State of Idaho

Department of Health and Welfare

Division of Medicaid

Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Prior Authorization (PA) Policy and Medical Criteria

TABLE OF CONTENTS

FOREWORD

PURPOSE:

This policy has been prepared to provide information and guidance to Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) providers who provide services to Idaho Medicaid participants. This policy document serves as official communication and instruction established by the Department. The intention of this document is to assist and guide Department stakeholders in relation to the prior authorization (PA) process and to demonstrate what the medical criteria is for most DMEPOS PA requests. Providers are held responsible for compliance with all policy and procedures contained herein if they wish to obtain a PA with the Department for DMEPOS.

APPENDIX A- GENERAL OVERVIEW

This chapter provides covered service information that applies specifically to services and supplies provided by DMEPOS providers. Like all health care services received by Medicaid clients, services rendered by these providers must also meet the general requirements as stated in all applicable federal and state laws & regulations including: Social Security Act (SSA), Code of Federal Regulations (CFR), Idaho Code, Idaho Administrative Code, Idaho Provider Handbooks and meet all requirements per Provider Agreement.

Idaho Medicaid recognizes Center for Medicare Medicaid Services (CMS) as the professionally- recognized establishment which demonstrates the national standard for healthcare. Medicare's coverage requirements are used as a benchmark for most DME items. A Medicare manual is available from the Durable Medical Equipment Regional Carrier (DMERC) website. Idaho Medicaid considers CMS/Medicare DME Coverage Manual and its medical review policies as the minimum DMEPOS industry standard. This document contains medical criteria requirements for providers, suppliers, and participants in relation to DMEPOS services. It also contains the criteria used for items, which are either in addition to Medicare requirements or are items that Medicare does not cover but Idaho Medicaid has elected to cover.

Idaho Medicaid coverage determinations are a combination of Medicare, Region D DMERC policies, Centers for Medicare and Medicaid Services (CMS) National Coverage Decisions, and Department designated medical review decisions. DMEPOS providers are required to follow Idaho Medicaid policy or the applicable Medicare policy when Idaho Medicaid policy does not exist.

Coverage for medical services must meet all federal and state requirements. Idaho Administrative Code (IDAPA) 16.03.09 is the chapter which describes Medicaid Basic Plan Benefits. This chapter of rules contains the general provisions regarding the administration of the Medical Assistance Program. In this chapter, DME and medical necessity (for adults) is defined. The definition of DME per IDAPA 16.03.09.010.23 is as follows:

Durable Medical Equipment (DME). Equipment and appliances that:

a. Are primarily and customarily used to serve a medical purpose;
b. Are generally not useful to an individual in the absence of a disability, illness, or injury;
c. Can withstand repeated use;
d. Can be reusable or removable;
e. Are suitable for use in any setting in which normal life activities take place; and
f. Are reasonable and medically necessary for the treatment of a disability, illness, or injury for a Medicaid participant.

The definition of medical necessity (for adults) per IDAPA 16.03.09.011.16 is as follows:

a. It is reasonably calculated to prevent, diagnose, or treat conditions in the participant that endanger life, cause pain, or cause functionally significant deformity or malfunction; and
b. There is no other equally effective course of treatment available or suitable for the participant requesting the service which is more conservative or substantially less costly.
c. Medical services must be of a quality that meets professionally-recognized standards of health care and must be substantiated by records including evidence of such medical necessity and quality. Those records must be made available to the Department upon request.

Services for Children

The Early and Periodic Screening, Diagnosis and Treatment Program (EPSDT) is a comprehensive approach to health care for Medicaid clients under age 21.

EPSDT services must be coverable within the scope of those listed in the federal law at 42 U.S.C. § 1396d(a) [1905(a) of the Social Security Act]. You can find information on EPSDT, the EPSDT request form, and its corresponding policy online at:
http://healthandwelfare.idaho.gov/Medical/Medicaid/EPSDT/tabid/3361/Default.aspx

EPSDT Criteria

It is important to note that the service can only be covered under EPSDT if all criteria specified below are met.

1. EPSDT services must be coverable services within the scope of those listed in the federal law at 42 U.S.C. § 1396d(a) [1905(a) of the Social Security Act].
2. The service must be medically necessary to correct or ameliorate a defect, physical or mental illness, or a medical condition diagnosed by the recipient's physician, therapist, or other licensed practitioner.
3. The requested service must be determined to be medical in nature and meet medical necessity per IDAPA 16.03.09.880-883.
4. The service must be proven safe.
5. The service must be proven effective.
6. The service must be generally recognized as an accepted method of medical practice or treatment.

Prior Authorization (PA) Overview

To ensure federal funding requirements are met, certain items are reviewed before delivery to a Medicaid participant. These items are identified by the Department and are captured with a PA requirement on the Idaho Medicaid Fee Schedule. These items are reviewed for appropriateness based on federal/state requirements and the participant's medical situation. In determining medical appropriateness of an item, Department staff apply six general criteria in addition to Department specified policy and criteria when reviewing requests for a PA. The requested service or equipment must meet all the following:

1. Must be determined as Medically Necessary as defined in IDAPA 16.03.09.011.16 or IDAPA 16.03.09.880 and meet any applicable service definition.
2. Be appropriate and effective to address the medical needs of the participant;
3. Be timely, considering the nature and present state of the participant's medical condition;
4. Be furnished by a provider with appropriate credentials;
5. Be the most medically appropriate alternative health service available;
6. Should represent an effective and appropriate use of program funds.
7. Meet all federal, state, and Department regulations, requirements, and procedures

Being granted a PA does not guarantee payment. It is a meaningful use tool utilized by the Department to ensure federal and state requirements are met. The Department reserves the right to amend, change, or add PA requirements and medical criteria at any time. Idaho Medicaid Fee Schedule can be found at http://healthandwelfare.idaho.gov/Providers/Providers-Medicaid/MedicaidFeeSchedule/tabid/268/Default.aspx

Participants have the right to choose a DMEPOS supplier and change that supplier at any time. The prior authorization initially given by the Department will not automatically transfer to a new provider if the participant chooses a new provider. The new provider will need to submit a request for a new prior authorization. The Department requires that communication must be verified with the participant in relation to the change.

If an item is considered medically necessary, payment authorization is based on when the request was received for review from the provider, not the delivery of the item to the participant. Prior authorization is required for dispensing units over the maximum allowed and supporting documentation must accompany. Supporting documentation must be physician driven.

The Department will only PA a service code for the following circumstances:

- If the service code has been identified as requiring a PA; or
- if the service code requested is above the Departments limitation; or
- if the Department deems it appropriate on a case-by-case basis

If Medicaid is the primary payer, the Department will determine if rental or purchase of the equipment ordered is appropriate and the most cost effective. Being granted a PA does not guarantee payment nor does it remove the requirement for proper billing and coding to Medicaid claims. It is the providers responsibility to ensure services billed to Medicaid are aligned with national coding and billing standards and are compliant with federal and state requirements.

PA Submission Process

To request a PA for an item/service:

• Check participant's eligibility and the service code to inquire if PA is required

• Check most recent Idaho Medicaid Fee Schedule to see if the service requires a PA

• Submit an accurate and complete Idaho Prior Authorization Request Form

• Include appropriate supporting documentation with the request which must include at a minimum:

- Prescription
- Letter of medical necessity
- Narrative summary from the prescribing authority detailing the need for each item
- MSRP or the contracted invoice demonstrating actual costs to the supplier plus all applicable product warranty information if not priced on Idaho Fee Schedule

• Any other required documentation as indicated on the "Additional Information" section of the service.

• Fax or mail the request and supporting documentation to the Medical Care Unit

Fax: 877-314-8782

Idaho Medicaid, Medical Care Unit
PO Box 83720
Boise, ID 83720-0009

Please email the Medical Care Unit at MedicalCareUnit@dhw.idaho.gov or call (866) 205-7403 if you have any questions or if you have any feedback on how to improve this material and its delivery.

Also, please see our DME website for additional information at:

http://healthandwelfare.idaho.gov/Medical/Medicaid/MedicalCare/DurableMedicalEquipment/tabid/271/default.aspx

The status of a prior authorization request may be checked online at the Molina Health PAS portal under "Authorization Status", using your NPI, or by contacting Molina at (866) 686-4272. If you have questions on a Denial, click on the Notes, which will explain the reason for the Denial, or ask the Molina Customer Service Representative to read you the Notes in the Denial.

PA Documentation Requirements for Manually Priced Codes

Per IDAPA 16.03.09.755.06- Manually Priced Codes. For codes that are manually priced, including miscellaneous codes, a copy of the manufacturer's suggested retail pricing (MSRP) or an invoice or quote from the manufacturer is required. Reimbursement will be seventy-five percent (75%) of MSRP. If the pricing documentation is the invoice, reimbursement will be at cost plus ten percent (10%), plus shipping, if that documentation is provided.

For codes with no price indicated on the Idaho Fee Schedule, you must submit documentation that demonstrates your usual and customary charge for that service item. You must provide documentation which supports those indicated charges. Your pricing information must be legible.

The PA request form and pricing documentation must match. If the PA request form and pricing documentation are not reflective of each other, the request to authorize will be denied.

MSRP

If you choose to submit MSRP, the MSRP quote or invoice must be from the manufacture of that service item. An invoice or quote from any other party will not be accepted. MSRP must be current and cannot be older than 365 days of the PA request. The name on the MSRP must be the manufacturer.

Invoice Cost

Invoice must clearly indicate if the provider has received a corporate discount or discounted amount on the requested service or item. Invoice must demonstrate if a discount or discounted amount is present. If documentation states that all discounts may not be reflected on invoice; this will not be acceptable. Failure to demonstrate vendor received discounts will be considered a fraudulent action against the Department.

Discount: the discount amount is billed separately from the unit cost

Discounted: the discount amount is included in the unit cost

If a HCPCS code is used for the service item, it must be the same HCPCS code being requested for the PA.

The description of the service code on the service line must match the requested item on the PA. The unit of measure/quantity must be clearly documented. The number of items for the "unit of measure/quantity" must be documented. All information on the invoice must be clearly legible. The invoice cannot be handwritten. The invoice must include all pages of the invoice.

If Department documentation requirements not met, the request for a PA cannot be authorized. Pricing submitted to the Department must be reflective of your company's customary charge and it cannot be more than the usual and customary rate per IDAPA 16.03.09.230.05. ii.

The definition of customary charges per IDAPA 16.03.09.010.19 is as follows:

Customary charges are the rates charged to Medicare participants and to patients liable for such charges, as reflected in the facility's records. Those charges are adjusted downward, when the provider does not impose such charges on most patients liable for payment on a charge basis or, when the provider fails to make reasonable collection efforts. The reasonable effort to collect such charges is the same effort

necessary for Medicare reimbursement as is needed for unrecovered costs attributable to certain bad debt as described in Chapter 3, Sections 310 and 312, PRM.

DME Repair & Replacement

Requests to repair or replace DME issued to a participant must include documentation as to why the current piece of equipment is not meeting or addressing the medical needs of the participant. A request to repair or replace a piece of DME must indicate that it is no longer under warranty.

Requests for DME repairs must explain why a repair is more cost effective then obtaining a new piece of equipment. Equipment issued over 5 years from the date of service does not serve as sole justification to issue a new piece of DME.

When multiple features, models or brands of equipment or supplies are newly available, coverage is still limited to the least costly version that will reasonably and effectively meet the needs of the individual's medical needs.

The participant has a responsibility to reasonably protect and preserve equipment issued to him. Replacement of medical equipment or supplies that are lost, damaged or broken due to participant misuse or abuse are the responsibility of the participant.

APPENDIX B- Items Identified as Non-DMEPOS

This appendix contains categories of listed items that have been determined not to be considered DMEPOS as a Basic State Plan benefit for adults. All coverage decisions are based on federal and state mandates for program funding by the U.S. Department of Health and Human Services and Idaho Code. These items have been identified as not meeting DMEPOS definition requirements.

Please note that a participant or provider should request a prior authorization for items they feel are medical necessity included in this appendix. (see PA Submission Process).

Any time the Department makes a decision determination for coverage, the participants right to appeal is thoroughly explained in the notice of decision.

