

Chapter 18

Durable Medical Equipment and Supplies

NOTE: Please review the following detail for specific processes and expectations with South Country Health Alliance (South Country). South Country may vary from the MHCP Manual and Minnesota Department of Human Services guidelines. For additional detail on this chapter, please go to the Minnesota Health Care Programs Provider Manual at [MHCP Provider Manual](#).

Billing Information – Please review the [South Country Provider Manual Chapter 4 Provider Billing](#) for general billing processes and procedures.

South Country Health Alliance (South Country) covers medical supplies and equipment that are medically necessary per policies established under the Centers for Medicare & Medicaid (CMS) and Minnesota Department of Health Services (DHS), subject to limitations, authorization and other requirements. Reference to these policies can be found at [MCD Search \(cms.gov\)](#) 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).

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

Providers must always verify member eligibility and prior receipts of DME item(s)/supply(s) before dispensing or requesting a prior authorization.

Covered Services

South Country 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 (2) 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.
- South Country assumes a reasonable useful lifetime of five years for all durable medical equipment.
- South Country will not cover equipment that serves the same purpose as usable equipment previously purchased for the member.
- South Country 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) Palmetto GBA [Durable Medical Equipment Coding System](#) webpage.

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, bed boards, 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 and grabbers
- 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

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, clinical nurse specialist, or a physician assistant. The face-to-face encounter may occur through telehealth. See [Chapter 33 Telehealth](#) for more information. Although not required to be face-to-face, renewal of medical supplies, equipment, and appliances must be approved by a physician, nurse practitioner, clinical nurse specialist, or physician assistant on an annual basis.

DME items subject to the face-to-face rule by Medicare are also 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.

Face-to-Face Documentation

Providers must maintain written or electronic documentation of face-to-face encounters on file and available upon request. Documentation must include:

- The identity of the physician or non-physician practitioner who conducted the face-to-face encounter. Non-physician practitioners are authorized to complete the documentation requirements
- The date of the face-to-face encounter
- The specific diagnosis or medical condition that was the reason for the face-to-face encounter and ordered service

Documentation of face-to-face encounters may be included in clinical and progress notes and discharge summaries.

Documentation for the medical supplier's records may be copies of physician or non-physician practitioner notes, documentation of a phone call with the physician or non-physician practitioner to confirm the face-to-face encounter or a written summary from the physician or non-physician practitioner.

On-going services are not subject to the face-to-face rule. A face-to-face encounter is only required for new medical equipment, supplies, or appliances.

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 the provider criteria for the primary payer will not be reimbursed by South Country.

If Medicare downcodes an item, South Country will make payment based on the downcoded Medicare explanation of benefits (EOB), regardless of any South Country 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, South Country 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 reasons:

- Has an allowed amount of \$1,500 or more
- Units that exceed 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 South Country Provider Contact Center at 1-888-633-4055 or view the prior authorization and notification list, which can be located on South Country's website: <https://mnscha.org/>.

Providers may submit a prior authorization via the provider portal <https://provider.mnscha.org/scha.provider.aspx>, which can be located on South Country's website: <https://mnscha.org/>

To fax authorizations, the Service Authorization form is located on the provider portal <https://provider.mnscha.org/scha.provider.aspx> or on South Country's website: <https://mnscha.org/>

Fax completed forms directly to South Country 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. South Country 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 South Country 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: 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. South Country 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, South Country will cover the upgraded item for members who meet criteria if medically necessary authorization is obtained.

If South Country pays for the equipment, a provider can bill a member for a noncovered add-on. Refer to the [South Country Advance Member Notice \(DHS-3640\) \(PDF\)](#). If South Country 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.

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

Dispensing of Equipment and Supplies

Follow these guidelines when dispensing equipment and supplies:

- Dispense no more than one month of supplies at a time unless specifically permitted by coverage policy.
- Requests must come from the member or an authorized representative each time additional supplies are needed.

It is acceptable for medical supply providers to call the member to verify a re-order.

- Automatically shipping supplies without the member or the members authorized representative's confirmation is not permitted.

Shipping, delivery, and set-up costs are included in the DME item/supply reimbursement rate and may not be separately billed to South Country or the member.

Allergen-Reducing Products for Children

Eligible Members

All South Country members under the age of 21 for Medical Assistance and under the age of 19 for MinnesotaCare members who are diagnosed as having poorly controlled asthma. The Minnesota Legislature has defined a person as having poorly controlled asthma when they have experienced one of the following:

- A hospital emergency department visit for asthma at least one time in the past year, or
- A hospitalization for the treatment of asthma at least one time in the past year.

Covered Services

All covered products require an order from a physician, physician assistant, nurse practitioner or clinical nurse specialist.

South Country will cover the following allergen-reducing products:

- Allergen encasements for mattresses, box springs and pillows
- An allergen-rated vacuum cleaner, filters and bags
- A dehumidifier and filters
- A HEPA single-room air cleaner and filters
- Integrated pest management, including traps and starter packages of food storage containers
- A damp mopping system
- A waterproof hospital-grade mattress (if the member does not have access to a bed)
- Furnace filters (for homeowners only)

Billing

- Bill all allergen-reducing products under miscellaneous code E1399. Use modifier HA to denote you are billing for a child. A child includes those 21 and under but you must also follow MinnesotaCare and Medicaid policy for who is considered a child.
- Authorization is required for E1399 when cost exceeds \$500

Ambulatory Assist Equipment

Ambulatory assist equipment is covered for eligible South Country members who meet medical necessity criteria. Canes are not covered for South Country members in nursing facilities or Intermediate Care Facilities for persons with developmental disabilities (ICF/DD). Walkers are not covered for South Country members in nursing facilities. Only walkers with trunk support are covered for South Country members in an ICF/DD. Gait trainers may be covered for members in nursing facilities or ICF/DD. Quantity limits and thresholds apply to all members.

