaching exhaustion, and to confirm any changes or modifications to the order.

All DMS items covered by Medicaid are listed in the fee schedule and are covered when medically necessary and the least costly means of meeting the participant's medical need. Limitations may apply, such as limits based on medical necessity, the participant's place of residence, and quantities. For example, sterile gloves should be billed only when medically necessary.

2.3.6.1 Oral, Enteral, or Parenteral Nutritional Products, Equipment, and Supplies

Oral, enteral, or parenteral nutritional products are covered when medically necessary according to the criteria described in the Medicare DME coverage manual. These products do not require prior authorization. However, the supplement is only reimbursable by Medicaid when:

- The participant requires tube feeding, or
- Oral supplements are necessary to meet caloric needs of a participant who, with traditional foods alone, is unable to maintain growth, weight, and strength commensurate with his general condition. When the participant is taking nutritional products orally always use the BO modifier.

The vendor must obtain and keep the following documentation on file for five years after the date of service:

- Physician's order with daily calorie count, length of need, diagnosis, and documentation of medical necessity.
- A Nutrition Plan of Care (POC) that includes appropriate nutritional history, the participant's current height, weight, age, goals for weight gain or weight maintenance, medical diagnosis, steps to decrease the participant's dependence on nutritional supplements or detail why that is not possible, and current enteral or oral nutritional product.
- For participants under age 21, a growth chart including weight or height percentile must be included.

The provider must obtain a nutritional history for each new client which should define the patient's need for the oral or enteral nutritional products. This may include:

- The medical diagnosis that makes the nutritional product necessary
- Appetite and/or oral nutritional intake
- GI history supporting need for therapy, such as nausea, vomiting, and/or diarrhea
- Oral feeding skills and ability: is the participant physically able to eat orally?
- Outlined history of failure to thrive
- Behaviors or lifestyle barriers that interfere with nutritional intake
- Detailed failed trial of modified traditional diet supporting need for current treatment

The schedule for reviewing and updating the nutritional plan will be determined by individual needs and progress, but must be done at least annually, and must be approved by the physician.

Note:

- *Traditional infant formulas are not covered.*
- *Thickener is covered when medically necessary for use with oral nutrition.*

Nutritional Product Units

One unit of a nutritional formula is defined in the HCPCS manual as 100 calories rather than the number of cans. For billing purposes, providers must convert the number of cans dispensed to the number of 100-calorie units dispensed.

Manual Pricing

If a procedure code shows a zero on the fee schedule, an invoice is required in order to be manually priced. For payment consideration, the following information must be included with the claim:

- Number of calories per day ordered by the physician,
- Number of calories per can,
- Number of cans per case, and
- Recent copy of the invoice including shipping costs or MSRP.

Enhanced Reimbursement

A large number of nutritional products are assigned to each HCPCS code, and the Department recognizes that one product may be more costly than others assigned to the same HCPCS code. Enhanced reimbursement is available for select medically necessary products for which there are no substitutes; and where the maximum allowable fee does not adequately cover the provider's wholesale costs. For those products, providers may use a GD modifier and follow the same procedure that is required for the manually priced codes.

2.3.6.2 Incontinence Supplies

Incontinence supplies, including diapers, liners, and under-pads, are covered for individuals who have a medical need for the items based on their diagnosis. These items are not

covered for members under 4 years of age or members in long-term care (nursing facility) settings.

The Department will reimburse for Pull-ups if the participant is between the ages of four (4) and twenty-one (21), and when the participant is participating in a formal toilet training program written by an Occupational Therapist, Qualified Intellectual Disabilities Professional (QIDP), or Developmental Specialist. A physician who specializes in a field related to children meets these criteria.

A toilet training plan should be individualized for the child based on their needs and abilities. It could include such things as a rationale for the use of Pull-ups, a toileting schedule, strategies to help at each toileting session, preferred location, hygienic needs, any rewards that work for the child, positioning, signs/signals that the child may need attention, precautions, goals appropriate for the child, skin care, etc. With an effective toileting plan in place, fewer Pull-ups may be needed. Documentation of the toilet training program must be updated on a yearly basis and maintained in the participant's file.

