# Chapter 18

# Durable Medical Equipment and Supplies

**NOTE:** *Please review the following detail for specific processes and expectations with South Country Health Alliance (South Country). South Country may vary from the MHCP Manual and Minnesota Department of Human Services guidelines. For additional detail on this chapter, please go to the Minnesota Health Care Programs Provider Manual at* MHCP Provider Manual.

**Billing Information** – Please review the South Country Provider Manual Chapter 4 Provider Billing for general billing processes and procedures.

South Country Health Alliance (South Country) covers medical supplies and equipment that are medically necessary per policies established under the Centers for Medicare & Medicaid (CMS) and Minnesota Department of Health Services (DHS), subject to limitations, authorization and other requirements. Reference to these policies can be found at MCD Search (cms.gov) and http://www.dhs.state.mn.us/.

## Eligible Providers

The following are eligible to provide most equipment and supplies:

- Federally qualified health centers
- Home health agencies
- Indian Health Services
- Medical suppliers (including oxygen contract vendors)
- Pharmacies
- Rural health clinics

The following are eligible providers for DME only when the DME are provided as a necessary adjunct to the direct treatment of a member's condition (for example: crutches, splints).

- Clinics
- Clinical nurse specialists
- Hospital outpatient facilities
- Nurse practitioners
- Physician assistants
- Physicians
- Podiatrists

*Providers must always verify member eligibility and prior receipts of DME item(s)/supply(s) before dispensing or requesting a prior authorization.*

## Covered Services

South Country covers medical supplies and equipment that are medically necessary, subject to limitations, authorization and other requirements. Additional restrictions apply to supply and equipment coverage for members residing in long term care (LTC) facilities.

- When the medical equipment or supply is purchased for a member, the item is the member's property.
- Depending on the member's coverage (Medicare or Medicaid primary), rent for most DME is covered (if medical necessity criteria are met) for the applicable Medicare or Medicaid coverage period or to the purchase price of the equipment. After 13 months of rental, or when the purchase price is reached, the item is the member's property.
- DME determined by Medicare to require frequent and substantial servicing is not subject to the 13-month rental limit.
- All rental months count toward the purchase price unless there is a break in continuous use. A break in continuous use is defined as a period of two (2) months or more during which the provider has removed the equipment from the member's home, or the member is not using the equipment because of an inpatient hospital or skilled nursing facility stay.
- South Country assumes a reasonable useful lifetime of five years for all durable medical equipment. Members cannot automatically obtain a new piece of equipment after five years if the first piece is still in working order. Likewise, if repairs are requested for a piece of equipment that is more than five years old, the integrity of the equipment and ability to last another five years will be assessed and the least costly alternative recommended (replacement versus repair).
- South Country will not cover equipment that serves the same purpose as usable equipment previously purchased for the member.
- South Country covers repairs to medically necessary member-owned equipment and maintenance on equipment that requires frequent cleaning or routine calibration to ensure proper working order.
- Covered devices that are subject to FDA approval must be dispensed according to its approval guidelines.
- All purchased equipment must be new upon delivery to the member. Equipment that is intended to rent until converted to purchase must be new equipment. Used equipment may be used for short-term rental, but if eventually converted to purchase, must be replaced with new equipment.
- To determine the appropriate HCPCS code to use for an item, refer to the Medicare Pricing, Data Analysis and Coding (PDAC) Palmetto GBA Durable Medical Equipment Coding System webpage.
- Refer to the DHS Medical Supply coverage guide for information about coverage and limits for supplies and equipment not included in this manual.

## Noncovered Services

The following categories of equipment and supplies are never covered by South Country:

- Items of convenience
- Items that are useful for individuals who don't have an illness or injury
- Environmental or home modifications
- Items that lack scientific evidence
- Not the standard of treatment for an illness or injury

**Typically non-covered services**

Authorization can be requested for any piece of medical equipment, supply, prosthetic, or orthotic that is considered a typically noncovered item, however, the item must be medically necessary. The following list of items are not typically covered because they meet one of the criteria under Noncovered Services:

- Air conditioners
- Bathroom scales
- Bathtub wall rails
- Beds - oscillating and lounge beds, bed baths and lifters, bed boards, tables and other bed accessories
- Blood glucose analyzer - reflectance colorimeter
- Car seats, standard use
- Cervical roll or pillow
- Clothing
- Control units and battery device adapters
- Dehumidifiers - room or central
- Diathermy machines
- Disposable wipes - including Attends wash cloths
- Disposable ice packs and disposable heat wraps
- Elevators and stair lifts that are affixed to the home
- Enuresis or bed-wetting alarms
- Environmental products (for example, air filters, purifiers, conditioners, hypoallergenic bedding and linens)
- Exercise equipment
- Food blenders
- Grab bars that are affixed to the home
- Heat and massage foam cushion pads
- Home security systems
- Household equipment and supplies such as ramps, switches, tableware and feeding instruments
- Humidifiers - room type or central
- Hygiene supplies and equipment, including hand-held shower units and shower trays, and dental care supplies and equipment
- Instructional materials (for example, pamphlets and books)
- Isolation gowns, surgical gowns and masks
- Magnifying glasses
- Massage devices
- Medical alert bracelets and response systems

- Medical supplies defined as drugs
- Medication boxes or medication dispensing equipment
- Menses products (e.g., sanitary pads)
- Motorized lifts for a vehicle
- Orthopedic mattresses
- Personal computers and printers, tape recorders or video recorders
- Pulse tachometers
- Ramps that are affixed to the home
- Reachers and grabbers
- Reading glasses
- Saline or other solutions for the care of contact lenses
- Table foods
- Telephones, telephone alert systems, telephone arms or answering machines
- Tennis or gym shoes
- Thermometer covers
- Toothbrushes and toothettes
- Toys
- Washable or reusable incontinence undergarments
- Waterbeds
- White canes for the blind

**Authorization requests for typically noncovered items**

Authorization can be requested for any piece of medical equipment, supply, prosthetic, or orthotic that is considered a typically noncovered item. The item must be medically necessary.

Documentation must demonstrate the item meets all the following criteria:

- Medically necessary, as determined by prevailing medical community standards or customary practice and usage
- Appropriate and effective for the member's medical needs
- Timely, considering the nature and present medical condition of the member
- Provided by a provider with the appropriate credential
- The least expensive, appropriate alternative available
- An effective and appropriate use of MHCP funds
- Not investigative, or investigative but should be approved for compassionate use
- Suitable for use in the member's home or any non-institutional setting in which normal life activities take place
- Is generally not useful in the absence of an illness, injury, or disability
- Is provided to correct or accommodate a physiological disorder of physical condition or is generally used primarily for a medical purpose.

## Billing and Documentation

Along with the general billing information in Chapter 4 of the South Country Provider Manual, the following requirements pertain to the billing of Durable Medical Equipment and Supplies.

- For equipment or medical supply items that require manual pricing or are not listed on the Minnesota Health Care Programs (MHCP) Fee Schedule, attach the manufacturer's invoice/price list to the claim
- Clearly indicate which item on the document corresponds to each item on the claim
- Do not modify, alter, change, or black out the price list or invoice (you may star or circle)
- The cost of shipping, handling, or freight charges are all-inclusive in the payment rate and are not reimbursable. If these charges are included on the invoice they will be excluded from the payment
- Do not bill for service calls that do not involve actual labor time for repairs
- Do not bill for sales tax. DME items are exempt from sales tax for the State of Minnesota. Refer to the Minnesota Department of Revenue's Durable Medical Equipment Sales Tax Fact Sheet 117B for additional information

Additional billing information about specific items can be found in the policy section for those items.

### Supplier documentation

The medical supplier must have the following information in the file:

- An order from the treating provider
- Documentation of the face-to-face encounter (when medically necessary)
- Member's diagnosis from the testing physician
- Any information required for us of specific modifiers or attestation statements
- Adequate information to assure that coverage criteria for an item have been met
- A medical record with information adequately supporting medical necessity
- Proof of delivery documentation

## Orders

South Country requires an order from a treating practitioner for all durable medical equipment, prosthetics, orthotics and supplies (DMEPOS). Treating practitioners can include: physicians, physician assistants, or advanced practice nurses. Ordering practitioners must be working within their scope of practice. Specific policies may have different treating practitioners allowed to prescribe, review each policy for specific details. South Country accepts the following order types according to Medicare guidelines.

### New Order

A new order is needed in the following circumstances:

- All new purchases and new rentals
- Whenever there is a change to an order from the treating practitioner
- Anytime an item is replaced
- When there is a change in supplier (when the new supplier does not have access to the previous order)

- Annually for supplies unless a specific product or policies requires one more frequently

## Face-to-Face Rule for DME, Appliances, and Supplies

The initiation of medical equipment requires a documented face-to-face encounter that must be related to the primary reason that the member requires medical equipment. This encounter must occur no more than six (6) months prior to the start of services. The face-to-face encounter may be conducted by one of the following: a physician, a nurse practitioner, clinical nurse specialist, or a physician assistant. The face-to-face encounter may occur through telehealth. See Chapter 33 Telehealth for more information. Although not required to be face-to-face, renewal of medical supplies, equipment, and appliances must be approved by a physician, nurse practitioner, clinical nurse specialist, or physician assistant on an annual basis.

DME items subject to the face-to-face rule by Medicare are also subject to this rule. A list of items subject to the face-to-face rule may be found in Chapter 3 of the Medicare DME MAC Jurisdiction B Supplier Manual. Refer to the Medicare contractor supplier documentation (PDF), ACA 6407.

### Face-to-Face Documentation

Providers must maintain written or electronic documentation of face-to-face encounters on file and available upon request. Documentation must include:

- The identity of the physician or non-physician practitioner who conducted the face-to-face encounter. Non-physician practitioners are authorized to complete the documentation requirements
- The date of the face-to-face encounter
- The specific diagnosis or medical condition that was the reason for the face-to-face encounter and ordered service

Documentation of face-to-face encounters may be included in clinical and progress notes and discharge summaries.

Documentation for the medical supplier's records may be copies of physician or non-physician practitioner notes, documentation of a phone call with the physician or non-physician practitioner to confirm the face-to-face encounter or a written summary from the physician or non-physician practitioner.

On-going services are not subject to the face-to-face rule. A face-to-face encounter is only required for new medical equipment, supplies, or appliances.

## Third Party Liability (TPL) and Medicare

Providers must meet any provider criteria, including accreditation and surety bond requirements, for third party insurance or for Medicare to assist members for whom South Country Health Alliance is not the primary payer. Providers who do not meet Medicare requirements must refer and document the referral of dual-eligible members to Medicare providers when Medicare is determined to be the appropriate payer for services. Providers who do not meet the provider criteria for the primary payer will not be reimbursed by South Country.

***If Medicare downcodes an item, South Country will make payment based on the downcoded Medicare explanation of benefits (EOB), regardless of any South Country prior authorization. Providers may choose to offer only Medicare-covered equipment to dual-eligible members if a Medicare Local Coverage Determination states that specific items will be downcoded.***

## National Correct Coding Initiative

South Country has implemented National Correct Coding Initiative (NCCI) edits. Two types of NCCI edits exist and apply to durable medical equipment, medical supplies, prosthetics and orthotics:

- Procedure code to procedure code (PTP) edits that define pairs of HCPCS/CPT codes that should not be reported together
- Medically Unlikely Edits (MUEs) or units-of-service edits that define for each HCPCS/CPT code the number of units of service beyond which the reported number of units is unlikely to be correct

How to correctly follow NCCI edits when billing:

- Bill a date span when there is an NCCI edit on a code you are billing for a month's worth of supplies. The first date in the date span should be the date the supplies are dispensed. The number of supplies distributed in the date span should not exceed the daily limit for any day within that date span unless an NCCI exception is allowed and the correct modifiers are used.
- You must follow our monthly and annual limits when applicable regardless of the MUE. Authorization is required for quantities exceeding our policy limits.
- An NCCI modifier may be used to bypass an NCCI edit only when appropriate according to NCCI policy
- Authorization requests must contain the NCCI modifier when applicable and must match exactly what is billed
- Review the Minnesota National Correct Coding Initiative (NCCI) webpage for additional information.
- Review Medicaid's Medicaid NCCI Edit Files webpage to look up PTP and MUE edits

## Coverage Criteria

South Country Health Alliance uses nationally accepted criteria such as InterQual®, clinical practice guidelines, State of Minnesota coverage policies, Minnesota Department of Human Services (DHS), and Centers for Medicare & Medicaid Services (CMS) guidelines, etc. Upon request from a provider, member, regulator, or commissioner of commerce, South Country will provide the criteria used to determine medical necessity, appropriateness, or efficacy of a service.

## Prior Authorization

Authorization is always required for any equipment or supply for the following reasons:

- The item has an allowed amount of $1,500 or more
- Units that exceed the threshold limit
- Repairs of $500 or more for part(s) and labor
- Any miscellaneous code that exceeds $500

Some equipment and supplies require authorizations outside of the above criteria. To inquire about authorization requirement for a certain equipment or supply not addressed in this chapter, please contact South Country Provider Contact Center at 1-888-633-4055 or view the prior authorization and notification list, which can be located on South Country's website: https://mnscha.org/.

Providers may submit a prior authorization via the provider portal https://provider.mnscha.org/scha.provider.aspx, which can be located on South Country's website: https://mnscha.org/

To fax authorizations, the Service Authorization form is located on the provider portal https://provider.mnscha.org/scha.provider.aspx or on South Country's website: https://mnscha.org/

Fax completed forms directly to South Country Utilization Management at 1-888-633-4052.

## Rental vs. Purchase

Rental of durable medical equipment will be the general practice. However, if there is evidence the durable medical equipment will be required long enough to justify purchase, reimbursement will be limited to the purchase price. South Country reserves the right to determine if an item will be approved for rental versus purchase.

## Capped Rental Items

- Item is rented primarily on a monthly basis.
- Reimbursement for all rental items will cap at the Medicare purchase rate, the DHS maximum allowed payment rate, or rented through the thirteenth (13) continuous month. Do not continue to bill monthly rental after the maximum rate has been reached, no further payments will be made. Apply full rental payments (including all payments received from primary third-party payers) to all purchases. After South Country purchases the equipment or supply for a member, the item is the member's property.
- Payment can be made for the purchase of the item even though rental payments may have been made for prior months. This could occur because of a change in member's condition, the member feels that it would be to member's advantage to purchase the equipment rather than to continue to rent it. Payment will not exceed the total purchase price of the equipment.
- Items that may be included in this category are: hospital-type bed, wheelchair, continuous airway pressure device (CPAP), and apnea monitoring devices.

## Replacement

Durable medical equipment that a member owns, is purchasing, or is a capped rental item may be replaced in the event of loss, irreparable damage (due to accident or natural disaster) or irreparable wear (i.e. deterioration due to usage over time, not due to a specific event) or when required because of a change in the member's medical condition. Replacement of equipment due to irreparable wear is not a covered service during the reasonable useful lifetime of the equipment; however, repair costs up to the estimated cost of replacement of such equipment may be a covered service. South Country reserves the right to re-evaluate medical necessity of durable medical equipment associated with a request for replacement of durable medical equipment.

## Repair

Separate charges for repair of durable medical equipment are covered services if such equipment is being purchased or is already owned by the member and repair is necessary to make the equipment serviceable. When repair costs exceed the estimated cost for purchasing or renting the same item for the remaining period of medical need, such excess repair costs are not a covered service. Rental of durable medical equipment while member's own durable medical equipment is being repaired is a covered service.

## Add-ons and Upgrades

An add-on is a noncovered item that can be added to a piece of covered equipment.

An upgrade is a piece of equipment with extra, more desirable features that substitutes for a less costly piece of equipment. Often, South Country will cover the upgraded item for members who meet criteria if medically necessary authorization is obtained.

If South Country pays for the equipment, a provider can bill a member for a noncovered add-on. Refer to the South Country Advance Member Notice (DHS-3640) (PDF). If South Country makes any payment toward the equipment, the provider cannot bill the member or accept payment on behalf of the member for the difference between the covered equipment and the upgraded equipment.

South Country will not pay for repairs or maintenance to any noncovered add-ons or upgraded equipment.

## Dispensing of Equipment and Supplies

Follow these guidelines when dispensing equipment and supplies:

- Dispense no more than one month of supplies at a time unless specifically permitted by coverage policy.
- Requests must come from the member or an authorized representative each time additional supplies are needed.

It is acceptable for medical supply providers to call the member to verify a re-order.

- Automatically shipping supplies without the member or the members authorized representative's confirmation is not permitted.

***Shipping, delivery, and set-up costs are included in the DME item/supply reimbursement rate and may not be separately billed to South Country or the member.***

## Allergen-Reducing Products for Children

South Country covers certain allergen-reducing products for children with poorly controlled asthma.

## Eligible Members

All South Country members under the age of 21 for Medical Assistance and under the age of 19 for MinnesotaCare members who are diagnosed as having poorly controlled asthma. The Minnesota Legislature has defined a person as having poorly controlled asthma when they have experienced one of the following:

- A hospital emergency department visit for asthma at least one time in the past year, or
- A hospitalization for the treatment of asthma at least one time in the past year.