Covered Services

Codes:

E0100-E0105: Canes

E0110-E0118, E0153: Crutches
E0130-E0149, E0154-E0159: Walkers
E8000-E8002: Gait trainers

Canes are covered for members who are unable to safely ambulate without an assistive device.

- South Country does not require that the cane is needed in the home. It can be utilized exclusively within the community if needed for safety.
- South Country covers a cane for members who primarily use walkers or wheelchairs, but who require a cane in specific situations
- South Country 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 without an assistive device.

- 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 (i.e. knee walker) 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 without an assistive device.

- South Country does not require that the walker is needed in the home. It can be utilized exclusively within the community if needed for safety.
- South Country 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.
- Pediatric walkers should be billed with the most appropriate HCPCS code.
- 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. If dispensing a walker with hand brakes, providers may bill E0159 as a replacement for glide-type brakes.
- Bill Medicare only for replacement of original glide-type brakes. Medicare does not pay for hand brakes. For new walkers, if a member requires hand brakes, bill Medicare only for the walker and bill South Country for the hand 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. These do not have a specific HCPCS code; please bill E1399.

Billing for Walkers and Replacement Brakes when the Member has Medicare

Bill Medicare first for replacement hand brakes for walkers if the brakes originally dispensed with the walker are in need of repair and need to be replaced. When dispensing a new walker with hand brakes, bill Medicare first for the walker. Bill South Country for hand brakes as a replacement for the standard glide-type brakes, as Medicare does not pay for hand brakes.

Gait trainers are covered with prior authorization for members who have the potential for therapeutic gait and have demonstrated the ability to use a gait trainer.

Documentation must include:

- Diagnosis, age, functional abilities
- Why less-costly alternatives have failed or were not appropriate
- Trial of gait trainer with specific device recommendations
- Location the gait trainer will be used and education provided to the caregiver who will oversee use
- Therapy program frequency and goals

Submit the appropriate HCPCS code for the requested gait trainer. Include a list of all accessories with documentation of medical necessity for each item added to the gait trainer.

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.

A stander in combination with a gait trainer is typically not covered. If both a stander and a gait trainer are requested, prior authorization must include specific documentation of medical necessity which notes why one device alone will not meet the member's needs.

Diabetic Equipment & Supplies

South Country covers diabetic equipment and supplies for 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 South Country's diabetic testing supplies may be found at www.mnscha.org at the bottom of the list of member materials.

South Country follows the limits on diabetic equipment and supplies set in the [MHCP Medical Supply Coverage Guide](#).

Covered Services

Blood Glucose Monitors: For all blood glucose monitors, the member must be diabetic (Type 1, Type 2 or gestational), or have a diagnosis that requires regular monitoring of blood glucose levels. The pharmacy or medical supplier's office must keep a written physician's order stating the need to monitor blood glucose levels.

- Standard blood glucose meters
 - Roche is South Country's preferred manufacturer for Part B diabetic testing supplies (meters, test strips and lancets) when processing through pharmacy claims. Part B diabetic testing supplies from all other manufacturers require a Service Authorization. **This does not apply to medical claims.
 - For Medicaid members, South Country is required to cover the same diabetic testing products as Minnesota Health Care Programs (MHCP). See the MHCP Preferred Drug List for a list of covered products.
- Blood glucose monitor with integrated voice synthesizer (E2100) 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 (E2101) 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:

Code: E2102 and A4238 (adjunctive CGM), E2103 and A4239 (therapeutic CGM)

CGM systems may be obtained from a medical supply provider or pharmacy. Only CGM systems coded as E2102 and A4238 by the Medicare Contractor for Pricing, Data Analysis and Coding (PDAC) may be covered as adjunctive CGM systems. Only CGM systems coded as E2103 and A4239 by the PDAC may be covered as therapeutic CGM systems.

*Effective 4/1/2022: Therapeutic CGM systems (Freestyle Libre and Dexcom) must be obtained through the pharmacy benefit for Medicaid members (see below authorization requirements).

*Effective 4/1/2022: Adjunctive CGM systems (previously billed with codes A9276-A9278) must now be billed using codes E2102 and A4238.

Authorization Requirements

South Country Medicaid Plans: Therapeutic CGM systems must be obtained through the pharmacy benefit. Dexcom G6 and Freestyle Libre systems are formulary and do not require prior authorization. Effective 1/1/2023, authorization is not required for Adjunctive CGM systems and they are obtainable through a DME provider.

South Country Medicare Plans: Authorization is not required for all CGM systems.

Members with other primary insurance: please follow the primary insurance plan processes for initial payment and submit any copays/coordination of benefits to South Country for payment.

Adjunctive CGM systems

Adjunctive continuous glucose monitoring does not replace traditional home blood glucose monitoring for making treatment decisions but may be authorized as a warning or alert system for individuals with insulin-dependent diabetes and a history of severe hypoglycemia (less than 50 mg/dL) with unawareness due to age or cognitive function.

South Country allows for one monitor (code E2102) or one receiver (code E2102) every three years for adjunctive CGM systems, and one unit per month for the supplies and accessories (code A4238).

Adjunctive CGM systems must be coded based on Pricing, Data Analysis and Coding for Medicare, [PDAC](#).

Therapeutic CGM systems - must be obtained through the pharmacy benefit for Medicaid members when South Country is primary payer.

Therapeutic CGM systems replace traditional home blood glucose monitoring because treatment decisions can be made based on the CGM. Therapeutic CGM systems are considered medically necessary for insulin-dependent members with frequent adjustments to insulin dosing based on blood glucose test results.

