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1. Section Modifications

Version	Section/ Column	Modification Description	Date	SME
36.0	All	Published version	11/1/2018	TQD
35.1	All	Removed Molina references	11/1/2018	D Baker E Garibovic
35.0	All	Published version	10/24/2018	TQD
34.1	2.4.2 Environmental/Home Modifications 2.4.3 Personal Emergency Response System (PERS)	Replace RMS with BLTC.	10/24/2018	E Garibovic W Deseron
34.0	All	Published version	8/27/2018	E Garibovic W Deseron
33.1	All	Format update, language clarification and breast pump requirements	8/27/2018	E Garibovic W Deseron
33.0	All	Published version	7/2/2018	TQD
33.2	2.4.8-2.4.8.4 Oxygen Services	Clarifications of coverage and billing	7/2/2018	E Garibovic W Deseron
33.1	2.4.6.1.(a) S9435 Medical Foods for Inborn Errors of Metabolism	New section	7/2/2018	E Garibovic W Deseron
33.0	All	Published version	5/31/2018	TQD
32.1	2.4.9.1 Program Requirements	Minor update for clarity	5/31/2018	K Eidemiller D Baker E Garibovic
32.0	All	Published version	3/8/2018	TQD
31.1	2.4.6.2 Incontinence Supplies	Updated information for Pull-ups	3/8/2018	W Deseron D Baker E Garibovic
31.0	All	Published version	2/9/2018	TQD
30.13	Billing Policy and all subsections	Removed/moved content	2/9/2018	W Deseron D Baker E Garibovic
30.12	2.4.10 Prior Authorization (PA) Procedure	Removed paragraph about most commonly requested DME items	2/9/2018	W Deseron D Baker E Garibovic
30.11	2.4.8.5 Certificate of Medical Necessity	Removed section	2/9/2018	W Deseron D Baker E Garibovic
30.10	2.4.8.4 Payment Methodology	Updates throughout	2/9/2018	W Deseron D Baker E Garibovic
30.9	2.4.8.3 Ventilator Dependent Participants	Minor update for clarity	2/9/2018	W Deseron D Baker E Garibovic
30.8	2.4.8.2 Cluster Headaches	Updates regarding criteria	2/9/2018	W Deseron D Baker E Garibovic
30.7	2.4.8 Oxygen Services	Updates throughout	2/9/2018	W Deseron D Baker E Garibovic
30.6	2.4.6.2 Incontinence Supplies	Minor updates regarding auth requests for Pull-ups	2/9/2018	W Deseron D Baker E Garibovic
30.5	2.4.6 Covered Equipment and Disposable Medical Supplies	Changed "calendar month" to "rolling month"	2/9/2018	W Deseron D Baker E Garibovic
30.4	2.4.5 Repairs and Replacement	Moved section up	2/9/2018	W Deseron D Baker E Garibovic

Version	Section/ Column	Modification Description	Date	SME
30.3	2.4.4.1 DME Rent/Purchase Decision	Minor reword for clarity	2/9/2018	W Deseron D Baker E Garibovic
30.2	2.4.2.3 Medicare and Medicaid	Removed section	2/9/2018	W Deseron D Baker E Garibovic
30.1	2.2 Reimbursement	New section	2/9/2018	W Deseron D Baker E Garibovic
30.0	All	Published version	2/1/2018	TQD
29.9	2.3.9 Prior Authorization (PA) Procedure	Minor update for clarity; added references to DMEPOS PA Policy and Medical Criteria	2/1/2018	K Eidemiller D Baker E Garibovic
29.8	2.3.8.2 Program Limitations	Updates to electronically powered or enhanced prosthetic devices, and breast pumps	2/1/2018	K Eidemiller D Baker E Garibovic
29.7	2.3.7.4 Ventilator Dependent Participants	Minor update for clarity	2/1/2018	K Eidemiller D Baker E Garibovic
29.6	2.3.7 Additional Equipment and Supplies for Children under EPSDT	Removed section	2/1/2018	K Eidemiller D Baker E Garibovic
29.5	2.3.6 Idaho Medicaid DMEPOS PA Policy and Medical Criteria	New section	2/1/2018	K Eidemiller D Baker E Garibovic
29.4	2.3.5.2 Incontinence Supplies	Changed "members" to "participants"	2/1/2018	K Eidemiller D Baker E Garibovic
29.3	2.3.5.1 Oral, Enteral, or Parenteral Nutritional Products, Equipment, and Supplies	Changed "client" to "participant"	2/1/2018	K Eidemiller D Baker E Garibovic
29.2	2.3.5 Covered Equipment and Disposable Medical Supplies	Added information for clarity	2/1/2018	K Eidemiller D Baker E Garibovic
29.1	2.3.4.2 Warranty Requirements	Added information for clarity	2/1/2018	K Eidemiller D Baker E Garibovic
29.0	All	Published version	12/5/2017	TQD
28.23	2.5.2.1 Repairs and Replacement 2.5.3 Participant Responsibility	New sections	12/5/2017	W Deseron K Eidemiller C Lord C Lovless
28.22	2.5.2 Billing Procedures	Updated name of CMS/Medicare DME Coverage Manual; added reference to General Billing Instructions	12/5/2017	W Deseron K Eidemiller C Lord C Lovless
28.21	2.4.5.5 Place of Service (POS) 2.5.3 Place of Service (POS)	Removed sections	12/5/2017	W Deseron K Eidemiller C Lord C Lovless
28.20	2.4.3.3 Limitations	Minor updates for clarity	12/5/2017	W Deseron K Eidemiller C Lord C Lovless
28.19	2.4.3.1 Overview	Added "but are not limited to"	12/5/2017	W Deseron K Eidemiller C Lord C Lovless

