

# Chapter 18

## Equipment and Supplies

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

### Eligible Providers

The following are eligible to provide most equipment and supplies:

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

The following are eligible providers for DME only when the DME are provided as a necessary adjunct to the direct treatment of a member's condition (for example: crutches, splints) and not incident to the service provided.

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

### Covered Services

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

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

Medicaid coverage period or to the purchase price of the equipment. After 13 months of rental, or when the purchase price is reached, the item is the member's property.

- DME determined by Medicare to require frequent and substantial servicing is not subject to the 13-month rental limit.
- All rental months, count toward the purchase price unless there is a break in continuous use. A break in continuous use is defined as a period of two months or more during which the provider has removed the equipment from the member's home, or the member is not using the equipment because of an inpatient hospital or skilled nursing facility stay.
- SCHA assumes a reasonable useful lifetime of five years for all durable medical equipment. SCHA will not cover equipment that serves the same purpose as usable equipment previously purchased for the member.
- SCHA covers repairs to medically necessary member-owned equipment and maintenance on equipment that requires frequent cleaning or routine calibration to ensure proper working order.
- All purchased equipment must be new upon delivery to the member. Equipment that is intended to rent until converted to purchase must be new equipment. Used equipment may be used for short-term rental, but if eventually converted to purchase, must be replaced with new equipment.

To determine the appropriate HCPCS code to use for an item, refer to the Medicare Pricing, Data Analysis and Coding (PDAC) [Product Classification List](#).

## Noncovered Services

South Country does not cover the following (this is not an all-inclusive list):

- Air conditioners
- Bathroom scales
- Bathtub wall rails
- Beds - oscillating and lounge beds, bed baths and lifters, bedboards, tables and other bed accessories
- Blood glucose analyzer - reflectance colorimeter
- Car seats, standard use
- Cervical roll or pillow
- Clothing
- Control units and battery device adapters
- Dehumidifiers - room or central
- Diathermy machines
- Disposable wipes - including Attends wash cloths
- Disposable ice packs and disposable heat wraps
- Elevators and stair lifts that are affixed to the home
- Enuresis or bed-wetting alarms

- Environmental products (for example, air filters, purifiers, conditioners, hypoallergenic bedding and linens)
- Exercise equipment
- Food blenders
- Grab bars that are affixed to the home
- Heat and massage foam cushion pads
- Home security systems
- Household equipment and supplies such as ramps, switches, tableware and feeding instruments
- Humidifiers - room type or central
- Hygiene supplies and equipment, including hand-held shower units and shower trays, and dental care supplies and equipment
- Instructional materials (for example, pamphlets and books)
- Isolation gowns, surgical gowns and masks
- Magnifying glasses
- Massage devices
- Medical alert bracelets and response systems
- Medical supplies defined as drugs
- Medication boxes or medication dispensing equipment
- Menses products (e.g., sanitary pads)
- Motorized lifts for a vehicle
- Orthopedic mattresses
- Personal computers and printers, tape recorders or video recorders
- Pulse tachometers
- Ramps that are affixed to the home
- Reachers
- Reading glasses
- Saline or other solutions for the care of contact lenses
- Table foods
- Telephones, telephone alert systems, telephone arms or answering machines
- Tennis or gym shoes
- Thermometer covers
- Toothbrushes and toothettes
- Toys

- Washable or reusable incontinence undergarments
- Waterbeds
- White canes for the blind

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

Beginning 1/1/2018 the initiation of medical equipment requires a documented face-to-face encounter that must be related to the primary reason that the member requires medical equipment. This encounter must occur no more than six (6) months prior to the start of services. The face-to-face encounter may be conducted by one of the following: a physician, a nurse practitioner or clinical nurse specialist, or a physician assistant. The face-to-face encounter may occur through telemedicine. In addition, the need for medical supplies, equipment, and appliances must be reviewed by a physician annually.