Therapeutic CGM systems that are classified as Class III devices by the Food and Drug Administration (FDA) require daily calibration. Therapeutic CGM systems that are classified as Class II devices by the FDA do not require calibration. Class III receivers and supplies for Class III receivers must be billed with modifier KF. Class II receivers and supplies for Class II receivers must be billed without modifier KF.

Members with therapeutic CGM systems require infrequent traditional home blood glucose testing. The therapeutic CGM supply allowance (A4239) includes all supplies needed for use of the CGM system for one month, including CGM sensors, CGM transmitters, and equipment and supplies for calibration and necessary traditional home blood glucose testing. The receiver (E2103) is durable medical equipment and should last three years or more.

Disposable Blood Glucose Monitor (A9275): 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 (4) per calendar month
- Blood glucose test strips may not be billed within 30 days of disposable blood glucose meters
- Bill one (1) unit per meter with test strips. Submit a claim with an attachment that includes the name of the product dispensed and required documentation for manual pricing.

Blood Glucose Test Strips (A4253):

South Country covers the same diabetic testing products as MHCP for South Country Medical Assistance (Medicaid) members. These products do not require prior authorization. All other blood glucose meters and strips will require prior authorization.

For South Country Medicare members, please see the [South Country Website](#) for a list of preferred diabetic supplies.

Blood Ketone Test Strips (A4252): may be obtained from a medical supply provider or pharmacy. Member must have insulin-dependent diabetes or be on a medically supervised ketogenic diet for intractable seizures.

Insulin Syringes (S8490): May be obtained from a medical supply provider or pharmacy.

Ambulatory Insulin Infusion Pumps (E0784): Authorization is required.

Insulin infusion pumps are covered for eligible South Country members 12 years old or younger with type 1 diabetes, or for eligible South Country 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 (3) injections of insulin per day, with frequent self-adjustments of dose, for at least six (6) months
- Documented self-testing an average of at least four (4) times per day

- Has one of the following:
 - Elevated glycosylated hemoglobin level of HbA1c greater than 7 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

External Ambulatory Insulin Infusion Systems (A9274): Authorization is required.

External ambulatory infusion pumps may be obtained from a medical supply provider or pharmacy and must meet the following criteria:

- Members must meet the criteria for an ambulatory insulin infusion pump (above)
- Documentation submitted for authorization must address why an ambulatory insulin infusion pump is not meeting the member needs and why a tubeless option is required for medical necessity

Enteral Nutritional Products and Related Supplies

Enteral nutritional products are covered for eligible South Country 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

Enteral Nutrition Products

Codes: B4149-B4162 (For these codes 100 calories = 1 unit), S9435 (Medical food for inborn errors of metabolism)

Only products classified by Medicare's Pricing, Data Analysis and Coding (PDAC) contractor are covered refer to the [DMECS Product Classification List](#) if you are unsure what HCPCS code to use. Up to 1,050 units per month of enteral nutrition is covered 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).

Nutrition for Members with Feeding Tubes:

Enteral nutritional products are medically necessary for members with feeding tubes. Up to 1,050 units per month is covered (without authorization) for members requiring tube feeding;

diagnosis of tube-feeding must be on the claim. Authorization is required if exceeding 1,050 units per month.

Oral Enteral Nutrition:

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 without authorization 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.

Nutrition for pediatric members

Enteral nutrition products are covered when an eligible provider has diagnosed and documented significant risk factors for malnutrition. These COULD include (but are not limited to):

- Weight loss >5% of the usual body weight for ages 2 to 20
- Less than 75% of the norm for expected weight gain for ages <2
- Deceleration in weight/length or height by 1 z score
- Weight/length or body mass index (BMI) z score -1 to -1.9
- Weight/length or BMI z score -2 or less
- Height/age below 5th percentile or length/height-for-age z score of -3 or less
- Weight consistently <80% of the median for age
- Weight on >1 occasion falling below the 3rd percentile for age

Potential diagnoses COULD include (but are not limited to):

- Intrauterine Growth Restriction (IUGR)
- Impaired GI Function
- Sensory issues related to medical conditions or maternal drug or alcohol use
- Metabolic Conditions
- Kidney, heart, pulmonary diseases
- Malabsorption
- Combined allergy to cow's milk, soy milk, and human milk

Oral Nutrition for Malabsorption or Malnutrition

Enteral nutritional products may be medically necessary for medical conditions related to malabsorption or malnutrition. The condition must have resulted in weight loss or difficulty maintaining a healthy weight. Medical necessity for enteral nutrition must demonstrate that if the member were left untreated by oral enteral nutrition, they would risk detrimental effects to their health. Authorization is required.

- Examples of a condition CAN include:
 - 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 nutrients
 - Weaning from TPN or feeding tube
 - Inborn errors of metabolism

Oral Nutrition for Members with Non-Healing Wounds

High protein enteral nutritional products are covered for up to six (6) 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

Enteral Feeding Supply Kits

Codes: B4034-B4036, B4148

Thirty-one (31) enteral feeding supply kits per month are medically necessary for members receiving enteral nutrition through a feeding tube. The feeding supply kit must correspond with the method of administration and must contain all supplies necessary for feeding using that method of administration for one (1) day. For members who use the same or a different method of administration at work or school, up to 20 additional enteral feeding supply kits per month are covered. Documentation on file at the provider's office must support the need for additional feeding supply kits. South Country will cover only 51 enteral feeding supply kits per month without authorization.