Version	Section/ Column	Modification Description	Date	SME
28.18	2.4.2.5 Diagnosis Codes 2.4.3.7 Diagnosis Code 2.4.4.5 Diagnosis Code	Removed ICD-9 information	12/5/2017	W Deseron K Eidemiller C Lord C Lovless
28.17	2.4.2.1 Overview	Minor clarification of last sentence	12/5/2017	W Deseron K Eidemiller C Lord C Lovless
28.16	2.4.2 Assistive Technology for Waiver Services	Modified section title	12/5/2017	W Deseron K Eidemiller C Lord C Lovless
28.15	2.3.10.1 Wheelchair Repairs	Added "and accessories"; removed authorization limits for repairs or replacement	12/5/2017	W Deseron K Eidemiller C Lord C Lovless
28.14	2.3.10 Prior Authorization (PA) Procedures	Significant revisions	12/5/2017	W Deseron K Eidemiller C Lord C Lovless
28.13	2.9.9.2 Program Limitations	Updated bulleted limitations list	12/5/2017	W Deseron K Eidemiller C Lord C Lovless
28.12	2.3.9.1 Program Requirements	Updated bulleted requirements list	12/5/2017	W Deseron K Eidemiller C Lord C Lovless
28.11	2.3.8.2 Exceptions to Lab Studies	Modified section title	12/5/2017	W Deseron K Eidemiller C Lord C Lovless
28.10	2.3.7 Additional Equipment and Supplies for Children under EPSDT	Modified section title; updated medical necessity information for clarity	12/5/2017	W Deseron K Eidemiller C Lord C Lovless
28.9	2.3.6 Non-covered Equipment and Supplies	Updated non-covered list	12/5/2017	W Deseron K Eidemiller C Lord C Lovless
28.8	2.3.5.2 Incontinence Supplies	Updated information on toilet training program	12/5/2017	W Deseron K Eidemiller C Lord C Lovless
28.7	2.3.6 Covered Equipment and Disposable Medical Supplies	Added information on equipment for purchase and on Medicare criteria	12/5/2017	W Deseron K Eidemiller C Lord C Lovless
28.6	2.3.4.1 DME Rent/Purchase Decision 2.3.5.1 Oral, Enteral, or Parenteral Nutritional Products, Equipment, and Supplies	Updated name of CMS/Medicare DME Coverage Manual	12/5/2017	W Deseron K Eidemiller C Lord C Lovless
28.5	2.3.3.1 Physician Orders	Changed "midlevel" to "non- physician"; removed verbal/preliminary order exclusions	12/5/2017	W Deseron K Eidemiller C Lord C Lovless
28.4	2.3.3 Documentation Requirements	Added bullet for face-to-face meeting	12/5/2017	W Deseron K Eidemiller C Lord C Lovless