The following is a list of some generic categories and items specifically determined not to be reimbursable by state plan (General) Medicaid as DMEPOS. This list may not be all-inclusive:

Environmental Accessibility Adaptation

- Alarms or environmental controls: Telephone, door, appliance, computer, and television
- Belts: Personal, transfer, walking
- Standard (non-medical grade) car seats
- Non-Medical Grade Hip boards/Transfer boards
- Injectors
- Jar openers
- Magnifying lenses
- Medi-planners
- Off the shelf shoes that could be purchased at general retail stores
- Pivot machine
- Plate guards
- Plates, Tongs, eating utensils
- Portable Ramps
- Raised toilet seat
- Reacher
- Track system: of any type
- Walking sticks
- Wedges; any type
- Secondary wheelchair: any additional wheelchair, manual or electric
- Accommodation to vehicles for wheelchairs
- Wheelchair puller
- Whirlpools
- Writing guides

Home or Building Modifications

- Wheelchair ramps
- Widening of doorways
- Ceiling and wall mounted equipment including track systems/devices
- Rails
- Fencing to include inside and outside the property
- Grab bars and stair lifts

Automobile Modifications

- Lifts
- Controls
- Restraints
- Seats
- Ramps
- Conversion Kits
- Compasses

Environmental Control Devices

- Switches
- Controls
- Telephones: Including telephone lights and alarms
- Air filter/conditioner/purifier
- Battery clubs: Hearing aid
- Control units for environmental equipment
- Dehumidifiers: Room or central
- Humidifiers: Except for oxygen
- Vaporizers
- Hot tubs
- Swimming pools

Exercise, Recreational, and Sensory Items

- Bicycles: exercise, recreational, therapeutic
- Dumbbells
- Equipment: Including in-home physical therapy items, pulleys, ropes, weights, mats, and balls
- Treadmill, pool, spa, sauna, massage table, massage mats, trampoline
- Weight Machines
- Wrist/hand strengthening
- Sensory equipment: Any type including: weighted vests, weighted blankets, under huggers, emotions putty, wrist bands, chewing devices, lights, rocker board, swings, balls, cuddle swing, blocks, etc.

Home Furniture

- Beds: any type; except a hospital bed as determined by CMS
- Bed board, bed mattress, bedding
- Any type of item or device that could be used for enclosure
- Blood pressure equipment: Except for renal dialysis participants
- Chairs: any type except shower chairs
- Masks: Except oxygen administration and burn
- Scales
- Strollers; general use

Personal Care Items

- Cloths: Disposable, wash, wipes
- Continuous Passive Motion Device Pads
- CO_2 monitoring device and periodic O_2 monitoring devices
- Deodorants
- Egg crate mattress
- Enemas, irrigation systems; any type
- Eye pads
- Food blenders and processors
- Lamps
- Mattresses: Except hospital beds with specified HCPCS
- Mattress pads: Except for hospital beds with specified HCPCS
- Monitoring Devices
- Nylon aid
- Pads: Heat, cold
- Paper: Toilet, facial tissues
- Pediatric cribs, enclosures, or bed furniture of any type
- Personal need, over the counter items
- Pocket Talkers
- Shoes: Tennis shoes or non-customized shoes. Includes extra depth and extra width shoes unless required for customized orthotic
- Tables: Including over the bed
- Toys
- Water bottles
- Water pics

Daily Living Items

- Activity Chairs
- Bottles: Hot water, nursing
- Bedwetting alarms
- Bicycles; any type
- Button aids
- Carafes
- Corner Chairs
- Chairs, lift chairs, chair cushions; any type
- Diapers for persons under the age of 4
- Dining Aids
- Disinfectants: Room, nebulizers
- Elastic laces
- Emesis basins
- Feeding Chairs
- Furniture items or items intended to be used as furniture
- Geolocation devices, applications, or systems
- Hand Held Shower Devices
- High Chairs
- Head bands
- Massage devices
- Medical alert bracelet
- Positioning Chairs

- Reacher
- Sock nylon aids
- Sponges: Bath
- Strollers; any general use to include jogging/off-terrain strollers
- Swim plugs, swimming vest, swimming equipment, swim diapers
- Swings; any type
- Tables
- Vaporizer

Institutional Items

- Medical supplies used by home health
- Paraffin baths
- Psoriasis lamps

Educational or Personal Use Items

- Books
- Wide diameter pencil/grips
- Brochures
- CDs, tapes, videos
- Cellphones
- Computer accessibility items
- iPads; for general use, to include accessories of any type • Switches
- Watches
- Handwriting Tools
- Locators

APPENDIX C – MEDICAL CRITERIA

The medical criteria contained in this chapter is intended to help guide providers in determining if Idaho Medicaid would potentially prior authorize a piece of DMEPOS. Idaho Medicaid reserves the right to add, change, or amend these guidelines. The guidelines and medical criteria contained in this policy document are not all-inclusive.

Please note for all items that are being reviewed for a PA, the following documentation is required plus any additional documentation that's captured in the items description:

- Idaho Prior Authorization Form
- Physician's Order
- Letter of Medical Necessity
- Supporting documentation to demonstrate medical need
- Pricing information (MSRP or invoice) if a manually priced code

NOTE: The Department reserves the right to request additional documentation to demonstrate medical necessity at any time for any request.

REMINDER: If you are unsure if a piece of equipment/supply might be covered, submit a request for a prior authorization before supplying.

Item Description:	Apnea Monitor
Coverage Requirements:	• One or more apparent life-threatening events A. Vigorous stimulation B. Episode characterized by some combination of apnea with color change, choking or gagging C. Symptomatic pre-term infants D. Medical condition such as central hyperventilation and bronchopulmonary dysplasia E. Infant with tracheostomy F. History of recent vent dependency G. Infant/child with severe respiratory complications resulting in periods of apnea
Other Documentation Required:	• Projected length of time equipment needs to be captured • Apnea monitor rental exceeding three months requires a physician's narrative report of client progress that must be maintained in the provider's files
Additional information:	• N/A

Item Description:	Ankle-Foot/Knee-Ankle-Foot Orthosis (AFO)-*not used* during ambulation
Coverage Requirements:	• Covered if criteria A, B, C, D are met or criteria E A. Participant has plantar fasciitis; and B. Plantar flexion contracture of the ankle with dorsiflexion on passive range of motion testing of at least 10 degrees (i.e., a nonfixed contracture); and C. Reasonable expectation of the ability to correct the contracture; and D. Contracture is interfering or expected to interfere significantly with the participant's functional abilities; or E. Used as a component of a therapy program which includes active stretching of the involved muscles and/or tendons
Other Documentation Required:	• N/A
Additional information:	• Static AFO will be denied as not medically necessary, if the contracture is fixed. • Replacement interface is covered if the AFO is allowed. • Replacement is allowed if there is a change in participant's condition and the current piece of equipment no longer meets medical needs. • The Department does not reimburse for a foot drop splint/recumbent positioning device.
Item Description:	Ankle-Foot/Knee-Ankle-Foot Orthosis- *used* during ambulation:
Coverage Requirements:	• Covered for ambulatory participants with weakness or deformity of the foot and ankle who: A. Require stabilization for medical reason and have the potential to benefit functionally. • AFOs and KAFOs that are custom-fabricated are covered for ambulatory participants when the basic coverage criteria above and one of the following criteria: A. The participant could not be fit with a prefabricated AFO; or, B. The condition necessitating the orthosis is expected to be permanent or of longstanding duration or, C. There is a need to control the knee, ankle or foot in more than one plane; or, D. The participant has a documented neurological, circulatory, or orthopedic status that requires custom fabricating over a model to prevent tissue injury; or,

	E. The participant has a healing fracture which lacks normal anatomical integrity or anthropometric.
Other Documentation Required:	• N/A
Additional information:	• Replacement interface is covered if the AFO is allowed. • Replacement is allowed if there is a change in the participant's condition and the current piece of equipment no longer meets their medical needs.

Item Description:	AFO and KAFO, Custom
Coverage Requirements:	• Any one of the listed conditions for an Ankle-Foot/Knee Ankle Foot Orthosis; and A. The participant could not be fitted with a prefabricated AFO, or B. Condition necessitating the orthosis is expected to be permanent or lasting more than 6 months, or C. Documented neurological, circulatory or orthopedic status that requires a model to prevent tissue injury, or D. The participant has a healing fracture which lacks normal anatomical integrity, or E. There is a need to control the knee, ankle or foot in more than one plane.
Other Documentation Required:	• Documentation in the supplier's records to support the medical necessity of that type of device rather than a prefabricated orthosis. • An itemized cost statement from suppliers must accompany the request.
Additional information:	• When an unlisted orthosis code is requested, the request must include a narrative description of the item and information justifying the medical necessity for the item. • A static AFO is non-covered when used solely for the prevention or treatment of pressure ulcers or treatment of edema.

Item Description:	Bone-Anchored Hearing Aid (BAHA), Soft Band
Coverage Requirements:	• Coverage criteria includes: A. Ear canal atresia (no ear canals) and unable to wear ear mold in the ear or B. Microtia (very small ear canal) and unable to attain satisfactory fitting ear mold or C. Persistently discharging ears, can't use air conduction aid, with documentation to show medical necessity and reason an air conduction aid will not work. D. An ear condition made worse when ear closed off with ear molds and E. Audiology test results indicating a pure tone average bone conduction threshold of up to 65 dB.
Other Documentation Required:	• Child is usually under 5 years of age. If child is over 5 years old, a Soft Band might be trialed prior to implant surgery and the device can be placed in surgery. • Documentation of MSRP for all items in requested service
Additional information:	• An auditory Non-Osseo integrated sound processor includes the headband.

Item Description:	Bath/Shower Chair or Tub Stool/Bench
Coverage Requirements:	A. Covered for medical conditions, which cause a participant to be unstable with ambulation and puts the participant at risk for falls/injury. B. Other bathing equipment: Bathtub participant lifts (see Lifts for criteria), rehabilitation shower chairs, shower gurneys, etc., are covered for participants with medical conditions who, without use of the equipment, would be unable to bath or shower.
Other Documentation Required:	• Must explain why this specific item is the least costly way to meet the minimum medical need of the participant compared to other options. Suppliers must provide cost comparison and justification for the requested item against 2 similar like items to include final DME supplier cost.
Additional information:	• N/A

Item Description:	Bilirubin Lights
Coverage Requirements:	• Covered if criteria listed below is met: A. History and physical assessment conducted by infant's attending physician, newborn discharge exam will suffice if home phototherapy begins immediately discharge from the hospital B. Required laboratory studies must have been performed, including CBC, blood on mother and infant, direct Coombs and direct Bilirubin level, without hemolysis C. Physician certifies that parent/caregiver can administer home phototherapy D. Parent/caregiver has successfully completed training on use of equipment E. Equipment must be delivered and set up within four hours of discharge from hospital or notification of provider, whichever is more appropriate. F. Repair and/or replacement service must be available 24-hours per day
Other Documentation Required:	• Narrative report outlining infant's progress
Additional information:	• PA is required after 14 days then every 7 days. • Rental only • Documentation of the above outlined criteria and conditions necessitating therapy must be maintained in provider's records • Idaho Medicaid considers genotyping of SLCO1B1 and UGT1A1 experimental and investigational for assessing risk of neonatal hyperbilirubinemia because the clinical value of this approach has not been established

Item Description:	Chest Wall Oscillating Device (Airway Vest System)
Coverage Requirements:	• The participant is unable to cough or remove phlegm on their own, and must meet one of the following criteria from A-C and must meet D: A. Diagnosis of moderate or severe cystic fibrosis, B. Bronchiectasis confirmed by CT scan, or C. Neuromuscular disorder (Muscular dystrophy, Multiple Sclerosis, ALS) D. Well-documented failure of standard treatments to adequately mobilize retained secretions • The Department considers: A. Does the participant currently have a vest/generator? B. What other bronchial drainage device/treatment has been tried, and how did it fail? C. Can the participant use the vest effectively? D. Does the vest/generator meet all the bronchial drainage therapy needs? E. What is the frequency of antibiotics or hospitalizations and the associated F. Costs over the past one year?
Other Documentation Required:	• Demonstration of standard chest physical therapy failure OR standard chest physical therapy is unavailable or not tolerated • Documentation of failure of standard treatments, i.e., the participant has frequent severe exacerbations of respiratory distress involving inability to clear mucus despite standard treatment
Additional information:	• Initial approvals may be given for a three-month trial period • Not covered as an alternative to chest physical therapy in participants with CF or chronic bronchiectasis in any other clinical situation • Chronic diffuse bronchiectasis is defined by daily productive cough for at least 6 continuous months or more than 2 times per year exacerbations requiring antibiotic therapy and confirmed by high-resolution or spiral chest computed tomography scan

Item Description:	Continuous Glucose Monitoring (Non-Therapeutic A9276-A9277-A9278)
Coverage Requirements:	• Type 1 diabetes mellitus, as indicated by the following: A. Long-term continuous glucose monitoring needed, as indicated by: 1. Intensive insulin regimen (3 or more insulin injections per day, or use of continuous subcutaneous insulin infusion pump) 2. Participant consistently monitors blood glucose 3 or more times per day (submit glucose self-testing logs) 3. Participant is motivated and knowledgeable about use of continuous glucose monitoring and is adherent to diabetic treatment plan. 4. Additional blood glucose criteria, as indicated by 1 or more of the a. Dawn phenomenon, known or suspected b. Hypoglycemic unawareness (blood glucose less than 60mg/dL) c. Nocturnal hypoglycemia, known or suspected d. Postprandial hyperglycemia, known or suspected >180. e. Significant change to diabetes treatment regimen (e.g., initiation of insulin, change from multiple-dose insulin to insulin pump therapy) f. Unexplained hyperglycemia-no medical justification can be found per PCP • Submit name of model being requested.
Other Documentation Required:	• Documentation needs to support the medical need for a CGM. Convenience purposes will not be covered.
Additional information:	• Sensors and transmitters may be renewed annually with a signed physician's order. • CGM receivers are authorized 1 every 5 years. PA submissions for replacement must include documentation of how equipment does not meet medical needs. • Upgrades or expired warranty are not available for replacement PA requests. • Non-Therapeutic devices are used as an adjunct to BGM testing.
Item Description:	Continuous Glucose Monitoring (Therapeutic K0553-K0554)
Coverage Requirements:	Therapeutic CGMs and related supplies are covered when all of the following coverage criteria A-F are met: A. The participant has type 1 or 2 diabetes mellitus (Reference the Medicare glucose monitor LCD for ICD-10 Codes that Support Medical Necessity section for applicable diagnoses); and, B. The participant has been using a blood glucose monitor and performing frequent (four or more times a day) testing; submit glucose self-testing logs documenting the frequency of glucose self-testing; and, C. The participant is insulin-treated with multiple (three or more) daily injections of insulin or a continuous subcutaneous insulin infusion pump; and,

