Aetna Better Health® of Louisiana

Appendix D: Durable Medical Equipment (DME)

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Contents

Section 1: DME Criteria and Limitations

Durable medical Equipment (DME) is covered when medical necessity criteria are met for use as part of the medical care of a beneficiary. The covered items and services include:

1. Durable medical equipment (DME);
2. Medical supplies;
3. Home dialysis supplies and equipment;
4. Therapeutic shoes;
5. Enteral nutrition, enteral/parenteral equipment and supplies;
6. Transfusion medicine; and
7. Prosthetic devices, prosthetics and orthotics.

DME supplies must meet following criteria:

1. Is primarily and customarily used to serve a medical purpose;
2. Generally is not useful to a beneficiary in the absence of an illness or injury; and
3. Is appropriate for use in the home.

The DME provider is responsible for delivery and set-up of all items if the member is physically or mentally unable to do so themselves. Delivery documentation must be maintained in the member's file. For minimum delivery documentation requirements, see section 18.4 of the **Medicaid Services Manual**.

With the exception of prosthetic and orthotic devices, DME provided to members is nursing facilities and intermediate care facilities are not reimbursable. DME providers should bill LA Medicaid directly for prosthetic and orthotic devices provided to members in nursing and intermediate care facilities.

Section 2: DME Provider Requirements

Approved Durable Medical Equipment (DME) providers can be found on our website using the online provider search tool: **https://www.aetnabetterhealth.com/louisiana/find-provider.**

All providers (both facility and ordering physicians) must be registered in the state and the health plan's registry. The provider should be a preferred provider for the health plan.

To enroll as a Medicaid provider, a DME and medical supply entity must meet the following criteria:

1. Be licensed by the local government agency as a business or merchant, or provide documentation from the city or county authority that no licensure is required;
2. Be licensed by the Department of Health, Medical Quality Assurance, Board of Orthotics and Prosthetics, if providing orthotics and prosthetic devices;
3. Be licensed by the Agency for Health Care Administration, Division of Health Quality Assurance, in possession of a home health equipment license;
4. Be in compliance with all applicable laws relating to qualifications or licensure; and
5. Have an in-state business location or be located not more than fifty (50) miles from the Louisiana state line.

The following entities may enroll as DME providers:

1. Businesses that supply DME and medical supplies;
2. Pharmacies that supply DME and medical supplies;
3. Home health agencies;
4. Orthopedic physician groups who supply orthotic and prosthetic devices that are not otherwise included in the physician's office visit charge; and
5. Optometrists and opticians who supply prosthetic eyes.

For a further list of provider requirements, including business location eligibility and accreditation requirements and exemptions, please see chapter 18 of the **Medicaid Services Manual**.

Section 3: Reimbursement Standards[1]

For DME claims, an individual provider should be listed as the ordering or referring provider. Claims or encounters listing a group or clinic as the ordering or referring provider will be denied.

Unless otherwise stated on the LA Medicaid DME Fee Schedule, the reimbursement for all DME will be the lesser of the following (per the Centers for Medicare and Medicaid Services):

1. Seventy percent (70%) of the Medicare fee schedule for all procedure codes that were listed on the Medicare fess schedule and at the same amount for the HIPAA compliant codes which replaced them; or
2. Seventy percent (70%) of the Medicare fee schedule under which the procedure code first appeared; or
3. Seventy percent (70%) of the manufacturer's suggested retail price (MSRP) amount; or
4. Billed charges if the lesser amount (submission must include original invoice for item); or
5. If an item is not available at the rate of seventy percent (70%) of the applicable established flat fee or seventy percent (70%) of the MSRP, the flat fee that will be utilized is the lowest cost at which the item has been determined to be widely available by analyzing usual and customary fees charged in the community.

[1] https://www.medicaid.gov/medicaid/spa/downloads/LA-23-0029.pdf

Section 4: Coverage Requirements

All services and products must be deemed medically necessary. All services require prior authorization (PA) unless otherwise noted. DME items, regardless of their inclusion in this manual or on the **LDH DME fee schedule**, will be considered for beneficiaries under the age of 21 based on medical necessity.

Members must be referred by a physician, have a prescription signed by the physician, and must not be institutionalized. For prosthetics and orthotics, DME providers must obtain PA from the fiscal intermediary (FI) for all services.

For a full list of Medicaid covered DME services and specific coverage criteria, including requirements, explanations, provider responsibilities, and non-covered services and items, please see the **DME Chapter of the Medicaid Services Manual**.

For a full list of member eligibility, PA requirements, and billing guidance please see the **Utilization Management** section of our website. Individual policies are linked below where applicable.

For all products and services, documentation of medical necessity must include the following:

1. Written prescription not more than 12 months old, with the printed name and the dated signature of the member's treating physician or the treating physician's advanced registered nurse practitioner (ARNP) or physician assistant. The prescription can be received by the DME and medical supply provider before or after the DME service has been initiated, but the prescription cannot be dated more than 21 days after the initiation of service (date of service);
2. Current hospital discharge plan with the dated signature of the member's treating physician or the treating physician's ARNP or physician assistant that clearly describes the type of DME item or service ordered;
3. Letter of Medical Necessity not more than 12 months old, which includes the printed name and the dated signature of the member's treating physician or the treating physician's ARNP or physician assistant. Medicaid prohibits vendors from preparing sections of the letter of medical necessity that are to be completed by the physician or authorized prescriber. The letter of medical necessity cannot be dated more than 21 days after the initiation of service (date of service); and
4. Plan of care, if the provider is a home health agency.

