

## Chapter 23

# Equipment and Supplies

## Eligible Providers

Medical suppliers (including oxygen contract vendors), pharmacies, Federally Qualified Health Centers (FQHCs), Rural Health Clinics (RHCs), Indian Health Service (IHS), and home health agencies must provide medical equipment and/or supplies for sale or rental to IMCare members. Unless otherwise indicated, IMCare only covers items/products/services that are covered under Minnesota Health Care Programs (MHCP). The medical supply provider must be able to perform or arrange necessary repairs and maintenance to equipment offered for sale or rental.

**If available, IMCare covers DME rental – NOT purchase.**

Hospital outpatient facilities, physicians, nurse practitioners (NPs), Clinical Nurse Specialists (CNSs), physician assistants (PAs), podiatrists, and clinics are eligible providers for medical equipment and supplies only when the medical equipment and supplies are provided as a necessary adjunct to the direct treatment of a member's condition (e.g., crutches, splints) and not incident to the service provided.

## 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 in order to assist members for whom IMCare 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 including supplies and equipment.

Providers who do not meet provider criteria for the primary payer will not be reimbursed by IMCare.

If Medicare downcodes an item, IMCare must make payment based on the downcoded Medicare explanation of benefits (EOB), regardless of any IMCare 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.

## Eligible Members

All IMCare members are eligible. Refer to *Benefits* section for coverage determination and exceptions indicated in Chapter 2, Health Care Programs and Services, of this manual.

## Covered Services

IMCare covers medical equipment and supplies, subject to limitations, authorization, and other requirements. All DME and Supplies over \$1000.00 require an authorization. Additional restrictions apply to medical equipment and supply coverage for members residing in long-term care facilities (LTCFs).

1. When the medical equipment or supply is purchased for a member, the item is the member's property.
2. Depending on the member's coverage (Medicare or Medicaid primary), rent for most Durable Medical Equipment (DME) is covered (if medical necessity criteria are met) for the applicable Medicare or Medicaid

coverage period based on InterQual™ criteria, 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.

3. DME determined by Medicare to require frequent and substantial servicing is not subject to the 13-month rental limit.
4. IMCare assumes a reasonable useful lifetime of five years for all DME.
5. IMCare will not cover equipment that serves the same purpose as usable equipment previously purchased for the member.
6. IMCare covers repairs to medically necessary member-owned equipment and maintenance on equipment that requires frequent cleaning and/or routine calibration to ensure proper working order.
7. All purchased equipment must be new upon delivery to the member. Equipment that is intended to be rented until converted to purchase must be new equipment. Used equipment may be used for short-term rental, but if eventually converted to purchase, it must be replaced with new equipment.

To determine the appropriate Healthcare Common Procedure Coding System (HCPCS) code to use with a covered service, access the [Medicare Pricing, Data Analysis, and Coding \(PDAC\) Product Classification List](#).

### Living Arrangement Codes

- 41:** NFI (Nursing Facility I) Medicare Cert
- 42:** NFII (Nursing Facility II) Non-Medicare Cert
- 43:** Intermediate Care Facility for the Developmentally Disabled (ICF/DD) – Public/Private
- 44:** Short-Term Stay NFI
- 45:** Short-Term Stay NFII
- 46:** Short-Term Stay ICF-DD
- 48:** Medical Hospital
- 55:** Rule 203 – Adult Foster Home
- 80:** Community

### Billing

All professional and institutional claims must be submitted electronically in order to comply with [MN Stat. sec. 62J.536](#). These include all claims currently processed by IMCare, including 837P (professional), 837I (institutional), 837D (dental), pharmacy claims, and crossover claims, which include payment information from other insurance carriers via the coordination of benefits (COB) process. For more information on billing, please see Chapter 4, Billing Policy.

### IMCare Provider Responsibilities

IMCare-enrolled providers advise the lead agency if either of the following is true:

1. A health care provider's order is necessary for other payers/TPL, Medicare, or IMCare to cover the item following health care industry standards
2. The item can be covered by other payers/Medicare/TPL or IMCare To determine this, check member eligibility using the Minnesota Information Transfer System (MN-ITS) and inquire if any other insurance coverage exists that is not currently reported to Minnesota Health Care Programs (MHCP).
  - a. If other coverage exists, find out from the other payer(s) if the item is or can be covered with an authorization.
  - b. If other coverage does not exist, keep documents showing you verified with other payer/TPL/Medicare Follow directions in the IMCare *Provider Manual* to determine if IMCare covers the item with or without an authorization.

Review authorization or purchase agreement for accuracy.

Document the items the lead agency requests your agency provide.  
Dispense the item according to your business policies and procedures.

Ensure you followed the appropriate processes (1 and 2 above) and have the correct documentation in the member's file.

Submit the claim to IMCare for payment according to the following:

1. Use the 837P Professional claim transaction
2. Follow IMCare Billing Policy guidelines
3. Itemize each item/service per service line
4. Enter the basic description of the item you dispensed in the notes section of the service line

## Coverage Criteria

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

All Electric Breast pumps, Tens Units, prosthetics, orthotics, or supplies (DMEPOS) over \$1000.00 or provided by out-of-network or non-contracted providers, (including medical suppliers or DME providers), require Service Authorization prior to the sale or rental of any Durable Medical Equipment. All Skilled Nursing Facilities (SNFs) that are contracted with IMCare who usually do business with DME providers or suppliers are encouraged to use in-network providers whenever possible for these items/supplies. However, if a provider is used that is not contracted with IMCare, the SNF can continue utilizing those suppliers without a separate out-of-network authorization from IMCare. Service Authorization is still required for the specific DMEPOS if it is part of the Service Authorization list indicated below.

Contracted providers or in-network providers require Service Authorization for the following DMEPOS. Also see Chapter 5, Service Authorizations, for more specific information regarding Service Authorizations.

### **Face-to-Face Encounter for Some Durable Medical Equipment (DME), Effective October 1, 2013**

Section 302(a)(2) of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) added Section 1834 (a)(1)(E)(iv) to the Act, which provides that payment may not be made for a covered item consisting of a motorized or power wheelchair unless a physician (as defined in section 1861[r][1] of the Act, or a PA, NP, or CNS as the terms are defined in Section 1861[aa][5] of the Act) has conducted a face-to-face examination of the member and written a prescription for the item.

The face-to-face encounter must be within six months before ordering or on the date of ordering. The documentation must show that the member was evaluated and/or treated for a condition that supports the DME item(s) ordered.

The following codes require a face-to-face encounter visit as defined above.

Healthcare Common Procedure Coding System (HCPCS) Code	Description
E0194	Air fluidized bed
E0260	Hospital bed semi-electric (head and foot adjustment) with any type side rails, with mattress
E0261	Hospital bed semi-electric (head and foot adjustment) with any type side rails, without mattress
E0265	Hospital bed total electric (head, foot, and height adjustments) with any type side rails, with mattress
E0266	Hospital bed total electric (head, foot, and height adjustments) with any type side rails, without mattress
E0294	Hospital bed semi-electric (head and foot adjustment) without rail, with mattress
E0295	Hospital bed semi-electric (head and foot adjustment) without rail, without mattress
E0296	Hospital bed total electric (head, foot, and height adjustments) without rail, with mattress
E0297	Hospital bed total electric (head, foot, and height adjustments) without rail, without mattress
E0300	Pediatric crib, hospital grade, fully enclosed
E0301	Hospital bed, heavy duty extra wide, with weight capacity 350 – 600 pounds, with any type of rail, without mattress
E0302	Hospital bed, heavy duty extra wide, with weight capacity greater than 600 pounds, with any type of rail, without mattress
E0303	Hospital bed, heavy duty extra wide, with weight capacity 350 – 600 pounds, with any type rail, with mattress
E0304	Hospital bed, heavy duty extra wide, with weight capacity greater than 600 pounds, with any type of rail, with mattress
E0450	Volume control ventilator without pressure support used with invasive interface
E0460	Negative pressure ventilator, portable or stationary
E0461	Volume control ventilator without pressure support node for a noninvasive interface
E0462	Rocking bed with or without side rail
E0463	Pressure support vent with volume control mode used for invasive surfaces
E0464	Pressure support vent with volume control mode used for noninvasive surfaces
E0470	Respiratory assist device, bi-level pressure capability, without backup rate used for a noninvasive interface
E0471	Respiratory assist device, bi-level pressure capability, with backup rate for a noninvasive interface
E0472	Respiratory assist device, bi-level pressure capability, with backup rate for invasive interface
E0480	Percussor electric/pneumatic home model
E0482	Cough stimulating device, alternating positive and negative airway pressure
E0483	High frequency chest wall oscillation air pulse generator system
E0575	Nebulizer, ultrasonic, large volume
E0601	Continuous airway pressure device
E0627	Seat lift mechanism incorporated lift chair

Healthcare Common Procedure Coding System (HCPCS) Code	Description
E0628	Separate seat lift mechanism for patient-owned furniture, electric
E0629	Separate seat lift mechanism for patient-owned furniture, non-electric
E0636	Multi-positional patient support system with integrated lift, patient accessible controls
E0652	Pneumatic compressor segmental home model with calibrated gradient pressure
E0675	Pneumatic compression device, high pressure, rapid inflation/deflation cycle, for arterial insufficiency
E0692	Ultraviolet light therapy system panel treatment, 4-foot panel
E0693	Ultraviolet light therapy system panel treatment, 6-foot panel
E0694	Ultraviolet multidirectional light therapy system in 6-foot cabinet
E0720	Transcutaneous Electrical Nerve Stimulator (TENS), two lead, local stimulation
E0730	Transcutaneous electrical nerve stimulation, four or more leads, for multiple nerve stimulation
E0731	Form fitting conductive garment for delivery of (TENS) or Neuromuscular Electrical Stimulation (NMES)
E0740	Incontinence treatment system, pelvic floor stimulator, monitor, sensor and/or trainer
E0744	Neuromuscular stimulator for scoliosis
E0745	Neuromuscular stimulator, electric shock unit
E0747	Osteogenesis stimulator, electrical, non-invasive, other than spine application
E0748	Osteogenesis stimulator, electrical, non-invasive, spinal application
E0749	Osteogenesis stimulator, electrical, surgically implanted
E0760	Osteogenesis stimulator, low intensity ultrasound, non-invasive
E0762	Transcutaneous electrical joint stimulation system, including all accessories
E0764	Functional neuromuscular stimulator, transcutaneous stimulations of muscles of ambulation with computer controls
E0765	Food and Drug Administration (FDA)-approved nerve stimulator for treatment of nausea and vomiting
E0782	Infusion pump, implantable, non-programmable
E0783	Infusion pump, implantable, programmable
E0784	External ambulatory infusion pump
E0786	Implantable programmable infusion pump, replacement
E0985	Wheelchair accessory, seat lift mechanism
E0986	Manual wheelchair accessory, push-activated power assist
E1031	Rollabout chair, any and all types with castors 5 inches or greater
E1035	Multi-positional patient transfer system with integrated seat operated by caregiver
E1036	Patient transfer system
E1037	Transport chair, pediatric size
E1038	Transport chair, adult size, up to 300 pounds
E1039	Transport chair, adult size, heavy duty (greater than 300 pounds)
E1161	Manual adult size wheelchair, includes tilt-in-space
E1227	Special height arm for wheelchair
E1228	Special back height for wheelchair

<b>Healthcare Common Procedure Coding System (HCPCS) Code</b>	<b>Description</b>
E1232	Wheelchair, pediatric size, tilt-in-space, folding, adjustable with seating system
E1233	Wheelchair, pediatric size, tilt-in-space, rigid, adjustable without seating system
E1234	Wheelchair, pediatric size, tilt-in-space, folding, adjustable without seating system
E1235	Wheelchair, pediatric size, rigid, adjustable, with seating system
E1236	Wheelchair, pediatric size, folding, adjustable, with seating system
E1237	Wheelchair, pediatric size, rigid, adjustable, without seating system
E1238	Wheelchair, pediatric size, folding, adjustable, without seating system
E1310	Whirlpool, non-portable
E2502	Speech generating devices, prerecord messages between 8 and 20 minutes
E2506	Speech generating devices, prerecord messages over 40 minutes
E2508	Speech generating devices, message through spelling, manual type
E2510	Speech generating devices, synthesized with multiple message methods
E2227	Rigid pediatric wheelchair, adjustable
K0001	Standard wheelchair
K0002	Stand hemi (low seat) wheelchair
K0003	Lightweight wheelchair
K0004	High strength, lightweight wheelchair
K0005	Ultra lightweight wheelchair
K0006	Heavy duty wheelchair
K0007	Extra heavy duty wheelchair
K0009	Other manual wheelchair/base
K0606	Automated external defibrillator (AED) garment with electronic analysis

All claims for DME and/or supplies for \$1,000 or more require Service Authorization before being submitted for payment. This is for contracted medical suppliers only. Non-contracted or out-of-network suppliers require Service Authorization for DME and /or supplies for \$1000.00 or more.

## **Equipment & Supplies Sections**

1. Airway Clearance Devices
2. Ambulatory Assist Equipment
3. Apnea Monitors
4. Augmentative Communication (AC) Devices
5. Bath and Toilet Equipment
6. Bone Growth Stimulators
7. Cranial Electrotherapy Stimulator (CES)
8. Diabetic Equipment and Supplies
9. Electrical Stimulation Devices
10. External Defibrillators
11. Functional Electrical Stimulation
12. Gloves
13. Hospital Beds
14. Humanitarian Use Devices
15. Incontinence Products
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17. Lower Limb Prosthetics
18. Miscellaneous Codes
19. Miscellaneous Products
20. Mobility Devices
21. Nebulizers
22. Non-Mobility Equipment Repairs
23. Nutritional Products
24. Orthopedic and Therapeutic Footwear
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27. Oxygen and Oxygen Equipment
28. Patient Lifts and Seat Lift Mechanisms
29. Positioning Equipment
30. Pneumatic Compression Devices
31. Positive Airway Pressure for Treatment of Obstructive Sleep Apnea
32. Pressure Reducing Support Surfaces
33. Prosthetics and Orthotics
34. Respiratory Assist Devices (Suitable for 12 Hours or Less Per Day)
35. Seasonal Affective Disorder (SAD) Lights/Light Therapy
36. Specialized Wound Treatment Technology
37. Spirometers
38. Stenders or Standing Frames
39. Suction Pump (Respiratory)
40. Topical Products Defined as Drugs
41. Transcutaneous Electrical Nerve Stimulator (TENS)
42. Ultraviolet Light Therapy Systems
43. Urological Supplies
44. Ventilators
45. Wigs

## **Airway Clearance Devices**

Airway clearance devices provide self-administered airway clearance for individuals with certain respiratory or neuromuscular conditions.

### **Eligible Providers**

Eligible providers include: medical suppliers, pharmacies, home health agencies, Federally Qualified Health Centers (FQHCs), and Rural Health Clinics (RHCs).

### **Third Party Liability (TPL) and Medicare**

Providers must meet any provider criteria, including accreditation, for third party insurance or for Medicare in order to assist members for whom IMCare is not the primary payer.

IMCare quantity limits and thresholds apply to all members unless only Medicare coinsurance or deductible is requested.

### **Eligible Members**

All IMCare members who meet the coverage criteria are eligible.

## Covered Services

1. A7025 (High-frequency chest wall oscillation [HFCWO] system vest, replacement)
2. E0480 (Percussor, electric, or pneumatic, home model)
3. E0482 (Cough stimulating device, alternating positive and negative airway pressure)
4. E0483 (HFCWO air-pulse generator system)
5. E0484 (Oscillatory positive expiratory pressure device, nonelectric, any type)

Nonelectric oscillatory devices (E0484) are covered for members with medical conditions that cause a need for assistance with mucus clearance from the airway.

Electric or pneumatic percussors (E0480) are covered for members who require chest physiotherapy with the assistance of a mechanical device.

Cough stimulating devices (E0482), also known as In-Exsufflation devices, are covered for members with neuromuscular disease that causes a significant impairment of chest wall and/or diaphragmatic movement, and that results in an inability to clear secretions when standard treatments have failed or are medically contraindicated.

HFCWO air-pulse generator systems (E0483) are covered for members when standard chest physiotherapy has failed or is medically contraindicated and the member has one of the following indications:

1. Cystic fibrosis (CF)
2. Chronic bronchiectasis, confirmed by radiological scan, **and**
3. Daily productive cough for at least 6 continuous months or more than 2 exacerbations in 12 months requiring antibiotic treatment
4. Chronic neuromuscular disease with a history of pneumonia

HFCWO replacement vests (A7025) are covered for use with member-owned systems when the original vest is lost, stolen, or damaged beyond repair and not covered by a warranty.

## Non-Covered Services

1. HFCWO systems are not covered for members with conditions other than CF or chronic bronchiectasis because they are investigative for other conditions.
2. HFCWO systems are not covered for members who have known cardiac conditions.
3. Intrapulmonary percussive ventilation devices are not covered for any indication because they are investigative.

## Authorization

IMCare allows rentals for cough stimulating devices, HFCWO systems, and replacement vests for HFCWO systems. A device over a \$1000.00 requires an Authorization.

**Cough stimulating devices:** Documentation must include a diagnosis of neuromuscular disease and the member's history of conservative treatment and why it is not meeting the member's needs or why it is medically contraindicated.

**HFCWO systems:** Documentation must include a diagnosis of CF or bronchiectasis and the member's history of chest physiotherapy and why it is not meeting the member's needs or why it is medically contraindicated.



A vest will not replace a precursor, caregiver, and/or self-administration unless it is demonstrated that these forms of therapy are no longer effective or available.

**Replacement vest for HFCWO systems:** Documentation must state why the vest needs replacement, and when the warranty period ended.

IMCare will not reimburse providers for bronchial drainage performed by a therapist or any other health care professional (including Personal Care Assistants [PCAs]) while the member has a functional bronchial drainage vest.

## **Billing**

1. An HFCWO air-pulse generator system includes hoses and vest with initial dispensing. Do not bill separately.
2. A cough stimulating device includes all necessary accessories with initial dispensing. Do not bill separately.
3. If the member has Medicare, IMCare will pay only the deductible/co-insurance on any item for which Medicare made payment, regardless of any prior authorization.
4. If the member has Medicare, any items for which Medicare denies payment must meet IMCare coverage and authorization requirements.
5. Shipping/delivery costs are included in the IMCare maximum allowable payment and may not be separately billed to IMCare or the member.
6. Durable Medical Equipment (DME) is 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.

Refer to *Non-Mobility Equipment Repairs* for billing requirements for repairs to DME.

## **Ambulatory Assist Equipment**

Canes, crutches, walkers, and gait trainers are used to assist individuals with safe ambulation.

### **Eligible Members**

All IMCare members who meet the coverage criteria are eligible.

Canes, crutches, and walkers are not covered for members in nursing facilities or Intermediate Care Facilities for the Developmentally Disabled (ICF/DDs). Only walkers with trunk support are covered for members in ICF/DDs. Gait trainers may be covered for members in nursing facilities or ICF/DDs.

### **Codes**

E0100 – E0105: Canes

E0110 – E0118, E0153: Crutches

E0130 – E0149, E0154 – E0159: Walkers

E8000 – E8002: Pediatric-size gait trainers

### **Canes**

Canes are covered for members who are unable to safely ambulate in one or more locations they routinely access due to a temporary or permanent medical condition.

1. IMCare does not require that the cane is needed in the home. Canes are also covered for members who are able to safely ambulate in the home, but who require a cane for stability in the community.
2. IMCare covers a cane for members who primarily use walkers or wheelchairs, but who require a cane in specific situations
3. IMCare defers to the prescribing and dispensing professionals regarding what kind of cane is required (E0100 or E0105)

### **Crutches**

Crutches are covered for members who are unable to safely ambulate in one or more locations they routinely access due to a temporary or permanent medical condition.

1. When dispensing two crutches, use the Healthcare Common Procedure Coding System (HCPCS) code for a pair, not 2 units of individual crutches.
2. Use the HCPCS code for an individual crutch when replacing one of a pair of crutches.
3. When dispensing articulating, spring assisted crutches, providers must maintain documentation as to why standard crutches will not meet the member's needs.
4. Rental of a crutch substitute is covered for members who are unable to safely use standard crutches.

### **Walkers**

Walkers are covered for members who are unable to safely ambulate in one or more locations they routinely access due to a temporary or permanent medical condition.

1. IMCare does not require that the walker is needed in the home. Walkers are also covered for members who are able to safely ambulate in the home, but who require a walker for safety in the community.
2. IMCare covers a walker for members who primarily use wheelchairs, but who require a walker in specific situations.
3. A heavy-duty walker is covered if a member's weight, body size, or stability makes a standard walker unsafe. Because very few walkers are made for children, IMCare will allow manual pricing of pediatric walkers.
4. A wheeled walker is assumed to include glide-type brakes that 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 E0159 as a replacement for glide-type brakes.
5. Reverse walkers are considered medically necessary for members who cannot safely use a standard walker.
6. Only walkers coded by the Pricing, Data Analysis, and Coding (PDAC) Administrative Services may be billed as E0147.

### **Gait Trainers**

Gait trainers are covered with prior authorization for members who require moderate to maximum support to walk and who require the equipment to establish or maintain functional gait.

Documentation must include the following:

1. Member's age, height, weight, and current level of mobility
2. A physical therapy evaluation with baseline measurements, functional goals, and recommendations for an assistive device to support gait training and ambulation, as well as any history of gait training and devices used
3. A specific therapy program detailing the frequency and duration of sessions during which the member will use the device
4. Training given to the caretakers to assure that the device is used appropriately
5. Results of a trial in the locations where the device is expected to be used

6. Less costly alternatives considered and why they were rejected (include specific product information)

Submit the 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.

### **Non-Covered Services**

1. Grab bars/wall rails
2. Portable or installed ramps
3. White canes for the blind

### **Authorization**

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.

Canes, crutches, and walkers do not require authorization. IMCare allows rentals of Gait trainers (E8000 – E8002), but requires a Service Authorization if the device is over a \$1000.00.

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

### **Billing**

1. Bill all ambulatory assist equipment using the most appropriate HCPCS code. Do not use a miscellaneous code regardless of special features or weight capacity.
2. Use A9999 for accessories for previously purchased gait trainers.
3. The HCPCS code and modifiers must match the authorization.

## **Apnea Monitors**

### **Overview**

Apnea monitors are used to monitor breathing and cardiac status for children at risk of apnea or sudden infant death syndrome (SIDS).

### **Third Party Liability (TPL) and Medicare**

Providers must meet any provider criteria, including accreditation, for third party insurance or for Medicare in order to assist members for whom IMCare is not the primary payer.

IMCare quantity limits and thresholds apply to all members unless only Medicare co-insurance or deductible is requested.

### **Covered Services**

**Codes:** A4556 (electrodes), A4557 (lead wires), E0618 (apnea monitor), E0619 (apnea monitor with recording feature)

**Authorization** is required after six months of rental for contracted providers (out-of-network providers require

authorization before providing the service).

Documentation of medical necessity should be kept in the member's file at the medical supplier's office. Providers should verify continued need for the equipment every three months. Apnea monitors are covered as capped rental items, no more than 13 months of rental will be paid.

Apnea monitors are considered medically necessary for members under age 2 with any of the following risk factors or similar medical conditions:

1. Apparent life-threatening episode(s) (ALTE)
2. Apnea (central or obstructive)
3. Choking or gagging
4. Skin color change (cyanosis, pallor, erythematous or plethoric)
5. Marked change in muscle tone
6. Tracheotomies or anatomical abnormalities that make them vulnerable to airway compromise
7. Metabolic or neurologic disorders affecting respiratory control
8. Chronic lung disease, especially those requiring mechanical ventilation, positive airway pressure or supplemental oxygen
9. Premature infants with delayed maturation of respiratory control
10. Apnea of prematurity
11. Preterm infant with bradycardia and/or desaturation
12. Diagnosis of pertussis

Apnea monitors are covered for infants with siblings who died of SIDS.

An apnea monitor with recording feature is considered medically necessary with documentation of unusual symptoms or reporting of alarms that cause the physician to request additional information.

### **Non-Covered Services**

Apnea monitors are not covered as an alternative to polysomnography for diagnosis of obstructive sleep apnea or other conditions.

### **Authorization**

Authorization is required only for maintenance service and repairs to member-owned equipment.

### **Included with Rental/Purchase**

1. Batteries
2. Battery charger
3. Carrying case
4. Cords
5. Connecting cable
6. Lights
7. Printed instructions

### **Bill Separately**

1. Electrodes
2. Lead wires
3. Rib belts

## Augmentative Communication (AC) Devices

### Overview

Augmentative communication (AC) or speech-generating devices are devices dedicated to transmitting or producing messages or symbols in a manner that compensates for the impairment and disability of a member with severe expressive communication disorders and limitations.

### Eligible Providers

AC devices are obtained from the following enrolled IMCare providers:

1. Medical equipment and supply providers.
2. Outpatient hospitals
3. AC device manufacturers

### Eligible Members

1. Members with Medical Assistance
2. Members with MinnesotaCare

### Covered Services

IMCare covers speech-language pathology and related services, including AC devices and related accessories. AC devices include, but are not limited to, the following:

1. Communication picture books
2. Communication charts and boards
3. Mechanical devices
4. Electronic devices
5. Electronic tablets\*
6. Communication software application

IMCare covers only one speech-generating device approved and purchased through IMCare. AC devices must be dedicated for speech communication use. Tablets must be locked to prevent use not related to communication.

\*Refer to MHCP Provider Update [Electronic Tablets as Augmentative Communication Devices](#) (MES-14-01).

Accessories may include the following:

1. A carrying case or mounting system
2. A protective case for non-traditional tablets
3. Other accessories determined to be medically necessary

IMCare will cover services necessary to set up and maintain dedicated non-traditional electronic tablets including the following:

1. Registering the device
2. Downloading software
3. Updating software application

## Coverage Criteria

To be covered as a rehabilitative and therapeutic service, an AC device must be specified in a plan of care, prepared by the member's speech-language pathologist and reviewed and revised as medically necessary by the member's attending physician, or other licensed practitioner of the healing arts.

Speech-language pathologists (SLPs), occupational therapists (OTs), and physical therapists (PTs) collaborate in preparing the required authorization documentation submitted by the equipment supply provider, outpatient hospital, or device manufacturer.

## Non-Covered Services

1. AC/speech-generating devices requested for the sole purpose of education
2. Environmental control devices such as switches, control boxes, or battery interrupters
3. Modification, construction, programming, or adaptation of traditional communication systems or devices
4. Repairs, cleaning, or other services for devices that are not dedicated communication devices
5. Upgrading to new technology that is not proven to be medically necessary
6. Replacing devices based on manufacturer's recommended replacement schedule (e.g., every five years)
7. Facilitated communication: a technique by which a "facilitator" provides physical and other supports in an attempt to assist a person with a significant communication disability to point to pictures, objects, and printed works or letters (IMCare does not cover facilitated communication by any provider)
8. Personal computers, laptop computers, and other personal media players that are not dedicated communication devices
9. Portable electronic devices that are not designated to have a primary use as AC devices
10. Telephones, smartphones, or cell phones
11. Carrying cases when a mounting system has been provided
12. Applications, software, or programs that have not been recommended by the speech-language pathologist or are not designated to have primary use as a communication tool
13. More than one speech-generating device funded through IMCare
14. Extended warranties

## Authorization Requirements – Device Purchase, Repairs, Rental, and Replacement

Authorization is required for the following:

1. All AC device purchases and rentals
2. Mounting systems exceeding \$1000
3. Repairs to any device in excess of \$1000

The cost of a device rental may be applied toward the purchase price for the same item supplied by the same provider.

IMCare expects reasonable care to be taken of AC devices. If a device must be replaced due to a change in medical conditions, loss, theft, or irreparable damage, the provider must request authorization for a new device. In the event of theft of a non-traditional tablet, a police report must be filed for a replacement to be considered.

Providers must list all accessories and options on the device authorization request, even if the individual items do not require authorization.

