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DEFINITIONS

For purposes of this section, the following definitions apply: Abuse - Intentional damage or destruction of equipment by member.

Auto-refill – The refilling of and mailing supplies to members without requests or consents from member or authorized caregiver for each refill. This practice is not allowed without confirmation of continued need.

Caregiver/Designee/Authorized Representative – Any person who can sign and accept the delivery of DMEPOS on behalf of the member.

Confined to bed – Member condition is so severe that member is essentially confined to bed.

Custom - Made for a specific member based according to their individualized measurements and/or patterns; substantial adjustments made to prefabricated items by specially trained professionals to meet the needs and/or unique shape of individual members. Customized items cannot be appropriately used by other members due to the individual specific features of said items.

Confirmation of Continued Need – A confirmation that the item continues to be needed by the member. Documentation of this must be in the DME provider notes for the member.

- Ongoing need for and use of an item must be documented in member records in order for Wyoming Medicaid to continue reimbursement for equipment or supplies.
- Information used to justify continued medical need must be timely for date(s) of service under review.
- Retrospective attestation statements by provider or the member is not sufficient.
- Contact with the member or designee regarding refills must take place no sooner than 24 calendar days prior to the delivery/shipping date.
- Refill record must include:
    - Member name and/or designee if different
    - Description of item being requested
    - Date of refill request
    - Verification of quantity of item and that it will be exhausted by refill date

Example: If an item is ordered monthly, the provider must contact the member ahead of scheduled delivery to determine if item(s) are still needed. This contact must be in the DME provider's documentation.

NOTE: An item, such as incontinence supplies, is not allowed to be auto refilled. Information must be kept on file and be available upon request. Items delivered without a valid, documented refill request are considered not reasonable and necessary.

Date of Delivery - Use the shipping date as the date of service on the claim if the provider uses a deliver/shipping service. Use the actual date of delivery as the date of service on the claim if the provider/supplier does the delivery or if the member picks the item up directly.

Disposable Medical Supplies - Medical supply or piece of equipment intended for one-time use; specifically related to the active treatment or therapy of Wyoming Medicaid members for medical illness or physical condition. This does not include personal care items (i.e., deodorants, talcum, bath powders, soaps, dentifrices, eye washes, contact solutions), oral or injectable over-the- counter drugs and medications.

Drop Shipping – DME providers utilizing a process of shipping goods directly to members from a third-party supplier or vendor without handling the fulfillment and shipping themselves.

Durable Medical Equipment (DME) - To qualify for coverage, DME must meet all of the following requirements:

- Must withstand repeated use
- Must be primarily and customarily used to serve a medical purpose
- Must not in general, be useful to a person in the absence of illness, disability or injury
- Must be appropriate for use in the home (this does not include an inpatient or nursing facility)
- Must not be considered experimental or investigational
- Must generally be accepted by the medical community
- Primary purpose must not be to enhance the personal comfort of the member or provide convenience for the member or care giver

Invoice - Document, which provides proof of purchase and actual cost(s) for equipment and/or supplies to the service provider. The lowest price on the invoice, including provider discounts, will be used to reimburse manually priced items.

Manufacturer - The original producer of equipment, components, parts, supplies or prosthetic devices.

Medical Necessity or Medically Necessary - Medical necessity for disposable medical supplies and equipment, prosthetic devices which are necessary in the treatment, prevention, or alleviation of an illness, injury, condition, or disability. Determination of medical necessity shall be made in accordance with the following criteria (from Wyoming Medicaid Rules, Chapter 11, Medical Supplies and Equipment):

i. It is prescribed by a physician or other licensed practitioner.

ii. It is a reasonable, appropriate, and effective method for treating the member's illness, injury, condition or disability.
iii. The expected use is in accordance with current medical standards or practices;
iv. Is cost effective;
v. Provides for a safe environment or situation for the member;
vi. For the purposes stated, utilization is not experimental, not investigational, and is generally accepted by the medical community; and
vii. Its primary purpose may not be to enhance the personal comfort of the recipient, nor to provide convenience for the recipient or the recipient's caregiver.

Misuse - Intentional utilization of equipment in a manner not prescribed or recommended which results in the need for repairs or replacement or allowing use by persons other than the member for whom the item was specifically prescribed.

Neglect - Failure to maintain the equipment as specified by the provider.

Orthotics - Rigid or semi-rigid devices to prevent or correct physical deformity or malfunction.

Over the Counter - All drugs and supplies, which by law do not require a prescription to be dispensed or sold to the public.

Proof of Delivery – When a provider delivers an item directly to the member or the member's authorized representative, the provider must maintain proof of delivery. Proof of delivery must meet all of the following:

- Signed and dated by the member or the member's authorized representative (the date of signature must be the date the item was received by the member.
- Include the member's name and a description of the item(s) delivered, including the quantity and brand name.

When a provider uses a delivery/shipping service, the tracking slip is the proof of the delivery. The tracking slip must include the following:

- The member's name or a reference to the member's package
- The delivery service package identification number
- The delivery address

If the provider supplier delivers the product, the proof of delivery is the delivery slip. The delivery slip must include the following:

- The member's name
- The shipping service package identification number
- The quantity, detailed description, and brand name of the items being shipped.

- The serial number for medical equipment that may require future repairs

Note: Use the shipping date as the date of service on the claim if the provider uses a deliver/shipping service. Use the actual date of delivery as the date of service on the claim if the provider /supplier does the delivery or if the member picks the item up directly.

Prosthetics - Replacement, corrective or supportive devices prescribed by a physician to:

- Artificially replace a missing portion of the body
- Prevent or correct physical deformity or malfunction
- Support a weak or deformed portion of the body

Reasonable - In accordance with current accepted standards of medical practice in the treatment of the member's condition, without excess or extreme function or expense beyond that which is necessary.

Specialized - For purposes of distinguishing whether equipment is specialized or routine, in order to determine whether Wyoming Medicaid covers the equipment outside of the nursing home per diem rate, the following criteria applies:

- Is the equipment generally needed by nursing home residents? If so, then it is not specialized (i.e., beds, mattresses, commodes, wheelchairs, walkers).
- Is the equipment customized or custom-fitted (i.e., orthotics, prosthetics, hearing aids, custom seating or wheelchair accessories, power wheelchair accessories)? If so, then it is specialized.
- Is the equipment intended solely for the use of a specific resident, and will never be (nor could it be) useful to another resident? If so, then it is specialized.

Standard versus Deluxe

- A standard item is cost effective for the condition, compared to alternative interventions, including no intervention. Cost effective does not necessarily mean the lowest price but is the most appropriate supply or level of services required to provide safe, efficient, and adequate care.
- A deluxe or Luxury item offers no additional medical advantage to the member, although it is more costly, extravagant, nicer in appearance, etc.

Stockpiling

- To accumulate and save excessive and inappropriate amounts of supplies for future use leading to waste and abuse of the healthcare system.
    - Ex. Requesting more than one month of supplies, not confirming continued need or amount and auto shipping

NOTE: If more than one piece of DME can meet the member's needs, coverage is only available for the most cost-effective piece of equipment.

GETTING HELP WHEN YOU NEED IT

Agency Name & Address	Phone Number	Fax	Agency Name & Address
Telligen Website: https://wymedicaid.telligen.com	(833) 610-1057	(877) 897-0111	• Prior authorization requests • How to complete PA forms • Troubleshooting prior authorization issues
Telligen Provider Portal: https://wymedicaid.telligen.com	(833) 610-1057 Call Center Agents are available- 7am-6 pm MST Mon-Fri		• Qualitrac questions or training
Provider Services Wyoming Department of Health PO Box 1248 Cheyenne, WY 82003-1248 Website: http://ww.wyomingmedicaid.com Email: Wyproviderservices@cns-Inc.com	1-888-996-6223 7am-6 pm MST Mon-Fri Fax (307) 460-7408 24/7 IVR Availability		• Bulletin/manual inquiries • Claims inquiries/submission problems • Member eligibility • Documentation of Medical Necessity • How to complete forms • Payment Inquiries • Request Field Representative visit • Training seminar questions • Timely filing inquiries • Provider Portal assistance/training • WY Companion Guide • Trading Partner Registration • Technical support for vendors, billing agents/clearinghouse • Web Registration

GENERAL GUIDELINES

The purpose of this program is to furnish disposable medical supplies and durable medical equipment to Wyoming Medicaid members for home use. Supplies and equipment must:

- Be reasonable and necessary for the treatment of illness or injury
- Be the most cost-effective supply or equipment necessary to meet the member's medical needs
- Enable members to cost effectively remain outside institutional settings by promoting, maintaining, or restoring health; or
- Restore members to their functional level by minimizing the effects of illness or disabling condition

Note: The HCPCS codes ranges listed in the *Medical Supplies and Equipment List* are subject to change without notice. Please use in conjunction with the HCPCS Level II.

Provider Participation

Wyoming Medicaid enrolls medical supply providers who provide services or items directly to members.

It is not necessary for physicians' offices to enroll as medical supply providers when providing supplies **incidental to** physician services.

Providers must:

- Enroll with Wyoming Medicaid as medical supply providers to bill for medical supplies and equipment included in this manual
- Be enrolled with Medicare as medical supply provider as condition for enrollment with Wyoming Medicaid
- Submit proof of DME accreditation (e.g., CARF, The Joint Commission) as condition for enrollment with Wyoming Medicaid
- Submit proof of re-enrollment as a Medicare DMEPOS provider **every three years** following initial enrollment into the Wyoming Medicaid program.

Provider Responsibilities

In supplying equipment and supplies providers are responsible for:

- Delivering correct, ordered/authorized equipment and/or supplies and providing equipment serial numbers upon request from Telligen or Wyoming Medicaid.

- Any modifications or additional equipment needed to correct provider error regarding member equipment and/or supplies. These costs are not billable to Wyoming Medicaid.
- Ensuring equipment provided be warranted by the manufacturer. Provider(s) shall not bill Wyoming Medicaid or members for equipment, parts, or services covered under warranty within the warranty period. Copies of warranties must be submitted to Telligen or Wyoming Medicaid upon request.
- Providing maintenance, repairs, and parts for rental equipment
- Providing medical supplies in quantities of not more than one month's use. "Stockpiling" is inappropriate.
- Obtaining prior authorization, PRIOR to delivery of services on codes identified as requiring "PA"
- Confirmation of continued need for disposable supplies, by contact with members or member's caretaker prior to shipment of supplies
- Retaining documentation of current physicians' orders in patient files
- Informing members in writing of their financial responsibility prior to providing services/equipment which Wyoming Medicaid does not cover
- Maintain documentation in files for six (6) years from date of service.

Coverage

The Medical Supplies and Equipment List included in this manual contain specific information indicating what items are and are not covered by Wyoming Medicaid. This is not an all- inclusive list; contact Medicaid Provider Relations to determine if a specific code is covered or visit the website https://www.wyomingmedicaid.com/portal/fee-schedules#.

Coverage is limited to the type or level of equipment that meets the needs of the member and is the most cost effective. Wyoming Medicaid or its designee reserves the right to request documentation stating why a less expensive, comparable alternative to requested equipment or supplies is not practical or stating alternate equipment or supplies are not available. Items of convenience are not considered medically necessary.

Authorization Requests for Non-Covered Items

Authorization can be requested for any piece of medical equipment, supply, prosthetic, or orthotic that is considered a non-covered item. The item must be medically necessary. Enter this request under the procedure code specified for the item, include the client's Medicaid identification number and information, and submit documentation that demonstrates the item meets all the following criteria:

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

Requests should be submitted to Wyoming Medicaid Provider Services P.O. Box 1248 Cheyenne, WY 82003. Fully completed requests will be acted upon within 30 days of receipt. Wyoming Medicaid will notify providers and members of the grant or denial of the request for coverage. If denied, clients will be notified of their right to request a fair hearing pursuant to Wyoming Medicaid Rules Chapter 4.

Reimbursement Guidelines

Reimbursement for most medical supplies is established by fee schedules and reviewed annually to ensure appropriateness. Payment is limited to the lower of the actual charge or the Fee Schedule amount. Some codes are manually priced off the manufacturer's invoice which must include an explanation of the expected dates of use, clearly marked items, and units.

For manually priced items an invoice which provides proof of purchase and actual cost(s) for equipment and/or supplies, is required. The lowest price on the invoice, including provider discounts, will be used. For dates of service 12/31/2020 and prior, manually priced items for DME are priced at lowest invoice cost, plus shipping, plus 15%. For dates of service 01/01/2021 forward manually priced items for DME are priced at lowest invoice cost, plus shipping, plus 12.13%. To receive the cost of shipping the manufacture must be the one to break down the shipping/handling on the invoice. If the manufacturer does not include an S/H breakdown on the invoice, and there is more than one item, it cannot be included in the cost of the item. NOTE: If more than one piece of DME can meet the member's needs, coverage is only available for the most cost-effective piece of equipment.

The invoice must be dated within 12 months (365 days) prior to the date of service being billed. If the invoice is older, a letter must be included with the claim explaining the age of the invoice (i.e. product purchased in large quantity previously, and is still in stock)

- All discounts will be taken on the invoice

- The discounted pricing or codes cannot be marked out
- A packing slip, price quote, purchase order, delivery ticket, etc. may be used only if the provider no longer has access to the invoice, is unable to obtain a replacement from the supplier/manufacturer, and a letter with explanation is included
- Items must be clearly marked (i.e. how many calories are in a can of formula, items in a case, milligrams, ounces, etc.)

Wyoming Medicaid reimbursement for purchase or rental of medical supplies and equipment shall include, but is not limited to:

- All elements of manufacturer's warranty
- All universal equipment servicing as provided to general public
- All adjustments and modifications to the item needed by the member to make the item useful and functional. This does not include modifications to the home
- Rental equipment includes delivery, set-up, and installation of equipment in the home (for additional information, see the coverage policy for delivery outside the service area).
- Purchased equipment, delivery and instillation are considered separate and may be considered if especially complex under the repair code. Set-up fees are not covered.
- Training and instruction to member or caregiver in the safe, sanitary, effective, and appropriate use of the item, and in any necessary servicing and maintenance to be done by the user
- Providing member and/or caregiver with all manufacturer's instructions, servicing manuals, and operating guides needed for routine service and operation

Medicare/ Wyoming Medicaid Dual Coverage Procedures

Some members have dual benefits/eligibility. Providers must accept assignment from Medicare and Wyoming Medicaid co-pay/deductible as payment in full for services. Not all medical supplies are covered by Medicare. Always check the Medicare manual for supplies you are providing to a member with dual coverage. If a DME item or supply is covered by Medicare, no prior authorization is required.

- If an item or supply is NOT COVERED by Medicare, and it is also an item that requires PA, then providers should follow standard PA procedures.
- If the item or service is one that IS COVERED by Medicare but the member does not meet Medicare criteria, then along with all other PA and documentation requirements, the provider may be asked to submit a copy of the Medicare ABN

(Advance Beneficiary Notice) that includes the reason the provider has determined that the member does not meet Medicare criteria.

- If the item or service is one that IS COVERED by Medicare, but the provider isn't certain whether the member meets Medicare criteria, the provider may request a PA

Face-to-Face Visit Requirement

For practitioners ordering new/initial Durable Medical Equipment (DME) or Prosthetic/Orthotic Supplies (POS) for a member, must comply with 42 CFR 440.70. The member must have a face-to-face visit related to the primary reason for which the item(s) are being ordered within the previous six (6) months with the ordering or prescribing practitioner. To assure correlation between the face-to-face visit, the practitioner ordering the services must document the face to face encounter which should indicate the reason the services are needed. The supplying provider must have the documentation of need, date and the name of the practitioner with whom the face-to- face visit occurred for their records in order to bill Wyoming Medicaid for the DME or POS supplied. The face-to-face encounter may occur through telehealth.

Note: This requirement is waived for renewals of existing DME or POS orders.

Documentation

Specific criteria for Wyoming Medicaid coverage of medical supplies and equipment are outlined in the Medical Supplies and Equipment List. In order to be covered by Wyoming Medicaid, the member's condition must meet the coverage criteria for the specific item. Telligen utilizes the MCG along with the Wyoming Medicaid Medical Supplies and Equipment Covered Services and Limitations Module when reviewing Prior Authorization requests.

Documentation substantiating the member's condition meets the coverage criteria must be on file with the DME provider and must be updated annually to substantiate the continued need for services. The following requirements indicate what documentation must be maintained in the member's file for all equipment and supplies provided to a Wyoming Medicaid member:

1. **Verbal or Written Order (Physician, Physician Assistant, or Nurse Practitioner order/prescription)**

Note: References to "Physician" also include Physician Assistant and/or Nurse Practitioner

Most DMEPOS items may be dispensed with a physician's verbal order. Items that require a written order prior to delivery (WOPD) include:

- Support Surfaces
- Transcutaneous Nerve Stimulators(TENS)
- Seat Lift Mechanisms
- Negative Pressure Wound Therapy(NPWT)
- Power Mobility Devices
- Wheelchair Seating

DMEPOS Providers/Suppliers must document all verbal orders with the following elements:

- Description of Item
- Member Name
- Physician Name
- Start date of verbal order

Written orders are required prior to claim submission for all items or services billed, even items dispensed based on verbal order. Elements required on all written orders include:

- Member's Name
    - Physician's printed name including signature and the date the order is signed. **Stamped signatures and dates are not accepted.**
    - Initial date of need or start date
    - Estimate of total length of time equipment will be needed, in months and years
- All options or additional features that will be separately billed or that will require an upgraded code. The description can be either a narrative description (e.g., lightweight wheelchair base) or a brand name/model number
- Someone other than the physician may complete the detailed description of the item.
- However, the treating physician must review the detailed description signature and date the order to indicate agreement
- A new order is required every twelve months or when there is a change in the prescription for supplies

A written order is not required when the documentation requirements include a CMN, and the CMN on file contains the necessary elements of a written order, including a signature and date from the ordering Physician. **Stamped signatures and dates are not accepted.**

2. Certification of Medical Necessity

A **Certificate of Medical Necessity (CMN)** is a customized form, or handwritten letter of medical necessity that provides essential information needed to determine if equipment, devices or other items are medically necessary. When a CMN is on file that contains all the required elements of a written order, including the signature of the ordering Physician, a separate written order is not necessary.

A CMN must be (signed and dated by the Practitioner) within (60) days of the begin service date for CMN to be valid.

For specific items, a CMN is required to support the medical indication(s) for the prescribed item. The Medical Supplies and Equipment List specify which items require a Wyoming Medicaid specific CMN. The original CMN must be kept on file by the supplier. A CMN may be faxed to a supplier by a physician and used to file a claim; however, the supplier must obtain the original CMN.

All CMN forms are available for downloading online at Provider Manuals and Bulletins, or use the links to the forms contained in the **"Forms"** section of this manual.

Other CMN forms can be used in place of the Wyoming Medicaid CMN form only if they contain at a minimum the same information requested on the Wyoming specific forms.

3. Written Order vs. CMN

When documentation requirements include a CMN, and the CMN contains the required elements of a written order, including the signature of the ordering Physician, it is not necessary to also have a separate written order. Any additional information which justifies the medical necessity of the item should also be maintained.

4. Recertification of Medical Necessity

Documentation of medical necessity, including a new written order, CMN or prescription must be updated annually or when physicians' estimated quantities, frequency or duration of member need has expired, whichever occurs first unless otherwise specified in the Medical Supplies and Equipment List of this manual.

5. Medical Records

Physicians must maintain medical records including sufficient documentation of the member's condition substantiating the need for the items. This information includes the member's diagnosis and other pertinent information including, but not limited to:

- Duration of the member's condition
- Clinical course (worsening or improvement)
- Prognosis
- Nature and extent of the functional limitations
- Other therapeutic interventions and results
- Past experience with related items

Wyoming Medicaid recommends that a copy of the CMN be kept in the member record. In cases where the CMN by itself does not provide sufficient documentation of medical necessity, there must be additional clinical information in the medical record. The physician must also retain a copy of the order or have equivalent information in the record.