All medical necessity documentation must include the type of medical equipment, services or consumable goods ordered, including the type, quantity, frequency and length of need ordered or prescribed.

Section 5: Covered Services

This appendix includes a list of services and products available through DME providers. For a full list of covered services and administrative procedures, please see the **ABHLA Provider Manual**.

Ambulatory Equipment

For a full list of covered equipment and additional criteria, see section 18.2.19 of the **Medicaid Services Manual**. Wheelchairs are approved only when the member is confined to a bed, chair, or room.

Canes and Crutches

Items are covered of the member's condition impairs or potentially impairs ambulation.

Walkers and Walker Accessories

A standard walker and related accessories are covered if all of the following criteria are met:

1. Prescribed by a physician for a beneficiary with a medical condition that impairs ambulation;
2. Member has a potential for ambulation; and
3. Member has a need for greater stability and security than can be provided by a cane or crutches.

A wheeled walker will be approved only if the member is unable to use a standard walker due to severe neurological disorders, debilitating medical condition that prohibits the use of a standard walker, or limited use of one hand. All requests for wheeled walkers must include documentation to support the need for a wheeled rather than standard walker.

Members weighing more than 300 pounds will qualify for a heavy duty walker. Members weighing more than 350 pounds who meet coverage criteria for a standard walker and are unable to use a standard walker due to a severe neurological disorder or other condition causing the restricted use of one hand qualify for a heavy duty, multiple braking system, variable wheel resistance walker. Obesity alone is not considered a medically necessary indication for this walker.

Walker Accessories

Leg extensions are covered for members six (6) feet tall or more.

Arm rest attachments are covered when the member's ability to grip is impaired.

Standard Wheelchairs

Requests for standard wheelchairs require documentation of medical necessity. Only one wheelchair will be approved at a time. Standard attachments include foot rests, brakes, and arm rests.

Custom Manual and Motorized Wheelchairs

All requests for a custom manual or power wheelchair require submission of a completed **Custom Wheelchair form**; all justification must be documented on the form, and all fields must be completed. Only one chair will be authorized at a time.

Request for repairs to manual or motorized wheelchairs will be considered for basic repairs only. Requests for modifications or reconstruction of the member's current wheelchair will not be considered basic repairs and must be submitted in accordance with PA criteria and submitted on the **Repair Form for Custom Wheelchairs**. Modifications, repairs, or reconstruction will be denied if it is more cost effective to provide a new wheelchair. All repairs and modifications of wheelchairs must be completed within one month, unless there is a justifiable reason for a dely. Rental of a manual wheelchair may be prior authorized on a monthly basis as a temporary replacement, if necessary, while the member's wheelchair is being repaired or modified.

In addition to standard documentation and a custom wheelchair form, PA requests for a custom manual wheelchair should include:

1. Completed PA form or the electronic PA demographics on ePA; and
2. Physician prescription for a custom manual wheelchair that includes:

a. Documentation the beneficiary is unable to propel a standard wheelchair; and
b. Diagnosis or limitations to justify the need for a custom manual wheelchair.

A motorized wheelchair is covered if the member's condition requires a use of a motorized wheelchair for a period of at least six months. The member must meet all of the following criteria:

1. Is not functionally ambulatory.
2. Unable to operate a wheelchair manually due to severe weakness of the upper extremities due to a congenital or acquired neurological or muscular disease/condition or is unable to propel any type of manual wheelchair because of other documented health problems; and
3. Capable of safely and independently operating the controls for a motorized wheelchair and can adapt to or be trained to use a motorized wheelchair effectively.

In addition to the required documentation needed for all PA requests and a custom wheelchair form. PA requests for motorized wheelchair must include:

1. Completed PA form or the electronic PA demographics on ePA;
2. Physician's prescription for a motorized wheelchair;
3. Medical documentation from a physician and/or physical/occupational therapist is required to support the provisions set forth regarding beneficiary criteria as noted above;
4. Custom Wheelchair form, seating evaluation performed, signed and dated by the physical therapist or occupational therapist that performed the seating evaluation. The seating evaluation shall:
    a. Indicate the appropriateness of the specific wheelchair requested and all modifications and/or attachments to the specific wheelchair and its ability to meet the beneficiary's long term medical needs. Options that are primarily beneficial in allowing the beneficiary to perform leisure or recreational activities are not covered;
    b. Beneficiary's diagnosis or condition is such that a motorized wheelchair is medically necessary; and
    c. They have seen the seating evaluation and motorized wheelchair recommendation.
5. Documentation indicating that the member is capable of safely and independently operating the controls for a motorized wheelchair and can adapt to or be trained to use the motorized wheelchair effectively. Such documentation shall include:
    a. Signed and dated statement from the beneficiary's physician and/or, physical/occupational therapist that they have determined that the beneficiary has the cognitive, motor and perceptual abilities needed to safely operate the controls of a motorized wheelchair. This statement -must be verified by the notes and recommendation of the physician, physical therapist or occupational therapist making such statement; and
    b. Signed and dated statement from the beneficiary's physician or physical/occupational therapist that they have determined that the beneficiary can adapt to or be trained to use the motorized wheelchair effectively. This statement must be verified by the notes and recommendation of the physician, physical therapist or occupational therapist making such statement.

