DURABLE MEDICAL EQUIPMENT, MEDICAL SUPPLIES, AND NUTRITIONAL PRODUCTS

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1 General Information

The information in this handbook is intended for Texas Medicaid durable medical equipment (DME) supplier and medical supply company providers. This handbook provides information about the Texas Medicaid benefits, policies, and procedures that are applicable to these providers.

This handbook contains information about Texas Medicaid fee-for-service benefits. For information about managed care benefits, refer to the Texas Medicaid Managed Care Handbook.

Managed care carve-out services are administered as fee-for-service benefits. A list of all carve-out services is available in Section 9, “* Carve-Out Services” in the Medicaid Managed Care Handbook (Vol. 2, Provider Handbooks).

All providers are required to report suspected child abuse or neglect as outlined in subsection 1.6.1.2, “Reporting Child Abuse or Neglect” in Section 1, “Provider Enrollment and Responsibilities” (Vol I, General Information).

Important: All providers are required to read and comply with Section 1: Provider Enrollment and Responsibilities. In addition to required compliance with all requirements specific to Texas Medicaid, it is a violation of Texas Medicaid rules when a provider fails to provide health care services or items to Medicaid clients in accordance with accepted medical community standards and standards that govern occupations, as explained in 1 Texas Administrative Code (TAC) §371.1659. Accordingly, in addition to being subject to sanctions for failure to comply with the requirements that are specific to Texas Medicaid, providers can also be subject to Texas Medicaid sanctions for failure, at all times, to deliver health-care items and services to Medicaid clients in full accordance with all applicable licensure and certification requirements including, without limitation, those related to documentation and record maintenance.

Refer to: Section 1: Provider Enrollment and Responsibilities (Vol. I, General Information) for more information about enrollment procedures.

1.1 Payment Window Reimbursement Guidelines for Services Preceding an Inpatient Admission

According to the three-day and one-day payment window reimbursement guidelines, most professional and outpatient diagnostic and nondiagnostic services that are rendered within the designated timeframe of an inpatient hospital stay, and are related to the inpatient hospital admission, will not be reimbursed separately from the inpatient hospital stay if the services are rendered by the hospital or an entity that is wholly owned or operated by the hospital.

These reimbursement guidelines do not apply in the following circumstances:

- The professional services are rendered in the inpatient hospital setting.
- The hospital and the physician office or other entity are both owned by a third party, such as a health system.
- The hospital is not the sole or 100-percent owner of the entity.

Refer to: Subsection 3.7.3.8, “Payment Window Reimbursement Guidelines” in the Inpatient and Outpatient Hospital Services Handbook (Vol. 2, Provider Handbooks) for additional information about the payment window reimbursement guidelines.
2 Texas Medicaid (Title XIX) Home Health Services

2.1 Enrollment
All DME providers must be Medicare-certified before applying for enrollment in Texas Medicaid.

Providers that render custom DME wheeled mobility systems to Texas Medicaid clients must enroll in Texas Medicaid as a specialized/custom wheeled mobility group provider and must have at least one qualified rehabilitation professional (QRP) performing provider.

Certified QRP providers must enroll in Texas Medicaid as performing providers under DME provider groups.

To enroll in Texas Medicaid as a QRP performing provider, individual professionals must be certified by the National Registry of Rehabilitation Technology Suppliers (NRRTS) or Rehabilitation Engineering and Assistive Technology Society of North America (RESNA) and must enroll as a performing provider under a Specialized /Custom Wheeled Mobility group.

Providers may download the Texas Medicaid Provider Enrollment Application at www.tmhp.com or request a paper application form by contacting Texas Medicaid & Healthcare Partnership (TMHP) directly at 1-800-925-9126.

Providers may also obtain the paper enrollment application by writing to the following address:

Texas Medicaid & Healthcare Partnership
Provider Enrollment
PO Box 200795
Austin, TX 78720-0795
1-800-925-9126
Fax: 1-512-514-4214

Providers may request prior authorization for home health services by contacting:

Texas Medicaid & Healthcare Partnership
Home Health Services
PO Box 202977
Austin, TX 78720-2977
1-800-925-8957
Fax: 1-512-514-4209

2.1.1 Pending Agency Certification
DME providers that submit claims before the enrollment process is complete or without prior authorization for services issued by the TMHP Home Health Services Prior Authorization Department will not be reimbursed. The effective date of enrollment is the date on which all Medicaid provider enrollment forms have been received and approved by TMHP.

Upon the receipt of notice of Medicaid enrollment, the supplier must contact the TMHP Home Health Services Prior Authorization Department before rendering to a Medicaid client, services that require a prior authorization number. Prior authorization cannot be issued before Medicaid enrollment has been completed. Regular prior authorization procedures are followed at that time.

Providers must not submit home health services claims for payment until they have received their Medicaid certification and a prior authorization number has been assigned.

Refer to: Subsection 2.1.1, “Clinical Laboratory Improvement Amendments (CLIA)” in the Radiology and Laboratory Services Handbook (Vol. 2, Provider Handbooks).
2.1.2 **Surety Bond Requirements**

All newly enrolling and re-enrolling durable medical equipment (DME) providers must, as a condition of enrollment and continued participation into Texas Medicaid, obtain a surety bond that complies with Title 1, Texas Administrative Code (TAC) §352.15.

**Important:** Surety bonds obtained for the purpose of accreditation in the Medicare program, which lists the Centers for Medicare & Medicaid Services (CMS) as obligee, do not fulfill the surety bond requirement for Texas Medicaid.

The surety bond submitted to Texas Medicaid must meet the following requirements:

- A bond in an amount of no less than $50,000 must be provided for each enrolled location.

  **Note:** Only one surety bond is required if the provider has multiple Medicaid DME provider numbers related to the same location. For example, if the provider has a TPI with a suffix for DME and a second suffix for Specialized Custom Wheeled Mobility all for the same practice location, only one surety bond is required.

- The bond must be submitted on the State of Texas Medicaid Provider Surety Bond Form. No other form will be accepted. The use of this form designates the Health and Human Services Commission (HHSC) as the sole obligee of the bond. Instructions are included with the form.

- The bond must be issued for a term of 12 months. Bonds for longer or shorter terms are not acceptable.

- The bond must be in effect on the date that the provider enrollment application is submitted to TMHP for consideration. The effective date stated on the bond must be:
  - No later than the date that the provider enrollment application is submitted.
  - No earlier than 12 months before the date that the provider enrollment application is submitted.

- The bond must be a continuous bond. A continuous bond remains in full force and effect from term to term unless the bond is canceled.

**Important:** An annual bond that specifies effective and expiration dates for the bond, is not acceptable.

At the time of enrollment or re-enrollment, providers must submit the surety bond form with original signatures and a copy of the Power of Attorney document from the surety company that issued the bond.

**Note:** Surety companies may refer to Texas Department of Insurance (TDI) file #9212562912 or TDI link #132456 when filing the bond.

2.1.2.1 **Proof of Continuation**

DME providers must maintain a current surety bond to continue participation in Texas Medicaid. Each year, providers must submit documentation that shows proof of continuation of the bond for a new 12-month term. The document may be submitted on the surety bond company’s form and must include the following components:

- Bond number
- Principal’s name, address, and Tax ID or Medicaid provider number (Texas Provider Identifier)
- Surety’s company name and address
- Date of the original bond
- New “good through” date
To avoid losing Medicaid enrollment status, providers must submit the proof of continuation to the TMHP Provider Enrollment before the expiration date of the bond that is currently on file. The completed proof of continuation document must include the original signatures of the authorized corporate representative of the DME provider (principal), and the attorney-in-fact of the surety company. Providers may submit a copy of the proof of continuation (i.e., scan, FAX, photocopy) pending the submission of the original document.

**Submission Information**

The surety bond must be submitted to the TMHP Provider Enrollment Department at the following address:

Texas Medicaid & Health Partnership  
ATTN: Provider Enrollment  
PO Box 200795  
Austin, TX 78720-0795  
Fax: 1-512-514-4214

2.2 **Services, Benefits, Limitations and Prior Authorization**

Home health services include home health skilled nursing (SN), home health aide (HHA), physical therapy (PT) and occupational therapy (OT) services; DME; and expendable medical supplies that are provided to eligible Medicaid clients at their place of residence.

**Note:** THSteps-eligible clients who qualify for medically necessary services beyond the limits of this Home Health Services benefit may receive those services through CCP.

**Refer to:** Subsection 5.1.1, “Overview” in the Children’s Services Handbook (Vol. 2, Provider Handbooks) for more information on clients who are birth through 20 years of age.  
The Physical Therapy, Occupational Therapy, and Speech Therapy Services Handbook (Vol. 2, Provider Handbooks) for more information about therapy services.  
The Home Health Nursing and Private Duty Nursing Services Handbook (Vol. 2, Provider Handbooks) for more information about nursing services.

2.2.1 **Home Health Services**

The benefit period for home health professional services is up to 60 days with a current plan of care (POC). For all DME and medical supplies with or without prior authorization requirements, providers must complete a Home Health Services (Title XIX) Durable Medical Equipment (DME)/Medical Supplies Physician Order Form except as outlined in subsection 2.2.11 of this handbook. In chronic and stable situations, the Home Health Services (Title XIX) Durable Medical Equipment (DME)/Medical Supplies Physician Order Form is valid for up to, but no more than, 6 months from the date of the physician’s signature on the form, unless otherwise noted in this handbook. If necessary, DME and supplies that are ordered on a Home Health Services (Title XIX) Durable Medical Equipment (DME)/Medical Supplies Physician Order Form may be prior authorized for up to 6 months with medical necessity determination. Because Medicaid clients have a one-month eligibility period, providers must bill for a one month supply at a time, even though prior authorization may be granted for up to 6 months. This extended prior authorization period begins on the date that clients receive their first prior-authorized home health service. Texas Medicaid allows additional DME or supplies that have been determined to be medically necessary and have been prior authorized by TMHP Home Health Services Prior Authorization Department. Providers must retain all orders, signed and dated Title XIX forms, delivery slips, and corresponding invoices for all supplies provided to a client and must disclose them to HHSC or its designee on request. These records and claims must be retained for a minimum of five years from the date of service (DOS) or until audit questions, appeals, hearings, investigations, or court cases are resolved. Use of these services is subject to retrospective review.
2.2.1.1 Client Eligibility

Home health clients do not have to be homebound to qualify for services.

To qualify for home health services, the Medicaid client must be eligible on the DOS and must:

- Have a medical need for home health professional services, DME, or supplies that is documented in the client’s POC and considered a benefit under home health services.
- Receive services that meet the client’s existing medical needs and can be safely provided in the client’s home.
- Receive prior authorization from TMHP for most home health professional services, DME, and medical supplies.

Unless otherwise noted in this handbook, certain DME/supplies may be obtained without prior authorization although providers must retain a Home Health Services (Title XIX) Durable Medical Equipment (DME)/Medical Supplies Physician Order Form that has been reviewed, signed, and dated by the treating physician for these clients.

Refer to: “Automated Inquiry System (AIS)” in “State, Federal, and TMHP Contact Information” (Vol. 1, General Information).

Section 6: Claims Filing in the Children’s Services Handbook (Vol. 2, Provider Handbooks) for more information on clients who are 20 years of age and younger.

2.2.1.2 Prior Authorization Requests for Clients with Retroactive Eligibility

Retroactive eligibility occurs when the effective date of a client’s Medicaid coverage is before the date on which the client’s Medicaid eligibility is added to TMHP’s eligibility file, which is called the “add date.”

For clients with retroactive eligibility, prior authorization requests must be submitted after the client’s add date and before a claim is submitted to TMHP.

For services provided to fee-for-service Medicaid clients during the client’s retroactive eligibility period (i.e., the period from the effective date to the add date), prior authorization must be obtained within 95 days of the client’s add date and before a claim for those services is submitted to TMHP. For services provided on or after the client’s add date, the provider must obtain prior authorization within three business days of the date of service.

The provider is responsible for verifying eligibility. The provider is strongly encouraged to access AIS or TexMedConnect to verify eligibility frequently while providing services to the client. If services are discontinued before the client’s add date, the provider must still obtain prior authorization within 95 days of the add date to be able to submit claims.

Refer to: Section 4: Client Eligibility (Vol. 1, General Information).

2.2.1.3 Prior Authorization

Prior authorization must be obtained for some supplies and most DME from TMHP within three business days of the DOS. Although providers may supply some DME and medical supplies to a client without prior authorization, they must still retain a copy of the Home Health Services (Title XIX) Durable Medical Equipment (DME)/Medical Supplies Physician Order Form that has Section B completed, signed, and dated by the client’s attending physician, unless otherwise noted in this handbook.

The following prior authorization requests can be submitted on the TMHP website at www.tmhp.com:

- External Insulin Pump
- Home Health Services (Title XIX) Durable Medical Equipment (DME)/Medical Supplies Physician Order Form
- Home Health Services POC
• Medicaid Certificate of Medical Necessity for CPAP/BiPAP or Oxygen Therapy
• Medicaid Certificate of Necessity for Chest Physiotherapy Device Form—Initial Request
• Medicaid Certificate of Necessity for Chest Physiotherapy Device Form—Extended Request
• Statement for Initial Wound Therapy System In-Home Use
• Statement for Recertification of Wound Therapy System In-Home Use
• Wheelchair/Scooter/Stroller Seating Assessment Form (CCP/Home Health Services) (Attachments will be sent separately due to size and detailed information)

Refer to: Subsection 5.5.1, “Prior Authorization Requests Through the TMHP Website” in Section 5, “Prior Authorization” (Vol. 1, General Information) for more information, including mandatory documentation requirements.

If a client’s primary coverage is private insurance and Medicaid is secondary, prior authorization is required for Medicaid reimbursement. If the primary coverage is Medicare, Medicare approves the service, and Medicaid is secondary, prior authorization is not required. TMHP will pay only the coinsurance or deductible according to current payment guidelines. If Medicare denied the service, then Medicaid prior authorization is required. TMHP must receive a prior authorization request within 30 days of the date of Medicare’s final disposition. The Medicare Remittance Advice Notice (MRAN) containing Medicare’s final disposition must accompany the prior authorization request. If the service is a Medicaid-only service, prior authorization is required within three business days of the DOS. The provider is responsible for determining whether eligibility is effective by using AIS, TexMedConnect, or an electronic eligibility inquiry through the TMHP EDI gateway.

The provider must contact the TMHP Home Health Services Prior Authorization Department within three business days of the DOS to obtain prior authorization for DME and medical supplies.

If inadequate or incomplete information is provided or medical necessity is lacking, the provider will be asked to furnish any required or additional documentation so that a decision about the request can be made. Because the documentation must often be obtained from the client’s physician, providers have two weeks to submit the requested documentation. If the additional documentation is received within the two-week period, prior authorization can be considered for the original date of contact. If the additional documentation is received more than two weeks after the request for the documentation, prior authorization is not considered before the date on which the additional documentation is received. It is the DME supplier’s responsibility to contact the physician to obtain the requested additional documentation. The physician must maintain documentation of medical necessity in the client’s record.

TMHP Home Health Services toll-free number is 1-800-925-8957.

Refer to: Subsection 2.2.2, “Prior Authorization” in this handbook for DME prior authorization information.

Subsection 2.3.1, “Medicaid Relationship to Medicare” in this handbook.

Client eligibility for Medicaid is for one month at a time. Providers should verify their client’s eligibility every month. Prior authorization does not guarantee payment.

2.2.2 Durable Medical Equipment (DME) and Supplies

Texas Medicaid defines DME as:

*Medical equipment or appliances that are manufactured to withstand repeated use, ordered by a physician for use in the home, and required to correct or ameliorate a client’s disability, condition, or illness.*
Since there is no single authority, such as a federal agency, that confers the official status of “DME” on any device or product, HHSC retains the right to make such determinations with regard to DME benefits of Texas Medicaid. DME benefits of Texas Medicaid must have either a well-established history of efficacy or, in the case of novel or unique equipment, valid, peer-reviewed evidence that the equipment corrects or ameliorates a covered medical condition or functional disability.

Requested DME may be a benefit when it meets the Medicaid definition of DME. The majority of DME and expendable supplies are covered home health services. If a service cannot be provided for a client who is 20 years of age or younger through home health services, these services may be covered through CCP if they are determined to be medically necessary.

To be reimbursed as a home health benefit:

- The client must be eligible for home health benefits.
- The criteria listed for the requested equipment or supply must be met.
- The requested equipment or supply must be medically necessary, and Federal Financial Participation (FFP) must be available.
- The client’s health status would be compromised without the requested equipment or supply.
- The requested equipment or supplies must be safe for use in the home.
- The client must be seen by a physician within one year of the DOS.

The provider must sign and have the client sign DME Certification and Receipt Form on the TMHP website at www.tmhp.com for all purchased DME for Medicaid clients before submitting a claim for payment. The client’s signature means the DME is the property of the client. The certification form must include the date the client received the DME, the name of the item, and the printed names and signatures of the provider and the client or primary caregiver. This form must be maintained by the DME provider in the client’s record.

The signed and dated DME Certification and Receipt Form must be submitted to TMHP for claims and appeals for DME that meet or exceed a billed amount of $2,500.00. The form must also be submitted when multiple items that meet or exceed a total billed amount of $2,500.00 are billed for the same DOS. The form is required in addition to obtaining prior authorization, when applicable.

If the DME Certification and Receipt Form is not submitted to TMHP, the claim payment or appeal will be reviewed and will be eligible for recoupment. Incomplete forms will be returned to the provider for correction and resubmission.

TMHP will contact clients that received DME that meets or exceeds a billed amount of $2,500.00 to verify that services were rendered. If the delivery of the equipment cannot be verified by the client, the claim payment will be eligible for recoupment.

The provider must keep all Home Health Services (Title XIX) Durable Medical Equipment (DME)/Medical Supplies Physician Order Forms and Addendum to Home Health Services (Title XIX) DME/Medical Supplies Physician Order Forms on file. Providers must retain delivery slips or corresponding invoices and the signed and dated DME Certification and Receipt Form documenting the item and date of delivery for all DME provided to a client and must disclose them to HHSC or its designee on request.

- The DME must be used for medical or therapeutic purposes, and supplied through an enrolled DME provider in compliance with the client’s POC.
• These records and claims must be retained for a minimum of five years from the DOS or until audit questions, appeals, hearings, investigations, or court cases are resolved. Use of these services is subject to retrospective review.

**Note:** All purchased equipment must be new upon delivery to client. Used equipment may be utilized for lease, but when purchased, must be replaced with new equipment.

HHSC/TMHP reserves the right to request the Home Health Services (Title XIX) Durable Medical Equipment (DME)/Medical Supplies Physician Order Form or Addendum to Home Health Services (Title XIX) DME/Medical Supplies Physician Order Form at any time.

DME must meet the following requirements to qualify for reimbursement under Home Health Services:

• The client received the equipment as prescribed by the physician.
• The equipment has been properly fitted to the client or meets the client’s needs.
• The client, the parent or guardian of the client, or the primary caregiver of the client, has received training and instruction regarding the equipment’s proper use and maintenance.

DME must:

• Be medically necessary due to illness or injury or to improve the functioning of a body part, as documented by the physician in the client’s POC or the Home Health Services (Title XIX) Durable Medical Equipment (DME)/Medical Supplies Physician Order Form.
• Be prior authorized by the TMHP Home Health Services Prior Authorization Department for rental or purchase of most equipment. Some equipment does not require prior authorization. Prior authorization for equipment rental can be issued for up to six months based on diagnosis and medical necessity. If an extension is needed, requests can be made up to 60 days before the start of the new prior authorization period with a new Home Health Services (Title XIX) Durable Medical Equipment (DME)/Medical Supplies Physician Order Form.
• Meet the client’s existing medical and treatment needs.
• Be considered safe for use in the home.
• Be provided through an enrolled DME provider or supplier.

**Note:** Texas Health Steps (THSteps)-eligible clients who qualify for medically necessary services beyond the limits of this home health benefit will receive those services through CCP.

DME that has been delivered to the client’s home and then found to be inappropriate for the client’s condition will not be eligible for an upgrade within the first six months following purchase unless there has been a significant change in the client’s condition, as documented by the physician familiar with the client. All adjustments and modifications within the first six months after delivery are considered part of the purchase price.

All DME purchased for a client becomes the Medicaid client’s property upon receipt of the item. This property includes equipment delivered which will not be prior authorized or reimbursed in the following instances:

• Equipment delivered to the client before the physician signature date on the Home Health Services (Title XIX) Durable Medical Equipment (DME)/Medical Supplies Physician Order Form or Addendum to Home Health Services (Title XIX) DME/Medical Supplies Physician Order Form.
• Equipment delivered more than three business days before obtaining prior authorization from the TMHP Home Health Services Prior Authorization Department and meets the criteria for purchase.
Additional criteria:

- A determination as to whether the equipment will be rented, purchased, replaced, repaired, or modified will be made by HHSC or its designee based on the client’s needs, duration of use, and age of the equipment.

- Periodic rental payments are made only for the lesser of either the period of time the equipment is medically necessary, or when the total monthly rental payments equal the reasonable purchase cost for the equipment.

- Purchase is justified when the estimated duration of need multiplied by the rental payments would exceed the reasonable purchase cost of the equipment or it is otherwise more practical to purchase the equipment.

- If a DME/medical supply provider is unable to deliver a prior authorized piece of equipment or supply, the provider should allow the client the option of obtaining the equipment or supplies from another provider.

Items or services are reimbursed at the lesser of:

- The provider’s billed charges

- The published fee determined by HHSC

- Manual pricing as determined by HHSC based on one of the following:
  - The manufacturer’s suggested retail price (MSRP) less 18 percent
  - The provider’s documented invoice cost

If an item is manually priced, providers must submit documentation of one of the following for consideration of purchase or rental with the appropriate procedure codes:

- The MSRP or average wholesale price (AWP), whichever is applicable

- The provider’s documented invoice cost

2.2.2.1 Modifications, Adjustments, and Repairs

Modifications are the replacement of components because of changes in the client’s condition, not replacement because the component is no longer functioning as designed. All modifications and adjustments within the first six months after delivery are considered part of the purchase price.

Modifications to custom equipment may be prior authorized should a change occur in the client’s needs, capabilities, or physical and mental status which cannot be anticipated.

Documentation must include the following:

- All projected changes in the client’s mobility needs

- The date of purchase, and serial number of the current equipment

- The cost of purchasing new equipment versus modifying the current equipment

All modifications within the first six months after delivery are considered part of the purchase price.

Adjustments do not require supplies. Adjustments made within the first six months after delivery will not be prior authorized. Adjustments made within the first six months after delivery are considered part of the purchase price. A maximum of one hour of labor for adjustments may be prior authorized as needed after the first six months following delivery.

Repairs to client-owned equipment may be prior authorized as needed with documentation of medical necessity. Technician fees are considered part of the cost of the repair. Repairs require the replacement of components that are no longer functional. Providers are responsible for maintaining documentation in the client’s medical record specifying the repairs and supporting medical necessity.
A DME repair will be considered based on the age of the item and cost to repair it.

A request for repair of DME must include a statement or medical information from the attending physician substantiating that the medical appliance or equipment continues to serve a specific medical purpose and an itemized estimated cost list from the vendor or DME provider of the repairs. Rental equipment may be provided to replace purchased medical equipment for the period of time it will take to make necessary repairs to purchased medical equipment.

Repairs will not be prior authorized in situations where the equipment has been abused or neglected by the client, client’s family, or caregiver. Routine maintenance of rental equipment is the provider’s responsibility. For clients requiring wheelchair repairs only, the date last seen by physician does not need to be filled in on the Home Health Services (Title XIX) Durable Medical Equipment (DME)/Medical Supplies Physician Order Form.

2.2.2.1.1 Accessories

Equipment accessories including, but not limited to, pressure support cushions, may be prior authorized with documentation of medical necessity.

2.2.2.2 Prior Authorization

Prior authorization is required for most DME and supplies provided through Home Health Services. These services include accessories, modifications, adjustments, and repairs for the equipment.

Providers must submit a completed Home Health Services (Title XIX) Durable Medical Equipment (DME)/Medical Supplies Physician Order Form to the TMHP Home Health Services Prior Authorization Department.

Unless otherwise noted in this handbook, a completed Home Health Services (Title XIX) Durable Medical Equipment (DME) or Medical Supplies Physician Order Form prescribing the DME or supplies must be signed and dated by a physician and by the representative of the DME/Medical Supply provider familiar with the client before requesting prior authorization for all DME equipment and supplies. A current signature and date is valid for no more than 90 days prior to the date of the requested prior authorization or the initiation of service. The completed Home Health Services (Title XIX) Durable Medical Equipment (DME)/Medical Supplies Physician Order Form must include the procedure codes and numerical quantities for services requested.

The completed, signed, and dated form must be maintained by the DME provider and the prescribing physician in the client’s medical record. The completed Home Health Services (Title XIX) Durable Medical Equipment (DME)/Medical Supplies Physician Order Form with the original dated signature must be maintained by the prescribing physician.

To complete the prior authorization process by paper, the provider must fax or mail the completed Home Health Services (Title XIX) Durable Medical Equipment (DME)/Medical Supplies Physician Order Form to the Home Health Services Prior Authorization Department and retain a copy of the signed and dated form in the client’s medical record at the provider’s place of business.

To complete the prior authorization process electronically, the provider must submit the prior authorization requirements through any approved electronic methods and retain a copy of the signed and dated Home Health Services (Title XIX) Durable Medical Equipment (DME)/Medical Supplies Physician Order Form in the client’s medical record at the provider’s place of business.

Retrospective review may be performed to ensure that the documentation included in the client’s medical record supports the medical necessity of the requested services. The date last seen by the physician must be within the past 12 months unless a physician waiver is obtained. The physician’s signature on the Home Health Services (Title XIX) Durable Medical Equipment (DME)/Medical Supplies Physician Order Form is only valid for 90 days before the initiation of services. The requesting provider may be asked for additional information to clarify or complete the request.
Providers must obtain prior authorization within three business days of providing the service by calling the TMHP Home Health Services Prior Authorization Department or faxing the Home Health Services (Title XIX) Durable Medical Equipment (DME)/Medical Supplies Physician Order Form.

To facilitate a determination of medical necessity and avoid unnecessary denials when requesting prior authorization, the physician must provide correct and complete information supporting the medical necessity of the equipment or supplies requested, including:

- Accurate diagnostic information pertaining to the underlying diagnosis or condition as well as any other medical diagnoses or conditions, to include the client’s overall health status.
- Diagnosis or condition causing the impairment resulting in a need for the equipment or supplies requested.

Purchased DME is anticipated to last a minimum of five years, unless otherwise noted, and may be considered for replacement when the time has passed or the equipment is no longer functional or repairable. A copy of the police or fire report, when appropriate, and the measures to be taken to prevent recurrence must be submitted.

Prior authorization for equipment replacement is considered within five years of equipment purchase when one of the following occurs:

- There has been a significant change in the client’s condition such that the current equipment no longer meets the client’s needs.
- The equipment is no longer functional and either cannot be repaired or it is not cost-effective to repair.

Replacement of equipment is also considered when loss or irreparable damage has occurred. The following must be submitted with the prior authorization request:

- A copy of the police or fire report, when appropriate
- A statement about the measures to be taken in order to prevent recurrence

Payment may be prior authorized for repair of purchased DME. Maintenance of rental equipment (including repairs) is the supplier’s responsibility. The toll-free number for the TMHP Home Health Services Prior Authorization Department is 1-800-925-8957. Requests for repairs must include the cost estimate, reasons for repairs, age of equipment, and serial number.

### 2.2.3 Medical Supplies

Medical supplies are benefits of the Home Health Services Program if they meet the following criteria:

- Unless otherwise noted in this handbook, the representative of the DME/medical supply provider and a physician who is familiar with the client must sign and date a completed Home Health Services (Title XIX) Durable Medical Equipment (DME)/Medical Supplies Physician Order Form that prescribes the DME or supplies before requesting prior authorization for the DME or supplies. A current signature and date is valid for no more than 90 days prior to the date of the requested prior authorization or the initiation of service. The completed Home Health Services (Title XIX) Durable Medical Equipment (DME)/Medical Supplies Physician Order Form must include the procedure codes and numerical quantities for the services requested.
- The provider must contact TMHP within three business days of providing the supplies to the client and obtain prior authorization, if required.
- The requesting provider and ordering physician must keep all Home Health Services (Title XIX) Durable Medical Equipment (DME)/Medical Supplies Physician Order Forms and Addendum to Home Health Services (Title XIX) DME/Medical Supplies Physician Order Forms on file. The physician must maintain the original signed and dated Home Health Services (Title XIX) Durable Medical Equipment (DME)/Medical Supplies Physician Order Form in their records.
• Providers must retain individual delivery slips or invoices for each DOS that documents the date of
delivery for all supplies provided to a client and must disclose them to HHSC or its designee upon
request. Documentation of delivery must include one of the following:

• Delivery slip or corresponding invoice signed and dated by client or caregiver, or

• A dated carrier tracking document with shipping date and delivery date must be printed from
the carrier’s website as confirmation that the supplies were shipped and delivered. The dated
carrier tracking document must be attached to the delivery slip or corresponding invoice.

• The dated delivery slip or invoice must include the client’s full name, the address to which supplies
were delivered, and an itemized list of goods that includes the descriptions and numerical quantities
of the supplies delivered to the client and the corresponding tracking number from the carrier. This
document could also include prices, shipping weights, shipping charges, or other descriptions.

• All claims submitted for medical supplies must include the same quantities or units that are
documented on the delivery slip or corresponding invoice and on the Home Health Services (Title
XIX) Durable Medical Equipment (DME)/Medical Supplies Physician Order Form. They must
reflect the number of units by which each product is measured. For example, diapers are measured
as individual units. If one package of 300 diapers is delivered, the delivery slip or corresponding
invoice and the claim must reflect that 300 diapers were delivered and not that one package was
delivered. Diaper wipes are measured as boxes or packages. If one box of 200 wipes is delivered, the
delivery slip or invoice and the claim must reflect that one box was delivered and not that 200
individual wipes were delivered. There must be one dated delivery slip or invoice for each claim
submitted for each client. All claims submitted for medical supplies must reflect the same date as the
delivery slip or corresponding invoice and the same timeframe covered by the Home Health
Services (Title XIX) Durable Medical Equipment (DME)/Medical Supplies Physician Order Form.
The DME Certification and Receipt Form is still required for all equipment delivered.

  Note:  These records and claims must be retained for a minimum of five years from the DOS or until
audit questions, appeals, hearings, investigations, or court cases are resolved. Use of these
services is subject to retrospective review.

• The requesting provider or ordering physician must document medical supplies as medically
necessary in the client’s POC or on a completed Home Health Services (Title XIX) Durable Medical
Equipment (DME)/Medical Supplies Physician Order Form and Addendum to Home Health
Services (Title XIX) DME/Medical Supplies Physician Order Form.

HHSC/TMHP reserves the right to request the signed and dated Home Health Services (Title XIX)
Durable Medical Equipment (DME)/Medical Supplies Physician Order Form or Addendum to Home
Health Services (Title XIX) DME/Medical Supplies Physician Order Form at any time.

  Note:  Client eligibility can change monthly. Providers are responsible for verifying eligibility before
providing supplies.

The DOS is the date on which supplies are delivered to the client or shipped by a carrier to the client as
evidenced by the dated tracking document attached to the invoice for that date. The provider must
maintain the signed and dated records supporting documentation that an item was not billed before
delivery. These records are subject to retrospective review.

  Note:  THSteps-eligible clients who qualify for medically necessary services beyond the limits of this
home health benefit will receive those services through CCP.
Refer to: Home Health Services (Title XIX) DME/Medical Supplies Physician Order Form on the TMHP website at www.tmhp.com.

Home Health Services (Title XIX) DME/Medical Supplies Physician Order Form Instructions on the TMHP website at www.tmhp.com.

Subsection 2.6, “Durable Medical Equipment (DME) Supplier (CCP)” in the Children’s Services Handbook (Vol. 2, Provider Handbooks) for specific information about certain DME and medical supplies.

Subsection 2.2.1.1, “Client Eligibility” in this handbook.

2.2.3.1 Supply Procedure Codes

When submitting supplies on the CMS-1500 claim form, itemize the supplies, including quantities, and also provide the Healthcare Common Procedure Coding System (HCPCS) national procedure codes.

Refer to: Subsection 6.3.3, “Procedure Coding” in Section 6, “Claims Filing” (Vol. 1, General Information) for more information about HCPCS procedure codes.

2.2.3.2 Prior Authorization

TMHP must prior authorize most medical supplies. They must be used for medical or therapeutic purposes, and supplied through an enrolled DME provider in compliance with the client’s POC.

Some medical supplies may be obtained without prior authorization; however, the provider must retain a copy of the completed POC or Home Health Services (Title XIX) Durable Medical Equipment (DME)/Medical Supplies Physician Order Form in the client’s file. Unless otherwise noted in this handbook, a completed Home Health Services (Title XIX) Durable Medical Equipment (DME)/Medical Supplies Physician Order Form for medical supplies not requiring prior authorization may be valid for a maximum of six months, unless the physician indicates the duration of need is less. If the physician indicates the duration of need is less than six months, then a new Home Health Services (Title XIX) Durable Medical Equipment (DME)/Medical Supplies Physician Order Form is required at the end of the determined duration of need.