Any combination of disposable diapers/liners/Pull-ups is limited to a total of 240 units per month. Under-pads are limited to 150 units per month. Additional supplies may be prior authorized if the request includes justification of medical necessity.

2.3.7 Non-covered Equipment and Supplies

The following are not covered under the DME program.

- Services, procedures, treatment, devices, drugs, or application of associated services that are considered investigative or experimental.
- More costly services or equipment when an effective, less costly service or equipment is available.
- Any service specifically excluded by statute or administrative code.
- Non-medical equipment and supplies and related services.
- Items for comfort, convenience, or cosmetic purposes. For example: wipes, peri-wash, exercise, or recreational equipment.

2.3.8 Additional Equipment and Supplies for Children

The following DME and supplies may be prior authorized for children through the month of their 21st birthday, when they are medically necessary and the least costly means of meeting the medical need.

- Therapy equipment such as therapy mats and therapy balls.
- Wheelchair tie down restraints.
- Personal items:
 - Toothettes for children who require oral stimulation or have severe spasticity or a deformity in the mouth which prevents proper cleaning using a regular toothbrush, waterpiks, or periodontal devices.
 - Eating/feeding utensils, such as rocker knives and special plates with rims.
 - Page-turners.
 - Reachers.

Standing Frame

Documentation must include the physician's order and the physical therapist's recommendation on how a standing frame will assist with the following:

- Stretching of heel cords.
- Prevention of hip dislocation.
- Improvement of bone density.
- Weight bearing to enhance muscle development.
- Transition to standing/help with transfers.

Gait Trainer

Documentation must include the physician's order and the physical therapist's recommendation on how a gait trainer will assist with the following:

- Promoting gross motor development.
- Promoting independent mobility.
- Initiating stepping.

Specialized Toilet Seat

Documentation must include the physician's order and the physical therapist's recommendation on how a specialized toilet seat will assist with the following:

- Inability to sit without support.
- Decreased muscle tone/lack of trunk control.

Specialized Car Seat

Documentation must include the physician's order and the physical therapist's recommendation on how a specialized car seat will assist with the following:

- Proper positioning which cannot be met by a regular car seat.
- Lack of trunk control/trunk support.
- Support needed due to decreased muscle weakness/tone; and the alternative is to take the child in the vehicle lying down or sitting without needed support.
- Supporting of the head during transport.

2.3.9 Oxygen Services

2.3.9.1 Overview

Medicaid will provide payment for oxygen and oxygen-related equipment based upon the Medicaid fee schedule. Such services are considered reasonable and necessary for participants with significant hypoxemia and certain related conditions.

Signed physician's orders are required. Refer to the following section for exceptions to DME MAC Coverage. A [Certificate of Medical Necessity CMS-484 Oxygen](#) (CMN) signed by the physician will be considered the same as a physician's order. Attaching the CMN will expedite claim processing. When billing electronically using the HIPAA Professional transaction, the oxygen information generally required on the CMN must be included on each claim.

The prescription and laboratory evidence justifying the use of oxygen must be included with the first claim for oxygen therapy for the participant. This prescription and laboratory evidence will be kept on file and will remain in effect for one year from the date the test was taken, unless a lifetime need is indicated. All claims submitted electronically must include the oxygen information on each transaction.

Medicaid does not accept Oxygen, "PRN," or "As-needed" prescriptions.

2.3.9.2 Exceptions to DME MAC Coverage

Lab Studies

Age 0—6 Months

- Lab studies are not required.
- Prior authorization (PA) is not required, but must be a physician-ordered therapy.

Age 7 Months—20 Years

- Requires lab studies and medical necessity documentation.
- PA is not required except for conditions that do not meet lab study parameters.

2.3.9.3 Cluster Headaches

Medicaid may prior authorize (PA) oxygen for participants with a diagnosis of cluster headaches. Lab studies are not required. PA requests must have physician orders that demonstrate the following medical necessity criteria:

- Other measures, such as Dehydroergotamine and Sumatriptan (Imitrex), have been tried and found to be unsuccessful.
- Oxygen therapy must have been proven successful on a trial basis for at least one treatment in the emergency room or in the physician's office before it can be authorized for home use.

If both criteria are met, authorization will be given for a six-month period. Documentation of successful use and continued need must be received from the attending physician for subsequent PA.