Standing Frames
Member criteria for a standing frame include, but are not limited to:

1. Being at a high risk for lower extremity contractures that cannot be improved with other interventions (stretching, medications, serial casting, splinting, and modalities);
2. Being able to tolerate a standing or upright position on the foot and ankle;
3. Being non-ambulatory or is unable to stand due to conditions such as, but not limited to, neuromuscular or congenital disorders, including acquired skeletal abnormalities;
4. Having tried more cost effective alternatives and still requires a stander;
5. Not having a walker or gait trainer and it is not anticipated they will require one;

6. Having demonstrated improved mobility, function and physiologic symptoms or has maintained status with the use of the requested stander and is able to follow a home standing program with the use of the requested stander; and
7. Using the equipment for personal use only. The equipment will not be used at school.

The following documentation must accompany PA requests:

1. Physician prescription;
2. Standing Frame Evaluation (**BHSF-SF-Form 1**) completed by a Louisiana State License Physician and Physical or Occupational Therapist in its entirety; and
3. Original Manufacture price.

Strollers of a Therapeutic Type
Item is covered if the member is confined to a bed, chair, or room, or if it is needed for transportation to a medical or training facility.

Special Needs Car Seat
A special needs car seat is covered when all of the following criteria apply:

1. Special needs car seat must be medically necessary and appropriate. The physician must submit a full description of the member's postural condition including head and trunk control, height, and weight. Weight must be between 20-105 pounds;
2. Member's condition is of such severity that they cannot be safely transported using a standard car seat, car seat belts, or modified vest travel restraints;
3. There is expected long-term need for the car seat; and
4. Special needs car seat must accommodate at least 36 months growth (if applicable, the car seat must be equipped with leg extensions to allow for the growth).

Apnea Monitors
Home apnea monitors are covered for members who meet any of the following criteria:

- Apnea of Prematurity
- Apnea of Infancy
- Following an Apparent Life-Threatening Event

The initial authorization period for apnea monitors will be three (3) months. Requests for extension must be accompanied by documented evidence of recurrence of apneic episodes. Providers may submit oral requests for approval for a period of one (1) month in the case of an emergency to avoid prolonged hospitalization. Following the one (1) month emergency period, providers must submit additional documentation to extend monitor usage for the additional two (2) months.

Augmentative and Alternative Communication Devices
Augmentative and alternative communication (AAC) devices are covered when a member meets the following criteria:

1. Have a diagnosis of a significant expressive or receptive (language comprehension) communication impairment or disability;
2. Impairment or disability either temporarily or permanently causes communication limitations that preclude or interfere with the beneficiary's meaningful participation in current and projected daily activities;
3. Had a speech language pathologist (and other health professional, as appropriate):
    a. Perform an assessment and submit a report pursuant to the criteria set forth in Assessment/Evaluation. (See Assessment/Evaluation below);
    b. Recommend speech language pathology treatment in the form of AAC devices and services;
    c. Document the mental and physical ability of a beneficiary to use, or learn to use a recommended AAC device and accessories for effective and efficient communication; and

d. Prepare a speech language pathology treatment plan that describes the specific components of the AAC devices and the required amount, duration, and scope of the AAC services that will overcome or ameliorate communication limitations as earlier described.

4. Requested AAC devices constitute the least costly, equally effective form of treatment that will overcome or ameliorate communication limitations as earlier described.

For a list of covered items, provider qualification, general medical necessity principals, replacement/modification requirements, and evaluation criteria, please see section 18.2.5 of the **Medicaid Services Manual**.

Repairs are covered for AAC devices that are out of warranty. Per the **Louisiana New Assistive Devices Warranty Act, La. R.S. § 51:2762 – 51:2767,** AAC device providers must provide members with a warranty period of at least one year from the date of delivery to the member. Repairs greater than $300.00 must be accompanied by a statement from the member's speech-language pathologist

Baclofen Therapy

ABHLA will cover implantation of an intrathecal baclofen therapy (IBT) infusion pump if the treatment is considered medically necessary, the candidate is four years of age or older with a body mass sufficient to support the implanted system, and any one or more of the criteria as described below apply.

Inclusive criteria for candidates with spasticity of cerebral origin:

1. There is severe spasticity of cerebral origin with no more than mild athetosis;
2. The injury is older than one year;
3. There has been a drop in Ashworth scale of 1 or more;
4. Spasticity of cerebral origin is resistant to conservative management; and
5. The candidate has a positive response to test dose of Intrathecal Baclofen.

Inclusive criteria for candidates with spasticity of spinal cord origin:

1. Spasticity of spinal cord origin that is resistant to oral antispasmodics or side effects unacceptable in effective doses;
2. There has been a drop in Ashworth scale of two or more; or
3. The candidate has a positive response to test dose of Intrathecal Baclofen.

Appropriate diagnoses include meningitis, encephalitis, dystonia, multiple sclerosis, spastic hemiplegia, infantile cerebral palsy (and other specified paralytic syndromes), acute (but ill-defined) cerebrovascular disease, open or closed fracture of base of skull, closed skull fracture, fracture of vertebral column with spinal cord injury, intracranial injury of other & unspecified nature, and spinal cord injury without spinal bone injury.

Prior authorization for chronic infusion of IBT must be requested after the screening trial procedure has been completed, but prior to pump implantation. The request to initiate chronic infusion must come from the multidisciplinary team that evaluates the beneficiary.