## Covered Services

All covered products require an order from a physician, physician assistant, nurse practitioner or clinical nurse specialist.

South Country will cover the following allergen-reducing products:

- Allergen encasements for mattresses, box springs and pillows
- An allergen-rated vacuum cleaner, filters and bags

- A dehumidifier and filters
- A HEPA single-room air cleaner and filters
- Integrated pest management, including traps and starter packages of food storage containers
- A damp mopping system
- A waterproof hospital-grade mattress (if the member does not have access to a bed)
- Furnace filters (for homeowners only)

## Billing

• Bill all allergen-reducing products under miscellaneous code E1399. Use modifier HA to denote you are billing for a child. A child includes those 21 and under but you must also follow MinnesotaCare and Medicaid policy for who is considered a child.

• Authorization is required for E1399 when cost exceeds $500

## Ambulatory Assist Equipment

Ambulatory assist equipment is used for individuals who have difficulty ambulating safely and require a device to help. Canes are used to provide relief to legs or promote balance with walking. Crutches are used to remove weight from an injured lower extremity or to compensate for a missing limb. Walkers are used to provide stability and balance with ambulation.

Ambulatory assist equipment is covered for eligible South Country members who meet medical necessity criteria. Canes are not covered for South Country members in nursing facilities or Intermediate Care Facilities for persons with developmental disabilities (ICF/DD). Walkers are not covered for South Country members in nursing facilities. Only walkers with trunk support are covered for South Country members in an ICF/DD. Gait trainers may be covered for members in nursing facilities or ICF/DD. Quantity limits and thresholds apply to all members.

## Covered Services

Codes:
E0100-E0105: Canes
E0110-E0118, E0153: Crutches
E0130-E0149, E0154-E0159: Walkers
E8000-E8002: Gait trainers

Canes are covered for members who are unable to safely ambulate without an assistive device.

- South Country does not require that the cane is needed in the home. It can be utilized exclusively within the community if needed for safety.
- South Country covers a cane for members who primarily use walkers or wheelchairs, but who require a cane in specific situations
- South Country defers to the prescribing and dispensing professionals regarding what kind of cane is required

Crutches are covered for members who are unable to safely ambulate without an assistive device.

- When dispensing articulating, spring assisted crutches, providers must maintain documentation as to why standard crutches will not meet the member's needs

- Rental of a crutch substitute (i.e. knee walker) is covered for members who are unable to safely use standard crutches, providers must maintain documentation as to why standard crutches will not meet the member's needs

Walkers are covered for members who are unable to safely ambulate without an assistive device.

- South Country does not require that the walker is needed in the home. It can be utilized exclusively within the community if needed for safety.
- South Country covers a walker for members who primarily use wheelchairs, but who require a walker in specific situations.
- A heavy-duty walker is covered if a member's weight, body size or stability makes a standard walker unsafe.
- Pediatric walkers should be billed with the most appropriate HCPCS code.
- A wheeled walker is assumed to include glide type brakes which raise the leg post of the walker off the ground when the patient is not pushing down on the frame. If dispensing a walker with hand brakes, providers may bill "brake attachment for wheeled walker" as a replacement for glide-type brakes. If dispensing a walker with hand brakes, providers may bill E0159 as a replacement for glide-type brakes.
- Bill Medicare only for replacement of original glide-type brakes. Medicare does not pay for hand brakes. For new walkers, if a member requires hand brakes, bill Medicare only for the walker and bill South Country for the hand brakes.
- Reverse walkers are considered medically necessary for members who cannot safely use a standard walker. Documentation must establish that the member's medical needs cannot be safely met using a standard walker, and that the requested walker is the least costly alternative to appropriately meet the member's needs. These do not have a specific HCPCS code; please bill E1399 (authorization is required for charge over $500).

*Billing for Walkers and Replacement Brakes when the Member has Medicare*

*Bill Medicare first for replacement hand brakes for walkers if the brakes originally dispensed with the walker are in need of repair and need to be replaced. When dispensing a new walker with hand brakes, bill Medicare first for the walker. Bill South Country for hand brakes as a replacement for the standard glide-type brakes, as Medicare does not pay for hand brakes.*

Gait trainers are covered with prior authorization for members who have the potential for therapeutic gait and have demonstrated the ability to use a gait trainer.

Documentation must include:

- Diagnosis, age, functional abilities
- Why less-costly alternatives have failed or were not appropriate
- Trial of gait trainer with specific device recommendations
- Location the gait trainer will be used and education provided to the caregiver who will oversee use
- Therapy program frequency and goals

Submit the appropriate HCPCS code for the requested gait trainer. Include a list of all accessories with documentation of medical necessity for each item added to the gait trainer.

Attach the manufacturer's invoice, a price list, or a quote from the manufacturer dated within three months of the authorization request. Clearly indicate each item being requested. Do not modify, alter or change the pricing documentation.

Gait trainers are reviewed as a complete package. The approved rate for purchase of a gait trainer will include all approved accessories.

A stander in combination with a gait trainer is typically not covered. If both a stander and a gait trainer are requested, prior authorization must include specific documentation of medical necessity which notes why one device alone will not meet the member's needs.

**Noncovered Services**

South Country does not cover the following:

- Powered walkers (E0152) as they are considered an item of convenience and substantive research is lacking
- Home modifications, including grab bars, wall rails, and portable or installed ramps
- White canes for the blind

## Diabetic Equipment & Supplies

South Country covers diabetic equipment and supplies for members with Type 1, Type 2 or gestational diabetes. Diabetic testing supplies are part of the Point of Sale Diabetic Testing Supply Program

Members with Medicare Part B must obtain diabetic testing supplies from a Medicare medical supplier or pharmacy. A list of South Country's diabetic testing supplies may be found at www.mnscha.org at the bottom of the list of member materials.

South Country follows the limits on diabetic equipment and supplies set in the MHCP Medical Supply Coverage Guide.

## Covered Services

**Blood Glucose Monitors**: For all blood glucose monitors, the member must be diabetic (Type 1, Type 2 or gestational), or have a diagnosis that requires regular monitoring of blood glucose levels. The pharmacy or medical supplier's office must keep a written physician's order stating the need to monitor blood glucose levels.

- Standard blood glucose meters
    - Roche is South Country's preferred manufacturer for Part B diabetic testing supplies (meters, test strips and lancets) when processing through pharmacy claims. Part B diabetic testing supplies from all other manufacturers require a Service Authorization. **This does not apply to medical claims.
    - For Medicaid members, South Country is required to cover the same diabetic testing products as Minnesota Health Care Programs (MHCP). See the MHCP Preferred Drug List for a list of covered products.
- Blood glucose monitor with integrated voice synthesizer (E2100) may be rented or purchased. Authorization is always required.
    - Blood glucose monitors with voice synthesizer are covered for members with a severe visual impairment. The visual impairment must be significant enough to make accurate use of a standard blood glucose monitor impossible. The member must be able to independently use the blood glucose monitor with voice synthesizer.
- Blood glucose monitor with integrated lancing/blood sample (E2101) may be rented or purchased. Authorization is always required.

- Blood glucose monitors with integrated lancing are covered for members with impairment of manual dexterity. The dexterity impairment must be significant enough to make accurate use of a standard blood glucose monitor impossible. The member must be able to independently use the blood glucose monitor with integrated lancing.

**Continuous Blood Glucose Monitoring**:

Code: E2102 and A4238 (adjunctive CGM), E2103 and A4239 (therapeutic CGM)

CGM systems may be obtained from a medical supply provider or pharmacy. Only CGM systems coded as E2102 and A4238 by the Medicare Contractor for Pricing, Data Analysis and Coding (PDAC) may be covered as adjunctive CGM systems. Only CGM systems coded as E2103 and A4239 by the PDAC may be covered as therapeutic CGM systems.

*Effective 4/1/2022: Therapeutic CGM systems (Freestyle Libre and Dexcom) must be obtained through the pharmacy benefit for Medicaid members (see below authorization requirements).

## Authorization Requirements

**South Country Medicaid Plans:** Therapeutic CGM systems must be obtained through the pharmacy benefit. Dexcom G6 and Freestyle Libre systems are formulary and do not require prior authorization. Adjunctive CGM systems are obtainable through a DME provider and do not require authorization.

**South Country Medicare Plans:** Authorization is not required for any CGM systems (can be obtained through the pharmacy or DME provider.

**Members with other primary insurance:** please follow the primary insurance plan processes for initial payment and submit any copays/coordination of benefits to South Country for payment.

## Adjunctive CGM systems

Adjunctive continuous glucose monitoring does not replace traditional home blood glucose monitoring for making treatment decisions but may be authorized as a warning or alert system for individuals with insulin-dependent diabetes and a history of severe hypoglycemia (less than 50 mg/dL) with unawareness due to age or cognitive function.

South Country allows for one monitor (code E2102) or one receiver (code E2102) every three years for adjunctive CGM systems, and one unit per month for the supplies and accessories (code A4238).

Adjunctive CGM systems must be coded based on Pricing, Data Analysis and Coding for Medicare, PDAC.

## Therapeutic CGM systems - must be obtained through the pharmacy benefit for Medicaid members when South Country is primary payer.

Therapeutic CGM systems replace traditional home blood glucose monitoring because treatment decisions can be made based on the CGM. Therapeutic CGM systems are considered medically necessary for insulin-dependent members with frequent adjustments to insulin dosing based on blood glucose test results.

Therapeutic CGM systems that are classified as Class III devices by the Food and Drug Administration (FDA) require daily calibration. Therapeutic CGM systems that are classified as Class II devices by the FDA do not require calibration. Class III receivers and supplies for Class III receivers must be billed with modifier KF. Class II receivers and supplies for Class II receivers must be billed without modifier KF.

Members with therapeutic CGM systems require infrequent traditional home blood glucose testing. The therapeutic CGM supply allowance (A4239) includes all supplies needed for use of the CGM system for one month, including CGM sensors, CGM transmitters, and equipment and supplies for calibration and necessary traditional home blood glucose testing. The receiver (E2103) is durable medical equipment and should last three years or more.

**Disposable Blood Glucose Monitor (A9275)**: Authorization is not required.

- Disposable blood glucose meters include any necessary test strips and calibration solution or chips
- Disposable blood glucose meters are limited to four (4) per calendar month
- Blood glucose test strips may not be billed within 30 days of disposable blood glucose meters
- Bill one (1) unit per meter with test strips. Submit a claim with an attachment that includes the name of the product dispensed and required documentation for manual pricing.

**Blood Glucose Test Strips (**obtained through the pharmacy):

South Country covers the same diabetic testing products as MHCP for South Country Medical Assistance (Medicaid) members. These products do not require prior authorization. All other blood glucose meters and strips will require prior authorization.

For South Country Medicare members, please see the South Country Website for a list of preferred diabetic supplies.

**Blood Ketone Test Strips (A4252)**: may be obtained from a medical supply provider or pharmacy. Member must have insulin-dependent diabetes or be on a medically supervised ketogenic diet for intractable seizures.

**Insulin Syringes (S8490)**: May be obtained from a medical supply provider or pharmacy.

**Ambulatory Insulin Infusion Pumps (E0784)**: Authorization is required.

Insulin infusion pumps are covered for eligible South Country members 12 years old or younger with type 1 diabetes, or for eligible South Country members over age 12 with diabetes who are beta cell autoantibody positive or have a documented fasting serum C-peptide level that is less than or equal to 110 percent of the lower limit of normal of the laboratory's measurement method. Members must meet the following criteria for coverage:

- Completion of a comprehensive diabetes education program
- On a program of at least three (3) injections of insulin per day, with frequent self-adjustments of dose, for at least six (6) months
- Documented self-testing an average of at least four (4) times per day
- Has one of the following:
    - Elevated glycosylated hemoglobin level of HbA1c greater than 7 percent
    - History of recurring hypoglycemia less than 60 mg/dL
    - Wide fluctuations in blood glucose before mealtime
    - Dawn phenomenon with fasting blood sugars often over 200 mg/dL
    - History of wide glycemic excursions
    - Otherwise unable to maintain optimal control

**External Ambulatory Insulin Infusion Systems (A9274):** Authorization is required**.**

External ambulatory infusion pumps may be obtained from a medical supply provider or pharmacy and must meet the following criteria:

- Members must meet the criteria for an ambulatory insulin infusion pump (above)
- Documentation submitted for authorization must address why an ambulatory insulin infusion pump is not meeting the member needs and why a tubeless option is required for medical necessity

## Enteral Nutritional Products and Related Supplies

Enteral nutritional products are covered for eligible South Country members who need nutritional supplementation and meet the enteral nutrition coverage requirements below.

Parenteral nutritional products are considered drugs; only a pharmacy may dispense these solutions.

Nasogastric tubes, gastrostomy, or jejunostomy tubes (feeding tubes), enteral supply kits, and enteral nutrition infusion pumps are supplies used to administer enteral nutritional products to individuals who are unable to take enteral nutritional products orally.

## Covered Services

*Enteral Nutrition Products*

Codes: B4149-B4162 (For these codes 100 calories = 1 unit), S9435 (Medical food for inborn errors of metabolism)

Only products classified by Medicare's Pricing, Data Analysis and Coding (PDAC) contractor are covered refer to the DMECS Product Classification List if you are unsure what HCPCS code to use. Up to 1,050 units per month of enteral nutrition is covered for members who meet medical criteria.

Documentation must support the need for the number of units requested.

Authorization is required for all enteral nutrition after one (1) month of dispensing with the exception of tube-feeding diagnosis and oral enteral nutrition for treatment of phenylketonuria (PKU), hyperlysinemia, or maple syrup urine disease (MSUD).

**Nutrition for Members with Feeding Tubes:**

Enteral nutritional products are medically necessary for members with feeding tubes. Up to 1,050 units per month is covered (without authorization) for members requiring tube feeding; diagnosis of tube-feeding must be on the claim. Authorization is required if exceeding 1,050 units per month.

**Oral Enteral Nutrition:**

Enteral nutritional products are medically necessary for members with many inborn errors of metabolism. Oral enteral nutritional products manufactured for the treatment of PKU, hyperlysinemia or MSUD are covered without authorization if the member has the associated diagnosis. Oral enteral nutritional products manufactured for the treatment of other inborn errors of metabolism are covered with authorization if the member has the associated diagnosis.

**Oral Nutrition for Members with Allergies**

Enteral nutritional products may be medically necessary for members with a combined allergy to cow's milk, human milk, and soy milk. Oral enteral nutritional products are covered with authorization if the member has a combined allergy to cow's milk, human milk, and soy, which is supported by appropriate medical testing and documentation. It is expected that the need for

oral enteral nutritional products will decrease as the member ages and additional foods are added to the diet. If the member gets less than 75 percent of daily nutrition from a nutritionally complete enteral nutrition product, a nutritionist, a speech-language pathologist, or a physician must write a detailed plan to decrease dependence on the supplement.

**Nutrition for pediatric members**

Enteral nutrition products are covered when an eligible provider has diagnosed and documented significant risk factors for malnutrition.

Potential diagnoses COULD include (but are not limited to):

- Intrauterine Growth Restriction (IUGR)
- Prematurity (less than 37 weeks gestational age)
- Very low birth weight (less than 1,500 grams or 3.3 pounds)
- Feeding intolerance
- Immunologic deficiency
- Congenital anomalies
- High risk of necrotizing enterocolitis
- Sepsis
- Hypoglycemia
- Impaired GI Function
- Sensory issues related to medical conditions or maternal drug or alcohol use
- Metabolic Conditions
- Kidney, heart, pulmonary diseases
- Malabsorption
- Combined allergy to cow's milk, soy milk, and human milk

**Oral Nutrition for Malabsorption or Malnutrition**

Enteral nutritional products may be medically necessary for medical conditions related to malabsorption or malnutrition. The condition must have resulted in weight loss or difficulty maintaining a healthy weight. Medical necessity for enteral nutrition must demonstrate that if the member were left untreated by oral enteral nutrition, they would risk detrimental effects to their health. Authorization is required.

- Examples of a condition CAN include:
    - A mechanical inability to chew or swallow solid, pureed or blenderized foods
    - A malabsorption problem due to disease or infection
    - An oral aversion which significantly limits the ability to get adequate nutrients
    - Weaning from TPN or feeding tube
    - Inborn errors of metabolism

**Oral Nutrition for Members with Non-Healing Wounds**

High protein enteral nutritional products are covered for up to six (6) months with authorization if the member has one or more wounds that have not responded to treatment for at least 30 days, and a dietary assessment has determined that the member has a nutritional deficit which may

be impeding healing. Documentation must include a nutritional plan written by a nutritionist, physician or other health care provider.

## Supplies for Enteral or Parenteral Nutrition

### Enteral Feeding Supply Kits

Codes: B4034-B4036, B4148

Thirty-one (31) enteral feeding supply kits per month are medically necessary for members receiving enteral nutrition through a feeding tube. The feeding supply kit must correspond with the method of administration and must contain all supplies necessary for feeding using that method of administration for one (1) day. For members who use the same or a different method of administration at work or school, up to 20 additional enteral feeding supply kits per month are covered. Documentation on file at the provider's office must support the need for additional feeding supply kits. South Country will cover only 51 enteral feeding supply kits per month without authorization.