Version	Section/ Column	Modification Description	Date	SME
28.3	2.3.2.4 Waiver Services for Enhanced Plan Participants	Modified section title; minor updates for clarity	12/5/2017	W Deseron K Eidemiller C Lord C Lovless
28.2	2.2 DME and DMS for Participants Residing in Facilities 2.3.2.1 Hospice Participants	Updated ICF/ID to ICF/IID	12/5/2017	W Deseron K Eidemiller C Lord C Lovless
28.1	2.1 Overview	Significant revisions	12/5/2017	W Deseron K Eidemiller C Lord C Lovless
28.0	All	Published version	10/20/2017	TQD
27.1	2.3.6.2 Incontinence Supplies	Clarified unit limitation is per rolling month	10/20/2017	D Baker E Garibovic
27.0	All	Published version	9/12/2016	TQD
26.2	2.3.10.2 Program Limitations	Updated breast pump information	9/12/2016	J Stevens D Baker
26.1	2.3.3 Documentation Requirements	Updated IDAPA reference	9/12/2016	E Garibovic D Baker
26.0	All	Published version	8/25/2016	TQD
25.1	2.4.3.5 Payment of Services	Added information in regards to shipping cost	8/25/2016	D Baker
25.0	All	Published Version	1/22/2016	TQD
24.1	2.3.2.2 Primary Care Case Management	Information removed to align with HC/PCMH changes	1/22/2016	D Baker C Loveless C Brock
24.0	All	Published version	12/3/15	TQD
23.1	2.2 DME and DMS for Participants Residing in Facilities	New section	12/3/15	J Siroky D Baker
23.0	All	Published version	12/1/15	TQD
22.1	2.4.3 Place of Service (POS) Codes	Updated for December 2015 COB changes	12/1/15	C Coyle D Baker
22.0	All	Published version	10/1/15	TQD
21.1	2.1 Overview	Clarified policy for RALFs and ICF/IDs	10/1/15	J Siroky D Baker
21.0	All	Published version	9/25/15	TQD
20.1	2.1 Overview	Updated what is included in per diem payment; clarified what items can be billed for ICF/ID participants	9/25/15	J Siroky D Baker
20.0	All	Published version	8/28/15	TQD
19.1	2.3.2.5 Diagnosis Codes 2.3.3.7 Diagnosis Code 2.3.4.5 Diagnosis Code	Updated for ICD-10	8/28/15	J Siroky D Baker C Taylor
19.0	All	Published version	6/26/15	TQD
18.1	2.2.5 Covered Equipment	Updated link to coverage criteria	6/26/15	J Siroky D Baker
18.0	All	Published version	3/12/15	TQD
17.1	2.5 Preventive Health Assistance and all subsections	Removed information and merged into General Provider and Participant Information handbook	3/12/15	C Brock C Taylor D Baker
17.0	All	Published version	2/26/15	TQD
16.1	2.5.1 Overview	Changed PHA Health Questionnaire information to reference current enrollment applications	2/26/15	C Brock C Taylor
16.0	All	Published version	2/12/15	TQD
15.2	2.2.6.2 Incontinence Supplies	Added information about toileting plans	2/12/15	J Siroky 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
15.0	All	Published version	07/07/14	TQD
14.1	2.3.2.5.; 2.3.3.7.; 2.3.4.5.; Diagnosis Codes	Updated ICD-9/10 dates to 2015	07/07/14	C Taylor
14.0	All	Published version	07/01/14	TQD
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
13.3	2.2.6.1. Oral, Enteral, or Parenteral Nutritional Products, Equipment, and Supplies	Updated information, added new subsections, and removed outdated information	07/01/14	J Siroky C Taylor D Baker
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
13.0	All	Published version	4/11/14	TQD
12.1	2.2.11 PA Procedures	Removed reference to fee schedule to determine if item requires PA	4/11/14	D Baker
12.0	All	Published version	3/7/14	TQD
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
11.0	All	Published version	2/21/14	C Taylor D Baker
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
10.0	All	Published version	1/24/14	C Taylor D Baker
9.1	2.5.3 Behavioral PHA – Tobacco Cessation	Removed section	1/24/14	A Coppinger
9.0	All	Published version	12/20/13	TQD
8.1	2.2.11 PA Procedures	Removed breast pumps	12/20/13	J Siroky C Taylor
8.0	All	Published version	10/25/13	C Taylor D Baker
7.1	2.2.11 PA Procedures Table	Removed (serum bilirubin level of 11.5 mg/dL or higher). Added "in accordance with the Clinical Practice Guideline ..."	10/25/13	J Siroky
7.0	All	Published version	9/13/13	C Taylor
6.1	2.5.2.3 Diagnosis Codes	Added missing 0 to 278.00; reviewed whole document for grammar and mechanics	9/12/13	H McCain
6.0	All	Published version	4/1/13	C Taylor
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

Version	Section/ Column	Modification Description	Date	SME
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
5.11	2.2.5 Covered Equipment	Updated for clarity	4/1/13	A Roy
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
5.2	2.2 General Policy	Removed Pharmacy – Unit Dose	4/1/13	J Siroky
5.1	2.1 Overview	Reorganized and updated sections for clarity and flow	4/1/13	A Roy
5.0	All	Published version	7/19/12	TQD
4.3	2.3.11 Oxygen Services	Replaced section, removed from General Billing Instructions	7/19/12	J Siroky
4.2	2.3.1 Overview	Updated second paragraph in the Note	7/19/12	J Siroky
4.1	2.2.3 Place of Service (POS) Codes	Removed from 12 Home “(includes residential care facility)”	7/19/12	J Siroky
4.0	All	Published version	5/23/12	TQD
3.1	2.3.11 Oxygen Services	Moved section to General Billing Instructions	5/23/12	C Taylor
3.0	All	Published version	06/27/11	TQD
2.1	2.2.3 Place of Service (POS) Codes	Updated with all POS codes	06/27/11	J Gillett
2.0	All	Published version	08/27/10	TQD
1.3	All	Changed member to participant	08/27/10	C Stickney
1.2	2.3.4 Prior Authorization (PA) Procedures	Updated PA information	08/27/10	C Stickney
1.1	All	Updated numbering for sections to accommodate Section Modifications	08/27/10	C Stickney
1.0	All	Initial document – Published version	05/07/10	TQD

2. Suppliers

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

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

Sections of the Idaho Medicaid Provider Handbook applicable in specific situations are listed throughout the handbook for provider convenience. Handbook sections that always apply to this provider type include the following.

- [General Billing Instructions](#)
- [General Provider and Participant Information](#)
- *Suppliers*

2.1 Provider Qualifications

Suppliers in any state are eligible to participate in the Idaho Medicaid Program. They must be licensed in the state where the services are performed, and enroll as a medical equipment vendor with Medicare and Idaho Medicaid prior to submitting claims for services. Providers must follow the provider handbook and all applicable state, and federal, rules and regulations.

See [General Provider and Participant Information](#), Idaho Medicaid Provider Handbook for more information on enrolling as an Idaho Medicaid provider.

2.2 Eligible Participants

Participants with Medicaid Basic and Enhanced Plans are eligible to receive DMEPOS. When billing for participants enrolled in other benefit plans, refer to [General Provider and Participant Information](#), Idaho Medicaid Provider Handbook for coverage. Providers must check eligibility prior to delivery to validate coverage as some participants may be on restrictive programs that include their DME and DMS. Eligibility may be checked by calling MACS at 1 (866) 686-4272; or through the trading partner account on the Idaho DXC Technology Medicaid website.

2.2.1 DME and DMS for Participants Residing in Facilities

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.

2.2.1.1 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.