For a list of DME/medical supplies that do not require prior authorization, providers can refer to Subsection 2.2.25, “Procedure Codes That Do Not Require Prior Authorization” in this handbook.

Clients with ongoing needs may receive up to six months of prior authorizations for some expendable medical supplies under Home Health Services when requested on a Home Health Services (Title XIX) Durable Medical Equipment (DME)/Medical Supplies Physician Order Form. Providers may deliver medical supplies as ordered on a Home Health Services (Title XIX) Durable Medical Equipment (DME)/Medical Supplies Physician Order Form for up to six months from the date of the physician’s signature. In these instances, a review of the supplies requested by the physician familiar with the client’s condition, and a new Home Health Services (Title XIX) Durable Medical Equipment (DME)/Medical Supplies Physician Order Form is required for each new prior authorization request. Requests for prior authorization can be made up to 60 days before the start of the new prior authorization period. Professional Home Health Services prior authorization requests require a review by the physician familiar with the client’s condition and a physician signature every 60 days when requested on a POC.

Note: These records and claims must be retained for a minimum of five years from the DOS or until audit questions, appeals, hearings, investigations, or court cases are resolved. Use of these services is subject to retrospective review.

2.2.3.3 Cancelling a Prior Authorization

The client has the right to choose his DME/medical supply provider and change providers. If the client changes providers, TMHP must receive a change of provider letter with a new Home Health Services (Title XIX) Durable Medical Equipment (DME)/Medical Supplies Physician Order Form. The client must sign and date the letter, which must include the name of the previous provider and the effective
date for the change. The client is responsible for notifying the original provider of the change and the effective date. Prior authorization for the new provider can only be issued up to three business days before the date TMHP receives the change of provider letter and the new Home Health Services (Title XIX) Durable Medical Equipment (DME)/Medical Supplies Physician Order Form.

2.2.4 Augmentative Communication Device (ACD) System

An ACD system, also known as an augmentative and alternative communication (AAC) device system, allows a client with an expressive speech language disorder to electronically represent vocabulary and express thoughts or ideas in order to meet the client’s functional speech needs.

Digitized speech devices and synthesized speech devices are benefits of Texas Medicaid Title XIX Home Health Services.

A digitized speech device, sometimes referred to as a “whole message” speech output device, uses words or phrases that have been recorded by someone other than the ACD system user for playback upon command by the ACD system user.

Providers must use procedure codes E2500, E2502, E2504, and E2506 when billing for a digitized speech device.

A synthesized speech device uses technology that translates a user’s input into device-generated speech using algorithms representing linguistic rules. Users of synthesized speech ACD systems are not limited to prerecorded messages, but can independently create messages as their communication needs dictate. Some synthesized speech devices require the user to make physical contact with a keyboard, touch screen, or other display containing letters.

Providers must use procedure code E2508 when billing for a synthesized speech device.

Other synthesized devices allow for multiple methods of message formulation and multiple methods of device access. Multiple methods of message formulation must include message selection by two or more of the following methods:

- Letters
- Words
- Pictures
- Symbols

Multiple methods of access must include the capability to access the device by direct physical contact with a keyboard or touch screen and one or more of the following indirect selection techniques:

- Joystick/switches
- Head mouse
- Optical head pointer
- Light pointer
- Infrared pointer
- Scanning device
- Morse code

**Note:** ACD systems that do not meet the criteria through Title XIX Home Health Services may be considered for clients who are birth through 20 years of age under CCP.

Providers must use procedure code E2510 when billing for other synthesized speech devices.
Items included in the reimbursement for an ACD system and not reimbursed separately include, but are not limited to, the following:

- ACD
- Basic, essential software (except for software purchased specifically to enable a client-owned computer or personal digital assistant [PDA] to function as an ACD system)
- Batteries
- Battery charger
- Power supplies
- Interface cables
- Interconnects
- Sensors
- Moisture guard
- Alternating current (A/C) or other adapters
- Adequate memory to allow for system expansion within a three-year timeframe
- Access device, when necessary
- Mounting device, when necessary
- All basic operational training necessary to instruct the client and family/caregivers in the use of the ACD system
- Manufacturer’s warranty

### 2.2.4.1 ACD System Accessories

Accessories are a benefit of Texas Medicaid if the criteria for ACD system prior authorization are met and the medical necessity for each accessory is clearly documented in the speech language pathologist (SLP) evaluation.

All accessories necessary for proper use of an ACD system, including those necessary for the potential growth and expansion of the ACD system (such as a memory card), must be included in the initial prescription/Title XIX form. The following accessories for an ACD system may be covered:

- Access devices for an ACD system include, but are not limited to, devices that enable selection of letters, words, or symbols by direct or indirect selection techniques such as optical head pointers, joysticks, and ACD scanning devices.
- Gross motor access devices, such as switches and buttons, may be considered for clients with poor fine motor and head control.
- Fine motor, head control access devices, such as laser or infrared pointers, may be considered for clients with poor hand control and good head control.

Mounting systems are devices necessary to place the ACD system, switches and other access devices within the reach of the client. Mounting devices may be considered for reimbursement when used to attach an ACD system or access device to a wheelchair or table.

A request for prior authorization of a wheelchair mounting device must include the manufacturer name, model, and purchase date of the wheelchair. One additional mounting device, separate from the one included in the system, may be considered for prior authorization for the same client.

Providers must use procedure codes E2512 and E2599 when billing for ACD system accessories.
2.2.4.1.1 Carrying Case
Carrying cases may be considered for separate reimbursement with supporting documentation of medical necessity.

Providers must use procedure code E2599 and modifier U1 when billing for the carrying case. Carrying cases are limited to one every three years.

Carrying cases may be considered for prior authorization. The prior authorization request must include the make, model, and purchase date of the ACD system.

2.2.4.1.2 Nonwarranty Repairs
Nonwarranty repairs of an ACD system may be considered for prior authorization using procedure code V5336 with documentation from the manufacturer explaining why the repair is not covered by the warranty.

2.2.4.1.3 Trial Period
In order to ensure the client’s needs are met in the most cost effective manner and to ascertain the most appropriate system and access device for the client, the ACD system is prior authorized for purchase only after the client has completed a three-month trial period that includes experience with the requested system.

The ACD system for the trial period may be obtained through the rental, the school setting, or another setting determined by the licensed SLP.

In the situation where an ACD system is not available for rental and the client has recent documented experience with the requested ACD system, purchase can be considered.

A trial period is not required when replacing an existing ACD system, unless the client’s needs have changed and another ACD system or access device is being considered.

2.2.4.1.4 Rental
Prior authorization may be provided for rental during this trial period. All components necessary for use of the device, such as access devices, mounting devices, and lap trays, must be evaluated during this trial period.

2.2.4.1.5 Purchase
Purchase of an ACD system may be considered for prior authorization when all of the following ACD system criteria are met:

- The evaluation/re-evaluation includes documentation that the client has had sufficient experience with the requested ACD system through trial, rental, school, or another setting. When the SLP has confirmed the appropriateness of a specific device for the client, the trial/rental period may be cancelled.
- A Home Health Services (Title XIX) Durable Medical Equipment (DME)/Medical Supplies Physician Order Form listing the prescribed ACD system, access device, and accessories (such as a mounting device) must be completed, signed by the physician, and dated.

ACD systems, equipment, and accessories that have been purchased are anticipated to last a minimum of three years.

2.2.4.1.6 Replacement
Prior authorization for replacement may be considered within three years of purchase when one of the following occurs:

- There has been a significant change in the client’s condition such that the current device no longer meets his or her communication needs.
• The ACD system is no longer functional and either cannot be repaired or it is not cost effective to
repair.
• Three years have passed and the equipment is no longer repairable.

  Note: Replacements for clients who are birth through 20 years of age that do not meet the criteria
above may be considered through CCP.

2.2.4.1.7 Software

Computer software that enables a client’s computer or PDA to function as an ACD system may be
covered as an ACD system. Providers must use procedure code E2511 when billing for a speech gener-
ating software. Requests for ACD software may be considered for prior authorization if the software is
more cost effective than an ACD system.

If an ACD system is more cost effective than adapting the client’s computer or PDA, an ACD system
may be prior authorized instead of the ACD software.

Laptop or desktop computers, PDAs, or other devices that are not dedicated ACD systems are not a
benefit of Texas Medicaid, because they do not meet the definition of DME.

2.2.4.2 Non-Covered ACD System Items

Noncovered items that are not necessary to operate the system and are unrelated to the ACD system or
software components are not benefits of Texas Medicaid. These items include, but are not limited to:

• Printer
• Wireless Internet access devices

2.2.4.3 Prior Authorization

Prior authorization is required for ACD systems provided through Home Health Services. The prior
authorization also includes all related accessories and supplies. The physician must provide information
supporting the medical necessity of the equipment or supplies requested, including:

• Accurate diagnostic information pertaining to the underlying diagnosis or condition and any other
medical diagnoses or conditions, including the client’s overall physical and cognitive limitations.
• Diagnosis or condition causing the impairment of speech.

Prior authorization for an ACD system and accessories (rental or purchase) must be requested using the
following information:

• Medical diagnosis and how it relates to the client’s communication needs.
• Any significant medical information pertinent to ACD system use.
• Limitations of the client’s current communication abilities, systems, and devices.
• Statement as to why the prescribed ACD system is the most effective, including a comparison of
benefits using other alternatives.
• Complete description of the ACD system with all accessories, components, mounting devices, or
modifications necessary for client use (must include manufacturer’s name, model number, and
retail price).
• Documentation that the client is mentally, emotionally, and physically capable of operating the
device.
• An evaluation and assessment must be conducted by a licensed SLP in conjunction with other disci-
plines, such as physical or occupational therapies. The prescribing physician must base the
prescription on the professional evaluation and assessment.
The prior authorization request must include the specifications for the ACD system, all component accessories necessary for the proper use of the ACD, and all necessary therapies or training. It is recommended that the preliminary evaluation for an ACD system include the involvement of an occupational therapist or physical therapist to address the client’s seating/postural needs and the motor skills required to utilize the ACD system.

The prescribing physician familiar with the client must review the SLP evaluation of the client’s cognitive and language abilities and base the prescription and treatment plan on the SLP’s recommendations.

An evaluation and assessment by a licensed SLP must be signed and dated before the date on the physician’s prescription or the Title XIX form and include the following information:

- Documentation of medical necessity for an ACD system, including a formal written evaluation performed by a licensed SLP.
- Medical status or condition and medical diagnoses underlying the client’s expressive speech-language disorder that justifies the need for an ACD system.
- Current expressive speech-language disorder, including the type, severity, anticipated course, and present language skills.
- Description of the practical limitations of the client’s current aided and unaided modes of communication.
- Other forms of therapy or intervention that have been considered and ruled out.
- Rationale for the recommended ACD system and each accessory, including a statement as to why the recommended device is the most appropriate and least costly alternative for the client and how the recommended system will benefit the client.
- Documentation that the client possesses the cognitive and physical abilities to use the recommended system.
- Comprehensive description of how the ACD system will be integrated into the client’s everyday life, including home, school, or work.
- Treatment plan that includes training in the basic operation of the recommended ACD system necessary to ensure optimal use by the client (if appropriate, the client’s caregiver) and a therapy schedule for the client to gain proficiency in using the ACD system.
- Description of the client’s speech-language goals and how the recommended ACD system will assist the client in achieving these goals.
- Description of the anticipated changes, modifications, or upgrades with projected time frames of the ACD system necessary to meet the client’s short- and long-term speech-language needs.
- Identification of the assistance or support needed by, and available to, the client to use and maintain the ACD system.
- Statement that the licensed SLP is financially independent of the ACD system manufacturer/vendor.
- Speech- and language-skills assessment that includes the prognosis for speech or written communication.
- Interactional/behavioral and social abilities.
- Capabilities, including intellectual, postural, sensory (visual and auditory), and physical status.
- Motivation to communicate.
- Residential, vocational, and educational setting.
• Alternative ACD system considered with comparison of capabilities.
• Ability to meet projected communication needs, growth potential, and length of time it will meet
  the client’s needs.

2.2.5 Bath and Bathroom Equipment
Bath and bathroom equipment is DME that is included in a treatment protocol, serves as a therapeutic
agent for life and health maintenance, and is required to treat an identified medical condition. Bath and
bathroom equipment may be considered for reimbursement for those clients who have physical limita-
tions that do not allow for bathing, showering, or bathroom use without assistive equipment.

Note: THSteps-eligible clients who qualify for medically necessary services beyond the limits of this
Home Health Services benefit may be considered under CCP.

Bath seats are not considered for clients who are younger than one year of age or weighing less than 30
pounds.

Rental of equipment includes all necessary supplies, adjustments, repairs, and replacement parts.

2.2.5.1 Hand-Held Shower Wand
A hand-held shower wand with attachments may be considered for prior authorization only if the client
currently owns or meets the criteria for a bath or shower chair, tub stool or bench, or tub transfer bench.
Prior authorization of a hand-held shower wand includes all attachments and accessories. Providers
must use procedure code E1399 when billing for a hand-held shower wand. Hand-held shower wands
with attachments are limited to one every five years.

2.2.5.2 Bath Equipment
2.2.5.2.1 Bath or Shower Chairs, Tub Stool or Bench, Tub Transfer Bench
A bath or shower chair is a stationary or mobile seat with or without upper body or head support used
to support a client who is unable to stand or sit independently in the shower or tub.

Bath/shower chairs are grouped into three levels of design to assist the client based on their physical
condition and mobility status:
• Level 1 - standard bath or shower chair is defined as stationary equipment.
• Level 2 - intermediate bath or shower chair is defined as mobile equipment with or without a
  commode cut out.
• Level 3 - complex bath or shower chair is defined as custom equipment (either stationary or mobile)
  with or without a commode cut out.

A tub stool or bench is a stationary seat or bench used to support a client who is unable to stand or sit
independently in the shower or tub.

A tub transfer bench is a stationary bench that sits in the tub and extends outside the tub. It is used to
support a client who is unable to stand or sit independently in the shower or tub and allows the client to
scoot or slide over the side of the tub.

Bath or shower chairs, tub stools or benches, and tub transfers are limited to one every five years.

A custom bath or shower chair may be considered for prior authorization only if the client does not also
have any type of commode chair.

Level 1 Group
A Level 1 device may be considered if the client:
• Is either unable to stand independently or is unstable while standing, or
• Is unable to independently enter or exit the shower or tub due to limited functional use of the upper or lower extremities, and
• Maintains the ability to ambulate short distances (with or without assistive device), or
• Has a condition that is defined as a short-term disability without a concomitant long-term disability (including, but not limited to postoperative status).

Providers must use procedure code E0240 without a modifier when billing for Level 1 group bath or shower chairs.

**Level 2 Group**

A Level 2 device may be considered if the client:

• Has good upper body stability, and
• Has impaired functional ambulation, including, but not limited to, lower body paralysis, osteoarthritis, or
• Is nonambulatory.

The client must have a shower that is adapted for rolling equipment; ramps will not be prior authorized for access to showers.

Providers must use procedure code E0240 and modifier TF (Intermediate Level) when billing for Level 2 group bath or shower chairs.

**Level 3 Group**

A Level 3 device may be considered if the client requires:

• Trunk or head or neck support, or
• Positioning to accommodate conditions, including, but not limited to, spasticity, or frequent and uncontrolled seizures.

Providers must use procedure code E0240 and modifier TG (Complex/high Level) when billing for Level 3 group bath/shower chairs.

A bath or shower chair may be prior authorized for clients who meet the Level 1, 2, or 3 criteria. A Level 3 custom bath or shower chair may be prior authorized only if the client does not also have any type of commode chair. A Level 3 mobile bath or shower chair may be considered for clients who have a shower that is adapted for rolling equipment; ramps will not be prior authorized for access to showers.

A tub stool or bench may be prior authorized for clients who meet the Level 1 criteria. Providers must use procedure code E0245 when billing for a tub stool or bench.

A tub transfer bench may be considered for clients who meet the Level 1 or 2 criteria. Providers must use procedure code E0247 when billing for a tub transfer bench.

A heavy duty tub transfer bench may be considered for clients who meet the Level 1 or 2 criteria and who weigh more than 200 pounds. Providers must use procedure code E0248 when billing for a heavy duty tub transfer bench.

**2.2.5.3 Bathroom Equipment**

**2.2.5.3.1 Non-fixed Toilet Rail, Bathtub Rail Attachment, and Raised Toilet Seat**

Nonfixed toilet rails are limited to two every five years. A bathtub rail is limited to one every five years.

Raised toilet seats are limited to one every five years. Nonfixed toilet rails and bathtub rail attachments may be considered for prior authorization for a client who has decreased functional mobility and is unable to safely self-toilet or self-bathe without assistive equipment. Raised toilet seats do not require
prior authorization. Providers must use procedure code E0243 when billing for non-fixed toilet rails, procedure code E0244 when billing for raised toilet seats, and procedure code E0246 when billing for bathtub rails.

2.2.5.3.2 Toilet Seat Lifts
A toilet seat lift mechanism is designed for the top of the toilet to assist lifting the body from a sitting position to a standing position.

A toilet seat lift mechanism must be prior authorized. To qualify for prior authorization, clients must meet all the following criteria:

- The client must have severe arthritis of the hip or knee or have a severe neuromuscular disease.
- The toilet seat lift mechanism must be a part of the physician’s course of treatment and be prescribed to correct or ameliorate the client’s condition.
- Once standing, the client must have the ability to ambulate.
- The client must be completely incapable of standing up from a regular armchair or any chair in the client’s home.

The client’s difficulty or incapability of getting up from a chair is not sufficient justification for a toilet seat lift mechanism. Almost all clients who are capable of ambulating can get out of an ordinary chair if the seat height is appropriate and the chair has arms.

Prior authorization will be given for either mechanical or powered toilet assist devices, not for both. If a client already owns one or more mechanical toilet-assist devices, a powered toilet seat lift mechanism will not be prior authorized unless there has been a documented change in the client’s condition such that the client can no longer use the mechanical equipment.

Toilet seat lift mechanisms are limited to those types that operate smoothly, can be controlled by the client, and effectively assist a client in standing up and sitting down without other assistance. A toilet seat lift operated by a spring release mechanism with a sudden, catapult-like motion that jolts the client from a seated to a standing position is not a benefit of Texas Medicaid.

Providers must use procedure code E0172 when billing for a toilet seat lift mechanism. A toilet seat lift mechanism is limited to one purchase very five years.

2.2.5.3.3 Commode Chairs and Foot Rests
Commode chairs, foot rests, and replacement commode pails or pans may be considered as benefits, depending on the client’s level of need. The client must meet the criteria for the level of commode chair or foot rest requested.

A commode chair with or without a foot rest may be considered a benefit for the client who also has a stationary bath chair without a commode cutout.

Documentation must support medical necessity for a customized commode chair or the addition of attachments to a standard commode chair.

**Level 1: Stationary Commode Chair**
A Level 1 commode chair is defined as a stationary commode chair with fixed or removable attachments to support the arms.

A stationary commode chair with fixed or removable arms may be considered for prior authorization when the client has a medical condition that results in an inability to ambulate to the bathroom safely (with or without mobility aids).

Providers must use procedure code E0163 or E0165 when billing for a stationary and mobile commode chair.
Level 2: Mobile Commode Chair

A Level 2 commode chair is defined as a mobile commode chair with fixed or removable attachments to support the arms.

A mobile commode chair with fixed or removable arms may be considered for prior authorization when the following criteria are met:

• In addition to meeting the criteria for a Level 1 commode chair, the client must be on a bowel program and require a combination commode or bath chair for performing the bowel program and bathing after.

• A mobile commode chair will be considered for reimbursement with prior authorization only if the client does not also have any type of bath chair. If the client meets the criteria for a stationary bath chair, prior authorization of a stationary chair may be considered.

Level 3: Custom Commode Chair

A Level 3 commode chair is defined as a custom commode chair with all of the following characteristics:

• Is stationary or mobile

• Has fixed or removable attachments to support the arms, head, neck, or trunk.

A custom stationary or mobile commode chair with fixed or removable arms and head, neck, and/or trunk support attachments may be considered for prior authorization when the following criteria are met:

• In addition to meeting the criteria for a Level 1 or 2 commode chair, the client must have a medical condition that results in an inability to support their head, neck, or trunk without assistance.

• A mobile custom commode chair may be considered for reimbursement only if the client does not also have any type of bath chair.

Providers must use procedure code E0163 or E0165 with modifier TG when billing for a custom stationary or mobile commode chair.

Extra-wide and Heavy-Duty Commode Chair

An extra-wide, heavy-duty commode chair is defined as one with a width greater than or equal to 23 inches, and capable of supporting a client who weighs 300 pounds or more.

An extra-wide or heavy-duty commode chair may be considered for prior authorization when the client meets the criteria for a Level 1, 2, or 3 commode chair and weigh 300 pounds or more.

Providers must use procedure code E0168 and the appropriate modifiers when billing for an extra-wide or heavy-duty commode chair. Use modifier TF when billing for a mobile extra-wide, heavy-duty commode chair. Use modifier TG when billing for a custom extra-wide, heavy-duty commode chair.

Commode Chair With Integrated Seat Lift

A commode chair with integrated seat lift is designed to assist lifting the body from a sitting position to a standing position.

A commode chair with integrated seat lift mechanism for top of the commode must be prior authorized for clients who meet all the following criteria:

• The client must have severe arthritis of the hip or knee or have a severe neuromuscular disease.

• The client must be completely incapable of standing up from a regular toilet, commode, or any chair in their home.

• The commode chair with integrated seat lift must be a part of the physician’s course of treatment and be prescribed to correct or ameliorate the client’s condition.
• Once standing, the client must have the ability to ambulate independently for a short distance of no more than ten feet.

Note: The fact that a client has difficulty or is even incapable of getting up from a chair, particularly a low chair, is not sufficient justification for a seat lift mechanism. Almost all clients who are capable of ambulating can get out of an ordinary chair if the seat height is appropriate and the chair has arms.

Providers must use procedure code E0170 or E0171 when billing for a commode chair with integrated seat lift. The purchase of a commode chair with integrated seat lift is limited to one every five years.

Replacement Commode Pail or Pan
Replacement commode pails or pans are a benefit through Title XIX Home Health Services and are limited to one per year. Additional quantities may be considered for prior authorization with documentation of medical necessity.

Providers must use procedure code E0167 when billing for a commode pail or pan.

Foot Rest
A foot rest is used to support feet during use of the commode chair.

A foot rest may be considered for prior authorization if the client meets the criteria for a Level 1, 2, or 3 commode chair and the foot rest is necessary to support contractures of the lower extremities of clients who are paraplegic or quadriplegic.

Providers must use procedure code E0175 when billing for a foot rest.

2.2.5.3.4 Portable Sitz Bath
Portable sitz baths that fit over commode seats are limited to two per year for clients requiring any of the following:

• Cleaning, irrigation, or pain relief of a perianal wound.

• Relief of pain associated with the pelvic area (hemorrhoids, bladder, vaginal infections, prostate infections, herpes, testicle disorders).

• Muscle toning for bowel and bladder incontinence.

Providers must use procedure codes E0160 or E0161 when billing for portable sitz baths.

2.2.5.3.5 Bath Lifts
The purchase of a bath lift is limited to one every five years. The rental of a bath lift is limited to one per month.

The two types of bath lifts that are considered for reimbursement include:

• An outside the tub bath lift which is a portable transfer system used to move a nonambulatory client a short distance from bed or chair to bath and is designed to accommodate the smaller space. This type of lift is either hydraulic or electric and consists of a base with wheels or casters and a sling which can transfer the client in and out of the bath.

• An inside the tub bath lift is a portable transfer system used to lower and raise a nonambulatory client into and out of the bath tub. This type of lift is either hydraulic or electric and consists of a base which adheres to the tub surface using suction cups and a seat that will lower and raise the client into and out of the tub.

Providers must use procedure code E0625 with the appropriate modifier (U1, U2, or U3) if necessary when billing for a bath lift.

The bath lift must be free standing, it cannot be attached to the floor, walls, or ceiling. Home adaptation for use of medical equipment is not a benefit of Home Health Services.
A hydraulic bath lift is for a client who is unable to assist in their own transfers and is operated by the weight or pressure of a liquid.

An electric bath lift is operated by electricity and may be considered when a hydraulic lift will not meet the client’s needs.

A bath lift is not a benefit for the convenience of a caregiver.

There are four levels of bath lifts:

- Level 1 - an outside the tub bath lift (hydraulic or electric) and must accommodate a client weighing up to 300 pounds. Providers must use procedure code E0625 when billing for the purchase of a Level 1 bath lift.
- Level 2 - an in-tub bath lift (hydraulic or electric) and must accommodate a client weighing up to 300 pounds. Providers must use procedure code E0625 and the U1 modifier when billing for the purchase of a Level 2 bath lift.
- Level 3 - a bariatric lift (hydraulic or electric, out of tub type) designed to lift a client weighing greater than 300 pounds. Providers must use procedure code E0625 and the U2 modifier when billing for the purchase of a Level 3 bath lift.
- Level 4 - a bariatric lift (hydraulic or electric, in tub type) designed to lift a client weighing greater than 300 pounds. Providers must use procedure code E0625 and the U3 modifier when billing for the purchase of a Level 4 bath lift.

A bath lift may be considered for prior authorization if the client:

- Has an inability to transfer to the bathtub or shower independently using assistive devices (including, but not limited to, a cane, walker, bathtub rails).
- Requires maximum assistance by the caregiver to transfer to the bathtub or shower.
- Has bathroom and tub or shower that meets the manufacturer’s recommended depth, width, and height for safe bath lift installation and operation.

Providers must use procedure code E0621 when billing for a lift sling. The purchase of a lift sling is limited to one every five years.

The following are payable procedure codes for bath and bathroom equipment:

<table>
<thead>
<tr>
<th>Procedure Code</th>
<th>Maximum Limitation</th>
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<tbody>
<tr>
<td>E0160</td>
<td>2 per year</td>
</tr>
<tr>
<td>E0161</td>
<td>2 per year</td>
</tr>
<tr>
<td>E0163</td>
<td>1 every 5 years</td>
</tr>
<tr>
<td>E0165</td>
<td>1 every 5 years</td>
</tr>
<tr>
<td>E0167</td>
<td>1 per year</td>
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<tr>
<td>E0168</td>
<td>1 every 5 years</td>
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<tr>
<td>E0170</td>
<td>1 every 5 years</td>
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<td>E0243</td>
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</tr>
<tr>
<td>E0244</td>
<td>1 every 5 years</td>
</tr>
<tr>
<td>E0245</td>
<td>1 every 5 years</td>
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</tbody>
</table>
2.2.5.4 Prior Authorization

Except as otherwise indicated in this section, prior authorization is required for all bath and bathroom equipment and related supplies, including any accessories, modifications, adjustments, replacements and repairs to the equipment. The bath and bathroom equipment must be able to accommodate a 20 percent change in the client’s height or weight.

Bathroom and toilet lift rentals may be prior authorized during the period of repair up to a maximum of four months per lifetime per client.

Prior authorization will not be considered for modifications, adjustments, or repairs to bath or bathroom equipment delivered to a client’s home and then found to be inappropriate for the client’s condition within the first six months after delivery. This applies unless there is a significant change in the client’s condition that is documented by a physician familiar with the client.

2.2.5.5 Documentation Requirements

2.2.5.5.1 Bath and Bathroom Equipment

To request prior authorization for all bath or bathroom equipment, the following documentation must be provided:

- Accurate diagnostic information pertaining to the underlying diagnosis or condition, including the client’s overall health status, any other medical needs, developmental level, and functional mobility skills and why regular bath or bathroom equipment will not meet the client’s needs.
- The age, height, and weight of the client.
- Assessment of the client’s home to ensure the requested equipment can be safely accommodated.
- Anticipated changes in the client’s needs, including anticipated modifications or accessory needs and the growth potential of any custom shower and bath equipment.

2.2.5.5.2 Toilet Seat Lifts

In addition to the above documentation, the submitted documentation for a toilet seat lift must include an assessment completed by a physician, physical therapist, or occupational therapist that includes all of the following:

- A description of the client’s current level of function without the device
- An explanation why a nonmechanical toilet elevation device, such as toilet rails or elevated toilet seat, will not meet the client’s needs
- Documentation that identifies how the toilet seat lift mechanism will improve the client’s function
- A list of the mobility related activities of daily living (MRADLs) the client will be able to perform with the toilet seat lift mechanism that the client is unable to perform without the toilet seat lift mechanism and how the device will increase the client’s independence
- The client’s goals for use of the toilet seat lift mechanism
Supporting documentation must be kept in the client’s record that all appropriate therapeutic modalities (e.g., medication or physical therapy) have been tried and that they failed to enable the client to transfer from a chair to a standing position.

### 2.2.6 Blood Pressure Devices

Blood pressure devices are a benefit of Home Health Services when:

- The devices are medically necessary and appropriate.
- The devices are prescribed by a physician.

A manual blood pressure device requires manual cuff inflation with real-time visualization of the results displayed on the manometer and does not require prior authorization for purchase when provided for one of the diagnosis codes listed in the table below. Providers must use procedure code A4660 when billing for a manual blood pressure device.

An automated blood pressure device inflates the cuff manually or automatically, displays the blood pressure results on a small screen, and does not require prior authorization for purchase when provided for one of the diagnosis codes listed in the table below. Providers must use procedure code A4670 when billing for an automated blood pressure device.

Repair of equipment may be considered with documentation of why the equipment needs repair. Providers must use procedure code A4660 when billing for the replacement of other components or repair of equipment.

Finger cuff automated blood pressure devices and ambulatory blood pressure devices for diagnostic purposes are not a benefit of Texas Medicaid.

If the client is not eligible for home health services, blood pressure devices may be provided under CCP for clients who are 20 years of age and younger.

#### 2.2.6.1 Prior Authorization

Procedure codes A4660 and A4670 do not require prior authorization if they are billed with one of the following diagnosis codes:

<table>
<thead>
<tr>
<th>Diagnosis Codes</th>
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<tbody>
<tr>
<td>I10</td>
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<tr>
<td>I132</td>
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<tr>
<td>I169</td>
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<td>I952</td>
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<td>N013</td>
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<tr>
<td>N052</td>
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</table>
Manual and automated blood pressure devices should last at least one year and may be considered for replacement after one year has passed. If it is medically necessary to replace nonfunctional and irreparable equipment before one year has passed, providers can submit prior authorization requests with documentation of medical necessity that explains the need for the replacement.

Prior authorization is required in the following situations:

- Another blood pressure device is medically necessary within the same year. Replacement of equipment within the same year as the purchase requires prior authorization. If equipment must be replaced before the end of the anticipated lifespan, the provider must submit a copy of the police or fire report, when appropriate, and the measures that will be taken to prevent reoccurrence.

- The diagnosis code is not in the table above. If the diagnosis code is not one of those listed in the table above, providers must submit a request for the prior authorization of the initial or replacement device and must include all of the documentation necessary to support the medical necessity of the blood pressure device.

### 2.2.7 Bone Growth Stimulators

Internal and external bone growth (osteogenic) stimulators are a benefit of Texas Medicaid. Bone growth stimulators are a benefit for skeletally-mature individuals only.

Electromagnetic bone growth stimulators promote healthy bone growth and repair by low intensity electrical stimulation. Electrical stimulation is provided by implanting low-voltage electrodes within the tissue surrounding the bone (internal) or by external placement of a device that transmits low-voltage currents through the soft tissue to the bone (external).

Ultrasonic bone growth stimulators promote healthy bone growth and repair through low-intensity, pulsed ultrasound waves.

**Note:** Bone growth stimulators that do not meet criteria for coverage through Title XIX Home Health Services may be considered through Comprehensive Care Program (CCP) for clients who are birth through 20 years of age.

A noninvasive electrical bone growth stimulator (procedure codes E0747 and E0748) and noninvasive ultrasound bone growth stimulator (procedure code E0760) are benefits of Texas Medicaid for DME providers when provided in the home setting. An invasive electrical bone growth stimulator (procedure code E0749) is a benefit of Texas Medicaid for freestanding and hospital-based ambulatory surgical centers when provided in the outpatient setting.

Electrical and ultrasonic bone growth stimulator devices for the treatment of orthopedic and neurosurgical conditions are a benefit for Texas Medicaid clients when the client experiences nonunion of a fracture, requires an adjunct to spinal fusion surgery, or experiences congenital pseudoarthrosis.

Nonunion is defined as a fractured bone that fails to heal completely. Diagnosis of nonunion is established when a minimum of six months has passed since the injury and the fracture site shows no progressive signs of healing for a minimum of three months and is not complicated by a synovial pseudoarthrosis. Serial radiographs must confirm that fracture healing has ceased for three months or longer before the client begins treatment with the bone growth stimulator.
2.2.7.1 Professional Services

Procedure codes 20974, 20975, and 20979 are a benefit of Texas Medicaid and limited to one per six months. During the six-month limitation period, a subsequent fracture that meets the above criteria for a bone growth stimulator may be reimbursed after the submission of an appeal with documentation of medical necessity that demonstrates the criteria have been met.

