Texas Medicaid

Provider Procedures Manual

November 2026

Volume 2

Provider Handbooks

Durable Medical Equipment, Medical Supplies, and Nutritional Products Handbook

The Texas Medicaid & Healthcare Partnership (TMHP) is the claims administrator for Texas Medicaid under contract with the Texas Health and Human Services Commission.

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 8, "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 1.7.1.2, "Reporting Child Abuse or Neglect" in "Section 1: Provider Enrollment and Responsibilities" (*Vol. 1, General Information*).

Important: *All providers are required to read and comply with "Section 1: Provider Enrollment and Responsibilities" (Vol. 1, General Information). 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. 1, 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 3.7.4.17, "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.

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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 can use the online Provider Enrollment and Management System (PEMS) tool to enroll electronically through the TMHP website at www.tmhp.com.

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.*

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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 an enrollment record for DME and an enrollment record 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 National Provider Identifier (NPI)
- 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.

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Submission Information

The surety bond can be submitted using the Provider Enrollment and Management System (PEMS).

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.

Refer to: 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) DME/Medical Supplies Prescribing Provider Order Form except as outlined in subsection 2.2.12, "Diabetic Equipment and Supplies" in this handbook. In chronic and stable situations, the Home Health Services (Title XIX) DME/Medical Supplies Prescribing Provider Order Form is valid for up to, but no more than, 6 months from the date of the physician or allowed practitioner'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) DME/Medical Supplies Prescribing Provider 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. Durable medical equipment providers must retain all orders; copies of completed, signed, and dated Title XIX forms; delivery slips; and corresponding invoices for all supplies provided to a client. Durable medical equipment providers must disclose these records 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. Durable medical equipment providers must retain a copy of the completed Home Health Services (Title XIX) DME/Medical Supplies Prescribing Provider Order Form that has been reviewed, signed, and dated by the treating physician or allowed practitioner for these clients.

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Refer to: Subsection A.12.3, "Automated Inquiry System (AIS)" in "Appendix A: State, Federal, and TMHP Contact Information" (*Vol. 1, General Information*).

"Section 6: Claims Filing" (*Vol. 1, General Information*) 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 and strongly encouraged to verify client eligibility frequently. Eligibility can be verified electronically by checking:

- TexMedConnect.
- The Medicaid Client Portal for Providers.

Additionally, providers can verify eligibility through AIS. To use the AIS, call the TMHP Contact Center at 800-925-9126 and select option 1.

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 durable medical equipment 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) DME/Medical Supplies Prescribing Provider Order Form that has Section B completed, signed, and dated by the client's attending physician or allowed practitioner, 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) DME/Medical Supplies Prescribing Provider Order Form
- Home Health Services POC
- 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: Fee-for-Service Prior Authorizations" (*Vol. 1, General Information*) for more information, including mandatory documentation requirements.

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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 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 or allowed practitioner to obtain the requested additional documentation. The physician or allowed practitioner 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 2.2.2.2, "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 or allowed practitioner 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 Texas Medicaid DME benefits. DME provided by Texas Medicaid must either have 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 Medicaid-eligible medical condition or functional disability.

Note: *An allowed practitioner is an individual licensed in Texas as a physician assistant (PA), a certified nurse practitioner (CNP), or clinical nurse specialist (CNS).*

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.

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- 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 or allowed practitioner no more than 6 months prior to the start of service.

For any purchased DME, the DME provider and the client must sign the DME Certification and Receipt Form that is available on the TMHP website at www.tmhp.com before the claim is submitted for payment. The client's signature on the certification form verifies that the DME is the property of the client. The certification form must include:

- The date that the client received the DME
- The name of the item
- The name of the separate receiver/monitor if applicable
- The printed name of the client or primary caregiver
- The printed name of the provider
- The signature of the client or primary caregiver
- The signature of the provider

The provider must maintain a completed copy of the certification form in the client's record.

The completed, 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.

A completed Home Health Services (Title XIX) DME/Medical Supplies Prescribing Provider Order Form prescribing the DME and/or supplies must be signed and dated by a physician or an allowed practitioner familiar with the client, before requesting prior authorization for all DME equipment and supplies. The completed Home Health Services (Title XIX) DME/Medical Supplies Prescribing Provider Order Form must include the procedure codes and quantities for services requested.

The completed Home Health Services (Title XIX) DME/Medical Supplies Prescribing Provider Order Form with the original dated signature must be maintained by the prescribing physician or an allowed practitioner in the client's medical record. A copy of the completed, signed, and dated form must be maintained by the DME provider in the client's medical record.

To document the item and date of delivery for all DME that is provided to a client, DME providers must also retain the following documentation:

- All delivery slips
- Corresponding invoices
- The completed, signed, and dated DME Certification and Receipt Form

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DME providers must disclose this documentation to HHSC or its designee upon 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) DME/Medical Supplies Prescribing Provider Order Form or Addendum to Home Health Services (Title XIX) DME/ Medical Supplies Prescribing Provider Order Form at any time.

To complete the prior authorization process by paper, the DME provider must fax or mail the completed form to the Home Health Services Prior Authorization Department. To complete the prior authorization process electronically, the DME provider must submit the prior authorization requirements through any approved electronic methods.

To facilitate the determination of medical necessity and avoid unnecessary denials, the physician or an allowed practitioner must provide correct and complete information, including documentation of medical necessity for the equipment and/or supplies requested and is subject to retrospective review. The physician or allowed practitioner 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 DME.

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

- The client received the equipment as prescribed by the physician or allowed practitioner.
- 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 or allowed practitioner in the client's POC or the Home Health Services (Title XIX) DME/Medical Supplies Prescribing Provider 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) DME/Medical Supplies Prescribing Provider 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.*

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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 or allowed practitioner familiar with the client. All adjustments and modifications within the first six months after delivery are considered part of the purchase price.

> ***Note:*** *Texas Medicaid fee-for-service requires providers to review for medical necessity of DME every six months. An MCO may approve an initial DME prior authorization request for a period of 6 months, unless otherwise stated, and may authorize an extension of 12 months after the initial 6 months, if medically necessary.*

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 or allowed practitioner signature date on the Home Health Services (Title XIX) DME/Medical Supplies Prescribing Provider Order Form or Addendum to Home Health Services (Title XIX) DME/Medical Supplies Prescribing Provider 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

> ***Note:*** *Handwritten alterations (crossing out of information or changing values) of the invoice render the invoice invalid.*

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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, adjustments, and repairs to a wheeled mobility system within the first six months after delivery are considered part of the purchase price. An exception is made for the push-rim activated power assist wheelchair (PAPAW) system, which may be considered for prior authorization with a new seating assessment form within the first six months after fitting and delivery.

Adjustments do not require supplies. Adjustments made within the first six months after delivery will not be prior authorized. 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 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 a physician or an allowed practitioner does not need to be filled in on the Home Health Services (Title XIX) DME/Medical Supplies Prescribing Provider Order Form. Rental of a wheeled mobility system during the time of repair should be offered at the time of equipment pick-up, if appropriate.

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) DME/Medical Supplies Prescribing Provider 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 Prescribing Provider Order Form prescribing the DME or supplies must be signed and dated by a physician or allowed practitioner 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

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the date of the requested prior authorization or the initiation of service. The completed Home Health Services (Title XIX) DME/Medical Supplies Prescribing Provider Order Form must include the procedure codes and numerical quantities for services requested.

A copy of the completed, signed, and dated Home Health Services (Title XIX) DME/Medical Supplies Prescribing Provider Order Form must be maintained by the DME provider. The ordering physician or allowed practitioner must maintain the completed, originally signed, and dated Home Health Services (Title XIX) DME/Medical Supplies Prescribing Provider Order Form in the client's medical record.

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

> ***Note:*** *Texas Medicaid fee-for-service requires providers to review for medical necessity of DME every six months. An MCO may approve an initial DME prior authorization request for a period of 6 months, unless otherwise stated, and may authorize an extension of 12 months after the initial 6 months, if medically necessary.*

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 or an allowed practitioner must be within the past six months. The physician or allowed practitioner's signature on the Home Health Services (Title XIX) DME/Medical Supplies Prescribing Provider 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) DME/Medical Supplies Prescribing Provider Order Form.

To facilitate a determination of medical necessity and avoid unnecessary denials when requesting prior authorization, the physician or allowed practitioner must provide correct and complete information supporting the medical necessity of the equipment or supplies requested and is subject to retrospective review, 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 reoccurrence 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.

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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

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 Home Health DME and Supplies Exceptional Circumstances Provision

The Home Health Durable Medical Equipment (DME) and Supplies Exceptional Circumstances provision is made available in accordance with Title 42 Code of Federal Regulations (CFR) §440.70 and Title 1 Texas Administrative Code (TAC) §354.1039. Under the Exceptional Circumstances provision, Texas Medicaid is obligated to consider coverage of medically necessary DME and supplies that are not currently listed as benefits of Texas Medicaid for clients who are 21 years of age or older.

2.2.3.1 Prior Authorization Requests for Home Health DME and Supplies under the Exceptional Circumstances Provision

All Exceptional Circumstances DME and supplies must be prior authorized. The Home Health DME and Supplies Exceptional Circumstances provision is not an available process to pursue for clients who receive prior authorization denials for medical necessity or technical reasons (e.g., missing essential fields, incomplete documentation). Clients that have been denied prior authorization under these circumstances may appeal the decision through the regular fair hearing process.

To request prior authorization for home health DME and supplies under the Exceptional Circumstances provision, providers must submit a written notice to TMHP. The written notice must include:

- Completed copies of all of the necessary forms for the requested home health DME or supplies, such as the Home Health Services (Title XIX) DME/Medical Supplies Prescribing Provider Order Form, Special Medical Prior Authorization (SMPA) Request Form, Prior Authorization Request for Oxygen Therapy Devices and Supplies, Wound Care Equipment and Supplies Order Form etc. The forms must be signed and dated by the prescribing physician or allowed practitioner along with a cover letter indicating the forms are being submitted under the Home Health DME and Supplies Exceptional Circumstances provision.
- The client's specific diagnosis, medical needs and the reasons why they can only be met by the requested home health DME or supply.
- A clear, concise description of the requested DME or supply.
- The manufacturer's suggested retail price (MSRP) for the requested DME or supply or an invoice documenting the provider's cost.
- Letters of Medical Necessity (LOMN) from the client's prescribing physician or allowed practitioner and other clinical professionals, as appropriate, documenting the alternative measures and alternative DME or supplies that have been tried and have failed to meet the client's medical needs, or have been ruled out and an explanation of why they have failed or have been ruled out.

Important: *TMHP may request additional supporting documentation after reviewing the initial request.*

2.2.3.2 Reimbursement and Billing

TMHP will only consider reimbursement for home health DME and supplies under the Exceptional Circumstances provision if:

- Providers request DME and supplies using the most appropriate procedure code available.

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- TMHP approves the prior authorization request.

2.2.4 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 or allowed practitioner who is familiar with the client must sign and date a completed Home Health Services (Title XIX) DME/Medical Supplies Prescribing Provider 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) DME/Medical Supplies Prescribing Provider 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 durable medical equipment provider must keep all completed copies of the Home Health Services (Title XIX) DME/Medical Supplies Prescribing Provider Order Forms and Addendum to Home Health Services (Title XIX) DME/Medical Supplies Prescribing Provider Order Forms on file. The ordering physician or allowed practitioner must maintain copies of the completed, originally signed, and dated Home Health Services (Title XIX) DME/Medical Supplies Prescribing Provider Order Form and Addendum to Home Health Services (Title XIX) DME/Medical Supplies Prescribing Provider Order Forms 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 as confirmation that the supplies were shipped and delivered. The dated carrier tracking document must be attached to the delivery slip or corresponding invoice.
  - If using a third-party distributor, delivery confirmation from the third-party distributor and corresponding tracking number from the third-party distributor's carrier.
- 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) DME/Medical Supplies Prescribing Provider 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 either one business day before or one business day after the date of service as documented on the delivery slip or corresponding invoice and the

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same time frame covered by the Home Health Services (Title XIX) DME/Medical Supplies Prescribing Provider 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 ordering physician or allowed practitioner must document medical supplies as medically necessary in the client's POC or on a completed Home Health Services (Title XIX) DME/Medical Supplies Prescribing Provider Order Form and Addendum to Home Health Services (Title XIX) DME/Medical Supplies Prescribing Provider Order Form.

HHSC/TMHP reserves the right to request the signed and dated Home Health Services (Title XIX) DME/Medical Supplies Prescribing Provider Order Form or Addendum to Home Health Services (Title XIX) DME/Medical Supplies Prescribing Provider 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.

Refer to: Home Health Services (Title XIX) DME/Medical Supplies Prescribing Provider Order Form on the TMHP website at www.tmhp.com.

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

Subsection 2.8, "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.

2.2.4.1 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.

2.2.4.2 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) DME/Medical Supplies Prescribing Provider Order Form in the client's file. Unless otherwise noted in this handbook, a completed Home Health Services (Title XIX) DME/Medical Supplies Prescribing Provider Order Form for medical supplies not requiring prior authorization may be valid for a maximum of six months, unless the physician or allowed practitioner indicates the duration of need is less. If the physician or allowed practitioner indicates the duration of need is less than six months, then a new Home Health Services (Title XIX) DME/Medical Supplies Prescribing Provider Order Form is required at the end of the determined duration of need.

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For a list of DME/medical supplies that do not require prior authorization, providers can refer to subsection 2.2.30, "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) DME/Medical Supplies Prescribing Provider Order Form. Providers may deliver medical supplies as ordered on a Home Health Services (Title XIX) DME/Medical Supplies Prescribing Provider Order Form for up to six months from the date of the physician or allowed practitioner's signature. In these instances, a review of the supplies requested by the physician or allowed practitioner familiar with the client's condition, and a new Home Health Services (Title XIX) DME/Medical Supplies Prescribing Provider 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 or allowed practitioner familiar with the client's condition and a physician or allowed practitioner 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.*

Note: *Texas Medicaid fee-for-service requires providers to review for medical necessity of DME every six months. An MCO may approve an initial DME prior authorization request for a period of 6 months, unless otherwise stated, and may authorize an extension of 12 months after the initial 6 months, if medically necessary.*

2.2.4.3 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) DME/Medical Supplies Prescribing Provider 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) DME/Medical Supplies Prescribing Provider Order Form.

2.2.5 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.

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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
- All basic operational training necessary to instruct the client and family/caregivers in the use of the ACD system
- Manufacturer's warranty

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2.2.5.1 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.

2.2.5.1.1 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.

2.2.5.1.2 Non-warranty Repairs

Non-warranty 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.

2.2.5.1.3 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.

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2.2.5.1.4 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.

2.2.5.1.5 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) DME/Medical Supplies Prescribing Provider Order Form listing the prescribed ACD system, access device, and accessories (such as a mounting device) must be completed, signed, and dated by the physician or allowed practitioner.

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

2.2.5.1.6 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.*

2.2.5.1.7 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 generating 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.

2.2.5.2 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

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Specialized evaluations required for the provision of new complex rehabilitation technology, such as augmentative communication devices, require physical in-person presence of the rendering provider.

Note: *For clients who are 21 years of age or older, requests for ACD systems that do not meet the criteria through Title XIX Home Health Services may be considered under the Texas Medicaid Home Health—Durable Medical Equipment (DME) Exceptional Circumstances process.*

2.2.5.3 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 or allowed practitioner 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 disciplines, such as physical or occupational therapies. The prescribing provider 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 provider 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 or allowed practitioner'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.

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- 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.

2.2.6 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 limitations that do not allow for bathing, showering, or bathroom use without assistive equipment.

Bath seats are not considered for clients who are younger than 1 year of age or weighing less than 30 pounds.

Note: *For clients who are 21 years of age or older, requests for bath and bathroom equipment that do not meet the criteria through Title XIX Home Health Services may be considered under the Texas Medicaid Home Health—Durable Medical Equipment (DME) Exceptional Circumstances process.*

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

2.2.6.1 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.

2.2.6.2 Bath Equipment

2.2.6.2.1 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

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- 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.

2.2.6.3 Bathroom Equipment

2.2.6.3.1 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.

2.2.6.3.2 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 or allowed practitioner'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.

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- 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.

2.2.6.3.3 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.

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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 or allowed practitioner'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.

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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.

2.2.6.3.4 Portable Sitz Bath

Portable sitz baths that fit over commode seats are limited to 1 per 180 days 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.

2.2.6.3.5 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.

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- 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:

Procedure Code	Maximum Limitation
E0160	2 per year
E0161	2 per year
E0163	1 every 5 years
E0165	1 every 5 years
E0167	1 per year
E0168	1 every 5 years
E0170	1 every 5 years
E0171	1 every 5 years
E0172	1 every 5 years
E0175	1 every 5 years
E0240	1 every 5 years
E0243	2 every 5 years
E0244	1 every 5 years
E0245	1 every 5 years
E0246	1 every 5 years
E0247	1 every 5 years
E0248	1 every 5 years
E0621	1 per 5 years
E0625	1 purchase every 5 years; 1-month rental
E0630	1 purchase every 5 years; 1 per month rental
E1399	1 every 5 years

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2.2.6.4 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.

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 or allowed practitioner familiar with the client.

2.2.6.5 Documentation Requirements

2.2.6.5.1 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.

2.2.6.5.2 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, an allowed practitioner, 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.

2.2.7 Blood Pressure Devices (Manual and Automated)

Blood pressure devices are benefits in the home setting for self-monitoring when:

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

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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.

2.2.7.1 * Prior Authorization

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

[Revised] Diagnosis Codes							
I10	I110	I119	I120	I129	I130	I1310	I1311
I132	I150	I151	I152	I158	I159	I160	I161
I169	I1A0	I219	I21A1	I21A9	I21B	I2601	I2602
I2603	I2604	I2609	I2690	I2692	I2693	I2694	I2695
I2696	I2699	I270	I271	I2720	I2721	I2722	I2723
I2724	I2729	I2781	I2782	I2783	I27840	I27841	I27848
I27849	I2789	I279	I340	I341	I342	I3481	I3489
I349	I350	I351	I352	I358	I359	I360	I361
I362	I368	I369	I370	I371	I372	I378	I379
I421	I422	I424	I425	I4281	I4289	I429	I43
I440	I441	I442	I4430	I4439	I444	I445	I4460
I4469	I447	I450	I4510	I4519	I452	I453	I454
I455	I456	I4581	I4589	I459	I4710	I4711	I4719
I4720	14722	I4729	I479	I480	I4811	I4819	I4820
I4821	I483	I484	I4891	I4892	I495	I501	I5020
I5021	I5022	I5023	I5030	I5031	I5032	I5033	I5040
I5041	I5042	I5043	I50810	I50811	I50812	I50813	I50814
I5082	I5083	I5084	I5089	I509	I5A	I950	I951
I952	I953	I9581	I9589	I959	N00A	N00B1	N00B2
N010	N011	N012	N013	N014	N015	N016	N017
N018	N01A	N02A	N02B1	N02B2	N02B3	N02B4	N02B5
N02B6	N02B9	N03A	N04A	N04B1	N04B2	N050	N051
N052	N053	N054	N055	N056	N057	N058	N059
N05A	N08	N130	N1330	N1339	N13721	N13722	N13729
N13731	N13732	N13739	N170	N171	N172	N178	N179

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[Revised] Diagnosis Codes							
N181	N182	N1830	N1831	N1832	N184	N185	N186
N189	N250	N2589	Q200	Q201	Q202	Q203	Q204
Q205	Q208	Q210	Q2110	Q2111	Q2112	Q2113	Q2114
Q2115	Q2116	Q2119	Q2120	Q2121	Q2122	Q2123	Q213
R001	T800XXA	T81718A	T8172XA	T82817A	T82855A	T82855D	T82855S
T82856A	T82856D	T82856S					

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.

2.2.7.2 Hospital-Grade Blood Pressure Devices

Hospital-grade blood pressure devices and their components are benefits of CCP in the home setting for self-monitoring when the equipment is prescribed by a physician or an allowed practitioner. A hospital-grade blood pressure device includes memory for continuous recording, has an alarm system to notify the caregiver of abnormal readings, and is capable of frequent or continuous automatic blood pressure and heart rate monitoring with correction of motion artifact.

Documentation that supports medical necessity of the requested equipment, including the diagnosis, must be maintained in the client's medical record and is subject to retrospective review.

Refer to: Section 9.2.26.1, "Blood Pressure Monitoring" in the *Medical and Nursing Specialists, Physicians, and Physician Assistants Handbook* (*Vol. 2, Provider Handbooks*) for information about ambulatory blood pressure devices.

Providers must use procedure code A9279 with modifier U1 when billing for hospital-grade blood pressure devices.

Hospital-grade blood pressure devices 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 when the equipment is not functional and not repairable.

For clients who are birth through 11 months of age, the rental or purchase of a hospital-grade blood pressure device is a benefit when documentation supports medical necessity and includes an explanation of why the client cannot use a standard automated blood pressure device.

For clients who are 12 months of age and older, the rental or purchase of a hospital-grade blood pressure device is a benefit on a case-by-case basis. Supporting documentation of medical necessity must be provided.

The following indications are recognized by Texas Medicaid for hospital-grade blood pressure devices:

- Hypotension

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- Essential hypertension
- Hypertensive heart disease
- Hypertensive renal disease
- Myocardial infarction
- Pulmonary embolism
- Acute pulmonary heart disease
- Chronic pulmonary heart disease
- Valve disorders
- Cardiomyopathy
- Conduction disorders
- Cardiac dysrhythmias
- Heart failure
- Acute kidney failure
- Chronic kidney disease
- Hydronephrosis
- Vesicoureteral reflux with neuropathy
- Bulbus cordis anomalies and anomalies of cardiac septal closure
- Embolism
- Stenosis of either coronary artery stent or peripheral vascular stent

All rental costs of the hospital-grade blood pressure device apply toward the purchase price.

2.2.7.3 Components, Replacements, and Repairs

The following may be considered for reimbursement of blood pressure device replacement and repairs with prior authorization:

- Replacement of blood pressure cuffs (procedure code A4663)
- Replacement of other components (procedure code A4660)
- Repairs of the equipment (procedure code A4660)

2.2.7.4 Prior Authorization

Prior authorization is required for the rental or purchase of a hospital-grade blood pressure device. A determination will be made by HHSC or its designee as to whether the equipment will be rented, purchased, repaired, or modified based on the client's needs, duration of use, and age of the equipment. Repairs and modifications can only be performed on purchased equipment.

Documentation of medical necessity for the hospital-grade blood pressure device must support the client's need for self-monitoring and address why an automated blood pressure device will not meet the client's needs. The documentation must include:

- All pertinent diagnoses.
- Initial evaluation.
- Symptoms.
- Duration of symptoms.

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- Any recent hospitalizations (within past 12 months).
- Comorbid conditions.
- How frequent or continuous self-monitoring will affect treatment.
- All pertinent laboratory and radiology results.
- Client's weight.
- A family or caregiver(s) who has an understanding of cause and effect and object permanence and who has agreed to accept the responsibility to be trained to use the hospital-grade monitor.

Prior authorization may be granted for a six-month rental period when the request is submitted with documentation of medical necessity supporting the client's need for self-monitoring and addressing why an automated blood pressure device will not meet the client's needs.

Recertification for an additional six-month period may be considered when the physician or allowed practitioner provides current documentation that supports the ongoing medical necessity for self-monitoring and confirms the client or family is compliant with its use.

A hospital-grade blood pressure device will not be considered for prior authorization of purchase until the client has completed a six-month trial period.

Purchase of a hospital-grade blood pressure device may be prior authorized when all of the following criteria are met:

- The client is 12 months of age or older.
- Documentation of medical necessity supports the client's need for ongoing self-monitoring and addresses why an automated blood pressure device will not meet the client's needs.

2.2.7.4.1 Components, Replacements, and Repairs

Replacement of blood pressure cuffs and other components may be considered for purchase with prior authorization and documentation of medical necessity that explains the need for the replacement.

Repair of equipment must be prior authorized when irreparable damage has occurred and documentation exists that supports the need for repair. Repair of equipment will be considered after the factory warranty has expired.

2.2.8 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.

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

Note: *For clients who are 21 years of age or older, requests for bone growth stimulators that do not meet the criteria through Title XIX Home Health Services may be considered under the Texas Medicaid Home Health—Durable Medical Equipment (DME) Exceptional Circumstances process.*

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.

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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 pseudarthrosis.

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.

2.2.8.1 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.

2.2.8.2 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 Prescribing Provider Order Form prescribing the DME and/or supplies must be signed and dated by a physician or an allowed practitioner familiar with the client, before requesting prior authorization for all DME equipment and supplies. The completed Home Health Services (Title XIX) DME/Medical Supplies Prescribing Provider Order Form must include the procedure codes and quantities for services requested.

A copy of the completed Home Health Services (Title XIX) DME/Medical Supplies Prescribing Provider Order Form with the original dated signature must be maintained by the prescribing physician or allowed practitioner in the client's medical record. A copy of the completed, signed, and dated form must be maintained by the DME provider in the client's medical record.

To facilitate the determination of medical necessity and avoid unnecessary denials, the physician or allowed practitioner must provide correct and complete information, including documentation of medical necessity for the equipment or supplies prescribed and is subject to retrospective review. Either provider may be asked for additional information to clarify or complete a request for the bone growth stimulator.

2.2.8.2.1 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 the following:

- Serial radiographs have confirmed that no progressive signs of healing have occurred.

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- 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.

2.2.8.2.2 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).

2.2.8.2.3 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).

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2.2.8.3 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 in subsection 2.2.8.2, "Prior Authorization Criteria and Documentation Requirements for Bone Growth Stimulators" in this handbook.
- 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.

2.2.9 Breast Feeding Support Services

Refer to: Section 3, "Breastfeeding Support Services" in the *Gynecological, Obstetrics, and Family Planning Title XIX Services Handbook* (*Vol. 2, Provider Handbooks*) for information about breastfeeding support services.

