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CHAPTER IV

COVERED SERVICES AND LIMITATIONS

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FREEDOM OF CHOICE

Virginia Medicaid recipients are free to choose a Medicaid enrolled medical equipment and supply provider when medical equipment and supplies are a covered service. Provision of “free” supplies or items to Medicaid recipients as an enticement for their business may violate federal law. If a provider is utilizing this practice, DMAS may impose a civil money penalty sanction against the DME provider.

MEDALLION

MEDALLION is a mandatory Primary Care Case Management Program that enables Medicaid recipients to select their personal Primary Care Physicians (PCPs) who are responsible for providing and/or coordinating the services necessary to meet all of the recipient’s health care needs. MEDALLION promotes the physician/patient relationship, preventive care and patient education while reducing the inappropriate use of medical services. The PCP serves as a care coordinator for access to most other non-emergency services that the PCP is unable to deliver through the normal practice of primary care medicine. The PCP must provide authorization for any other non-emergency, non-exempted services in order for another provider to be paid for services rendered. To provide services to a MEDALLION recipient, prior authorization from the recipient’s PCP is required. Before rendering services, either direct the patient back to his or her PCP to request a referral or contact the PCP to inquire whether a referral is forthcoming. This referral may be obtained in writing or orally and must be documented in the recipient’s record.

The PCP referral is valid as long as the CMN is effective, provided there is no change in the eligibility of the recipient or PCP.

The preauthorization/referral for MEDALLION should not be confused with the preauthorization process for durable medical equipment and supplies described in Appendix D of this manual.

Please refer to the MEDALLION section (Appendix A) of this manual for further details on the program.

Medallion II

In areas where the Medallion II program is available, many Medicaid recipients receive primary and acute care through mandatory enrollment in managed care organizations (MCOs). Recipients enrolled in a Medallion II MCO have a MCO Member Identification Card or may be identified by using the various Medicaid eligibility verification systems. Medicaid recipients enrolled in the traditional Medicaid program or MEDALLION program will have a regular Medicaid card. Except for family planning and emergency services, Medallion II recipients must utilize providers that participate within the MCO’s provider network. Providers must adhere to the MCO’s requirements regarding referrals and Prior Authorization, or, payment for services may be denied. Providers may not bill the recipient for Medicaid covered services, including in those instances where a provider fails to follow the MCO’s established guidelines.

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Providers who do not participate with the recipient's MCO must inform the recipient prior to the provision of services so that the recipient may choose to go to a provider that participates with their MCO. The recipient should be instructed to call the MCO's Customer Service to assist with locating an in-network DME provider. If the recipient chooses to stay with the provider, the DME provider must notify the recipient that they will be responsible for payment. This notification and the recipient's response must be documented in the recipient's record.

Custom Preauthorized DME for Medallion II

DME providers who are billing DMAS for specialized equipment must have valid preauthorizations from DMAS dated prior to the date the recipient enters the MCO. This specialized equipment includes, but is not limited to, the following:

- Customized wheelchairs and required components;
- Customized prone standers; and
- Customized positioning devices.

For the items listed above, the DME provider may bill DMAS using the valid preauthorization begin date as the invoice date if DMAS preauthorization is received prior to the recipient entering the MCO. The DME provider must maintain proof of delivery documentation, signed by the recipient or responsible party, in accordance with the delivery ticket criteria found in Chapter VI. For non- MCO recipients, the delivery date is the invoice date.

Reference the section titled "Medallion II" in Chapter I of this manual for further details regarding individuals who are enrolled in Medallion II.

COVERED SERVICES

DME and supplies are a covered service available to the entire Medicaid population *as described in this manual*. In addition, the Department of Medical Assistance Services (DMAS) may cover DME services when the recipient is under age 21 and the item or supply could be covered under the *Virginia State Plan for Medical Assistance* (the *State Plan*) through the Early and Periodic Screening, Diagnosis and Treatment Program (EPSDT);

All medically necessary medical equipment and supplies under the *Virginia Administrative Code* may be covered only if they are necessary to carry out a treatment prescribed by a physician. Unusual amounts, types, and duration of usage must be authorized by DMAS in accordance with published policies and procedures. When determined to be cost-effective by DMAS, payment may be made for rental of the equipment in lieu of purchase. (12 VAC 30-50-165)

DME providers shall adhere to all applicable DMAS policies, laws, and regulations for durable medical equipment and supplies. DME providers shall comply with all other applicable Virginia laws and regulations requiring licensing, registration, or permitting. Failure to comply with such laws and regulations shall result in denial of reimbursement for durable medical equipment and supplies that are regulated by licensing agency or agencies. (12 VAC 30-50-165)

MEDICAL NECESSITY

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Only supplies, equipment, and appliances that are determined medically necessary may be covered for reimbursement by DMAS. The following criteria must be satisfied through the submission of adequate and verifiable documentation satisfactory to DMAS. Medically necessary DME and supplies shall be:

- Ordered by the physician on the CMN/DMAS-352;
- A reasonable and medically necessary part of the recipient's treatment plan;
- Consistent with the recipient's diagnosis and medical condition, particularly the functional limitations and symptoms exhibited by the recipient;
- Not furnished for the safety or restraint of the recipient, or solely for the convenience of the family, attending physician, or other practitioner or supplier;
- Consistent with generally accepted professional medical standards (i.e., not experimental or investigational);
- Furnished at a safe, effective, and cost-effective level; and
- Suitable for use in the recipient's home environment.

(12 VAC 30-50-165)

NON-COVERED DME AND SUPPLIES

For individuals under age 21, coverage must be explored under Early and Periodic Screening, Diagnosis and Treatment (EPSDT). For details, see the "DME Covered under Early and Periodic Screening, Diagnosis and Treatment" section in this manual.

For all other recipients, non-covered supplies and equipment include, but are not limited to, all of the following:

- Space conditioning equipment, such as room humidifiers, air cleaners, and air conditioners;
- Durable medical equipment and supplies for any hospital or nursing facility resident, except ventilators and the associated supplies that are approved by DMAS and provided to nursing facility residents;
- Furniture or appliances not defined as medical equipment (such as blenders, bedside tables, mattresses other than for a hospital bed, pillows, blankets or other bedding, special reading lamps, chairs with special lift seats, hand-held shower devices, exercise bicycles, geri-chairs, and bathroom scales);
- Items that are only for the recipient's comfort and convenience or for the convenience of those caring for the recipient (e.g., a hospital bed or mattress because the recipient does not have a decent bed, a wheelchair tray used as a desk surface, and mobility items used, in addition to the primary assistive mobility aid), for the caregiver's or the recipient's convenience (e.g., an electric wheelchair plus a manual chair); underpads (such as chux) in addition to incontinence briefs, unless there is a specific medical need for using both; and cleansing wipes;
- Prostheses, except for artificial arms, legs, breast and their supportive devices which must be preauthorized by DMAS (effective July 1, 1989).
- Items and services which are not reasonable and necessary for the diagnosis or treatment of illness or injury or for improving the functioning of a malformed body member (for example, over-the-counter drugs, dentifrices, toilet articles, shampoos which do not require a physician's prescription, dental adhesives, electric

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toothbrushes, cosmetic items, soaps, and lotions which do not require a physician's prescription; sugar and salt substitutes; non-compression type support stockings; and non-legend drugs);

- Home or vehicle modifications;
- Orthotics (including braces, splints, and supports);
- Items not suitable for or not used primarily in the home environment (e.g., car seats except when medically necessary under EPSDT, equipment to be used while at school, etc.); and
- Equipment for which the primary function is vocationally or educationally related (e.g., computers, environmental control devices, speech devices, etc.).

(12 VAC 30-50-165)

CERTIFICATE OF MEDICAL NECESSITY (CMN)/DMAS-352

All DME and supplies must be ordered by a physician on the CMN/DMAS-352 (revised 8/95) and must be medically necessary to treat a health condition. The CMN (DMAS-352) may be completed by the physician, DME provider, or other health care professionals, but the physician must sign and date the completed CMN. (See "EXHIBITS" at the end of this chapter for a sample of this form.) The CMN and any supporting verifiable documentation must be completed (signed and dated by the physician) within 60 days from the time the ordered DME and supplies are initially furnished to the recipient by the DME provider. DMAS will not reimburse the DME provider for services provided prior to the date of the physician's signature when the signature is not obtained within 60 days of the first day the DME supplies are furnished to the recipient. (12 VAC 30-50-165)

A CMN shall contain a physician's diagnosis of a recipient's medical condition and an order for the durable medical equipment and supplies that are medically necessary to treat the diagnosed condition and the recipient's functional limitation. The order for DME or supplies must be justified in the written documentation either on the CMN or on an attachment to the CMN. The additional documentation to justify the DME or supplies must coincide with the date of service for the item(s) ordered and the name and title must identify the medical discipline. The CMN must also be completed for equipment repairs. (12 VAC 30-50-165)

DME must be furnished exactly as ordered by the attending physician on the CMN. The physician must specifically order each component of the DME on the CMN. The CMN shall not be changed, altered, or amended after the attending physician has signed it. If changes are necessary for the ordered DME or supplies, as indicated by the recipient's condition, the DME provider must obtain a new CMN. The attending physician must sign and date the new CMNs within 60 days from the time the ordered supplies are furnished by the DME provider. Supporting documentation may be attached to the CMN, but the attending physician's entire order must be on the CMN. (12 VAC 30-50-165)

NOTE: If technical information changes on the CMN, a new CMN is not required because it does not affect the physician's order or delivery of services. Examples of technical information include changes in a recipient address, phone number, or provider enrollment number. The next CMN renewal must include this updated technical information. Faxed copies of the CMN are acceptable.

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Length of Certification on the CMN (DMAS-352)

The CMN shall be valid for a maximum period of six months for Medicaid recipients 21 years of age and younger. The maximum validity time for Medicaid recipients older than 21 years is twelve months. DMAS has the authority to determine an alternative length of time different from the timeframes stated above that a CMN may be valid based on medical documentation submitted on the CMN. The validity of the CMN shall terminate when the recipient's medical need for the prescribed DME or supplies ends. (12 VAC 30-50-165)

Retention of Medical Records

For recipients currently receiving a DME service, copies of all CMNs, all supporting verifiable medical documentation, and all associated billing documentation must be kept on file at the location serving the recipient. For recipients no longer receiving a DME service, completed CMNs, all supporting verifiable medical documentation, and all associated billing documentation must be retained by the provider for at least five years. (12 VAC 30-50-165)

Retroactive Eligibility

DMAS may make an exception to the 60-day physician signature requirement if retroactive eligibility is determined. All remaining criteria (e.g., fully completed CMN, documentation requirements, and specific coverage criteria) must be satisfied in accordance with the *State Plan* and DMAS policy guidelines.

CMN Exceptions

A CMN is not necessary for AIDS waiver recipients for nutritional supplements.

A CMN is not required for recipients for whom Medicare is the primary insurance carrier and Medicaid is the secondary carrier. In those instances, if Medicare approves the DME item(s), the provider must bill on the DMAS-30 invoice. Medicaid will pay the appropriate deductible and/or co-insurance, and no CMN is needed for this Medicare crossover coverage. If the item(s) is not covered by Medicare and is covered by Medicaid, the fully completed CMN is required in order for Medicaid to pay as the primary carrier.

For private primary insurance where Medicaid is secondary payer, the CMN is required, even if it only applies to a co-payment. Medicare is the only exception where a CMN and preauthorization would not be required (e.g.: crossover claim).

DOCUMENTATION REQUIREMENTS FOR ALL DME

All items and supplies must meet the coverage criteria in Chapter IV of this manual and the Virginia Administrative Code. DMAS requires specific categories of items meet Interqual criteria. These categories are: adaptive strollers, nebulizers (including compressors), augmentative communication devices (AAC and speech generating devices), continuous passive motion devices, cranial molding orthosis, oxygen, hospital beds, insulin pumps, lower extremity orthosis (knee braces and immobilizers), lymphadema compression devices, manual wheelchairs, negative pressure wound therapy devices, CPAP and BiPAP devices, power wheelchairs and

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scooters, seat lift mechanisms (not lift chairs), secretion clearance devices, standing frames, support surfaces, TENS, wheelchair cushions and seating systems.

The above list is subject to change with Interqual updates and at the discretion of DMAS.

- The recipient meets Interqual criteria upon admission and continued stay. These criteria may be obtained through:

McKesson Health Solutions LLC
 275 Grove Street
 Suite 1-110
 Newton, MA 02466-2273
 Telephone: 800-274-8374

Fax: 617-273-3777
 website: mckesson.com or Interqual.com

Medical documentation must provide DMAS with a clear understanding of the recipient's needs. The following applies to the medical justification necessary for all DME services regardless of whether preauthorization (PA) is required. The documentation is necessary to identify:

- The medical need for the requested DME;
- The diagnosis related to the reason for the DME request;
- The recipient's functional limitation and its relationship to the requested DME;
- How the DME service will treat the recipient's medical condition;
- The quantity needed and the medical reason the requested amount is needed;
- The frequency of use;
- The estimated length of use of the equipment;
- Any conjunctive treatment related to the use of the DME or supplies;
- How the needs were previously met identifying changes that have occurred which necessitate the DME;
- Other alternatives tried or explored and a description of the success or failure of these alternatives;
- How the DME service is required in the recipient's home environment; and
- The recipient or caregiver's ability, willingness, and motivation to use the DME.

There must be a physician-generated diagnosis and treatment order which demonstrates the need for the item(s) and supporting documentation, especially for expendables which are beyond the established guidelines for use. If the recipient is enrolled in MEDALLION, the ordering physician must be the MEDALLION primary care physician (PCP), or there must be a referral for the service from the MEDALLION PCP. The PCP referral is valid as long as the CMN is effective, provided there is no change in the eligibility of the recipient or the PCP. This referral may be obtained in writing or orally and must be documented in the recipient's record. All covered services must be reasonable and medically necessary; recipient assessments may be required to determine that a particular treatment is reasonable and necessary. (12 VAC 30-50-165)

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If the amount requested exceeds the limit specified in the DME Listing/Appendix B, the provider must request preauthorization for those items exceeding the limit. The provider may supply the recipient with the amount of items up to the limit prior to obtaining preauthorization from DMAS for the overages. If the physician orders items or quantities that are not consistent with the standard in medical or nursing practice, supporting documentation must be provided to justify the order.

Specialized DME, such as hospital beds, specialized wheelchairs, augmentative communication devices, adaptive equipment, and rehabilitative therapy equipment, must be accompanied by a recipient assessment performed by a qualified therapist which details the recipient's functional abilities and disabilities, therapy goals, rehabilitation potential, suitability for use in the home environment, and how the equipment will be used in the recipient's home. (See the section of this chapter concerning specific documentation requirements). If in-home rehabilitative therapy equipment is ordered, the in-home therapy plan must be included.