2.2.7.2 Prior Authorization Criteria and Documentation Requirements for Bone Growth Stimulators

Procedure codes E0747, E0748, E0749, and E0760 require prior authorization. Additional bone growth stimulators may be considered for prior authorization with documentation that supports treatment of a different fracture.

A completed Home Health Services (Title XIX) DME/Medical Supplies Physician Order Form prescribing the DME or medical supplies must be signed and dated by the prescribing physician familiar with the client prior to requesting authorization. The completed Home Health Services (Title XIX) Durable Medical Equipment (DME)/Medical Supplies Physician Order Form must be maintained by the requesting provider and the prescribing physician. The original signature copy must be kept in the physician’s medical record for the client.

To avoid unnecessary authorization denials, the physician must provide correct and complete information, including documentation for medical necessity of the equipment or supplies requested. The requesting provider may be asked for additional information to clarify or complete a request for the bone growth stimulator.

Documentation that supports medical necessity for a bone growth stimulator must be maintained by the ordering physician and requesting provider in the client’s medical record and is subject to retrospective review.

2.2.7.2.1 Documentation for Noninvasive Electrical Bone Growth Stimulator

Documentation of one of the following is required for prior authorization of the external, electromagnetic bone stimulator (procedure code E0747):

- Nonunions, failed fusions, and congenital pseudarthrosis where there is no evidence of progression of healing for three or more months despite appropriate fracture care.
- Delayed unions of fractures of failed arthrodesis at high risk sites (e.g., open or segmental tibial fractures, carpal navicular fractures).

Documentation must also indicate all of the following:

- Serial radiographs have confirmed that no progressive signs of healing have occurred.
- The fractured gap is 1 cm or less.
- The individual can be adequately immobilized and is likely to comply with non-weight-bearing restrictions.

Documentation of one of the following is required for prior authorization of the external, electromagnetic bone stimulator for spinal application (procedure code E0748):

- One or more failed fusions.
- Grade II or worse spondylolisthesis.
- A multiple-level fusion with extensive bone grafting is required.
- Other risk factors for fusion failure are present, including gross obesity, degenerative osteoarthritis, severe spondylolisthesis, current smoking, previous fusion surgery, previous disc surgery, or gross instability.
2.2.7.2.2 Documentation for Invasive Electrical Bone Growth Stimulators

Documentation of one of the following is required for prior authorization of the surgically implanted bone growth stimulator (procedure code E0749):

- Nonunion of long bone fractures (i.e., clavicle, humerus, radius, ulna, femur, tibia, fibula, and metacarpal, metatarsal, carpal, and tarsal bones). Nonunion of long bone fractures is considered to exist only when serial radiographs have confirmed that fracture healing has ceased for three or more months prior to starting treatment with the bone growth stimulator. Serial radiographs must include a minimum of two sets of radiographs separated by a minimum of 90 days. Each set of radiographs must include multiple views of the fracture site.

- Failed fusion of a joint other than the spine when a minimum of three months has elapsed since the joint fusion was performed.

- Congenital pseudoarthrosis.

- An adjunct to spinal fusion surgery for patients at high risk for pseudoarthrosis due to previously failed spinal fusion at the same site.

- An adjunct to multiple-level fusion, which involves three or more vertebrae (e.g., L3-L5, L4-S1, etc).

2.2.7.2.3 Documentation for Ultrasound Bone Growth Stimulator

Documentation of the following is required for prior authorization of the external, low-intensity ultrasound bone growth stimulator device (procedure code E0760):

- Nonunion of a fracture, other than the skull or vertebrae, in a skeletally mature person, which is documented by a minimum of two sets of radiographs that were:
  - Obtained prior to starting treatment with the bone growth stimulator.
  - Separated by a minimum of 90 days.
  - Taken with multiple views of the fracture site.
  - Accompanied by a written interpretation by a physician who states that there has been no clinically significant evidence of fracture healing between the two set of radiographs.

- Evidence of all of the following:
  - The fracture is not tumor-related.
  - The fracture is not fresh (less than seven days), closed or grade I open, tibial diaphyseal fractures, or closed fractures of the distal radius (Colles fracture).

2.2.7.3 Claims Reimbursement for Professional Services

Professional claims that are submitted for bone growth stimulation (procedure codes 20974, 20975, and 20979) may be reimbursed if the claim includes documentation of one of the following:

- Documentation of medical necessity as outlined above in subsection 2.2.7.2, “Prior Authorization Criteria and Documentation Requirements for Bone Growth Stimulators”

- The corresponding bone growth stimulator device was submitted within 95 days of the date the bone growth stimulation procedure was performed.

The appropriate evaluation and management (E/M) procedure code must be billed for monitoring the effectiveness of bone growth stimulation treatment.

2.2.8 Breast Pumps

A manual or non-hospital-grade electric breast pump may be considered for purchase only with the appropriate documentation supporting medical necessity. The purchase of a breast pump is limited to one every three years. Providers must use procedure code E0602 or E0603 when billing for the purchase
of a manual or non hospital-grade electric breast pump. A hospital-grade breast pump (procedure code E0604) may be considered for rental, not purchase. Rental of a hospital-grade breast pump is not time-limited. If more than one type of breast pump is billed on the same day by the same provider, only one will be reimbursed.

The following procedure codes for replacement parts are benefits of Texas Medicaid: A4281, A4282, A4283, A4284, A4285, and A4286.

Breast pumps are also available through the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC).

2.2.8.1 Prior Authorization

Electric breast pumps, including non-hospital-grade and hospital grade, and replacement parts require prior authorization. Manual breast pumps do not require prior authorization. The replacement parts may be reimbursed if the client already owns a breast pump device (procedure code E0602 or E0603). The prior authorization request must include documentation of a client-owned device. Additional documentation such as the purchase date, serial number, and purchasing entity of the device may be required. Replacement of the breast pump will be considered when loss or irreparable damage has occurred, with a copy of the police or fire report when appropriate, and with the measures to be taken to prevent reoccurrence. Replacement will not be authorized in situations where the equipment has been abused or neglected by the client, the client’s family, or the caregiver.

2.2.9 Cochlear Implants

Cochlear implant services (procedure codes L8499, L8615, L8616, L8617, L8618, L8619, L8623, and L8624) may be reimbursed in the home setting to DME providers.

Refer to: Subsection 9.2.23, “Cochlear Implants” in the Medical and Nursing Specialists, Physicians, and Physician Assistants Handbook (Vol. 2, Provider Handbooks) for more information about cochlear implant services.

2.2.10 Continuous Passive Motion (CPM) Device

A CPM device is reimbursed on a daily basis and is limited to once per day. Reimbursement includes delivery, set-up and all supplies. Providers must use procedure code E0935 when billing for a CPM machine.

Note: THSteps-eligible clients who qualify for medically necessary services beyond the limits of this Home Health Services benefit may be considered under CCP.

2.2.10.1 Prior Authorization

A CPM device may be considered for prior authorization through Home Health Services. Reimbursement for a CPM device is considered after joint surgery, such as knee replacement, when prescribed by a physician and submitted with clinical documentation of medical necessity and appropriateness.

2.2.11 Diabetic Equipment and Supplies

Diabetic equipment and supplies are a benefit through Title XIX Home Health Services and do not require prior authorization unless otherwise specified.

Diabetic equipment and supplies may be obtained through one of the following methods:

- A Home Health Services (Title XIX) Durable Medical Equipment (DME)/Medical Supplies Physician Order Form prescribing the DME or medical supplies. The Title XIX Form must be signed and dated by the prescribing physician who is familiar with the client prior to supplying any medical equipment or supplies.
- A verbal or a detailed written order provided by a physician, physician assistant (PA), nurse practitioner (NP), clinical nurse specialist (CNS), or a certified nurse midwife (CNM).
2.2.11.1 Obtaining Equipment and Supplies Through a Title XIX Form

The completed Title XIX Form must be maintained by the dispensing provider and the prescribing physician in the client’s medical record. The physician must maintain the original signed and dated copy of the Title XIX Form. The completed Title XIX Form is valid for a period up to six months from the physician’s signature date.

2.2.11.2 Obtaining Equipment and Supplies Through a Verbal or Detailed Written Order

If the dispensing provider does not have a detailed written order then a verbal order is required to be on file until the written order is received from the prescribing provider and before providing diabetic equipment and supplies. The prescribing provider’s order may be a written, fax, electronic, or verbal order and must include:

- A description of the item(s).
- The client’s name.
- The name of the physician or authorized prescribing provider.
- The date of the order.

A detailed written order must be received by the DME supplier within 90 days from the date of the prescribing provider’s signature. The detailed written order for diabetic equipment and supplies is valid for six months from the date of the order or the date of the prescribing provider’s signature, whichever is earlier, for initial orders, and from the start date of renewal orders. In the absence of a start date, then the authorized prescribing signature date will be the beginning date of service.

A completed, detailed written order must be signed and dated by the authorized prescribing provider. The prescribing provider is required to retain a copy of the signed and dated detailed written order in the client’s medical record. The DME provider must retain the original, faxed, photocopied, or electronic, signed and dated detailed written order in the client’s medical record.

A completed detailed written order must contain all the following components:

- The client’s name
- The date of the verbal order if different from the date the authorized prescribing provider signed the written order
- Description of item(s) to be provided
- Quantity to dispense (quantity required per day or month)
- Diagnosis code or description supporting the medical necessity

Before submitting a claim to Texas Medicaid, DME providers must have on file a detailed written order with the required information. No other documentation is required.

Prior Authorization

Prior authorization, when necessary, may be considered with documentation of medical necessity, which must include one of the following:

- A completed Title XIX Form that has been signed and dated by the physician who is familiar with the client
- Or all the following:
  - A completed and signed detailed written order.
  - A Title XIX Form with section A completed.
2.2.11.3  Glucose Testing Equipment and Other Supplies

The prescribing provider must indicate on a completed, signed and dated Title XIX Form, or a signed and dated detailed written order how many times a day the client is required to test blood glucose or ketone levels when applicable (not all supplies are related to testing glucose or urine, e.g., batteries).

Glucose tablets or gel (procedure code A9150) may be considered with prior authorization when provided to a client with a diagnosis from the diagnosis code table below. Procedure code A9150 is limited to one per six months.

The procedure codes for the diabetic supplies listed in the following table do not require prior authorization, up to the quantities listed in the table, when provided to a client with a diagnosis from the diagnosis code table below. These limitations are not dependent on the client's use of insulin:

<table>
<thead>
<tr>
<th>Procedure Code</th>
<th>Limitation</th>
</tr>
</thead>
<tbody>
<tr>
<td>A4233</td>
<td>1 per 6 months</td>
</tr>
<tr>
<td>A4234</td>
<td>1 per 6 months</td>
</tr>
<tr>
<td>A4235</td>
<td>1 per 6 months</td>
</tr>
<tr>
<td>A4236</td>
<td>1 per 6 months</td>
</tr>
<tr>
<td>A4252</td>
<td>10 strips per month</td>
</tr>
<tr>
<td>A4256</td>
<td>2 per year</td>
</tr>
<tr>
<td>A4258</td>
<td>2 per year</td>
</tr>
<tr>
<td>A9275*</td>
<td>2 per month*</td>
</tr>
<tr>
<td></td>
<td>*Combined total with code A4253</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Procedure Code</th>
<th>Limitation</th>
</tr>
</thead>
<tbody>
<tr>
<td>A4253*</td>
<td>2 boxes per month</td>
</tr>
<tr>
<td>A4259</td>
<td>1 box per month</td>
</tr>
<tr>
<td>A9275*</td>
<td>2 per month</td>
</tr>
<tr>
<td></td>
<td>*A client may receive a combined total of two per calendar month of procedure codes A4253 and A9275, either two or one procedure code or one of each procedure code</td>
</tr>
</tbody>
</table>

Insulin-Dependent Clients

The following procedure codes for diabetic supplies do not require prior authorization up to the quantities listed when the supplies are provided to an insulin-dependent client with a valid diagnosis. If the client is insulin-dependent, providers must submit claims for these procedure codes with modifier U9:

<table>
<thead>
<tr>
<th>Procedure Code</th>
<th>Limitation</th>
</tr>
</thead>
<tbody>
<tr>
<td>A4253*</td>
<td>2 boxes per month</td>
</tr>
<tr>
<td>A4259</td>
<td>1 box per month</td>
</tr>
<tr>
<td>A9275*</td>
<td>2 per month</td>
</tr>
<tr>
<td></td>
<td>*A client may receive a combined total of two per calendar month of procedure codes A4253 and A9275, either two or one procedure code or one of each procedure code</td>
</tr>
</tbody>
</table>

Non-Insulin-Dependent Clients

The following procedure codes for diabetic supplies do not require prior authorization up to the quantities listed when they are provided to a non-insulin-dependent client with a valid diagnosis. If the client is not insulin-dependent, providers must submit claims for these procedure codes with no modifier:

<table>
<thead>
<tr>
<th>Procedure Code</th>
<th>Limitation</th>
</tr>
</thead>
<tbody>
<tr>
<td>A4253*</td>
<td>1 box per month</td>
</tr>
<tr>
<td>A4259</td>
<td>1 box every 2 months</td>
</tr>
<tr>
<td>A9275*</td>
<td>1 per month</td>
</tr>
</tbody>
</table>
|                | *A client may receive only one per calendar month of either procedure code A4253 or A9275.
The following diagnosis codes apply to the tables listed above:

<table>
<thead>
<tr>
<th>Diabetic Diagnosis Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>E0800 E0801 E0810 E0811 E0821 E0822 E0829 E08311</td>
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<tr>
<td>E08319 E083211 E083212 E083213 E083219 E083291 E083292 E083293</td>
</tr>
<tr>
<td>E083299 E083311 E083312 E083313 E083319 E083391 E083392 E083393</td>
</tr>
<tr>
<td>E083399 E083411 E083412 E083413 E083419 E083491 E083492 E083493</td>
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<tr>
<td>E08641 E08649 E0865 E0869 E088 E089 E090 E0901</td>
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<tr>
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<tr>
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<td>E0969 E098 E099 E1010 E1011 E1021 E1022 E1029</td>
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<tr>
<td>E113553 E113559 E113591 E113592 E113593 E113599 E1136 E1137X1</td>
</tr>
</tbody>
</table>
Non-diabetic Diagnosis Codes

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<th>Diabetic Diagnosis Codes</th>
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<td>O24012</td>
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<tr>
<td>O24434</td>
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</table>

Non-diabetic Diagnosis Codes

<table>
<thead>
<tr>
<th>Non-diabetic Diagnosis Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>E161</td>
</tr>
<tr>
<td>E7132</td>
</tr>
</tbody>
</table>

**Note:** THSteps-eligible clients who qualify for medically necessary services beyond the limits of this home health benefit will receive those services through CCP.

Alcohol wipes (procedure code A4245) and urine test or reagent strips or tablets (procedure code A4250) are a benefit of Texas Medicaid when they are necessary for the treatment of some diabetic conditions or other conditions and therefore are not limited to the diagnoses listed in the diagnosis code table above.

Procedure code A4245 is limited to four boxes per month and procedure code A4250 is limited to one box per six months. Prior authorization is not required for these procedure codes up to the quantities listed.

The quantity of glucose testing supplies billed for a one-month supply should relate to the number of tests ordered per day by the prescribing provider.

Glucose testing supplies may be reimbursed for the quantities prescribed or the quantity prior authorized.

Blood glucose test or reagent strips (procedure code A4253) and home glucose disposable monitors with test strips (procedure code A9275) are limited to a combined total of two per month.

### 2.2.11.3.1 Prior Authorization

Glucose tablets or gel (procedure code A9150) requires prior authorization with documentation supporting medical necessity.
Glucose testing supplies for quantities beyond the limits listed in the procedure code table above or for diagnoses other than those listed in the diagnosis code table above in subsection 2.2.11.3, “Glucose Testing Equipment and Other Supplies” in this handbook may be considered for prior authorization with documentation of medical necessity. Quantities will be prior authorized based on the documentation of medical necessity related to the number of tests ordered per day by the physician.

2.2.11.4 Blood Glucose Monitors

Blood glucose monitors with integrated voice synthesizers (procedure code E2100) and blood glucose monitors with integrated lancing blood sample (procedure code E2101) may be considered for prior authorization with documentation of medical necessity. Glucose monitors that have been purchased are anticipated to last a minimum of three years and may be considered for replacement when three years have passed or the equipment is no longer repairable.

Standard home glucose monitors (procedure code E0607) are not a benefit of Texas Medicaid.

Invasive continuous glucose monitoring (CGM) is used for diagnostic purposes to assist the clinician in establishing or modifying the client’s treatment plan. A CGM device is worn up to 72 hours for the diagnostic purpose of collecting continuous blood sugar readings. These are later analyzed by the clinician.


2.2.11.4.1 Prior Authorization

Blood glucose monitors with special features (procedure code E2100 or E2101) may be considered for prior authorization with documentation supporting medical necessity for the special feature requested.

Purchase of a blood glucose monitor with integrated voice synthesizer (procedure code E2100) may be considered for prior authorization with documentation that includes a diagnosis of diabetes and significant visual impairment.

Purchase of a blood glucose monitor with integrated lancing and blood sample (procedure code E2101) may be considered for prior authorization with documentation that includes a diagnosis of diabetes and significant manual dexterity impairment related but not limited to neuropathy, seizure activity, cerebral palsy, or Parkinson’s disease.

The invasive CGM device will not be prior authorized as it is considered part of the physician interpretation and report for CGM.

2.2.11.5 External Insulin Pump and Supplies

An external insulin infusion pump is a programmable, battery-powered mechanical syringe or reservoir device controlled by a microcomputer to provide a basal continuous subcutaneous insulin infusion (CSII) and release a “bolus” dose at meals and at programmed intervals. The pump is connected to an infusion set with an attached small needle or cannula that is inserted into the subcutaneous tissue. The purpose of the insulin pump is to provide an accurate, continuous, controlled delivery of insulin which can be regulated by the user to achieve intensive glucose control and prevent the metabolic complications of hypoglycemia, hyperglycemia and diabetic ketoacidosis. The typical external insulin pump capacity is two to three days of insulin.

Note: External insulin pumps that do not require tubing may be considered for clients who are birth through 20 years of age through CCP.

An external insulin pump must be ordered by, and the client’s follow-up care must be managed by, a prescribing provider with experience managing clients with insulin infusion pumps and who is knowledgeable in the use of insulin infusion pumps.
The external insulin pump (procedure code E0784) may be considered for prior authorization with documentation of medical necessity. Procedure code E0784 is limited to one purchase every three years, and one rental per month. External insulin pumps that have been purchased are anticipated to last a minimum of three years and may be considered for replacement when three years have passed or the equipment is no longer repairable.

The following procedure codes for external insulin pump supplies are a benefit through Title XIX Home Health Services and do not require prior authorization up the maximum quantities allowed. Additional quantities may be considered with documentation of medical necessity and prior authorization.

<table>
<thead>
<tr>
<th>Procedure Code</th>
<th>Limitation</th>
</tr>
</thead>
<tbody>
<tr>
<td>A4230</td>
<td>15 per month</td>
</tr>
<tr>
<td>A4231</td>
<td>15 per month</td>
</tr>
<tr>
<td>A4232</td>
<td>10 per month</td>
</tr>
<tr>
<td>A4601</td>
<td>1 per 6 months</td>
</tr>
<tr>
<td>A4602</td>
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<td>A6257</td>
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<td>K0604</td>
<td>1 per 6 months</td>
</tr>
<tr>
<td>K0605</td>
<td>1 per 6 months</td>
</tr>
</tbody>
</table>

Providers must bill replacement batteries (procedure codes K0601 through K0605) with modifier U1. When there is not an appropriate procedure code for supplies providers may request prior authorization using procedure code A9900.

The external insulin pump supplies (including batteries) are not included in the external insulin pump rental. Routine maintenance of rental equipment is the provider’s responsibility.

Infusion sets for the external insulin pump (procedure codes A4230 or A4231) are limited to clients with a previously billed external insulin pump device or supply. Infusion sets for clients who did not receive the external insulin pump through Texas Medicaid are considered for reimbursement on appeal with a physician’s statement documenting medical necessity.

An internal insulin pump will not be prior authorized as it is considered part of the surgery to place the pump.

2.2.11.5.1 Prior Authorization

Prior authorization is required for an external insulin pump (procedure code E0784) with carrying cases.

Rental of External Insulin Pump

An external insulin pump may be considered for prior authorization of rental with submission of clinical documentation indicating one of the following:

- A client who has a diagnosis of type 1 or 2 diabetes must meet at least two of the following criteria while on multiple daily injections of insulin:
  - Elevated glycosylated hemoglobin level (HbA1c) > 7.0 percent
  - History of dawn phenomenon with fasting blood sugars frequently exceeding 200 mg/dl
• History of severe glycemic excursions with wide fluctuations in blood glucose
• History of recurring hypoglycemia (less than 60 mg/dL) with or without hypoglycemic unawareness
• Anticipation of pregnancy within three months
• A client with a diagnosis of gestational diabetes must meet at least one of the following criteria:
  • Erratic blood sugars in spite of maximal compliance and split dosing
  • Other evidence that adequate control is not being achieved by current methods

In addition to the clinical documentation the provider must submit the External Insulin Pump form indicating:
• The client or caregiver possess the following competencies:
  • The cognitive and physical abilities to use the recommended insulin pump treatment regimen
  • An understanding of cause and effect
  • The willingness to support the use of the external insulin pump
• The prescribing provider must attest that:
  • A training/education plan will be completed prior to initiation of pump therapy.
  • The client or caregiver will be given face-to-face education and instruction and will be able to demonstrate proficiency in integrating insulin pump therapy with their current treatment regimen for ambient glucose control.

**Purchase of External Insulin Pump**
An external insulin pump may be considered for prior authorization of purchase after it has been rented for a three-month trial and all of the following documentation is provided:
• The training/education plan has been completed
• The pump is the appropriate equipment for the specific client
• The client is compliant with the use of the pump

**2.2.11.6 Insulin and Insulin Syringes**
Insulin and insulin syringes (0.5 and 1.0 cc sizes only) that are prescribed to fee-for-service clients are reimbursed through the Medicaid Vendor Drug Program and are not covered under Title XIX Home Health Services. The Medicaid Vendor Drug Program (VDP) only enrolls pharmacies.

Refer to: “Appendix B: Vendor Drug Program” (*Vol. 1, General Information*) for more information about VDP.

**2.2.12 Hospital Beds and Equipment**
A hospital bed and related equipment are considered for reimbursement for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member. A hospital bed is not one that is typically sold as home furniture.

The following items are a benefit of Home Health Services with prior authorization:
• Hospital bed
• Air-fluidized bed
• Pressure pads or a nonpowered pressure-reducing mattress overlay
• Nonpowered pressure-reducing mattress
• Powered pressure-reducing mattress overlay system
• Powered pressure-reducing mattress
• Advanced nonpowered pressure-reducing mattress overlay
• Powered pressure-reducing mattress overlay
• Advanced nonpowered pressure-reducing mattress
• Sheepskin and lamb’s wool pads
• Decubitus care accessories

Note: For clients who are 20 years of age and younger and do not meet criteria through Title XIX Home Health Services, hospital beds and equipment may be considered through CCP.

Side rails or mattresses may be considered for replacement only and may be considered if it is a client-owned hospital bed and the client’s condition requires a replacement of an innerspring mattress or side rails.

2.2.12.1 Hospital Beds
A hospital bed is defined as a medical device with all of the following features:
• An articulating frame that allows adjustment of the head and foot of the bed
• A headboard
• A foot board
• A mattress
• Side rails of any type (A side rail is defined as a hinged or removable rail, board, or panel of any height.)

Note: Without all the components listed above, Texas Medicaid will not consider a request for any hospital bed.

2.2.12.2 Prior Authorization
Hospital beds may be considered for prior authorization for clients who cannot safely utilize a regular bed.

Fixed-Height Hospital Bed
A fixed-height bed (procedure code E0250), which allows for manual adjustment to the head and leg elevation but not height, may be considered for prior authorization if at least one of the following criteria exists:
• The client’s medical condition requires positioning of the body in ways that are not feasible in an ordinary bed.
• The client’s medical condition requires special positioning to alleviate pain.
• It is necessary to elevate the head of the bed 30 or more degrees most of the time due to, but not limited to, congestive heart failure, chronic pulmonary disease, or problems with aspiration, and alternative measures such as wedges or pillows, have been attempted but have failed to manage the client’s medical condition.

Note: Texas Medicaid defines a failed measure as having no clinically significant improvement after being introduced.
• The client requires traction equipment that can only be attached to a hospital bed.
Variable-Height Hospital Bed
A variable-height hospital bed (procedure E0255), which allows manual adjustments to height as well as to head and leg elevations, may be considered for prior authorization if the client meets the criteria for a fixed-height hospital bed and requires a bed height that is different from a fixed-height hospital bed to permit transfers in and out of the bed to a chair, wheelchair, or to a standing position. Medical conditions that require a variable-height hospital bed include, but are not limited to, the following:

- Severe arthritis and other injuries to lower extremities that require the variable height feature to assist in ambulation by enabling the client to place his or her feet on the floor while sitting on the edge of the bed.
- Severe cardiac conditions, where the client is able to leave the bed, but must avoid the strain of “jumping” up and down.
- Spinal cord injuries (including quadriplegia and paraplegia), multiple limb amputations, and stroke, where the client is able to transfer from a bed to a wheelchair with or without help.
- Other severely debilitating diseases and conditions if the client requires a bed height different than a fixed-height hospital bed to permit transfers to a chair, wheelchair, or to a standing position.

Semi-Electric Hospital Bed
A semi-electric hospital bed (procedure code E0260), which allows manual adjustments to height and electric adjustments to head and leg elevation, may be considered for prior authorization if the client meets the criteria for a fixed-height hospital bed and has a condition that requires frequent changes in body position or might require an immediate change in body position to avert a life-threatening situation.

Fully-Electric Hospital Bed
A fully-electric bed (procedure code E0265), which allows electric adjustments to height and head and leg elevation, may be considered for prior authorization when all of the following criteria are met:

- The client has paraplegia or hemiplegia.
- The fully-electric hospital bed will allow the client to have functional independence with self-care.

Documentation must include an attestation statement from the client’s physician or physical or occupational therapist that verifies a determination has been made that the fully-electric hospital bed will allow the client to independently meet their daily self-care needs.

The following hospital beds may be considered for prior authorization if the client meets the criteria for a hospital bed and the weight requirements for a bariatric bed as listed below:

- Heavy-duty, extra-wide hospital bed (procedure code E0303) capable of supporting a client who weighs more than 350 pounds, but no more than 600 pounds
- Extra heavy-duty, extra-wide hospital bed (procedure code E0304) capable of supporting a client who weighs more than 600 pounds

2.2.12.3 Documentation Requirements
To request prior authorization for a hospital bed, the following documentation must be submitted:

- Accurate diagnostic information pertaining to the underlying medical diagnoses or conditions (e.g., gastrostomy feeding, suctioning, ventilator dependent, other respiratory equipment or ventilation assistance devices) to include the client’s overall health status
- Client height and weight
- Client functional mobility status
- Client use of any pressure-reducing support surfaces, if applicable
2.2.12.4 Mattresses and Support Surfaces

A pressure-reducing support surface includes three separate groups of mattress or mattress-like equipment designed to assist in the healing of wounds. These devices are used in conjunction with conventional wound care therapy to prevent the occurrence of said wounds in susceptible clients. Pressure-reducing support surfaces are designed to prevent skin breakdown or to promote the healing of pressure ulcers by reducing or eliminating tissue interface pressure. Most of these devices reduce interface pressure by conforming to the contours of the body so that pressure is distributed over a larger surface area rather than concentrated on a more circumscribed location.

For all types of pressure-reducing support surfaces, the support surface provided for the client should be one in which the client does not “bottom out.” The Centers for Medicare & Medicaid Services (CMS) define “bottoming out” as: when an outstretched hand, palm up, between the undersurface of the overlay or mattress and in an area under the bony prominence can readily palpate the bony prominence (coccyx or lateral trochanter). This “bottoming out” criterion should be tested with the client in the supine position with head flat, in the supine position with head slightly elevated (no more than 30 degrees), and in the side-lying position.

Pressure-reducing support surfaces containing multiple components are categorized according to the clinically predominant component (usually the top-most layer of a multi-layer product) and the presence and stage of pressure ulcers.

The staging of pressure ulcers is as follows:

**Stage I:** Observable pressure related alteration of intact skin whose indicators are as follows:
- Compared to the adjacent or opposite area on the body may include changes in one or more of the following: skin temperature (warmth or coolness), tissue consistency (firm or boggy feel), or sensation (pain, itching).
- The ulcer appears as a defined area of persistent redness in lightly pigmented skin, whereas in darker skin tones, the ulcer may appear with persistent red, blue, or purple hues.

**Stage II:** Partial thickness skin loss involving epidermis, dermis, or both. The ulcer is superficial and presents clinically as an abrasion, blister, or shallow crater.

**Stage III:** Full thickness skin loss involving damage to, or necrosis of, subcutaneous tissue that may extend down to, but not through, underlying fascia. The ulcer presents clinically as a deep crater with or without undermining of adjacent tissue.

**Stage IV:** Full thickness skin loss with extensive destruction, tissue necrosis, or damage to muscle, bone, or supporting structures (e.g., tendon, joint capsule). Undermining and sinus tracts also may be associated with Stage IV pressure ulcers.

2.2.12.4.1 Documentation Requirements

A support surface that does not meet the characteristics specified in the criteria for grouping levels may be denied and considered to be not medically necessary.

To request prior authorization for a pressure-reducing support surface, the following documentation must be provided:

- Client’s overall health status and all other medical diagnoses or conditions (e.g., history of decubitus)
- Documentation of the client’s limited mobility or confinement to a bed
- History of previous use and results of pressure-reducing support surfaces, (e.g., wound improvement, stasis, or degradation)
- Current wound therapy, if any
2.2.12.4.2 Group 1 Support Surfaces

A group 1 Support Surface may be considered for prior authorization with documentation of medical necessity if the client is completely immobile without assistance, or the client has limited mobility or existing pressure ulcer on the pelvis or trunk and at least one of the following conditions:

- Impaired nutritional status
- Fecal or urinary incontinence
- Altered sensory perception
- Compromised circulatory status

All of the support surfaces described below are considered a benefit of the Home Health Services Program when medical necessity criteria for Group 1 support surfaces are met.

Pressure pads or a nonpowered pressure-reducing mattress overlay for mattresses with the following features may be considered for reimbursement with documentation of medical necessity:

- A gel or gel-like layer with a height of two inches or greater
- An air mattress overlay with interconnected air cells that are inflated with an air pump and a cell height of three inches or greater
- A water mattress overlay with a filled height of three inches or greater
- A foam mattress overlay with all the following features:
  - Base thickness of two inches or greater and peak height of three inches or greater if it is a convoluted overlay (e.g., eggcrate) or an overall height of at least three inches if it is a nonconvoluted overlay
  - Foam with a density and other qualities that provide adequate pressure reduction
  - Durable, waterproof cover

Nonpowered pressure-reducing mattresses, with the following features, may be considered for reimbursement with documentation supporting medical necessity:

- A foam mattress with all the following features may be considered with documentation supporting medical necessity. Documentation must include all of the following features:
  - A foam height of five inches or greater
  - Foam with a density and other qualities that provide adequate pressure reduction
  - Durable, waterproof cover
  - Can be placed directly on a hospital bed frame
- An air, water, or gel mattress with all the following features may be considered for reimbursement:
  - A height of five inches or greater
  - Durable, waterproof cover

A powered pressure reducing mattress overlay system, with all the following features, may be considered for reimbursement when documentation supports medical necessity:

- The system includes an air pump or blower which provides either sequential inflation and deflation of air cells, or a low interface pressure throughout the overlay.
- Inflated cell height of the air cells through which air is being circulated is 2.5 inches or greater.
• Height of the air chambers, proximity of the air chambers to one another, frequency of air cycling (for alternating pressure overlays), and air pressure provide adequate client lift, reduces pressure, and prevents bottoming out.

2.2.12.4.3 Group 2 Support Surfaces

A Group 2 support surface may be considered for prior authorization with documentation of medical necessity if the client has multiple stage II ulcers on the trunk or pelvis and has been on a comprehensive ulcer treatment program for at least the past month which has included the use of a Group 1 support surface.

The client must also have at least one of the following:

• The ulcers have remained the same or worsened over the past month.
• There are large or multiple stage III or IV pressure ulcers on the trunk or pelvis.
• Received a myocutaneous flap or skin graft for a pressure ulcer on the trunk or pelvis within the last 60 days, and have been prescribed or placed on a Group 2 or 3 support surface immediately before discharge (within the last 30 days) from the hospital or a nursing facility.

All of the support surfaces described below are considered a benefit of the Home Health Services Program when medical necessity criteria for Group 2 support surfaces are met.

The powered pressure reducing mattress (alternating pressure low air loss, or powered flotation without air loss) device with all the following features may be considered for reimbursement when documentation supports medical necessity:

• The system includes an air pump or blower which provides either sequential inflation and deflation of the air cells or a low interface pressure throughout the mattress.
• Inflated cell height of the air cells through which air is being circulated is five inches or greater.
• Height of the air chambers, proximity of the air chambers to one another, frequency of air cycling (for alternating pressure mattress), and air pressure to provide adequate client lift, reduce pressure, and prevent bottoming out.
• A surface designed to reduce friction and shear.