## Authorization Criteria

For an authorization to be considered, the request must include all of the following:

1. A description of the current medical status and history
2. An assessment of the verbal and physical capabilities in relation to need and use of an AC device (electronic and non-electronic)
3. 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
4. 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
5. Details of the speech-language pathology approaches in relation to the need and use of an AC device
6. An explicit evaluation of each AC device or method of communication tried by the member and information on the effectiveness of each device
7. Manufacture's price list or invoice and pricing package for non-traditional tablets and related components supplied through a DME supplier
8. [Augmentative Communication Devices and Accessories Authorization Form](#) (DHS-4535)

Please note, a trial period of the device is required when there is no device currently being used

All **parameters of device selection** (i.e., interactive ability in all situational contexts) must be addressed, including the following:

1. School
2. Home
3. Community
4. Vocational
5. Work
6. Social environments
7. Detailed description of the member's ability to use the proposed device, including speed and accuracy

For tablets obtained through a DME supplier, include the name of the person responsible for set up and maintenance of the tablet on the authorization request. A tablet used for as an AC device is considered DME and must be dedicated for a member's communication needs.

**Situational references** dependent upon the mobility level of the member must be addressed.

1. How will the device be adapted to meet the needs of a member who uses a walker?
2. Is the communication device less obtrusive than other methods when mobility levels are considered?
3. What is the frequency of device use in various settings?
4. What is the empirical data regarding the trial period of use with the device?
5. What is a description of the level of communication initiation with the selected communication device and is the equipment used accurately and spontaneously? If the pattern of initiation is different from past history, provide an explanation and justification for the change.
6. What is 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?

In addition, please do the following on authorization requests:

1. Refer to the [AC device HCPCS codes](#) when requesting an authorization for purchase or rental. Include the device model name and model number and software, if it applies.
2. List the title of appropriate software applications for electronic tablets supplied through a DME supplier
3. List all standard and non-standard accessories and options (including mounting systems) on separate lines on the authorization request, even if the individual item does not require authorization

4. When multiple accessories are requested that are different but use the same code, each item must be listed on a separate line of the authorization request, with appropriate modifiers to distinguish a separate and distinct service or item
5. Include a description of each item and model numbers where applicable
6. List each item by HCPCS code, appropriate modifier, quantity, charges, and medical necessity documentation for non-standard 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). Effective immediately, authorizations for repairs must include the following:

1. One unit of the [AC device code](#) that best represents the device being repaired
2. The correct repair/replacement modifier (RB)
3. The device model number
4. An itemization of the repair service(s) provided (e.g., replaced display, replaced touch screen panel, replaced cable) including the provider's usual and customary amount charged

### **Order/Delivery**

Traditional AC devices are supplied through MHCP-enrolled device manufacturers who work with speech-language pathologists to obtain documentation, request authorization, and provide training on use of the device.

Non-traditional electronic tablets are supplied through an enrolled DME supplier, who will work with the speech-language pathologist to request authorization and coordinate set up and delivery to the member. The speech-language pathologist has other responsibilities as defined in Provider Update [Electronic Tablets as Augmentative Communication Devices](#).

A non-traditional tablet warranty begins on the day it leaves a DME supplier's possession, regardless of the delivery means. A date and signature is required at the time of delivery. IMCare expects that the device be ready for use and delivered to the member within a few days.

To comply with Minnesota Statute, the passcode used to lock the device or application will be noted in the member's records held by member's speech-language pathologist, the DME supplier, or other responsible party as designated by the speech-language pathologist.

### **AC Device Obtained with Alternative Funding**

Authorizations for ongoing individual speech or language treatment for members whose AC device was purchased with alternate (non-IMCare) funding must be supported with the evaluation of medical appropriateness for the device. The medical appropriateness of the device must be determined before the medical need for ongoing speech or language treatment can be determined. Examples of alternative funding sources include, but are not limited to, the following:

1. Funding through civic groups
2. Fraternal organizations
3. Private donations
4. Private insurance

Requests for accessories such as mounting systems for augmentative communication devices obtained with alternative funding must include information on the availability of funding from the same source for the requested accessory.



**Billing**

1. Bill using MN–ITS Direct Data Entry claim form 837P Professional or 837I Institutional.
2. Bill on the claim format appropriate for the provider type:
  - a. Rehabilitative Services (837P) Professional
  - b. Outpatient Services for Rehab (837I)
3. X12 Batch users: Refer to [Minnesota Uniform Companion Guides](#) and [Best Practices](#) for billing instructions
4. For speech-language pathologists: Only direct time spent with the member is billable. Documentation in the member’s records must support the need for face-to-face involvement.
5. Indirect time spent programming, upgrading, modifying, or setting up an augmentative communication device or communication/picture book for a member is not billable by the speech-language pathologist.
6. Claims for repairs must include the following:
  - a. Appropriate augmentative communication device HCPCS code – one unit
  - b. Repair modifier (RB)
  - c. Device model number
  - d. Itemized statement describing each element of the repair service
  - e. Provider’s usual and customary charge for each element of the repair
7. Bill professional time spent repairing an AC device with the HCPCS code K0739: “Repair or non-routine service for durable medical equipment requiring the skill of a technician, labor component, per 15 minutes”

**Traditional AC Devices from a Manufacturer**

Code	Description	Modifiers
E2500	Speech-generating device, digitized speech, using pre-recorded messages, less than or equal to eight minutes recording time	NU, UE, RR, RA, RB
E2502	Speech-generating device, digitized speech, using prerecorded messages, greater than eight minutes but less than or equal to 20 minutes recording time	NU, UE, RR, RA, RB
E2504	Speech-generating device, digitized speech, using prerecorded messages, greater than 20 minutes but less than or equal to 40 minutes recording time	NU, UE, RR, RA, RB
E2506	Speech-generating device, digitized speech, using prerecorded messages, greater than 40 minutes recording time	NU, UE RA, RB
E2508	Speech-generating device, synthesized speech, requiring message formulation by spelling and access by physical contact with the device	NU, UE RR, RA, RB
E2510	Speech-generating device, synthesized speech, permitting multiple methods of message formulation and multiple methods of device access; for electronic tablets – use U3 modifier	NU, UE, U3*, RR, RA, RB
E2512	Accessory for speech-generating device, mounting system	NU, UE, U3*, RA, RB
E2599	Accessory for speech-generating device, not otherwise classified	NU, UE, U3*, RA, RB

\*Modifier U3 is required for all tablets, tablet accessories, and related services.

**Electronic Tablets as AC Devices from a DME Supplier**

Code	Description	Modifiers
E2510	Speech-generating device, including electronic tablets, synthesized speech, permitting multiple methods of message formulation and multiple methods of device access	NU, UE, U3*, RR, RA, RB
E2511	Software applications for electronic tablets	NU, UE, U3*, RA
E2512	Accessory for speech-generating device, mounting system	NU, UE, U3*, RA, RB

E2599	Accessory for speech-generating device, not otherwise classified	NU, UE, U3*, RA, RB
K0739	Repair or non-routine service for DME per 15 minutes. For tablets – includes technical support by supplier	NU, UE, U3*, RA, RB

\*Modifier U3 is required for all tablets, tablet accessories, and related services.

## Definitions

**Dedicated** – Intended for a specific use or purpose

**Non-Traditional Tablet** – Any electronic tablet designed for multipurpose use and sold (provided) by various retailers and suppliers. Examples of these tablets include Apple iPad® or Samsung Galaxy®.

**Traditional AC Devices and Tablets** – Traditional AC devices and tablets are those designed, trademarked, and supplied by the individual manufacturer.

## Bath and Toilet Equipment

Bath and toilet equipment is used to provide support and safety to individuals during hygiene tasks.

Bath and toilet equipment is covered for members who meet medical necessity criteria. Bath and toilet equipment is included in the nursing facility per diem and is not separately reimbursable.

Most bath and toilet equipment is included in the Intermediate Care Facility for the Developmentally Disabled (ICF/DD) per diem. Seat lift mechanisms and rehab shower commode chairs may be covered outside the ICF/DD per diem for members who meet medical necessity criteria.

## Codes

E0163 –E0168: Commodes  
 E0170 – E0172: Seat lift for commode/toilet  
 E0240: Bath/shower chair  
 E0244: Raised toilet seat  
 E0245: Tub stool/bench  
 E0247 – E0248: Transfer benches  
 E0625: Bath lift

## Commodes

Commodes are covered for members who are unable to safely and promptly access the toilet in the bathroom in their homes due to a medical condition.

IMCare does not require that members are confined to their beds or to their rooms.

A heavy-duty commode may be dispensed if a member's weight, body size, or stability makes a standard commode unsafe.

A pediatric commode is covered if the member is unable to safely and promptly access the bathroom in his/her home due to a medical condition and his/her size requires a pediatric commode.

## **Commode Chair with Integrated Seat Lift Mechanism/Toilet Seat Lift Mechanism**

Commode chairs with non-electric seat lift mechanism are covered without authorization for members who meet criteria for a commode but are unable to safely raise or lower themselves to use the commode.

Commode chairs with electric seat lift mechanisms or seat lift mechanisms to be placed over the toilet are covered with authorization.

Documentation must establish all of the following:

1. The member is unable to safely and promptly access the toilet in the bathroom in the home because of a medical condition
  - a. The medical condition is reasonably expected to last more than 13 months if purchase rather than rental is requested
2. The member is unable to safely raise or lower him/herself to use the toilet/commode
  - a. A trial has shown that the seat lift mechanism will allow the member to independently use the toilet/commode and that the item fits the member's home.
  - b. Other less costly ways to meet the member's needs (raised toilet seat, non-electric seat lift mechanism) have been considered.
  - c. The member has acknowledged that the increased independence offered by the seat lift mechanism may affect future requests for Personal Care Assistant (PCA) or home care services.
  - d. Requests for authorization must address the member's ability to transfer onto/off of other furniture, caregiver availability to assist with transfers and transfer method used for toileting in the community.

## **Bath/Shower Chairs or Tub Stools/Benches**

Bath/shower chairs or tub stools/benches are covered without authorization for members who are unable to safely use the bathtub or shower in their homes.

## **Raised Toilet Seats**

Raised toilet seats are covered without authorization for members who are unable to safely raise or lower themselves to use a standard height toilet.

## **Transfer Benches**

Transfer benches are covered for members who are unable to safely transfer to the toilet or bath/shower chair without the use of the transfer bench.

A transfer bench is considered a duplication of equipment if the member has a patient lift that can be used in the bathroom unless the transfer bench allows the member to transfer without assistance.

## **Rehab Shower Commode Chairs**

Rehab shower commode chairs are covered for members who are unable to safely and promptly access the toilet and/or shower in the bathroom of their homes due to a medical condition and who require significantly more positioning assistance than is available from a commode and/or shower chair.

Providers should use the bath/shower chair Healthcare Common Procedure Coding System (HCPCS) code that most appropriately describes the item, not a miscellaneous code.

Claims must include modifier U3.

Documentation should establish all of the following:

1. The member is unable to safely and promptly access the toilet and/or shower in the bathroom in the home because of a medical condition
2. The specific medical condition(s) that makes a commode and/or shower chair unsafe and how the requested item will address the member's medical condition(s)
3. The member's living arrangement and caregiver status
4. The requested equipment is appropriate to the member's height and weight
5. Other related equipment in use (mobility device, patient lift, etc.)

### **Bath Lift Equipment**

Bath chairs that lower the member into the bathtub are covered for members who are unable to safely access the bathtub in their home due to a medical condition.

Providers should use the bath lift HCPCS code that most appropriately describes the item, not a miscellaneous code.

Documentation must establish all of the following:

1. The member is unable to safely access the bathtub in the home due to a medical condition
2. The medical condition is reasonably expected to last more than 10 months if purchase rather than rental is requested
3. The specific medical condition(s) that requires the member to be lowered into the bathtub to soak in the water rather than using a bath/shower chair for a shower
4. The member's living arrangement and caregiver status
5. The requested equipment is appropriate to the member's height and weight
6. A trial has shown that the requested equipment will fit in the member's bathtub and can safely meet all of the member's bathing needs
7. Details about the member's current equipment, and why it is no longer meeting the member's needs
8. Other related equipment in use (mobility device, patient lift, etc.). Bath lift equipment may be considered a duplication of equipment if the member has a patient lift that can be used in the bathroom.
9. Other less costly ways to meet the member's needs that have been considered and why they will not meet the member's needs. Include details such as make and model of multiple less costly items considered and rejected.
10. Evaluation by PT/OT/other professional with experience evaluating bath and toilet equipment

### **Non-Covered Services**

1. Bathtub wall rails
2. Grab bars
3. Hand-held shower units
4. Modifications to bathrooms
5. "Potty" chairs/seats for toilet training children

### **Authorization**

Authorization is required for all Durable Medical Equipment (DME)/supplies with a paid amount greater than \$1,000, and for all repairs where the submitted charge including parts and labor exceeds \$1000.

When authorization is required, list all requested parts/accessories on the authorization request. If approved, the approved rate will include all requested and approved parts/accessories.

Attach the manufacturer's invoice, a price list, or a quote from the manufacturer dated within three months of the authorization request.

### **Billing**

1. Use the 837P professional claim format.
2. Bill a pediatric commode using the appropriate commode HCPCS code and modifiers NU or RR and U3. Do not use E1399.
3. Bill rehab shower commode chairs using the most appropriate bath/shower chair HCPCS code and modifiers NU or RR and U3. Do not use E1399.
4. Bill bath lift equipment using the appropriate bath lift HCPCS code and modifiers NU or RR and U3. Do not use E1399.
5. Bill repairs using the HCPCS code of the item being repaired and modifier RB. The submitted charge must include all materials. Labor for repairs may be billed on a separate line.
6. The HCPCS code and modifiers must match the authorization.

It is not necessary to submit a claim to Medicare for denial if authorization was approved for purchase or repair of bath or toilet equipment that Medicare is known not to cover. If a claim for approved equipment is denied because it was not submitted to Medicare, call IMCare at 1-800-843-9536 (toll free).

### **Bone Growth Stimulators**

Bone growth (osteogenesis) stimulators are used to stimulate bone growth and healing of fractures when healing has stalled.

Bone growth stimulators are covered for members who meet medical necessity criteria.

IMCare follows InterQual™ criteria for medical necessity.

### **Codes**

E0747: osteogenesis stimulator, electrical, noninvasive, other than spinal application

E0748: osteogenesis stimulator, electrical, noninvasive, spinal applications

E0749: osteogenesis stimulator, electrical, surgically implanted

E0760: osteogenesis stimulator, low intensity ultrasound

### **Nonspinal, noninvasive electrical bone growth stimulators (E0747) are covered for treatment of fracture nonunion:**

1. At least 3 months have elapsed since the date of fracture
2. The fracture gap is less than one-half the bone diameter or less than one centimeter
3. Patient can be adequately immobilized
4. Patient is compliant with medical treatment including orders to be non-weight bearing
5. Patient is capable of using the bone growth stimulator or has a caregiver capable of using it
6. The device is requested for an FDA approved indication
7. None of the conditions listed as contraindications for the requested device are present

### **Noninvasive electrical bone growth stimulators (E0747) are covered for congenital pseudoarthroses in the appendicular skeleton (only if the specific device requested is FDA approved for this indication):**

1. Patient can be adequately immobilized

2. Patient is compliant with medical treatment including orders to be non-weight bearing
3. Patient is capable of using the bone growth stimulator or has a caregiver capable of using it
4. None of the conditions listed as contraindications for the requested device are present

**Noninvasive electrical spinal bone growth stimulators (E0748) for treatment of failed spinal fusion:**

1. Spinal fusion has not healed 9 months after the original surgery
2. Patient is compliant with medical treatment, including any appropriate restrictions on mobility
3. Patient is capable of using the bone growth stimulator or has a caregiver capable of using it
4. The device is requested for an FDA approved indication
5. None of the conditions listed as contraindications for the requested device are present

**Noninvasive (E0748) or invasive (E0749) electrical spinal bone growth stimulators as an adjunct to spinal fusion surgery for patients at high risk of fusion failure:**

1. One or more previous failed spinal fusions
2. Grade III or worse spondylolisthesis
3. Multi-level fusion
4. Current smoker
5. Diabetes
6. Renal disease
7. Alcoholism
8. Patient is compliant with medical treatment, including any appropriate restrictions on mobility
9. Patient is capable of using the bone growth stimulator or has a caregiver capable of using it
10. The device is requested for an FDA approved indication
11. None of the conditions listed as contraindications for the requested device are present

**Low-intensity ultrasound bone growth stimulators (E0760) are covered for treatment of fracture nonunion:**

1. At least 3 months have elapsed since the date of fracture
2. The fracture gap is one centimeter or less
3. Patient can be adequately immobilized
4. Patient is compliant with medical treatment including orders to be non-weight bearing
5. Patient is capable of using the bone growth stimulator or has a caregiver capable of using it
6. The device is requested for an FDA approved indication
7. None of the conditions listed as contraindications for the requested device are present

**Low-intensity ultrasound bone growth stimulators (E0760) are covered as an adjunct to conventional treatment of fresh, closed fractures for patients at high risk of nonunion:**

1. Patient has one or more of the listed risk factors
2. Fracture associated with extensive soft tissue or vascular damage
3. Diabetes
4. Recent steroid therapy
5. Osteoporosis
6. Current smoker
7. Patient can be adequately immobilized
8. Patient is skeletally mature
9. Patient is compliant with medical treatment including orders to be non-weight bearing
10. Patient is capable of using the bone growth stimulator or has a caregiver capable of using it
11. The device is requested for an FDA approved indication
12. None of the conditions listed as contraindications for the requested device are present

**Provide documentation of the following for spinal applications:**

1. Comorbidities and risk factors
2. History of failed fusion and date of last surgery if applicable
3. Compliance with treatment and physician orders
4. Surgery date
5. Type of spinal fusion: multi-level, revision, etc.
6. Is the member capable of effectively using the stimulator?

**Provide documentation of the following for non-spinal applications:**

1. Surgery date
2. Type of fracture
3. History of the healing of the fracture since injury or surgery
4. Radiographic findings since the surgery
5. Any fracture gap
6. Comorbidities
7. Member's compliance with treatment
8. Is the member capable of effectively using the stimulator?

**Non-Covered Services**

1. Noninvasive or invasive electrical bone growth stimulators are considered investigative for treatment of a fresh fracture.
2. Noninvasive or invasive electrical bone growth stimulators and low-intensity ultrasound bone growth stimulators are considered investigative for treatment of delayed (as opposed to stalled) union fracture.
3. Invasive bone growth stimulators are considered investigative for any indication other than as an adjunct to spinal fusion.
4. Low-intensity bone growth stimulators for treatment of congenital pseudoarthroses are considered investigative.
5. Low-intensity bone growth stimulators are considered investigative for treatment of open fractures.
6. Low-intensity bone growth stimulators are not considered an appropriate and effective use of limited program funds and are not the least costly, medically appropriate treatment for patients without the specified fractures and risk factors.
7. Bone growth stimulators are not covered for members who have any contraindication listed in the device's package insert.
8. Bone growth stimulators are not covered for any indication for which the specific stimulator has not been approved by the FDA.

**Authorization**

Authorization is required for DME over \$1000.00.

Authorization for noninvasive bone growth stimulators will be approved for up to three months' rental at a time unless the device is approved by the FDA only as a single user product (for single user products: if criteria are met, purchase will be approved). If authorization is requested beyond the approved three months, new X-rays or radiology reports must be submitted.

All authorization requests for treatment of nonunion must include serial X-rays that demonstrate no progressive signs of healing have occurred. For non-healing spinal fusions, at least two X-rays over the course of three months are required. For non-healing fractures, at least two X-rays 30 days or more apart are required.

All authorization requests must document that the device is requested for an FDA-approved indication, that coverage criteria listed above are met, and that no contraindications are present.

### **Billing**

1. Use the 837P professional claim format.
2. The Healthcare Common Procedure Coding System (HCPCS) code and modifiers must match the authorization.

### **Cranial Electrotherapy Stimulator (CES)**

This is not covered as it is considered investigative for all conditions.

### **Diabetic Equipment and Supplies**

Diabetic equipment and supplies are used to monitor and control blood glucose levels.

For dates of service on or after January 1, 2014, diabetic testing supplies are part of the [Point of Sale Diabetic Testing Supply Program](#).

1. Members with Medicare Part B may continue to obtain diabetic testing supplies from a medical supplier or pharmacy.
2. Diabetic equipment and supplies other than testing supplies may be obtained from a medical supplier or pharmacy.

### **Eligible Members**

IMCare members with type 1, type 2, or gestational diabetes.

### **Blood Glucose Monitors**

**Codes:** E0607, E2100, E2101

Effective for dates of service January 1, 2014, and beyond, standard blood glucose meters are included in the [Point of Sale Diabetic Testing Supply Program](#) unless the member has Medicare Part B.

The member must be diabetic (type 1, type 2, or gestational) or have a diagnosis that requires monitoring of blood glucose levels. A written physician's order for use to monitor diabetes must be kept in the member's file at the medical supplier's office.

1. **E 0607 (home blood glucose monitor)** is purchase only.  
**Authorization** is not required. One monitor is allowed every five years. If more than allowed quantity is medically necessary, providers must submit a claim with an attachment explaining circumstances.
2. **E 2100 (blood glucose monitor with integrated voice synthesizer)** is rent or purchase.  
**Authorization** is 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.



3. **E 2101 (Blood glucose monitor with integrated lancing/blood sample)** is rent or purchase. **Authorization** is 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**

**Codes:** A9276 – A9278

#### **Authorization**

Authorization is required for A9277 and A9278.

No authorization is required for A9276.

#### **Criteria**

Continuous glucose monitoring does not replace traditional home blood glucose monitoring but may be approved as an adjunct for individuals with type 1 diabetes with a history of severe hypoglycemia less than 50 mg/dL with unawareness due to age or cognitive function. Documentation must show frequent self-monitoring and appropriate modifications to insulin regimen.

### **Disposable Blood Glucose Monitor**

**Code:** A9275

#### **Authorization**

Authorization is not required.

Members who require testing more frequently than is possible with four disposable meters per month may use a traditional meter/test strips.

#### **Criteria**

1. Disposable blood glucose meters include any necessary test strips and calibration solution/chips.
2. Disposable blood glucose meters are limited to four per calendar month.
3. Blood glucose test strips may not be billed within 30 days of disposable blood glucose meters.

Bill 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**

**Code:** A4253

Effective for dates of service January 1, 2014, and beyond, standard blood glucose meters are included in the [Point of Sale Diabetic Testing Supply Program](#) unless the member has Medicare Part B.

**Authorization**

Authorization is not required. However, the provider must have documentation on file regarding the medical need for this item. IMCare may retroactively review claims for more than four units (200 test strips) a month. If medical necessity is not met, the excess amount will not be covered.

**Criteria**

Providers must have documentation for additional test strips indicating that the member needs frequent testing to determine optimal treatment in the following situations:

1. The member was recently diagnosed with diabetes. Higher quantities will be approved for up to 12 months following diagnosis.
2. The member is pregnant and has either preexisting diabetes or a diagnosis of gestational diabetes. Higher quantities will be approved through two months postpartum.
3. The member recently received an ambulatory insulin infusion pump. Authorization for higher quantities may be requested following authorization for the insulin pump. Higher quantities will be approved for up to six months.
4. The member has a history of unstable blood glucose levels and frequently documents blood glucose levels. Higher quantities will be approved for up to six months.
5. The member recently documented HgbA1c levels greater than nine. Higher quantities will be approved for up to six months.
6. The member is undergoing adjustments to medications. Higher quantities will be approved for up to three months.
7. The member has a history of wide glycemic excursions and lacks the capacity to self-diagnose or report episodes of hypoglycemia due to age or cognitive functioning. Higher quantities will be approved for up to 12 months.

Bill 1 unit per 50 test strips.

**Multiple Suppliers**

When a second supplier submits a diabetic test strip claim for a span date already approved for the same member from a different supplier, IMCare will deny the second supplier's claim as a duplicate claim when the following conditions are met:

1. It has the same member ID
2. It has an overlapping Date of Service (DOS) span (from DOS and through DOS)
3. It has the same Healthcare Common Procedure Coding System (HCPCS) code
4. The same type of service on the incoming claim matches a previously approved claim in history
5. The item is a diabetic testing supply

Please include the following information:

1. Member identification (ID) number
2. Member name
3. Date of birth (DOB)
4. Individual prescriber National Provider Identifier (NPI)
5. Drug name
6. Fill date
7. Quantity
8. Day supply
9. Balance due amount

**Blood Ketone Test Strips**

**Code:** A4252

**Authorization**

Authorization is not required. However, the provider must have documentation on file regarding the medical need for this item.

**Insulin Syringes**

**Code:** S8490

**Authorization**

Authorization is not required.

**Reusable Insulin Pens**

**Codes:** S5560 – S5561

**Authorization**

Authorization is required.

**Criteria**

Reusable insulin pens are covered for members who self-administer insulin but who are unable to accurately administer insulin using a syringe and vial. Provide documentation supporting these criteria.

**Insulin Infusion Pumps**

**Code:** E0784

**Authorization**

Authorization is required.

**Criteria**

IMCare uses InterQual™ criteria to determine medical necessity. Provide documentation of the medical need including the following:

1. Three months of Hemoglobin (Hgb) A1c levels
2. Three months of blood sugars; specify time of day and fasting status
3. Number of injections per day and the dosage
4. Results of Beta cell autoantibody
5. Renal function: normal or impaired?
6. Fasting C-peptide (for members with negative Beta cell antibody)
7. Creatinine clearance (for members with impaired renal function)
8. Any pattern related to hypoglycemia or hyperglycemia or unawareness of symptoms by member
9. History of ketoacidosis and hospitalizations
10. Lifestyle flexibility needs
11. Compliance with treatment and knowledge of dietary needs
12. Indication the member is capable of following treatment regimen; specify member motivation or caregiver motivation for care
13. Completion of a comprehensive diabetes education program

When requesting a replacement pump authorization for a member with an existing pump, include the date the current pump's warranty expires.

### **Billing**

1. Use the 837P professional claim format.
2. Report the ordering provider.
3. Bill services approved through the authorization process on a separate claim from the one used for services not requiring authorization.
4. If the member has Medicare, IMCare will pay the deductible/co-insurance on any units for which Medicare made payment. Any units for which Medicare denies payment must meet IMCare quantity and authorization requirements. Authorization can be retroactively requested.
5. The KL modifier must be used with certain diabetic supplies that are remotely ordered (e.g., by phone, email, Internet, or mail) and delivered to the member's home by common carriers (e.g., United States Postal Service [USPS], Federal Express [FedEx], United Parcel Service [UPS]). The KL modifier must not be used with diabetic supplies obtained by members in person from a provider's place of business. Follow Medicare guidelines for use of the KL modifier. Supplies requiring the KL modifier are: A4233 – A4236, A4253, A4256, A4258, and A4259.
6. Rates for claims using the KL modifier will be based on the lower of the submitted charge or the Medicare fee schedule rate for claims with the KL modifier.
7. Shipping costs are included in the IMCare maximum allowable payment and may not be separately billed to IMCare or the member.

### **Electrical Stimulation Devices**

Electrical stimulation devices are suggested for treating musculoskeletal dysfunction, pain, or disease. Electrical or electromagnetic devices for wound care are addressed in the *Specialized Wound Treatment Technology* section. Transcutaneous electrical stimulation devices are addressed in the *Transcutaneous Electrical Nerve Stimulator (TENS)* section.

Authorization for a TENS unit for in-network and out-of-network providers is required. Documentation of a face-to-face encounter remains a requirement and must be available upon request for all in-network providers. Authorization remains a requirement for. Face-to-face encounter visits are also a requirement for out-of-network providers. Effective October 1, 2013, the following TENS unit codes require the face-to-face encounter documentation: TENS units – E0720, E0730, E0731.

### **Eligible Providers**

1. Medical suppliers
2. Indian Health Service (IHS)
3. Federally Qualified Health Centers (FQHCs)
4. Rural Health Clinics (RHCs)

### **Third Party Liability (TPL) and Medicare**

Providers must meet any provider criteria, including accreditation, for third party insurance or for Medicare in order to assist members for whom IMCare is not the primary payer.

IMCare quantity limits and thresholds apply to all members unless only Medicare co-insurance or deductible is requested.