If more than two months elapse without an incidence of a cluster headache, the oxygen authorization will be discontinued. When billing for oxygen that is necessary to treat cluster headaches, attach a CMN to the claim indicating that the oxygen is *for cluster headaches*.

2.3.9.4 Ventilator Dependent Participants

Idaho Medicaid *will authorize* payment of oxygen and oxygen supplies and equipment when the participant is ventilator dependent. The participant does not have to meet the PO₂ level of 55 mm Hg or arterial oxygen saturation at or below 88 percent. The supplier must use the appropriate diagnosis code to indicate that the participant is ventilator dependent.

2.3.9.5 Payment Methodology

Idaho Medicaid pays for medically necessary oxygen with an all-inclusive monthly rate. This rate includes the rental of the delivery system and any necessary accessories such as flow valve, humidifiers, and nebulizers for humidification, tubing, masks, contents for compressed gas and liquid systems, and nasal cannula/face masks.

In a limited number of cases, the participant owns the stationary or portable oxygen delivery system. Medicaid will pay to maintain such systems and pay a monthly charge for compressed gas and liquid systems. Medicaid will cover the cost of disposable items such as cannulas and tubing.

All rentals must specify actual, inclusive dates of rental and must be billed monthly. For participants who are dually eligible for both Medicare and Medicaid, all Medicare policies must be followed. After 36 months of Medicare payment, the provider may not shift payment to Medicaid.

2.3.9.6 Certificate of Medical Necessity

The information from a valid Oxygen [Certificate of Medical Necessity](#) (CMN) must be included with the original claim in order to be on file in the Molina system.

2.3.10 Prosthetic/Orthotic Description

Medicaid will purchase or repair medically necessary prosthetic and orthotic devices and related services that artificially replace a missing portion of the body or support a weak or deformed portion of the body within the limitations established by Medicaid.

2.3.10.1 Program Requirements

The Medicaid program follows the criteria established in the DME MAC Supplier Manual unless otherwise specified. The following program requirements will be applicable for all prosthetic and orthotic devices or services covered by Medicaid.

- A replacement prosthesis or orthotic device is covered when it is the less costly than repairing or modifying the current prosthesis or orthotic device.
- An individual who is certified or registered by the American Board for Certification in Orthotics and Prosthetics shall provide all prosthetic and orthotic devices that require customization and/or fitting.
- All orthotic and prosthetic devices must be new at the time of purchase.
- Modification to existing covered prosthetic or orthotic equipment.
- Purchased prosthetic limbs shall be guaranteed to fit properly for three months from the date of service. Any modifications, adjustments, or replacements within those three months are the responsibility of the provider that supplied the item at no additional cost to Medicaid or the participant.
- No more than 90 days shall elapse between the time the attending physician orders the equipment and the equipment is delivered to the participant.

2.3.10.2 Program Limitations

The following limitations shall apply to orthotic and prosthetic (O&P) services and equipment.

- Replacement for prosthetic devices—not allowed within 60 months of the date of purchase, except in cases where there is clear documentation that there has been major physical change to the residual limb, and a replacement is ordered by the attending physician.
- Refitting, repairs, or additional parts—limited to one per calendar year for all O&P, unless a documented major medical change has occurred to the limb and refitting is ordered by the attending physician.
- Cosmetic or convenience O&P devices are not covered by Medicaid. Exceptions are:
 - Artificial eyes (coverage per DME MAC criteria).
 - Breast prosthesis; prefabricated (coverage per *DME MAC* criteria).
- Electronically powered or enhanced prosthetic devices are not covered.
- Corrective shoes or modification to an existing shoe owned by the participant are covered only when they are attached to an orthosis or prosthesis or when specially constructed to provide for a totally or partially missing foot.
- Shoes and accessories such as mismatched shoes, comfort shoes following surgery, shoes to support an overweight individual, or shoes used as a bandage following foot surgery, arch supports, foot pads, metatarsal head appliances or foot supports are **not** covered under the program.
- Corsets and canvas braces with plastic or metal bones are **not** covered. However, special braces enabling a participant to ambulate will be covered when the attending

physician documents that the only other method of treatment for this condition would be application of a cast.