A semi-electric hospital bed with fully integrated powered pressure-reducing mattress that has all of the features described above may be considered for reimbursement when documentation supports medical necessity.

The advanced nonpowered pressure-reducing mattress overlay device with all the following features may be considered for reimbursement when documentation supports medical necessity:

• Height and design of individual cells which provide significantly more pressure reduction than Group 1 overlay and prevent bottoming out.
• Total height of 3 inches or greater.
• A surface designed to reduce friction and shear.
• Manufacturer product information that substantiates the product is effective for the treatment of conditions described by the coverage criteria for Group 2 support surfaces.

The powered pressure-reducing mattress overlay device with all the following features may be considered for reimbursement when documentation supports medical necessity:

• The system includes an air pump or blower that provides either sequential inflation and deflation of the air cells or a low interface pressure throughout the overlay.
• Inflated cell height of the air cells through which air is being circulated is three and a half inches or greater.
• Height of the air chambers, proximity of the air chambers to one another, frequency of air cycling (for alternating pressure overlays), and air pressure to provide adequate client lift, reduce pressure and prevent bottoming out.

The advanced nonpowered pressure-reducing mattress device with all the following features may be considered for reimbursement when documentation supports medical necessity:

• Height and design of individual cells designed to provide significantly more pressure than a Group 1 mattress and prevent bottoming out
• Total height of 5 inches or greater
• A surface designed to reduce friction and shear
• Documented evidence substantiates that the product is effective for the treatment of conditions described by the coverage criteria for Group 2 support surfaces

Sheepskin and lambs wool pads are considered a benefit of the Home Health Services Program under the same conditions as alternating pressure pads and mattresses (Group 2 pressure-reducing support surfaces) when prior authorized.

2.2.12.4.4 Group 3 Support Surfaces

A Group 3 support surface may be considered for prior authorization with documentation of medical necessity when all the following criteria are met:

• There is a presence of a stage III or IV ulcer.
• Severely limited mobility rendering the client bed or chair bound.
• Without an air-fluidized bed, the client would be institutionalized.
• The client has been placed on a Group 2 support surface for at least a month before ordering the air-fluidized bed with the ulcers not improving or worsening.
• There has been at least weekly assessment of the wound by the physician, a nurse or other licensed health-care professional and the treating physician has done a comprehensive evaluation of the client’s’s condition within the week before ordering the air-fluidized bed.
• A trained adult caregiver is available to assist the client with activities of daily living, maintaining fluid balance, supplying dietary needs, aiding in repositioning and skin care, administering prescribed treatments, recognizing and managing altered mental status, and managing the air-fluidized bed system and its potential problems, such as leakage.
• The physician continues to re-evaluate and direct the home treatment regimen monthly.
• All other alternative equipment has been considered and ruled out.

The existence of any one of the following conditions may result in noncoverage of the air-fluidized bed:

• Coexisting pulmonary disease (the lack of firm back support can render coughing ineffective and dry air inhalation thickens pulmonary secretions).
• Wounds requiring moist wound dressings that are not protected with an impervious covering such as plastic wrap or other occlusive material (if wet-to-dry dressings are being utilized, dressing changes must be frequent enough to maintain their effectiveness).
• For clients who are 21 years of age and older, the caregiver is unwilling or unable to provide the type of care required by the client who uses an air-fluidized bed.
• The home’s structural support or electrical system cannot safely accommodate the air-fluidized bed.
Initial prior authorization for a Group 3 pressure-reducing support surface will be for no more than 30 days. Prior authorized extensions may be considered for reimbursement in increments of 30-day periods, up to a maximum of four months, when documentation supports continued significant improvement in wound healing. Coverage beyond four months will be on a case-by-case basis after review by the medical director or designee.

Air-fluidized beds may be considered for reimbursement when the medical necessity criteria for Group 3 support surfaces are met.

### 2.2.12.5 Equipment and Other Accessories

The following equipment or accessories may be considered with documentation of medical necessity:

- Positioning devices
- Bed cradle (keeps bed covers from touching affected skin)
- Trapeze bars

#### 2.2.12.5.1 Accessories

A mattress of any size with innerspring may be considered for prior authorization with procedure code E0271.

Replacement rails and hospital bed frame padding or covers may be considered for prior authorization as a hospital bed accessory (procedure code E0315) with documentation that the padding, covers or rails are required to prevent injury (for example, related to seizure activity) or to prevent entrapment.

#### 2.2.12.5.2 Prior Authorization

Heel or elbow protector (procedure code E0191) does not require prior authorization. Prior authorization is required for all other hospital beds, equipment, and services provided through Texas Medicaid Title XIX Home Health Services. Prior authorization also includes any accessories, modifications, adjustments, and repairs of the equipment. Positioning cushions or pillows (procedure code E0190) may be considered with documentation of medical necessity that the item will provide pressure relief and positioning in the treatment of decubiti, burns, or musculoskeletal injuries. Documentation must include a listing of other devices that have been used and why the devices proved ineffective.

A trapeze bar attached to a bed (procedure code E0910 or E0911) may be considered if the client requires this device to sit up, to change body position, to get in or out of bed, or for other medical reasons with documentation of medical necessity.

“Free-standing” trapeze equipment (procedure code E0940 or E0912) may be considered if the client does not have an eligible hospital bed, but the client needs this device to sit up, to change body position, to get in or out of bed, or for other medical reasons with documentation of medical necessity.

An over-bed table (procedure code E0315) may be considered if the client is bed-bound and needs the over-bed table for treatments.

### 2.2.12.6 Decubitus Care Accessories

For prior authorization of decubitus care accessories, the following documentation must be provided:

- Wound measurements including location, length, width, and depth
- Any undermining or tunneling
- Odor, if applicable

### 2.2.12.7 Replacement

Beds rails and frames that have been purchased are anticipated to last a minimum of five years.
2.2.12.7.1 Prior Authorization

Prior authorization for replacement may be considered within five years of purchase when one of the following occurs:

- There has been a significant change in the client’s condition, such that the current equipment no longer meets the client’s needs.
- The equipment is no longer functional and cannot be repaired or it is not cost effective to repair.

Replacement of equipment may be considered when loss or irreparable damage has occurred. A copy of the police or fire report, when appropriate, and the measures to be taken to prevent reoccurrence must be submitted.

In situations where the equipment has been abused or neglected by the client, the client’s family, or the caregiver, a referral to the Department of State Health Services (DSHS) Health Screening and Case Management unit will be made by the Home Health Services prior authorization unit for clients who are 20 years of age and younger. Providers will be notified that the state will be monitoring this client’s services to evaluate the safety of the environment for both the client and equipment.

2.2.12.8 Non-covered Items

A safety enclosure (procedure code E0316) used to prevent a client from leaving the bed is not a benefit of Home Health Services. A safety enclosure may be considered through CCP.

Traction equipment (procedure codes E0890, E0947, and E0948) is not a benefit of Home Health Services.

The following types of beds will not be considered for prior authorization, because they are not considered medically necessary or are inappropriate for use in the home setting:

- Institutional type beds (procedure code E0270)
- An ordinary or standard bed typically sold as furniture (may consist of a frame, box spring, and mattress, and is of fixed height with no head or leg elevation adjustments). These types of beds are not primarily medical in nature, not primarily used in the treatment of disease of injury, and are normally of use in the absence of illness or injury. They are not considered durable medical equipment (DME) by Texas Medicaid.
- All non-hospital adjustable beds available to the general public as furniture. These types of beds are not primarily medical in nature, not primarily used in the treatment of disease or injury, and are normally of use in the absence of illness or injury. They are a comfort and convenience item and are not considered DME by Texas Medicaid.
- Hospital beds without rails. Texas Medicaid considers side rails an integral part of medically necessary bed.
- Beds with rails of any height that do not allow head and foot elevation (e.g., platform beds with rails), and are primarily used to prevent clients from leaving the bed. This types of beds are not primarily medical in nature.

2.2.12.9 Hospital Beds and Equipment Procedure Code Table

<table>
<thead>
<tr>
<th>Procedure Code</th>
<th>Maximum Limitation</th>
</tr>
</thead>
<tbody>
<tr>
<td>E0184</td>
<td>1 purchase every 5 years; 1-month rental</td>
</tr>
<tr>
<td>E0185</td>
<td>1 purchase every 5 years; 1-month rental</td>
</tr>
<tr>
<td>E0186</td>
<td>1 purchase every 5 years; 1-month rental</td>
</tr>
<tr>
<td>E0187</td>
<td>1 purchase every 5 years; 1-month rental</td>
</tr>
<tr>
<td>E0188</td>
<td>1 every year</td>
</tr>
</tbody>
</table>
### 2.2.13 Incontinence Supplies

Incontinence supplies billed for a one-month period must be based on the frequency or quantity ordered by the physician on the Home Health Services (Title XIX) Durable Medical Equipment (DME)/Medical Supplies Physician Order Form.

**Note:** THSteps-eligible clients who qualify for medically necessary services beyond the limits of this Home Health benefit will receive those services through CCP.

**Refer to:** Subsection 2.2.1.1, “Client Eligibility” in this handbook.

#### 2.2.13.1 Skin Sealants, Protectants, Moisturizers, and Ointments for Incontinence-Associated Dermatitis

Incontinence-associated dermatitis is classified by category:

- **Category 1**—Small area of skin breakdown (<20 cm²) with mild redness (blotchy and non-uniform) and mild erosion involving the epidermis only.
• Category 2—Moderate area of skin breakdown (20-50 cm²) with moderate redness (severe in spots, but not uniform in appearance) and moderate erosion involving epidermis and dermis with no or little exudate.

• Category 3—Large area of skin breakdown (>50 cm²) with severe redness (uniformly severe in appearance) and severe erosion of epidermis with moderate involvement of the dermis and no or small volume of exudate.

• Category 4—Large area of skin breakdown (>50 cm²) with severe redness (uniformly severe in appearance) and extreme erosion of epidermis and dermis with moderate volume of persistent exudate.

Skin sealants, protectants, moisturizers, and ointments (procedure code A6250) may be considered for clients who are 4 years of age or older and have documented incontinence-associated dermatitis.

For clients who have Category 1 or Category 2 incontinence-associated dermatitis, prior authorization is not required for a maximum quantity of 2 containers (no less than 4 ounces per container) per month and 12 containers per year of skin sealants, protectants, moisturizers, and ointments. Providers must use procedure code A6250 with modifier UA to bill for these products.

For clients who have Category 3 or Category 4 incontinence-associated dermatitis, prior authorization and documentation of medical necessity is required for skin sealants, protectants, moisturizers, and ointments that are not used for Category 1 or Category 2 incontinence-associated dermatitis. Providers must use procedure code A6250 without a modifier to bill for these products.

Providers must use procedure code A6250 instead of procedure code A5120 when billing for skin sealants, protectants, moisturizers, and ointments.

Note: Skin sealants, protectants, moisturizers, ointments for diagnoses other than incontinence-related dermatitis (i.e., wounds, decubitus ulcers, periwound skin complications, peristomal skin complications) may be considered for reimbursement with prior authorization.

2.2.13.2 Diapers, Briefs, Pull-ons, and Liners

Diapers and briefs are defined as incontinence items attached with tabs. Pull-ons are defined as incontinence items that do not attach with tabs and are slip-on items, such as “pull-ups.” Liners are intended to be worn inside diapers, briefs, and pull-ons to increase absorbency. Reusable diapers or briefs are not a benefit of Home Health Services.

For clients who are 4 years of age and older and have a medical condition that results in chronic incontinence, up to a maximum total combination of 240 per month of diapers, briefs, or liners may be considered without prior authorization. Quantities in excess of 240 per month may be considered with documentation of medical necessity and prior authorization.

Note: Gloves used to change diapers and briefs are not considered medically necessary unless the client has skin breakdown or a documented disease that may be transmitted through the urine or stool.

2.2.13.3 Diaper Wipes

For clients who are 4 years of age and older and are receiving diapers/briefs/pull-ons, up to 2 boxes of diaper wipes do not require prior authorization. Exceptions will not be considered through Title XIX Home Health Services. Quantities in excess of 2 boxes per month may be considered through CCP for clients who are 20 years of age and younger with documentation of medical necessity and prior authorization.

Providers must use procedure code A4335 with modifier U9 instead of procedure code A5120 when billing for diaper wipes.

If there is not an appropriate procedure code for supplies, providers may request prior authorization using procedure code A4335.
2.2.13.4 Underpads
For clients who are 4 years of age and older and are receiving diapers/briefs/pull-ons/liners/urine collection devices/bowel management supplies, up to a maximum of 120 underpads per month may be considered without prior authorization. Quantities in excess of 120 per month may be considered with documentation of medical necessity and prior authorization.

Reusable underpads are not a benefit of Home Health Services.

Note: The Home Health Services (Title XIX) Durable Medical Equipment (DME)/Medical Supplies Physician Order Form for the supplies listed above must reflect no more than a one-month’s supply of the incontinence product. The Home Health Services (Title XIX) Durable Medical Equipment (DME)/Medical Supplies Physician Order Form must not reflect more than the maximum allowed quantity per month without requesting prior authorization.

2.2.13.5 Ostomy Supplies
The physician must specify the type of ostomy device or system to be used and how often it is to be changed on the Home Health Services (Title XIX) Durable Medical Equipment (DME)/Medical Supplies Physician Order Form. The quantity of ostomy supplies billed for a one-month period must relate to the number of changes per month based on the frequency ordered by the physician.

Ostomy supplies may be considered for reimbursement without prior authorization.

2.2.13.6 Indwelling or Intermittent Urine Collection Devices
The home setting is considered a clean environment, not a sterile one. Sterile incontinence supplies, (including the supplies in procedure codes A4311, A4312, A4313, A4314, A4315, A4316, and A4353) are a benefit in the home setting when requested for the following:

- Indwelling urinary catheters
- Intermittent catheters for clients who:
  - Are immunosuppressed
  - Have radiologically documented vesico-ureteral reflux
  - Are pregnant and have a neurogenic bladder due to spinal cord injury
  - Have a history of distinct, recurrent urinary tract infections, defined as a minimum of two within the prior 12-month period, while on a program of clean intermittent catheterization

Nonsterile or sterile gloves for use by a health-care provider in the home setting, such as a registered nurse (RN), licensed vocational nurse (LVN), or attendant, are not a benefit of Home Health Services.

2.2.13.6.1 Indwelling Catheters and Related Insertion Supplies
Indwelling catheters and related supplies may be considered without prior authorization up to a maximum of 2 per month for clients who have a medical condition that results in an impairment of urination. Quantities in excess of 2 per month may be considered with documentation of medical necessity and prior authorization.

2.2.13.6.2 Intermittent Catheters and Related Insertion Supplies
Intermittent catheters and related supplies, up to a maximum of 150 per month, may be considered without prior authorization for clients who have a medical condition that results in an impairment of urination. Quantities in excess of 150 per month may be considered with documentation of medical necessity and prior authorization.

Procedure code A4351 denotes catheters used for intermittent catheterizations. Procedure code A4351 must be accompanied with modifier SC when a hydrophilic catheter is used.
A completed Home Health Services (Title XIX) Durable Medical Equipment (DME)/Medical Supplies Physician Order Form may be valid for up to 12 months for intermittent catheters and related insertion supplies for quantities within the stated benefit limits for clients who have one of the following chronic conditions:

<table>
<thead>
<tr>
<th>Diagnosis Codes (Submitted as stand-alone diagnosis codes)</th>
</tr>
</thead>
<tbody>
<tr>
<td>G35</td>
</tr>
<tr>
<td>N311</td>
</tr>
<tr>
<td>Q0703</td>
</tr>
</tbody>
</table>

*Note:* The diagnosis codes R32 and R339 are not specific enough to allow for the extension of the prior authorization to 12 months.

For clients who have a diagnoses other than those listed in the above table, the completed Title XIX Form may be valid for up to six months for intermittent catheters and related insertion supplies for quantities within the stated benefit limits.

For quantities greater than the stated benefit limits, prior authorization will be required and may be granted for up to six months regardless of diagnosis.

Nonsterile gloves are a benefit with prior authorization when a family member or friend is performing the catheterization.

Providers must use procedure codes A4351 or A4352 when billing for intermittent catheters. Providers must use procedure code A4353 when billing for intermittent catheters with insertion supplies. For hydrophilic catheters, procedure code A4351 must be accompanied with modifier SC.

**2.2.13.6.3 External Urinary Collection Devices**

For clients who are 4 years of age and older and have a medical condition that results in a permanent impairment of urination, external urinary collection devices, including, but not limited to, male external catheters, female collection devices, and related supplies may be considered without prior authorization. Male external catheters are limited to 31 per month. Female collection devices are limited to 4 per month. Male external catheters in excess of 31 per month and female collection devices in excess of 4 per month may be considered with documentation of medical necessity and prior authorization.

**2.2.13.6.4 Urinals and Bed Pans**

Urinals and bed pans may be considered without prior authorization for clients who have a medical condition that results in an inability to ambulate to the bathroom safely (with or without mobility aids) up to a limit of 2 per year. Quantities in excess of 2 per year may be considered with documentation of medical necessity and prior authorization.

Urinals and bed pans are purchase only.

**2.2.13.7 Prior Authorization**

Prior authorization is required for incontinence supplies if amounts greater than the maximum limits are medically necessary.

**2.2.13.8 Documentation Requirements**

To request prior authorization for incontinence supplies and equipment, the following documentation must be provided:

- Diagnostic information pertaining to the underlying diagnosis or condition, the diagnosis causing incontinence, and any other medical diagnoses or conditions, including the client’s overall health status
- Weight and height or waist size, when applicable
- Number of times per day the physician has ordered the supply be used
- Quantity of disposable supplies requested per month by the physician

Additional information may be requested to clarify or complete a request for the supplies.

### 2.2.13.9 Incontinence Procedure Codes with Limitations

Any service or combination of services, except diaper wipes, requires prior authorization if the maximum limitation is exceeded. Requests for prior authorization of diaper wipes that exceed more than two boxes per month will not be considered through Home Health Services.

<table>
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Providers must include modifier U1 with procedure code T4528 when submitting claims for bariatric adult size products.

Refer to: Subsection 2.2.13.2, “Diapers, Briefs, Pull-ons, and Liners” in this handbook for an explanation of the item limitations identified with an asterisk (*).

The following procedure codes always require prior authorization even if the maximum benefit limitation allowed has not been exceeded:

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### 2.2.14 Intravenous (IV) Therapy Equipment and Supplies

The following equipment and supplies are used in the delivery of IV therapy and are a benefit of Home Health Services. Additional supply procedure codes may be considered with documentation of medical necessity:

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Types of IV access devices include but are not limited to:

- Peripheral IV lines.
- Central IV lines, including but not limited to, peripherally-inserted central catheters, subclavian catheters, and vena cava catheters.
- Central venous lines, including but not limited to, tunneled and peripherally inserted central venous catheters.
- Implantable ports, including but not limited to, access devices with subcutaneous ports.

Stopcocks increase the risk of infection and should not be routinely used for infusion administration. Routine use of in-line filters is not recommended for infection control.

*Note: Nonsterile or sterile gloves for use by a health-care provider in the home setting, such as an RN, LVN, or attendant, are not a benefit of Home Health Services.

Stationary infusion pumps may be a benefit when the infusion rate must be more consistent and cannot be obtained with gravity drainage. Ambulatory infusion pumps may be a benefit when the length of infusion is greater than two hours, the client must be involved in activities away from home, and when the infusion rate must be more consistent and cannot be obtained with gravity drainage. Elastomeric infusion pumps may be a benefit for short-term use when the caregiver cannot administer the infusion by pump. Dial flow regulators are a benefit and are incorporated into IV extension sets or IV tubing. Elastomeric devices may be reimbursed using procedure codes A4305 and A 4306.

Rental of an infusion pump may be prior authorized on a monthly basis for a maximum of four months per lifetime. Purchase of an infusion pump (ambulatory or stationary) may be prior authorized with documentation of medical necessity that supports repeated IV administration for a chronic condition.
For clients who require cardiovascular medications, infusion pumps will be rented, but not purchased. Repairs to client-owned equipment may be prior authorized as needed with documentation of medical necessity. Technician fees are considered part of the cost of the repair. Providers are responsible for maintaining documentation in the client’s medical record that specifies the repairs and supports medical necessity. All repairs and replacement parts within the first six months after delivery are considered part of the purchase price. Batteries for client-owned equipment require prior authorization. Additional documentation, such as the purchase date, serial number, and manufacturer’s information, may be required.

IV therapy, supplies, and equipment are not considered a benefit when the infusion or medication being administered:

- Is not considered medically necessary to the treatment of the client’s illness.
- Exceeds the frequency or duration ordered by the physician.
- Is a chemotherapeutic agent.
- Is not FDA-approved, unless the physician documents why the off-label use is medically appropriate and not likely to result in an adverse reaction. In order to consider coverage of an off-label (non-FDA approved) use of a drug, documentation must include why a drug usually indicated for the specific diagnosis or condition has not been effective for the client.

Routine maintenance of rental equipment is included in the rental price.

Repairs or replacement parts may be reimbursed with documentation of a client-owned device.

Replacement batteries (procedure codes K0601, K0602, K0603, K0604, and K0605) for client-owned pumps are limited to one battery per 180 days.

### 2.2.14.1 Prior Authorization

Additional replacement batteries for client-owned pumps (procedure codes K0601, K0602, K0603, K0604, and K0605) beyond the limit of 1 per 180 days may be considered for prior authorization with documentation of medical necessity.

All IV equipment and supplies, with the exception of implantable access catheter (A4300) require prior authorization. Prior authorization of IV equipment and supplies may be considered when administration of the drug in the home is medically necessary and is appropriate in the home setting. IV equipment may be prior authorized for rental or purchase depending on the clinician’s predicted length of treatment.

The following standards are used when considering prior authorization of IV supplies:

- The aseptic technique is acceptable for IV catheter insertion and site care; the sterile technique is not required:
  - Nonsterile gloves are acceptable for the insertion of a peripheral IV catheter and for changing any IV site dressing.
  - The sterile technique may be medically necessary. Examples of medical necessity include, but are not limited to, a client who is immuno-compromised.
- A peripheral IV site is rotated no more frequently than every 72 hours, but it is rotated at least weekly.
- The IV administration set (with or without dial flow regulator), extension set (with or without dial flow regulator), and any add-on devices are changed every 72 hours.
- One IV access catheter is used per insertion.
- Saline or heparin-locked catheters:
• Use one syringe to flush the catheter before administration of an intermittent infusion to assess.
• Use two syringes to flush the catheter after the intermittent infusion—one to clear the medication and one to infuse the anticoagulant or other medication used to maintain IV patency between doses, including, but not limited to, heparin.
• An injection port is cleaned before administering an intermittent infusion and capped after the infusion.
• IV catheter site care:
  • Disinfect the site with an appropriate antiseptic (including but not limited to 2 percent chlorhexidine-based preparation, tincture of iodine, or 70 percent alcohol).
  • Cover with sterile gauze, transparent dressing, or semi-permeable dressing.
  • Replace the dressing if it becomes damp, loosened, or visibly soiled.

Elastomeric devices and dial flow regulators are specialized infusion devices that may be considered for prior authorization when the device:
• Will be used for short-term medication administration (less than two weeks duration).
• Is expected to increase client compliance.
• Will better facilitate drug administration.
• Costs less than the cost of pump rental or tubing.
• The caregiver can not administer the infusion by pump.

The following criteria must be met for prior authorization of a stationary infusion pump:
• An infusion pump is required to safely administer the drug.
• The standard method of administration of the drug is through prolonged infusion or intermittent infusion, and the infusion rate must be more consistent than can be obtained with gravity drainage.
• The drug being administered requires IV infusion (i.e., the drug cannot be administered orally, intramuscularly, or by push technique).

The following criteria must be met for prior authorization of an ambulatory infusion pump:
• An infusion pump is required to safely administer the drug.
• The standard method of administration of the drug is through prolonged infusion or intermittent infusion and the infusion rate must be more consistent than can be obtained with gravity drainage.
• The drug being administered requires IV infusion (i.e., the drug cannot be administered orally, intramuscularly, or by push technique).
• The infusion administration is more than two hours and the client is involved in activities away from home, including but not limited to, physician visits.

2.2.14.2 Documentation Requirements
To request prior authorization for IV supplies and equipment, the following documentation must be provided:
• Diagnostic information pertaining to the underlying diagnosis or condition
• A physician’s order and documentation supporting medical necessity
• The medication and dose being administered, the duration of drug therapy, and the frequency of administration
If additional supplies are needed beyond the standards listed, prior authorization may be considered with documentation supporting medical necessity.

For additional IV access catheters, supporting documentation must have evidence that includes, but is not limited to, the following:

- Dehydration
- Vein scarring
- Fragile veins, including but not limited to, clients who are infants or elderly

For more frequent IV site changes, supporting documentation must have evidence that includes, but is not limited to, the following:

- Phlebitis
- Infiltration
- Extravasation

For more frequent IV tubing or add-on changes, supporting documentation must have evidence that includes, but is not limited to, the following:

- Phlebitis
- IV catheter-related infection
- The administered infusion requires more frequent tubing changes

### 2.2.15 Mobility Aids

Mobility aids and related supplies, including, but not limited to canes, crutches, walkers, wheelchairs, and ramps are a benefit through Title XIX Home Health Services to assist clients to move about in their environment.

**Note:** A mobility aid for a client who is birth through 20 years of age is medically necessary when it is required to correct or ameliorate a disability or physical illness or condition.

#### 2.2.15.1 Canes, Crutches, and Walkers

Canes, crutches, and walkers are a benefit through Title XIX Home Health Services when medically necessary to assist clients to move about in their environment. Walkers require prior authorization. Prior authorization is not required for canes, crutches, or walker accessories. Documentation of medical necessity must be provided by a physician familiar with the client and must include information on the client’s impaired mobility.

#### 2.2.15.2 Wheelchairs

A wheelchair is a non-customized chair mounted on four wheels that incorporates a non-adjustable frame, a sling or solid back and seat, and arm rests. Optional items included in this definition include, but are not limited to, the following:

- Handles at the back
- Foot rest
- Seat belt or safety restraint

A wheelchair includes all of the following:

- Standard (manual) wheelchairs
- Standard hemi (manual) wheelchairs
- Standard reclining (manual) wheelchairs
• Lightweight (manual) wheelchairs
• High strength lightweight (manual) wheelchairs

2.2.15.2.1 Prior Authorization
A wheelchair may be prior authorized for short-term rental or for purchase with documentation supporting medical necessity and an assessment of the accessibility of the client’s residence to ensure that the wheelchair is usable in the home (i.e., doors and halls wide enough, no obstructions). The wheelchair must be able to accommodate a 20 percent change in the client’s height or weight.

2.2.15.2.2 Documentation Requirements
Documentation by a physician familiar with the client must include information on the client’s impaired mobility and physical requirements. In addition, the following information must be submitted with documentation of medical necessity:
• Why the client is unable to ambulate a minimum of 10 feet due to their condition (including, but not limited to, AIDS, sickle cell anemia, fractures, a chronic diagnosis, or chemotherapy)
• If the client is able to ambulate further than 10 feet, why a wheelchair is required to meet the client’s needs

2.2.15.3 Manual Wheelchairs-Standard, Standard Hemi, and Standard Reclining
A standard manual wheelchair is defined as a manual wheelchair that:
• Weighs more than 36 pounds.
• Does not have features to appropriately accept specialized seating or positioning.
• Has a weight capacity of 250 pounds or less.
• Has a seat depth of between 15 and 19 inches.
• Has a seat width of between 15 and 19 inches.
• Has a seat height of 19 inches or greater.
• Is fixed height only, fixed, swing away, or detachable armrest.
• Is fixed, swing away, or detachable footrest.

A standard hemi (low seat) wheelchair is defined as a manual wheelchair that:
• Has the same features as a standard manual wheelchair.
• Has a seat to floor height of less than 19 inches.

A standard reclining wheelchair is defined as a manual wheelchair that:
• Has the same features as a standard or standard hemi manual wheelchair.
• Has the ability to allow the back of the wheelchair to move independently of the seat to provide a change in orientation by opening the seat-to-back angle and, in combination with leg rests, open the knee angle.

2.2.15.3.1 Prior Authorization
A standard manual wheelchair may be considered for prior authorization for short-term rental or purchase when all the following criteria are met:
• The client has impaired mobility and is unable to ambulate more than 10 feet.
• The client does not require specialty seating components.
• The client is not expected to need powered mobility within the next 5-year period.
A standard hemi wheelchair may be considered for prior authorization for short-term rental or purchase when the client meets criteria for a standard manual wheelchair and the following criteria is met:

- The client requires a low seat-to-floor height.
- The client must use their feet to propel the wheelchair.

A standard reclining wheelchair may be considered for prior authorization for short-term rental or purchase when the client meets criteria for a standard manual wheelchair and one or more of the following criteria are met:

- The client develops fatigue with longer periods of sitting upright.
- The client is at increased risk of pressure sores with prolonged upright position.
- The client requires assistance with respirations in a reclining position.
- The client needs to perform mobility related activities of daily living (MRADLs) in a reclining position.
- The client needs to improve venous return from lower extremity in a reclining position.
- The client has severe spasticity.
- The client has excess extensor tone of the trunk muscles.
- The client has quadriplegia.
- The client has a fixed hip angle.
- The client must rest in a reclining position two or more times per day.
- The client has the inability or has great difficulty transferring from wheelchair to bed.
- The client has trunk or lower extremity casts or braces that require the reclining feature for positioning.

2.2.15.4 Manual Wheelchairs-Lightweight and High-Strength Lightweight

A lightweight manual wheelchair is defined as a manual wheelchair that:

- Has the same features as a standard or hemi manual wheelchair.
- Weighs 34 to 36 pounds.
- Has available arm styles that are height adjustable.

A high-strength lightweight wheelchair is defined as a manual wheelchair that:

- Has the same features as a lightweight manual wheelchair.
- Weighs 30 to 34 pounds.
- Has a lifetime warranty on side frames and cross braces.

2.2.15.4.1 Prior Authorization

A lightweight manual wheelchair may be considered for prior authorization for rental or purchase when all the following criteria are met:

- The client is unable to propel a standard manual wheelchair at home.
- The client is capable of independently propelling a lightweight wheelchair to meet their MRADLs at home.
A high-strength lightweight wheelchair may be considered for prior authorization for rental or purchase when the client meets all of the criteria for a lightweight manual wheelchair and meets one or more of the following criteria:

- The high-strength lightweight wheelchair will allow the client to self-propel while engaging in frequently performed activities that cannot otherwise be completed in a standard or lightweight wheelchair.
- The client requires frame dimensions (seat width, depth, or height) that cannot be accommodated in a standard, lightweight, or hemi wheelchair and the wheelchair is used at least 2 hours a day.

### 2.2.15.5 Manual Wheelchairs-Heavy-Duty and Extra Heavy Duty

A heavy-duty wheelchair is defined as a manual wheelchair that:

- Meets the standard manual wheelchair definition.
- Has a weight capacity greater than 250 pounds.

An extra heavy-duty wheelchair is defined as a manual wheelchair that:

- Meets the standard manual wheelchair definition.
- Has a weight capacity greater than 300 pounds.

#### 2.2.15.5.1 Prior Authorization

A heavy-duty wheelchair may be considered for prior authorization for short-term rental or purchase when the client has severe spasticity or all the following criteria are met:

- The client meets criteria for a standard manual wheelchair.
- The client weighs between 250 and 300 pounds.

An extra heavy-duty wheelchair may be considered for prior authorization for short-term rental or purchase when all the following criteria are met:

- The client meets criteria for a standard manual wheelchair.
- The client weighs more than 300 pounds.

### 2.2.15.6 Wheeled Mobility Systems

A wheeled mobility system is a manual or power wheelchair, or scooter that is a customized power or manual mobility device, or a feature or component of the mobility device, including but not limited to, the following:

- Seated positioning components
- Powered or manual seating options
- Specialty driving controls for powered chairs
- Adjustable frame
- Other complex or specialized components

A wheeled mobility system includes all of the following:

- Tilt-in-space (manual) wheelchairs
- Pediatric size (manual) wheelchairs and strollers
- Custom ultra lightweight (manual) wheelchairs
- All power wheelchairs
- All scooters
2.2.15.6.1 Definitions and Responsibilities

The following definitions and responsibilities apply to the provision of wheeled mobility systems.

Adjustments—The adjustment of a component or feature of a wheeled mobility system.

Adjustments require labor only and do not include the addition, modification, or replacement of components or supplies needed to complete the adjustment.

Texas Medicaid will consider adjustments only to client-owned equipment that is considered a benefit of Texas Medicaid.

Major Modification—The addition of a custom or specialized feature or component of a wheeled mobility system that did not previously exist on the system due to changes in the client’s needs, including, but not limited to, the items listed in this paragraph. This definition also includes the modification of a custom or specialized feature or component due to a change in the client’s needs, including, but not limited to, the following:

- Seated positioning components, including, but not limited to, specialized seating or positioning components
- Powered or manual seating options, including, but not limited to, power tilt or recline seating systems and seat elevation systems
- Specialty driving controls, including, but not limited to, non-standard alternative power drive control systems
- Adjustable frame, including, but not limited to, non-standard seat frame dimensions
- Other complex or specialized components, including, but not limited to, power elevating leg rests and specialized electronic interfaces

The replacement of a previously existing custom or specialized feature or component with an identical or comparable component is considered a repair and not a major modification.