2.2.1.2 ICF/IID (Intermediate Care Facility for Individuals with Intellectual Disabilities)

While a participant is a resident of an ICF/IID 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.

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.
- Prosthetics and orthotics.
- Specialized wheelchair and seating systems that 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/IID, providers may consult a list of Idaho ICF/IID facilities found at:

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

2.2.1.3 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://healthandwelfare.idaho.gov/Medical/LicensingCertification/StateOnlyPrograms/AssistedLiving/tabid/273/Default.aspx>.

2.2.2 Home Health Participants

If a participant is receiving home health services, the home health agency is responsible for any DME and supplies that are necessary. Information on home health can be found in the [Agency Institutional](#), Idaho Medicaid Provider Handbook.

2.2.3 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/IIDs. Information on hospice can be found in the [Agency Institutional](#), Idaho Medicaid Provider Handbook.

2.2.4 Primary Care Case Management

Healthy Connections (HC)

Effective 2/1/16, a referral from the HC physician is not required for DME. Information on the Healthy Connections program can be found in the [General Provider and Participant](#), Idaho Medicaid Provider Handbook.

2.2.5 School-Based Services

Durable medical equipment and supplies for Medicaid participants to use in a school setting must be billed to the school. Reimbursement rates, policies and documentation requirements are the same as if the supplier had billed Medicaid directly. See the [Agency Professional](#), Idaho Medicaid Provider Handbook for more information.

2.2.6 Waiver Services for Enhanced Plan Participants

Participants enrolled in the Medicaid Enhanced Plan and the Waiver Program are eligible for services beyond the scope of the Idaho Medicaid State Plan. See the [Waiver Services](#) section of this handbook for more information.

2.3 Covered Services and Limitations: General

Idaho Medicaid will purchase or rent medically necessary durable medical equipment (DME) and disposable medical supplies (DMS) for eligible participants residing in community settings. Medical equipment for purchase must be new when dispensed unless specifically requested and authorized by DHW as used on a case by case basis. This includes equipment that is issued or authorized as "rent-to-purchase." It does not apply to short-term rental equipment.

DME is equipment and appliances that:

- Can withstand repeated use.
- Are primarily and customarily used to serve a medical purpose.
- Are generally not useful to an individual in the absence of a disability, illness or injury.
- Are suitable for use in any setting in which normal life activities take place.
- Are reasonable and medically necessary for the treatment of a disability, illness or injury.

DMS refers to healthcare related items that are consumable, disposable, or cannot withstand repeated use by more than one individual, are suitable for use in any setting in which normal life activities take place, and are reasonable and medically necessary for the treatment of a disability, illness or injury.

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

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

2.3.1 Covered Equipment and Disposable Medical Supplies

All DMEPOS items with designated HCPC codes listed on the fee schedule could qualify for coverage when determined to meet medical necessity per IDAPA 16.03.09.011.16. The supplied item must be the least costly means of meeting the participant's medical need. The Medicaid fee schedule identifies medical supplies, equipment, and appliances commonly ordered for Medicaid participants. If a participant requires an item that is not listed on the fee schedule, a request should be submitted to the Department to assess items for coverage. This request must include justification of the medical necessity, amount of, and duration for the item or service, and all supporting documentation. Limitations apply, such as limits based on

medical necessity, the participant's place of residence, standard medical practice and quantities.

Idaho Medicaid follows criteria set in the Idaho Medicaid Provider Handbook and the [Idaho Medicaid DMEPOS PA Policy and Medical Criteria](#). Covered items and services not detailed in these documents default to criteria established by Medicare in the DMAC CMS/Medicare DME Coverage Manual or local or national coverage determinations (LCD or NCD) when available. Medicare coverage criteria can be found at <https://med.noridianmedicare.com/web/jddme/policies>. Adherence to these documents is a condition of payment.

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

For all DMS, 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.

The following are not covered under the DME program.

- Services, procedures, treatment, devices, drugs, or application of associated services that are considered investigational 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.

2.3.1.1 References: Covered Equipment and Disposable Medical Supplies

"Attention DME Providers: Corrections." *MedicAide Newsletter*, April 2018, <https://www.idmedicaid.com/MedicAide%20Newsletters/April%202018%20MedicAide.pdf>.

"Attention DME Providers: Rolling Months and Limitations." *MedicAide Newsletter*, March 2018, <https://www.idmedicaid.com/MedicAide%20Newsletters/March%202018%20MedicAide.pdf>.

"DMEPOS PA Policy and Medical Criteria." *MedicAide Newsletter*, January 2018, <https://www.idmedicaid.com/MedicAide%20Newsletters/January%202018%20MedicAide.pdf>.

2.3.2 Prior Authorization (PA) Procedure

The medical and documentation requirements set by the Department for most commonly requested DMEPOS items which require a PA are captured in the [Idaho Medicaid DMEPOS PA Policy and Medical Criteria](#). This material also explains in detail the PA procedural requirements and provides direction as to how to submit a PA. 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. When a PA for DMEPOS 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.

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; e.g., a hospital discharge, outside of business hours, etc. An explanation of the delay in submission must accompany the request and be submitted to the Department for an exception 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.

Claims for services requiring PA will be denied if the provider did not obtain a PA from the Department. In addition, the provider may not bill the Medicaid participant for equipment and/or supplies not reimbursed by Medicaid because the prior authorization was not obtained in a timely manner or because the provider failed to verify that a PA was required.