A member's medical record is not limited to the physician's office records. They may include hospital or nursing home records and records from other professionals (e.g., nurses, physical therapists, prosthetist, orthotist and dieticians). This documentation is not sent to the supplier or Wyoming Medicaid; however, it may be requested.

6. Supplier's Records

For purposes of billing Wyoming Medicaid, a supplier/DME provider must maintain patient records, which include:

- Current, original physician orders
- Documentation of ordering practitioner's face-to-face visit with the member, including date and practitioner's name
- CMN and additional medical necessity information provided by the physician or required by Wyoming Medicaid
- Proof of delivery
- Approved prior authorization; and
- Documentation supporting the member or caregiver was provided with manufacturer instructions, warranty information, service manual, and operating instructions.
- Documentation must be kept in the DME provider files for six (6) years from date of service.

Forms

The following forms should be used for documentation purposes. Please refer to each DME item's coverage policy for specific documentation requirements that apply. Forms are available on the Wyoming Medicaid web site – Provider Manuals and Bulletins.

- PA Request Form DME
- Medical Necessity Form
- Wheelchair Necessity
- Electric Breast Pump CMN
- Parenteral Nutrition Necessity
- DME Mileage Verification Form

Replacement

Replacement DME, orthotics, and prosthetics owned by the member are covered if there is a change in the member's medical condition, wear or loss. Replacement required due to abuse, misuse or neglect would not be covered.

When an item is no longer suitable because of growth, development or changes to the member's condition, the member, the provider, and Wyoming Medicaid may negotiate a trade-in. Trade-ins are used to reduce charges paid in reimbursement from the Wyoming Medicaid program.

Rental and Capped Rental

Wyoming Medicaid covers rental of DME; when submitting claims for rental use the "RR" modifier along with the appropriate HCPCS code. Any codes lacking the "RR" modifier are perceived as a purchase and the claim is processed as such. All rental payments are applied towards the purchase of DME. When rental charges equal the amount allowed by Wyoming Medicaid for purchase or at the end of ten months rental, the item is considered purchased and the equipment becomes the property of the member for whom it was approved. Exceptions exist for equipment associated with oxygen, ventilators, and limited other equipment.

Items in this category are paid on a daily or monthly rental basis not to exceed a certain period of use. After the fee schedule amount has been paid for the maximum amount of time, no further payment can be made except for maintenance and servicing. All per day rentals are capped at one hundred days and all monthly rentals are capped at ten months.

Wyoming Medicaid does not cover routine maintenance and repairs for rental equipment. Purchased DME is the property of the Wyoming Medicaid member for whom it was approved. Items subject to capped rental are considered to have been purchased when the capped rental limit has been reached, and therefore are considered to be the property of the member.

In order to verify whether a specific item is allowed as a purchase, or a capped rental, refer to the code search function on the Wyoming Medicaid website:

1. https://www.wyomingmedicaid.com/portal/fee-schedules#
2. Click on 'fee schedule" then review/accept terms of use.
3. Click on "Procedure Code Search Page"
4. Enter the code and search.

Prior Authorization

Wyoming Medicaid requires prior authorization for some medical services and supplies. Telligen has been contracted by Wyoming Medicaid to provide medical necessity

reviews for prior authorization of DME. To obtain prior authorization, submit the **Telligen Prior Authorization form** and all required documentation to Telligen through Qualitrac.

Contact Telligen Provider Help Desk for Qualitrac training or questions at:

- Phone (833) 610-1057
- Staffed 7AM to 6PM MT, Monday-Friday

The Prior Authorization (PA) form and Certificates of Medical Necessity (CMN) forms are available on the Telligen website at https://wymedicaid.telligen.com/ or the Wyoming Medicaid website at Provider Manuals and Bulletins.

Note: Do not request prior authorization for codes that do not require one. Check the fee schedule for the code to determine if the code requires a prior authorization. This information is under "indicators" at https://myhp.wyomingmedicaid.us/CMToolkit/search when you have found the code. Requesting codes that do not require one may cause your claim to deny.

Denied Prior Authorization – Reconsideration Process

Prior Authorization requests can be denied for two basic reasons: Technical Administrative reasons such as incomplete or missing forms and documentation, etc.; or the member does not meet the established criteria for coverage of the item. Prior Authorization requests can be denied for two basic reasons: Administrative reasons such as incomplete or missing forms and documentation, etc.; or the client does not meet the established criteria for coverage of the item.

Following a denial for administrative reasons, the client, the DME provider, or the Physician may send additional information in order to request that the decision be reconsidered. If the information is received within thirty (30) days of the denial, with a clearly articulated request for reconsideration, it will be handled as such. If the information is received more than thirty days after the denial, it will be a new Prior Authorization request. As such, a new Prior Authorization form must be submitted, and all information to be considered must accompany it.

In the case of a denial that is based on the member not meeting criteria there are 2 options available.

1. A peer- to-peer conversation can be requested between the ordering Physician and the Physician who reviewed the PA request within **14 calendar days** of the denial. Contact Telligen at (833) 610-1057 to request a peer-to-peer conversation.
2. If the peer-to-peer resulted in the denial being upheld or if you chose not to request a peer- to- peer conversation, a reconsideration may be requested within **30 business days** of the issuance of the denial. The reconsideration review will be conducted by a physician other than the physician that issued the initial

denial. To request a reconsideration, please submit the request via the electronic provider portal.

Medical Supplies and Equipment for Nursing Facilities

Wyoming Medicaid pays a per diem rate to provide room, dietary services, routine services, medical supplies, equipment, etc. for nursing facilities. In general, routine medical supplies and equipment covered in the per diem rate for members residing in nursing facilities are not reimbursed separately, but specialized equipment can be covered in addition to the per diem rate. Refer to the Definition section of this manual for information about specialized equipment versus routine equipment.

To review the DME items that are included in the nursing facility per diem rate, you can access the Nursing Facility Covered Services Manual at: Provider Manuals and Bulletins

Exceptions to items that are included in the per diem rate include such specialized items as:

- Orthotics, prosthetics
- Ventilators
- Customized wheelchairs
- Power Wheelchairs and related accessories
- Hearing Aids
- Repairs to specialized items, if due to normal wear and tear and not because of abuse or neglect.

To verify whether an item is included in the SNF per diem reimbursement, or whether separate Wyoming Medicaid coverage is allowed, refer to the Wyoming Medicaid website.

1. https://www.wyomingmedicaid.com/portal/fee-schedules#
2. Click on 'fee schedule" then review/accept terms of use.
3. Click on "Procedure Code Search Page"
4. Enter the code and search.

In order to secure payment for medical equipment and/or supplies outside of the nursing facility per diem, the DME provider must obtain prior authorization from Telligen. Telligen will determine:

1. Whether the requested equipment or supply is considered 'specialized' and allowed as an exception, in addition to the nursing facility per diem, and if so,
2. Whether the requested equipment or supplies are considered medically necessary for the member.

On the Prior Authorization Form, the DME provider must indicate that the request is for prior authorization for equipment and/or supplies outside of the nursing facility per diem. As well, all other documentation and medical records requirements stand, as noted in each policy.

MEDICAL SUPPLIES AND EQUIPMENT LIST – COVERAGE POLICIES

The following pages outline specific coverage policy for supplies and services; for specific codes, please refer to the Healthcare Common Procedure Coding System (HCPCS) or on the Wyoming Medicaid website (https://www.wyomingmedicaid.com/portal/fee-schedules#) for online fee schedules. This list contains the medical supplies and equipment covered by Wyoming Medicaid, subject to the conditions stated herein and subject to changes adopted by federal or state law, changes in policy or procedures, or changes announced in Wyoming Medicaid Information Bulletins, or via Remittance Advice banners.

The Supplies and Equipment List includes the following:

- Criteria for approval
- Information regarding whether Prior Authorization is required
- Limits on quantity

Please remember that all rental items are subject to capped rental unless otherwise specified. Claims that are submitted with rental items should contain the appropriate code followed by the "RR" modifier.

To verify whether a particular item requires Prior Authorization, contact Provider Relations or refer to the Wyoming Medicaid website.

- https://www.wyomingmedicaid.com/portal/fee-schedules#
- Click on 'fee schedule" then review/accept terms of use.
- Click on "Procedure Code Search Page"
- Enter the code and search.

Providers may contact Provider Relations in writing with a request to cover any code not covered. This request must include a complete description of the item, including brand, product number, size, etc. Use procedure code modifiers when appropriate. A physician's written order is required. Wyoming Medicaid may request additional documentation. Prior authorization is required.

MEDICAL SUPPLIES AND EQUIPMENT LIST	PA REQUIREMENT
AIR FLUIDIZED AND LOW AIR LOSS BED UNITS- See also "BEDS and ACCESSORIES"	Yes
APNEA MONITOR	No
BATH and TOILET AIDS	No
BEDPANS and URINALS	No
BEDS AND ACCESSORIES (includes TRAPEZE)	Yes
BLOOD PRESSURE MONITORS	No
BREAST PROSTHESES	No
BREAST PUMPS • Standard/manual grade breast pump	 • No • Yes

MEDICAL SUPPLIES AND EQUIPMENT LIST	PA REQUIREMENT
• Heavy duty, hospital-grade electric breast pump	
CANES AND CRUTCHES	No
COMMODES	Required for E0170
CONTINUOUS PASSIVE MOTION (CPM) DEVICES	Yes
C-PAP/BI-PAP MACHINE	Yes
DELIVERY of DME OUTSIDE PROVIDER NORMAL SERVICE AREA (Mileage)	No
DIALYSIS EQUIPMENT and SUPPLIES	**Not covered as DME – see policy
DRESSINGS	No
EYE PROSTHESES	No
GAIT TRAINERS	Yes
HEAT/COLD APPLICATION DEVICES	No
INCONTINENCE APPLIANCES and CARE SUPPLIES	No
INFUSION PUMPS, EXTERNAL and ACCESSORIES; maintenance of infusion pumps	Yes
INHALATION – CONTROLLED DOSE DRUG DELIVERY INHALATION SYSTEM	Yes
INTERMITTENT POSITIVE PRESSURE BREATHING (IPPB) MACHINES	No
LIFTS	Yes
MEDICAL FOODS	Yes
MEDICAL/SURGICAL SUPPLIES	No
MEDICATION DISPENSER (Automatic)	Yes
NEBULIZERS and COMPRESSORS	No
NEUROMUSCULAR ELECTRICAL STIMULATORS (NMES)	No
NUTRITION THERAPY, Enteral or Parenteral	Yes
ORTHOTICS	Required for some codes. Refer to code look-up at https://www.wyomingmedicaid.com/portal/fee-schedules#
OSTEOGENESIS STIMULATORS	Yes
OSTOMY SUPPLIES	No
OXIMETERS, EARS/PULSE	Yes
OXYGEN and OXYGEN EQUIPMENT	Required for purchase of codes E0425, E0435, E0440
PACEMAKER MONITORS, SELF CONTAINED	No
PARAFFIN BATH UNITS, PORTABLE	No
PEAK FLOW METERS	No
PERCUSSORS	Yes
PHOTOTHERAPY SERVICES	No

MEDICAL SUPPLIES AND EQUIPMENT LIST	PA REQUIREMENT
PNEUMATIC COMPRESSORS and APPLIANCES	No
PRESSURE REDUCING SUPPORT SURFACES - see also "HOSPITAL BEDS AND ACCESSORIES", "WHEELCHAIRS (Manual and Power)"	Required for some codes. Refer to code look-up at https://www.wyomingmedicaid.com/portal/fee-schedules#
PROSTHETICS	Yes
REPAIRS/MAINTENANCE/LABOR	Yes
SITZ BATHS	No
STANDERS / STANDING FRAMES	Yes
SUCTION PUMPS	No
SUPPORTS	No
TRACHEOSTOMY CARE SUPPLIES	No
TRACTION EQUIPMENT	Yes
TRANSCUTANEOUS ELECTRICAL NERVE STIMULATORS (TENS)	No
TRANSFER EQUIPMENT	No
VEHICLE, POWER-OPERATED (POV)	Yes
VENTILATORS	Yes
WALKERS	No
WHEELCHAIRS (Manual & Power) • Power wheelchairs and accessories, (includes E2300 & E2378) • Seat and back cushions, including E2609, E2617, E2622, E2623, E2624, and E2625 • Ultralight manual wheelchair • Other Manual wheelchairs • Miscellaneous codes, such as E1399 and K0108 • Wheel lock brake extensions E0961	 Yes Yes Yes No Yes No
WHEELCHAIR SEATING SYSTEMS	Yes
WOUND V.A.C.	Yes
NOT OTHERWISE CLASSIFIED (NOC) CODES i.e. E1399 or K0108	Yes

DELIVERY of DME OUTSIDE PROVIDER NORMAL SERVICE AREA (Mileage)

Covered for equipment purchases and also in conjunction with repairs on purchased equipment.

Indications/Limitations:

1. Does not cover delivery of disposable supplies
2. Delivery destination must be outside the DME Provider's normal service area
3. Delivery of items must be more cost effective than shipping, unless fitting is necessary, or assembly is required. In some instances, it is acceptable to have someone (family, team, guardian, etc.) other than the provider, assemble the equipment
4. Reimbursement is paid according to the total distance from the city of the provider's place of business to the DME destination city; the **first 50 miles** are not reimbursable
5. Providers may only bill for one trip regardless of the number of items being delivered to the same destination or general area and should therefore, make every effort to coordinate delivery of items e.g. if a provider from Cheyenne had to deliver equipment to the following areas, Casper, Riverton and Lander, the provider should bill the mileage on the claim for the member in Lander or Riverton whichever is the furthest distance away

Documentation:

- Claims for travel miles must be included with a claim for the equipment that was delivered and the **DME Mileage Verification Form** must be attached to the claim.
- To obtain mileage form visit https://www.wyomingmedicaid.com/portal/Provider-Manuals-and- Bulletins
- Reimbursement will be at the state rate of $0.40 per mile
- Use code A9901 (1 unit equals 1 mile) for any miles over 25 (each way) e.g. A provider traveling 52 miles (roundtrip) to deliver and fit a wheelchair would bill 2 units using code A9901

Prior Authorization: Not Required

All deliveries will be subject to post payment review.

DME providers must retain documentation that supports medical necessity for all DME equipment. Questions and/or concerns should be directed to the Provider Relations Call Center at (307) 772-8401 or toll free at (800) 251-1268. Call Center hours are Monday through Friday from 7am-6pm.

References:

Wyoming Medicaid News dated September 2005 CME-1500 Bulletin – 05-017

AIR FLUIDIZED AND LOW AIR LOSS BED UNITS - *See Also "HOSPITAL BEDS"*

Constant pressure mattresses or mattress overlays are covered when used to prevent pressure ulcers in high-risk member or to promote healing of existing pressure ulcers.

Constant pressure devices provide conforming support surfaces that distribute body weight over large areas. Standard foam mattress, alternative foam mattress, or mattress overlay (i.e. high specification foam, convoluted foam, and cubed foam); other mattresses and overlays using gel, fluid, fiber, or air.

Equipment/Supplies:

HCPCS Code Range E0193-E0194

Powered air flotation bed (low air loss therapy):

- An air pump or blower, which provides both sequential inflation and deflation of the air cells or low interface pressure throughout the mattress
- Inflated cell height of air cells through which air being circulated is five inches or more;
- Height of air chambers, proximity of air chambers to one another, frequency of air cycling (for alternating pressure mattresses), and air pressure that provides adequate member lift, reduces pressure, and prevents bottoming out
- Surface designed to reduce friction, shear, and can be placed directly on a hospital bed frame
- Automatically re-adjusts inflation pressures with change in position of bed (head or foot elevation)
- Purchased through capped rental only

Air fluidized beds:

- Employ circulation of filtered air through silicone coated ceramic beads creating characteristics of fluid
- May be purchased through capped rental only

Indications/Limitations:

- Constant low- pressure support mattress or mattress overlay is indicated for limited mobility or immobility and ANY ONE of the following:
    - Presence or history of pressure ulcers
    - Acute illness
    - Advanced age
    - Impaired level of consciousness, acute or chronic
    - Sensory or motor neurologic deficits

- Chronic or terminal disease
- Peripheral vascular disease
- Malnutrition or dehydration
- Fecal incontinence
- Low tissue tolerance for pressure (tissue paper skin)
- Diabetes

Documentation:

- Written Order or **Certificate of Medical Necessity** or a letter of medical necessity or medical records to document that the following conditions are met:
  - Member is bedridden or chair bound
  - Attending physician has performed comprehensive assessment documenting Stage III, or IV decubitus ulcer(s) or post-operative healing of major skin grafts or myocutaneous flaps on trunk and pelvis. Member should be placed on b e d unit immediately after surgical procedure to promote healing and protect skin integrity
  - Description of all alternative equipment and conservative treatment methods that have been attempted and why attempts were deemed inappropriate or ineffective
  - Trained adult caregiver is available to assist member with activities of daily living and management and support of the air fluidized bed system
  - Evidence that absence of bed would leave member needing to be institutionalized

Prior Authorization: Required

APNEA MONITOR

Apnea monitors are exempt from capped rental and covered on a rental basis for members that meet one of the following:

- One or more apparent life-threatening events requiring mouth-to-mouth resuscitation or vigorous stimulation
- Episode characterized by some combination of apnea or color change, choking or gagging
- Symptomatic pre-term infants
- Sibling of SIDS victim
- Medical condition such as central hyperventilation and bronchopulmonary dysplasia
- Infant with tracheostomy
- History of recent vent dependency
- Infant born to substance abusing mother
- Infant/child with severe respiratory complications resulting in periods of apnea

Equipment/Supplies:

HCPCS Code Range E0618-E0619; A4556-A4557

Apnea monitor including all supplies, accessories, and services necessary for proper functioning and effective use of equipment.

Indications/Limitations:

1. All supplies, accessories, and services necessary for proper functioning and effective use of the equipment in the rental fee for the monitor and CANNOT be billed separately.
2. Reimbursement for remote alarms and complete parent/caregiver training in use of equipment and completion of necessary medical record paperwork will be included in the monitor rental payment.

Documentation:

Prior to initiation of home apnea monitoring the following must be met:

1. Letter of medical necessity from attending physician describing criteria for use of apnea monitor including the projected length of time equipment will be needed
2. Apnea monitor rental exceeding six months requires a physician's narrative report of member progress that must be maintained in the provider's files.
3. A new progress report is required every two months, after the initial six months.

The report must include:

A. Number of apnea episodes during the previous two-month period of use
B. Tests and results of tests performed during the previous two-month period of use
C. Estimated additional length of time monitor would be needed
D. Any additional pertinent information the physician may wish to provide

Prior Authorization: Not Required

BATH and TOILET AIDS

Covered for purchase for members with medical conditions, which cause decreased stability and safety with ambulation.

Bathtub patient lifts and rehabilitation shower chairs are covered for members with medical conditions who, without use of the equipment, would be unable to bathe or shower.

Equipment/Supplies:

HCPCS Code Range: E0240-E0249; E0167-E0175

Covered items include, but are not limited to, bath/toilet rails, raised toilet seats, tub stools and benches, transfer tub benches and attachments, and bath support chairs.

Indications/Limitations:

Hand-held shower attachments, faucet adapters, etc. are not covered.

Documentation: Written Order

Prior Authorization: Not Required

BEDPANS and URINALS

Covered for members who are confined to bed.

Equipment/Supplies:

HCPCS Code Range: E0275-E0276; E0325-E0326

Includes, but is not limited to, bed pans and urinals.

Indications/Limitations: N/A

Documentation: Written Order

Prior Authorization: Not Required

BEDS AND ACCESSORIES

Covered for members which require positioning of the body in ways not feasible with ordinary bed due to a medical condition.