Feeding Tubes

Codes: B4081-B4088

Most people who use a feeding tube require only one (1) tube every two (2) to three (3) months. Up to two (2) tubes per month may be medically necessary for people with more than one (1) 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

Codes: B9002-B9006, E0791 (Enteral/Parenteral Infusion Pumps)

A parenteral infusion pump is medically necessary for members for whom parenteral nutrition is required. An enteral infusion pump is medically necessary for members with feeding tubes for whom gravity or syringe feeding is not appropriate. One pump is covered every five (5) years. Consider the member's current and expected lifestyle when selecting a stationary versus portable pump

Food thickeners

Code: B4100 (For this code, 1 ounce = 1 unit)

Food thickeners (Simply Thick, Thicken-It) may be medically necessary for individuals at risk of choking or aspirating liquids. Authorization is always required for food thickener. A member must have a history of aspiration to qualify.

Authorization request must include the following:

- A swallow study (or a swallow evaluation) completed by a speech and language pathologist
- A plan of care
- A plan for follow-up at least annually

Requests for thickeners for members under the age of 1 must include gestational age at birth.

Noncovered Services

South Country 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 (1) regardless of gestational age at birth is not covered due to FDA caution
- Energy drinks and sport shakes

Billing

Enteral Nutrition Products When Authorization is Not Required:

A valid diagnosis of PKU, hyperlysinemia, MSUD, or tube-feeding must be on the claim or the claim will deny for needing authorization.

Enteral Nutrition Products When Authorization is Required:

HCPCS codes and modifiers on submitted claims must be identical to the approved authorization to prevent a denial.

All Claims for Enteral Nutritional Products:

Enter the following information on all claims for enteral nutritional products:

- Modifier BO for members taking their enteral nutrition orally
- A valid diagnosis code to the greatest specificity indicating the medical condition that requires the product

- The date of service (DOS) is the date the product was dispensed to the member. Do not use a date span.
- The appropriate HCPCS code for the product dispensed
- The appropriate number of units dispensed (1 unit = 100 calories)
- The product name in the comments/description field when product-specific pricing is requested

***Include pricing documentation with claims for products that are listed as “*By-Report” on the Enteral Nutrition Price List B4149 – B4155 and B4157 – B4162.*

Breast Pumps

Codes: E0602, E0603, E0604

South Country covers breast pumps when ordered by a physician, certified nurse midwife or nurse practitioner for any nursing mother experiencing separation from her infant because of work, school, illness or any other medical reason.

E0602, manual breast pumps and E0603, personal electric breast pumps, are purchase only. Inform members that breast pumps are a personal care item that cannot be shared by mothers and can be used for future pregnancies. The purchase of an electric breast pump is limited to one (1) per pregnancy. Bill with modifier NU.

E0604, heavy-duty hospital grade electric breast pumps are rental only. Bill with modifier RR. Bill accessory kits for E0604 breast pumps with HCPCS code A9999.

The rental period of heavy-duty hospital grade electric breast pumps is three months. Additional months require prior authorization for each additional 30 days.

If a member has a medical necessity for a heavy-duty hospital grade electric breast pump beyond the initial three-month rental period, providers must request authorization for the additional month of rental.

Hearing Aids

South Country 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 3 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.

Replacement

South Country covers one (1) hearing aid or set of binaural hearing aids within a period of five years for an eligible recipient. If hearing aids must be replaced due to change in hearing, or hearing aid loss, theft, or irreparable damage, the provider must request authorization for a new aid. South Country considers the recipient's physical or mental impairment in determining whether circumstances were beyond the recipient's control if the aid is lost or broken and will only approve a replacement in those cases.

Always verify recipient eligibility and prior receipt of a hearing aid(s) before dispensing or requesting an authorization.

South Country will not replace a lost, stolen or broken hearing aid when South Country has replaced a hearing aid twice within the five-year period previous to the date of request. Per federal requirements, this replacement policy does not apply to children under 21.

Hearing Aids Repair

- Hearing aid repair over \$400 requires authorization.
- South Country 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 (6) 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.

Systems Other Than Personal Hearing Aids

Non-Personal Hearing Aids

When systems such as FM systems, vibrotactile devices, [cochlear implants](#) or personal communicators (e.g., pocket talkers) are requested, justification is needed, just as for non-contract aids. The audiologist must also address each of the following points:

- Why the person cannot use personal hearing aids (e.g., person's unique inability to use auditory information provided via hearing aids)
- Documentation of expectation of person's ability to recognize and use vibrotactile information, specific to vibrotactile instruments (e.g., response to environmental vibratory information or low frequency bone conducted vibratory information).

Cochlear Implants

A cochlear implant is a prosthetic device that may help provide hearing to those who have moderate to profound hearing loss and would receive little or no benefits from hearing aids. The implant consists of an external portion that sits behind the ear and a second portion that is surgically placed under the skin.

Authorization: All cochlear implant purchases and replacement devices require authorization.

Bone-anchored Hearing Aids (BAHA)

A bone-anchored hearing aid (BAHA) is a type of hearing aid that attaches to the bone behind the ear. The device transmits sound vibrations directly to the inner ear through the skull and bypasses the middle ear. It is primarily suited for people who have conductive hearing losses, unilateral hearing loss, single-sided deafness and people with mixed hearing losses who cannot wear in the ear or behind the ear hearing aids.

Nonsurgical devices are worn on a headband or attached directly to the skin with adhesive. Surgical devices include an internal component and an external speech processor. BAHAs are also referred to as auditory osseointegrated devices.

South Country covers U.S. Food and Drug Administration approved BAHA devices which must be dispensed according to their approval guidelines.

Authorization

Device repairs over \$400 require authorization. Replacement of a BAHA and its external components is considered medically necessary when the existing device cannot be repaired or when replacement is required because a change in the member's condition makes the present unit non-functional and improvement is expected with a replacement unit.

Certain BAHA devices require authorization per the list below.

HCPCS codes requiring authorization:

L8690: Auditory osseointegrated device, includes all internal and external components

L8691: Auditory osseointegrated device, external sound processor, excludes transducer/actuator, replacement only, each

L8692: Auditory osseointegrated device, external sound processor, used without osseointegration, audio body worn, includes headband or other means of external attachment

Hospital Beds

Hospital beds are used for positioning patients and 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 Codes: E0250, E0251, E0290, E0291 - Authorization is not required but providers must follow documentation requirements.