For items that may be either used for the convenience of the caregiver or recipient or to treat or manage a medical condition (e.g., hospital beds), supporting documentation of the medical need and use of the equipment must be included. Medicaid does not cover items for restraint of the recipient or for the convenience or safety of the recipient, the family, the attending practitioner, other practitioners, or the supplier. (12 VAC 30-50-165)

Note: Supplies used during the course of the home visit by personnel of the home health agency are not subject to separate reimbursement by DMAS. These expendable medical supplies (e.g., gauze, cotton, and adhesive bandages, Foley catheters and Foley insertion trays) are included in the visit fee paid to the home health agency. The only supplies relative to the home health visit for which the DME provider may receive separate reimbursement are those supplies which remain in the home beyond the time of the visit to allow the recipient or caregiver to continue the treatment.

For recipients enrolled in Hospice, durable medical equipment as well as other self-help and personal comfort items related to the palliation or management of the recipient's terminal illness are covered by the hospice provider. Medical supplies include, but are not limited to, those supplies that are part of the written plan of care. Medical supplies and appliances must be provided as needed for the palliation and management of the terminal illness and related conditions by the hospice provider. The DME provider may not bill DMAS for these items.

SPECIFIC DOCUMENTATION REQUIREMENTS

In addition to the Medical Necessity guidelines described on page 2 of this chapter, and the previously described documentation requirements for all DME, specific medical justification and/or documentation requirements are in place for the following DME:

Hospital Beds

Describe all of the following: How the bed will be used to treat a medical condition; how needs have and are currently being met; the functional abilities/disabilities; other alternatives tried; and why a non-hospital bed would not meet the recipient's medical needs.

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Patient Lifts

Describe all of the following: the recipient's weight; identify the caregiver and his or her ability to use the lift; the recipient's functional limitations; how needs were previously met and what has changed in the recipient's condition to require the lift; and the home accessibility for the lift.

Wheelchairs and Components

Specialized wheelchairs must be accompanied by a comprehensive "hands on" evaluation completed by a health care professional with experience in fitting wheelchairs and making recommendations based on the individual recipient's need (specifically, physician, physical therapist, occupational therapist, or rehabilitation engineer in coordination with the physical therapist or occupational therapist). The physical therapy and/or occupational therapy wheelchair evaluation is a covered service that may be billed to DMAS. DMAS requires the assessment to be performed by a physical therapist or occupational therapist, especially for wheelchairs with specialized seating and positioning components and features, or for wheelchairs operated via specialty electronics. Specialized or customized wheelchairs may also include HCPCS codes in the DME list which do not require preauthorization, but that may require a physical therapist's and/or occupational therapist's evaluation. For all wheelchairs and components, the provider must identify all of the following:

- Document the diagnosis or condition requiring the wheelchair, AND how the requested wheelchair treats that diagnosis/condition.
- Document the diagnosis or condition requiring each requested component AND how the requested component treats that diagnosis/condition.
- Describe the distance (in feet) that the recipient can functionally ambulate with assistive devices if any.
- Describe upper and lower extremity strength/weakness in relation to the type of wheelchair/components requested.
- Identify problems with tone or spasticity in relation to the specific components/type of wheelchair requested.
- Describe the recipient's head and trunk control in relation to the specific components/type of wheelchair requested.
- Describe the recipient's ability/inability for self-propulsion in relation to the specific wheelchair/components requested.
- Identify how the recipient's needs have been unmet/met previously and what has changed in the recipient's condition to require a mobility device.
- If the recipient currently owns a wheelchair, describe the type of wheelchair, condition of the wheelchair (describe damage/cost to repair), and any special features included on the wheelchair.
- Identify cost-effective alternatives explored/tried and describe how these alternatives do not presently meet the recipient's medical needs within the home environment.
- Describe the home accessibility for the mobility device and how the requested mobility device is required within the recipient's home environment. (Documentation must indicate that the recipient is able to use the wheelchair within the home environment.)
- If requesting the wheelchair under a miscellaneous code, describe any special

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features that the requested wheelchair has that are not available on a standard, light weight, or high strength, light weight wheelchair for which Medicaid has an established HCPCS code; include size, construction, and weight restrictions, etc., as applicable.

- Documentation for powered mobility devices must describe how the recipient's needs cannot be met within the home environment in a manual wheelchair, i.e., a standard, light weight, or ultra light weight wheelchair.
- For special seats, backs, and cushions, document postural concerns, asymmetries, levels of sensation, history, or actual risk of skin breakdown; the length of time the recipient will be in the wheelchair per day; mobility impairments; and how all of these conditions relate to the need for the seating system/cushion requested.

Note: All items related to wheelchairs, including correct quantities, hardware, upgraded foam, labor, any item that is an upcharge, etc., must be ordered on the CMN, and justified either on the CMN or in attached, supporting, verifiable documentation, regardless of whether or not the item requires preauthorization. All supporting documentation must be recipient-specific and must be signed and dated by the physician.

If the recipient is enrolled in MEDALLION, the ordering physician must be the MEDALLION primary care physician (PCP), or there must be a referral for the service from the MEDALLION PCP. The PCP referral is valid as long as the CMN is effective, provided there is no change in the eligibility of the recipient or PCP.

The following wheelchair related items are not covered: mobility devices used in addition to the primary means of mobility; mobility devices not required for use primarily within the home environment, i.e., strollers, scooters, or wheelchairs for community use; wheelchairs for restraint purposes; and home or vehicle modifications, i.e., wheelchair ramps. (12 VAC 30-50-165)

Wound Care Supplies

Describe all of the following: The total number of wounds; the location, stage, size, depth, drainage, and color of each wound; who is providing the wound care (recipient, caregiver, home health nurse); the frequency of the wound care; and the complete physician's order for the wound care.

Additional documentation requirements for specific items may be found in the "Medicaid DME and Supplies Listing" in Appendix B and in the following pages describing specific coverage criteria.

SPECIFIC COVERAGE CRITERIA

Augmentative Communication Devices

DMAS will consider reimbursement for electronic or manual augmentative communication devices when the device is deemed medically necessary. Medical necessity will be determined by DMAS after reviewing all submitted documentation. Communication devices to improve educational and/or vocational abilities are not covered services by Medicaid. (12 VAC 30-50-

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One of the following criteria must be met before an augmentative communication device can be considered for approval:

- The recipient cannot functionally communicate basic needs verbally or through gestures due to medical conditions, and expressive language is not expected to be restored. Basic needs include eating, drinking, toileting, and indicating discomfort or pain; or
- The recipient cannot verbally or through gestures participate in medical care, i.e., indicate decisions regarding medical care or indicate medical needs; or
- The recipient cannot verbally or through gestures functionally communicate informed consent on medical decisions.

In accordance with the Virginia State Plan for Medical Assistance, all of the following must be met before an augmentative communication device can be considered for approval. The communication device must be:

- Ordered by the physician on the CMN/DMAS-352, and if the recipient is enrolled in MEDALLION, the ordering physician must be the MEDALLION PCP;
- A reasonable and medically necessary part of the recipient's treatment plan;
- Consistent with the recipient's diagnosis and medical condition, particularly the functional limitations and symptoms exhibited by the recipient;
- Not furnished solely for the convenience of the recipient, the family, the attending practitioner, or other practitioner or supplier;
- Consistent with generally accepted professional medical standards (i.e., not experimental or investigational); and
- Furnished at a safe, effective, and cost effective level, primarily for use in the recipient's home environment.

Requests for augmentative communication devices must be submitted on a DMAS-363 Outpatient Prior Authorization Request Form as described in Appendix D of this manual. . Requests must be accompanied by documentation of a systematic and comprehensive speech/language evaluation, completed by a speech-language pathologist licensed by the Department of Health Professions and signed and dated by the recipient's physician. If the recipient is enrolled in MEDALLION, the ordering physician must be the MEDALLION PCP, or there must be a referral for the service from the MEDALLION PCP. The PCP referral is valid as long as the CMN is effective, provided there is no change in the eligibility of the recipient or PCP. The speech-language pathologist may not be a provider of augmentative communication systems nor have a financial relationship with a provider/manufacturer.

A 30 to 60 day trial rental period must be considered for all electronic devices to assure that the

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chosen device is the one most appropriate to meet the recipient's medical needs. (Note: For those recipients whose needs can be clearly defined by the comprehensive speech-language pathologist's evaluation, a trial rental period is not necessary.) At the end of the trial rental period, if purchase of the device is recommended, documentation by the speech-language pathologist of the recipient's ability to use the communication device must be provided. The speech-language pathology documentation must show that the recipient's ability to use the device is improving and that the recipient is motivated to continue to use the device. If the communication device(s) supplied for the required two-month rental period is new upon delivery, DMAS will consider paying the full purchase price listed in the DME Listing in addition to the initial two-month rental period for these items.

The DMAS-352, speech/language evaluation, and/or other verifiable supporting documentation must include all the following:

- The complete physician's prescription for the augmentative communication device, including an itemization of the components (i.e., special switches, special mounting devices, etc.) required by the recipient;
- Documentation describing the recipient's medical condition/diagnosis, including a description of the recipient's disease, general prognosis, and prognosis for intelligible speech. (Is the condition permanent, temporary, or changing? Will this medical condition result in an increased or decreased need for a device in the future?);
- A description of how the recipient communicates medical needs now and how communication needs are currently unmet\met;
- Is the recipient cognitively/physically able and motivated to use an augmentative communication device? Documentation must include an assessment of the recipient's gross and fine motor skills, e.g., hand use skill, including finger dexterity;
- A description of related impairments including audio/visual, perceptual, and/or memory, that would limit his or her ability to use a device, or that would require the use of a particular augmentative communication device;
- A description of the plan to provide ongoing speech-language pathology training and support in the use of the communication device in the recipient's home and community; A list of other devices that have been tried by the recipient (describe the success/failure); a description of how the requested device better meets the recipient's medical needs than more cost-effective devices available;
- A description of the extent to which the recipient and/or family/caregivers are able to program and utilize the device; and
- Specific information about the device including: the manufacturer's name, catalog number, product description, a picture (if available), and documentation of the provider's cost, less any discounts available.

Collaborative Funding

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Based on House Joint Resolution 697 (1995), an effort should be made to promote the removal of identified barriers and seek to broaden and improve access to assistive technology devices and services to persons with disabilities, within the guidelines established in the Virginia Administrative Code. When the requested device is needed partially for medical purposes and partly for educational, vocational, or social needs, the communication assessment team must pursue the possibility of a collaboration of funding sources. In addition to DMAS, these funding sources might include the local school division, the Department of Rehabilitative Services, private foundations, the recipient's family/friends, and charities or other non-profit groups.

If the recipient/family requests to act as a funding source for portions of the device found to be "not medically necessary" and therefore, not covered by Medicaid, the DME provider must maintain documentation that the recipient/family was charged, per their request, for Medicaid non-covered services. However, the recipient/family may not be charged for services that are medically necessary and covered by Medicaid. The DME provider must accept Medicaid's payment as payment in full for services that are medically necessary and covered by Medicaid.

Once another funding source is identified, DMAS must be contacted to negotiate a collaborative funding formula. When pursuing collaborative funding of a device, the speech/language pathologist must include previously described documentation and must delineate which components are felt to be medically necessary and which are educational, vocational, etc. If a device is determined to be medically necessary, DMAS will approve the level of funding for a device that meets the recipient's medical needs. If a more complex device is required to meet the educational/social/vocational needs as well as the medical needs of the recipient, the remainder of the funding must be provided by an alternative funding source.

Each request for collaborative funding will be reviewed on an individual basis. The assessment team must notify DMAS as soon as possible of a situation that might require collaborative funding so that acquisition of the device by the recipient will not be delayed.

Payments toward funding of the device must be made directly to the provider and not to the recipient. Payments to the recipient may be viewed as "income" and could potentially affect the recipient's eligibility for Medicaid.

Although collaborate funding is primarily utilized for communication devices, there may be other DME for which collaborate funding is appropriate.

Assistive-Technology Equipment

Assistive-technology equipment includes, but is not limited to, recipient lifts, bath chairs, wall-mounted insulin delivery devices, and automatic feeder systems. All assistive-technology equipment must be medically necessary and essential for the treatment of illness or injury. Assistive technology equipment does not include home modifications (e.g., devices that are permanently affixed to the walls of the home such as grab bars, ramps, barrier free lifts, and widening of doorways); furniture and appliances not defined as medical equipment such as bathroom scales and hand-held shower devices; items that are not for the diagnosis and treatment of illness or injury or to improve the functioning of a malformed body part; and equipment when the primary function is vocationally or educationally related (e.g., computers and environmental control devices). (12 VAC 30-50-165)

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The following conditions must be met for DMAS to approve reimbursement of assistive-technology equipment. These conditions are applicable whether the equipment is for initial use or replacement. Approval may occur under one of the following categories:

1. Recipient-Based Outcomes (one of the following must be met):
 - An identified, realistic goal exists that makes necessary the use of the assistive-technology equipment for the treatment of the medical condition; or
 - Anticipated stabilization of the medical condition or progress toward goal achievement is clearly related to the use of the equipment.
2. Supportive Activities to Accomplish Outcomes (all of the following must be met):
 - Goal(s) must be a part of an active, rehabilitative, therapeutic plan of care in place at the initiation of the use of the equipment. The goal(s) must be realistic in that it is consistent with the recipient's cognitive, environmental, and physical status;
 - The recipient or caregiver demonstrates the ability cognitively, motivationally, and physically to effectively utilize the equipment toward goal achievement. Someone is available to regularly assist the recipient as necessary in the use of the equipment to facilitate progress toward the goal achievement;
 - Within the plan of care, documentation exists that other equipment and/or health care alternatives have been considered and rejected as not appropriate for the treatment of the medical condition;
 - The recipient does not have a deficient level of "energy" or other systemic condition (e.g., CHF, COPD) that adversely impacts the ability to participate in the use of the equipment; and
 - The equipment must reduce the need for other reimbursed health care such as personal care, private duty nursing, rehabilitation services, and/or home health services.

Blood Glucose Monitors

DMAS will reimburse for blood glucose monitors and associated supplies for recipients eligible for the DME program or EPSDT when all of the following criteria are met:

- The recipient has a condition that requires adjustment of insulin dosage based on at least daily blood glucose findings, or the recipient has clinically demonstrated unstable glucose readings and must report frequent findings to a physician for adjustment of hypoglycemic medications; and
- There must be written verification that the recipient and/or caregiver have participated

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in diabetic training (diet, medication, monitoring, etc.) and that the recipient and/or caregiver have demonstrated the ability to appropriately use the prescribed blood glucose monitor.