Only DME items subject to the face-to-face rule by Medicare are subject to this rule. A list of items subject to the face-to-face rule may be found in Chapter 3 of the Medicare DME MAC Jurisdiction B Supplier Manual. Refer to the [Medicare contractor supplier documentation \(PDF\)](#), ACA 6407 Specified Items, pages 11-17.

### Third Party Liability (TPL) and Medicare

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

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

### Coverage Criteria

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

### Prior Authorization

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

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

Some equipment and supplies require authorizations outside of the above criteria. To inquire about authorization requirement for a certain equipment or supply not addressed in this chapter, please contact SCHA provider call center at 1-888-633-4055.

Providers will submit a prior authorization and/or notification via the provider portal <https://provider.mnscha.org/scha.provider.aspx> located on SCHA website: <https://mnscha.org/>

To Fax authorizations, the Service Authorization form is located on the provider portal <https://provider.mnscha.org/scha.provider.aspx> located on the SCHA website: <https://mnscha.org/>

Fax directly to SCHA Utilization Management at 1-888-633-4052.

## Rental vs. Purchase

Rental of Durable Medical Equipment will be the general practice. However, if there is evidence the Durable Medical Equipment will be required long enough to justify purchase, reimbursement will be limited to the purchase price. SCHA reserves the right to determine if an item will be approved for rental versus purchase.

## Capped Rental Items

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

## Replacement

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

## Repair

Separate charges for repair of Durable Medical Equipment are covered services if such equipment is being purchased or is already owned by the member and repair is necessary to make the equipment serviceable. When repair costs exceed the estimated cost for purchasing

or renting the same item for the remaining period of medical need, such excess repair costs are not a covered service. Rental of Durable Medical Equipment while member's own Durable Medical Equipment is being repaired is a covered service.

### Add-ons and Upgrades

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

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

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

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

### Ambulatory Assist Equipment

Ambulatory assist equipment is covered for eligible SCHA members who meet medical necessity criteria. Canes are not covered for SCHA members in nursing facilities or ICFs/DD. Walkers are not covered for SCHA members in nursing facilities. Only walkers with trunk support are covered for SCHA members in ICFs/DD. Gait trainers may be covered for members in nursing facilities or ICFs/DD. Quantity limits and thresholds apply to all members.

### Covered Services

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

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

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

- When dispensing articulating, spring assisted crutches, providers must maintain documentation as to why standard crutches will not meet the member's needs
- Rental of a crutch substitute is covered for members who are unable to safely use standard crutches, providers must maintain documentation as to why standard crutches will not meet the member's needs

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

- SCHA does not require that the walker is needed in the home. Walkers are also covered for members who are able to safely ambulate in the home, but who require a walker for safety in the community.
- SCHA covers a walker for members who primarily use wheelchairs, but who require a walker in specific situations
- A heavy-duty walker is covered if a member's weight, body size or stability makes a standard walker unsafe
- Because very few walkers are made for children, DHS will allow manual pricing of pediatric walkers. Authorization is required if the expected payment exceeds the fee schedule rate.
- A wheeled walker is assumed to include glide type brakes which raise the leg post of the walker off the ground when the patient is not pushing down on the frame. If dispensing a walker with hand brakes, providers may bill "brake attachment for wheeled walker" as a replacement for glide-type brakes.
- Reverse walkers are considered medically necessary for members who cannot safely use a standard walker. Documentation must establish that the member's medical needs cannot be safely met using a standard walker, and that the requested walker is the least costly alternative to appropriately meet the member's needs.

Gait trainers: requires authorization for coverage to members who require moderate to maximum support to walk, and who require the equipment to establish or maintain functional gait. Documentation must include:

- Member's age, height, weight and current level of mobility
- A physical therapy evaluation with baseline measurements, functional goals and recommendations for an assistive device to support gait training and ambulation, as well as any history of gait training and devices used
- A specific therapy program detailing the frequency and duration of sessions during which the member will use the device
- Training given to the caretakers to assure that the device is used appropriately
- Results of a trial in the locations where the device is expected to be used
- Less costly alternatives considered and why they were rejected (include specific product information)

Include a list of all accessories with documentation of medical necessity for each item added to the gait trainer.