	D. The participant's insulin treatment regimen requires frequent adjustment by the participant on the basis of blood glucose monitor or continuous glucose monitor testing results; and, E. Within six (6) months prior to ordering the CGM, the treating practitioner has an in-person visit with the participant to evaluate their diabetes control and determined that criteria (A-D) above are met; and, F. Every six (6) months following the initial prescription of the CGM, the treating practitioner has an in person visit with the participant to assess adherence to their CGM regimen and diabetes treatment plan. • The Department only covers the DeXcom G5/G6 Mobile Continuous Glucose Monitoring System for ages 2 years and older. • The Department only covers the FreeStyle Libre Flash Glucose Monitoring System for ages 18 years and older. • Submit name of model being requested.
Other Documentation Required:	• Glucose self-testing logs documenting the frequency of glucose self-testing with an average of > 4 times per day. • Documentation needs to support the medical need for a CGM. Convenience purposes will not be covered.
Additional information:	• Sensors and transmitters may be renewed annually with a signed physician's order. • CGM receivers are authorized 1 every 5 years. PA submissions for replacement must include documentation of how equipment does not meet medical needs. • Upgrades or expired warranty are not available for replacement PA requests. • Therapeutic devices are used to replace other blood glucose monitoring testing and to make diabetes treatment decisions.

Item Description:	Commodes/Chairs
Coverage Requirements:	• The participant is: A. Physically incapable of utilizing regular toilet facilities B. Is confined to a single room, one level of the home with no toilet on that level C. Is confined to the home and there is no toilet facilities in the home
Other Documentation Required:	• N/A
Additional information:	• Extra wide/heavy duty allowed, if participant weighs more than 300 lbs. • Mobile chair is not medically necessary and is non-covered/ no exceptions. • Commode chair with detachable arms allowed if necessary to facilitate transferring the participant. • Commode chair with seat lift mechanism is non-covered/ no exceptions. • Raised toilet seats are non-covered/ no exceptions. • A commode chair that is used as a raised toilet seat by positioning it over the toilet is non-covered/ no exceptions. • Footrest is non-covered and not medical in nature

Item Description:	PAP for Obstructive Sleep Apnea-Adults (E0601 & E0470)
Coverage Requirements:	• Criteria A. Participant has had a face-to face clinical evaluation by the treating physician prior to the sleep test B. Participant's apnea-hypopnea index (AHI) or respiratory disturbance index (RDI) is greater than or equal to 15 events/hour with a minimum of 30 events OR C. AHI or RDI greater than or equal to 5 and less than 15 events/hour with a minimum of 10 events and at least one of the following is met: D. Documented history of stroke; or E. Documented hypertension (systolic blood pressure greater than 140 mm Hg and/or diastolic blood pressure greater than 90 mm Hg); or F. Documented ischemic heart disease; or G. Documented symptoms of impaired cognition, mood disorders, or insomnia; or H. Excessive daytime sleepiness (documented by either Epworth greater than 10); or I. Greater than 20 episodes of oxygen desaturation (i.e., oxygen saturation of less than 85 %) during a full night sleep study, or any one episode of oxygen desaturation (i.e., oxygen saturation of less than 70 %) • Requests for a respiratory device, bi-level pressure capability *without* backup rate feature (E0470) must meet all the above coverage criteria in addition to documentation that a continuous positive airway pressure device was tried and proven ineffective based on a therapeutic trial conducted in either a facility or home setting. • Continued use of a positive airway pressure device beyond the initial authorization period is considered medically necessary if the treating physician documents that the participant is benefiting from positive airway pressure therapy. Documentation of clinical benefit is demonstrated by: A. Face-to-face clinical reevaluation by the treating physician with documentation that symptoms of obstructive sleep apnea are improved; and Objective evidence of adherence to use of the positive airway pressure device, reviewed by the treating physician. Adherence to therapy is defined as use of positive airway pressure four (4) or more hours per night on at least 70% of nights during a consecutive thirty (30) day period anytime during the initial period of usage.

Other Documentation Required:	N/A
Additional information:	• A Bi-Level Positive Pressure device *with* back up rate (E0471) is not covered if the primary diagnosis is OSA. Refer to Respiratory Assist Devices-RAD for a diagnosis other than OSA for E0470 & E0471. • Idaho Medicaid considers PAP experimental and investigational for the treatment of participants with upper airway resistance syndrome or for the improvement of seizure control in participants with epilepsy. • Treatment of snoring alone, without significant obstructive sleep apnea, is not considered medically necessary • PAP machines are not automatically replaced every 5 years. The device will need to be evaluated by a trained medical device professional, a Respiratory Therapist or a certified technician. Documentation must be submitted with the PA request from the evaluator indicating why the current machine does not meet the medical needs of the participant, what the malfunction is, and if the device is repairable. Also, if a new machine is requested the Supplier must include why it is more cost effective to issue a new machine rather than repairing the current machine.

Item Description:	PAP for Obstructive Sleep Apnea-Pediatric
Coverage Requirements:	• Must meet the following criteria: A. Participant has had a face-to face clinical evaluation by the treating physician prior to the sleep test. B. There is a documented diagnosis of obstructive sleep apnea (OSA). C. Polysomnography demonstrates apnea-hypopnea index (AHI) equal to or greater than 1 for children under 21 years of age. D. Documentation that supports the following: 1. Adentonsillectomy has been unsuccessful in relieving OSA; or 2. Adentonsillar tissue is minimal; or 3. Adentonsillectomy is inappropriate based on OSA being attributable to another underlying cause (such as craniofacial anomaly); or 4. Adentonsillectomy is contraindicated. E. Participant must be able to adequately manage secretions and possess a degree of respiratory autonomy to prevent morbidity if the mask slips. F. There must be documentation of competent caregivers that have had formal training. G. Other diagnosis considered on an individual basis as reviewed by a medical director for medical necessity • Continued use of a positive airway pressure device beyond the initial authorization period is considered medically necessary if the treating physician documents that the participant is benefiting from positive airway pressure therapy. Documentation of clinical benefit is demonstrated by: A. Face-to-face clinical reevaluation by the treating physician with documentation that symptoms of obstructive sleep apnea are improved; and B. Documented evidence of a 30 day download from the device showing usage of approximately 80 hours.
Other Documentation Required:	• Documentation must address corrective measures if adherence to therapy is not achieved.

Additional information:	• Exceptions to the criteria to include other diagnosis maybe considered on an individual basis as reviewed by the medical director for medical necessity. Must indicate on the request form that a medical director review is being requested because the clinical guidelines are not met. • Requests for respiratory device, bi-level pressure capability without backup rate feature must meet all the above coverage criteria in addition to documentation that a continuous positive airway pressure device (CPAP) was tried and proven ineffective. Ineffective is defined as not meeting therapeutic goals. There must be documentation of the mask being appropriately fitted, the pressure settings of the CPAP have been adjusted and still fail to lower symptoms or AHI. • Idaho Medicaid considers PAP experimental and investigational for the treatment of seizure control in participants with epilepsy. • Treatment of snoring alone, without significant OSA, is not considered medically necessary • The FDA rules recommend the type of ventilator or PAP device for small children based on their weight are indicated below: 1. Over 66 pounds the participant may be placed on any home PAP device - rent or purchase as appropriate 2. Participants 30-65 pounds may be placed on a: a. VPAP, rent or purchase as appropriate or b. VPAP ST-A, rent or purchase as appropriate c. These are home PAP devices which have alarms. d. Participants under 11-30 pounds or need invasive ventilation, may be placed on a home ventilator. These ventilators are rental only. • PAP machines are not automatically replaced every 5 years. The device will need to be evaluated by a trained medical device professional, a Respiratory Therapist or a certified technician. Documentation must be submitted with the PA request from the evaluator indicating why the current machine does not meet the medical needs of the participant, what the malfunction is, and if the device is repairable. Also, if a new machine is requested the Supplier must include why it is more cost effective to issue a new machine rather than repairing the current machine.

Item Description:	Cranial Remolding Orthosis
Coverage Requirements:	• Cranial vault remodeling surgery for synostosis
Other Documentation Required:	• Letter of medical necessity indicating participant has had cranial vault remodeling surgery for synostosis
Additional information:	• Use of an adjustable cranial orthosis for synostosis in the absence of cranial vault remodeling surgery is considered not medically necessary. • An adjustable cranial orthosis as a treatment of plagiocephaly or brachycephaly without synostosis is considered not medically necessary.

Item Description:	Dynamic Stretch Device
Coverage Requirements:	• Coverage for use on the knee, elbow, wrist or finger in any of the following clinical settings A. As an addition to physical therapy in the subacute injury or post-operative period (≥ 3 weeks but ≤ 4 months after injury or operation) in participants with signs and symptoms of persistent joint stiffness. B. In the acute post-operative period for participants who are undergoing additional surgery to improve the range of motion of a previously affected joint. C. For participants, unable to benefit from standard physical therapy modalities because of an inability to exercise for as long as four months to see if improvement occurs, and then for as long as improvement can be documented.
Other Documentation Required:	• Physical therapy or surgical report
Additional Information:	• This is a rental item that can be rented up to three-months for an initial trial. • An additional three-month authorization may be approved if submitted for a renewal and documentation captures that the device is demonstrating a medical benefit.

Item Description:	External Defibrillators-Automatic
Coverage Requirements:	• Wearable Criteria A. One of the following criteria must be met: 1. A documented episode of ventricular fibrillation or a sustained, lasting 30 second or longer, ventricular tachyarrhythmia. These dysrhythmias may be either spontaneous or induced during an electro physiologic (EP) study, but may not be due to a transient or reversible cause and not occur during the first 48 hours of an acute myocardial infarction; or 2. Familial or inherited conditions with a high risk of life-threatening ventricular tachyarrhythmia such as long QT syndrome or hypertrophic cardiomyopathy; or 3. Either documented prior myocardial infarction or dilated cardiomyopathy and a measured left ventricular ejection fraction less than or equal to 0.35; or 4. A previously implanted defibrillator now requires explanation 5. Use of a wearable external defibrillator is considered investigational for all other indications not listed in the above criteria, including immediately (i.e., less than 40 days) following an acute myocardial infarction. • Nonwearable Criteria A. One of the following criteria must be met: 1. A documented episode of cardiac arrest due to ventricular fibrillation, not due to a transient or reversible cause 2. A sustained, lasting 30 second or longer, ventricular tachyarrhythmia, either spontaneous or induced during an electro physiologic (EP) study, not associated with acute myocardial infarction, and not due to a transient or reversible cause 3. Familial or inherited conditions with a high risk of life-threatening ventricular tachyarrhythmia's such as long QT syndrome or hypertrophic cardiomyopathy 4. Coronary artery disease with a documented prior myocardial infarction with a measured left ventricular ejection fraction less than or equal to 0.35, and inducible, sustained ventricular tachycardia (VT) or ventricular fibrillation (VF) during an EP study. To meet this criterion; 5. The myocardial infarction must have occurred more than 4 weeks prior to the external defibrillator prescription; and, 6. The EP test must have been performed more than 4 weeks after the qualifying myocardial infarction. 7. Documented prior myocardial infarction and a measured left ventricular ejection fraction less than or equal to 0.30. Participants must not have: 8. Cardiogenic shock or symptomatic hypotension while in a stable baseline rhythm; or,

	9. Had a coronary artery bypass graft (CABG) or percutaneous transluminal coronary angioplasty (PTCA) within past 3 months; or, 10. Had an enzyme-positive MI within past month; or 11. Clinical symptoms or findings that would make them a candidate for coronary revascularization; or, 12. Irreversible brain damage from preexisting cerebral disease; or, 13. Any disease, other than cardiac disease (e.g. cancer, uremia, liver failure), 14. associated with a likelihood of survival less than one year. 15. Participants with ischemic dilated cardiomyopathy (IDCM), documented prior myocardial infarction (MI), New York Heart Association (NYHA) Class II and III heart failure, and measured left ventricular ejection fraction (LVEF) ≤ 35%. 16. Participants with non-ischemic dilated cardiomyopathy (NIDCM) > 3 months, NYHA Class II and III heart failure, and measured LVEF ≤ 35% 17. Participants who meet one of the previous criteria and have NYHA Class IV heart failure or; 18. Implantation surgery is contraindicated or; 19. A previously implanted defibrillator now requires explanation.
Other Documentation Required:	N/A
Additional information:	For a specific list of qualifying ICD-10 diagnoses, refer to the Noridian coverage criteria.