Texas Medicaid will consider major modifications only to client-owned equipment that is considered a benefit of Texas Medicaid.

Minor Modification—The addition or modification of non-custom or non-specialized features or components due to changes in the client’s needs, including but not limited to, the following:

- Armpads/armrests
- Legrests/Leg extensions
- Modification of seating and positioning components to accommodate for a change in the client’s size.

The replacement of a previously existing non-custom or non-specialized feature or component with an identical or comparable component is considered a repair and not a minor modification.

Texas Medicaid will consider minor modifications only to client-owned equipment that is considered a benefit of Texas Medicaid.

Mobility Related Activity to Daily Living (MRADL)—An activity of daily living requiring the use of mobility aids (i.e., toileting, feeding, dressing, grooming, and bathing).

Occupational Therapist—A person who is currently licensed by the Executive Council of Physical Therapy & Occupational Therapy Examiners to practice occupational therapy.

Physical Therapist—A person who is currently licensed by the Executive Council of Physical Therapy & Occupational Therapy Examiners to practice physical therapy.

Note: A physical or occupational therapist is responsible for completing the seating assessment of a client required for obtaining a wheeled mobility system.
Qualified Rehabilitation Professional (QRP)—A person who meets one or more of the following criteria:

- Holds a certification as an Assistive Technology Professional (ATP) or a Rehabilitation Engineering Technologist (RET) issued by, and in good standing with, the Rehabilitation Engineering and Assistive Technology Society of North America (RESNA).
- Holds a certification as a Seating and Mobility Specialist (SMS) issued by, and in good standing with, RESNA.
- Holds a certification as a Certified Rehabilitation Technology Supplier (CRTS) issued by, and in good standing with, the National Registry of Rehabilitation Technology Suppliers (NRRTS).

The QRP is responsible for:

- Being present at and involved in the seating assessment of the client for the rental or purchase of a wheeled mobility system.
- Being present at the time of delivery of the wheeled mobility system to direct the fitting of the system to ensure that the system functions correctly relative to the client.

Repairs—The replacement of a component or feature of a wheeled mobility system that is no longer functioning as designed, with an identical or comparable component that does not change the size or function of the system.

Texas Medicaid will consider repairs only to client-owned equipment that is considered a benefit of Texas Medicaid.

Additional Benefit Information

The initial purchase of all manual wheelchairs and wheeled mobility systems must include the wheelchair base or frame, and the following standard components, which will not be prior authorized separately:

- Complete set of standard propulsion and caster wheels, including all of the following:
  - Propulsion or caster tires of any size, made of solid rubber or plastic
  - Standard hand rims
  - Complete wheel lock assembly
  - Bearings
  - Standard footrest assembly (fixed, detachable, or swing away), including standard footplates, calf rests/pads, and ratchet assembly
  - Standard armrests (fixed non-adjustable or detachable non-adjustable), including standard foam or plastic arm pads
  - Standard seat and back upholstery

Medically necessary non-standard components may be considered for prior authorization with documentation of medical necessity for the requested component. Such components include, but are not limited to, the following:

- Flat-free inserts
- Foam filled propulsion or caster tires
- Pneumatic propulsion or caster tires
- Non-standard hand rims (including ergonomic and contoured)
- Non-standard length footrests
- Custom footrests
• Elevating footrests
• Angle adjustable footplates
• Adjustable height fixed armrests
• Adjustable height detachable armrests
• Custom size arm pads
• Gel arm pads
• Arm troughs
• Elevating leg rests

Claims for wheelchairs, components, and accessories must be submitted using the most appropriate procedure code that describes the item.

2.2.15.6.2 Prior Authorization
A wheeled mobility system may be prior authorized for short-term rental or for purchase with documentation supporting medical necessity and an assessment of the accessibility of the client’s residence to ensure that the wheelchair is usable in the home (i.e., doors and halls wide enough, no obstructions). The wheelchair must be able to accommodate a 20 percent change in the client’s height or weight.

2.2.15.6.3 Documentation Requirements
Documentation by a physician familiar with the client must include information on the client’s impaired mobility and physical requirements. In addition, the following information must be submitted with documentation of medical necessity:

• Why the client is unable to ambulate a minimum of 10 feet due to their condition (including, but not limited to, AIDS, sickle cell anemia, fractures, a chronic diagnosis, or chemotherapy), or
• If the client is able to ambulate further than 10 feet, why a wheelchair is required to meet the client’s needs.
• A completed Wheelchair/Scooter/Stroller Seating Assessment Form with seating measurements that includes documentation supporting medical necessity
• An itemized component list for custom manual or power wheeled mobility systems.

When medically necessary, prior authorization may also be considered for the rental or purchase of an alternative wheelchair on a case-by-case basis, as follows:

• A manual wheelchair will be considered for a client who owns or is requesting a power wheeled mobility system with no custom features.
• A manual wheelchair or a manual wheeled mobility system will be considered for a client who owns or is requesting a power wheeled mobility system with custom features.

2.2.15.7 Manual Wheeled Mobility System - Tilt-in-Space
A tilt-in-space manual wheeled mobility system is defined as a manual wheelchair that meets the following requirements:

• Has the ability to tilt the frame of the wheelchair greater than or equal to 45 degrees from horizontal while maintaining a constant back to seat angle to provide a change of orientation and redistribute pressure from one area (such as the buttocks and the thighs) to another area (such as the trunk and the head)
• Adult size has a weight capacity of at least 250 pounds
• Pediatric size has a seat width or depth of less than 15 inches

2.2.15.7.1 Prior Authorization
A tilt-in-space wheeled mobility system may be considered for prior authorization for short-term rental or purchase when all the following criteria are met:
• The client meets criteria for a standard manual wheelchair.
• The client has a condition that meets criteria for a tilt-in-space feature, including but not limited to:
  • Severe spasticity
  • Hemodynamic problems
  • Quadriplegia
  • Excess extensor tone
  • Range of motion limitations prohibit a reclining system, such as hip flexors, hamstrings, or even heterotopic ossification
  • The need to rest in a recumbent position two or more times per day and the client has an inability to transfer between bed and wheelchair without assistance
  • Documented weak upper extremity strength or a disease that will lead to weak upper extremities
  • At risk for skin breakdown because of inability to reposition body in a chair to relieve pressure areas

2.2.15.8 Manual Wheeled Mobility System- Pediatric Size
A pediatric sized wheeled mobility system is defined as a manual standard/custom wheelchair (including those optimally configured for propulsion or custom seating) that has a seat width or depth of less than 15 inches.

2.2.15.9 Manual Wheeled Mobility System -Custom (Includes Custom Ultra-Lightweight)
Custom manual wheeled mobility systems may be considered for a client who meets criteria for a manual wheelchair, has a condition that requires specialized seating, and cannot safely utilize a standard manual wheelchair.

A custom ultra lightweight wheeled mobility system is defined as an optimally configured wheelchair for independent propulsion which cannot be achieved in a standard, lightweight, or high-strength lightweight wheelchair that:
• Meets the high-strength lightweight definition and weighs less than 30 pounds.
• Has one or more of the following features to appropriately accept specialized seating or positioning:
  • Adjustable seat-to-back angle
  • Adjustable seat depth
  • Independently adjustable front and rear seat-to-floor dimensions
  • Adjustable caster stem hardware
  • Adjustable rear axle
  • Adjustable wheel camber
  • Adjustable center of gravity
• Has a lifetime warranty on side frames and cross braces
2.2.15.9.1 Prior Authorization

A custom ultra-lightweight wheeled mobility system may be considered for prior authorization for rental or purchase when the client meets all the criteria for a lightweight manual wheelchair and one or more of the following criteria:

- The client is able to self-propel, will have independent mobility with the use of an optimally configured chair, and meets all of the following criteria:
  - The client uses the wheelchair for a significant portion of their day to complete MRADLs.
  - The client uses the wheelchair in the community to complete MRADLs.
  - Powered mobility is not anticipated within the next 5-year period.
- The client is able to self-propel, will have independent mobility with the use of an optimally configured chair, has a medical condition that cannot be accommodated by the seating available on a standard, lightweight, or high-strength lightweight wheelchair and one or more of the following features needed by the client to ensure optimal independence with MRADLs:
  - Adjustable seat to back angle.
  - Adjustable seat depth.
  - Independently adjustable front and rear seat-to-floor dimensions.
  - Adjustable caster stem hardware.
  - Adjustable rear axle (adjustable center of gravity).
  - Powered mobility is not anticipated within the next 5-year period.
- The client meets all of the following criteria:
  - The client is unable to self-propel.
  - The client has a documented condition that requires custom seating, including, but not limited to:
    - Poor trunk control.
    - Contractures of elbow or shoulders.
    - Muscle spasticity.
    - Tone imbalance through shoulders or back.
    - Kyphosis or Lordosis.
    - Lack of flexibility in pelvis or spine.
  - The client requires custom seating that cannot be accommodated on a standard, lightweight, or hemi-wheelchair.

Prior authorization for labor to create a custom molded seating system is limited to a maximum of 15 hours.

2.2.15.10 Seating Assessment for Manual and Power Custom Wheelchairs

A seating assessment is required for:

- The rental or purchase of any device meeting the definition of a wheeled mobility system as defined under subsection 2.2.15.6, “Wheeled Mobility Systems” in this handbook.
- The purchase of any device meeting the definition of a wheelchair as defined under subsection 2.2.15.2, “Wheelchairs” in this handbook for a client with a congenital or neurological condition, myopathy, or skeletal deformity, which requires the use of a wheelchair.
A seating assessment with measurements, including specifications for exact mobility/seating equipment and all necessary accessories, must be completed by a physician, licensed occupational therapist, or licensed physical therapist.

A QRP directly employed or contracted by the DME provider must be present at and participate in all seating assessments, including those provided by a physician.

Upon completion of the seating assessment, the QRP must attest to his or her participation in the assessment by signing the Wheelchair/Scooter/Stroller Seating Assessment Form. This form must be submitted with all requests for wheeled mobility systems.

When the practitioner completing the seating assessment is an occupational or physical therapist, the occupational or physical therapist may perform the seating assessment as the therapist, or as the QRP, but may not perform in both roles at the same time. If the occupational or physical therapist is attending the seating assessment as the QRP, the occupational or physical therapist must meet the credentialing requirements and be enrolled in Texas Medicaid as a QRP.

If the practitioner completing the seating assessment is a physician, the seating assessment is considered part of the evaluation and management service provided.

**Note:** If a client who is birth through 20 years of age requires seating support and meets the criteria for a seating system, a stroller may be considered through CCP, or a wheelchair may be considered through Texas Medicaid Title XIX Home Health Services.

### 2.2.15.10.1 Prior Authorization

A seating assessment performed by an occupational therapist, physical therapist, or a physician, with the participation of a QRP, does not require prior authorization. A seating assessment performed by a physician is considered part of the physician evaluation and management service.

The QRP’s participation in the seating assessment requires authorization before the service can be reimbursed. Authorization must be requested at the same time and on the same prior authorization request form as the prior authorization request for the QRP fitting and the wheeled mobility system or major modification to the wheeled mobility system.

Prior authorization requests for the QRP’s participation in the seating assessment will be returned to the provider if the seating assessment is requested separately from the prior authorization for the QRP fitting and the wheeled mobility system or major modification to the wheeled mobility system.

The QRP participating in the seating assessment must be directly employed by or contracted with the DME provider requesting the wheeled mobility system or major modification to a wheeled mobility system.

An authorization for the QRP’s participation in the seating assessment for a wheeled mobility system or major modification to a wheeled mobility system may be issued to the QRP in 15-minute increments, for a time period of up to one hour (4 units).

If the seating assessment is completed by a physician, reimbursement is considered part of the physician office visit and will not be reimbursed separately.

The practitioner (occupational therapist or physical therapist) completing the assessment must submit procedure code 97001 or 97003 with modifier U1, in order to bill for the seating assessment.

Services for the QRP’s participation in the seating assessment must be submitted for reimbursement by the DME provider billing for the wheeled mobility system using procedure code 97542 with modifier U1. The DME provider must include the QRP specialty as the performing provider on the claim for all components of the wheeled mobility system, including the QRP’s participation in the seating assessment.

Seating assessment services performed by a QRP is limited to four units (one hour).
2.2.15.10.2 Documentation Requirements

The seating assessment must:

- Explain how the client or family will be trained in the use of the equipment.
- Anticipate changes in the client’s needs and include anticipated modifications or accessory needs, as well as the growth potential of the wheelchair. A wheelchair must have growth potential that will accommodate a 20 percent change in the client’s height and/or weight.
- Include significant medical information pertinent to the client’s mobility and how the requested equipment will accommodate these needs, including intellectual, postural, physical, sensory (visual and auditory), and physical status.
- Address trunk and head control, balance, arm and hand function, existence and severity of orthopedic deformities, as well as any recent changes in the client’s physical and/or functional status, and any expected or potential surgeries that will improve or further limit mobility.
- Include information on the client’s current mobility/seating equipment, how long the client has been in the current equipment and why it no longer meets the client’s needs.
- Include the client’s height, weight, and a description of where the equipment is to be used.
- Include seating measurements.
- Include the accessibility of client’s residence.
- Include manufacturer’s information, including the description of the specific base, any attached seating system components, and any attached accessories, as well as the manufacturer’s retail pricing information and itemized pricing for manually priced components.
- Include documentation supporting medical necessity for all accessories.
- Be documented on the Wheelchair/Scooter/Stroller Seating Assessment Form, which must be signed and dated by the qualified practitioner completing the assessment (occupational therapist, physical therapist, or physician), and the QRP who was present and participated in the assessment. All signatures and dates must be current, unaltered, original, and handwritten. Computerized or stamped signatures and dates will not be accepted.
- Be submitted with the prior authorization request for the wheeled mobility system. The Form must be completed, signed and dated as outlined above.

2.2.15.11 Fitting of Custom Wheeled Mobility Systems

The fitting of a wheeled mobility system is defined as the time the QRP spends with the client fitting the various systems and components of the system to the client. It may also include time spent training the client or caregiver in the use of the wheeled mobility system. Time spent setting up the system, or travel time without the client present, is not included.

A fitting is required for any device meeting the definition of a wheeled mobility system as defined under subsection 2.2.15.6, “Wheeled Mobility Systems” in this handbook.

The fitting of a wheeled mobility system must be:

- Performed by the same QRP that was present for, and participated in, the seating assessment of the client.
- Completed prior to submitting a claim for reimbursement of a wheeled mobility system.

The QRP performing the fitting will:

- Verify the wheeled mobility system has been properly fitted to the client.
- Verify that the wheeled mobility system will meet the client’s functional needs for seating, positioning, and mobility.
• Verify that the client, parent, guardian of the client, and/or caregiver of the client has received training and instruction regarding the wheeled mobility system’s proper use and maintenance.

The QRP must complete and sign the DME Certification and Receipt form after the wheeled mobility system has been delivered and fitted to the client. Completion of this form by the QRP signifies that all components of the fitting as outlined above have been satisfied. The form must be completed prior to submission of a claim for a wheeled mobility system, and submitted to HHSC’s designee according to instructions on the form to allow for proper claims processing.

Services for fitting of a wheeled mobility system by the QRP must be submitted for reimbursement by the DME provider of the wheeled mobility system using procedure code 97542 with modifier U2. The DME provider must list the QRP who participated in the seating assessment as the performing provider on the claim for all components of the wheeled mobility system, including the fitting performed by the QRP.

All adjustments and modifications to the wheeled mobility system, as well as the associated services by the QRP for the seating assessment and fitting, within the first six months after delivery are considered part of the purchase price and will not be separately reimbursed.

Procedure code 97542 with modifier U2 must be billed on the same claim as the procedure code(s) for the wheeled mobility system in order for both services to be reimbursed.

2.2.15.11.1 Prior Authorization
Prior authorization is required for the QRP performing the fitting of a wheeled mobility system, and must be included with the request for the wheeled mobility system.

The QRP must be directly employed by or contracted with the DME company providing the system, and must be the same QRP who was present at and participated in the client’s seating assessment.

A prior authorization may be issued to the QRP in 15-minute increments, for a time period of up to two hours (8 units), for the fitting of any manual or power wheeled mobility system. Up to one additional hour (4 units) may be authorized to the QRP with documentation of medical necessity demonstrating that fitting of three or more major systems is required, or that additional client training is required for such systems. Major systems can include, but are not limited to, the following:

• Complete complex seating system (planar system with trunk supports and hip supports or abductor or custom contoured seating system such as a molded system) Off-the-shelf seat and back cushions do not constitute a complex seating system.

• Alternative drive controls (such as a head array, mini-proportional system, etc.).

• Additional specialty control features (such as infrared access).

• Power positioning features (such as power tilt, power recline).

• Specific purpose specialty features (such as power seat elevation systems, power elevating leg rests).

2.2.15.11.2 Documentation Requirements
When the QRP that participated in the assessment of the client is not available to conduct the fitting of the wheeled mobility system, the DME provider must update the prior authorization for the wheeled mobility system and fitting by submitting all of the following information:

• A letter written on the DME provider’s letterhead, signed and dated by a representative of the DME provider other than the new QRP.

• Documentation explaining why the original QRP could not conduct the fitting. Examples may include, but are not limited to, documentation that the QRP:

  • Is no longer associated with the DME provider requesting the wheeled mobility system.
• Is on an extended leave from the DME provider requesting the wheeled mobility system.

  Note: For purposes of this policy, an extended leave is any leave of more than 30 consecutive calendar days.

• The name, TPI, and NPI of the original QRP who performed the initial assessment, and the date the assessment was completed.

• The name, TPI, and NPI of the QRP who will be performing the fitting.

• A copy of the original, physician-signed Home Health Services (Title XIX) DME/Medical Supplies Physician Order Form.

A copy of this documentation must be maintained by the provider in the client’s medical record and be available upon request by HHSC or its designee.

2.2.15.12 Power Wheeled Mobility Systems- Group 1 through Group 5

A power wheeled mobility system or powered mobility device (PMD) is a professionally manufactured device that provides motorized wheeled mobility and body support specifically for individuals with impaired mobility. PMDs are four- or six-wheeled motorized vehicles whose steering is operated by an electronic device or joystick to control direction, turning, and alternative electronic functions, such as seat controls.

Each PMD must include all of the following basic components that may not be billed separately:

• Lap belt or safety belt (This does not include multiple-attachment-point positioning belts or padded belts.)
• Battery charger, single mode
• Batteries (initial)
• Complete set of tires and casters, any type
• Leg rests
• Foot rests or foot platform
• Arm rests
• Any weight-specific components (braces, bars, upholstery, brackets, motors, gears, etc.) as required by client weight capacity
• Controller and input device

The following definitions apply to PMDs:

• No-Power Option - A category of PMDs that cannot accommodate a power tilt, recline, or seat elevation system. A PMD that can accept only power-elevating leg rests is considered to be a no-power option chair.

• Single-Power Option - A category of PMDs that can accept and operate a power tilt, power recline, or a power seat elevation system, but not a combination power tilt and recline seating system. A single-power option PMD might be able to accommodate power elevating leg rests, or seat elevator, in combination with a power tilt or power recline. A PMD does not have to be able to accommodate all features to meet this definition.

• Multiple-Power Option - A category of PMDs that can accept and operate a combination power tilt and recline seating system. A multiple-power option PMD might also be able to accommodate power elevating leg rests, or a power seat elevator. A PMD does not have to accommodate all features to qualify to meet this definition.
2.2.15.12.1 Prior Authorization
Prior authorization for a power wheeled mobility system/PMD requires the following documentation in addition to all documentation required for a custom manual wheelchair:

- The client's physical and mental ability to receive and follow instructions related to responsibilities of using equipment. The client must be able to operate a PMD independently. The therapist must provide written documentation that the client is physically and cognitively capable of managing a PMD.
- How the PMD will be operated (i.e., joystick, head pointer, puff-and-go).
- The capability of the client to understand how the PMD operates.
- The capability of the caregiver or client to care for the PMD and accessories.

2.2.15.12.2 Group 1 PMDs
All Group 1 PMDs must have all the specified basic components and meet all the following requirements:

- Standard integrated or remote proportional joystick
- Nonexpandable controller
- Incapable of upgrade to expandable controller
- Incapable of upgrade to alternative control devices
- May have cross brace construction
- Accommodates nonpowered options and seating systems (e.g., recline-only backs, manually elevating leg rests [except captains chairs])
- Length - less than or equal to 40 inches
- Width - less than or equal to 24 inches
- Minimum top end speed - 3 mph
- Minimum range - 5 miles
- Minimum obstacle climb - 20 mm
- Dynamic stability incline - 6 degrees

Prior Authorization Requirements
A Group 1 PMD may be considered for prior authorization for rental or purchase when all the following criteria are met:

- The client will use the PMD for less than 2 hours per day.
- The client will use the PMD indoors on smooth, hard surfaces.
- The client will not encounter obstacles in excess of 0.75 inch.

2.2.15.12.3 Group 2 PMDs
All Group 2 PMDs must have all the specified basic components and meet all the following requirements:

- Standard integrated or remote proportional joystick
- May have cross brace construction
- Accommodates seating and positioning items (e.g., seat and back cushions, headrests, lateral trunk supports, lateral hip supports, medical thigh supports [except captains chairs])
• Length - less than or equal to 48 inches
• Width - less than or equal to 34 inches
• Minimum top end speed - 3 mph
• Minimum range - 7 miles
• Minimum obstacle climb - 40 mm
• Dynamic stability incline - 6 degrees

**Prior Authorization Requirements**
A Group 2 PMD may be considered for prior authorization for rental or purchase when the following criteria are met:

- The client will use the PMD for 2 or more hours per day.
- The client will not routinely use the PMD for MRADLs outside the home.
- The client will not encounter obstacles in excess of 1.5 inches.

**2.2.15.12.4 Group 3 PMDs**
All Group 3 PMDs must have all the specified basic components and meet all the following requirements:

- Standard integrated or remote proportional joystick
- Nonexpandable controller
- Capable of upgrade to expandable controller
- Capable of upgrade to alternative control devices
- May not have cross brace construction
- Accommodates seating and positioning items (e.g., seat and back cushions, headrests, lateral trunk supports, lateral hip supports, medial thigh supports [except captains chairs])
- Drive wheel suspension to reduce vibration
• Length - less than or equal to 48 inches
• Width - less than or equal to 34 inches
• Minimum top end speed - 4.5 mph
• Minimum range - 12 miles
• Minimum obstacle climb - 60 mm
• Dynamic stability incline - 7.5 degrees

**Prior Authorization Requirements**
A Group 3 PMD may be considered for prior authorization for rental or purchase when the following criteria are met:

- The client’s mobility limitation is due to a neurological condition, myopathy, or congenital skeletal deformity.
- The client may routinely use the PMD for MRADLs outside of the home.
- The client will use the PMD primarily on smooth or paved surfaces.
- The client will not encounter obstacles in excess of 2.5 inches.
2.2.15.12.5 Group 4 PMDs

All Group 4 PMDs must have all the specified basic components and meet all the following requirements:

- Standard integrated or remote proportional joystick
- Nonexpandable controller
- Capable of upgrade to expandable controller
- Capable of upgrade to alternative control devices
- May not have cross brace construction
- Accommodates seating and positioning items (e.g., seat and back cushions, headrests, lateral trunk supports, lateral hip supports, medial thigh supports [except captains chairs])
- Drive wheel suspension to reduce vibration
- Length - less than or equal to 48 inches
- Width - less than or equal to 34 inches
- Minimum top end speed - 6 mph
- Minimum range - 16 miles
- Minimum obstacle climb - 75 mm
- Dynamic stability incline - 9 degrees

Prior Authorization Requirements

A Group 4 PMD may be considered for prior authorization for rental or purchase when all the following criteria are met:

- In addition to using the PMD in the home, the client will routinely use the PMD for MRADLs outside the home.
- The client will routinely use the PMD on rough, unpaved or uneven surfaces.
- The client will encounter obstacles in excess of 2.25 inches.
- The client has a documented medical need for a feature that is not available on a lower level PMD.

Documentation Requirements

The submitted documentation for a Group 4 PMD must include a completed assessment that is signed and dated by a physician or a licensed occupational or physical therapist and includes the following:

- A description of the environment where the PMD will be used in the routine performance of MRADLs.
- A listing of the MRADLs that would be possible with the use of a Group 4 PMD that would not be possible without the Group 4 PMD.
- The distance the client is expected to routinely travel on a daily basis with the Group 4 PMD.

Note: The enhanced features found on a Group 4 PMD must be medically necessary to meet the client’s routine MRADL and will not be approved for leisure or recreational activities.

In addition to meeting criteria for Group 2 through Group 4 PMDs, the submitted documentation of medical necessity must demonstrate that the client requires the requested power option (e.g., the need for a power recline or tilt in space, or a combination power tilt and power recline), the no-power option, single-power option, or multiple-power option as defined in subsection 2.2.15.12, "Power Wheeled Mobility Systems- Group 1 through Group 5" in this handbook.
2.2.15.12.6 Additional Requirements - Group 2 through Group 4 No-Power Option
Group 2 through Group 4 no-power option PMDs must have all the specified basic components and meet all the following requirements:

- Nonexpandable controller
- Incapable of upgrade to expandable controller
- Incapable of upgrade to alternative control devices
- Meets the definition of no-power option
- Accommodates nonpowered options and seating systems (e.g., recline-only backs, manually elevating leg rests [except captains chairs])

2.2.15.12.7 Group 2 through Group 4 Single-Power Option
Group 2 through Group 4 single-power option PMDs must have all the specified basic components and meet all the following requirements:

- Nonexpandable controller
- Capable of upgrade to expandable controller
- Capable of upgrade to alternative control devices
- Meets the definition of single-power option

2.2.15.12.8 Group 2 through Group 4 Multiple-Power Option
Group 2 through Group 4 multiple-power option PMDs must have all the specified basic components and meet all the following requirements:

- Nonexpandable controller
- Capable of upgrade to expandable controller
- Meets the definition of multiple-power option
- Accommodates a ventilator

2.2.15.12.9 Group 5 PMDs
All Group 5 PMDs must have all the specified basic components and meet all the following requirements:

- Standard integrated or remote joystick
- Nonexpandable controller
- Capable of upgrade to expandable controller
- Seat width - minimum of 5 one-inch options
- Seat depth - minimum of 3 one-inch options
- Seat height - adjustment requirements = 3 inches
- Back height - adjustment requirements minimum of 3 options
- Seat-to-back angle range of adjustment - minimum of 12 degrees
- Accommodates nonpowered options and seating systems
- Accommodates seating and positioning items (e.g., seat and back cushions, headrests, lateral trunk supports, lateral hip supports, medial thigh supports)
- Adjustability for growth (minimum of 3 inches for width, depth, and back height adjustment)
• Special developmental capability (i.e., seat to floor, standing, etc.)
• Drive wheel suspension to reduce vibration
• Length - less than or equal to 48 inches
• Width - less than or equal to 34 inches
• Minimum top end speed - 4 mph
• Minimum range - 12 miles
• Minimum obstacle climb - 60 mm
• Dynamic stability incline - 9 degrees
• Passed crash test

Prior Authorization Requirements
A Group 5 pediatric PMD may be considered for prior authorization for rental or purchase when all the following criteria are met:
• The client weighs less than 125 pounds.
• The client is expected to grow in height.
• The client may require growth of up to 5 inches in width.
• The client may require a change in seat to floor height up to 3 inches.
• The client may require a seat to back angle range of adjustment in excess of 12 degrees.
• The client requires special developmental capability (i.e., seat to floor, standing, etc.).

2.2.15.12.10 Group 5 Single-PMDs
A group 5 single-power option PMD must have all the specified basic components and have the capability to accept and operate a power tilt or recline or seat elevation system, but not a combination power tilt and recline seating system, and may be able to accommodate power elevating leg rests, or seat elevator, in combination with a power tilt or power recline.

Prior Authorization Requirements
A Group 5 pediatric PMD with single power option may be considered for prior authorization for rental or purchase when all the following criteria are met:
• The client meets criteria for a Group 5 PMD.
• The client requires a drive control interface other than a hand or chin-operated standard proportional joystick (examples include but are not limited to head control, sip and puff, or switch control).

2.2.15.12.11 Group 5 Multiple-PMDs
Group 5 multiple-power option PMD must have all the specified basic components and meet all the following requirements:
• Has the capability to accept and operate a combination power tilt and recline seating system, and may also be able to accommodate power elevating leg rests, or a power seat elevator.
• Accommodates a ventilator.

Prior Authorization Requirements
A Group 5 pediatric PMD with multiple power option may be considered for prior authorization for rental or purchase when the following criteria are met:
• The client meets criteria for a Group 5 PMD.
- The client requires a drive control interface other than a hand or chin-operated standard proportional joystick (examples include but are not limited to head control, sip and puff, switch control).
- The client has a documented medical need for a power tilt and recline seating system and the system is being used on the wheelchair or the client uses a ventilator which is mounted on the wheelchair.

### 2.2.15.13 Wheelchair Ramp-Portable and Threshold

Portable and threshold ramps are a benefit of Texas Medicaid.

A portable ramp is defined as a unit that is able to be carried as needed to access a home, weighs no more than 90 pounds, or measures no more than 10 feet in length. A threshold ramp is defined as a unit that provides access over elevated thresholds.

One portable ramp and one threshold ramp for wheelchair access may be considered for prior authorization when documentation supports medical necessity. The following documentation supporting medical necessity is required:

- The date of purchase and serial number of the client’s wheelchair or documentation of a wheelchair request being reviewed for purchase
- Diagnosis with duration of expected need
- A diagram of the house showing the access points with the ground-to-floor elevation and any obstacles

Ramps may be considered for rental for short term disabilities and for purchase for long term disabilities. Mobility aid lifts for vehicles and vehicle modifications are not a benefit of Texas Medicaid.

### 2.2.15.14 Power Elevating Leg Lifts

A power elevation feature involves a dedicated motor and related electronics with or without variable speed programmability, which allows the leg rest to be raised and lowered independently of the recline and/or tilt of the seating system. It includes a switch control which may or may not be integrated with the power tilt and/or recline control(s).

#### 2.2.15.14.1 Prior Authorization

Power elevating leg lifts may be prior authorized for clients who have compromised upper extremity function that limits the client’s ability to use manual elevating leg rests. The client must meet criteria for a PMD with a reclining back and at least one of the following:

- The client has a musculoskeletal condition such as flexion contractures of the knees and legs, or the placement of a brace that prevents 90-degree flexion at the knee.
- The client has significant edema of the lower extremities that requires elevating the client’s legs.
- The client experiences hypotensive episodes that require frequent positioning changes.
- The client needs power tilt-and-recline and is required to maintain anatomically correct positioning and reduce exposure to skin shear.

#### 2.2.15.14.2 Documentation Requirements

The submitted documentation must include an assessment completed, signed, and dated by a physician or a licensed occupational or physical therapist that includes the following:

- A description of the client’s current level of function without the device
- Documentation that identifies how the power elevating leg lifts will improve the client’s function
- A list of MRADLs the client will be able to perform with the power elevating leg lifts that the client is unable to perform without the power elevating leg lifts and how the device will increase independence
• The duration of time the client is alone during the day without assistance
• The client’s goals for use of the power elevating leg lifts

2.2.15.15 Power Seat Elevation System
A power seat elevation system is used to raise and lower the client in their seated position without changing the seat angles to provide varying amounts of added vertical access.

The use of a power seat elevation system will:
• Facilitate independent transfers, particularly uphill transfers, to and from the wheelchair, and
• Augment the client’s reach to facilitate independent performance of MRADLs in the home.

2.2.15.15.1 Prior Authorization
A power seat elevation system may be prior authorized to promote independence in a client who meets all of the following criteria:
• The client does not have the ability to stand or pivot transfer independently.
• The client requires assistance only with transfers across unequal seat heights, and as a result of having the power seat elevation system, the client will be able to transfer across unequal seat heights unassisted.
• The client has limited reach and range of motion in the shoulder or hand that prohibits independent performance of MRADLs (such as, dressing, feeding, grooming, hygiene, meal preparation, and toileting).

2.2.15.15.2 Documentation Requirements
The submitted documentation must include an assessment completed, signed, and dated by a physician or a licensed occupational or physical therapist that includes the following:
• A description of the client’s current level of function without the device
• Documentation that identifies how the power seat elevation system will improve the client’s function
• A list of MRADLs the client will be able to perform with the power seat elevation system that the client is unable to perform without the power seat elevation system and how the device will increase independence
• The duration of time the client is alone during the day without assistance
• The client’s goals for use of the power seat elevation system

Note: A power seat elevation system option will not be authorized for the convenience of a caregiver, or if the device will not allow the client to become independent with MRADLs and transfers.

2.2.15.16 Seat Lift Mechanisms
A medically necessary seat lift mechanism is one that operates smoothly, can be controlled by the client, and effectively assists the client in standing up and sitting down without other assistance.