For Pregnant Women

DMAS will reimburse for blood glucose monitors and test strips for pregnant women suffering from diabetes for whom the physician determines nutritional counseling alone will not be sufficient to assure a positive pregnancy outcome (effective for dates of service on and after July 1, 1993).

The Certificate of Medical Necessity (CMN-352) is not required. However, the physician's orders for the blood glucose monitor and test strips and supplies must be documented on the Maternity Risk Screen form. This form is initiated/completed by the local health department clinic or the attending physician.

If the recipient is enrolled in MEDALLION, the ordering physician must be the MEDALLION PCP, or there must be a referral for the service from the MEDALLION PCP. The PCP referral is valid as long as the CMN is effective, provided there is no change in the eligibility of the recipient or the PCP.

Disposables to Carry Out Infection Control Procedures

The following recommendations regarding disposable items are based on current guidelines from the Centers for Disease Control. Disposable items, including, but not limited to, gloves, gowns, and masks, will be covered only when necessary to carry out universal precautions if the caregiver (e.g., family member) is in contact with the recipient's blood and/or other body fluids containing visible blood, or for the specific and medically documented symptoms of impaction.

For individuals enrolled in the Medicaid-funded Technology Assisted Waiver Program, non-sterile gloves may be used when performing tasks related to tracheostomy care, such as suctioning. The reason for this exception in the use of non-sterile gloves is to reduce the risk of coming in contact with blood and reducing the risk of infection. The Technology Assisted Waiver recipient is more susceptible to serious infection and possible repeated hospitalizations due to their fragile respiratory needs.

Disposable items will not be covered for use by the caregiver (e.g., family or provider agency) in carrying out routine infection control procedures (e.g., gloves to clean an incontinent recipient, handle soiled linen, clean or empty a bedside commode, empty a urinary drainage bag, or to bathe a recipient). (12 VAC 30-50-165)

DMAS will not provide reimbursement for items necessary to carry out either routine or universal precautions when the care is being supplied by a provider agency. The provider will be responsible for the provision of equipment and supplies necessary to minimize the risk of infection including the transmission of the HIV virus and other blood-borne pathogens.

Disposables Related to Incontinent Supplies

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DMAS will not provide reimbursement for the routine use of diapers for children under three years of age. Preauthorizations for diapers for children must be associated with a medical condition and will not be made solely because toilet training has not been accomplished.

The quantity of incontinence briefs per case may vary per manufacturer. DMAS has established minimum quantity requirements based upon an analysis of the industry standards. In order to bill for a case under the assigned HCPCS codes listed in Appendix B, the quantity per case provided must fall within or exceed the range listed in the comments section of the DME Listing. The case must be delivered as packaged by the manufacturer and cannot be opened and repackaged by the provider, due to sanitation reasons.

The CMN must include a description of the recipient's incontinent condition and the frequency of use to justify the quantity ordered by the physician. Additional medical justification is required for quantities requested beyond the established allowable limits and shall be individualized to each recipient. The provider shall contact and document the contact with the recipient/caregiver prior to the recertification CMN to assure that the quantity, frequency and product are appropriate.

Once medical necessity (i.e. incontinence) is established the decision to use tab diapers or pull-ups shall be left to the recipient/caregiver and documented by the provider on the CMN.

Unless the recipient has a specific medical need, in addition to incontinence, for using an underpad along with the incontinence briefs, DMAS will not provide reimbursement for underpads when used in conjunction with incontinent briefs since a washable pad serves the same purpose as the disposable underpad. (12 VAC 30-50-165)

Enteral Nutrition

Coverage of enteral nutrition, which does not include a legend drug, is limited to instances in which the supplement is the sole source of nutrition. Exceptions include those recipients authorized through the Technology-Assisted and AIDS Waivers. DMAS will reimburse under EPSDT for medically necessary formula and medical foods when used under a physician's direction to augment dietary limitations or provide primary nutrition to individuals via enteral or oral feeding methods. Coverage of oral administration does not include the provision of routine infant formulae. (12 VAC 30-50-165)

Effective 10/1/07, enteral nutrition for all children under age 21 is carved out of the MCO contract and is covered under the DMAS Fee-for-Service Program within the DMAS established criteria and guidelines.

“Sole source” means that the recipient is unable to tolerate (swallow or absorb) any other form of oral nutrition. “Primary source” means that nutritional supplements are medically indicated for the treatment of the recipient's condition if the recipient is unable to tolerate nutrients. The recipient may either be unable to take any oral nutrition or the oral intake that can be tolerated is inadequate to sustain life. The focus must be the maintenance of weight and strength commensurate with the recipient's medical condition.

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All of the following shall apply to the provision of enteral nutrition:

- Enteral nutrition shall be reimbursed only to enrolled DME providers. If a pharmacy is currently providing enteral nutrition, but is not enrolled as a DME provider, the pharmacy must become an enrolled DME provider in order to be reimbursed for services;
- Enteral nutrition shall be based on categories of nutritional components (refer to the DME Listing/Appendix B: Feeding Pumps, Nutritional Supplements, Feeding Kits and Tubes);
- The physician's order (the CMN) must specify either a brand name of the supplement being ordered or the category of enteral nutrition which must be provided. If a physician orders a specific brand of supplement, the DME provider must supply the brand prescribed. If the recipient is enrolled in MEDALLION, the ordering physician must be the MEDALLION PCP, or there must be a referral for the service from the MEDALLION PCP. The PCP referral is valid as long as the CMN is effective provided there is no change in the eligibility of the recipient or the PCP. The physician's order must include the daily caloric order and the route of administration for the supplement. Where applicable, existing Medicare codes and reimbursement rates will be utilized. An additional category has been added to include certain pediatric supplements that are not covered by Medicare;
- The physician's order (the CMN) is valid for a maximum of six months regardless of the recipient's age. A face-to-face nutritional assessment completed by trained clinicians (e.g., physician, registered nurse, or a registered dietitian) must be completed as required documentation of enteral nutrition for both the initial order and every six (6) months. The DMAS-115 Nutritional Status Evaluation Form (Revised 10/99) is required every six (6) months and contains the elements listed below. The only exception to completion of the DMAS-115 form is for enrollees with Heritable Disorders and Genetic Disease followed through a metabolic clinic. See below for documentation requirements for these enrollees.

General Population

The DMAS-115 form is required for all individuals receiving nutritional supplements, and the DMAS-115 must be signed and dated by the assessor within 60 days of the DMAS-115 begin service date. If the DMAS-115 is not signed and dated by the assessor within 60 days of the DMAS-115 begin service date, the DMAS-115 will not become valid until the date of the assessor's signature. (See the "EXHIBITS" section at the end of this chapter for a sample of the form). Note: Home health visits for the sole purpose of performing a nutritional assessment for recipients whose conditions are stable and chronic in nature will not be covered under the home health program;

- The Nutritional Status Evaluation Form/DMAS-115 must include all of the following elements:
 1. Height (or length for pediatric recipients);

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2. Weight (if unobtainable, may provide mid-arm circumference and triceps skinfold test data). For initial assessments, indicate the recipient's weight loss over time;
3. Formula tolerance (e.g., is the recipient experiencing diarrhea, vomiting, constipation?). This element is only required if the recipient is already receiving a supplement;
4. Tube or stoma site assessment, as applicable;
5. Indication of whether the supplement is the primary or sole source of nutrition;
6. Route of administration;
7. Section F must include the daily caloric order and the number of calories per package, can, etc.
8. Extent to which the quantity of the formula is available through WIC;
9. Title, signature, and date of the person completing the assessment; and
10. Physician signature and date in accordance with criteria for supporting documentation. See Chapters IV and VI of the Medicaid Durable Medical Equipment and Supplies Manual.

Enrollees with Heritable Disorders and Genetic Disease Followed Through a Metabolic Clinic--Nutritional Status Evaluation Documentation Requirements

In addition to the CMN requirements, a face-to-face nutritional assessment completed by trained clinicians (e.g., physician, registered nurse, or a registered dietitian) must be completed for both the initial order and every six (6) months.

For enrollees with Heritable Disorders and Genetic Disease followed through a metabolic clinic, an assessment is required every six (6) months that includes:

- The recipient's name
- Date of birth
- Diagnosis
- Height
- Weight
- Ideal body weight
- Identification of the supplement being the sole or primary source of nutrition
- The route of administration
- The daily caloric need of the requested formula for the recipient
- The category or specific supplement ordered
- The calories per can/package of the supplement ordered
- The name and title of the assessor
- The signature and date of the assessor
- Physician signature and date in accordance with criteria for supporting documentation." See Chapters IV and VI of this Manual.

Note: For recipients with Heritable Disorders and Genetic Disease followed through a metabolic clinic, an assessment is required every six (6) months. If the clinic uses another form, other than the DMAS-115 it must contain the above information. All other populations are required to use the DMAS-115 form.

Preauthorization of enteral nutrition is not required. The DME provider must assure that there is

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a valid physician's order (CMN) and DMAS-115 Nutritional Status Evaluation Form or as described above for recipients with heritable disorders and genetic disease completed every six months in accordance with DMAS policy and on file for any Medicaid recipient for whom enteral nutrition is provided. The DME provider is further responsible for assuring that enteral nutrition is provided in accordance with DMAS reimbursement criteria (e.g., sole source or primary source.) Upon postpayment review, DMAS will deny or retract reimbursement for any supplements that are not provided and billed in accordance with the criteria described in the manual.

For recipients under the age of five, the DME provider must have documentation from the Women, Infant, and Children Supplemental Food Program (WIC) regarding the extent of coverage of nutritional supplements through WIC. WIC offices will cover medically necessary formula through the DME program. Medicaid may cover any remaining amounts not covered by the WIC Program up to the current allowable reimbursement limits for nutritional supplements outlined in the DME Appendix B listing which appears at the end of this manual. DME providers will not duplicate formula provided by WIC offices.

Recipients in the AIDS/HIV Waiver must continue to have their enteral nutrition authorized as part of the AIDS Waiver authorization process.

The DMAS-352 (CMN) is required for all nutritional supplements and supplies regardless of whether or not the recipient is enrolled in a waiver program.

For recipients eligible for enteral nutrition, the DME provider must obtain and maintain all of the following information:

- The CMN;
- Nutritional Status Evaluation form (DMAS-115); or Nutritional Status Evaluation for enrollees with Heritable Disorders and Genetic Diseases as described above.
- A statement of eligibility for WIC services for children under the age of five.
- Delivery tickets for the items provided as described in Chapter VI of this manual
- Documentation of usual and customary charge (UCC) to the public for codes with 'UCC' listed in the Fee column of the Appendix B.

See the "Medicaid DME and Supplies Listing" in Appendix B for a current listing of the supplements covered by DMAS. If the supplement that has been ordered by the physician is not found on the list, contact the DMAS Provider HELPLINE. The Provider HELPLINE will assist the DME provider in obtaining a classification for all supplements not listed.

Early Periodic Screening Diagnosis and Treatment (EPSDT) Update

The Early Periodic Screening Diagnosis and Treatment (EPSDT) program allows the Virginia Department of Medical Assistance Services (DMAS) to provide medically necessary formula and medical foods to EPSDT eligible children under the age of 21 based on medical necessity. The current DMAS Durable Medical Equipment (DME) provider manual defines EPSDT formula approval criteria in Chapter 4 of that manual. Routine infant formula is not covered. DMAS will reimburse for medically necessary formula and medical foods when used under physician direction to augment dietary limitations or provide primary nutrition to individuals via

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enteral or oral feeding methods.

Medical formula and nutritional supplements must be physician recommended to correct or ameliorate a health condition that requires specialized formula and medical foods to supplement diet due to metabolic limitations or provide primary nutrition to individuals via enteral or oral feeding methods. Enrollees under the age of 5 may receive medical formula and nutritional supplements through either a local Women, Infants and Children (WIC) office or a DMAS enrolled DME providers. If the individual is enrolled in the WIC program, they also receive nutrition education services and checkups as well as referrals to other services that can help the family. Individuals enrolled in Medicaid may already financially qualify for WIC. When a local WIC office provides the formula for children under the age of 5 then the WIC program forms are used to document medical necessity.

To obtain formula through a DMAS enrolled DME provider, the physician must document medical necessity by using the Certificate of Medical Necessity (DMAS 352) and the Nutritional Status Evaluation (DMAS 115) form when the family uses a DME provider to provide the medical formula.

Provision of medically necessary formula and medical foods for children under the age of 21 is not required of DMAS contracted MCO's as this service is carved out from the DMAS Managed Care Contract.

Referral Process:

- The enrollee should contact their physician or metabolic treatment center to determine the medical need for medical formula or medical foods.
- Children under 5 years who require medical formula may use either DMAS DME providers or a local Women, Infants, and Children (WIC) office for dispensing the medical formula (individual must be enrolled in WIC to receive formula through WIC) .
- For all children aged below 5 years that are being served by the local WIC office, the physician will complete the required WIC documents for providing medical formula to WIC eligible children. WIC offices will provide the medical formula.
- Children aged 5 or older must receive medical formula and nutritional supplements through DMAS enrolled DME providers
- The Certificate of Medical Necessity (DMAS-352) and Nutritional Assessment (DMAS-115) forms must be completed by a regional metabolic treatment center or a primary care physician.
- Deliver the forms to the DME provider
- The DME provider will provide the formula according to the DME manual specifications and retain the DMAS 352 and nutritional assessment forms.
- Formula that is not priced in appendix B of the DME manual will be reimbursed at the amount of the provider's usual and customary charge.

Home Infusion Therapy

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Home Infusion Therapy is the intravenous (IV) administration of fluids, drugs, chemical agents, or nutritional substances to recipients in the home setting. DMAS will reimburse for the services, supplies, and drugs only when they are determined to be:

- Medically necessary to treat a recipient's medical condition;
- In accordance with accepted medical practice; and
- Not for the convenience of the recipient or the recipient's caregiver.

The recipient must:

- Reside in either a private home or a domiciliary care facility, such as an adult care residence. Recipients in hospitals, nursing facilities, rehabilitation centers, and other institutional settings are not eligible for this service;
- Be under the care of a physician who prescribes the home infusion therapy and monitors the progress of the therapy;
- Have body sites available for I.V. catheter or needle placement or have central venous access; and
- Be capable of self-administering or have a caregiver who can be adequately trained, is capable, and is willing to administer/monitor home infusion therapy safely and efficiently following the appropriate teaching and adequate monitoring. In those cases where the recipient is incapable of administering or monitoring the prescribed therapy, and there is no adequate or trained caregiver, it may be appropriate for a home health agency to administer the therapy.

Provider Eligibility

Providers must have a valid Medicaid provider number to participate in the home I.V. therapy program. Providers eligible to participate in this program are:

- I.V. therapy providers;
- Home health agencies;
- Pharmacies; and
- DME providers.