- Some AFOs that are not covered for adults may be covered for children. Use MACS or call Provider Services 1 (208) 373-1424 or 1 (866) 686-4272 to check for age limitations.
- Breast pumps are covered for women who choose to breast feed and who will use one. When the breast pump is purchased, the limit is one every three years while breast feeding and is to be billed to the mother's Medicaid ID number.
- Breast pumps can be rented if, for example, the new mother is only trying to establish a milk supply or is on short-term medication contraindicating breastfeeding. Rental of a breast pump is not subject to the three year limitation and may be billed to the baby's Medicaid ID number, if the mother is no longer eligible. The physician's order should include the expected duration of the rental.
- Purchasing or renting a breast pump prior to the birth is considered a convenience and is not covered by the Department.

2.3.11 Prior Authorization (PA) Procedures

Medicaid payment will be denied for the medical item or service, or portion thereof, which was provided prior to obtaining authorization.

An exception may be allowed on a case-by-case basis in which, despite efforts on the part of the provider to submit a timely request or due to events beyond the control of the provider, prior authorization was not obtained. An explanation of the delay in submission must accompany the request.

If an individual was not eligible for Medicaid at the time items were provided, but was subsequently found eligible pursuant to *IDAPA 16.03.05.051.03*, the medical item or service will be reviewed by DHW using the same medical necessity guidelines that apply to other prior authorization requests. The request must be submitted within 30 days of the date the provider became aware of the individual's Medicaid eligibility.

The following applies to all requests for DME or suppliers requiring PA.

- A valid PA request contains all information and documentation as required by rules to justify the medical necessity, amount, and duration for the item(s) or service.
- Documentation for any item requiring a PA must include a detailed written physician's order. Stamped signatures are not accepted.
- For items that must be manually priced (if there is no Medicaid price on file), pricing documentation must be attached to the PA request (invoice). Incomplete prior authorization requests will be denied. If a request has been denied and if there is additional documentation to support the request, a new request form and all required documentation can be submitted.
- Medical necessity documentation must show that the participant meets the criteria set forth in the DME MAC Supplier Manual (incorporated into Medicaid rule by reference) at <https://www.noridianmedicare.com/>. Select **Durable Medical Equipment**; select **Supplier Manual** under the *News and Publications* section. Coverage criteria are in Chapters three and four.
- For those items that do not have criteria in the DME MAC Supplier Manual, submit documentation from the physician, therapist, etc., that documents the medical necessity of the equipment for the participant. If less costly equipment was considered and ruled out, the documentation should identify the equipment and the reasons it would not meet the minimum medical needs of the participant.

- Urgent requests may be faxed and marked, *urgent* on the top of the request form. Call the DME Unit at 1 (866) 205-7403 to notify staff of the incoming request. For urgent equipment and supplies that required dispensing on the weekend or holiday or after business hours, the DME Unit must receive the request the next business day.
- A copy of the Idaho Medicaid DME/Supplies Request form is available at www.idmedicaid.com or call Provider Services at 1 (866) 686-4272 to request a paper copy.
- If a request has been denied, a new request form and all required documentation may be submitted if there is additional documentation to support the request.

Claims for services requiring PA will be denied if the provider did not obtain a PA from the authorizing authority.

Note: The provider may not bill the Medicaid participant for equipment and/or supplies not reimbursed by Medicaid solely because the prior authorization was not obtained in a timely manner.

The following table lists the most commonly requested DME items that are prior authorized by the Department.

For a complete list of items requiring PA, providers can call Molina or look online.

- Contact Molina Medicaid Solutions at 1 (866) 686-4272 or 1 (208) 373-1424 in the Boise calling area.
- Check the Molina Medicaid website for PA forms.