### Feeding Tubes

Codes: B4081-B4088

Most people who use a feeding tube require only one (1) tube every two (2) to three (3) months. Up to two (2) tubes per month may be medically necessary for people with more than one (1) tube site or for those with highly acidic GI tracts. Low-profile feeding tubes are medically necessary for infants, children, and adults with cognitive impairments who are at risk of dislodging a standard feeding tube or those determined by a physician to need this type of feeding tube. The provider must maintain documentation to support the quantity and type of feeding tubes supplied.

### Feeding Pumps

Codes: B9002-B9006, E0791 (Enteral/Parenteral Infusion Pumps)

A parenteral infusion pump is medically necessary for members for whom parenteral nutrition is required. An enteral infusion pump is medically necessary for members with feeding tubes for whom gravity or syringe feeding is not appropriate. One pump is covered every five (5) years. Consider the member's current and expected lifestyle when selecting a stationary versus portable pump

### Supplies not otherwise classified

Codes: B9998–B9999 (For Enteral/Parenteral Supplies)

Up to 31 extension sets per month are medically necessary for members with low-profile feeding tubes. Up to thirty 35 ml or 60 ml syringes per month are medically necessary for people receiving medication through a feeding tube. One carrying case per year is covered for members with portable feeding pumps.

### In-line cartridge containing digestive enzymes

Code: B4105

Authorization is always required. Member must meet the criteria for enteral feeding and have a diagnosis of exocrine pancreatic insufficiency or fat malabsorption as shown in clinical documentation (not just a letter of medical necessity). Coverage is indicated for use with members ages 2 years and older who require the delivery of absorbable fatty acids and monoglycerides. This device has 510(k) clearance by the FDA, and therefore does not need a full review for safety and effectiveness.

**Pasteurized Donor Human Milk**

Code: T2101 (For this code, one ounce = one unit)

Pasteurized donor human milk is covered for eligible South Country members from birth up to 12 months old who meet nutrition criteria for pediatric members.

Up to 32 units per day are covered for members who meet criteria. Additional units may be acquired through an approved prior authorization.

Donor human milk must be obtained from a milk bank and adhere to quality guidelines consistent with the Human Milk Bank Association of North America. When receiving donor human milk, the milk bank screens and approves all donor mothers and monitors and tests all donated milk. Pasteurization removes bacteria and other harmful organisms from the donor human milk. The entire process ensures the milk is completely safe to be consumed by infants in need.

The provider must address the benefits and risks of using donor human milk such as the effects of pasteurization, immune properties, nutrients, and growth factors to the parent. The provider must also address the milk banking process including donor screening, pasteurization, milk storage, and transport of the milk. The physician may procure this information from the donor milk bank.

**Documentation requirements for donor human milk**

Documentation must include the following:

- The ordering physician has documented medical necessity, including applicable diagnoses and length of need
- The provider must discuss with the infant's parent or guardian and document in the medical record the benefits and risks of donor human milk and other feeding alternatives

**Authorization requirements for donor human milk**

Authorization is not required

## Food Thickeners

Code: B4100 (For this code, 1 ounce = 1 unit)

Food thickeners (Simply Thick, Thicken-It) may be medically necessary for individuals at risk of choking or aspirating liquids. Authorization is always required for food thickener. A member must have a history of aspiration to qualify.

Authorization request must include the following:

- A swallow study (or a swallow evaluation) completed by a speech and language pathologist
- A plan of care
- A plan for follow-up at least annually

Requests for thickeners for members under the age of 1 must include gestational age at birth.

## Electrolyte-Containing Fluids

Codes B4102 and B4103

Electrolyte-containing fluids may be medically necessary for medical conditions related to malabsorption or malnutrition. Authorization is required.

**Authorization requests must include all of the following:**

- The ordering physician has documented medical necessity, including applicable diagnoses and length of need. Documentation must demonstrate that the member cannot absorb adequate nutrients or requires fluids. Fluids for members only requiring electrolytes are not covered.
- The provider must discuss with the member and document in the medical record the benefits of these fluids and why other nutritional products do not satisfy the needs of the member.

**Amino-Acid Based Elemental Formula**

Amino-acid based elemental formula is covered for medically necessary conditions including, but not limited to:

- Cystic fibrosis
- Metabolic and malabsorption disorders for amino acids, organic acids, and fatty acids
- Immunoglobulin E mediated allergies to food proteins
- Foot protein-induced enterocolitis syndrome
- Eosinophilic esophagitis
- Eosinophilic gastroenteritis
- Eosinophilic colitis
- Mast cell activation syndrome

## Noncovered Services

South Country does not cover the following:

- Nutritional products for healthy newborns
- Nutritional products for people living in LTC facilities (included in the per diem)
- Nutritional products for which the need is nutritional rather than medical or is related to an unwillingness to consume solid or pureed foods
- Nutritional products that are requested as a convenient alternative to preparing or consuming regular foods
- Nutritional products for which coverage is requested because of an inability to afford regular foods or supplements (refer member to county human services)
- Food thickeners for infants under age one who were born at less than 37 weeks gestation due to FDA caution
- SimplyThick brand thickener for infants under age one (1) regardless of gestational age at birth is not covered due to FDA caution
- Energy drinks and sport shakes

## Billing

*Enteral Nutrition Products When Authorization is Not Required:*

A valid diagnosis of PKU, hyperlysinemia, MSUD, or tube-feeding must be on the claim or the claim will deny for needing authorization.

*Enteral Nutrition Products When Authorization is Required:*

HCPCS codes and modifiers on submitted claims must be identical to the approved authorization to prevent a denial.

*All Claims for Enteral Nutritional Products:*

Enter the following information on all claims for enteral nutritional products:

- Modifier BO for members taking their enteral nutrition orally
- A valid diagnosis code to the greatest specificity indicating the medical condition that requires the product
- The date of service (DOS) is the date the product was dispensed to the member. Do not use a date span.
- The appropriate HCPCS code for the product dispensed
- The appropriate number of units dispensed (1 unit = 100 calories)
- The product name in the comments/description field when product-specific pricing is requested

***Include pricing documentation with claims for products that are listed as "*By-Report" on the Enteral Nutrition Price List B4149 – B4155 and B4157 – B4162.*

## Breast Pumps

Codes: E0602, E0603, E0604

South Country covers breast pumps when ordered by a physician, certified nurse midwife or nurse practitioner for any nursing mother experiencing separation from her infant because of work, school, illness or any other medical reason.

E0602, manual breast pumps and E0603, personal electric breast pumps, are purchase only. Inform members that breast pumps are a personal care item that cannot be shared by mothers and can be used for future pregnancies. The purchase of an electric breast pump is limited to one (1) per pregnancy. Bill with modifier NU.

E0604, heavy-duty hospital grade electric breast pumps are rental only. Bill with modifier RR. Bill accessory kits for E0604 breast pumps with HCPCS code A9999.

The rental period of heavy-duty hospital grade electric breast pumps is three months. Additional months require prior authorization for each additional 30 days.

If a member has a medical necessity for a heavy-duty hospital grade electric breast pump beyond the initial three-month rental period, providers must request authorization for the additional month of rental.

Breast pumps are a personal care item that cannot be shared by mothers. Breast pumps can be used for future pregnancies. South Country members are allowed one pump per pregnancy without authorization.

## Authorization

Authorization is required for rentals of hospital-grade pumps beyond the initial three months and for pump supplies when the quantity limit is exceeded.

Authorization is not required for manual or electric pumps.

## Noncovered Services

South Country does not cover the following:

- Clothing or other products that permit hands-free pump operation

- Nursing bras, bra pads, breast shells, nipple shields, and other similar products
- Replacement parts when the original part of the breast pump is functional
- Travel bags and other accessories for transporting breast pumps and supplies

## Hearing Aids

South Country covers the following hearing aids services to eligible members:

- Dispensing
- Hearing aid checks and programming
- Hearing aid repairs
- Hearing aids (once every 3 years)
- Replacement parts and accessories necessary for the function of the hearing aid
- Batteries
- Chargers for rechargeable hearing aids
- Ear impressions
- Ear molds (not disposable) replaced about every three months

Hearing aids must be purchased through a manufacturer listed on the DHS Hearing Aid Volume Purchase Contract and include the model number and brand name of the hearing aid on all claim submissions. Hearing aid service providers are not separately reimbursed for audiologic evaluations, hearing aid exams and selection, or home visits.

### Trial Period

The trial period for a new hearing aid(s) is 90 days. Hearing aids obtained under the DHS Volume Purchase Contract that are not satisfactory to the user may be returned to the manufacturer within 90 days after the dispensing date, but no sooner than 30 days. The trial period consists of consecutive days beginning the day the hearing aid is provided to the member and must extend at least 30 days, but no more than 90 days. The hearing aid service provider must inform the member of the beginning and ending dates of the trial period and refer the member to the prescribing audiologist when the aid cannot be adjusted to the member's satisfaction. If the audiologist prescribes a hearing aid to replace the unsatisfactory aid, the hearing aid service provider must order the prescribed replacement aid.

## Replacement

South Country covers one (1) hearing aid or set of binaural hearing aids within a period of three years for an eligible recipient. If hearing aids must be replaced due to change in hearing, or hearing aid loss, theft, or irreparable damage, the provider must request authorization for a new aid. South Country considers the recipient's physical or mental impairment in determining whether circumstances were beyond the recipient's control if the aid is lost or broken and will only approve a replacement in those cases.

Always verify recipient eligibility and prior receipt of a hearing aid(s) before dispensing or requesting an authorization.

## Hearing Aids Repair

Repairs, including re-casing, re-makes and shell modifications are South Country covered services.

- Hearing aid repair over $400 requires authorization.
- South Country does not cover repairs or the cost of returning the aid to the manufacturer while the aid is under warranty. All claims for hearing aid repairs must include the hearing aid expiration warranty date. To verify the hearing aid warranty has expired, hearing aid service providers must obtain the purchase date and purchase warranty expiration date from the manufacturer, and submit with hearing aid repair claims.
- All hearing aid repairs are required to have a minimum six (6) months warranty, whether sent to the manufacturer or performed by the hearing aid service provider. Most manufacturers on the hearing aid volume purchase contract provide a one-year repair warranty. Providers are responsible to check the manufacturer's repair warranty information listed on the contract.
- The hearing aid repair rate is determined by the hearing aid volume purchase contract under which the aid was purchased. The hearing aid volume purchase contracts require manufacturers to honor the contracted repair rate for the life of the hearing aid following the expiration of the contract.
- For non-contracted hearing aids, parts and labor (including manufacturer fees) constitute one repair charge.

Authorization is required for a new hearing aid when hearing aids must be replaced due to change in hearing, or hearing aid loss, theft, or irreparable damage.

South Country follows MHCP guidelines for documentation requirements and approval criteria. Please refer to the MHCP Provider Manual for additional information.

## Systems Other Than Personal Hearing Aids

Non-Personal Hearing Aids

When systems such as FM systems, vibrotactile devices, cochlear implants or personal communicators (e.g., pocket talkers) are requested, justification is needed, just as for non-contract aids. The audiologist must also address each of the following points:

- Why the person cannot use personal hearing aids (e.g., person's unique inabilities to use auditory information provided via hearing aids)
- Documentation of expectation of person's ability to recognize and use vibrotactile information, specific to vibrotactile instruments (e.g., response to environmental vibratory information or low frequency bone conducted vibratory information).

## Cochlear Implants

A cochlear implant is a small electronic device that may help provide hearing to individuals who have moderate to profound hearing loss and would receive little or no benefits from hearing aids. The implant consists of an external portion that sits behind the ear and a second portion that is surgically placed under the skin.

**Authorization:** All cochlear implant purchases and replacement devices require authorization.

Authorization requests must include the following:

- Diagnosis with the appropriate ICD-10 code
- Medical history pertaining to the cochlear implant
- Reports:
    - Audiology: including the final report from any pre-cochlear implant hearing training (children)

- Speech: including test results of age-appropriate closed-set work identification tasks and other tests
- Psychology: including a clear statement as to the individual's cognitive ability to participate in the post-surgical rehabilitation program

### HCPCS codes requiring authorization:

L8614: Cochlear device, includes all internal and external components

L8619: Cochlear implant, external speech processor and controller, integrated system, replacement

L8627: Cochlear implant, external speech processor, component, replacement

L8628: Cochlear implant, external controller component, replacement

L8629: Transmitting coil and cable, integrated, for use with cochlear implant device, replacement

## Bone-anchored Hearing Aids (BAHA)

A bone-anchored hearing aid (BAHA) is a type of hearing aid that attaches to the bone behind the ear. The device transmits sound vibrations directly to the inner ear through the skull and bypasses the middle ear. It is primarily suited for people who have conductive hearing losses, unilateral hearing loss, single-sided deafness and people with mixed hearing losses who cannot wear in the ear or behind the ear hearing aids.

Nonsurgical devices are worn on a headband or attached directly to the skin with adhesive. Surgical devices include an internal component and an external speech processor. BAHAs are also referred to as auditory osseointegrated devices.

South Country covers U.S. Food and Drug Administration approved BAHA devices which must be dispensed according to their approval guidelines.

### Authorization

Device repairs over $400 require authorization. Replacement of a BAHA and its external components is considered medically necessary when the existing device cannot be repaired or when replacement is required because a change in the member's condition makes the present unit non-functional and improvement is expected with a replacement unit.

Certain BAHA devices require authorization per the list below.

### HCPCS codes requiring authorization:

L8690: Auditory osseointegrated device, includes all internal and external components

L8691: Auditory osseointegrated device, external sound processor, excludes transducer/actuator, replacement only, each

L8692: Auditory osseointegrated device, external sound processor, used without osseointegration, audio body worn, includes headband or other means of external attachment

L8693: Auditory osseointegrated device abutment, any length, replacement only

## Hospital Beds

Hospital beds are used for positioning patients and are covered for eligible South Country members who meet the medical necessity criteria. Quantity limits and thresholds apply to all members.

## Covered Services

### Fixed height manual hospital beds

Codes: E0250, E0251, E0290, E0291 - Authorization is not required but providers must follow documentation requirements.

Covered for members with one of the following:

- A medical condition that requires positioning of the body not feasible in an ordinary bed, where pillows or wedges do not meet the member's needs
- Protection needed from serious injury not feasible in an ordinary bed, where pillows or wedges do not meet the member's needs.
- A medical condition that requires special attachments, such as traction equipment, that cannot be fixed and used on an ordinary bed
- A medical condition that requires the head of the bed to be elevated more than 30 degrees, where pillows or wedges do not meet the member's needs

### Variable height manual hospital beds

Codes: E0255, E0256, E0292, E0293 - Authorization is not required but providers must follow documentation requirements.

Covered for members who meet criteria for a fixed height manual hospital bed and require one of the following criteria:

- A bed height different than a fixed height hospital bed to permit transfers in or out of the bed
- A change of bed height to enable caregivers(s) to assist with member care

### Semi-electric hospital beds

Codes: E0260, E0261, E0294, E0295 - Authorization is always required.

Covered for members who meet criteria for a fixed height manual hospital bed and require one of the following criteria:

- Frequent changes in body position to alleviate pain or address a medical condition
- Immediate changes in body position to alleviate pain or address a medical condition

### Total electric hospital beds

Codes: E0265, E0266, E0296, E0297 - Authorization is always required.

Covered for members who meet criteria for a hospital bed and both of the following criteria:

- Require a change of bed height at least once per day to allow a caregiver to assist with the member's care
- The caregiver is unable to change the bed height manually, but is able to assist with all necessary cares in bed

### Bariatric, extra-heavy duty, extra wide hospital beds

Codes: E0301 – E0302: Bed without a mattress; E0303 – E0304: Bed with a mattress - Authorization is always required.

Covered for members who meet criteria for the type of hospital bed requested (manual, semi-electric, total electric) and whose weight is within the capacity limits of the requested bed.

Coverage may be considered for members with daily seizure activity, uncontrolled movement disorder, or a medically necessary condition putting the member at significant risk for injury in a

standard bed. Requests for a manual, semi-electric, or total electric bed must meet the criteria for the type of hospital bed requested.

**Pediatric hospital beds**

Codes: E0328 (manual) - E0329 (electric or semi-electric) - Authorization is required for E0329

Covered for members who meet criteria for a manual, semi-electric or total electric hospital bed and who have medical needs best met by a pediatric-sized bed with footboard and side rails up to 24 inches above the spring. The bed must be reasonably expected to meet the member's needs for at least five years.

**Enclosed Beds**

Codes: E0316 (enclosure), E0300 (hospital grade enclosed crib), E1399 (Enclosed bed manufactured as a unit) - Authorization is always required.

Enclosed beds are considered medically necessary and the least costly alternative only in the most extreme conditions due to the restrictive nature of the beds and the confinement they entail. Enclosed beds may be fully or partially enclosed. All requests for enclosed beds and accessories require an evaluation from an occupational therapist or a behavioral therapist that works directly with the member.