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

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

## Diabetic Equipment & Supplies

South Country Health Alliance covers diabetic equipment and supplies to members with Type 1, Type 2 or gestational diabetes. Diabetic testing supplies are part of the [Point of Sale Diabetic Testing Supply Program](#)

Members with Medicare Part B must obtain diabetic testing supplies from a Medicare medical supplier or pharmacy. A list of SCHA Diabetic testing supplies may be found at [www.mnscha.org](http://www.mnscha.org).

## Covered Services

**Blood Glucose Monitors:** The medical supplier's office must keep a written physician's order stating the need to monitor blood glucose levels.

- Standard blood glucose meters are included in the [Point of Sale Diabetic Testing Supply Program](#) unless the member has Medicare Part B.
- Blood glucose monitor with integrated voice synthesizer may be rented or purchased. Authorization is always required.
  - Blood glucose monitors with voice synthesizer are covered for members with a severe visual impairment. The visual impairment must be significant enough to make accurate use of a standard blood glucose monitor impossible. The member must be able to independently use the blood glucose monitor with voice synthesizer.
- Blood glucose monitor with integrated lancing/blood sample may be rented or purchased. Authorization is always required.
  - Blood glucose monitors with integrated lancing are covered for members with impairment of manual dexterity. The dexterity impairment must be significant enough to make accurate use of a standard blood glucose monitor impossible. The member must be able to independently use the blood glucose monitor with integrated lancing.

**Continuous Blood Glucose Monitoring:** Authorization is always required

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

**Disposable Blood Glucose Monitor:** Authorization is not required.

Disposable blood glucose meters include any necessary test strips and calibration solution or chips

Disposable blood glucose meters are limited to four per calendar month

Bill one unit per meter with test strips. Submit a claim with an attachment that includes the name of the product dispensed and required documentation for manual pricing.

**Blood Glucose Test Strips:** are included in the [Point of Sale Diabetic Testing Supply Program](#) unless the member has Medicare Part B.

**Insulin Syringes:** Authorization is required for quantities exceeding monthly threshold.

**Reusable Insulin Pens:** Authorization is required.

Reusable insulin pens are covered for members who self-administer insulin, but who are unable to accurately administer insulin using a syringe and vial.

**Ambulatory Insulin Infusion Pumps:**

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

- Completion of a comprehensive diabetes education program
- On a program of at least three injections of insulin per day, with frequent self-adjustments of dose, for at least six months
- Documented self-testing an average of at least four times per day
- Has one of the following:
  - Elevated glycosylated hemoglobin level of HbA1c greater than 7.0 percent
  - History of recurring hypoglycemia less than 60 mg/dL
  - Wide fluctuations in blood glucose before mealtime
  - Dawn phenomenon with fasting blood sugars often over 200 mg/dL
  - History of wide glycemic excursions
  - Otherwise unable to maintain optimal control

**Enteral Nutritional Products and Related Supplies**

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

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

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

**Covered Services**

Only products classified by Medicare's Pricing, Data Analysis and Coding (PDAC) contractor are covered. Up to 1,050 units per month of enteral nutrition is cover for members who meet medical criteria. Documentation must support the need for the number of units requested.

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

Nutrition for Members under Age One: Authorization is always required.

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

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

Nutrition for Members with Feeding Tubes:

Enteral nutritional products are medically necessary for members with feeding tubes. Authorization is not required for members over the age of one (1); diagnosis of tube-feeding must be on the claim.