### **Eligible Members**

All IMCare members who meet the coverage criteria are eligible.

### **Covered Services**

#### **Incontinence treatment systems**

**Code:** E0740 (Incontinence treatment system, pelvic floor stimulator, monitor, sensor, and/or trainer)

Pelvic floor stimulators are covered with authorization for members with stress, urge, or mixed incontinence who have undergone a documented trial of pelvic muscle exercises for a period of at least six months with no significant improvement in incontinence.

#### **Neuromuscular stimulation for scoliosis**

**Code:** E0744 (Neuromuscular stimulator for scoliosis)

Neuromuscular stimulators are covered with authorization for members with juvenile or adolescent single or double major idiopathic scoliosis, who are at risk for curve progression and whose curvature is between 25 and 40 degrees. Neuromuscular stimulators may be covered for members in the 20 to 25 degree range if there is a documented progression of curvature of at least 5 degrees in the preceding six months.

#### **Neuromuscular stimulators**

**Code:** E0745 (Neuromuscular stimulator, electronic shock unit)

Neuromuscular stimulators are covered with authorization for treatment of disuse muscle atrophy where nerve supply to the muscle is intact and where there is a non-neurological reason for the disuse atrophy.

#### **Functional electrical stimulators**

**Code:** E0770 (Functional electrical stimulator, transcutaneous stimulation of nerve, and/or muscle groups, any type, complete system, not otherwise specified [NOS])

Upper extremity functional electrical stimulators (e.g., NESS H200, Handmaster) are covered with authorization when documented improvement has been shown in the supervised rehabilitation setting for patients with upper limb paralysis due to cervical spinal cord injury (SCI) or chronic upper extremity paresis due to stroke.

### **Non-Covered Services**

1. Pelvic floor stimulators are considered investigative for members who do not have stress, urge, or mixed incontinence.
2. Pelvic floor magnetic stimulation devices (e.g., ExMI, NeoControl Pelvic Floor System) are considered investigative.

3. Neuromuscular stimulators for scoliosis are not medically necessary for members with curvature less than 20 degrees.
4. Inferential current simulators (e.g., RS-4i) for use in the home are considered investigative for all indications.
5. Cranial electrotherapy stimulation (e.g., Alpha-Stim, CES Ultra) is considered investigative for all indications.
6. Electrical or electromagnetic stimulation for the treatment of osteoarthritis or rheumatoid arthritis (e.g., BioniCare Bio-1000) is considered investigative.
7. Use of neurofeedback/EEG biofeedback devices in the home is considered investigative.
8. Use of an electronic salivary reflex stimulator is considered investigative, not the standard of care, and not an effective use of Medicaid dollars.
9. Non-invasive nerve stimulators for treatment of nausea (e.g., ReliefBand, PrimaBella) are considered investigative.
10. Use of the Sympathetic Therapy System (e.g., Dynatron STS) is considered investigative for all indications.
11. Use of electroceutical/bioelectric nerve block is considered investigative for all indications.
12. Use of an upper extremity functional electrical stimulator in the home setting for indications other than specified above is considered investigative.
13. Use of a lower extremity functional electrical stimulator in the home setting (e.g., ParaStep, NESS L300, WalkAide) is considered investigative.
14. Use of functional electrical stimulators designed as ergometers (e.g., StimMaster, ERGYS, REGYS, RT300) is considered investigative and not the prevailing standard of care for any condition.
15. Electrical stimulation devices used for cancer treatment are considered investigative, not the standard of care and not an effective use of Medicaid dollars.

## Authorization

Authorization is required for the following:

1. For pelvic floor stimulators, documentation must include the type of incontinence and a trial of pelvic muscle exercises for a period of at least six months with no significant improvement in incontinence.
2. For neuromuscular stimulators for scoliosis, documentation must include the diagnosis or condition, the degree of curvature, and progression of the curvature in the last six months.
3. For neuromuscular stimulators, documentation must clearly show the reason for the disuse atrophy and must demonstrate that the nerve supply to the affected muscles is intact.
4. For functional electrical stimulators for the upper extremities, documentation must clearly show upper limb paralysis due to cervical SCI or upper extremity paresis due to stroke. There must be improvement shown in the supervised rehabilitation setting when using the functional electrical stimulator device.

Submit authorization requests to IMCare with the required documentation, physician's orders, and appropriate additional information to the medical review agent.

## Billing

1. Use 837P professional electronic claim.
2. Report the ordering provider.
3. If the member has Medicare, IMCare will consider only the deductible/co-insurance on any item for which Medicare made payment, regardless of any IMCare prior authorization.
4. Shipping/delivery/set-up costs are included in the IMCare maximum allowable payment and may not be separately billed to IMCare or the member.
5. When billing labor for repairs, specify the number of units and the hourly rate. Do not bill for setup and delivery, or for service calls that do not involve actual labor time for repairs.

6. When billing for items approved on a prior authorization, make sure the Healthcare Common Procedure Coding System (HCPCS) codes, modifiers, and descriptions on the claim match the same information on the prior authorization. Enter the authorization number in the authorization field for each line
7. Submit the usual and customary (U&C) charge for each line, not the approved amount from the authorization letter. Payment will be the balance of the lesser of the billed amount or the approved amount after any primary or secondary payers have made payment.

## External Defibrillators

Automated external defibrillators (AEDs) are used to administer an electric shock to the heart to stop ventricular fibrillation.

External defibrillators are covered for all IMCare members who meet medical necessity criteria.

### Codes

E0617: External defibrillator with integrated electrocardiogram analysis

K0606: Automatic external defibrillator, with integrated electrocardiogram analysis, garment type

K0607 – K0609: replacement accessories for garment-type defibrillator

### Automated Non-Wearable

#### Criteria

Rental for up to 13 months only and rental includes all necessary supplies. After 13 months of rental, the AED belongs to the member, and supplies may be purchased without authorization using A9999. Authorization requests must include expected duration of need.

A non-wearable AED will be approved for a member if he/she has one of the following conditions with implantation of a defibrillator currently contraindicated:

1. A documented episode of cardiac arrest due to ventricular fibrillation, not due to a transient or reversible cause
2. A sustained ventricular tachyarrhythmia, lasting 30 seconds or longer, either spontaneous or induced during an electrophysiologic (EP) study, not associated with acute myocardial infarction and not due to a transient or reversible cause
3. Familial or inherited conditions with a high risk of life-threatening ventricular tachyarrhythmia such as long QT syndrome or hypertrophic cardiomyopathy
4. Coronary artery disease with a prior documented myocardial infarction (more than four weeks prior to the external defibrillator prescription) with a measured left ventricular ejection fraction less than or equal to 0.35 and inducible, sustained ventricular tachycardia or ventricular fibrillation during an EP study (tested at least four weeks after the most recent myocardial infarction)
5. Documented prior myocardial infarction and a measured left ventricular ejection fraction less than or equal to 0.30. Members must not have any of the following:
  - a. Cardiogenic shock or symptomatic hypotension while in a stable baseline rhythm
  - b. Had a coronary artery bypass graft or percutaneous transluminal coronary angioplasty within the past three months
  - c. Had an enzyme-positive myocardial infarction (MI) within the past month
  - d. Clinical symptoms or findings that would make them a candidate for coronary revascularization

6. Members with ischemic dilated cardiomyopathy, documented prior myocardial infarction, New York Heart Association Class II and III heart failure, and measured left ventricular ejection fraction less than or equal to 35 percent
7. Members with non-ischemic dilated cardiomyopathy for greater than three months, New York Heart Association Class II and III heart failure, and measured left ventricular ejection fraction less than or equal to 35 percent
8. Members who meet one or more of the previous criteria and have New York Heart Association Class IV heart failure
9. Member has a previously implanted defibrillator that now requires explanation and immediate replacement of the implanted defibrillator is contraindicated

An AED **will not** be approved for members who:

1. Currently have an implantable cardioverter-defibrillator (ICD)
2. Lack a caregiver who is able to correctly use the AED and is available to promptly use the AED 24 hours per day. If the member does not have caregivers awake 24 hours a day, documentation must address how the member's health will be assured during sleep hours.

### **Wearable/Garment Type**

#### **Criteria**

The device is rental for up to 13 months only. Rental includes all necessary supplies. After 13 months of rental, the AED belongs to the member, and supplies may be purchased without authorization. Authorization requests must include expected duration of need.

An AED, wearable/garment type will be approved for members over age 21 if they have one of the following conditions with implantation of a defibrillator currently medically contraindicated or contraindicated due to a standard 40 or 90 day waiting period:

1. A documented episode of ventricular fibrillation or a sustained, lasting 30 seconds or longer, ventricular tachyarrhythmia. These dysrhythmias may be either spontaneous or induced during an EP study, but may not be due to a transient or reversible cause and may not occur during the first 48 hours of an acute myocardial infarction
2. Familial or inherited conditions with a high risk of life-threatening ventricular tachyarrhythmia such as long QT syndrome or hypertrophic cardiomyopathy
3. Either documented prior myocardial infarction or dilated cardiomyopathy and a measured left ventricular ejection fraction less than or equal to 0.35.
4. A previously implanted defibrillator that now requires explanation and immediate replacement of the implanted defibrillator is contraindicated
5. Results of EP or indication of why EP is not appropriate

An AED, garment type, will not be approved for members who:

1. Currently have an ICD
2. Have hearing, vision, or developmental problems that may prevent interpreting device messages
3. Are on medication that may impair proper response to device alarms
4. Are unable or unwilling to wear the device continuously, except when bathing

#### **Authorization**

Authorization is required. Submit chart documentation to support history, diagnosis, treatment plan, etc.

#### **Billing**

1. Use the 837P professional claim format.



2. The Healthcare Common Procedure Coding System (HCPCS) codes and modifiers on submitted claims must be identical to the approved authorization to prevent a denial.
3. If the member has Medicare, IMCare will pay the deductible/co-insurance on any units for which Medicare made payment.

## **Functional Electrical Stimulation**

### **Functional Neuromuscular Stimulator (e.g., Parastep I System)**

#### **Muscle Stimulators E0744, E0745**

##### **Authorization**

Authorization is required.

##### **Criteria**

Rental for up to 13 months only.

A functional neuromuscular stimulator may be approved to enable a member with spinal cord injury (SCI) to walk when all of the following criteria are met:

1. Diagnosis of paraplegia
2. Intact lower motor units (L1 and below)
3. Can bear weight on upper and lower extremities that demonstrate balance and control sufficient to maintain an upright posture independently
4. Shows brisk muscle contraction to neuromuscular electrical stimulation and has sensory perception of electrical stimulation sufficient for muscle contraction
5. Cognitive ability to use the device for walking, and is highly motivated and highly committed to using the device
6. Can transfer independently and stand for at least three minutes
7. Hand and finger function sufficient to manipulate the controls
8. At least six months post recovery of SCI and restorative surgery
9. Successfully completed a training program of at least 32 physical therapy sessions with the device over a three-month period

A functional neuromuscular stimulator will not be approved for members with any of the following conditions:

1. Autonomic dysreflexia
2. Cardiac pacemaker
3. Hip and knee degenerative disease
4. History of long bone fracture secondary to osteoporosis
5. Irreversible contracture
6. Severe osteoporosis
7. Severe scoliosis
8. Skin disease or cancer in the area of stimulation

### **Leg Cycle Ergometry (e.g., StimMaster, ERGYS, REGYS, RT300 motorized FES Ergometer)**

**Code:** E1399

**Criteria:** Not covered.

Experimental for improvement of the following:

1. Improvement of muscle strength
2. Reduction of spasticity and atrophy
3. Facilitation of functional motor movement
4. Loss of bone mineral density

Note the following:

1. Least costly appropriate treatment for loss of bone mineral density
2. Prevailing standard of care for any condition

## Gloves

Non-sterile gloves are used by a member or caregiver when performing non-sterile medical procedures for the member. Sterile gloves are used by a member or caregiver when performing sterile medical procedures for the member.

Non-sterile and sterile gloves are covered for eligible IMCare members.

## Codes

A4927: 1 unit = 100 non-sterile gloves

A4930: 1 unit = 1 pair of sterile gloves

## Documentation

The supplier must maintain the following required documentation to support the quantities dispensed. See *Supplier Documentation* at the end of this chapter.

1. Description of item (non-sterile or sterile gloves)
2. Quantity ordered
3. Medical procedures requiring gloves
4. Duration of the order
5. Name of member
6. Name of physician
7. Date of order

IMCare pays for sterile and non-sterile gloves for use by the member or caregiver when ordered by the prescribing provider for use in performing medical procedures for the member.

Non-sterile gloves are medically necessary for clean procedures including, but not limited to, most wound care/dressing changes, application of topical medications, clean catheterization, tracheostomy cares, gastrostomy tube/jejunostomy tube cares, and all tube feedings. Non-sterile gloves are medically necessary for hygiene cares only if the member has open sores, diarrhea, a diagnosed infection, or a compromised immune system. If a member has a history of frequent diarrhea, the provider may dispense gloves to be kept on hand.

Sterile gloves are medically necessary for sterile procedures including sterile catheterization, sterile wound care, and other procedures a prescribing provider determines cannot be safely done using clean techniques.

## Non-Covered Services

1. Gloves for use while performing hygiene cares, including routine incontinence care
2. Sterile gloves for use for non-sterile procedures

3. Non-sterile or sterile gloves for members living in nursing facilities or Intermediate Care Facilities for the Developmentally Disabled (ICF/DDs)

**Authorization**

Authorization is not required.

**Billing****Non-Sterile**

1. Bill the correct Healthcare Common Procedure Coding System (HCPCS) code with the NU modifier
2. Bill in units, not quantity of gloves (1 unit equals 100 gloves)
3. If billing 50 gloves, bill 1 unit with the 52 modifier (reduced services)

**Sterile**

1. Bill using the correct HCPCS code with the NU modifier
2. Bill in units, not quantity of gloves (1 unit equals 2 gloves or 1 pair)

If gloves are ordered for cares or procedures where no resolution is expected for the member, the order may be written without an expiration date and does not need to be annually renewed.

If gloves are ordered for cares or procedures with reasonable expectations of resolution (e.g., wound care), the order may not exceed 12 months.

**Hospital Beds**

Hospital beds are used for positioning patients.

**Fixed Height Manual Hospital Beds**

**Codes:** E0250, E0251, E0290, E0291

Authorization is not required.

**Providers must follow documentation requirements.**

1. The prescription must establish medical necessity and include a description of the medical condition. The medical condition must be one that requires one or more of the following:
  - a. Positioning of the body in ways not feasible in an ordinary bed, where pillows or wedges do not meet the member's needs
  - b. Special attachments, such as traction equipment, that cannot be fixed and used on an ordinary bed
  - c. The head of the bed to be elevated more than 30 degrees, where pillows or wedges do not meet the member's needs
2. The prescription must document severity and frequency of symptoms of the condition that necessitate a hospital bed for positioning versus fixed attachments used on an ordinary bed.

**Variable Height Manual Hospital Beds**

**Codes:** E0255, E0256, E0292, E0293

Authorization is not required.

**Providers must follow documentation requirements.**

The same documentation is required as for a fixed height manual hospital bed and documentation of one of the following:

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

**Semi-Electric, Total Head, and Foot Adjustment**

**Codes:** E0260, E0261, E0294, E0295

Authorization is required.

**Criteria:** IMCare follows InterQual™ criteria. Provide documentation of the following:

1. Medical necessity to include description of medical condition
2. Reason for need of hospital bed
3. Severity and frequency of symptom of the condition that necessitates a hospital bed for positioning versus fixed attachment used on an ordinary bed
4. Indicate any need for accessories and medical necessity for the accessories
5. Specify if there is a need for adjustments in body positioning and why this is needed
6. Document that the member's judgment and skill level is adequate to operate the controls
7. Provide a summary of the status of the attendant/caregiver
8. Describe functional limitations of the member or caregiver that preclude use of a conventional bed or a standard hospital bed

**Total-Electric**

**Codes:** E0265, E0266, E0296, E0297

**Authorization** is required.

**Criteria:** Must meet above requirements in addition to documentation of all of the following:

1. A significant amount of care must be provided by a caregiver to the person in bed
2. A change of bed height is required at least once a day to enable the caregiver to assist with member care
3. The caregiver is physically unable to change bed height manually
4. If the member uses a transfer board and is independent for transfers with it, indicate that in the documentation

**Bariatric, Extra-Heavy Duty, Extra-Wide****Codes**

E0301 – E0302: Bed without a mattress

E0303 – E0304: Bed with a mattress

**Authorization**

Authorization is required.

Documentation provided with the request should indicate:

1. The member meets above requirements for other hospital beds
2. The member's weight has been documented to meet qualifications

3. Any need for accessories and medical necessity for the accessories

**E0271 or E0272 with modifier U3**

Authorization is **not** required: Bariatric mattress replacement for patient-owned bariatric bed.

When replacing a mattress on a patient-owned heavy duty or bariatric bed, include “bariatric mattress for patient owned bariatric bed” and the prior authorization number or purchase date for the bed, if known, in the claim notes field or in the line item notes field.

**Pediatric**

**Codes:** E0328 (manual) or E0329 (electric or semi-electric)

**Authorization**

Authorization is required.

**Criteria**

Manual pediatric hospital beds:

1. Must meet criteria for fixed or variable height hospital beds above
2. Size must be appropriate to meet the member’s needs over the next five years

Semi-electric pediatric hospital beds:

1. Must meet the same criteria as for semi-electric hospital beds; provide documentation as indicated for those type of beds as listed above
2. Either the member or the caregiver has sufficient judgment to operate the controls
3. There are functional limitations on the part of the member and the caregiver that preclude the use of a manual hospital bed

Electric pediatric hospital beds:

1. Must meet the same criteria as for electric hospital beds; provide documentation as indicated for those type of beds as listed above
2. A significant amount of care must be provided by a caregiver to the member in bed
3. A change in bed height is required at least once a day to enable the caregiver to assist with member care
4. The caregiver is physically unable to change the bed height manually

**Bed Rails (E0305, E0310)**

Covered when used with a hospital bed.

**Bed Enclosure**

**Codes:** E0316 (Enclosure) or E0300 (Hospital grade enclosed crib)

**Authorization** is required.

**Criteria**

This type of bed is considered medically necessary and the least costly alternative in only the most extreme conditions, due in part to the following:

1. The restrictive nature of the bed
2. The confinement it entails

### 3. The high cost

Based on advice from medical consultants, Minnesota Medicaid considers the bed medically necessary when the member is mobile, but cognitively impaired, and his/her unrestricted mobility results in documented injuries sustained as a result of wandering unsupervised. Even then it must be shown that other, less costly methods have been attempted and have failed to effectively treat 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 in this process.

Coverage will be considered for members who have documented evidence of unsafe mobility (climbing out of bed, not just standing at the side of the bed), including mobility that will put the member at risk for serious injury, not just a possibility of injury.

Documentation of the following must be provided:

1. Diagnosis of one of the following:
  - a. Brain injury (BI)
  - b. Moderate to severe cerebral palsy
  - c. Seizure disorder with daily seizure activity
  - d. Developmental disability (DD)
  - e. Severe behavioral disorder
2. Documentation of a specific risk form unrestricted mobility including:
  - a. Tonic-clonic type seizures
  - b. Uncontrolled perpetual movement related to diagnosis
  - c. Self-injurious behavior, such as head banging, where a helmet was tried and failed; must be documentation to this effect
  - d. Evidence of need due to a proven safety risk (more than head banging, as a helmet can be used), balance problems (explain why padding and side rails did not solve the problem), history of injuries that have occurred up to this request
3. Less costly alternatives including any of the following have been tried or considered and rejected (not an inclusive list):
  - a. Create a bed on the floor, put a mattress on the floor or inside of a small portable tent
  - b. Padding around regular or hospital bed
  - c. Lining a crib with padding, or placing a crib tent over crib
  - d. Medications to prevent seizures and to correct behaviors/other behavior modifications used for sleep disturbances that would promote/maintain sleep
  - e. Behavior modification strategies.
  - f. Helmets for head banging
  - g. Removing all safety hazards from the member's room and using a child protection device on the door knob or placing a baby gate across the door to prevent the child from leaving their room
  - h. Baby monitors to listen in on member's activity
4. Documentation of answers to the following questions:
  - a. When will this bed be used? List specific time periods. Do not substitute this bed for responsible parenting or supervision of the child.
  - b. Are there outside caregivers providing care to this individual? If so, how many hours a day and at what times during the day (number of days/weeks, etc.)? Is the member in school/daycare, and how many

hours per day? Paid providers caring for the individual are considered a duplication of service with this bed.

5. There are other types of beds that have bumper pads, removable tops, adult sized cribs, etc. Many members have been in a hospital and used the enclosed bed there and have not tried any of the other options.
6. There must be verification that the primary care giver is willing and able to clean the mesh canopy per the manufacturer's recommendations.

IMCare believes that there is no clear-cut medical justification for enclosed bed systems. The real need is to proactively address with intervention the underlying medical and/or behavioral issues that give rise to the risk of harm.

### **Rocking Bed (E0462)**

Authorization is 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. IMCare will determine if an approval outside of the member's benefit set is appropriate for that member.

### **Non-Covered Services**

1. Beds that are typically sold as furniture, including adjustable beds that are not manufactured as Durable Medical Equipment (DME)
2. Orthopedic mattresses
3. Waterbeds
4. Oscillating and lounge beds
5. Bed tables and other bed accessories
6. Bedding or linens, including hypoallergenic bedding
7. Heat and massage pads
8. Enclosed beds for members with caregivers who are awake 24 hours per day

### **Billing**

1. 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.
2. 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.
3. Codes E0290, E0292, E0294, and E0296 include the bed and mattress. Do not bill mattress (E0271, E0272) within 180 days of billing these codes.
4. Use the 837P professional electronic claim.
5. If the member has Medicare, any items for which Medicare denies payment must meet IMCare coverage and authorization requirements.
6. Shipping/delivery/set-up costs are included in the IMCare maximum allowable payment and may not be separately billed to IMCare or the member.

7. 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.
8. Refer to [Non-Mobility Equipment Repairs](#) for billing requirements for repairs to hospital beds.

## Humanitarian Use Devices

A humanitarian use device is defined by the Food and Drug Administration (FDA) as “a device that is intended to benefit patients by treating or diagnosing a disease or condition that affects fewer than 4,000 individuals in the United States per year.”

### Covered Services

Humanitarian use devices are covered when all of the following are met:

1. The device has received a Humanitarian Device Exemption from the FDA
2. The device is requested for the specific indication for which it received a Humanitarian Device Exemption
3. All treatment options within the community standard of care have failed or are medically contraindicated for the member.

### Non-Covered Services

Humanitarian use devices are not covered for any indication which has not been specifically approved by the FDA under a Humanitarian Device Exemption.

### Authorization

1. Authorization is required for the humanitarian use device.
2. Authorization may be required for associated medical procedures (i.e., surgeries). Refer to the relevant chapter for information about authorization requirements for medical procedures.

## Incontinence Products

Disposable incontinence products are a covered service for members who meet criteria for medical necessity.

Eligible IMCare members may receive a reasonable quantity of incontinence products with the proper diagnosis and documentation of medical necessity.

### Authorization

Authorization is only needed for members under age 4. Requests for authorization must include the appropriate Healthcare Common Procedure Coding System (HCPCS) code, NU and 76 modifiers, and U1 or U2 modifier, if appropriate.

### Members under Age 4

1. Authorization requests for diapers for members under age 4 must include documentation of diagnosis of excessive urine or fecal output requiring more than 10 diapers per day.
2. IMCare will not pay for pull-on undergarments for children under age 4.

### Covered Services

#### Disposable Diapers, Undergarments, Liners/Pads, and Underpads



**Codes:** T4521-T4535, T4541-T4543

**For dates of service (DOS) prior to April 1, 2013, IMCare** had reimbursement rates that varied depending on product performance. Any product may be covered at the moderate performance rate. For youth and adult size briefs, and disposable underwear, only products that appear on the [2009 - 2012 Incontinence Product List \(PDF\)](#) as maximum performance products are eligible for payment at the enhanced rates. For liners/pads, only products that appear on the Incontinence Product List as added or maximum performance products are eligible for payment at the enhanced rates. For pediatric and bariatric sizes, and for underpads, only one rate is available.

**For DOS April 1, 2013 and beyond, IMCare** has one reimbursement rate per HCPCS code. For DOS April 1, 2013 through June 30, 2013, any adult sized brief or disposable underwear will be covered. For DOS July 1, 2013 and beyond, only adult sized briefs or disposable underwear that appear on the new [2013 Incontinence Product List](#) may be covered. Any pediatric or youth sized product, or any pads, liners, guards, or shields may be covered effective April 1, 2013.

### Coverage Criteria for All Members

1. Member must have a diagnosis of an underlying medical condition that involves loss of bladder or bowel control for briefs, pull-on disposable underwear, guards, shields, pads, or liners.
2. Member must be ambulatory or toilet training for pull-on disposable underwear (this is not a service for children under age 4).
3. Pull-on disposable underwear is appropriate for individuals who have light or infrequent incontinence, or for individuals who are toilet training (not for children under age 4).
4. Moderate performance products should meet the needs of 95 percent of eligible IMCare members, even at quantities significantly below Minnesota Health Care Programs (MHCP) limits.
5. The average adult produces 1500 – 2000 ml of urine per day. The average adult bladder holds 300 – 500 ml at a time. Virtually all products currently available will absorb this volume of urine.
6. Most products produced today have super absorbent polymers to draw moisture away from the skin and have a snug fit to prevent leakage. More than one product at a time is rarely justified when an appropriate and well-fitting product is selected.
7. Underpads may be appropriate for diagnoses not related to incontinence, such as wounds with heavy fluid excretions.
8. Use T4538 for diapers from a diaper service.

IMCare does not impose quantity restrictions at this time. Incidents of apparent excessive use will be investigated. Providers are required to maintain documentation to support quantities dispensed.

### Non-Covered Services

1. Bed wetting alarms
2. Disposable wipes and washcloths
3. Reusable bed or chair pads
4. Reusable incontinence undergarments, including pants to wear with disposable pads
5. Pull-on undergarments for children under age 4
6. Adult-sized briefs or disposable underwear that are not on the [Incontinence Product List](#) for DOS July 1, 2013, and beyond
7. Purchase of cloth diapers. Members with services through the following waivers may contact their case managers if purchase of cloth diapers is needed: community alternative care (CAC), community alternative for disabled individuals (CADI), Elderly Waiver (EW), and BI waivers.

## Billing and Documentation

1. Follow standard documentation policy for proof of delivery.
2. A new physician's order is required annually for incontinence products for children under age 16.
3. A new physician's order is required one year after the initial order for incontinence products for members ages 16 and over, and every five years after that.
4. Bill 1 unit per diaper.
5. The submitted charge should be the usual and customary (U&C) charge including all applicable shipping costs and sales taxes.
6. Do not separately bill shipping costs.
7. Include manufacturer and product name on the claim.
8. Dispense and bill only a one-month supply.
9. Providers may choose to supply upgraded products but can only charge IMCare for the non-upgraded item. Use the GL modifier.

Medicare/Third Party Liability (TPL): Medicare does not cover incontinence products. Most TPL policies do not cover incontinence products. Bill directly to IMCare unless the TPL is known to cover incontinence products. Verify TPL coverage of incontinence products annually.

For DOS prior to March 31, 2013, reference the [2009 – 2012 Incontinence Product List](#) for product performance classification and size information.

For DOS after April 1, 2013, refer to the [2013 Incontinence Product List](#) for reimbursement rates based on performance level.

Product Performance	Billing for Dates of Service (DOS) Prior to April 1, 2013
Moderate performance	Use appropriate HCPCS code with modifier NU. Include an appropriate diagnosis code, manufacturer, and product name.
Added performance	Use appropriate HCPCS code with modifiers NU and U1. Include a specific diagnosis code to support the need for added performance. Include manufacturer and product name.
Maximum performance	Use appropriate HCPCS code with modifiers NU and U2. Include a specific diagnosis code to support the need for maximum performance. Include manufacturer and product name.