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

Codes: E0255, E0256, E0292, E0293 - Authorization is not required but providers must follow documentation requirements.

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

Codes: E0260, E0261, E0294, E0295 - Authorization is always required.

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

Codes: E0265, E0266, E0296, E0297 - Authorization is always required.

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

Codes: E0301 – E0302: Bed without a mattress; E0303 – E0304: Bed with a mattress - Authorization is always required.

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

Codes: E0328 (manual) - E0329 (electric or semi-electric) - Authorization is required for E0329

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

Codes: E0316 (enclosure), E0300 (hospital grade enclosed crib), E1399 (Enclosed bed manufactured as a unit) - Authorization is always required.

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.

Coverage will be considered for members who have documented evidence of unsafe mobility (climbing out of bed and moving around the home, not just standing at the side of the bed).

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

Codes: E0271-E0272 (mattress), E0305, E0310 (bed rails)

South Country 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.

Rocking Bed (E0462)

Authorization is always required.

Provide documentation regarding the medical condition and how this type of bed will assist the member.

Hospital Bed, Institutionalized Type Including Oscillating, Circulating, and Stryker Frame (E0270)

This is usually not a covered item in the member’s benefit set. If the physician can indicate medical need for this type of bed, a request for service authorization should be initiated with documentation of the medical need. South Country will determine if an approval outside of the member’s benefit set is appropriate for that member.

Non-Covered Services

- Beds that are typically sold as furniture, including adjustable beds that are not manufactured as DME
- Orthopedic mattresses
- Waterbeds
- Oscillating and lounge beds
- Bed tables and other bed accessories
- Bedding or linens, including hypoallergenic bedding
- Heat and massage pads
- Enclosed beds for members with one-on-one caregiver supervision 24 hours per day
- The following accessories for enclosed beds:
 - Extra windows
 - Mattress protector
 - Vibration pad
 - Dual multi-side doors

Billing

- Codes E0250, E0255, E0260, E0265, E0303, E0304, E0328, and E0329 include the bed, bed rails, and mattress. Do not bill rails (E0305, E0310) or mattress (E0271, E0272) within 180 days of billing these codes.
- Codes E0251, E0256, E0261, E0266, E0301, and E0302 include the bed and bed rails. Do not bill rails (E0305, E0310) within 180 days of bill these codes.
- Codes E0290, E0292, E0294, and E0296 include the bed and mattress. Do not bill mattress (E0271, E0272) within 180 days of billing these codes.

- If the member has Medicare, any items for which Medicare denies payment must meet South Country's coverage and authorization requirements
- Hospital beds are expected to serve the member for at least five years. If a device is stolen or damaged beyond repair, a replacement device may be covered with authorization.

Incontinence Products

South Country covers a specified quantity of disposable incontinence products to eligible members with the proper diagnosis and documentation of medical necessity. Quantity limits and thresholds apply – see MHCP Provider Manual for limits.

Covered Services

Incontinence products and services covered are:

- disposable briefs or diapers
- protective underwear or pull-on
- liner
- shield
- guard
- pad
- undergarment
- under pads

HCPCS Codes: T4521–T4535, T4541–T4544

Any youth or pediatric-sized product and any underpad can be covered when medically necessary. . Adult-sized disposable briefs, diapers, protective underwear, pull-ons, liners, shields, guards and pads are covered if they are listed on the [Incontinence Product List \(PDF\)](#).

Incontinence products for members under age four (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 toilet training or have light or infrequent incontinence
- 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 are covered by South Country 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

Codes: A5500-A5501 (therapeutic shoes), A5503-A5507 (modifications to therapeutic shoes), A5510-A5513, K0903 (inserts for therapeutic shoes)

Custom-made or stock therapeutic shoes and modifications to therapeutic shoes are covered for South Country 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 (2) pairs of therapeutic shoes, three (3) pairs of inserts (A5512, A5513, K0903) and two (2) pairs of inserts (A5510) are covered without authorization in a calendar year. They can be dispensed at the same time or at different times.

South Country 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

Authorization is always required for orthopedic shoes.

If orthopedic shoes are approved with authorization, the inserts do not require authorization for up to three (3) pairs per year. If more than three (3) pairs of inserts are needed in a year, authorization is required.

Codes: L3000-L3031 (custom inserts), L3040-L3060 (premolded, removable arch supports), L3070-L3100 (nonremovable arch supports), L3140-L3150 (abduction and rotation bars), L3224-L3253 (orthopedic footwear), L3300 – L3595 (additions and modifications to orthopedic shoes), L3600-L3640 (transfer of orthotic), L3649

South Country 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

South Country 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 covered for use in covered orthopedic shoes.

Foot Pressure Off-Loading Device (A9283)

A foot pressure off-loading device is covered for pressure reduction for existing pressure ulcers on the foot. No authorization is needed for a foot pressure offloading device if the provider is contracted.

Noncovered Services

South Country 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 South Country members.

Covered Services

South Country follows CMS's Medically Unlikely Edits (MUE) for orthotics. If CMS has not published an MUE, South Country has established quantity limits. South Country will not pay claims for more units per line than are allowed by the MUE. When dispensing bilateral orthotics where more units are required than are allowed by the MUE or limit, the units must be billed on different lines, using modifiers NU RT and NU LT as appropriate.

Orthotics for the spine

Codes: L0112-L1499

An orthotic for the spine is considered medically necessary:

- 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

Codes: L1600 – L1755, L2040 – L2090

An orthotic for the hip is considered medically necessary

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

One (1) orthotic for the hip is covered per calendar year without authorization when medically necessary.