Oral Nutrition for Members with Inborn Errors of Metabolism

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

Oral Nutrition for Members with Allergies

Enteral nutritional products may be medically necessary for members with a combined allergy to cow's milk, human milk, and soy milk. Oral enteral nutritional products are covered with authorization if the member has a combined allergy to cow's milk, human milk, and soy, which is supported by appropriate medical testing and documentation. It is expected that the need for oral enteral nutritional products will decrease as the member ages and additional foods are added to the diet. If the member gets less than 75 percent of daily nutrition from a nutritionally complete enteral nutrition product, a nutritionist, a speech-language pathologist, or a physician must write a detailed plan to decrease dependence on the supplement.

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

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

- The member has a diagnosed medical condition such as, but not limited to:
  - A mechanical inability to chew or swallow solid, pureed or blenderized foods
  - A malabsorption problem due to disease or infection
  - An oral aversion which significantly limits the ability to get adequate nutrition through solid or pureed or blenderized foods
  - Weaning from TPN or feeding tube
- The medical condition leads to inability to consume or absorb adequate nutrients
- The member has experienced significant weight loss over the past six months or, for children under aged 21, has experienced significantly less than expected weight gain

- If the member gets less than 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.

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

High protein enteral nutritional products are covered for up to six months with authorization if the member has one or more wounds that have not responded to treatment for at least 30 days, and a dietary assessment has determined that the member has a nutritional deficit which may be impeding healing. Documentation must include a nutritional plan written by a nutritionist, physician or other health care provider.

#### Supplies for Enteral or Parenteral Nutrition

##### **Food thickeners**

Food thickeners (Simply Thick, Thicken-It) may be medically necessary for individuals at risk of choking or aspirating liquids.

##### **Enteral Feeding Supply Kits**

The feeding supply kit must correspond with the method of administration and must contain all supplies necessary for feeding using that method of administration for one day.

##### **Feeding Tubes**

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

##### **Feeding Pumps**

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

##### **Breast Pumps**

Limited to one purchase in three rolling years.

#### Noncovered Services

SCHA does not cover the following:

- Nutritional products for healthy newborns
- Nutritional products for people living in LTC facilities (included in the per diem)
- Nutritional products for which the need is nutritional rather than medical or is related to an unwillingness to consume solid or pureed foods
- Nutritional products that are requested as a convenient alternative to preparing or consuming regular foods

- Nutritional products for which coverage is requested because of an inability to afford regular foods or supplements (refer member to county human services)
- Food thickeners for people living in LTC facilities (included in the per diem)
- Food thickeners for infants under age one who were born at less than 37 weeks gestation due to FDA caution
- SimplyThick brand thickener for infants under age one regardless of gestational age at birth is not covered due to FDA caution
- Energy drinks and Sport shakes

## Hearing Aids

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

- Batteries and Replacing battery doors
- Ear impressions
- Ear molds, including open dome style ear molds (not disposable) (once every 3 months)
- Hearing aids (once every 5 years)
- Hearing aid checks (programming)
- Hearing aid repairs
- Parts and Accessories
- Programming/reprogramming
- Re-casing, re-makes, shell modifications

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

## Trial Period

Hearing aids obtained under the DHS Volume Purchase Contract that are not satisfactory may be returned to the manufacturer within 90 days but no sooner than 30 days. The trial period consists of consecutive days beginning the day the hearing aid is provided to the member and must extend at least 30 days, but no more than 90 days. The hearing aid service provider must inform the member of the beginning and ending dates of the trial period and refer the member to the prescribing audiologist when the aid cannot be adjusted to the member's satisfaction.

## Hearing Aid Repairs

- Hearing aid repair over \$400 requires authorization.
- SCHA does not cover repairs or the cost of returning the aid to the manufacturer while the aid is under warranty. All claims for hearing aid repairs must include the hearing aid expiration warranty date.
- All hearing aid repairs are required to have a minimum six months warranty.
- The hearing aid repair rate is determined by the hearing aid volume purchase contract under which the aid was purchased. The hearing aid volume purchase contracts require

manufacturers to honor the contracted repair rate for the life of the hearing aid following the expiration of the contract.

- Do not bill re-casing, remakes or shell modifications as repairs.