DME Item	PA Requirement	Criteria
Apnea Monitors (with recording feature)	PA**	Current documentation of apneic episodes. For renewal, include documentation (download) of the apneic episodes for previous two months. Apnea monitors are not covered for bradycardia or if the only indication is a sibling with SIDS.
Bilirubin Lights	PA after 14 days, then every 7 days	To treat hyperbilirubinemia in an infant/child in accordance with the Clinical Practice Guideline on Management of Hyperbilirubinemia published by the American Academy of Pediatrics .
Bi-level Respiratory Assist Device	PA**	See current Medicare Coverage Determination guidelines.
Communication Device	PA	See criteria listed in <i>IDAPA 16.03.09.752.02.c</i> .
Continuous Positive Airway Pressure (CPAP) Device	PA**	See current Medicare Coverage Determination guidelines.
Cough Assist In-exsufflator	PA	See current Medicare Coverage Determination guidelines.
Defibrillator (ambulatory)	PA	See current Medicare Coverage Determination guidelines.
Glucose Monitor (voice synthesized)	PA	See current Medicare Coverage Determination guidelines.
Hand-Held Showers	PA	Physician order and letter of medical necessity.

DME Item	PA Requirement	Criteria
Heating Pads (electric standard, electric moist, or water circulating with pump)	PA	See current Medicare Coverage Determination guidelines.
Hospital Bed, Semi-Electric	PA**	Semi-electric hospital beds may be rented or purchased when all of the following are met: <ul style="list-style-type: none"> The physician identifies the participant as unable to operate a manual hospital bed. The participant resides in an independent living situation where there is no one to provide assistance with a manual bed for the major portion of the day. The participant is unable to change position as needed without assistance, per DME MAC coverage criteria. See current Medicare Coverage Determination guidelines.
Insulin Pumps	PA	See current Medicare Coverage Determination guidelines.
Lift Devices (electric or hydraulic).	Check fee schedule	See current Medicare Coverage Determination guidelines.
Negative Pressure Wound Therapy	PA**	See current Medicare Coverage Determination guidelines.
Neuromuscular Electric Stimulators	PA	See current Medicare Coverage Determination guidelines.
Orthotics	Check the L-code Limitations under <i>Resources</i> on the DME website.	Check for age limitations on ankle foot orthotics. May include splints such as Dynasplints and Benik splints. See current Medicare Coverage Determination guidelines.
Osteogenesis (bone growth) Stimulator	PA	See current Medicare Coverage Determination guidelines.
Oximeters & Probes	PA	Oxygen (O2) saturation level. Physician's order specifies continuous/spot-check monitoring. Renewal specifies O2 saturations and O2 liter flow adjustment log. MSRP documentation. Capped rental item. Adults - See current Medicare Coverage Determination guidelines.
Oxygen Concentrators or Tanks (stationary and portable)	PA for Cluster Headaches	PA required when O2 is needed for cluster headaches. See <i>Section Cluster Headaches, section 2.2.9.3</i> . See current Medicare Coverage Determination guidelines.
Percussors (manual or electric airway clearance device)	PA	See current Medicare Coverage Determination guidelines.
Pneumatic Compression Device	PA	See current Medicare Coverage Determination guidelines.
Power Operated Vehicles	PA**	See mobility evaluation form.

DME Item	PA Requirement	Criteria
Pressure Reducing Support Surfaces (Mattress/overlay) Groups two and three	PA	See current Medicare Coverage Determination guidelines.
Prosthetics	Check fee schedule	See current Medicare Coverage Determination guidelines.
Transcutaneous Electric Nerve Stimulators (TENS)	PA	When proven effective for acute postoperative or chronic intractable pain AND more conservative treatment modalities have failed. Documentation by the physician showing the effectiveness following a maximum trial period of two months. See current Medicare Coverage Determination guidelines.
Ventilators	PA	For diagnoses and conditions of COPD, polio, amyotrophic lateral sclerosis, myasthenia gravis, muscular dystrophy, emphysema, bronchitis, musculoskeletal disorders, phrenic nerve damage, spinal cord injuries, multiple sclerosis, congenital trauma, or osteogenesis imperfecta. Authorized only if CPAP or Bi-PAP has been proven ineffective or is not appropriate for the patient's medical condition.
Walkers with hand brakes	PA	Documentation on why a less costly standard walker will not meet the participant's medical needs. See current Medicare Coverage Determination guidelines.
Wheelchairs*	PA**	The requested wheelchair is the least costly item to meet the participant's medical needs. Limited to one wheelchair per participant every five years. See CMS Local Coverage Determination for coverage criteria.