## Infusion Pumps

### Definitions

**Affiliate:** A person who directly or indirectly, through one or more intermediaries, controls or is controlled by, or is under common control with, the ordering physician or consultant.

**Physiatrist:** A physician who specializes in physical medicine or who possesses specialized knowledge of rehabilitation and who is certified by the American Board of Physical Medicine and Rehabilitation (ABPMR).

**Prosthetic:** An artificial device, as defined by Medicare, to replace a missing or nonfunctional body part.

### Stationary and Ambulatory Infusion Pumps

**Codes:** E0779 (rental only), E0780 (purchase only), E0781 (rental or purchase)

**Authorization** is not required.

**Documentation of the following is required:**

The physician's order must include the length of need (number of days per month and/or total number of months), diagnosis, name of drug, frequency of administration, and a copy of the treatment plan.

**Enteral and Parenteral Nutrition Infusion Pumps**

**Codes:** B9000, B9002, B9004, B9006, E0791

**Authorization** is required for maintenance service or for repairs to patient-owned pumps where parts and labor exceed \$1000.

**Implantable (E0782, E0783, E0786)**

Implantable infusion pumps require Service Authorization before they are provided.

Documentation regarding the medical condition and the medical need for these pumps is required.

The physician's order must include the length of need (number of days per month and/or total number of months), diagnosis, name of drug, frequency of administration, and a copy of the treatment plan.

**Lower Limb Prosthetics**

**Overview**

Lower limb prosthetics are used to restore ambulation to people with missing or amputated legs.

**Third Party Liability (TPL) and Medicare**

Providers must meet any provider criteria, including accreditation, for third party insurance coverage or for Medicare coverage in order to assist members for whom IMCare is not the primary payer.

IMCare quantity limits and thresholds apply to all members unless only the Medicare co-insurance or deductible is requested.

**Covered Services**

**All Covered Lower Limb Prosthetics**

A lower limb prosthetic must be prescribed by an enrolled IMCare provider. The provider must be:

1. A physician who is knowledgeable in orthopedics, physiatry, or vascular surgery
2. A physician in consultation with an orthopedist, physiatrist, or physical therapist (PT); or
3. A podiatrist within the scope of his/her professional practice.

**Evaluation**

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 who is certified by the American Board for Certification in Orthotics, Prosthetics & Pedorthics (ABCOP) or who has similar training and expertise.

Use the following functional levels in the evaluation. Provide specific information about the member's ambulation history, performance, and activities of daily living (ADL) to support assignment of an individual to a functional level. Note that these functional level definitions are not identical to the Medicare definitions. (For dual eligible members, if billing under the Medicare coverage, documentation must meet Medicare definitions)

1. Level 0: The member does not have the ability or potential to ambulate or transfer safely with or without assistance and a prosthesis does not enhance the quality of life or mobility
2. Level 1: The member has the ability or potential to use a prosthesis for transfers or ambulation on level surfaces at a fixed cadence. Limited or unlimited household ambulator.
3. Level 2: The member has the ability or potential for ambulation with the ability to traverse low level environmental barriers such as curbs, stairs, or uneven surfaces. Limited community ambulatory.
4. Level 3: The member has the ability to ambulate over significant distances and over uneven surfaces. Unlimited community ambulator.
5. Level 4: The member has the ability for prosthetic ambulation that exceeds basic ambulation skills, exhibiting high impact, stress, or energy levels. The member has a demonstrated need for ambulation requiring variable cadence over at least 400 continuous yards or a demonstrated need for regular ambulation on uneven terrain. Unlimited community ambulator with especially rigorous demands.

### **Specific Additions to Lower Limb Prosthetics**

1. A microprocessor controlled ankle foot system (L5973) may be medically necessary for members whose functional level is 4.
2. A dynamic response foot with multi-axial ankle (L5979), flex foot system (L5980), flex-walk system or equal (L5981), or shank foot system with vertical loading pylon (L5987) may be medically necessary for members whose functional level is 3 or above.
3. An energy storing foot (L5976) may be medically necessary for members whose functional level is 2 or above.
4. An axial rotation ankle unit (L5982-L5986) may be medically necessary for members whose functional level is 2 or above.
5. 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.
6. A pneumatic knee (L5614, L5822, L5830 – L5840) may be medically necessary for members whose functional level is 2 or above.
7. A fluid/hydraulic knee (L5610, L5613, L5614, L5722-L5780, L5814, L5824-L5828, L5848) may be medically necessary for members whose functional level is 3 or above.
8. A knee with stance phase microprocessor control feature (L5858) may be medically necessary for highly motivated members whose functional level is 2 or above.
9. A knee with powered and programmable flexion/extension assist control (L5859) may be medically necessary for highly motivated members whose functional level is 3 or above who have a documented comorbidity in their sound limb or spine, or for bilateral amputees.
10. A knee with swing and stance phase microprocessor control feature (L5856) may be medically necessary for members whose functional level is 4.
11. A pneumatic or hydraulic polycentric hip joint (L5961) may be medically necessary for highly motivated members whose functional level is 2 or above.

**Non-Covered Services**

1. A prosthetic or orthotic device for which Medicare has denied the claim as not medically necessary.
2. A device whose primary purpose is to serve as a convenience to a person caring for the member.
3. A device that serves to address social and environmental factors and that does not directly address the member's physical or mental health.
4. 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.
5. Repair costs for a prosthetic device that is under warranty.
6. Repair costs for any rented prosthetic equipment.
7. Lower limb prosthetics for members who have been found to have functional ability or potential functional ability of level 0.
8. User-adjustable heel height feature (L5990) is considered not medically necessary.

**Authorization**

Prosthetic charges greater than \$1,000 require a Service Authorization.

1. Submit the prosthetic base Healthcare Common Procedure Coding System (HCPCS) code with appropriate modifiers on the first line of the authorization request if a new prosthetic is being requested.
2. List all add-on items by HCPCS code with appropriate modifiers, quantity, and submitted charge.
3. Documentation must address the member's medical and functional need, and how the requested prosthetic meets those needs.
4. Documentation must include the assessment of the member's functional status, and how the member's functional status relates to the need for the requested items.
5. Documentation for purchase must establish that the requested device is the least costly appropriate way to meet the member's needs.
6. When requesting authorization for identical replacement of components on an existing prosthetic, it is not necessary to establish medical necessity for those components. Document that the component needs to be replaced and is not covered by a warranty.
7. When requesting authorization for non-identical replacement of components on an existing prosthetic, document the medical necessity for the requested components.

**Billing**

1. Use X12 Batch or the 837P professional electronic claim.
2. Report the ordering provider.
3. Shipping/delivery/set-up costs are included in the IMCare maximum allowable payment and may not be separately billed to IMCare or the member.
4. IMCare will not pay claims for more units per line than are allowed by Medicare's Medically Unlikely Edits (MUE). When billing for bilateral prosthetics where more units are required than are allowed by the MUE, the units must be billed on different lines, with modifiers NU RT and NU LT as appropriate.
5. Prosthetic devices for which fabrication has begun but which have not been dispensed as of the date of the member's termination from IMCare eligibility may be reimbursed on a prorated basis to the extent that customization renders all or part of the device unsuitable for use by someone else.
6. When billing labor for repairs, specify the number of units and the hourly rate. Do not bill for setup and delivery, or for service calls that do not involve actual labor time for repairs.
7. When billing for items approved on a prior authorization:
  - a. Submit one claim for all approved lines. Make sure the HCPCS codes, modifiers, and descriptions on the claim match the same information on the prior authorization.
  - b. Enter the authorization number in the authorization field for each line.

## Miscellaneous Codes

Use the most specific Healthcare Common Procedure Coding System (HCPCS) code for the item being dispensed. Do not use miscellaneous codes for the sole purpose of trying to receive higher reimbursement.

IMCare accepts the following miscellaneous HCPCS codes:

Procedure Code	Description	Usage	Prior Authorization Requirements
E1399	Durable Medical Equipment (DME), miscellaneous	Use for DME that does not have a specific code and only for the entire piece of equipment, not parts.	Over \$1000
A9999	Miscellaneous DME supply or accessory, not otherwise specified (NOS)	Use for an accessory or an added-on part to a piece of DME that has no code. Not used for the entire piece of equipment, just a part of it.	Over \$1000
T5999	Supply, NOS	Use for disposable supplies that do not fit into any of the other more specific miscellaneous supply codes.	None
S8189	Tracheostomy supply, not otherwise classified	Use for miscellaneous tracheostomy supplies only.	None
A4649	Surgical supply, miscellaneous	Use for miscellaneous wound care supplies and items related to surgical procedures.	Over \$1000
A4335	Incontinence supply, miscellaneous	Use for supplies (with no specific HCPCS code) relating to urinary or fecal incontinence.	None
A4421	Ostomy supply, miscellaneous	Use for any miscellaneous supplies for ostomies in the colon, ileum, abdomen, etc. (use S8189 for tracheostomies).	None
B9998	Enteral supplies, not otherwise classified	Use for supplies relating to enteral nutrition.	None
B9999	Parenteral supplies, not otherwise classified	Use for supplies relation to parenteral nutrition.	None

## Billing Miscellaneous Codes

When billing for multiple products that are different but require the use of the same miscellaneous HCPCS code, use the correct miscellaneous code and modifier for the first line item, and add the 76 modifier to each additional line using the same miscellaneous HCPCS code. If billing multiple units of the same product, bill using the correct miscellaneous code and modifier and indicate the number of units dispensed.

Add the description for each line with a miscellaneous code.

The following miscellaneous HCPCS/procedure codes will be automatically priced if the correct description of the product is entered on the claim:

1. **A7520, A7521, and B4088** require the use of the NU modifier for auto pricing at the fee schedule rate. For auto pricing of specialized items, enter the appropriate HCPCS code with the U3 modifier and the long description.
2. **A4335, A4421, A4649, A9999, B9998, and S8189** require the use of the NU modifier and the long description for auto pricing.

## Miscellaneous Products

### Augmentative Communication Devices (E2500 – E2599)

Authorization is required.

An augmentative communication device is a device dedicated to transmitting or producing messages or symbols in a manner that compensates for the impairment and disability of a member with severe expressive communication disorders (e.g., communication picture books, communication charts and boards, and mechanical/electronic devices). Devices requested for the sole purpose of education will not be approved.

1. Augmentative communication devices can be obtained from medical equipment and supply providers and manufacturers of augmentative communication devices.
2. Technical services, such as repairs, are covered.
3. Documentation sent with request should include the following:
  - a. A description of the current medical status and history
  - b. An assessment of the verbal and physical capabilities in relation to need and use of an augmentative communication device (electronic and non-electronic)
  - c. A detailed description of the therapeutic history in the areas of physical and occupational therapy and speech-language pathology and the nature, frequency, and duration of total therapeutic history provided to the member. Speech-language treatment approaches in relation to the need and use of an augmentative communication device must be detailed.
  - d. An explicit evaluation of each augmentative communication device or method of communication tried by the member and information on the effectiveness of each device. All parameters of device selection must be addressed (i.e., interactive ability in all situational contexts; school, home, community, vocational, work, and social environments). A trial period of at least four weeks with the requested device must be documented.
  - e. A detailed description of the member's ability to use the proposed device, including speed and accuracy. Situation references dependent upon the mobility level of the member must be addressed (i.e., 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?). Empirical data regarding the trial period of use with the device is required (i.e., frequency of device use in various settings).
  - f. 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.
  - g. A detailed description and plan for the proposed nature, frequency, and duration of therapeutic intervention in relation to the augmentative communication device. Include all therapeutic intervention necessary.

### Non-Covered Services Relating to Augmentative Communication Devices

1. Augmentative communication/speech-generating devices requested for the sole purpose of education
2. Environmental control devices such as switches, control boxes, or battery interrupters
3. Modification, construction, programming, or adaptation of communication systems

4. Repairs, cleaning, or other services for devices that are not dedicated communication devices
5. Upgrading to new technology that is not proven to be medically necessary
6. Replacing devices based on the manufacturer's recommended replacement schedule (i.e., every five years)
7. Facilitated communication: a technique by which a "facilitator" provides physical and other supports in an attempt to assist a person with a significant communication disability to point to pictures, objects, and printed works or letters (IMCare does not cover facilitated communication by any provider)
8. Personal computers, laptop computers, electronic tablet such as iPods or iPads, and other personal media players that are not dedicated communication devices
9. Telephones
10. Carry cases when a mounting device has been purchased

### **Bilirubin Lights (E0202)**

**Authorization** is required if rental exceeds one month for contracted providers (out-of-network providers require authorization before providing the service).

### **Breast Pumps (E0602 – E0604)**

Breast pumps are covered when ordered by a physician, certified nurse midwife (CNM), or nurse practitioner (NP) for any nursing mother.

No authorization is required for E0602 or E0603; they are for purchase only. Inform members that breast pumps are a personal care item that cannot be shared by mothers. They can be used for future pregnancies. The purchase of an electric breast pump is limited to one pump every three years. Bill with modifier NU.

Bill breast pumps using the mother's IMCare member identification (ID) number or the infant's IMCare member ID number if the mother is ineligible.

**E0604:** heavy-duty hospital grade electric breast pumps are rental only. Prior authorization is required for rental beyond three months. Documentation should include why E0602 or E0603 cannot be used for the member.

The authorization will indicate the amount of time a heavy-duty hospital grade electric breast pump can be rented for, when approved.

Bill with modifier RR. Bill accessory kits for E0604 breast pumps with modifier RA.

### **Cochlear Device (L8614, L8619)**

Authorization is required. Provide all information to demonstrate medical need.

### **Continuous Passive Motion (CPM) Machines (E0935, E0936)**

Authorization is required. Documentation should include the following:

1. Nature of injury and/or surgery, affected joint
2. Date surgery performed
3. Amount of time prescribed for CPM use and frequency
4. For E0935, knee range of motion (ROM) and flexion in degrees
5. Type of rehabilitation ordered and member's compliance

For continued use after 23 days from surgery, provide documentation about the following:

1. Has range of motion improved?



2. Current flexion in degrees for E0935
3. Use of CPM by member, for how many hours and frequency of use
4. Any other rehabilitation ordered?

### **EarPopper**

**Code:** E1399 NU

EarPopper Home Version is covered when prescribed by a physician for members over age 3 with otitis media with effusion or eustachian tube dysfunction who are unable to independently perform the Politzer maneuver.

### **Enema System**

**Code:** A4459

A manual pump-operated enema system requires a Service Authorization before being provided to a member age 2 and over. This is not covered for members under 2 years old.

Provide documentation indicating the following:

- Prescription by a physician
- Member's condition for which the manual pump-operated enema system is needed (neurogenic bowel dysfunction)
- Indication of any fecal incontinence, chronic constipation, and/or time-consuming bowel management procedures
- Other conservative bowel management alternatives tried and their effectiveness.

If a Service Authorization is approved, the limit is purchase of up to two per year.

### **Oral Appliances for Sleep Disorder**

**Codes:** E0485, E0486

**Authorization** is required. Provide documentation of medical need for the appliance and treatment tried with outcome.

Dental providers billing for a sleep apnea appliance should also refer to the *Dental Providers Billing for Sleep Apnea Appliance* section in Chapter 19, Dental Services, of the **Provider Manual**.

### **Piercing Device, Skin (E0620)**

Authorization is required. Provide documentation regarding the medical need and why a lancet cannot be used instead.

### **QR Powder/Nosebleed QR/Wound Seal Powder**

**Code:** A4649 NU

WoundSeal Powder, QR Powder for Lacerations, QR Powder for Kid's Cuts and Scrapes, QR Powder for Nosebleeds, and Gentle Formulation QR Powder for Nosebleeds are covered without an authorization when

prescribed by a physician for members with bleeding disorders, including bleeding disorders caused by use of anticoagulants.

The claim must include a diagnosis code specific to the bleeding disorder. Up to 4 units may be dispensed in anticipation of future need. It is not necessary to open packaging; providers may dispense a box of two or four applications. 1 unit = 1 application.

### **Sharps Disposal Containers**

Members who self-administer medications using syringes may receive sharps disposal containers. Bill using A4211 and modifier U3 along with appropriate pricing information as outlined in Chapter 4, Billing Policy.

### **Mobility Devices**

Manual wheelchairs, power operated vehicles, and power wheelchairs assist individuals with mobility-related disabilities to complete activities of daily living (ADL) in their homes and communities. They are a covered service for eligible IMCare members who meet criteria for medical necessity.

Mobility device vendors must be enrolled as medical equipment providers. Providers must be able to provide support services such as the following:

1. Emergency services
2. Delivery and setup
3. Repairs
4. Warranty service (a copy of the warranty must be given to the member and a copy kept in the provider's records)
5. Education and ongoing assistance with the use of the wheelchair or scooter

Providers must have skilled and knowledgeable service personnel, with an adequate inventory of replacement parts to provide timely, on-site (in member's home or work environment) mobility device services and repairs.

Providers must have loaner chairs available for the member whose chair requires repair. If the member's chair is customized and unique to his/her specific needs, IMCare does not expect providers to have an equivalent chair on hand. If providers do not have an equivalent loaner chair available, they may provide a rental chair to accommodate the member's needs while repairing the customized chair.

IMCare will reimburse providers for the rental of mobility devices. To bill, use code K0462 with modifier RR and include the Healthcare Common Procedure Coding System (HCPCS) code of the item being repaired or the item dispensed as a rental if different and less costly in the claim notes field. If the rental is longer than one month, providers must submit a request for authorization. Explain the additional circumstances and rental time needed. IMCare does not pay for repairs of rental or loaner chairs.

### **Third Party Liability (TPL) and Medicare**

Providers must meet any provider criteria, including accreditation for third party insurance or for Medicare in order to assist members for whom IMCare is not the primary payer.

Medicare requires providers dispensing Group 2 single power option wheelchairs/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 eligibles) 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.

If Medicare downcodes a mobility device, IMCare must make payment based on the downcoded Medicare explanation of benefits (EOB), regardless of any prior authorization. Providers may choose to offer only Medicare-covered mobility devices to dual eligible members.

### **Eligible Members – Criteria for All Covered Mobility Devices**

Mobility devices are covered for eligible IMCare members with a mobility limitation that significantly impairs their ability to participate in one or more mobility-related ADLs and the mobility limitation cannot be sufficiently resolved by the use of an appropriately fitted cane or walker. Daily living refers to activities such as toileting, feeding, grooming, education, working, or job training. The mobility device must:

1. Enable the member to participate in mobility related ADLs
2. Be appropriate to the member's needs and abilities

A “backup” manual chair may be covered if needed to allow the member to access medical care or essential services in the community, or when the member's power chair includes custom molded seating such that the member cannot be served with a loaner or rental chair during repairs.

When a power wheelchair is purchased for a member who already has a manual wheelchair, IMCare 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.

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.

IMCare follows InterQual™ criteria for medical necessity determinations for wheelchairs and other mobility devices.

### **Covered Services**

1. Specific mobility devices, options, and accessories
2. Manual wheelchairs
3. Power operated vehicles
4. Power wheelchairs
5. Wheelchair options and accessories
6. Custom molded and prefabricated seating systems
7. Wheelchairs in long-term care facilities (LTCFs)

### **Specific Mobility Devices, Options, and Accessories**

Providers must be prepared to submit additional documentation of medical necessity beyond what is typically required, when asked.

**Standard options and accessories** for manual wheelchairs include the following:

1. Calf rests/pads
2. Fixed height arm rests (fixed, swingaway, or detachable)
3. Foot rests and footplates (fixed, swingaway, or detachable)
4. Hand rims with or without projections
5. Wheel lock assemblies

**Non-standard options and accessories** for manual wheelchairs may include the following:

1. Adjustable height arm rests
2. Anti-rollback device
3. Elevating leg rests
4. Head rest extensions
5. Nonstandard seat frames (standard is 15 – 19” wide by 15 – 19” deep)
6. One-arm drive attachments
7. Positioning accessories
8. Push activated power assist
9. Safety belts/straps
10. Skin protection seat cushions

The following codes may not be filled within 30 days of initial issue of a manual wheelchair:

<b>Manual Wheelchair Accessory Codes</b>				
E0967	E2210	E2225	K0042	K0050
E0981	E2220	E2226	K0043	K0052
E0982	E2221	K0015	K0044	K0069
E0995	E2222	K0017	K0045	K0070
E2205	E2223	K0018	K0046	K0071
E2206	E2224	K0019	K0047	K0072

### **Manual Wheelchairs (K0001 – K0004, E1229)**

Authorization is required for all purchases and after the third month of rental. An exception to the authorization requirement is for manual wheelchairs provided to members who are 65 years or over.

### **Special Manual Wheelchairs (E1161, E1231, E1232, E1233, E1234, E1235, E1236, E1237, E1238, K0005, K0006, K0007, K0009)**

Authorization is required. IMCare follows InterQual™ criteria for medical necessity determinations.

### **Roll about/Transport chairs (E1031, E1037 – E1039)**

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

1. The member is not expected to be able to self-propel a manual or power wheelchair in the next five years
2. The member has needs that cannot be met by a less costly manual wheelchair
3. The proposed chair has casters of at least five inches in diameter and is specifically designed to meet the needs of ill, injured, or otherwise impaired individuals

**Geri Chair (E1031)**

**Authorization** is required after the third month of rental and for all purchases. Provide documentation of medical need and prescription.

**Power Operated Vehicles (E1230, K0800 – K0802, K0806 – K0808, K0812)**

Power operated vehicles are covered if the member meets medical necessity criteria. IMCare follows InterQual™ criteria for medical necessity determinations. Standard equipment includes the following:

1. Battery or batteries required for operation
2. Single mode battery charger
3. Weight appropriate upholstery and seating system
4. Tiller steering
5. Non-expandable controller with proportional response to input
6. Complete set of tires
7. 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. IMCare follows InterQual™ criteria for determining medical necessity.

**Standard equipment** includes the following:

1. All types of tires and wheels
2. Any back width
3. Any seat width and depth
4. Weight specific components required by member's weight capacity
5. Battery charger
6. Fixed swing-away or detachable:
  - a. Footrests/foot platform
7. Non-adjustable armrests with arm pad
8. Non-elevating leg rests with/without calf pad
9. Lap belt or safety belt
10. Non expandable controller
11. Standard integrated or remote proportional joystick

**Non-standard options or accessories** may include the following:

1. Adjustable height arm rests
2. Elevating leg rests
3. Manual fully reclining back option
4. Power tilt
5. Power recline
6. Seat elevator
7. Shoulder harness/straps or chest straps/vest
8. Skin protection seat cushions, position accessories
9. Standing feature

Do not bill the following codes at the time of initial issue of a power wheelchair:

Power Wheelchair Accessory Codes				
E0971	E2369	E2386	E2395	K0042
E0978	E2370	E2387	E2396	K0043
E0981	E2374	E2388	K0015	K0044
E0982	E2375	E2389	K0017	K0045
E0995	E2376	E2390	K0018	K0046
E1225	E2381	E2391	K0019	K0047
E2366	E2382	E2392	K0020	K0051
E2367	E2384	E2393	K0037	K0052
E2368	E2385	E2394	K0041	K0098

Do not bill E2377 when used with a Group 1 or Group 2 no power option power wheelchair, and do not bill K0040 when used with a Group 1 or Group 2 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.

1. **One arm drive attachments (E0958)** are covered if:
  - a. The member meets the criteria for a manual wheelchair, but is unable to use both arms or at least one lower extremity to safely propel the manual wheelchair
  - b. A trial demonstrated the member has the strength, stamina, and cognitive ability to propel the wheelchair using the one arm drive attachment
2. **Push activated power assist (E0986)** is covered (**authorization required**) if the member:
  - a. Has expressed an unwillingness to operate a power wheelchair
  - b. Has one of the following:
    - i. Was self-propelling in a manual wheelchair but no longer has sufficient upper extremity function to self-propel a manual wheelchair
    - ii. Was self-propelling in a manual wheelchair but has weakness or repetitive motion stress to the shoulders or upper arms

Documentation must include the following:

- a. An assessment of the distance the member is expected to need to operate the manual wheelchair
  - b. A trial sufficient to demonstrate the member is able to operate the manual wheelchair for that distance
  - c. An estimate indicating how long the push activated power manual wheelchair is expected to meet the member's mobility needs
3. **Power tilt (E1002)** is covered (**authorization required**) if the member:
    - a. Meets criteria for a power wheelchair
    - b. Has one of the following needs:
      - i. Is at risk for pressure ulcers and is unable to perform a functional weight shift
      - ii. Has a fixed hip angle
      - iii. Has increased or excess muscle tone/spasticity related to a medical diagnosis which impairs his/her ability to tolerate the fully upright sitting position for significant periods of time
    - c. Is able to independently operate the power tilt system

- 4. Power recline (E1003 – E1005)** is covered (**authorization required**) if the member:
- Meets criteria for a power wheelchair
  - Is able to independently operate the power recline system
  - Has one of the following:
    - Is unable to tolerate a full upright position due to a medical condition that impairs his/her 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

If a reclining seating system is approved because a member has edema, manual or power elevating leg rests must be requested.

- 5. Power tilt and recline seating systems, with or without power elevating legs rests (E1006 – E1008)** are covered (**authorization required**) if the member:
- Meets criteria for a power wheelchair
  - Is able to independently operate the power tilt and recline system
  - Has more than one of the following:
    - A fixed hip angle
    - Increased or excess muscle tone/spasticity related to a medical diagnosis that impairs his/her ability to tolerate the fully upright sitting position for significant periods of time
    - Is at high risk for pressure ulcers and is unable to perform a functional weight shift
    - Uses intermittent catheterization
    - Edema and is unable, for physical or other reasons, to periodically transfer from the wheelchair

If a reclining seating system is approved because a member has edema, manual or power elevating leg rests must be requested.

- 6. 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

- 7. Power leg elevation systems (E1010)** are covered if the member:
- Meets criteria for a power wheelchair
  - 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
    - Is able to independently operate the power leg elevation system

- 8. Manual, fully, or semi-reclining backs (E1225, E1226)** are covered (**authorization required**) if the member has one of the following:
- At high risk for pressure ulcers and is unable to perform a function weight shift

- b. Uses intermittent catheterization for bladder management and is unable to independently transfer from the wheelchair
  - c. Is unable to tolerate a full upright position due to a medical condition
- 9. Gear reduction drive wheels (E2227)** are covered (**authorization required**) if the member:
- a. Meets criteria for a manual wheelchair
  - b. Is at risk for weakness or repetitive motion injury to the arms or shoulders
- 10. Dynamic seating frame (E2295)** is covered when:
- a. The requested dynamic seating frame is made by the same manufacturer as the requested pediatric wheelchair
  - b. The requested pediatric wheelchair independently meets all criteria for medical necessity and least costly appropriate equipment
  - c. The member does not require tilt-in-space or reclining back
  - d. The member is able to engage in some hip or knee extension
- 11. Seat elevation feature (E2300)** is covered (**authorization required**) if the member has one of the following:
- a. Must routinely transfer between uneven surfaces and the surfaces cannot be adjusted and the seat elevation feature allows the member to independently transfer
  - b. Cannot be safely transferred using a patient lift or standing transfer but can safely transfer with the seat elevation feature
  - c. The seat elevation feature has been demonstrated to allow the member to independently access areas in the home necessary for completion of 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/standing transfer.

A seat elevation feature is not covered when requested to allow the member to socialize with peers.

If a wheelchair with a seat elevation feature is approved and purchased for a member, the provider must obtain documentation from the member acknowledging 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 to IMCare staff upon request.

- 12. Standing feature (manual: E2230; power: E2301)** is covered (**authorization required**) if:
- a. The member meets the InterQual<sup>TM</sup> criteria for a stander
  - b. IMCare has not purchased a stander for the member in the previous three years
  - c. The standing function has been demonstrated to allow the member to independently access areas in the home necessary for completion of ADLs (cupboards, closets, etc.)

A standing feature is not covered when requested to allow the member to socialize at eye level with peers.

If a wheelchair with a standing feature is approved and purchased for a member, the provider must obtain documentation from the member acknowledging IMCare will not pay for future repairs to a stander and 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 to IMCare staff upon request.