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

## Hospital Beds

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

## Covered Services

### **Fixed height manual hospital beds**

Covered for members with one of the following:

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

### **Variable height manual hospital beds**

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

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

### **Semi-electric hospital beds**

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

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

### **Total electric hospital beds**

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

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

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

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

Coverage may be considered for members with daily seizure activity, uncontrolled movement disorder, or a medically necessary condition putting the member at significant risk for injury in a standard bed. Requests for a manual, semi-electric, or total electric bed must meet the criteria for the type of hospital bed requested.

### **Pediatric hospital beds**

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

### **Enclosed Beds**

Enclosed beds are considered medically necessary and the least costly alternative only in the most extreme conditions due to the restrictive nature of the beds and the confinement they entail. Enclosed beds may be fully or partially enclosed.

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

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

The member must meet the following criteria:

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

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

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

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

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

### **Replacement mattress / bed rails**

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

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

### **Incontinence Products**

South Country Health Alliance covers a specified quantity of disposable incontinence products to eligible members with the proper diagnosis and documentation of medical necessity.

### **Covered Services**

Incontinence products and services covered are:

- disposable briefs or diapers,
- protective underwear or pull-on liner,
- shield,
- guard,
- pad,
- undergarment,
- underpad, and
- diaper service for reusable diaper.

Any pediatric sized product and any liner, shield, guard, pad, undergarment, and underpad may be covered. Adult and youth-sized disposable briefs, diapers and protective underwear or pull-on are only covered if they are listed on the [Incontinence Product List \(PDF\)](#).

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

### **Coverage Criteria**

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

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

## Orthopedic and Therapeutic Footwear

Therapeutic footwear and Orthopedic footwear is covered by SCHA for eligible members who meet medical criteria. Quantity limits and thresholds apply to all members.

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

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

## Covered Services

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

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

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

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

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

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

### **Orthopedic Shoes and Inserts**

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

- Foot deformity accompanied by pain
- Plantar fasciitis
- Calcaneal bursitis (acute or chronic)
- Calcaneal spurs

- Inflammatory conditions such as submetatarsal bursitis, synovial cyst or plantar fascial fibromatosis
- Medial osteoarthritis of the knee
- Musculoskeletal or arthropathic deformities
- Neurologically impaired feet
- Vascular conditions
- Hallus valgus deformities in children

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

### **Foot Pressure Off-Loading Device**

A foot pressure off-loading device is covered for pressure reduction for existing pressure ulcers on the foot.

### **Noncovered Services**

SCHA does not cover the following:

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

### **Orthotics**

Orthotics are used to restrict movement or support weak body parts. Orthotic devices are covered for all eligible SCHA members.

### **Covered Services**

SCHA follows CMS's Medically Unlikely Edits (MUE) for orthotics. If CMS has not published an MUE, SCHA has established quantity limits.

### **Orthotics for the spine**

An orthotic for the spine is considered medically necessary:

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

Orthotics for the spine are covered without authorization when medically necessary.

### **Orthotics for the hip**

An orthotic for the hip is considered medically necessary

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

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

### **Lower limb orthotics**

A lower limb orthotic is considered medically necessary:

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

Four lower limb orthotics (two sets of bilateral orthotics) are covered per calendar year without authorization when medically necessary

### **Upper extremity orthotics**

An upper extremity orthotic is considered medically necessary:

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

Four upper extremity orthotics (two sets of bilateral orthotics) are covered per calendar year without authorization when medically necessary.

### **Cranial remolding orthotics**

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

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

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

## **Oxygen Equipment**

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

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

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

## Covered Services

### **Oxygen equipment and contents; oxygen conserving device:**

SCHA covers oxygen and oxygen equipment in the following circumstances:

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

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

### **Portable Concentrators, Home Liquefier Systems and Home Compressor Systems**

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

## Noncovered Services

SCHA does not cover the following:

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

## Patient Lifts and Seat Lift Mechanisms

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

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

## Covered Services

Sling or seat, patient lift, canvas or nylon; Patient lifts; Seat lift mechanisms

**Hydraulic or mechanical patient lifts** are covered for members who meet the following criteria:

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

**Multi-positional patient support systems with integrated lift and moveable patient lifts** are covered for members who meet criteria for a patient lift and whose unique medical needs cannot be met with a less costly lift.