Based on advice from medical consultants, an enclosed bed is considered medically necessary when the member is cognitively impaired and mobile if his or her unrestricted mobility demonstrates significant risk for serious injury, not just a possibility of injury. Even then, it must be shown that other, less costly methods have been attempted and have failed to effectively address the problem.

Generally, such confinement is not medically necessary nor the least costly way of managing seizures or behaviors such as head banging, rocking, etc. Issues of sensory deprivation and the potential for overuse must also be addressed.

Coverage will be considered for members who have documented evidence of unsafe mobility (climbing out of bed and moving around the home, not just standing at the side of the bed).

The member must meet the following criteria:

- Diagnosis of one of the following:
    - Brain injury
    - Moderate to severe cerebral palsy
    - Seizure disorder with daily seizure activity
    - Developmental disability
    - Severe behavioral disorder
- Documentation of a specific risk from unrestricted mobility including:
    - Tonic-clonic type seizures
    - Uncontrolled perpetual movement related to diagnosis
    - Self-injurious behavior

Documentation must show that you have tried or considered, and rejected less costly alternatives, including any of the following (not all-inclusive):

- Padding around a regular or hospital bed
- Placing the mattress on the floor
- Medications to address seizures or behaviors

- Behavior modification strategies
- Helmets for head banging
- Removing safety hazards from the member's bedroom and using a child protection device on the doorknob
- Baby monitors to listen to the member's activity

The real need is to proactively address with intervention the underlying medical or behavioral issues that give rise to the risk of harm.

**Enclosed bed options and accessories**
Enclosed bed options and accessories are covered if they are medically necessary and address a specific medical need of the member. All requested accessories require an evaluation from an occupational therapist or a behavioral therapist that works directly with the member. The following list of options and accessories is not all-inclusive; many additional options and accessories may be covered if medically necessary.

- High-side door system: Covered for members that have documented of being able to stand taller than or climb over the standard size side door system.
- Gel-infused mattress: Covered for members that have a documented diagnosis of dysautonomia or a condition that is exacerbated by increased temperatures.
- Padding on inside of bed: Covered for members that have a documented diagnosis of seizures or uncontrolled movement disorders.
- Semi-electric or electric articulation: Covered for members that have a documented medical reason why the caregiver is unable to use a manually adjustable bed.

**Replacement mattress / bed rails**

Codes: E0271-E0272 (mattress), E0305. E0310 (bed rails)

South Country covers replacement mattress and bed rails when used with a member-owned hospital bed.

When replacing a mattress on a member-owned heavy duty or bariatric bed, include "bariatric mattress for member-owned bariatric bed" and the authorization number or purchase date of the bed, if known, in the Claim Notes field on the Claim Information tab or in the line item Notes field on the Services tab.

**Rocking Bed (E0462)**

Authorization is always required.

Provide documentation regarding the medical condition and how this type of bed will assist the member.

Hospital Bed, Institutionalized Type Including Oscillating, Circulating, and Stryker Frame (E0270)

This is usually not a covered item in the member's benefit set. If the physician can indicate medical need for this type of bed, a request for service authorization should be initiated with documentation of the medical need. South Country will determine if an approval outside of the member's benefit set is appropriate for that member.

## Non-Covered Services

- Beds that are typically sold as furniture, including adjustable beds that are not manufactured as DME

- Orthopedic mattresses
- Waterbeds
- Oscillating and lounge beds
- Bed tables and other bed accessories
- Bedding or linens, including hypoallergenic bedding
- Heat and massage pads
- Enclosed beds for members with one-on-one caregiver supervision 24 hours per day
- The following accessories for enclosed beds:
    - Technology hub
    - Extra windows
    - Mattress protector
    - Vibration pad
    - Dual multi-side doors

### Billing

- Codes E0250, E0255, E0260, E0265, E0303, E0304, E0328, and E0329 include the bed, bed rails, and mattress. Do not bill rails (E0305, E0310) or mattress (E0271, E0272) within 180 days of billing these codes.
- Codes E0251, E0256, E0261, E0266, E0301, and E0302 include the bed and bed rails. Do not bill rails (E0305, E0310) within 180 days of bill these codes.
- Codes E0290, E0292, E0294, and E0296 include the bed and mattress. Do not bill mattress (E0271, E0272) within 180 days of billing these codes.
- If the member has Medicare, any items for which Medicare denies payment must meet South Country's coverage and authorization requirements
- Hospital beds are expected to serve the member for at least five years. If a device is stolen or damaged beyond repair, a replacement device may be covered with authorization.

## Incontinence Products

South Country covers a specified quantity of disposable incontinence products to eligible members with the proper diagnosis and documentation of medical necessity. Quantity limits and thresholds apply – see MHCP Provider Manual for limits.

### Covered Services

Incontinence products and services covered are:

- disposable briefs or diapers
- protective underwear or pull-on
- liners
- shields
- guards

- pads
- belted undergarments
- under pads

HCPCS Codes: T4521–T4535, T4541–T4544

Any youth or pediatric-sized product and any underpad can be covered when medically necessary. Adult-sized disposable briefs, diapers, protective underwear, pull-ons, liners, shields, guards and pads are covered if they are listed on the Incontinence Product List (PDF).

Incontinence products for members under age four (4) requires authorization. Documentation must include a medical condition or diagnosis of excessive urine or fecal output requiring more than 10 briefs or diapers per day.

## Coverage Criteria

The member must have a diagnosis of an underlying medical condition that involves loss of bladder or bowel control to be eligible for covered incontinence products. Some incontinence products have specific criteria as follows:

- For protective underwear or pull-on: The member must be toilet training or have light or infrequent incontinence
- Underpads: may be appropriate for other diagnosis not related to incontinence, such as wounds with heavy fluid excretion.

## Orthopedic and Therapeutic Footwear

Therapeutic footwear is used to prevent diabetic ulcers. Orthopedic footwear is used by people with structural conditions of the foot. Therapeutic and Orthopedic footwear are covered by South Country for eligible members who meet medical criteria. Quantity limits and thresholds apply to all members.

Orthopedic/therapeutic shoes, modifications, and inserts must be prescribed by a podiatrist or physician knowledgeable in the fitting of orthopedic/diabetic shoes, and inserts.

All shoes, modifications and inserts must be fitted and furnished by a qualified individual such as a podiatrist, pedorthist, orthotist or prosthetist.

## Covered Services

### Therapeutic Shoes, Modifications and Inserts for People with Diabetes

Codes: A5500-A5501 (therapeutic shoes), A5503-A5507 (modifications to therapeutic shoes), A5510-A5513, K0903 (inserts for therapeutic shoes)

Custom-made or stock therapeutic shoes and modifications to therapeutic shoes are covered for South Country members with diagnosed diabetes and one or more of the following conditions:

- Previous amputation of the other foot, or part of either foot
- History of foot ulceration of either foot
- History of pre-ulcerative calluses of either foot
- Peripheral neuropathy of either foot
- Foot deformity of either foot
- Poor circulation of either foot

Inserts for therapeutic shoes, whether custom-made or stock, are covered only when the member has covered therapeutic shoes.

Two (2) pairs of therapeutic shoes, three (3) pairs of inserts (A5512, A5513, K0903) and two (2) pairs of inserts (A5510) are covered without authorization in a calendar year. They can be dispensed at the same time or at different times.

South Country follows the coding guidelines for therapeutic shoes, modifications and inserts that are found in the Medicare Local Coverage Article for Therapeutic Shoes for Persons with Diabetes for CMS DME MAC contractor for the state of Minnesota.

**Orthopedic Shoes and Inserts**

Authorization is always required for orthopedic shoes.

If orthopedic shoes are approved with authorization, the inserts do not require authorization for up to three (3) pairs per year. If more than three (3) pairs of inserts are needed in a year, authorization is required.

Codes: L3000-L3031 (custom inserts), L3040-L3060 (premolded, removable arch supports), L3070-L3100 (nonremovable arch supports), L3140-L3150 (abduction and rotation bars), L3224-L3253 (orthopedic footwear), L3300 – L3595 (additions and modifications to orthopedic shoes), L3600-L3640 (transfer of orthotic), L3649

South Country covers custom-made orthopedic shoes, modifications, and inserts when the shoe is an integral part of a leg brace, or for members with one or more of the following medical conditions:

- Foot deformity accompanied by pain
- Plantar fasciitis
- Calcaneal bursitis (acute or chronic)
- Calcaneal spurs
- Inflammatory conditions such as submetatarsal bursitis, synovial cyst or plantar fascial fibromatosis
- Medial osteoarthritis of the knee
- Musculoskeletal or arthropathic deformities
- Neurologically impaired feet
- Vascular conditions
- Hallus valgus deformities in children

South Country covers stock orthopedic shoes only if the shoes are an integral part of a covered leg brace and if they are medically necessary for the proper functioning of the leg brace. Stock inserts are only covered for use in covered orthopedic shoes.

Foot Pressure Off-Loading Device (A9283)

A foot pressure off-loading device is covered for pressure reduction for existing pressure ulcers on the foot. No authorization is needed for a foot pressure offloading device if the provider is contracted.

## Noncovered Services

South Country does not cover the following:

- A prosthetic or orthotic device for which Medicare has denied the claim as not medically necessary
- A device whose primary purpose is to serve as a convenience to a person caring for the member
- A device that serves to address social and environmental factors and that does not directly address the member's physical or mental health
- Deluxe features of therapeutic shoes
- A device that is supplied to the member by the physician who prescribed the device or by a provider who is an affiliate of the physician who prescribed the device

## Orthotics and Prosthetics

Orthotic and prosthetic devices are used to support weak body parts, replace body parts, or restore ambulation.

Orthotic and prosthetics devices are covered for all eligible South Country members.

## Covered Services

South Country covers orthotic and prosthetic devices, supplies, and services that are medically necessary and prescribed by a physician or licensed health care prescriber who has authority in Minnesota to prescribe orthoses and prostheses, including devices customized to the member's needs. South Country covers an additional orthotic and prosthetic device for all members for purposes of bathing or showering. For eligible members, South Country also covers an orthotic and prosthetic device for purposes of performing physical activities including, but not limited to, running, biking, swimming, and maximizing the enrollee's limb function. Devices for purposes of bathing or showering do not require prior authorization unless the member already has devices for both everyday use and recreation. Prior authorization is required for devices for recreational purposes.

South Country follows CMS's Medically Unlikely Edits (MUE) for orthotics. If CMS has not published an MUE, South Country has established quantity limits. South Country will not pay claims for more units per line than are allowed by the MUE. When dispensing bilateral orthotics where more units are required than are allowed by the MUE or limit, the units must be billed on different lines, using modifiers NU RT and NU LT as appropriate.

When providing orthotics and prosthetics, providers must:

- Provide the product that is specified by the treating physician; and
- Ensure the treating physician's medical record justifies the need for the type of device; and
- Only bill for the HCPCS code that accurately reflects both the type of device and appropriate level of fitting; and
- Have detailed documentation in the record justifying the HCPCS code selected.

<u>Orthotics for the spine</u>

Codes: L0112-L1499

An orthotic for the spine is considered medically necessary:

- To facilitate healing of the spine or related soft tissues
- To reduce pain by restricting mobility
- To support weak spinal muscles or a deformed spine

- To treat scoliosis

Orthotics for the spine are covered without authorization when medically necessary with the following exception: billed charges exceeding $3000 (per claim) require prior authorization.

Orthotics for the hip

Codes: L1600 – L1755, L2040 – L2090

An orthotic for the hip is considered medically necessary

- To stabilize the hip
- To correct and maintain hip abduction

One (1) orthotic for the hip is covered per calendar year without authorization when medically necessary.

Lower limb orthotics

Codes: L1810 – L2038, L2106 – L2999, L4350 – L4631

A lower limb orthotic is considered medically necessary:

- For treatment of contractures
- To immobilize a limb to promote healing
- To provide support and stability during ambulation

Four (4) lower limb orthotics (two (2) sets of bilateral orthotics) are covered per calendar year without authorization when medically necessary with the following exceptions:

- Authorization is required for the third or subsequent set of lower limb orthotics in any calendar year.
- Billed charges (per claim) exceed $3000

Upper limb orthotics

Codes: L3650 – L3999

An upper extremity orthotic is considered medically necessary:

- To immobilize an extremity to promote healing
- For treatment of contractures
- To provide support and stability during activities of daily living

Four (4) upper extremity orthotics (two (2) sets of bilateral orthotics) are covered per calendar year without authorization when medically necessary with the following exceptions:

- Authorization is required for the third or subsequent set of upper extremity orthotics in any calendar year.
- Billed charges (per claim) exceed $3000.

**Lower Limb Prosthetics**

Codes: L5000-L5999 (authorization required when billed charges exceed $3000)

**Evaluation and Management**

Evaluation of the member's functional ability is required. For members with existing prostheses, for whom a similar replacement is requested, evaluation can be based on the member's history and current condition. For members for whom a first prosthesis is requested or for whom a significantly different prosthetic is requested, evaluation must be based on clinical observation.

Evaluations must be performed by a professional certified by the American Board of Certification in Orthotics and Prosthetics, or the Board of Certification in Orthotics and Prosthetics or a professional who has similar training or expertise.

**Medical records must include:**

- Reason for amputation
- Date of amputation
- Status of current limb
- Description of prosthetic being provided
- Which activities of daily living are affected and how they are impacted
- Functional capabilities before and after amputation
- Functional level (level 0-4)

*Use the MHCP functional levels in the evaluation. Provide specific information about the member's ambulation history, performance, and activities of daily living to support assignment of an individual to a functional level.*

**Feet and Ankles**

- A power-assist ankle-foot or ankle system (L5969) or multiaxial ankle with swing-phase active dorsiflexion feature (L5968) may be medically necessary for members whose functional level is 3 or above.
- An external keel SACH foot (L5970) or single-axis ankle or foot (L5974) may be medically necessary for members whose functional level is 1 or above.
- A flexible-keel foot (L5972) or multi-axial ankle/foot (L5978) may be medically necessary for members whose functional level is 2 or above.
- A microprocessor-controlled ankle foot system (L5973), energy-storing foot (L5976), dynamic response foot with multi-axial ankle (L5979), flex-foot system (L5980), flex-walk system of equal (L5981), or shank-foot system with vertical loading pylon (L5987) may be medically necessary for members when one of the following criteria is met:
    - The member's functional level is 3 or above; or,
    - The member's functional level is 2; and,
        - Meets the functional level 2 coverage criteria for a fluid, pneumatic, or electronic/microprocessor control addition for a prosthetic knee; and,
        - A higher-level (that is, functional level 3) foot is required for the safe and proper use of the prescribed knee system.
- An axial rotation ankle unit (L5982-L5986) may be medically necessary for members whose functional level is 2 or above.

**Knees**

- A fluid or pneumatic knee unit (L5610, L5613, L5614, L5615, L5722-L5780, L5814, L5822-L5841) or control addition, fluid (L5848), or electronic/microprocessor (L5856-L5858) may be medically necessary for members whose functional level is 3 or above.
- A fluid or pneumatic knee unit (L5610, L5613, L5614, L5615, L5722-L5780, L5814, L5822-L5841) or control addition, fluid (L5848), or electronic/microprocessor (L5856-L5858) may be medically necessary for members whose functional level is 2 or above when all of the following criteria are met:

- The member has had a clinical evaluation to determine their functional level; and,
- Documentation in the medical record outlines the rationale for selection of a fluid, pneumatic, or electronic/microprocessor-controlled knee, including how the selected knee will:
    - Improve the member's functional health outcomes (for example, fall-reduction, injury prevention, lower energy expenditure); and,
    - Help the member accomplish their ADLs; and,
- Lower-level knee systems (for example, knee systems which exclude use of fluid, pneumatic, or microprocessor) have been considered and ruled out based on the member's specific functional and medical needs.
- An electronic/microprocessor-controlled knee system (L5856, L5857, or L5858 plus associated components) may be medically necessary for members whose functional level is 2 or above when all of the following criteria are met:
    - The electronic/microprocessor knee is indicated for functional level 2; and,
    - The electronic/microprocessor knee has integrated technology that allows the knee to detect when the user trips or stumbles and can automatically adjust to stabilize the knee unit (for example, stumble recovery); and,
    - The member is able to make use of a product that requires daily charging; and,
- The member is able to understand and respond to error alerts and alarms indicating problems with the function of the unit.

- A knee with powered and programmable flexion/extension assist control (L5859) may be medically necessary for members when all of the following criteria are met:
    - The member has a microprocessor (swing and stance phase type (L5856)) controlled (electronic) knee; and,
    - The member has a functional level of K3; and,
    - The member has a comorbidity of the spine or sound limb affecting hip extension or quadriceps function that impairs K3 level function with the use of a microprocessor-controlled knee alone; and,
    - The member is able to make use of a product that requires daily charging; and,
    - The member is able to understand and respond to error alerts and alarms indicating problems with the function of the unit.
- A high-activity knee control frame (L5930) may be medically necessary for members whose functional level is 3 or above, or for members whose weight requires the increased strength of this kind of frame.
- Other knee systems (L5611, L5616, L5710-L5718, L5810-L5818) may be medically necessary for members whose functional level is 1 or above.

**Hip**
A pneumatic or hydraulic polycentric hip joint (L5961) may be medically necessary for highly motivated members whose functional level is 2 or above.