- 13. Alternative Interface Devices (E2312, E2321 – E2330, E2373)** is covered if the member:
- a. Meets criteria for a power wheelchair and cannot safely operate the wheelchair using a hand- or chin-operated standard proportional joystick



- b. Can safely operate the wheelchair using the alternative device

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

- a. Meets criteria for a mobility device but is unable to operate a manual or power wheelchair
- b. Requires a power wheelchair or lacks a caregiver able to propel a manual chair
- c. Has a caregiver willing and able to operate the power wheelchair and assist the member

**15. Wheelchair component or accessory, NOS (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

Authorization is 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, Prosthetics & Pedorthics (ABCOP) or by RESNA with the authorization request.

**Code:** E2610 – Power wheelchair seat cushion also requires authorization

### Authorization

Authorization is required.

Bill labor and material costs associated with fabricating an individually made sitting support spinal orthoses to IMCare using one of the following HCPCS codes:

1. **K0108 with modifier UD:** Professional services associated with the evaluation, molding, and fitting of custom molded seating systems
2. **E2609:** Seat module molded to fit a member, custom fabricated for attachment to wheelchair base
3. **E2609, E2617:** Seat and back sections molded as one piece, custom fabricated for attachment to wheelchair base
4. **E2609, E2617; for repairs:** Repair to custom seating systems. Detail the cost of material. For DOS before January 1, 2009, use modifier RP; for dates of service (DOS) on or after January 1, 2009, use modifier RB.
5. **K0739 :** Repairs to seating systems, per 15 minutes labor. Clearly state in the documentation that the repairs are for a seating system and not for the wheelchair.

### Prefabricated Seating Systems

Bill using codes: **E2605 – E2608, E2613 – E2316, E2620 – E2621, and K0669.** Use **K0108** when billing a head support attached to the prefabricated seating system. Payment for a head support includes mounting hardware.

## Wheelchairs in Long-Term Care Facilities (LTCFs)

Wheelchair purchases and rentals are not included in the Intermediate Care Facility for the Developmentally Disabled (ICF/DD) per diem.

Standard wheelchairs for members in a nursing facility are included in the nursing facility per diem.

Wheelchairs for members in a nursing facility may be approved if one of the following criteria is met:

1. The member needs a wheelchair that must be modified. Modified means one of the following:
  - a. The addition of an item to the wheelchair that cannot be removed without damaging the wheelchair
  - b. It permanently alters the wheelchair so it is no longer usable by other residents of the facility

- c. Wheelchairs manufactured in various widths and sizes for larger individuals are not considered modified
2. The wheelchair is necessary for the continuous care and exclusive use by the member to meet his/her unusual medical need. Please note the following:
  - a. Exclusive use alone does not justify approval of a wheelchair for a member if the chair required is a standard chair
  - b. Medical conditions common or expected in nursing facility populations are not “unusual” just because they are rare in one specific facility. For example, Alzheimer’s disease, osteoporosis, and vulnerability to pressure ulcers are common in nursing facilities.
3. The member is being discharged to the community. Document the member’s planned discharge date.

Facilities must exhaust other options for meeting a member’s needs, such as non-permanent positioning items, before requesting authorization for a wheelchair.

Authorization is required for the purchase of wheelchair seating devices, headrests, and additions/modifications to the seating system regardless of the amount billed.

Wheelchair cushions for prevention and treatment of skin pressure areas, including cushions used on patient owned wheelchairs, are not covered. These items are included in the facility per diem.

When a wheelchair is approved for a member, all medically necessary parts and accessories of the wheelchair are covered except skin protection cushions.

For member-owned wheelchairs in nursing facilities, repairs are covered if the chair would be approved outside the facility per diem. All repairs to wheelchairs in nursing facilities require authorization.

### **Replacement of worn batteries, battery chargers, wheels, tires/arm pads is not considered a repair.**

Follow authorization request guidelines for repairs, and include the following information:

1. State “patient-owned wheelchair, living in long-term care (LTC)” in the “Notes” field or on an attachment
2. The original wheelchair authorization number, if available
3. If IMCare did not authorize the original purchase of the wheelchair/if the wheelchair was purchased prior to admission to the nursing facility, include documentation to support medical necessity
4. Bill using place of service (POS) code 31 and modifier U3.

Medicare does not cover the rental, purchase, or repair of mobility devices when the member is living in an LTCF. Providers must follow IMCare authorization and billing procedures. It is not necessary to bill Medicare before billing IMCare.

### **Non-Covered Services**

Mobility devices are not covered in the following circumstances:

1. Power mobility devices if requested solely for the purpose of community outings such as attending social activities
2. Mobility devices requested to meet behavioral needs rather than mobility needs
3. Mobility devices requested solely for use in a public school if the device can be covered through an individualized education plan (IEP)
4. “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
5. Mobility devices designed for sports or recreational purposes
6. Wheelchairs with stair climbing ability
7. Options and accessories to convert a manual chair to a power chair (E0983 – E0984)

8. 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](#).

### **Authorization**

1. Required Authorization
2. Authorization Requests for Purchase/Rental
3. Repair/Modification Authorization Requests

### **Required Authorization**

Authorization is required under the following circumstances:

1. All mobility device purchases and rentals except:
  - a. Standard wheelchairs (K0001, K0002, K0003, K0004, and E1229) rentals after three months
  - b. Roll about and transport chairs (E1031, E1037, E1038, and E1039) rentals after three months
2. Modifications to an existing wheelchair if the submitted combined charges for parts and labor are a \$1,000 or more
3. Repairs or replacement of parts/accessories if the submitted combined charges for parts and labor are a \$1,000 or more
4. Repairs or replacement of parts/accessories that are less than 365 days old
5. Miscellaneous parts billed with HCPCS code K0108 when the submitted charge for the part is \$1,000 or more, regardless of the submitted combined charges for repairs or modifications
6. Professional services associated with custom molded seating systems
7. Custom molded seating systems and accessories as indicated above
8. All mobility devices purchases, rentals, and repairs when the member lives in a nursing facility

### **Authorization Requests for Purchase/Rental**

#### **Manual Wheelchairs, Power Operated Vehicles and Group 1 or Group 2 No Power Option Wheelchairs**

Authorization requests for members with progressive diseases or conditions must include an assessment by a licensed/certified medical professional of the effects of the disease's progress on the member's ability to use the requested mobility device and an estimate indicating how long the requested mobility device is expected to meet the member's mobility needs. Medical professional includes physical therapist (PT), occupational therapist (OT), or physician with training in rehabilitation wheelchair evaluations.

#### **Group 2, 3, 4, or 5 Single or Multiple Power Option Power Wheelchairs**

Authorization requests must include a functional assessment by a licensed/certified medical professional (PT, OT, or physician with training in rehabilitation wheelchair evaluations).

#### **Mobility Devices for Members under Age 21**

Authorization requests must include an assessment by a licensed/certified medical professional (PT, OT, or physician with training in rehabilitation wheelchair evaluations). The assessment must address both the member's current and expected future mobility needs.

#### **Mobility Devices for Members with Recent Spinal Cord Injuries (SCIs) or Brain Injuries (BIs)**

Authorization requests must include therapy notes detailing the member's progress toward goals, the expected outcome of therapy for the member, and the expected time until maximum benefit from therapy is achieved.

### **Power Mobility Devices for Members under Age 4**

Power mobility devices will not be considered for members under age 18 months.

Authorization requests for power mobility devices for children under age 4 must include the following:

1. Documentation, including any relevant assessments, that the child is developmentally and cognitively ready to begin to operate a power wheelchair
2. Documentation that the child is expected to use a powered mobility device as a primary means of mobility for several years. It is not necessary that there is no expectation or hope of functional walking in the future.
3. Documentation of the age-appropriate ADLs for which the child is expected to use the power mobility device
4. Documentation that the caregivers have carefully considered the risks and benefits of independent power mobility for very small children
5. Due to the expense of mobility devices for very small children, it is particularly important that issues of transportation be addressed to eliminate the need for multiple mobility devices

### **Documentation of Member Ability to Use In-Home and Transportation Trials**

All authorization requests must include a trial in the home that demonstrates the mobility device fits in all necessary areas of the home and the member is able to use the mobility device in all necessary areas of the home.

1. During the trial, also address transportation of the mobility device in the member's vehicle if appropriate. If the member does not have a vehicle, address the member's primary transportation method.
2. For manual wheelchairs without seating or propulsion options, the trial may be performed with the same or similar equipment.
3. For other mobility devices, the trial must be performed with equipment with the same specifications as to measurement and maneuverability and power options.

In all cases, the trial must demonstrate the proposed device is medically necessary and appropriate for the member.

Mobility device authorization requests must include the physician's order for the device. The order must be signed and dated by the physician.

An authorization request form must be completed for both the wheelchair and the accessories, if applicable. The [\*\*Mobility Device Authorization Form \(DHS-4315-ENG\)\*\*](#) must be completed and signed by the person recommending and fitting the mobility device. The form must indicate the credentials (doctor of medicine [MD], PT, OT, ATP) of each person signing the form.

1. Submit the mobility device base HCPCS code for an authorization number when requesting an authorization for purchase or rental beyond three months. List the recommended device by name and model number.
2. List all standard and non-standard accessories/options on separate lines on the authorization request, even if the individual item does not require authorization. List each item by HCPCS code, appropriate modifier, and quantity, with the charge and medical necessity documentation for non-standard items.
3. When multiple items that are different but require the miscellaneous code K0108 are requested, each item must be listed on a separate line of the authorization request, with modifier 76 on the second and subsequent lines. A unique description of each item must be entered into the model number field for each line. The unique description may be a model number or narrative description up to 20 characters.
4. Documentation must address the member's medical need, and how the mobility device and each option or accessory meets that need. All options and accessories, and the specific medical justification for each option or accessory, must be listed on the request, although only the major accessories will be reviewed for medical necessity.

5. Standard items included in the initial issue of the device will not be reviewed for medical necessity but will be listed on the authorization letter as an approved item.
6. All major accessories will be listed on the authorization letter by procedure code, whether approved or denied, with the allowed dollar amount if approved.
7. All coverage determinations are based on the least costly, most effective, and medically necessary mobility device for the individual member.

### **Repair/Modification Authorization Requests**

When requesting authorization for repairs/modifications to a mobility device not originally authorized by IMCare, include documentation of medical necessity for the device and the accessories to be repaired/replaced.

### **Replacement of worn batteries, battery chargers, wheels, or tires/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 \$1,000 limit.

Authorization may be denied if:

1. The repairs/modifications are not cost effective because of the age/condition of the device
2. The frequency/extent of repairs requested indicates the member lacks the ability to safely and appropriately operate the device
3. The repairs/modifications are requested for a device that does not currently meet Minnesota Health Care Programs (MHCP) criteria for coverage

When submitting authorization requests:

1. List all accessories/options to be replaced or repaired on separate lines on the authorization request. List each item by HCPCS code, quantity, and the usual and customary (U&C) charge. Use appropriate modifier(s) as determined by DOS.
2. When multiple items that are different but require the miscellaneous code K0108 are requested, each item must be listed on a separate line of the authorization request with modifier 76 on the second and subsequent lines. A unique description of each item must be entered into the model number field for each line. The unique description may be a model number or narrative description up to 20 characters.
3. Include the estimated labor time on the authorization request with K0739, as appropriate.
4. If adding accessories to an existing wheelchair, include medical necessity documentation for each accessory.
5. Include the original mobility device prior authorization number, if available, or the approximate purchase DOS.
6. If repairs are needed because of damage to the device, specify the cause of the damage.
7. All approved items will be listed on the authorization, with the approved payment amount.

### **When requesting authorization for repairs/modifications to a mobility device:**

1. For all parts and accessories to be repaired or replaced:
  - a. Use modifier RB for items being repaired
  - b. Use modifier NU for items being installed as a modification
  - c. Use modifier RA for items being installed as a replacement for the same accessory
  - d. U&C charge(s)

### **Billing**

1. Submit the U&C charge for the mobility device and part/accessories. Payment will be the balance of the lesser of the billed amount or the approved amount, after any primary or secondary payers have made payment.

2. If billing for parts/accessories for two approved wheelchairs, clearly indicate this in the notes field. Include the authorization number that refers to the appropriate wheelchair in the notes field.
3. Do not bill repairs over a span of dates.
4. When a provider sends a part or accessory to a manufacturer for repair, bill using the appropriate HCPCS code for the part and RB modifier. Submit the invoice from the manufacturer as an attachment to show cost. Bill K0739 for the provider's labor for removal/reinstallation of the part or accessory. Follow usual IMCare policies in determining if a prior authorization is necessary.
5. Bill items that require manual pricing using the 837P professional electronic claim format with the manufacturer's invoice or price list as an attachment as described in Chapter 4, Billing Policy. Items included in an approved authorization do not require manual pricing.
6. If billing for parts/accessories for two medically necessary member-owned wheelchairs, clearly indicate this in the notes field, including the authorization number or serial number that refers to the appropriate in the notes field.
7. If you bill K0739, IMCare will deny additional claims billed by the same provider for the same DOS.
8. Repairs to equipment owned by Medicare members: Effective April 1, 2009, Medicare established Unit of Service Allowances for repairs to some commonly repaired items. When the actual repair time exceeds Medicare's allowance, bill the labor on two lines. Line one must follow Medicare billing rules. On line two, bill K0739 or K0740 as appropriate and use modifier GZ (item or service expected to be denied as not reasonable and necessary) and the number of units that exceed Medicare's allowance.

#### **Approved Purchase/Rental Billing for Devices Approved on a Single-line Authorization**

Submit a claim for the approved power-operated vehicle or wheelchair base; make sure the HCPCS code, modifiers, and the description on the claim match the same information on the prior authorization.

Submit the U&C charge for the mobility device, not the approved amount, on the authorization letter. Payment will be the balance of the lesser of the billed amount or the approved amount, after any primary or secondary payers have made payment.

On a second claim, submit all options and accessories provided at the initial issue of the mobility device. For any accessories for which authorization was approved, enter the authorization number in the notes/comments field on the claim information tab, or attach documentation that lists each approved option/accessory. Do not enter the authorization number in the authorization field.

#### **Repairs/Modifications Billing for Devices Approved on a Single-Line Authorization**

##### **Submit one claim per mobility device.**

1. Bill each repaired part or accessory using the appropriate HCPCS code for that part/accessory with modifier RB.
2. Bill each part/accessory installed as a modification using the appropriate HCPCS code for that part/accessory with modifier NU.
3. Bill each part/accessory being installed as a replacement for the identical item using the appropriate HCPCS code for that part/accessory with modifier RA.
4. Bill multiple items that are different but require the miscellaneous code K0108 using the appropriate HCPCS code with appropriate modifiers on the first line item, and K0108 with modifier 76 and the appropriate modifier(s) NU/RA/RB on each additional line. Enter a description on each line specific enough to clearly identify each different item, such as manufacturer, part, or item number and brief description of the item.
5. Bill labor on the same claim, using K0739.
6. Enter the number from the approved authorization request in the "Notes" field. Do not enter the number in the "Authorization" field.

**Approved Purchase/Rental/Repair Billing for Devices Approved on a Multi-Line Authorization**

Submit one claim for the approved power-operated vehicle or wheelchair base (for purchase/rental) and all approved parts/accessories (for all claims); make sure the HCPCS codes, modifiers, and the description on the claim match the same information on the prior authorization.

Enter the authorization number in the authorization field in the authorization field for each line.

**Use of Modifiers KC and KE**

Providers must follow Medicare guidelines for use of modifiers KC (replacement of special power wheelchair interface) and KE (items bid under round one of the Medicare Durable Medical Equipment, prosthetics, orthotics, and supplies [DMEPOS] competitive bidding program for use with noncompetitive bid base equipment). IMCare will apply the appropriate Medicare rate to lines billed with KC and KE modifiers.

**Members with Third Party Coverage or Medicare**

When IMCare is not the primary payer, other insurance **must be exhausted** before submitting a claim for payment to IMCare.

1. Utilization Management (UM) at IMCare must approve an authorization before IMCare can make a payment.
2. UM will make an authorization request after the fact, but authorization must be obtained. Refer to the “Authorization” subsection in the *Mobility Devices* section for instructions.
3. The mobility device must meet all IMCare medical necessity requirements, and documentation included in the request must identify the mobility device in detail.
4. Include the amount the primary payer will reimburse for the mobility device in the authorization request.
5. Members/providers must comply with policies/procedures of the primary insurance.

**Nebulizers****Codes**

E0570: with compressor (Pulmo Aide Type)

E0571: portable with small compressor with limited flow (battery operated)

**Authorization**

**Authorization** is not required.

One nebulizer is allowed every five years. If more than allowed quantity is medically necessary, providers must submit a claim with an attachment explaining the circumstances requiring replacement.

**Provider must maintain required documentation in member’s file.**

The need for a battery operated model and one or more of the following conditions must be documented:

1. Previous life-threatening bronchospasms
2. Aerosol drug therapy is more frequent than twice per day for a member who is away from home at school or work on a daily basis
3. Cystic fibrosis (CF)
4. Bronchiectasis

**Initial dispensing includes the following:**

1. Compressor
2. Mask

3. Mouthpiece
4. Reusable nebulizer
5. Tubing

**Separately bill the following:**

1. Disposable mouthpieces
2. Face mask
3. Replacement of disposable hand held nebulizer
4. Replacement tubing

**Ultrasonic Nebulizer (E0575)**

Authorization is required. Provide documentation of the medical necessity for this service and what type of treatment has been tried in the past with outcome of that past treatment.

**Non-Mobility Equipment Repairs**

IMCare pays for repairs to medically necessary member-owned Durable Medical Equipment (DME) and prosthetics/orthotics. IMCare pays for maintenance service agreements for some member-owned equipment that requires frequent servicing or calibration.

**Third Party Liability (TPL) and Medicare**

Providers must meet any provider criteria, including accreditation, for third party insurance or for Medicare in order to assist members for whom IMCare is not the primary payer.

IMCare quantity limits and thresholds apply to all members unless only Medicare co-insurance or deductible is requested.

**Eligible Members**

Repairs to member-owned medically necessary DME and prosthetics/orthotics are covered for eligible IMCare members.

**Covered Services****Codes**

K0462: temporary replacement for patient-owned equipment being repaired, any type

K0739: repair or non-routine service for DME other than oxygen, labor component, per 15 minutes

K0740: repair or non-routine service of oxygen equipment, labor component, per 15 minutes

The following codes are eligible for maintenance service contracts if the equipment is recipient-owned and meets criteria: B9000, B9002, B9004, B9006, E0445, E0450, E0460, E0461, E4063, E0464, E0470, E0471, E0482, E0483, E0600, E0609, E0617, E0779, E0781, E1390, E1392, E1399, K0606, and K0730.

Authorization is sometimes required.

If providers do not have appropriate loaner equipment for the member to use while equipment is being repaired, rental equipment may be provided. IMCare will reimburse providers for one month's rental. To bill, use K0462 and include the Healthcare Common Procedure Coding System (HCPCS) code of the item being repaired in the "Comments" section of the claim.



If the rental is longer than one month, providers must submit a request for authorization. Explain the unusual circumstances and rental time needed.

Equipment should not be repaired if the cost to repair exceeds the cost to replace, or if the repair will not significantly extend the usable life of the equipment.

Maintenance service contracts are available for patient-owned equipment that is necessary to sustain life, and which requires regular, professional attention beyond the capability of most members. Examples of the types of equipment that may require a maintenance service contract are patient-owned oximeters, ventilators, respiratory assist devices, and defibrillators.

When a maintenance service contract is approved, the provider becomes responsible for all regularly scheduled service to keep equipment functioning correctly for six months. If repairs are needed, the repairs may be provided in addition to the maintenance service contract.

See the *Mobility Devices* section for information on repairs to wheelchairs or power operated vehicles.

### **Authorization**

Equipment that always requires authorization for purchase always requires authorization for repair or modification.

Equipment that sometimes requires authorization for purchase and equipment that never requires authorization for purchase will require authorization for repair or modification if parts combined with labor charges total \$1000.00 or more.

Maintenance service agreements for E1399 always require authorization.

When requesting authorization for a maintenance service agreement for a member-owned equipment item, use the appropriate equipment procedure code with modifier MS and include the date the warranty period ended. One unit equals a six-month service agreement.

If IMCare did not authorize or purchase the equipment being repaired/maintained, include documentation that the equipment meets current medical necessity criteria.

Requests for repairs where the cost to repair exceeds 90 percent of the cost to replace must include documentation to show that the repair is a less costly alternative over time than replacement with a new item under warranty.

If the equipment is nearing the end of its expected usable life (usually five years), document how long the repair is expected to extend the lifespan of the equipment.

### **Billing**

1. Use the 837P professional claim format.
2. If the member has Medicare, IMCare will pay the deductible/co-insurance on any units for which Medicare made payment. Any units for which Medicare denies payment must meet IMCare quantity and coverage limits.
3. Do not bill repairs over a span of dates.

4. When replacing a battery or power cord that does not require billing associated labor, providers may use either the HCPCS code for the equipment with modifier RB or A9999 with modifier NU.
5. For other repairs, use the HCPCS code for the equipment with modifier RB for materials.
6. Use K0739 or K0740 for labor associated with the repair.
7. Bill for the number of units actually performed based on the actual repair time.
8. For repairs to equipment owned by Medicare beneficiaries: Effective April 1, 2009, Medicare established Unit of Service Allowances for repairs to some commonly repaired items. When the actual repair time exceeds Medicare's allowance, bill the labor on two lines. Line 1 must follow Medicare billing rules. On line 2, bill K0739 or K0740 as appropriate and use modifier GZ (item or service expected to be denied as not reasonable and necessary) and the number of units that exceed Medicare's allowance.
9. Attach appropriate documentation for pricing materials/parts.

## Nutritional Products and Related Supplies

A nutritional product is a commercially formulated substance that provides nourishment and affects the nutritive and metabolic processes of the body. Enteral nutritional products are a covered service for eligible IMCare members who meet criteria for medical necessity.

Parenteral nutritional products are considered drugs and only a pharmacy may dispense these solutions. See Chapter 22, Pharmacy Services, for information about parenteral nutrition.

Nasogastric tubes, gastrostomy/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.

### Eligible Members

Enteral nutrition is covered for eligible IMCare members who need nutritional supplementation because solid food or the nutrients in the food cannot be properly absorbed by the body; for treatment of phenylketonuria (PKU); hyperlysinemia; maple syrup urine disease (MSUD); or a combined allergy to human milk, cow's milk, and soy formula. Enteral nutrition may be covered for members with other specific medical conditions.

### Covered Services

#### Enteral Nutritional Products

**Codes:** B4149 – B4162 (For these codes 100 calories = 1 unit), S9435

Only products classified by Medicare's Pricing, Data Analysis, and Coding (PDAC) contractor are covered. If you are unsure of what Healthcare Common Procedure Coding System (HCPCS) code to use refer to the [Durable Medical Equipment Coding System \(DMECS\) Product Classification List](#). Up to 1,050 units per month of enteral nutrition are covered for members who meet criteria.

Documentation must support the need for the number of units requested. Oral enteral nutrition for treatment of PKU, hyperlysinemia, or MSUD do not require authorization unless the member is under age one.

### Authorization

Authorization is required for all orally consumed enteral nutrition after the first 30 days of dispensing, for contracted providers (out-of-network providers require authorization before providing the service).

For contracted providers, no authorization is needed if the member has one of the following:

1. PKU
2. Hyperlysinemia
3. MSUD
4. Members (over age one) receiving enteral nutritional supplements through a feeding tube (a valid tube—feeding diagnosis must be on the claim or it will be denied). Members under age one do require a Service Authorization, even if receiving enteral nutritional through a feeding tube.

The prescribing physician must complete and sign the [Prior Authorization Form](#) and provide the completed form to the pharmacy, home health agency, or medical supply provider.

The provider must submit the authorization request along with the completed the [Prior Authorization Form](#) and any other documentation that indicates the medical need for oral feeding with an enteral nutrition product.

Documentation for all requests should include the following:

1. The specific enteral nutrition product requested (and the HCPCS code)
2. The average number of calories to be obtained per day from the enteral nutritional product
3. The average number of calories to be obtained per day from other sources
4. The medical condition that requires enteral nutrition product (plus the specific documentation indicated under each category of medical condition, see below)
5. A list of all the foods the member is able to consume and a list of all the foods the member has tried but cannot consume
6. The types of food preparation that have been tried (mechanically chopped, blenderized)

### **Categories of Medical Conditions**

#### **Nutrition for Members under Age 1**

Children under age 1 may be able to get infant formula through the Women, Infants, and Children (WIC) program. Instruct families to contact their county human services or county public health office.

All enteral nutrition products for children under age 1 require authorization. Document that the specific formula that is required is not available to the child through WIC or that WIC does not provide the formula in quantities sufficient to meet the child's medical need. The child must meet one of the medical necessity criteria below.

#### **Nutrition for Members with Feeding Tubes**

Enteral nutritional products are medically necessary for members with feeding tubes. Authorization will be approved for members under age one with documentation that WIC cannot meet the child's medical needs. Authorization is not required for members over age 1.

#### **Oral Nutrition for Members with Inborn Errors of Metabolism**

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 with authorization for members under age 1 and without authorization for members over age 1 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.

Solid food products specially manufactured for treatment of amino-acid transport and metabolism including PKU and MSUD are covered up to \$525 per calendar month when obtained from an enrolled medical food supplier.

#### **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 that 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, there must be a detailed plan to decrease dependence on the supplement. The plan may be written by a nutritionist, an SLP, or a physician.

**Oral Nutrition for Members Who Cannot Properly Absorb Solid Food or Nutrients**

Enteral nutritional products are medically necessary if the member has a medical condition that causes an inability to absorb adequate nutrients, and which has led to weight loss. Oral enteral nutritional products are covered with authorization if the member meets criteria. Documentation must establish all of the following:

1. The member has a diagnosed medical condition:
  - a. Mechanical inability to chew or swallow solid or pureed/blenderized foods
  - b. Mal-absorption problem due to disease or infection
  - c. Oral aversion which significantly limits the ability to get adequate nutrition through solid or pureed/blenderized foods
  - d. Weaning from total parenteral nutrition (TPN) or feeding tube
2. The medical condition leads to inability to consume or absorb adequate nutrients
3. The member has experienced significant weight loss over the past six months or, for children under age 21, has experienced significantly less than expected weight gain
4. If the member gets less than 75 percent of daily nutrition from a nutritionally complete enteral nutrition product, there must be a detailed plan to decrease dependence on the supplement. The plan may be written by a nutritionist, an SLP, or a physician.

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

High protein enteral nutritional products are covered for up to six 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 which is written by a nutritionist, physician, or other health care provider.

**Supplies for Enteral/Parenteral Nutrition****Enteral Feeding Supply Kits**

**Codes:** B4034 – B4036

Thirty-one enteral feeding supply kits per month are medically necessary for members receiving enteral nutritional products 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 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.

**Feeding Tubes**

**Codes:** B4081 – B4088

Although most individuals who use a feeding tube only require one tube every 2 – 3 months, up to two tubes per month may be medically necessary for individuals with more than one tube site or for individuals with highly acidic gastrointestinal (GI) tracts. Low-profile feeding tubes are medically necessary for infants and children, for individuals with cognitive impairments who are at risk of dislodging a standard feeding tube, and for other individuals as determined by the physician. The provider must maintain documentation to support the quantity and type of feeding tubes supplied.

## Feeding Pumps

**Codes:** B9000 – 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. Authorization is required only for maintenance service or for repairs when parts and labor exceed \$1000. One pump is covered per five years. Consider the member's current and expected lifestyle when selecting a stationary versus portable pump. If a pump must be replaced due to theft or damage, providers must submit a claim with an attachment explaining the circumstances. Authorization is required for maintenance service contracts or for repairs to patient owned pumps where parts and labor exceed \$1000. Refer to the *Non-Mobility Equipment Repairs* section for more information.

## 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 30, 35 ml or 60 ml syringes per month are medically necessary for individuals receiving medication through a feeding tube. One carrying case per year is covered for members with portable feeding pumps.