* Wheelchair authorizations require an evaluation to be completed by a physical therapist or occupational therapist. Wheelchair rentals needed for less than three months do not require a physical therapist or an occupational therapist evaluation if the need is self-limiting (e.g., fractured femur). The physician or physical therapist must document why a cane, crutches, or walker will not meet the participant's medical needs. Additional months may require a physical therapist's or occupational therapist's evaluation.

** For prior authorization of these items, you will find necessary authorization forms online at www.idmedicaid.com.

2.3.11.1 Wheelchair Repairs

The Department of Health and Welfare (DHW) or its designee may prior authorize wheelchair repairs or parts replacements including, but not limited to, tires, footplates, seating systems, drive belts, and joysticks. Repairs or replacement of any of the above items will not be authorized more than once every 12 months.

Specially designed seating systems for wheelchairs may be replaced no more than once every five years. Seating systems for participants in growth stages must provide for system enlargement without complete system replacement. Flat-free inserts may be prior authorized for medical necessity using Medicare criteria.

2.4 Waiver Services

2.4.1 Covered Equipment and Supplies

Waiver services are covered for Medicaid Enhanced Plan participants who are also on the Waiver Program. These are services beyond the scope of the Idaho Medicaid State Plan. The following may be covered under certain conditions for waiver participants. See section 2.4.3.5 for more information.

- Environmental control devices, air cleaners/purifiers, dehumidifiers, portable room heaters or fans, heating or cooling pads.
- Wheelchair lifts for vans.
- Emergency response system services.
- Generators.
- Eating/feeding utensils, such as rocker knives and special plates with rims.
- Diverter valves for bathtub.
- Home improvements such as:
 - Timers.
 - Wheelchair lifts or ramps.
 - Electrical wiring.
 - Structural modification to the house.

Note: Lift devices provided under the waiver program require PA.

2.4.2 Assistive Technology

2.4.2.1 Overview

Assistive Technology (AT) is any item, piece of equipment, or product system beyond the scope of the Idaho Medicaid State Plan, whether acquired off the shelf or customized, that is used to increase, maintain, or improve the functional capability of the participant. Assistive technology items also include items necessary for life support, ancillary supplies and equipment necessary to the proper functioning of such items, and durable and non-durable medical equipment. Items for recreational purposes are not covered.

All items shall meet applicable standards of manufacture, design, and installation. The equipment must be the most cost effective to meet the participant's need.

2.4.2.2 Provider Qualifications

Providers must be enrolled as medical equipment vendors with the Idaho Medicaid Program.

2.4.2.3 Payment

Medicaid reimburses waiver services on a fee-for-service basis for participants who are eligible for waiver services. Usual and customary fees are paid up to the Medicaid allowance. Environmental modifications and personal emergency response systems must be authorized by the Regional Medicaid Services (RMS). All services must be the most cost-effective way to meet the needs of the participant.

Other items must be submitted to the DME Unit for review. If the item cannot be covered under the State Plan, DME program, it may be considered under a waiver benefit for those participants who are on the waiver. It must be the least costly means of meeting the needs of the participant.

2.4.2.4 Procedure Codes

Refer to [CMS 1500 Instructions](#), *Suppliers* for waiver service codes.

2.4.2.5 Diagnosis Codes

Based on dates of service, enter the ICD-9-CM or ICD-10-CM code for the participant's disability as the primary diagnosis in field 21 on the CMS-1500 claim form or in the appropriate field of the electronic claim form.

For more information on which ICD version to use, refer to [ICD-9 and ICD-10 Diagnosis Billing Requirements](#).

2.4.2.6 Place of Service (POS) Codes

Assistive technology can only be provided in the following places of service:

- 12** Home
- 13** Assisted Living Facility
- 33** Custodial Care Facility

Enter this information in field 24B on the CMS-1500 claim form, or in the appropriate field of the electronic claim form.

2.4.3 Environmental/Home Modifications

2.4.3.1 Overview

Environmental/home modifications are interior or exterior physical adaptations to the home, required by the participant's Plan of Care, necessary to ensure the health, welfare, and safety of the individual. The modifications enable the participant to function with greater independence in the home and without which, the participant would require institutionalization.

Such adaptations may include:

- Installation of ramps and lifts.
- Widening of doorways.
- Modification of bathroom and kitchen facilities.
- Installation of electric and plumbing systems which are necessary to accommodate the medical equipment and supplies necessary for the welfare of the participant.