**Additional Criteria**
Vacuum suspension system (L5781 or L5782) may be medically necessary for functional level 2 and above.

**Upper Limb Prostheses**

**Codes: L6000-L7259, L7400-L7499, L8701, L8702** (authorization required when billed charges exceed $3000)

**Evaluation and Management**

Evaluation of the member's functional ability is required. For members with existing prostheses, for whom a similar replacement is requested, evaluation can be based on the member's history and current condition. For members for whom a first prosthesis is requested or for whom a significantly different prosthetic is requested, evaluation must be based on clinical observation.

Evaluations must be performed by a professional certified by the American Board of Certification in Orthotics and Prosthetics, or the Board of Certification in Orthotics and Prosthetics or a professional who has similar training or expertise. Document the evaluation. The evaluation must be less than 90 days old.

Medical records must include:

- Reason for amputation
- Date of amputation
- Status of current limb
- Description of prosthetic being provided
- Which activities of daily living are affected and how they are impacted
- Functional capabilities before and after amputation

Use the following categories for upper limb prosthetics when evaluating the member. Provide specific information about the member's ambulation history, performance, and activities of daily living to support assignment of a particular device.

**Passive Prostheses**
Passive prostheses do not move on their own, are lightweight, and enhance the member's condition by stabilizing or carrying objects. A passive upper extremity prosthetic may be medically necessary for members when all of the following are true:

- The member is an amputee or has a congenital limb deficiency or absence of limb; and
- The member has the cognitive ability and desire to perform activities of daily living using the device; and
- The member's evaluation demonstrates the anticipated functioning goals using the device to accomplish daily tasks, appropriate to the member's condition, in a reasonable time period; and
- The member is cognitively, developmentally, or physically unable to use a body-powered prosthetic and is able to use the passive prosthetic; and
- The member is able to lock the prosthetic in place or, if a child, with the assistance of a parent or caregiver; and
- The device is the least costly alternative that meets the member's medical needs.

**Body-Powered Prostheses**
Body-powered prostheses use body movements to control the device. A body-powered upper extremity prosthetic may be medically necessary for members when all of the following are true:

- The member is an amputee or has a congenital limb deficiency or absence of limb; and

- The member has the cognitive and musculoskeletal ability and desire to perform activities of daily living using the device; and
- The member's evaluation demonstrates the anticipated functioning goals using the device to accomplish daily tasks, appropriate to the member's condition, in a reasonable time period; and
- A passive device does not meet the member's functional needs to perform daily tasks; and
- The member does not have a comorbidity that may impede with functioning of the device; and
- The member is able to lock the prosthetic in place or, if a child, with the assistance of a parent or caregiver; and
- The device is the least costly alternative that meets the member's medical needs.

**Myoelectric or Hybrid Prostheses**
Myoelectric prostheses use electromyographic signals in muscle contractions to control the device. A myoelectric or hybrid upper extremity prosthetic may be medically necessary for members when all of the following are true:

- The member is an amputee or has a congenital limb deficiency or absence of limb; and
- The member has the cognitive and musculoskeletal ability and desire to perform activities of daily living using the device; and
- The member's evaluation demonstrates the anticipated functioning goals using the device to accomplish daily tasks, appropriate to the member's condition, in a reasonable time period; and
- A passive or body-powered device does not meet the member's functional needs to perform daily tasks; and
- The muscle to which the electrode is attached generates sufficient microvoltage to operate the device; and

Documentation establishes that the member's environmental factors, including wet environments, do not contraindicate using the device.

South Country covers prosthetic sheaths (L8400, L8410, L8415, L8417), shrinkers (L8440, L8460, L8465), and socks (L8420, L8430, L8435, L8470, L8480, L8485) for member-owned devices.

**Breast Protheses**

Codes: L8000-L8002, L8010, L8015, L8020, L8030-L8033, L8035, L8039

**Evaluation and Management**

Evaluation of the member's functional ability is required. For members with existing prostheses, for whom a similar replacement is requested, evaluation can be based on the member's history and current condition. For members for whom a first prosthesis is requested or for whom a significantly different prosthetic is requested, evaluation must be based on clinical observation.

Evaluations must be performed by a professional certified by the American Board of Certification in Orthotics and Prosthetics, or the Board of Certification in Orthotics and Prosthetics or a professional who has similar training or expertise. Document the evaluation. The evaluation must be less than 90 days old.

Medical records must include:

- Order
- Member's diagnosis and clinical history
- Status of absence, defect, or condition of breast
- Description of prosthetic being provided

A breast prosthetic is covered for members who have had a mastectomy or other conditions that result in absence or defect of the breast. Authorization is not required for mastectomy bras. South Country covers only one breast prosthetic per side for members who have undergone bilateral mastectomies. Use the following HCPCS code descriptions when evaluating the member.

Mastectomy bras without integrated prosthesis form (L8000) and with integrated prosthesis form (L8001 and L8002) come in various materials and sizes to fit patients who have undergone a mastectomy.

A mastectomy sleeve (L8010) is covered for members with post-mastectomy lymphedema.

An external breast prosthesis garment (L8015) is covered for the postoperative period before a permanent breast prosthetic, or as an alternative to a mastectomy bra and breast prosthetic.

A mastectomy bra (L8000) is covered for members with mastectomy form (L8020) or silicone breast prosthetic without integrated adhesive (L8030) when the pocket of the bra is used to hold the prosthetic.

South Country covers silicone breast prosthetics with integrated adhesives (L8031), prefabricated and custom nipple prosthetics (L8032 and L8033), and custom breast prosthetics (L8035). Documentation must clearly articulate why prefabricated prosthetics do not satisfy the needs of the member. HCPCS code L8039 should only be used when a breast prosthetic is not described by a more specific HCPCS code (L8000 to L8035).

**Eye and Iris Prostheses**

Codes: 66683, C1839, V2623-V2629

**Evaluation and Management**

Evaluation of the member's condition is required. For members with existing prostheses, for whom a similar replacement is requested, evaluation can be based on the member's history and current condition. For members for whom a first prosthesis is requested or for whom a significantly different prosthetic is requested, evaluation must be based on clinical observation.

Evaluations must be performed by a professional certified by the American Board of Certification in Orthotics and Prosthetics, or the Board of Certification in Orthotics and Prosthetics or a professional who has similar training or expertise. Document the evaluation. The evaluation must be less than 90 days old.

Medical records must include:

- Order
- Member's diagnosis and clinical history
- Status of absence, shrinkage, defect, or condition of eyes
- Description of prosthetic being provided

Eye Prostheses

Eye prostheses are covered for members with absence or shrinkage of an eye due to disease, congenital defect of eye, surgery, or trauma. The usual reasonable useful lifetime (RUL) of five

years for durable medical equipment (DME) does not apply to artificial eyes. Use the following HCPCS code descriptions when evaluating the member.

An ocular prosthetic (V2623) is an artificial eye that fits over an orbital implant and under the eyelids that produces the appearance of a normal human eye. Eye prosthetics assist in maintaining the internal orbital eye structures by filling in the void created by the missing natural eye.

Polishing and resurfacing (V2624) is covered for members without authorization two times per calendar year.

One enlargement (V2625) or reduction (V2626) is covered without authorization. Additional enlargements or reductions are rarely medically necessary and are therefore covered only when there is documentation in the medical record which supports medical necessity. This information must be made available to South Country upon request.

South Country covers scleral cover shells (V2627) and the fabrication and fitting of ocular conformers (V2628). HCPCS code V2629 should only be used when a facial prosthetic is not described by a more specific HCPCS code (V2623 to V2628).

Iris Prostheses

Iris prosthetics compensate for a defect of the iris of an eye. An iris prosthetic (C1839) is considered medically necessary for treatment of aniridia for members three years of age and older. The implantation is described by CPT code 66683. Iris prosthetics are not covered for members with certain eye conditions, such as uncontrolled inflammation, severe chronic uveitis, microphthalmos, untreated retinal detachment, untreated chronic glaucoma, rubella cataract, rubeosis of the iris, proliferative diabetic retinopathy, Stargardt's retinopathy, or intraocular infections, or in pregnant women.

**Facial Prostheses**

Codes: L8040-L8049

**Evaluation and Management**

Evaluation of the member's condition is required. For members with existing prostheses, for whom a similar replacement is requested, evaluation can be based on the member's history and current condition. For members for whom a first prosthesis is requested or for whom a significantly different prosthetic is requested, evaluation must be based on clinical observation.

Evaluations must be performed by a professional certified by the American Board of Certification in Orthotics and Prosthetics, or the Board of Certification in Orthotics and Prosthetics or a professional who has similar training or expertise. Document the evaluation. The evaluation must be less than 90 days old.

Medical records must include:

- Order
- Member's diagnosis and clinical history
- Status of facial tissue
- Description of prosthetic being provided

A facial prosthetic is covered for members with loss or absence of facial tissue due to disease, congenital defect, surgery, or trauma. Use the following HCPCS code descriptions when evaluating the member.

A nasal prosthesis (L8040) is a removable superficial prosthesis, which restores all or part of the nose. It may include the nasal septum.

A midfacial prosthesis (L8041) is a removable superficial prosthesis, which restores part or all of the nose plus significant adjacent facial tissue but does not include the orbit or any intraoral maxillary component. Adjacent facial tissue includes one or more of soft tissue of the cheek, upper lip, or forehead.

An orbital prosthesis (L8042) is a removable superficial prosthesis, which restores the eyelids and the hard and soft tissue of the orbit. It may also include the eyebrow. This code does not include the ocular prosthesis component.

An upper facial prosthesis (L8043) is a removable superficial prosthesis, which restores the orbit plus significant adjacent facial tissue but does not include the nose or any intraoral maxillary component. Adjacent facial tissue includes one or more of the following: soft tissue of the cheek or forehead. This code does not include the ocular prosthesis component.

A hemi-facial prosthesis (L8044) is a removable superficial prosthesis, which restores part or all of the nose plus the orbit plus significant adjacent facial tissue but does not include any intraoral maxillary component. This code does not include the ocular prosthesis component.

An auricular prosthesis (L8045) is a removable superficial prosthesis, which restores all or part of the ear.

A partial facial prosthesis (L8046) is a removable superficial prosthesis which restores a portion of the face, but which does not specifically involve the nose, orbit, or ear.

A nasal septal prosthesis (L8047) is a removable prosthesis, which closes a hole in the nasal septum but does not include superficial nasal tissue.

HCPCS code L8048 should only be used when a facial prosthetic is not described by a more specific HCPCS code (L8040 to L8047) or for components used to attach the facial prosthetic to a bone-anchored implant or to an internal prosthesis. HCPCS code L8048 code should not be used for implanted prosthesis-anchoring components. Medically necessary modifications and repairs are covered under L8048 for materials used and L8049 for labor components.

**Devices for Bathing or Recreation**

Orthotic and prosthetic devices for purposes of bathing or showering and for purposes of recreation are covered. Devices for both bathing and recreation are covered per five years. Members cannot automatically obtain a new device if the original is still in working order. Members whose functional level is 2 or above are eligible for recreational prosthetics. Authorization is required for devices for recreation if the billed cost exceeds $3000. Use modifier U2 for billing. Authorization is required for devices for bathing or showering if the cost exceeds $3000. Use modifier U1 for billing. It is the expectation of South Country that devices for bathing or showering are made from the least costly and waterproof materials.

**Cranial remolding orthotics**

Code: S1040

A cranial remolding orthotic is considered medically necessary for treatment of head deformities associated with:

- Premature birth
- Restrictive intrauterine positioning
- Torticollis
- “Back to Sleep” sleeping positions

Up to two (2) cranial remolding orthotics are covered without authorization for members under age two (2). Authorization is required for subsequent cranial remolding orthotic.

**Scalp Hair Prostheses**

*Code: A9282*

A scalp hair prosthesis is considered medically necessary for treatment of medical conditions that result in hair loss.

One medical wig is covered per calendar year.

**Implantation of Iris Prosthesis**

Codes: 66683 (implantation of iris prosthesis) and C1839 (iris prosthesis)

The implantation of an iris prosthesis is considered medically necessary for treatment of aniridia for members three years of age and older. Not covered for members with certain eye conditions, such as uncontrolled inflammation, severe chronic uveitis, microphthalmos, untreated retinal detachment, untreated chronic glaucoma, rubella cataract, rubeosis of the iris, proliferative diabetic retinopathy, Stargardt's retinopathy, or intraocular infections, or in pregnant women.

## Noncovered Services

South Country does not cover the following:

- A prosthetic or orthotic device for which Medicare has denied the claim as not medically necessary
- A device that does not meet criteria as indicated in this policy is considered not medically necessary
- A device whose primary purpose is to serve as a convenience to a person caring for the recipient
- A device that serves to address social and environmental factors and that does not directly address the recipient's physical or mental health
- A device that is supplied to the recipient by the physician who prescribed the device or by a provider who is an affiliate of the physician who prescribed the device
- Repair costs for a prosthetic or orthotic device that is under warranty
- Repair costs for any rented equipment
- Lower limb prosthetics for a member whose functional level is 0 are considered not medically necessary
- Orthotics when used to prevent injury in a previously uninjured limb
- A custom fabricated device when the recipients needs can be met with a prefabricated device
- Additions or components that are not required for the effective use of the device or do not serve a functional purpose are considered not medically necessary
- Additions provided for cosmetic reasons are considered not medically necessary

## Oxygen Equipment

Oxygen is covered for eligible South Country members who meet medical necessity criteria. Quantity limits and thresholds apply to all members unless they are requesting only Medicare coinsurance or deductible.

Medicare payment for oxygen equipment is limited to 36 months. Providers may not bill South Country for oxygen equipment supplied to Medicare beneficiaries when the 36-month cap is reached. Providers may not transfer dual eligible members to the contract provider when the 36-

month cap is reached. Follow Medicare policy when serving SeniorCare Complete (MSHO), AbilityCare (SNBC), and Medicare primary eligible members.

## Covered Services

Codes: E0424, E0431, E0434, E0439, E0441-E0444, E1390, E1392, S8120-S8121- Oxygen equipment and contents; E1399 with modifier QH - oxygen conserving device

South Country covers oxygen and oxygen equipment in the following circumstances:

- When the member's blood oxygen levels indicate the need for oxygen therapy and one of the following is present:
    - Diagnosis of severe lung disease such as chronic obstructive pulmonary disease, diffuse interstitial lung disease, cystic fibrosis, bronchiectasis, etc.
    - Diagnosis of hypoxia-related symptoms caused by an underlying medical condition such as pulmonary hypertension, congestive heart failure, erythrocytosis, etc.
    - Short-term need due to diagnosis of conditions that usually resolve with limited oxygen therapy such as pneumonia, croup, bronchitis, etc.
- The member has a diagnosis not directly related to hypoxia for which short-term or intermittent use of oxygen has been shown to be beneficial:
    - Cluster headaches when other treatment has failed, and the member has expressed a willingness to keep portable oxygen accessible throughout the day. If the member is not willing to keep portable oxygen accessible while away from home, oxygen is not an appropriate treatment.
    - Pediatric bronchopulmonary dysplasia where the need for oxygen is variable and cannot be clearly established with blood oxygen levels.
    - Hemoglobinopathies in patients with a history of vaso-occlusive crises.

South Country does not require specific $PaO_2$ or oxygen saturation values for coverage. The physician's order must clearly state the member's diagnosis, the $PaO_2$ or oxygen saturation levels, the ordered flow rate and number of hours per day that oxygen is required.

Portable Concentrators, Home Liquefier Systems and Home Compressor Systems

- For portable concentrators, home liquefier systems and home compressor systems, the provider must determine if the system is sufficient to meet all of the member's needs, and whether the member or member's caregivers are able to use the system safely and effectively.
- Portable concentrators may be appropriate for patients traveling for out-of-state medical care.
- A second concentrator may be dispensed if necessary to meet the member's needs due to high oxygen flow, or when it is necessary to have one concentrator at home and a second at school or a work place. The concentrators must be delivered on different days. Contractors must pick up concentrators for use at school during school breaks over four weeks. South Country will cover portable gas or portable liquid oxygen systems for members with stationary concentrators.
- All members with covered concentrators must have gaseous oxygen supplies sufficient for 12 hours emergency use.

## Noncovered Services

South Country does not cover the following:

- Oxygen purchased from airlines for use during travel
- Stands, racks and wheeled carts for oxygen equipment are not separately covered
- Replacement accessories for portable concentrators are not covered because South Country does not purchase portable concentrators
- Portable liquid or gas oxygen systems for members with portable concentrators, home liquefier systems or home compressor systems
- Second concentrators for use at school or work for members with portable concentrators, home liquefier systems or home compressor systems

## Patient Lifts and Seat Lift Mechanisms

Patient lifts and seat lift mechanisms are covered for all eligible South Country members who meet coverage criteria. Members in nursing facilities and intermediate care facilities for persons with developmental disabilities are not eligible for patient lifts or seat lift mechanisms. Quantity limits and thresholds apply to all members.

A seat lift mechanism is used to allow a person to move from a seated position to a standing position. A patient lift is used to transfer the person from one surface to another.