## 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.

## Non-Covered Services

1. Nutritional products for healthy newborns
2. Nutritional products for persons living in long-term care facilities (LTCFs) (included in the per diem)
3. Nutritional products for which the need is nutritional rather than medical or is related to an unwillingness to consume solid or pureed foods
4. Nutritional products which are requested as a convenient alternative to preparing/consuming regular foods
5. Nutritional products for which coverage is requested because of an inability to afford regular foods or supplements (refer the member to their county human services office)
6. Food thickeners for persons living in LTCFs (included in the per diem)
7. Food thickeners for infants under age 1 who were born at less than 37 weeks gestation due to Food and Drug Administration (FDA) caution
8. SimplyThick brand food thickener for infants under age 1 regardless of gestational age at birth is not covered due to FDA caution
9. Energy drinks
10. Sport shakes
11. More than one enteral supply kit per day for syringe or gravity-fed feedings

## Billing

1. Use the 837P professional claim format.

2. Report the ordering provider in the “Other Provider Types” section of the claim format.

### **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:

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

### **Pricing for Enteral Nutritional Products**

1. B4149 – B4152 with modifier NU, with or without modifier BO: Medicare fee schedule rate
2. B4153 – B4155 with modifier NU, with or without modifier BO: Medicare fee schedule rate
3. B4153 – B4155 with modifiers NU and U3, with or without modifier BO: product-specific pricing
4. B4157 – B4162 with modifier NU, with or without modifier BO: product-specific pricing

### **Gastrostomy/Jejunostomy Tubes and Supplies Not Otherwise Classified**

1. Bill B4087 – B4088 only for the feeding tubes. Use B9998 for all related supplies including extension sets.
2. Include a valid diagnosis code to the greatest specificity indicating the medical condition that requires the tube feeding.
3. The DOS is the date the item was dispensed to the member. Do not use a date span.
4. Enter the item name in the comments/description field.
5. Do not use B9998 for feeding supply kits or for syringes smaller than 35 ml.

### **Enteral Feeding Kits**

1. Use the HCPCS code that is appropriate to the ordered method of feeding.
2. The DOS is the date the item was dispensed to the member. Do not use a date span.

## **Orthopedic and Therapeutic Footwear**

Therapeutic footwear is used to prevent diabetic ulcers. Orthopedic footwear is used by individuals with structural conditions of the foot.

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

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

Orthotics are covered for all eligible IMCare members.

### Definition

**Affiliate:** A person who directly or indirectly, through one or more intermediaries, controls or is controlled by, or is under common control with, the ordering physician or consultant.

### Covered Services

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

##### Codes

A5500 – A5501: therapeutic shoes

A5503 – A5507: modifications to therapeutic shoes

A5510 – A5513: inserts for therapeutic shoes

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

1. Previous amputation of the other foot, or part of either foot
2. History of foot ulceration of either foot
3. History of pre-ulcerative calluses of either foot
4. Peripheral neuropathy of either foot
5. Foot deformity of either foot
6. 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 pairs of therapeutic shoes, modifications, and inserts are covered without authorization in a calendar year. They can be dispensed at the same time, or at different times.

For members in IMCare Classic, Medicare covers one pair of therapeutic shoes and three pairs of inserts in a calendar year. The second pair of therapeutic shoes, if needed, will be covered under the Medicaid benefit.

Service Authorization is required for therapeutic shoes or inserts beyond the threshold.

IMCare uses 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 Medicare's Durable Medical Equipment (DME) Medicare Administrative Contractor (MAC) for the state of Minnesota.

### Orthopedic Shoes and Inserts

Authorization is required for orthopedic shoes. Provide documentation as indicated below.

**If the orthopedic shoe is approved, the inserts do not need authorization for up to two pairs a year. If more than two pairs of inserts are needed in a year, authorization is required.**

##### Codes

L3000 – L3031: custom inserts

L3040 – L3060: premolded, removable arch supports

L3070 – L3100: non-removable 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: orthopedic shoe, modification, or transfer NOS

IMCare will cover 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:

1. Foot deformity accompanied by pain
2. Plantar fasciitis
3. Calcaneal bursitis (acute or chronic)
4. Calcaneal spurs
5. Inflammatory conditions such as submetatarsal bursitis, synovial cyst, or plantar fascial fibromatosis
6. Medial osteoarthritis of the knee
7. Musculoskeletal/arthropathic deformities
8. Neurologically impaired feet
9. Vascular conditions
10. Hallus valgus deformities in children

IMCare will cover stock orthopedic shoes for members 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.

IMCare will cover stock inserts only for use in covered orthopedic shoes. Two pair of inserts are covered without authorization in a calendar year. **Authorization** is required only when a third or subsequent pair of inserts is required in a calendar year. Authorization will be granted when the items are needed because of a change in the member's medical condition or size which requires replacement.

### **Foot Pressure Offloading Device (A9283)**

Covered for pressure reduction of existing pressure ulcers on the foot with the appropriate diagnosis. No authorization is needed for a foot pressure offloading device if the provider is contracted.

### **Non-Covered Footwear**

1. Stock orthopedic shoes, **except** when attached to a leg brace.
2. Repair costs for a prosthetic or orthotic device purchased by IMCare that is covered under warranty, or repair costs for any rented orthotic or prosthetic equipment.
3. A prosthetic or orthotic device for which Medicare has denied the claim as not medically necessary.
4. A device whose primary purpose is to serve as a convenience to a person caring for the member.
5. A device that serves to address social, recreational, and environmental factors and does not directly address the member's physical or mental health.
6. Deluxe features of therapeutic shoes.
7. A device that is supplied to the member by the physician who prescribed the device, or by the consultant to the physician.
8. A device that is supplied to the member by an affiliate of the physician who prescribed the devices, or of the consultant to the physician.

## Orthotics

### Overview

Orthotics are used to restrict movement or support weak body parts.

### Definitions

**Affiliate:** A person who directly or indirectly, through one or more intermediaries, controls or is controlled by, or is under common control with, the ordering physician or consultant.

**Certain Customized Items:** Items that require custom fabrication are unsuitable for grouping together for profiling purposes. Therefore, there are neither customary and prevailing charges nor fee schedules established. Contractors make payment for customized items without appropriate Healthcare Common Procedure Coding System (HCPCS) codes in a lump-sum based upon individual consideration for each item. For Part A providers, this is a final payment and is not reflected as a Medicare cost in provider cost reports.

**Custom-made/custom-fabricated:** Made for a specific patient from his/her individual measurements and/or pattern, starting with basic materials such as plastic, metal, or leather.

**Orthotic:** A rigid or semi-rigid device that is used for the purpose of supporting a weak or deformed body member or for restricting or eliminating motion in a diseased or injured part of the body. Elastic support garments do not meet the definition of an orthotic because they are not rigid or semi-rigid devices. Devices that are not rigid or semi-rigid should be coded as A4466.

**Physiatrist:** A physician who specializes in physical medicine or who possesses specialized knowledge of rehabilitation and who is certified by the American Board of Physical Medicine and Rehabilitation (ABPMR).

**Stock/off-the-shelf/prefabricated:** Orthotic items that are not fabricated to an individual's specifications. They may be adjusted or altered to meet the member's needs, but are not made specifically for the member. An orthotic that is assembled solely from prefabricated components is considered prefabricated.

### Eligible Providers

1. Medical suppliers
2. Indian Health Service (IHS)
3. Federally Qualified Health Centers (FQHCs)
4. Rural Health Clinics (RHCs)

### Third Party Liability (TPL) and Medicare

Providers must meet any provider criteria, including accreditation, for third party insurance or for Medicare in order to assist members for whom IMCare is not the primary payer.

IMCare quantity limits and thresholds apply to all members unless only Medicare co-insurance or deductible is requested.

### Eligible Members

Orthotic devices are covered for all eligible members.

## Covered Services

IMCare has adopted the Medically Unlikely Edits (MUE) published by the Centers for Medicare & Medicaid Services (CMS). If CMS has not published an MUE, IMCare has established quantity limits. IMCare 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.

### Orthotics for the spine

**Codes:** L0112 – L1499

An orthotic for the spine is considered medically necessary:

1. To facilitate healing of the spine or related soft tissues
2. To reduce pain by restricting mobility
3. To support weak spinal muscles or a deformed spine
4. To treat scoliosis

### Orthotics for the hip

**Codes:** L1600 – L1755, L2040 – L2090

An orthotic for the hip is considered medically necessary:

1. To stabilize the hip
2. To correct and maintain hip abduction

One orthotic for the hip is covered per calendar year without authorization when medically necessary with the exception that authorization is required for the second or subsequent orthotic for the hip in any calendar year.

### Lower limb orthotics

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

A lower limb orthotic is considered medically necessary:

1. For treatment of contractures
2. To immobilize a limb to promote healing
3. To provide support and stability during ambulation

Four lower limb orthotics (two sets of bilateral orthotics) are covered per calendar year when medically necessary. Authorization is required for the third or subsequent set of lower limb orthotics in any calendar year.

### Upper extremity orthotics

**Codes:** L3650 – L3999

An upper extremity orthotic is considered medically necessary:

1. To immobilize an extremity to promote healing
2. For treatment of contractures
3. To provide support and stability during activities of daily living (ADL)

Four upper extremity orthotics (two sets of bilateral orthotics) are covered per calendar year when medically necessary. Authorization is required for the third or subsequent set of upper extremity orthotics in any calendar year.

**Repairs to orthotic devices****Codes:** L4000 – L4210

Repairs to orthotic devices are covered without authorization with the exception that authorization is required for repair/modification to an orthotic if the submitted charge for parts combined with labor charges total \$1000 or more

**Cranial remolding orthotics****Code:** S1040

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

1. Premature birth
2. Restrictive intrauterine positioning
3. Torticollis
4. “Back to Sleep” sleeping positions

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

**Non-Covered Services**

1. A prosthetic or orthotic device for which Medicare has denied the claim as not medically necessary
2. A device whose primary purpose is to serve as a convenience to a person caring for the member
3. A device that serves to address social and environmental factors and that does not directly address the member’s physical or mental health
4. 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
5. Repair costs for a prosthetic or orthotic device that is under warranty
6. Repair costs for any rented equipment
7. Orthotics when used to prevent injury in a previously uninjured limb
8. Orthotics that are to be used only during sports or other leisure activities
9. A custom fabricated orthotic when the member’s needs can be met with a prefabricated orthotic
10. Stance control orthotics (L2005)
11. Externally powered upper extremity orthotics (L3904)
12. Electronic/microprocessor-controlled orthotics, including the Sensor Walk, E-MAG

**Authorization**

Authorization is required when the cumulative costs in a claim are \$1,000 or greater for contracted providers (out-of-network providers require authorization before providing the service, regardless of cost). Request the authorization for the **base item only**, but document **all add-on items** to allow the reviewer to have an overall picture of the item.

Authorization is required for quantities over the annual limit for hip, lower limb, upper extremity, and cranial orthotics.

Authorization is required for repair/modification to an orthotic if the submitted charge for parts combined with labor charges total \$1000 or more.

1. If requesting authorization for quantities over the annual limit, document why the additional orthotic is required and how the requested orthotic meets the member's medical and functional needs.
2. If requesting authorization for repairs, document that the repair can reasonably be expected to delay replacement by at least one year.
3. IMCare will not authorize more units per line than are allowed by Medicare's MUE. When requesting authorization for bilateral orthotics where more units are required than are allowed by the MUE, the units must be requested on different lines, with modifiers NU RT and NU LT as appropriate. Documentation must clearly establish that the greater number of units is required.
4. When multiple items that are different but require the same miscellaneous code are requested, each item must be listed on a separate line of the authorization request. A unique description of each item must be entered for each line. The unique description may be a model number or a narrative description.
5. Each line will be approved or denied.

### **Billing**

1. If the member has Medicare, IMCare will pay only the deductible/co-insurance on any item for which Medicare made payment, regardless of any IMCare authorization.
2. Shipping/delivery/set-up costs are included in the IMCare maximum allowable payment and may not be separately billed to IMCare or the member.
3. IMCare will not pay claims for more units per line than are allowed by Medicare's MUE. When billing for bilateral prosthetics where more units are required than are allowed by the MUE, the units must be billed on different lines, with modifiers NU RT and NU LT as appropriate.
4. When billing labor for repairs, specify the number of units and the rate. Do not bill for setup and delivery, or for service calls that do not involve actual labor time for repairs.
5. When billing for items approved on an authorization, submit one claim for all approved lines. Make sure the HCPCS codes, modifiers, and descriptions on the claim match the same information on the authorization.
6. Enter the authorization number in the authorization field for each claim line.
7. Submit the usual and customary (U&C) charge for each line, not the approved amount from the authorization letter.

## **Oximeters**

### **Overview**

Oximeters are used to measure a member's blood oxygen saturation levels.

### **Third Party Liability (TPL) and Medicare**

Providers must meet any provider criteria, including accreditation, for third party insurance or for Medicare in order to assist members for whom IMCare is not the primary payer.

IMCare quantity limits and thresholds apply to all members unless only Medicare co-insurance or deductible is requested.

### **Eligible Members**

All IMCare members who meet the coverage criteria are eligible.

## Covered Services

**Codes:** A4606, E0445

Purchase or monthly rental of oximeters that are suitable for intermittent use or spot checks may be medically necessary for the following:

1. Periodically checking the oxygen saturation levels in members using long-term oxygen
2. Checking oxygen saturation levels of the member during or following a seizure

Short-term, 24-hour, or overnight continuous oximetry may be medically necessary for the following:

1. To evaluate nocturnal desaturation in patients with chronic respiratory disease
2. To determine the appropriate oxygen needs of the member, particularly when there has been a change in the member's medical condition
3. To evaluate the need for a sleep study

Monthly rental of an oximeter that is suitable for continuous use may be medically necessary for the following:

1. Members being weaned from home oxygen
2. Infants less than 12 months of age using home oxygen
3. Members with a temporary medical need to maintain oxygen saturation within a very narrow range

Purchase or monthly rental of an oximeter that is suitable for continuous use may be medically necessary for the following:

1. Members who require mechanical ventilation
2. Members with a tracheostomy
3. Members with a long-term medical need to maintain oxygen saturation within a very narrow range

Replacement oxygen probes are covered for members using oximeters.

1. Durable probes are expected to last six months.
2. Up to five disposable probes are covered every 30 days.
3. Disposable probes may be appropriate for members whose age or disability prevents them from safely using durable probes.
4. Durable probes should be used by members who use spot check or intermittent oximetry.

## Non-Covered Services

1. Oximeters are not the community standard of care for monitoring members with asthma.
2. Oximeters are not demonstrated to be effective for diagnosis of members with suspected obstructive sleep apnea.
3. Back-up or portable oximeters are a duplication of equipment when the member has an oximeter. Providers should dispense equipment that can meet the member's needs at home and in the community.

## Authorization

Authorization is required for repairs or maintenance service to member-owned oximeters when parts and labor is more than \$1000. Authorization is required for rental beyond three months of oximeters and for all purchases of oximeters. Authorization is required for quantities of oximeter probes that exceed limits.

Authorization requests for rental or purchase of oximeters must include the following:

1. The member's diagnosis and pertinent medical history
2. Written plan of care that includes a step-by-step protocol to be used in case of desaturation

3. Other equipment, such as apnea monitor, oxygen, or ventilator, that is used by the member and how the various equipment works together in the plan of care
4. Expected duration of need
5. Documentation of the specific oximeter model requested and its suitability to meet the member's medical needs
6. If an oximeter suitable for continuous use is requested, clearly document why a less costly oximeter will not meet the member's needs.

Authorization requests for additional quantities of oxygen probes must include the following:

1. The member's diagnosis and pertinent medical history
2. Frequency of monitoring
3. Expected duration of need
4. If a durable probe is requested because replacement is required less than six months after dispensing, document the reason replacement is required.
5. A Service Authorization is required if more than five disposable probes are needed in a 30-day period. Documentation of why a durable probe does not meet the member's needs is also required.

### **Billing**

1. When billing for overnight oximetry, use modifiers RR and U4. Up to two units per month may be billed.
2. When billing for rental or authorized purchase of an oximeter that is suitable for intermittent use, use modifier NU or RR as appropriate, and modifier U7.
3. When billing for rental or authorized purchase of an oximeter that is suitable for continuous use, use modifiers NU or RR as appropriate.
4. Oxygen probe(s) suitable for one month use is included with the original dispensing of all oximeters.
5. When billing for a durable oxygen probe, use modifiers NU and U3.

## **Oxygen and Oxygen Equipment**

Home oxygen therapy is used to treat and prevent symptoms and complications of hypoxemia and for treatment of certain other medical conditions.

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

### **Oxygen Services Covered under Medicaid**

Providers should refer to their provider agreement with IMCare for reimbursement terms when billing for oxygen services covered under the Medicaid benefit.

### **Medicare**

#### **Authorization**

**Portable oxygen concentrators (E1392)** will require authorization for rental of a portable oxygen concentrator except for IMCare Classic (HMO SNP) or where IMCare is secondary to Medicare coverage if Medicare approves for payment of the portable oxygen concentrator. A portable oxygen concentrator will only be authorized for members for whom IMCare has authorized out-of-state medical care requiring air travel. Authorization is not required for other oxygen equipment or for oxygen contents provided by contracted providers.

**Required documentation must be maintained** in the member's file at the medical supplier's office.

Documentation of the following shows medical necessity:

1. When the member's blood oxygen levels indicate the need for oxygen therapy and one of the following is present:
  - a. Diagnosis of severe lung disease such as chronic obstructive pulmonary disease (COPD), diffuse interstitial lung disease, cystic fibrosis (CF), bronchiectasis, etc.
  - b. Diagnosis of hypoxia-related symptoms caused by an underlying medical condition such as pulmonary hypertension, congestive heart failure (CHF), erythrocytosis, etc.
  - c. Short-term need due to diagnosis of conditions that usually resolve with limited oxygen therapy such as pneumonia, croup, bronchitis, etc.
2. 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:
  - a. 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.
  - b. Pediatric bronchopulmonary dysplasia where the need for oxygen is variable and cannot be clearly established with blood oxygen levels
  - c. Hemoglobinopathies in patients with a history of vaso-occlusive crisis
3. The member's blood oxygen levels, as evidenced by blood gas or oximetry, indicates the need for oxygen therapy; and
4. Alternative treatment measures have been tried or considered and deemed clinically ineffective.

IMCare does not require specific PaO<sub>2</sub> or oxygen saturation values for coverage. The physician's order must clearly state the recipient's diagnosis, the PaO<sub>2</sub> or oxygen saturation levels, the ordered flow rate, and number of hours per day that oxygen is required.

### **Oxygen Services Covered by Medicare**

IMCare follows Medicare guidelines for the coverage of oxygen rental. Payment for monthly rental of oxygen equipment during a period of continuous use will be made for up to 36 months. The oxygen rental payment includes reimbursement for the equipment, oxygen contents, maintenance, supplies and accessories, and other services necessary for furnishing oxygen and oxygen equipment. After 36 monthly rental payments have been made for the oxygen equipment, monthly payments will cease. The supplier that furnishes the oxygen during the 36-month payment period must continue to furnish the oxygen equipment during any period of medical need for the remainder of the reasonable and useful lifetime of the equipment, which is normally five years. After the five-year reasonable useful lifetime of the equipment has been reached, if the member still needs the equipment (i.e., the member meets the medical necessity for the oxygen), a new capped rental period may begin.

After the 36-month rental payment period, the supplier can bill for and receive a monthly payment for furnishing oxygen contents. Please refer to [National Government Services website](#) for a listing of those codes that are billable after the 36-month rental period.

Medicare payment for oxygen equipment is limited to 36 months. Providers may not bill IMCare for oxygen equipment supplied to Medicare beneficiaries when the 36-month cap is reached. IMCare quantity limits and thresholds only apply to dual eligible members. Providers may not transfer dual eligible members to the contract provider when the 36-month cap is reached. Providers must follow Medicare policy when serving dual eligible recipients.



To ensure reimbursement on your oxygen rental claims submitted to IMCare, we encourage you to follow the standards for claim submission. Please ensure that you are using the correct place of service (POS) code on your claims. The POS on oxygen rental claims should be the location where the member is residing at the time he/she is receiving oxygen. If the member is residing in his/her home, the POS should reflect this. If he/she is residing in a Skilled Nursing Facility (SNF), use the appropriate code to indicate the type of SNF. A complete listing of POS codes can be found on the [Centers for Medicare & Medicaid Services \(CMS\) website](#).

### **Non-Covered Services**

Oxygen purchased from airlines for use during travel.

### **Billing**

1. Use the 837P professional electronic claim format.
2. Appropriate codes should be used to reflect the oxygen service that was provided. If the code billed indicates contents are included in the rental, codes for additional contents will not be allowed.
3. Medicare has codes for oxygen contents that should be billed if the service is covered by Medicare.
4. If the provider knows the item is not covered by Medicare, bill using the appropriate Medicare code and modifier GY to indicate the service is not covered by Medicare.

### **Patient Lifts and Seat Lift Mechanisms**

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.

### **Eligible Members**

Patient lifts and seat lift mechanisms are covered for all eligible IMCare members who meet coverage criteria. IMCare follows InterQual™ and/or Minnesota Department of Human Services (DHS) criteria for medical necessity determinations. Members in nursing facilities and Intermediate Care Facilities for the Developmentally Disabled (ICF/DDs) are not eligible for patient lifts or seat lift mechanisms.

### **Covered Services**

#### **Codes:**

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

E0630, E0635, E0636, E0639: Patient lifts

E0627 – E0629: Seat lift mechanisms

Hydraulic/mechanical patient lifts described by E0630 require Service Authorization. Provide documentation of the following:

1. The member requires the assistance of two people to transfer between a wheelchair, bed, commode, or other surfaces in the home. The member is bedridden without the lift.
2. The member cannot be safely transferred without a lift due to the member's medical condition or caregiver limitations. The caregiver is capable of operating the lift.
3. The lift is documented as fitting in all necessary parts of the member's home.

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

Electric patient lifts described by E0635 require Service Authorization. Provide documentation as indicated for hydraulic/mechanical patient lifts, plus the following:

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

Seat lift mechanisms require Service Authorization. Provide documentation of the following:

1. The member has arthritis of the hip or knee, neuromuscular disease, or other medical condition affecting the member's strength or mobility;
2. The member is unable to stand up from any at home; and
3. Once standing, the member has the ability to ambulate independently or with a properly fitted walker or cane.

### **Non-Covered Services**

1. 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.
2. 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.
3. The following items are not covered because they are home or vehicle modifications, not Durable Medical Equipment (DME):
  - a. Vehicle lifts
  - b. Platform lifts
  - c. Stair lifts
  - d. Elevators
  - e. Wheelchair lifts
  - f. Ramps
  - g. Ceiling lifts
  - h. Wall mounted lifts

### **Authorization**

Authorization is required for any rental or purchase of all lift mechanisms. Authorization is required for any rental or purchase of a patient lift when the patient's current lift, regardless of lift type, is less than five years old. Refer to the *Non-Mobility Equipment Repairs* section for authorization requirements for repairs to lift equipment.

For all requests for patient lifts, documentation must include the following:

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

### **Billing**

1. All hydraulic/mechanical/electric lifts include a seat or sling with initial dispensing. Do not bill separately.

2. Use the 837P professional electronic claim format.
3. Report the ordering provider in the “Other Provider Types” section of the claim.
4. If the member has Medicare, IMCare will pay only the deductible/co-insurance on any item for which Medicare made payment, regardless of any IMCare prior authorization.
5. If the member has Medicare, any items for which Medicare denies payment must meet IMCare coverage and authorization requirements.
6. Shipping/delivery costs are included in the IMCare maximum allowable payment and may not be separately billed to IMCare or the member.
7. Patient lifts and seat lift mechanisms 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. Equipment should not be replaced if still usable and meeting the patient’s needs after five years.

## Positioning Equipment

Positioning cushions, positioning car seats, and positioning feeding chairs are used by individuals who require significant postural support. Reflux wedges are used by infants with severe gastroesophageal reflux.

### Eligible Members

All IMCare members who meet the coverage criteria are eligible.

### Covered Services

Use the most appropriate of the following Healthcare Common Procedure Coding System (HCPCS) codes for the services described below:

1. E0190 (positioning cushion/pillow/wedge, any shape or size, includes all components and accessories)
2. T5001 (positioning seat for persons with special orthopedic needs)

### Reflux Wedges

Reflux wedges are covered for infants with severe gastroesophageal reflux that has been diagnosed by a physician. Documentation must specify the medical condition that requires the reflux wedge.

### Positioning Cushions/Pillows/Wedges

Covered for members who need significant postural support. Positioning cushions/pillows must be manufactured to meet positioning needs rather than for general use, and may include items such as Versa Form® Positioning Pillows.

**E0190** includes all components and accessories including pillow covers and vacuum pumps. When billing for positioning pillows, needed accessories may not be separately billed. Accessories dispensed to replace lost or damaged accessories for a patient-owned positioning pillow should be billed with E0190 and modifier RB unless a more specific HCPCS code is available for the accessory.

### Positioning Seats for Use in Vehicles

Positioning seats for use in vehicles are covered for members with special orthopedic/medical needs that cannot be met using conventional car seats or with needs that make conventional car seats medically inappropriate. A positioning seat may be medically necessary for a member with an inability to maintain an unsupported sitting

position independently, which is caused by a medical condition such as any of the following (list is not all-inclusive):

1. Severe head and trunk instability
2. Severe hypotonicity, hypertonicity, spasticity, or muscle spasm that results in uncontrollable movement and position changes
3. Severe seizure activity that results in uncontrollable movement and position changes
4. Orthopedic disease processes resulting in significant bony fragility
5. Significant contractures that would result in an inability to perform postural corrections due to vehicle motion
6. Orthopedic condition, such as a curvature of the spine, which interferes with proper positioning

Document the member's current height and weight, and the weight capacity and growth potential for the requested seat.

### **Positioning Seats for Use in Homes**

Positioning seats for use in homes are covered for members with special orthopedic/medical needs during essential activities of daily living (ADLs) that cannot be met using conventional chairs or with needs that make conventional chairs medically inappropriate. A positioning seat may be medically necessary for a member with an inability to maintain an unsupported sitting position independently, which is caused by a medical condition such as any of the following (list is not all-inclusive):

1. Severe head and trunk instability
2. Severe hypotonicity, hypertonicity, spasticity, or muscle spasm that results in uncontrollable movement and position changes
3. Severe seizure activity that results in uncontrollable movement and position changes
4. Orthopedic condition, such as curvature of the spine, which interferes with proper positioning

Document the member's current height and weight, and the weight capacity for the requested seat.

### **Non-Covered Services**

1. Car seats when used simply to prevent injury to a child as required by law and community practice are not medically necessary
2. Car seats for members who use mobility devices with positioning/support attachments, and whose primary caregiver has a van equipped for wheelchair transportation are a duplication of service
3. Car seats for children who do not require positioning assistance
4. Cervical rolls or pillows are not medically necessary
5. Feeding chairs/high chairs for members without significant positioning needs due to a medical condition are not medically necessary
6. Positioning seats, including feeding chairs/high chairs, for home use for members who use mobility devices with positioning/support attachments are a duplication of service
7. Furniture that is marketed to or useful to the general population, such as recliners, is not medically necessary and is not Durable Medical Equipment (DME)
8. Heat and massage cushion pads/recliners are not medically necessary and are not DME
9. Pillows designed to reduce allergens are not medically necessary and are not DME
10. Vehicle restraint belts or harnesses except where part of a covered positioning seat are a duplication of services

## Authorization

Authorization is not required. Providers are expected to maintain documentation in the member's file supporting need for equipment provided.

## Billing

1. Use the 837P professional claim format.
2. Bill purchase of all reflux wedges and positioning cushions/pillows/wedges using E0190 and modifier NU unless a more specific code has been assigned by the Medicare Pricing, Data Analysis, and Coding (PDAC).
3. Bill replacement of accessories for a patient-owned positioning pillow using E0190 and modifier RB unless a more specific code has been assigned by the PDAC.
4. Bill purchase of all positioning seats for home or vehicle use using T5001 and modifier NU unless a more specific code has been assigned by the PDAC.
5. Positioning equipment that requires an authorization must be billed on a separate claim from equipment/supplies that do not require authorization.
6. The HCPCS code and modifiers must match the authorization.
7. If authorization is not required, the electronic claim must include the manufacturer's invoice or price list as an attachment.