For provider criteria, exclusion criteria, and documentation requirements, see section 18.2.18 of the **Medicaid Services Manual**.

Bath and Toileting Aids

Bathroom and toileting aids are covered when medically necessary for members who are unable to use standard facilities. For a list of covered items, see section 18.2.6 of the **Medicaid Services Manual**.

Cochlear Implants

ABHLA covers one unilateral or bilateral cochlear implants per lifetime, per ear (barring device failure or irreparable damage) for members under 21 years of age when deemed medically necessary for treatment of severe-to-profound, bilateral sensorineural hearing loss. Implants must be used in accordance with Food and Drug Administration (FDA) guidelines.

For eligibility criteria, please see Appendix A: Medical and Surgical Services.

All costs for upgrades and repairs to the component parts of the implant, cords, and batteries are covered. Reimbursement will not be authorized until the surgical procedure is approved.

Continuous Positive Airway Pressure (CPAP)
Policy 7100.70

CPAP machines are covered with prior authorization for members who have moderate to severe obstructive sleep apnea (OSA) as diagnosed through either polysomnography (PSG) or home sleep apnea tests (HSAT). PSG studies may not be performed by a DME provider.

For adults, a single level CPAP device is covered if the member has a diagnosis of OSA that has been documented by an attended polysomnogram (performed at a facility-based sleep study laboratory, in the home, or in a mobile facility), or home-based HSAT and meets either of the following criteria:

- The AHI is greater than or equal to 15 events per hour; or
- The AHI is from 5 to 14 events per hour with documented symptoms of:
    - Excessive daytime sleepiness, impaired cognition, mood disorders, or insomnia;
    - Hypertension, ischemic heart disease, or history of stroke.

For members under the age of 21, a single level CPAP device is covered if the member has a diagnosis of OSA that is documented by an attended, facility-based polysomnogram and has the following:

- Documentation of physical exam (including airway) and of any other medical condition, which may be correctable (e.g., tonsillectomy and/or adenoidectomy) prior to the institution of assisted ventilation;
- Documentation of how sleep disturbance reduces the quality of life and affects the activities of daily living;
- Prescription by a physician with training and expertise in pediatric respiratory sleep disorders;
- Documentation of the medical diagnosis, which is known to cause respiratory/sleep disorders;
- Sleep or respiratory study documenting two or more of the following:
    - Oxygen saturation of less than 90 percent pulse oximetry or partial pressure of transcutaneous or arterial of less than 60mm. Hg.;
    - Carbon dioxide greater than 55 mm. Hg. by end tidal, transcutaneous, arterial, or capillary blood measurement; and
    - Apnea of 10 to 20 seconds duration on the average of one per hour.
- A follow up plan should be submitted identifying the responsible physician or facility, giving data collected to demonstrate the success or failure of intervention, and showing a visit within the first month of use and a second assessment within the first three months of use;
- Indication of a responsible, committed home environment and of caregivers properly trained in appropriate respiratory care; and
- A written plan for home health follow-up care.

Bi-level positive airway pressure (BiPAP) devices are covered for patients who meet additional medical necessity criteria.

Humidifiers are covered for patients who have been approved for a CPAP, BiPAP or oxygen device when prescribed, but they are not automatically included in approvals for ventilator devices. Separate PA and prescription are required.

CPT Vest-High Frequency Chest Wall Oscillation Device
Policy 7100.72

CPT Vest-High Frequency Chest Wall Oscillation devices are covered when medically necessary and require prior authorization. To be eligible, a member must have one of the following:

- Diagnosis of Cystic Fibrosis
- Diagnosis of Bronchiectasis

    - Must be characterized by daily productive cough for at least six (6) continuous months or frequent (i.e. more than two years)exacerbations requiring antibiotic therapy; and
    - Confirmed by high resolution, spiral, or standard CT scan
- Have a neuromuscular disorder OR well documented failure of standard treatments to adequately mobilize retained secretions with all of the following:
    - Chest Physical Therapy and flutter device at least twice daily (when age appropriate)
    - Pattern of hospitalizations at least annually or more
    - Significantly deteriorating clinical condition
    - Be under the care of a pulmonologist
    - Have copies of two pulmonary test results that indicate the member's condition improved with the use of the vest

Diabetic Supplies

Effective with dates of service on or after 12/01/2023, diabetic supplies are reimbursed as a pharmacy benefit. Insulin pumps requiring tubing and supplies are covered through the durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) program. All reservoirs and canisters will be covered through the DMEPOS program.

Continuous Subcutaneous Insulin External Infusion Pumps

Payment for a continuous subcutaneous insulin external infusion pump and related supplies will be authorized for treatment of Type I diabetes. Members must meet either Criterion A or B as follows:

Criterion A: The member has completed a comprehensive diabetes education program and, for at least six months prior to initiation of the insulin pump, has been on a program of multiple daily injections of insulin (at least three injections per day) with frequent self-adjustments of insulin dosages; and has documented an average frequency of glucose self-testing of at least four times per day during the two months prior to initiation of the insulin pump; and meets two or more of the following criteria while on the multiple daily injection regimen:

1. Glycosylated hemoglobin level (HbAlc) greater than 7.0 percent;
2. History of recurring hypoglycemia;
3. Wide fluctuations in blood glucose levels (regardless of A1C);
4. Demonstrated microvascular complications;
5. Recurrent severe hypoglycemia;
6. Suboptimal diabetes control (A1C exceeds target range for age);
7. Adolescents with eating disorders;
8. Pregnant adolescents;
9. Ketosis-prone individual;
10. Competitive athletes; and
11. Extreme sensitivity to insulin in younger children.