2.2.10 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 9.2.22, "Cochlear Implants" in the *Medical and Nursing Specialists, Physicians, and Physician Assistants Handbook* (*Vol. 2, Provider Handbooks*) for more information about cochlear implant services.

2.2.11 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.

2.2.11.1 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.

2.2.12 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.

Note: *For clients who are 21 years of age or older, requests for diabetic equipment and supplies that do not meet the criteria through Title XIX Home Health Services may be considered under the Texas Medicaid Home Health—Durable Medical Equipment (DME) Exceptional Circumstances process.*

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

- A Home Health Services (Title XIX) DME/Medical Supplies Prescribing Provider Order Form
- 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).

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2.2.12.1 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 or allowed practitioner in the client's medical record. The physician or allowed practitioner 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 or allowed practitioner's signature date.

Note: *Texas Medicaid fee-for-service requires providers to review for medical necessity of DME every six months. An MCO may approve an initial DME prior authorization request for a period of 6 months, unless otherwise stated, and may authorize an extension of 12 months after the initial 6 months, if medically necessary.*

2.2.12.2 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).
- Make and model for a device.
- 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.

Note: *Texas Medicaid fee-for-service requires providers to review for medical necessity of DME every six months. An MCO may approve an initial DME prior authorization request for a period of 6 months, unless otherwise stated, and may authorize an extension of 12 months after the initial 6 months, if medically necessary.*

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, including make and model for a device
- 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.

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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 or an allowed practitioner who is familiar with the client. The make and model of a requested device must also be included on the Home Health Services Title XIX Form.
- Or all the following:
  - A completed and signed detailed written or verbal order.
  - A Title XIX Form with section A completed, along with the make and model information of the requested device.

Note: *Daily blood glucose logs are not required for prior authorization.*

2.2.12.3 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:

Procedure Code	Limitation
A4233	1 per 180 days
A4234	1 per 180 days
A4235	1 per 180 days
A4236	1 per 180 days
A4252	10 strips per month
A4256	2 per year
A4258	2 per year

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:

Procedure Code	Limitation
A4253*	2 boxes per month
A4259	1 box per month
A9275*	2 per month
***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**	

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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:

Procedure Code	Limitation
A4253*	1 box per month
A4259	1 box every 2 months
A9275*	1 per month
***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:

Diabetic Diagnosis Codes							
E0800	E0801	E0810	E0811	E0821	E0822	E0829	E08311
E08319	E083211	E083212	E083213	E083219	E083291	E083292	E083293
E083299	E083311	E083312	E083313	E083319	E083391	E083392	E083393
E083399	E083411	E083412	E083413	E083419	E083491	E083492	E083493
E083499	E083511	E083512	E083513	E083519	E083521	E083522	E083523
E083529	E083531	E083532	E083533	E083539	E083541	E083542	E083543
E083549	E083551	E083552	E083553	E083559	E083591	E083592	E083593
E083599	E0836	E0837X1	E0837X2	E0837X3	E0837X9	E0839	E0840
E0841	E0842	E0843	E0844	E0849	E0851	E0852	E0859
E08610	E08618	E08620	E08621	E08622	E08628	E08630	E08638
E08641	E08649	E0865	E0869	E088	E089	E0900	E0901
E0910	E0911	E0921	E0922	E0929	E09311	E09319	E093211
E093212	E093213	E093219	E093291	E093292	E093293	E093299	E093311
E093312	E093313	E093319	E093391	E093392	E093393	E093399	E093411
E093412	E093413	E093419	E093491	E093492	E093493	E093499	E093511
E093512	E093513	E093519	E093521	E093522	E093523	E093529	E093531
E093532	E093533	E093539	E093541	E093542	E093543	E093549	E093551
E093552	E093553	E093559	E093591	E093592	E093593	E093599	E0936
E0937X1	E0937X2	E0937X3	E0937X9	E0939	E0940	E0941	E0942
E0943	E0944	E0949	E0951	E0959	E09610	E09618	E09620
E09621	E09622	E09628	E09630	E09638	E09641	E09649	E0965
E0969	E098	E099	E1010	E1011	E1021	E1022	E1029
E10311	E10319	E103211	E103212	E103213	E103219	E103291	E103292
E103293	E103299	E103311	E103312	E103313	E103319	E103391	E103392
E103393	E103399	E103411	E103412	E103413	E103419	E103491	E103492
E103493	E103499	E103511	E103512	E103513	E103519	E103521	E103522
E103523	E103529	E103531	E103532	E103533	E103539	E103541	E103542
E103543	E103549	E103551	E103552	E103553	E103559	E103591	E103592
E103593	E103599	E1036	E1037X1	E1037X2	E1037X3	E1037X9	E1039

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Diabetic Diagnosis Codes							
E1040	E1041	E1042	E1043	E1044	E1049	E1051	E1052
E1059	E10610	E10618	E10620	E10621	E10622	E10628	E10630
E10638	E10641	E10649	E1065	E1069	E108	E109	E10A0
E10A1	E10A2	E1100	E1101	E1110	E1121	E1122	E1129
E11311	E11319	E113211	E113212	E113213	E113219	E113291	E113292
E113293	E113299	E113311	E113312	E113313	E113319	E113391	E113392
E113393	E113399	E113411	E113412	E113413	E113419	E113491	E113492
E113493	E113499	E113511	E113512	E113513	E113519	E113521	E113522
E113523	E113529	E113531	E113532	E113533	E113539	E113541	E113542
E113543	E113549	E113551	E113552	E113553	E113559	E113591	E113592
E113593	E113599	E1136	E1137X1	E1137X2	E1137X3	E1137X9	E1139
E1140	E1141	E1142	E1143	E1144	E1149	E1151	E1152
E1159	E11610	E11618	E11620	E11621	E11622	E11628	E11630
E11638	E11641	E11649	E1165	E1169	E118	E119	E11A
E1300	E1301	E1310	E1311	E1321	E1322	E1329	E13311
E13319	E133211	E133212	E133213	E133219	E133291	E133292	E133293
E133299	E133311	E133312	E133313	E133319	E133391	E133392	E133393
E133399	E133411	E133412	E133413	E133419	E133491	E133492	E133493
E133499	E133511	E133512	E133513	E133519	E133521	E133522	E133523
E133529	E133531	E133532	E133533	E133539	E133541	E133542	E133543
E133549	E133551	E133552	E133553	E133559	E133591	E133592	E133593
E133599	E1336	E1337X1	E1337X2	E1337X3	E1337X9	E1339	E1340
E1341	E1342	E1343	E1344	E1349	E1351	E1352	E1359
E13610	E13620	E13621	E13622	E13628	E13638	E13641	E13649
E1365	E1369	E138	E139	O24011	O24012	O24013	O2402
O2403	O24414	O24415	O24424	O24425	O24434	O24435	O99810
O99814	O99815	P702					

Non-diabetic Diagnosis Codes

Non-diabetic Diagnosis Codes								
E161	E162	E16A1	E16A2	E16A3	E71111	E71310	E71311	E71312
E71313	E71314	E71318	E7132	E7420	E7421	E7429	E88810	E88811
E88818	E88819	E8882	E88A	K911	R7303	R7309	R81	

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.

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Procedure code A4245 is limited to four boxes per month and must be submitted with modifier U4. 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.

2.2.12.3.1 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 2.2.12.3, "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 or allowed practitioner.

2.2.12.4 Blood Glucose Monitors (BGM)

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.

2.2.12.4.1 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.

2.2.12.5 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.

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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.

Procedure Code	Limitation
A4224	4 per month
A4225	15 per month
A4230	15 per month
A4231	15 per month
A4232	10 per month
A4601	1 per 180 days
A4602	1 per 180 days
A6257	30 per month
A6258	30 per month
A6259	15 per month
K0601	4 per 2 months
K0602	4 per 2 months
K0603	4 per 2 months
K0604	1 per 6 months
K0605	1 per 6 months

Providers must bill replacement batteries (procedure codes K0601, K0602, K0603, K0604, and 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 or allowed practitioner'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.

2.2.12.5.1 Prior Authorization

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

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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 administrations of insulin:
  - Elevated glycosylated hemoglobin level (HbA1c) > 7.0 percent
  - History of dawn phenomenon or Somogyi phenomenon with fasting blood sugars frequently exceeding 200 mg/dl
  - History of severe glycemic excursions with wide fluctuations in blood glucose
  - History of problematic 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

2.2.12.6 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 Texas Vendor Drug Program (VDP) and are not covered under Title XIX Home Health Services. The Texas Vendor Drug Program only enrolls pharmacies.

Refer to: The *Outpatient Drug Services Handbook* (*Vol. 2, Provider Handbooks*) for more information about VDP.

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2.2.12.7 Continuous Glucose Monitors (CGM)

CGMs are devices that measure glucose levels taken from interstitial fluid continuously throughout the day and night, providing real-time data to the client, physician, or an allowed practitioner.

The CGM is comprised of three parts:

- A disposable sensor (attaches to the skin and inserts a tiny wire into the subcutaneous tissue to measure glucose levels)
- A transmitter (attaches to the sensor and sends the data to a wireless receiver/monitor)
- A receiver/monitor (records and stores the data and alerts the client when glucose levels are too high or too low)

Only CGM consisting of all three parts including the sensor, transmitter, and receiver/monitor are covered. Coverage requires a dedicated receiver/monitor. A CGM that uses a smart device (e.g., smart phone, tablet, watch, personal computer, etc.) as a receiver is not classified as durable medical equipment and therefore not covered by Medicaid.

The general term CGM refers to both non-adjunctive (formerly referred to as therapeutic) and adjunctive (formerly referred to as nontherapeutic) CGMs.

A non-adjunctive CGM can be used to make treatment decisions without the need for a stand-alone BGM to confirm testing results. An adjunctive CGM requires the user to verify their glucose levels or trends displayed on a CGM with a BGM prior to making treatment decisions.

A long-term personal CGM system for clients who have diabetes to use at home may be considered as a Medicaid DME benefit with prior authorization using procedure codes E2102 (device) and A4238 (supplies) for adjunctive CGM; procedure codes E2103 (device) and A4239 (supplies) for non-adjunctive CGM.

Note: *There are no devices on the United States market that function as stand-alone adjunctive CGM devices. Current technology for adjunctive CGM devices operates in conjunction with an insulin pump.*

The short-term CGM (worn a minimum of 72 hours) is used for diagnostic purposes to establish or modify the client's treatment plan, which is a distinct and separate Texas Medicaid benefit.

When a CGM (procedure code E2102 or E2103) is covered, the related supply allowance (procedure code A4238 or A4239) is also covered. Supplies (procedure code A4238) for an adjunctive CGM integrated into an external insulin infusion pump are covered when the client meets both the CGM coverage criteria and the coverage criteria for an external insulin infusion.

The following non-adjunctive CGM device procedure codes and related supplies will be a benefit when provided by medical supplier durable medical equipment (DME) providers in the home setting:

Procedure Code	Limitation
E2102	1 per 3 years
E2103	1 per 3 years
A4238	1 per month
A4239	1 per month

Refer to: Subsection 9.2.24, "Continuous Glucose Monitoring (CGM)" in the *Medical and Nursing Specialists, Physicians, and Physician Assistants Handbook* (*Vol. 2, Provider Handbooks*)

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2.2.12.7.1 Prior Authorization

A personal CGM for clients with diabetes to use at home may be considered as a Medicaid DME benefit with prior authorization using procedure code E2102 for adjunctive CGM and E2103 for non-adjunctive CGM.

A CGM must be prescribed by the client's treating practitioner performing the glucose monitoring.

The following initial criteria must be met for the client to qualify for the CGM benefit:

- A client must have diabetes mellitus and meet all of the following medical necessity criteria:
  - The client is insulin treated; or
  - The client has a history of problematic hypoglycemia with documentation of at least one of the following:
    - Recurrent (more than one) level 2 hypoglycemic events (glucose <54 mg/dL [3.0 mmol/L] that persist despite multiple (more than one) attempts to adjust medication(s) and/or modify the diabetes treatment plan; or
    - A history of one level 3 hypoglycemic event (glucose <54 mg/dL [3.0 mmol/L]) characterized by altered mental and/or physical state requiring third-party assistance for treatment of hypoglycemia.
- A client with hypoglycemia unawareness or several episodes of hypoglycemia a day also qualifies for the CGM benefit if the client does not meet the criteria outlined above.
- The client's treating practitioner has concluded that the client (or the client's caregiver) has sufficient training using the CGM prescribed as evidenced by providing a prescription for the appropriate supplies and frequency of blood glucose testing.
- Have documentation of medical necessity and a provider statement in the medical record that the client has a history of performing daily self-blood glucose monitoring.
- The CGM is prescribed in accordance with its FDA indications for use.

Note: *Daily blood glucose logs are not required for prior authorization.*

Within six (6) months prior to ordering the CGM, the treating practitioner has an in-person or Medicaid-approved telemedicine visit with the client to evaluate their diabetes control and determined that the criteria in this section are met.

For continued CGM coverage, every six (6) months following the initial prescription of the CGM, the treating practitioner has an in-person or Medicaid-approved telemedicine visit with the client to document adherence to the CGM regimen and diabetes treatment plan.

Prior authorization is not required for CGM supplies once a device is approved. When a CGM (procedure code E2102 or E2103) is covered, the related supply allowance (procedure code A4238 or A4239) is also covered.

There are no devices on the United States market that function as stand-alone adjunctive CGM devices according to the CMS definition of DME. Current technology for adjunctive CGM devices (procedure code E2102) operates in conjunction with an insulin pump, and its supplies (procedure code A4238) are covered when the beneficiary meets both the CGM coverage criteria and the coverage criteria for an external insulin infusion pump.

CGM devices that have been purchased are expected 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 replacement of the equipment may also be considered when the equipment has been lost or irreparably damaged. A copy of the police or fire report, when appropriate, and the measures to be taken to prevent a reoccurence must be submitted. Additional services may be reimbursed with prior authorization based on documentation of medical necessity.

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2.2.12.7.2 Claims Filing Requirements

Only one CGM system may be authorized for the qualified diabetic client. The ordering provider is responsible for requesting the appropriate device and supplies according to the client's medical need.

The ordering provider should also verify that the client's condition meets the manufacturers' recommendations for appropriate age range, testing and calibration requirements, etc., prior to prescribing the CGM device.

The provider must submit procedure codes E2102 or E2103 with the KF modifier when billing for a class III CGM device (designated by FDA). No modifier is required for a class II device (designated by FDA).

No prior authorization is required for CGM integrated insulin pump supplies. When a CGM integrated pump is covered, its supplies (procedure code A4238 or A4239) are also covered.

The supply allowance (procedure code A4238 or A4239) is billed as one unit of service per 30 days. Only one unit of service of procedure code A4238 or A4239 may be billed to the claim system at a time. Billing more than one unit of service per 30 days of procedure code A4238 or A4239 will be denied as not reasonable and necessary.

Non-adjunctive CGM devices replace standard home BGMs and related supplies. The following procedure codes for BGM and its related supplies will be denied when billed with a non-adjunctive CGM (procedure code E2103) and its associated supply allowance (procedure code A4239):

Procedure Code									
A4233	A4234	A4235	A4236	A4244	A4245	A4246	A4247	A4250	A4253
A4255	A4256	A4257	A4258	A4259	E0607	E2100	E2101		

Adjunctive CGM devices do not replace a standard home BGM. The supply allowance for an adjunctive CGM (procedure code A4238) encompasses all items necessary for the use of the device and includes, but is not limited to, CGM sensors and transmitters. Procedure code A4238 does not include a home BGM and related BGM testing supplies. Clients on an insulin pump with adjunct CGM capability may be billed separately, in addition to procedure code A4238:

- Two boxes for test strips (procedure code A4253), and
- One box for lancets (procedure code A4259) during the same calendar year by any provider.

The initial order from a health-care provider who manages the client's diabetes is valid for the first six months. If the client continues to be compliant with use of the CGM and treatment plan, the provider may write an order for an additional six months. After the first year, an order(s) for replacement sensors, transmitter, and receiver (following frequency rules) may be written for a 12-month period.

> ***Note:*** *Texas Medicaid fee-for-service requires providers to review for medical necessity of DME every six months. An MCO may approve an initial DME prior authorization request for a period of 6 months, unless otherwise stated, and may authorize an extension of 12 months after the initial 6 months, if medically necessary.*

Requests for the supplies for client-owned CGM devices require the ordering provider to submit a statement attesting that the client meets one of the following conditions:

- The client owns a CGM device and the client's current condition meets the criteria outlined in this policy for the CGM.
- The client owns a CGM device and is compliant with using the CGM device to manage their diabetes.

2.2.12.7.3 Non-Covered Services

CGM devices (procedure code A9278) and supplies (procedure codes A9276 and A9277) for use with non-durable medical equipment are informational only. DME is defined as:

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- Medical equipment or appliances that are manufactured to withstand repeated use, ordered by a physician or allowed practitioner for use in the home, and required to correct or ameliorate a client's disability, condition, or illness.

Refer to: Subsection 2.2.2, "Durable Medical Equipment (DME) and Supplies" in this handbook.

The following services are not benefits of Texas Medicaid:

- Rental of adjunct CGM devices
- Smart devices (smart phones, tablets, personal computers, etc.) used as GCM monitors
- Medical supplies used with non-covered equipment

2.2.12.8 CGM Integrated External Insulin Pump

A CGM integrated pump is an insulin pump that has the CGM capability. The system uses an algorithm to calculate insulin doses from the CGM readings based on thresholds of measured glucose levels and tells the pump to deliver or suspend the insulin into the client's body.

A CGM integrated pump system may be considered for prior authorization when the client meets both the CGM coverage criteria and the coverage criteria for an external insulin infusion pump. Use pump procedure code E0784 with modifier UD and procedure code E2102 with modifier U4 for an insulin pump that has adjunctive CGM capability. Pump procedure code E0784 with modifier UD and procedure code E2103 with modifier U4 may be used for an insulin pump that has non-adjunctive CGM capability.

A tubeless external insulin pump (Omnipod) may be considered as an alternative to the CGM integrated pump system through prior authorization using pump procedure code E0784 with modifier U1 combined with the disposable supply procedure code A9274.

Procedure Code	Limitation
E0784	1 per 3 years
E2102	1 per 3 years
E2103	1 per 3 years
A9274	15 per month

2.2.12.8.1 Prior Authorization

A CGM integrated pump system may be considered for prior authorization when the client meets both the CGM coverage criteria and the coverage criteria for an external insulin infusion pump outlined in this handbook.

Providers must submit the pump (procedure code E0784) with modifier UD and CGM device (procedure code E2102 or E2103) to specify a CGM integrated pump system.

Some CGM integrated pump systems use smart devices to monitor the system to carry out their function. The device provider is responsible for supplying the software applications to make the system work appropriately.

Prior authorization requests for the tubeless external insulin pump (Omnipod) must be submitted using procedure code E0784 with U1 modifier. Disposable pods requests are submitted using supply procedure code A9274.

2.2.12.8.2 Claims Filing Requirements

To qualify for a CGM integrated external insulin pump, the client must meet both CGM criteria and external insulin pump criteria outlined in this handbook.

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Only one CGM integrated pump may be authorized for the qualified diabetic client. The ordering provider is responsible for requesting the appropriate device and supplies according to the client's medical need using the appropriate procedure codes.

Once the client is on a CGM integrated insulin pump, either with non-adjunctive CGM capability or with adjunctive CGM capability, claims for a stand-alone CGM will be denied.

Once the client is on a CGM integrated insulin pump, either with non-adjunctive CGM capability or with adjunctive CGM capability, claims for a regular external insulin pump will be denied.

Provider's must bill the pump (procedure code E0784) used in the CGM integrated system with modifier UD. Providers also must bill the CGM capability device (procedure code J-E2102 or J-E2103) with modifier U4 for the integrated system.

Some CGM integrated pump systems might use smart devices to monitor the system. The Medicaid DME Benefit excludes coverage for non-medical items, even when the items may be used to serve a medical purpose. The device provider is responsible for supplying the software applications to make the system work appropriately.

The alternative tubeless external insulin pump (Omnipod) should be billed using the same external insulin pump code E0784 with a U1 modifier and A9274 for its disposable pod including all supplies and accessories.

Refer to: Subsection 2.2.12.5.1, "Prior Authorization" in this handbook for prior authorization criteria that will also apply to a CGM integrated pump system or an Omnipod.

2.2.13 Donor Human Milk

Donor human milk is a benefit for clients who are birth through 11 months of age when documentation submitted clearly shows that it is medically necessary and will correct or ameliorate the client's disability or physical or mental illness or condition. Documentation must include all of the following:

- The ordering physician or allowed practitioner has documented medical necessity and appropriateness.
- The parent or guardian has signed and dated an informed consent form indicating that the risks and benefits of using banked donor human milk have been discussed with them.
- The donor human milk bank adheres to quality guidelines consistent with the Human Milk Bank Association of North America or such other standards as may be adopted by HHSC.

Additional donor human milk benefits beyond the limitations listed in this handbook may be available to clients who are birth through 20 years of age with documentation of medical necessity.

Procedure code B9998 must be used when requesting or billing for donor human milk.

Donor human milk is reimbursed at a maximum fee determined by HHSC or manual pricing.

Donor human milk is only reimbursed to a Texas Medicaid-enrolled donor milk bank and only for children who are in the home setting.

The physician or allowed practitioner must address the benefits and risks of using donor human milk, such as HIV, freshness, effects of pasteurization, nutrients, and growth factors to the parent. The physician or allowed practitioner also must address donor screening, pasteurization, milk storage, and transport of the donor milk. The physician or allowed practitioner may obtain this information from the donor milk bank.

2.2.13.1 Prior Authorization and Documentation Requirements

Donor human milk may be considered for a maximum of six months per authorization. The authorization may be extended with documentation of medical necessity.

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Prior authorization is required for donor human milk provided through Texas Medicaid THSteps CCP Services.

Note: *Texas Medicaid fee-for-service requires providers to review for medical necessity of DME every six months. An MCO may approve an initial DME prior authorization request for a period of 6 months, unless otherwise stated, and may authorize an extension of 12 months after the initial 6 months, if medically necessary.*

To obtain prior authorization, ordering providers must complete the CCP Prior Authorization Request Form and a Donor Human Milk Request Form every 180 days. The completed CCP Prior Authorization Request Form must be signed and dated by a physician or allowed practitioner familiar with the client before submitting the prior authorization request, and must include the procedure codes and quantities for the services requested.

The physician or allowed practitioner ordering the donor human milk must complete all of the fields in Part A of the original form, including the documentation of medical necessity. This information must be substantiated by written documentation in the clinical report. The physician or allowed practitioner must specify the quantity and the time frame in the Quantity Requested field (e.g., cubic centimeters per day or ounces per month). All of the fields in Part B of the form must be completed by the donor milk bank providing the donor human milk.

The completed CCP Prior Authorization Request Form and Donor Human Milk Request Form with the original dated signature must be maintained by the prescribing physician or allowed practitioner in the client's medical record. A copy of the completed, signed, and dated form must be maintained by the milk bank in the client's medical record.

To complete the prior authorization process by paper, the rendering provider must fax or mail the completed form to the CCP prior authorization unit. To complete the prior authorization process electronically, the rendering provider must submit the prior authorization requirements through any approved electronic methods.

The completed documentation of medical necessity and appropriateness and the signed and dated written informed consent form must be maintained in the client's clinical records. The documentation must address all of the following:

- Medical necessity, including why the particular client cannot survive and gain weight on any appropriate formula (e.g., elemental, special, or routine formula or food), or any enteral nutritional product other than donor human milk.
- Clinical feeding trial of an appropriate nutritional product has been considered with each authorization.
- The informed consent provided to the parent or guardian details the risks and benefits of using banked donor human milk.
- A copy of the CCP Prior Authorization Request Form and the Donor Human Milk Request Form.

Refer to: Donor Human Milk Request Form on the TMHP website at www.tmhp.com.

CCP Prior Authorization Request Form on the TMHP website at www.tmhp.com.

2.2.13.2 Donor Human Milk Services for Inpatient Clients

Donor human milk may be reimbursed to hospital providers for services rendered to inpatient clients. Hospital providers may receive reimbursement for the donor human milk service separate from the inpatient diagnosis-related group (DRG) payment.

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The hospital may be reimbursed using the following revenue and procedure code combination as an outpatient hospital service using the CMS-1450 (UB-04) claim form with the most appropriate outpatient type of bill (TOB):

Revenue Code	Procedure Code
220 (special charges)	T2101

For proper reimbursement when billing procedure code T2101, the Units field on the claim form must indicate the number of ounces rendered to the client.

Procedure code T2101 may be reimbursed for donor human milk as medically necessary for clients who are 6 months of age and younger. Prior authorization is not required.

Hospitals must follow clinical recommendations for administering donor human milk to inpatient clients, and must maintain all applicable and appropriate medical necessity documentation in the client's medical record.

2.2.14 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. A standard bed typically sold as furniture may consist of a frame, box spring, and mattress, and is of fixed height, and has no head or leg elevation adjustments. These types of beds are not:

- Primarily medical in nature.
- Made with materials that can withstand frequent cleaning and disinfecting.
- Primarily used in the treatment of disease or injury.
- Considered Durable Medical Equipment (DME) by Texas Medicaid.

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 the Texas Health Steps—Comprehensive Care Program (THSteps-CCP).*

Note: *For clients who are 21 years of age or older, requests for hospital beds and equipment that do not meet the criteria through Title XIX Home Health Services may be considered under the Texas Medicaid Home Health—Durable Medical Equipment (DME) Exceptional Circumstances process.*

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Beds which are primarily used for the purpose of safety are not a benefit of Texas Medicaid. These beds do not meet the definition of durable medical equipment as described by 42 CFR § 414.202. 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.