**Electric patient lifts** are covered for members who meet criteria for a hydraulic or mechanical lift and who meet one of the following criteria:

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

**Seat lift mechanisms** are covered for members who meet all of the following criteria:

- The member has arthritis of the hip or knee, neuromuscular disease or another medical condition that affects his or her strength or mobility

- The member is unable to stand up from a regular armchair at home
- Once standing, the member has the ability to ambulate independently or with a properly fitted walker or cane

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

### Authorization

Authorization is required for the following:

- When the charge is over \$500.00
- Rental or purchase of electric patient lifts, multi-positional patient support systems, moveable patient lifts, and seat lift mechanisms
- Rental or purchase of a patient lift when the patient's current lift, regardless of lift type, is less than five years old

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

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

### Positive Airway Pressure for Treatment of Obstructive Sleep Apnea

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

### Covered Services

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

SCHA will pay for the first three (3) months' rental of a Bi-PAP device, for members with obstructive sleep apnea, when there has been a failed trial of CPAP or if there is a medical contraindication to CPAP with a physician's order. During the 6th to 12th week of treatment, the

supplier must verify that the member is complying with the ordered therapy. If the member has not achieved compliance by the 12th week, but has made consistent progress toward compliance, SCHA will continue to cover the Bi-PAP device for an additional eight weeks. If the member has not achieved compliance after the additional eight weeks, the rental will end, and the provider should retrieve the equipment back. Authorization is required for rental of the fourth (4) month and after.

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

## Member Compliance

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

Keep documentation of the compliance verification in the members file. Recommended documentation includes the following:

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

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

Included with initial dispensing:

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

Separately billable at initial dispensing:

- Head gear
- Mask
- Tubing
- Humidification device

## Noncovered Services

- Carrying case is a noncovered convenience item and is not medically necessary.

- A positive airway pressure device is not covered after the third month unless the supplier has verified patient compliance as described above.

### SAD Lights

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

### Covered Services

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

### Noncovered Services

Therapeutic light boxes are not covered when prescribed for:

- Conditions other than SAD as there is no proven medical benefit for other indications
- Members in nursing facilities or intermediate care facilities for developmentally disabled

### Authorization

Authorization is required for a SAD light box when the charge is \$500 or greater. All authorization requests must include:

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

### Wheelchair/Mobility Devices

South Country Health Alliance covers mobility devices for eligible members with a mobility limitation that significantly impairs their ability to participate in one or more mobility-related activities of daily living and the mobility limitation cannot be sufficiently resolved by the use of an appropriately fitted cane or walker.

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

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

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

#### Criteria for All Covered Mobility Devices:

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

- The mobility device must enable the member to participate in mobility related activities of daily living and be appropriate to the member's needs and abilities.
- A "back up" manual chair may be covered for members with powered mobility if needed to allow the member to access medical care or essential services in the community, or when the member's power chair includes custom molded seating such that the member cannot be served with a loaner or rental chair during repairs.
- When a power wheelchair is purchased for a member who already has a manual wheelchair, SCHA will assume that the power wheelchair is replacing the manual wheelchair. Repairs to the manual wheelchair will not be covered unless documentation is submitted that the manual wheelchair meets criteria as a backup wheelchair.
- Documentation submitted with previous authorization requests will be considered when determining if criteria are met for a backup wheelchair.
- To be considered custom molded seating, the wheelchair must require significant customization to maintain the member in an appropriate position. The use of supports alone does not constitute customization.
- A basic manual wheelchair, transport chair or roll about chair may be covered if needed to allow the member to access medical care in the community, even if not needed for other activities of daily living.