Criterion B: The beneficiary with Type I diabetes has been on a pump prior to enrollment in Medicaid and has documented an average frequency of glucose self-testing of at least four times per day during the month prior to Medicaid enrollment.

In addition to meeting Criterion A or B above, the member must be insulinopenic per the updated fasting C-peptide testing requirement, or must be autoantibody positive (e.g. islet cell autoantibodies (ICA), glutamic acid decarboxylase (GAD65), the 40K fragment of tyrosine phosphatase (IA2), insulin autoantibodies (IAA), or zinc transporter 8 autoantibodies (ZnT8)).

Updated fasting C-peptide testing requirement (NOTE: Levels only need to be documented once in the medical record):

1. Insulinopenia (defined as fasting C-peptide level less than or equal to 110 percent of the lower limit of normal of the laboratory's measurement method); and

2. Fasting C-peptide levels will only be considered valid with a concurrently obtained fasting glucose of less than 225 mg/dl.

For provider requirements, see section 18.2.20 of the **Medicaid Services Manual**.

Dialysis Equipment and Supplies
Dialysis equipment and supplies are approved only if the beneficiary is under treatment for chronic renal disease and is trained in the use of the equipment. All requests must have:

1. The diagnosis and prognosis;
2. Any other pertinent medical and social data;
3. The date the beneficiary was first dialyzed;
4. A statement from the facility that the beneficiary is capable of operating the equipment;
5. A statement from the equipment provider for home dialysis verifying that the beneficiary has been trained to use the dialysis equipment;
6. The name of the provider;
7. A prescription for the machine and the supplies; and
8. Frequency of dialysis.

Disposable (Elastomeric) Infusion Pumps
Disposable (elastomeric) infusion pumps are covered for short term use (less than 30 days) for antibiotic infusion therapy per **LDH Informational Bulletin 24-34**. PA requests must include information on the underlying diagnosis or condition, a physician's order and documentation supporting medical necessity, and the name of the antibiotic, dosage, the duration of therapy, and the frequency of administration.

Coverage criteria includes:

1. Device will be used for short-term antibiotic infusion therapy (less than 30-day duration);
2. Device is expected to increase member compliance with antibiotic therapy;
3. Caregiver cannot administer the antibiotic by pump;
4. To avoid hospitalization of an immuno-compromised beneficiary, which may increase the risk of further infection; or
5. Outside of antibiotic therapy, the member has no need for hospitalization.

Disposable Incontinent Supplies
Policy 7200.81

Disposable Incontinent Supplies are covered with prior authorization for members who meet eligibility requirements:

- Children ages four (4) to twenty (20) years of age
    - The member must have a medical condition resulting in permanent bowel and/or bladder incontinence.
    - The member would not benefit or has failed a bowel and bladder training program when appropriate for the medical condition.
    - The member must meet all Louisiana Medicaid eligibility criteria, verified monthly by the provider.
- Adults ages twenty-one (21) and over
    - May be covered under the Home and Community Services Based Waivers (HCBS)
    - Members with the HCBS waiver will have a Rate code of 53ADT; 05H02; 15ADT
    - Must have a physician's order and have documentation that the use of incontinence briefs and supplies are needed.
    - Cost may not exceed $2,500 in a single plan of care year.

Incontinent DME Options

- For Pull-on briefs, the member must have a medical condition resulting in permanent bowel and /or bladder incontinence and the member must have the cognitive and physician ability to assist in his or her toileting needs. For liners or incontinence guards, the member must be cost-effective in reducing the amount of other incontinence supplies needed.
- Permanent loss of bladder and/or bowel control is defined as a condition that is not expected to be medically or surgically corrected and that is of long and indefinite duration.
- Members who have a Nocturnal Incontinence diagnosis due to inability to wake up to go to the bathroom at night, but do not have a daytime problem are eligible for liners or guards.

For a full list of member eligibility, reporting requirements, and applicable CPT/HCPCS codes, please see the linked policy.

Electric Breast Pump

Breast pumps are covered for expectant mothers at 32 weeks gestational age. Prior authorization is not required, but an **Electric Breast Pump Request Form** must accompany the claim.

Required documentation for electric breast pumps are outlined in bold below:

- A prescription from the prescribing physician for the electric pump;
- Documentation of education/training on breastfeeding by the prescribing physician, licensed breastfeeding practitioner, or healthcare professional;
- Documentation that Louisiana Medicaid has not purchased a breast pump within the past three years for the same delivery; and
- A completed Electric Breast Pump Request Form signed by the prescribing physician and the mother or her authorized representative.

Electrical Stimulators

Bone Growth Stimulators

Osteogenic Bone Growth Stimulators are not covered.

Non-spinal non-invasive electrical bone growth stimulators may be considered under the following circumstances:

1. Failure of long bone fractures to heal after a period of six (6) months from the initial date of treatment;
2. Failure of long bone fusions after a period of nine (9) months from the initial date of treatment; or
3. Treatment of congenital pseudoarthrosis. There is no minimal time requirement after the diagnosis.