For information regarding prior authorizations, providers can:

- Check participant eligibility and PA requirements through your Trading Partner Account at www.idmedicaid.com.
- Contact DXC Technology Medicaid Solutions at 1 (866) 686-4272 or 1 (208) 373-1424 in the Boise calling area.
- Check the Idaho Medicaid Fee Schedule available online for items that always require a PA.

Prior authorization requests with supporting documentation are submitted to 1 (877) 314-8782.

2.3.3 Rental of Durable Medical Equipment

The Department may determine to rent or purchase DME. 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. This includes equipment that is issued or authorized as "rent-to-purchase."

The Department of Health and Welfare may choose to continue to rent certain equipment without purchasing it such as oxygen services and ventilators. 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 CMS/Medicare DME Coverage 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.

2.3.3.1 References: Rental of Durable Medical Equipment

"Capped Rental Clarification for Durable Medical Equipment (DME)." *MedicAide Newsletter*, January 2017,

<https://www.idmedicaid.com/MedicAide%20Newsletters/January%202017%20MedicAide.pdf>

2.3.4 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. Warranty information from the Manufacturer must also be available to the Department upon request. Medicaid requires the following warranty periods at a minimum:

- 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 Repairs and Replacement

If equipment has exceeded its warranty, is still medically necessary, and is no longer functional, Medicaid may pay to replace or repair the item. Equipment should only be replaced when it is more cost effective than repairs, or if the repaired equipment would no longer meet the medical needs of the participant. 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.

Modifiers should be included on claims to distinguish between repair and replacement items. Modifier RA should be used for replacement items and modifier RB should be used to denote parts for a repair.

2.3.6 Upgrades

Upgrades are not permissible for Idaho Medicaid participants. Per the provider agreement, IDAPA 16.03.09.210.03, "Medicaid Basic Plan Benefits," and CFR providers must accept Idaho Medicaid's payment as payment in full. However, if the participant desires to purchase a separate non-covered item, this would not be considered an upgrade. For example, if a tray for a wheelchair is denied for not being medically necessary the participant could decide to purchase that item separately. See the [General Provider and Participant](#), Idaho Medicaid Provider Handbook for more information about charging participants.

2.3.6.1 References: Upgrades

"Acceptance of State Payment." IDAPA 16.03.09, "Medicaid Basic Plan Benefits," Sec. 201.03. Department of Administration, State of Idaho, <https://adminrules.idaho.gov/rules/current/16/160309.pdf>.

Acceptance of State Payment as Payment in Full, 42 C.F.R. Sec. 447.15 (2013). Government Printing Office, https://www.ecfr.gov/cgi-bin/text-idx?SID=d8492fd799d90100fe7846aa3aac4ca&mc=true&node=se42.4.447_115&rgn=div8.

State-Only Code Changes, Information Release MA03-16 (5/1/2003). Division of Medicaid, Department of Health and Welfare, State of Idaho, <http://healthandwelfare.idaho.gov/Providers/Providers->

[Medicaid/InformationReleases/tabid/264/ctl/ArticleView/mid/1942/articleId/1258/MedicAide-Information-Release-MA0316.aspx](https://www.idmedicaid.com/MedicAide%20Newsletters/InformationReleases/tabid/264/ctl/ArticleView/mid/1942/articleId/1258/MedicAide-Information-Release-MA0316.aspx).

2.3.7 Breast Pumps

Electronic and manual breast pumps (E0602 and E0603) are covered for women who choose to breast feed. Coverage is limited to one every three years. Pumps should be billed as purchase only and to the mother's Medicaid ID number. Idaho Medicaid will not authorize an additional breast pump purchase within the three-year limitation. Breast pumps prior to the birth is considered a convenience and is not covered by the Department.

Hospital grade breast pumps (E0604) are available for rental only, for up to three months maximum, and must be prior authorized by the Department. Rental 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. Criteria for hospital grade breast pumps is available in the [Idaho Medicaid DMEPOS PA Policy and Medical Criteria](#).

2.3.8 Home Modifications

Home modifications are not covered in DMEPOS benefits under the Idaho Medicaid State Plan. Home modifications may be available for participants who are eligible under a waiver program. See [Covered Services and Limitations: Waiver Services](#) for more information.

2.3.9 Incontinence Supplies

Incontinence supplies including diapers, liners, pull-ups, and under-pads, are covered for participants who have a medical need for the items based on their diagnosis. These items are not covered for participants under 4 years of age or participants in long-term care (nursing facility) settings.

The Department will only reimburse for pull-ups if the participant is able to perform toileting activities on their own some of the time, and when briefs would prevent independence and cause a risk to the participant. Pull-ups are not covered for the convenience of the caregiver. Documentation must be kept on file with a statement of necessity from the ordering physician or non-physician practitioner that the participant meets the requirements for coverage. Toilet training plans are encouraged for participants transitioning out of diapers and briefs.

Any combination of disposable diapers, liners, or pull-ups is limited to a total of 240 units per rolling month. Under-pads are limited to 150 units per rolling month. Additional supplies may be prior authorized if the request includes medical justification of why the maximum limitation will not meet the participants needs. Authorizations that exceed limitations are only for acute, short term medical circumstances. See the [Idaho Medicaid DMEPOS PA Policy and Medical Criteria](#) for additional information.