#### Covered Services

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

## Manual wheelchairs

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

- A caregiver who is available, willing and able to provide assistance
- Sufficient upper extremity function to propel an optimally configured manual wheelchair to participate in mobility-related activities of daily living during a typical day

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

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

Lightweight (34 – 36 lbs.) or ultra-lightweight (less than 30 lbs.) manual wheelchairs are covered if the member:

- Primarily uses a manual wheelchair rather than a power mobility device
- Can propel themselves in the requested chair
- May be at risk for shoulder pain or injury related to propelling the wheelchair

High strength, lightweight wheelchairs are covered if the member primarily uses a manual wheelchair rather than a power mobility device and:

- Can propel themselves in the requested chair or
- Needs a high strength wheelchair to be safe because of medical conditions such as spasticity or seizures

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

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

Tilt in Space manual wheelchairs are covered if the member has one of the following needs:

- Is at high risk for pressure ulcers and is unable to perform a functional weight shift
- Has increased or excess muscle tone or spasticity related to a medical condition that is anticipated to be unchanging for at least one year

Rollabout or Transport chairs are covered if:

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

Standard options and accessories for manual wheelchairs include:

- Calf rests or pads
- Fixed height arm rests (fixed, swing-away or detachable)
- Foot rests and footplates (fixed, swing-away or detachable)

- Hand rims with or without projections
- Wheel lock assemblies

Nonstandard options and accessories for manual wheelchairs may include:

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

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

### Power Operated Vehicles (POV)

Power operated vehicles are covered if the member:

- Meets the criteria for a mobility device
- Does not have sufficient upper extremity function to self-propel an optimally-configured manual wheelchair to perform mobility-related activities of daily living
- Is able to safely transfer to and from the POV
- Has both the physical and cognitive ability to operate the tiller steering system
- Is able to maintain postural stability and position while operating the POV
- Is able to bring the POV into the home for use and storage or if homeless, has demonstrated a plan to safely charge and store the POV

Standard equipment for a POV includes:

- Battery or batteries required for operation
- Single mode battery charger
- Weight appropriate upholstery and seating system
- Tiller steering
- Non-expandable controller with proportional response to input
- Complete set of tires
- All accessories needed for safe operation

- Options and accessories provided at the time of initial issue of a power operated vehicle are not separately billable

## Power Wheelchairs

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

Standard equipment for power wheelchair includes:

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

Nonstandard options or accessories for power wheelchair may include:

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

Group 1 or Group 2 no power option power wheelchairs are covered if the member:

- Meets the criteria for a power wheelchair

- Does not require a single or multiple power option wheelchair
- Does not require a drive control interface other than a hand operated standard proportional joystick

Group 2 single power option power wheelchairs are covered if the member has one of the following:

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

Group 2 multiple power option power wheelchairs are covered if the member has one of the following:

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

Group 3 no power option power wheelchairs are covered if the member:

- Has mobility limitations due to a neurological condition, myopathy, congenital skeletal deformity or the member has a significant medical condition which requires the use of seating, positioning or other accessories that cannot be adequately accommodated by a Group 1 or Group 2 power wheelchair

Group 3 single power option power wheelchairs are covered if the member:

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

Group 3 multiple power option power wheelchairs are covered if the member:

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

Group 4 no power option power wheelchairs are covered if the member:

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

Group 4 single power option power wheelchairs are covered if the member:

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

Group 4 multiple power option power wheelchairs are covered if the member:

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

Group 5 power wheelchairs are covered if the member:

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

### Wheelchair Options and Accessories

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

One arm drive attachments are covered if:

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

Push activated power assist is covered if the member:

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

Documentation must include:

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

Power tilt is covered if the member:

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

Power recline is covered if the member:

- Meets criteria for a power wheelchair
- Is able to independently operate the power recline system
- Has one of the following:
  - Is unable to tolerate a full upright position due to a medical condition which impairs their ability to tolerate the fully upright sitting position for significant periods of time
  - Uses intermittent catheterization
  - Has edema and is unable, for physical or other reasons, to periodically transfer from the wheelchair to elevate the legs

Power tilt and recline seating systems, with or without power elevating legs rests are covered if the member:

- Meets criteria for a power wheelchair
- Is able to independently operate the power tilt and recline system
- Meets criteria for both power tilt and power recline

Mechanical leg elevation systems are covered if the member:

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

Power leg elevation systems are covered if the member:

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

Manual, fully or semi-reclining backs are covered if the member has one of the following:

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

Gear reduction drive wheels are covered if the member:

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

Dynamic seating frame is covered when:

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

Seat elevation feature is covered if the member has one of the following:

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

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

If a seat elevation feature is approved for a member, the provider must obtain documentation from the member or the member's authorized representative acknowledging that he or she understands that the seat elevation function may affect future requests for PCA or home care

services before dispensing and billing for this item. This documentation must be made available upon request.

Standing feature is covered if:

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

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

#### Alternative Interface Devices

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

Power wheelchair attendant control is covered if the member:

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

#### Wheelchair component or accessory, not otherwise specified

Miscellaneous items are covered if medically necessary or if required for the functioning of other covered items. For example, if a high mount footrest is needed because the chair has a power or manual tilt, the high mount bracket is covered.

### Custom Molded and Prefabricated Custom Seating Systems

#### Custom molded seating systems

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

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

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

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

#### **Replacement of worn batteries, battery chargers, wheels, tires or arm pads**

Replacement of worn batteries, battery chargers, wheels, tires or arm pads is not considered a

repair. Authorization is not required, regardless of submitted charge, unless the part being replaced is less than one year old. Replacement of other components is considered a repair and subject to the \$500 limit.

### **Wheelchairs in long-term care facilities**

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

Standard wheelchairs for members in a nursing facility are included in the nursing facility (NF) per diem. Wheelchairs and accessories for member in a NF will always require authorization.

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

- The member needs a wheelchair that must be modified. Wheelchairs manufactured in various widths and sizes are not considered modified. Modified means one of the following:
  - The addition of an item to the wheelchair that cannot be removed without damaging the wheelchair
  - It permanently alters the wheelchair, so it is no longer usable by other residents of the facility
- The wheelchair is necessary for the continuous care and exclusive use by the member to meet their unusual medical need. Please note:
  - Exclusive use alone does not justify approval of a wheelchair for a member if the chair required is a standard chair
  - Medical conditions common or expected in nursing facility populations are not “unusual” just because they are rare in one specific facility. For example, Alzheimer’s disease, osteoporosis and vulnerability to pressure ulcers are common in nursing facilities
- The resident is being discharged to the community. Document the resident’s planned discharge date. If the member is being discharged, a standard wheelchair may be approved if it meets the member’s needs

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

Authorization for a power wheelchair will be considered only if it allows the member to experience inclusion and integration in the long-term care facility. All coverage criteria for a power wheelchair must be met.

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

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

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

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

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

### Noncovered Services

Mobility devices are not covered in the following circumstances:

- Power mobility devices if requested solely for the purpose of community outings such as attending social activities
- Mobility devices requested to meet behavioral needs rather than mobility needs
- Mobility devices requested solely for use in a public school if the device can be covered through an individualized education program (IEP)
- Backup devices if requested in case of equipment malfunction, unless the member's power chair has custom molded seating such that the member cannot be served by a loaner or rental chair
- Mobility devices designed for sports or recreational purposes
- Wheelchairs with stair climbing ability
- Options and accessories to convert a manual chair to a power chair
- Adult power mobility devices (power wheelchairs or power operated vehicles) not reviewed by Medicare's Pricing, Data Analysis and Coding (PDAC) contractor or reviewed by the PDAC contractor and found not to meet the definition of a specific power mobility device.