## Pneumatic Compression Devices

Pneumatic compression devices are used for treatment of chronic venous insufficiency of the lower extremities, lymphedema, or peripheral artery disease.

## Eligible Members

All IMCare members who meet the coverage criteria are eligible.

## Covered Services

### Codes

E0650 – E0652, E0675: Pneumatic compressors

E0653 – E0673: appliances for use with pneumatic compressor

Only compressors approved by the Food and Drug Administration (FDA) are covered. Only appliances approved by the FDA for use on extremities are covered.

Non-segmental pneumatic compression devices (E0650) and segmental pneumatic compression devices without calibrated gradient pressure (E0651) are covered without authorization for treatment of chronic venous insufficiency of the lower extremities when the member has had one or more lower extremity venous stasis ulcers and meets the following criteria:

1. The member has undergone at least six months of conservative therapy. Conservative therapy includes the following:
  - a. The use of appropriate compression bandage systems or compression garments
  - b. Appropriate dressings for the wound
  - c. Exercise
  - d. Elevation of the limb
  - e. Aggressive skin care
2. The venous stasis ulcer has failed to heal after a six-month trial

Non segmental pneumatic compression devices (E0650) and segmental pneumatic compression devices without calibrated gradient pressure (E0651) are covered without authorization for treatment of lymphedema when the member meets the following criteria:

1. The member has undergone at least four weeks of conservative therapy. Conservative therapy includes the following:
  - a. The use of appropriate compression bandage systems or compression garments
  - b. Manual lymph massage
  - c. Exercise
  - d. Elevation of the limb
  - e. Aggressive skin care
  - f. Education in lymphedema self-management
2. No significant improvement has occurred or significant symptoms remain following a four-week trial

One segmental or non-segmental appliance for each affected extremity is covered per year for use with a medically necessary pneumatic compressor.

Prior to dispensing the pneumatic compressor and appliances, the medical supplier must obtain a letter of medical necessity detailing the conservative treatment that was tried and failed.

Segmental pneumatic compression devices with calibrated gradient pressure (E0652) are covered with authorization when the member's medical condition cannot be treated with non-segmental devices or with segmental devices without calibrated gradient pressure.

Integrated appliances with 2 full legs and trunk (E0670) are covered with authorization for members that cannot use other appliances due to co-existing medical conditions, including obesity.

High-pressure, rapid cycling pneumatic compression devices (E0675) are covered with authorization for treatment of peripheral artery disease for patients who might otherwise require surgical treatment of the arterial insufficiency.

### **Non-Covered Services**

1. Appliances for use on the trunk, pelvis, or chest (E0656, E0657) are not reimbursed separately from the compressor
2. Pneumatic compressors/appliances for indications other than chronic venous insufficiency of the lower extremities, lymphedema, or peripheral artery disease are considered investigative.

### **Authorization**

Authorization is required for segmental pneumatic compression devices with calibrated gradient pressure (E0652). Authorization requests must include the following:

1. Documentation the member meets basic coverage criteria for pneumatic compression devices as described above (lack of efficacy of conservative treatment)
2. Clinical notes detailing prior treatments
3. Results of trial with non-segmental pneumatic compression devices (E0650)/segmental pneumatic compression devices without calibrated gradient pressure (E0651) or documentation of why a trial with these devices would not be safe or effective for the member
4. Complete treatment plan including the prescribed pressure in each chamber and the frequency and duration of each treatment session

Authorization is required for high pressure, rapid inflation/deflation cycle pneumatic compression devices (0675). Authorization requests must include the following:

1. Documentation that the member has severe peripheral artery disease, established by vascular testing including ankle-brachial index, transcutaneous oximetry, Doppler ultrasound examination, etc.
2. Documentation that all conservative treatment has been tried or considered and failed, and that the member will need surgical intervention if the device is not approved, or the member is not a candidate for surgery
3. For second and subsequent requests, documentation that the member has responded to treatment and continues to require treatment with the pneumatic compression device

Authorization is required for integrated appliances with 2 full legs and trunk (E0670). Authorization requests must include:

1. Documentation the member meets basic coverage criteria for pneumatic compression devices as described above (lack of efficacy of conservative treatment)
2. Clinical notes detailing prior treatments
3. Description of the co-existing medical conditions that require the use of this appliance rather than other, less costly appliances.
4. Complete treatment plan including the prescribed pressure in each chamber and the frequency and duration of each treatment session

### **Billing**

1. Use the correct Healthcare Common Procedure Coding System (HCPCS) code and the modifier NU or RR.
2. Make sure the HCPCS code, modifiers, and description match the authorization, if appropriate.
3. Use the 837P professional claim format.

### **Positive Airway Pressure (PAP) for Treatment of Obstructive Sleep Apnea**

Continuous positive airway pressure (CPAP) and bi-level positive airway pressure (Bi-PAP) devices are used for treatment of obstructive sleep apnea.

### **Eligible Members**

Positive airway pressure (PAP) devices and related supplies are covered for eligible members with a diagnosis of obstructive sleep apnea made by a physician with experience diagnosing and treating sleep apnea, using a sleep study.

### **Covered Services**

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

### **CPAP (E0601)/Bi-PAP Device Coverage**

IMCare allows rentals for CPAP and Bi-PAP devices. A device over a \$1000.00 requires an Authorization.

### **CPAP**

Members are limited to one CPAP every five years.

Provide documentation of the following:

1. Diagnosis
2. Sleep study
3. Contracted providers should also include: statement from the physician of use of CPAP by the member and effectiveness

**Included with rental:** Compressor, manometer, CPAP valve (if separate from mask), filters, fuses, instruction manual, carrying case, and a disconnection alarm (if needed).

### Continuous Positive Airway Pressure (CPAP) Supply Limitations

Continuous Positive Airway Pressure (CPAP) Supply Limitations			
Healthcare Common Procedure Coding System (HCPCS) Code	Description	Minnesota Senior Health Options (MSHO)	Medical Assistance (Medicaid) Limitations
A4604	Tubing with integrated heating element	1 per 3 months	4 per month
A7027	Combination oral/nasal mask	1 per 3 months	3 per year
A7028	Oral cushion for combination oral/nasal mask, replacement, only each	2 per month	1 per month
A7029	Nasal pillows for combination oral/nasal mask, replacement only, pair	2 per month	1 per month
A7030	Full face mask used with positive airway pressure device	1 per 3 months	3 per year
A7031	Full mask interface, replacement for full face mask	1 per month	1 per month
A7032	Cushion for use on nasal mask interface, replacement only	2 per month	1 per month
A7033	Pillow for use only on nasal cannula type interface	2 per month	1 per month
A7034	Nasal interface (mask or cannula type)	1 per 3 months	3 per year
A7035	Headgear	1 per 6 months	3 per year
A7036	Chinstrap	1 per 6 months	1 per 6 months
A7037	Tubing	1 per 3 months	1 per month
A7038	Filter, disposable	2 per month	3 per month
A7039	Filter, non-disposable	1 per 6 months	3 per year
A7044	Oral interface		3 per year
A7045	Exhalation port with or without swivel		1 per 6 months
A7046	Water chamber for humidifier	1 per 6 months	5 per month

**Bill separately:** Replacement parts, tubing, head gear, and mask



**Bi-PAP (E0470, E0471, E0472)**

Provide documentation of the following:

1. Diagnosis
2. Sleep study, including response to CPAP
3. Documentation of any day time symptoms
4. Contracted providers should also include: statement from the physician of use of Bi-PAP by the member and effectiveness

**Included with rental/purchase:** Compressor unit, filters, carrying case, power cord, fuses, permanent circuit, swivel adapters, and instruction manual.

**Bill separately:** Humidification device, mask, and head gear

**Non-Covered Services**

A carrying case is a non-covered convenience item and is not medically necessary.

A CPAP device is not covered after the third month unless the supplier has verified patient compliance.

**Pressure Reducing Support Surfaces**

Pressure reducing support surfaces are used to prevent and treat pressure sores/decubitus ulcers. Support surface products are divided into three groups.

**Eligible Members**

Pressure reducing support surfaces are covered for eligible members who **do not** live in nursing facilities.

**Covered Services****Group 1**

**Codes:** A4640, E0181 – E0189, E0196 – E0199 (bed overlays such as static air mattress overlays, etc.)

**Authorization** is not required. However, the medical supplier must have filed the following documentation:

1. Member is completely immobile
2. Member cannot independently make changes in body position significantly enough to alleviate pressure and has one of the following conditions:
  - a. Current pressure ulcer on the trunk or pelvis
  - b. History of pressure ulcer on the trunk or pelvis
  - c. Impaired nutritional status
  - d. Fecal or urinary incontinence
  - e. Altered sensory perception
  - f. Compromised circulatory status

**Group 2****Codes**

E0193: powered air flotation bed (low air loss) therapy

E0277: powered pressure-reducing air mattress

E0371: non-powered advanced pressure reducing overlay for mattress, standard mattress length and width

E0372: powered air overlay for mattress, standard mattress length and width

E0373: non-powered advanced pressure reducing mattress

**Authorization is required.** Provide documentation of the following with the request:

1. The member's attending physician must order based on a comprehensive assessment and evaluation of the member after conservative treatment has been tried without success. The physician must direct the home treatment regimen and reevaluate and re-certify the need for the bed on a monthly basis. Member must have healing as the goal of treatment and any one of the following:
  - a. Multiple stage II pressure ulcers located on the trunk or pelvis; member has been on a comprehensive ulcer treatment plan for at least the past month and has had poor response to treatment; and, member has used lower level support surface and ulcers have worsened
  - b. Large stage III or IV pressure ulcer(s) on the trunk or pelvis and the member cannot be positioned off the ulcer areas with a comprehensive treatment plan
  - c. Recent mycutaneous flap or skin graft for pressure ulcer on the trunk or pelvis and the member has been on a pressure reducing support surface immediately prior to discharge from a hospital or long-term care facility (LTCF) (surgery within past 60 days) and comprehensive treatment plan
  - d. Member has been on a group 2 or 3 support surface immediately prior to a recent discharge from a hospital or LTCF (discharge within past 30 days) and comprehensive treatment plan
  - e. After six months on a group 2 support surface and there has been no improvement in the member's condition, alternative treatments must be considered before additional monthly rental will be authorized

### Group 3

**Code:** E0194 (air fluidized beds)

**Authorization** is required. Documentation of the following should be provided with the request:

1. Must have healing as the goal of treatment with recertification monthly:
  - a. Stage III or IV pressure sore on the trunk or pelvis, comprehensive treatment plan for the pressure sore and response to that treatment and documentation indicating the following:
  - b. What other alternative equipment has been considered and why they were ruled out
  - c. Is the member bedridden or chair bound as a result of severely limited mobility?
  - d. After six months on a group 3 support surface and there has been no improvement in the member's condition, alternative treatments must be considered before additional monthly rental will be authorized (i.e., wound vac, wound warm-up therapy, dressings with silver or other additives).
  - e. List of co-morbidities or list of co-existing conditions (not covered with co-existing pulmonary disease)

### Documentation, All Groups

A comprehensive treatment plan must be in place for any of the support surface products to be covered. This includes the following:

1. Education of the member and caregiver on prevention and management of pressure ulcers
2. History of conservative treatment
3. Regular assessment by a physician or other licensed practitioner
4. Appropriate turning and positioning
5. Appropriate management of moisture/incontinence
6. Nutritional assessment and intervention
7. Baseline albumin and pre-albumin levels, with tests repeated as necessary
8. Necessary medications when infection is present
9. Treatment plan of care of the wound
10. Indication that the home can accommodate this equipment

Authorization requests must include the following:

1. Physician order
2. Member information: diagnosis, height, weight, mental status, mobility, nutritional status, continence, activity level, care setting, turning surface, and medications
3. Wound description: size, stage, location, wound bed color, texture, drainage, and surgery dates
4. Therapies: treatment plan

## Prosthetics and Orthotics

### Definitions

**Affiliate:** A person who, directly or indirectly, through one or more intermediaries, controls or is controlled by, or is under common control with, the ordering physician or consultant.

**Physiatrist:** A physician who specializes in physical medicine or who possesses specialized knowledge of rehabilitation and who is certified by the American Board of Physical Medicine and Rehabilitation (ABPMR).

**Prosthetic or Orthotic Device:** An artificial device, as defined by Medicare, to replace a missing or nonfunctional body part, to prevent or correct a physical deformity or malfunction, or to support a deformed or weak body part.

### Criteria

A prosthetic or orthotic must be prescribed by one of the following:

1. A physician who is knowledgeable in orthopedics or physiatry
2. A physician in consultation with an orthopedist, physiatrist, physical therapist (PT), or occupational therapist (OT)
3. A podiatrist within the scope of their profession. IMCare covers podiatrist services to treat below the knee.

### Authorization

Authorization is required when the cumulative costs are \$1,000 or greater, for contracted providers (out-of-network providers require authorization before providing the service, regardless of cost). Request the authorization for the **base item only**, but document **all add-on items** to allow the reviewer to have an overall picture of the item.

Authorization is required for Standers Orthotics (L1500, L1510) for thoracic-hip-knee-ankle-orthotic (THKAO), mobility frame, and THKAO standing frame, regardless of price. Provide documentation indicating the medical need for this type of orthotic (see *Standers or Standing Frames* section for more information).

Authorization is required for female sexual dysfunction prosthetics.

Authorization is required for implantable prosthetics (L8609, L8614, L8619); artificial cornea, cochlear device, and cochlear implant external speech processor, replacement. This is regardless of price. Provide documentation indicating the medical need for this type of prosthetic.

For all authorization requests:

1. Submit any add-on items with specific codes without authorization to IMCare for processing after the base

item has been approved for medical necessity

2. Request replacement of a temporary prosthetic if less than three months old, regardless of price
3. Request replacement of a permanent prosthetic if less than three years old, regardless of price

### **Non-Covered Services**

1. Repair costs for a prosthetic or orthotic device purchased by IMCare that is covered under warranty, or repair costs for any rented orthotic or prosthetic equipment
2. A device that serves to address social, recreational, and environmental factors and does not directly address the member's physical or mental health
3. A device that is supplied to the member by the physician who prescribed the device, or by the consultant to the physician
4. A device that is supplied to the member by an affiliate of the physician who prescribed the devices, or of the consultant to the physician.

### **Respiratory Assist Devices (Suitable for 12 Hours or Less Per Day)**

**Codes:** E0470, E0471, E0472 (bi-level positive airway pressure [Bi-PAP])

**Authorization** IMCare allows rentals for Respiratory Assist devices. A device over a \$1000.00 requires an Authorization.

**Document** one of the following diagnoses in the member's file at the medical supplier's office:

1. Chronic obstructive pulmonary disease (COPD)
2. Central sleep apnea
3. Obstructive sleep apnea
4. Neuromuscular respiratory insufficiency
5. Thoracic deformity which inhibits respiration
6. Idiopathic or central hypoventilation syndrome
7. Post-polio syndrome
8. Other diagnosis which requires ventilation assistance for 12 hours or less for the spontaneously breathing member

#### **Included with rental:**

1. Carrying case
2. Compressor unit
3. Filters
4. Fuses
5. Instruction manual
6. Power cord
7. Permanent circuit
8. Swivel adapters

#### **Separately bill:**

1. Headgear
2. Humidification device
3. Mask

### **Intermittent Positive Pressure Breathing (IPPB) Machine**

**Code:** E0500

**Authorization-** IMCare allows rentals for this devices. A device over a \$1000.00 requires an Authorization.

### **Ventilator, Stationary or Portable**

**Codes:** E0450, E0460, E0461, E0463, E0464

**Authorization** IMCare allows rentals for this devices. A device over a \$1000.00 requires an Authorization.

**Provide documentation** of the following:

1. Diagnosis
2. Medical need for the ventilator
3. Manufacturer make and model of ventilator
4. Current settings, FIO<sub>2</sub>
5. Other respiratory equipment in use

### **Included with rental:**

1. Cart
2. Stand
3. Positive End-Expiratory Pressure (PEEP) valve
4. Intermittent Mandatory Ventilation (IMV) devices
5. Electric cord
6. High/low/disconnect alarms
7. Pressure manometers
8. Exhaustion valves
9. Spirometer
10. Water traps
11. Battery
12. Carrying cases
13. High pressure hoses
14. Breathing circuits (effective January 1, 2014)

### **Bill separately:**

1. Humidifiers
2. Oxygen
3. Oxygen analyzers
4. Remote alarms
5. Manual resuscitation bags

## **Seasonal Affective Disorder (SAD) Lights/Light Therapy**

### **SAD Lights (E0203)**

Therapeutic light boxes are used for treatment of SAD. Only tabletop therapeutic light boxes approved by the Food and Drug Administration (FDA) are covered when prescribed by a mental health practitioner. The light bulb is included in the initial purchase/rental of the light box and may not be separately billed. Replacement light bulbs are covered.

## Eligible Providers

The following providers may provide SAD lights and related supplies:

1. Federally Qualified Health Centers (FQHCs)
2. Home health agencies
3. Indian Health Services (IHS)
4. Medical suppliers
5. Pharmacies
6. Rural Health Clinics (RHCs)

## Third Party Liability (TPL) and Medicare

Providers must meet any provider criteria, including accreditation, for third party insurance in order to assist members for whom IMCare is not the primary payer.

## Eligible Members

SAD lights are covered for eligible IMCare members with a history of winter depressive episodes with seasonal onsets which substantially outnumber any non-seasonal depressive episodes.

## Covered Services

**Codes:** E0203, A4634

## Non-Covered Services

Therapeutic light boxes prescribed for the following:

1. Conditions other than SAD as there is no proven medical benefit for other indications
2. Members in nursing facilities or Intermediate Care Facilities for the Developmentally Disabled (ICF/DDs)

**Authorization** is required. Provide the following documentation with the authorization request:

1. Credentials of the prescribing mental health practitioner
2. Written diagnosis of bipolar disorder or recurrent major depression
3. Summary of at least two consecutive years of seasonal depressive episodes with spring remission, including:
  - a. Statement detailing depressive symptoms
  - b. Month and year of onset and remission of depressive episodes
  - c. Dates of any other depressive episodes
4. Evidence of a positive response to light therapy, if available
5. Summary of member's ability and willingness to do the light therapy
6. Summary of member's compliance with other mental health treatment regimen

Fax authorization request and required documentation to the IMCare Utilization Management (UM) department at **1-218-327-5545**.

## Billing

When billing with an approved authorization:

1. Use the 837P professional claim format
2. Use the correct Healthcare Common Procedure Coding System (HCPCS) code and the modifier NU or RR as noted on the authorization

## Specialized Wound Treatment Technology

Specialized wound treatment technology is used to treat non-healing wounds.

### Eligible Members

Specialized wound treatment technology may be medically necessary for eligible IMCare members with wounds that have not responded to standard wound treatment for at least a 30 – 60 day period. Negative Pressure Wound Therapy (NPWT) may be medically necessary for eligible IMCare members with wounds of less than 30 days duration if the patient is inpatient and preparing for discharge.

### Covered Services

#### Codes (these are not all-inclusive codes)

E2402, A6550, A6551, K0743, K0744, K0745: Negative pressure wound therapy

E1399, A4649: Platelet rich plasma systems (e.g., AutoloGel system, Magellan)

The platelet rich plasma centrifuge is not covered in long-term care facilities (LTCFs). Device-specific supplies (i.e., applicators, reagents) may be covered in LTCFs.

#### Negative Pressure Wound Therapy (NPWT) Pump (E2402)

**Authorization** is required. Wound vac or NPWT will be considered when a wound does not respond to standard wound treatment for at least 30 to 60 days, except in the case of skin grafts and acute/trauma wounds.

For **all wounds**, the following documentation is needed and should be part of a comprehensive treatment plan:

1. Wound type, including etiology and stage when appropriate, date of onset and evaluation, previous wound care (dressings [moist, gel, impregnated], debridement, etc.), and assessments done by a licensed medical professional (every 30 days by doctor of medicine [MD], physician assistant [PA], doctor of osteopathy [DO], nurse practitioner [NP] is strongly recommended)
2. Weekly wound assessment and measurements (length, width, depth, color, exudates, odor, evidence of healing, tunneling, etc.). This should be done by nursing staff in the skilled facility or in the home setting.
3. Evaluation and provision for adequate nutritional status. Include both prealbumin and albumin levels. Ideally, albumin levels are 3.5 – 5. If albumin levels are below 3.5, specialized wound therapy may be approved if prealbumin levels are 20 – 40, show improvement over the previous 30 days, and if there is a nutritional plan in place written by an appropriate professional. Specialized wound therapy will not be authorized for albumin levels below 2.8. Baseline albumin and prealbumin levels are required and as medically necessary thereafter. If albumin levels are below 3.5, enteral nutritional support may be covered.
4. How is moisture and incontinence being addressed and managed?
5. Documentation of any compliance issues (refusal of dressing changes, smoking, poor nutritional choices, etc.) and how they are being addressed
6. Documentation of any underlying conditions (infections, etc.) that may hinder the healing process of the wound and how they are being corrected
7. Assessment of medications that may delay healing (steroids, immunosuppressant, etc.)
8. Evaluation of arterial sufficiency, when appropriate
9. Licensed professional (registered nurse [RN], licensed practical nurse [LPN], physical therapist [PT]) services in place for treatment in the home
10. Document how this request is appropriate for the type of wound being treated

For **pressure ulcers and arterial ulcers**, also document the following:

1. Whether moist wound environment was tried, for how long, and the outcome

2. Whether member is appropriately turned and positioned
3. Care plan for pressure management surface while the member is in bed or wheelchair
4. For chronic ulcers, how long the member has had this ulcer

For **diabetic neuropathic ulcers**, also document the following:

1. Whether moist wound environment was tried, for how long, and the outcome
2. Whether non-weight bearing or pressure reduction is in place and for how long. Appropriate offloading may include crutches, walkers, wheelchairs, custom shoes, depth shoes, shoe modifications, custom inserts, custom relief orthotic walkers, diabetic boots, forefoot and heel relief shoes, or total contact casts.
3. Whether blood glucose levels are monitored and if the member has a diabetes management program

For **venous ulcers**, also document the following:

1. Whether compression is in place—what is used, how long, and results

For **acute/traumatic wounds**, there should be an inpatient stay. Also document the following:

1. Date of wound and cause
2. Any evidence of healing in the last week
3. Whether NPWT was applied during inpatient stay
4. The member's pre-existing condition(s)

For **post-split thickness skin graft**, also document the following:

1. What part of the body is the graft or flap (uneven surface, joint, bony prominence)
2. Whether NPWT was applied intraoperatively

Remember the following contraindications for the negative pressure wound therapy:

1. Untreated osteomyelitis within the vicinity of the wound
2. Presence in the wound of necrotic tissue with eschar, if debridement has not been attempted
3. Cancer present in the wound
4. Presence of a fistula to an organ or body cavity within the vicinity of the wound

**Ongoing need of Wound Vac or NPWT:** After initial approval, updated documentation is needed every 30 days while treatment continues to use NPWT. Every 30 days provide the following:

1. Weekly wound assessment and measurements
2. Treatment applied

Remember if NPWT is needed for more than four months, an alternate treatment might be needed.

### **AutoloGel System**

**Codes:** E1399, A4649

Authorization is needed for IMCare members when the cost is more than \$1000.

The AutoloGel centrifuge is not covered in nursing facilities. Device-specific (e.g., applicators, reagents) may be covered in LTCFs.

Remember the following contraindications for AutoloGel System:

1. Active cancer at wound site
2. Chemotherapy within the past five years
3. Hematological disorder



4. Bleeding disorder
5. Perfusion to extremity of wound
6. Untreated osteomyelitis at wound site
7. Member being treated with Methotrexate
8. Allergy to beef or dairy

### **Non-Covered Services**

1. Topical hyperbaric oxygen for the treatment of wounds is considered investigative due to lack of evidence demonstrating its impact in health outcome.
2. Electrical stimulation using low-intensity direct current, high voltage pulsed current, alternative current, and transcutaneous electrical stimulation for the treatment of wounds is considered investigative due to a lack of evidence demonstrating its impact on improved health outcomes.
3. Electrical stimulation for the treatment of wounds performed by the patient in the home setting is considered investigative due to a lack of evidence demonstrating its impact on improved health outcomes.
4. Electromagnetic therapy for the treatment of wounds is considered investigative due to a lack of evidence demonstrating its impact on improved health outcomes.
5. Non-contact ultrasound treatment for wounds is considered investigative due to a lack of evidence demonstrating its impact on improved health outcomes.
6. Electrochemical low-dose tissue oxygenation systems are considered investigative due to a lack of evidence demonstrating impact on improved health outcomes.

### **Spirometers**

Spirometers are pulmonary function tests used to measure the volume/flow of inhaled and exhaled air.

#### **Codes**

A9284: non-electronic

E0487: electronic

Only spirometers approved by the Food and Drug Administration (FDA) are covered. Do not use A9284 or E0487 for incentive spirometers.

### **Non-Covered Services**

Spirometers prescribed for home monitoring of members who have not had a lung or heart-lung transplant.

#### **Authorization**

Authorization is not required. Payment is made only when the member has had a lung or heart-lung transplant. Provider needs to maintain documentation of the following:

1. Date of lung or heart-lung transplant
2. Statement detailing medical need for home monitoring, including specific patient orders
3. If electronic spirometer is supplied, explain why a non-electronic spirometer does not meet the member's needs

### **Standers or Standing Frames**

**Codes:** E0637, E0638, E0641, E0642, L1500, L1510

## Eligible Members

Standers are covered for eligible IMCare members who:

1. Have little or no potential for walking
2. Cannot stand unassisted for appreciable amounts of time
3. Meet coverage criteria

## Authorization

Authorization is required. Provide documentation of the member, condition, therapy program, trial, and physical therapy assessment to include the following:

1. Diagnosis. Must have a diagnosis of an underlying medical condition that involves inability to walk or loss of walking ability.
2. For pediatric members, a stander can be considered for developmental delay in ambulation for members at least 2 years old, or can be considered for neurological impairment for members at least 1 year old
3. Age
4. Height (for pediatric members) and weight
5. Description of function (sitting ability, standing ability, mobility) documentation of standing tolerance
6. Description of transfers
7. How long this equipment is needed and frequency of proposed use
8. Document that the member is under the care of a rehab specialist or physician
9. Documentation that the caregiver is available and able to assist the member or that the member has normal upper extremity strength

If the member is currently in a nursing facility, authorization will be considered if requested as part of a discharge plan or if documentation establishes that there is sufficient space in the member's room for the equipment, and that use of the stander will be part of the member's care plan. All other criteria must be met.

The stander must be an integral part of a therapy program in the home with specific, measurable outcomes unique to the member in at least two of the following areas:

1. Improvement of respiratory function where the member has impaired respiratory function due to the medical condition that impairs walking ability
2. Prevention of contractures and improvement of range of motion in the lower extremities
3. Reduction of pain associated with hypertonia
4. Maintenance of skin integrity/prevention of pressure ulcers
5. Decrease of frequency of urinary tract infections
6. Decrease in the frequency of digestive disorders
7. Improvement of bowel function.
8. Maintenance of bone density in adults when requested no later than 18 months from the onset of the condition that caused the loss of ability to walk or in children under age 21

The therapy program must require the following:

1. Adult members to stand at least 30 minutes per day at least five times per week
2. Children members to stand at least 7 – 10 hours per week
3. A child with a standing program at school must stand a total of at least 10 hours per week when adding the standing of his/her school program and home program together

The therapy program must be established by a therapist with experience working with standers.

## Trial

A trial of the requested stander in the member's home is required.

If the requested stander is replacing an existing stander of the same type (prone, supine, sit to stand), the trial need only establish the following:

1. The new stander fits in the member's home
2. The new stander is configured to meet the member's standing needs. This can usually be accomplished within a few hours.