The following items may be considered for clients who are birth through 20 years of age when documentation submitted clearly shows that the equipment is medically necessary and will correct or ameliorate the client's disability or physical or mental illness or condition:

- Pediatric hospital cribs and beds
- Enclosure frame, canopy, or bubble tops
- Positioning pillows or cushions
- Reflux wedges
- Reflux slings

Hospital beds, cribs, and equipment are a benefit when all the following criteria are met:

- FFP must be available.
- The requested equipment or supplies must be safe for use in the home.

2.2.14.1 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 for the purpose of repositioning
- A headboard
- A foot board
- A mattress
- Side rails of any type (Texas Medicaid defines side rail 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.*

2.2.14.2 Pediatric Hospital Bed

A pediatric hospital bed or pediatric crib is defined as a medical device with all of the following features:

- A bed that allows adjustment of the head and foot of the bed.
- A manual pediatric hospital bed (procedure code E0328) or pediatric crib (procedure code E0300) allows manual adjustment to the head and leg elevation.
- A semi-electric or fully electric hospital bed (procedure code E0329) allows manual or electric adjustments to height and electric adjustments to head and leg elevation.
- A headboard
- A footboard
- A mattress
- Side rails of any type (A side rail is defined as a hinged or removable rail, board, or panel.)

Pediatric hospital beds and pediatric cribs that do not have all of these features will not be considered for prior authorization.

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A bed that has side rails that extend 24 inches or less above the mattress is considered a pediatric hospital bed (procedure code E0328 or E0329). A pediatric hospital bed may be fixed or variable height. Variable height beds may be adjusted manually or electrically as required for the client's medical condition.

Procedure codes E0328 and E0329 are restricted to clients who are 20 years of age and younger.

A bed that has side rails that extend more than 24 inches above the mattress is considered a pediatric crib (procedure code E0300).

A pediatric hospital bed or pediatric crib of any width that has all of the features defined above may be considered for prior authorization using only procedure code E0300, E0328, or E0329.

Hospital beds that are not fully enclosed can be considered through Texas Medicaid home health services.

Note: *Texas Medicaid defines a fully enclosed crib or bed as having 360-degree side enclosures.*

The following procedure codes are used when billing for the rental or purchase of pediatric hospital beds, cribs, and equipment:

Procedure Codes									
E0190*	E0300	E0316	E0328	E0329	E1399	K0739*			
*** Purchase only**									

Note: *Reflux slings must be billed using procedure code E1399.*

The purchase of a safety enclosure frame, canopy, or bubble top (procedure code E0316) may be a benefit when the protective crib top or bubble top is for safety use. It is not considered a benefit when it is used as a restraint or for the convenience of family or caregivers.

Procedure code E0316 may be used in conjunction with procedure codes E0300, E0328, or E0329 to request a pediatric fully-enclosed bed with a canopy.

Reflux slings or wedges may be considered for clients who are birth through 11 months of age. Reflux slings or wedges may be used as positioning devices for infants who require elevation after feedings when prescribed by a physician or allowed practitioner as medically necessary and appropriate.

Procedure code E0190 with modifier UD must be used to bill the purchase of reflex wedges and positional devices (positioning pillows and cushions). This code and modifier will require manual pricing. Procedure code E0190 is limited to once per three years, per client, any provider.

Procedure code K0739 may be reimbursed for the repair of equipment.

2.2.14.3 Prior Authorization

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

2.2.14.3.1 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.

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- 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.

2.2.14.3.2 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.

2.2.14.3.3 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.

2.2.14.3.4 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, allowed practitioner, 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

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2.2.14.3.5 Pediatric Hospital Beds and Safety Enclosure

Pediatric hospital beds and pediatric cribs (procedure codes E0300, E0316, E0328, and E0329) may be considered for prior authorization when the documentation submitted clearly shows that the requested bed or crib will correct or ameliorate the client's condition. The documentation must meet at least one of the following criteria:

- The client's medical condition requires positioning of the body in ways that are not feasible in an ordinary bed, including, but not limited to, the need for positioning to alleviate pain.
- The head of the bed must be elevated 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.

A semi-electric or fully electric hospital bed (procedure code E0329) may be considered for prior authorization when the submitted documentation shows that the client has a medical condition that requires frequent changes in body position or might require an immediate change in body position to avert a life-threatening situation.

The safety enclosure frame, canopy, or bubble top may be considered for prior authorization with documentation that the protective canopy top or bubble will provide for the client's safety. Prior authorization will not be considered when it will be used as a restraint or for the convenience of family or caregivers.

Reminder: *A safety enclosure (procedure code E0316) is an accessory used in conjunction with a pediatric hospital bed or crib.*

Reflux slings or wedges may be considered for prior authorization for clients who are 11 months of age and younger. These may be used as positioning devices for infants who require the head of the bed or crib to be elevated greater than 30 degrees after feedings when prescribed by a physician or an allowed practitioner as medically necessary and appropriate.

Positioning pillows and cushions may be considered for prior authorization with documentation of medical necessity that indicates the item will provide for or assist in the positioning needs of the client to maintain proper body alignment and skin integrity. Documentation must include what other devices have been used previously and why they proved to be ineffective.

Items used for PT or rehabilitation in the home are provided by the therapist. Requests for authorization for these purposes will not be considered.

2.2.14.4 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

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The following documentation must be submitted for clients who are birth through 20 years of age:

- The diagnosis, medical needs, treatments, developmental level, and functional skills of the child. A diagnosis alone is insufficient information to consider prior authorization of the requested equipment.
- The age, length, and weight of the child.
- Description of any other devices that have been used, the length of time used, and why they were ineffective.
- How the requested equipment will correct or ameliorate the client's condition beyond that of a standard child's crib, regular bed, or standard hospital bed.
- The name of the manufacturer and the manufacturer's suggested retail price (MSRP).

A determination will be made by HHSC or its designee whether the equipment will be rented, purchased, repaired, or modified based on the client's needs, duration of use, and age of equipment. All modifications, adjustments, and repairs within the first six months after delivery are considered to be part of the purchase price.

2.2.14.5 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) defines "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.

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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.

2.2.14.5.1 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

2.2.14.5.2 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 an unconvoluted 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 the following features:
    - A foam height of five inches or greater

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  - 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.

2.2.14.5.3 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 the features described above may be considered for reimbursement when documentation supports medical necessity.

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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 lamb's 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.

2.2.14.5.4 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 or allowed practitioner has done a comprehensive evaluation of the client's condition within the week before ordering the air-fluidized bed.

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- 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 or allowed practitioner 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.

2.2.14.6 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

2.2.14.6.1 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.

2.2.14.6.2 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.

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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 E0912 or E0940) 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.

2.2.14.7 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

2.2.14.8 Replacement

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

2.2.14.8.1 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.

Repairs require replacement of components that are no longer functional. Technician fees are considered to be part of the cost of the repair.

Repairs to client-owned equipment may be considered with documentation of medical necessity.

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

Rental equipment may be considered during the period of repair. Routine maintenance of rented equipment is the provider's responsibility.

Pediatric hospital cribs and beds, enclosed beds, and safety enclosure frames, canopies, or bubble tops that have been purchased are anticipated to last a minimum of five years.

2.2.14.9 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 or enclosed bed may be considered through CCP for safety use.

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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 not made with materials that can withstand frequent cleaning and disinfecting. 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.

2.2.14.10 Hospital Beds and Equipment Procedure Code Table

Procedure Code	Maximum Limitation
E0184	1 purchase every 5 years; 1-month rental
E0185	1 purchase every 5 years; 1-month rental
E0186	1 purchase every 5 years; 1-month rental
E0187	1 purchase every 5 years; 1-month rental
E0188	1 every year; Only one of either procedure code E0188 or E0189 is allowed every rolling year.
E0189	1 every year; Only one of either procedure code E0188 or E0189 is allowed every rolling year.
E0193	1 per month
E0194	1 per month
E0196	1 per month
E0197	1 per month
E0198	1 purchase every 5 years; 1-month rental
E0199	1 every 5 years
E0250	1 purchase every 5 years; 1-month rental
E0255	1 purchase every 5 years; 1-month rental
E0260	1 purchase every 5 years; 1-month rental
E0265	1 purchase every 5 years; 1-month rental
E0271	1 every 5 years
E0277	1 per month
E0280	1 purchase every 5 years; 1-month rental
E0303	1 purchase every 5 years; 1-month rental, 4 rentals per lifetime

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Procedure Code	Maximum Limitation
E0304	1 purchase every 5 years; 1-month rental, 4 rentals per lifetime
E0305	1 every 5 years
E0310	1 every 5 years
E0315	1 every 5 years
E0371	1 purchase every 5 years; 1-month rental
E0372	1 purchase every 5 years; 1-month rental
E0373	1 purchase every 5 years; 1-month rental
E0910	1 purchase every 5 years; 1-month rental
E0911	1 purchase every 5 years; 1-month rental
E0912	1 purchase every 5 years; 1-month rental
E0940	1 purchase every 5 years; 1-month rental

2.2.15 Incontinence Supplies

Incontinence supplies, such as diapers, briefs, pull-ons, liners, wipes, and underpads, may be considered for reimbursement through CCP for those clients who are birth through 3 years of age with a medical condition resulting in an increased urine or stool output beyond the typical output for this age group, such as celiac disease, short bowel syndrome, Crohn's disease, thymic hypoplasia, Acquired Immunodeficiency Syndrome (AIDS), congenital adrenal hyperplasia, diabetes insipidus, Hirschsprung's disease, or radiation enteritis.

For clients who are 4 years of age or older, incontinence supplies may be considered through Title XIX Home Health Services when their medical conditions result in an impairment of urination and/or stool. For clients who do not meet criteria through Title XIX Home Health Services, incontinence supplies may be considered through CCP with documentation of medical necessity.

> ***Note:*** *For clients who are 21 years of age or older, requests for incontinence supplies that do not meet the criteria through Title XIX Home Health Services may be considered under the Texas Medicaid Home Health—Durable Medical Equipment (DME) Exceptional Circumstances process.*

Lack of bladder or bowel control is considered normal development for clients who are 4 years of age or younger.

Reusable diapers, briefs, pull-ons, liners, wipes, and underpads are not a benefit of CCP. Gloves used to change diapers, briefs, and pull-ons are not considered medically necessary unless the client has skin breakdown or a documented disease that may be transmitted through the urine.

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

2.2.15.1 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.

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- 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.*

2.2.15.2 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.

The following procedure codes must be used when billing for diapers, briefs, and liners and are limited to a combined total of 240 per month:

Procedure Codes									
T4521	T4522	T4523	T4524	T4525	T4526	T4527	T4528	T4529	T4530
T4531	T4532	T4533	T4534	T4535	T4543	T4544			

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.*

2.2.15.3 Diaper Wipes

For clients who are 4 years of age and older and are receiving diapers, briefs, or pull-ons up to 2 boxes of diaper wipes per month do not require prior authorization. Additional quantities may be considered, with documentation of medical necessity and prior authorization, for clients:

- Who are 4 through 20 years of age, through THSteps-CCP.

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- Who are 21 years of age or older, through the Texas Medicaid Home Health – Durable Medical Equipment (DME) Exceptional Circumstances process.

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.

Diaper wipes may be considered for clients who are receiving diapers, briefs, or pull-ons through CCP.

2.2.15.4 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.

Underpads may be considered for clients who are receiving diapers, briefs, or pull-ons through CCP.

Providers must use procedure code A4554 when billing for underpads. Procedure code A4554 is limited to 120 per month.

Note: *The Home Health Services (Title XIX) DME/Medical Supplies Prescribing Provider 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) DME/Medical Supplies Prescribing Provider Order Form must not reflect more than the maximum allowed quantity per month without requesting prior authorization.*

2.2.15.5 Ostomy Supplies

The physician or allowed practitioner 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) DME/Medical Supplies Prescribing Provider 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 or allowed practitioner.

Ostomy supplies may be considered for reimbursement without prior authorization.

2.2.15.6 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.

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2.2.15.6.1 Indwelling Catheters and Related Insertion Supplies

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

2.2.15.6.2 Intermittent Catheters and Related Insertion Supplies

Intermittent catheters (A4351, A4352, A4295, A4296) 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.

A completed Home Health Services (Title XIX) DME/Medical Supplies Prescribing Provider 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:

Diagnosis Codes							
G35A	G35B0	G35B1	G35B2	G35C0	G35C1	G35C2	G35D
G8221	G8222	G8250	G8253	G8254	G834	N310	N311
N312	N319	Q054	Q057	Q058	Q0701	Q0702	Q0703
Q6410	Q6412	Q6419	Q760	Q794			

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.

Note: *Texas Medicaid fee-for-service requires providers to review for medical necessity of DME every six months. An MCO may approve an initial DME prior authorization request for a period of 6 months, unless otherwise stated, and may authorize an extension of 12 months after the initial 6 months, if medically necessary.*

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, A4352, A4295, or A4296 when billing for intermittent catheters. Providers must use procedure code A4353 when billing for intermittent catheters with insertion supplies.

2.2.15.6.3 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.

External urinary collection devices, including, but not limited to, male external catheters, female collection devices, and related supplies may be considered with a documented medical condition resulting in an increased urine or stool output beyond the typical output.

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The following procedure codes must be used when billing for external urinary collection devices:

Procedure Code	Maximum Limitation
A4326	31 per month
A4327	4 per month
A4328	4 per month
A4349	31 per month

2.2.15.6.4 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.

2.2.15.7 Prior Authorization

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

Prior authorization is required for incontinence supplies through CCP.

A determination is made by HHSC or its designee as to the number of incontinence supplies prior authorized based on the client's medical needs.

Additional quantities may be considered with documentation of medical necessity.

The quantity of incontinence supplies billed for a one-month period must be consistent with the number of times per day the physician or allowed practitioner has ordered the supply be used on the CCP Prior Authorization Request Form.

To request prior authorization for incontinence supplies, the following documentation must be provided for the items requested:

- 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 increased urination or stooling
- Client's height, weight, and waist size
- Number of times per day the physician or allowed practitioner has ordered the supply be used
- Quantity of disposable supplies requested per month

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

2.2.15.8 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 or allowed practitioner has ordered the supply be used

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- Quantity of disposable supplies requested per month by the physician or allowed practitioner

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

2.2.15.9 Incontinence Procedure Codes with Limitations

Any service or combination of services 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 be considered for clients:

- Who are 4 through 20 years of age through THSteps-CCP.
- Who are 21 years of age or older, through the Texas Medicaid Home Health-Durable Medical Equipment (DME) Exceptional Circumstances process.

Procedure Code	Maximum Limitation
A4310	2 per month
A4311	2 per month
A4312	2 per month
A4313	2 per month
A4314	2 per month
A4315	2 per month
A4316	2 per month
A4320	15 per month
A4322	4 per month
A4326	31 per month
A4327	4 per month
A4328	4 per month
A4330	As needed
A4331	2 per month
A4332	50 per month
A4333	2 per month
A4334	2 per month
A4335	2 per month
A4338	2 per month
A4340	2 per month
A4344	2 per month
A4346	2 per month
A4349	31 per month
A4351	150 per month
A4352	150 per month
A4353	150 per month
A4354	2 per month
A4355	2 per month
A4356	2 per month
A4357	2 per month

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Procedure Code	Maximum Limitation
A4358	2 per month
A4360	31 per month
A4361	As needed
A4362	As needed
A4363	As needed
A4364	8 per month
A4366	As needed
A4367	As needed
A4368	As needed
A4369	As needed
A4371	As needed
A4372	As needed
A4373	As needed
A4375	As needed
A4376	As needed
A4377	As needed
A4378	As needed
A4379	As needed
A4380	As needed
A4381	As needed
A4382	As needed
A4383	As needed
A4384	As needed
A4385	As needed
A4387	As needed
A4388	As needed
A4389	As needed
A4390	As needed
A4391	As needed
A4392	As needed
A4393	As needed
A4394	As needed
A4395	As needed
A4396	1 per day
A4398	As needed
A4399	1 per day
A4400	As needed
A4402	4 per month
A4404	As needed
A4405	As needed

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Procedure Code	Maximum Limitation
A4406	As needed
A4407	As needed
A4408	As needed
A4409	As needed
A4410	As needed
A4411	As needed
A4412	As needed
A4413	As needed
A4414	As needed
A4415	As needed
A4416	As needed
A4417	As needed
A4418	As needed
A4419	As needed
A4420	As needed
A4421	As needed
A4422	As needed
A4423	As needed
A4424	As needed
A4425	As needed
A4426	As needed
A4427	As needed
A4428	As needed
A4429	As needed
A4430	As needed
A4431	As needed
A4432	As needed
A4433	As needed
A4434	As needed
A4435	As needed
A4436	4 per month
A4437	4 per month
A4455	4 per month
A4456	60 per month
A4554	120 per month
A4927	1 per month
A5051	As needed
A5052	As needed
A5053	As needed
A5054	As needed

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Procedure Code	Maximum Limitation
A5055	As needed
A5056	As needed
A5057	As needed
A5061	As needed
A5062	As needed
A5063	As needed
A5071	As needed
A5072	As needed
A5073	As needed
A5081	As needed
A5082	As needed
A5083	As needed
A5093	As needed
A5102	2 per month
A5105	4 per year
A5112	2 per month
A5113	2 per month
A5114	2 per month
A5120	50 per month
A5121	30 per month
A5122	15 per month
A5126	40 per month
A5131	1 per month
A5200	2 per month
T4521	*240 per month
T4522	*240 per month
T4523	*240 per month
T4524	*240 per month
T4525	*240 per month
T4526	*240 per month
T4527	*240 per month
T4528	*240 per month
T4529	*240 per month
T4530	*240 per month
T4531	*240 per month
T4532	*240 per month
T4533	*240 per month
T4534	*240 per month
T4535	*240 per month
T4543	*240 per month

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Procedure Code	Maximum Limitation
T4544	*240 per month
E0275	1 per 180 days
E0276	1 per 180 days
E0325	1 per 180 days
E0326	1 per 180 days

Refer to: Subsection 2.2.15.2, "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:

Procedure Code	Maximum Limitation
A4927	1 per month
A6250	2 per month

2.2.16 * 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. The following procedure codes require prior authorization unless otherwise specified:

[Revised] Procedure Code									
A4221	A4222	A4223	A4228	A4305	A4306	A4649	A4930	A9900	E0776
E0779	E0780	E0781	E0791	K0455	K0552	S1015	S5036		

Note: *Additional supply procedure codes not listed may be considered with documentation of medical necessity.*

The following IV supplies listed are available without prior authorization up to the stated quantity limitations. Prior authorization is required for any quantities exceeding the limitations with documentation supporting the medical necessity of the quantity requested.

Procedure Code	Limitation
A4206	30 per month
A4207	30 per month
A4208	30 per month
A4209	180 per month
A4202	2 per month
A4216	60 per month
A4245	1 per month
A4247	1 per month
A4248	1 per month
A4300	4 per month
A4450	100 per month
A4452	100 per month
A4602	1 per 180 days
A4927	1 per month

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Procedure Code	Limitation
A5200	2 per month
A6206	60 per month
A6207	30 per month
A6216	200 per month
A6257	30 per month
A6258	30 per month
A6402	200 per month
K0601	1 per 180 days
K0602	1 per 180 days
K0603	1 per 180 days
K0604	1 per 180 days
K0605	1 per 180 days

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 client or 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 10 months per lifetime, with the same provider. Rentals for the same infusion pump exceeding 10 months with the same provider within a one-year period will be considered purchased. 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. The documentation must include the date of purchase, serial number, and the reason for the

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repairs. All repairs and replacement parts, including batteries, within the first six months after delivery are considered part of the purchase price. Rental equipment includes all necessary accessories, supplies, modifications, adjustments, replacement parts, and repairs.

Note: *For clients who are 21 years of age or older, requests for IV supplies and equipment that do not meet the criteria through Title XIX Home Health Services may be considered under the Texas Medicaid Home Health—Durable Medical Equipment (DME) Exceptional Circumstances process.*

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 or allowed practitioner.
- Is a chemotherapeutic agent.
- Is not FDA-approved, unless the physician or allowed practitioner 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.

2.2.16.1 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:

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    - Use one syringe to flush the catheter, and one syringe per each additional lumen(s) if applicable, before administration of an intermittent infusion to assess.
    - Use two syringes to flush the catheter and two syringes per each additional lumen(s) if applicable, 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 or allowed practitioner visits.

2.2.16.2 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 completed signed and dated Home Health Services (Title XIX) DME/Medical Supplies Prescribing Provider Form and documentation supporting medical necessity

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- 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

2.2.17 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.

Mobility aids and related supplies, including, but not limited to, strollers, special-needs car seats, travel safety restraints, and thoracic-hip-knee-ankle orthoses (THKAO)/parapodiums are a benefit to assist clients to move about in their environment when medically necessary and Federal Financial Participation is available.

Mobility aids and related supplies may be considered for reimbursement through CCP for clients who are 20 years of age or younger who are CCP-eligible when documentation submitted clearly shows that the equipment is medically necessary and will correct or ameliorate the client's disability or physical or mental illness or condition. Documentation must include the following:

- The client's mobility status would be compromised without the requested equipment.
- The requested equipment or supplies are safe for use in the home.

Mobility aids may be considered through CCP if the requested equipment is not available through Title XIX Home Health Services or the client does not meet criteria through Title XIX Home Health Services

> ***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.*

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2.2.17.1 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 or allowed practitioner familiar with the client and must include information on the client's impaired mobility.

2.2.17.2 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
- Manual seating options
- Adjustable frame
- Other complex or specialized components

A stroller (a multipositional client transfer system with integrated seat, operated by caregiver) for medical needs may be considered for clients who are CCP-eligible when documentation submitted clearly shows that the equipment is medically necessary and will correct or ameliorate the client's disability or physical or mental illness or condition. Documentation must include the following:

- The client does not own another seating system, including, but not limited to, a wheelchair
- The client's condition does not require another type of seating system, including, but not limited to, a wheelchair

If the client does not meet criteria for a stroller, a wheelchair may be considered through Texas Medicaid (Title XIX) Home Health Services.

Scooters may be considered for reimbursement through Texas Medicaid (Title XIX) Home Health Services.

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

2.2.17.2.1 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).

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2.2.17.2.2 Documentation Requirements

Documentation by a physician or an allowed practitioner 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
- A completed Wheelchair/Scooter/Stroller Seating Assessment Form with seating measurements.

Refer to: Section "Seating Assessment for Manual and Power Custom Wheelchairs"

  - A description of growth allowance for clients
    - For clients who are 12 years of age or younger, if the wheelchair frame allows for at least a 3 inch growth potential in both width and depth, accept as sufficient growth potential.
    - For clients who are 13 years of age through 17 years of age, if the wheelchair frame allows for at least a 2 inch growth potential in both width and depth, accept as sufficient growth potential.
    - For clients who are 18 years of age or older, if the wheelchair frame allows for at least a 1 inch growth potential in depth and 2 inches in width, accept as sufficient growth potential.
  - Growth allowance to the dimensions specified may be made with frame modification or growth kit.

2.2.17.3 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.

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2.2.17.3.1 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 consistently ambulate more than 10 feet.
- The client does not require specialty seating components.

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.

2.2.17.4 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.

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2.2.17.4.1 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.

2.2.17.5 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.

2.2.17.5.1 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.

2.2.17.6 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

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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

2.2.17.6.1 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:

- Arm pads/armrests
- Leg rests/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.

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Mobility Related Activity of Daily Living (MRADL)—An activity of daily living, including, but not limited to, toileting, feeding, dressing, grooming, and bathing performed in customary locations in the residence.

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 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. Rental of a wheeled mobility system during the time of repair should be offered at the time of equipment pick-up, if appropriate.

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

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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.

2.2.17.6.2 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).

2.2.17.6.3 Documentation Requirements

Documentation by a physician or an allowed practitioner 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.
- An itemized component list for custom manual or power wheeled mobility systems.
- A completed Wheelchair/Scooter/Stroller Seating Assessment Form with seating measurements that includes documentation supporting medical necessity, including:
- For clients 12 years of age and younger, the wheelchair frame must accommodate a minimum of 3 inches of growth potential in width and depth.
- For clients 13 years of age through 17 years of age, the wheelchair frame must accommodate a minimum of 2 inches of growth potential in width and depth.

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- For clients 18 years of age and older, the wheelchair frame must accommodate a minimum of 1 inch in depth and 2 inches in width of growth potential.

Documentation of frame modifications or growth kits may be submitted to demonstrate growth allowances to the dimensions specified above.

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.

2.2.17.7 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

2.2.17.7.1 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 break down because of inability to reposition body in a chair to relieve pressure areas

2.2.17.8 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.

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2.2.17.9 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 light-weight 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

2.2.17.9.1 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.
- 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).
- 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.

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- 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.

A medical stroller does not have the capacity to accommodate the client's growth. Strollers for medical use may be considered for prior authorization when all of the following criteria are met:

- The client weighs 30 pounds or more.
- The client does not already own another seating system, including, but not limited to, a standard or custom wheelchair.
- The stroller must have a firm back and seat, or insert.
- The client is expected to be ambulatory within one year of the request date or is not expected to need a wheelchair within two years of the request date.

To request prior authorization for the purchase of procedure code E1035, the criteria must be met for the level of stroller requested:

- Level One, Basic Stroller—The client meets the criteria for a stroller. Providers must use procedure code E1035.
- Level Two, Stroller with Tray for Oxygen or Ventilator—The client meets the criteria for a level-one stroller and is oxygen- or ventilator-dependent. Providers must use procedure code E1035 with modifier TF.
- Level Three, Stroller with Positioning Inserts—The client meets the criteria for a level-one or level-two stroller and requires additional positioning support. Providers must use procedure code E1035 with modifier TG.

The following supporting documentation must be submitted:

- A completed Wheelchair/Stroller Seating Assessment Form that includes documentation supporting medical necessity. This documentation must address why the client is unable to ambulate a minimum of 10 feet due to his or her condition (including, but not limited to, AIDS, sickle cell anemia, fractures, a chronic diagnosis, or chemotherapy), or if able to ambulate further, why a stroller is required to meet the client's needs.
- If the client is three years of age or older, documentation must support that the client's condition, stature, weight, and positioning needs allow adequate support from a stroller.