A provider must be enrolled as a Medicaid provider, to include all of the following:

- Meet any state licensing and certification requirements;
- Render infusion therapy covered services;

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- Use Medicaid-established billing guidelines; and
- Accept Medicaid reimbursement as payment in full.

Therapy Coverage

Medicaid has assigned a service day rate code and reimbursement rate for each of the covered therapies:

- Hydration therapy;
- Pain management;
- Chemotherapy;
- Drug therapy; and
- Total parenteral nutrition (TPN).

Service Day Rate Definition

This payment methodology provides a fixed amount for each day of infusion therapy. The service day rate (per diem) reimburses for all services delivered in a single day. This payment methodology will be mandatory for the reimbursement of all I.V. therapy services, unless the recipient is enrolled in one of the waived services outlined under “Special Considerations.” Service day rates are based on an average day of service, and there will be no additional reimbursement for special or extraordinary services. In the event of incompatible drug administration, the separate HCPCS code (see Appendix B of this Manual for the appropriate HCPCS Code to use) has been developed to allow for the rental of a second infusion pump and the purchase of extra administration tubing. When applicable, this code may be billed in addition to the other service day rate codes. There must be documentation to support the use of this code on the I.V. Implementation Form (DMAS-354). (See the “Exhibits” section at the end of this chapter for a sample of this form.) Proper documentation includes the need for pump administration of the medications ordered, the frequency of administration to support that they are ordered simultaneously, and an indication of incompatibility. The service day rate payment will be in two service categories: durable medical equipment (DME) and pharmacy.

Items in the DME service day rate include all supplies required to administer I.V. therapy, including, but not limited to, the:

- I.V. pump/pole rental/control devices;
- Tubings, adapters, caps, needles, filters, cannulas, extension sets, and alcohol swabs; and
- I.V. start kits and central venous catheter dressing kits.

Items in the pharmacy service day rate include the:

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- Diluent for the therapeutic agent;
- Mixing and compounding;
- Flush kits and solutions (heparin and saline); and
- Cassettes and bags/mini-bags.

See the DMAS Pharmacy Manual for instructions regarding billing pharmacy services day rate.

Drugs used in addition to I.V. therapy, such as intramuscular and subcutaneous injections (Compazine, insulin, etc.) and subcutaneous therapies for hydration and/or pain management, are not covered under the I.V. service day rate policy. These medications and their associated DME supplies must be ordered and billed separately according to current Medicaid guidelines.

Special Considerations

Providers of I.V. therapy services to those recipients enrolled in special or waived Medicaid programs must abide by all the guidelines of the program in which the recipient is enrolled.

Nursing Visits

Nursing visits for I.V. therapy are reimbursed under home health services. To receive reimbursement for the I.V. therapy nursing services, the provider must be a Medicaid home health provider with a valid home health provider number. If a nurse from a company that is a non-participating Medicaid home health provider acts as a “back up” for the nurse at the home health agency, the two companies must make arrangements between themselves for reimbursement. The home health visit reimbursement for all nursing services, includes but is not limited to, travel time, recipient education, and I.V. administration. A home health nurse must be present delivering a service that is deemed medically necessary in order to receive reimbursement. Supplies used by the nurse during the course of the home health visit for I.V. therapy, such as I.V. start kits, angiocaths, midline catheters, etc., will be reimbursed under the DME service day rate allowance to whichever provider furnishes the supplies.

Multiple Therapies

Multiple therapies of the same therapy are included in one service day rate of reimbursement. For example, if a recipient receives two antibiotics under drug therapy on the same day, the provider may only bill one service day rate for the DME and pharmacy services. In the event of incompatible drug administration, a separate HCPCS code has been developed to allow for the rental of a second infusion pump and the purchase of an extra administration tubing for each day of service. When applicable, this code may be billed in addition to the other service day rate codes. There must be documentation to support the use of this code on the I.V. Therapy Implementation Form (DMAS-354). Proper documentation includes the need for pump administration of the medications ordered, the frequency of administration to support that they are ordered simultaneously, and an indication of incompatibility.

Multiple therapies of different therapies under DME will be reimbursed at 100% for the most

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expensive therapy and 50% for the second and each additional therapy. For example, if a recipient receives chemotherapy, hydration, and pain management on the same day, the DME provider may bill \$44.00 for pain management, \$18.50 for chemotherapy, and \$15.00 for hydration, based on current rates.

Certificate of Medical Necessity (CMN)

The CMN must be completed for I.V. therapy DME services. The provider may fill out the CMN, but the physician must date and sign the CMN within 60 days of the begin date of service. If the recipient is enrolled in MEDALLION, the ordering physician must be the MEDALLION PCP, or there must be a referral for the service from the MEDALLION PCP. The PCP referral is valid as long as the CMN is effective, provided there is no change in the eligibility of the recipient or PCP.

DMAS will not reimburse the DME provider for any DME and supplies provided prior to the date of the physician's signature when the signature is not obtained within 60 days of the first date of service. Under the item/service and HCPCS code on the CMN, list the proper code and therapy service as well as the estimated length of time needed. The I.V. Therapy Implementation Form (DMAS-354) must be completed, signed, and dated by the physician within 60 days of the therapy start date. Additionally, a copy of the doctor's order for discontinuing the therapy must also be attached to each CMN and I.V. Therapy Implementation form upon completion of the therapy. The I.V. Therapy Implementation form must be initiated with the beginning of each drug and therapy service provided. The I.V. Therapy Implementation Form (DMAS-354) may be completed by the provider, but must be signed and dated by the physician. **DO NOT ATTACH EITHER THE I.V. THERAPY IMPLEMENTATION FORM (DMAS-354) OR THE CMN TO CLAIM REQUESTS.** DME providers must adhere to all requirements set forth in the *Virginia State Plan for Medical Assistance* and the DME provider manual and DME Medicaid Memos as they relate to the completion of the CMN and supporting documentation.

Hydration Therapy

Definition: Hydration therapy is the intravenous administration of fluids, electrolytes, and/or other additives.

The pharmacy service day rate includes, but is not limited to:

- Covered drugs: Electrolytes and flushes (heparin and saline); and
- Cassettes/bags/mini-bags, mixing, and compounding.

The hydration solution is billed on the most current version of the Daily Pharmacy Drug Claim Ledger (DMAS-173), Point-of-Service (POS) on-line billing, or approved electronic billing method.

The DME service day rate includes, but is not limited to:

- The I.V. pump/pole rental, administration sets, tubings, adapters, cannulas, extension

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sets, gloves, alcohol wipes, needles, dressing/start kits, etc.

Special Notes:

- There is no additional reimbursement for special or extraordinary services.
- The pharmacy service allowance includes containers (cassettes/bags/minibags) and flushes (heparin and saline).

Pain Management

Definition: Pain management is the intravenous administration of narcotics and other drugs to relieve pain.

The pharmacy service day rate includes, but is not limited to:

- Covered drugs: Diluent, electrolytes, and flushes (heparin and saline); and
- Cassettes/bags/mini-bags, mixing, and compounding.

The DME service day rate includes, but is not limited to: I.V. pump/pole rental, administration sets, tubings, adapters, cannulas, extension sets, remote reservoirs, needles, alcohol wipes, gloves, dressing/start kits, etc.

Special Notes:

- There is no additional reimbursement for special or extraordinary services.
- The pharmacy service allowance includes containers (cassettes/bags/minibags) and flushes (heparin and saline).

Chemotherapy

Definition: Chemotherapy is the administration of chemical agents designed to have a specific effect upon disease causing cells or organisms.

The pharmacy service day rate includes, but is not limited to:

- Covered drugs: Diluent, electrolytes, and flushes (heparin and saline); and
- Cassettes/bags/mini-bags, mixing, and compounding.

The DME service day rate includes, but is not limited to:

- The I.V. pump/pole rental, administration sets, tubings, adapters, cannulas, extensions sets, needles, alcohol wipes, gloves, dressing/start kits, spill kits, etc.

Special Notes:

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- There is no additional reimbursement for special or extraordinary services.
- The pharmacy service allowance includes containers (cassettes/bags/minibags) and flushes (heparin and saline).
- Multiple chemotherapies are included in the one service day rate.
- Hydration solutions may be billed separately.

Drug Therapy

Definition: Drug therapy is the intravenous administration of antibiotics or other drugs.

The pharmacy service day rate includes, but is not limited to:

- Covered drugs: Diluent, electrolytes, and flushes (heparin and saline); and
- Cassettes/bags/mini-bags, mixing, and compounding.

The DME service day rate includes, but is not limited to, the:

- I.V. pump/pole rental, administration sets, tubings, cannulas, extension sets, adapters, needles, remote reservoirs, alcohol wipes, gloves, dressing/start kits, etc.

Special Notes:

- There is no additional reimbursement for special or extraordinary services.
- The pharmacy service allowance includes containers (cassettes/bags/minibags) and flushes (heparin and saline).
- Multiple drug therapies are included in the one service day rate.

TPN

Definition: TPN is the administration of nutritional substance by intravenous infusion to nourish recipients who are malnourished or may develop malnutrition and who are not candidates for enteral support.

The pharmacy service day rate includes, but is not limited to:

- Covered drugs: Diluent, electrolytes, nutritional additives, lipids, and flushes (heparin and saline); and
- Cassettes/bags/mini-bags, mixing, and compounding.

The DME service day rate includes, but is not limited to:

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- I.V. pump/pole rental, administration sets, tubings, cannulas, extension sets, adapters, needles, alcohol wipes, gloves, dressing/start kits, etc.

Special Notes:

- There is no additional reimbursement for special or extraordinary services.
- The pharmacy service allowance includes containers (cassettes/bags/minibags) and flushes (heparin and saline).
- The pharmacy service allowance includes solutions, additives (such as KCL and MVI), and lipids. Insulin is an example of a medication that may be billed separately with TPN therapy.

Post-Payment Review

The Medicaid Program must ensure that only medically necessary I.V. therapy is provided to Medicaid recipients. For DME services, I.V. therapy providers must maintain records that contain the fully completed CMN, signed and dated by the physician; the I.V. Therapy Implementation Form (DMAS-354), with the begin and end dates for each drug/therapy provided and signed and dated by the physician; and the order to discontinue the therapy (the official end date), signed and dated by the physician. These forms shall be furnished to DMAS staff or its contractors upon request. The absence of documentation to support I.V. therapy services may result in the retraction of moneys.

Codes for Use with Purchased I.V. Pumps

For those cases where a recipient owns an I.V. pump for the long-term administration of I.V. therapy, two DME codes have been created to reimburse for service day rate services.

Use HCPCS code defined in Appendix B of this Manual for those recipients who own their own IV pump and require IV drug therapy. The reimbursement does not include the pump rental, but does include an allowance for battery reimbursement.

Use HCPCS code as defined in Appendix B of this Manual for those recipients who own their own I.V. pump and require TPN therapy. The reimbursement does not include the pump rental, but does include an allowance for the battery reimbursement.

Code to Use for Incompatible Drug Therapy

In the event of incompatible drug administration, the provider may bill the rental of a second infusion pump for each day of service and extra administrative tubing. There must be documentation to support the use of this code on the I.V. Therapy Implementation Form (DMAS-354). Proper documentation includes the need for pump administration of the medications ordered, the frequency of administration to support that they are ordered simultaneously, and an indication of incompatibility.

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Equipment Repairs

The cost to repair rental equipment is considered the DME provider's responsibility. Therefore, rental repair charges, caused by normal wear and tear, abuse, or neglect, may neither be billed to DMAS nor to the recipient. All HCPCS codes listed in Appendix B must have a CMN physician order, including equipment repairs.

Charges for repair(s) to medically necessary, recipient owned equipment may be billed to DMAS using the proper DMAS HCPCS code. The provider should document in the recipient record if the equipment is recipient owned. If the repair cost is less than the rate paid under the appropriate HCPCS code as defined in Appendix B of this Manual, and the repair is done by the DME provider, the DME provider must bill DMAS under the miscellaneous parts/repair code and the labor code as applicable. If the cost of the repair parts exceeds the rate paid under the appropriate HCPCS code, or if the repair requires that the item be shipped to the manufacturer, the provider must use the miscellaneous (E1399) HCPCS code, and preauthorization is required.

The provider must accept Medicaid payment as payment in full and may not bill the recipient for any portion of the repair, including shipping and handling charges. Costs incurred for shipping and handling, except when otherwise noted, are considered to be a part of the DME provider's overhead/business expenses. If the repair is covered under warranty, the provider serving the recipient's DME needs is responsible for the cost of shipping and handling. If a provider accepts a Medicaid recipient as a client, the provider must provide all of the DME services that are provided to the general population.

Rehabilitative Equipment

Rehabilitation equipment includes, but is not limited to, tilt tables, prone standers, parallel bars, and balance balls. This equipment is designed to bring a recipient into an upright position or to stimulate vestibular function, or to stimulate balance.

The following conditions must be met for DMAS to approve reimbursement of these types of rehabilitation equipment. These conditions are applicable whether the equipment is for initial use or replacement. (12 VAC 30-50-165)

1. Recipient-Based Outcomes (at least one of the following must be met):
 - An identified, realistic goal of functional ambulation exists and/or the recipient has achieved progressive mobility goals at the time the equipment is requested (i.e., the recipient is able to come from supine to sit, able to maintain dynamic sitting balance, and to right balance; the recipient is actively pursuing ambulation goals; and there is a reasonable expectation the goal(s) will be achieved, such as with the use of tilt tables, prone standers, etc.); or
 - An identified goal of a level of functional independence in activities of daily living exists, the achievement of which depends upon the recipient's maintaining an upright position in order to maximize the use of the upper extremities and/or to increase visual/perceptual integration, such as with the use of tilt tables, prone standers, etc.; or

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- An identified goal of a level of functional independence in ambulation and/or activities of daily living exists, the achievement of which is dependent upon the stimulation of vestibular function, balance, and/or neurodevelopmental progression, such as with the use of balance balls, etc.
2. Supportive Activities to Accomplish Outcomes (all of the following must be met):
- Goal(s) must be part of an active, rehabilitative, therapeutic plan of care in place at the initiation of use of the equipment. The goal(s) must be realistic in that it is consistent with the recipient's cognitive, environmental, and physical status;
 - The recipient and/or caregiver demonstrates the ability cognitively, motivationally, and physically to effectively utilize the equipment toward goal achievement. Someone is available to regularly assist the recipient as necessary in the use of the equipment in order that progress toward goal achievement can occur;
 - The recipient does not have a deficient level of "energy" or other systemic condition (e.g., CHF, COPD) that adversely impacts the ability to participate in the use of the equipment; and
 - The equipment must reduce the need for other reimbursed health care such as personal care, private duty nursing, rehabilitation services, and/or home health services.