Item Description:	External Insulin Infusion Pump- Pediatric
Coverage Requirements:	• Participant meets at least one of the following criteria while on multiple daily injections, which is defined as more than 3 injections per day, of insulin: A. Elevated glycosylated hemoglobin level: A1c greater than 7.0%, where the upper range of normal is less than 6.0%; for other A1c assays, 1.0% over upper range of normal; or B. History of recurring hypoglycemia: less than 60 mg/dL; OR C. Wide fluctuations in blood glucose before mealtime (e.g., pre-prandial blood glucose levels commonly exceed 140 mg/dL); OR D. Dawn phenomenon with fasting blood sugars frequently exceeding 200 mg/dL; or E. History of severe glycemic excursions.
Other Documentation Required:	• Glucose self-testing logs documenting the frequency of glucose self-testing with an average of > 4 times per day during the 2 months prior to initiation of the insulin pump or documentation of the last 2 months of CGM downloads and glucose self-testing logs showing minimum testing of twice a day. • Completion of a comprehensive diabetes education program
Additional information:	• An exception to the above medical necessity criteria may be made for a participant with Type I diabetes during pregnancy, if initiation of an external insulin infusion pump is required to avoid fetal and maternal complications of diabetes and pregnancy. • External insulin infusion pumps will not be approved in the following cases: A. Participant who are unable, because of, behavioral, psychological problems, or functional ability, to technically operate the pump and perform frequent blood glucose monitoring. B. Participant convenience when control is achieved with multiple daily injections

Item Description:	External Insulin Pump - Adult
Coverage Requirements:	• An external infusion pump is covered if criterion A or B is met and if criterion C or D is met: A. C-peptide testing requirement – must meet criterion 1 or 2 and criterion 3: 1. C-peptide level is less than or equal to 110 percent of the lower limit of normal of the laboratory's measurement method. 2. For participants with renal insufficiency and a creatinine clearance (actual or calculated from age, weight, and serum creatinine) less than or equal to 50 ml/minute, a fasting C-peptide level is less than or equal to 200 per cent of the lower limit of normal of the laboratory's measurement method. 3. A fasting blood sugar obtained at the same time as the C-peptide level is less than or equal to 225 mg/dl. B. Beta cell autoantibody test is positive. C. The participant has completed a comprehensive diabetes education program, has been on a program of multiple daily injections of insulin (i.e., at least 3 injections per day) with frequent self-adjustments of insulin dose for at least 6 months prior to initiation of the insulin pump, and has documented frequency of glucose self-testing an average of at least 4 times per day during the 2 months prior to initiation of the insulin pump, and meets one or more of the following criteria (1 - 5) while on the multiple injection regimen: 1. Glycosylated hemoglobin level (HbA1C) greater than 7 percent 2. History of recurring hypoglycemia 3. Wide fluctuations in blood glucose before mealtime 4. Dawn phenomenon with fasting blood sugars frequently exceeding 200 mg/dL 5. History of severe glycemic excursions D. The participant has been on an external insulin infusion pump and has documented frequency of glucose self-testing an average of at least 4 times per day over the last month
Additional Information:	• For other medical request for an insulin pump not listed above, please refer to the Medicare External Infusion Pumps for specific medical necessity criteria. • Continued coverage of an external insulin pump and supplies requires that the participant be seen and evaluated by the treating physician at least every 3 months.

Item Description:	Eye Prosthesis-Scleral Schell
Coverage Requirements:	• Criteria A. Eye prostheses are covered for a participant with absence or shrinkage of an eye due to birth defect, trauma or surgical removal. B. New enucleation, surgery with an implantation, the scleral shell is worn over the implantation. C. Post Tarsorrhaphy surgery
Other Documentation Required:	• Include on the DME request form the ICD-10 diagnosis if it is not clear in the surgical report or supporting documentation.
Additional Information:	• NA

Item Description:	FM Communication Systems – Pediatric Hearing aids/BAHA implant/Hearing impairment
Coverage Requirements:	• Criteria for children without hearing aids: A. If a child has deficits with their central auditory processing, ALL the requirements below must be met. The deficits would present as: 1. Monaural separation closure deficits, which exhibits as problems filling in missing information in noisy situations; 2. Temporal recognition deficits, resulting in reduced speech perception, both in content and intent; 3. Binaural separation/integration deficits which manifests as difficulty attending to one piece of information and ignoring noise. B. Test results that identify monaural, closure and temporal deficits listed above. • Criteria for children with hearing aids or BAHA: A. Submit a letter of medical necessity
Other Documentation Required:	• Providers are required to submit invoice or MSRP. • A prescription signed by the physician or audiologist is required.
Additional information:	• Accessories such as a microphone or toolbar keyguard may be prior authorized if medical necessity documentation is included in the request.

Item Description:	Gait Trainers (GT) -Pediatric
Coverage Requirements:	• Covered for pediatric participants only A. Considered medically necessary for participants with: 1. Documented acquired injury (for example, spinal cord or traumatic brain injury or 2. Documented chronic physical limitation that affects the ability to ambulate independently (for example: cerebral palsy, neuromuscular disease, or spina bifida) and 3. Participant requires moderate to maximum support for ambulation and 4. Demonstrates the ability to ambulate independently with the device 5. Gait trainer must be used in the home and/or community by the participant without significant assistance by another individual. B. Potential benefits to the participant from the GT must be clearly documented as follows: 1. The participant must be involved in a therapy program established by a physical therapist. 2. The program must include measurable documented objectives and functional goals related to the participant and GT that includes a written carry over plan to be utilized by the participant and/or caregiver. 3. The GT must match the participant's needs and ability level. Documentation should demonstrate how the GT will promote gross motor development, independent mobility and initiate stepping. 4. The participant has had a trial of the requested GT and the participant shows compliance, willingness, and ability to use the GT in the home. 5. Provide a picture of the requested GT which clearly depicts the type of GT device and any accessories.
Other Documentation Required:	• Cost comparison of at least two other like items with MSRP information must be submitted. • Documentation supporting that the gait trainer will accommodate the participant's growth for at least 5 years.
Additional Information:	• This item needs to be reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body part. • Accessories or additional features must address a medical need. Items for convenience or that are preventative in nature are not covered.

Item Description:	Hearing Aids – Non-implantable -Pediatric
Coverage Requirements:	• No prior authorization is required for the first monaural or binaural hearing aid. • Coverage for non-implantable hearing aid is allowed for participants under the age of twenty-one (21) when there is a documented hearing loss of at least thirty (30) decibels based on the standard Pure Tone Average (500, 1000, 2000 hertz), with the following requirements and limitations: A. Covered services included with the purchase of the hearing aid include proper fitting and refitting of the ear mold or aid, or both, during the first year, instructions related to the aid's use, and extended insurance coverage for 2 years. B. The following services may be covered in addition to the purchase of the hearing aid for participants under the age of twenty-one (21):
Other Documentation Required:	• Documentation submitted needs to include the following: A. The participant's diagnosis; B. The results of the basic comprehensive audiometric exam which includes pure tone, air and bone conduction, speech reception threshold, most comfortable loudness, discrimination and impedance testing; and C. The brand name and model type of the hearing aid needed.
Additional Information:	• The Department has no responsibility for the repair of hearing aids that have been damaged because of neglect, abuse or use of the aid in a manner for which it was not intended. • Participants are eligible for replacement hearing devices once every three years. If a participant requires a hearing aid before the 3 year limitation, an Early Periodic Screening, Diagnosis and Treatment (EPSDT) request may be submitted to the Department. • Batteries purchased monthly, follow-up testing, necessary repairs resulting from normal use after the second year, and the refitting of the hearing aid or additional ear molds no more often than forty-eight (48) months from the last fitting.

Item Description:	Helmet, Protective
Coverage Requirements:	• Protective helmets may be covered for a seizure disorder or post-operative protection. • Protective helmets used for sports, recreation or behaviors are not covered.
Other Documentation Required:	• N/A
Additional Information:	• The above criteria do not include fabricated cranial remolding orthosis. • For coverage criteria for fabricated cranial remolding orthosis, refer to the Cranial Remolding Orthosis section in this manual.

Item Description:	Hospital Beds
Coverage Requirements:	• A fixed height hospital bed is covered if one or more of the following criteria are met: A. The participant has a medical condition which requires positioning of the body in ways not feasible with an ordinary bed. Elevation of the head/upper body less than 30 degrees does not usually require the use of a hospital bed, or B. The participant requires positioning of the body in ways not feasible with an ordinary bed to alleviate pain, or C. The participant requires the head of the bed to be elevated more than 30 degrees most of the time due to congestive heart failure, chronic pulmonary disease, or problems with aspiration, or D. The participant requires traction equipment, which can only be attached to a hospital bed. • A variable height hospital bed is covered if the participant meets one of the criteria above and A. Requires a bed height different than a fixed height hospital bed to permit transfers to chair, wheelchair or standing position. • A Semi-Electric Bed is covered if a participant meets the criteria for a fixed height hospital bed, and A. Participant's judgment and skill level must be adequate to operate the controls and functional limitations that precludes use of a conventional bed or a fixed hospital bed B. Frequent changes in body position and/or has an immediate need for a change in body position. C. Request must clearly document why a standard hospital bed will not meet the participant's living situation and why the electrical feature is medically necessary. • A Heavy-Duty Bed -Allowed if participant meets the criteria for a fixed bed and the participant is greater than 350 lbs.,but does not exceed 600 pounds. • A Total Electric Bed - is not covered; height adjustment feature is a convenience feature. These are deemed not reasonable and necessary.
Other Documentation Required:	• If electric feature is requested; must explain medical need and living arrangements which warrant an electric feature; cannot be justified for convenience.

Additional Information:	• Side Rails are covered if required by the participant's condition and used with a hospital bed. • Bed board and over bed table are non-covered/no exception. • Hospital Grade ICU beds are not covered

Item Description:	Hospital Grade Breast Pump
Coverage Requirements:	• Hospital-grade breast pumps may be considered clinically appropriate when there is prolonged infant hospitalization and one or more of the following conditions when such conditions adversely impact feeding directly from the breast: A. Prematurity (including multiple gestation); B. Neurologic disorder C. Genetic abnormality D. Anatomic or mechanical malformation (e.g. cleft lip or palate) or E. Congenital malformation requiring surgery (e.g. respiratory, cardiac, gastrointestinal or central nervous system malformation).
Other Documentation Required:	• Documentation must demonstrate that above criteria is met and outline the expected timeframe requirement for this item
Additional information:	• The hospital grade breast pump will be covered only upon the mother's discharge from the hospital • Medicaid will not reimburse for a pump while the mother is inpatient • This is a rental only item which is limited to up to 3 months per birth. • The following are included in the rental payment for a hospital-grade breast pump: A. Set-up and education on proper use and care of pump B. Maintenance and all repairs/replacements needed during the rental period C. Applicable cleaning/return service charges

Item Description:	Incontinence Supplies
Coverage Requirements:	A. Coverage for over limitation of incontinence supplies for participants over the age of 4 will be granted for those who possess medical conditions which require additional supplies due to loss of bowel or bladder control B. The participant can perform toileting activities on their own at least some of the time; and C. Use of the pull-ups instead of briefs will allow them to independently and safely complete toileting activities; and D. The pull-ups are not for the convenience of the caregiver. E. Submit a letter of medical necessity and physician's order
Other Documentation Required:	• N/A
Additional Information:	• Incontinence supplies are not covered for participants under 4 years of age • Only a one-month supply may be dispensed at any time • Participants residing in an intermediate care facility for persons with intellectual disabilities or skilled nursing facility residence are excluded from this criteria since these are included in the facility per diem. • Per IDAPA-the coverage limitation without a prior authorization is: • Diapers/pull-ups limited to 240/month. • Liners limited to 150/month.

Item Description:	Lifts
Coverage Requirements:	• Basic Criteria A. Participant lift is covered if transfer between bed and a chair, wheelchair, or commode is required and, without the use of a lift, the participant would be bed confined. • Multi-positional participant transfer systems are covered if: A. The basic coverage criteria for a lift are met B. The participant requires supine positioning for transfers
Other Documentation Required:	• N/A
Additional information:	• The HCFA definition of Bed-Confinement is: The inability to get up from bed without assistance, ambulate and sit in a chair, including a wheelchair. (ALL MUST BE MET) • Requests for lifts may be due to a temporary condition. The Department may authorize a rental for these instances. • Requests for lifts must demonstrate the medical need for the participant, not the caregiver. Items for convenience, comfort, or cosmetic reasons are not covered. • Overhead track and ceiling lifts are not considered DME.

Item Description:	Mechanical Insufflation/Exsufflation Devices (Cough Assist)
Coverage Requirements:	• Basic Criteria A. Participant has a neuromuscular disease (for a specific list of qualifying ICD-10 diagnoses, refer to the Noridian eligibility criteria.), and B. This condition is causing a significant impairment of chest wall and/or diaphragmatic movement, such that it results in an inability to clear retained secretions.
Other Documentation Required:	• N/A
Additional information:	• For children under 21, the department may review requests under EPSDT on a case by case basis.