Equipment/Supplies:

HCPCS Code Range: E0250-E0373;

- Fixed height hospital bed - manual head and leg elevation adjustments, but no height adjustment
- Variable height hospital bed - manual height adjustment and with manual head and leg elevation adjustments
- Semi-electric hospital bed - manual height adjustment and with electric head and leg elevation adjustments
- Total electric hospital bed - electric height adjustment and with electric head and leg elevation adjustments
- Ordinary bed – typically sold as furniture. May consist of a frame, box spring, and mattress, and are fixed height and may or may not have head or leg elevation adjustments

Fixed - covered if one or more of the following criteria are met:

1. Member has medical condition, which requires positioning of the body in ways not feasible with an ordinary bed. Elevation of the head/upper body less than 30 degrees does not usually require the use of a hospital bed, or
2. Member requires positioning of the body in ways not feasible with an ordinary bed in order to alleviate pain, or
3. Member requires the head of the bed to be elevated more than 30 degrees most of the time due to congestive heart failure, chronic pulmonary disease, or problems with aspiration. Pillows or wedges must have been considered and ruled out, an attempt must have been made at using pillows or wedges and there must be documentation as to why they did not work; or
4. Member requires traction equipment, which can only be attached to a hospital bed

Variable - covered if member meets one of the criteria for a fixed height hospital bed and requires a bed height different than a fixed height hospital bed to permit transfers to chair, wheelchair or standing position.

Semi-Electric - covered if member meets one of the criteria for a fixed height bed and requires frequent changes in body position and/or has an immediate need for a change in body position.

Heavy Duty - covered if member meets one of the criteria for a fixed height hospital bed and the member's weight is more than 350 pounds but does not exceed 600 pounds.

Extra-Heavy Duty - covered if the member meets one of the criteria for a hospital bed and the member's weight exceeds 600 pounds.

Pressure reducing mattress – covered for members with or who are highly susceptible to pressure ulcers and whose physician will be supervising its use in connection with member's course of treatment.

Trapeze equipment – covered if member needs this device to sit up because of a respiratory condition, to change body position for other medical reasons, or to get in or out of bed.

Heavy duty trapeze equipment –covered if member meets the criteria for regular trapeze equipment and member's weight is more than 250 pounds.

Bed cradles – covered when necessary to prevent contact with bed coverings,

Side rails or safety enclosures –covered when required by member's condition and are an integral part of, or an accessory to, a covered hospital bed.

Indications/Limitations:

1. If member does not meet any of the coverage criteria for any type of hospital bed, request for bed will be denied as not medically necessary.
2. Total Electric Beds - not covered as the height adjustment feature is a convenience feature.
3. Over bed tables are not covered as they are not primarily medical in nature
4. Replacement innerspring or foam rubber mattresses are covered for member owned hospital bed when medically necessary.

Documentation:

1. Written Order, **Certificate of Medical Necessity,** letter of medical necessity or medical records to explain how the member meets the established criteria below:

    A) Other conservative methods of treatment have been tried; reasons why those treatments were deemed inappropriate or ineffective; or

    B) Member has one or more Stage III or IV decubitus ulcers, pressure sores, or related conditions, or is highly susceptible to decubitus ulcers, or has a condition of fragile skin integrity, or a history of skin ulcers, or insult to skin integrity; or

    C) Member has multiple Stage II decubitus ulcers on trunk or pelvis which have been unresponsive to a comprehensive treatment for at least 30 days using a lesser support surface; or

    D) Member has myocutaneous flap or skin graft for pressure ulcer on the trunk or pelvis within the past 60 days; or

E) Member is bedridden or chair bound, or has limited mobility, but cannot independently make changes in body position significant enough to alleviate pressure; or

F) Member is completely immobile and cannot make changes in body position without assistance

G) Documentation must show member's medical condition, which necessitates the manual variable-height feature. This feature is not reimbursable when it is used convenience of a caregiver

2. Member must have a care plan established by the physician or other licensed healthcare practitioner directly involved in the member's care that should include the following:

   A) Education of member and caregiver on prevention and/or management of pressure ulcers

   B) Regular assessment by a licensed healthcare practitioner

   C) Appropriate turning and positioning

   D) Appropriate wound care (for Stage II, III, or IV ulcer)

   E) Moisture/incontinence control, if needed; and

   F) Nutritional assessment and intervention consistent with the overall plan of care if there is impaired nutritional status

3. Adherence to care plan/treatment is not to be construed as elements for coverage criteria.

Prior Authorization: Required References:

CMS National Coverage Policy

CMS Pub. 100-3 (Medicare National Coverage Determinations Manual) Chapter 1, Sections 280.1, 280.7

BLOOD GLUCOSE MONITORING (CGM)

Covered for members with diabetes.

Equipment/Supplies:

HCPCS Code Range: A4258; E0607; E2100-E2101; A9277

- Includes, but is not limited to, glucometers, alcohol or peroxide pints, alcohol wipes, Betadine or iodine wipes, test strips, batteries and lancets. Continuous glucose monitoring systems are covered for select patients.
- Supplies necessary for effective use and proper functioning of a blood glucose monitor are covered for use with rental and member-owned monitors for member whose condition meets the criteria for coverage of the monitor.

Indications/Limitations:

To be eligible for coverage of a CGM and related supplies, the Member just meet all of the following initial coverage critieria:

1. The Member has diabetes mellitus (Refer to the ICD-10 code list in the LCD-related Policy Article for applicable diagnoses); and,
2. Physician documents that member is capable of being trained to use the particular device prescribed in an appropriate manner. In some cases, the member may not be able to perform this function, but a responsible individual can be trained to use the equipment and monitor the member to ensure that the intended effect is achieved. This is permissible if this information is properly documented by the member's physician; and
3. The CGM is prescribed in accordance with its FDA indications for use; and,
4. The beneficiary for whom a CGM is being prescribed, to improve glycemic control, meets at least one of the criteria below:
    - The beneficiary is insulin-treated; or,
    - The beneficiary has a history of problematic hypoglycemia with documentation of at least one of the following:
        - Recurrent (more than one) level 2 hypoglycemic events (glucose <54mg/dL (3.0mmol/L)) that persist despite multiple (more than one) attempts to adjust medication(s) and/or modify the diabetes treatment plan; or,
        - A history of one level 3 hypoglycemic event (glucose <54mg/dL (3.0mmol/L)) characterized by altered mental and/or physical state requiring third-party assistance for treatment of hypoglycemia
5. Within six (6) months prior to ordering the CGM, the treating practitioner has an in-person or Medicaid-approved telehealth visit with the beneficiary to evaluate their diabetes control and determined that criteria (1)-(4) above are met.

Documentation:

1. Written Order

    A) For Continuous glucose monitoring system, documentation required includes: Written order or CMN

    B) Medical records that document that the member meets the above criteria, including records of finger stick results.

Prior Authorization: Required only for continuous glucose monitoring system.

BLOOD PRESSURE MONITORS

Covered for members with hypertension whose condition must be self-monitored at home. An electronic blood pressure monitor is covered only if the member is unable to use a standard cuff and stethoscope due to conditions such as poor eyesight or hearing, arthritis, or other physical disability.

Equipment/Supplies:

HCPCS Code Range: A4660-A4670

Includes, but is not limited to Sphygmomanometer/blood pressure apparatus with cuff and stethoscope, automatic blood pressure monitor and cuff.

Indications/Limitations:

Blood pressure monitors required for renal dialysis are payable ONLY to approved renal dialysis facilities. (See Dialysis Equipment and Supplies)

Documentation: Written Order

Prior Authorization: Not Required

Reference: Wyoming Medicaid update to website - 7/2008

BREAST PROSTHESES

Covered for members who have had mastectomy.

Equipment/Supplies:

HCPCS Code Range: L8000-L8035; L8600

Includes, but is not limited to, all breast prostheses such as mastectomy bra, mastectomy sleeve, mastectomy form, and silicone or equal.

Indications/Limitations: N/A **Documentation**: Written Order **Prior Authorization**: Not Required

BREAST PUMPS

Breast pumps are not covered for convenience of the mother.

Manual or standard grade electric breast pumps (E0602 or E0603) are covered as a purchase.

Heavy duty, hospital grade breast pumps (E0604) are available for short term rental. Only when "*Certification of Medical Necessity*" is supplied by the prescribing physician. Pumps are rented for a 3- month time frame with re-evaluation of need assessed every 3 months.

Equipment/ Supplies:

HCPCS Code Range: E0602-E0604; A4281-A4286

- May include, but is not limited to manual, standard grade electric or heavy duty, hospital grade breast pump including breast pump starter kit.
- Indicate the RR modifier for rental of heavy duty, hospital grade breast pumps.

Indications:

Breast pumps are covered under the following conditions:

1. Prescribing provider (Physician, Nurse Practitioner or Physician Assistant) certifies that breastfeeding is medically necessary for the infant; AND
2. Mother has received education regarding health, nutritional, immunological, developmental, psychological, social and economic benefits of breastfeeding from the prescribing physician
3. Mother has initiated contact with and plans to receive follow-up support from a community breastfeeding program such as WIC, La Leche League or the community Public Health Nursing Office; or
4. Infant is pre-term or low birth weight with increased nutritional needs; or
5. Infant requires hospitalization longer than the mother; or
6. Infant has diagnosis of cleft palate, cleft lip, Downs Syndrome, cardiac problems, Cystic Fibrosis, PKU, neurological impairment, failure to thrive or other conditions that necessitate breastfeeding; or
7. Infant has cranial facial abnormalities or is unable to such adequately, or
8. Infant has severe feeding problems

Accessories:

Breast pump starter kit must be billed with TH modifier. The TH modifier should only be billed for three months.

For billing: Indicate the RR modifier for rental of breast pumps.

Limitations:

Rental of breast pumps is limited to a maximum of three months per pregnancy unless additional months are medically necessary.

Criteria for Rental

E0604- Prior Authorization is only required for BREAST PUMP, HEAVY DUTY HOSPITAL GRADE. The breast pump is covered when documentation of medical necessity is supplied by the prescribing provider.

Pumps may be rented for up to three-month time period under the following conditions:

1. Mother has diagnosis of breast abscess, mastitis, engorgement or other medical problem that necessitates short term rental of breast pump, or
2. Mother is hospitalized due to illness or surgery on a short-term basis; or
3. Mother will receive short term treatment with medications that may be transmitted to the infant; or
4. Pediatric Healthcare provider determines need for short term rental of heavy-duty pump due to serious medical condition of the infant

Documentation:

1. Written Order or Breast Pump Certificate of Medical Necessity or a letter of medical necessity or medical records to substantiate that the criteria are met
2. Billing under either mother's or infant's Medicaid ID number is acceptable, however all documentation **must match** whichever ID number is being used.

Prior Authorization

Not required for standard/ manual grade. Required for heavy duty, hospital grade electric breast pumps

References: Wyoming Medicaid News dated July 2005 Medical Bulletin 05-014 Wyoming Medicaid News dated April 2006 CMS-1500 Bulletin06-003

CANES AND CRUTCHES

Covered for members with medical condition that causes instability or impairs balance.

Equipment/Supplies:

HCPCS Code Range: E0100-E0105; E0110-E0118

Includes, but is not limited to, canes, walkers, pads, handgrips, and tips.

Indications/Limitations:

1. Payment for purchase and rental includes all accessories necessary for proper functioning and effective use of the item. Accessories such as tips and handgrips are payable for member owned equipment when the member's condition meets the criteria for coverage of the item.
2. Supplies and/or accessories CANNOT be billed in addition to rental equipment.

Documentation: Written Order

Prior Authorization: Not Required

COMMODES/CHAIRS

Covered for members confined to bed, room or home where without bathroom facilities on floor or bathroom facilities are inaccessible.

Equipment/Supplies:

HCPCS Code Range: E0160-E0175

Includes but is not limited to, commode chairs, pails and footrests.

Indications/Limitations:

1. A commode chair with detachable arms is covered only if documentation supports medical necessity in cases such as obesity, paraplegia, etc.
2. Payment for purchase and rental of a commode includes all accessories necessary for proper functioning and effective use of the commode.
3. Accessories such as a commode pail or pan are payable only as replacement for use with member- owned commodes whose condition meets the criteria for coverage.
4. Supplies/accessories CANNOT be billed in addition to rental equipment
5. ACTIVITY CHAIRS ARE NOT COVERED CHAIRS.

Documentation: Written Order

Prior Authorization: Not required for most commodes, but is required for E0170 (Purchase Only)

CONTINUOUS PASSIVE MOTION (CPM) DEVICES

Covered for members who have had surgical knee replacement or arthroplasty.

Equipment/Supplies:

HCPCS Code Range E0935

Payment for rental includes all accessories necessary for proper functioning and effective use of the device.

Indications/Limitations:

1. Use of CPM device must begin within 2 days following surgery
2. Coverage is limited to 10 days-21 days following knee replacement/arthroplasty when device is used in member's home

Role of CPM in long-term benefit for elbow and shoulder surgeries remains uncertain; for hallux valgus and bunions, a systematic review suggested that using CPM appeared to improve range of motion and provide somewhat earlier post-bunionectomy recovery, however, evidence of incremental long-term benefit was lacking. CPM did not enable an earlier return to normal shoes.

Documentation:

Written Order from physician with letter of medical necessity to explain length of need if device is to be used longer than 21 days.

Prior Authorization: Required

C-PAP/BI-PAP MACHINE

This item subject to capped rental and covered for members diagnosed with mild to moderate or severe obstructive sleep apnea and for whom surgical intervention may be a likely alternative.

Intermittent assistive devices (BiPAP S or BiPAP ST, and C-PAP) are covered and are reimbursable for skilled nursing facility members.

CPAP/BI-PAP MACHINES initiate positive pressure therapy in members with obstructive sleep apnea (OSA) or other respiratory difficulties.

AHI is equal to the average number of episodes of apnea and hypopnea per hour and must be based on a minimum of 2 hours of sleep recorded by polysomnography using actual recorded hours of sleep. AHI may not be extrapolated or projected.

Apnea is defined as a cessation of airflow for at least 10 seconds.

Hypopnea is defined as an abnormal respiratory event lasting at least 10 seconds with at least a 30% reduction in thoracoabdominal movement or airflow as compared to baseline, and with at least a 4% oxygen desaturation.

Equipment/Supplies:

HCPCS Code Range: E0601; A7030-A7044

- Continuous positive airway pressure devices (CPAP), auto-titration (A-PAP), bi-level positive airway pressure devices (BiPAP S or BiPAP ST), nasal applications, filters, tubing, headgear, and chin strap.
- Combination oral/nasal masks (A7029) should be used when billing for combination oral/nasal masks.
- Supplies and accessories such as masks, filters, tubing, headgear, and chin straps are covered as replacement for member owned systems and CANNOT be billed in addition to rental equipment.
    - Humidifier units (E0561 or E0562) can be billed separate from the CPAP when it is ordered documented as medically necessary by the treating physician.
- The following codes may be used when billing for replacement accessories:
    - A7028- Oral cushion for combination oral/nasal mask, replacement only, each
    - A7029- Nasal pillows for combination oral/mask, replacement only, pair

Initial Coverage:

1. An E0601 device is covered for the treatment of obstructive sleep apnea (OSA) if criteria A – C are met:

    A. The beneficiary has an in-person clinical evaluation by the treating practitioner prior to the sleep test to assess the beneficiary for obstructive sleep apnea.

B. The beneficiary has a sleep test (as defined below) that meets either of the following criteria (1 or 2):

1. The apnea-hypopnea index (AHI) or Respiratory Disturbance Index (RDI) is greater than or equal to 15 events per hour with a minimum of 30 events; or,
2. The AHI or RDI is greater than or equal to 5 and less than or equal to 14 events per hour with a minimum of 10 events and documentation of:
   a. Excessive daytime sleepiness, impaired cognition, mood disorders, or insomnia; or,
   b. Hypertension, ischemic heart disease, or history of stroke.

C. The beneficiary and/or their caregiver has received instruction from the supplier of the device in the proper use and care of the equipment.

2. An E0470 device is covered for those beneficiaries with obstructive sleep apnea who meet criteria above in addition to criterion D:

D. An E0601 has been tried and proven ineffective based on a therapeutic trial conducted in either a facility or home setting.

Ineffective is defined as documented failure to meet therapeutic goals using an E0601 during the titration portion of a facility-based study or during home use despite optimal therapy (i.e., proper mask selection and filling and appropriate pressure settings.)

If an E0601 device is tried and found ineffective during the initial facility based titration or home trial, substitution of an E0470 does not require a new initial in-person clinical evaluation or a new sleep test.

If an E0601 device has been used for more than 3 months and the beneficiary is switched to an E0470 a new initial in-person clinical evaluation is required, but a new sleep study test is not required. A new 3 month tribal would begin for the use of the E0470.

Coverage

Coverage and Payment rules for diagnostic sleep tests may be found in the CMS National Coverage Determination (NCD) 240.4.1 (CMS Pub.100-03, Chapter 1, Part 4), the applicable A/B MAC LCDs and Billing and Coding articles. The sleep test must be either a polysomnogram performed in a facility-based laboratory (Type I study) or an inpatient hospital-based or home-based sleep test (HST) (Types II, III, IV, Other).

Coverage of a PAP device for the treatment of OSA is limited to claims where the diagnosis of OSA is based upon all of the following:

1. A sleep test (Type I, II, III, IV, Other) that meets the Medicare requirements for a valid sleep test as outlined in NCD 240.4.1 and the applicable A/B MAC LCD and Billing and Coding article; and,
2. A sleep test that is approved by the Food and Drug Administration (FDA) as a diagnostic device; and,
3. The sleep test results meet the coverage criteria in effect for the date of service of the claim for the PAP device; and,

4. The sleep test is ordered by the beneficiary's treating practitioner; and,
5. The sleep test is conducted by an entity that qualifies as a Medicare provider of sleep tests and is in compliance with all applicable state regulatory requirements.

CONTINUED COVERAGE BEYOND THE FIRST THREE MONTHS OF THERAPY:

Continued coverage of a PAP device (E0470 or E0601) beyond the first three months of therapy requires that, no sooner than the 31st day but no later than the 91st day after initiating therapy, the treating practitioner must conduct a clinical re-evaluation and document that the beneficiary is benefiting from PAP therapy.

For PAP devices with initial dates of service on or after November 1, 2008, documentation of clinical benefit is demonstrated by:

1. In-person clinical re-evaluation by the treating practitioner with documentation that symptoms of obstructive sleep apnea are improved; and,
2. Objective evidence of adherence to use of the PAP device, reviewed by the treating practitioner.

Adherence to therapy is defined as use of PAP ≥4 hours per night on 70% of nights during a consecutive thirty (30) day period anytime during the first three (3) months of initial usage.

If the above criteria are not met, continued coverage of a PAP device and related accessories will be denied as not reasonable and necessary.

If the treating practitioner re-evaluation does not occur until after the 91st day but the evaluation demonstrates that the beneficiary is benefiting from PAP therapy as defined in criteria 1 and 2 above, continued coverage of the PAP device will commence with the date of that re-evaluation.

Beneficiaries who fail the initial 12 week trial are eligible to re-qualify for a PAP device but must have both:

1. In-person clinical re-evaluation by the treating practitioner to determine the etiology of the failure to respond to PAP therapy; and,
2. Repeat sleep test in a facility-based setting (Type 1 study). This may be a repeat diagnostic, titration or split-night study.

If an E0601 device is tried and found ineffective during the initial facility-based titration or home trial, substitution of an E0470 does not change the length of the trial unless there is less than 30 days remaining in the trial period. If more than 30 days remain in the trial period, the clinical re-evaluation would still occur between the 31st and 91st day following the initiation of an E0601 and objective documentation of adherence on the E0470 would need to occur prior to the 91st day following initiation of the E0601. If less than 30 days remain in the trial period, the clinical re-evaluation and objective documentation of adherence must occur before the 120th day following the initiation of the E0601.

If an E0601 device was used for more than 3 months and the beneficiary was then switched to an E0470, the clinical re-evaluation must occur between the 31st and 91st day following the initiation of the E0470. There would also need to be documentation of adherence to therapy during the 3 month trial with the E0470.

If there is discontinuation of usage of a PAP device at any time, the supplier is expected to ascertain this and stop billing for the equipment and related accessories and supplies.