Non-Spinal non-invasive ultrasonic bone growth stimulators may be considered under the following circumstances:

1. Failure of a non-union fracture to heal after a period of ninety (90) days following treatment;
2. Documentation consists of two sets of radiographs, one before treatment and the second occurring ninety (90) days after treatment; and
3. Radiographs include multiple views and are accompanied by a written interpretation by a physician stating that there has been no clinically significant evidence of the fracture healing between the two sets of radiographs.

Spinal non-invasive electrical bone growth stimulators may be considered:

1. When a minimum of nine (9) months has elapsed since the member had fusion surgery which resulted in a failed spinal fusion;
2. When there is a history of a previously failed spinal fusion at the same site following spinal fusion surgery (meaning more than nine months has elapsed since fusion surgery was performed at the same level which is being fused again); or
3. Following a multi-level spinal fusion. There is no minimum requirement for application after surgery.

Vagus Nerve Stimulators

Implantation of vagus nerve stimulators (VNS) are covered when the treatment is considered medically necessary, the member meets criteria in section 18.2.25.2 of the **Medicaid Services Manual**, and the member has a diagnosis of

medically intractable epilepsy. PA request must be submitted after the member's evaluation but before implantation. Provider and documentation requirements are listed in the Medicaid Services Manual.

Surgery to implant the VNS is restricted to an outpatient hospital, unless medically contraindicated. If it is medically necessary for the beneficiary to be hospitalized, the hospital must obtain pre-certification for the stay as well as obtain PA to perform the surgery and purchase the device.

Battery replacement and subsequent implants require PA.

Environmental Modifications or Repairs
Environmental modifications to improve the safety, sanitation and adaptability of a beneficiary's home are covered when medically necessary. Installation of equipment is not covered.

Hospital Beds, Mattresses, and Lifts
Policy 7200.73

Hospital beds, mattresses, and lifts are covered for members with a documented medical need who meet medical necessity criteria. Prior authorization is required.

The following equipment is covered. Please see the linked policy for specific member eligibility criteria and prior authorization requirements for each item:

- Standard Hospital Beds
    - Fixed and Variable Height
    - Semi-Electric
    - Total Electric
- Pediatric Hospital Beds
- Trapeze Accessory
- Patient Lifts

Hospital bed mattresses are considered part of the hospital bed and will only be approved to replace mattresses that are no longer functional when the beneficiary meets the criteria to receive a hospital bed. Pressure relieving air mattresses must be ordered and authorized separately.

For a full list of criteria, limitations, and covered items, please see the policy.

Human Donor Milk and Human Milk Storage Bags
Human donor milk is covered as an outpatient service for use by medically vulnerable infants. Eligibility and reimbursement criteria can be found in the COVERED SERVICES chapter of the ABHLA Provider Manual.

Human milk storage bags are covered for lactating beneficiaries who meet the following criteria. Prior authorization is required:

- Prescription signed by prescribing physician
- Documentation that beneficiary is lactating
- 100 bags/month limit

Per **LDH Informational Bulletin 25-5,** Donor Human Milk Banks are partially exempt from enrolling in the Medicaid program: "A bank must be accredited by, and in good standing with, the Human Milk Banking Association of North America (HMBANA) to supply donor human milk to Louisiana Medicaid beneficiaries. The bank will be exempted from all other Durable Medical Equipment (DME) accreditation requirements."

Intravenous (IV) Therapy and Administrative Supplies
IV medication and supplies (including cannulas, central lines, Picc lines, and Portacaths) are considered medically necessary when:

1. An oral form of the medication is not available;

2. IV will be more effective than oral medicine per the prescribing physician; and/or
3. The member is unable to take medication by mouth.

Syringes and needles (not including diabetic supplies) are covered only for IV therapy, intramuscular (IM) injections, subcutaneous (Sub Q) injections, for dialysis purposes when used to inject heparin into the dialysis system, and for wound care. Documentation must show that a home health agency is administering and/or monitoring the administration of IV therapy provided in the home in order for these supplies to be approved.

Larynx, Artificial

An artificial larynx is approved only if the larynx is removed and the member is unable to use an esophageal voice. Repairs and batteries are included.

Nebulizers

Nebulizers are reimbursed for purchase only. Medications for use with the nebulizer are reimbursed through the Pharmacy program.

Negative Pressure Wound Therapy (NPWT) (Wound VAC)

Policy 7200.77

A wound care system may be considered for reimbursement for beneficiaries with a Stage III or IV chronic, nonhealing wound, such as a pressure, venous stasis, and diabetic ulcers, postsurgical wound dehiscence, non-adhering skin grafts, or surgical flaps required for covering such wounds. The wound care systems include the sealed suction dressing and suction pump. One NPWT pump is covered per month.

Prior authorization is required. A full list of member eligibility and documentation requirements are outlined in the linked policy.

Ocular Implants/Devices

Intraocular Lense Implant (IOL)

Only one provider may bill for the IOL. Payment for the IOL is a flat fee-for-service. Prior authorization is not required.

IOLs implanted during or subsequent to cataract extraction surgery performed on an outpatient basis are reimbursable. When billing on an outpatient basis, claims must be submitted on the CMS-1500 by the provider who actually supplies the lens. Providers are required to submit separate claim forms for the surgery and for the lens. IOLs included on surgical claims will be denied. The initials “DME” should be written in bold letters on the very top of the claim form. Procedures codes must be in conjunction with an ICD-10 CM diagnosis code for cataracts.