Item Description:	Medical Food for PKU or Low PHE
Coverage Requirements:	• Criteria A. Current physician's order to include duration of treatment B. Letter of Medical Necessity C. Nutritional Care Plan D. Documentation that outlines how the calories required is weekly or monthly corresponds to the cost of food products being requested
Other Documentation Required:	• Invoice demonstrating at least 3-month purchase order as ordered by the patient or family. Must reflect a balanced nutrition approach.
Additional information:	• The Department may issue a prior authorization that covers up to one year but the provider is must bill monthly.

Item Description:	Oral Appliances for Obstructive Sleep Apnea- Adult
Coverage Requirements:	• A custom fabricated mandibular advancement oral appliance is used to treat obstructive sleep apnea (OSA) and covered if all the criteria below are met. A. The participant has a face-to-face clinical evaluation by the treating physician prior to the sleep test to assess the participant for obstructive sleep apnea testing. B. The participant has a current sleep test that meets one of the following criteria: 1. The apnea-hypopnea index (AHI) or Respiratory Disturbance Index (RDI) is greater than or equal to 15 events per hour with a minimum of 30 events; or, 2. The AHI or RDI is greater than or equal to 5 and less than or equal to 14 events per hour with a minimum of 10 events and documentation of: a. Excessive daytime sleepiness, impaired cognition, mood disorders, or insomnia; or, b. Hypertension, ischemic heart disease, or history of stroke; or, 3. If the AHI> 30 or the RDI> 30 and meets either of the following (a or b): a. The participant is not able to tolerate a positive airway pressure (PAP) device; or, b. The treating physician determines that the use of a PAP device is contraindicated. C. The device is ordered by the treating physician following a review of the report of the sleep test.
Other Documentation Required:	Submit invoice with PA request.
Additional information:	N/A

Item Description:	Oral Appliances for Obstructive Sleep Apnea- Pediatric
Coverage Requirements:	• A custom fabricated mandibular advancement oral appliance is used to treat obstructive sleep apnea (OSA) and covered if all the criteria below are met. A. Participant has had a face-to face clinical evaluation by the treating physician prior to the sleep test. B. There is a documented diagnosis of obstructive sleep apnea (OSA). C. Polysomnography demonstrates apnea-hypopnea index (AHI) equal to or greater than 1 for children under 21 years of age. D. Documentation that supports the following: 1. Adentonsillectomy has been unsuccessful in relieving OSA; or 2. Adentonsillar tissue is minimal; or 3. Adentonsillectomy is inappropriate based on OSA being attributable to another underlying cause (such as craniofacial anomaly); or 4. Adentonsillectomy is contraindicated. E. The device is ordered by the treating physician following a review of the report of the sleep test
Other Documentation Required:	Submit invoice with PA request.
Additional information:	N/A

Item Description:	Oral, Enteral, or Parenteral Nutritional Products (medical grade)
Coverage Requirements:	• Covered when following medically criteria is met: A. Participant must require tube feedings, or B. Oral supplements are necessary to meet caloric needs of a participant who, with traditional foods alone, is unable to maintain growth, weight, and strength commensurate with their general condition C. Physician's order with daily calorie count, length of need, diagnosis, and documentation of medical necessity.
Other Documentation Required:	A. A Nutrition Plan of Care that includes appropriate nutritional history, the participant's current height, weight, age, goals for weight gain or weight maintenance, medical diagnosis, steps to decrease the participant's dependence on nutritional supplements or detail why that is not possible, and current enteral or oral nutritional product. B. For participants under age 21, a growth chart including weight or height percentile must be included. C. Enhanced reimbursement is available for select medically necessary products for which there are no substitutes; and where the maximum allowable fee does not adequately cover the provider's wholesale costs. Vendor needs to include: 1. Number of calories per day ordered by the physician, 2. Number of calories per can, 3. Number of cans per case, and 4. Invoice including shipping costs or MSRP
Additional information:	• Traditional, typical over the counter, or non-medical grade infant formulas are not covered • One unit of a nutritional formula is defined as 100 calories rather than the number of cans.

Item Description:	Osteogenesis Bone Growth Stimulator
Coverage Requirements:	• A non-spinal electrical osteogenesis stimulator is covered only if any of the following criteria are met: A. Nonunion of a long bone fracture defined as radiographic evidence that fracture healing has ceased for three or more months prior to starting treatment with the osteogenesis stimulator. B. Failed fusion of a joint other than in the spine where a minimum of nine months has elapsed since the last surgery, or C. Congenital pseud arthrosis. D. Nonunion of a long bone fracture must be documented by a minimum of two sets of radiographs obtained prior to starting treatment with the osteogenesis stimulator, separated by a minimum of 90 days, each including multiple views of the fracture site, and with a written interpretation by a physician stating that there has been no clinically significant evidence of fracture healing between the two sets of radiographs. • A spinal electrical osteogenesis stimulator is covered only if any of the following criteria are met: A. Failed spinal fusion where a minimum of nine months has elapsed since the last surgery. B. Following a multilevel spinal fusion surgery. C. Following spinal fusion surgery where there is a history of a previously failed spinal fusion at the same site. • An ultrasonic osteogenesis stimulator is covered only if the following criteria are met: A. Nonunion of a fracture documented by a minimum of two sets of radiographs obtained prior to starting treatment with the osteogenesis stimulator, separated by a minimum of 90 days. Each radiograph set must include multiple views of the fracture site accompanied by a written interpretation by a physician stating that there has been no clinically significant evidence of fracture healing between the two sets of radiographs. Radiographs must indicate fracture is not of the skull or vertebrae or tumor related.
Other Documentation Required:	• Documentation capturing the criteria justification listed above must be submitted with the request for service. • Physicians order must include duration of treatment. For example: 20 minutes a day for 90 days.
Additional Information:	• Use of an ultrasonic osteogenesis stimulator for the treatment of a fresh fracture or delay union will be denied as not medical criteria.

Item Description:	Oximeter-Continuous Monitoring Model Only
Coverage Requirements:	• Oximeters used for "spot checking" are not medically necessary and are considered needed for monitoring purposes rather than medical purposes. • Service requests which demonstrate the medical need for continuous O_2 monitoring maybe covered under the following criteria: • For Adults: A. Only covered for overnight oximetry • Pediatrics: A. Requires continuous monitoring B. Applicable if the participant meets the following criteria: 1. Oxygen and/or ventilator dependent (8-24hrs. a day) or; 2. Participant has frequent need for changes in oxygen and ventilator settings or; 3. Participant is in the weaning process from oxygen and/or ventilator and is experiencing respiratory complications or; 4. Participant needs continuous monitoring of oxygen saturation during sleep and/or to maintain optimal levels.
Other Documentation Required:	• Current prescription signed by the physician specifying the need for continuous monitoring, diagnosis, length of need and indication for the oximeter. • For a renewal: A. Current progress notes or download that detail saturation levels or last month of O2 saturation and oxygen liter flow adjustment log
Additional Information:	• An oximeter is usually rented and authorized for a trial of 3 months. Probes are included in the initial rental authorization. • Payment for oximeter rental includes the pricing for the probe. Do not request additional or replacement probes during rental period duration. • If the participant owns the machine, replacement disposable probes can be authorized up to four per month.

Item Description:	Oxygen for Cluster Headaches
Coverage Requirements:	• PA requests must have physician orders that demonstrate the following medical necessity criteria: A. Other measures, such as Dihydroergotamine and Sumatriptan (Imitrex), have been tried and found to be unsuccessful. B. Oxygen therapy must have been proven successful on a trial basis for at least one treatment in the emergency room or in the physician's office before it can be authorized for home use.
Other Documentation Required:	• Documentation of successful use and continued need must be received from the attending physician for subsequent PA.
Additional information:	• If more than two months' elapse without an incidence of a cluster headache, the oxygen authorization will be discontinued. • Authorization will be no more than six months.

Item Description:	Pneumatic Compression Devices (PCD)
Coverage Requirements:	• PCD covered for both primary and secondary lymphedema in participants with chronic and severe lymphedema when all the following requirements are met: A. The participant has a diagnosis of lymphedema, and B. The participant has persistence of chronic and severe lymphedema as identified by the documented presence of at least one of the following clinical findings: 5. Marked hyperkeratosis with hyperplasia and hyperpigmentation 6. Papillomatosis cutis lymphostatica, 7. Deformity of elephantiasis, 8. Skin breakdown with persisting lymphorrhea, 9. Detailed measurements over time confirming the persistence of the lymphedema with a history evidencing a likely etiology, and C. In addition to this documented persistence, the lymphedema is then documented to be unresponsive to other clinical treatment over the course of a required four-week trial. 1. A four-week trial of conservative therapy demonstrating failed response to treatment is required. The trial of conservative therapy must include all the following: a. Regular and compliant use of an appropriate compression bandage system or compression garment to provide adequate graduated compression b. Adequate compression is defined as sufficient pressure at the lowest pressure point to cause fluid movement and sufficient pressure across the gradient to move fluid from distal to proximal. The compression used must not create a tourniquet effect at any point c. The garment may be prefabricated or custom-fabricated but must provide adequate graduated compression starting with a minimum of 30 mmHg distally D. Regular exercise E. Elevation of the limb
Coverage Requirements:	• Chronic Venous Insufficiency with Venous Stasis Ulcers (CVI) maybe covered for the lower extremities only if the participant has the following: A. Edema in the affected lower extremity B. One or more venous stasis ulcer(s) C. The ulcer(s) have failed to heal after a six-month trial of conservative therapy directed by the treating physician.

	1. The six-month trial of conservative therapy must include all the following: a. Compliant use of an appropriate compression bandage system or compression garment to provide adequate graduated compression - Adequate compression is defined as: i. 1. sufficient pressure at the lowest pressure point to cause fluid movement and ii. 2. sufficient pressure across the gradient to move fluid from distal to proximal. The compression used must not create a tourniquet effect at any point. b. The garment may be prefabricated or custom-fabricated but must provide adequate graduated compression starting with a minimum of 30 mmHg distally c. Medications as appropriate (e.g. diuretics and/or other treatment of congestive failure, etc.) d. Regular exercise e. Elevation of the limb f. Appropriate wound care for the ulcer
Coverage Requirements:	• Lymphedema extending onto the chest, trunk and/or abdomen A. The only time that a segmented, calibrated gradient pneumatic compression device could be covered is when the participant has unique characteristics that prevent them from receiving satisfactory pneumatic compression treatment using a non-segmented device in conjunction with a segmented appliance or a segmented compression device without manual control of pressure in each chamber. 1. A PCD is covered for the treatment of lymphedema extending onto the chest, trunk and/or abdomen when all the following are met: a. The participant has lymphedema of an extremity b. The participant has lymphedema extending onto the chest, trunk and/or abdomen that extends past the limits of a standard compression sleeve, and the chest, trunk and/or abdominal lymphedema has failed to improve with a four-week trial. 2. The four-week trial of conservative therapy must include all the following: a. Daily, multiple-hour home usage of the pneumatic compressor, non-segmented home model or segmental home

	model after careful, in person fitting, training and supervision by a skilled technician b. Compliant use of an appropriate compression bandage system or compression garment to provide adequate graduated compression c. Manual lymphatic drainage and self-manual lymphatic drainage for at least 30 minutes per day d. Evaluation of diet and implementation of any necessary change e. Medications as appropriate (e.g. diuretics and/or other treatment of congestive failure, etc.) f. Correction (where possible) of anemia and/or hypoproteinemia
Other Documentation Required:	N/A
Additional Information:	N/A

Item Description:	Power Mobility Devices (PMD)
Coverage Requirements:	• PMD include power operated vehicles (POVs) and power wheelchairs (PWCs). The following are the criteria for power mobility devices (PMD) and push-rim activated power assist device: <u>Basic Coverage Criteria</u>: • All of the following basic criteria must be met for a power operated vehicles, power wheelchairs or push-rim activated power assist device. Additional coverage criteria for specific devices are listed under each item: A. The participant has a mobility limitation that significantly impairs their ability to participate in one or more mobility-related activities of daily living (MRADLs) such as toileting, feeding, dressing, grooming, and bathing in customary locations in the home. 1. A mobility limitation is one that: a. Prevents the participant from accomplishing an MRADL entirely. b. Places the participant at reasonably determined heightened risk of morbidity or mortality secondary to the attempts to perform an MRADL. c. Prevents the participant from completing an MRADL within a reasonable time frame. d. The participant's mobility limitation cannot be sufficiently and safely resolved using an appropriately fitted cane or walker. e. The participant does not have sufficient upper extremity function to self-propel an optimally-configured manual wheelchair in the home to perform MRADLs during a typical day. <u>Power operated Vehicles (POV)</u> • Covered if all the basic coverage criteria indicated above have been met and if criteria below have been met. A. The participant can: 1. Safely transfer to and from a POV 2. Operate the tiller steering system 3. Maintain postural stability and position while operating the POV in the home. 4. The participant's mental capabilities (e.g., cognition, judgment) and physical capabilities (e.g., vision) are sufficient for safe mobility using a POV in the home. 5. The participant's home provides adequate access between rooms, maneuvering space, and surfaces for the operation of the POV that is provided. 6. The participant's weight is less than or equal to the weight capacity of the POV that is provided and greater than or equal to 95% of the weight capacity of the next lower weight class POV.