REPLACEMENT:

This section applies to PAP devices initially provided and covered while the beneficiary was in Medicare fee-for-service (FFS).

If a PAP device is replaced during the 5 year reasonable useful lifetime (RUL) because of loss, theft, or irreparable damage due to a specific incident, there is no requirement for a new clinical evaluation, sleep test, or trial period.

If a PAP device is replaced following the 5 year RUL, there must be an in-person evaluation by their treating practitioner that documents that the beneficiary continues to use and benefit from the PAP device. There is no requirement for a new sleep test or trial period.

Child Qualification Criteria Includes:

1. Signs and symptoms consistent with obstructive sleep apnea
2. Nocturnal signs and symptoms such as:
    A. Pauses in breathing
    B. Gasps
    C. Signs of increased respiratory effort (i.e., nasal flaring)
    D. Enuresis
    E. Sweating
    F. Snoring
3. Daytime signs and symptoms such as:
    A. Nonspecific behavioral problems

Documentation:

1. Written Order or **Certificate of Medical Necessity** or letter of medical necessity to describe specific indications for the member
2. Documentation must also be maintained in the file to include the following if applicable to condition/symptoms:
    a. AHI greater than or equal to 15 events per hour or
    b. AHI greater than or equal to 5 and less than or equal to 14 events per hour with documented symptoms of excessive daytime sleepiness, impaired cognition, mood disorder or insomnia, or documented hypertension, ischemic heart disease, or history of stroke

c. Any other relevant copies of member's sleep lab evaluations, pulmonary function tests, sleep latency testing and 02 saturations
d. Present physical symptoms: Morning headache, fatigue level, increase in irritability, difficulty with memory or intellect
e. Pertinent lab values (e.g. elevated PaC02, etc.)
f. Other methods attempted and why they were deemed inappropriate or ineffective
g. Follow-up at 1-3 months intervals documenting improvement in the member's condition

Prior Authorization: Required

References:

Wyoming Medicaid News dated November 2007 CMS-1500 Bulletin 07-012

DIALYSIS EQUIPMENT and SUPPLIES

Wyoming Medicaid reimburses for dialysis systems, related supplies and equipment only **to approved renal dialysis facilities** under the Medicare payment methodology.

Payment CANNOT be made to DME suppliers, pharmacies or home health agencies for dialysis systems, related supplies and equipment.

DRESSINGS

Covered for members who require treatment of a wound or surgical incision

HCPCS Code Range: A4450-A6457

Indications/Limitations: None

Documentation: Written order

Prior Authorization: Not Required

EYE PROSTHESES

Covered for members with absence or shrinkage of eye due to birth defect, trauma, or surgical removal

Equipment/Supplies:

HCPCS Code Range: V2623-V2629 (V2627 and V2629 require a prior authorization)

Includes, but is not limited to:

- Prosthetic eye, plastic, custom
- Polishing/resurfacing of ocular prosthesis
- Enlargement of ocular prosthesis
- Reduction of ocular prosthesis
- Scleral cover shell
- Fabrication and fitting of ocular conformer
- Prosthetic eye, other type

Indications/ Limitations:

1. One enlargement or reduction of the prosthesis is covered without documentation. Additional enlargements or reductions are rarely medically necessary and are covered only when information in the medical record supports the medical necessity.
2. Replacement of an ocular prosthesis before five years is covered if the prosthesis is irreparably damaged, lost or stolen.

Documentation: Written Order

Prior Authorization: Not Required (V2627 and V2629 require a prior authorization)

References: www.medicare.gov/

GAIT TRAINERS

This policy is designed to address medical guidelines that are appropriate for the majority of individuals with a particular disease, illness, or condition. Each person's unique clinical circumstances may warrant individual consideration, based on review of applicable medical records.

Rental/Purchase: Purchase

Definition: Gait Trainer is a term used to describe certain devices (types of walkers) that are used to support a member during ambulation.

Examples: Mobility devices other than standard walkers including those with trunk support

HCPCS Codes (this is not an all-inclusive list)

A4636	A4637	A9270	A9900	E0130	E0135
E0140	E0141	E0143	E0144	E0147	E0148
E0149	E0154	E0155	E0156	E0157	E0158
E0159	E1399				

Criteria:

1. Gait trainers are billed using one of the codes for walkers.
2. The member is unable to ambulate independently with a **standard** front or reverse walker because of the need for postural support, due to a chronic neurological condition including abnormal movement patterns, poor balance, poor endurance, or other clearly documented reasons.
3. The anticipated functional benefits of walking are not attainable with the use of a **standard** walker.
4. Must demonstrate tolerance for standing and weight bearing through the lower extremities.
5. Used in the home and/or community by the individual without significant assistance by another individual.
6. The medical necessity for a walker with an enclosed frame (E0144) compared to a standard folding wheeled walker, E0143, has not been established. Therefore, if the basic coverage criteria for a walker are met and code E0144 is billed, payment will be based on the allowance for the least costly medically appropriate alternative, E0143.
7. A walker with trunk support (E0140) is covered for patients who meet coverage criteria for a standard walker and who have documentation in the medical record justifying the medical necessity for the special features. If an E0140 walker

is provided and the special features are not justified, but the patient does meet the coverage criteria for a standard walker, payment will be based on the allowance for the least costly medically appropriate alternative.

Documentation:

- An order for each item billed must be signed and dated by the treating physician.
- Potential benefits to the individual of assisted walking must be clearly documented as follows:
    - The member must be involved in a therapy program established by a physical therapist.
    - The program must include measurable documented objectives and functional goals related to the member and equipment that includes a written carry over plan to be utilized by the member and/or caregiver.
    - The equipment must match the user's needs and ability level.
    - The member has had a trial of the requested gait trainer (GT) and the member shows compliance, willingness, and ability to use the GT in the home.
    - Provide a picture of the requested gait trainer which clearly depicts the type of gait training device and any accessories.

Indications: Need to be reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member/part.

Prior Authorization: Required

References:

Section 1833(e) of the Social Security Act.

CMS Pub. 100-3 Medicare National Coverage Determinations Manual, Chapter 1, Section 280.3 Medicare Advantage Medical Policy Bulletin-Section-DME-Number-E-76-Topic-Walkers

Issue Date-12/31/07-Effective Date-1/1/08

HEAT/COLD APPLICATION DEVICES

Covered for members with medical conditions for which the application of heat and cold is therapeutic.

Equipment/ Supplies:

HCPCS Code Range: E0200-E0249

Includes, but is not limited to:

- Heating pads (moist and dry)
- Water circulating pumps
- Hot water bottles
- Ice cap or collar
- Pads for water circulating heat units

Indications/Limitations:

Supplies/accessories are covered as replacement for member-owned equipment only and CANNOT be billed in addition to the equipment with rental equipment.

Documentation: Written Order

Prior Authorization: Not Required

INCONTINENCE APPLIANCES and CARE SUPPLIES

Covered for members who are unable to control bladder or bowel function

Equipment/Supplies:

HCPCS Code Range: A4310-A5200; T4521 – T4537; T4539 – T4544

Please check the HCPCS book for appropriate codes

Indications/Limitations:

Incontinence diapers/briefs and liners are not covered for members under age three; limited to a 30 - day supply. The below codes are limited as indicated and when noted are a combined amount:

T4521 – T4524 and T4529 – T4534: 390 per calendar month (codes combined amount)

T4525 - T4528 and T4543 and T4544: 210 per calendar month (codes combined amount)

T4535: 210 per calendar month (codes combined amount)

T4536 – T4537: 4 per calendar month

T4539 – T4540: 3 per calendar month

T4535, T4541 and T4542 - 210 per calendar month (codes combined amount)

Documentation: Written Order

Prior Authorization: Not Required

INFUSION PUMPS, EXTERNAL and ACCESSORIES

Covered for members with conditions requiring intermittent or continual infusion of medication or nutrition when this form of administration is safe, reasonable and necessary (e.g. chemotherapy, severe spasms, chronic intractable pain), and when an infusion pump is necessary to safely administer medication.

Also covered for members with conditions that require the subcutaneous infusion of insulin in the treatment of diabetes.

Infusion Pump - A device whether internal or external used for venous access, infusion of medication, chemotherapy, blood transfusions or nutrition i.e. enteral pumps, parenteral pumps, insulin pumps, and ambulatory pumps.

Equipment/Supplies:

HCPCS Code Range: E0776-E0791; C1772; C2626; B4220-B4224; B9000-B9006

- Supplies necessary for effective use and proper functioning of an external infusion pump are covered for use with rental and member-owned pumps for members whose condition meets the criteria for coverage of the pump.
- Services necessary for maintenance of an infusion pump that is in use for an indefinite period of time are covered after the capped rent limit has been reached. Providers should bill this maintenance with code S5035 Home Infusion Therapy, Routine Service of Infusion Device (e.g. Pump Maintenance). This requires a Prior Authorization.
- Note: For billing of medications administered with external infusion pumps, see Pharmacy
- Services Billing Module. Please see the HCPCS book for appropriate codes.

Indications/Limitations:

1. When considering location for administration of long-term infusion, home provides an option for many individuals. While high-tech home care is perceived to have value to patients, families, healthcare providers, and insurers, this technology may trigger some levels of anxiety.
2. Recognizing physical and psychological limitations, and environmental barriers, measures can be taken to ensure appropriate and successful use of technology in the home. A team, consisting of the patient, physician, nurse, and pharmacist, must work together to ensure that all the required elements are in place.
3. With proper education, support, and oversight, home infusions can be safely managed by the patient, a family member, a health care professional, or a designated caregiver.
4. When pump is to be used for infusing of medication, the following criteria must be met (A, B, and C or A, D, and E):
    a. Parenteral administration of medication in the home is reasonable and necessary

b. The drug is administered by a prolonged infusion of at least 4 hours because of proven improved clinical efficiency
c. Therapeutic regimen is proven or generally accepted to have significant advantages over:
d. intermittent bolus administration regimens
e. infusions lasting less than eight hours, or
f. when pump is used for infusion of medications such as antibiotics or steroids which require an intermittent syringe pump
g. Drug is administered by intermittent infusion (each episode lasting less than eight hours), which does not require the patient to return to the physician's office prior to the beginning of each infusion
h. Systemic toxicity or adverse effects of the drug is unavoidable without infusing it at a strictly controlled rate as indicated by the Facts and Comparisons, American Medical Association's Drug Evaluations, or the U.S. Pharmacopeia Drug Information

Documentation: Written Order or **Certificate of Medical Necessity** or letter of medical necessity or medical records to clearly document that member meets criteria above including:

1. Medical history of member
2. Parenteral nutrition solution or medication to be administered, quantity, frequency and duration
3. Specific route of administration (i.e. Hep lock, PICC line, central line, etc.)
4. Person who will be administering the medication or nutrition; and
5. All other methods attempted and why they were deemed ineffective or inappropriate
6. For routine maintenance of an infusion pump, a written order substantiating the need for ongoing/long-term infusion pump needs, and a PA request form documenting the length of time since the last maintenance was performed.
7. Additional Information:
    a. If pump is to be used for chemotherapy:
        i. Location of cancer
        ii. Specific medication to be given; and
        iii. Expected outcome
    b. If pump is to be used for anti-spasmodic drugs:
        i. Length and severity of spasms
        ii. Minimum six-week trial documenting that member cannot be maintained on noninvasive methods of spasm control or that these methods have intolerable side effects
        iii. Prior to pump placement, member must have responded favorably to a trial dose of the intrathecal, anti-spasmodic medication
    c. If pump is to be used for chronic, intractable pain:
        i. Specific location of pain

ii. Length and severity of pain
iii. Member history indicates adequate response to non-invasive methods of pain control including attempts to eliminate physical and behavioral abnormalities which may cause an exaggerated reaction to a drug
iv. Preliminary trial of intraspinal opioid drug administration must be undertaken with temporary intrathecal/epidural catheter to substantiate adequately acceptable pain relief and degree of side effects (including effects on the activities of daily living) and member acceptance

d. If pump is to be used for uncontrolled diabetes:
   i. Length of time the member has had condition
   ii. Frequency of blood sugar testing; and
   iii. Member's previous treatment regimen

Prior Authorization: Required, for pump rental and maintenance codes

INHALATION - CONTROLLED DOSE DRUG DELIVERY INHALATION SYSTEM

Covered for members for the administration of Iloprost inhalation solution. Item is subject to capped rental.

Iloprost - also known as Ventavis, is a prescription medication for adults with certain kinds of severe pulmonary hypertension. It is used to improve exercise ability and symptoms for a brief time.

Equipment/Supplies:

HCPCS Code Range K0730 Includes the following:

- Nebulizers
- Compressors
- Iloprost Inhalation Solution
- Mouthpiece
- Filters
- Tubing

Accessories and supplies are covered as replacement for use with member owned systems and CANNOT be billed in addition to rental equipment. Distilled water is NOT covered.

Indications/Limitations:

1. Member diagnosed 416.0-Primary Pulmonary Hypertension OR 416.8 – Other Chronic Pulmonary Heart Disease AND pulmonary hypertension is not secondary to pulmonary venous hypertension (e.g. left sided atrial or ventricular disease, left sided valvular heart disease) or disorders of the respiratory system (e.g. chronic obstructive pulmonary disease, alveolar hypoventilation disorders), AND
2. Member has primary pulmonary hypertension or pulmonary hypertension, which is secondary to one of the following conditions: connective tissue disease, thrombo- embolic disease of the pulmonary arteries, human immunodeficiency virus (HIV) infection, cirrhosis, diet drugs, congenital left to right shunts, etc. AND
3. The following criteria (A-D) must be met:
    a. Pulmonary hypertension has progressed despite maximal medical and/or surgical treatment of the identified condition; AND
    b. Mean pulmonary artery pressure is greater than 25 mm Hg at rest or greater than 30 mm Hg with exercise; AND
    c. Member has significant symptom from pulmonary hypertension (such as severe dyspnea on exertion, and either fatigability, angina, or syncope); AND
    d. Treatment with oral calcium channel blocking agents has been tried and failed, or has been considered and ruled out

Ultrasonic nebulizers are covered ONLY when other means of mobilization are documented by the physician to be ineffective.

Portable compressors with an internal battery feature REQUIRE specific documentation from the physician justifying the medical necessity of the portable feature.

All rental items must be billed with the RR modifier to indicate rental not purchase.

If K0730 is used to administer any other covered nebulizer drug other than Iloprost and the coverage criteria for (not covered) are met, payment will be based on the allowance for the least costly medically appropriate alternative.

Documentation:

Written Order or **Certificate of Medical Necessity or** letter of medical necessity or medical records to clearly document that member meets criteria above

Prior Authorization: Required

References:

Wyoming Medicaid News dated November 2007

CMS-1500

Bulletin 7-14

http://www.fda.gov/Cder/Drug/InfoSheets/patient/iloprostPIS.htm

INTERMITTENT POSITIVE PRESSURE BREATHING (IPPB) MACHINES

Covered for members whose ability to breathe is severely impaired or whose condition or diagnosis indicates the necessity for IPPB therapy.

Equipment/ Supplies:

HCPCS Code Range E0500

- IPPB machine, all types
- Built-in nebulization
- Manual or automatic valves
- Internal or external power source

Payment for rental of an IPPB machine includes all accessories necessary for proper functioning and effective use of the machine.

Indications/Limitations:

The following supplies/accessories are covered as replacement for member-owned IPPB machines only and CANNOT be billed in addition to rental equipment:

1. Breathing circuits
2. Humidifiers **Documentation**: Written Order **Prior Authorization**: Not Required

LIFTS

Covered for members who are unable to transition from lying or sitting to standing

Equipment/Supplies:

HCPCS Code Range: E0621-E0642

- Seat lift mechanism
- Sling or seat-patient lift
- Member lift-non electric
- Hydraulic/Hoyer lift-with seat or sling
- Multi-positional patient support system
- Combination sit to stand system-pediatric

Indications/Limitations: Seat-Lift Mechanisms

1. Seat lift mechanisms **meet the definition of medical necessity** when **ALL** of the following criteria are met:
    a. The individual has severe arthritis of the hip or knee, or has a severe neuromuscular disease
    b. The seat lift is part of the physician's treatment plan and is prescribed to effect
    c. improvement or arrest/retard deterioration of the individual's condition
    d. The individual is completely incapable of standing up from any chair in their home. (It is not sufficient justification for a seat lift mechanism if the individual has difficulty rising from a chair or is unable to stand up from a low chair. Almost all individuals capable of ambulation are able to rise from an ordinary chair if the seat height is appropriate and the chair has arms.)
    e. Once standing, the individual is capable of ambulation.
    f. Have all appropriate therapeutic modalities to enable the patient to transfer from a chair to a standing position (e.g., medication, physical therapy) been tried and failed? If yes, this is documented in the patient's medical records.
2. Medically necessary seat lift mechanisms are those devices that operate smoothly, can be controlled by the individual, and effectively assist the individual in standing up and sitting down without other assistance.

NOTE: For a seat-lift mechanism, coverage is only allowed for the **E0627** (Seat Lift Mechanism Incorporated Into A Combination Lift-Chair Mechanism). Providers should submit the charge for the corresponding recliner chair under code **A9270** (Non-Covered Item Or Service) and may balance bill members for this charge.

NOTE: Vehicle lifts such as those used for transporting scooters, power wheelchairs, or manual chairs are not covered

NOTE: Seat lift mechanisms that operate by spring release action with a sudden, catapult-like motion that jolts the individual from a seated position to a standing position are not covered.

1. For other patient lifts
    a. Member/caregiver must be able to use lift and has completed successful trial, if first time
    b. Without the use of a lift, member would be confined to bed; or
    c. Transfer between bed and a chair, wheelchair or commode requires the assistance of more than one person
2. Supplies/accessories are covered as replacement for member-owned patient lift only and CANNOT be billed in addition to rental equipment-slings or seats-canvas or nylon.

Documentation:

Written Order or **Certificate of Medical Necessity** or letter of medical necessity or medical records to document that member meets established criteria above

Prior Authorization: Required

MEDICAL FOODS

Benefits, Limitations, and Authorization Requirements

Medical foods are a benefit of the Wyoming Medicaid program for members under age 21 with inborn errors of metabolism that prohibit them from eating a regular diet.

Medical foods are defined as:

- Lacking in the compounds which cause complications of the metabolic disorder.
- Not generally available in grocery stores, health food stores, or pharmacies.
- Not used as food by the general population.
- Not foods covered under the Food Stamps program.

Providers must use procedure codes S9434 or S9435 when submitting claims for medical foods. Procedure codes S9434 and S9435 will require prior authorization.

Wyoming Medicaid will only pay for food with nutritional value. The following will be excluded from coverage:

Foods with Minimal Nutritional Value				
Cakes	Cake mixes	Candy	Candy covered items	Chips
Chocolate	Chocolate covered items	Cookies	Cookie dough	Dessert items
Gum	Onion rings	Pies		

Foods described as gluten-free are not a benefit of the Wyoming Medicaid program. For purposes of billing, one unit is equal to one package/case

Providers must dispense the most cost-effective product in accordance with a prescription from a licensed physician. Quantity of food billed must be substantiated by a dietician's meal plan.

Documentation/Prior Authorization Requirements:

Providers requesting medical foods must be enrolled as a Wyoming Medicaid DME provider. The following must be included with any prior authorization requests for Medical Food:

- Written order
- Letter of Medical Necessity for coverage of medical foods signed by dietician and physician (please see included sample letter)
- Detailed dietary plan written by dietician/physician
- Total number of units requested

Please submit all prior authorization requests for Medical Foods through Qualitrac: To gain access to Qualitrac please register on the following webpage: https://wymedicaid.telligen.com

For general questions or Qualitrac training please contact your Provider Relations representative or email wymedicaidum@telligen.com.