Respiratory Equipment and Services

Apnea Monitors

Apnea monitor usage for recipients with one of the following diagnoses or identified high-risk conditions may be approved for payment if the diagnosis/condition is supported with a completed CMN and includes appropriate supporting and verifiable documentation:

- Apparent life-threatening episode(s), i.e., gastro esophageal reflux, severe; apnea; seizures; cardiac arrhythmias;
- Apnea of prematurity;
- Bronchopulmonary dysplasia/chronic lung disease of infancy with oxygen dependency;
- Respiratory control disorder such as: congenital hypoventilation, obstructive sleep apnea, central apnea, obstructive airway disease;
- Infant or child with tracheostomy;
- Infant of drug-dependent mother, symptomatic for apnea;
- Sibling of SIDS (payment will be made for six months from birth or up to one month beyond age of sibling at time of death); and
- Congenital anomalies, at risk of airway obstruction.

If the recipient does not have any of the above diagnoses, the request will be reviewed in accordance with the following criteria:

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Criteria for Home Monitoring

The instrument recommended for home use must monitor both cardiac and respiratory status. Apnea mattresses or displacement pads are not covered. The recipient may use either the recording or non-recording monitor. At least one of the following must be evidence for an initial and/or ongoing continued use, with appropriate, supporting, individualized documentation:

- Observed or recorded episode of prolonged apnea with no identifiable and/or treatable cause, or an inadequate response to treatment; or
- Documented apnea associated with bradycardia, cyanosis, or pallor; or
- History of apnea described by parent or caretaker and documented in the medical records; or
- Evidence of abnormal respiratory control.

Guidelines for Discontinuation of Monitor Reimbursement

Initial approval for payment will be for a period up to four months (120 days). If continued use is indicated by medical necessity, supporting and verifiable medical documentation must be submitted to DMAS for review and preauthorization.

Reimbursement for apnea monitors will be discontinued when a clinical evaluation (including neurological, developmental, and physical examinations) shows that the initial problems or conditions requiring the monitor have been resolved or stabilized. Reimbursement will be discontinued when one of the following scenarios occurs:

- The recipient has been free of events requiring stimulation or resuscitation for 2-4 months; or
- The recipient has experienced significant stressors such as respiratory illness or immunizations without apnea; or
- There is normalization of a previously abnormal respiratory pattern or no prolonged apnea episodes for 2-4 months.

Pneumograms/Downloads, Polysomnograms, and Multi-Channel Sleep Studies

Definitions:

A pneumogram is a 2-channel study of breathing and heart rate, including EKG signal and chest wall movement. A download serves the same purpose as a pneumogram if the recipient is monitored on a recording apnea monitor.

A multi-channel sleep study contains three or more signal sources that may include: cardiac EKG signal, respiratory air flow, body position, oximetry, esophageal pH, and quantitative end tidal CO₂.

A polysomnogram includes cardiac EKG signal, respiratory chest wall movement, respiratory abdominal wall movement, respiratory air flow, body position, oximetry, esophageal pH, and quantitative end tidal CO₂, EEG x2, EOG x2, and EMG, attended by a technologist.

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Reimbursement for these studies will be considered by DMAS based on the number of channels in the study. Criteria for determining the number of appropriate channels to be studied must be determined by the attending or ordering physician.

Documentation on the CMN must specify the number of signals, what signals are to be done and whether or not interpretation is to be done. Documentation must also include the download findings and a wave form analysis. A summary report of the study must be maintained at the provider's location.

If a recording monitor is being used and downloaded, a pneumogram is not needed to document the continuing need for the monitor. This information will be obtained from the download summary report. Should a recipient with a recording monitor need a pneumogram, the DME provider must submit a request for preauthorization.

Documentation Requirements for Reimbursement of Apnea Monitors and Diagnostic Studies:

For the initial 120 days which do not require preauthorization, there must be a Certificate of Medical Necessity (CMN) stating the recipient's diagnosis that indicates the need for a monitor or a description of the recipient's condition. If the recipient is enrolled in MEDALLION, the ordering physician must be the MEDALLION PCP, or there must be a referral for the service from the MEDALLION PCP. The PCP referral is valid as long as the CMN is effective, provided there is no change in the eligibility of the recipient or PCP.

The following documentation is required for the continued use of an apnea monitor over 120 days (both 1 and 2):

1. A CMN and documentation outlining the condition of the recipient related to apnea in the previous 120 days of monitoring, including all of the following:
 - a) The dates and the number of occurrences of observed apnea;
 - b) An interpretation of any related diagnostic tests;

For example: an upper GI series for GE reflux; pneumograms or downloads for recording apnea monitors, that are interpreted and indicate the child had clinically significant apnea during the first 120 days and/or the condition is resolving;
 - c) Download reports with clinical interpretation from recording monitors. The physician is encouraged to order a pneumogram for those children on non-recording apnea monitors in order to document the clinical status;
 - d) Adequate and verifiable documentation of the oxygen flow rate for those recipients who continue on oxygen; and
 - e) Adequate and verifiable documentation of the month of death of any sibling who expired due to Sudden Infant Death Syndrome (SIDS) if the child was placed on the monitor for this reason.

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2. A comprehensive history and record of physical examination, with appropriate work-up including specific pulmonary studies as indicated (i.e., sleep airway studies and fluoroscopy, transcutaneous oxygen, pulse oximetry, recording monitor download analysis, and carbon dioxide monitor findings or pneumogram studies).

The provider must submit a clinical description to DMAS staff of what happened during the first 120 days and why the monitor continues to be needed. This description is comprised of a history and physical, interpreted downloads or pneumograms that show a test history, indication of special considerations (need for oxygen, need to receive immunization stressors, need to reach significant age for a sibling of SIDS), and a physician's assessment of what happened during the first 120 days of monitoring to warrant continued use. It is the responsibility of the recipient's physician to interpret the data. It is the responsibility of the provider to obtain the interpretation from the physician and submit the interpretation to DMAS.

Documentation for pneumograms, polysomnograms, and multi-channel sleep studies must specify the number of signals, what signals are to be done, and whether or not interpretation is to be done. Documentation must include the download documentation and a wave form analysis.

Criteria for Rental Versus Purchase of an Apnea Monitor

DMAS does not require preauthorization for the initial 120 days of use. If the physician determines that the recipient will need the apnea monitor beyond 120 days, but less than eight (8) months, the DME provider must obtain preauthorization for continued rental from the DMAS preauthorization contractor. To obtain preauthorization, the DME provider must submit supporting documentation for the additional time requested. If the physician determines that the recipient will need the apnea monitor eight (8) months or longer, the DME provider must request purchase of the apnea monitor. This request must include supporting documentation at the initiation of service or at the time of determination of long-term usage. At the time of purchase, the DME provider is required to provide a new monitor with a full manufacturer's warranty. (12 VAC 30-50-165))

Non-Compliant Behavior

The provider shall document the non-compliant use of the apnea monitor in the recipient's file. Non-compliant use of the apnea monitor by the recipient or the recipient's caregiver is a refusal to provide care necessary for the child's health and creates a substantial risk of death for the child. The provider shall report non-compliant behavior to the attending physician or health care professional. There shall be compliance with 12 VAC 30-50-165. DMAS shall continue to reimburse for the monitor while reasonable efforts to ensure compliant behavior are taken.

Service Maintenance Agreements for Purchased Apnea Monitors

Use the appropriate HCPCS code which covers the service and maintenance of purchased apnea monitors and requires preauthorization. The service maintenance agreement will allow for trouble-shooting and download visits (18 visits per six [6] months). Downloading can be done during a trouble-shooting visit. The provider can utilize these 18 visits for any combination of trouble-shooting or download visits. (See the "Medicaid DME and Supplies Listing" in Appendix B for the allowable limits and reimbursement information.)

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Providers must agree to send the purchased monitor to the manufacturer for necessary servicing. The cost for servicing, shipping, and handling is covered in HCPCS code and preauthorization is required. A copy of the manufacturer's invoice for servicing must be attached to the claims invoice. The claim invoices will pend for manual review before reimbursement is made.

The service maintenance agreement does not include repairs. All repairs must be requested under the established HCPCS code for repairs.

All of the following services must be included as part of the service maintenance agreement:

- The provider agrees to employ or contract with staff who are available to make timely necessary home visits related to the use of the apnea monitor. The provider must assure that the staff is qualified to render the necessary services;
- The provider agrees to perform routine maintenance of the apnea monitor in the home, replacing rib belts, lead wires, and electrodes (disposable or reusable) associated with this routine maintenance. Supplies that must be provided under this agreement are:
 - 12 disposable electrodes or 2 reusable electrodes
 - 2 leadwires, and 2 rib belts.

Additional supplies that are medically justified must be preauthorized;

- The costs for trouble-shooting and download visits will be included in the service maintenance agreement fee (18 visits per six [6] months). Downloading can be done during a trouble-shooting visit. These 18 visits can be used by the provider for any combination of trouble-shooting or download visits;
- The provider agrees to provide a back-up apnea monitor throughout the period of apnea monitor repairs or services. The provider may bill DMAS for a rental apnea monitor for up to one month during routine repairs/services using the established HCPCS code. The rental must only be for the actual time the monitor is out of the home being serviced by the manufacturer;
- The cost of parts which constitute a repair must be billed separately, as a repair, using the established HCPCS codes for repairs; and
- The provider agrees to send the apnea monitor for necessary servicing by the manufacturer. The cost for servicing, shipping, and handling will be covered in a separate HCPCS code. The provider must attach a copy of the CMN and manufacturer's invoice to the claim in order for the claim to be paid. DMAS will pend claims for this HCPCS code for manual review.

CO₂ Monitors

CO₂ monitors are typically used for ventilator dependent recipients in the acute care setting, often in conjunction with a pulse oximeter. Their use is typically required in conjunction with a

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sleep study in conjunction with efforts to wean recipients from ventilator use. Continuous use of the CO₂ monitor in the home has not been demonstrated to be medically necessary, and its use by non-skilled caregivers to change ventilator settings is not advisable. Coverage is available only in certain limited circumstances for the cost of conducting a capnograph study, when ordered by the physician.

CO₂ studies will be approved for the purpose of weaning from a ventilator or for recipients who have a history of CO₂ retention which requires periodic monitoring. These studies will not be approved for obstructive sleep apnea. All requests must be preauthorized. The DME provider must obtain a CMN, completed by the physician who treats the recipient's pulmonary condition. If the recipient is enrolled in MEDALLION, the ordering physician must be the MEDALLION PCP, or there must be a referral for the service from the MEDALLION PCP. The PCP referral is valid as long as the CMN is effective, provided there is no change in the eligibility of the recipient or PCP. The CMN must address the reason for the study, the length of time the study will require, and the frequency requested within the six-month preauthorization period. Two nights will be the maximum length of the study which will be reimbursed. The CO₂ monitor reading must be submitted to the physician for assessment, and the physician must report back to the DME provider regarding any changes to be made based upon the physician's evaluation of the reading taken. Requests for further studies after the first request must include documentation of the progress toward weaning or evidence of continued CO₂ retention. If the physician does not indicate that progress toward weaning is shown or can be expected, the request may be denied.

The amount of reimbursement for the CO₂ study will depend on whether DMAS is reimbursing for the professional component necessary to assure an accurate reading is obtained. For a recipient receiving in-home nursing care (e.g., Technology-Assisted Waiver recipients), the health care coordinator will discuss with the nursing agency and DME provider whether the private duty nurse is knowledgeable and comfortable with the use of the equipment for the study. If the nurse is able to assure an adequate reading, the DME provider will be reimbursed for the cost of the delivery of the equipment, a one-day rental of the equipment, and a scoring fee for the CO₂ study. If the nurse is not able to assure the accurate reading, or the recipient does not receive nursing services during the time the study would be conducted, DMAS reimbursement will be limited to the time spent by the respiratory therapist, who must be present during the entire period of the study (8-10 hours), rental of the equipment for one day, and the scoring fee. In all cases, the CO₂ monitor must be equipped with a printer, and the DME provider must send the results of the study to the physician for interpretation.

Humidification Systems

DMAS will reimburse for an aerosol humidification system when the recipient's upper airway is bypassed. A vapor phase humidification system will be reimbursed when the recipient is on a ventilator. The components of the aerosol system are:

- Reusable dry nebulizer;
- Water trap;
- Compressor;
- Swivel adapter; and
- Corrugated tubing.

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A disposable dry nebulizer will only be considered for reimbursement when it is expected that the need for the humidification system will be short-term; (it is expected that the tracheostomy will be closed).

A vapor phase humidification system will be considered for reimbursement for treatment of humidity deficit for a recipient with a tracheostomy only when there is justification for the necessity of this device versus an aerosol humidification system, and the aerosol humidification system is documented as contraindicated.

All humidification systems must be purchased except in those instances when humidification is expected to be required for less than nine months. Reimbursement will be a bundled rate for all the components of the system.

Oxygen

DMAS provides reimbursement to DME providers for medically necessary respiratory/oxygen equipment and supplies. Any respiratory/oxygen equipment and supplies must be physician-ordered via the CMN. The flow rate, frequency, and duration of use (an order for PRN use of oxygen must identify the circumstances under which oxygen is to be used) must be identified on the CMN as part of the physician's order. For portable systems, documentation must provide a description of the activities in which the recipient participates, on a regular basis, that require a portable system in the home, and the therapeutic purpose served by that portable system that cannot be met by a stationary system. Coverage of home oxygen and oxygen equipment will be considered reasonable and necessary only for recipients with significant hypoxemia who evidence the following laboratory results, health conditions and for whom the required medical documentation exists. (12 VAC 30-50-165)

Medical Documentation

While there is no substitute for oxygen therapy, it is appropriate that each recipient should receive optimum therapy before long-term home oxygen therapy is ordered. The physician must have examined the recipient recently (within 30 days of the start of therapy). If the recipient is enrolled in MEDALLION, the ordering physician must be the MEDALLION PCP, or there must be a referral for the service from the MEDALLION PCP. The PCP referral is valid as long as the CMN is effective, provided there is no change in the eligibility of the recipient or PCP.

The CMN must include all of the following:

- A diagnosis of the disease requiring home use of oxygen;
- The oxygen flow rate; and
- An estimate of the frequency, duration of use (e.g., 2 liters per minute, 12 hours a day) and duration of need (e.g., six months or lifetime). Oxygen that is ordered PRN must include justification to determine the amount of oxygen that is reasonable and necessary for the recipient.

The physician must also specify the type of oxygen delivery system to be used (i.e., gas, liquid, or concentrator). If the type of system is not specified, the provider must provide services in the most cost-effective manner to carry out the physician's order and meet the needs of the recipient.