7. Use of a POV will significantly improve the participant's ability to participate in MRADLs and the participant will use it in the home.
8. The participant has not expressed an unwillingness to use a POV in the home.

<u>Power Wheelchairs</u>

- Covered if the following are met:

A. All the basic coverage criteria indicated initially above is met; and

1. The participant does not meet coverage criterion for a POV
2. The participant has the mental and physical capabilities to safely operate the power wheelchair that is provided
3. If the participant is unable to safely operate the power wheelchair, the participant has a caregiver who is unable to adequately propel an optimally configured manual wheelchair, but is available, willing, and able to safely operate the power wheelchair that is provided
4. The participant's weight is less than or equal to the weight capacity of the power wheelchair that is provided and greater than or equal to 95% of the weight capacity of the next lower weight class.
5. The participant's home provides adequate access between rooms, maneuvering space, and surfaces for the operation of the power wheelchair that is provided.
6. Use of a power wheelchair will significantly improve the participant's ability to participate in MRADLs and the participant will use it in the home. For participants with severe cognitive and/or physical impairments, participation in MRADLs may require the assistance of a caregiver.
7. The participant has not expressed an unwillingness to use a power wheelchair in the home.

- A Group 2 Single Power Option PWC is covered if all the coverage criteria for a PWC are met and if:

A. The participant requires a drive control interface other than a hand or chin-operated standard proportional joystick or
B. The participant meets coverage criteria for a power tilt or a power recline seating system and the system is being used on the wheelchair and
C. The participant has had a specialty evaluation that was performed by a licensed/certified medical professional and
D. The wheelchair is provided by a supplier that employs a RESNA-certified Assistive Technology Professional

- A Group 2 Multiple Power Option PWC is covered if all the coverage criteria for a PWC are met an if:

A. The participant meets coverage criteria for a power tilt and recline seating system and the system is being used on the wheelchair or

B. The participant uses a ventilator which is mounted on the wheelchair and

	C. The participant has had a specialty evaluation that was performed by a licensed/certified medical professional and D. The wheelchair is provided by a supplier that employs a RESNA-certified Assistive Technology Professional • A Group 3 PWC with no power options is covered if: A. All the coverage criteria for a PWC are met; and 1. The participant's mobility limitation is due to a neurological condition, myopathy, or congenital skeletal deformity; and 2. The participant has had a specialty evaluation that was performed by a licensed/certified medical professional and 3. The wheelchair is provided by a supplier that employs a RESNA-certified Assistive Technology Professional • A Group 3 PWC with Single Power Option or with Multiple Power Options is covered if: A. The Group 3 criteria A are met; and 1. The Group 2 Single Power Option criteria or Multiple Power Options criteria are met. • Group 5 (Pediatric) PWC with Single Power Option or with Multiple Power Options is covered if: A. All the coverage criteria for a PWC are met; and 1. The participant is expected to grow in height; and 2. The Group 2 Single Power Option or Multiple Power Options criteria are met.
Other Documentation Required:	• Idaho Medicaid Seating and Mobility Form-must be completed by a physical or occupational therapist. Wheelchair rentals needed for less than three months do not require a physical therapist or an occupational therapist evaluation if the need is self-limiting (e.g., fractured femur). The physician or physical therapist must document why a cane, crutches, or walker will not meet the participant's medical needs. Additional months may require a physical therapist's or occupational therapist's evaluation. • Supporting information regarding the medical necessity for each HCPCS being requested for a prior authorization • MSRP/Invoice pricing information for all non-priced items on the most recent Idaho Fee Schedule

Item Description:	Pressure Reducing Support Surfaces – Group 2
Coverage Requirements:	• A group 2 support surface is covered if the participant meets at least one of the listed criteria of the following criteria: A. The participant has multiple stage II pressure ulcers located on the trunk or pelvis which have failed to improve over the past month, during which time the participant has been on a comprehensive ulcer treatment program including each of the following: 1. Use of an appropriate group 1 support surface, and 2. Regular assessment by a nurse, physician, or other licensed healthcare practitioner, and 3. Appropriate turning and positioning, and 4. Appropriate wound care, and 5. Appropriate management of moisture/incontinence, and 6. Nutritional assessment and intervention consistent with the plan of care B. The participant has large or multiple stage III or IV pressure ulcer(s) on the trunk or pelvis. C. Participant had a myocutaneous flap or skin graft for a pressure ulcer on the trunk or pelvis within the past 60 days and has been on a group 2 or 3 support surface immediately prior to discharge from a hospital or nursing facility within the past 30 days. • Continued use of a group 2 support surface is covered until the ulcer is healed, or if healing does not continue, there is documentation in the medical record to show that: A. Other aspects of the care plan are being modified to promote healing, or B. The use of the group 2 support surface is reasonable and necessary for wound management.
Other Documentation Required:	• If the participant is on a group 2 surface, there should be a care plan established by the physician or nurse which includes the above elements and provided with request. • Currently wound measurements are required with renewal requests.
Additional Information:	• When a group 2 surface is covered following a myocutaneous flap or skin graft, coverage generally is limited to 60 days from the date of surgery.

Item Description:	Pressure Reducing Support Surfaces – Group 3
Coverage Requirements:	• An air-fluidized bed is covered only if all the following criteria are met: A. The participant has a stage III (full thickness tissue loss) or stage IV (deep tissue destruction) pressure ulcer. B. The participant is bedridden or chair bound because of severely limited mobility. C. In the absence of an air-fluidized mattress, the participant would require institutionalization. D. The air-fluidized mattress is ordered in writing by the participant's physician based upon comprehensive assessment of the participant after completion of a course of conservative treatment designed to optimize conditions that promote wound healing. The evaluation generally must be performed within one month prior to initiation of therapy with the air-fluidized mattress. E. The course of conservative treatment must have been at least one month in duration without progression toward wound healing. This month of prerequisite conservative treatment may include some period in an institution rendered. Conservative treatment must include: 1. Frequent repositioning of the participant with attention to relief of pressure over bony prominences (usually every 2 hours); and 2. Use of a Group 2 support surface to reduce pressure and shear forces on healing ulcers and to prevent new ulcer formation; and 3. Necessary treatment to resolve any wound infection; and 4. Optimization of nutrition status to promote wound healing; and 5. Debridement by any means, including wet-to-dry gauze dressings, to remove devitalized tissue from the wound bed; and 6. Maintenance of a clean, moist bed of granulation tissue with appropriate moist dressings protected by an occlusive covering, while the wound heals. • Continued use of an air fluidized mattress may be covered until the ulcer is healed or, if healing does not continue, there is documentation to show that: A. Other aspects of the care plan are being modified to promote healing, or B. The use of the bed is reasonable and necessary for wound management.
Other Documentation Required:	• The continued coverage of an air-fluidized mattress as reasonable and necessary must be documented by the treating physician every month.
Additional information:	Conservative treatment should include: A. Education of the participant and caregiver on the prevention and management of pressure ulcers; and

	B. Assessment by a physician, nurse, or other licensed healthcare practitioner at least weekly, and C. Appropriate management of moisture/incontinence.

Item Description:	Prosthetic Devices
Coverage Requirements:	• Many prosthetic devices do not require a PA for initial order. Check the Idaho Fee Schedule and the participants eligibility for that service item to look at the limitations set by the Department. Below are the criteria used generally for prosthetic devices over the limitation. • Coverage allowed if the following are met: A. Ordered by a physician; and B. Participant is evaluated for their individual needs by a healthcare professional with the qualifications and training and under the supervision of the ordering physician to make an evaluation (documentation should accompany the order); and C. Ordering physician signs the final prosthetic proposal; and D. The records must document the participant's current functional capabilities and their expected functional rehabilitation potential, including an explanation for the difference, if that is the case and E. Prosthetic will help participant regain or maintain function; and F. Participant is willing and able to participate in the training for the use of the prosthetic and G. Participant can physically function at a level necessary for valuable use of the prosthetic device. • Accessories: A. Covered when they aid in, or are essential to, the effective use of the artificial limb.
Other Documentation Required:	All modifications to the prosthetic or orthotic device must be supported by the attending physician's description on the prescription. A. A request for a replacement prosthesis or orthotic device must be justified to be the least costly alternative as opposed to repairing or modifying the current prosthesis or orthotic device; B. The treating physician and/or the prosthetist, based upon the functional needs of the participant, must decide the type of prosthesis dependent on the participant's functional level. Documentation must be provided to the Department at the time of the request to support the functional level of the participant. C. All prosthetic and orthotic devices that require fitting must be provided by an individual who is certified or registered by the American Board for Certification in Orthotics and/or Prosthetics D. MSRP or Invoice

Additional information:	• Prosthetic limbs purchased by the Department must be guaranteed to fit properly for three (3) months from the date of service; therefore, any modifications, adjustments, or replacements within the three (3) months are the responsibility of the provider that supplied the item at no additional cost to the Department or the participant. • No replacement will be allowed for prosthetic or orthotic devices within sixty (60) months of the date of purchase except in cases where there is clear documentation that there has been major physical change to the residual limb and ordered by the attending physician. • Refitting, repairs or additional parts must be limited to once per calendar year for all prosthetics and/or orthotics unless it has been documented that a major-medical change has occurred to the limb and ordered by the attending physician. • All refitting, repairs or alterations require preauthorization based on medical justification by the participant's attending physician • Prosthetic and orthotic devices provided for cosmetic or convenience purposes are not covered by the Department. • Electronically powered or enhanced prosthetic devices are not covered.

Item Description:	Respiratory Assist Devices (RAD)- for Adults
Coverage Requirements:	• Central Sleep Apnea or Complex Sleep Apnea (E0470 or E0471) Must meet all the criteria A and B below after a complete facility-based, attended PSG is performed documenting the following: A. The diagnosis of CSA or CompSA; and B. Significant improvement of the sleep-associated hypoventilation with the use of an E0470 or E0471 device on the settings that will be prescribed for initial use at home, while breathing the beneficiary's prescribed FIO2. • Either an E0470 or E0471 for Central Sleep Apnea or Complex Sleep Apnea (based on the judgment of the treating physician) is covered if the criteria is met.
Coverage Requirements:	• Severe COPD (E0470) Must meet all criteria A-C below: A. An arterial blood gas PaCO2, done while awake and breathing the beneficiary's prescribed FIO2, is greater than or equal to 52 mm Hg. B. Sleep oximetry demonstrates oxygen saturation less than or equal to 88% for greater than or equal to a cumulative 5 minutes of nocturnal recording time (minimum recording time of 2 hours), done while breathing oxygen at 2 LPM or the beneficiary's prescribed FIO2 (whichever is higher). C. Prior to initiating therapy, sleep apnea and treatment with a continuous positive airway pressure device (CPAP) has been considered and ruled out. (Note: Formal sleep testing is not required if there is sufficient information in the medical record to demonstrate that the beneficiary does not suffer from some form of sleep apnea (Obstructive Sleep Apnea (OSA), CSA and/or CompSA) as the predominant cause of awake hypercapnia or nocturnal arterial oxygen desaturation). • Severe COPD (E0471) Depending on the test performed to demonstrate the need, the E0471 may be covered in either scenario 1 or 2 below: 1. Participants who qualified for an E0470 can have an E0471 started any time after a period of initial use of the E0470 if both criteria A and B are met below: A. An arterial blood gas PaCO2, done while awake and breathing the beneficiary's prescribed FIO2, shows that the beneficiary's PaCO2 worsens greater than or equal to 7 mm HG compared to the original result from criterion A, for E0470 criteria above.