Note: *A stroller may be considered on a case-by-case basis with documentation of medical necessity for a client who does not meet the criteria listed above.*

A seating assessment must be completed by a physician or licensed occupational therapist or physical therapist, who is not employed by the equipment supplier, before requesting prior authorization.

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2.2.17.10 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 in subsection 2.2.17.6, "Wheeled Mobility Systems" in this handbook.
- The purchase of any device meeting the definition of a wheelchair as defined under subsection 2.2.17.2, "Wheeled Mobility Systems" 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 is required for the rental or purchase of any device meeting the definition of a wheeled mobility system or purchase of any device meeting the definition of a wheelchair for a client with a congenital or neurological condition, myopathy, or skeletal deformity that requires the use of a wheelchair as defined under subsection 2.6.9.1.2, "Wheeled Mobility Systems" in this handbook.

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 qualified rehabilitation professional (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.

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

Specialized evaluations required for the provision of new complex rehabilitation technology, such as power mobility and adaptive seating systems, require physical in-person presence of the rendering provider. Texas Medicaid may reimburse only for seating assessments, fitting, or training completed in-person.

Refer to: The *Physical Therapy, Occupational Therapy, and Speech Therapy Services Handbook* (*Vol. 2, Provider Handbooks*) for information about telehealth services.

2.2.17.10.1 * 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.

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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 physical therapist completing the seating assessment must submit procedure code 97542 with the GP and UC modifiers to bill for the seating assessment.

The occupational therapist completing the seating assessment must submit procedure code 97542 with the GO and UC modifiers 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 (used for participation in the seating assessment up to four units or one hour). 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 assessments are reimbursed in 15-minute increments (units) and are limited to four units (one hour).

Clients who are not receiving therapy services may require a therapy evaluation or re-evaluation. The therapy evaluation or re-evaluation may be performed on the same day as the seating assessment, at different times. The claim must be submitted with documentation showing that the evaluation or re-evaluation and seating assessment were performed at distinctly separate times to be considered for reimbursement.

2.2.17.10.2 Documentation Requirements

The seating assessment must clearly show that the equipment is medically necessary and will correct or ameliorate the client's disability or physical or mental illness or condition.

Documentation must include the following:

- 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.
- 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.

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- 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.
- Be submitted with the prior authorization request for the wheeled mobility system. The Form must be completed, signed and dated as outlined above.

2.2.17.11 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 2.2.17.6, "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 (used for final fitting of wheeled mobility system performed by QRP up to eight units or two hours). 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, modifications, and repairs to the wheeled mobility system within the first six months after delivery are considered part of the purchase price.

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.

2.2.17.11.1 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.

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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).

2.2.17.11.2 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.

An extended leave is any leave of more than 30 consecutive calendar days.

- The name and NPI of the original QRP who performed the initial assessment, and the date the assessment was completed.
- The name and NPI of the QRP who will be performing the fitting.
- A copy of the original, physician- or allowed practitioner-signed Home Health Services (Title XIX) DME/Medical Supplies Prescribing Provider 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.

2.2.17.12 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

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- 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.

2.2.17.12.1 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.

2.2.17.12.2 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])

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- 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.

2.2.17.12.3 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.

2.2.17.12.4 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

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- 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.

2.2.17.12.5 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

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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, an allowed practitioner, 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 2.2.17.12, "Power Wheeled Mobility Systems- Group 1 through Group 5" in this handbook.

2.2.17.12.6 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])

2.2.17.12.7 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

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2.2.17.12.8 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

2.2.17.12.9 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.

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- 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.).

2.2.17.12.10 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).

2.2.17.12.11 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.

2.2.17.13 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.

Portable ramps exceeding the above criteria may be considered on a case-by-case basis with documentation of medical necessity and a statement that the requested equipment is safe for use.

One portable ramp and one threshold ramp for wheelchair or stroller 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

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- A diagram of the house showing the access points with the ground-to-floor elevation and any obstacles

Providers must use procedure code E1399 for the purchase of portable and threshold stroller ramps.

A request for prior authorization must include documentation from the provider to support the medical necessity of the service, equipment, or supply.

Permanent ramps, vehicle ramps, and home modifications are not a benefit of Texas Medicaid.

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.

2.2.17.14 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).

2.2.17.14.1 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.

2.2.17.14.2 Documentation Requirements

The submitted documentation must include an assessment completed, signed, and dated by a physician, an allowed practitioner, 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

2.2.17.15 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.

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2.2.17.15.1 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).

2.2.17.15.2 Documentation Requirements

The submitted documentation must include an assessment completed, signed, and dated by a physician, an allowed practitioner, 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.*

2.2.17.16 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.

2.2.17.16.1 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 or allowed practitioner'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.*

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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.

2.2.17.16.2 Documentation Requirements

The submitted documentation must include an assessment completed, signed, and dated by a physician, an allowed practitioner, 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.

2.2.17.17 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.

2.2.17.17.1 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.

2.2.17.17.2 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

2.2.17.18 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

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- 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.

2.2.17.18.1 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 a power wheelchair.

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).

2.2.17.18.2 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.

2.2.17.19 Push-Rim Activated Power Assist Wheelchair (PAPAW) System

A push-rim activated power assist wheelchair (PAPAW) system is a wheelchair accessory that adds a power component to manual wheelchairs for additional power for propulsion and for braking. These systems may include specially designed wheels with sensors and motors embedded to determine the force that is exerted by the person upon the wheel. The system includes components, such as the drive wheels, batteries, battery chargers, controls, and mounting hardware.

2.2.17.19.1 Prior Authorization Documentation Requirements

A PAPAW system can be prior authorized using the Wheelchair/Scooter/Stroller/Seating Assessment Form (CCP/Home Health Services). All sections of the form must be completed, including the wheelchair and power wheelchair section.

The client must have the physical and mental ability to receive and follow instructions related to responsibilities of using equipment. The client must have the capability to:

- Understand how the PAPAW system and components function.
- Operate and control the PAPAW system safely.
- Self-propel and maneuver a manual wheelchair independently.

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  - Clients who primarily use one arm to self-propel and maneuver independently utilizing a one-arm drive manual wheelchair may be considered.
- The PAPAW must be medically necessary for the client to perform MRADLs in a typical day. Medical necessity may include but is not limited to:
  - Client's medical needs, such as limitations in upper body strength and endurance, and can include the presence of pain.
  - Prevention of the client from completing an MRADL within a reasonable time frame in their environment.
  - Heightened risk of repetitive strain injuries.
- The client or caregiver must have the capability to maintain care for the PAPAW system and accompanying components.

The cost of purchasing new equipment as opposed to the cost of modifying current equipment is not required for the PAPAW system prior authorization.

2.2.17.19.2 Seating Assessment

The addition of a PAPAW system as a wheelchair accessory is considered a type of major modification, which requires a seating assessment and a completed copy of the Wheelchair/Scooter/Stroller/Seating Assessment Form (CCP/Home Health Services).

Documentation of a new seating assessment demonstrating criteria of medical necessity is required for the PAPAW system.

A description is required of a trial with the equipment requested during the seating assessment by a therapist, in a variety of environments (or simulations of customary environments), including safety awareness, ability to navigate in the environment, and operate the PAPAW system independently. The description of a trial is required on the Wheelchair/Scooter/Stroller/Seating Assessment Form (CCP/Home Health Services) for a PAPAW system with a new wheeled mobility system or a major modification.

If a wheeled mobility system has been fitted and delivered to the client's home by a QRP, a PAPAW system may be considered for prior authorization with submission of a new Wheelchair/Scooter/Stroller/Seating Assessment Form (CCP/Home Health Services) any time within or beyond the first six months after fitting and delivery.

If a wheeled mobility system has not previously been fitted and delivered to the client's home by a QRP, initial prior authorization may be considered with submission of the same Wheelchair/Scooter/Stroller/Seating Assessment Form (CCP/Home Health Services) for both a manual wheelchair and PAPAW system.

2.2.17.20 Client Lifts

A lift is an item of DME that is a mechanical system used to lift or transfer a nonambulatory client between a bed, chair, wheelchair, bedside commode, bathroom, or other location. A lift may be medically necessary to ameliorate a client's medical condition or disability that results in impaired functional mobility impacting mobility related activities of daily living (MRADLs).

Electric and hydraulic lifts are movable single-stand mechanisms, often on casters, with a lifting arm attached to a sling, and lifting power that is provided by a manual hydraulic pump or an electric motor. Electric and hydraulic lifts are benefits for clients of all ages through Title XIX Home Health Services with documented medical necessity.

2.2.17.21 Hydraulic Lifts

Hydraulic lifts require prior authorization.

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2.2.17.21.1 Documentation Requirements

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

- The inability of clients 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

2.2.17.22 Electric Lifts

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 does not meet the client's needs.

2.2.17.23 Overhead, Fixed, and Portable Lifts

Overhead and fixed client lifts will be considered for reimbursement through CCP for clients who are 20 years of age or younger and are CCP-eligible. In order to consider a client lift outside of those specified in the home health benefit, consideration must be given to the client's medical needs (e.g., muscle tone, pain, fear, etc.), environmental factors, and caregiver abilities.

A client lift will not be prior authorized solely for the convenience of a caregiver. Prevention of caregiver injury or consideration of client safety during transfer due to caregiver factors, such as physical abilities, is not considered "caregiver convenience."

Final set up and installation costs of client lifts, including labor costs associated with ceiling or other fixed lifts, are included in the initial purchase price of the client lift and will not be separately reimbursed. Components and accessories are also considered part of the initial purchase price of a client lift. Components and accessories include, but are not limited to, the following:

- Lift motor and gear box
- Any type of sling
- Hand controls and connectors
- Carry or spreader bar and sling attachments or straps
- Ceiling tracks or rails and components
- All mounting hardware and brackets
- Batteries
- Charger system
- Emergency stop and lowering systems
- Lifting tape
- Wheels or castors of any type
- Installation of the fixed lift systems

Repair or replacement of components, such as a sling, to client-owned equipment may be considered a benefit as needed with documentation of medical necessity. Rental of an electric or hydraulic lift may be considered during a repair of a client lift.

2.2.17.24 Overhead Lifts

The purchase of a free-standing overhead client lift (procedure code E0639) is a benefit in the home setting when services are provided by DME providers.

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An overhead lift is anticipated to last a minimum of five years but may be replaced in less than five years with documentation of medical necessity.

Delivery and labor to assemble the overhead lift are not separately reimbursed.

2.2.17.24.1 Prior Authorization

Procedure code E0639 requires prior authorization.

A free-standing overhead lift may be considered for prior authorization when the client meets the criteria for a hydraulic or electric lift and additional documentation explains why a hydraulic or electric lift will not meet the client's needs. Documentation that supports the medical necessity of the requested free-standing overhead lift must include all of the following:

- A written statement from a licensed physical therapist, licensed occupational therapist, physician, or allowed practitioner that clearly outlines the client's medical need to be transferred with a free-standing overhead lift versus a hydraulic or electric lift.
- Diagrams of the home (rooms) indicating the location where the free-standing lift will be used. Diagrams must include dimensions of the rooms, including doorways, as well as the dimensions and placement of all furnishings and equipment (i.e., hospital bed, wheelchair, bedside commode, etc.) in the room.
- A list of all equipment the lift will interact with (i.e., wheelchair, hospital bed, or therapy equipment). Documentation should clearly indicate if the client owns other mobility aids, including any type of bath chair or bath lift, and explain why those pieces of equipment are not sufficient for mobility.

2.2.17.25 Fixed Lifts

The purchase of a fixed client lift (procedure code E0640) is a benefit in the home setting when the services are provided by home health medical supplier DME providers.

Home modifications that are necessary for the final set up and installation of a fixed lift are not benefits of Texas Medicaid. Suppliers must not submit claims for any structural changes or remodeling necessitated by the installation of a lift system.

> ***Note:*** *Home modifications are physical changes to the home to prepare the structure for the final set up and installation of the equipment.*

A fixed lift is anticipated to last a minimum of five years but may be replaced in less than five years with documentation of medical necessity.

Delivery and labor to assemble and install the fixed lift are not separately reimbursed.

2.2.17.25.1 Prior Authorization

Procedure code E0640 requires prior authorization.

A fixed lift may be considered for prior authorization when the client meets criteria for a hydraulic or electric lift and additional documentation explains why a hydraulic, electric, or free-standing overhead lift will not meet the client's needs. Documentation that supports the medical necessity of the requested fixed lift must include all of the following:

- A signed and dated statement from the DME provider attesting that the home in which the lift will be installed meets the manufacturer's requirements for installation, including documentation that the ceiling and wall structures of the residence are adequate to safely support the fixed lift.
- Documentation of whether the home is owned by the client, parent, guardian, or responsible party, such as a signed and dated document attesting to the ownership of the home. If the home is not owned by the client, parent, guardian, or responsible party, written consent of the installation from the home owner or property manager must be submitted.

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- A written statement from a licensed physical therapist, licensed occupational therapist, physician, or allowed practitioner that clearly outlines the client's medical need to be transferred with a fixed lift.
- Indication of what type of home the client lives in (i.e., traditional 1-story or 2-story home, mobile home, or apartment), including diagrams of the home where the fixed lift system will be installed. Diagrams must include dimensions of the rooms including doorways, as well as the dimensions and placement of all furnishings and equipment (i.e. hospital bed, wheelchair, bedside commode, etc.) in the room. Diagrams must also include the proposed placement of all fixed components (i.e. railing or track) of the system.
- A list of all equipment the lift will interact with (i.e., wheelchair, hospital bed, or therapy equipment). Documentation should clearly indicate if the client owns other mobility aids, including any type of bath chair or bath lift, and explain why those pieces of equipment are not sufficient for mobility.
- Attestation from the DME provider stating that the provider has personnel who have been trained to install the lift system.
- Documentation confirming the home modifications necessary to allow for installation of the lift have been done or are scheduled to be completed prior to installation.

2.2.17.26 Portable Client Lifts for Outside Home Setting

Portable client lifts are benefits for clients who are 20 years of age and younger. Providers must bill procedure code E0635 with modifier TG for the purchase of the portable client lift. Purchase of procedure code E0635 is limited to once per lifetime, any provider. Rental for E0635 is limited to once per month.

2.2.17.26.1 Prior Authorization

Prior authorization is required and will be considered on a case-by-case basis for portable client electric lifts that fold-up for transport and are necessary for use outside the home setting.

The provider must submit a prior authorization request with the following documentation for consideration of medical necessity:

- An explanation of why a home-based portable lift will not meet the client's needs
- A description of the circumstances, including duration of need
- The family member or caregivers who support the client with the use of the portable client lift when the client travels outside the home setting

2.2.17.27 Standers

A stander is a device used by a client with a neuromuscular condition 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).

2.2.17.27.1 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.

2.2.17.27.2 Documentation Requirements

Prior authorization may be considered for 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

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- 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

2.2.17.28 Gait Trainers

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

2.2.17.28.1 Prior Authorization

Prior authorization for a gait trainer may be considered with the following documentation:

- Documentation of medical necessity
- An assessment of the accessibility of the client's residence to ensure that a gait trainer is usable in the home (i.e., doors and halls are wide enough and have no obstructions)
- A physician or allowed practitioner familiar with the client documents that the client has ambulatory potential and will benefit from a gait training program
- The client meets the criteria for a stander

2.2.17.29 Accessories, Modifications, Adjustments and Repairs

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

- All major and minor 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 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 or allowed practitioner familiar with the client.

2.2.17.29.1 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.

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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 by a qualified practitioner (physician, physical therapist, or occupational therapist) 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 or a repair 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.

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2.2.17.30 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 Texas Health Steps CCP.

2.2.17.31 Procedure Codes and Limitations for Mobility Aids

For clients who are 20 years of age and younger, the limitations listed below may not apply with evidence of medical necessity. Procedures include, but are not limited to, the following:

Procedure Code	Maximum Limit
Canes	
E0100	1 per 5 years
E0105	1 per 5 years
Crutches	
A4635	As needed
E0110	1 purchase every 5 years; 1-month rental
E0111	1 purchase every 5 years; 1-month rental
E0112	1 purchase every 5 years; 1-month rental
E0113	1 purchase every 5 years; 1-month rental
E0114	1 purchase every 5 years; 1-month rental
E0116	1 purchase every 5 years; 1-month rental
E0153	1 purchase every 5 years
Walkers	
A4636	1 per month
A4637	As needed
E0130	1 purchase every 5 years; 1-month rental
E0135	1 purchase every 5 years; 1-month rental
E0141	1 purchase every 5 years; 1-month rental
E0143	1 purchase every 5 years; 1-month rental
E0144	1 purchase every 5 years; 1-month rental
E0147	1 purchase every 5 years; 1-month rental
E0148	1 purchase every 5 years; 1-month rental
E0149	1 purchase every 5 years; 1-month rental
E0154	1 per 5 years
E0155	1 per 5 years
E0157	1 per 5 years
E0158	1 per 5 years
E0159	1 per 5 years
Gait Trainers	

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Procedure Code	Maximum Limit
E8001	1 purchase every 5 years
Wheelchairs	
97542	N/A
E1050	1 purchase every 5 years; 1-month rental
E1060	1 purchase every 5 years; 1-month rental
E1070	1 purchase every 5 years; 1-month rental
E1100	1 purchase every 5 years; 1-month rental
E1110	1 purchase every 5 years; 1-month rental
E1161	1 purchase every 5 years; 1-month rental
E1220	1 per 5 years
E1229	1 per 5 years
E1231	1 purchase every 5 years; 1-month rental
E1232	1 purchase every 5 years; 1-month rental
E1233	1 purchase every 5 years; 1-month rental
E1234	1 purchase every 5 years; 1-month rental
E1235	1 purchase every 5 years; 1-month rental
E1236	1 purchase every 5 years; 1-month rental
E1237	1 purchase every 5 years; 1-month rental
E1238	1 purchase every 5 years; 1-month rental
E1239	1 per 5 years
Power Wheelchairs	
K0001	1 purchase every 5 years; 1-month rental
K0002	1 purchase every 5 years; 1-month rental
K0003	1 purchase every 5 years; 1-month rental
K0004	1 purchase every 5 years; 1-month rental
K0005	1 purchase every 5 years; 1-month rental
K0006	1 purchase every 5 years; 1-month rental
K0007	1 purchase every 5 years; 1-month rental
K0008	1 purchase every 5 years; 1-month rental
K0009	1 purchase every 5 years; 1-month rental
K0010	1 per 5 years; 1 per month rental
K0011	1 per 5 years
K0012	1 per 5 years
K0013	1 purchase every 5 years; 1-month rental
K0015	As needed
K0017	As needed
K0018	As needed
K0019	As needed
K0020	As needed
K0037	As needed

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Procedure Code	Maximum Limit
K0038	As needed
K0039	As needed
K0040	As needed
K0041	As needed
K0042	As needed
K0043	As needed
K0044	As needed
K0045	As needed
K0046	As needed; 1 per month
K0047	As needed; 1 per month
K0050	As needed
K0051	As needed
K0052	As needed
K0053	As needed; 1 per month
K0056	As needed
K0065	As needed
K0069	As needed; 1 per month
K0070	As needed
K0071	As needed
K0072	As needed
K0073	As needed
K0077	As needed
K0098	As needed
K0105	As needed; 1 per month
K0195	As needed; 1 per month
K0669	As needed
K0813	1 purchase every 5 years; 1-month rental
K0814	1 purchase every 5 years; 1-month rental
K0815	1 purchase every 5 years; 1-month rental
K0816	1 purchase every 5 years; 1-month rental
K0820	1 purchase every 5 years; 1-month rental
K0821	1 purchase every 5 years; 1-month rental
K0822	1 purchase every 5 years; 1-month rental
K0823	1 purchase every 5 years; 1-month rental
K0824	1 purchase every 5 years; 1-month rental
K0825	1 purchase every 5 years; 1-month rental
K0826	1 purchase every 5 years; 1-month rental
K0827	1 purchase every 5 years; 1-month rental
K0828	1 purchase every 5 years; 1-month rental
K0829	1 purchase every 5 years; 1-month rental

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Procedure Code	Maximum Limit
K0835	1 purchase every 5 years; 1-month rental
K0836	1 purchase every 5 years; 1-month rental
K0837	1 purchase every 5 years; 1-month rental
K0838	1 purchase every 5 years; 1-month rental
K0839	1 purchase every 5 years; 1-month rental
K0840	1 purchase every 5 years; 1-month rental
K0841	1 purchase every 5 years; 1-month rental
K0842	1 purchase every 5 years; 1-month rental
K0843	1 purchase every 5 years; 1-month rental
K0848	1 purchase every 5 years; 1-month rental
K0849	1 purchase every 5 years; 1-month rental
K0850	1 purchase every 5 years; 1-month rental
K0851	1 purchase every 5 years; 1-month rental
K0852	1 purchase every 5 years; 1-month rental
K0853	1 purchase every 5 years; 1-month rental
K0854	1 purchase every 5 years; 1-month rental
K0855	1 purchase every 5 years; 1-month rental
K0856	1 purchase every 5 years; 1-month rental
K0857	1 purchase every 5 years; 1-month rental
K0858	1 purchase every 5 years; 1-month rental
K0859	1 purchase every 5 years; 1-month rental
K0860	1 purchase every 5 years; 1-month rental
K0861	1 purchase every 5 years; 1-month rental
K0862	1 purchase every 5 years; 1-month rental
K0863	1 purchase every 5 years; 1-month rental
K0864	1 purchase every 5 years; 1-month rental
K0868	1 purchase every 5 years; 1-month rental
K0869	1 purchase every 5 years; 1-month rental
K0870	1 purchase every 5 years; 1-month rental
K0871	1 purchase every 5 years; 1-month rental
K0877	1 purchase every 5 years; 1-month rental
K0878	1 purchase every 5 years; 1-month rental
K0879	1 purchase every 5 years; 1-month rental
K0880	1 purchase every 5 years; 1-month rental
K0884	1 purchase every 5 years; 1-month rental
K0885	1 purchase every 5 years; 1-month rental
K0886	1 purchase every 5 years; 1-month rental
K0890	1 purchase every 5 years; 1-month rental
K0891	1 purchase every 5 years; 1-month rental
K0898	1 purchase every 5 years; 1-month rental

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Procedure Code	Maximum Limit
K0899	1 purchase every 5 years; 1-month rental
K0900	1 purchase every 5 years; 1-month rental
Scooters	
E1230	1 per 5 years
K0800	1 per 5 years
K0801	1 per 5 years
K0802	1 per 5 years
Wheelchair Parts	
E0942	1 per year
E0944	2 per year
E0945	2 per year
E0950	1 per year
E0951	2 per year
E0952	2 per year
E0953	As needed
E0954	2 per year
E0955	As needed
E0956	As needed
E0957	As needed
E0958	1 per year
E0959	As needed; 1 per month
E0960	As needed
E0961	2 per year
E0967	As needed; 1 per month
E0969	1 per 5 years
E0970	1 pair per year
E0971	2 per year
E0973	2 per year
E0974	2 per year
E0978	1 per year
E0980	1 per year
E0981	As needed
E0982	As needed
E0986	1 per 5 years
E0990	2 per year; 1 per month
E0992	1 per year
E0994	2 per year
E0995	2 per year
E1002	1 per 5 years
E1003	1 per 5 years

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Procedure Code	Maximum Limit
E1004	1 per 5 years
E1005	1 per 5 years
E1006	1 per 5 years
E1007	1 per 5 years
E1008	1 per 5 years
E1009	1 per 5 years
E1010	1 per 5 years
E1011	As needed
E1012	1 per 5 years
E1014	1 per 5 years
E1015	2 per year
E1016	2 per year
E1017	2 per year
E1018	2 per year
E1020	1 per 5 years
E1022	2 per year
E1028	1 per 5 years
E1032	1 per 5 years
E1033	As needed
E1034	As needed
E1029	1 per 5 years
E1225	As needed; 1 per month
E1226	As needed; 1 per month
E2201	1 per 5 years
E2202	1 per 5 years
E2203	1 per 5 years
E2204	1 per 5 years
E2205	1 per 5 years
E2206	1 per 5 years
E2207	1 purchase every 5 years
E2208	1 purchase every 5 years
E2209	1 purchase every 5 years
E2210	4 per year
E2211	2 per year
E2212	2 per year
E2213	2 per year
E2214	2 per year
E2215	2 per year
E2216	2 per year
E2217	2 per year

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Procedure Code	Maximum Limit
E2218	2 per year
E2219	2 per year
E2220	2 per year
E2221	2 per year
E2222	2 per year
E2224	2 per year
E2225	2 per year
E2226	2 per year
E2227	1 per 5 years
E2228	1 per 5 years
E2291	1 per 5 years
E2292	1 per 5 years
E2293	1 per 5 years
E2294	1 per 5 years
E2298	1 per 5 years
E2310	1 per 5 years
E2311	1 per 5 years
E2312	1 purchase every 5 years; 1-month rental
E2313	1 per 5 years
E2321	1 per 5 years
E2323	1 per 5 years
E2324	1 per 5 years
E2325	1 per 5 years
E2326	1 per 5 years
E2327	1 per 5 years
E2328	1 per 5 years
E2329	1 per 5 years
E2330	1 per 5 years
E2340	1 per 5 years
E2341	1 per 5 years
E2342	1 per 5 years
E2343	1 per 5 years
E2351	1 per 5 years
E2359	1 per 5 years
E2368	1 per 5 years
E2369	1 per 5 years
E2370	1 per 5 years
E2373	1 per 5 years
E2374	1 per 5 years
E2375	1 per 5 years

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Procedure Code	Maximum Limit
E2376	1 per 5 years
E2377	1 per 5 years
E2378	1 per 5 years
E2381	2 per year
E2382	2 per year
E2383	2 per year
E2384	2 per year
E2385	2 per year
E2386	2 per year
E2387	2 per year
E2388	2 per year
E2389	2 per year
E2390	2 per year
E2391	2 per year
E2392	2 per year
E2394	1 per 5 years
E2395	1 per 5 years
E2396	1 per 5 years
E2398	1 per 5 years
Wheelchair/Pressure/Positioning Cushions	
E0190	1 per 3 years
E2601	1 per year
E2602	1 per year
E2603	1 per year
E2604	1 per year
E2605	1 per year
E2606	1 per year
E2607	1 per year
E2608	1 per year
E2609	1 per year
E2611	1 per year
E2612	1 per year
E2613	1 per year
E2614	1 per year
E2615	1 per year
E2616	1 per year
E2617	1 per year
E2619	1 per year
E2620	1 per year
E2621	1 per year

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Procedure Code	Maximum Limit
E2622	1 per year
E2623	1 per year
E2624	1 per year
E2625	1 per year
Batteries	
E2361	1 per 5 years
E2363	1 per 5 years
E2366	1 per 5 years
E2371	1 per 5 years
K0733	2 per year
Safety Equipment	
E0700	2 per year
E0705	1 per 5 years
Lifts	
E0627	1 per 5 years
E0629	1 per 5 years
E0630	1 per 5 years; 1 per month rental
E0635	1 per 5 years; 1 per month rental
E0637	1 per 5 years
E0638	1 per 5 years
E0641	1 per 5 years
Miscellaneous	
A9900	As needed
E1399	As needed
K0108	As needed
K0739	As needed

The following mobility aids are not a benefit of Home Health Services:

- 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
- Chairs with incorporated seat lifts
- An attendant control, for safety, all power chairs are to include a stop switch

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- Powered mobility device for use only outside the home

  Note: *For clients who are 21 years of age or older, requests for mobility aids that do not meet the criteria through Title XIX Home Health Services may be considered under the Texas Medicaid Home Health—Durable Medical Equipment (DME) Exceptional Circumstances process.*

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.