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The physician must submit a new CMN whenever there is a revision to the oxygen requirements based on a change in condition and the subsequent need for oxygen therapy. In the absence of any revision, the CMN authorization is valid for a 12-month period for adults and six months for children. The physician may only certify the need for oxygen therapy if the recipient has been examined by a physician within the past 12 months.

Laboratory Evidence

The CMN must also include the results of a blood gas study ordered and evaluated by the attending physician. This will usually be in the form of a measurement of the partial pressure of oxygen (PO₂) in arterial blood. A measurement of arterial oxygen saturation obtained by ear or pulse oximetry, however, will also be acceptable when ordered and conducted by a qualified provider or supplier of laboratory services and evaluated by the attending physician. The conditions under which the laboratory tests are performed must be specified in writing and submitted with the CMN (i.e., at rest, while sleeping, while exercising, on room air, or if while on oxygen, the amount, body position during testing, and any similar information necessary for interpreting the evidence).

In situations when the arterial blood gas and the oximetry studies are both used to determine the medical need for home oxygen therapy and the results are conflicting, the arterial blood gas study is the preferred source for this determination.

A DME supplier is not considered a qualified provider or supplier of laboratory services for purposes of these guidelines. This prohibition does not extend to the results of an arterial blood gas test conducted by a hospital certified to do such tests. The preferred sources of laboratory evidence are existing physician and/or hospital records that reflect the recipient's medical condition. If more than one arterial blood gas test is performed during the recipient's hospital stay, the test result obtained closest to the hospital discharge date must be submitted. The attending physician's statement of recent hospital test results are acceptable in lieu of copies of the actual hospital records.

A DME provider may be the provider of pulse oximetry services, in accordance with the established DMAS pulse oximetry criteria, for a recipient with a progressive disease who may require oxygen at night. The overnight pulse oximetry study must be ordered by the physician, and the DME provider must send a copy of the pulse oximetry readings to the attending physician for interpretation. If the physician determines that oxygen therapy is medically indicated, the oximetry test results and the physician's order for oxygen therapy must be recorded on the CMN. DMAS will reimburse the DME provider for the oxygen therapy as ordered by the physician, and in accordance with the coverage criteria for oxygen therapy.

If the recipient is enrolled in MEDALLION, the ordering physician must be the MEDALLION PCP, or there must be a referral for the service from the MEDALLION PCP. The PCP referral is valid as long as the CMN is effective, provided there is no change in the eligibility of the recipient or PCP.

A repeat arterial blood gas or oximetry study will normally be necessary only when evidence indicates that a recipient receiving oxygen has undergone a major change relevant to the home use of oxygen. For example, if there has been a significant increase in the amount of oxygen required (e.g., an increase to more than 4 liters per minute), a repeat blood gas or oximetry study

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may be necessary.

Health Conditions

Coverage is available for recipients with significant hypoxemia in a chronic and stable state if the following three conditions are met:

1. The physician has determined that the recipient has one of the following health conditions:
 - A severe lung disease, such as chronic obstructive pulmonary disease (COPD), diffuse interstitial lung disease of known or unknown etiology; cystic fibrosis, bronchiectasis; and symptoms of widespread pulmonary neoplasm; or
 - Hypoxia-related diagnoses or symptoms that might be expected to improve with oxygen therapy. Examples of these are pulmonary hypertension, recurring congestive heart failure (CHF) due to chronic cor pulmonale, erythrocytosis, impairment of cognitive processes, nocturnal restlessness, and morning headache.
2. The recipient meets the blood gas evidence requirements in Groups I-III:

Group I: Coverage is provided for recipients with significant hypoxemia evidenced by at least one of the following:

- An arterial PO₂ at or below 55 mm Hg, or an arterial oxygen saturation at or below 88%, taken at rest, breathing room air (an oxygen saturation at or below 94% is an acceptable level for children).
- An arterial PO₂ at or below 55 mm Hg, or an arterial oxygen saturation at or below 88%, taken during sleep for a recipient who demonstrates an arterial PO₂ at or above 56 mm Hg, or an arterial oxygen saturation at or above 89%, while awake; or a greater than normal fall in oxygen level during sleep (a decrease in arterial PO₂ more than 10 mm Hg, or a decrease in arterial oxygen saturation more than 5%) associated with symptoms or signs reasonably attributable to hypoxemia (e.g., impairment of cognitive processes and nocturnal restlessness or insomnia). In either of these cases, coverage is provided only for nocturnal use of oxygen. For children, the arterial oxygen saturation levels would be at or below 94%, taken during sleep for a recipient who demonstrates an arterial oxygen saturation at or above 95%, while awake.
- An arterial PO₂ at or below 55 mm Hg, or an arterial oxygen saturation at or below 88%, taken during exercise for a recipient who demonstrates an arterial PO₂ at or above 56 mm Hg, or an arterial oxygen saturation at or above 89%, while at rest. In this case, supplemental oxygen is provided during exercise if there is evidence that the use of oxygen improves the hypoxemia that was demonstrated during exercise when the recipient was breathing room air. For children, the arterial oxygen saturation levels would be at or below 94%, taken during exercise for a recipient who demonstrates an arterial oxygen saturation at

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or above 95%, while at rest.

Group II: Coverage is available for recipients whose PO₂ is 56-59 mm Hg or whose arterial blood oxygen saturation is 89%, if there is evidence of:

- Dependent edema suggesting cor pulmonale.
- “P” pulmonale on EKG (P wave greater than 3 mm in standard leads II, III, or AVF).
- Erythrocythemia with a hematocrit greater than 56%.

Group III: Coverage of home oxygen must be preauthorized by DMAS for recipients with arterial PO₂ levels at or above 60 mm Hg or whose arterial blood oxygen saturation is at or above 90% (or at or above 95% for children.) The physician must submit documentation, in addition to the CMN, which specifies why oxygen is medically necessary.

3. The recipient has appropriately tried other alternative treatment measures without demonstrable success or other forms of treatment have not been tried, but oxygen therapy is needed as part of the recipient’s initial treatment.

Conditions for which oxygen therapy is not covered are:

- Angina pectoris in the absence of hypoxemia. This condition is generally not the result of a low oxygen level in the blood, and there are other preferred treatments.
- Breathlessness without cor pulmonale or evidence of hypoxemia. Although intermittent oxygen is sometimes prescribed to relieve this condition, it is potentially harmful and may be psychologically contraindicated.
- Severe peripheral vascular disease resulting in clinically evident desaturation in one or more extremities. There is no evidence that increased PO₂ will improve the oxygenation of tissues with impaired circulation.
- Terminal illnesses that do not affect the lungs.
- Treatment of headaches, including migraines.
- Treatment of other conditions in which oxygen therapy is determined to be experimental or investigational.

If the recipient is enrolled in MEDALLION, the ordering physician must be the MEDALLION PCP, or there must be a referral for the service from the MEDALLION PCP. The PCP referral is valid as long as the CMN is effective, provided there is no change in the eligibility of the recipient or PCP.

DMAS will not provide reimbursement for respiratory/oxygen equipment and supplies which do

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not meet medical necessity guidelines. Furthermore, DMAS will not provide reimbursement for oxygen and equipment which is not being used by the recipient, regardless of the medical necessity. The DME provider must monitor utilization and report to the physician when oxygen is not being used as prescribed. This notification must be in writing, and a follow-up must be submitted to DMAS which shows that either the recipient has resumed compliance with medical orders or continues to be non-compliant. If non-compliance continues, DMAS will notify the recipient of the effective date that coverage of the oxygen will cease.

DMAS reimburses for an oxygen set-up based upon the amount of oxygen used, prescribed liter flow rate, and whether humidification is used. The rate does not vary according to the type of oxygen system: concentrator, liquid system, or gaseous system. There are three reimbursement rates for oxygen set-ups, based upon the prescribed liter flow rate. The reimbursement is for daily rental of the system (with or without humidification) which includes:

- Oxygen set-up;
- Nasal cannulas;
- Extension tubings; and
- Bubble bottle for humidification, if needed.

A separate portable oxygen code can be used for reimbursement for portable oxygen, up to a maximum of 24 portables in a year without preauthorization. Documentation must provide a description of the activities in which the recipient participates on a regular basis that require a portable system in the home, and the therapeutic purpose served by that portable system that cannot be met by a stationary system.

DMAS does not cover oxygen analyzers.

Pulse Oximetry (Continuous Pulse Oximeter Utilization)

Coverage for daily pulse oximetry may be available when ordered by a physician who can document that the recipient meets one of the following criteria:

- The recipient is dependent on both a ventilator and oxygen; or
- The recipient has a tracheostomy and is oxygen dependent; or
- The recipient has a tracheostomy and is unable, due to some factor such as age, developmental delay, cognitive status, or neuromuscular involvement, to summon assistance thereby placing the recipient at risk of obstruction of the tracheostomy; or
- The recipient requires supplemental oxygen and has unstable saturations. The desired saturation level will depend on the recipient's diagnosis and must be documented by the physician at the time continuous pulse oximetry is ordered. At the time of the next authorization period, the saturation levels will be reviewed for stability.

If the recipient is enrolled in MEDALLION, the ordering physician must be the MEDALLION PCP, or there must be a referral for the service from the MEDALLION PCP. The PCP referral is valid as long as the CMN is effective, provided there is no change in the eligibility of the recipient or PCP.

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A recipient who is ventilator-dependent with room air and who is stable does not qualify for daily pulse oximetry coverage.

Medical Documentation

The physician must document on the CMN that the recipient's condition meets one of the above criteria, that pulse oximetry readings are necessary on a daily basis in order for the recipient to remain in the home, that the recipient does not have a condition which contraindicates the effective use of pulse oximetry (e.g., oxygen toxicity is a concern), alternative treatments which have been attempted (e.g., periodic arterial blood gases), and why periodic pulse oximetry readings (e.g., pulse oximetry reading submitted bimonthly showing SaO₂ trends over a specified period of time) would not meet the physician's need for monitoring. In addition, the physician must specify the current oxygen flow rate and the assessment parameters: the setting at which the device should be set to alarm and the intervention response or corrective action to be taken (e.g., increase oxygen to 50%, increase oxygen to 2 l/min.).

Laboratory Evidence

Documentation of the recipient's current SaO₂ must be submitted on the CMN and must show desaturation (SaO₂ less than 85% for adults and less than 94% for neonates).

Exceptions: DMAS will consider requests for daily pulse oximetry for recipients who do not meet the health condition criteria, but who require daily pulse oximetry due to complications presented (e.g., acute illness, weaning from oxygen use).

Reimbursement for pulse oximeters determined to be medically necessary in the home on a continuous basis will be reimbursed on a rental basis for a maximum of three months. The decision to rent the equipment must be based on the physician's attempt to wean the recipient from a tracheostomy or a ventilator, or when the recipient requires supplemental oxygen and has unstable saturations, but does not have a tracheotomy or ventilator, and the physician is unable to determine the length of time the recipient will require the continuous pulse oximetry. DMAS will purchase the pulse oximeter for any rental that exceeds two authorizations of three months each when the physician cannot definitely state how much longer the recipient will require the continuous pulse oximetry.

Reimbursement will be established for the oximeter with a recording device and a permanent probe (unless documented inability to attain an accurate reading exists which would justify use of disposable probes). There will be four rental rates: one for the use of the permanent probe, one for the use of disposable probes, and two additional rates for the inclusion of a battery pack, one with a disposable probe and one with a permanent probe, when determined medically necessary for the recipient who requires transport and is at risk of desaturation when transported. A copy of the pulse oximetry printout must be attached to the request for the rental preauthorization.

Pulse Oximetry (Periodic or Intermittent Pulse Oximeter Studies)

Coverage of pulse oximetry on a periodic or intermittent basis is available for any of the following conditions:

- Any recipient on a ventilator or on continuous oxygen when periodic pulse oximetry

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is ordered by the physician as a necessary component of monitoring appropriate oxygen saturation levels;

- Any recipient with a progressive disease that may require oxygen in the future (e.g., emphysema); or
- Any recipient for whom oxygen has been recently discontinued and for whom the oxygen saturation level is needed to indicate successful weaning.

The physician must order the frequency of pulse oximetry readings and the period of time over which the reading must be taken. If the recipient is enrolled in MEDALLION, the ordering physician must be the MEDALLION PCP, or there must be a referral for the service from the MEDALLION PCP. The PCP referral is valid as long as the CMN is effective, provided there is no change in the eligibility of the recipient or PCP.

The pulse oximetry reading must be submitted to the physician for assessment, and the physician must report back to the DME provider regarding any changes to be made based upon the reading taken.

Authorization of periodic pulse oximetry will only be given if there are persons in the home environment who are approved by the physician as trained and capable of recording accurate readings during the period of pulse oximetry. There is no DMAS reimbursement for the personnel who may be required to assure that the pulse oximetry readings are accurate. In the event that the physician is not satisfied that the family member can adequately monitor to assure that the reading is accurate, the periodic pulse oximetry may have to be performed in a sleep lab or hospital setting. Children who receive private duty nursing through the Technology-Assisted Waiver or EPSDT may have access to nursing services which can assure the accurate reading. All periodic pulse oximetry must be preauthorized by DMAS. The maximum allowable number of studies will be 12 in a 12-month period. (It is the physician's responsibility to assure that the persons who will be in the home during the periodic pulse oximetry are capable of assuring the accurate reading before authorization of the pulse oximetry is requested.)

Reimbursement to the DME provider for pulse oximetry studies includes a two-day rental of the monitor. To bill for pulse oximetry studies, a respiratory therapist must set up the equipment in the home. This rate will be all-inclusive; there will be no further reimbursement for printer, paper, probes or any other supplemental equipment. The DME provider will be responsible for sending a copy of the readings to the physician for interpretation.

Suction Machines

Suction machines are covered by DMAS for any recipient who has a tracheostomy or who cannot manage his or her own secretions. Suction machines will only be rented when the CMN indicates the expected length of use is three months or less. Suction machines must be purchased whenever the expected use exceeds three months. Purchase of the suction machine will include the cost of a portable back-up suction machine, one set of tubing, two collection jars, a battery, and a charger. Supplies can be purchased as necessary according to the limits in the "Medicaid DME and Supplies Listing" in Appendix B. Rental includes the cost of the rental of the machine and a portable backup, tubing, collection jars, a battery, and a charger.

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Ventilators/CPAP/BiPAP

Both ventilators and non-continuous ventilators (i.e., CPAP/BiPAP) are covered items when ordered by a physician and preauthorized by DMAS. If the recipient is enrolled in MEDALLION, the ordering physician must be the MEDALLION PCP, or there must be a referral for the service from the MEDALLION PCP. The PCP referral is valid as long as the CMN is effective, provided there is no change in the eligibility of the recipient or PCP. The CMN from the physician must indicate the prognosis for weaning from the ventilator together with the expected length of use of the ventilator. The stability of the recipient on the ventilator at the time of discharge from the hospital, the need for continuous or periodic pulse oximetry, and the current or projected need for sleep studies must be addressed on the CMN.