2.3.9.1 References: Incontinence Supplies

"Attention DME Providers: Corrections." *MedicAide Newsletter*, April 2018,
<https://www.idmedicaid.com/MedicAide%20Newsletters/April%202018%20MedicAide.pdf>.

"Attention DME Suppliers: Incontinence Supplies." *MedicAide Newsletter*, March 2018,
<https://www.idmedicaid.com/MedicAide%20Newsletters/March%202018%20MedicAide.pdf>.

"Medicaid Program Integrity Unit: Durable Medical Equipment and Supplies Billing Requirements." *MedicAide Newsletter*, June 2015,
<https://www.idmedicaid.com/MedicAide%20Newsletters/June%202015%20MedicAide.pdf>.

New Pricing Methodology for Incontinence Supplies, Information Release MA08-20 (11/05/2008). Division of Medicaid, Department of Health and Welfare, State of Idaho, <http://healthandwelfare.idaho.gov/Portals/0/Providers/Medicaid/IR%202008-20%20New%20pricing%20methodolgy%20for%20Incontinence%20Supplies-signed.pdf>.

"Reminder for DME Suppliers: Incontinence Supplies." *MedicAide Newsletter*, January 2018, <https://www.idmedicaid.com/MedicAide%20Newsletters/January%202018%20MedicAide.pdf>.

2.3.10 Oral, Enteral, or Parenteral Nutritional Products

Oral, enteral or parenteral nutritional products are covered when medically necessary according to the criteria described in the CMS/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 (including thickener) 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 to be supplied, 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 participant 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.

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.

2.3.10.1 Infant Formula, Medical Grade

Idaho Medicaid will cover medical grade infant formula for infants requiring dietary management for specific diseases or conditions that are clinically serious or life-threatening. Formulas that may be eligible are those that have been declared exempt by the U.S. Food and Drug Administration. Usually they are not available on retail shelves for general consumer purchase. The formula must be prescribed by a physician, and must be requested from a pharmacist, or distributed directly to institutions such as hospitals, clinics, and State or Federal agencies.

Traditional (non-medical grade) infant formulas are only covered for participants that are tube fed. Participants should be directed to the Women, Infants, and Children (WIC) program for traditional formula that would be administered orally.

2.3.10.2 S9435 Medical Foods for Inborn Errors of Metabolism

Medical foods for inborn errors of metabolism are only covered for a diagnosis of phenylketonuria. Claims should be billed with one (1) unit per month of food.

2.3.10.3 References: Nutritional Products

Exempt Infant Formulas: Terms and Conditions, 21 C.F.R. Sec. 107.50 (1985). Government Printing Office, https://www.ecfr.gov/cgi-bin/text-idx?SID=0b3856c6076977b859599fe8090104c0&mc=true&node=se21.2.107_150&rgn=div8.

"Idaho Medicaid Establishes Fees for two Enteral Nutrition Products." *MedicAide Newsletter*, April 2010, <http://healthandwelfare.idaho.gov/Portals/0/Providers/Medicaid/April%202010%20MedicAide%20Newsletter.pdf>.

"Information Needed to Process Billings for Enteral Formula." *MedicAide Newsletter*, October 2007, <http://healthandwelfare.idaho.gov/Portals/0/Medical/MedicaidCHIP/September.pdf>.

"Medically Necessary Infant Formula." *MedicAide Newsletter*, May 2017, <https://www.idmedicaid.com/MedicAide%20Newsletters/May%202017%20MedicAide.pdf>

2.3.11 Oxygen Services

Medicaid covers medically necessary oxygen services for participants that meet the DME MAC coverage criteria. Refer to the following sections for exceptions to DME MAC requirements.

A completed [Certificate of Medical Necessity CMS-484 Oxygen](#) (CMN) signed by the physician must be attached to each claim. A separate physician's order is not necessary. The laboratory evidence justifying the use of oxygen must be included with the first claim for oxygen therapy for the participant. The CMN and laboratory evidence must 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. Clinical trials are not covered.

2.3.11.1 Exceptions to Lab Studies required by DME MAC

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.

2.3.11.2 Cluster Headaches

Medicaid may prior authorize (PA) oxygen for participants with a diagnosis of cluster headaches. Criteria may be found in the Idaho Medicaid DMEPOS PA Policy and Medical Criteria. Lab studies are not required.

When billing for oxygen that is necessary to treat cluster headaches, the CMN attached to the claim indicating that the oxygen is *for cluster headaches*.

2.3.11.3 Ventilator Dependent Participants

Idaho Medicaid will authorize payment of oxygen services 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 to qualify for oxygen supplies. The supplier must use the appropriate diagnosis code to indicate that the participant is ventilator dependent.

2.3.11.4 Payment Methodology

Idaho Medicaid pays for medically necessary liquid or gas oxygen, or an oxygen concentrator with an all-inclusive monthly rate found on the [Medicaid Fee Schedule](#). This rate includes the rental of the delivery system, its contents, maintenance, repair, and any necessary supplies. Separate payments may be made for both stationary and portable systems when medically necessary. Suppliers may bill equipment for the first 36 months, and then the contents afterwards. Oxygen concentrators, however, are considered purchased after a 10-month rental. If a participant is on both stationary and portable oxygen, the RUL for equipment will be calculated separately. In the event of theft or damage beyond repair, a prior authorization will be required to receive new equipment.

If the participant owns a stationary or portable oxygen delivery system Medicaid will pay the monthly all-inclusive rate for the compressed gas or liquid contents. Supplies are only separately payable for oxygen concentrators, and only if the participant owns the equipment.