2.4.3.2 Exclusions

Exclusions are those adaptations or improvements to the home that are not of direct medical or remedial benefit to the participant, such as:

- Carpeting
- Repairs (roof, plumbing, or electrical, etc.)
- Air conditioning

2.4.3.3 Limitations

Permanent modifications are limited to modifications to a home owned by the participant or the participant's family when the home is the participant's principal residence.

Portable or non-stationary modifications may be made when such modifications can follow the participant to the next place of residence or be returned to DHW.

2.4.3.4 Provider Qualifications

Modification services must be completed with a permit or other applicable requirements of the city, county, or state in which the modifications are made. The provider must demonstrate that all modifications, improvements, or repairs are made in accordance with local and state housing, building, plumbing and electrical codes and/or requirements for certification.

2.4.3.5 Payment of Services

Medicaid reimburses waiver services on a fee-for-service basis. Usual and customary fees are paid up to the Medicaid allowance. For medical equipment or retail items such as adaptive eating utensils or the chair portion of a lift chair, reimbursement will be 75 percent of the manufacturer's suggested retail price or invoice plus 10% and shipping if supplied on invoice. Medicaid will reimburse for the least costly means of meeting the participant's need. Rates for Waiver services that require a provider to have a license or certification will be negotiated. For home modifications, van lifts, etc., rates will be the cost of the service up to \$500 or the lowest of three bids if the cost exceeds \$500.

For A&D Waiver services, all home modifications must be authorized by the RMS prior to payment and must be the most cost-effective way to meet the needs of the participant. In addition, the participant must be enrolled in the Medicaid Enhanced Plan.

For DD Waiver services, all home modifications must be authorized by the RMS prior to payment and must be the most cost-effective way to meet the needs of the participant. In addition, the participant must be enrolled in the Medicaid Enhanced Plan.

2.4.3.6 Procedure Codes

Refer to [CMS 1500 Instructions](#), *Suppliers* for service codes.

2.4.3.7 Diagnosis Code

Based on dates of service, enter the appropriate ICD-9-CM or ICD-10-CM code for the participant's disability as the primary diagnosis in field 21 on the CMS-1500 claim form or in the appropriate field of the electronic claim form, and one of the following, as the secondary diagnosis.

- ICD-9-CM: V60.4 – *No Other Household Member Able to Render Care*
- ICD-10-CM: Z74.2 – *Need for assistance at home and no other household member able to render care*

For more information on which ICD version to use, refer to [ICD-9 and ICD-10 Diagnosis Billing Requirements](#).

2.4.3.8 Place of Service (POS)

Environmental/home modification services can only be provided in the following POS:

12 Home

Enter this information in field 24B on the CMS-1500 claim form, or in the appropriate field of the electronic claim form.

2.4.4 Personal Emergency Response System (PERS)

2.4.4.1 Overview

Personal emergency response systems are provided to monitor the participant's safety and/or provide access to emergency crisis intervention for emotional, medical, or environmental emergencies through the provision of communication connection systems. Personal emergency response systems are limited to participants who are enrolled in the Medicaid Enhanced Plan, qualify for waiver services, and:

- Rent or own their home.
- Are alone for significant parts of the day.
- Have no regular caretaker for extended periods of time.
- Would otherwise require extensive routine supervision.

2.4.4.2 Provider Qualifications

Providers of PERS must demonstrate that the devices installed in participant's home meet Federal Communications Commission standards, Underwriter's Laboratory standards, or equivalent standards. Providers must be able to provide, install, and maintain the necessary equipment and operate a response center capable of responding on a 24-hours a day, seven days per week basis.

2.4.4.3 Payment

Medicaid reimburses Waiver services on a fee-for-service basis. Usual and customary fees are paid up to the Medicaid maximum allowance. All PERS services must be authorized prior to payment and must be the most cost-effective way to meet the minimum medical needs of the participant.

2.4.4.4 Procedure Codes

Refer to [CMS 1500 Instructions](#), *Suppliers*, Appendix P.2 for covered service codes.

2.4.4.5 Diagnosis Code

Based on dates of service, enter the appropriate code for the primary diagnosis in field 21 on the CMS-1500 claim form or in the appropriate field of the electronic claim form.