Lower limb orthotics

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

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 (4) lower limb orthotics (two (2) sets of bilateral orthotics) are covered per calendar year without authorization when medically necessary. Authorization is required for the third or subsequent set of lower limb orthotics in any calendar year.

Upper extremity orthotics

Codes: L3650 – L3999

An upper extremity orthotic is considered medically necessary:

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

Four (4) upper extremity orthotics (two (2) sets of bilateral orthotics) are covered per calendar year without authorization when medically necessary. Authorization is required for the third or subsequent set of upper extremity orthotics in any calendar year.

Cranial remolding orthotics

Code: S1040

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

Cranial prostheses

Code: A9282

A cranial prosthesis is considered medically necessary for treatment of medical conditions that result in hair loss.

One medical wig is covered per calendar year.

Noncovered Services

South Country 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 recipient
- A device that serves to address social and environmental factors and that does not directly address the recipient's physical or mental health
- A device that is supplied to the recipient by the physician who prescribed the device or by a provider who is an affiliate of the physician who prescribed the device
- Repair costs for a prosthetic or orthotic device that is under warranty
- Repair costs for any rented equipment
- Orthotics when used to prevent injury in a previously uninjured limb
- Orthotics that are to be used only during sports or other leisure activities
- A custom fabricated orthotic when the recipients needs can be met with a prefabricated orthotic
- Stance control orthotics
- Externally powered upper extremity orthotics
- Electronic /microprocessor-controlled orthotics, including the Sensor Walk, E-MAG

Oxygen Equipment

Oxygen is covered for eligible South Country 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 South Country 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:

South Country 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.

South Country does not require specific PaO₂ or oxygen saturation values for coverage. The physician's order must clearly state the member's diagnosis, the PaO₂ 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. South Country 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

South Country 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 South Country 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 South Country 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

Codes:

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

E0630, E0635, E0636, E0639: Patient lifts

E0627, E0629: Seat lift mechanisms

Hydraulic or mechanical patient lifts described by E0630 require authorization. Please provide documentation of the following:

- 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 lift described by E0636 and moveable patient lifts described by E0639 are covered for members who meet criteria for a patient lift and whose unique medical needs cannot be met with a less costly lift. Both require authorization.

Electric patient lifts described by E0365 requires authorization. Provide documentation as indicated for hydraulic/mechanical patient lifts, plus the following:

- 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 (E0627, E0629) 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 – see Prior Authorization Grid by code at www.mnscha.org
- Rental or purchase of a patient lift when the patient’s current lift, regardless of lift type, is less than five (5) 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

Noncovered Services

Non-electric seat lift mechanisms that operate by spring-release mechanism are not covered because they are not the community standard of care and pose a risk to members with limited strength.

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.

- The following items are not covered because they are home or vehicle modifications, not durable medical equipment:
 - Vehicle lifts
 - Platform lifts
 - Stair lifts
 - Elevators
 - Wheelchair lifts
 - Non-portable ramps
 - Ceiling-mounted lifts
 - Wall-mounted lifts

Positive Airway Pressure for Treatment of Obstructive Sleep Apnea

South Country 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

Codes: E0470, E0601, A4604, A7027 – A7039, A7044 – A7046CPAP (E0601):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, South Country 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.

Continuous Positive Airway Pressure (CPAP) Supply Limitations

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

BiPAP (E0470):

South Country 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, South Country 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.

South Country 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 member's 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.

If the member is not using the equipment, the rental should end and the provider should take the equipment back.

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 (E0203)

Therapeutic light boxes are used for treatment of Seasonal Affective Disorder (SAD). South Country 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

Codes: E0203, A4634

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 \$500.00 or greater. All authorization requests must include:

- A written diagnosis of SAD, 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 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 South Country directly for these accessories that are part of a covered wheelchair. Follow South Country authorization requirements. When billing, include an attachment that clearly states, "wheelchair transportation accessory not covered by Medicare." South Country 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, South Country 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 (E1031, E1037-E1039, E1161, E1229, E1231-E1238, K0001-K0007, K0009)

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 (K0002) are covered if the member has one of the following needs:

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

Lightweight (34 – 36 lbs.) manual wheelchairs (K0003) are covered if the member meets all the following criteria:

- Primarily uses a manual wheelchair rather than a power mobility device
- Cannot self-propel in a standard wheelchair for various reasons; and
- Can propel themselves in the requested chair

High strength, lightweight wheelchairs (K0004) are covered if the member primarily uses a manual wheelchair rather than a power mobility device and:

- Can propel themselves in the requested chair while engaging in frequent activities that cannot be performed in a standard or lightweight wheelchair; or
- Requires a seat width, depth, or height that cannot be accommodated in a standard, lightweight or hemi-wheelchair, and spends at least two hours per day in the wheelchair.

Ultra-lightweight wheelchairs (K0005) are covered if criteria (1) or (2) is met and criteria (3):

- The member must be a full-time manual wheelchair user; or
- The member must require individualized fitting and adjustments for one or more features such as, but not limited to, axle configuration, wheel camber, or seat and back angles, and which cannot be accommodated by a K0001 through K0004 manual wheelchair.
- The member must have a specialty evaluation that was performed by a licensed or certified medical professional (LCMP), such as a PT or OT, or physician who has specific training and experience in rehabilitation wheelchair evaluations and that documents the medical necessity for the wheelchair and its special features. The LCMP may have no financial relationship with the supplier.