SAMPLE LETTER FOR MEDICAID COVERAGE OF MEDICAL FOODS

(To be put on provider's letterhead)

(Date)

RE: (member name)

D.O.B.: (member date of birth)

To Whom It May Concern:

We are writing a letter of medical necessity regarding the treatment of (member first name & last name). (member name) has been under the consultative care of the (clinic name). He/She has an inborn error of metabolism, a genetic disorder, known as phenylketonuria (PKU, ICD 9 270.1). We are writing to request that medical food/formula be covered by his/her current medical insurance.

PKU is a lifelong problem that requires a phenylalanine-restricted diet and the prescription of special medical foods by a license physician with the support of a registered dietician in order to control the blood phenylalanine level. The term medical food/formula as defined in section 5(b) of the Orphan Drug Act {21 U.S.C. 360ee (b) (3)} is a "food which is formulated to be consumed or administered internally under the supervision of a physician and which is intended for the specific dietary management of a disease or condition for which distinctive nutritional requirements, based on recognized scientific principles are established by medical evaluation."

PKU results from a deficiency of the enzyme responsible for metabolizing the amino acid phenylalanine. This results in the build-up of phenylalanine to toxic levels. An untreated child with PKU will suffer irreversible brain damage as well as severe and progressive neurological disorders. Normal growth and development are possible if an infant with PKU is treated appropriately. In adolescents and adults, neurological deterioration, phobias, difficulty in concentration and impulse control, and loss of IQ points can occur if treatment is not sustained.

Patients are treated with prescribed medical foods/formulas (in a variety of forms, powder, capsule, liquid, bar, etc.), special low-protein modified food products as well as a phenylalanine-restricted diet. This diet excludes all foods high in protein (i.e. meat, poultry, fish, dairy, nuts and legumes) and markedly restricts all grains, including rice, breads, and pastas. Currently, (patient name) is prescribed (name of medical formula) which is a medical formula used to manage PKU. Medical foods/formulas provide the primary protein constituent (80-85% of RDA protein) for the PKU dietary treatment regimen. Use of these products is medically supervised by a physician and implemented by a registered dietician specially trained in the nutrition management of inborn errors of metabolism. Nutrition therapy must also provide a sufficient and balanced intake of other nutrients to avoid nutritional deficiencies. Nutrition therapy of PKU solely via protein restriction is not possible, because it will result in protein malnutrition, calorie deprivation, vitamin and mineral deficiency, failure-to-thrive, and potentially death.

The standard of care for PKU requires the use of the medical food/formulas and a phenylalanine- restricted diet, as well as routine nutrition follow-up with a specially trained registered dietician. The two primary goals of treatment are:

1. To maintain the blood phenylalanine at a level that is not toxic, but still allows for normal growth and development.
2. To ensure that the individual's overall nutritional requirements are met, allowing for normal growth and development, and the avoidance of nutritional deficiencies.

The recommended treatment range of blood phenylalanine levels for individuals with PKU is between 2 and 6mg/dL (120 and 360f1moi/L). There is good correlation of cognitive function and maintenance of blood phenylalanine levels in this treatment range. Elevated blood phenylalanine in patients has been associated with behavior and learning problems which can reverse when the blood levels return to the treatment range. Currently, indefinite continuation of dietary management is recommended to all patients with PKU. These recommendations are based on a growing body of evidence indicating there is a decline in average IQ and development of difficulties in school performance after diet discontinuation.

We appreciate your attention to this request for (patient's name)'s medical formula, (name of medical formula) to be covered by his/her current medical insurance. Please to not hesitate to contact us if you have any questions at (clinic contact info).

Sincerely,

(dietician name), RD, LDN

(Physician name), M.D.

cc: (parents name)

(physician credentials, clinic name)

MEDICAL/SURGICAL SUPPLIES

Covered for members who require home treatment of a specific medical condition, protection or support of a wound, surgical incision, or diseased or injured body part.

Equipment/Supplies:

HCPCS Code Range: A4206-A6404

Includes, but is not limited to:

- Syringes
- Needles
- Irrigation trays
- Tape
- Disposable under pads
- Lubricant

Indications/Limitations: None

Documentation: Written Order

Prior Authorization: Not Required

MEDICATION DISPENSER (Automatic)

Covered for members who are unable to effectively and safely self-medicate, due to a medical or mental condition, or are non-compliant due to lack of supervision. Item is subject to capped rental.

Equipment/Supplies:

HCPCS Code Range S5185

- Electronic medication dispenser
- Pillbox timer
- Vibrating pillbox timers
- Video medication reminder

Indications/Limitations:

1. A determination that the member may be non-compliant due to one or more of the following factors:
    a. Complex drug regimen
    b. Forgetfulness
    c. Sensory deficit
    d. Lack of understanding
    e. Lack of supervision
    f. Inability to self-medicate
2. Documentation that non-compliance has resulted in the following conditions due to INAPPROPRIATE use of medication:
    a. Relapse into illness
    b. Under-utilization of medications
    c. Ineffective drug therapy
    d. Over dosage
    e. Hospitalization
    f. Varying drug levels leading to unpredictable therapeutic results
3. Not covered for residents of skilled nursing facilities

Documentation:

Written Order or **Certificate of Medical Necessity or** letter of medical necessity or medical records to document that member meets established criteria above

Prior Authorization: Required

NEBULIZERS and COMPRESSORS

Covered to administer aerosol therapy when use of a metered dose inhaler is not adequate or appropriate.

Equipment/Supplies:

HCPCS Code Range: E0570-E0585; E0565-E0570; (K0738; Prior Auth: Required) Includes but is not limited to:

- Nebulizers
- Compressors

Indications/Limitations:

1. Member must meet one of the following:
    a. Member's ability to breathe is severely impaired, or
    b. Required for use in connection with durable medical equipment for purposes of moisturizing oxygen, or
    c. Treat respiratory conditions including chronic bronchitis, emphysema, cystic fibrosis, HIV, organ transplant complications, tracheostomy or other illnesses that cause thick mucus secretions
2. Ultrasonic nebulizers are covered only when other means of mobilization are documented by the physician to be ineffective.
3. Heated nebulizers are covered for members with tracheotomies that require heated oxygen.
4. Portable compressors with an internal battery feature requires specific documentation from the physician justifying the medical necessity of the portable feature.
5. The following supplies/accessories are covered as replacement for use with member-owned equipment for a member whose condition meets the criteria for coverage of the compressor and CANNOT be billed with rental equipment:
    a. Mouth pieces
    b. Face tents
    c. Filters
    d. Tubing
6. Distilled water is not covered; for billing of medications for inhalation therapy, see the Pharmacy Services Billing Module.

Documentation: Written Order

Prior Authorization: Not Required

References: Centers for Medicare & Medicaid Services

NEUROMUSCULAR ELECTRICAL STIMULATORS (NMES)

Intact, including brain, spinal cord, and peripheral nerves, and other non-neurological reasons for disuse are causing atrophy such as:

- Castings or splinting of a limb,
- Contracture due to scarring of soft tissue as in burn lesions
- Hip replacement surgery (until orthotic training begins)

Equipment/ Supplies:

HCPCS Code Range E0745-E0762

- Neuromuscular stimulator
- Electronic shock unit

Indications/Limitations:

1. Neuromuscular electric stimulators are not covered for treatment of Scoliosis.
2. The following supplies/accessories are covered as replacement for member-owned equipment only and CANNOT be billed in addition to the equipment with rental equipment:
    a. Electrodes
    b. Lead wires

Documentation: Written Order

Prior Authorization: Not required

NUTRITION THERAPY

Nutrition therapy is providing essential nutrients, vitamins, and minerals to meet recommended dietary allowances, adequate calories to meet energy requirements, and adequate proteins to maintain weight and strength. Nutrition therapy is provided in two ways, enteral or parenteral. Since Parenteral nutrition is not considered DME it does not require prior authorization.

Equipment/Supplies:

The following medical supplies are covered when used in conjunction with home enteral/ parenteral therapy and are considered necessary for administration of the therapy:

- IV Poles
- Parenteral/Enteral Pumps
- Cassettes
- Administration Kits
- Dressing Kits
- Preparation Supplies
- Pump Supplies
- Flush Supplies

Indications/Limitations:

Nutrition Therapy Provider Guidelines:

1. Providers must be enrolled as medical supply (DME) providers to be eligible for reimbursement for any legend nutrition therapy (mainly parenteral)
2. Providers must comply with current Wyoming State Board of Pharmacy rules and regulations for parenteral
3. Providers are required to verify member eligibility
4. Maintain required documentation and coordinate with other healthcare providers involved in the member's care
5. Providers must provide education to include instructions and demonstrations in aseptic technique and appropriate storage methods for solution
6. Providers must document that the above requirements and education standards have been met before providing enteral/parenteral therapy

Members or their family who administer the enteral or parenteral therapy must:

1. Be trainable and able to maintain the appropriate procedures needed in the home setting
2. Provide a clean and safe environment in which to administer therapy
3. Demonstrate appropriate disposal of hazardous solutions, intravenous administration supplies, and substances
4. Be able to properly dispose of controlled substances in the home

5. Have documentation stating the member can perform independent administration

Nursing Facility:

1. Parenteral nutrition is separately reimbursable in addition to the nursing facility per diem if the member meets the requirements.
2. Enteral nutrition is not a legend drug and is included in the nursing facility per diem rate.

Documentation: Written Order, AND

1. Current home assessment stating that environment in which nutrition therapy is to be given is safe and sanitary
2. Documented systematic ongoing process, which will increase member compliance and
3. decrease negative outcomes
4. Member profile consisting of the following:
    a. Name, age, sex, height, and weight of member
    b. Current drug therapy, including prescription and nonprescription drugs and home remedies
    c. Member's current diagnosis(es) in relation to therapy
    d. Member specific drug-related problem list
    e. Goals for nutrition therapy
    f. Pertinent medical history
    g. Pertinent physical findings
    h. Pertinent laboratory findings

Profiles must be updated on a quarterly basis to include:

1. Documentation of member education
2. Additions to or deletions from nutrition therapy
3. Outcomes associated with nutrition therapy
4. Ongoing member assessments
5. Results of ongoing laboratory tests
6. Ongoing pertinent medical findings

Information shall be made available upon request and maintained for six years after therapy is completed.

ENTERAL NUTRITION THERAPY

Enteral Nutrition Codes: B4100, B4102, B4103, B4104 – B4162 (require prior authorization)

Please go to the fee schedule to determine how each HCPCS code is reimbursed. Some are by ml and some by calories. https://www.wyomingmedicaid.com/portal/fee-schedules#

If enteral nutrition is taken orally, use modifier BO on the claim (the BO also needs to be part of the request during the prior authorization process).

Enteral nutrition may be covered for the following reasons:

1. When ordered by a physician who has seen the member within 60-day prior for oral nutrition and within 180 days prior for nasogastric, jejunostomy, or gastrostomy tube to ordering the therapy and has documented that the member cannot receive adequate nutrition by dietary adjustments and/or oral supplements. The face-to-face visit requirement is for first time prescriptions and annually thereafter. The face-to-face visit can be completed via telehealth. If an individual goes to a new DME provider, this is considered a first-time prescription. Enteral therapy may be given by:
    a. Nasogastric
    b. Jejunostomy
    c. Gastrostomy tube
    d. Orally
2. Enteral Nutrition Therapy is considered reasonable and necessary for members with:
    a. Functioning gastrointestinal tracts who, due to pathology or non-function of the structures that normally permit food to reach the digestive tract, cannot maintain weight, strength, and overall health status
3. Oral enteral nutrition therapy is covered if the patient has a diagnosed medical condition such as, but not limited to:
    a. A mechanical inability to chew or swallow solid or pureed or blenderized foods;
    b. A malabsorption inability due to disease of infection;
    c. Weaning from Total Parenteral Nutrition or feeding tube;
    d. A significant weight lost over the past six (6) months or, for children under age 21, has experienced significantly less than expected weight; or
    e. If patient receives less that 75 percent of daily nutrition from a nutritionally complete enteral nutrition product, a nutritionist, speech-language pathologist or a physician must write a detailed plan to decrease dependence on the supplement.
4. Enteral nutrition therapy is not covered:
    a. For members whose nutritional deficiencies are due to a lack of appetite or cognitive problem; or

b. For healthy newborns; or
c. For individuals living in a nursing facility or residential facilities as this should be part of the per diem or room and board; or
d. For members whose need is nutritional rather than medical or is related to an unwillingness to consume solid or pureed foods; or
e. As a convenient alternative to preparing or consuming regular foods; or
f. Because of an inability to afford regular foods or supplements.

Documentation:

For all requests for authorization of enteral nutritional products, documentation must include the following:

A. Specific enteral product requested
B. Average number of calories to be obtained per day from the enteral nutritional product
C. Average number or calories to be obtained per day for other sources
D. Medical condition that requires an enteral nutrition product
E. Type of food preparation that have been tried (mechanically chopped, pureed or blenderized)
F. Documentation if a swallowing study or swallowing evaluation has been completed with a history of aspiration
G. Medical document to support the clinical need of the prescribed product
H. Written order

Documentation of medical necessity must be kept on file by the provider and made available upon request.

Prior Authorization: PA required

PARENTERAL NUTRITION THERAPY

Covered for members with severe pathology of the alimentary tract, which does not allow absorption of sufficient nutrients to maintain weight, strength, and general health status

Equipment/Supplies: (See also page 47, "Infusion Pump" section, to include but not limited to B9000- B9999)

HCPCS Code Range: B4164-B5000

- Parenteral Solution
- Supply kits

Indications/Limitations:

1. Parenteral therapy is given intravenously when ordered by a physician who has seen the member within 30 days prior to ordering the therapy and has documented that the member cannot receive adequate nutrition by dietary adjustments and/or oral supplements, or tube enteral nutrition
2. Parenteral therapy is covered for members who have a condition of the GI tract that prevents absorption of sufficient nutrients and require IV feedings to sustain life
3. Parenteral therapy will not be covered for convenience or when the member's nutritional needs can be met with enteral therapy
4. Nutrition therapy is not covered for members whose nutritional deficiencies are due to lack of appetite or cognitive problem

Documentation: Written Order, AND Wyoming Medicaid "Certificate of Medical Necessity: Parenteral Nutrition" form

Prior Authorization: Not required. DME providers should refer to the policy for Infusion Pumps, as some related equipment and supplies do require Prior Authorization.

ORTHOTICS

Orthotic appliances are covered for the correction or prevention of skeletal deformities (i.e. braces, splints, etc.) and post-operative or post-injury rehabilitation.

Equipment/Supplies:

HCPCS Code Range: E1800 – E1840; L0000-L4999; S1040

Orthotic services include:

- Replacement or repair of braces
- Devices for the legs, arms, back and neck; and trusses
- Braces include rigid and semi-rigid devices that are used for the purpose of supporting weak or deformed body members or for restriction or eliminating motion in a diseased or impaired part of the body
- Back braces include, but are not limited to corsets, special sacroiliac, sacrolumbar, or dorso-lumbar
- Foot/shoe inserts

Indications/Limitations:

1. Except when documentation indicates excessive wear or necessary increase in size due to growth, only one pair of orthopedic shoes is covered in a one-year period
2. Coverage of orthopedic shoes is limited to one pair at the time of purchase.
3. Cranial orthotics will be covered when initiated in patients who are 18 months or younger and the following criteria are met:
    a. As part of the post-operative treatment plan following surgical correction of synostotic plagiocephaly (i.e. craniosynostosis); or
    b. For the treatment of moderate to severe positional plagiocephaly when the following conditions are met:
        i. Documentation of failure of a 2-month trial of conservative therapy (repositioning and/or physical therapy); and
        ii. Anthropometric data verifying moderate to severe plagiocephaly through a difference of asymmetry greater than 6 mm in one of the following measurements:
            1. Skull base
            2. Cranial vault
            3. Orbitotragical depth; or
        iii. Cephalic index 2 standards deviations below mean (head is narrow for its length) or 2 standard deviations above mean (head wide for its length)

A second cranial remodeling band or helmet is considered medically necessary if the above criteria were met and asymmetry has not resolved after 2 to 4 months.

Wyoming Medicaid considers the use of cranial orthotics (bands or helmets) for other indications not listed above to be experimental and investigational. This includes but is not limited to the use in infants with synostotic plagiocephaly (craniosynostosis) who have not had surgical correction.

Documentation: Written Order & CMN or other medical records to support member need.

Prior Authorization: Required for some codes.

Refer to website code look-up at https://www.wyomingmedicaid.com/portal/fee-schedules#

OSTEOGENESIS STIMULATORS

Electrical osteogenesis stimulators provide electrical stimulation to augment bone repair.

Noninvasive electrical stimulators are characterized by an external power source, which is attached to a coil or electrodes placed on the skin or on a cast or brace over a fracture or fusion site.

Ultrasonic osteogenesis stimulators are noninvasive devices that emit low intensity, pulsed ultrasound. The ultrasound signal is applied to the skin surface at the fracture location via ultrasound conductive coupling gel in order to stimulate fracture healing.

Equipment/Supplies:

HCPCS Code Range: E0747-E0749; E0760

Includes but is not limited to:

- Osteogenic stimulator, electrical, noninvasive other than spinal applications
- Osteogenic stimulator, electrical, noninvasive, spinal applications
- Osteogenic stimulator, electrical, (surgically implanted) (for purchase only)
- Osteogenesis stimulator, low intensity ultrasound, non-invasive

Indications/Limitations:

Electrical stimulation is considered medically necessary for any of the following indications:

1. Fresh fractures, fusions or delayed unions of the shaft (diaphysis) of the tibia that are open or segmental; or
2. Fresh fractures, fusions, or delayed unions of the scaphoid (carpal navicular)
3. For non-unions, failed arthrodesis, and congenital pseudarthrosis (pseudoarthrosis) of the appendicular skeleton if there has been no progression of healing for three or more months despite appropriate fracture care
4. Non-unions, failed fusions, and congenital pseudarthrosis where there is no evidence of progression of healing for three or more months despite appropriate fracture care, or delayed unions of fractures or failed arthrodesis at high-risk sites (i.e., open or segmental tibial fractures, carpal navicular fractures), or
5. Members at high risk for spinal fusion failure when any of the following criteria is met:
    a. One or more failed fusions, or
    b. Grade II or worse spondylolisthesis, or
    c. A multiple level fusion entailing 3 or more vertebrae (e.g., L3 to L5, L4 to S1, etc.), or

d. Other risk factors for fusion failure are present, including gross obesity, degenerative osteoarthritis, current smoking, previous fusion surgery, or gross instability; or
e. Any other condition where it is determined after medical review, that electrical stimulation is likely to avoid the need for open reduction and bone graft

The following indications are non-covered:

1. Ultrasonic osteogenesis stimulation of fractures, failed fusions, or non-unions of the axial skeleton (skull and vertebrae)
2. Stress fractures
3. Pathological fractures due to malignancy (unless the neoplasm is in remission)
4. Avascular necrosis of the femoral head

Consider direct current stimulation experimental and investigational for all other indications, including the treatment of Charcot foot, avascular necrosis of the hip and fractures of the scapula or pelvis because of a lack of adequate evidence of its effectiveness for these conditions.

Documentation:

1. Written or Certificate of Medical Necessity
2. A detailed record of the item(s) provided to include brand name, model number, quantity, and date of delivery
3. A minimum of two sets of radiographs obtained prior to starting treatment with the osteogenesis stimulator, separated by a minimum of 90 days. Each radiograph must
4. include multiple views of the fracture site accompanied with a written interpretation by a physician stating that there has been no clinically significant fracture healing between the two sets of radiographs

Prior Authorization: Required

References:

Centers for Medicare and Medicaid Services (CMS). Decision memo for ultrasound stimulation for nonunion fracture healing (CAG-00022R). Medicare Coverage Database. Baltimore, MD: CMS; April 27, 2005.