- ICD-9-CM: V60.4 - *No Other Household Member Able to Render Care*
- ICD-10-CM: Z74.2 – *Need for assistance at home and no other household member able to render care*

For more information on which ICD version to use, refer to [ICD-9 and ICD-10 Diagnosis Billing Requirements](#).

2.4.4.6 Place of Service (POS) Code

PERS services can only be billed in the following POS:

12 Home

Enter this information in field 24B on the CMS-1500 claim form, or in the appropriate field of the electronic claim form.

2.4.1 Specialized Medical Equipment and Supplies

2.4.1.1 Overview

Specialized medical equipment and supplies include devices, controls, or appliances, specified in the Individual Service Plan (ISP). The equipment and supplies must enhance the participant's daily living and enable the participant to control and communicate within his or her environment. This also includes items necessary for life support, ancillary supplies and equipment necessary to the proper functioning of such items, and durable and non-durable medical equipment not available under the Medicaid program.

Items covered under the DD waiver are in addition to any medical equipment and supplies furnished under the Medicaid Basic Plan and exclude those items that are of no direct medical, adaptive, or remedial benefit to the participant. All items available under the Medicaid Basic Plan must be billed by a DME provider. A participant must be enrolled in the Medicaid Enhanced Plan to be eligible for items covered under the DD Waiver Program.

2.4.1.2 Provider Qualifications

Providers must demonstrate that the specialized equipment and supplies purchased under this service meet applicable standards of manufacturer, design and installation, including Underwriter's Laboratory (UL), Federal Drug Administration (FDA), and Federal Communication Commission (FCC) standards.

Specialized equipment must be obtained or provided by authorized dealers of the specific product when applicable (medical supply businesses or organizations that specialize in the design of the equipment).

2.4.1.3 Payment of Services

Rates will be determined by Medicaid on a case-by-case basis. (See costing and prior authorization guidelines for Targeted Service Coordinators for Durable Medical Equipment and Supplies available through the ACCESS units.)

2.4.1.4 Procedure Codes

Refer to [CMS 1500 Instructions](#), *Suppliers*, Appendix P.2 for covered service codes.

2.4.1.5 Place of Service (POS)

Specialized medical equipment and supply services can only be billed with the following POS:

- 12** Home
- 99** Community

Enter this information in field 24B on the CMS-1500 claim form, or in the appropriate field of the electronic claim form.

2.5 Billing Policy

2.5.1 Payment

Medicaid reimburses durable medical equipment (DME) and disposable medical supplies (DMS) services on a fee-for-service basis. Usual and customary fees are paid up to the Medicaid maximum allowance.

2.5.2 Billing Procedures

Claims are billed to Medicaid on the CMS-1500 claim form (see [CMS 1500 Instructions](#)) or electronically using the HIPAA compliant 837 transaction. Use the appropriate HCPCS procedure codes with each claim. Medicaid uses the same HCPCS codes and modifiers that are used by Medicare. Refer to the *DME MAC Manual* for updated HCPCS codes at <https://www.noridianmedicare.com/>.

2.5.3 Place of Service (POS) Codes

Enter the appropriate numeric code in the POS box on the CMS-1500 claim form or in the appropriate field of the electronic claim. Not all DME procedure codes are payable at all POS locations.

- 01** Pharmacy
- 11** Office
- 12** Home
- 13** Assisted Living Facility
- 14** Group Home
- 24** Ambulatory Surgical Center
- 31** Skilled Nursing facility
- 32** Custodial care Facility
- 34** Hospice
- 50** Federally Qualified Health Center
- 54** Intermediate Care Facility/Intellectually Disabled (ICF/ID)
- 56** Psychiatric Residential Treatment
- 71** State or Local Public Health Clinic
- 72** Rural Health Clinic
- 99** Other Unlisted Facility

See [General Billing Instructions](#), *Third Party Recovery*, *Coordination of Benefits*, and *Crossover Claims* regarding Medicaid policy on billing all other third party resources before submitting claims to Medicaid. Participants cannot be billed for any non-reimbursed amount. Providers may only bill non-covered services to the participant if the provider has informed the participant of their responsibility to pay, preferably in writing, prior to rendering services.