## Covered Services

Codes:

*E0621: Sling or seat, patient lift, canvas, or nylon*

*E0630, E0635, E0636, E0639: Patient lifts*

*E0627, E0629: Seat lift mechanisms*

Hydraulic or mechanical patient lifts described by E0630 require authorization. Please provide documentation of the following:

- The member requires help from another person to transfer between a wheelchair, bed, commode or other surfaces in the home
- The member cannot be safely transferred without a lift due to the member's medical condition or the caregiver's limitations

The lift is documented as fitting in all necessary parts of the member's homeElectric patient lifts described by E0635 are covered for members who meet criteria for a hydraulic or mechanical lift an who meet one of the following criteria:

- The member has a medical condition that prevents safe transfer using a hydraulic or mechanical lift
- The primary caretaker is unable to operate a hydraulic or mechanical lift but can operate an electric lift and can perform all necessary cares

Multi-positional patient support systems with integrated lift and moveable patient lift described by E0636 and moveable patient lifts described by E0639 are covered for members who meet criteria for a patient lift and whose unique medical needs cannot be met with a less costly lift. Both require authorization.

Electric patient lifts described by E0365 requires authorization. Provide documentation as indicated for hydraulic/mechanical patient lifts, plus the following:

- The member has a medical condition that prevents safe transfer using a hydraulic or mechanical lift
- The primary caretaker is unable to operate a hydraulic or mechanical lift but can operate an electric lift and can perform all necessary cares

Seat lift mechanisms (E0627, E0629) are covered for members who meet all of the following criteria:

- The member has arthritis of the hip or knee, neuromuscular disease or another medical condition that affects his or her strength or mobility
- The member is unable to stand up from a regular armchair at home
- Once standing, the member has the ability to ambulate independently or with a properly fitted walker or cane

Although a seat lift mechanism may be covered, the chair for which the mechanism is intended is not covered because it is furniture rather than medical equipment.

## Authorization

Authorization is required for the following:

- When the charge is over $500.00 for the seat lift mechanism
- Rental or purchase of electric patient lifts, multi-positional patient support systems, moveable patient lifts, and seat lift mechanisms – see Prior Authorization Grid by code at www.mnscha.org
- Rental or purchase of a patient lift when the patient's current lift, regardless of lift type, is less than five (5) years old

All requests for patient lifts, documentation must include the following:

- Member weight and height, and general strength and age of primary caretaker
- Documentation of the medical condition that requires the specific kind of lift requested
- Description of the current method of transfer and why it does not meet the member's needs
- Description of how the lift will be used in critical areas of the residence
- The plan of care
- Documentation of satisfactory member and caretaker use of the lift
- Documentation that the lift will fit in all necessary areas of the home
- Less costly alternatives considered and why they were rejected

## Noncovered Services

Non-electric seat lift mechanisms that operate by spring-release mechanism are not covered because they are not the community standard of care and pose a risk to members with limited strength.

Although a seat lift mechanism may be covered, the chair for which the mechanism is intended is not covered because it is furniture rather than medical equipment.

- The following items are not covered because they are home or vehicle modifications, not durable medical equipment:
    - Vehicle lifts

- Platform lifts
- Stair lifts
- Elevators
- Wheelchair lifts
- Non-portable ramps
- Ceiling-mounted lifts
- Wall-mounted lifts

## Positive Airway Pressure for Treatment of Obstructive Sleep Apnea

South Country covers Continuous Positive Airway Pressure (CPAP) and Bi-level Positive Airway Pressure (Bi-PAP) devices and related supplies for eligible members with a diagnosis of obstructive sleep apnea.

## Covered Services

Codes: A4604, A7027 – A7039, A7044 – A7046, E0470-E0472, E0601

South Country covers the following devices:

- Bi-level pressure respiratory assist device without backup rate with noninvasive interface (E0470)
- Bi-level pressure respiratory assist device with backup rate with noninvasive interface (E0471)
- Bi-level pressure respiratory assist device with backup rate with invasive interface (E0472)
- Continuous positive airway pressure device (E0601)

A CPAP device (E0601) may be dispensed for the first three (3) months' rental based on a physician's order that includes a diagnosis of obstructive sleep apnea. During the 6th to 12th week of treatment, the supplier must verify that the member is complying with the ordered therapy. If the member has not achieved compliance by the 12th week, but has demonstrated use of the CPAP device, South Country will continue to cover the CPAP device for an additional eight weeks. During the additional eight-week period, compliance is defined as use of CPAP four or more hours per 24-hour period for 70% of days. If the member has not achieved compliance after the additional eight weeks, the rental will end, and the provider should retrieve the equipment back.

South Country will pay for the first three (3) months' rental of a Bi-PAP device without backup rate (E0470), for members with obstructive sleep apnea, when there has been a failed trial of CPAP or if there is a medical contraindication to CPAP with a physician's order. During the 6th to 12th week of treatment, the supplier must verify that the member is complying with the ordered therapy. If the member has not achieved compliance by the 12th week, but has made consistent progress toward compliance, South Country will continue to cover the Bi-PAP device for an additional eight weeks. If the member has not achieved compliance after the additional eight weeks, the rental will end, and the provider should retrieve the equipment back.

South Country will pay for the purchase of a CPAP or Bi-PAP device with authorization if the member has a third-party insurance that requires purchase rather than rental. Documentation must show that the primary payer requires purchase rather than rental of the device.

South Country will pay for the rental of a BiPAP device with backup rate (E0471, E0472) without authorization for members with obstructive sleep apnea and coexisting breathing disorders that require ventilation assistance. Diagnoses must be on the claim.

Refer to the Medical Supply Coverage Guide for coverage information and limits on supplies.

## Member Compliance

To accomplish an accurate and valid verification of compliance, it must be clear that the member is using the equipment.

Keep documentation of the compliance verification in the member's file. Recommended documentation includes the following:

- Date of verification
- Method of verification
- Name of the treating provider
- Name of the person within your organization that performed the verification

Before dispensing masks or other supplies, providers must verify with the member that the CPAP or BiPAP device is still in use, and that replacement of the supply is necessary because the existing supply is damaged or otherwise worn out.

If the member is not using the equipment, the rental should end and the provider should take the equipment back.

**Included with initial dispensing:**

- Compressor
- CPAP valve (if separate from mask)
- Disconnection alarm (if needed)
- Filters
- Fuses
- Instruction manual
- Manometer

**Separately billable at initial dispensing:**

- Head gear
- Mask
- Tubing
- Humidification device

## Noncovered Services

- Carrying case is a noncovered convenience item and is not medically necessary.
- A positive airway pressure device is not covered after the third month unless the supplier has verified patient compliance as described above.

## Respiratory Equipment

Respiratory equipment and related supplies are covered for eligible South Country members with a diagnosis of restrictive thoracic disorders, severe chronic obstructive pulmonary disease,

central sleep apnea, neuromuscular respiratory insufficiency or other diagnoses which require ventilation assistance.

**Covered Services**

Codes: A4604, A4605, A4611-A4620, A7027-A7039, A7044-A7046, E0465-E0468, E0470-E0472, E0601

South Country covers the following devices:

- Home ventilator with invasive interface (E0465)
- Home ventilator with noninvasive interface (E0466)
- Multifunction respiratory ventilator (E0467)
- Dual-function respiratory ventilator (E0468)
- Bi-level pressure respiratory assist device without backup rate with noninvasive interface (E0470)
- Bi-level pressure respiratory assist device with backup rate with noninvasive interface (E0471)
- Bi-level pressure respiratory assist device with backup rate with invasive interface (E0472)
- Continuous positive airway pressure device (E0601)

South Country covers the following services:

- Rental of BiPAP device for members with medical conditions that require ventilation assistance if the member has spontaneous respiration. Diagnosis must be on the claim.
- Rental of BiPAP device with backup rate for members with obstructive sleep apnea and coexisting breathing disorders. Diagnoses must be on the claim.
- Rental of CPAP device for members with breathing disorders other than obstructive sleep apnea.
- Purchase of CPAP or BiPAP device with authorization if the member has a third-party insurance that requires purchase rather than rental.
- Rental of a ventilator for members who have been determined by a physician to need a ventilator.
- Rental of a portable and a stationary ventilator if the documentation establishes that a portable ventilator alone does not meet the member's needs. Examples of this could include the following:
    - The member requires the use of one type of respiratory device during a portion of the day and the use of a second device during another portion of the day (with documentation that both modalities cannot be served by a multifunction respiratory device).
    - The member is wheelchair bound and requires a respiratory assist device to be mounted to the wheelchair for use when out of the bed as well as the same type of device for use while in bed AND without both pieces of equipment, the individual may be prone to medical complications, may be unable to achieve appropriate medical outcomes, or may not be able to use the medical equipment effectively.
- Rental of the multifunction ventilator (E0467) is covered for members who would otherwise require both a portable and a stationary ventilator but can be served by the

multifunction ventilator alone. E0467 must be billed without another ventilator rental. Additionally, the multifunction ventilator also has the capability of completing the nebulizer, oxygen, cough assist and suction functions. All codes encompassed by E0467 are not separately reimbursable unless the client has oxygen needs of more than six liters per minute. If a member is utilizing the oxygen feature of the multifunction ventilator, providers must adhere to the requirements of the oxygen policy found on the Oxygen Equipment section of the MHCP Provider Manual, including supplying 12 hours of emergency gaseous oxygen at no additional charge.

**Authorization**

Authorization is required for:

- Home ventilator with noninvasive interface (E0466)
- Multifunction respiratory ventilator (E0467)
- Dual-function respiratory ventilator (E0468)
- Second ventilators
- When purchase or monthly rental cost exceeds $1500

## SAD Lights (E0203)

Therapeutic light boxes are used for treatment of Seasonal Affective Disorder (SAD). South Country covers SAD lights for eligible members with a history of winter depressive episodes with seasonal onset that substantially outnumber any non-seasonal depressive episodes. Eligible diagnoses include:

- SAD
- Bipolar disorder
- Recurrent major depression

### Covered Services

Codes: E0203, A4634

Only tabletop therapeutic light boxes approved by the Food and Drug Administration (FDA) are covered. The light bulb is included in the initial purchase or rental of the light box and may not be separately billed. Replacement light bulbs are covered.

### Noncovered Services

Therapeutic light boxes are not covered when prescribed for:

- Conditions other than SAD, bipolar disorder, or recurrent major depression as there is no proven medical benefit for other indications
- Members in nursing facilities or intermediate care facilities for developmentally disabled

### Authorization

Authorization is required for a SAD light box when the charge is $500.00 or greater. All authorization requests must include:

- Credentials of the mental health practitioner
- A written diagnosis of SAD, bipolar disorder or recurrent major depression

- Summary of at least two consecutive years of seasonal depressive episodes with spring remission, including:
    - Statement detailing depressive symptoms
    - Month and year of onset and remission of depressive episodes
    - Dates of any other depressive episodes
- Evidence of a positive response to light therapy, if available
- Summary of member's ability and willingness to do the light therapy
- Summary of member's compliance with other mental health treatment regimens

## Seizure Detection Devices

Seizure detection devices are covered for South Country members who have a medical diagnosis of convulsive seizures, have active epilepsy, and meet one of the following criteria:

- The device will likely assist in reducing bodily harm or death from convulsive seizures; or
- The device will provide data to the health care provider necessary to diagnose or treat a health condition of the member that causes the seizure activity.

The device must be FDA approved.

**Covered Services**

*A9279: Monitoring feature/device, stand-alone or integrated, any type, includes all accessories, components, and electronics, not otherwise classified. South Country covers one device every five years. Bill using U2 modifier.*

*99454: Remote monitoring of physiologic parameters, initial supply of devices with daily recordings or programmed alerts transmission, each 30 days. Bill using U2 modifier.*

*Prior authorization is not required.*

## Wheelchair/Mobility Devices

South Country covers mobility devices for eligible members with a mobility limitation that significantly impairs their ability to participate in one or more mobility-related activities of daily living and the mobility limitation cannot be sufficiently resolved by the use of an appropriately fitted cane or walker. Activities of daily living refer to any activity a member must complete during a given day including (but not limited to): toileting, feeding, grooming, education, working or job training. The mobility device must enable the member to participate in mobility-related activities of daily living and be appropriate to the member's needs and abilities.

- The mobility device must enable the member to participate in mobility related activities of daily living and be appropriate to the member's needs and abilities.
- When a power wheelchair is purchased for a member who already has a manual wheelchair, South Country will assume that the power wheelchair is replacing the manual wheelchair. Repairs to the manual wheelchair will not be covered unless documentation is submitted that the manual wheelchair meets criteria as a backup wheelchair.
- .
- To be considered custom molded seating, the wheelchair must require significant customization to maintain the member in an appropriate position. The use of supports alone does not constitute customization.

- A basic manual wheelchair, transport chair or roll about chair may be covered if needed to allow the member to access medical care in the community, even if not needed for other activities of daily living.

## Covered Services

- Specific mobility devices, options, and accessories
- Manual wheelchairs
- Power operated vehicles
- Power wheelchairs
- Wheelchair options and accessories
- Custom molded and prefabricated seating systems
- Wheelchairs in long-term care facilities (LTCFs)

Medicare requires providers dispensing Group 2 single power option wheelchairs or any multiple power option wheelchairs to employ a Rehabilitative Engineering and Assisted Technology Society of America (RESNA)-certified Assistive Technology Professional (ATP) specializing in wheelchairs who is directly involved in the wheelchair selection for the member. Providers assisting members who have both Medicare and Medicaid (dual eligible) must comply with this Medicare rule.

Providers who do not meet Medicare requirements must refer and document the referral of dual eligible members to Medicare providers when Medicare is determined to be the appropriate payer for services and supplies and equipment.

Medicare does not cover wheelchair transit systems or tie downs, transport brackets, or similar wheelchair accessories. Providers may bill South Country directly for these accessories that are part of a covered wheelchair. Follow South Country authorization requirements. When billing, include an attachment that clearly states, “wheelchair transportation accessory not covered by Medicare.” South Country does not cover accessories that are modifications to a vehicle.

## Specific Mobility Devices, Options and Accessories

The following criteria are not all inclusive. Providers must be prepared to submit additional documentation of medical necessity, beyond what is typically required, when asked.

### Backup Manual Wheelchairs

- A “backup” manual chair may be covered for members with a powered mobility device. Requests will be reviewed individually to determine medical necessity. Clearly state that the request is for a backup chair when requesting authorization.
- When a power wheelchair is purchased for a member who already has a manual wheelchair, South Country will assume that the power wheelchair is replacing the manual wheelchair. Repairs to the manual wheelchair will not be covered unless documentation is submitted that the manual wheelchair meets criteria as a backup wheelchair.
- Documentation submitted with previous authorization requests will be considered when determining if criteria are met for a backup wheelchair.
- A basic manual wheelchair, transport chair or rollabout chair may be covered if needed to allow the member to access medical care in the community - even if not needed for other activities of daily living.

- Documentation must clearly justify why other, less-costly manual wheelchairs, will not meet the member's needs. The wheelchair must require significant customization to maintain the member in an appropriate position to be considered custom-molded. The use of supports does not constitute a custom-molded seating system or custom-molded back.

In addition to the general backup manual wheelchair criteria listed under Backup Manual Wheelchairs, the following specific criteria must be met when requesting one of the following backup manual wheelchairs:

- Hemi-wheelchairs (K0002). The member requires a lower seat height (less than 19 inches) because of short stature
- Light-weight wheelchairs (K0003). The member is unable to propel themselves in a standard wheelchair or their caregiver is unable to push a standard wheelchair
- High-strength, lightweight wheelchairs (K0004). The member requires a seat width, depth, or height that cannot be accommodated in a standard, lightweight or hemi-wheelchair
- Ultra-lightweight wheelchair (less than 30 lbs.) (K0005):
    - The member must require individualized fitting and adjustments for one or more features such as, but not limited to, axle configuration, wheel camber, or seat and back angles, and which cannot be accommodated by a K0001 through K0004 manual wheelchair.
    - If requesting additions to K0005 backup wheelchair, the member must have a specialty evaluation that was performed by a licensed or certified medical professional (LCMP), such as a physical therapist or occupational therapist or physician who has specific training and experience in rehabilitation wheelchair evaluations and that documents the medical necessity for the wheelchair and its special features. The LCMP may have no financial relationship with the supplier.
- Heavy-duty or extra-heavy-duty wheelchairs (K0006-K0007), the member:
    - Requires the chair because of weight; or
    - Has a medical condition such as spasticity, which requires a heavy-duty chair for safety
- Tilt-in-Space manual wheelchairs (E1161) are covered if the member meets ONE of the following criteria:
    - Is at high risk for pressure ulcers and is unable to perform a functional weight shift; or
    - Has increased or excess muscle tone or spasticity related to a medical condition that is anticipated to be unchanging for at least one year; or
    - Has decreased muscle tone related to a medical condition that inhibits their ability to sit up against gravity and requires tilt in space for head and trunk control

### Manual wheelchairs (E1031, E1037-E1039, E1161, E1229, E1231-E1238, K0001-K0007, K0009)

Manual wheelchairs are covered if the member meets the criteria for a mobility device and has one of the following:

- A caregiver who is available, willing and able to provide assistance

- Sufficient upper extremity function to propel an optimally configured manual wheelchair to participate in mobility-related activities of daily living during a typical day

Hemi-wheelchairs (K0002) are covered if the member has one of the following needs:

- Requires a lower seat height (less than 19 inches) because of short stature
- Requires a lower seat height (less than 19 inches) to propel the chair with their feet

Lightweight (34 – 36 lbs.) manual wheelchairs (K0003) are covered if the member meets all the following criteria:

- Primarily uses a manual wheelchair rather than a power mobility device
- Cannot self-propel in a standard wheelchair for various reasons; and
- Can propel themselves in the requested chair

High strength, lightweight wheelchairs (K0004) are covered if the member primarily uses a manual wheelchair rather than a power mobility device and meets ONE of the following criteria:

- Can propel themselves in the requested chair while engaging in frequent activities that cannot be performed in a standard or lightweight wheelchair; or
- Requires a seat width, depth, or height that cannot be accommodated in a standard, lightweight or hemi-wheelchair, and spends at least two hours per day in the wheelchair.