2.2.18 Nutritional (Enteral) Products, Supplies, and Equipment

Medical nutritional products including enteral formulas and food thickener, may be approved for clients who have specialized nutritional requirements.

Medical nutritional products must be prescribed by a physician or allowed practitioner and be medically necessary.

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.

For clients who are 20 years of age and younger and do not meet criteria through Home Health Services, products, supplies, and equipment can be considered through the Comprehensive Care Program (CCP).

Note: *For clients who are 21 years of age or older, requests for nutritional (enteral) products, supplies and equipment that do not meet the criteria through Title XIX Home Health Services may be considered under the Texas Medicaid Home Health—Durable Medical Equipment (DME) Exceptional Circumstances process.*

2.2.18.1 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 or allowed practitioner.

Enteral nutritional products may be reimbursed with the following procedure codes:

Procedure Codes									
B4100	B4103	B4104	B4149	B4150	B4152	B4153	B4154	B4155	B4157
B4158	B4159	B4160	B4161	B4162					

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 or allowed practitioner indicating the client's medical needs for these special enteral formulas.

Special enteral formula may be reimbursed with the following procedure codes:

Procedure Codes						
B4149	B4153	B4154	B4155	B4157	B4161	B4162

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

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Food thickener may be considered for clients with a swallowing disorder. B4100 is reimbursed per unit; 1 unit = 1 ounce. Food thickener option (powder, gel, or liquid) should be appropriate for the client's medical condition.

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

Procedure Codes	Limitations
A4322	30 per month
A5200	2 per month
B4034	Up to 31 per month
B4035	Up to 31 per month
B4036	Up to 31 per month
B4081	As needed
B4082	As needed
B4083	As needed
B4087	As needed
B4088	As needed
B4105	Up to 62 per month
B9002	1 purchase every 5 years; 1 rental per month
T1999*	As needed* If procedure code T1999 is used for a needleless syringe, the allowed amount is 8 per month.
*** Appropriate limitations for miscellaneous procedure code T1999 are determined on a case-by-case basis through prior authorization.**	

Procedure code B9998 may be reimbursed as needed without a modifier or with the following modifiers and limitations:

Procedure Codes	Descriptions	Limitations
B9998		As Needed
B9998 with modifier U1	Disposable G-tube adapter set	4 per month
B9998 with modifier U2	Nonobturated gastrostomy or jejunostomy tube with insertion supplies and extensions	2 per rolling year
B9998 with modifier U3	Low profile enteral extension set	4 per month
B9998 with modifier U4	Standard gastrostomy tube	2 per rolling year
B9998 with modifier U5	Standard enteral extension set	4 per month

Note: *Appropriate limitations for miscellaneous procedure codes B9998 without a modifier 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.

2.2.18.2 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 or an allowed practitioner.

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2.2.18.2.1 Clients who are 21 years of age and older

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 or allowed practitioner 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 six months. Prior authorization may be recertified with documentation supporting ongoing medical necessity for the nutritional products requested.

2.2.18.2.2 Clients who are 20 years of age and younger

Prior authorization for nutritional products is not required for a client who is 20 years of age and younger and who meets at least one of the following criteria:

- Client receives all or part of their nutritional intake through a tube.
- Client has a metabolic disorder that has been documented with one of the following diagnosis codes:

Diagnosis Codes							
C8800	C8801	C965	C966	D472	D800	D801	D802
D803	D804	D805	D806	D807	D808	D809	D810
D811	D812	D814	D816	D817	D8189	D819	D820
D821	D822	D823	D824	D828	D829	D830	D831
D832	D838	D839	D840	D841	D8481	D84821	D84822
D8489	D849	D890	D891	D893	D8982	D8989	D899
E201	E670	E671	E672	E673	E678	E68	E700
E701	E7020	E7021	E7029	E7030	E70310	E70311	E70318
E70319	E70320	E70321	E70328	E70329	E70330	E70331	E70338
E70339	E7039	E7040	E7041	E7049	E705	E7081	E7089
E709	E710	E71110	E71111	E71118	E71120	E71121	E71128
E7119	E712	E7130	E71310	E71311	E71312	E71313	E71314
E71318	E7132	E7139	E7140	E7141	E7142	E7143	E71440
E71448	E7150	E71510	E71511	E71518	E71520	E71521	E71522
E71528	E71529	E7153	E71540	E71541	E71542	E71548	E7200
E7201	E7202	E7203	E7204	E7209	E7210	E7211	E7212
E7219	E7220	E7221	E7222	E7223	E7229	E723	E724
E7250	E7251	E7252	E72530	E72538	E72539	E72540	E72541

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Diagnosis Codes							
E72548	E72549	E7259	E7289	E729	E730	E738	E739
E7400	E7401	E7402	E7403	E7404	E7405	E7409	E7410
E7411	E7412	E7419	E7420	E7421	E7429	E7431	E7439
E744	E74810	E74818	E74819	E74820	E74829	E7489	E749
E7500	E7509	E7510	E7511	E7519	E7521	E7522	E7523
E75240	E75241	E75242	E75243	E75244	E75248	E75249	E7526
E7527	E7528	E7529	E753	E755	E756	E7601	E7602
E7603	E761	E76210	E76211	E76219	E7622	E7629	E763
E768	E769	E770	E771	E778	E779	E781	E782
E783	E785	E786	E7870	E7879	E7881	E7889	E789
E791	E792	E7981	E7982	E7989	E799	E800	E801
E8020	E8021	E8029	E803	E804	E805	E806	E807
E8300	E8301	E8309	E8310	E8319	E8330	E8331	E8332
E8339	E8340	E8341	E8342	E8349	E8350	E8351	E8352
E8359	E8381	E83820	E83821	E83822	E83823	E83824	E83825
E8389	E839	E840	E8411	E8419	E848	E849	E850
E851	E852	E853	E854	E8581	E8589	E859	E860
E861	E869	E870	E871	E8720	E8721	E8722	E8729
E873	E874	E875	E876	E8770	E8779	E878	E8801
E8802	E8809	E8810	E8811	E8812	E8813	E8814	E8819
E882	E8840	E8841	E8842	E8843	E8849	E88810	E88811
E88818	E88819	E8882	E8889	E889	E88A	H49811	H49812
H49813	M1000	M10011	M10012	M10019	M10021	M10022	M10029
M10031	M10032	M10039	M10041	M10042	M10049	M10051	M10052
M10059	M10061	M10062	M10069	M10071	M10072	M10079	M1008
M1009	M10111	M10112	M10121	M10122	M10131	M10132	M10141
M10142	M10151	M10152	M10161	M10162	M10171	M10172	M10211
M10212	M10221	M10222	M10231	M10232	M10241	M10242	M10251
M10252	M10261	M10262	M10271	M10272	M1030	M10311	M10312
M10319	M10321	M10322	M10329	M10331	M10332	M10339	M10341
M10342	M10349	M10351	M10352	M10359	M10361	M10362	M10369
M10371	M10372	M10379	M1038	M1039	M1040	M10411	M10412
M10419	M10421	M10422	M10429	M10431	M10432	M10439	M10441
M10442	M10449	M10451	M10452	M10459	M10461	M10462	M10469
M10471	M10472	M10479	M1048	M1049	M109	M1A00X0	M1A00X1
M1A0110	M1A0111	M1A0120	M1A0121	M1A0190	M1A0191	M1A0210	M1A0211
M1A0220	M1A0221	M1A0290	M1A0291	M1A0310	M1A0311	M1A0320	M1A0321
M1A0390	M1A0391	M1A0410	M1A0411	M1A0420	M1A0421	M1A0490	M1A0491
M1A0510	M1A0511	M1A0520	M1A0521	M1A0590	M1A0591	M1A0610	M1A0611
M1A0620	M1A0621	M1A0690	M1A0691	M1A0710	M1A0711	M1A0720	M1A0721

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Diagnosis Codes							
M1A0790	M1A0791	M1A08X0	M1A08X1	M1A09X0	M1A09X1	M1A20X0	M1A20X1
M1A2110	M1A2111	M1A2120	M1A2121	M1A2190	M1A2191	M1A2210	M1A2211
M1A2220	M1A2221	M1A2290	M1A2291	M1A2310	M1A2311	M1A2320	M1A2321
M1A2390	M1A2391	M1A2410	M1A2411	M1A2420	M1A2421	M1A2490	M1A2491
M1A2510	M1A2511	M1A2520	M1A2521	M1A2590	M1A2591	M1A2610	M1A2620
M1A2621	M1A2690	M1A2691	M1A2710	M1A2711	M1A2720	M1A2721	M1A2790
M1A2791	M1A28X0	M1A28X1	M1A29X0	M1A29X1	M1A30X0	M1A30X1	M1A3110
M1A3111	M1A3120	M1A3121	M1A3190	M1A3191	M1A3210	M1A3211	M1A3220
M1A3221	M1A3290	M1A3291	M1A3310	M1A3311	M1A3320	M1A3321	M1A3390
M1A3391	M1A3410	M1A3411	M1A3420	M1A3421	M1A3490	M1A3491	M1A3510
M1A3511	M1A3520	M1A3521	M1A3590	M1A3591	M1A3610	M1A3611	M1A3620
M1A3621	M1A3690	M1A3691	M1A3710	M1A3711	M1A3720	M1A3721	M1A3790
M1A3791	M1A38X0	M1A38X1	M1A39X0	M1A39X1	M1A40X0	M1A40X1	M1A4110
M1A4111	M1A4120	M1A4121	M1A4190	M1A4191	M1A4210	M1A4211	M1A4220
M1A4221	M1A4290	M1A4291	M1A4310	M1A4311	M1A4320	M1A4321	M1A4390
M1A4391	M1A4410	M1A4411	M1A4420	M1A4421	M1A4490	M1A4491	M1A4510
M1A4511	M1A4520	M1A4521	M1A4590	M1A4591	M1A4610	M1A4611	M1A4620
M1A4621	M1A4690	M1A4691	M1A4710	M1A4711	M1A4720	M1A4721	M1A4790
M1A4791	M1A48X0	M1A48X1	M1A49X0	M1A49X1	M1A9XX0	M1A9XX1	M3508
M3581	M3589	M359	Z431	Z87738	N200	P7422	P7432
P7441	P74422	P7449	Z931	Z934			

Prior authorization is required for nutritional products that are provided through CCP to clients who do not meet the criteria above.

A completed CCP Prior Authorization Request Form that prescribes the nutritional product and/or related services must be signed and dated by a prescribing physician or an allowed practitioner who was familiar with the client before requesting prior authorization. The completed CCP Prior Authorization Request Form must include the procedure codes and numerical quantities for the services requested. The completed CCP Prior Authorization Request Form with the original dated signature must be maintained by the prescribing physician or allowed practitioner in the client's medical record. A copy of the completed, signed, and dated form must be maintained by the DME provider in the client's medical record.

Requests for prior authorization must include the following documentation:

- Accurate diagnostic information pertaining to the underlying diagnosis or condition that resulted in the requirement for a nutritional product, as well as any other medical diagnoses or conditions, including:
  - The client's overall health status.
  - Height and weight.
  - Growth history and growth charts.
  - Why the client cannot be maintained on an age-appropriate diet.
  - Other formulas tried and why they did not meet the client's needs.
- Diagnosis or condition.

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- The goals and timelines on the medical plan of care.
- Total caloric intake prescribed by the physician or allowed practitioner.
- Acknowledgement that the client has a feeding tube in place.

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

Prior authorization may be given for up to 12 months. Prior authorization may be recertified with documentation that supports the ongoing medical necessity of the requested nutritional products.

A retrospective review may be performed to ensure that the documentation included in the client's medical record supports the medical necessity of the requested service.

Requests for prior authorization, when required, must include the necessary product information.

Prior authorization of nutritional pudding products may be considered for children who have a documented oropharyngeal motor dysfunction and receive greater than 50 percent of their daily caloric intake from a nutritional pudding product.

Requests for electrolyte replacement products, such as Pedialyte or Oralyte, require documentation of medical necessity, including:

- The underlying acute or chronic medical diagnoses or conditions that indicate the need to replace fluid and electrolyte losses.
- The presence of mild to moderate dehydration due to the persistent mild to moderate diarrhea or vomiting.

Electrolyte replacement products are not indicated for clients with:

- Intractable vomiting
- Adynamic ileus
- Intestinal obstruction or perforated bowel
- Anuria, oliguria, or impaired homeostatic mechanism
- Severe, continuing diarrhea, when intended for use as the sole therapy

2.2.18.2.3 Enteral Formulas

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

2.2.18.2.4 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.

2.2.18.2.5 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

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- 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

2.2.18.2.6 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 A5200) 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.

Procedure code B4105 will require prior authorization, and may be considered with documentation of medical necessity indicating that the client meets all the following criteria:

- The client has exocrine pancreatic insufficiency.
- The client utilizes an enteral feeding pump.
- The client utilizes a compatible formula and the amount of formula (mL) the client is receiving daily is documented.

  Note: *One cartridge can be used with up to 500mL of formula, with a maximum of two cartridges used per day. Procedure code B4105 will be limited to 62 per month.*

For clients who are 5 through 20 years of age, procedure code B4105 will be considered through the Comprehensive Care Program (CCP).

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 outpatient therapies ordered by the physician or allowed practitioner.
  - 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.

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2.2.18.3 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 or allowed practitioner 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 or allowed practitioner
- Acknowledgement that the client has a feeding tube in place

2.2.18.4 Nutritional Counseling

Clients for whom nutritional products are being requested may benefit from nutritional counseling. Nutritional counseling is a benefit of CCP if it is provided to treat, prevent, or minimize the effects of illness, injury, or other impairment.

Refer to: Subsection 2.11, "Medical Nutrition Counseling Services (CCP)" in the *Children's Services Handbook* (*Vol. 2, Provider Handbooks*) for information about nutritional counseling.

2.2.18.5 Women, Infants, and Children Program (WIC)

Generic nutritional products that have been approved by the United States Department of Agriculture (USDA) for use in the Women, Infants, and Children Program (WIC) may be approved for use by CCP clients.

While CCP does not require that a client access WIC, it is only recommended as another source of services for clients who are 4 years of age and younger, or clients who are pregnant or breast feeding. Nutritional products are not provided to infants who are 11 months of age and younger unless medical necessity is documented.

2.2.18.6 Managed Care Clients

Nutritional products that are provided to WIC clients are carved-out of the Medicaid Managed Care Program and must be billed to TMHP for payment consideration. Carved-out services are those that are rendered to Medicaid Managed Care clients but are administered by TMHP and not the client's managed care organization (MCO).

Nutrition products that are provided to other Medicaid Managed Care Program clients (other than WIC clients) are not carved out and must be submitted to the managed care organization that administers the client's Medicaid managed care benefits.

2.2.18.7 Noncovered Services

CCP will not cover the following:

- Nutritional products that are traditionally used for infant feeding.
- Nutritional products for the primary diagnosis of failure to thrive, failure to gain weight, or lack of growth. The underlying cause of failure to thrive, gain weight, and lack of growth is required.
- Nutritional bars.
- Nutritional products for clients who could be sustained on an age-appropriate diet.

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2.2.19 Orthotic Services (CCP)

Orthoses, including orthopedic shoes, wedges, and lifts, are a benefit of Texas Medicaid when provided by a licensed orthotist or a licensed prosthetist/orthotist through CCP for clients who are birth through 20 years of age.

The following orthoses and related services may be reimbursed when medical necessity criteria are met:

- Spinal orthoses and additions to spinal orthoses, including those for scoliosis
- Lower-limb orthoses and additions to lower-limb orthoses, including fracture orthoses
- Foot orthoses, including inserts, orthopedic shoes, surgical boots, heel lifts, and wedges
- Upper-limb orthoses and additions to upper-limb orthoses, including fracture orthoses
- Other orthopedic devices, including protective helmets and dynamic splints
- Repairs, replacements, and modifications
- Orthotic device training

Note: *Training in the use of an orthotic device for a client who has not worn one previously, has not worn one for a prolonged period, or is receiving a different type is a benefit when the training is provided by a physical or occupational therapist.*

Refer to: The *Physical Therapy, Occupational Therapy, and Speech Therapy Services Handbook* (*Vol. 2, Provider Handbooks*) for additional information about physical and occupational therapy services.

The following definitions are used by Texas Medicaid:

- An orthosis is defined as: A custom-fabricated or custom-fitted medical device designed to provide for the support, alignment, prevention or correction of neuromuscular or musculoskeletal disease, injury, or deformity. The term does not include a fabric or elastic support, corset, arch support, low temperature plastic splint, a truss, elastic hose, cane, crutch, soft cervical collar, orthosis for diagnostic or evaluation purposes, dental appliance, or other similar device carried in stock and sold by a drugstore, department store or corset shop.
- A brace is defined as: An orthosis or orthopedic appliance that supports or holds in correct position any movable part of the body, and that allows for motion of that part. It must be a rigid or semirigid device used for the purpose of supporting a weak or deformed body part or restricting or eliminating motion in a diseased or injured body part.

To be considered for reimbursement, orthoses must be dispensed, fabricated, or modified by a licensed orthotist or licensed prosthetist/orthotist enrolled with Medicare and CCP. The following applies:

- Upper extremity customized splints made with low-temperature materials and inhibitive casting may be provided by occupational or physical therapists.
- Other orthopedic devices addressed in the orthotic section may be provided by a Medicaid-enrolled DME vendor.
- Orthopedic shoes must be provided by a shoe vendor enrolled as a DME provider.

The date of service for a custom-made or custom-fitted orthosis is the date the supplier places an order for the equipment and incurs liability for the equipment. The custom-made or custom-fitted orthosis will be eligible for reimbursement as long as the service is provided during a month the client is eligible for Medicaid.

The following items and services are included in the reimbursement for an orthotic device and not reimbursed separately:

- Client evaluation, measurement, casting, or fitting of the orthosis.

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- Repairs due to normal wear and tear during the 90 days following delivery.
- Adjustments or modifications of the orthotic device made when fitting the orthosis and for 90 days from the date of delivery (adjustments and modifications during the first 90 days are considered part of the purchase of the initial device).

Orthopedic shoes that are attached to a brace must be billed by the vendor that bills for the brace.

Reimbursement for lifts and wedges may include the cost of the prescription shoe.

2.2.19.1 Noncovered Orthotic Services

The following circumstances are not a benefit of Texas Medicaid:

- Orthoses whose sole purpose is for restraint
- Orthoses provided solely for use during sports-related activities in the absence of an acute injury or other indicated medical condition
- Orthotic devices prescribed by a chiropractor

Diagnoses that are not considered medically necessary include, but are not limited to, the following:

- Tired feet
- Fatigued feet
- Nonsevere bow legs
- Valgus deformity of the foot, except as outlined in the orthotic section
- Pes planus (flat feet), except when there is a coexisting medical condition as outlined in the orthotic section

Orthopedic shoes with deluxe features, such as special colors, special leathers, and special styles, are not considered medically necessary, and the features do not contribute to the accommodative or therapeutic function of the shoe.

A foot-drop splint and recumbent positioning device and replacement interface are not considered medically necessary in a client with foot drop who is nonambulatory, because there are other more appropriate treatment modalities.

A static ankle-foot orthosis (AFO) or AFO component is not medically necessary if:

- The contracture is fixed.
- The client has foot drop without an ankle flexion contracture.
- The component is used to address knee or hip positioning, because the effectiveness of this type of component is not established.

A pneumatic thoracic-lumbar-sacral orthosis is considered experimental and investigational and is not a benefit of Texas Medicaid.

2.2.19.2 Prior Authorization and Documentation Requirements

Prior authorization is required for all orthoses and related services.

Before submitting a request for prior authorization for orthosis, the orthosis provider must have a completed CCP Prior Authorization Form requesting the orthosis or related services that has been signed and dated by a physician who is familiar with the client. The completed CCP Prior Authorization Form must include the procedure codes and quantities for requested services. A copy of the completed, signed, and dated form must be maintained by the orthosis provider in the client's medical record. The completed CCP Prior Authorization Form with the original dated signature must be maintained by the prescribing physician in the client's medical record.

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- To complete the prior authorization process electronically, the orthosis provider must complete the prior authorization requirements through any approved electronic method and retain a copy of the signed and dated CCP Prior Authorization Request form in the client's medical record at the provider's place of business.
- To complete the prior authorization process by paper, the orthosis provider must fax or mail the completed CCP Prior Authorization Request Form to the CCP prior authorization unit and retain a copy of the signed and dated CCP form in the client's medical record at the provider's place of business.

To facilitate determination of medical necessity and avoid unnecessary denials, the physician must provide correct and complete information, including documentation for medical necessity of the equipment and supplies requested. The physician must maintain documentation of medical necessity in the client's medical record. The provider may be asked for additional information to clarify or complete a request for the service or device.

All requests for prior authorization must include documentation of medical necessity including, but not limited to, documentation that the device is needed for one of the following general indications:

- To reduce pain by restricting mobility of the affected body part.
- To facilitate healing following an injury to the affected body part or related soft tissue.
- To facilitate healing following a surgical procedure on the affected body part or related soft tissue.
- To support weak muscles or a deformity of the affected body part.

Prior authorization requests for some types of orthosis require additional documentation. See the appropriate sections for additional documentation needed for each service.

The provider must keep the following written documentation in the client's medical record:

- The prescription for the device.
- Orthotic devices must be prescribed by a physician (M.D. or D.O.) or a podiatrist. A podiatrist prescription is valid for conditions of the ankle and foot.
- The prescription must be dated on or before the initial date of the requested dates of service, which can be no longer than 90 days from the signature date on the prescription.
- Accurate diagnostic information that supports the medical necessity for the requested device. A retrospective review may be performed to ensure that the documentation included in the client's medical record supports the medical necessity of the requested service or device.

A prior authorization is valid for a maximum period of six months from the prescription signature date.

At the end of the six-month authorization period, a new prescription is required for prior authorization of additional services.

> ***Note:*** *Texas Medicaid fee-for-service requires providers to review for medical necessity of DME every six months. An MCO may approve an initial DME prior authorization request for a period of 6 months, unless otherwise stated, and may authorize an extension of 12 months after the initial 6 months, if medically necessary.*

The actual date of service is the date the supplier has placed an order for the equipment and has incurred liability for the equipment.

2.2.19.2.1 Spinal Orthoses

Spinal orthoses include, but are not limited to, cervical orthoses, thoracic rib belts, thoracic-lumbar-sacral orthoses (TLSO), sacroiliac orthoses, lumbar orthoses, lumbar-sacral orthoses (LSO), cervicalthoracic-lumbar-sacral orthoses (CTLSO), halo procedures, spinal corset orthoses, and spinal orthoses for scoliosis.

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Spinal orthoses will be considered for prior authorization with documentation of one of the general indications.

2.2.19.2.2 Lower-Limb Orthoses

Lower-limb orthoses include, but are not limited to, hip orthoses (HO), Legg Perthes orthoses, knee orthoses (KO), ankle-foot orthoses (AFO), knee-ankle-foot orthoses (KAFO), hip-knee-ankle-foot orthoses (HKAFO), fracture orthoses, and reciprocating gait orthoses (RGO).

In addition to the general indication requirements, lower-limb orthoses will be considered for prior authorization with documentation of the following criteria for specific orthotic devices:

Ankle-Foot Orthoses

AFOs used during ambulation will be considered for prior authorization for clients with documentation of all of the following:

- Weakness or deformity of the foot and ankle.
- A need for stabilization for medical reasons.
- Anticipated improvement in functioning during activities of daily living (ADLs) with use of the device.

AFOs not used during ambulation (static AFO) will be considered for prior authorization for clients with documentation of one of the following conditions:

- Plantar fasciitis.
- Plantar flexion contracture of the ankle, with additional documentation that includes all of the following:
  - Dorsiflexion on pretreatment passive range of motion testing is at least ten degrees.
  - The contracture is interfering or is expected to interfere significantly with the client's functioning during ADLs.
  - The AFO will be used as a component of a physician-prescribed therapy plan care, which includes active stretching of the involved muscles or tendons.
  - There is reasonable expectation that the AFO will correct the contracture.