	B. A facility-based PSG demonstrates oxygen saturation less than or equal to 88% for greater than or equal to a cumulative 5 minutes of nocturnal recording time (minimum recording time of 2 hours) while using an E0470 device that is not caused by obstructive upper airway events – i.e., AHI less than 5. 2. Participants who qualified for an E0470 can receive coverage for an E0471 if, at a time no sooner than 61 days after the initial issue of the E0470 when criteria is met for A and B below: A. An arterial blood gas PaCO2 is done while awake and breathing the beneficiary's prescribed FIO2, still remains greater than or equal to 52 mm Hg. B. Sleep oximetry while breathing with the E0470 device, demonstrates oxygen saturation less than or equal to 88% for greater than or equal to a cumulative 5 minutes of nocturnal recording time (minimum recording time of 2 hours), done while breathing oxygen at 2 LPM or the beneficiary's prescribed FIO2 (whichever is higher).
Coverage Requirements:	• Restrictive Thoracic Disorders (E0470 or E0471) Must meet all criteria A-C below: A. There is documentation in the beneficiary's medical record of a neuromuscular disease (for example, amyotrophic lateral sclerosis) or a severe thoracic cage abnormality (for example, post-thoracoplasty for TB). B. One of the following: 1. An arterial blood gas PaCO2, done while awake and breathing the beneficiary's prescribed FIO2 is greater than or equal to 45 mm Hg, or 2. Sleep oximetry demonstrates oxygen saturation less than or equal to 88% for greater than or equal to 5 minutes of nocturnal recording time (minimum recording time of 2 hours), done while breathing the beneficiary's prescribed recommended FIO2, or 3. For a neuromuscular disease (only), either i or ii, i. Maximal inspiratory pressure is less than 60 cm H20, or ii. Forced vital capacity is less than 50% predicted C. Chronic obstructive pulmonary disease does not contribute significantly to the beneficiary's pulmonary limitation. • If criteria is met, either an E0470 or E0471 for Restrictive Disorders (based on the judgment of the treating physician) is covered.
Coverage Requirements:	• Hypoventilation Syndrome (E0470) Must meet criteria A and B and either C or D below:

	A. An initial arterial blood gas PaCO2, done while awake and breathing the beneficiary's prescribed FIO2, is greater than or equal to 45 mm Hg B. Spirometry shows an FEV1/FVC greater than or equal to 70%. (Refer to SEVERE COPD (above) for information about device coverage for beneficiaries with FEV1/FVC less than 70%.) C. An arterial blood gas PaCO2, done during sleep or immediately upon awakening, and breathing the beneficiary's prescribed FIO2, shows the beneficiary's PaCO2 worsened greater than or equal to 7 mm HG compared to the original result in criterion A (above). D. A facility-based PSG or HST demonstrates oxygen saturation less than or equal to 88% for greater than or equal to 5 minutes of nocturnal recording time (minimum recording time of 2 hours) that is not caused by obstructive upper airway events (OSA) – i.e., AHI less than 5. • Hypoventilation Syndrome (E0471) Must meet criteria A and B and either C or D below: A. A covered E0470 device is being used. B. Spirometry shows an FEV1/FVC greater than or equal to 70%. (Refer to SEVERE COPD (above) for information about device coverage for beneficiaries with FEV1/FVC less than 70%). C. An arterial blood gas PaCO2, done while awake, and breathing the beneficiary's prescribed FIO2, shows that the beneficiary's PaCO2 worsens greater than or equal to 7 mm HG compared to the ABG result performed to qualify the beneficiary for the E0470 device (criterion A under E0470). D. A facility-based PSG or HST demonstrates oxygen saturation less than or equal 88% for greater than or equal to 5 minutes of nocturnal recording time (minimum recording time of 2 hours) that is not caused by obstructive upper airway events (OSA) – i.e., AHI less than 5 while using an E0470 device.
Additional Information for all the above	• An E0471 is not covered if the primary diagnosis is OSA. • Initial authorization for E0470 or E0471 is for 3 months. • Continued authorization for E0470 or E0471 after the 3-month initial trial period requires documentation demonstrating an average of 4 hours per 24-hour period by the time of re-evaluation (on or after 61 days after initiation of therapy) and progress notes that the participant is benefiting from the use of the device. • PAP machines are not automatically replaced every 5 years. The device will need to be evaluated by a trained medical device professional, a Respiratory Therapist or a certified technician. Documentation must be submitted with the PA request from the evaluator indicating why the current machine does not meet the medical needs of the participant, what the malfunction is, and if the device is repairable. Also, if a new machine is requested the Supplier must include why it is more cost effective to issue a new machine rather than repairing the current machine.

Item Description:	Respiratory Assist Devices (RAD) -Pediatrics

Coverage Requirements:	• Complex Sleep Apnea (E0470 or E0471)
	  • Must meet the criteria below:
	  A. Under 21 years of age with an AHI ≥1 and
	  B. Be actively under PAP treatment during PSG.
	  C. Obstructive apneas are resolved by treatment.
	  D. Central apneas and hypopneas must account for more than 50% of AHI during therapy.
	  • Either an E0470 or E0471 for Central Sleep Apnea (based on the judgment of the treating physician) is covered if the criteria is met.

Coverage Requirements:	• Restrictive Thoracic Disorder (E0470 or E0471)
	  • Must meet the following criteria:
	  A. Documentation of neuromuscular disease or severe thoracic cage abnormality.
	  B. While on FIO_2: An arterial $PaCO_2$ greater than 45 mmHg; Sleep oximetry with oxygen saturation <88% for 5 minutes or more; or a neuromuscular disease with maximal inspiratory pressure <60 cm H20 or forced vital capacity is <50%.
	  • Either an E0470 or E0471 for Central Sleep Apnea (based on the judgment of the treating physician) is covered if the criteria is met.

Coverage Requirements:	• Central Sleep Apnea (E0470 or E0471)
	  • Must meet the criteria below:
	  A. Under 21 years of age, AHI ≥1 and
	  B. Central apneas and hypopneas must account for more than 50% of AHI.
	  C. One of these symptoms: Sleepiness; Awaking short of breath; Snoring; Witnessed apneas; Difficulty initiating or maintaining sleep.
	  D. No evidence of daytime or nocturnal hypoventilation.

	• Either an E0470 or E0471 for Central Sleep Apnea (based on the judgment of the treating physician) is covered if the criteria is met.
Coverage Requirements:	• Hypoventilation Syndrome
	• RAD, bi-level pressure capability *without* back-up rate feature (E0470) • Must meet the following criteria: A. While awake on FIO2 have an arterial PaCO2 greater than 45 mmHg. B. Spirometry shows an FEV1/FVC greater than or equal to 70% • RAD, bi-level pressure capability *with* back-up rate feature (E0471) • Must meet the above criteria and the following criteria: A. While asleep on FIO_2 have an arterial $PaCO_2$ change greater than 7 mmHg compared to results from initial criteria or B. PSG shows oxygen saturation <88% for 5+ minutes that is not caused by obstructive apneas with AHI <5 and C. RAD, bi-level pressure capability without back-up rate feature fails to improve symptoms.
Other Documentation Required:	• Continued use of a RAD device beyond the initial 3-month authorization period is considered medically necessary if the treating physician documents that the participant is benefiting from RAD therapy. Documentation of clinical benefit is demonstrated by: A. Face-to-face clinical reevaluation by the treating physician with documentation that symptoms are improved; and B. Objective evidence of 30 day download from the device showing usage of 80 hours. C. Documentation must address corrective measures if adherence to therapy is not achieved.
Additional Information	• PAP machines are not automatically replaced every 5 years. The device will need to be evaluated by a trained medical device professional, a Respiratory Therapist or a certified technician. Documentation must be submitted with the PA request from the evaluator indicating why the current machine does not meet the medical needs of the participant, what the malfunction is, and if the device is repairable. Also, if a new machine is requested the Supplier must include why it is more cost effective to issue a new machine rather than repairing the current machine.

Item Description:	Roll About
Coverage Requirements:	• Below-the-knee injuries/conditions if the participant meets criteria for a standard walker, crutch or cane, but is unable to use one of those devices due to other impairments
Other Documentation Required:	• Documentation from the physician and/or the physical therapist of why the participant is not able to use a cane, crutches or walker to meet in the home ADL's
Additional information:	• We also take into consideration recent surgeries, accident related injury, pregnancy, lack of upper body strength, and impairment of another limb. • Rental item only-not intended to be used as a long term medical device or solution. • These will not be approved due to convenience matters. There must be a medically driven related matter that this device attempts to address.

Item Description:	Speech Generating Devices – Designated
Coverage Requirements:	• A designated speech generating device (SGD) is covered when all the following criteria are met: A. Prior to the delivery of the SGD, the participant has had a formal evaluation of their cognitive and communication abilities by a speech-language pathologist (SLP). The formal, written evaluation must include, at a minimum, the following elements: B. Current communication impairment, including the type, severity, language skills, cognitive ability, and anticipated course of the impairment; C. An assessment of whether the participant's daily communication needs could be met using other natural modes of communication; D. A description of the functional communication goals expected to be achieved and treatment options; E. Rationale for selection of a specific device and any accessories; F. Demonstration that the participant possesses a treatment plan that includes a training schedule for the selected device; G. The cognitive and physical abilities to effectively use the selected device and any accessories to communicate; H. For a subsequent upgrade to a previously issued SGD, information regarding the functional benefit to the participant of the upgrade compared to the initially provided SGD; and I. The participant’s medical condition is one resulting in a severe expressive speech impairment; and J. The participant’s speaking needs cannot be met using natural communication methods; and K. Other forms of treatment have been considered and ruled out; and L. The participant’s speech impairment will benefit from the device ordered; and M. Formal training plan that has been constructed for the individual participant once requested service is ready to be utilized; and

	N. A copy of the SLP's written evaluation and recommendation have been forwarded to the participant's treating physician prior to ordering the device; and O. The SLP performing the participant evaluation may not be an employee of or have a financial relationship with the supplier of the SGD. P. Documentation of all SGD devices trialed. • Minimum of three SGD trials from at least two different vendors. • Trial length of 1 week to 1 month for each device that may meet the participant's communication needs • The amount of time the participant used the device each week • Documentation that the parents and participant have tried the device in the participant's home.
Other Documentation Required:	• MSRP information for all requested items that require manual pricing • Idaho DME request form and Idaho Speech Generating Device Supplemental Form
Additional information:	• IDAPA 16.03.09.755.02 Least Costly Limitation. When multiple features, models or brands of equipment or supplies are available, coverage will be limited to the least costly version that will reasonably and effectively meet the minimum requirements of the individual's medical needs • iPads/Commercial phones are not considered speech generating devices or DME. They are not available as a DMEPOS covered service under state plan. • The Department will allow the authorization of 1 SGD and its applicable accessories for a one time purchase every 5 years. If the SGD or the applicable accessories are lost, stolen, damaged, or broken, the responsibility for repairs is left to the participant.

Item Description:	Standing Frame-Pediatrics
Coverage Requirements:	• Idaho Medicaid does not cover standing frames for adults • The use of a standing frame is considered medically necessary for pediatric participants with: A. Spastic quadriplegia and other neuromuscular conditions who have impaired ability to stand, but once standing can maintain this position due to residual strength in the hips, legs and lower body. B. Must be medically necessary and the least costly means of meeting the participant's medical need.
Other Documentation Required:	• Physical therapist's recommendation on how a standing frame will assist with the following: A. Stretching of heel cords. B. Prevention of hip dislocation. C. Improvement of bone density. D. Weight bearing to enhance muscle development. E. Transition to standing/help with transfers. • Letter of medical necessity indicating other least costly equipment tried and why it would not meet the participant's standing needs. • MSRP or invoice
Additional information:	• The use of standing frame is not considered medically necessary for participants with complete paralysis of the hips and legs as there is insufficient clinical literature to support medical necessity. • Standers have not proven value for the prevention or treatment of contracture. • The individual standing frame accessories have no specific criteria. They are reviewed on a case-by-case basis to determine the medical justification and the least costly option to meet that medical need.

Item Description:	Transcutaneous Electric Nerve Stimulators (TENS)
Coverage Requirements:	• Covered for acute post-operative pain. Coverage is limited to 30 days from the day of surgery. • Chronic Pain Other than Low Back Pain when all the following criteria below is met: A. The presumed etiology of the pain must be a type that is accepted as responding to TENS therapy. B. The pain must have been present for at least three months C. Other appropriate treatment modalities must have been tried and failed • Chronic Low Back Pain only when all the following criteria are met: A. The participant has one of the diagnosis codes listed in the ICD-10 Codes that Support Medical Necessity section captured in Nordian Medicare LCD Jurisdiction D Manual. B. The participant is enrolled in an approved clinical study that meets all the requirements set outlined in NCD §160.27 (CMS Internet Only Manual 100-03, Chapter 1).
Coverage Requirements:	• A conductive garment used with a TENS unit is rarely reasonable and necessary, but is covered only if all the following conditions are met: A. It has been prescribed by the treating physician for use in delivering covered TENS treatment B. One of the medical indications outlined below is met: 1. The participant cannot manage without the conductive garment because a. There is such a large area or so many sites to be stimulated and the stimulation would have to be delivered so frequently that it is not feasible to use conventional electrodes, adhesive tapes, and lead wires 2. The participant cannot manage without the conductive garment for the treatment of chronic intractable pain because a. the areas or sites to be stimulated are inaccessible with the use of conventional electrodes, adhesive tapes, and lead wires 3. The participant has a documented medical condition, such as skin problems, that preclude the application of conventional electrodes, adhesive tapes, and lead wires 4. The participant requires electrical stimulation beneath a cast to treat chronic intractable pain.

	• A conductive garment is not covered for use with a TENS device during the trial period unless: A. The participant has a documented skin problem prior to the start of the trial period; and the TENS is reasonable and necessary for the participant.
Other Documentation Required:	• Documentation must support justification and other modalities that may have been tried and failed
Additional Information:	• Rental only item-usually authorized for a two- month trial • Continuous Passive Motion Device Pads are included in the cost of the rental. • For coverage of a purchase after the rental period, the physician must determine that the beneficiary is likely to derive significant therapeutic benefit from continuous use of the unit over a long period of time. • A TENS unit will be denied as not reasonable and necessary for acute pain (less than three months' duration) other than for post-operative pain. • Examples of conditions for which TENS therapy is not considered to be reasonable and necessary are (not all-inclusive): A. Headache B. Visceral abdominal pain C. Pelvic pain D. Temporomandibular joint (TMJ) pain • Electrodes are two units per month • Lead Wires: only allowed for replacement if inoperative and not under warranty. A max of one/year is allowed.