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 for the equipment to Medicaid.

Providers should bill the following modifiers on claims for oxygen supplied through stationary equipment:

Modifier	Description	Reimbursement
QE	Prescribed amount of oxygen is less than 1 liter per minute (LPM).	Paid at 50%.
QF	Prescribed amount of oxygen is greater than 4 liter per minute (LPM) and portable oxygen is prescribed.	Paid at 150%.
QG	Prescribed amount of oxygen is greater than 4 liters per minute (LPM).	Paid at 150%.

2.3.11.5 References: Oxygen Services

"Oxygen Service Clarifications." *MedicAide Newsletter*, May 2018,
<https://www.idmedicaid.com/MedicAide%20Newsletters/May%202018%20MedicAide.pdf>.

"Oxygen Services." *MedicAide Newsletter*, March 2018,
<https://www.idmedicaid.com/MedicAide%20Newsletters/March%202018%20MedicAide.pdf>.

2.3.12 Prosthetic and Orthotics

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.

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 prosthetic or orthotic equipment will be covered by the Department when it no longer meets the medical needs of the participant.
- 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 prior authorization request is presented to the Department for consideration.

2.3.12.1 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.
 - Breast prosthesis; prefabricated.
- Electronically powered or enhanced prosthetic devices of any kind 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 ankle foot orthotics 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.

2.3.13 Vehicular Modifications

Vehicular modifications are not within the definition of durable medical equipment as they are a component of a vehicle that is not medical in nature. Modifications may be available for participants through a waiver program. See [Covered Services and Limitations: Waiver Services](#) for more information.

2.3.14 Wheelchair Seating Systems and Accessories

Specially designed seating systems and accessories for wheelchairs may be replaced no more than once every five years. Seating systems and accessories for participants in growth stages must provide for system enlargement without complete system replacement.

2.4 Covered Services and Limitations: Waiver Services

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.

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

- Wheelchair lifts or ramps.
- Electrical wiring.
- Structural modification to the house.
- Lift devices.
- Wheelchair lifts for vans.

Other items must be submitted to the Medical Care Unit for review. If the item cannot be covered under the State Plan's DME program, it may be considered under a waiver benefit. Items must be the least costly means of meeting the needs of the participant.

2.4.1 Assistive Technology for Waiver Services

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 assistive technology must be prior authorized.

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

HCPCS	Description	Diagnosis	Place of Service
E1399	Assistive Technology (A&D)	ICD-10-CM code for participant's disability as the primary diagnosis.	12 Home 13 Assisted Living Facility 33 Custodial Care Facility

2.4.2 Environmental/Home Modifications

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. Environmental/home modifications must be authorized by the Bureau of Long Term Care (BLTC).

Such adaptations may include, but are not limited to:

- 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.

Environmental/Home Modifications Billing			
HCPCS	Description	Diagnosis	Place of Service
S5165	Environmental Accessibility Adaptations	ICD-10-CM code for participant's disability as the primary diagnosis and Z74.2 as the secondary diagnosis.	12 Home

2.4.2.1 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.

Participants on the DD waiver must be twenty-one (21) years of age to use this service. There is no age restriction for participants on the Aged and Disabled waiver.

Improvements to the home that are not of direct medical or remedial benefit to the participant are excluded, such as:

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

2.4.2.2 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 Personal Emergency Response System (PERS)

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. The system does not include monthly telephone service. Installation is limited to once per residence, and includes the first month of service.

PERS must be prior authorized by the Bureau of Long Term Care (BLTC). Services are limited to participants who:

- 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.

Participants on the DD waiver must be twenty-one (21) years of age to use this service. There is no age restriction for participants on the Aged and Disabled waiver.

Personal Emergency Response System (PERS) Billing			
HCPCS	Description	Diagnosis	Place of Service
S5160	Initial Installation	Appropriate Primary ICD-10-CM code and Z74.2 as a secondary diagnosis.	12 Home
S5161	Monthly service, 1 Unit = 1 month		

2.4.3.1 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 Specialized Medical Equipment and Supplies

Specialized medical equipment and supplies for the Aged and Disabled waiver and the DD waiver include devices, controls, or appliances. 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 and equipment that are of no direct medical, adaptive, or remedial benefit to the participant are excluded.

Participants on the DD Waiver must have the specialized equipment and supplies in their Individual Service Plan (ISP).

Specialized Medical Equipment and Supplies Billing

HCPCS	Description
E1399	Specialized Medical Equipment/Supplies and Service

2.4.4.1 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), Food and 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).

2.5 Documentation Requirements

The vendor is required to obtain all medical necessity documentation prior to billing for DME and supplies. 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.
- Verification that the participant has met face-to-face with the physician within six months of the order for equipment or supplies.
- Medical necessity documentation as required by *IDAPA 16.03.09*. These rules are available online at <https://adminrules.idaho.gov/rules/current/16/160309.pdf>.

2.5.1 Physician 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/non-physician 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/non-physician 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.

2.5.2 Physician Verbal/Preliminary Order

Providers may dispense DME, prosthetic, orthotic, and medical supplies based on a verbal or preliminary written order from the treating physician/non-physician practitioner. A detailed written order that is signed and dated by the physician/non-physician 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/non-physician 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.

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.