CMS Pub. 100-3 (Medicare National Coverage Determination Manual), Chapter 1, Section 150.2

OSTOMY SUPPLIES

Covered for members with an ostomy

Equipment/Supplies:

HCPCS Code Range: A4361-A4434

Following are covered if medically necessary for use with ostomy:

- Skin moisturizers
- Protectants
- Sealants

Indications/Limitations: None

Documentation: Written Order

Prior Authorization: Not Required

OXIMETERS, EARS/PULSE

Covered for members requiring a minimum of daily monitoring of arterial blood oxygen saturation levels for evaluating and regulating home oxygen therapy

Coverage for other indications will be determined on a case-by-case basis

Equipment/Supplies:

HCPCS Code Range: E0445; A4606

Oximeter

Indications/Limitations:

1. Pulse oximetry readings are covered in the monthly fee for concentrators.
2. Supplies and accessories necessary for proper functioning and effective use of the device are included in the rental reimbursement.
3. In-home, overnight, 12-hour, or similar oximetry trend studies and other single "one- time" oximetry testing are not covered.
4. Oximeters are manufactured with a wide variance in features, each of which impact the cost. Therefore, medical necessity must be documented for additional features, such as:
    a. Extra alarms
    b. Additional cables that extend the distance between the probe and readout device
    c. Various types of probes, i.e., disposable versus re-useable
    d. Internal memory
5. Ports to allow printing of recorded data or downloading to a computer (this list is not all- inclusive)

Documentation:

1. Written Order or **Certificate of Medical Necessity** or letter of medical necessity or medical records that document:
    a. Member's medical condition that indicates the need for in-home use of an oximeter;
    b. Medical justification for additional features (listed above) that impact the cost
    c. Estimated length of time member will require monitoring; and
    d. Frequency of monitoring required (e.g., continuous, daily, etc.)
    e. Monthly report for evaluation and regulation of home oxygen therapy.
    f. O2 saturation readings by a pulse oximeter may be performed by a provider and reviewed and signed off by the physician. The provider must maintain all supporting documentation.

Prior Authorization: Required

References: World Health Organization Global Pulse Oximetry Project, 2007.

OXYGEN and OXYGEN EQUIPMENT

Covered on a rental basis for members with severe hypoxemia in the chronic stable state; oxygen concentrators are exempt from capped rental.

For Wyoming Medicaid purposes, "severe hypoxemia" is defined as a PO2 below 55mmHg or an O2 Saturation of 89% or less.

Equipment/Supplies:

HCPCS Code Range E0424-E0487; E1353-E1406

Contents may be billed in addition to the oxygen delivery system. Oxygen contents are billed on a monthly basis, not daily or weekly. Includes, but is not limited to:

- Stationary and portable gas systems or liquid systems or
- Concentrators
- Contents for each system

Indications/Limitations:

Oxygen Therapy is reimbursable when:

2. Physician has determined that member suffers from severe lung disease or hypoxia-related symptoms that might be expected to improve with oxygen therapy, or
3. Member's blood gas levels or O2 Saturation indicate the need for oxygen therapy. Oxygen saturation less than or equal to 88% or PAO2 less than or equal to 55mm Hg(7.3 kPa) while patient otherwise clinically stable
    a. Oxygen saturation 89% or PAO2 56-59 Hg (7.5 to 7.9 kPa) while patient otherwise clinically stable and any of the following:
    b. Pulmonary hypertension
    c. Cor Pulmonale
    d. Dependent edema suggestive of heart failure
    e. P-pulmonale on ECG
    f. Hematocrit greater than 55% (o,55)
    g. Angina

Portable oxygen systems alone or to complement a stationary oxygen system may be covered if the member is mobile within the residence.

Claims submitted for oxygen delivery systems and contents must be billed on a monthly basis. Rental reimbursement includes:

1. Concentrator, regulator, demurrage, supplies and accessories;
2. Equipment testing, cleaning, repair and routine maintenance; and
3. Delivery, setup and patient instruction

Oxygen therapy is **not reimbursable** for:

1. Angina pectoris in the absence of hypoxemia
2. Dyspnea without Cor pulmonale or evidence of hypoxemia
3. Severe peripheral vascular disease resulting in clinically evident desaturation in one or more extremities; and
4. Terminal illness that does not affect the lungs

Respiratory therapy services are not covered. The durable medical equipment benefit provides coverage of oxygen and oxygen equipment but does not include a professional component in the delivery of such services.

A "piped-in" oxygen system is not considered durable medical equipment for reimbursement purposes and is not reimbursable.

Gas and liquid oxygen cannot be used together.

Supplies/accessories are covered as replacements for member-owned oxygen equipment only and **CANNOT** be billed with rental equipment. The rental fee includes all of the items required to operate the equipment.

Documentation:

1. Written Order or Certificate of Medical Necessity or a letter of medical necessity or medical records that documents that the member meets the above criteria, and includes the following clinical information:
    a. Results of blood gas study that has been ordered and evaluated by the attending physician; specifically, a measurement of partial pressure of oxygen (PO2) in the arterial blood; or
    b. Measurement of oxygen saturation by pulse oximetry may also be acceptable when ordered and evaluated by the attending physician and performed under his/her supervision or when performed by a qualified provider or supplier of laboratory services. A pulse oximetry reading of the members O2 saturation may be performed and documented by a provider and reviewed and signed off by the physician
2. Documentation must be updated on a yearly basis for continued rental

Prior Authorization:

1. Not Required for most oxygen and related equipment/supplies
2. Prior Authorization is required for purchase of the following codes: E0424, E0425, E0435, E0440, E1390

PACEMAKER MONITORS, SELF CONTAINED

Covered for members with cardiac pacemakers.

Equipment/Supplies:

HCPCS Code Range: E0610-E0620

Includes, but is not limited to:

- Pacemaker monitor, self-contained, checks battery depletion, includes audible and visible check systems
- Pacemaker monitor, self-contained, checks battery depletion and other pacemaker components, includes digital/visible check systems

Documentation: Written Order

Prior Authorization: Not Required

PARAFFIN BATH UNITS, PORTABLE

Covered for members with conditions that are expected to be relieved by long term use of this modality and who have undergone a successful trial period of paraffin therapy.

Equipment/Supplies:

HCPCS Code Range: A4265; E0235

Includes, but is not limited to:

- Portable paraffin bath units
- Paraffin covered for use with rental and member-owned paraffin bath units for members whose condition meets the criteria for coverage of the device

Documentation: Written Order

Prior Authorization: Not Required

PEAK FLOW METERS

Covered for members with chronic asthma.

Equipment/Supplies:

HCPCS Code Range: S8110; S8096

Includes, but is not limited to:

- Handheld peak expiratory flow rate meters

Documentation: Written Order

Prior Authorization: Not Required

PERCUSSORS

Covered for mobilizing respiratory tract secretions.

Equipment/Supplies:

HCPCS Code Range E0480

Supplies necessary for proper use and maintenance of equipment and complete member/caregiver training are included in the rental/purchase reimbursement. Reimbursement includes, but is not limited to:

- Chest compression vest
- Chest compression generator and hoses
- Percussive ventilation system
- Cough stimulator
- Percussor

Indications/Limitations:

Covered in member with the following conditions:

1. Cystic Fibrosis for members age 2 years or older when conventional chest physical therapy is not feasible
2. Chronic Obstructive Lung Disease
3. Chronic Bronchitis or
4. Emphysema when member or operator of powered percussor has received appropriate training by a physician or therapist and no one competent to administer manual therapy is available.
5. Current diagnosis:
    a. V46.0 – Dependence on aspirator
    b. V46.1 – Dependence on respirator
    c. V46.8 – Dependence on enabling machines Percussors are not covered when used for members less than age 2

Documentation:

1. Written Order or **Certificate of Medical Necessity** or letter of medical necessity or medical records that document:
    a. Diagnosis of cystic fibrosis or similar condition that causes an over production of secretions
    b. Other methods of treatment attempted, the length of time of each and why they were deemed inappropriate and/or ineffective
    c. Member's medical and social history
    d. Caregiver/member understanding of use and cleaning of equipment

Prior Authorization: Required

References: Hayes Inc.

PHOTOTHERAPY SERVICES

This item can be billed by the following types of practitioners in addition to DME Suppliers – refer to the CMS-1500 Provider Manual for details:

2. All physicians (20s)
3. Nurse Practitioners (363Ls, 367A00000X)
4. Public Health Nurse's Offices (251K00000X)

Covered on a rental basis for infants with:

1. Neonatal hyperbilirubinemia is the infant's sole clinical problem
2. Infant greater than or equal to 37 weeks gestational age and birth weight greater than 2.270 gm (5lbs)
3. Infant more than 48 hours old
4. Bilirubin level, without hemolysis, at initiation of phototherapy (after infant reaches 48 hours of age or more) is ***14 mgs per deciliter or above***; and
5. Bilirubin level, without hemolysis, less than two mgs per deciliter

Equipment/Supplies:

HCPCS Code Range: E0202 with the RR modifier Phototherapy (bilirubin) light with photometer

Indications/Limitations:

The following conditions must be met prior to initiation of home phototherapy:

1. History and physical assessment conducted by infant's attending physician. Newborn discharge exam will suffice if home phototherapy begins immediately upon discharge from the hospital
2. Required laboratory studies must have been performed, including CBC, blood type on mother and infant, direct Coombs and direct Bilirubin level, without hemolysis
3. Physician certifies that parent/caregiver is capable of administering home phototherapy
4. Parent/caregiver has successfully completed training on use of equipment; and
5. Equipment must be delivered and set up within four hours of discharge from the hospital or notification of provider, whichever is more appropriate
6. Repair and/or replacement service must be available 24-hours per day

A global fee has been established that includes:

1. Rental of the phototherapy unit, per day, and also **all** supplies, accessories, and services necessary for proper functioning and effective use of the therapy
2. Complete caregiver training on use of equipment and completion of necessary records Reimbursement is limited to five units per lifetime for a member.

Documentation: Written Order, AND

1. Narrative report outlining member's progress
2. Documentation of the above outlined criteria and conditions necessitating therapy must be maintained in provider's records.

Prior Authorization: Not Required

PNEUMATIC COMPRESSORS and APPLIANCES

Covered for members with intractable edema of the extremities to administer pressure on the involved extremity, with a pump set to deliver a prescribed amount of intermittent pressure.

Equipment/Supplies:

HCPCS Code Range E0650-E0652; E0675; E0655-E0673, L4350-L4380

- Pneumatic compressors (rental only)
- Upper and lower extremity pneumatic appliance for use with compressor (purchase only)

Indications/Limitations:

1. Severe Swelling
2. Lack of drainage of lymphatic fluid
3. Severe circulation problems
4. Ulcers

Documentation: Written Order

Prior Authorization: Not Required

PRESSURE REDUCING SUPPORT SURFACES - see also "HOSPITAL BEDS AND ACCESSORIES", "WHEELCHAIRS (Manual and Power)"

Covered for members with or highly susceptible to pressure ulcers and whose physician will be supervising its use in connection with member's course of treatment.

Equipment/Supplies:

HCPCS Code Range E0181-E0199

Includes, but is not limited to:

- Pressure pads
- Dry pressure mattress
- Gel pads
- Air mattresses
- Water pressure mattresses
- Sheepskin
- Gel mattresses

Indications/Limitations:

Covered when the member meets one of the following criteria:

1. Complete immobility (i.e., the member cannot make changes in body position without assistance)
2. Limited mobility (i.e., the member cannot independently make changes in body position significant enough to alleviate pressure); or
3. Any stage pressure ulcer on trunk or pelvis

If the member meets criteria 2 or 3 above, the member must also meet at least one of the following criteria:

1. Impaired nutritional status
2. Fecal or urinary incontinence
3. Altered sensory perception; or
4. Compromised circulatory status

Pressure reducing mattress replacements are covered:

1. When member meets the coverage criteria for a pressure reducing mattress pad/overlay, and
2. Anticipated length of need is at least one year or
3. "Bottoming out" is anticipated on a comparable pad/overlay.
    a. ("Bottoming out" is the finding that the member's body will be in contact with a flat outstretched hand (palm up) that is placed underneath the support surface in various body positions.

   b. Powered mattress pads/overlays, except alternating pressure pads, are not reimbursable.
4. Supplies/accessories are covered as replacement for member-owned alternating pressure pads only and **CANNOT** be billed in addition to rental equipment.

Documentation:

1. Written Order or **Certificate of Medical Necessity** or letter of medical necessity or medical records to document:
   a. Other conservative methods of treatment tried, the length of time of each and why those treatments were deemed inappropriate or ineffective
   b. Has one or more Stage III or IV decubitus ulcers, pressure sores, or related conditions, or is highly susceptible to decubitus ulcers, or has a condition of fragile skin integrity, or a history of skin ulcers, or insult to skin or integrity; or
   c. Has multiple Stage II decubitus ulcers on trunk or pelvis which have been unresponsive to a comprehensive treatment for at least 30 days using a lesser support surface; or
   d. Has myocutaneous flap or skin graft for pressure ulcer on the trunk or pelvis within the past 60 days; or
   e. Is bedridden or chair bound, or has limited mobility, but cannot independently make changes in body position significant enough to alleviate pressure; or
   f. Is completely immobile and cannot make changes in body position without assistance
2. The member must have a care plan established by the physician or other licensed healthcare practitioner directly involved in the member's care, which should include the following:
   a. Education of the member and caregiver on the prevention and/or management of pressure ulcers
   b. Regular assessment by a licensed healthcare practitioner
   c. Appropriate turning and positioning
   d. Appropriate wound care (for Stage II, III, or IV ulcer)
   e. Moisture/incontinence control, if needed; and
   f. Nutritional assessment and intervention consistent with the overall plan of care if there is impaired nutritional status

Adherence to the care plan/treatment is not to be construed as elements for coverage criteria.

Prior Authorization:

Items in this category may require PA. Please refer to online fee schedule located on the Wyoming Medicaid website or contact Provider Relations to determine if PA is required.

PROSTHETICS

Coverage for prosthetics

Equipment/Supplies:

HCPCS Code Range: L5000-L9999

Indications/Limitations:

Coverage based upon medical necessity and clinical assessment of member rehabilitation potential. Member rehabilitation potential based on the following classification levels:

Level 0 - Does not have the ability or potential to ambulate or transfer safely with or without assistance and prosthesis does not enhance their quality of life or mobility

Level 1 - Has the ability or potential to use prosthesis for transfers or ambulation on level surfaces at fixed cadence. Typical of the limited and unlimited household ambulatory

Level 2 - Has the ability or potential for ambulation with the ability to traverse low level environmental barriers such as curbs, stairs or uneven surfaces. Typical of the limited community ambulatory

Level 3 - Has the ability or potential for ambulation with variable cadence. Typical of the community ambulator who has the ability to traverse most environmental barriers and may have vocational, therapeutic, or exercise activity that demands prosthetic utilization beyond simple locomotion

Level 4 - Has the ability or potential for prosthetic ambulation that exceeds basic ambulation skills, exhibiting high impact, stress, or energy levels. Typical of the prosthetic demands of the child, active adult, or athlete

Potential functional ability is based on the reasonable expectations of prosthetist and treating physician, considering factors including, but not limited to:

1. Diagnosed with condition(s) that require prosthetic devices due to accident, injury, surgery, birth defects or disease process
2. Member's history, including prior prosthetic use if applicable; and
3. Member's current condition including status of residual limb and nature of other medical problems; and
4. Member's desire to ambulate

Determination of type of prosthesis to be made by treating physician and/or prosthetist based upon functional needs of member. Prostheses will be denied as not medically necessary if the patient's potential functional level is 0.

If prosthesis is denied as not medically necessity, related additions will also be denied as not medically necessary. Exceptions will be considered on a case-by-case basis and must include additional documentation which justifies medical necessity.

More than 2 test (diagnostic) sockets for an individual prosthesis are not medically necessary unless there is documentation in the medical record which justifies the need.

Devices in this section do not include surgically implanted prosthesis. The devices in this section are considered as "base" or "basic devices" and may be modified by listing devices from the additions section and adding them to the base procedure.

Exception: A test socket is not medically necessary for an immediate prosthesis.

No more than two of the same socket inserts are allowed per individual prosthesis at the same time. Repair/Replacement:

Socket replacements are covered when medically necessary. Documentation of medical necessity

includes but is not limited to functional and/or physiological needs such as changes in residual limb, functional need changes, irreparable damage or wear/tear due to excessive patient weight or prosthetic demands of very active amputees.

Prosthetic services include repair or replacement of prosthetic devices, other than dental. Replacement of usable appliances or artificial limbs may be required because of a change in the member's physical condition. Wyoming Medicaid will reimburse for repairs and adjustment of appliances when necessary, even when the appliance had been in use before the member became eligible for Wyoming Medicaid.

Adjustments and repairs of prostheses and prosthetic components are covered under the original order. Claims involving the replacement of a prosthesis or major component (foot, ankle, knee, socket) must be supported by a new physician's order. Prosthetist must retain documentation of the prosthesis or prosthetic component replaced, the reason for replacement, and a description of the labor involved irrespective of the time since the prosthesis was provided to the beneficiary. Information must be available upon request.

It is recognized that there are situations where the reason for replacement includes, but is not limited to:

1. Changes in the residual limb
2. Functional need changes
3. Irreparable damage or wear/tear due to excessive patient weight or prosthetic demands of very active amputees

When submitting a prosthetic claim, the billed code for knees, feet, and ankles components must be submitted with modifiers K0 - K4, indicating the expected patient functional level. This expectation of functional ability information must be clearly

documented and retained in the prosthetist's records. The simple entry of a K modifier in those records is not sufficient. There must be information about the patient's history and current condition which supports the designation of the functional level by the prosthetist.

Documentation:

1. Written Order or **Certificate of Medical Necessity** or letter of medical necessity listing each component being requested and the codes
2. History & Physical including pre-amputation level of activity
3. Medical records that document the member's functional capabilities and expected functional potential, including an explanation for the difference, if that is the case. It is recognized within the functional classification hierarchy that bilateral amputees often cannot be strictly bound by functional level classifications

Terminal device (s):

1. Hook
2. Hand

Lower limb device(s):

FEET: Basic lower extremity prostheses include a SACH foot. Based on members functional classification, other prosthetic feet may be covered. Coverage is extended only if there is sufficient clinical documentation of functional need for the technologic or design feature of a given type of foot:

1. External keel SACH foot or single axis ankle/foot is covered for members whose functional level is 1 or above
2. Flexible-keel foot or multiaxial ankle/foot is covered for member whose functional level is 2 or above
3. Flex foot system, energy storing foot, multiaxial ankle/foot, dynamic response, flex-walk system or equal, or shank foot system with vertical loading pylon is covered for members whose functional level is 3 or above

KNEES: Basic lower extremity prostheses include single axis, constant friction knee. Based on member functional classification, other prosthetic knees may be covered. Coverage is extended only if there is sufficient clinical documentation of functional need for the technologic or design feature of a given type of knee:

1. A high activity knee control frame is covered for members whose functional level is 4
2. A fluid, pneumatic, or electronic knee covered for member whose functional level is 3 or above
3. Other knee systems are covered for member whose functional level is 1 or above

ANKLES: Basic ankle prostheses include single axis, constant friction knee. Based on member functional classification, other prosthetic ankles may be covered. Coverage is extended only if there is sufficient clinical documentation of functional need for the technologic or design feature of a given type of ankle:

1. Axial rotation unit covered for member whose functional level is 2 or above
2. Stump socks and harnesses, including replacements, are covered when documentation substantiates that the appliance was in use before the member became eligible for Wyoming Medicaid.

Prior Authorization: Required

Reference: https://www.medicare.gov/ Article # L11453

REPAIRS/MAINTENANCE/LABOR

Wyoming Medicaid reimburses repairs when:

1. Equipment is still medically necessary for member(s)
2. Equipment is no longer under warranty

Wyoming Medicaid reimburses labor for certain additional services performed by skilled professionals, such as:

1. Replacement of batteries that require the skills of a trained technician such as the battery changes for power wheelchair and scooter batteries.
2. Wheelchair and seating evaluations performed by a "qualified technician". A "qualified technician" is an ATP (Assistive Technology Practitioners) certified thru RESNA, or an RTS or CRTS (Certified Rehab Technology Supplier) certified thru NRRTS.
3. "Fitting/Evaluations" of custom compression hose that require the skills of a trained technician

Wyoming Medicaid reimburses services necessary for routine maintenance of infusion pumps (parenteral and enteral feeding pumps) that are in use for an indefinite period of time after the capped rent limit has been reached.