*Authorization is required for K0005

Heavy duty or extra heavy-duty wheelchairs (K0006-K0007) 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 (E1161) are covered, with authorization, 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 (1) year; or
- Had decreased muscle tone related to a medical condition that inhibits their ability to sit up against gravity and requires tilt in space for head and trunk control

Rollabout or Transport chairs (E1031, E1037-E1039):

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

- The member is not expected to be able to self-propel a manual or power wheelchair in the next five (5) years
- The member has needs that cannot be met by a less costly manual wheelchair
- The proposed chair has casters of at least five (5) inches in diameter and is specifically designed to meet the durable medical equipment standards

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) (K0800-K0802, K0806-K0808)

Power operated vehicles are covered, with prior authorization, 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 (K0813-K0898)

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

- Meets the criteria for a mobility device; and
- Does not have sufficient upper extremity function to self-propel an optimally configured manual wheelchair to perform mobility-related activities of daily living; and
- Is not able to safely operate a POV or maintain postural stability and position while operating a POV; and
- Has a caregiver who cannot push a manual chair, but can propel the power chair using an attendant control
- For a member under age four (4), has been evaluated and found to be developmentally ready to begin to operate a power chair equipped with appropriate attendant control and safeguards
- Is able to bring the power wheelchair into the home for use and storage or if homeless, has demonstrated a plan to safely charge and store the power wheelchair

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 (K0813-K0816) or Group 2 no power option (K0820-K0829) power wheelchairs are covered, with prior authorization, 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 (K0835-K0840) are covered, with prior authorization, 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 (K0841-K0843) are covered, with prior authorization, 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 (K0848-K0855) are covered, with prior authorization, if the member:

- Has mobility limitations due to a neurological condition, myopathy, congenital skeletal deformity
- 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 (K0856-K0860) are covered, with prior authorization, 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; AND
- The Group 2 single power option criteria are met

Group 3 multiple power option power wheelchairs (K0861-K0864) are covered, with prior authorization, 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; AND
- The Group 2 multiple power option criteria are met

Group 4 no power option power wheelchairs (K0868-K0871) are covered, with prior authorization, if the member:

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

Group 4 single power option power wheelchairs (K0877-K0880) are covered, with prior authorization, 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 (K0884-K0886) are covered, with prior authorization, 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 (K0890-K0891) are covered, with prior authorization, 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 (1) arm drive attachments (E0958) are covered if:

- The member meets the criteria for a manual wheelchair, but is unable to use both arms or at least one (1) 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 (1) arm drive attachment

Push activated power assist (E0986) is covered, with prior authorization, 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 (E1002) is covered, with prior authorization, 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

Power recline (E1003-E1005) is covered, with prior authorization, if the member:

- Meets criteria for a power wheelchair
- 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 (E1006-E1008) are covered, with prior authorization, if the member:

- Meets criteria for a power wheelchair
- Meets criteria for both power tilt and power recline

Mechanical leg elevation systems (E1009) are covered if the member:

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

Power leg elevation systems (E1010, E1012) are covered (E1012 requires an authorization) 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 (E1014, E1225, E1226) are covered, with prior authorization, 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 (E2227) are covered, with prior authorization, 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 (E2295, E2398) is covered when:

- The requested dynamic seating frame is made by the same manufacturer as the requested pediatric wheelchair
- The requested 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 (E2300) is covered, with prior authorization, 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 (manual: E2230; power: E2301) is covered, with prior authorization, 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 (3) 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 South Country 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 (E2312, E2321-E2330, E2373, E2399) 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 (E2331) 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 (K0108)

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

Custom Molded and Prefabricated Custom Seating Systems

Custom molded seating systems

Custom molded seating systems provide positioning or pressure relief that cannot be met with a

standard, mass produced cushion or searing system. They are fabricated from an impression or digital image of the member using molded-to-patient techniques.

Custom fabricated 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 fabricated 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

ICD/DD Coverage

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

SNF per diem coverage

- Standard wheelchairs (K0001) 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.
- All other wheelchairs (including tilt-in-space) are billable outside of the nursing facility per diem if they are necessary for the continuous care and exclusive use by a member. The member must also meet any of the policy criteria for their requested chair.

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.

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 South Country authorization and billing procedures. It is not necessary to bill Medicare before billing South Country.

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
- Unbundling is not allowed for titanium, carbon fiber, and so on. Manual wheelchair bases (K0001, K0002, K0003, K0004, K0005, K0006, K0007, K0008, and K0009) include construction of any type material, including, but not limited to, titanium, carbon, or any other lightweight high-strength material. Suppliers must not bill a wheelchair component or accessory, not otherwise specified (K0108) in addition to the wheelchair base (K0001, K0002, K0003, K0004, K0005, K0006, K0007, K0008, and K0009) for construction materials or for a "heavy-duty package" reflecting the type of material used to construct the manual wheelchair base. Billing for construction material is incorrect coding.
- 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. To determine the correct HCPCS code for a power mobility

device, access the [Durable Medical Equipment Coding System \(DMECS\) Product Classification List](#).

Augmentative Communication (AC) Devices

South Country covers augmentative (AC) devices under the durable medical equipment benefit. AC or speech-generating devices are devices dedicated to transmitting or producing messages or symbols in a manner that compensates a member's expressive communication disorder and limitations.

Covered Services

AC Devices (E2500, E2502, E2504, E2506, E2508, E2510, E2511, E2512, E2599 - *U3 modifier is required for all electronic tablets used as an AC device, tablet accessories and related services)

AC devices include, but are not limited to:

- Communication picture books
- Communication charts and boards
- Mechanical devices
- Electronic devices
- Electronic tablets
- Communication software application

Accessories may include the following:

- A carrying case
- A mounting system and hardware
- A protective case for nondedicated tablets
- Other accessories determined to be medically necessary

Coverage Criteria

To be covered as a rehabilitative and therapeutic service, the member's physician must prescribe an AC device following a required face-to-face encounter with the member within six months before the dispensing date of the device.

The speech-language pathologist must specify the device in a plan of care (POC) that is reviewed and revised as medically necessary by the member's physician or other licensed practitioner of the healing arts.