Knee-Ankle-Foot Orthoses

KAFOs used during ambulation will be considered for prior authorization for clients with documentation that supports medical necessity for additional knee stabilization.

KAFOs that are custom-fabricated (molded-to-patient model) for ambulation will be considered for prior authorization when at least one of the following criteria is met:

- The client cannot be fit with a prefabricated AFO/KAFO.
- The condition that necessitates the orthosis is expected to be permanent or of long-standing duration (more than six months).
- There is a need to control the knee, ankle, or foot in more than one plane.
- The client has a documented neurological, circulatory, or orthopedic status that requires custom fabrication to prevent tissue injury.
- The client has a healing fracture that lacks normal anatomical integrity or anthropometric proportions.

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Reciprocating Gait Orthoses

Reciprocating gait orthoses will be considered for prior authorization for clients with spina bifida or similar functional disabilities.

The prior authorization request must include a statement from the prescribing physician that indicates medical necessity for the RGO, the PT treatment plan, and documentation that the client and family are willing to comply with the treatment plan.

2.2.19.2.3 Foot Orthoses

Foot orthoses include, but are not limited to, foot inserts, orthopedic shoes, wedges, and lifts.

Foot orthoses will be considered for prior authorization for clients with documentation of all of the following:

- The client has symptoms associated with the particular foot condition.
- The client has failed to respond to a course of appropriate, conservative treatment, including PT, injections, strapping, or anti-inflammatory medications.
- The client has at least one of the following:
  - Torsional conditions, such as metatarsus adductus, tibial torsion, or femoral torsion
  - Structural deformities
  - Hallux valgus deformities
  - In-toe or out-toe gait
  - Musculoskeletal weakness

In addition to the general indication requirements, foot orthoses will be considered for prior authorization with documentation of the following criteria for specific orthotic devices:

Foot Inserts

Removable foot inserts will be considered for prior authorization for clients with documentation of at least one of the following medical conditions:

- Diabetes mellitus.
- History of amputation of the opposite foot or part of either foot.
- History of foot ulceration or pre-ulcerative calluses of either foot.
- Peripheral neuropathy with evidence of callus formation of either foot.
- Deformity of either foot.
- Poor circulation of either foot.

Removable foot inserts may be covered independently of orthopedic shoes with documentation that the client has appropriate footwear into which the insert can be placed.

A University of California at Berkeley (UCB) removable foot insert will be considered for prior authorization with documentation that the device is required to correct or treat at least one of the following conditions:

- A valgus deformity and significant congenital pes planus with pain.
- A structural problem that results in significant pes planus, such as Down syndrome.
- Acute plantar fasciitis.

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Orthopedic Shoes

Orthopedic shoes must be prescribed by a licensed physician (M.D. or D.O.) or a podiatrist. An orthopedic shoe is used by clients whose feet, although impaired, are essentially intact. An orthopedic shoe differs from a prosthetic shoe, which is used by clients who are missing all or most of the forefoot.

Orthopedic shoes will be considered for prior authorization when at least one of the following criteria is met:

- The shoe is permanently attached to a brace.
- The shoe is necessary to hold a surgical correction, postoperative casting, or serial or clubfoot casting.

An orthopedic shoe may be prior authorized up to one year from the date of the surgical procedure.

Only one pair of orthopedic shoes will be prior authorized every three months. Two pairs of shoes may be purchased at the same time; however, additional requests for shoes will not be considered for another six months.

Requests for orthopedic shoes that do not meet the criteria listed above may be considered for prior authorization with documentation of medical necessity.

Wedges and Lifts

Wedges and lifts must be prescribed by a licensed physician (M.D. or D.O.) or a podiatrist and must be for treatment of unequal leg length greater than one-half inch.

2.2.19.2.4 Upper-Limb Orthoses

Upper-limb orthoses include, but are not limited to, shoulder orthoses (SO), elbow orthoses (EO), elbow-wrist-hand orthoses (EWHO), elbow-wrist-hand-finger orthoses (EWHFO), wrist-hand-finger orthoses (WHFO), wrist-hand orthoses (WHO), hand-finger orthoses (HFO), finger orthoses (FO), shoulder-elbow-wrist-hand orthoses (SEWHO), shoulder-elbow orthoses (SEO), and fracture orthoses.

In addition to the general indication requirements, upper-limb orthoses will be considered for prior authorization with documentation of the following criteria for specific orthotic devices.

2.2.19.2.5 Other Orthopedic Devices

Protective Helmets

Protective helmets will be considered for prior authorization for clients with a documented medical condition that makes the client susceptible to injury during ADLs. Covered medical conditions include the following:

- Neoplasm of the brain
- Subarachnoid hemorrhage
- Epilepsy
- Cerebral palsy

Requests for all conditions other than those listed above require submission of additional documentation that supports the medical necessity of the requested device.

Dynamic Splints

Static and dynamic mechanical stretching devices will be considered for prior authorization for a four month rental period when the request is submitted with the following documentation:

- Client's condition
- Client's current course of therapy

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- Rationale for the use of the static or dynamic mechanical stretching device
- Agreement by the client or family that the client will comply with the prescribed use of the static or dynamic mechanical stretching device

After completion of the four-month rental period, the provider may submit a request for purchase of the static or dynamic mechanical stretching device. Requests for purchase of the static or dynamic mechanical stretching device must include documentation that the four-month rental period was successful and showed improvement in the client's condition as measured by the following:

- Demonstrated increase in range of motion
- Demonstrated improvement in the ability to complete ADLs or perform activities outside the home

2.2.19.2.6 Related Services

Repairs, Replacements, and Modifications to Orthoses

Within the guarantee of the manufacturer, providers are responsible, without charge to the client or to Texas Medicaid, for replacement or repair of equipment or any part thereof that is found to be nonfunctional because of faulty material or workmanship.

Service and repairs must be handled under any warranty coverage an item may have. If there is no warranty, providers may request prior authorization for the necessary service and repairs.

A repair because of normal wear or a modification because of growth or change in medical status will be considered for prior authorization if it proves to be more cost effective than replacing the device.

The request for repairs must include a breakdown of charges for parts and the number of hours of labor required to complete the repairs. No charge is allowed for pickup or delivery of the item or for the assembly of Medicaid-reimbursed parts. The following information must be submitted with the request:

- The description and procedure code of the item being serviced or repaired.
- The age of the item.
- The number of times the item has been previously repaired.
- The replacement cost for the item.

The anticipated life expectancy of an orthotic device is six months. Requests for prior authorization for the replacement of a device before its usual life expectancy has ended must include documentation that explains the need for the replacement.

Replacement of orthotic equipment will be considered when the item is out of warranty and repairing the item is no longer cost-effective or 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 with the prior authorization request.

2.2.19.3 Cranial Remolding Orthosis

2.2.19.3.1 Services, Benefits, and Limitations

Cranial remolding orthoses (CRO) (procedure code S1040) may be a benefit when all of the following criteria are met:

- The client is 3 through 18 months of age.
- The client requires a CRO as part of the treatment plan for a documented diagnosis of deformational plagiocephaly, brachycephaly, asymmetrical brachycephaly, dolichocephaly, or post-operatively following surgery for craniosynostosis.

The limitation for procedure code S1040 is one device per lifetime, any provider. This limitation may be exceeded with prior authorization.

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CRO is defined by Subchapter B, Chapter 32, Human Resources Code, Section 32.03126, as a custom-fitted or custom-fabricated medical device that is applied to the head to correct a deformity, improve function, or relieve symptoms of a structural cranial disease.

Plagiocephaly refers to an asymmetrical, flattened deformity of the skull and can be used to describe both synostotic and non-synostotic head asymmetry.

Craniosynostosis occurs when there is a premature fusion of cranial sutures. Craniosynostosis may cause synostotic plagiocephaly, a flattened deformity of the skull as a result of the premature fusion of cranial suture(s). This pathological condition generally requires surgical intervention, with or without post-operative use of a cranial orthosis.

Non-synostotic deformational plagiocephaly (DP) is head flattening that results from external forces that mold the skull in the first year of life. There are four categories of DP which may require treatment with a CRO:

- Lateral deformational plagiocephaly (LDP) is often simply referred to as plagiocephaly. It describes an asymmetric head which occurs when an infant's skull is flattened on one side. This can be predominantly anterior (forehead flattening) or posterior (occipital flattening). The flattening may be accompanied by anterior displacement of the ear, forehead, and in severe cases the orbit.
- Brachycephaly describes a short, wide head. The occiput flattens and there may be bilateral widening in the tempo-parietal regions. There may be bulging noted above the ears.
- Asymmetric brachycephaly is the combination of plagiocephaly and brachycephaly. It may be characterized by occipital flattening accompanied by parietal asymmetry. The flattening may be accompanied by anterior displacement of the ear, forehead, and in severe cases the orbit.
- Dolichocephaly is characterized by flattening of the sides of the head and elongation from anterior to posterior.

Cosmetic services include surgery or other services used primarily to improve appearance and not to restore or correct significant deformity resulting from disease, trauma, congenital or developmental anomalies, or previous therapeutic process. Conservative therapy for treatment of non-synostotic plagiocephaly involves non-surgical, proactive methods to reshape an infant's skull, primarily through consistent repositioning, increased "tummy time," and sometimes physical therapy to treat underlying torticollis. These methods are most effective when started early (before 4–6 months of age) to alleviate pressure on the flat spot.

2.2.19.3.2 Prior Authorization and Documentation Requirements

CRO requires prior authorization. Documentation of medical necessity must be maintained in the client's medical record.

If the client has craniosynostosis, a diagnosis of the type of craniosynostosis and synostotic plagiocephaly must be documented.

If the client has a diagnosis of a non-synostotic plagiocephaly (e.g., brachycephaly, asymmetric bracycephaly, or dolichocephaly), one of the following criteria must be met:

- Cranial vault asymmetry (CVA) confirmed by a right/left discrepancy of greater than six millimeters in a craniofacial anthropometric measurement to include but not limited to criteria set by the Children's Healthcare of Atlanta Plagiocephaly Severity Scale.
- Brachycephalic disproportion in the comparison of head length to head width confirmed by a cephalic index of two standard deviations above the mean.
- Dolichocephalic disproportion in the comparison of head length to head width confirmed by a cephalic index of two standard deviations below the mean.

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If the client has a diagnosis of a non-synostotic plagiocephaly (e.g., brachycephaly, asymmetric brachycephaly, or dolichocephaly), there must be documentation of conservative therapy as described above, or physical or occupational therapy by a qualified health care professional of at least two months' duration that did not achieve a reduction of asymmetry or disproportion that would no longer meet the above criteria.

Prior authorization may be approved for the following diagnoses:

Diagnosis Code	Description
Q040	Congenital malformations of corpus callosum
Q041	Arhinencephaly
Q042	Holoprosencephaly
Q308	Other congenital malformations of nose
Q672	Dolichocephaly
Q673	Plagiocephaly
Q674	Other congenital deformities of skull, face and jaw
Q75001	Craniosynostosis, unspecified type, unilateral
Q75002	Craniosynostosis, unspecified type, bilateral
Q75009	Craniosynostosis, unspecified
Q7501	Sagittal craniosynostosis
Q75021	Coronal craniosynostosis, unilateral
Q75022	Coronal craniosynostosis, bilateral
Q75029	Coronal craniosynostosis, unspecified
Q7503	Metopic craniosynostosis
Q75041	Lambdoid craniosynostosis, unilateral
Q75042	Lambdoid craniosynostosis, bilateral
Q75049	Lambdoid craniosynostosis, unspecified
Q75051	Cloverleaf skull
Q75052	Pansynostosis
Q75058	Other multi-suture craniosynostosis
Q7508	Other single-suture craniosynostosis
Q751	Craniofacial dysostosis
Q752	Hypertelorism
Q753	Macrocephaly
Q754	Mandibulofacial dysostosis
Q755	Oculomandibular dysostosis
Q758	Other specified congenital malformations of skull and face bones
Q759	Congenital malformation of skull and face bones, unspecified
Q781	Polyostotic fibrous dysplasia
Q870	Congenital malformation syndromes predominantly affecting facial appearance

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Prior authorization requests for CRO for congenital conditions that are not outlined in this section may be considered by the TMHP Medical Director on an individual basis with documentation of medical necessity. Additional devices beyond the once-per-lifetime benefit may be considered for prior authorization with documentation of all of the following:

- The initial device was obtained to treat synostotic plagiocephaly as a result of craniosynostosis, or non-synostotic plagiocephaly, brachycephaly, asymmetric brachycephaly, or dolichocephaly.
- Treatment with the device has been effective, but the client has not yet met the treatment goal.
- The new device is needed due to growth.

To facilitate determination of medical necessity and avoid unnecessary denials, the physician must provide correct and complete information, including documentation of medical necessity for the equipment requested. The physician 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 an additional CRO.

The completed CCP Prior Authorization Form, which includes the DME must be signed and dated by the prescribing physician familiar with the client's condition. The completed CCP Prior Authorization Form must be maintained by the requesting provider and the prescribing physician. The original signature copy must be kept by the physician in the client's medical record.

2.2.19.4 Thoracic-Hip-Knee-Ankle Orthoses (THKAO) (Vertical or Dynamic Standers, Standing Frames, Braces, and Parapodiums)

2.2.19.4.1 Services, Benefits, and Limitations

THKAO (vertical or dynamic standers, standing frames or braces, and parapodiums), including all accessories, require prior authorization. A THKAO may be considered if the client requires assistance to stand and remain standing.

Parapodium

A parapodium is used to help clients with neuromuscular diseases or conditions resulting in a lack of sufficient muscle power in the trunk and lower extremities to stand with their hands free. It helps develop a sense of balance and aids in learning functional movements such as standing with the hands free. A parapodium acts as an exoskeleton, providing side struts and chest, hip, knee, and foot bracing.

A parapodium may be considered for reimbursement for one of the following levels:

- Level One: Small Parapodium—The client has a maximum axillary height of 35 inches and a maximum weight of 55 pounds (normal age range is 1 through 10 years of age).
- Level Two: Medium parapodium—The client has a maximum axillary height of 41 inches and a maximum weight of 77 pounds (normal age range is 5 through 12 years of age).
- Level Three: Large parapodium—The client has a maximum axillary height of 45 inches and a maximum weight of 115 pounds (normal age range is 10 through 16 years of age). Labor for parapodium assembly may be prior authorized.

Procedure code E0638 must be submitted with one of the following modifiers:

- UA-Standing frame/table system, one position (e.g., upright, supine, or prone stander), any size, including pediatric, with or without wheels. Medicaid level of care 10, as defined by each state

  Note: *Use modifier UA to identify an upright or prone system stander.*

- UB-Standing frame/table system, one position (e.g., upright, supine, or prone stander), any size, including pediatric, with or without wheels. Medicaid level of care 11, as defined by each state

  Note: *Use modifier UB to identify a supine stander.*

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Standing Frame or Brace

A standing frame or brace is used to help very young clients, who are 12 months of age and older, who have good head control in the upright position and who have a neuromuscular disease or condition resulting in a lack of sufficient muscle power in the trunk and lower extremities to stand with their hands free.

Providers must use procedure code E0638 for a standing frame or brace.

Vertical or Dynamic Stander

A vertical stander or dynamic stander is used to initiate standing for clients who cannot maintain a good standing posture or may never be able to stand independently. A vertical stander is used to develop weight bearing through the legs in order to decrease demineralization and to promote better body awareness. Documentation for these standers must address medical necessity for the standers to be mobile.

Providers must use procedure code E0642 for the purchase of a dynamic stander.

2.2.19.4.2 Prior Authorization and Documentation Requirements

THKAO (vertical or dynamic standers, standing frames or braces, and parapodiums), including all accessories, requires prior authorization.

THKAO may be considered for clients who are CCP-eligible and who require assistance to stand and remain standing when documentation submitted clearly shows that it is medically necessary and will correct or ameliorate the client's disability or physical or mental illness or condition.

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

- Diagnoses relevant to the requested equipment, including functioning level and ambulatory status
- Anticipated benefits of the equipment
- Frequency and amount of time of a 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

2.2.20 Prosthetic Services

2.2.20.1 Services, Benefits, and Limitations

External prostheses are a benefit of Texas Medicaid when provided by a licensed prosthetist or licensed prosthetist/orthotist through CCP for clients who are birth through 20 years of age.

The following prostheses and related services may be reimbursed when medical necessity criteria are met:

- Lower limb
- Upper limb
- Craniofacial
- External breast
- Repair, replacements, and modifications
- Prosthetic training
- Accessories to prostheses

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Prosthetic training by a physical or occupational therapist for a lower limb prosthesis or an upper extremity prosthesis is a benefit for clients who have not worn one previously or for a prolonged period or who are receiving a different type.

Refer to: Section 5, "Children's Therapy Services Clients birth through 20 years of age" in the *Physical Therapy, Occupational Therapy, and Speech Therapy Services Handbook* (*Vol. 2, Provider Handbooks*).

To be considered for reimbursement, prostheses must be dispensed, fabricated, or modified by a licensed prosthetist or licensed prosthetist/orthotist enrolled with Medicare and CCP.

The date of service for a custom-made or custom-fitted prosthesis is the date the supplier places an order for the equipment and incurs a liability for the equipment. The custom-made or custom-fitted prosthesis will be eligible for reimbursement as long as the service is provided during a month the client is eligible for Medicaid.

The following items and services are included in the reimbursement for a prosthetic device and not reimbursed separately:

- Evaluation of the residual limb and gait
- Measurement, casting, or fitting of the prosthesis
- Cost of base component parts and labor contained in the base procedure code description
- Repairs due to normal wear and tear during the 90 days following delivery
- Adjustments or modifications of the prosthesis or the prosthetic component made when fitting the prosthesis or component and for 90 days from the date of delivery when the adjustments are not necessitated by changes in the residual limb or the client's functional ability

In general, base codes do not represent a complete device. To include the additional components necessary for a complete device, providers may bill additional components with a code that is used in addition to a base code. Addition codes may also be used to indicate modifications to a device. The values assigned to the additional codes do not represent the actual value of the component or modification, but only the difference between the total value and the value of the base code. As a result, reimbursement of an addition does not involve subtraction of any amounts from the base code allowance.

2.2.20.1.1 Noncovered Prosthetic Services

Prosthetic devices prescribed by a chiropractor are not a benefit of Texas Medicaid.

A vacuum-assisted socket system (procedure code L5781 or L5782), which is a specialized vacuum pump, is considered experimental and investigational, and is not a benefit of Texas Medicaid.

Myoelectric hand prostheses for conditions other than the absence of forearm(s) and hand(s) are considered experimental and investigational and are not a benefit of Texas Medicaid.

A prosthetic device customized with enhanced features is not considered medically necessary if ADLs can be met with a standard prosthetic device.

Accessories that are not required for the effective use of a prosthetic device are not considered medically necessary.

2.2.20.2 Prior Authorization and Documentation Requirements

Prior authorization is required for all prosthetic devices.

A completed CCP Prior Authorization Form requesting the prosthesis must be signed and dated by a physician familiar with the client before requesting prior authorization for all prostheses. The completed CCP Prior Authorization Form must include the procedure codes and numerical quantities for services

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requested. A copy of the completed, signed, and dated form must be maintained by the prosthesis provider in the client's medical record. The completed CCP Prior Authorization Form with the original dated signature must be maintained by the prescribing physician in the client's medical record.

To complete the prior authorization process by paper, the prosthesis provider must fax or mail the completed CCP Prior Authorization Request Form to the CCP prior authorization unit and retain a copy of the signed and dated CCP form in the client's medical record at the provider's place of business.

To complete the prior authorization process electronically, the prosthesis provider must complete the prior authorization requirements through any approved electronic methods and retain a copy of the signed and dated CCP Prior Authorization Request form in the client's medical record at the provider's place of business.

To facilitate determination of medical necessity and avoid unnecessary denials, the physician must provide correct and complete information, including documentation for medical necessity of the equipment or supplies requested. The physician must maintain documentation of medical necessity in the client's medical record. The provider may be asked for additional information to clarify or complete a request for the service or device.

All requests for prior authorization must include documentation of medical necessity including, but not limited to, documentation that the client meets the following general indications for the requested device:

- The prosthesis replaces all or part of the function of a permanently inoperative, absent, or malfunctioning part of the limb, and identification of the specific limb that is being replaced by the prosthesis.
- The prosthesis is required for ADLs or for rehabilitation purposes, and identification of the ADLs or rehabilitation purpose for which the prosthesis is required.

The provider must keep the following written documentation in the client's medical record:

- The prescription for the device.
  - Prosthetic devices must be prescribed by a physician (M.D. or D.O.).
  - The prescription must be dated prior to or on the initial date of the requested dates of service, which can be no longer than 90 days from the signature date on the prescription.
- Accurate diagnostic information that supports the medical necessity for the requested device. (A retrospective review may be performed to ensure that the documentation included in the client's medical record supports the medical necessity of the requested service or device.)
- The specific make, model, and serial number of the prosthetic components.
- The treatment plan outlining the therapy program prescribed by the treating physician, including expected goals with the use of the prosthesis.
- A statement submitted by the physician that indicates that the client or client's family or caregiver demonstrates willingness to comply with the therapy program.

Prior authorization is valid for a maximum period of six months from the prescription signature date.

At the end of the six-month authorization period, a new prescription is required for prior authorization of additional services.

> ***Note:*** *Texas Medicaid fee-for-service requires providers to review for medical necessity of DME every six months. An MCO may approve an initial DME prior authorization request for a period of 6 months, unless otherwise stated, and may authorize an extension of 12 months after the initial 6 months, if medically necessary.*

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The actual date of service is the date the supplier has placed an order for the equipment and has incurred liability for the equipment.

2.2.20.2.1 Lower-Limb Prostheses

Lower limb prostheses include, but are not limited to, the following:

- Partial foot, ankle, and knee disarticulation sockets
- Above-knee short prostheses
- Hip and knee disarticulation prostheses
- Postsurgical prostheses
- Preparatory prostheses
- Additions to lower extremity prostheses
- Replacement sockets

A basic lower limb prosthesis consists of the following:

- A socket or connection between the residual limb and the prosthesis
- A suspension mechanism attaching the socket to the prosthesis
- A knee joint that provides support during stance, smooth control during the swing phase, and unrestricted motion for sitting and kneeling
- An exoskeleton or endoskeleton pylon (tube or shell) that attaches the socket to the terminal device
- A terminal device (foot)

In addition to the general indication requirements, the following additional documentation is also required for all lower limb prostheses:

- Written documentation of the client's current and potential functional levels. A functional level is defined as a measurement of the capacity and potential of the individuals to accomplish their expected post-rehabilitation daily function. The potential functional ability is based on reasonable expectations of the treating physician and the prosthetist and includes, but is not limited to, the following:
  - The client's history, including prior use of a prosthesis if applicable
  - The client's current condition, including the status of the residual limb and any coexisting medical conditions
  - The client's motivation to ambulate and ability to achieve independent transfers or ambulation with the use of a lower limb prosthesis
- The following functional modifiers and levels have been defined by the Centers for Medicare & Medicaid Services (CMS):

Functional Level	Functional Modifier	Description
Level 0	K0	Does not have the ability or potential to ambulate or transfer safely with or without assistance, and a prosthesis does not enhance quality of life or mobility.
Level 1	K1	Has the ability or potential to use a prosthesis for transfers or ambulation on level surfaces at fixed cadence. Typical of the limited and unlimited household ambulator

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Functional Level	Functional Modifier	Description
Level 2	K2	Has the ability or potential for ambulation with the ability to traverse low level environmental barriers such as curbs, stairs, or uneven surfaces. Typical of the limited community ambulator.
Level 3	K3	Has the ability or potential for ambulation with variable cadence. Typical of the community ambulator who has the ability to traverse most environmental barriers and may have vocational, therapeutic, or exercise activity that demands prosthetic utilization beyond simple locomotion.
Level 4	K4	Has the ability or potential for prosthetic ambulation that exceeds basic ambulation skills, exhibiting high-impact, stress, or energy levels. Typical of the prosthetic demands of the child, active adult, or athlete.

A client whose functional level is zero (0) is not a candidate for a prosthetic device; the device is not considered medically necessary.

Advanced knee, ankle, and foot prostheses procedure codes must be submitted with the appropriate functional modifier in the table above.

Microprocessor-Controlled Lower Limb Prostheses

Microprocessor-controlled lower limb prostheses (e.g., Otto Bock C-Leg, Intelligent Prosthesis, or Ossur Rheo Knee) will be considered for prior authorization for clients who have a transfemoral amputation from a nonvascular cause, such as trauma or tumor and a functional level of 3 or above, and who meet the following criteria:

- The individual has adequate cardiovascular reserve and cognitive learning ability to master the higher level of technology and to allow for faster than normal walking speed.
- The individual demonstrates the ability to ambulate at a faster than baseline rate using a standard prosthetic application with a swing and stance control knee.
- The individual has a demonstrated need for long-distance ambulation at variable rates (greater than 400 yards) on a daily basis. Use of the limb in the home or for basic community ambulation is not sufficient to justify provision of the computerized limb instead of standard limb applications.
- The individual has a demonstrated need for regular ambulation on uneven terrain or for regular use on stairs. Use of the limb for limited stair climbing in the home or employment environment is not sufficient evidence for prescription of this device over standard prosthetic application.

The licensed prosthetist or licensed prosthetist/orthotist providing the device must be trained in the fitting and programming of the microprocessor-controlled prosthetic device.

Foot Prostheses

The following foot prostheses will be considered for prior authorization for clients whose documented functional level is 1 or above:

- A solid ankle-cushion heel (SACH) foot
- An external keel SACH foot or single axis ankle/foot

A flexible-keel foot or multi-axial ankle/foot will be considered for prior authorization for clients whose documented functional level is 2 or above.