NOTE: If billing as an inpatient, the charges for the lens must be included on the inpatient claim form (UB-04).

Artificial Eyes

An artificial eye is approved if an eyeball is removed and replacement is necessary to maintain the contour of the face.

Orthotics

Orthotic Devices

PA requests for orthotic devices (leg braces, neck braces, knee braces and supports, spinal supports, splints, brace attachments and repairs) must include:

1. Complete description of special type brace;
2. Beneficiary’s mental and physical ability to use the device;
3. Whether the device is a replacement;
4. Whether training is indicated; and
5. Plan of training, when indicated.

Orthopedic Shoes and Corrections

Orthopedic shoes and corrections are considered medically necessary when:

1. Needed to protect gains from surgery or casting (qualifies as an emergency prior authorization (PA));
2. Prevent clinical deterioration of the foot as with beneficiaries with severe diabetes;
3. Prevent clinical deterioration of the foot as with beneficiaries with severe peripheral vascular disease; or
4. Attached to braces.

Shoes to correct minor orthopedic problems are not covered

Shoes for Diabetics
Shoe lifts are covered only if the lift needed is greater than one-half inch. Inserts are only covered for shoes which are attached to braces, or when there is sufficient documentation from the treating physician to justify medical coverage without the attachments to braces.

Special shoes and corrections are covered for diabetics. Coverage is provided for extra-depth or custom molded shoes, as well as inserts or modifications, when the physician:

1. Documents that the member has diabetes;
2. Certifies that the member is being treated under a comprehensive plan of care for their diabetes and that they need therapeutic shoes; and
3. Documents that the member has one or more of the following conditions:
    a. Previous amputation of the foot or part of the foot due to complications that resulted from diabetes;
    b. History of previous foot ulceration;
    c. Pre-ulcerative callus formation, or peripheral neuropathy with a history of callus formation;
    d. Foot deformity; or
    e. Poor circulation.

Because Medicare requires that the member either have diabetes with peripheral complications or the shoe be attached to braces, ABHLA will consider payment when Medicare's criteria are not met. The provider must use a GY modifier when submitting the PA request for consideration or the claim for payment.

Traction Equipment
Traction equipment, including cervical traction collars, is approved only if the member has significant orthopedic impairment which prevents ambulation.

Oxygen Supplies
Prescribed oxygen services must include rates of flow, concentration, level of frequency, duration of use, and circumstances under which oxygen is to be used. If this information is not included, a new prescription that clarifies the order is required.

Emergency Oxygen Equipment and Supplies
Medically necessary backup oxygen and equipment provided during an official state and/or federally declared emergency is covered. Backup oxygen and equipment provided outside an official state and/or federally declared emergency is non-covered. Providers are responsible for ensuring that medical oxygen and oxygen-related equipment are available during official state and/or federally declared emergencies, if medically necessary. Providers will not be reimbursed for unused equipment and supplies picked up after an emergency.

Portable Oxygen, Supplemental Oxygen, and Oxygen Supplies
Policy 7200.75

Portable oxygen, supplemental oxygen, and oxygen supplies are covered for members with a documented medical need who meet medical necessity criteria. Prior authorization is required. Prescribing providers must see the member within sixty (60) days of prescribing oxygen therapy.

The linked policy includes a full list of eligibility criteria, reporting requirements, and covered devices.

The initial request for oxygen concentrators must include a prescription which is signed and dated by the treating physician and include:

1. Oxygen flow rate
2. Frequency and duration of use
3. Estimated length of need and
4. Results of a current blood gas laboratory report done at rest and at room air (performed no more than 30 days prior to the prescription) from an appropriate facility giving the arterial blood gases (ABGs) and arterial saturation. However, oxygen saturation may be determined by pulse oximetry when ABGs cannot be taken.

Peak Flow Meters and Mucus Clearance (Flutter) Devices

Peak flow meters are covered for members with an asthma diagnosis as part of an effective asthma management program. Flutter devices are covered for members with lung diseases or conditions producing retained secretions (such as COPD).

Prosthetic Devices

Prosthetic devices are covered with PA. A complete description of the prosthesis is required. The request should indicate the following:

1. Whether the request is for the first prosthesis or a replacement;
2. The mental and physical ability of the member to use the device; and
3. Whether training is required for a replacement (a plan of training must always be a part of a first request for prosthesis).

Breast or Mammary Prostheses

A breast or mammary prosthesis is approved only after breast removal. Replacement of a prosthesis may be approved if medical need is established and documented.

Pulse Oximeter

Pulse oximeters are covered for EPSDT eligible members who are already approved for supplemental home oxygen and/or vent dependent and whose blood saturation levels fluctuate.

A non-recording/alarming pulse oximeter is covered when the member meets one or more of the following criteria:

1. Is dependent on a ventilator with supplemental oxygen;
2. Has a tracheostomy, on oxygen, and requires monitoring of O2 saturation as determined by the physician;
3. Requires supplemental oxygen and has unstable saturations; and
4. Is on supplemental oxygen and weaning is in process.

A recording/alarming pulse oximeter is covered when a member meets all of the following criteria:

1. Member's condition meets one of the criteria for a non-recording/alarming oximeter;
2. Recording/alarming oximeter is being ordered by the physician to monitor the beneficiary during a specific event such as a weaning attempt from oxygen or ventilator; and
3. Feeding times for an infant, or other times for which the physician needs documentation of the beneficiary's blood oxygen saturation.