Ultra-lightweight wheelchairs (K0005) are covered if criteria (1) or (2) is met and criteria (3):

- The member must be a full-time manual wheelchair user; or
- The member must require individualized fitting and adjustments for one or more features such as, but not limited to, axle configuration, wheel camber, or seat and back angles, and which cannot be accommodated by a K0001 through K0004 manual wheelchair.
- The member must have a specialty evaluation that was performed by a licensed or certified medical professional (LCMP), such as a PT or OT, or physician who has specific training and experience in rehabilitation wheelchair evaluations and that documents the medical necessity for the wheelchair and its special features. The LCMP may have no financial relationship with the supplier.
- The wheelchair is provided by a Rehabilitative Technology Supplier that employs a RESNA - certified Assistive Technology Professional (ATP) who specializes in wheelchairs and who has direct, in-person involvement in the wheelchair selection for the member.

*Authorization is required for K0005

Heavy duty or extra heavy-duty wheelchairs (K0006-K0007) are covered if the member has one of the following needs:

- Requires the chair because of weight
- Has a medical condition such as spasticity, which requires a heavier duty chair for safety

Tilt in Space manual wheelchairs (E1161) are covered, with authorization, if the member has one of the following needs:

- Is at high risk for pressure ulcers and is unable to perform a functional weight shift
- Has increased or excess muscle tone or spasticity related to a medical condition that is anticipated to be unchanging for at least one (1) year; or
- Had decreased muscle tone related to a medical condition that inhibits their ability to sit up against gravity and requires tilt in space for head and trunk control

Rollabout or Transport chairs (E1031, E1037-E1039):

Authorization is required after the third month of rental and for all purchases. Provide documentation of the following:

- The member is not expected to be able to self-propel a manual or power wheelchair in the next five (5) years
- The member has needs that cannot be met by a less costly manual wheelchair
- The proposed chair has casters of at least five (5) inches in diameter and is specifically designed to meet the durable medical equipment standards

Standard options and accessories for manual wheelchairs include:

- Calf rests or pads
- Fixed height arm rests (fixed, swing-away or detachable)
- Foot rests and footplates (fixed, swing-away or detachable)
- Hand rims with or without projections
- Wheel lock assemblies

Nonstandard options and accessories for manual wheelchairs may include:

- Adjustable height arm rests
- Anti-rollback device
- Elevating leg rests
- Head rest extensions
- Nonstandard seat frames (standard is 15” – 19” width and depth)
- One-arm drive attachments
- Positioning accessories
- Push activated power assist
- Safety belts/straps
- General use seat and back cushions
- Skin protection seat and back cushions

Options and accessories provided at the time of initial issue of a transport chair or roll about chair are not separately billable.

## Power Operated Vehicles (POV) (K0800-K0802, K0806-K0808)

Power operated vehicles are covered, with prior authorization, if the member meets all of the following criteria:

- Meets the criteria for a mobility device
- Does not have sufficient upper extremity function to self-propel an optimally configured manual wheelchair to perform mobility-related activities of daily living
- Is able to safely transfer to and from the POV
- Has both the physical and cognitive ability to operate the tiller steering system
- Is able to maintain postural stability and position while operating the POV

- Is able to bring the POV into the home for use and storage or if homeless, has demonstrated a plan to safely charge and store the POV

Standard equipment for a POV includes:

- Battery or batteries required for operation
- Single mode battery charger
- Weight appropriate upholstery and seating system
- Tiller steering
- Non-expandable controller with proportional response to input
- Complete set of tires
- All accessories needed for safe operation
- Options and accessories provided at the time of initial issue of a power operated vehicle are not separately billable

### Power Wheelchairs (K0813-K0898)

A power wheelchair may be covered if the member has a specific medical need that cannot be met with a less costly alternative and meets all of the criteria as stated below.

- Meets the criteria for a mobility device; and
- Does not have sufficient upper extremity function to self-propel an optimally configured manual wheelchair to perform mobility-related activities of daily living; and
- Is not able to safely operate a POV or maintain postural stability and position while operating a POV; and
- Has a caregiver who cannot push a manual chair, but can propel the power chair using an attendant control
- For a member under age four (4), has been evaluated and found to be developmentally ready to begin to operate a power chair equipped with appropriate attendant control and safeguards
- Is able to bring the power wheelchair into the home for use and storage or if homeless, has demonstrated a plan to safely charge and store the power wheelchair

Standard equipment for power wheelchair includes:

- All types of tires and wheels
- Any back width
- Any seat width and depth
- Weight-specific components required by the patient-weight capacity of the wheelchair
- Battery charger
- Fixed swing-away or detachable footrests or foot platform, including angle adjustable footrests for group 1 or 2 power wheelchairs
- Fixed swing-away or detachable non-adjustable armrests with arm pad
- Fixed swing-away or detachable non-elevating leg rests with or without calf pad
- Lap belt or safety belt

- Non-expandable controller
- Standard integrated or remote proportional joystick
- All labor charges involved in the assembly of the wheelchair

Nonstandard options or accessories for power wheelchair may include:

- Adjustable height arm rests
- Elevating leg rests
- Angle adjustable footrests for group 3, 4 or 5 power wheelchairs
- Manual fully reclining back option
- Power tilt
- Power recline
- Seat elevator
- Shoulder harness or straps or chest straps or vest
- Skin protection seat cushions, position accessories
- Standing feature
- Expandable controller
- Nonstandard joystick or alternative control device

Group 1 (K0813-K0816) or Group 2 no power option (K0820-K0829) power wheelchairs are covered, with prior authorization, if the member:

- Meets the criteria for a power wheelchair; and
- Does not require a single or multiple power option wheelchair; and
- Does not require a drive control interface other than a hand operated standard proportional joystick

Group 2 single power option power wheelchairs (K0835-K0840) are covered, with prior authorization, if the member has one of the following:

- Meets coverage criteria for a power tilt or power recline seating system; or
- Requires a drive control interface other than a hand operated standard proportional joystick (examples include but are not limited to chin control, head control, sip and puff, switch control)

Group 2 multiple power option power wheelchairs (K0841-K0843) are covered, with prior authorization, if the member has one of the following:

- Meets coverage criteria for power tilt and recline seating system; or
- Requires a drive control interface other than a hand operated standard proportional joystick and meets criteria for a power tilt or power recline seating system; or
- Uses a ventilator mounted on the wheelchair

Group 3 no power option power wheelchairs (K0848-K0855) are covered, with prior authorization, if the member:

- Has mobility limitations due to a neurological condition, myopathy, congenital skeletal deformity; or

- The member has a significant medical condition which requires the use of seating, positioning or other accessories that cannot be adequately accommodated by a Group 1 or Group 2 power wheelchair

Group 3 single power option power wheelchairs (K0856-K0860) are covered, with prior authorization, if the member:

- Has mobility limitations due to a neurological condition, myopathy, congenital skeletal deformity or the member has a significant medical condition which require the use of seating, positioning or other accessories that cannot be adequately accommodated by a Group 1 or Group 2 power wheelchair; AND
- The Group 2 single power option criteria are met

Group 3 multiple power option power wheelchairs (K0861-K0864) are covered, with prior authorization, if the member:

- Has mobility limitations due to a neurological condition, myopathy, congenital skeletal deformity or the member has a significant medical condition which require the use of seating, positioning or other accessories that cannot be accommodated by a Group 1 or Group 2 power wheelchair; AND
- The Group 2 multiple power option criteria are met

Group 4 no power option power wheelchairs (K0868-K0871) are covered, with prior authorization, if the member:

- Cannot safely use an equivalent Group 3 power wheelchair without significant modifications to the member's living environment; AND
- Has mobility limitations requiring the use of seating and positioning items that cannot be accommodated by a Group 1 or Group 2 power wheelchair; AND
- Meets the criteria for a power wheelchair

Group 4 single power option power wheelchairs (K0877-K0880) are covered, with prior authorization, if the member:

- Has mobility limitations due to a neurological condition, myopathy, congenital skeletal deformity or the member has a significant medical condition which require the use of seating, positioning or other accessories that cannot be accommodated by a Group 1 or Group 2 power wheelchair; and
- Cannot safely use an equivalent Group 3 power wheelchair without significant modifications to the member's living environment or meets criteria for accessories that are not available on a Group 3 power wheelchair; and
- Meets the Group 2 single power wheelchair criteria

Group 4 multiple power option power wheelchairs (K0884-K0886) are covered, with prior authorization, if the member:

- Has mobility limitations due to a neurological condition, myopathy, congenital skeletal deformity or the member has a significant medical condition which require the use of seating, positioning or other accessories that cannot be accommodated by a Group 1 or Group 2 power wheelchair; and
- Cannot safely use an equivalent Group 3 power wheelchair without significant modifications to the member's living environment or meets criteria for accessories that are not available on a Group 3 power wheelchair; and
- Meets the Group 2 multiple power options criteria

Group 5 power wheelchairs (K0890-K0891) are covered, with prior authorization, if the member:

- Meets the criteria for a power wheelchair; and
- Meets the criteria for a single or multiple power option; and
- Is expected to grow in height or whose size is best served by a Group 5 power wheelchair

## Wheelchair Options and Accessories

Wheelchair options and accessories are covered if they are medically necessary and address a specific medical need of the member. The following list of options and accessories is not all-inclusive; many additional options and accessories may be covered if medically necessary.

One (1) arm drive attachments (E0958) are covered if:

- The member meets the criteria for a manual wheelchair, but is unable to use both arms or at least one (1) lower extremity to safely propel the manual wheelchair, and
- A trial demonstrated the member has the strength, stamina and cognitive ability to propel the wheelchair using the one (1) arm drive attachment

Push activated power assist (E0986) is covered, with prior authorization, if the member:

- Has expressed an unwillingness to operate a power wheelchair
- Was self-propelling in a manual wheelchair but no longer has sufficient upper extremity function to self-propel a manual wheelchair or has weakness or repetitive motion stress to the shoulders or upper arms

Documentation must include:

- An assessment of the distance the member is expected to need to operate the manual wheelchair
- A trial sufficient to demonstrate the member is able to operate the manual wheelchair for that distance
- An estimate indicating how long the push activated power assisted manual wheelchair is expected to meet the member's mobility needs

Power tilt (E1002) is covered, with prior authorization, if the member:

- Meets criteria for a wheelchair and;
- Has one of the following needs:
    - Is at risk for pressure ulcers and is unable to perform a functional weight shift
    - Has a fixed hip angle
    - Has increased or excess muscle tone or spasticity related to a medical diagnosis which impairs their ability to tolerate the fully upright sitting position for significant periods of time

Power recline (E1003-E1005) is covered, with prior authorization, if the member:

- Meets criteria for a power wheelchair
- Has one of the following:
    - Is unable to tolerate a full upright position due to a medical condition which impairs their ability to tolerate the fully upright sitting position for significant periods of time

- Uses intermittent catheterization
- Has edema and is unable, for physical or other reasons, to periodically transfer from the wheelchair to elevate the legs

Power tilt and recline seating systems, with or without power elevating legs rests (E1006-E1008) are covered, with prior authorization, if the member:

- Meets criteria for a power wheelchair
- Meets criteria for both power tilt and power recline

Mechanical leg elevation systems (E1009) are covered if the member:

- Meets criteria for a wheelchair
- Has one of the following:
  - Has a medical condition which prevents 90 degrees of knee flexion
  - A treatment program to decrease flexion contractures of the knee
  - Leg edema which cannot be treated by an edema control wrap, a recline feature as part of the wheelchair and is unable, for physical or other reasons, to periodically independently transfer from the wheelchair to elevate legs

Power leg elevation systems (E1010, E1012) are covered (E1012 requires an authorization) if the member:

- Meets criteria for a power wheelchair
- Is able to independently operate the power leg elevation system
- Has one of the following:
  - A medical condition which prevents 90 degree of knee flexion
  - A treatment program to decrease flexion contractures of the knee
  - Leg edema which cannot be treated by an edema control wrap, a recline feature as part of the wheelchair and is unable for physical or other reasons, to periodically independently transfer from the wheelchair to elevate the legs

Manual, fully or semi-reclining backs (E1014, E1225, E1226) are covered, with prior authorization, if the member has one of the following:

- At high risk for pressure ulcers and is unable to perform a function weight shift
- Uses intermittent catheterization for bladder management and is unable to independently transfer from the wheelchair
- Is unable to tolerate a full upright position due to a medical condition

Wheelchair transportation or transit securement systems (E1022, E1023) are covered if the member meets ALL of the following criteria:

- Meets criteria for a mobility device; and
- Is at risk for unsafe transfers in private vehicles or public transportation; and
- Is dependent for transfers and transitions in transportation

Retractable or removable mounting hardware (E1028, E1023-E1034) is covered if the member needs accessories to be manually moved or removed from the wheelchair mount.

Gear reduction drive wheels (E2227) are covered, with prior authorization, if the member:

- Meets criteria for a manual wheelchair
- Is at risk for weakness or repetitive motion injury to the arms or shoulders

Dynamic seating frame (E2295, E2398) is covered when:

- The requested dynamic seating frame is made by the same manufacturer as the requested pediatric wheelchair
- The requested wheelchair independently meets all criteria for medical necessity and least costly appropriate equipment
- The member does not require tilt-in-space or reclining back
- The member is able to engage in some hip or knee extension

Power seat elevation feature (E2298) is covered, with prior authorization, if the member has one of the following:

- Must routinely transfer between uneven surfaces and the surfaces cannot be adjusted and the seat elevation feature allows them to independently transfer; or
- Cannot be safely transferred using a patient lift or standing transfer but can safely transfer with the seat elevation feature; or
- The seat elevation system has been demonstrated to allow the member to independently access areas in the home necessary for completion of activities of daily living (ADLs) (cupboards, closets, etc.)

Documentation must specify where uneven transfers will be needed in the member's home, or where in the home safe transfers cannot be made using a patient lift or standing transfer.

If a seat elevation feature is approved for a member, the provider must obtain documentation from the member or the member's authorized representative acknowledging that he or she understands that the seat elevation function may affect future requests for PCA or home care services before dispensing and billing for this item. This documentation must be made available upon request.

Standing feature (manual: E2230; power: E2301) is covered, with prior authorization, if:

- The member meets the Minnesota Health Care Programs (MHCP) criteria for a stander
- A stander has not been purchased for the member in the previous three (3) years
- The standing function has been demonstrated to allow the member to independently access areas in the home necessary for completion of ADLs

If a standing feature is approved for a member, the provider must obtain documentation from the member or the member's authorized representative acknowledging that he or she understands South Country will not pay for future repairs to a stander and that the standing function may affect future requests for PCA or home care services before dispensing and billing for this item. This documentation must be made available upon request.

Alternative interface devices (E2312, E2321-E2330, E2373, E2399) are covered if a member meets criteria for a power wheelchair and cannot safely operate the wheelchair using a hand or chin-operated standard proportional joystick but can safely operate the wheelchair using the alternative device.

Power wheelchair attendant control (E2331) is covered if the member:

- Meets criteria for a mobility device but is unable to operate a manual or power wheelchair
- Requires a power wheelchair or lacks a caregiver able to propel a manual chair

- Has a caregiver willing and able to operate the power wheelchair and assist the member

Mobile arm supports and additions (E2626-E2633) are covered if the member meets ALL of the following criteria:

- Meets criteria for a mobility device; and
- The member has a medical condition that only allows them to use their upper extremities to move through partial range of motion against gravity, as evident by manual muscle testing; and
    - If requesting for positioning needs, include documentation explaining why less costly positioning equipment is not appropriate for the member's medical needs; or
    - If requesting for assistance in performing ADLs, include documentation illustrating how the device will allow the member to be independent in one or more ADLs; and
- A trial demonstrates the member is able to operate the equipment.

Wheelchair component or accessory, not otherwise specified (K0108)
Miscellaneous items are covered if medically necessary or if required for the functioning of other covered items. For example, if a high mount footrest is needed because the chair has a power or manual tilt, the high mount bracket is covered.