The payment for a recliner or chair with the incorporated seat lift mechanism is limited to the amount of the seat lift mechanism.

2.2.15.16.1 Prior Authorization
A seat lift mechanism may be prior authorized for clients who meet all the following criteria:
• The client must have severe arthritis of the hip or knee or have a severe neuromuscular disease.
• The seat lift mechanism must be a part of the physician’s course of treatment and be prescribed to correct or ameliorate the client’s condition.
• Once standing, the client must have the ability to ambulate.
• The client must be completely incapable of standing up from a regular armchair or any chair in their home.

**Note:** The fact that a client has difficulty or is even incapable of getting up from a chair, particularly a low chair, is not sufficient justification for a seat lift mechanism. Almost all clients who are capable of ambulating can get out of an ordinary chair if the seat height is appropriate and the chair has arms.

Seat lift mechanisms are limited to those types that operate smoothly, can be controlled by the client, and can effectively assist a client in standing up and sitting down without other assistance. A seat lift operated by a spring release mechanism with a sudden, catapult-like motion and jolts the client from a seated to a standing position is not a benefit of Texas Medicaid.

### 2.2.15.16.2 Documentation Requirements

The submitted documentation must include an assessment completed, signed, and dated by a physician or a licensed occupational or physical therapist that includes the following:

- A description of the client’s current level of function without the device
- Documentation that identifies how the seat lift mechanism will improve the client’s function
- A list of MRADLs the client will be able to perform with the seat lift mechanism that the client is unable to perform without the seat lift mechanism and how the device will increase independence
- The duration of time the client is alone during the day without assistance
- The client’s goals for use of the seat lift mechanism

Supporting documentation must be kept in the client’s record that shows that all appropriate therapeutic modalities (such as medication, physical therapy) have been tried and that they failed to enable the client to transfer from a chair to a standing position.

### 2.2.15.17 Batteries and Battery Charger

A battery charger and initial batteries are included as part of the purchase of a PMD. Replacement batteries or a replacement battery charger may be considered for reimbursement if they are no longer under warranty.

A maximum of one hour of labor may be considered to install new batteries. Labor is not reimbursed with the purchase of a new PMD or with replacement battery chargers.

#### 2.2.15.17.1 Prior Authorization

Batteries and battery chargers will not be prior authorized for replacement within six months of delivery. Batteries and battery chargers within the first six months after delivery are considered part of the purchase price.

A maximum of one hour of labor may be prior authorized to install new batteries. Labor will not be prior authorized for a new power wheelchair or for replacement battery chargers.

#### 2.2.15.17.2 Documentation Requirements

To request prior authorization for replacement batteries or a replacement battery charger, the provider must document the date of purchase and serial number of the currently owned wheelchair as well as the reason for the replacement batteries or battery charger.

Documentation required supporting the need to replace the batteries or battery charger must include:

- Why the batteries are no longer meeting the client’s needs, or
- Why the battery charger is no longer meeting the client’s needs
2.2.15.18 Power Wheeled Mobility Systems- Scooter

A scooter is a professionally manufactured three- or four-wheeled motorized base operated by a tiller with a professionally manufactured basic seating system for clients who have little or no positioning needs.

A scooter must meet all the following requirements:

- Length - less than or equal to 48 inches
- Width - less than or equal to 28 inches
- Minimum top end speed - 3 mph
- Minimum range - 5 miles
- Minimum obstacle climb - 20 mm
- Radius pivot turn of less than or equal to 54 inches
- Dynamic stability incline - 6 degrees

Custom seating for scooters is not a benefit of Texas Medicaid Title XIX Home Health Services. Repairs to scooters will be considered only for a scooter purchased by the Texas Medicaid.

2.2.15.18.1 Prior Authorization

A scooter may be prior authorized for ambulatory-impaired clients with good head, trunk, and arm/hand control, without a diagnosis of progressive illness (including, but not limited to, progressive neuromuscular diseases such as amyotrophic lateral sclerosis [ALS]).

To request prior authorization for a scooter, the client must not own, or be expected to require, a power wheelchair within five years of the purchase of a scooter.

A scooter may be prior authorized for a short-term rental or an initial three-month trial rental period based on documentation supporting the medical necessity and appropriateness of the device.

Assessment of the accessibility of the client's residence must be completed and included in the prior authorization documentation to ensure that the scooter is usable in the home (i.e., doors and halls wide enough, no obstructions).

A scooter must be able to accommodate a 20 percent change in the client's height and/or weight.

2.2.15.18.2 Documentation Requirements

Prior authorization for a scooter requires all the documentation required for a standard power wheelchair and meets all the following criteria:

- The client's physical and cognitive ability to receive and follow instructions related to the responsibilities of using the equipment.
- The ability of the client to physically and cognitively operate the scooter independently.
- The capability of the client to care for the scooter and understand how it operates.

2.2.15.19 Client Lift

A lift is a portable transfer system used to move a nonambulatory client over a short distance from bed to chair and chair to bed.

A client lift for the convenience of a caregiver is not a benefit of Texas Medicaid.

A hydraulic lift is for a client who is unable to assist in their own transfers and is operated by the weight or pressure of a liquid.
An electric lift is operated by electricity and may be considered when a hydraulic lift will not meet the client’s needs.

**Note:** Portable lifts that can be used outside the home setting, hydraulic or electric, are not a benefit through Title XIX Home Health Services. For clients who are birth through 20 years of age, portable lifts that can be used outside the home setting may be considered through CCP.

2.2.15.19.1 Prior Authorization

A client lift will not be prior authorized for the convenience of a caregiver.

A client limit must be able to accommodate a 20 percent change in the client’s height and/or weight.

2.2.15.20 Electric Lift

Prior authorization for an electric lift may be considered when the client meets criteria for a hydraulic lift and additional documentation explains why a hydraulic lift will not meet the client’s needs.

**Note:** Portable lifts that can be used outside the home setting, hydraulic or electric, are not a benefit through Title XIX Home Health Services. For clients who are birth through 20 years of age, portable lifts that can be used outside the home setting may be considered through CCP.

2.2.15.21 Hydraulic Lift

Hydraulic lifts require prior authorization.

2.2.15.21.1 Documentation Requirements

Prior authorization for a hydraulic lift may be considered with the following documentation:

- The inability of the client to assist in their own transfers
- The weight of the client and the weight capacity of the requested lift
- The availability of a caregiver to operate the lift
- Training by the provider to the client and the caregiver on the safe use of the lift

2.2.15.22 Standers

A stander is a device used by a client with neuromuscular conditions who is unable to stand alone. Standers and standing programs can improve digestion, increase muscle strength, decrease contractures, increase bone density, and minimize decalcification (this list is not all inclusive).

2.2.15.22.1 Prior Authorization

Standers, including all accessories, require prior authorization. Standers and gait trainers will not be prior authorized for a client within one year of each other.

2.2.15.22.2 Documentation Requirements

Prior authorization may be considered for the standers with the following documentation:

- Diagnoses relevant to the requested equipment, including functioning level and ambulatory status
- Anticipated benefits of the equipment
- Frequency and duration of the client’s standing program
- Anticipated length of time the client will require this equipment
- Client’s height, weight, and age
- Anticipated changes in the client’s needs, anticipated modifications, or accessory needs, as well as the growth potential of the stander
2.2.15.23  Gait Trainers

Gait trainers are devices with wheels used to train clients with ambulatory potential. They provide the same benefits as the stander, in addition to assisting with gait training.

2.2.15.23.1  Prior Authorization

Prior authorization for a gait trainer may be considered with documentation supporting medical necessity and an assessment of the accessibility of the client’s residence to ensure that the gait trainer is usable in the home (i.e., doors and halls are wide enough and have no obstructions), when a physician familiar with the client documents that the client has ambulatory potential and will benefit from a gait training program, and when the client meets the criteria for a stander.

2.2.15.24  Accessories, Modifications, Adjustments and Repairs

Accessories, modifications, adjustments, and repairs are benefits of Texas Medicaid as outlined below.

- All modifications, adjustments, and repairs to standard mobility aid equipment within the first six months after delivery are considered part of the purchase price.
- All modifications and adjustments to a wheeled mobility system, as well as the associated services by the QRP for the seating assessment and fitting, within the first six months after delivery are considered part of the purchase price.

Mobility aids that have been purchased are anticipated to last a minimum of five years.

A major modification to a wheeled mobility system requires the completion of a new seating assessment by a qualified practitioner (physician, occupational therapist, or physical therapist), with the participation of a QRP.

Prior authorization for equipment replacement is considered within five years of equipment purchase when one of the following occurs:

- There has been a significant change in the client’s condition such that the current equipment no longer meets the client’s needs.
- The equipment is no longer functional and either cannot be repaired or it is not cost-effective to repair.

A wheeled mobility system that has been fitted and delivered to the client’s home by a QRP and then found to be inappropriate for the client’s condition will not be eligible for an upgrade, replacement, or major modification within the first six months following purchase unless there has been a significant change in the client’s condition. The significant change in the client’s condition must be documented by a physician familiar with the client.

2.2.15.24.1  Prior Authorization

Modifications

Modifications to custom equipment after the first six months from fitting and delivery may be considered for prior authorization if a change occurs in the client’s needs, capabilities or physical/mental capability, that cannot be anticipated.

Documentation supporting the medical necessity of the requested modification must include the following:

- Description of the change in the client’s condition that requires accommodation by different seating, drive controls, electronics, or other mobility base components.
- All projected changes in the client’s mobility needs.
- The date of purchase, the serial number of the current equipment, and the cost of purchasing new equipment versus modifying current equipment.
Major modifications to a wheeled mobility system also require that a new seating assessment be completed and submitted with the prior authorization request. A request for authorization of the QRP’s participation in the seating assessment for the major modification must be included with the prior authorization request for the major modification.

Minor modifications to a wheeled mobility system do not require the completion of a new seating assessment.

Requests for equipment submitted as a minor modification to a wheeled mobility system must be submitted with modifier RB.

**Adjustments**

Adjustments within the first six months after delivery, including adjustments to a wheeled mobility system within the first six months after fitting and delivery by a QRP will not be prior authorized.

A seating or positioning component alteration that does not require replacement components to accommodate a change in the client’s size (height or weight) is considered an adjustment and not a major modification.

A maximum of one hour of labor for adjustments may be prior authorized as needed after the first six months from delivery.

Documentation must include the date of purchase, the serial number of the current equipment, and the reason for adjustments.

**Repairs**

Repairs to client-owned equipment may be considered for prior authorization as needed with documentation of medical necessity. Technician fees are considered part of the cost of the repair.

HHSC or its designee reserves the right to request additional documentation about the need for repairs when there is evidence of abuse or neglect to equipment by the client, client’s family, or caregiver. Requests for repairs when there is documented proof of abuse or neglect will not be authorized.

Requests for equipment submitted as a repair to a wheeled mobility system must be submitted with modifier RB.

Providers are responsible for maintaining documentation in the client’s medical record specifying the repairs and supporting medical necessity.

Documentation must include the date of purchase and serial number of the current equipment, the cause of the damage or need for repairs, the steps the client or caregiver will take to prevent further damage if repairs are due to an accident, and when requested, the cost of purchasing new equipment as opposed to repairing current equipment.

**2.2.15.25 Replacement**

Replacement of equipment is also considered when loss or irreparable damage has occurred. The following must be submitted with the prior authorization request:

- A copy of the police or fire report, when appropriate.
- A statement about the measures to be taken in order to prevent reoccurrence.
- Replacement equipment for clients who are birth through 20 years of age and do not meet the criteria in this handbook may be considered for prior authorization through CCP.
## 2.2.15.26 Procedure Codes and Limitations for Mobility Aids

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<td>E2619</td>
<td>1 per year</td>
</tr>
<tr>
<td>E2620</td>
<td>1 per year</td>
</tr>
<tr>
<td>E2621</td>
<td>1 per year</td>
</tr>
<tr>
<td>E2622</td>
<td>1 per year</td>
</tr>
<tr>
<td>E2623</td>
<td>1 per year</td>
</tr>
<tr>
<td>E2624</td>
<td>1 per year</td>
</tr>
<tr>
<td>E2625</td>
<td>1 per year</td>
</tr>
</tbody>
</table>

**Batteries**

<table>
<thead>
<tr>
<th>Procedure Code</th>
<th>Maximum Limit</th>
</tr>
</thead>
<tbody>
<tr>
<td>E2361</td>
<td>1 per 5 years</td>
</tr>
<tr>
<td>E2363</td>
<td>1 per 5 years</td>
</tr>
<tr>
<td>E2366</td>
<td>1 per 5 years</td>
</tr>
<tr>
<td>E2371</td>
<td>1 per 5 years</td>
</tr>
<tr>
<td>K0733</td>
<td>2 per year</td>
</tr>
</tbody>
</table>

**Safety Equipment**

<table>
<thead>
<tr>
<th>Procedure Code</th>
<th>Maximum Limit</th>
</tr>
</thead>
<tbody>
<tr>
<td>E0700</td>
<td>2 per year</td>
</tr>
<tr>
<td>E0705</td>
<td>1 per 5 years</td>
</tr>
</tbody>
</table>

**Lifts**

<table>
<thead>
<tr>
<th>Procedure Code</th>
<th>Maximum Limit</th>
</tr>
</thead>
<tbody>
<tr>
<td>E0628</td>
<td>1 per 5 years</td>
</tr>
<tr>
<td>E0629</td>
<td>1 per 5 years</td>
</tr>
<tr>
<td>E0630</td>
<td>1 per 5 years</td>
</tr>
</tbody>
</table>
The following mobility aids are not a benefit of Home Health Services:

- Feeder seats, floor sitters, corner chairs, and travel chairs are not considered medically necessary devices
- Items including but not limited to tire pumps, a color for a wheelchair, gloves, back packs, and flags are not considered medically necessary
- Mobile standers, power standing system on a wheeled mobility device
- Vehicle lifts and modifications
- Permanent ramps, vehicle ramps, and home modifications
- Stairwell lifts of any type
- Elevators or platform lifts of any type
- Patient lifts requiring attachment to walls, ceilings, or floors
- Chairs with incorporated seat lifts
- An attendant control, for safety, all power chairs are to include a stop switch
- Powered mobility device for use only outside the home

Texas Medicaid does not reimburse separately for associated DME charges, including battery disposal fees or state taxes. Reimbursement for associated charges is included in the reimbursement for the specific piece of equipment. White canes for the blind are considered self help adaptive aids and are not a benefit of Home Health Services.

*Note:* THSteps-eligible clients who have a medical need for services beyond the limits of this Home Health Services benefit may be considered under CCP.

*Refer to:* Subsection 2.2.1.1, “Client Eligibility” in this handbook.

### 2.2.16 Nutritional (Enteral) Products, Supplies, and Equipment

Enteral nutritional products are those food products that are included in an enteral treatment protocol. They serve as a therapeutic agent for health maintenance and are required to treat an identified medical condition. Nutritional products, supplies, and equipment may be a benefit when provided in the home under Home Health Services.

#### 2.2.16.1 Enteral Nutritional Products, Feeding Pumps, and Feeding Supplies

Enteral nutritional products and related feeding supplies and equipment are a benefit through Home Health Services for clients who are 21 years of age and older and require tube feeding as their primary source of nutrition. The enteral product, supply, or equipment must be part of the medical POC outlined and maintained by the treating physician.
Enteral nutritional products may be reimbursed with the following procedure codes:

<table>
<thead>
<tr>
<th>Procedure Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>B4100</td>
</tr>
</tbody>
</table>

Enteral nutritional supplies and equipment may be reimbursed with the following procedure codes and limitations:

<table>
<thead>
<tr>
<th>Procedure Codes</th>
<th>Limitations</th>
</tr>
</thead>
<tbody>
<tr>
<td>A4322</td>
<td>4 per month</td>
</tr>
<tr>
<td>A5200</td>
<td>2 per month</td>
</tr>
<tr>
<td>B4034</td>
<td>Up to 31 per month</td>
</tr>
<tr>
<td>B4035</td>
<td>Up to 31 per month</td>
</tr>
<tr>
<td>B4036</td>
<td>Up to 31 per month</td>
</tr>
<tr>
<td>B4081</td>
<td>As needed</td>
</tr>
<tr>
<td>B4082</td>
<td>As needed</td>
</tr>
<tr>
<td>B4083</td>
<td>As needed</td>
</tr>
<tr>
<td>B4087</td>
<td>2 per rolling year</td>
</tr>
<tr>
<td>B4088</td>
<td>2 per rolling year</td>
</tr>
<tr>
<td>B9000</td>
<td>1 purchase every 5 years; 1 rental per month</td>
</tr>
<tr>
<td>B9002</td>
<td>1 purchase every 5 years; 1 rental per month</td>
</tr>
<tr>
<td>B9998*</td>
<td>As needed*</td>
</tr>
<tr>
<td>B9998 with modifier U1</td>
<td>4 per month</td>
</tr>
<tr>
<td>B9998 with modifier U2</td>
<td>2 per rolling year</td>
</tr>
<tr>
<td>B9998 with modifier U3</td>
<td>4 per month</td>
</tr>
<tr>
<td>B9998 with modifier U4</td>
<td>2 per rolling year</td>
</tr>
<tr>
<td>B9998 with modifier U5</td>
<td>4 per month</td>
</tr>
<tr>
<td>T1999*</td>
<td>As needed*</td>
</tr>
</tbody>
</table>

If procedure code T1999 is used for a needleless syringe, the allowed amount is 8 per month.

* Appropriate limitations for miscellaneous procedure codes B9998 and T1999 are determined on a case-by-case basis through prior authorization. Specific items may be requested using procedure code B9998 using the modifiers outlined in the table above.

A backpack or carrying case for a portable enteral nutrition infusion pump may be a benefit of Home Health Services, when medically necessary and prior authorized, using procedure code B9998.

2.2.16.2 Prior Authorization Requirements

Prior authorization is required for most enteral products, supplies, and equipment provided through Home Health Services. Requests are reviewed for medically necessary amounts based on caloric needs as indicated by the client’s physician.

Enteral nutrition and related supplies and equipment may be considered for prior authorization for clients who are 21 years of age and older when all or part of the client’s nutritional intake is received through a feeding tube, and the enteral formula is:

- The client’s sole source of nutrition
- The client’s primary source of nutrition
• An enteral tube feeding is considered the primary source of nutrition when it comprises more than 70 percent of the caloric intake needed to maintain the client's weight.

• The percent of calories provided by an enteral formula may be calculated by dividing the client’s daily calories supplied by the enteral formula by the daily caloric intake ordered by the physician to maintain the client’s weight. The result is multiplied by 100 to determine the percentage of calories provided by the enteral formula.

Related supplies and equipment may be considered for prior authorization when criteria for nutritional products are met, and medical necessity is included for each item requested.

Renewal of the prior authorization will be considered based on medical necessity.

Prior authorization may be given for up to 6 months. Prior authorization may be recertified with documentation supporting ongoing medical necessity for the nutritional products requested.

2.2.16.2.1 Enteral Formulas
Enteral formulas require prior authorization. Requests for prior authorization must include the necessary product information.

Enteral formulas consisting of semi-synthetic intact protein or protein isolates (procedure codes B4150 and B4152) are appropriate for the majority of clients requiring enteral nutrition.

Special enteral formulas or additives (procedure code B4104) may be considered for prior authorization with supporting documentation submitted by the client's physician indicating the client's medical needs for these special enteral formulas. Special enteral formula may be reimbursed with the following procedure codes:

<table>
<thead>
<tr>
<th>Procedure Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>B4149</td>
</tr>
</tbody>
</table>

Pediatric nutritional products (procedure codes B4103, B4158, B4159, B4160, B4161, and B4162) are restricted to clients who are 20 years of age and younger.

Food thickener may be considered for clients with a swallowing disorder.

2.2.16.2.2 Nasogastric, Gastrostomy, or Jejunostomy Feeding Tubes
Feeding tubes require prior authorization.

Additional feeding tubes may be prior authorized if documentation submitted supports medical necessity, such as infection at gastrostomy site, leakage, or occlusion.

2.2.16.2.3 Enteral Feeding Pumps
Enteral feeding pumps, with and without alarms, require prior authorization.

Enteral feeding pumps may be considered for prior authorization for lease or purchase with documentation of medical necessity indicating that the client meets the following criteria:

• Gravity or syringe feedings are not medically indicated
• The client requires an administration rate of less than 100 ml/hr
• The client requires night-time feedings
• The client has one of the following medical conditions (this list is not all-inclusive):
  • Reflux or aspiration
  • Severe diarrhea
  • Dumping syndrome
• Blood glucose fluctuations
• Circulatory overload

2.2.16.2.4 Enteral Supplies
Enteral supplies require prior authorization, with the exception of irrigation syringes (procedure code A4322) and percutaneous catheter or tube anchoring devices (procedure code A4520) within the allowable limits.

Procedure code B4034 will not be prior authorized for use in place of procedure code A4322 for irrigation syringes when they are not part of a bolus administration kit.

Gravity bags and pump nutritional containers are included in the feeding supply kits and will not be prior authorized separately.

Specific items may be considered for prior authorization using miscellaneous procedure code B9998 and modifiers U1, U2, U3, or U5.

Requests for a backpack or carrying case for a portable enteral feeding pump may be considered for prior authorization for purchase only, under miscellaneous code B9998, for clients who meet all of the following medical necessity criteria:

• The client requires enteral feedings lasting greater than eight hours continuously, or feeding intervals exceed the time that the client must be away from home to:
  • Attend school or work.
  • Participate in extensive, physician-ordered outpatient therapies.
  • Attend frequent, multiple medical appointments.

• The client is ambulatory, or uses a wheelchair which will not support the use of a portable pump by other means, such as an IV pole.

• The portable enteral feeding pump is client owned.

2.2.16.3 Documentation Requirements
To request prior authorization for nutritional formula, supplies, or equipment, the following documentation must be provided:

• Accurate diagnostic information pertaining to the underlying diagnosis or condition as well as any other medical diagnoses or conditions, to include the client’s overall health status
• Diagnosis or condition (including the appropriate International Classification of Diseases, Tenth Revision, Clinical Modification [ICD-10-CM] code)
• A statement from the ordering physician noting that enteral nutritional products for tube feedings are the client’s sole or primary source of nutrition
• The goals and timelines on the medical POC
• Total caloric intake prescribed by the physician
• Acknowledgement that the client has a feeding tube in place

2.2.17 Phototherapy Devices
Phototherapy devices are not a benefit of Title XIX Home Health Services. Phototherapy devices are a benefit of Texas Medicaid through CCP for clients who are birth through 20 years of age.

Refer to: Subsection 2.6.13, “Phototherapy Devices” in the Children’s Services Handbook (Vol. 2, Provider Handbooks) for more information on phototherapy devices.
2.2.18 Prothrombin Time/International Normalized Ratio (PT/INR) Home Testing Monitor

PT/INR home testing monitors are a benefit of Title XIX Home Health Services for clients who require chronic oral anticoagulation due to one of the following:

- Mechanical heart valve
- Chronic atrial fibrillation
- Venous thromboembolism (including both deep vein thrombosis [DVT] and pulmonary embolism)
- Ventricular assist device (VAD) awaiting a heart transplant

The PT/INR home testing monitor is a portable, battery-operated instrument for the quantitative determination of PT/INR from whole blood obtained by finger-stick. This product is designed to aid in the management of high-risk clients who take oral anticoagulants.

*Note:* For clients who are 20 years of age and younger and do not meet criteria for coverage through Title XIX Home Health Services, home PT/INR monitors and related testing supplies may be considered through CCP.

The following procedure codes are included in this benefit:

- Procedure code E1399 may be reimbursed for the rental or purchase of the monitor.
- Procedure code A9900 may be reimbursed for the related testing supplies.

Procedure codes E1399 and A9900 may be reimbursed to DME providers for services rendered in the home setting.

2.2.18.1 Prior Authorization

Prior authorization is required for the home PT/INR monitors and related testing supplies.

Prior authorization requests must be submitted within three business days of the date of service and must include documentation of medical necessity and a completed Home Health Services (Title XIX) DME/Medical Supplies Physician Order Form.

The completed Title XIX Form must be maintained by the requesting provider and the prescribing provider. The original signature copy must be kept in the provider’s medical record for the client.

To avoid unnecessary denials, the prescribing provider must provide correct and complete information, including documentation for medical necessity of the equipment and/or supplies requested. The prescribing provider must maintain documentation of medical necessity in the client’s medical record. The requesting provider may be asked for additional information to clarify or complete a request for the PT/INR monitor.

Prior authorization for the rental or purchase of a home PT/INR monitor and related testing supplies will be considered for clients who meet all the following criteria:

- The client is on anticoagulation therapy and has a current prescription for Warfarin or other oral anticoagulant.
- The client has been on anticoagulation therapy for at least three months prior to the request for the home PT/INR monitor.
- The client is required to self-test at least every two weeks.

Additionally, the client must have at least one of the following conditions documented in the request for prior authorization:

- Fluctuations of INR or PT/PTT levels with titration greater than once per week in anticoagulation dosing with copies of laboratory reports and resultant medication changes.
• A medical condition that limits physical movement, places the client under medical restrictions for isolation, or requires non-emergency ambulance transport for the purpose of obtaining laboratory specimens.

• Limited venous access that compromises the ability to obtain laboratory specimens for the adequate monitoring of anticoagulation therapy.

The prior authorization request will be evaluated upon receipt to determine whether the equipment will be rented, purchased, repaired, or modified based on the client’s needs, duration of use, and age of equipment.

Note: Skilled nursing (SN) visits will not be approved for the sole purpose of instructing the client on the use of the PT/INR home testing monitor. Any necessary instruction must be performed as part of the office visit with the prescribing physician.

2.2.19 Respiratory Equipment and Supplies

Respiratory equipment and supplies may be provided in the home under Home Health Services. Rental of equipment includes all necessary supplies, adjustments, repairs, and replacement parts.

Note: Respiratory equipment and related supplies that are not considered a benefit under Home Health Services may be considered for reimbursement through CCP for clients who are 20 years of age and younger, who are CCP eligible (e.g., clients who are residing in residential treatment centers).

2.2.19.1 Prior Authorization

Most respiratory equipment and supplies, with the exception of the codes noted below, require prior authorization.

The following procedure codes do not require prior authorization:

<table>
<thead>
<tr>
<th>Procedure Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>A4481 A4615 A4616 A4617 A4619 A4620 A4623 A7003 A7004 A7005</td>
</tr>
<tr>
<td>A7006 A7007 A7009 A7010 A7012 A7015 A7016 A7017 A7018</td>
</tr>
</tbody>
</table>

Prior authorization is required for rental or purchase of respiratory equipment and supplies not listed above provided through the Texas Medicaid Title XIX Home Health Services. To complete the prior authorization process, the provider should submit the completed Title XIX Form to the Home Health Unit.

• A completed Title XIX Home Health Durable Medical Equipment (DME)/Medical Supplies Physician Order Form prescribing the DME or medical supplies must be signed and dated by the prescribing physician familiar with the client prior to requesting authorization. The completed Title XIX Form must be maintained by the requesting provider and the prescribing physician. The original signature copy must be kept in the physician’s medical record for the client.

• In addition to the Texas Medicaid Title XIX Home Health Durable Medical Equipment (DME)/Medical Supplies Physician Order Form, all other required forms must be signed and dated by the prescribing physician who is familiar with the client before requesting authorization.

Requests for prior authorization or recertification must include documentation by the physician who is familiar with the client that the client is compliant with the use of the equipment and that the treatment is effective.

To avoid unnecessary denials, when requesting prior authorization for respiratory equipment and supplies, the physician must provide correct and complete information, supporting the medical necessity of the equipment or supplies requested, including:

• Diagnosis or condition causing impairment of respiratory function.
• Accurate diagnostic information pertaining to any other medical diagnoses or conditions, to include the client’s overall health status.

The provider may be asked to provide additional information to clarify or complete a request for respiratory supplies or accessories.

The following includes, but is not limited to, respiratory equipment that require prior authorization:

• IPPB device
• Electrical percussor
• HFCWCS
• Cough stimulating device
• CPAP system
• Bi-level positive airway pressure system without backup (such as BiPAP S)
• Bi-level positive airway pressure system with backup (such as BIPAP ST)
• All home ventilation and humidification equipment
• Home oxygen systems
• Controlled dose inhalation drug delivery system
• Aerosols, humidifiers, and nebulizers to add moisture to air or oxygen

2.2.19.2 Nebulizers

Nebulizers may be reimbursed for purchase only, and that purchase is limited to 1 every 5 years. Providers must use procedure code E0570 when billing for the purchase of the nebulizer.

For fee-for-service, medications that are used with the nebulizer will not be reimbursed to a DME company. These medications may be considered under the Vendor Drug Program.

Refer to: “Appendix B: Vendor Drug Program” (Vol. 1, General Information) for more information about VDP.

2.2.19.2.1 Prior Authorization

Nebulizers and nebulizer supplies do not require prior authorization for the diagnoses listed below. Other diagnoses require prior authorization and may be considered based on review of documentation by HHSC or its designee.

<table>
<thead>
<tr>
<th>Diagnosis Codes (Submitted as stand-alone diagnosis codes)</th>
</tr>
</thead>
<tbody>
<tr>
<td>B59</td>
</tr>
<tr>
<td>J121</td>
</tr>
<tr>
<td>J219</td>
</tr>
<tr>
<td>J438</td>
</tr>
<tr>
<td>J4550</td>
</tr>
<tr>
<td>J479</td>
</tr>
<tr>
<td>J677</td>
</tr>
<tr>
<td>P271</td>
</tr>
</tbody>
</table>

Purchase of nebulizers may be considered for prior authorization for diagnoses other than those listed in the diagnosis table for nebulizers, with documentation of medical necessity.
The following procedure codes for nebulizer supplies may be billed with the diagnosis codes listed above:

<table>
<thead>
<tr>
<th>Procedure Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>A4617</td>
</tr>
</tbody>
</table>

Ultrasonic nebulizers may be considered for prior authorization for the following diagnoses with documentation for failure of standard therapy:

<table>
<thead>
<tr>
<th>Diagnosis Codes (Submitted as stand-alone diagnosis codes)</th>
</tr>
</thead>
<tbody>
<tr>
<td>B59</td>
</tr>
</tbody>
</table>

Providers must use procedure code A7009, A7014, or A7016 when billing supplies with an ultrasonic nebulizer.

Providers must include documentation by the physician who is familiar with the client that the client is compliant with the use of the equipment and that the treatment is effective.

### 2.2.19.3 Vaporizers

Vaporizers may be reimbursed for purchase only, and that purchase is limited to 1 every 5 years.

Providers must use procedure code E0605 when billing for vaporizers. Vaporizer use is associated with a risk of bronchospasm, infection, edema of the airway, and client, caregiver, parent or guardian exposure to airborne microorganisms.

#### 2.2.19.3.1 Prior Authorization

Vaporizers require prior authorization for limited indications that includes one of the following:

- Laryngotracheobronchitis
- Subglotic edema
- Post-extubation edema
- Postoperative management of the upper airway
- The need for sputum specimens or mobilization of secretions
- The presence of a bypass upper airway

Prior authorization for use beyond the clinical indications listed above is only considered with clinical documentation that demonstrates that the benefit of the use of the device outweighs the noted risks.

### 2.2.19.4 Humidification Units

Humidification units for nonmechanically ventilated clients may be purchased when a purchase is determined to be more cost effective than leasing the device with supplies. Providers must use procedure code E1399 when billing for the purchase of humidification units for nonmechanically ventilated clients. Procedure code E1399 will be reimbursed with a maximum fee of $1,230.00 or MSRP less 18 percent, which ever is the lesser cost. Supplies to be used with client owned humidification units may be considered for purchase and must be billed with the appropriate HCPCS code for each item requested. Documentation of medical necessity must be included with submission of the request.

### 2.2.19.5 Secretion Clearance Devices

Secretion clearance devices and incentive spirometers do not require authorization.

#### 2.2.19.5.1 Intermittent Positive-Pressure Breathing (IPPB) Devices

Purchase of the IPPB device (procedure code E0500) is not a benefit.
Rental of an IPPB device (procedure code E0500) requires prior authorization. Prior authorization may be granted when the request is submitted with documentation that indicates an ineffective response with other modalities such as treatment with a cough assist device for four months or longer. Rental of the IPPB device includes all supplies, such as humidification and tubing.

Purchase of the IPPB device will not be reimbursed.

In accordance with the American Association for Respiratory Care recommendations, IPPB may be considered when one of the following is documented:

- Presence of clinically significant atelectasis.
- Reduced pulmonary function as evidenced by reductions in timed volumes, and vital capacity.
- Neuromuscular disorders or kyphoscoliosis with associated decreases in lung volumes and capacities.
- Fatigue or muscle weakness with impending respiratory failure.
- Presence of acute severe bronchospasm or exacerbated COPD that fails to respond to other therapy.
- Patients who are at risk for the development of atelectasis and are unable or unwilling to deep breathe without assistance.