Coverage of a CPAP/BiPAP will only be considered for reimbursement when documentation on the CMN includes the results of a sleep study, except for those recipients diagnosed with a neuromuscular disease. Those recipients with neuromuscular disease must have demonstrated hypoventilation or hypoxemia documented with a pneumogram or overnight oximetry study. Preauthorization of the BiPAP is possible only if the CMN documents that use of the CPAP has been tried and is not a feasible alternative for the recipient. When BiPAP is ordered, the BiPAP "S" will be covered by DMAS unless the recipient has central apnea and requires the "ST" version. Condition of central apnea must be documented in the sleep study results submitted with the CMN. If the CPAP/BiPAP supplied for the required two-month rental period is new upon delivery, DMAS will consider paying the full purchase price listed in the DME listing in addition to the initial two-month rental period for these items.

Coverage of a non-continuous ventilator for an adult shall be for a two-month rental period. At the end of this period, the physician must determine whether continued use is indicated. In an adult, weight loss is usually the most significant factor to consider. If the recipient continues to need the ventilator support at the end of the two-month period, the equipment must be purchased as long as there is documentation that the recipient is compliant with the treatment and documentation clearly indicates recipient benefit (e.g., SaO₂, ABG's).

Coverage of a non-continuous ventilator for a child shall be based upon the expected length of use. Any time the CMN indicates that the ventilator/CPAP/BiPAP is to be used for a period which will exceed nine months, the equipment must be purchased. Purchase of the ventilator will include the cost of the ventilator, battery, charger, three sets of reusable circuits and valves, and an initial supply of filters. Purchase of the CPAP/BiPAP will include the cost of filters, tubing, headgear, and masks. DMAS will pre-authorize a service maintenance contract for all recipients for whom a ventilator/CPAP/BiPAP is purchased.

Service Maintenance for Ventilators

In accordance with the DMAS DME participation agreement, the DME provider agrees to provide authorized service maintenance for purchased ventilators for Medicaid-eligible recipients. The service maintenance requires preauthorization in order for the provider to be reimbursed. Following preauthorization, the provider may bill using the HCPCS codes in the DME Listing/Appendix B. All of the following services must be included as part of the service maintenance agreement:

- The provider agrees to employ or contract with registered or certified respiratory

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therapists who will be available in a timely manner on a 24-hour-a-day basis for emergency care. The respiratory therapist will conduct monthly home visits to conduct a respiratory assessment and to check equipment.

- The provider agrees to perform routine maintenance of the ventilator in the home, replacing filters, cartridges or any other disposables associated with this routine maintenance. Routine maintenance supplies are not billed separately to DMAS by the DME provider; such items are included in the reimbursement for the service agreement.
- The provider agrees to send the ventilator to the manufacturer for routine servicing every 6,000 hours, or as recommended by the manufacturer. The cost for this routine servicing, including shipping and handling, are included in the service maintenance agreement fee. The cost of parts which would constitute a repair may be billed separately, as a ventilator repair, under HCPCS code. Any ventilator repair which exceeds \$500.00 must be preauthorized by DMAS. The cost of a back-up ventilator during the period of time that the purchased ventilator is at the manufacturer's for routine servicing is included in reimbursement for the service agreement.
- The provider agrees to provide a back-up ventilator throughout the period of ventilator service or repair; the DME provider may bill DMAS for a rental ventilator during the period of non-routine service or repair.

Service Maintenance for CPAP, BiPAP, and BiPAP S/T

In accordance with the DMAS participation agreement, the DME provider agrees to provide authorized service maintenance for purchased CPAP, BiPAP, and BiPAP S/T equipment for Medicaid-eligible recipients. The service maintenance requires preauthorization by DMAS in order for the provider to be reimbursed. Following preauthorization of service maintenance, the provider may bill using the HCPCS codes listed in the "Medicaid DME and Supplies Listing" in Appendix B. The following services must be included as part of the service maintenance agreement:

- The provider agrees to employ or contract with registered or certified respiratory therapists who will be available in a timely manner on a 24-hour-a-day basis for emergency care. The respiratory therapist will make regular home visits to conduct respiratory assessments and to check equipment. For CPAP and BiPAP, visits shall be a minimum of once each month for the first three months, or as ordered by the prescribing physician. After the first three months, visits must be made at a minimum of once every three months. For BiPAP S/T, visits shall be a minimum of once each month for the first three months, or as ordered by the prescribing physician. After the first three months, visits must be made at a minimum of once every other month.
- The provider agrees to abide by the recommended manufacturer maintenance schedule as defined in the "Manufacturer's Recipient Product Pamphlet" and "Service Manual."
- The provider agrees to provide a back-up ventilator throughout the period of ventilator service or repair; the DME provider may bill DMAS for a rental ventilator during the

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period of non-routine service or repair.

The cost of parts which would constitute a repair may be billed separately as a ventilator repair under HCPCS code. Claims for service maintenance agreements must be submitted for the calendar month in which the service is rendered per the authorization.

THERAPEUTIC BEDS AND MATTRESSES

Therapeutic beds are defined as devices that consist of specially equipped frames and turning mechanisms, specially equipped adaptive tables that rotate continuously, and specially designed support surfaces. The term “therapeutic beds” will be used to describe four categories of high-technology beds:

- Air Fluidized beds use warm air under pressure to set small ceramic beads in motion which stimulate the movement of fluid. Beds in this category include, but are not limited to, Clinitron (Support Systems International), Skytron (Skytron), Fluidair (Kinetic Concepts), and SMI 5000 (SMI Recipient Care). This category of beds is contraindicated by clients who 1) have a history of electrolyte imbalance; 2) need the head of the bed elevated or need to frequently come to a sitting position (i.e., client’s with pulmonary diseases); 3) have a large draining wound; or 4) have altered proprioception.
- Air Loss devices are equipped with a mattress that contains a large volume of constantly moving air, water, mud, or sand. The mattress may be artificially heated. Beds in this category include, but are not limited to, Kinair (Kinetic Concepts), Flexicair (Support Systems International), Mediscus (The Mediscus Group), SMI 3000 (SMI Recipient Care), Biodyne (Kinetic Concepts), Therapulse (Kinetic Concepts), Restcure (Support Systems International), Pulmonair 40 (The Mediscus Group), Synergy Pulse (Cardio Systems), and Orthoderm (Health Products, Inc.). This group of beds should not be used by clients with altered proprioception or who are prone to infection as the warm air from the bed may increase the growth of bacteria.
- Rotation or Turning beds have specially equipped frames and turning tables designed to turn in a forward or backward motion or that vibrate, fluctuate, or variate in continuous movements. Beds in this category include, but are not limited to, Turn and Tilt Paragon (SMI Recipient Care), Keane Mobility (The Mediscus Group), Rotorest (Kinetic Concepts), Circoelectric (Stryker), LIC Turnover Bed (Century Manufacturing Company), and Stryker Wedge Turning Frame (Stryker). This category of beds is contraindicated by clients with altered proprioception or with a history of orthostatic hypotension.
- Mattresses with special support surfaces that are placed on top of a standard mattress or replace a standard mattress on a standard bed frame. Mattresses in this category include, but are not limited to, Fluid Flotation Mattress (filled with fluid and conform to the shape of the body); Non-Powered/Self-Adjusting, Alternating Air Mattress (have compartments in which air pressure is varied periodically throughout the mattress); and Foam Mattress (made of foam, in varying thickness, which alter the pressure imposed on bony prominences).

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Special mattresses are contraindicated for clients 1) with altered proprioception; 2) with very sensitive skin; 3) who require additional padding on the bed, thereby negating the beneficial effect of the surface; and 4) with poor circulation. The decision to use therapeutic beds must be based on reasonable and necessary requirements that include all of the following:

- All other alternative equipment and conservative treatment modalities must have been exhausted without success.
- Review of group 2 products: Medicaid criteria previously required if the bed was ordered for the treatment of decubitus ulcers, more than one ulcer, one of which is a stage IV, had to be present. Effective June 1, 2006, if decubitus ulcer is the primary reason for the Group 2 support surface, the bed must meet the McKesson InterQual criteria. InterQual criteria begins considering Group 2 products when two or more stage II pressure ulcers are present. More advanced products, such as an air-fluidized beds begin review with stage III pressure ulcers. Requests for skin flaps or grafts will be considered.
- The recipient must be bedridden or chair-bound due to immobility or a terminal/progressive disease process, or the recipient must have a medical condition where frequent manipulation of the body is contraindicated.
- In the absence of the proposed bed, the recipient would require care outside of the home, which would result in an increased financial expenditure.
- There must be documentation that a trained caregiver is willing and able to assist or supervise in carrying out the prescribed treatment regimen and to support the use and management of the therapeutic bed, including the problems that may occur. A trained caregiver must demonstrate knowledge of the use and intended benefits of the applicable therapeutic bed.
- The DME provider must certify that:
 1. The home electrical system is sufficient to meet the requirements of the proposed bed.
 2. The housing structure is adequate to support the weight of the bed or mattress as well as will accommodate admission of the bed to the house.

A physician must coordinate the home treatment regimen, which will include the use of other treatment modalities, where applicable, including, but not limited to, nursing care, appropriate nutrition, the creation of a tissue-growth environment, caregiver training/participation. The DME provider must document this information.

The treatment regimen must be evaluated, and its continued use recertified, at least every 60 days, by the physician. There must be written documentation describing all areas of skin breakdown. Documentation must be updated at least every 30 days. Documentation must include the total number of wounds, location, size (circumference and depth), drainage (amount, appearance, and odor), and the presence of tunneling. Staging is as follows:

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- Stage I: Skin redness that is not relieved within 15 to 30 minutes of relief from pressure.
- Stage II: Superficial skin excoriation or blister formation. Epidermal and/or dermal tissue involved.
- Stage III: Full-thickness skin loss exposing subcutaneous tissue and producing serosanguineous drainage.
- Stage IV: Full-thickness skin loss with invasion of fascia, muscle, and/or bone.

Home use of a therapeutic bed should NOT be considered if any of the following conditions are met:

- The bed is the only identifiable treatment modality being employed to treat the problem.
- The bedding system being used does not meet the positioning needs of the recipient.
- Use of the type of bed prescribed is medically contraindicated by the recipient's treatment plan as described above.

The use of therapeutic beds should be discontinued when:

- Documentation within the home health plan of treatment *or* physician progress notes demonstrates that the recipient's condition continues to worsen with the use of the bed; or
- A trained and willing caregiver is not available to assist with the prescribed treatment plan; or
- The required documentation does not demonstrate that the intended benefits of the bed are being accomplished; or
- Documentation of the decubitis indicates that a less expensive mode of treatment would be appropriate for the patient; (i.e., alternating pressure pad, gel type mattress, etc.); or
- At any time, conditions for NOT considering use of a therapeutic bed exist.

Authorizations for therapeutic bed, mattresses and overlays will be considered in 60 day maximum increments. To request continued authorization, the item must continue to meet the InterQual and criteria above. In addition, progress towards healing must be documented. If progress has not been made, documentation regarding the physician's changes or efforts in the treatment program to promote healing is required.

If the recipient is enrolled in MEDALLION, the ordering physician must be the MEDALLION PCP, or there must be a referral for the service from the MEDALLION PCP. The PCP referral is valid as long as the CMN is effective, provided there is no change in the eligibility of the recipient or PCP.

Transcutaneous Electrical Nerve Stimulators (TENS)

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Requests for transcutaneous electrical nerve stimulator units may be approved if all of the following criteria are met; these criteria are applicable to all types of transcutaneous electrical stimulators:

- Documentation verifies that other alternative equipment and conservative treatment modalities have been exhausted without success;
- The use of the TENS unit will benefit the recipient to a degree not attainable by the use of other methods of care and treatment;
- A physician must direct the home treatment regimen, which will include the use of treatment modalities including, but not limited to, nursing services and physical therapy. If the recipient is enrolled in MEDALLION, the ordering physician must be the MEDALLION PCP, or there must be a referral for the service from the MEDALLION PCP. The PCP referral is valid as long as the CMN is effective, provided there is no change in the eligibility of the recipient or PCP;
- The treatment regimen must be evaluated at least bi-monthly and can be determined effective after one month's use;
- The absence of this device would require that the recipient visit the physician or therapist for treatment or medications more often than with the device;
- There must be documentation that the recipient or the caregiver is able to manage the application of the device; and
- Rental of the TENS unit will be approved for the first two months, and purchase will be made after that period. Rental is only applicable to the initiation of new therapy. If the TENS device supplied for the required two-month rental period is new upon delivery, DMAS will consider paying the full purchase price listed in the Appendix B "Medicaid DME and Supplies Listing" in addition to the initial two-month rental period for these items.

The purchase of the TENS unit and supplies will be considered after the 60 day trial rental when all of the following occur:

- Documentation indicates that the recipient is compliant with treatment;
- Documentation describes how the TENS treatment modality is effective; and
- Use of the TENS unit is not contraindicated and/or not effective.

COVERAGE OF ORTHOTICS

Orthotic device services include devices that support or align extremities to prevent or correct deformities or improve functioning and services necessary to design the device, including measuring, fitting, and instructing the recipient in its use.

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General Medicaid Population

Practitioners may bill for supplies and/or equipment, beyond those routinely included in the office visit, when used in the course of treatment in the practitioner's office. These supplies include ace bandage, sling, splint, rib belt, cervical collar, lumbosacral support, etc. The applicable CPT/HCPCS codes may be used when billing for a specific supply item used. See the "Durable Medical Equipment" section in the *Physician Manual* for additional information.

If the recipient is enrolled in MEDALLION, the ordering physician must be the MEDALLION primary care physician (PCP), or there must be a referral for the service from the MEDALLION PCP. The PCP referral is valid as long as the CMN is effective, provided there is no change in the eligibility of the recipient or PCP.

Items made for the recipient by an occupational therapist, including splints, slings, and any normally stocked supplies, are part of the cost of the DMAS approved outpatient rehabilitation visit. These items are billed as ancillary charges on the UB-92, HCFA-1450 Universal Claim Form.

Orthotics, including braces, splints, and supports, are not covered for the general adult Medicaid population under the DME program, with the exception of the Intensive Rehabilitation program described below.