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A flex foot system, energy storing foot, multiaxial ankle/foot, dynamic response, or flex-walk system or equivalent will be considered for prior authorization for clients whose documented functional level is 3 or above.

A prosthetic shoe will be considered for prior authorization if it is an integral part of a prosthesis for clients with a partial foot amputation.

Ankle Prosthesis

An axial rotation unit will be considered for prior authorization for clients whose documented functional level is 2 or above.

Knee Prosthesis

A single-axis, constant-friction knee and other basic knee systems will be considered for prior authorization for clients whose documented functional level is 1 or above. A fluid, pneumatic, or electronic knee prosthesis will be considered for prior authorization for clients whose documented functional level is 3 or above. A high-activity knee control frame will be considered for prior authorization for clients whose documented functional level is 4.

Prosthetic Substitutions or Additions for Below-Knee Prostheses

Prosthetic substitutions or additions (procedure codes L5629, L5638, L5639, L5646, L5647, L5704, L5785, L5962, and L5980) are not considered medically necessary when an initial below-knee prosthesis (procedure code L5500) or a preparatory below-knee prosthesis (procedure codes L5510, L5520, L5530, or L5540) is provided.

Prosthetic substitutions or additions (procedure codes L5620, L5629, L5645, L5646, L5670, L5676, L5704, and L5962) are not considered medically necessary when a below-knee preparatory, prefabricated prosthesis (procedure code L5535) is provided.

Sockets

Prior authorization for test (diagnostic) sockets for an individual prosthesis is limited to a quantity of two test sockets. Prior authorization for same-socket inserts for an individual prosthesis is also limited to a quantity of two. Requests for test sockets or same-socket inserts beyond these limitations must include documentation of medical necessity that supports the need for the additional sockets.

2.2.20.2.2 Upper-Limb Prostheses

Upper limb prostheses include, but are not limited to, the following:

- Partial hand prostheses
- Wrist and elbow disarticulation prostheses
- Shoulder and interscapular thoracic prostheses
- Immediate postsurgical or early fitting prostheses
- Preparatory prostheses
- Terminal devices
- Replacement sockets
- Inner sockets-externally powered
- Electric hand, wrist, and elbow prostheses

Upper limb prostheses will be considered for prior authorization with documentation of all of the general indication requirements. The additional criteria in the following sections apply for specific prosthetic devices.

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Myoelectric Upper Limb Prostheses

A myoelectric upper limb prosthetic device is considered medically necessary when all of the following criteria have been met:

- The client has sufficient neurological, myocutaneous, and cognitive function to operate the prosthesis effectively.
- The client has an amputation or missing limb at the wrist or above (e.g., forearm, elbow, and so on).
- The client is free of comorbidities that could interfere with maintaining function of the prostheses (e.g., neuromuscular disease).
- The client retains sufficient microvolt threshold in the residual limb to allow proper function of the prostheses.
- Standard body-powered prosthetic devices cannot be used or are insufficient to meet the functional needs of the patient in performing ADLs.
- The client does not function in an environment that would inhibit function of the prosthesis (e.g., a wet environment or a situation involving electrical discharges that would affect the prosthesis).

2.2.20.2.3 External Breast Prostheses

External breast prostheses will be considered for prior authorization for clients who have congenital absence of a breast or who have had a mastectomy.

2.2.20.2.4 Craniofacial Prostheses

Craniofacial prostheses include, but are not limited to, external nasal, ear, and facial prostheses.

Craniofacial prostheses will be considered for prior authorization with documentation that the device is necessary to correct an absence or deformity of the affected body part.

2.2.20.2.5 Related Services

Accessories to Prostheses

Accessories to prostheses, such as stump stockings and harnesses will be considered for prior authorization when they are essential to the effective use of the prosthetic device.

Repairs, Replacements, and Modifications to Prostheses

Repairs due to normal wear and tear will be considered for prior authorization after 90 days from the date of delivery of the initial prosthesis, when the repair is:

- Necessary to make the equipment functional.
- More cost-effective than the replacement of the prosthetic device.

Providers must include documentation that supports medical necessity when they request prior authorization.

Additional information from the provider may be requested to determine cost-effectiveness.

Replacement of prosthetic equipment will be considered for coverage 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 re-occurrence must be submitted with the prior authorization request.

Socket replacements will be considered for prior authorization with documentation of functional or physiological need, including, but not limited to, changes in the residual limb, functional need changes, or irreparable damage or wear due to excessive weight or prosthetic demands of very active amputees.

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Children typically require new prosthetic devices every 12 to 18 months, although the actual lifespan of a device depends on the child's rate of skeletal growth. Prosthetic devices for children must accommodate growth and other physiological changes.

Components and systems that allow for growth or increase the lifespan of the prosthesis may include the following:

- Growth-oriented suspension systems and modifications
- Use of modular systems
- Use of flexible sockets
- Use of removable sockets (slip or triple-wall sockets)
- Use of distal pads
- Modification of socket liners
- Increasing or decreasing sock thickness

Modifications due to growth or change in medical status will be considered for prior authorization with documentation of medical necessity.

Medical necessity for requested components or additions to the prosthesis is based on the client's current functional ability and the expected functional potential as defined by the prosthetist and the ordering physician.

2.2.21 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.

2.2.21.1 Services, Benefits, and Limitations

The rental of phototherapy devices (procedure code E0202) for use in the home are a benefit of Texas Medicaid for low-risk infants.

Low-risk infants are 35 or more weeks gestation at birth, without comorbidity, and with a total serum bilirubin (TSB) level within the following ranges:

Infant's Gestation at Birth	TSB for infant 0-24 hours of age*	TSB for infant 25-48 hours of age*	TSB for infant 49-72 hours of age*	TSB for infant older than 72 hours of age*
35–37 weeks	3–7	7–13	10–15	13–18
38 weeks or greater	6–11	12–15	15–18	18–21

*** Infant age when TSB level is drawn.**
TSB levels are expressed in milligrams per deciliter (mg/dl).

The DME provider must perform routine maintenance and provide instructions to the parent or guardian on the safe use of the phototherapy device. Rental of a phototherapy device is reimbursed as a daily global fee and is limited to one per day, per client, any provider.

Providers may not bill for those days the phototherapy device is at the client's home and is not in use.

Skilled nursing (SN) visits for clients requiring phototherapy services may be reimbursed separately through Title XIX Home Health Services for nonroutine clinical teaching and assessment. Routine laboratory specimens are obtained during the SN visit, and may only be considered when the alternative to obtaining the specimen is to transport the client by ambulance.

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If a client who is receiving PDN services requires phototherapy, instructions in the use of the equipment must be part of the existing PDN authorized hours. SN visits will not be allowed on the same day as PDN services.

In accordance with American Academy of Pediatrics (AAP) guidelines, providers must conduct ongoing assessments for risk of severe hyperbilirubinemia for all infants who receive home phototherapy.

Initiation of home phototherapy for medium- and high-risk infants is not a benefit of Texas Medicaid. As defined by the AAP, medium- and high-risk infants should be considered for more extensive initial treatment in an inpatient setting. Medium- and high-risk infants include, but are not limited to, those who have one of the following known risk factors:

- Acidosis
- Albumin less than 3.0 g/dl
- Asphyxia
- Glucose-6-phosphate dehydrogenase (G6PD) deficiency
- Isoimmune hemolytic disease (blood group incompatibility)
- Jaundice within the first 24 hours
- Sepsis
- Significant lethargy
- Temperature instability

2.2.21.2 Prior Authorization and Documentation Requirements

Home phototherapy devices require prior authorization and are provided only for the days that are medically necessary.

For low-risk infants, prior authorization will be considered for phototherapy services that begin in the home.

For stabilized infants who began phototherapy treatment during their hospitalization and have been discharged from the hospital, prior authorization will be considered for the continuation of phototherapy services in the home. Initial prior authorization may be given for a maximum of seven days of home phototherapy. A new CCP Prior Authorization Request Form must be submitted to request more than seven days of home phototherapy.

The following documentation is required to support medical necessity when requesting home phototherapy services:

- A diagnostic evaluation, which must include, but is not limited to, a normal history and physical exam, and normal laboratory values for the following, as medically indicated:
  - Complete blood count with differential
  - Platelets
  - Blood smear for red blood cell morphology
  - Reticulocyte count
  - Urinalysis
  - Maternal and infant blood typing
  - Coombs test
- TSB level (in mg/dl)

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- Gestational age
- Documentation of adequate infant hydration, as demonstrated by 4-6 wet diapers per day and 3-4 stools per day
- Documentation stating that infant weight loss does not exceed 10 percent of the infant's birth weight
- Physician's plan of care
- Anticipated number of days the client will need the phototherapy treatment
- Documentation of parental education regarding the importance of monitoring and follow-up

When requesting prior authorization for a hospitalized infant that requires continued home phototherapy, providers must submit documentation that indicates all pre-existing medium- or high-risk factors have resolved or stabilized.

Providers must submit the following additional documentation for prior authorization requests for previously hospitalized infants that require continued home phototherapy or for more than seven days of home phototherapy:

- TSB level greater than 13 mg/dl and trending downward. TSB levels less than 13 will require medical review to determine medical necessity.

  Note: *According to AAP guidelines, phototherapy may be discontinued when the TSB level falls below 13-14 mg/dl; however, exceptions to the guidelines may be considered. As a result, documentation must include the rationale for not discontinuing phototherapy when the TSB level drops below 13 mg/dl.*

- Birth weight and current weight demonstrating weight gain.

  Note: *According to AAP guidelines, breast-fed infants are expected to gain 15-30 grams per day (1/2-1 ounce per day) through the first 2-3 months of life.*

2.2.21.2.1 Retroactive Eligibility

Newborn babies may not have a Medicaid number at the time that services are ordered by the physician and provided by the supplier. In these cases, prior authorization may be given retroactively for services rendered between the start date and the date that the client's Medicaid number becomes available.

The provider is responsible for finding out the effective dates of client eligibility.

The provider has 95 days from the date on which the client's Medicaid number becomes available (add date) to obtain prior authorization for services that were already rendered.

2.2.22 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

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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.*

Note: *For clients who are 21 years of age or older, requests for PT/INR monitors and related testing supplies that do not meet the criteria through Title XIX Home Health Services may be considered under the Texas Medicaid Home Health—Durable Medical Equipment (DME) Exceptional Circumstances process.*

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.

2.2.22.1 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 Prescribing Provider Order Form.

The completed Home Health Services (Title XIX) DME/Medical Supplies Prescribing Provider Order Form with the original dated signature must be maintained by the prescribing physician or allowed practitioner in the client's medical record. A copy of the completed, signed, and dated form must be maintained by the DME provider in the client's medical record.

To facilitate the determination of medical necessity and avoid unnecessary denials, the physician or allowed practitioner must provide correct and complete information, including documentation of medical necessity for the equipment and/or supplies requested and is subject to retrospective review. The physician or allowed practitioner 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/partial thromboplastin time (PTT) levels with titration greater than once per week in anticoagulation dosing with copies of laboratory reports and resultant medication changes.

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- 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 provider.*

2.2.23 Respiratory Equipment and Supplies

Respiratory equipment and supplies may be provided in the home under Title XIX Home Health Services.

Respiratory equipment and supplies must be prescribed by a physician or an allowed practitioner, be FDA approved for the medical condition, and have federal financial participation available to be considered a medically necessary benefit. An eligible client must have compromised health status without the requested equipment or supplies.

Equipment provided for rental may be new or used. Equipment provided for purchase must be new and unused.

HHSC or its designee will determine whether respiratory equipment will be rented, purchased, or repaired based on the client's needs and expected duration of use.

Note: *When new unused equipment is initially provided for rental and is subsequently authorized for purchase, the provider is not required to replace the equipment.*

Rental of equipment includes all necessary supplies, adjustments, repairs, and replacement parts. Supplies needed for use with client-owned equipment may be purchased separately within the limitations.

Note: *For clients who are 20 years of age and younger, respiratory equipment and supplies that do not meet the criteria under Title XIX Home Health Services may be considered through the Texas Health Steps-Comprehensive Care Program (THSteps-CCP).*

Note: *For clients who are 21 years of age and older, respiratory equipment and supplies that do not meet the criteria under Title XIX Home Health Services may be considered under the Texas Medicaid Home Health-Durable Medical Equipment (DME) Exceptional Circumstances process. Respiratory equipment and supplies are available without prior authorization up to the stated quantity limitation, unless otherwise specified in this handbook. Prior authorization is required for quantities exceeding the limitation.*

2.2.23.1 Prior Authorization

Unless otherwise indicated, prior authorization is required for rental or purchase of respiratory equipment provided through Home Health services.

All miscellaneous procedure codes listed in this handbook require prior authorization.

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2.2.23.1.1 Initial Request

A completed Home Health Services (Title XIX) DME/Medical Supplies Prescribing Provider Order Form prescribing the DME and/or supplies must be signed and dated by a physician or an allowed practitioner familiar with the client, before requesting prior authorization for all DME equipment and supplies. The completed Home Health Services (Title XIX) DME/Medical Supplies Prescribing Provider Order Form must include the procedure codes and quantities for services requested.

A Home Health Services (Title XIX) DME/Medical Supplies Prescribing Provider Order Form must be submitted for all DME services and supplies, unless the ordering physician or allowed practitioner is requesting the following:

- A continuous positive airway pressure (CPAP) or Bi-level positive airway pressure (BiPAP) and respiratory assist devices (RADs) are to be requested using a Texas Medicaid Prior Authorization Request for CPAP or RAD (Bi-level PAP) form.

  Note: *Home ventilators (procedure codes E0465, E0466, E0467, and E0468) requested with CPAP or RAD settings must also be submitted on the Texas Medicaid Prior Authorization Request for CPAP or RAD (Bi-level PAP) form with a letter of medical necessity explaining why CPAP or RAD is not medically appropriate for the client.*

- Oxygen Therapy is to be requested using a Texas Medicaid Prior Authorization Request for Oxygen Therapy Devices and Supplies form.
- Secretion and mucus clearance device are to be requested using a Texas Medicaid Prior Authorization Request for Secretion and Mucus Clearance Devices - Initial Request form or a Texas Medicaid Prior Authorization Request for Secretion and Mucus Clearance Devices -Renewal Request form for secretion and mucus clearance devices.

  Note: *It is not necessary to submit a Title XIX form if one of the prior authorization forms listed above are submitted.*

The following prior authorization request forms with the original dated signature must be maintained by the prescribing physician or allowed practitioner in the client's medical record. A copy of the completed, signed, and dated form must be maintained by the DME provider in the client's medical record. The following forms will not be accepted beyond 90 days from the date of the ordering physician's signature:

- Home Health Services (Title XIX) DME/Medical Supplies Prescribing Provider Order Form
- Texas Medicaid Prior Authorization Request for CPAP or RAD (Bi-level PAP) form
- Texas Medicaid Prior Authorization Request for Oxygen Therapy Devices and Supplies form
- Texas Medicaid Prior Authorization Request for Secretion and Mucus Clearance Devices - Initial Request form
- Texas Medicaid Prior Authorization Request for Secretion and Mucus Clearance Devices -Renewal Request form

Prior authorization requests may be submitted to the TMHP Prior Authorization Department via mail, fax, or the electronic portal. Prescribing or ordering providers, dispensing providers, clients' responsible adults, and clients may sign prior authorization forms and supporting documentation using electronic or wet signatures.

Refer to: Subsection 5.5.1.2, "Document Requirements and Retention" in "Section 5: Fee-for-Service Prior Authorizations" (*Vol. 1, General Information*) for additional information about electronic signatures.

To complete the prior authorization process electronically, the provider must complete the prior authorization requirements through any approved electronic method.

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To complete the prior authorization process by paper, the DME provider must fax or mail the completed form to the Home Health Services Prior Authorization Department.

To facilitate the determination of medical necessity and avoid unnecessary denials, the physician or allowed practitioner must provide correct and complete information, including documentation of medical necessity for the equipment and/or supplies requested and is subject to retrospective review. The physician or allowed practitioner 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 respiratory equipment and supplies.

The requesting provider may be asked for additional information to clarify or complete a request.

Retrospective review may be performed to ensure documentation supports the medical necessity of the requested equipment or supplies.

A determination as to whether the equipment will be rented, purchased, 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.

Equipment that has been purchased may be considered for replacement when loss or irreparable damage has occurred outside the warranty terms, conditions, and limitations. A copy of the police or fire report when appropriate and the measures to be taken to prevent reoccurrence must be submitted with the prior authorization request.

2.2.23.1.2 Respiratory Equipment for Clients not Meeting Required Criteria

Clients who are 20 years of age and younger

For clients who are 20 years of age and younger, respiratory equipment and supplies that do not meet the criteria under Title XIX Home Health Services may be considered through the Texas Health Steps-Comprehensive Care Program (THSteps-CCP).

Clients who are 21 years of age and older

For clients who are 21 years of age and older, respiratory equipment and supplies that do not meet the criteria under Title XIX Home Health Services may be considered through the Texas Medicaid Home Health-Durable Medical Equipment (DME) Exceptional Circumstances provision.

Refer to: Subsection 2.2.3, "Home Health DME and Supplies Exceptional Circumstances Provision" in this handbook for additional information about the Exceptional Circumstances provision.

Providers are expected to submit documentation for recertification requests as outlined in this handbook. If no specific documentation requirements are outlined, providers are to submit the following:

- A new prior authorization request form
- All of the initial request requirements
- A physician or an allowed practitioner attestation that the treatment has been effective and the client has been compliant with treatment

2.2.23.1.3 Repair to Client-Owned Equipment

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.

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. When there is documented proof of abuse or neglect, requests for repairs will not be prior authorized.

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Providers are responsible for maintaining documentation in the client's medical record specifying the repairs and supporting medical necessity and must include all the following:

- The date of purchase
- The serial number of the current equipment (as applicable)
- The cause of the damage or need for repairs
- What steps the client or caregiver will take to prevent further damage if repairs are due to an accident
- When requested, the cost of purchasing new equipment as opposed to repairing current equipment

Temporary replacement of client-owned respiratory equipment during the repair may be considered for prior authorization for one month using procedure code K0462.

Labor for repair of client-owned respiratory equipment may be considered for prior authorization using procedure code K0739 up to a maximum of two hours per day (maximum quantity of 8 units).

Routine maintenance of rental equipment is the provider's responsibility.

2.2.23.2 Small Volume Nebulizers (SVN)

Small volume nebulizers (SVNs) (procedure code E0570) and related supplies (procedure codes A7003, A7004, and A7005) may be considered for purchase without prior authorization for the conditions listed below:

Condition
Bronchiectasis - Any type
Cystic Fibrosis (CF) with pulmonary manifestations
Pneumonia - Any type
Influenza
Bronchitis - Any type
Emphysema - Any type
Asthma - Any type
Chronic Obstructive Pulmonary Disease (COPD) - any type
Pneumoconiosis - Any type
Acute, Sub-acute or Chronic Respiratory conditions
Respiratory conditions due to radiation, smoke, unspecified and specified external agents
Abnormal Sputum
Other diseases of the of the trachea and bronchus
Tracheostomy Status
Attention to tracheostomy
HIV with pulmonary manifestations
Pneumocystosis
Complications of a specified or unspecified transplanted organ, bone marrow or stem cells
Primary Pulmonary Hypertension
Other Chronic Pulmonary Heart Disease

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Supporting documentation of medical necessity must be maintained in the client's medical record, which must be available on request and is subject to retrospective review including but not limited to the following:

- Completed Title XIX Form signed and dated by the client's prescribing physician or allowed practitioner
- Name of the medication(s) ordered for administration through the nebulizer treatments
- Frequency and duration of the need for the prescribed nebulizer treatments

SVN and related supplies may be considered for conditions not listed above with prior authorization when submitted with the following documentation of medical necessity:

- Completed Title XIX Form signed and dated by the client's treating physician or allowed practitioner
- Justification supporting the use of an SVN to treat the client's diagnosis
- Name of the medication(s) ordered for administration through the nebulizer
- Frequency and duration of need for the prescribed nebulizer treatments

2.2.23.3 Ultrasonic Nebulizers (USNs)

An ultrasonic nebulizer (USN) or electronic aerosol generator (procedure code E0574) is an electrically powered device that uses a piezoelectric crystal to generate aerosol. This crystal transducer converts radio waves into high-frequency mechanical vibrations (sound).

Ultrasonic nebulizers are a benefit when medically necessary and may be considered for purchase with prior authorization.

2.2.23.3.1 Prior Authorization

Purchase of a USN may be considered medically necessary when submitted with all the following documentation:

- Client meets the criteria for a SVN
- Client requires equipment for delivery of one of the following:
  - Treprostinil to treat pulmonary arterial hypertension (PAH) when used to diminish symptoms associated with exercise
  - Tobramycin to treat cystic fibrosis (CF)

USN may also be considered medically necessary for conditions other than those listed only when all of the following criteria have been met:

- Client meets the criteria for a SVN
- Client's treating physician or allowed practitioner attests that the client has been compliant with other nebulizer and medication therapy
- Use of a SVN has failed to control the client's disease, such as preventing the client from utilizing the hospital or emergency room

2.2.23.4 Humidification Therapy and Heating Elements

Humidification involves adding water vapor and sometimes heat to the inspired gas. Humidification therapy and heating elements are provided using the following procedure codes:

Procedure Codes
Large Volume nebulizer jar (water jar)

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Procedure Codes			
A7007	A7017	E0575	E0580
Humidifiers			
E0550	E0561	E0562	
Other Supplies			
E0565	E1372	E0585	

2.2.23.4.1 Heating Elements

Heated humidifiers (procedure code E0562) and heated nebulizers (procedure code E0585) are used for clients with bypassed upper airways, clients receiving mechanical ventilatory support, and clients with high flow positive airway pressure devices. If heat is required for use with a large volume nebulizer (LVN), an immersion element (procedure code E1372) can be added.

2.2.23.4.2 Prior Authorization

Humidification therapy and heating elements may be considered for rental or purchase with prior authorization with documentation of medical necessity.

Indications for humidification and warming of inspired gases are humidifying dry medical gases and overcoming humidity deficit created when upper airway is bypassed.

Clinical signs and symptoms that may be an indication that airway humidification is medically necessary include the following:

- Dry, nonproductive cough
- Increased airway resistance
- Increased incidence of infection
- Increased work of breathing
- Complaint of substernal pain and airway dryness
- Thick, dehydrated secretions

Providers must specify the site of room air or oxygen delivery (e.g., nose or mouth, hypopharynx, trachea) and state how much heat and humidity is needed to mitigate the cold, dry gas delivered through the site.

Providers must submit a Title XIX form and all of the following documentation to obtain prior authorization for the monthly rental or purchase of humidification therapy or heating elements:

- Evidence that the client has a tracheostomy or tracheobronchial stent
- Evidence that the client has thick tenacious secretions not responsive to normal levels of humidification provided with routine humidifiers used with regulators or flow meters
- Evidence that the client is not currently renting a ventilator
- Evidence that the client is not currently renting a compressor for the delivery of humidification

Providers must specify the site of room air or oxygen delivery (e.g., nose or mouth, hypopharynx, trachea) and state how much heat and humidity is needed to mitigate the cold, dry gas delivered through the site.

2.2.23.5 Large Volume Nebulizer Jars (Water Jars) and Compressors

Large volume nebulizer jars (procedure codes A7007 and A7017) used with compressors in humidification systems are a benefit when medically necessary and may be considered for purchase without prior authorization.

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If heat is required, a heating element, such as an immersion element, can be added.

The autoclavable nebulizer (procedure code E0580 - glass or plastic) for use with a regulator or flow meter may be considered with prior authorization and documentation of medical necessity.

Equipment used with a large volume nebulizer to create a humidification system is a benefit when medically necessary with prior authorization.

A compressor (procedure code E0565) may be considered for rental or purchase with prior authorization. A compressor and heater (procedure code E0585), or large volume ultrasonic nebulizer (procedure code E0575) used to create the humidification systems when combined with a compressor are available for purchase and require prior authorization.

2.2.23.5.1 Prior Authorization

A large volume ultrasonic nebulizer and a nebulizer with compressor and heater may be considered for purchase with prior authorization when all the following criteria are met:

- The client has thick, tenacious secretions
- The client has one of the following medical conditions:
  - Cystic fibrosis
  - Bronchiectasis
  - A tracheostomy
  - A tracheobronchial stent

The compressor may also be considered when all of the following criteria are met:

- The compressor is needed for the administration of pentamidine using a filtered nebulizer
- The client has one of the following medical conditions:
  - HIV with pulmonary complications
  - Pneumocystosis
  - Complications of organ transplants

2.2.23.6 Intermittent Positive-Pressure Breathing (IPPB) Devices

IPPB is not the therapy of first choice for delivering aerosol or as a method of lung hyperinflation when other therapies can reliably meet the clinical objectives prescribed for the client. Prior authorization of an IPPB device (procedure code E0500) is available for rental or purchase and will be considered with documentation of ineffective response with use of other modalities such as treatment with a cough assist device.

Rental of the IPPB device includes all supplies, such as humidification and tubing.

In accordance with the American Association for Respiratory Care (AARC) recommendations, IPPB may be considered when one of the following indications is documented:

- The client has a need to improve lung expansion
- The need to deliver aerosol medication to a client when other methods of delivery have been unsuccessful

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2.2.23.6.1 Prior Authorization

IPPB requires prior authorization and may be considered with documentation of ineffective response to treatment when other modalities, such as a cough assist device, have failed, when prescribed in accordance with the AARC recommendations, and there is medical necessity to improve lung expansion due to one of the following:

- The presence of clinically significant pulmonary atelectasis when other forms of therapy have been unsuccessful or the client cannot cooperate with the treatment
- The inability to clear secretions adequately due to pathology that severely limits the client's ability to ventilate or cough effectively and failure to respond to other modes of treatment, including but not limited to:
- Neuromuscular disorders or kyphoscoliosis with associated decreases in lung volumes and capacities
- Presence of acute severe bronchospasm or exacerbated COPD that fails to respond to other therapy
- Deliver aerosol medication when other methods of delivery have been unsuccessful including, but not limited to:
- The client who has fatigue as a result of ventilatory muscle weakness such as neuromuscular disease, kyphoscoliosis, or spinal cord injury
- The clients with severe hyperinflation where IPPB may decrease dyspnea and discomfort during nebulized therapy

2.2.23.7 Controlled Dose Inhalation Drug Delivery Systems

A controlled dose inhalation drug delivery system (procedure code K0730) is a benefit when it is medically necessary to deliver the drug iloprost (e.g. Ventavis) and is restricted to clients with pulmonary artery hypertension. The controlled dose inhalation drug delivery system is available for purchase with prior authorization when medically necessary.