The IPPB device may be prior authorized for rental with the following diagnoses:

<table>
<thead>
<tr>
<th>Diagnosis Codes (Submitted as stand-alone diagnosis codes)</th>
</tr>
</thead>
<tbody>
<tr>
<td>E840</td>
</tr>
<tr>
<td>G710</td>
</tr>
<tr>
<td>J449</td>
</tr>
<tr>
<td>J84115</td>
</tr>
<tr>
<td>J952</td>
</tr>
</tbody>
</table>

2.2.19.5.2 Mucous Clearance Valve

Providers must use procedure code S8185 when billing for the purchase of a mucous clearance valve. Purchase of the mucous clearance valve requires prior authorization.

Rental of the mucous clearance valve is not a benefit.

The mucous clearance valve may be prior authorized for the following diagnoses:

<table>
<thead>
<tr>
<th>Diagnosis Codes (Submitted as stand-alone diagnosis codes)</th>
</tr>
</thead>
<tbody>
<tr>
<td>E840</td>
</tr>
<tr>
<td>J411</td>
</tr>
<tr>
<td>J441</td>
</tr>
<tr>
<td>J4540</td>
</tr>
<tr>
<td>J45909</td>
</tr>
<tr>
<td>J672</td>
</tr>
</tbody>
</table>
2.2.19.6 Electrical Percussor
The electrical percussor device requires prior authorization. The electrical percussor may be prior authorized for rental or purchase depending on the physician’s predicted length of treatment.

In addition to the completed Title XIX order form, a description of all previous courses of therapy and why they did not adequately assist the client in airway mucus clearance is required to obtain authorization for an electrical percussor.

2.2.19.7 Chest Physiotherapy Devices
Either a cough-stimulating device (cofflator) or the High-Frequency Chest Wall Compression System (HFCWCS) generator with vest may be prior authorized. These systems are not prior authorized simultaneously.

Chest physiotherapy to promote bronchial drainage that is performed by a therapist or any other healthcare professional, including a private duty nurse, will not be prior authorized during the period of time that the HFCWCS or cough-stimulating device is prior authorized.

Intrapulmonary percussive ventilation (IPV) is not a benefit of Texas Medicaid.

2.2.19.7.1 HFCWCS
A HFCWCS may be reimbursed only when it is demonstrated that other mechanical devices or chest physiotherapy by a client, parent, guardian, or caregiver have been ineffective.

Rental cost of the HFCWCS applies toward the purchase price. A HFCWCS generator purchase and vest purchase may be reimbursed only once per lifetime, due to the lifetime warranty provided by the manufacturer. Requests for a vest replacement due to growth may be considered with appropriate documentation.

Prior authorization for the rental or purchase of equipment in this section requires a Home Health Services (Title XIX) Durable Medical Equipment (DME)/Medical Supplies Physician Order Form and the Medicaid Certificate of Medical Necessity for Chest Physiotherapy Device Initial Request or Extended Request form. These signed and dated forms must be maintained by the provider and prescribing physician in the client’s medical record.

Providers must use procedure code E0483 when billing for HFCWCS for either a rental or purchase.

Prior authorization of the HFCWCS may be considered for the following diagnosis codes:

<table>
<thead>
<tr>
<th>Diagnosis Codes (Submitted as stand-alone diagnosis codes)</th>
</tr>
</thead>
<tbody>
<tr>
<td>E840 E8411 E8419 E848 E849 G121 G128 G129 G710 G800 G801 G802 G804 G808 G809 G8381 G8382 G8383 G8384 G8389 J09X1 J8410</td>
</tr>
</tbody>
</table>

Other diagnosis may be considered based on review of documentation by HHSC or its designee.

Rental of the HFCWCS
The HFCWCS requires prior authorization. An initial three-month rental may be authorized for the HFCWC. If the HFCWC is documented to be effective, at the end of the initial three-month rental, purchase of the system may be prior authorized. If at the end of the initial three-month rental a determination of purchase cannot be made, an additional three-month rental may be given.
To obtain prior authorization for the initial three-month rental of a HFCWCS generator and vest, all of the following information must be provided:

- A description of all previous therapy courses that have been tried and why these treatments did not adequately assist the client in airway mucus clearance. This must include the information that the client has used a cough assist device for a minimum of four months before the request and that this therapy has been ineffective.

- A physician’s statement of a trial of the HFCWCS in a clinic, hospital, or the home setting documenting the effectiveness and tolerance of the system, including a statement that the client has not exacerbated any gastrointestinal manifestations, nor caused aspiration and exacerbation of pulmonary manifestations, nor an exacerbation of seizure activity secondary to the use of the system.

- Diagnosis and background history including complications, medications used, history of any IV antibiotic therapy with dosage, frequency and duration, history of recent hospitalizations or history of school, work, or extracurricular activity absences due to diagnosis-related complications.

- Any recent illnesses or hospitalizations due to respiratory problems or complications.

- Medical diagnosis or other limitations preventing the client or caregiver from doing chest physiotherapy.

Prior authorization for an extension of another three months rental may be considered with the above documentation.

**Purchase of the HFCWCS Generator**

Requests for prior authorization of the purchase of a HFCWCS generator may be considered based on the outcome of a six-month rental period and the following required documentation. Documentation of vest tolerance and positive outcomes/results of therapy, including:

- Physician’s description or assessment of the effectiveness such as decreased medication use, shorter hospital length of stay, decreased hospitalizations, and fewer school, work, or extracurricular activity absences due to diagnosis related complications.

- The frequency and compliance graphs for the six-month period showing use of the system at least 50 percent of the maximum time prescribed by the physician for each day.

- Respiratory status, including any recent hospitalization.

- A statement that the client has not exacerbated any gastrointestinal manifestations, nor caused aspiration and exacerbation of pulmonary manifestations, nor an exacerbation of seizure activity secondary to the use of the system.

**2.2.19.8 Cough-Stimulating Device (Cofflator)**

The cough stimulating device requires prior authorization. Prior authorization may be given for monthly rental only. Purchase of the cough stimulating device is not a benefit and will not be considered for prior authorization.

The completed Title XIX Form and the Medicaid Certificate of Medical Necessity for Chest Physiotherapy Devices Initial or Extended form must be maintained by the provider in the client’s medical record.

The cough stimulating device (procedure code E0482) may be prior authorized for those clients who have chronic pulmonary disease or neuromuscular disorders that affect the respiratory musculature.
The cofflator may be approved initially for a three-month rental period based on the following required documentation:

- Diagnosis and background history including recent illnesses, complications, medications used, history of recent hospitalizations, results of pulmonary function studies if applicable, or history of school, work, or extracurricular activity absences due to diagnosis related complications.
- Medical reasons why the client, parent, or guardian/caregiver cannot do chest physiotherapy.

Requests for prior authorization of an extension must include documentation by the physician familiar with the client that the client is compliant with the use of the equipment and that the treatment is effective.

2.2.19.8.1 Tracheostomy Tubes

A tracheostomy tube may be reimbursed for purchase only and is limited to one per month. Add modifier TF when billing a tracheostomy with specialized functions. Add modifier TG when billing a custom-made tracheostomy. The MSRP information and a physician statement addressing the reason the client cannot use a standard tracheostomy tube are required when requesting prior authorization. Disposable tracheostomy inner cannulas are considered a convenience item and are not a benefit.

Prior authorization requests for tracheostomy tubes must provide sufficient information to support the determination of medical necessity for the requested item. Prior authorization for a tracheostomy tube will be considered with procedure codes A7520, A7521, or A7522. Providers must use procedure code A4623 when requesting prior authorization for the tracheostomy tube inner cannula. An inner cannula is limited to one per month and will not be prior authorized when a custom manufactured tracheostomy tube (procedure code A7520-TG or A7521-TG) is requested.

2.2.19.9 Positive Airway Pressure System Devices

In addition to the Home Health Services (Title XIX) Durable Medical Equipment (DME)/Medical Supplies Physician Order Form, a Medicaid Certificate of Medical Necessity for CPAP/BiPAP or Oxygen Therapy Form must be signed and dated by the physician familiar with the client and submitted by the provider for all positive pressure system devices. The original signed copy must be kept in the medical record.

2.2.19.9.1 Heated and Non-heated Humidification For Use With Positive Airway Pressure System

Humidification devices require prior authorization. Documentation of medical necessity including the diagnosis and expected outcome must be submitted with the request for prior authorization.

2.2.19.9.2 Continuous Positive Airway Pressure (CPAP) System

Purchase is limited to a maximum of once every five years with medical necessity. Reimbursement for rental is limited to once per month and includes all supplies and accessories.

Headgear, tubing, and filters are considered part of the rental and will not be reimbursed separately.

Providers must use procedure code E0601 when requesting prior authorization for the rental or purchase of the CPAP system.

Adult CPAP (19 years of age and older)

CPAP may be approved initially for three months for adults if one of the following conditions are met:

- A Sleep Study Respiratory Disturbance Index (RDI) or Apnea/Hypopnea Index (AHI) greater than or equal to 15 per hour
- A Sleep Study RDI or AHI greater than 5 per hour and at least one of the following:
• Excessive daytime sleepiness (documented by either Epworth greater than 10 or multiple sleep latency test (MSLT) less than 6
• Documented symptoms of impaired cognition, mood disorders, or insomnia
• Documented hypertension (systolic blood pressure greater than 140 mm Hg or diastolic blood pressure greater than 90 mm Hg)
• Documented ischemic heart disease
• Documented history of stroke
• Greater than 20 episodes of oxygen desaturation less than 85 percent during a full night sleep study
• Any one episode of oxygen desaturation less than 70 percent

**Pediatric CPAP Criteria**
One of the following AHI or oxygen saturation levels may be used for clients who are 18 years of age and younger:
- Polysomnography documentation AHI greater than 1
- An oxygen saturation less than 92 percent, taken upon exertion breathing room air

**2.2.19.9.3 Prior Authorization**
The CPAP system requires prior authorization and may be prior authorized for rental or purchase depending on the physician’s predicted length of treatment. Headgear, tubing, and filters used with patient owned positive airway pressure devices require prior authorization. Humidifiers may be prior authorized when used with a CPAP with documentation of medical necessity. Clients who have a current prior authorization for a CPAP/BiPAP S may continue to rent these items until the prior authorization period expires. After the current prior authorization period expires, then the criteria in the following paragraph applies to any further prior authorizations of CPAP/BiPAP. Providers must supply a new CPAP/BiPAP to clients at the beginning of the new prior authorization period.

The CPAP system may be approved initially for a three-month rental period based on documentation supporting the medical necessity and appropriateness of the device.

**CPAP Prior Authorization Renewal**
Prior authorization for purchase after the initial three-month rental period may be granted if the client is continuing to use the equipment at a minimum of four hours per night and symptoms are improved as documented by a physician familiar with the client. This documentation of compliance and effectiveness must be provided with a new completed Home Health Services (Title XIX) Durable Medical Equipment (DME)/Medical Supplies Physician Order Form and a Medicaid Certificate of Medical Necessity for CPAP/BiPAP or Oxygen Therapy form. Rental of a CPAP/BiPAP system includes all supplies. CPAP/BiPAP S may be rented up to a maximum of 13 months. The equipment is considered purchased after 13 months rental.

**2.2.19.9.4 Bi-level Positive Airway Pressure System (BiPAP S) Without Backup**
Purchase is limited to a maximum of once every five years with medical necessity. Reimbursement for rental is limited to once per month and includes all supplies.

Providers must use procedure code E0470 when requesting prior authorization for the rental or purchase of the BiPAP S.

The BiPAP S may be approved initially for a three-month rental period based on documentation supporting the medical necessity and appropriateness of the device.
The BiPAP S may be approved initially for three months if the following conditions are met:

- The client has demonstrated the inability to tolerate the CPAP system.
- The duration of symptoms is at least six months.
- The Sleep Study RDI or AHI is greater than 15 per hour.
- The Sleep Study RDI or AHI greater than 10 per hour with the lowest oxygen saturation during study is less than 80 percent.
- Oxygen saturation is equal to or less than 92 percent for clients who are 20 years of age and younger.

Rental of CPAP/BiPAP S includes all supplies. CPAP/BiPAP S may be rented up to a maximum of 13 months. The equipment is considered purchased after 13 months rental.

**Prior Authorization**

The BiPAP S requires prior authorization and may be reimbursed for rental or purchase depending on the physician’s predicted length of treatment. The BiPAP S will not be prior authorized once a CPAP is purchased. Clients who have a current prior authorization for a CPAP/BiPAP S may continue to rent these items until the prior authorization period expires. After the current prior authorization period expires, then the criteria in the following paragraph applies to any further prior authorizations of CPAP/BiPAP. Providers must supply a new CPAP/BiPAP to clients at the time of purchase, if the item is purchased after a rental period.

Prior authorization for purchase after the initial three-month rental period may be granted if the client is continuing to use the equipment at a minimum of four hours per night and symptoms are improved as documented by a physician familiar with the client. This documentation of compliance and effectiveness must be provided with a new completed Home Health Services (Title XIX) Durable Medical Equipment (DME)/Medical Supplies Physician Order Form and a Medicaid Certificate of Medical Necessity for CPAP/BiPAP or Oxygen Therapy form.

**2.2.19.9.5 Bi-level Positive Airway Pressure System With Backup (BiPAP ST)**

Purchase of a BiPAP ST is not a benefit. The BiPAP ST may be approved initially for a three-month rental period based on documentation supporting the medical necessity and appropriateness of the device. Providers must use either procedure code E0471 or E0472 when requesting prior authorization for the rental of the BiPAP ST.

BiPAP ST may be approved initially for three months if the following conditions are met:

- A diagnosis of central sleep apnea or a neuromuscular disease producing respiratory insufficiency, and
- Sleep study records central apnea greater than 5 RDI or AHI per hour, or
- For clients who are 18 years of age and younger with:
  - Central apneas greater than 20 seconds regardless of bradycardia
  - Desaturation or central apneas of less than 20 seconds with desaturation greater than 4 percent
  - Bradycardia
- The client has an arterial PO2 at or below 56 mm Hg, or an arterial oxygen saturation at or below 89 percent by transcutaneous oximetry associated with a diagnosis of neuromuscular respiratory insufficiency or failure (not COPD).

**2.2.19.9.6 Prior Authorization**

The rental of a BiPAP ST requires prior authorization and may be reimbursed only once per month.
Continued prior authorization for rental after the initial three-month rental period may be granted if the client is continuing to use the equipment at a minimum four hours per night and has a transcutaneous saturation greater than 88 percent while using the equipment as documented by a physician familiar with the client or 92 percent or less for clients who are 20 years of age and younger. This documentation of compliance and effectiveness must be provided with the above documentation plus a new completed Home Health Services (Title XIX) Durable Medical Equipment (DME)/Medical Supplies Physician Order Form and a Medicaid Certificate of Medical Necessity for CPAP/BiPAP or Oxygen Therapy form.

2.2.19.10 Home Mechanical Ventilation Equipment

Continuous use ventilators are used for 12 or more hours per day. Intermittent use ventilators are used for less than 12 hours per day. Mechanical ventilation is either provided by positive pressure ventilation (volume ventilator) or negative pressure ventilation (iron lung).

Prior Authorization

All ventilators require prior authorization. The completed, signed, and dated Home Health Services (Title XIX) Durable Medical Equipment (DME)/Medical Supplies Physician Order Form must specify all ventilator settings and must be maintained by the DME provider and the prescribing physician in the client’s medical record.

Volume Ventilators

A volume ventilator may be operated in any of the following:

Ventilation Modes

- Control
- Assist control
- Synchronized intermittent mandatory ventilation (SIMV)
- CPAP

Breath Types

- Spontaneous (client triggered and cycled)
- Ventilator assisted (client or machine triggered or cycled) (e.g., pressure support or pressure-assisted)
- Mandatory (machine triggered or machine cycled)

The monthly ventilator rental includes all ventilator supplies, such as (but not limited to):

- Internal filters
- External filters
- Ventilator circuits with an exhalation valve
- High and low pressure alarms
- All humidification systems including supplies and solutions (i.e., sterile or distilled water)
- Compressors and supplies
- Tracheostomy filters/heat moisture exchangers
- Humidifiers

*Note:* Oxygen rental is not considered a ventilator supply and may be considered for separate prior authorization.
Prior authorization of a volume ventilator rental may be granted for clients who have a tracheostomy. For all ventilator procedure codes, providers must include documentation by the physician who is familiar with the client, which states that the client is compliant with the use of the equipment and that the treatment is effective.

Refer to: Subsection 2.2.19.13, “Procedure Codes and Limitations for Respiratory Equipment and Supplies” in this handbook for additional information about ventilator procedure codes.

2.2.19.10.1 Negative Pressure Ventilators
The ventilator rental includes all component parts (pillow, mattress, gaskets, etc.).

Application devices may be purchased following the initial three-month rental period depending on the physician’s predicted length of treatment and the client’s compliance.

The purchase of a chest shell (cuirass) and chest wrap is limited to a maximum of 1 every 5 years. Reimbursement for rental is limited to once per month for a total of 4 months.

Prior Authorization
Negative pressure ventilators may be prior authorized for rental only for individuals who have the ability to speak, eat, drink, and do not have a tracheostomy. One of the following devices may be prior authorized with a portable negative pressure ventilator using procedure codes E0457 and E0459. These devices may be reimbursed for an initial three-month rental period. Application devices may be prior authorized for rental of an initial period of three months.

2.2.19.10.2 Ventilator Service Agreement
A ventilator service agreement may be reimbursed only once per month. Providers must use procedure code A9900 when requesting the ventilator service agreement. The ventilator service agreement contract may be considered for renewal every six months.

The provider must agree to include all of the following components in the ventilator service agreement:

- Ensure that all routine service procedures as outlined by the ventilator manufacturer are followed
- Provide all internal filters, external filters, and tracheostomy filters
- Provide all ventilator circuits (with the exhalation valve) as a part of the ventilator service agreement
- Provide a respiratory therapist and back-up ventilator on a 24-hour call basis
- Provide monthly home visits by a certified respiratory therapist to verify proper functioning of the ventilator system and the client’s status (and maintain documentation of monthly visits)
- Provide a substitute ventilator while the manufacturer’s recommended preventive maintenance is being performed on the client-owned ventilator

Prior Authorization
A ventilator service agreement may be prior authorized for a client who owns their own ventilator, when documentation supports medical necessity/appropriateness for continued ventilator usage. A ventilator service agreement requires prior authorization, which must include submission of a completed Title XIX form and the ventilator service agreement. The completed Home Health Services (Title XIX) Durable Medical Equipment (DME)/Medical Supplies Physician Order Form must include all ventilator settings.

The completed, signed, and dated Home Health Services (Title XIX) Durable Medical Equipment (DME)/Medical Supplies Physician Order Form and the Ventilator Service Agreement form must be maintained by the provider and the prescribing physician in the client’s medical record. The client-owned ventilator must be functional at the time of the request for prior authorization and documen-
tation must include the make, model number, serial number, and the date of ventilator purchase and all ventilator settings. Requests for a continued six-month prior authorization of a ventilator service agreement must include the above documentation and the following:

- The recommended preventive maintenance schedule for the ventilator make and model
- Documentation of the monthly ventilator and client assessments
- Documentation of all service performed during the previous service agreement

### 2.2.19.11 Oxygen Therapy

Oxygen therapy home delivery systems may be reimbursed for rental only once per month.

Moisture exchangers for use with non-mechanically ventilated clients may be considered for reimbursement when billed with procedure code A9900.

Rental of oxygen equipment includes all supplies and refills.

One of the following clinical indications must be present when requesting approval for in-home oxygen therapy:

- Bronchopulmonary dysplasia and other respiratory diagnoses due to prematurity.
- Respiratory failure or insufficiency.
- Musculoskeletal weakness, such as that caused by Duchenne’s or spinal muscle atrophy.
- Diagnosis of cluster headaches.
- Hypoxemia-related symptoms and findings that might be expected to improve with oxygen therapy (examples of these symptoms and findings are pulmonary hypertension, recurring congestive heart failure due to chronic cor pulmonale, erythrocytosis, impairment of the cognitive process, nocturnal restlessness, and morning headache).
- Severe lung disease, such as COPD, diffuse interstitial lung disease, whether known or unknown etiology such as cystic fibrosis, bronchiectasis or widespread pulmonary neoplasm.

#### 2.2.19.11.1 Oxygen Therapy Home Delivery System

Providers must use procedure code E1390 when billing for the rental of an oxygen concentrator system. The reimbursement payment for the rental of the oxygen concentrator system includes, but is not limited to, cannula or mask, tubing, and humidification. These items will not be reimbursed separately.

If other types of oxygen therapy home delivery systems are required, documentation of medical necessity exception must be provided.

Other types of delivery systems include:

- Compressed gas cylinder systems (nonportable tanks) (procedure code E0424)
- Liquid oxygen reservoir systems (procedure code E0439)

**Note:** The reimbursement for compressed gas cylinder and liquid oxygen reservoir systems includes all of the supplies that are noted in the procedure code description.

- Portable oxygen systems—Portable oxygen therapy may be prior authorized if the medical necessity conditions are met and the medical documentation indicates that the client requires the use of oxygen in the home and would benefit from the use of a portable oxygen system when traveling outside the home environment.
- Portable oxygen systems are not considered a benefit of the Home Health Services Program for clients who qualify for oxygen solely based on blood gas studies obtained during sleep.
Providers must use procedure codes E0431, E0434, and K0738 when billing for the portable oxygen systems. When procedure code K0738 is billed for the same dates of service as procedure code E0431, procedure code E0431 will be denied.

Rental of the portable oxygen system includes all supplies and refills. Refills for a client-owned system must be obtained from a DSHS-licensed vendor.

2.2.19.11.2 Prior Authorization

All oxygen therapy, supplies, and related equipment requires prior authorization. Humidifiers may not be prior authorized separately for rental for use with oxygen equipment. Multiple oxygen delivery systems (e.g., liquid or gas) will not be prior authorized concurrently. Supplies and refills may be prior authorized for those clients who own their own oxygen systems.

Note: In addition to the completed Home Health Services (Title XIX) Durable Medical Equipment (DME)/Medical Supplies Physician Order Form, a Medicaid Certificate of Medical Necessity for CPAP/BiPAP or Oxygen Therapy form must be completed, signed, and dated by the physician familiar with the client and submitted by the provider.

2.2.19.11.3 Initial Oxygen Therapy Medical Necessity Certification

Prior authorization of home oxygen therapy for the initial period of three months will be granted if the Home Health Services (Title XIX) Durable Medical Equipment (DME)/Medical Supplies Physician Order Form and the Medicaid Certificate of Medical Necessity for CPAP or BiPAP or Oxygen Therapy form is completed and all of the following conditions are met:

- Symptoms have a duration of at least three months (or less with special circumstances).

- For clients who are 20 years of age and younger, one of the following parameters must be used:
  - An oxygen saturation of 89 to 92 percent, taken at rest, breathing room air.
  - An oxygen saturation less than 92 percent with documentation of medical necessity provided by a physician familiar with the client.

- An arterial PO2 at or below 56 mm Hg or an arterial oxygen saturation at or below 89 percent, taken at rest, breathing room air, or during sleep and associated with signs or symptoms reasonably attributed to hypoxemia.

- Hypoxemia associated with obstructive sleep apnea must be unresponsive to CPAP or BiPAP S therapy before oxygen therapy can be approved. In these cases, coverage is provided only for use of oxygen during sleep, and then only one type of delivery system will be considered a benefit under the Home Health Services Program.

- Portable oxygen systems are considered a benefit of the Home Health Services Program when the medical documentation indicates that the client requires the use of oxygen in the home and would benefit from the use of a portable oxygen system when traveling outside the home environment. Portable oxygen systems are not considered a benefit of the Home Health Services Program when traveling outside the home environment for clients who qualify for oxygen usage based solely on oxygen saturation levels during sleep.

- A client who demonstrates an arterial PO2 at or above 56 mm Hg, or an arterial oxygen saturation at or above 89 percent, during the day while at rest and who subsequently experiences a decreased arterial PO2 of 55 mm Hg or below, or decreased arterial oxygen saturation of 88 percent or below during exercise. In this case supplemental oxygen can be provided if there is evidence that the use of oxygen improves the hypoxemia that was demonstrated during exercise when the client was breathing room air.
In-home oxygen therapy can be approved for cluster headaches with the documentation of both the following clinical indications:

- Neurological evaluation with diagnosis
- Documented failed medication therapy

**Note:** Lab values are not indicated with this diagnosis

### 2.2.19.11.4 Oxygen Therapy Recertification

Prior authorization of oxygen therapy after an initial three-month rental period may be granted with the submission of a new completed Home Health Services (Title XIX) Durable Medical Equipment (DME)/Medical Supplies Physician Order Form and a new Medicaid Certificate of Medical Necessity for CPAP/BiPAP or Oxygen Therapy form and the following:

- Documentation of continued need
- Documentation of client compliance by the physician familiar with the client

**Note:** The initial Medicaid Certificate of Medical Necessity for CPAP/BiPAP or Oxygen Therapy Form cannot be used for recertification purposes.

### 2.2.19.12 Pulse Oximetry

Pulse oximeters are not a benefit of Title XIX Home Health Services. Pulse oximeters are a benefit of Texas Medicaid through CCP for clients who are birth through 20 years of age.

**Refer to:** Subsection 2.6.6, "Pulse Oximeter" in the Children’s Services Handbook (Vol. 2, Provider Handbooks) for more information on pulse oximeters.

### 2.2.19.12.1 Prior Authorization

Pulse oximeter sensor probes (procedure code A4606) for client owned equipment are limited to four per month without prior authorization. If additional sensor probes are needed, prior authorization must be requested through Home Health Services with documentation supporting medical necessity.

### 2.2.19.13 Procedure Codes and Limitations for Respiratory Equipment and Supplies

<table>
<thead>
<tr>
<th>Procedure Code</th>
<th>Limitations</th>
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</thead>
<tbody>
<tr>
<td>Nebulizers</td>
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<tr>
<td>A4617</td>
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<td>A7003</td>
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<td><strong>Vaporizers</strong></td>
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<td><strong>Chest Physiotherapy Devices</strong></td>
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<td>E0562</td>
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**Ventilator Maintenance Agreement**

| A9900          | 1 per month                                     |

**Oxygen Therapy**

| A4615          | 2 per month                                     |
| A4616          | 4 per year                                      |
| A4618          | 4 per month                                     |
| A4619          | 2 per month                                     |
| A4620          | 2 per month                                     |
| E0424          | 4 per lifetime                                  |
| E0431          | 4 per lifetime                                  |
| E0433          | 1 per month                                     |
| E0434          | 4 per lifetime                                  |
| E0439          | 4 per lifetime                                  |
| E0441          | 4 per lifetime                                  |
| E0442          | 4 per lifetime                                  |
| E0443          | 1 per month                                     |
| E0444          | 1 per month                                     |
| E0565          | 1 purchase every 5 years; rental allowed 4 per lifetime |
| E1353          | 1 per year                                      |
| E1355          | 1 purchase every 3 years; 1-month rental        |
| E1372          | 1 every 3 years                                 |
| K0730          | 1 every 5 years                                 |

**Suction Pumps**

| A4605          | 10 per month                                    |
2.2.20 Special Needs Car Seats and Travel Restraints

Special needs car seats and travel restraints are not services available under Home Health Services.

Refer to: Subsection 2.6.14, “Special Needs Car Seats and Travel Restraints” in the Children’s Services Handbook (Vol. 2, Provider Handbooks) for details about coverage through CCP.

2.2.21 Subcutaneous Injection Ports

A subcutaneous injection port is a sterile medication delivery device through which physician-prescribed medications can be injected directly into the subcutaneous tissue using a standard syringe and needle, an injection pen, or other manual injection device. The device can be used for multiple subcutaneous injections for a period of up to 72 hours, thereby avoiding repeated needle punctures of the skin. The device cannot be used with an injection pump.

A subcutaneous injection port, such as the I-Port or Insuflon, is a benefit of Texas Medicaid as a Title XIX Home Health service with prior authorization. Claims for a subcutaneous injection port must be submitted with procedure code A4211 and modifier U4.

Texas Medicaid may reimburse the device for clients who require multiple daily injections of a physician-prescribed medication and who meet the medical necessity criteria.

The subcutaneous injection port is not a benefit of Texas Medicaid as an item of convenience or for clients who are already receiving the medication through an ambulatory infusion pump. The device is considered an item of convenience if the client does not meet the criteria for medical necessity.

2.2.21.1 Prior Authorization

Prior authorization is required for a subcutaneous injection port. Initial prior authorizations will be issued for a trial period of up to 3 months. Prior authorizations that are issued after the successful completion of the initial trial period may be issued for a period of up to 6 months. Prior authorizations for subcutaneous injection ports are limited to a quantity of 10 individual ports per month. Additional ports will be considered for prior authorization with documentation of medical necessity.

<table>
<thead>
<tr>
<th>Procedure Code</th>
<th>Limitations</th>
</tr>
</thead>
<tbody>
<tr>
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<tr>
<td>A4628</td>
<td>2 per month</td>
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<td>A7000</td>
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<td>A7002</td>
<td>8 per month</td>
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<tr>
<td>E0600</td>
<td>Every 5 years</td>
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<table>
<thead>
<tr>
<th>Procedure Code</th>
<th>Limitations</th>
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</thead>
<tbody>
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</tr>
<tr>
<td>A4627</td>
<td>Every 6 months</td>
</tr>
<tr>
<td>E1399</td>
<td>Limited by policy</td>
</tr>
<tr>
<td>S8999</td>
<td>1 per year</td>
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</table>

A4624 90 per month
A4628 2 per month
A7000 4 per month
A7002 8 per month
E0600 Every 5 years

<table>
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<th>Procedure Code</th>
<th>Limitations</th>
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<td>A4627</td>
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<td>E1399</td>
<td>Limited by policy</td>
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<tr>
<td>S8999</td>
<td>1 per year</td>
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</table>
2.2.21.2 Documentation Requirements

The initial request for prior authorization must include documentation that indicates the client meets the following criteria for medical necessity:

- The client has a medical condition that requires multiple (i.e., 2 or more) subcutaneous, self-administered injections on a daily basis and has a current prescription for the injectable medication. Documentation must indicate the specific medical condition that is being treated, the name of the injectable medication, and the dosage and frequency of the injections.

  **Note:** "Self-administered" includes those injections administered by the client through a subcutaneous injection or by the caregiver to the client through a subcutaneous injection.

- The client or the caregiver has been unsuccessful with the self-administration of injections using a standard needle and syringe because the client demonstrates trypanophobia (i.e., severe needle phobia), as evidenced by documented physical or psychological symptoms. Documented symptoms may include, but are not limited to, the following:

<table>
<thead>
<tr>
<th>Condition</th>
<th>Possible Exhibited Symptoms</th>
</tr>
</thead>
<tbody>
<tr>
<td>Vaso-vagal trypanophobia</td>
<td>Physical symptoms such as changes in blood pressure, syncope, sweating, nausea, pallor, and tinnitus</td>
</tr>
<tr>
<td>Associate trypanophobia</td>
<td>Psychological symptoms such as extreme anxiety, insomnia, and panic attacks</td>
</tr>
<tr>
<td>Resistive trypanophobia</td>
<td>Signs and symptoms such as combativeness, elevated heart rate, high blood pressure, and violent resistance to procedures involving needles or injections</td>
</tr>
</tbody>
</table>

The prescribing physician must include with the prior authorization request a written statement of medical necessity that identifies the client as an appropriate candidate for the subcutaneous injection port device. The physician’s statement or medical record documentation that is submitted with the prior authorization request must indicate the following:

- The client or caregiver has received instruction during an office visit on the proper placement and use of the device, with successful return demonstration. (Prior authorization requests for skilled nursing visits for the sole purpose of client instruction on the use of the subcutaneous injection port device will not be approved. Necessary instruction must be performed as part of the office visit with the prescribing physician.)

- The client has no known allergies or sensitivities to adhesives, silicone, or similar materials.

- The client has no skin infection at potential injection sites.

- The client’s most recent lab results related to the medical condition requiring treatment with daily subcutaneous injections must also be submitted with the prior authorization request. Lab results may include, but are not limited to, hemoglobin A1c (HbA1c) levels for clients with insulin dependent diabetes mellitus (IDDM) and partial thromboplastin time (PTT) for clients who are receiving anticoagulant therapy.

Requests for the renewal of the prior authorization after the initial trial period has ended must include documentation of the following:

- Ongoing signs and symptoms associated with the client’s trypanophobia.

- Improved compliance with the physician-prescribed injection regimen.

- Successful use of the device with no persistent pattern of the client’s dislodging the device during the initial trial period.
• Results of relevant lab tests performed upon completion of the initial trial period, including, but not limited to, HbA1c levels for clients with IDDM and PTT for clients who are receiving anticoagulant therapy.

**Note:** For clients with IDDM, if the HbA1c level has not declined with use of the subcutaneous injection port, additional documentation must be submitted by the physician who documents the clinical determination about the lack of significant improvement in the HbA1c level. The renewal of the prior authorization will not be approved without this information.

### 2.2.22 Total Parenteral Nutrition (TPN) Solutions

In-home TPN is a benefit for eligible clients who require long-term nutritional support. “Long-term nutritional support” refers to treatment lasting 30 days or longer.

Conditions that may require TPN include, but are not limited to the following:

- Bowel disease or disorder
- Cancer
- AIDS
- Coma
- Burns
- Peritonitis

**Note:** Conditions or a duration of need not listed above may be considered by HHSC or its designee with documentation of medical necessity.