Suction Pumps

Suction machines may be considered only if the machine specified is medically required and appropriate for home use without technical or professional supervision. Accessories and supplies may be considered when medically necessary and used with a medically necessary suction pump. Purchase of a respiratory suction pump may be considered for members who have difficulty raising and clearing secretions secondary to:

1. Cancer or surgery of the throat or mouth;
2. Dysfunction of the swallowing muscles;
3. An unconscious or obtunded state; or
4. Tracheostomy.

Sterile suction catheters are considered to be medically necessary only for tracheostomy suctioning.

Supplemental Nutrition Supplies

Total Parenteral Nutrition (TPN)

TPN is covered as a Pharmacy benefit. Associated supplies and equipment are covered services as Durable Medical Equipment (DME). Prior authorization is required and must include documentation to establish medical necessity for TPN services as outlined in Section 37.5.10 of the LDH Pharmacy Benefits Management Services Provider Manual.

Enteral Nutrition and Infusion Pump

Policy 7200.71

Enteral formula is covered for beneficiaries of all ages who require formula to fulfill at least 70% of their caloric need and beneficiaries with known or suspected inborn errors of metabolism served by the OPH Genetic Disease Program. All prior authorizations must be submitted without an NDC entered into the PA01 or ePA system. Units requested must be calculated based on 100 kcals and not cans, pouches, packets, etc.

Enteral infusion pumps are covered for members with one of the following conditions:

- designated as "terminally ill" by a physician
- Inborn errors of metabolism
- Intellectual disability
- Failure to thrive

Prior authorization is required, and requests must include:

- Name of the nutrient product or nutrient category;
- Number of calories prescribed by enteral feeding per day (100 calories equals one unit) and whether the prescribed amount constitutes 70 percent or more of the daily caloric intake;
- Frequency of administration per day;
- Method of administration (oral or, if tube, whether syringe, gravity, or pump fed);
- Route of administration, if tube fed (i.e., nasogastric, jejunostomy, gastrostomy, percutaneous enteral gastrostomy, or naso-intestinal tube); and
- Reason for use of a pump, if prescribed

For members of the Office of Public Health (OPH) Genetic Diseases Program, no PA is required.

Amino Acid-Based Elemental Formula

Per LDH IB 26-7, amino acid-based formula is covered regardless of delivery method effective 01/01/26. PA is required and must include one of the following:

- A diagnosis provided be a board-certified allergist or gastroenterologist
- A written order from the treating physician indicating that the amino acid-based elemental formula is medically necessary for the treatment of the child due to any of the following conditions:
    - Immunoglobulin E and non-immunoglobulin E mediated allergies to multiple food proteins
    - Severe food protein-induced enterocolitis syndrome
    - Eosinophilic disorders confirmed by the results of a biopsy
    - Impaired nutrient absorption caused by disorders affecting the absorptive surface, functional length, or motility of the gastrointestinal tract.

Tracheostomy Care Supplies

Tracheostomy care supplies are covered for beneficiaries following an open surgical tracheostomy. Tracheostomy care or cleaning starter kits may be covered for a maximum of two weeks postoperative of an open surgical tracheostomy. Tracheostomy care kits for an established tracheostomy may be covered for routine care. One care kit per day is considered normal usage. Additional kits may be considered only with medical necessity documentation. Sterile suction catheters are considered medically necessary only for tracheostomy suctioning. Please see the **DME Chapter of the Medicaid Services Manual** for a list of tracheostomy care kit and starter care kit content requirements.

Wearable Cardioverter Defibrillator

Procedure code K0606: Wearable Cardioverter Defibrillator device is a covered DMEPOS service for rental only and is located on the DMEPOS Fee Schedule/ Prior Authorization is required for this service to verify the medical necessity of the WCD and the WCD will not be used for experimental or investigational purposes. Device is for patients 18 years or older.

Wound Care Supplies

Surgical dressings, bandages, and other wound care supplies, after receiving PA, are approved for three (3) months at a time. Requests must include the corresponding prescription and the following documentation:

1. Accurate diagnostic information pertaining to the underlying diagnosis/condition as well as any other medical diagnoses/conditions, to include the member's overall health status;
2. Appropriate medical history related to the current wound;
3. Wound measurements to include length, width and depth, any tunneling and/or undermining;
4. Wound color, drainage (type and amount) and odor, if present;
5. Prescribed wound care regimen, to include frequency, duration and supplies needed;
6. Treatment for infection, if present;
7. Member's use of a pressure reducing mattress and/or cushion, when appropriate; and
8. Whether or not a home health agency is involved in the care.

The prescription must be updated for any extensions to be granted. A Medicaid approved home health agency must be involved in the care of the member for consideration of approval for wound care supplies. Any routine supplies provided by the home health agency that are not covered as DME and must be provided in the skilled nursing visit rate.

A wound care system may be reimbursed for members with a Stage III or IV chronic, nonhealing wound, postsurgical wound dehiscence, non-adhering skin grafts, or surgical flaps required for covering such wounds.

Surgical dressings and bandages are covered when medically necessary for wound dressing and post-operative care.

Burn garments and stockings are only covered for severe burns and major vascular problems.

Reimbursement for wound care supplies is manually priced. See Section 3 of this appendix.