If the member participated in a standing program at school, a day program, or previous residence and has lost access to the stander, the trial needs to establish the following:

1. The new stander fits in the member's home
2. The new stander is configured to meet the member's standing needs
3. The member is willing to use the stander in the new environment
4. Caregivers are willing and able to assist with the standing program (this can usually be accomplished within a few days)

If the member does not have a history of a standing program within the previous 12 months, the trial needs to establish the following:

1. The stander fits in the member's home
2. The stander is configured to meet the member's standing needs
3. The member is willing to use the stander
4. Caregivers are willing and able to assist with the standing program
5. The standing program has resulted in progress toward the stated goals or the member has significantly increased standing time (this can usually be accomplished within two weeks)
6. A log completed by the member or caregiver must be included in the authorization request

If the requested stander is replacing an existing stander but is of a different type (prone, supine, sit to stand), the trial needs to establish the following:

1. The stander fits in the member's home
2. The stander is configured to meet the member's standing needs
3. The member is willing to use the stander
4. Caregivers are willing and able to assist with the standing program
5. The standing program has resulted in progress toward the stated goals or the member significantly increased standing time (this can usually be accomplished within two weeks)
6. A log completed by the member or caregiver must be included in the authorization request

All authorization requests must include an assessment by the physical therapist (PT). The assessment must include the following:

1. The current program and functional goals
2. Baseline for each goal
3. The effect of the trial period or previous standing on the goals
4. A description of the member's history of standing
5. Functional mobility status, including the amount of assistance required for sitting, standing, ambulation, and transfers
6. All authorization requests must include descriptions of what less costly alternatives were considered/tried, and why they were rejected. This should address other standing devices considered, as well as other approaches for meeting the member's goals.
7. Authorization requests for members under age 21 must describe how the requested device will accommodate expected growth
8. Authorization requests for members with progressive diseases or conditions must include the following:
  - a. An assessment of the effects of the disease's progress on the member's ability to use the requested device

- b. An estimate of how long the requested device is expected to meet the member's needs

**Accessories Purchase Criteria for Rented Standers**

1. Member must have a diagnosis of an underlying medical condition that involves inability to walk
2. Rental of the stander for 2 – 3 months must be necessary for continuation of a school-based therapy program or for temporary use when there is a decline in functional mobility (e.g., following orthopedic surgery)

**Non-Covered Services**

A stander will not be purchased for a member with any of the following contraindications:

1. Inadequate bone density to safely allow standing
2. History of syncope
3. History of sudden changes in blood pressure
4. Uncontrolled dependent edema
5. Adverse reactions while standing during the trial period

A stander will not be purchased for a member who regularly uses a stander in a school or day program, although 2 – 3 months' rental may be appropriate when school is not in session.

“Regularly” means a child who uses a stander 10 hours per week or an adult who uses a stander five times per week for 30 minutes or more each time.

A stander will not be purchased for a member who has a gait trainer.

**Suction Pump (Respiratory)**

**Code:** E0600

**Authorization** is not required.

A portable suction pump may be used as a stationary suction. IMCare will not cover both portable and stationary suction pumps unless documentation supports the need for both types.

**Included with purchase/rental:**

1. Battery
2. Battery charger
3. Carrying case
4. Overflow valve
5. Permanent collection bottles
6. Pump

**Separately bill:**

1. Connecting tubing
2. Disposable collection bottles
3. Suction catheters

When billing for both a portable and a stationary suction pump on the same date of service (DOS), bill both units on one line. Include in the description: medically necessary – 1 stationary/1 portable.

## Topical Products Defined as Drugs

Skin care products classified as drugs and provided for members with catheters, ostomies, or other conditions may be covered only under the following circumstances:

1. The member has a valid Healthcare Common Procedure Coding System (HCPCS) code assigned to and it is eligible for reimbursement on the Minnesota Department of Human Services (DHS) fee schedule; **or**
2. If no HCPCS code exists, an appropriate provider may submit a claim using the 11-digit National Drug Codes (NDC). The provider will be reimbursed at the contracted pharmacy rate if the NDC is on the formulary. State law does **not** allow medical equipment and supply providers or home health care agencies to provide items that meet the definition of a drug.

The following items are defined as drugs and may be covered only as described above. This is not an inclusive list. Not all products that fit into one of the categories listed below are covered.

1. Urea solutions
2. Antifungal compounds
3. Antiseptics
4. Topical anesthetic and antipruritic solutions
5. Topical corticosteroids
6. Topical anti-infective agents and cleaners
7. Anti-psoriasis and anti-eczema medications
8. Aluminum chloride, fluorouracil, and hydroquinone solutions
9. Sterile saline or water (includes irrigation solutions labeled as Rx legend)
10. Aluminum acetate solution and lime sulfur dressing and soaks
11. Antibiotic-steroid combination
12. Zinc oxide compounds
13. Vitamin A & D ointments
14. Scabicides and pediculicides
15. Lactic acid lotion
16. Anti-acne medications
17. Burn anti-infective agents
18. Wart medications
19. Enzymes

## Non-Topical Products

Lubricants for ostomy patients, non-legend sterile saline irrigation solutions, skin barriers, and other topical products that do not contain active ingredients and are not classified as drugs may be billed on the 837P professional claim with the appropriate HCPCS code. These items require a written order from the physician that includes the exact description of the product to be dispensed, the amount needed, and the length of time needed.

## Transcutaneous Electrical Nerve Stimulator (TENS)

A TENS is a device that uses electrical current delivered through electrodes placed on the skin to decrease a member's perception of pain by inhibiting the transmission of pain nerve impulses toward the brain, stimulating the release of endorphins.

## Covered Services

**Codes:** E0720, E0730, E0731, A4557, A4595

Only TENS units and conductive garments approved by the Food and Drug Administration (FDA) are covered.

One, two lead TENS supply is covered each month of use for members using a two lead (E0720) TENS unit.

Two, two lead TENS supplies are covered each month of use for members using a four lead (E0730) TENS unit. TENS supplies necessary for use of the TENS unit for one month include, but are not limited to, the following:

1. Adhesive
2. Adhesive remover
3. Batteries
4. Conductive paste or gel
5. Electrodes

Replacement lead wires are covered to a maximum of twice per year.

Suppliers must verify the TENS unit is still being used before dispensing TENS supplies/lead wires. A new order is not required unless the original order had an end date.

### **Non-Covered Services**

TENS is not medically necessary for the treatment of chronic low back pain, defined as low back pain from any cause lasting six weeks or more.

Supplies other than listed above for use with the TENS unit are not covered.

If criteria is met, rental of a TENS unit is covered for members with acute pain. If criteria is met, purchase or rental of a TENS unit is covered for chronic pain other than chronic low back pain.

### **Authorization**

**Service Authorization is required for the purchase or rental of all TENS units.** Service Authorization decisions are based on medical necessity. TENS units are not medically necessary for the treatment of chronic low back pain, defined as low back pain from any cause lasting six weeks or more. Please review Chapter 5, Service Authorization, for specific information regarding Service Authorizations.

Each month rental is 1 unit. If 2 months' rental is needed, request 2 units.

For the authorization request, provide the following documentation:

1. For acute (non-malignant) post-operative or post-traumatic pain, TENS unit will be approved for rental for a period of no more than 60 days following surgery or injury.
  - a. Submit a description of the member's operation or trauma and the need for TENS. Date of the surgery or injury (should be less than 30 days)
  - b. If a four lead TENS unit is requested, document why two leads are not sufficient to meet the member's needs.
  - c. If the device is required for more than 60 days, the member must meet the criteria for chronic pain.
2. For chronic pain conditions that are refractory to other member-appropriate methods of treatment, TENS units will be approved for purchase or rental up to 13 months. After 13 months' rental, the unit is the member's property. Provide the following:
  - a. Diagnosis and description of the pain and approximate date of onset of pain
  - b. Description of prior therapies attempted and member's response

- c. Documentation of any treatments considered but rejected as not appropriate for the member
  - d. If a four lead TENS unit is requested, document why two leads are not sufficient to meet the member's needs.
  - e. Include an estimate of duration of need. Each month rental is 1 unit. Request 1 unit for each month needed when requesting rental.
  - f. Documentation of the member's use, how often, and whether the TENS alleviates the pain
3. A form fitting conductive garment may be medically necessary for use with a TENS unit for some members. IMCare will authorize the purchase of form fitting conductive garments for use with authorized TENS units if any of the following criteria are met:
- a. The area receiving stimulation is inaccessible to the member or caregiver with the use of conventional electrodes, tapes, and lead wires
  - b. The area receiving stimulation is so large or the areas so numerous conventional electrodes, tapes, and lead wires are not practical
  - c. The member has a skin condition or other medical condition that prevents the application of conventional electrodes, tapes, and lead wires
  - d. Submit documentation addressing one or more of the criteria above. If requesting authorization because the area is inaccessible, include information about the availability of caregivers to assist the member.

## Ultraviolet Light Therapy Systems (E0691-E0693)

Authorization is required for ultraviolet light systems.

Provide documentation of the medical necessity for this service and what type of treatment has been tried in the past with outcome of that past treatment.

### Covered Services

#### Codes

A4633: replacement bulbs for ultraviolet light systems

E0691 – E0693: ultraviolet light systems

Ultraviolet light B (UVB) therapy systems for use in the home may be considered medically necessary for treatment of severe psoriasis in members for whom topical or oral medication has failed or is contraindicated, but who have responded to phototherapy, and who meet one of the following criteria:

1. Unable to attend therapy in the clinic due to a medical condition or disability.
2. Require treatment more than two times weekly over a period of several months.
3. Lack access to treatment in the nearest appropriate clinic due to one-way travel time in excess of one hour

### Non-Covered Services

1. Ultraviolet multidirectional light therapy systems are not covered because they are not proven to produce better outcomes than other systems and because they are not the least costly effective treatment for any condition.
2. Home ultraviolet light A (UVA) systems are not covered for any indication because they are not proven to be safe for treatment in the home.
3. Home ultraviolet light systems are considered investigative for conditions other than severe psoriasis.

## Authorization

Authorization is required for purchase or rental, or repair of ultraviolet light therapy systems. Documentation must include the following:

1. Member's diagnosis, including the extent and severity of the disease
2. History of oral and topical medications, and why they have failed or are contraindicated
3. Response to phototherapy in a clinic setting
4. Specific reason why treatment in the home is requested rather than treatment in the clinic
5. Evidence of the member or caregiver's ability to safely and effectively use the equipment in the home.

## Urological Supplies

Catheters and related urological supplies are used to drain urine from the bladder when a member is unable to completely empty the bladder by voiding.

### Eligible Members

Catheters and related urological supplies are covered for eligible IMCare members unable to completely empty their bladder by voiding.

### Covered Services

#### Codes

A4310 – A4316 and A4354: insertion trays for indwelling catheters

A4338 – A4346: indwelling catheters without insertion trays

A4351 – A4353: intermittent catheters

A4357 – A4358, A5102, A5112: drainage collection systems

A4320 – A4334, A4349, A4355 – A4356: related supplies

A4335: miscellaneous incontinence supplies

### Indwelling Catheters/Insertion Trays

Most members can be served with one indwelling catheter per month. A second catheter may be required if the catheter is accidentally removed, malfunctions, or becomes obstructed or if the member has a medical history that requires the catheter to be replaced more than once per month. One insertion tray is covered per episode of indwelling catheter insertion. An insertion tray is not covered for use with an intermittent catheter.

Documentation must support the quantity dispensed.

### Intermittent Catheterization

Most members can be served with 150 – 180 intermittent catheters per month. Additional intermittent catheters may be required if the member has a medical history that requires more than six episodes of catheterization daily. Intermittent catheters with sterile insertion supplies are covered if the member has a medical history that requires sterile, rather than clean, catheterization and documentation of medical necessity for sterile catheterization is maintained in the medical supplier's files. Documentation must support the quantity dispensed.

### Drainage Collection Devices

Most members can be served with 1 – 2 drainage bags/bottles per month. Additional drainage bags/bottles may be required if the member has a medical history that requires the bag to be replaced more frequently.

Documentation must support the quantity dispensed.



## Irrigation Supplies

Most members who require intermittent irrigation can be served with one irrigation tray/syringe per week. Up to 31 irrigation syringes/trays may be required if the member has a medical condition that requires daily irrigation with a new syringe. Documentation must support the quantity dispensed. Supplies for intermittent irrigation of an indwelling catheter include either an irrigation tray or an irrigation syringe, and sterile water/saline.

Most members who require continuous irrigation can be served with one irrigation tubing set per day for up to two weeks. Up to 31 continuous days may be required if the member has persistent obstructions. Supplies for continuous irrigation include a three-way Foley catheter, irrigation tubing set, and sterile water/saline.

## Authorization

IMCare does not currently require authorization for urological supplies. Identified excessive use will be investigated. Providers are required to maintain documentation to support quantity dispensed.

## Billing

1. If the member has Medicare, IMCare will pay the deductible/co-insurance on any units for which Medicare has made payment. Any units that Medicare denies payment for must meet IMCare's quantity and authorization requirements. Authorization can be requested retroactively.
2. Only products that have undergone coding verification review by the Medicare Pricing, Data Analysis, and Coding (PDAC) contractor may be billed with A4326. Include the name of the product in the notes field.

## Ventilators

Ventilators are used to move air in and out of the lungs.

Because ventilators are life-sustaining equipment, providers must do the following:

1. Conduct an in-home environmental assessment to confirm the patient's residence will safely sustain the ventilator and auxiliary equipment, along with routine household appliances and activities. The assessment includes, but is not limited to, checking for grounded electrical outlets and functional smoke detectors, emergency protection planning, and escape route planning.
2. Train the member and caregivers in proper use of the ventilator, including infection control, alternative ventilation, and emergency ventilation procedures
3. Have 24 hour/day support for troubleshooting and ventilator exchange due to unresolved malfunction
4. Ensure critical alarms are appropriately set on the ventilator
5. Ensure a backup alarm system is in place for when the patient is not directly observed by a fully trained caregiver
6. Perform periodic maintenance at least as frequently as recommended by the manufacturer

## Covered Services

**Codes:** E0450, E0460, E0461, E0463, E0464

Ventilators are covered for members who have been determined by a physician to need a ventilator.

Both a portable and a stationary ventilator may be covered when documentation in the medical supplier's files establishes that a portable ventilator alone does not meet the member's needs. If two different types of ventilators are medically necessary (for example, a positive pressure ventilator and a negative pressure ventilator), both types can be covered.

## Non-Covered Services

Back-up ventilators are not covered because it is a duplication of equipment.

### Authorization

Authorization is required.

### Billing

#### Included with rental:

1. Battery
2. Carrying case
3. Cart
4. Electric cord
5. Exhaustion valves
6. High/low/disconnect alarms
7. High pressure hoses
8. Intermittent Mandatory Ventilation (IMV) devices
9. Positive End-Expiratory Pressure (PEEP) valve
10. Pressure manometers
11. Spirometer, any kind
12. Stand
13. Water traps

#### Separately billable:

1. Breathing circuits
2. Humidifier
3. Manual resuscitation bags
4. Oxygen
5. Oxygen analyzers

## Wigs

**Code:** A9282

**Authorization** is not required for contracted providers.

**Criteria:** Covered only for diagnosis of alopecia areata. IMCare will cover one wig per 366-day period (one year plus one day).

## Non-Covered Services

The following list of non-covered services is not all-inclusive:

1. Air conditioners
2. Bathroom scales
3. Bathtub wall rails
4. Beds – oscillating and lounge beds, bed baths and lifters, bedboards, tables, and other bed accessories
5. Blood glucose analyzer – reflectance colorimeter
6. Car seats, standard use

7. Cervical roll, or pillow clothing
8. Control units and battery device adapters
9. Dehumidifiers – room or central
10. Diathermy machines
11. Disposable wipes – including Attends wash cloths
12. Disposable ice packs/disposable heat wraps
13. Elevators and stair lifts
14. Enuresis or bed-wetting alarms
15. Environmental products (e.g., air filters, purifiers, conditioners, hypoallergenic bedding, and linens)
16. Exercise equipment
17. Food blenders
18. Grab bars
19. Heat and massage foam cushion pads
20. Home security systems
21. Household equipment and supplies such as ramps, switches, tableware, and feeding instruments
22. Humidifiers – room type or central
23. Hygiene supplies and equipment, including hand-held shower units and shower trays, and dental care supplies and equipment
24. Ice packs (disposable)
25. Incontinence undergarments (includes pants to wear with pads)
26. Instructional materials (e.g., pamphlets and books)
27. Isolation gowns, surgical gowns, and masks
28. Leg Cycle Ergometry (e.g., StimMaster, ERGYS, REGYS, RT300 motorized FES Ergometer)
29. Magnifying glasses
30. Massage devices
31. Medical alert bracelets and response systems
32. Medical supplies defined as drugs
33. Menses products (e.g., sanitary pads)
34. Motorized lifts for vehicle
35. Orthopedic mattresses
36. Personal computers and printers, tape recorders, or video recorders
37. Pulse tachometers
38. Ramps
39. Reachers
40. Reading glasses
41. Reusable bed or chair pads
42. Saline or other solutions for the care of contact lenses
43. Table foods
44. Telephones, telephone alert systems, telephone arms, or answering machines
45. Tennis/gym shoes
46. Thermometer covers
47. Toothbrushes and toothettes
48. Toys
49. Waterbeds
50. White canes for the blind

### **Reclassification of Certain Durable Medical Equipment (DME) to the Capped Rental Payment Category**

Effective April 1, 2014, certain DME HCPCS codes from the Inexpensive and Routinely Purchased DME payment category were reclassified to the Capped Rental DME payment category.

As shown in Attachment A of [Medicare Learning Network \(MLN\) Matters # 8566](#), the effective date is April 1, 2014 for HCPCS codes not included in a Competitive Bidding Program (CBP). A forthcoming change request will address the codes that will be reclassified to the Capped Rental DME payment category effective July 1, 2016 and January 1, 2017.

## Documentation of Orders

This documentation is required whether the Durable Medical Equipment, prosthetics, orthotics, and supplies (DMEPOS) requires authorization or not.

### Dispensing Orders

Dispensing orders are limited Durable Medical Equipment (DME) orders that are written, faxed, or verbal.

For any DME/supply item to be covered by IMCare, the supplier must have an order from the prescribing physician before dispensing the item. Acting within the scope of practice, the prescribing provider may be a Clinical Nurse Specialist (CNS), nurse midwife, nurse practitioner (NP), physician, podiatrist, or physician assistant (PA).

IMCare requires that providers dispense one month of supplies at a time. Providers may not ship items on a regular, monthly basis without an indication from the member, family member, or authorized representative that the supply is needed.

Except for items requiring a written order prior to delivery, the “dispensing” order may be a written order (original or fax) or a verbal order. **The order must contain** the following:

1. Description of item
2. Name of member
3. Name of physician
4. Date of order

The supplier must maintain written documentation of the dispensing order (this documentation must be available to IMCare upon request).

### Detailed Written Orders

Detailed written orders contain the dispensing order and follow Medicare guidelines. Detailed written orders must be signed and dated by the treating physician. Detailed written orders are **in addition** to the dispensing order, as described above.

A new order is needed at the following times:

1. An order changes for accessory, supply, drug, etc.
2. Yearly (even if there is no change in the order), for specific items only
3. The item is replaced
4. The supplier changes

### Re-Order

1. Requests must come from the member or an authorized representative each time additional supplies are needed.
2. It is acceptable for medical supply providers to call the member to verify a re-order.

3. Automatically shipping supplies without the member's confirmation is not acceptable.

## Medical Records

Medical records must contain the following information:

1. The medical condition to substantiate the necessity of the type and quantity of items ordered and for the frequency of use or replacement (if applicable)
2. The diagnosis and other pertinent information including duration of the condition; clinical course (worsening or improvement); prognosis, nature, and extent of functional limitation; other therapeutic interventions and results; past experience with related item; etc.
3. The clinical information supports the medical necessity for the item and substantiates the information on a supplier prepared statement or physician attestation, if applicable. Clinical information:
  - a. is not limited to the physician's office records;
  - b. may include hospital, nursing home, or home health agency records; and
  - c. may include records from other professionals including nurses, physical therapists (PTs) or occupational therapists (OTs), prosthetists, and orthotists.

IMCare may request this information in selected cases. The supplier is liable for dollar amount involved if the information is not received, or does not substantiate medical necessity.

Neither a physician's order, a supplier-prepared statement, nor a physician attestation by itself provides sufficient documentation of medical necessity, even though it is signed by the treating physician.

## Supplier Documentation

The medical supplier must have the following information on file:

1. The original detailed written order
2. Member's diagnosis from the testing physician
3. Any information required for use of specific modifiers or attestation statements
4. Adequate information to assure that coverage criteria for an item has been met
5. Information in the medical record must adequately support the medical necessity for the item, or the supplier is liable for the dollar amount involved
6. Proof of delivery documentation

**Method 1:** Supplier delivering items directly to the member or authorized representative:

1. The delivery slip must be signed and dated by the member or authorized representative to verify the DME/supply item was received.
2. The date of the signature on the delivery slip must be the date DME/supply was received by the member or authorized representative.
3. The delivery slip must include the member's name, quantity, a detailed description of the item(s) delivered, brand name, and serial number (if applicable).
4. The date of service (DOS) on the claim must be the date the DME/supply item was received by the member or authorized representative. An exception to this would be when an item must be billed using a date span and the quantity dispensed crosses over into next month.

**Method 2:** Supplier utilizing a delivery/shipping service to deliver items:

1. Acceptable proof of delivery includes the delivery service's tracking slip **and** the supplier's shipping invoice.
2. The supplier's shipping invoice must include the member's name, quantity, detailed description of the item(s) delivered, brand name, serial number (if applicable), and delivery service's package identification (ID) number associated with member's package(s).

3. The delivery service's tracking slip must reference the member's package(s), delivery address, and the corresponding package ID number given by the delivery service.
  - a. Without the delivery service's tracking log that identifies each individual package with a unique ID number and delivery address, the item will be denied and any overpayment will be recouped.
  - b. When the member denies receipt of an item, the item will be denied and an overpayment will be recouped, unless the supplier maintains a detailed shipping invoice and the delivery service's tracking log.
4. Mail order DME/supply items: The DOS on the claim must be the shipping date.

**Method 3:** Delivery of items to a long-term care facility (LTCF) on behalf of the member:

1. Proof of delivery must be maintained in the supplier's records as described in Methods 1 and 2.
2. Suppliers must work with the LTCF staff to implement inventory control to ensure the following:
  - a. The LTCF received delivery and was provided with receipt of what was delivered
  - b. Supplies were identified and retained for use only by intended members
  - c. Intended members use the supplies
  - d. Suppliers receive proof of delivery from the LTCF
3. Medical records in the LTCF must document use of all supplies/items billed to IMCare. Documentation may be in the nurse's notes of a special treatment record or form.
4. The DOS on the claim must be the date the DME item was received by the LTCF if delivered by the supplier, or the shipping date if the supplier used the delivery/shipping service.

The only exception to the DOS on the claim is when items are provided in anticipation of discharge from a hospital or LTCF. If the DME item is delivered to a member in a hospital up to two days prior to discharge (home) **and** for the benefit of the member for the purpose of fitting or training of the member in its use, the supplier must bill the DOS on the claim as the date of discharge (home) and must use POS "12" (home).

All services that do not have appropriate proof of delivery from the supplier will be denied, and all overpayments must be returned to IMCare.

### **Hospitalized Members**

Except as noted in the "Supplier Documentation" subsection of the *Documentation of Orders* section, do not bill for medical equipment and supplies ordered for subsequent use in the member's home prior to the date of the member's discharge (home). This includes the following:

1. Drugs, supplies used with the DME, or prosthetic devices
2. Surgical dressing, urological supplies, or ostomy supplies applied in the hospital, including items worn home by the member

Suppliers are responsible for delivering the DME to the member's home.

The [Benefit Code Guide](#) is available online at the Minnesota Department of Human Services (DHS) website or by calling the IMCare Member Services at **1-800-843-9536** (toll free).

### **Dispensing of Equipment/Supplies**

1. Dispense no more than one month of supplies at a time unless specifically permitted by coverage policy.
2. Requests must come from the member or an authorized representative each time additional supplies are needed.
3. It is acceptable for medical supply providers to call the member to verify a re-order.
4. Automatically shipping supplies without an indication from the member or the member's authorized representative confirmation is not permitted.

## Billing Policy

1. Use the 837P professional claim format.
2. Report the name and National Provider Identifier (NPI) number of the actively enrolled ordering provider in the “Other Provider Types” section of the 837P professional claim format.
3. Use current Healthcare Common Procedure Coding System (HCPCS) procedure codes and modifiers.
4. To determine the appropriate HCPCS code to use with a covered service, access the [Medicare Pricing, Data Analysis, and Coding \(PDAC\) Product Classification List](#) website.
5. Use a modifier to indicate purchase, rental, repair, or replacement of part. Additional modifiers may be appropriate depending on the item or service.
  - a. For capped rental items that are billed as rental, use modifier KH for the first month, KI for the second and third months, and KJ for months 4 – 13 of rental. IMCare will reimburse for modifiers KH and KI at 100 percent of the Minnesota Health Care Programs (MHCP) fee schedule monthly rental rate and modifier KJ at 75 percent of the MHCP fee schedule monthly rental rate. Modifiers KH, KI, and KJ also apply to any authorization request for a capped rental item. Each K modifier must be on a separate line on the authorization request.
6. The cost of shipping, handling, or freight charges are all-inclusive in the IMCare payment rate and are not reimbursable. If these charges are included on the invoice or as part of the manufacturer’s suggested retail price (MSRP), they will be excluded from the payment.
7. Follow Medicare guidelines for when to use modifiers AU, AV, AW, KC, KE, KL, KM, and KN. When billing for these modifiers, providers must also include modifier NU to be reimbursed at the appropriate Medicare rate. Do not bill setup, pickup, or delivery expenses—the cost of delivery is included in the rental or purchase payment.
8. Do not bill for service calls that do not involve actual labor time for repairs.
9. Reimbursement for all rental items will cap at the Medicare purchase rate or the MHCP maximum allowed payment rate when renting any equipment. Do not continue to bill monthly rental after the maximum rate has been reached. Apply full rental payments (including all payments received from primary third party payers) to all purchases. After MHCP purchases the medical equipment or supply for a recipient, the item is the recipient's property.
10. For an equipment or medical supply item that requires manual pricing or is not listed on the Minnesota Health Care Programs (MHCP) Fee Schedule, attach the manufacturer’s invoice/price list to the claim.
11. Clearly indicate which item on the documentation corresponds to each item on the claim.
12. Do not modify, alter, or change the price list or invoice.
13. Do not block out any information on the invoice/price list.
14. If the manufacturer’s invoice/price list is not available, submit a quote from the manufacturer, dated no earlier than three months before the DOS and no later than the DOS.
15. If authorization is required, the claim must match HCPCS code, modifiers, and description/model number as noted on the authorization letter. Report the description/model number in the Model Number field in the “DME Information” section of the *Services* tab. When the Model Number field is used, do not use the “Notes” field on the *Services* tab. Use the “Claim Notes” field on the *Claim Information* tab. Enter the line item number and then the text or narrative that is required.
16. 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.

## Legal References

[MN Stat. sec. 62J.536](#) – Uniform Electronic Transactions and Implementation Guide Standards

[MN Stat. sec. 148.235, subd. 2](#) – Prescribing Drugs and Therapeutic Devices: Certified nurse practitioners

[MN Stat. sec. 256B.04, subd. 14](#) – Duties of State Agency: Competitive bidding

[MN Stat. sec. 256B.0625, subd. 31](#) – Covered Services: Medical supplies and equipment

[MN Rules part 9505.0310](#) – Medical Supplies and Equipment

[MN Rules part 9505.0365](#) – Prosthetic and Orthotic Devices

[MN Rules part 9505.0445](#) – Payment Rates

[MN Rules part 9549.0020](#) – Definitions

[MN Rules part 9549.0040](#) – Reporting by Cost Category

[Title 42 Code of Federal Regulations \(CFR\) 410.10 \(g, h\)](#) – Medical and other health services: Included services

[42 CFR 410.36](#) – Medical supplies, appliances, and devices: Scope

[42 CFR 410.38](#) – Durable medical equipment: Scope and conditions