TPN services are not a benefit when oral or enteral intake will maintain adequate nutrition.

Parenteral nutrition solution services may be reimbursed using the following procedure codes:

<table>
<thead>
<tr>
<th>Procedure Codes</th>
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<tr>
<td>B4164</td>
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<tr>
<td>B4199</td>
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</table>

Parenteral nutrition supplies may be reimbursed using the following procedure codes: B4220, B4222, B4224, and B9999.

Parenteral nutrition infusion pumps may be reimbursed using procedure codes B9004 and B9006.

A backpack or carrying case for a portable parenteral nutrition infusion pump may be a benefit of Home Health Services, when medically necessary and prior authorized, using procedure code B9999.

In-home TPN for clients who are 20 years of age and younger that do not meet the criteria through Title XIX Home Health Services may be considered through CCP. No more than a one-week supply of solutions and additives may be reimbursed if the solutions and additives are shipped and not used because of the client’s loss of eligibility, change in treatment, or inpatient hospitalization. Any days that the client is an inpatient in a hospital or other medical facility or institution must be excluded from the daily billing. Payment for partial months will be prorated based upon the actual days of administration.

The administration of intravenous fluids and electrolytes cannot be billed as in-home TPN.

Claims for TPN must contain the 9-character prior authorization number in Block 23. Providers must consult with their vendor for the location of this field in the electronic claims format. The prescribing physician name and provider identifier must be in Block 17 and 17a or in the appropriate field of the provider’s electronic software.
2.2.22.1 Prior Authorization
TPN solutions, lipids, supply kits, and infusion pumps must be prior authorized.

2.2.22.2 Documentation Requirements
Requests for prior authorization must include the following information:

- Medical condition necessitating the need for TPN and long-term nutritional support.
- Documentation of any trials with oral or enteral feedings.
- Percent of daily nutritional needs from TPN.
- A copy of the TPN formula or prescription, including amino acids and lipids, signed and dated by the physician.
- A copy of the most recent laboratory results (to include potassium, calcium, liver function studies and albumin).

The requesting provider may be asked for additional information to clarify or complete a request for TPN services.

Prior authorization requests for a portable parenteral nutrition infusion pump (procedure code B9004) must also include documentation of medical necessity demonstrating that:

- The client requires continuous feedings
- Feeding intervals exceed the time that the client must be away from home to:
  - Attend school or work.
  - Participate in extensive, physician-ordered outpatient therapies.
  - Attend frequent, multiple medical appointments.

Prior authorization for parenteral nutrition infusion pumps will be limited to one portable pump (procedure code B9004) or one stationary pump (procedure code B9006) at any one time, unless medical necessity for two infusion pumps is established. Supporting documentation for the additional pump must be included with the prior authorization request.

Prior authorization requests for miscellaneous procedure code B9999 must include the following:

- A detailed description of the requested item or supply.
- Documentation supporting the medical necessity for the requested item or supply.

Requests for a carrying case or backpack for the portable infusion pump will be considered for prior authorization under miscellaneous code B9999, for clients who meet the medical necessity criteria for the portable pump as outlined above. The following additional criteria apply:

- The client is ambulatory, or uses a wheelchair which will not support the use of a portable pump by other means, such as an intravenous (IV) pole.
- The portable enteral feeding pump is client-owned.

Renewal of the prior authorization will be considered based on medical necessity.

Refer to: Home Health Services (Title XIX) DME/Medical Supplies Physician Order Form on the TMHP website at www.tmhp.com.

2.2.23 Wound Care Supplies or Systems

Wound care supplies and wound care systems are a benefit through Home Health Services when provided to clients in the home setting. Wound care supplies and wound care systems are designed to assist in the healing of wounds in conjunction with an individualized wound care therapy regimen prescribed by a physician.
Wounds are recognized as acute or chronic:

- Acute wounds are defined as wounds taking less than up to 30 days for complete healing.
- Chronic wounds are defined as wounds taking more that 30 days for complete healing.

Skin ulcers represent the majority of chronic wounds. Skin ulcers include but are not limited to:

- Venous ulcers—also known as venous insufficiency ulcers, stasis ulcers, or varicose veins, and are due to sustained venous hypertension, which results from chronic venous insufficiency or an impaired muscle pump.
- Arterial insufficiency ulcers—ulcers caused by insufficient arterial flow resulting in ischemia and eventual necrosis. Atherosclerosis is the most common cause of arterial ulcers. Other arterial vascular diseases include vasospastic disease and vasculitis. Arterial ulcers are frequently found at the most distal point of arterial perfusion. No drainage is apparent unless the ulcer is infected.
- Pressure ulcers—any skin wound caused by unrelieved pressure resulting in damage to various sections of the skin structure that worsen over time.
- Diabetic ulcers—skin lesions associated with clients with Type 1 and Type 2 diabetes mellitus. The majority of all amputations in diabetic clients are preceded by an infected ulcer.

Wound care includes:

- Optimization of nutritional status
- Debridement by any means to remove devitalized tissue
- Maintenance of a clean, moist bed of granulation tissue
- Any necessary treatment to resolve any infection that may be present

Based on the specific type of wound, wound care may include:

- Use of a compression system for clients with a venous ulcer
- Establishment of adequate circulation for a client with an arterial ulcer
- Frequent repositioning of a client with a pressure ulcer
- Off-loading pressure and good glucose control for a client with a diabetic ulcer

Measurable signs of improved healing include:

- A decrease in wound size, either in surface area or volume
- A decrease in amount of exudate
- A decrease in amount of necrotic tissue

First line wound care therapy may include the following:

- Cleansing, antibiotics, and pressure off-loading
- Debridement
- Dressings
- Compression

Second line wound care therapy may include:

- Negative pressure wound therapy (NPWT)
- Irrigation, including pulsatile jet irrigation
2.2.23.1 **Wound Care Supplies**

Medically necessary wound care supplies are designed to assist in wound healing, and include, but are not limited to dressings, cleansers, enzymatic debriders, and fillers.

Wound dressings include:

- Absorbent dressings
- Alginate
- Antimicrobials
- Collagen dressings
- Compression dressings and wraps
- Composite dressings
- Contact layers
- Foam dressings
- Hydrocolloid dressings
- Hydrofiber dressings
- Hydrogel dressings, including sheets and impregnated gauze
- Odor absorbing dressings
- Transparent films

2.2.23.2 **Wound Care System**

A medically necessary wound care system includes a medical device and its component supplies, and is designed to assist in healing of wounds unresponsive to conventional wound care therapy.

A wound care system may be considered for reimbursement for clients with a Stage III or IV chronic, non-healing wound (such as a pressure, arterial or venous stasis, diabetic ulcer), post-surgical wound dehiscence, non-adhering skin grafts, or surgical flaps required for covering such wounds.

Types of wound care systems include the following:

- NPWT system
- Pulsatile jet irrigation wound care system

2.2.23.2.1 **NPWT System**

NPWT systems and associated supplies (procedure codes E2402 and A6550) are benefits of Home Health Services.

An NPWT system provides and maintains a moist wound environment, and protects the wound during the healing process by sealing it with an adhesive drape and applying continuous or intermittent suction.

An NPWT system consists of a cell foam dressing that is placed in the wound bed, a suction catheter tip, an adhesive drape to cover the wound, suction tubing, and a computerized vacuum pump. An NPWT system uses continuous or intermittent sub-atmospheric pressure to evacuate the excess interstitial fluid and remove growth factor inhibitors. The removal of inhibitors allows the growth factor to stimulate cell proliferation and migration. Removal of excess fluid also helps decrease periwound induration.

Dressing changes associated with an NPWT system are performed every one to three days depending on the amount of exudate produced by the wound. The computerized vacuum pump is rented on a monthly basis. A licensed health-care provider with appropriate training is required to perform an NPWT system dressing change.
Pulsatile Jet Irrigation Wound Care System

Pulsatile jet irrigation wound care systems (procedure code E1399) are a benefit of Home Health Services for rental only.

A pulsatile jet irrigation wound care system uses antibiotics or water under pressure to irrigate the wound and uses suction to remove the irrigation fluid and debris.

A pulsatile jet irrigation wound care system consists of a pistol-style hand piece with a trigger to control the pulsatile jet. A suction pump is used to remove the fluid. The wound is then dressed using standard wound care supplies.

Dressing changes associated with a pulsatile jet irrigation wound care system are performed every one to three days depending on the amount of exudate produced by the wound. A licensed health-care provider with appropriate training is required to perform a pulsatile jet irrigation wound care system dressing change.

Noncovered Services

The following services are not a benefit of Texas Medicaid:

- Wound care supplies for use in the office or outpatient setting. Supplies provided in an outpatient setting, such as a wound care clinic, are part of the facility fee and are not separately reimbursed.
- Equipment and supplies for stand-by use.
- Portable hyperbaric oxygen chambers (procedure code A4575) that are placed directly over the wound and provide higher concentrations of oxygen to the damaged tissue.
- Metabolically active skin equivalents or skin equivalents used in wound care, in the home setting.
- Non-contact normothermic wound therapy (NNWT) systems and associated supplies (procedure codes A6000, E0231, and E0232).
- Non-sterile gloves (procedure code A4927), when the gloves are for use by a health care provider, such as a RN, LVN, or attendant, in the home setting.
- Rental or purchase of an electrical stimulation or electromagnetic wound treatment device (procedure code E0769), for use by the client or caregiver in the home setting.

Prior Authorization

Prior authorization is required for all wound care supplies and wound care systems addressed below with the exception of procedure code A4455.

Note: THSteps-eligible clients who qualify for medically necessary services beyond the limits of this home health benefit will receive those services through CCP.

The requesting provider may be asked for additional information to clarify or complete a prior authorization request for the wound care supplies or wound care system.

Retrospective review may be performed to ensure documentation supports the medical necessity of the requested wound care supplies or system.

Recertification will be considered based on medical necessity, with a new prior authorization request. Providers should only bill for a one month supply at a time, even though prior authorization may be granted for up to six months.

Wound Care Supplies

Nonsterile/clean wound care supplies may be considered for prior authorization for use in the home setting when documentation supports medical necessity.

Note: The home setting is considered a clean environment, not a sterile environment.
Sterile wound care supplies, other than those required with a wound care system, may be considered for prior authorization for use in the home setting when documentation supports medical necessity and justifies that nonsterile/clean wound care supplies will not meet the client’s needs.

**Note:** Established tracheostomies or gastrostomies/buttons are not considered wounds, therefore dressing supplies will not be considered for prior authorization. Dressing supplies for tracheostomies or gastrostomies may be considered for prior authorization with documentation of medical necessity.

Nonsterile gloves may be considered for prior authorization when a family member or friend is performing the medical wound care.

### 2.2.23.4.2 Wound Care System

Prior authorization for a wound care system may be considered for reimbursement for an initial 30-day period.

Medically necessary prior authorized recertifications may be considered for additional 30-day periods at a time, up to a maximum of four, when documentation supports continued significant improvement in wound healing. Wound care systems may be considered for reimbursement beyond four months of treatment on a case-by-case basis after review of the medical necessity documentation by the medical director or designee.

Wound care system supplies are limited to a maximum of:

- 15 dressing kits or supplies per wound per month unless documentation supports that the wound size requires more than one dressing kit for each dressing change, or if the physician has ordered more frequent dressing changes.

- 10 disposable canisters (procedure code A7000) per month, unless documentation provided indicates medical necessity for additional canisters.

**Note:** When documentation supports evidence of high-volume drainage, defined as greater than 90 milliliters (ml) per day, a stationary pump with the largest capacity canister must be used. Extra canisters related to the equipment failure are not considered medically necessary.

Wound care systems and related supplies will not be prior authorized nor considered for reimbursement when:

- The client has one of the following contraindications:
  - A fistula to the body
  - Wound ischemia
  - Gangrene
  - Skin cancer in the wound margins
  - Presence of necrotic tissue, including bone (this does not apply to the pulsatile jet irrigation wound care system)
  - Osteomyelitis (unless it is being treated; the treatment must be identified)
  - In the judgment of the treating physician, adequate wound healing has occurred and the wound care system is no longer required.
  - No measurable wound healing has occurred over the previous 30-day period.
  - A wound care system was used for four months or more in the inpatient setting prior to discharge, except when documentation supports continued significant improvement in wound healing.
  - The wound care equipment and supplies are no longer being used by the client.
2.2.23.5 Documentation Requirements

2.2.23.5.1 Wound Care Supplies

To request prior authorization for wound care supplies, the following documentation must be provided with the completed Home Health Services (Title XIX) Durable Medical Equipment (DME)/Medical Supplies Physician Order Form:

- Accurate diagnostic information pertaining to the underlying diagnosis/condition as well as any other medical diagnoses/conditions, to include the client’s overall health status.
- Appropriate medical history related to the current wound including:
  - Wound measurements to include length, width and depth, any tunneling or undermining
  - Wound color, drainage (type and amount), and odor, if present
  - The prescribed wound care regimen, to include frequency, duration and supplies needed
  - Treatment for infection, if present
  - All previous wound care therapy regimens, if appropriate
  - The client’s use of a pressure reducing support surface, when appropriate
  - Identification of the client or caregiver who will be instructed how to perform the wound care, and will be responsible for the wound care.

2.2.23.5.2 Wound Care Systems

To request prior authorization for a wound care system, the documentation listed below must be provided on the Statement for Initial Wound Therapy System In-Home Use Form for an initial request or on the Statement for Recertification of Wound Therapy System In-Home Use Form for a recertification request, in addition to the Title XIX form.

The prescribing physician and provider must submit the appropriate initial or recertification form, which must also be maintained in the client’s medical record.

The following documentation must be submitted with the prior authorization request, and must be maintained in the client’s medical record:

- Accurate diagnostic information pertaining to the underlying diagnosis/condition and all other medical diagnoses/conditions, including the client’s overall health status.
- The client’s use of a pressure reducing support surface, when appropriate.
- Albumin level within the last 30 days (If the albumin level is below 3.0, documentation must show that a nutritional supplement has been prescribed, and that the client is compliant with its use.)
- Hemoglobin A1c obtained within last 30 days, if the client has a diagnosis of diabetes mellitus.
- Appropriate medical history related to the current wound, including:
  - Documentation that the wound is free of necrotic tissue and infection, or if infection is present, that it is being treated with antibiotics.
  - Wound measurements to include length, width, and depth, any tunneling or undermining.
  - Wound characteristics, including color, wound drainage (type and amount), and odor if present.
  - The prescribed wound care regimen, to include frequency, duration and supplies needed.
- Identification of the caregiver who agrees to be available to assist the client during this time and agreement of this person not to operate the negative pressure or the pulsatile jet irrigation system if used.
• Documentation that a licensed health-care provider who has received the appropriate training in the use of the wound care system is performing the wound care when a negative pressure or pulsatile jet irrigation wound care system is used. All requirements for skilled nursing care must be met.

• For recertification, documentation that the wound is improving.

### 2.2.23.6 Wound Care Procedures and Limitations

<table>
<thead>
<tr>
<th>Procedure Code</th>
<th>Maximum Limitation</th>
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<td>A4452</td>
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<td>T1999</td>
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</table>
2.2.24 Limitations and Exclusions

Payment cannot be made for any service, supply or equipment for which FFP is not available. For clients who are 20 years of age and younger and who are eligible to receive THSteps services, refer to subsection 2.1, “CCP Overview” in the Children’s Services Handbook (Vol. 2, Provider Handbooks) to find which of these items are a benefit for CCP.

Home Health Services does not cover the following:

- Adaptive strollers, travel seats, push chairs, and car seats
- Administration of non-FDA-approved medications/treatments or the supplies and equipment used for administration
- Aids for daily living, such as toothpaste, spoons, forks, knives, and reachers
- Any services, equipment, or supplies furnished to a client who is a resident of a public institution or a client in a hospital, SN facility, or intermediate care facility
- Any services or supplies furnished to a client before the effective date of Medicaid eligibility as certified by HHSC or after the date of termination of Medicaid eligibility
- Any services or supplies furnished without prior approval by TMHP, except as listed
- Any supplies or equipment used in a physician’s office, or inserted by a physician (e.g., low profile gastrostomy tube)
- Apnea monitors
- Blood products (the administration or the supplies and equipment used to administer blood products)
- Cardiac telemetry monitoring
- Chemotherapy administration or the supplies and equipment used to administer chemotherapy
- Diapers and wipes for clients who are 3 years of age and younger
- Dynamic orthotic cranioplasty (DOC)
- Environmental equipment, supplies, or services, such as room dehumidifiers, air conditioners, heater/air conditioner filters, space heaters, fans, water purification systems, vacuum cleaners, treatments for dust mites, rodents, and insects
- Home whirlpool baths, spas, home exercisers/gym equipment, hemodialysis equipment, safety wall rails, toys/therapy equipment
- IPV
- Nutritional counseling
- Orthotics, braces, prosthetics including but not limited to voice prosthetic, and artificial larynx
- Parapodiums
- Personal protective equipment (such as gloves, masks, gowns, and sharps containers) for use by a health-care provider, including but not limited to an RN, LVN, or attendant in the home setting
- Pneumocardiograms
- Seat lift chairs
- Shipping, freight, delivery travel time
- Structural changes to homes, domiciles, or other living arrangements
- Vehicle mechanical or structural modifications, such as wheelchair lifts
Refer to: Subsection 1.11, “Texas Medicaid Limitations and Exclusions” in Section 1, “Provider Enrollment and Responsibilities” (Vol. 1, General Information).

2.2.25 Procedure Codes That Do Not Require Prior Authorization

The procedure codes listed in the following table do not require prior authorization for clients who are receiving services under Home Health Services. Although prior authorization is not required, providers must retain a completed Home Health Services (Title XIX) Durable Medical Equipment (DME)/Medical Supplies Physician Order Form for these clients. For medical supplies not requiring prior authorization, a completed Home Health Services (Title XIX) Durable Medical Equipment (DME)/Medical Supplies Physician Order Form may be valid for a maximum of six months unless the physician indicates the duration of need is less. If the physician indicates the duration of need is less than six months, then a new Home Health Services (Title XIX) Durable Medical Equipment (DME)/Medical Supplies Physician Order Form is required at the end of the duration of need. It is expected that reasonable, medically necessary amounts will be provided.

The use of these services is subject to retrospective review. This is not an all inclusive list.

<table>
<thead>
<tr>
<th>Procedure Codes</th>
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<tr>
<td><strong>Nebulizer Supplies/Equipment</strong>*</td>
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<td><strong>Incontinence Supplies</strong></td>
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<tr>
<td><strong>Inhaler Equipment</strong></td>
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<td>A4614  A4627</td>
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</table>

* Prior authorization is required for certain diagnoses and if limitations are exceeded. Refer to Subsection 2.2.19.2, “Nebulizers” in this handbook.
** Prior authorization is required for some procedure codes if the maximum limitation is exceeded. Refer to Subsection 2.2.13.9, “Incontinence Procedure Codes with Limitations” in this handbook.

2.3 Other or Special Provisions

2.3.1 Medicaid Relationship to Medicare

2.3.1.1 Possible Medicare Clients

It is the provider’s responsibility to determine the type of coverage (Medicare, Medicaid, or private insurance) that the client is entitled to receive. Home health providers must follow these guidelines:

- Clients who are 64 years of age and younger without Medicare Part A or B:
  - If the agency erroneously submits an SOC notice to Medicare and does not contact TMHP for prior authorization, TMHP does not assume responsibility for any services provided before contacting TMHP. The SOC date is no more than three business days before the date the agency contacts TMHP. Visits made before this date are not considered a benefit of the Home Health Services Program.

- Clients who are 65 years of age and older without Medicare Part A or Part B and clients with Medicare Part A or B regardless of age:
• In filing home health claims, home health providers may be required to obtain Medicare denials before TMHP can approve coverage. When TMHP receives a Medicare denial, the SOC is determined by the date the agency requested coverage from Medicare. If necessary, the 95-day claims filing deadline is waived for these claims, provided TMHP receives notice of the Medicare denial within 30 days of the date on the MRAN containing Medicare's final disposition.

• If the agency receives the MRAN and continues to visit the client without contacting TMHP by telephone, mail, or fax within 30 days from the date on the MRAN, TMHP will provide coverage only for services provided from the initial date of contact with TMHP. The SOC date is determined accordingly. TMHP must have the MRAN before considering the request for prior authorization.

2.3.1.2 Benefits for Medicare and Medicaid Clients

For eligible Medicare/Medicaid clients, Medicare is the primary payer and providers must bill Medicare before submitting a claim to Medicaid. Medicaid pays the Medicare deductible on Part B claims for qualified home health clients.

Home health service prior authorizations may be given for HHA services, certain medical supplies, equipment, or appliances suitable for use in the home in one of the following instances:

• When an eligible Medicaid client (enrolled in Medicare) who does not qualify for home health services under Medicare because SN care, PT, or OT are not a part of the client’s care.

• When the medical supplies, equipment, or appliances are denied by Medicare Part B and are a benefit of Home Health Services.

Federal and state laws require the use of Medicaid funds for the payment of most medical services only after all reasonable measures have been made to use a client’s third party resources or other insurance.

Note: If the client has Medicare Part B coverage, contact Medicare for prior authorization requirements and reimbursement. If the service is a Part B benefit, do not contact TMHP for prior authorization. Texas Medicaid will only pay the deductible and coinsurance according to current payment guidelines on the electronic crossover claim.

TMHP will not prior authorize or reimburse the difference between the Medicare payment and the retail price for Medicare Part B eligible clients.

Refer to: Subsection 4.12, “Third Party Liability (TPL)” in Section 4, “Client Eligibility” (Vol. 1, General Information).

Section 2.7, “Medicare Crossover Claim Reimbursement” (Vol. 1, General Information).

2.3.1.3 Medicare and Medicaid Prior Authorization

Contact TMHP for prior authorization of Medicaid services (based on medical necessity and benefits of Home Health Services) within 30 days of the date on the MRAN.

Note: For MQMB clients, do not submit prior authorization requests to TMHP if the Medicare denial reason states “not medically necessary.” Medicaid only will consider prior authorization requests if the Medicare denial states “not a benefit” of Medicare.

Qualified Medicare Beneficiaries (QMB) are not eligible for Medicaid benefits. Texas Medicaid is only responsible for premiums, coinsurance, or deductibles on these clients according to payment guidelines. Providers should not submit prior authorization requests to the TMHP Home Health Services Prior Authorization Department for these clients.

To ensure Medicare benefits are used first in accordance with Texas Medicaid regulations, the following procedures apply when requesting Medicaid prior authorization and payment of home health services for clients.
Contact TMHP for prior authorization of Medicaid services (based on medical necessity and benefits of Home Health Services) within 30 days of the date on the MRAN. Fax a copy of the original Medicare MRAN and the Medicare appeal review letter to the TMHP Home Health Services Prior Authorization Department for prior authorization.

**Note:** Claims for STAR+PLUS MQMB clients (those with Medicare and Medicaid) must always be submitted to TMHP as noted on these pages. The STAR+PLUS health plan is not responsible for these services if Medicare denies the service as not a benefit.

When the client is 65 years of age and older or appears otherwise eligible for Medicare such as blind and disabled, but has no Part A or Part B Medicare, the TMHP Home Health Services Prior Authorization Department uses regular prior authorization procedures. In this situation, the claim is held for a midyear status determined by HHSC. The maximum length of time a claim may be held in a “pending status” for Medicare determination is 90 days. After the waiting period, the claim is paid or denied. If denied, the EOB code on the R&S report indicates that Medicare is to be billed.

Refer to: Section 3, “Home Health Skilled Nursing and Home Health Aide Services” in the Home Health Nursing and Private Duty Nursing Services Handbook (Vol. 2, Provider Handbooks).

Refer to: Subsection 3.2.3, “Home Health Skilled Nursing Services” in the Nursing and Therapy Services Handbook (Vol. 2, Provider Handbooks).

### 2.4 Claims Filing and Reimbursement

#### 2.4.1 Claims Information

Providers must use only type of bill (TOB) 321 in Form Locator (FL) 4 of the UB-04 CMS-1450. Other TOBs are invalid and result in claim denial.

Home Health services must be submitted to TMHP in an approved electronic format or on a CMS-1500 or a UB-04 CMS-1450 paper claim form. Submit home health DME and medical supplies to TMHP in an approved electronic format, or on a CMS-1500 or on a UB-04 CMS-1450 paper claim form. Providers may purchase UB-04 CMS-1450 and CMS-1500 paper claim forms from the vendor of their choice. TMHP does not supply them.

When completing a CMS-1500 or a UB-04 CMS 1450 paper claim form, providers must include all required information on the claim, as TMHP does not key information from attachments. Superbills, or itemized statements, are not accepted as claim supplements.

Refer to: Section 3: TMHP Electronic Data Interchange (EDI) (Vol. 1, General Information) for information on electronic claims submissions.

Section 6: Claims Filing (Vol. 1, General Information) for general information about claims filing.


Outpatient claims must have the appropriate revenue code and, if appropriate, the corresponding HCPCS code or narrative description. The prior authorization number must appear on the UB-04 CMS-1450 claim in Block 63 and in Block 23 of the CMS-1500 claim. The certification dates or the revised request date on the POC must coincide with the DOS on the claim. Prior authorization does not waive the 95-day filing deadline requirement.

Home health service claims should not be submitted for payment until Medicaid certification is received and a prior authorization number is assigned.
2.4.2 Reimbursement

DME and expendable medical supplies are reimbursed in accordance with 1 TAC §355.8021. Providers can refer to the Online Fee Lookup (OFL) or the applicable fee schedule on the TMHP website at www.tmhp.com. Providers may also request a hard copy of the fee schedule by contacting the TMHP Contact Center at 1-800-925-9126.

DME and expendable supplies, other than nutritional products, that have no established fee, are subject to manual pricing at the documented MSRP less 18 percent or the provider’s documented invoice cost.

Nutritional products that have no established fee are subject to manual pricing at the documented AWP less 10.5 percent or at the provider’s documented invoice cost.

For reimbursement, providers must note the following:

- Claims are approved or denied according to the eligibility, prior authorization status, and medical appropriateness.
- Claims must represent a numerical quantity of 1 month for supplies according to the billing requirements.
- DME/supplies must be provided by either a Medicaid enrolled home health agency’s Medicaid/DME supply provider or an independently-enrolled Medicaid/DME supply provider. Both must enroll and bill using the provider identifier enrolled as a DME supplier. File these services on a CMS-1500 claim form.

Note: Medical social services and speech-language pathology services are available to clients who are 20 years of age and younger and are not a benefit of Home Health Services. These services may be considered a benefit for clients who qualify for CCP.

Texas Medicaid does not reimburse separately for associated DME charges, including but not limited to, battery disposal fees or state taxes. Reimbursement for any associated charges is included in the reimbursement for a specific piece of equipment.

Refer to: Subsection 2.2, “Fee-for-Service Reimbursement Methodology” in Section 2, “Texas Medicaid Fee-for-Service Reimbursement” (Vol. 1, General Information) for more information about reimbursement.

Texas Medicaid implemented mandated rate reductions for certain services. The Online Fee Lookup (OFL) and static fee schedules include a column titled “Adjusted Fee” to display the individual fees with all mandated percentage reductions applied. Additional information about rate changes is available on the TMHP website at www.tmhp.com/pages/topics/rates.aspx.

2.4.3 Home Health Agency Reimbursement for DME Services

Home health agencies are reimbursed for DME and medical supplies in accordance with 1 TAC §355.8021. Providers can refer to the OFL or the applicable fee schedule on the TMHP website at www.tmhp.com. Providers may also request a hard copy of the fee schedule by contacting the TMHP Contact Center at 1-800-925-9126. DME and medical supplies, other than nutritional products, that have no established fee are subject to manual pricing at the documented MSRP less 18 percent or the provider’s documented invoice cost.

2.4.4 Prohibition of Medicaid Payment to Home Health Agencies Based on Ownership

Medicaid denies home health services claims when TMHP records indicate that the physician ordering treatment has a significant ownership interest in, or a significant financial or contractual relationship with, the nongovernmental home health agency billing for the services. Federal regulation Title 42 CFR §424.22 (d) states that “a physician who has a significant financial or contractual relationship with, or a significant ownership in a nongovernmental home health agency may not certify or recertify the need for home health services care services and may not establish or review a plan of treatment.”
A physician is considered to have a significant ownership interest in a home health agency if either of the following conditions apply:

- The physician has a direct or indirect ownership of five percent or more in the capital, stock, or profits of the home health agency.
- The physician has an ownership of five percent or more of any mortgage, deed of trust, or other obligation that is secured by the agency, if that interest equals five percent or more of the agency’s assets.

A physician is considered to have a significant financial or contractual relationship with a home health agency if any of the following conditions apply:

- The physician receives any compensation as an officer or director of the home health agency.
- The physician has indirect business transactions, such as contracts, agreements, purchase orders, or leases to obtain services, supplies, equipment, space, and salaried employment with the home health agency.
- The physician has direct or indirect business transactions with the home health agency that, in any fiscal year, amount to more than $25,000 or 5 percent of the agency’s total operating expenses, whichever is less.

When providing CCP services and general home health services, the provider must file these on two separate UB-04 CMS-1450 paper claim forms with the appropriate prior authorization number, and must send them to the appropriate address.

Claims denied because of an ownership conflict will continue to be denied unless the home health agency submits documentation indicating that the ordering physician no longer has a significant ownership interest in, or a significant financial or contractual relationship with, the home health agency providing services. Documentation must be sent to TMHP Provider Enrollment at the address indicated in “Written Communication With TMHP” in “Appendix A: State, Federal, and TMHP Contact Information” (Vol. 1, General Information).

3 Claims Resources

Refer to the following sections or forms when filing claims:

<table>
<thead>
<tr>
<th>Resource</th>
<th>Location</th>
</tr>
</thead>
<tbody>
<tr>
<td>Appendix A: State, Federal, and TMHP Contact Information</td>
<td>Appendix A (Vol. 1, General Information)</td>
</tr>
<tr>
<td>Appendix D: Acronym Dictionary</td>
<td>Appendix D (Vol. 1, General Information)</td>
</tr>
<tr>
<td>Automated Inquiry System (AIS)</td>
<td>Appendix A (Vol. 1, General Information)</td>
</tr>
<tr>
<td>CMS-1500 Paper Claim Filing Instructions</td>
<td>Subsection 6.5 (Vol. 1, General Information)</td>
</tr>
<tr>
<td>Section 3: TMHP Electronic Data Interchange (EDI)</td>
<td>Section 3 (Vol. 1, General Information)</td>
</tr>
<tr>
<td>TMHP Electronic Claims Submission</td>
<td>Subsection 6.2 (Vol. 1, General Information)</td>
</tr>
<tr>
<td>UB-04 CMS-1450 Paper Claim Filing Instructions</td>
<td>Subsection 6.6 (Vol. 1, General Information)</td>
</tr>
</tbody>
</table>

4 Contact TMHP

The TMHP Contact Center at 1-800-925-9126 is available Monday through Friday from 7 a.m. to 7 p.m., Central Time.
5  Forms

The following linked forms can also be found on the Forms page of the Provider section of the TMHP website at www.tmhp.com:

<table>
<thead>
<tr>
<th>Forms</th>
</tr>
</thead>
<tbody>
<tr>
<td>Addendum to Home Health Services (Title XIX) DME/Medical Supplies Physician Order Form</td>
</tr>
<tr>
<td>DME Certification and Receipt Form</td>
</tr>
<tr>
<td>External Insulin Pump Prior Authorization Form</td>
</tr>
<tr>
<td>Home Health Services (Title XIX) DME/Medical Supplies Physician Order Form Instructions</td>
</tr>
<tr>
<td>Home Health Services (Title XIX) DME/Medical Supplies Physician Order Form</td>
</tr>
<tr>
<td>Home Health Plan of Care (POC) Instructions</td>
</tr>
<tr>
<td>Home Health Plan of Care (POC)</td>
</tr>
<tr>
<td>Home Health Prior Authorization Checklist</td>
</tr>
<tr>
<td>Medicaid Certificate of Medical Necessity for Chest Physiotherapy Device Form—Initial Request</td>
</tr>
<tr>
<td>Medicaid Certificate of Medical Necessity for Chest Physiotherapy Device Form—Extended Request</td>
</tr>
<tr>
<td>Medicaid Certificate of Medical Necessity for CPAP/BiPAP or Oxygen Therapy Form</td>
</tr>
<tr>
<td>Pulse Oximeter Form</td>
</tr>
<tr>
<td>Statement for Initial Wound Therapy System In-Home Use</td>
</tr>
<tr>
<td>Statement for Recertification of Wound Therapy System In-Home Use</td>
</tr>
<tr>
<td>Texas Medicaid Provider Surety Bond and Instructions</td>
</tr>
<tr>
<td>Ventilator Service Agreement</td>
</tr>
<tr>
<td>Wheelchair/Scooter/Stroller Seating Assessment Form (CCP/Home Health Services)</td>
</tr>
</tbody>
</table>

6  Claim Form Examples

The following linked claim form examples can also be found on the Claim Form Examples page of the Provider section of the TMHP website at www.tmhp.com:

<table>
<thead>
<tr>
<th>Claim Form Examples</th>
</tr>
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<tbody>
<tr>
<td>Home Health Services DME/Medical Supplies</td>
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