Equipment/Supplies:

HCPCS Code Range K0739-K0740; S5035

- K0739 will be used for Repair or Nonroutine Service for Durable Medical Equipment Other than Oxygen Equipment Requiring the Skill of a Technician, Labor Component, Per 15 Minutes.
- K0740 will be used for Repair or Nonroutine Service for Oxygen Equipment Requiring the Skill of a Technician, Labor Component, Per 15 Minutes.
- Suppliers should use K0739 on DME claims to bill for the labor associated with the reasonable and necessary repair of beneficiary-owned durable medical equipment.
- S5035 - Home Infusion Therapy, Routine Service of Infusion Device (E.G. Pump Maintenance).

Limitations: This code does **NOT** cover the following:

1. Repairs for rental equipment or equipment under warranty
2. Assembling, delivering and setting up member equipment
3. Routine maintenance such as equipment inspection and battery change, etc.

Note: Coverage is allowed for the labor related to battery changes that require the skills of a trained technician such as the battery changes for power wheelchair and scooter batteries.

Documentation:

1. For wheelchair repairs,
    a. No script, or written order is required
    b. The **Certificate of Medical Necessity** may be completed and signed by an ATP (Assistive Technology Professional). Prior authorization is required, but the request may be submitted the same day the repairs were completed.
2. For wheelchair evaluations (no more than 2 hours will be allotted)
    a. Written order to complete a wheelchair evaluation
3. For all other repairs and for routine maintenance of an infusion pump:
    a. Written Order, Certificate of Medical Necessity or letter of medical necessity is required:
        i. to provide information about when the equipment was originally purchased (estimate if not known) and any required repairs
        ii. to provide justification of labor exceeding 8 units
4. For routine maintenance of an infusion pump, a written order substantiating the need for ongoing/long-term infusion pump needs, and a PA request form documenting the length of time since the last maintenance was performed.

Prior Authorization:

1. Required for all labor or repairs
2. Required for routine maintenance for infusion pumps
3. Wheelchair repair requires a prior authorization. However, it is considered acceptable to complete the repairs and submit the PA request the same day that the repairs were already completed.
4. Wheelchair evaluations require prior authorization.

SITZ BATHS

Covered for members with infection or injury of the perineal area and use of the item is part of the physician ordered planned regimen of treatment in the member's home.

Equipment/Supplies:

HCPCS Code Range E0160-E0162

- Sitz baths
- Sitz bath chairs

Documentation: Written Order

Prior Authorization: Not Required

Equipment/Supplies:

Speech generating devices (SGD) are defined as durable medical equipment that provide an individual with a severe speech impairment, who is unable to communicate using natural means (e.g., spoken, written, gestures, sign language), the ability to meet their functional communication needs. SGD may include digitized speech devices, synthesized speech devices, and tablets when installed with speech generating software.

HCPCS Code Range: E2500, E2502, E2504, E2506, E2508, E2510, E2511, E2512 E2599

E2500: Speech generating device, digitized speech, using pre-recorded messages, less than or equal to 8 minutes recording time

E2502: Speech generating device, digitized speech, using pre-recorded messages, greater than 8 minutes but less than or equal to 20 minutes recording time

E2504: Speech generating device, digitized speech, using pre-recorded messages, greater than 20 minutes but less than or equal to 40 minutes recording time

E2506: Speech generating device, digitized speech, using pre-recorded messages, greater than 40 minutes recording time

E2508: Speech generating device, synthesized speech, requiring message formulation by spelling and access by physical contact with the device

E2510: Speech generating device, synthesized speech, permitting multiple methods of message formulation and multiple methods of device access

E2599: Accessory for speech generating device, not otherwise classified

E2511: Speech generating software only, when installed on a tablet

E2512: Accessory for speech generating device, mounting

E1399: Tablet used as speech generating device

Indications/Limitations:

SGD and augmentative communication equipment are covered when all the following criteria are met:

1. The individual has a medical condition that results in a severe expressive speech impairment;
2. The individual has the cognitive and physical abilities to effectively use the selected device;

3. The individual is unable to communicate using natural communication means (e.g. spoken, written, gestures, sign language); and,
4. Other forms of treatment have been considered and ruled out.

Documentation:

The following documentation must be submitted with a prior authorization request and have been conducted within the last 180 days:

1. An evaluation (using objective functional baseline measures and/or standardized testing) of the client's receptive and expressive communication abilities by a speech language pathologist (SLP) in conjunction with other applicable disciplines (e.g. occupations therapist, physical therapist, psychologist, seating specialist, etc.) as needed.
    A) Evaluation must contain:
        i. Current communication impairment including the type, severity, language skills, cognitive ability and anticipated course of the impairment;
        ii. An assessment of whether the client's daily communication needs could be met using other natural modes of communication or with low-technology devices;
        iii. A description of the functional communication goals expected to be achieved and treatment options;
        iv. A full description of the recommended device and rationale for any accessories and include data from device trials that document the use of recommended device and how abilities changed over time;
        v. Evidence that the client possesses a treatment plan that includes a training schedule for the selected device;
        vi. Detailed information outlining the cognitive and physical abilities of the client which demonstrates the ability to effectively use the selected device and any accessories to communicate;
        vii. Discussion regarding the client's strengths/deficits relevant to speech/language abilities and all factors that affect communication which justify the need for the device;
        viii. Description of the client's ability to use the device throughout their daily activities;
        ix. Client demonstrates the cognitive, physical, visual and hearing skills necessary to communicate using the requested device;
        x. Results of trial period using the requested device. The SLP must document a description of the trial period with the requested device, including length of trial, settings, outcome and additional training needs identified;

xi. The device is the least costly device that meets the client's basic communication needs. Supporting documentation substantiating the requested device as the least costly alternative to meet the client's needs; and,

xii. For adults only: The report must include information regarding medical diagnosis, including onset, previous level of communicative functioning, current level of communicative functioning, and any potential changes to client functioning that may be likely to occur.

2. Physician's order with the diagnosis/diagnoses directly related to the client's communication deficit. The order must be based on the SLP's evaluation of the client's communication abilities and medical needs.
3. A plan of care identifying other disciplines involved in the care, goals for therapy and a training timeline. Parents and caregivers must be involved in the plan of care and training.

Non-covered items

- Items that are not medical in nature or dedicated medical equipment used for communication;
- Software or hardware to play games, create spreadsheets or documents not specific to augmentative communication;
- Environmental control units;
- More than one SGD per beneficiary;
- A device used solely for education, vocational or recreational purposes. An SGD is intended to be the primary source of communication. It is expected that the client will be able to use the device in all environments;
- Replacements based on manufacturer recommended replacement schedules;
- Replacements due to new technology when the client's current SGD continues to meet their medical and functional needs;
- Extended warranties;
- Optional accessories (USB cables, Bluetooth adapters, extra batteries or chargers, etc.);
- More than one mounting system if needed;
- Devices and applications recommended solely for educational purposes;
- Smartphones;
- Wi-Fi or Internet Access; and
- Repairs completed during the original warranty of the device.

Devices are limited to one every 5 years. Exceptions may be considered in situations where there has been a recent and significant change in the beneficiary's medical or functional status relative to the beneficiary's communication skills.

Prior Authorization: Required

CMS LCD L33739

STANDERS / STANDING FRAMES

Standers and stander programs can aid in digestion, increase muscle strength, decrease contractures, increase bone density and minimize decalcifications. Standers are covered for members with neuromuscular conditions who are unable to stand alone.

Equipment/Supplies:

- Standers/Standing Frames

HCPCS Codes: E0637, E0638, E0641, E0642

Documentation:

1. Written Order or Certificate of Medical Necessity or letter of medical necessity or medical records to document:
    a. Diagnosis relevant to the requested equipment including functioning level and ambulatory potential
    b. Include information about other equipment currently being used by the member
    c. Anticipated benefits of the equipment
    d. Frequency and amount of time of a standing program
    e. Anticipated length of time of a standing program
    f. Member's height/weight/age
    g. Anticipated changes in the member's needs, anticipated modifications, or accessory needs, as well as the growth potential of the stander

Prior Authorization: Required

SUCTION PUMPS

Covered for members who have difficulty raising and clearing secretions secondary to cancer or surgery of the throat or mouth; dysfunction of the swallowing muscles; unconsciousness or obtunded state; or tracheostomy.

Equipment/Supplies: HCPCS Code Range E0600

- Suction pump

Documentation: Written Order

Prior Authorization: Not Required

SUPPORTS

Covered for post-surgical members, and members with intractable edema of the lower extremities or other circulatory disorders.

Equipment/Supplies:

HCPCS Code Range L3040-L3090; L0120; A6530-A6549; L0970-L0999; A4561-A4562

- Elastic Supports
- Elastic/Surgical Stockings
- Slings
- Trusses

Indications/Limitations:

2. Support pantyhose are **NOT** covered

Documentation: Written Order

Prior Authorization: Not Required

TRACHEOSTOMY CARE SUPPLIES

Covered for members with an open surgical tracheostomy

Equipment/Supplies:

HCPCS Code Range: A4623-A4626; A4628; A4629; A7523-A7526; S8189

- Tracheostomy care or cleaning starter kit covered following an open surgical tracheostomy for a two-week post-operative period
- An artificial larynx is covered for members that have had a laryngectomy or whose larynx is permanently inoperable

Documentation: Written Order

Prior Authorization: Not Required

TRACTION EQUIPMENT

Covered for members with orthopedic impairments requiring traction equipment that prevents an ambulation and meet the following criteria:

3. Member has musculoskeletal or neurological impairment requiring traction equipment
4. Appropriate use of a home cervical device demonstrated to member and member tolerates device

Equipment/Supplies:

HCPCS Code Range E0840-E0948

- Traction frame/stand
- Fracture frame/stand

Indications/Limitations:

1. Payment for purchase and rental of traction equipment includes all accessories necessary for proper functioning and effective use of the equipment. Accessories are payable only as replacement for use with member-owned traction equipment for member whose condition meets the criteria for the equipment.
2. Cervical traction that attach to a headboard or a free-standing frame have no proven clinical advantage compared to cervical tractions attached to an over-the-door mechanism.
3. The following supplies/accessories are covered replacements for member-owned traction equipment only and **CANNOT** be billed with rental equipment:
    a. Cervical head harness/halter
    b. Cervical pillow
    c. Pelvic belt/harness/boot
    d. Extremity belt/harness

Documentation:

1. Written Order or **Certificate of Medical Necessity** or letter of medical necessity or medical records to document member condition meets criteria above

Prior Authorization: Required

Reference: www.medicare.gov

TRANSCUTANEOUS ELECTRICAL NERVE SIMULATORS (TENS)

Covered for members with chronic, intractable pain that has been present for at least three months and presumed etiology of pain is accepted as responding to TENS therapy and for members with acute post- operative pain.

Equipment/Supplies:

HCPCS Code Range E0720-E0749

- TENS, two and four lead

Indications/Limitations:

1. Transcutaneous electrical nerve stimulation (TENS) involves the direct stimulation of nerves by short-duration, small amplitude electrical pulses designed to provide non-pharmacological
2. Pain relief. Indications include:
    a. Post stroke
    b. Rheumatoid arthritis
    c. Chronic leg ulcers
    d. Labor pain
    e. Arthropathy associated with other viral diseases
    f. Rheumatoid arthritis
    g. Osteoarthrosis
    h. Ankylosing spondylitis
    i. Unspecified inflammatory spondylopathy,
    j. Lumbosacral spondylosis with no mention of myelopathy
    k. Cervical region pain
    l. Lumbago
    m. Low back pain
    n. Backache
    o. Unspecified vertebrogenic (pain) syndrome
    p. Myofascial pain syndrome
    q. Neuromuscular pain
    r. Neuralgia
    s. Neuritis
    t. Radiculitis
    u. Pain in limb
3. The following supplies/accessories are covered as replacement for members owned equipment only and **CANNOT** be billed with rental equipment:
    a. Electrodes
    b. Lead wires
    c. TENS supplies, two lead, per month

4. For purchase, physician must determine that the member is likely to derive significant therapeutic benefit from continuous usage of the unit over a long period of time.
5. A TENS unit is not covered for acute pain (less than three months duration) other than post- operative pain.
6. For acute, post -operative pain, coverage is for no more than one month following the day of surgery.
    a. A trial period is recommended for at least one month including a trial of different modes of stimulation and adjustment of electrodes.
    b. Several therapy sessions are needed to establish the most effective stimulation parameters.

Documentation:

1. Written Order, AND
2. Documentation of chronic, intractable pain must also include the following:
    a. A trial period of at least one month, but not to exceed two months
    b. Trial period may not begin sooner than the three months or used to establish the existence of chronic pain
    c. The trial period must be monitored by the physician to determine effectiveness of the TENS unit in modulating the pain
    d. The physician's record must document a re-evaluation at the end of the trial period and must indicate how often the member used the TENS unit, the typical duration of use each time, and the results
    e. Location and duration of time member has had the pain
    f. Other appropriate treatment modalities that have been attempted and why they were deemed inappropriate or ineffective (this is to include any medication name and dosage, duration and results of treatment)
    g. If a four lead TENS unit is ordered, the medical record must document why a two lead TENS is insufficient to meet the member's needs

Prior Authorization: Not Required.

Reference: Hayes Inc.

TRANSFER EQUIPMENT

Covered for members that require assistance with transfer.

Equipment/Supplies: HCPCS Code Range E0705

- Transfer board
- Transfer device

Documentation: Written Order

Prior Authorization: Not Required

VEHICLE, POWER-OPERATED (POV)

Covered for members diagnosed with medical condition, which impairs ability to walk, and would otherwise be confined to bed or chair.

Equipment/Supplies:

HCPCS Code Range: K0800-K0802; K0806-K0808; K0812 and K0825

- Power Operated Vehicle

Indications/Limitations:

1. POV indicated for increasing independence and ability to perform major life functions and/or activities that the average person in the general population can perform with little or no difficulty. These functions/activities include, but are not limited to:
    a. Caring for oneself
    b. Mobility
    c. Learning
    d. Working
    e. Performing manual tasks
    f. Breathing
    g. Seeing and communicating
2. Criteria for Coverage includes possessing significant limited limb function and cannot propel manual wheelchair due to any ONE of the following:
    a. Absence or deformity of an upper extremity
    b. Inadequate upper extremity strength, range of motion, or coordination
    c. Inadequate endurance
    d. Decreased cardiopulmonary tolerance
3. Have no means of safe independent mobility.
4. Compared to use of a manual wheelchair, member's use of POV must result in significant improvement in independent mobility and ability to perform major life activities; and
5. No other uncompensated conditions that limit ability to participate in daily activities, including significant impairment of ANY ONE of the following:
    a. Vision
    b. Cognition
    c. Judgment
6. Member must demonstrate through trial period with similar POV the following:
    a. Ability to safely and independently operate POV controls
    b. Ability to transfer safely in and out of POV
    c. Has adequate strength and postural stability to safely ride in POV
7. A POV is not appropriate due to any ONE of the following:
    a. Alternative to joystick, finger, or thumb-controlled tilter required
    b. Modified frame required

c. Member requires complex supports or seating needs that can only be met via power wheelchair options
d. Member's prognosis indicates a potential for further decline in the short term (i.e. there will be a requirement for additional support offered by a power wheelchair)

Documentation:

1. Written Order that specifies ALL of the following components and accessories
2. Post Ural supports, including ANY ONE of the following:
    a. None
    b. Safety belts or straps
3. Arm rests, including ANY ONE of the following:
    a. None
    b. Fixed
    c. Swing up
4. Battery, including ANY ONE of the following types (units sufficient to run the chair – back up batteries are not covered):
    a. Gel Cell
    b. Lead-acid (wet cell)
    c. Sealed lead- acid
5. Wheel drive, including ANY ONE of the following:
    a. Front
    b. Mid or center
    c. Rear
6. Tires, including ANY ONE of the following:
    a. Pneumatic
    b. Foam Filled
    c. Solid
7. Control system, including ANY ONE of the following:
    a. Standard filter with thumb controls
    b. Tilter with joystick
    c. Tilter with finger controls
    d. Other
8. An evaluation (refer to the repair/labor policy) of the member's wheelchair needs is required and includes:
    a. Justification for type of POV as well as any options or accessories
    b. Evidence of coordinated assessment, which includes communication between member, caregiver(s), physician, physical and/or occupational therapist, and equipment supplier. Assessment should address physical, functional, and cognitive issues as well as accessibility, appropriateness of use in home (able to maneuver around home), ability to transport POV, and cost effectiveness of equipment
    c. Credentials and signature or evaluator

Prior Authorization: Required

VENTILATORS

Ventilators are covered for rental when necessary in the treatment of neuromuscular diseases, thoracic restrictive diseases, chronic respiratory failure consequent to chronic obstructive pulmonary disease, and respiratory paralysis. Ventilators are exempt from the capped rental policy that applies to most other medical equipment rental.

Equipment/Supplies:

HCPCS Code Range: E0450-E0483

- Volume and negative pressure ventilators

Indications/Limitations:

1. Reimbursement for rental of ventilators includes all back-up equipment and accessories necessary for proper functioning and effective use of the device.
2. Accessories are payable only as replacement for use with member-owned ventilators for members whose condition meets the criteria for the device.
3. The following supplies/accessories are covered as replacement for member-owned ventilators only and **CANNOT** be billed with rental equipment:
    a. Batteries
    b. Chest shell or wrap

Documentation

For initial authorizations:

1. Written Order, **Certificate of Medical Necessity**, letter of medical necessity or medical records that document:
    a. Pertinent lab values (e.g. elevated PaCO2, etc.)
    b. Number and frequency of hospitalizations secondary to respiratory exacerbation or failure
    c. Other methods of treatment and why those methods were deemed inappropriate or ineffective
    d. Member's social history
    e. Number and frequency of intubations
    f. History of member having difficulty being weaned from ventilator
    g. Episodes and frequency of disabling dyspnea, if pertinent
    h. Any other pertinent information documenting the necessity of home ventilation

For renewal authorizations:

2. Written Order, **Certificate of Medical Necessity**, letter of medical necessity, or medical records that document:
    a. Recent clinical note from provider/specialist within 90 days of authorization outlining need for home ventilator

b. Any recent pertinent lab values (e.g. elevated PaCO2, etc.) completed (only if already completed and available)
c. Number and frequency of intubations in the last 12 months
d. Number and frequency of hospitalizations secondary to respiratory exacerbation of failure in the last 12 months
e. Any other pertinent information documenting the necessity of home ventilation

Prior Authorization: Required

WALKERS

Covered for members with conditions that impair ambulation and who have a need for greater stability and security than provided by a cane or crutches.