Speech-language pathologists, occupational therapists, physical therapists and other professionals should collaborate to prepare the required authorization documentation submitted by the equipment supply provider, outpatient hospital, or device manufacturer.

Electronic Tablets as AC Devices

South Country covers electronic tablets when members use them as augmentative communication (AC) devices. A tablet used for this purpose is considered durable medical equipment (DME) and must be dedicated for a member's communication needs.

Electronic tablets used as AC devices must meet the same coverage criteria as other devices. In addition, they must meet the following:

- The member's speech language pathologist (SLP) must determine the tablet and software application that is the most appropriate, cost-effective choice for a member's communication needs
- The tablet must be locked to prevent use not related to communication. Locking features include Parental Controls and Guided Access (for iPad®) or other comparable feature for other tablets

Speech-language pathologist's responsibilities

The SLP determines the communication needs of the member through an evaluation and device trials. If the SLP recommends a nontraditional style tablet, the SLP will complete and send the request and medical documentation to an DME provider who obtains the tablet through their distributors and provides it for the member. Based on the member's existing support system, the SLP must also identify who is responsible for all of the following:

- Setting up the device account and registration
- Purchasing and downloading the speech software application and updating as needed
- Enabling the device's accessibility feature (such as Guided Access for iPad®)
- Keeping a record of the passcode
- Upgrading the device's operating system when required
- Handling or ordering repairs

This information must be included in the member's plan of care and the DME provider's records. To comply with Minnesota Statutes, the member's therapist, the DME provider or another responsible party will retain the passcode used to lock the device or application.

DME provider's responsibilities

The DME provider is responsible for submitting the authorization for a tablet they intend to provide.

If South Country approves the authorization, the provider does the following:

- Orders and purchases the tablet, software and accessories
- Prepares it for the member's use
- Delivers it to the SLP or member
- Bills South Country for the equipment

Authorization Requirements:

Authorization is required for all AC devices.

For dual-eligible members, please refer to CMS guidelines for coverage guidelines. See [LCD L33739](#)

Authorization Criteria

Address all points outlined here for South Country to consider your authorization:

- A description of the current medical status and history
- An assessment of the verbal and physical capabilities in relation to need and use of an AC device (electronic and nonelectronic)
- The speech-language pathologist and occupational therapist or physical therapist assessments may be submitted in a collaborative format as long as the documentation clearly delineates the specific goals and assessment of each therapy discipline

- A detailed description of the therapeutic history (physical therapy, occupational therapy and speech-language pathology), including the nature, frequency and duration of therapeutic services provided to the member
- Details of the speech-language pathology approaches in relation to the need and use of an AC device
- The dates of the trial period of the device as required when the member is not currently using a device
- An explicit evaluation of each AC device or method of communication tried by the recipient and information on the effectiveness of each device

Address all parameters of device selection, that is, interactive ability in all situational contexts, including:

- School
- Home
- Community
- Vocational
- Work
- Social environments
- Detailed description of the member's ability to use the proposed device, including speed and accuracy

Note: For tablets obtained through a durable medical equipment (DME) provider, the authorization request must identify the person or people who will be responsible for locking the tablet and indicate who will be responsible for initial set up and future maintenance of the tablet.

Address these situational references dependent upon the mobility level of the member:

- How will the device be adapted to meet the needs of a member who uses a walker?
- Is the communication device less obtrusive than other methods when mobility levels are considered?
- Frequency of device use in various settings
- Empirical data regarding the trial period of use with the device
- A description of the level of communication initiation with the selected communication device and whether or not the equipment is used accurately and spontaneously. If the pattern of initiation is different from past history, provide an explanation and justification for the change
- A detailed description and plan for the proposed nature, frequency and duration of therapeutic intervention, including all necessary therapeutic interventions, in relation to the AC device

Refer to the augmentative communication device HCPCS codes when requesting an authorization for purchase or rental. Include the device model name and model number and software, if it applies. In addition, note the following on the authorization request:

- List the title of appropriate software applications for electronic tablets supplied through a DME provider

- List all standard and nonstandard accessories and options (including mounting systems) on separate lines on the authorization request, even if the individual item does not require authorization
- When multiple accessories are requested that are different but use the same code, list each item on a separate line of the authorization request, with appropriate modifiers to distinguish a separate and distinct service or item
- Include a description of each item and model numbers where applicable
- List each item by HCPCS code, appropriate modifier, quantity, charges and medical necessity documentation for nonstandard items

Authorizations for repairs

All AC device HCPCS codes have a maximum unit limit of one, according to the National Correct Coding Initiative (NCCI) Medically Unlikely Edit (MUE). Authorizations for repairs must include:

- One unit of the AC device code that best represents the device being repaired
- Modifier RB for a repair or modifier RA for a part to be replaced on the device
- The device model number
- An itemization of the repair service(s) provided (for example, replaced display, replaced touch screen panel, replaced cable) including the provider's usual and customary amount charged

Medicare Supplemental Benefit - DME/Safety/Home Modifications

Effective 1/1/2024, SeniorCare Complete members will be eligible for Home & Safety devices and modifications. The home and safety devices or modifications covered under this benefit include devices, equipment or modifications that promote health or safe independent living (authorization is required). The annual maximum is \$1000.

Examples of included items would be grab bars, shower or bathtub seats, handrails, non-slip flooring, temporary wheelchair ramps, electronic medicine dispenser, oral health items, and lift chairs. Note: this is not an all-inclusive list.

Prior authorization is required - provider may contact member's care coordinator or fax authorization request using the Supplemental Benefit request form #6747 found in the provider forms section at <https://mnscha.org>. Providers must submit the claim using South Country's required billing code for this benefit: T2025 with S3 modifier.