Item Description:	Ventilator
Coverage Requirements:	Initial Approval: • Ventilators are considered medically necessary for participants with diagnosis of one of the following: A. Conditions of COPD, polio, amyotrophic lateral sclerosis, myasthenia gravis, muscular dystrophy, emphysema, bronchitis, musculoskeletal disorders, phrenic nerve damage, spinal cord injuries, multiple sclerosis, congenital trauma, or osteogenesis imperfecta. • Current physician's order • Current medical documentation supporting medical necessity for ventilator use B. Ventilators will only be authorized if CPAP or Bi-PAP has been proven ineffective or is not appropriate for the participant's medical condition.
Other Documentation Required:	• Documentation must clearly demonstrate how a CPAP or Bi-PAP has been ineffective or is not appropriate for the participants' medical condition. Ventilator renewals require the following: • Current physician's order including ventilator settings. • Download reports for the last 90 days. • Current progress notes. • Documentation of changes in medical status and/or hospitalizations over the last 6 to 12 months.
Additional information:	• If the participant does not have a tracheostomy, the authorization will only be for 6 months. • If the participant has a tracheostomy, the authorization may be up to 12 months. • The Department does not authorize rentals for secondary ventilators. • Ventilators containing modes which allow the ventilator to function as another machine (i.e., secretion clearance or HFCWO) are considered one device and will not be authorized as separate items.

Item Description:	Ventilator- Pediatric for Obstructive Sleep Apnea (OSA)
Coverage Requirements:	• Must meet the following criteria for initial approval: A. Participant has had a face-to face clinical evaluation by the treating physician prior to the sleep test. B. Current physician's order with ventilator settings C. Medical records with documented diagnosis of OSA (G47.33). D. Current polysomnography for OSA (G47.33). E. Polysomnography demonstrates apnea-hypopnea index (AHI) equal to or greater than 1 for children under 21 years of age. F. The FDA rules recommend the type of ventilator for small children based on their weight are indicated below: Over 66 pounds the participant may be placed on any home PAP device - rent or purchase as appropriate Participants 30-65 pounds may be placed on a: • VPAP, rent or purchase as appropriate or • VPAP ST-A, rent or purchase as appropriate • These are home PAP devices which have alarms. • Participants under 11-30 pounds or need invasive ventilation, may be placed on a home ventilator. These ventilators are rental only. • Children who are 3 years and older who are in need of a ventilator for CPAP use should have an adenoidtonsillectomy.
Additional information:	• When children who are on a ventilator for OSA have reached over the weight limit, they will need to be switched from a ventilator rental to a purchased PAP machine based on the weight listed above. A PA request must be submitted for this change to occur. In addition, if the child is 3 years or older, they should also have an adenoidtonsillectomy. Ventilator renewals Required documentation: 1. Current physician's order including ventilator settings. 2. Download reports for the last 90 days. 3. Current progress notes. 4. Participant's current weight 5. Documentation of changes in medical status and/or hospitalizations over the last 6 to 12 months.

	• If the participant does not have a tracheostomy, the authorization will only be for 6 months. • If the participant has a tracheostomy, the authorization may be up to 12 months. • The Department does not authorize rentals for secondary ventilators.

Item Description:	Wheelchair-Accessories
Coverage Requirements:	• Power Tilt or Recline Seating System • <u>Tilt only, recline only, or combination tilt and recline – with or without power elevating leg rests will be covered if:</u> A. The participant meets all the coverage criteria for a power wheelchair and 1. A specialty evaluation that was performed by a licensed/certified medical professional (PT, OT or physician) with specific training and experience in rehabilitation wheelchair evaluations participant's seating and positioning needs. The evaluator may have no financial relationship with the supplier; and 2. The wheelchair is provided by a supplier that employs a RESNA-certified Assistive Technology ATP who specializes in wheelchairs and who has direct, in-person involvement in the wheelchair selection for the participant. B. One of the following must also be met: 1. The participant is at high risk for development of a pressure ulcer and is unable to perform a functional weight shift; or 2. The participant utilizes intermittent catheterization for bladder management and is unable to independently transfer from the wheelchair to bed; or 3. The power seating system is needed to manage increased tone or spasticity. • <u>Manual Fully Reclining Back</u> A. The participant is at high risk for development of a pressure ulcer and is unable to perform a functional weight shift; or B. The participant utilizes intermittent catheterization for bladder management and is unable to independently transfer from the wheelchair to the bed. • <u>Arm Trough</u> A. Quadriplegia, hemiplegia, or uncontrolled arm movements. • <u>Elevating Leg rests</u> A. Has a musculoskeletal condition or the presence of a cast or brace which prevents 90-degree flexion at the knee; or B. Has significant edema of the lower extremities that requires an elevating leg rest; or C. Meets the criteria for and has a reclining back on the wheelchair.

	• Gear Reduction Drive Wheel A. Has been self-propelling in a manual wheelchair for at least one year; and B. Has had a specialty evaluation that was performed by a licensed/certified medical professional, such as a PT or OT, or physician who has specific training and experience in rehabilitation wheelchair evaluations and that documents the need for the device in the participant's home; and C. The wheelchair is provided by a supplier that employs a RESNA-certified ATP who specializes in wheelchairs and who has direct, in-person involvement in the wheelchair selection for the participant. • Skin Protection Cushions A. if current pressure ulcer or history of an ulcer, absent B. or impaired sensation in the area that contacts the seating surface and inability to carry out functional weight shift. • Anti-rollback device A. Participant propels self and needs device because of ramps • Safely belts/pelvic straps A. Allowed if weak upper muscles, upper body instability or B. Muscle spasticity requiring this device for positioning
Other Documentation Required:	• Idaho Medicaid Seating and Mobility Evaluation- must be completed by a physical or occupational therapist. Wheelchair rentals needed for less than three months do not require a physical therapist or an occupational therapist evaluation if the need is self-limiting (e.g., fractured femur). The physician or physical therapist must document why a cane, crutches, or walker will not meet the participant's medical needs. Additional months may require a physical therapist's or occupational therapist's evaluation. • Pricing information for all items that do not have a price on the most recent Idaho Medicaid Fee Schedule • Documented justification for each HCPCS code being requested for an authorization
Additional information:	• Vehicle modifications to accommodate a wheelchair are non-covered/no exceptions as they are not addressing a medical condition nor are they constituted as Durable Medical Equipment • Cane/Crutch Holder-non-covered and not medically necessary • A power seat elevation feature and power standing feature are non-covered because they are not primarily medical in nature.

	• If an attendant control is provided in addition to a participant-operated drive control system, it will be denied as non-covered. • Options that allow the participant to perform leisure or recreational activities are non-covered/ no exceptions
Item Description:	Wheel Chair Power Seat Elevation - Pediatric
Coverage requirements:	• A power seat elevation system may be prior authorized to promote independence in a participant who meets all of the following criteria: A. Must meet power wheelchair coverage criteria; and B. Unable to independently stand or pivot transfer; and C. Limited reach and range of motion that prohibits the ability to perform MRADL's independently; and D. Requires assistance only with transfers across unequal seat heights; and E. Cannot safely transfer using a lift or standing transfer, but can safely transfer independently with the seat elevation feature; and F. A child under 21 years of age.
Other Documentation Required:	• A completed evaluation must be signed and dated by a physician, or a licensed occupational or physical therapist specifying the current level of function without the Power Seat Elevation, how the device will improve function & how it will increase independence, a list of MRADL's that the participant will be able to perform with the device and the duration of time the participant is alone without assistance daily. • Physician's order • MSRP or invoice documentation
Additional information:	• A power seat elevation system will not be authorized for caregiver convenience, or when requested solely for the purpose of socializing with peers, or if the device does not allow the participant to be independent with MRADLs and transfers. • The evaluation must be completed by a licensed/certified medical professional, such as a physical therapist (PT) or occupational therapist (OT) or physician who has specific training and experience in rehabilitation wheelchair evaluations of the participant's seating and positioning needs. The PT, OT, or physician may have no financial relationship with the supplier.

Item Description:	Wheelchair-Manual (Adult)
Coverage Requirements:	• A manual wheelchair for use inside the home (adults only) is covered if : A. The participant has a mobility limitation that significantly impairs his/her ability to participate in one or more mobility-related activities of daily living in customary locations in the home. A mobility limitation is one that: B. Prevents the participant from accomplishing an MRADL entirely, or C. Places the participant at reasonably determined heightened risk of morbidity or mortality secondary to the attempts to perform an MRADL; or D. Prevents the participant from completing an MRADL within a reasonable time frame. E. The participant's mobility limitation cannot be sufficiently resolved with a cane or walker. F. Participant's home provides adequate access between rooms, maneuvering space, and surfaces for use of the manual wheelchair that is provided. G. Use of a manual wheelchair will significantly improve the participant's ability to participate in MRADLs and the participant will use it on a regular basis in the home. H. The participant has not expressed an unwillingness to use the manual wheelchair that is provided in the home. • In addition, one of the following criteria must be met: A. The participant has sufficient upper extremity function and other physical and mental capabilities needed to safely self-propel the manual wheelchair that is provided in the home during a typical day. Limitations of strength, endurance, range of motion, or coordination, presence of pain, or deformity or absence of one or both upper extremities are relevant to the assessment of upper extremity function or; B. The participant has a caregiver who is available, willing, and able to aid with the wheelchair. C. A high strength lightweight wheelchair is covered when a participant self-propels the wheelchair while engaging in frequent activities in the home that cannot be performed in a standard or lightweight wheelchair and 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.

	D. A lightweight wheelchair is covered when a participant cannot self-propel in a standard wheelchair in the home; and can and does self-propel in a lightweight wheelchair. • An ultra-lightweight manual wheelchair is covered for a participant if the following are met: A. The participant must be a full-time manual wheelchair user or; B. The participant 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. C. The participant must have a specialty evaluation that was performed by a licensed/certified medical professional, PT or OT, or physician who has specific training and experience in rehabilitation wheelchair evaluations and; D. The wheelchair is provided by a Rehabilitative Technology Supplier (ATP). • A heavy-duty wheelchair is covered if the participant weighs more than 250 pounds or has severe spasticity. • An extra heavy-duty wheelchair is covered if the participant weighs more than 300 pounds. • A standard hemi-wheelchair is covered when the participant requires a lower seat height to place feet on the ground for propulsion. • A manual wheelchair with tilt in space is covered if the participant meets the general manual wheelchair coverage criteria, specialty evaluation completed by PT, OT or physician, the wheelchair is provided by ATP and there is significant documentation of spinal cord impairments, inability to shift or recline to relieve pressure, or inability to tolerate full up right positions.
Additional Information	• All Pediatric wheelchairs are reviewed under EPSDT per IDAPA 16.03.09.880-883.
Other Documentation Required:	• Idaho Medicaid Seating and Evaluation Form (Not applicable for Standard Wheelchair requests only) • Supporting documentation for the medical necessity of each HCPCS code being requested for authorization

Item Description:	Medical Adaptive Stroller- Pediatric
Coverage Requirements:	• A medical grade adaptive stroller may be covered in lieu of a wheelchair if the following are met: A. The participant must weigh 30 pounds or more. B. Participant must exhibit one or more of the following medical condition(s): - Significant head or trunk instability, and /or weakness - Congenital or neurological condition, - Myopathy, or - Skeletal deformity C. The participant does not have complex seating and positioning needs. D. Participant is not capable of independently propelling a pediatric wheelchair. The primary use/need is for mobility. E. Participant spends less than 2 hours per day in the adaptive stroller. F. The participant is not expected to be ambulatory within one year of the request date or is not expected to need a wheelchair within five years of the request date. G. Documentation must address why the participant is unable to ambulate a minimum of 10 feet due to a medical condition, or if able to ambulate further, why an adaptive stroller and not a wheelchair is required to meet the participant's needs. H. Documentation must support the participant's condition, stature, weight, and positioning needs. I. The participant does not already own another seating system, including, but not limited to a standard, custom or power wheelchair. J. There must be documentation and supportive clinical evidence provided as to why a non-medical stroller will not meet the participant's needs. K. The stroller must have a firm back and seat, or insert. L. The adaptive stroller must accommodate growth with modification for three to five years. The adaptive stroller must have the ability to be modified for changes in the participant's medical need for postural support and/or function. M. Documentation of the ability of the family to manage the device- position child, propel device, transport, get into home and store/use in the home.
Other Documentation Required:	• Completed Idaho Seating & Mobility Evaluation Form • Letter of medical necessity addressing all adaptive stroller components requiring prior authorization. • Current pricing documentation. • Documentation of least costly option.
Additional information	• One adaptive stroller will be authorized per a period of at least 5 years. Requests for strollers must reasonably be expected to meet the medical needs of the participant for at least 5 years-this must be supported in the documentation. Significant changes in medical conditions will be reviewed on a case by case basis-if less than 5 yrs. • Non-medical grade strollers are not covered. • Medical adaptive strollers are not covered for children who are able to ambulate greater than 10 feet, for safety, behavioral issues or recreational use.

	• If the participant can or is anticipated to self-propel in a manual wheelchair, an adaptive stroller will not be approved. • Medical adaptive strollers for travel, recreation or convenience reasons are not covered.