2.5.3 References: Documentation Requirements

"Attention DMEPOS Suppliers." *MedicAide Newsletter*, March 2018,
<https://www.idmedicaid.com/MedicAide%20Newsletters/March%202018%20MedicAide.pdf>

"Attention Durable Medical Equipment (DME) and Supplies: Requirements for Verbal and Preliminary Written Orders." *MedicAide Newsletter*, October 2009,
<http://healthandwelfare.idaho.gov/Portals/0/Providers/Medicaid/MedicAide%20October%202009.pdf>.

2.6 Reimbursement

When billing for medical equipment and supplies, the provider must bill with a DME provider number. The date of service must be the date items were dispensed, and not a date span for when the items were used. 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 allowance. For medical equipment, waiver items and supplies that do not have a price on the fee schedule reimbursement will be 75% 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 will be determined by Medicaid on a case-by-case basis. 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 the A&D waiver or \$1500 for participants on the DD waiver. Targeted Service Coordinators should reference the costing and prior authorization guidelines for Durable Medical Equipment and Supplies available through the ACCESS units.

See the [General Billing Instructions](#), Idaho Medicaid Provider Handbook regarding billing, codes without a price on the fee schedule, co-pays, prior authorization, and requirements for billing all other third-party resources before submitting claims to Medicaid.

See the [General Provider and Participant Information](#), Idaho Medicaid Provider Handbook for information on when billing a participant is allowable.

2.7 References: General

2.7.1 CMS Guidance

Active Local Coverage Determinations. DME Jurisdiction D.

<https://med.noridianmedicare.com/web/jddme/policies/lcd/active>.

"Chapter 2 – State Organization." *The State Medicaid Manual*, Centers for Medicare & Medicaid Services,

<https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Paper-Based-Manuals-Items/CMS021927.html>.

"Chapter 15 – Covered Medical and Other Health Services." *Medicare Benefit Policy Manual*, Centers for Medicare & Medicaid Services, <https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c15.pdf>.

"Chapter 20 – Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS)." *Medicare Claims Processing Manual*, Centers for Medicare & Medicaid Services,

<https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c20pdf.pdf>.

Medicare National Coverage Determinations (NCD) Manual. Centers for Medicare & Medicaid Services, <https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs-Items/CMS014961.html>.

2.7.2 Idaho Medicaid Publications

"Attention DME Providers." *MedicAide Newsletter*, May 2018,

<https://www.idmedicaid.com/MedicAide%20Newsletters/May%202018%20MedicAide.pdf>.

"Attention DMEPOS Suppliers Dispensing Refill Orders, Documentation Must Show the Participant Has Nearly Exhausted Their Supplies and be Kept in the Participant Record."

MedicAide Newsletter, July 2018,

<https://www.idmedicaid.com/MedicAide%20Newsletters/July%202018%20MedicAide.pdf>.

"Attention: Durable Medical Equipment (DME) and Pharmacy Providers," *MedicAide Newsletter*, March 2009,

<http://healthandwelfare.idaho.gov/Portals/0/Providers/Medicaid/March%20newsletter.pdf>.

Basic Alternative Benefit Plan. Division of Medicaid, Department of Health and Welfare, State of Idaho,

<http://www.healthandwelfare.idaho.gov/Portals/0/Medical/MedicaidCHIP/BasicBenchmark.pdf>.

"Billing DME Supplies." *MedicAide Newsletter*, January 2005,

<http://healthandwelfare.idaho.gov/Portals/0/Medical/MedicaidCHIP/Jan-Apr%2005.pdf>.

"Billing DME Supplies." *MedicAide Newsletter*, July 2006,

http://healthandwelfare.idaho.gov/Portals/0/Providers/Medicaid/2006_07.pdf.

Idaho Medicaid DMEPOS PA Policy and Medical Criteria. Medical Care Unit, Division of Medicaid, Department of Health and Welfare, State of Idaho,

<http://healthandwelfare.idaho.gov/Medical/Medicaid/MedicalCare/DurableMedicalEquipment/tabid/271/Default.aspx>.

"**Medicaid Program Integrity Unit: Durable Medical Equipment and Supplies Billing Requirements.**" *MedicAide Newsletter*, June 2015,

<https://www.idmedicaid.com/MedicAide%20Newsletters/June%202015%20MedicAide.pdf>.

2.7.3 Regulations

"Definitions." Social Security Act, Sec. 1905(a) (1935). Social Security Administration,

https://www.ssa.gov/OP_Home/ssact/title19/1905.htm.

Definitions: Prescribed Drugs, Dentures, Prosthetic Devices, and Eyeglasses, 42 C.F.R. Sec. 440.120(c) (2012). Government Printing Office, https://www.ecfr.gov/cgi-bin/text-idx?SID=3d211c6511934b470a26c3b733c291fc&mc=true&node=se42.4.440_1120&rgn=div8.v8.

"Definitions of Services, Institutions, Etc." Social Security Act, Sec. 1861(n) (1935). Social Security Administration, https://www.ssa.gov/OP_Home/ssact/title18/1861.htm.

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Sec. 750 – 779. Department of Administration, State of Idaho, <https://adminrules.idaho.gov/rules/current/16/160309.pdf>.

Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) of Individuals Under Age 21: Required Activities, 42 C.F.R. Sec. 441.56(c) (1984). Government Printing Office,

<https://www.govinfo.gov/content/pkg/CFR-2017-title42-vol4/pdf/CFR-2017-title42-vol4-sec441-56.pdf>.

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