Intensive Rehabilitation Program

Coverage for both adults and children is available for medically necessary orthotics when recommended as part of an approved intensive rehabilitation program (including CORF), and when all of the following criteria are satisfied via adequate and verifiable documentation. Documentation for orthotics must include:

- Ordered by the physician on the DMAS-352 (CMN), and if the recipient is enrolled in MEDALLION, the ordering physician must be the MEDALLION PCP, or there must be a referral for the service from the MEDALLION PCP. The PCP referral is valid as long as the CMN is effective, provided there is no change in the eligibility of the recipient or PCP;
- Directly and specifically related to an active, written, and physician-approved rehabilitation treatment or discharge plan;
- Based upon a physician's assessment of the recipient's rehabilitation potential, where the recipient's condition will improve significantly in a reasonable and predictable period of time, or shall be necessary to establish an improved functional state of maintenance; and
- Consistent with generally accepted professional medical standards (i.e., not experimental or investigational).

The orthotist participating as a DMAS DME provider coordinates completion of the DMAS-352 (CMN) with the prescribing physician, using the correct HCPCS "L" codes. Preauthorization is

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required. Please reference the PA Chapter of this manual for instructions on how to obtain preauthorization. Documentation of the provider cost will be required for “L” procedure codes that do not have an established reimbursement allowance. Reimbursement (under the HCPCS “L” codes) to the DME orthotic provider is all inclusive; no supplemental reimbursement will be made for time involved in fitting, measuring, and designing the orthotic, or for providing the recipient with instructions for proper use.

EPSDT (Children Under 21 Years of Age)

Children do not have to be enrolled in Children’s Specialty Services (CSS) to receive orthotics (effective December 1, 1997). All medically necessary orthotics are covered for children under the age of 21 years. The same program guidelines, as identified in the above paragraph, apply to this category.

COVERAGE OF PROSTHETICS

Prosthetic arms, legs, breast and their supportive devices are covered for all Medicaid recipients, and require preauthorization by the Medical Support Unit. Prosthetic providers must complete a prosthetic preauthorization request form and send to the Medical Support Unit for consideration. (See the “Coverage and Limitations” section in Chapter IV of the *Prosthetic Device Manual* for further instructions.)

MEDICAID WAIVER PROGRAMS

Technology-Assisted Waiver Program

All equipment and supplies for this population are handled by the DMAS preauthorization contractor. If the recipient is enrolled in MEDALLION, the ordering physician must be the MEDALLION PCP, or there must be a referral for the service from the MEDALLION PCP. The PCP referral is valid as long as the CMN is effective, provided there is no change in the eligibility of the recipient or PCP.

Providers must have a completed Certificate of Medical Necessity (CMN-352) for all equipment and supplies. Signed delivery tickets are not required as part of the preauthorization process. However, proof of delivery will be verified upon post payment review. If a recipient requires an item that needs preauthorization, the provider must call the preauthorization contractor with the appropriate information. The DMAS preauthorization contractor will approve, deny, or pend the request. Items that do not require preauthorization may be provided to the recipient in accordance with regular DME policy. Any item which requires preauthorization and was previously authorized as part of a recipient’s monthly rate, must be preauthorized by the preauthorization contractor with a separate preauthorization number. Failure to obtain this preauthorization will result in the denial of payment.

AIDS Waiver Program

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A recipient in the AIDS Waiver may receive any medically necessary DME available to the general Medicaid population. DMAS coverage of enteral nutrition under the AIDS Waiver is broader than that of the general Medicaid population as outlined in the “Enteral Nutrition Section.”

Enteral Nutrition Coverage Criteria

Coverage of nutritional supplements for the general Medicaid population, which do not include a legend drug, are limited to when the supplement is the sole source form of nutrition and is necessary to treat a medical condition. Sole source is defined as the inability of the individual to handle (swallow or absorb) any other form of oral nutrition.

Coverage of nutritional supplements for individuals authorized through the Technology-Assisted and AIDS Waiver, or through the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program, DMAS will reimburse through EPSDT for medically necessary formula and medical foods when used under a physician’s direction to augment dietary limitations or provide primary nutrition to individuals via enteral or oral feeding methods.

Coverage is available for nutritional supplements regardless of whether the supplement is administered orally or through a nasogastric or gastrostomy tube. Coverage does not include the provision of “routine” infant formulae.

DME Covered under Early and Periodic Screening, Diagnosis and Treatment (EPSDT)

Early and Periodic Screening, Diagnosis and Treatment (EPSDT) is a federally mandated program that provides screening and treatment for Medicaid recipients from birth to age 21. Some DME not otherwise available to Medicaid recipients may be available for this age group through the EPSDT program, if medically necessary.

EPSDT is not a separate Medicaid program. EPSDT is distinguished only by the scope of treatment services available to children who are under the age of 21. Because EPSDT criteria (service/item is physician ordered and is medically necessary to correct, ameliorate “make better” or maintain the individual’s condition) must be applied to each service that is available to EPSDT eligible children, EPSDT criteria must be applied to all pre authorization reviews of prior authorized Medicaid services. For example, a child who needs a piece of equipment for transportation (e.g., a car seat), or a child who is able to ambulate in the home but requires a wheelchair for the school environment, may request coverage under EPSDT. If it is determined that the child will need a piece of equipment to function in the home environment, then the request may be covered under the DME program. Another common example is nutritional supplements which are not the sole source of nutrition. If a recipient, under the age of 21, is receiving some nourishment by mouth and some supplementation orally or by tube, the recipient does not qualify for coverage for the supplements under the DME program. When the service needs of a child are such that current Medicaid programs do not provide the relevant treatment service, then the service request will be sent directly to the DMAS Maternal and Child Health Division for consideration under the EPSDT program.

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DME Covered in Intensive Rehabilitation Settings

If the DME is for use only during the course of the rehabilitation program, these items are included in the per diem rate, and are entered on the rehabilitation hospital bill as ancillary services.

If the DME (e.g., wheelchair, hospital bed, recipient lift, etc.) is required to facilitate the recipient's discharge home or to an Assisted Living Facility (not to an extended care facility) authorization/reimbursement would follow the DME criteria.

If the DME (e.g., customized wheelchair) is required to facilitate discharge to a nursing facility, the three options for reimbursement follow:

- 1) The cost of the equipment can be included on the rehabilitation hospital bill as an ancillary service.
- 2) The social worker from the nursing facility can assist the recipient in requesting preauthorization of the equipment via the "MAP-122 process." This is only an option if the recipient has a recipient co-pay toward the cost of long-term care. (For additional information, see the *DMAS Nursing Facility Manual*.)
- 3) The cost of the equipment may be covered under the EPSDT program for children under the age of 21; preauthorization is required.

If the recipient is not eligible for any of these three options, outside resources would need to be explored (e.g., Department of Rehabilitation Services, OBRA fund for recipients with specific disabilities with a date of onset prior to age 22, Consumer Service Fund, churches, etc.).

DME Covered in Nursing Facilities

Supplies and Equipment

Supplies and equipment that are medically necessary for the direct care and treatment of inpatients are covered nursing facility services and are included in the cost of the nursing facility services. These include, but are not limited to, wheelchairs, walkers, trapeze bars, eggcrate and other specialized mattresses, dressing or catheter trays, suture sets, special beds, IV infusion pumps, incontinent supplies, etc. Coverage of resident-specific, customized items must be made through the DMAS MAP-122 process (see the *Nursing Facility Manual* for further instructions).

Certain medical supplies required to facilitate discharge are covered as allowable cost to the nursing facility. These supplies do not include items such as hospital beds and wheelchairs. Deductible and coinsurance amounts will be paid when these items are covered by Medicare.

If a nursing facility without a DMAS specialized care contract admits a resident requiring special equipment (e.g., ambulatory infusion pump, etc.) which is medically justified and prescribed by the physician, the nursing facility is responsible for obtaining the equipment. No additional Medicaid reimbursement will be provided to a DME provider or to the nursing facility.

Ventilators and Associated Supplies

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DMAS requires preauthorization for all ventilators and associated supplies furnished to nursing facility residents who are not residing in a nursing facility with a DMAS specialized care contract. (12 VAC 30-50-165) Additional information on specialized care requirements for contracts can be obtained by calling the Supervisor of the Long-Term Care Section, at (804) 225-4222. Additional information on specialized care can be found in the Medicaid *Nursing Facility Manual*, Chapter VI.

The nursing facility must supply ventilators and other special equipment or supplies needed by a recipient enrolled as a “specialized care recipient” and admitted to a nursing facility with a Medicaid contract for specialized services. The DME provider may not bill Medicaid for this equipment and supplies.

For those ventilator-dependent residents residing in a nursing facility without a DMAS specialized care contract, DMAS requires the nursing facility to obtain preauthorization before admitting the resident. DMAS will make direct reimbursement to DME providers for the following for nursing facility use for these residents:

- Ventilator rental
- Portable back-up suction machine
- Heated Cascade humidifier system
- Ventilator circuits
- Tracheotomy tubes
- Tracheotomy care kits
- Tracheotomy dressing
- Suction machine
- Suction catheter
- Sterile water
- Oxygen and oxygen equipment
- Manual resuscitator
- IV pole or other suitable support for circuits

The reimbursement to the DME provider includes the services and consultation of and teaching by a respiratory therapist to the nursing facility.

Requests for Medicaid payment for ventilators for recipients expected to be placed in nursing facilities without a DMAS specialized care contract must be sent to the Supervisor, Facility and Home Based Services Unit, 600 East Broad Street, Suite 1300, Richmond, Virginia 23219. The written request for authorization must include all of the following:

- The recipient’s Medicaid number;
- The present location of the recipient;
- The proposed nursing facility placement;
- The current medical status;
- The UAI, DMAS-96, and MI/MR Supplement;
- A written statement from the attending physician justifying the need and the type of equipment required. If the recipient is enrolled in MEDALLION, the ordering physician must be the MEDALLION PCP or there must be a referral for the service from the MEDALLION PCP. The PCP referral is valid as long as the CMN is effective, provided there is no change in the eligibility of the recipient or PCP; and

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- An itemized list of the equipment required, the rental cost of machine-associated supplies and services, and the name, address, and phone number of the respiratory equipment supplier.

RENTAL AND PURCHASE GUIDELINES

Equipment rental is indicated for short-term use when recipient's need or condition is expected to change, including when the recipient is expected to recover. When usage is anticipated to be long-term, and the recipient's need or condition is not expected to change, the items must be considered for purchase. Most items can be rented for a short time without preauthorization; an extension may be requested if the continued use is expected to continue short-term. If it is determined through utilization review activities that a rented item should have been purchased, DMAS will only provide reimbursement up to the established purchase price. (12 VAC 30-50-165) A description of the equipment and limitations for rental is found in the "Medicaid DME and Supplies Listing" in Appendix B.

The purchase prices listed in the "Medicaid DME and Supplies Listing" in Appendix B represents the amount that DMAS will pay for new equipment purchases. Unless otherwise approved by DMAS, documentation on the delivery ticket must reflect that the purchased equipment is "new" upon the date of service billed. Any warranties associated with new equipment shall be effective with the date of service billed. Medicaid is the payer of last resort; therefore, the DME provider is responsible for exploring coverage available under the warranty prior to requesting coverage of repairs, etc., through DMAS.

DMAS will consider paying the full purchase price listed in the "Medicaid DME and Supplies Listing," in addition to the initial required two-month rental period, for communication devices, TENS Units, CPAPs, and BiPAPs, when this equipment is new upon delivery.

Medicaid reimbursement for rental items is a daily rate. DMAS will not provide rental reimbursement for days that the recipient is not receiving or using the services. DMAS will also not provide reimbursement for rental equipment that is damaged or abused by the recipient.

MANAGED CARE

MEDALLION

MEDALLION is a primary care case management program designed to link qualified recipients with a source for coordinated primary care and, in so doing establish a *medical home* for those recipients. If the recipient is enrolled in MEDALLION, the ordering physician must be the MEDALLION PCP, or there must be a referral for the service from the MEDALLION PCP. The PCP referral is valid as long as the CMN is effective, provided there is no change in the eligibility of the recipient or PCP. This referral may be obtained in writing or orally and must be documented in the recipient's record. DME providers must follow the established DMAS criteria for providing medically necessary DME services for recipients with MEDALLION coverage. See the *Medallion Supplement* for more information.

Medallion II

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Some recipients are enrolled in a Managed Care Organization (MCO) – the Medallion II Program. See Chapter I for more detail about these programs. DME providers must contact the recipient’s MCO directly for information regarding the contractual and reimbursement criteria for Medicaid covered services contracted to the MCOs.

Insurance coverage must be verified before services are rendered. Failure to do so may result in denial of payment. To verify eligibility, call the HMO’s enrollment verification system or the automatic response system (ARS) at 1-800-884-9730 (outside of Richmond) or (804) 965-9732 or (804) 965-9733 for Richmond and the surrounding counties. If using the ARS system MCO information, if applicable, follows Medicaid eligibility information. Providers who do not participate in the recipient’s MCO must inform the recipient prior to the provision of service that the recipient will be responsible for payment.

Custom Preauthorized DME (Medallion II)

DME providers who are billing DMAS for specialized equipment must have valid preauthorizations from DMAS dated prior to the date the recipient enters the HMO. This specialized equipment includes, but is not limited to, the following:

- Customized wheelchairs and required components;
- Customized prone standers; and
- Customized positioning devices.

For the items listed above, the DME provider may bill DMAS using the valid preauthorization begin date as the invoice date if DMAS preauthorization is received prior to the recipient’s entering the MCO. The DME provider must maintain proof of delivery documentation. For DME provided to non-MCO recipients, the delivery date is used as the invoice date.

PAYMENT FOR SERVICES

General Information

The payment criteria established for medical supplies, equipment, and appliances are designed to enlist the participation of a sufficient number of suppliers so that Medicaid-eligible recipients can receive covered services at least to the extent that these services are available to the general population. Participation as a medical equipment and supply provider is limited to those who accept as payment in full the amounts paid by the Virginia Medicaid Program. Payments for services will not exceed the amounts indicated to be paid in accordance with the policy and methods described in Virginia Administrative Code, and payment will not be made in excess of the upper limits described in 42 CFR 447.304(a).

Cost Sharing

No Medicaid deductible or coinsurance amounts are imposed for any medical supplies, equipment, and appliances provided to Medicaid recipients. Medicaid will pay the Medicare deductible and coinsurance amounts up to Medicaid limits imposed on Medicaid recipients whose Medicare claims are processed initially by the Medicare carrier.

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ORDERING FORMS

DMAS no longer provides a supply of agency forms. Provider's can download forms from the DMAS web site (www.dmas.virginia.gov). To access the forms, click on the "Search Forms" function on the left-hand side of the DMAS home page and select "provider" to access provider forms. Then you may either search by form name or number. If you do not have Internet access, you may request one form for copying by calling the DMAS form order desk at 1-804-780-0076.