## Custom Molded and Prefabricated Custom Seating Systems

Custom molded seating systems
Custom molded seating systems provide positioning or pressure relief that cannot be met with a standard, mass produced cushion or searing system. They are fabricated from an impression or digital image of the member using molded-to-patient techniques.

Custom fabricated seating systems may be entirely created by the provider or may be purchased from the manufacturer. Seating systems that are purchased from the manufacturer must have been coded E2609 or E2617 by the PDAC to be considered custom fabricated seating.

Authorization is *always* required for professional services associated with custom molded seating systems. Include a statement and certification number to verify the provider is certified by the American Board for Certification of Orthotics or by the RESNA with the authorization request.

Professional services associated with custom molded seating systems include evaluating the member's seating needs, taking impressions or creating digital images, and making any necessary adjustments to the seating system.

Replacement of worn batteries, battery chargers, wheels, tires or arm pads
Replacement of worn batteries, battery chargers, wheels, tires or arm pads is not considered a repair. Authorization is not required, regardless of submitted charge, unless the part being replaced is less than one year old. Replacement of other components is considered a repair and subject to the $500 limit.

Wheelchairs in long-term care facilities

ICD/DD Coverage

- Wheelchair purchases and rentals are not included in the ICF/DD per diem.

SNF per diem coverage

- Standard wheelchairs (K0001) for members in a nursing facility are included in the nursing facility (NF) per diem. Wheelchairs and accessories for member in a NF will always require authorization.
- All other wheelchairs (including tilt-in-space) are billable outside of the nursing facility per diem if they are necessary for the continuous care and exclusive use by a member. The member must also meet any of the policy criteria for their requested chair.

Medicare does not cover the rental, purchase or repair of mobility devices when the member is living in a long-term care facility. Providers must follow South Country authorization and billing procedures. It is not necessary to bill Medicare before billing South Country.

### Noncovered Services

Mobility devices are not covered in the following circumstances:

- Power mobility devices if requested solely for the purpose of community outings such as attending social activities
- Mobility devices requested to meet behavioral needs rather than mobility needs
- Mobility devices requested solely for use in a public school if the device can be covered through an individualized education program (IEP)
- Backup devices if requested in case of equipment malfunction, unless the member's power chair has custom molded seating such that the member cannot be served by a loaner or rental chair
- Mobility devices designed for sports or recreational purposes
- Wheelchairs with stair climbing ability
- Unbundling is not allowed for titanium, carbon fiber, and so on. Manual wheelchair bases (K0001, K0002, K0003, K0004, K0005, K0006, K0007, K0008, and K0009) include construction of any type material, including, but not limited to, titanium, carbon, or any other lightweight high-strength material. Suppliers must not bill a wheelchair component or accessory, not otherwise specified (K0108) in addition to the wheelchair base (K0001, K0002, K0003, K0004, K0005, K0006, K0007, K0008, and K0009) for construction materials or for a "heavy-duty package" reflecting the type of material used to construct the manual wheelchair base. Billing for construction material is incorrect coding.
- Options and accessories to convert a manual chair to a power chair
- Adult power mobility devices (power wheelchairs or power operated vehicles) not reviewed by Medicare's Pricing, Data Analysis and Coding (PDAC) contractor or reviewed by the PDAC contractor and found not to meet the definition of a specific power mobility device. To determine the correct HCPCS code for a power mobility device, access the Durable Medical Equipment Coding System (DMECS) Product Classification List.

### Augmentative Communication (AC) Devices

South Country covers augmentative (AC) devices under the durable medical equipment benefit. AC or speech-generating devices are devices dedicated to transmitting or producing messages or symbols in a manner that compensates a member's expressive communication disorder and limitations.

## Covered Services

AC Devices (E2500, E2502, E2504, E2506, E2508, E2510, E2511, E2512, E2599 - *U3 modifier is required for all electronic tablets used as an AC device, tablet accessories and related services)

AC devices include, but are not limited to:

- Communication picture books
- Communication charts and boards
- Mechanical devices
- Electronic devices
- Electronic tablets
- Communication software application

Accessories may include the following:

- A carrying case
- A mounting system and hardware
- A protective case for nondedicated tablets
- Other accessories determined to be medically necessary

South Country will cover services necessary to set up and maintain nondedicated electronic tablets including:

- Registering the device
- Downloading software
- Updating software applications

## Coverage Criteria

To be covered as a rehabilitative and therapeutic service, the member's physician must prescribe an AC device following a required face-to-face encounter with the member within six months before the dispensing date of the device.

The speech-language pathologist must specify the device in a plan of care (POC) that is reviewed and revised as medically necessary by the member's physician or other licensed practitioner of the healing arts.

Speech-language pathologists, occupational therapists, physical therapists and other professionals should collaborate to prepare the required authorization documentation submitted by the equipment supply provider, outpatient hospital, or device manufacturer.

Electronic Tablets as AC Devices
South Country covers electronic tablets when members use them as augmentative communication (AC) devices. A tablet used for this purpose is considered durable medical equipment (DME) and must be dedicated for a member's communication needs.

Electronic tablets used as AC devices must meet the same coverage criteria as other devices. In addition, they must meet the following:

- The member's speech language pathologist (SLP) must determine the tablet and software application that is the most appropriate, cost-effective choice for a member's communication needs

- The tablet must be locked to prevent use not related to communication. Locking features include Parental Controls and Guided Access (for iPad®) or other comparable feature for other tablets

Speech-language pathologist's responsibilities

The SLP determines the communication needs of the member through an evaluation and device trials. If the SLP recommends a nontraditional style tablet, the SLP will complete and send the request and medical documentation to an DME provider who obtains the tablet through their distributors and provides it for the member. Based on the member's existing support system, the SLP must also identify who is responsible for all of the following:

- Setting up the device account and registration
- Purchasing and downloading the speech software application and updating as needed
- Enabling the device's accessibility feature (such as Guided Access for iPad®)
- Keeping a record of the passcode
- Upgrading the device's operating system when required
- Handling or ordering repairs

This information must be included in the member's plan of care and the DME provider's records. To comply with Minnesota Statutes, the member's therapist, the DME provider or another responsible party will retain the passcode used to lock the device or application.

DME provider's responsibilities

The DME provider is responsible for submitting the authorization for a tablet they intend to provide.

If South Country approves the authorization, the provider does the following:

- Orders and purchases the tablet, software and accessories
- Prepares it for the member's use
- Delivers it to the SLP or member
- Bills South Country for the equipment

## Authorization Requirements:

*Authorization is required for all AC devices.*

For dual-eligible members, please refer to CMS guidelines for coverage guidelines. See LCD L33739

Authorization Criteria

Address all points outlined here for South Country to consider your authorization:

- A description of the current medical status and history
- An assessment of the verbal and physical capabilities in relation to need and use of an AC device (electronic and nonelectronic)
- The speech-language pathologist and occupational therapist or physical therapist assessments may be submitted in a collaborative format as long as the documentation clearly delineates the specific goals and assessment of each therapy discipline
- A detailed description of the therapeutic history (physical therapy, occupational therapy and speech-language pathology), including the nature, frequency and duration of therapeutic services provided to the member

- Details of the speech-language pathology approaches in relation to the need and use of an AC device
- The dates of the trial period of the device as required when the member is not currently using a device
- An explicit evaluation of each AC device or method of communication tried by the recipient and information on the effectiveness of each device

Address all parameters of device selection, that is, interactive ability in all situational contexts, including:

- School
- Home
- Community
- Vocational
- Work
- Social environments
- Detailed description of the member's ability to use the proposed device, including speed and accuracy

*Note: For tablets obtained through a durable medical equipment (DME) provider, the authorization request must identify the person or people who will be responsible for locking the tablet and indicate who will be responsible for initial set up and future maintenance of the tablet.*

Address these situational references dependent upon the mobility level of the member:

- How will the device be adapted to meet the needs of a member who uses a walker?
- Is the communication device less obtrusive than other methods when mobility levels are considered?
- Frequency of device use in various settings
- Empirical data regarding the trial period of use with the device
- A description of the level of communication initiation with the selected communication device and whether or not the equipment is used accurately and spontaneously. If the pattern of initiation is different from past history, provide an explanation and justification for the change
- A detailed description and plan for the proposed nature, frequency and duration of therapeutic intervention, including all necessary therapeutic interventions, in relation to the AC device

Refer to the augmentative communication device HCPCS codes when requesting an authorization for purchase or rental. Include the device model name and model number and software, if it applies. In addition, note the following on the authorization request:

- List the title of appropriate software applications for electronic tablets supplied through a DME provider
- List all standard and nonstandard accessories and options (including mounting systems) on separate lines on the authorization request, even if the individual item does not require authorization

- When multiple accessories are requested that are different but use the same code, list each item on a separate line of the authorization request, with appropriate modifiers to distinguish a separate and distinct service or item
- Include a description of each item and model numbers where applicable
- List each item by HCPCS code, appropriate modifier, quantity, charges and medical necessity documentation for nonstandard items

## Authorizations for repairs

All AC device HCPCS codes have a maximum unit limit of one, according to the National Correct Coding Initiative (NCCI) Medically Unlikely Edit (MUE). Authorizations for repairs must include:

- One unit of the AC device code that best represents the device being repaired
- Modifier RB for a repair or modifier RA for a part to be replaced on the device
- The device model number
- An itemization of the repair service(s) provided (for example, replaced display, replaced touch screen panel, replaced cable) including the provider's usual and customary amount charged

## Robotic Arms

Robotic arms refer to assistive devices that are attached to a member's power wheelchair and help people with disabilities perform activities of daily living (ADLs) or instrumental activities of daily living (IADLs). Robotic arms may enhance or increase the functional capabilities of people living with heavily limited use of upper extremities.

Robotic arms are covered for eligible South Country members who suffer from a disability that severely restricts use of their upper extremities.

**Potential diagnoses could include (but are not limited to):**

- Amyotrophic lateral sclerosis (ALS)
- Arthrogryposis
- Cerebral palsy
- Multiple sclerosis
- Muscular dystrophy
- Parkinson's disease
- Quadriplegia
- Spinal cord injury
- Spinal muscular atrophy
- Stroke

**Covered Services:**

South Country covers robotic arms for MHCP members who have a condition that severely restricts use of their upper extremities and meet all of the following criteria:

- The member must be a full-time power wheelchair user; and

- Documentation indicates the member is unable to use both of their upper extremities against gravity, as evident by Manual Muscle Testing; and
- Documentation shows the device will allow the member to be independent in one or more ADLs or IADLs.
- ADLs include but are not limited to bathing, dressing, drinking, eating, hygiene activities and toileting, and other activities specified in the treatment plan.
- IADLs allow an individual to live independently and include but are not limited to accessing public transportation, food preparation, housekeeping, opening doors, shopping, and taking medication.

**Noncovered Services**

South Country does not cover robotic arms that are not registered with the U.S. Food and Drug Administration.

**Authorization Requirements**

Prior authorization is required for all robotic arms billed with E1399 and cost exceeding $500. Coverage determinations are based upon a review of submitted case-specific information.

Documentation for authorization requests must include:

- Member's diagnosis and clinical history
- Order
- Letter of medical necessity
- A face-to-face evaluation by a physical or occupational therapist
- Results of device trial period including links to unedited trial videos of the member completing ADLs or other desired IADLs
- Consideration of less-costly alternatives to robotic arms including documentation stating why alternative devices are not appropriate for member's condition and medical needs
- A detailed list of products and accessories including manufacturer, model number, product description, and manufacturer's suggested retail price (MSRP)

The provider must appropriately train the member on the use of the equipment, including any necessary adjustments. These costs are not separately reimbursable.

South Country policy requires a three-month trial before purchase. Authorization is required for purchase of the device. Trial periods must be initiated before requesting authorization and payment will only be provided upon the successful completion of the trial period. The review process is as follows:

- The provider and medical supplier evaluate the member's medical needs, attach the device to the member's power wheelchair, and provide necessary training and adjustments.
- The member uses the device in their usual living arrangement.
- During the three-month trial period, a request for purchase of the device must be submitted along with documentation from a physician or therapist illustrating ongoing, safe use of the device. Note:
    - Requests for purchase may be submitted four weeks into the trial period or later, however, purchase will only be effective after completion of the full three-month trial.

    - If during the trial period the member does not wish to convert the robotic arm to a purchase, the device must be detached and returned to the provider.
- South Country receives and reviews request for robotic arm according to procedures for reviewing DME.
- If the robotic arm is approved, the device becomes the member's property.

If a robotic arm is approved for a member, the provider must obtain documentation from the member or the member's authorized representative acknowledging that the member understands the robotic arm may affect future requests for PCA or home care services before dispensing and billing for this item.

**Billing**

- Bill using HCPCS code E1399 for robotic arms and K0108 for accessories that do not have a more appropriate HCPCS code.
- Use modifier U9 with E1399.
- Use modifier NU for purchases.
- Use modifier RR for rentals.
- Do not bill South Country for repairs when the device is under warranty.
- If the member has Medicare or other insurance coverage as primary, include documentation with the request demonstrating the device is a noncovered item by the primary insurance.

Robotic arms have a warranty period in which the manufacturer is to pay for maintenance and repair. South Country will only reimburse for one month of rental while a device is being repaired.

When adding a robotic arm to an existing mobility device, the provider is responsible for the replacement of the joystick and interface controls or electronics needed for the operation of the robotic arm.

## Mechanical Stretching Devices

Mechanical stretching devices, or extension and flexion devices, are used for the treatment of joint contractures in lower and upper extremities. These devices are intended to maintain or restore range of motion and replace some therapy-directed sessions through consistent and frequent joint mobilization in an outpatient setting or in the home.

Mechanical stretching devices are covered for eligible South Country members who:

- suffer from joint stiffness and are not responding to, or as a complement to, physical or occupational therapy during the subacute injury or postoperative period (for example, at least three weeks but less than four months after injury or surgery); or
- have a documented history of motion stiffness or loss in a joint, have had a surgery or procedure done to improve motion to that joint, and are in the acute postoperative period following a second or subsequent surgery or procedure.

### Covered Services

Codes: E1800, E1802-E1805, E1807, E1808, E1810, E1812-E1815, E1820, E1822, E1823, E1825-E1830, E1840

South Country covers dynamic splinting systems for eligible members. Dynamic splinting systems for extension and/or flexion are covered for ankles (E1815, E1822, and E1823), elbows (E1800, E1803, and E1804), fingers (E1825 to E1827), forearms (E1802), knees (E1810,

E1812 to E1814), shoulders (E1840), toes (E1828 to E1830), or wrists (E1805, E1807, and E1808).

**Noncovered Services**

South Country does not cover the following devices because they are considered investigative and substantive research is lacking:

- Static progressive stretch (SPS) or bi-directional SPS devices (E1801, E1806, E1811, E1816, E1818, E1821, E1831, E1832, and E1841)
- Patient-actuated serial stretch (PASS) or high-intensity stretch devices

**Authorization**

*Authorization is not required for mechanical stretching devices.*

Providers must keep documentation in the medical record of:

- Member's diagnosis
- Order
- A face-to-face evaluation by a physical or occupational therapist
- Clinical history of member's joint stiffness and prior treatments, including physical or occupational therapy, any surgeries, and other procedures
- Treatment plan, including baseline measurements of range of motion limitations

**Billing**

- Use modifier NU for purchases.
- Use modifiers KH, KI, KJ, and RR for rentals.

## Miscellaneous Products

**Sharps Disposal Containers**
**Code:** A4211 U3
Members who self-administer medications using syringes may receive sharps disposal containers. Bill using A4211 and modifier U3 along with appropriate pricing information.

**Weighted Blankets or Vests**
**Code:** E1399 NU
Weighted blankets or vests are covered for members who have developmental disabilities, including autism spectrum disorders. The function of the weighted blankets is to provide proprioception (deep pressure), which has a calming effect that allows people with developmental disabilities to interact with their environment. Documentation needs to include relevant diagnoses of the member and evaluation performed by an occupational therapist that justifies medical necessity. Authorization is required for submitted charge over $500.

**Protective Helmets**
**Codes**: A8000-A8004
Protective helmets, including prefabricated and custom fabricated items and soft interface replacements, are covered for members at risk of head injury due to a medical condition such as seizures or developmental disability. Most members older than 2 years old can be served with one protective helmet per year. Members younger than 2 years old may require more frequent replacements. Documentation needs to explain why a prefabricated helmet does not suffice.Medicare Supplemental Benefit - DME/Safety/Home Modifications

SeniorCare Complete and AbilityCare members are eligible for Home & Safety devices and modifications; if the member is on a waiver, waiver funds should be exhausted before use of this

benefit.  The home and safety devices or modifications covered under this benefit include devices, equipment or modifications that promote health or safe independent living (authorization is required). The annual maximum is $1000.

Examples of included items would be grab bars, shower or bathtub seats, handrails, non-slip flooring, temporary wheelchair ramps, electronic medicine dispenser, oral health items, and lift chairs. Note: this is not an all-inclusive list.

Prior authorization is required - provider may contact member's care coordinator or fax authorization request using the Supplemental Benefit request form #6747 found in the provider forms section at https://mnscha.org. Providers must submit the claim using South Country's required billing code for this benefit: A9270 with SC modifier.