Equipment/Supplies:

HCPCS Code Range E0130-E0149

- Any type of walker

Indications/Limitations:

3. Heavy duty walker covered for member's whose weight (within one month of providing the walker) is greater than 300 pounds;
4. Heavy duty, multiple braking system, variable wheel resistance walker covered for members who meet coverage criteria for a standard walker and are unable to use a standard walker due to a severe neurologic disorder or other condition causing the restricted use of one hand.
    a. Note: Obesity, by itself, is not a sufficient reason for heavy duty, multiple braking system, variable wheel resistance walker. If heavy duty walker is provided and the coverage criteria for a standard walker are met, but the additional coverage criteria for a heavy duty, multiple braking system, variable wheel resistance walker are not met, payment will be based on the allowance for the least costly medically appropriate alternative, depending on the member's weight.
5. Medical necessity of a walker with an enclosed frame when compared to a standard folding wheeled walker has not been established. Therefore, if the basic coverage criteria for a walker are met and a walker with an enclosed frame is billed, payment will be based on the allowance for the least costly medically appropriate alternative.
6. Walker with trunk support is considered a gait trainer – please refer to the gait trainer policy.
7. Enhancement accessories for walkers are non-covered because enhancement accessories do not contribute significantly to the therapeutic function of the walker. Enhancement accessories may include, but are not limited to:
    a. Style
    b. Color
    c. Hand operated brakes (other than those described in code E0147),or
    d. Basket (or equivalent)
8. Leg extensions are covered only for members 6 feet tall or more
9. Payment for purchase and rental of walkers includes all accessories necessary for proper functioning and effective use of the item.
10. The following supplies/accessories are covered as replacement for member-owned walkers only and **CANNOT** be billed in addition to the equipment with rental equipment:

   a. Handgrip
   b. Tip
   c. Platform attachment
   d. Wheels
   e. Leg extensions
11. Criteria for coverage include:
   a. Member is unable to ambulate independently with a standard cane or quad cane because of clearly documented reasons

Documentation:

1. Written Order, **Certificate of Medical Necessity**, a letter of medical necessity or medical records to clearly document the potential benefits to member and indicate the following:
   a. Equipment matches member's needs and ability level

Prior Authorization: Not required

References:

Section 1833(e) of the Social Security Act.

CMS Pub. 100-3 Medicare National Coverage Determinations Manual, Chapter 1, Section 280.3 Medicare Advantage Medical Policy Bulletin-Section-DME-Number-E-76-Topic-Walkers

Issue Date-12/31/07-Effective Date-1/1/08

WHEELCHAIRS (Manual & Power)

Wheelchairs are available for purchase or rental; wheelchairs are intended for home use and must be accessible in the home.

All wheelchairs must carry the manufacturer's warranty as part of the purchase price.

Serial numbers must be provided upon request from Wyoming Medicaid for new equipment. Assembly and delivery are included in purchase price.

Repairs:

Wyoming Medicaid covers repairs to a wheelchair owned by a member with appropriate documentation and a determination of cost-effectiveness.

Note: Rental of replacement equipment may be covered when excessive time is necessary to repair a member's only mobility device/wheelchair. When there is a delay in repairs on a personal power wheelchair (PWC), rental requests should be sent to Telligen with an explanation stating why there is a delay in repairs.

Replacements:

1. Wheelchairs may only be replaced on a five-year basis, unless there are extenuating circumstances such as:
    a. Member has grown more than expected
    b. A change in the member's physical condition
    c. Extensive wear of the wheelchair
2. If a wheelchair is lost or stolen, the medical provider requesting a new wheelchair must obtain a copy of the police report. The medical provider must either document on the prior authorization request that a copy has been obtained or send a copy with the request. Wyoming Medicaid will not consider authorization until two months after the filing of the police report to ensure adequate time for possible recovery of the wheelchair. If the chair is necessary for the member to maintain independence, Wyoming Medicaid will consider a short-term rental chair for a period not to exceed 120 days.
3. Replacement due to malicious damage, culpable neglect or wrongful disposition will not be covered.
4. When a wheelchair is no longer suitable because of growth, development or changes to the member's condition, and must be replaced, the member, the provider and Wyoming Medicaid may negotiate a good faith trade-in of the item no longer needed. Such a trade-in shall be used to reduce the reimbursement from Wyoming Medicaid on the new item.
5. No more than 2 hours will be allotted for wheelchair evaluations. The evaluation must include evaluator's credentials and signature, and measurements of:
    a. Height & Weight

   b. Seat Width and Depth
   c. Hip to Knee
   d. Knee to Foot
   e. Back Height
6. Please refer to the policy on Repairs/Labor/Maintenance for further information on documentation and prior authorization requirements for evaluations

Equipment/Supplies:

HCPCS Code Range: E0950-E1298; E2201-E2399; E2601-E2621

Mounting hardware is covered when it is needed in conjunction with other covered accessories.

Must be medically necessary and may include, but is not limited to:

1. Manual wheelchairs
2. Light weight and heavy-duty wheelchairs
3. Powered wheelchairs Including ANY ONE of the following:
4. Standard sling back and seat
5. Specialty seating including ANY ONE of the following:
   a. Custom molded (refer to policy on Seating Systems)
   b. Solid
   c. Gel
   d. Air flotation
   e. Foam
6. Frame modifications including ANY ONE of the following:
   a. Fixed
   b. Reclining
   c. Tilt-in-space
   d. Standing
   e. Variable seat height
7. Postural support including ANY ONE of the following:
   a. No additional postural support
   b. Collateral support
   c. Scoliosis support
   d. Kyphosis support
   e. Lumbar support
   f. Safety belts or strap
8. Head support including ANY ONE of the following:
   a. Flat head rest
   b. Winged head rest
   c. Head wedge
   d. Lateral head support
   e. Occipital head rest

   f. Head sling for hydrocephalus
   g. Head strap
9. Arm rests ANY ONE of the following:
   a. Swing away
   b. Full-length
   c. Desk length
   d. Fixed
   e. Adjustable height
10. Leg rests including ANY ONE of the following:
   a. Removable
   b. Swing away
   c. Fixed
   d. Elevating
11. Battery, including ANY ONE of the following types, units as needed to operate the chair (back up batteries are not covered):
   a. Gel cell
   b. Lead-acid (wet cell)
   c. Sealed lead acid
12. Wheel drive, including ANY ONE of the following:
   a. Front
   b. Mid or center
   c. Rear
   d. One arm drive
   e. Hand rims
   f. Wheel locks
13. Tires and casters, including ANY ONE of the following:
   a. Pneumatic
   b. Foam filled
   c. Solid
   d. Anti-tippers
14. Control system, including ANY ONE of the following:
   a. Joystick
   b. Breath-control (i.e. sip and puff)
   c. Visual scanning
   d. Head control
   e. Chin control
   f. Switches for patient without use of hands but able to control other anatomic sites
   g. Tray
   h. Safety vest
15. Ancillary features, such as
   a. Tilt-in-space
   b. Power seat elevation system

Indications/Limitations:

Manual wheelchair covered for members who:

1. Have a diagnosed medical condition which impairs the ability to walk; where long term risk of injury is high, or the energy cost of standing mobility is great; AND
2. The member requires a wheelchair for the purpose of:
    a. Increasing independence with mobility, resulting in significant difference in ability to perform major life activities; or
    b. Providing assisted mobility for members who show no means of safe independent mobility
    c. Preventing falls
    d. Preserving energy and strength
    e. Member should be evaluated for the most appropriate frame, seating system (including postural supports and cushions), arm and leg rests, propulsion method, and tires or castors
    f. The goals of wheelchair seating are to maintain proper alignment, accommodate skeletal deformity, improve tone management, decrease the likelihood of skin breakdown, improve sitting tolerance and reduce pain
    g. Tilt in space and reclining back wheelchairs are appropriate for those who need significant assistance in positioning

Power Wheelchair - covered instead of a manual wheelchair if the member meets the criteria for a manual wheelchair, but is unable to operate wheelchair manually due to ANY ONE of the following:

1. Absence or deformity of an extremity
2. Inadequate upper extremity strength, range of motion, or coordination
3. Inadequate endurance
4. Decreased cardiopulmonary tolerance
5. The member has demonstrated, through a trial period with a similar powered wheelchair, the ability to safely and independently operates the controls of a power wheelchair
    a. AND, the member has no other significant uncompensated conditions that limit ability to participate in daily activities including of ANY ONE of the following:
    b. Vision
    c. Cognition
    d. Judgment
    e. Physical layout, surfaces and obstacles of the area in which the motorized wheelchair is to be used permit safe operation of the device

Multiple Wheelchairs - Wyoming Medicaid only covers purchase, rental or repair of multiple or duplicate wheelchairs used for the same or similar purposes when substantial

documentation of medical necessity is received. Wyoming Medicaid does not cover back-up equipment for convenience. The provider may supply back-up equipment, but the provider may not bill Wyoming Medicaid.

Nursing Facilities - Wheelchairs, accessories and repairs of personal wheelchairs are always included in the per diem for a resident of a nursing facility. However, under limited circumstances, the customization of a wheelchair may be covered outside the per diem with written prior authorization for the member's permanent and full-time use.

Repairs to, or replacement of, specialized parts (including power wheelchair accessories) or customization of a wheelchair may be covered in addition to the per diem with appropriate documentation of need.

Option/Accessories - Wheelchair options/accessories are covered when medically necessary for use with a medically necessary rental or member-owned wheelchair base, to allow the member to perform activities of daily living, or to function in the home. An option/accessory that is beneficial primarily in allowing the member to perform leisure or recreational activities or for the convenience of the member or caregiver is not covered. Mounting hardware is covered when it corresponds to appropriate, covered options and accessories.

Reclining back wheelchair frame - the angle between the seat and the back of the frame is adjustable between 90 and 180 degrees. May include elevating leg rests. A reclining back may be manually operated (by a caregiver) or power operated (usually by the wheelchair user).

Reclining back wheelchair frames are covered for members who:

1. Have a diagnosed medical condition, which impairs their ability to tolerate the fully upright sitting position for significant amounts of time (usually greater than two hours)
2. Need to remain in a wheelchair (or unable to transfer between wheelchair and bed without assistance) for purposes of mobility or other interaction with their environment; and
3. Require frequent, significant adjustment of their position in the wheelchair, either to change hip angle or their sitting position relative to the ground

Tilt -in-space wheelchair frame - the angle between the seat and the back remain relatively fixed, but the seat and back pivot as a unit away from the fully upright position, such that the angle that both the seat and back make with the ground is able to be adjusted, usually more than 30 degrees. A tilt-in-space wheelchair frame may be manually operated (by a caregiver) or power operated (usually by the wheelchair user).

A tilt in space option is covered if the patient has one or more of the following:

1. High risk for development of a pressure ulcer and is unable to perform a functional weight shift.
2. A medical condition which necessitates changes in position while accomplishing basic activities of daily living, where the position changes cannot be performed manually and where reclining is contraindicated because of shear forces to the skin
3. A medical condition which necessitates changes in position due to severe fatigue or potential for loss of skin integrity AND where timely transfer to a bed to rest is not possible
4. Lower extremity edema is NOT an indication for tilt in space as the legs are not elevated level with or higher than the heart with tilt-in-space positioning.
5. Power operation of the reclining or tilt-in-space mechanism, which may include power operated elevation leg rests, is covered for members that meet the criteria for a reclining or tilt-in-space mechanism and:
    a. Have the cognitive and motor ability to operate the required control switch(es); and
    b. Are routinely in situations (e.g., home, community, school, work, etc.) where caregivers are not available within a reasonable time to manually recline or tilt them as needed

Combination power recline/tilt -in-space frames, if unavailable in manually operated forms, are covered for members that require both recline and tilt-in-space features (e.g., lack of necessary passive hip flexion for use of a standard tilt-in-space or inability to tolerate a significantly greater hip extension angle during sitting).

Custom Wheelchair - Uniquely constructed or substantially modified for a specific member and is so different from another item used for the same purpose that the two items cannot be grouped together for pricing purposes. The assembly of a wheelchair from modular components does not meet the requirement of a custom wheelchair for payment purposes. The use of customized options or accessories does not result in the wheelchair being considered customized. There must be customization of the frame of the wheelchair for it to be considered customized. Additionally, for nursing facility patients, the item must be needed for discharge.

Documentation:

1. Written Order
2. The "Wheelchair Certificate of Medical Necessity" is required for all requests for prior authorization of power wheelchairs, power wheelchair options and accessories unless the evaluation of the member's wheelchair needs addresses all information in this form. Documentation must be provided for all requests and a written order signed by a physician involved in the member's care.
3. An evaluation of the member's wheelchair needs by a physician, licensed physical or occupational therapist, or a "qualified technician" is required. A "qualified technician" is an ATP (Assistive Technology Practitioners) certified thru

RESNA, or RTS and CRTS (Certified Rehab Technology Supplier) certified thru NRRTS. **Please refer to the policy on Repairs/Labor/Maintenance for further information on documentation and prior authorization requirements for evaluations

4. In addition, if a customized wheelchair is prescribed for nursing facility members, the physician must include a statement describing the rehabilitation potential and how the customized wheelchair will enhance the prognosis. A written discharge plan stating the planned date of discharge to home or to a non-nursing facility setting must accompany the request for the wheelchair.

Prior Authorization:

- Required for rental and purchase of power wheelchairs and power wheelchair options, accessories, and repairs.
- Required for seat and back cushions with codes E2609 - E2625
- Required for Ultralight manual wheelchairs
- Not required for other manual wheelchairs, but all documentation must be maintained in the provider's files.

Note: Do not request prior authorization for codes that do not require one. Check the fee schedule for the code to determine if the code requires a prior authorization. This information is under "indicators" at https://myhp.wyomingmedicaid.us/CMToolkit/search when you have found the code. Requesting codes that do not require one may cause your claim to deny.

References:

Wyoming Medicaid News dated November 21, 2003

Wyoming Medicaid News dated July 2005 Medical Bulletin 06-014

WHEELCHAIR SEATING SYSTEM (Spinal Orthosis Seating System)

1. Must be ordered by a physician, pediatrician, orthopedist, neurosurgeon, neurologist or a physiatrist (a physician specializing in physician rehabilitation).
2. It is expected that physicians be experienced in evaluating the child's special needs for the purpose of prescribing the correct customized features
3. Covered when required to support a weak or deformed body member or to restrict or eliminate motion in a diseased or injured body part
4. A seating system for use with a wheelchair is covered when medically necessary for use with a medically necessary wheelchair base, for a member who has a diagnosed medical condition that impairs their ability to sit
5. Supporting the member in a position that minimizes the development or progression of musculoskeletal impairment

A wheelchair seating system may be covered for the purpose of:

1. Relieving pressure; or
2. Providing support in a position that improves the member's ability to perform functional activities

A customized fabricated back module for Orthosis seating may be considered medically necessary when **all** of the following criteria are met:

1. The member is expected to be in the wheelchair at least 6 hours/day; **and**
2. The member's need for prolonged sitting tolerance, postural support to permit functional activities, or pressure reduction cannot be met adequately by a seating system, lap tray, and/or prefabricated spinal orthosis; **and**
3. The member has a significant fixed spinal deformity and/or severe weakness of the trunk muscles

Seating Systems may only be replaced on a five-year basis, unless there are extenuating circumstances such as:

1. Member has grown more than expected
2. A change in the member's physical condition
3. Extensive wear of the current seating system

Documentation must include:

1. Completion of the **Wheelchair Certificate of Medical Necessity** form
2. A seating assessment or evaluation by a physician rehabilitative specialist, physical therapist or occupational therapist, or a "qualified technician". A "qualified technician" is an ATP (Assistive Technology Practitioners) certified thru RESNA, or RTS and CRTS (Certified Rehab Technology Supplier) certified thru NRRTS. **Please refer to the policy on Repairs/Labor/Maintenance for further information on documentation and prior authorization requirements for evaluations

3. No more than 2 hours will be allotted for the seating evaluation. The evaluation must justify the type of wheelchair seating system and include the evaluator's credentials and signature, and measurements of:
    a. Height & Weight
    b. Seat Width and Depth
    c. Hip to Knee
    d. Knee to Foot
    e. Back Height
4. Provide evidence of a coordinated assessment that includes communication between the member, caregiver(s), physician, physical and/or occupational therapist, and equipment supplier. The assessment should address physical, functional, and cognitive issues, as well as accessibility and cost effectiveness of equipment
5. A seating system may or may not part of a custom wheelchair. A wheelchair seating system consists of components used to position the member. It is mounted on a mobility base that may be manual or electric. The seating system for a child must be fitted to allow for growth.

Prior Authorization: Required for any seating systems

References:

Wyoming Medicaid News dated November 21, 2003

Wyoming Medicaid News dated July 2005 Medical Bulletin 06-014

WOUND V.A.C.

Covered for members who present with Level III or IV Stage decubitus ulcers including:

A. Diabetic Foot Ulcers
B. Wounds
C. Skin grafts

Not subject to capped rental

Equipment/ Supplies: Code: A6550; WOUND CARE SET, FOR NEGATIVE PRESSURE WOUND THERAPY ELECTRICAL PUMP. **INCLUDES:** ALL SUPPLIES AND ACCESSORIES.

HCPCS Code Range E2402

- Vacuum assisted closure machine
- Canisters
- Dressings

Indications/Limitations:

A. Treatment is authorized for no more than one month at a time
B. If a member falls into any of the following **contraindicated** categories, listed below V.A.C. treatment is **NOT** appropriate:
    a. Fistulas to organs or body cavities
    b. Presence of greater than 20% necrotic tissue in wound bed
    c. Osteomyelitis
    d. Cancer in the wound margins

Wound V.A.C. - treatment is reimbursable outside of the per diem for member's residing in a nursing facility. If a member is in an acute care setting and must be placed in a nursing facility on a short-term basis (three months or less) while the wound heals, the nursing facility will be reimbursed for that period of time, providing all other criteria has been met.

Documentation:

1. Written Order; AND
2. Medical records that document measurement and location of one of the following wound types:
    a. Stage III or IV Pressure ulcers
    b. Neuropathic (diabetic) ulcers
    c. Venous or arterial insufficiency ulcers
    d. Chronic- present for at least 30 days
    e. Acute
    f. Traumatic
    g. Dehisced wounds

   h. Flaps, grafts & burns on a case-by-case basis of greater than 1mm in depth and
3. Medical records that document:
   a. Wound is not infected
   b. No active bleeding
   c. No eschar
   d. Minimal or no necrotic tissue
   e. Area of decubitus, (must be in an area which is difficult to heal e.g.: sacral or ischial area); and
4. **Certificate of Medical Necessity**, letter of medical necessity or medical records that document
   a. That the member does not fall into any of the Precaution or Contraindication categories listed; and
   b. Description of conservative treatments and alternative measures or equipment attempted and why they were deemed inappropriate or ineffective; and
5. Information regarding who will maintain the equipment and provide ongoing communication as to the effectiveness of the V.A.C; and
6. For continuation beyond one month of therapy, documentation must reflect the following:
   a. After four weeks of therapy - a minimum of a twenty-percent decrease in size and volume of decubitus ulcer
   b. After eight weeks of therapy - a minimum of a sixty-percent decrease in size and volume of decubitus ulcer
   c. After twelve weeks of therapy - a minimum of a ninety-percent decrease in size and volume of decubitus ulcer
7. Circumstances that lead to wound development:
   a. Current wound labs as well as current nutritional status including any prescribed supplements
   b. Evidence (as pertains to individual member) that member has been appropriately encouraged and/or turned and repositioned while seated or while in bed
   c. Member's turning and repositioning schedule as pertains to individual
   d. Explanation of member's incontinence and how it is being appropriately managed
   e. Documentation of debridement of necrotic tissue **AND** documentation of how much necrosis **CURRENTLY** in wound bed
   f. Description of any current infection; systemic and/or wound site **AND** current treatment
8. For diabetic ulcers, documentation that member has been on a comprehensive diabetic management program as evidenced by:
   a. Fingerstick/other blood glucose results
   b. Current hemoglobin A1C

   c. Current diabetic medication regimen
9. For Venous insufficiency ulcers, evidence that the following interventions have been utilized:
   a. Compression stockings and/or bandages have been consistently applied
   b. Leg elevation above the level of the heart
   c. Avoidance of extended periods of time in one position; sitting or standing
   d. Ambulation has been encouraged as appropriate
10. Written documentation that member does not fall into any contraindicated categories listed under limitations below; and why vacuum assisted closure is appropriate if member does have any of the following precautionary therapy/symptoms:
   a. Members receiving anticoagulant therapy.
   b. Members experiencing difficult hemostasis following debridement

Prior Authorization: Required

NOT OTHERWISE CLASSIFIED (NOC) CODES

Providers may contact Provider Relations in writing with requests to cover code(s). All requests must include a complete description of the item, including brand, product number, size, etc. Use procedure code modifiers when appropriate.

Documentation:

1. Written Order, AND
2. Other documentation may be requested.

Prior Authorization: Prior authorization is required for rental and purchase of durable medical equipment not otherwise classified.