2.2.23.7.1 Prior Authorization

Prior authorization is required for purchase of a controlled dose inhalation drug delivery system when used with iloprost and may be considered when the client has a diagnosis of pulmonary artery hypertension and the pulmonary hypertension is not secondary to pulmonary venous hypertension or disorders of the respiratory system.

2.2.23.8 Continuous Positive Airway Pressure (CPAP) and Respiratory Assist Devices (RAD) including Bi-Level PAP

Continuous positive airway pressure (CPAP) (procedure code E0601) and respiratory assist devices (RADs) (procedure code E0470) without set back up rate are available for rental or purchase with prior authorization.

RADs with set back up rate (procedure codes E0471 and E0472) are a benefit when medically necessary and may be considered for rental with prior authorization for clients requiring:

- Treatment of obstructive sleep apnea
- Restrictive thoracic disorders
- Severe chronic obstructive pulmonary disease
- Central sleep apnea
- Complex sleep apnea
- Hypoventilation syndrome

Note: *Other conditions may be considered based on medical necessity.*

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RADs with a set backup respiratory rate are available for rental, only when medically necessary.

Humidification devices (heated and non-heated) may be a benefit with prior authorization when medically necessary for rental or purchase for use with CPAP devices and RADs.

The following related supplies procedure codes are included in the CPAP and RAD rental and will not be reimbursed separately:

Procedure Codes									
A7029	A7030	A7031	A7032	A7033	A7034	A7035	A7036	A7037	A7038
A7039									

The following procedure codes will deny if billed in the same month by any provider as procedure code E0472:

Procedure Codes									
A7029	A7030	A7031	A7032	A7033	A7034	A7035	A7036	A7037	A7038
A7039									

2.2.23.8.1 Prior Authorization

CPAP devices (procedure code E0601) and RADs (procedure codes E0470, E0471, and E0472) require prior authorization. CPAP devices deliver a single, fixed pressure to the client during the night while sleeping. Some sleep breathing disorders do not benefit from CPAP and require treatment with RADs that are able to recognize the client's breathing patterns and adjust pressure during the respiratory cycle during sleep.

Note: *CPAP and RAD criteria are based on CMS coverage determinations.*

CPAP and RAD accessories (headgear, chin straps, face masks, nasal pillows, cushions, nasal interfaces, tubing and filters), when used with the following procedure codes and within the maximum allowed limits, do not require prior authorization with a fee-for-service history of a client-owned CPAP and RAD device:

Procedure Codes									
A7029	A7030	A7031	A7032	A7033	A7034	A7035	A7036	A7037	A7038
A7039									

Note: *RAD with backup rate used with an invasive interface (procedure codes E0471 and E0472) do require prior authorization. Supplies are included in the rental of procedure code E0472 and will not be authorized separately.*

In the case of a client-owned RAD with backup rate that is used with invasive interface (procedure code E0472) that was purchased as a result of a rental or purchased through another payer source, proof of ownership of the device is required for consideration of reimbursement of associated supplies and accessories. A statement from the treating physician or allowed practitioner providing the make and model of the client-owned device, submitted with the claims appeal, will meet this requirement if the claims history is not available.

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A CPAP device or a RAD without a set backup rate may be considered for an initial three month rental period with prior authorization. Following the initial three month rental period, if the CPAP or RAD without a set backup rate is effective, the device may be considered for purchase. Both devices may also be considered for continued rental with renewal at three month intervals up to 12 months.

A CPAP device and a RAD without a set backup rate will be considered purchased after 12 months of rental through the same provider and a request for purchase or further rental will not be considered.

A RAD with a set backup respiratory may be considered for an initial 3 month rental period with prior authorization and will be considered for rental only.

Humidification devices (heated or non-heated) for use with a CPAP or RAD device may be a benefit with prior authorization when medically necessary. Documentation submitted must support why humidification is medically necessary for use with positive pressure ventilation.

Prior authorization may be considered for initial and renewal requests for CPAP and RAD devices with submission of the Texas Medicaid Prior Authorization Request for CPAP or RAD (Bi-level PAP) form (new with each request) completed, signed and dated by the treating physician or allowed practitioner with the following sections completed:

- A and B for initial requests
- A and C for renewal requests

Additional documentation (e.g., titration sleep studies) as necessary to support the medical necessity of the service required as outlined below for the initial and renewal requests.

Initial Request for a Continuous Positive Airway Pressure (CPAP) System

The American Academy of Sleep Medicine (AASM) Guidelines state that it is clinically appropriate to treat clients who are 18 through 20 years of age using adult criteria.

A CPAP device (procedure code E0601) may be considered for an initial three-month rental period based on documentation supporting the medical necessity and appropriateness of the device. Documentation must include that the client has had a sleep study, lasting minimum of two hours, and at least one of the following criteria:

- For clients who are 17 years of age and younger, polysomnography results documenting an apnea-hypopnea index (AHI) greater than one event per hour may be used to establish medical necessity
- For clients who are 18 years of age and older, polysomnography results documenting an AHI or a respiratory disturbance index (RDI) greater than or equal to 15 events per hour
- For clients who are 18 years of age and older, an AHI or RDI greater than five events per hour with documentation of at least one of the following:
    - Excessive daytime sleepiness assessed by either the Epworth Sleepiness Scale (ESS) with a result greater than 10 or the Multiple Sleep Latency Test (MSLT) with a result less than 6
    - Symptoms of impaired cognition, mood disorders, or insomnia
    - Hypertension (systolic blood pressure greater than 140 mm Hg or diastolic blood pressure greater than 90 mm Hg)
    - Ischemic heart disease or previous myocardial infarction
    - History of stroke
    - Greater than 20 episodes of oxygen desaturation to less than 85 percent during a full night sleep study
    - Any one episode of oxygen desaturation of less than 70 percent
    - Pulmonary hypertension

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CPAP may be medically necessary for the treatment of obstructive sleep apnea (OSA) in clients younger than 18 years of age when one of the following criteria is documented:

- Adenoidectomy or tonsillectomy is contraindicated
- Adenoidectomy or tonsillectomy is delayed
- Adenoidectomy or tonsillectomy has been unsuccessful in relieving symptoms of OSA

Documentation must be maintained in the client's medical record that the client or responsible caregiver has received instruction from the DME provider on the proper use and care of the device and supplies.

Renewal Request for a CPAP System

Prior authorization for purchase or an additional three month CPAP rental after the initial three-month rental period will be considered with all of the following documentation completed, signed, and dated by the client's treating physician or allowed practitioner:

- A new Texas Medicaid Prior Authorization Request for CPAP or RAD (Bi-level PAP) form
- Documentation of medical necessity supporting:
  - The client's continuous use of the equipment for a minimum of four hours per 24 hour period
  - The client's symptoms as documented by the treating physician or allowed practitioner are improved with use of the CPAP

Continued rental of CPAP may be considered for up to 12 months with renewal at 3 month intervals. A CPAP device will be considered purchased after 12 months of continuous rental through the same provider.

Initial Request for Respiratory Assist Devices (RADs), including BiPAP - with and without a Set Backup Respiratory Rate

A RAD with or without a set back up rate may be considered for prior authorization when the client has one of the following medical conditions as documented by a sleep study and meets criteria for medical necessity for the specific medical condition:

- Obstructive sleep apnea (OSA)
- Restrictive thoracic disorders (i.e., neuromuscular diseases or severe thoracic cage abnormalities)
- Severe COPD
- Central sleep apnea (CSA), complex sleep apnea (CompSA)
- Hypoventilation syndrome

Initial Request for RAD for the Treatment of Obstructive Sleep Apnea (OSA)

A RAD without backup may be considered for an initial three month trial period for the treatment of OSA with prior authorization and submission of all of the following:

- All the required documentation delineated on the Texas Medicaid Prior Authorization Request for CPAP or RAD (Bi-level PAP) form outlined in the section for CPAP
- The client meets the criteria for the initial CPAP rental
- The documentation supports that CPAP has been tried and one of the following is documented:
  - The client's treating physician or allowed practitioner verifies that a therapeutic trial of CPAP was conducted in the home or a facility setting and failed to be effective in treating the client's OSA
  - A CPAP device was found to be ineffective during the initial facility based or sleep laboratory titration trial testing

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If a CPAP device is tried and found ineffective during the initial facility-based titration or home trial, substitution of a RAD does not require a new face-to-face clinical evaluation or a new sleep test.

Initial Request for RAD for the Treatment of Restrictive Thoracic Medical Conditions

A RAD without a set backup rate requires prior authorization and may be considered for the treatment of thoracic medical conditions when all of the following are met:

- The client is diagnosed with a neuromuscular disorder (e.g., Duchenne muscular dystrophy, ALS, spinal cord injuries) or the client has a diagnosis of a severe thoracic cage abnormality (e.g., severe chest wall deformities) negatively impacting the client's respiratory effort
- Significant respiratory insufficiency is documented by one of the following:
  - An arterial blood gas (ABG) PaCO2 greater than or equal to 45 mm Hg, obtained while awake and breathing the client's routinely prescribed fraction of inspired oxygen concentration (FiO2)
  - Sleep oximetry demonstrates oxygen saturation less than or equal to 88 percent for 5 minutes or longer of continuous nocturnal recording time (minimum recording time of 2 hours), obtained while client is breathing his or her routinely prescribed FiO2

Note: *FIO2 is the concentration of oxygen prescribed for routine use by the client. For example, if the client does not normally use supplemental oxygen, their prescribed oxygen is room air (FiO2 of 21 percent).*

For clients who have been diagnosed with a neuromuscular disorder only, documentation must support one of the following:

- Maximal inspiratory pressure less than 60 cm H20
- Forced vital capacity less than 50 percent of predicted volume

A RAD with a set backup rate requires prior authorization and may be considered for the treatment of thoracic medical conditions when all of the following are met:

- The client meets the criteria for use of the RAD without a backup rate for the treatment of a thoracic medical condition
- The ordering physician or allowed practitioner certifies to all of the following:
  - Client has tried a RAD without a backup rate for at least 60 days
  - The client was compliant in the use of the device (using the device on average 4 or more hours in a 24 hour day)
  - The desired therapeutic respiratory response was not achieved with the RAD without a set backup rate

Initial Request for RAD for the Treatment of Severe Chronic Obstructive Pulmonary Disease (COPD)

A RAD without a backup rate may be considered for the treatment of severe COPD, with prior authorization, when all of the following criteria are met:

- An arterial blood gas PaCO2 less than 52 mm Hg, obtained while awake and when the client is either using 2 LPM of oxygen or the client's prescribed FIO2 (the blood gas should be drawn while the client is using whichever concentration of oxygen is the higher of the two)
- Sleep oximetry demonstrates oxygen saturation less than or equal to 88 percent for 5 minutes or longer of continuous nocturnal recording time (minimum recording time of 2 hours), obtained while breathing oxygen at 2 LPM or the client's prescribed FIO2 (whichever is higher)
- Prior to initiating therapy, documentation of sleep apnea and that treatment with CPAP has been considered with an explanation of why it was ruled out

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To rule out the use of a CPAP, formal sleep testing is not required if there is sufficient information in the medical record submitted with the request to demonstrate that the client does not suffer from some form of sleep apnea (obstructive sleep apnea (OSA), CSA, or CompSA) as the predominant cause of awake hypercapnia or nocturnal arterial oxygen desaturation).

A RAD with a backup feature will be considered with prior authorization for severe COPD when the all of the following criteria are met:

- The client meets the criteria for use of the RAD without a backup rate for COPD
- The ordering physician or allowed practitioner certifies to all of the following:
  - Client has tried a RAD without a backup rate for at least 60 days
  - The client was compliant in the use of the device (using on average 4 or more hours in a 24 hour day)
  - The desired therapeutic respiratory response was not achieved with the RAD without a set backup rate

Initial Request for RAD for the Treatment of Central Sleep Apnea (CSA) or Complex Sleep Apnea (CompSA)

CSA or CompSA is characterized by the development of central apneas or central hypopneas during pressure titrations performed in a sleep lab titration study for CPAP or RAD without a backup rate.

A RAD without a backup rate will be considered with prior authorization for the treatment of CSA or CompSA when a facility based polysomnogram is performed and supports all of the following:

- The client has a diagnosis of CSA or CompSA
- The sleep study documents one of the following:
  - The sum total of central hypopneas plus central apneas is greater than 50 percent of the total apneas and hypopneas rate
  - A central hypopnea/apnea rate index greater than 5 events per hour; and significant improvement of the sleep-associated hypoventilation while breathing the clients prescribed FiO2
  - Documentation ruling out CPAP as effective therapy if either OSA or CSA is a component of the initially observed sleep associated hypoventilation

A RAD with a backup rate will be considered with prior authorization for the treatment of CSA or CompSA when all of the following are met:

- The client meets the criteria for use of the RAD without a backup rate for the treatment of CSA or CompSA
- The ordering physician or allowed practitioner certifies to all of the following:
  - Client has tried a RAD without a backup rate for at least 60 days
  - The client was compliant in the use of the device (using on average 4 or more hours in a 24 hour day)
  - The desired therapeutic respiratory response was not achieved with the RAD without a set backup rate

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Initial Request for RAD for the Treatment of Hypoventilation Syndrome

A RAD without a backup rate may be considered for treatment of hypoventilation syndrome with prior authorization when all of the following criteria are met:

- An initial arterial blood gas PaCO2, obtained while awake with the client breathing their prescribed FIO2, greater than or equal to 45 mm Hg
- Spirometry shows a forced expired volume in 1 sec (FEV1) or the forced vital capacity (FVC) greater than or equal to 70 percent
- A facility-based polysomnogram demonstrates oxygen saturation less than or equal to 88 percent for 5 minutes or longer of continuous nocturnal recording time (minimum recording time of 2 hours) not caused by obstructive upper airway events

A RAD with a set backup respiratory rate may be considered with prior authorization for the treatment of hypoventilation syndrome when one of the following are met:

- The client has hypoventilation syndrome as determined by a facility-based polysomnogram that demonstrates the desired respiratory therapeutic effects were not achieved with a RAD without a backup rate
- The client meets the criteria for RAD without a backup rate for hypoventilation syndrome, and the physician or allowed practitioner documents the desired respiratory therapeutic effects were not achieved with the RAD without a backup rate.

Renewal Request for RAD with or without a Backup Rate

Prior Authorization is required for renewal of a RAD with or without a backup rate.

Prior authorization for purchase of RAD without a set back up rate or continued rental of a RAD with or without a backup rate, after completion of the initial three-month rental period, may be considered with all of the following documentation completed, signed, and dated by the client's treating physician or allowed practitioner:

- A new Texas Medicaid Prior Authorization Request for CPAP or RAD (Bi-level PAP) form
- Attestation from the treating physician or allowed practitioner that states the client is continuing to use the equipment at a minimum of four hours in a 24 hour period
- Client symptoms are improved as documented by the client's treating physician or allowed practitioner

When recertifying a RAD with or without a set backup rate for significant respiratory insufficiency, documentation of a capillary blood gas (CBG) demonstrating a PaCO2 greater than or equal to 45 mm Hg, obtained while awake and breathing the client's routinely prescribed FiO2 may be submitted in lieu of an ABG.

2.2.23.9 Mechanical Ventilation

Invasive and noninvasive ventilators (procedure codes E0465, E0466, E0467, and E0468) are considered for rental only with prior authorization and documentation of medical necessity indicating a clinical need for mechanical ventilation.

Mechanical ventilation may be considered for the treatment of, but not limited to:

- Neuromuscular or musculoskeletal diseases and conditions affecting the respiratory muscles
- Thoracic restrictive diseases
- Chronic respiratory failure
- The following procedure codes will deny if billed in the same month by any provider as procedure codes E0465 and E0466:

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Procedure Codes									
A4481	A4483	A4611	A4612	A4613	A4618				

The following procedure codes will deny if billed in the same month by any provider as procedure code E0467:

Procedure Codes									
A4216	A4217	A4481	A4483	A4605	A4611	A4612	A4613	A4618	A4619
A4624	A4628	A7000	A7002	A7003	A7004	A7005	A7006	A7007	A7012
A7013	A7014	A7015	A7017	A7025	A7026	A7027	A7028	A7029	A7030
A7031	A7032	A7033	A7034	A7035	A7036	A7037	A7038	A7039	A7046
A7525	E0424	E0431	E0433	E0434	E0439	E0441	E0442	E0443	E0444
E0465	E0466	E0470	E0471	E0472	E0482	E0483	E0561	E0562	E0565
E0570	E0585	E0600	E0601	E1372	E1390	K0738			

Any of the following procedure codes will deny if billed with E0468:

Procedure Codes									
A4216	A4217	A4481	A4483	A4611	A4612	A4613	A4618	A7027	A7028
A7029	A7030	A7031	A7032	A7033	A7034	A7035	A7036	A7037	A7038
A7039	A7046	E0465	E0466	E0470	E0471	E0472	E0482	E0561	E0562
E0601									

2.2.23.9.1 Prior Authorization

All ventilators and related equipment require prior authorization.

The DME provider is responsible for ensuring that there is a contingency plan to manage interruptions in the use of equipment such as emergency situations and mechanical failures that would be life threatening for the client. Acceptable plans include input from the client's treating practitioner that takes into account the severity of the client's medical condition and time constraints in providing emergency support.

A ventilator may be considered for an initial three-month rental period. Following the initial three-month rental period, if the ventilator was effective, it may be considered for ongoing six-month rental periods.

A home ventilator with an invasive or noninvasive interface (procedure codes E0465, E0466, E0467, and E0468) is not intended for use as a CPAP or RAD; however, a home ventilator may be considered when medically necessary. A home ventilator requested with CPAP or RAD settings must be submitted on the Texas Medicaid Prior Authorization Request for CPAP or RAD (Bi-level PAP) form with a letter of medical necessity explaining why a CPAP or RAD is not medically appropriate for the client.

Prior authorization may be considered for initial and renewal requests for mechanical ventilators with submission of all of the following:

- A completed Title XIX Form signed and dated by the client's treating physician or allowed practitioner (new with each request)
- Attestation from the treating physician or allowed practitioner that the mechanical ventilator is medically necessary and the client is compliant with the use of the equipment

The completed Title XIX Form must specify all ventilator settings and must be maintained by the DME provider and the treating physician, or allowed practitioner, in the client's medical record.

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The monthly ventilator rental includes all ventilator related supplies regardless of the client's duration of use, whether 24 hours per day or less, including, but not limited to:

- Internal filters
- External filters
- Ventilator circuits with an exhalation valve
- High and low pressure alarms
- Humidification systems including supplies and solutions (e.g., sterile or distilled water)
- In-line compressors and related supplies
- Replacement ventilator
- Tracheostomy tube filters and humidification devices, such as heat moisture exchangers (procedure code A4483)

Note: *A replacement ventilator is a replacement for the primary ventilator due to mechanical or other malfunction and is considered a part of the rental agreement and is not authorized separately from the primary ventilator request.*

Oxygen rental is not considered a ventilator supply and may be considered for separate prior authorization.

Refer to: Subsection 2.2.23.12, "Oxygen Therapy" in this handbook for more information.

Heated or non-heated humidification requires a separate prior authorization for rental or purchase for client owned ventilators. Documentation submitted must support why it is medically necessary for the use with the ventilation.

Refer to: Subsection 2.2.23.4, "Humidification Therapy and Heating Elements" in this handbook for more information.

When prescribed by a treating physician or allowed practitioner and medically necessary for clients who require mechanical ventilation, the following devices will be prior authorized for rental:

- A home ventilator that uses an invasive interface, such as a tracheostomy tube (procedure code E0465)
- A home ventilator that uses a non-invasive interface, such as a mask or chest shell (procedure code E0466)
- A multifunction respiratory device (procedure code E0467)
- A dual-function respiratory device (procedure code E0468)

Rental of a chest shell (cuirass or "clam shell") (procedure code E0457) and chest wrap (procedure code E0459) for use with a mechanical ventilator is limited to up to three months.

A dual-function respiratory device home ventilator (procedure code E0468) may be prior authorized for rental for those clients who require mechanical ventilation with documentation that also meets the medical necessity criteria for a cough augmentation device.

Purchase of a chest shell (cuirass or "clam shell") may be prior authorized for purchase following the initial three-month rental period of the mechanical ventilator. The prescribing physician or allowed practitioner must include the predicted length of treatment and the client's compliance with the equipment.

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2.2.23.10 Back-Up Mechanical Ventilator

A back-up ventilator is defined as an identical or similar device used to meet the same medical needs as the primary ventilator for the client, but provided in the home as a precaution in case of malfunction of the primary ventilator.

Requests for a back-up ventilator in the home must meet both the following criteria to be considered medically necessary:

- The client cannot maintain spontaneous ventilations for four or more consecutive hours.
- The client lives in an area where a replacement ventilator cannot be provided within two hours.

Prior authorization requests for a back-up ventilator must include all of the following documentation:

- The amount of time the client is able to maintain spontaneous ventilation.
- The distance and/or delivery time of a replacement ventilator to the clients home.

All requests for a back-up ventilator in the home must be sent to the TMHP for Medical Director for review.

2.2.23.11 Secretion and Mucus Clearance Devices

Secretion and mucus clearance devices are a benefit when medically necessary, and are typically needed by clients diagnosed with cystic fibrosis (CF), chronic bronchitis, bronchiectasis, and ciliary dyskinesia syndromes, some forms of asthma, neuromuscular degenerative disorders, post-operative atelectasis, or thoracic wall defects.

Secretion and mucus clearance devices may be considered when documentation clearly shows the client has one of the following indications for this form of therapy as described by the AARC in the Clinical Practices Guidelines for Postural Drainage Therapy:

- Evidence of retained secretions
- Evidence that the client is having difficulty with the secretion clearance
- Presence of atelectasis caused by mucus plugging

The following secretion and mucus clearance devices or procedures do not require prior authorization:

- Incentive spirometers (procedure code A9284)
- Mucous clearance valved chamber (oscillating positive expiratory pressure (PEP), such as the Flutter Valve) (procedure code S8185)
- Moisture exchangers (procedure code A4483) only when used for mechanically ventilated clients who own their ventilator
- Tracheostoma filters, such as Thermovent T (procedure code A4481) for clients with a tracheotomy who are not mechanically ventilated

The following secretion and mucus clearance devices require prior authorization:

- Insufflation-exsufflation devices (e.g. Cough Assist, Cofflator) (procedure code E0482)
- Electrical percussors (procedure code E0480)
- The high-frequency chest wall oscillation (HFCWO) system with full anterior and/or posterior thoracic region receiving simultaneous external oscillation (procedure code E0483)
- Percussion cup (procedure code E1399)
- Intermittent positive pressure breathing (IPPB) devices (procedure code E0500)

Procedure codes A7025 and A7026 will deny if billed in the same month by any provider as rental of procedure code E0483.

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2.2.23.11.1 Prior Authorization

Prior authorization requests for the rental or purchase of secretion and mucus clearance devices require submission of a Texas Medicaid Prior Authorization Request for Secretion and Mucus Clearance Devices - Initial Request form or a Texas Medicaid Prior Authorization Request for Secretion and Mucus Clearance Devices -Renewal Request form completed, signed, and dated by the client's treating physician or allowed practitioner unless otherwise specified.

Clients requiring more than one secretion and mucus clearance device must have a pulmonologist or allowed practitioner specialized in pulmonology as the treating provider who submits a signed and dated letter of medical necessity (LMN) on the physician's letterhead stating the need of two devices.

Percussion Cups

Percussion cups, used when performing chest physiotherapy, may be medically necessary to loosen thick, mucus secretions, assist respiration, and prevent infections and require prior authorization. Percussion cups should be requested using the miscellaneous DME procedure code E1399.

Electrical Percussor

An electrical percussor (procedure code E0480) may be considered for rental or purchase with documentation of medical necessity including a description of all previous courses of therapy (such as manual percussion and postural drainage (P&PD) or valved devices) and why they did not adequately assist the client in airway mucus clearance.

Cough Augmentation Device (e.g., mechanical insufflation-exsufflation or cough assist machine)

A cough augmentation device (procedure code E0482) may be considered for prior authorization for rental only for those clients who have chronic pulmonary disease or neuromuscular disorders (including spinal cord injury) that affect the respiratory musculature, causing a weak, ineffectual, or absent cough.

Prior authorization of a cough augmentation device may be considered for an initial three-month rental period with all of the following documentation completed, signed, and dated by the client's treating physician or allowed practitioner:

- Diagnosis and background history including, as applicable, recent illnesses, complications, medications used, history of recent hospitalizations, and results of pulmonary function studies (if applicable) due to diagnosis related complications
- History of school, work, or extracurricular activity absences or other clinical evidence supporting natural deterioration to the level of requiring the use of a cough augmentation device to clear the airways, such as a weak, ineffective cough as demonstrated by pulmonary function studies (PFTs)
- Medical reasons why the client, parent, guardian, or caregiver cannot perform chest physiotherapy, or why such therapies were previously not effective

Requests for prior authorization recertification must include documentation by the client's treating physician or allowed practitioner that the client is compliant with the use of the equipment and that the treatment is effective.

High-Frequency Chest Wall Oscillation (HFCWO) System

A high-frequency chest wall oscillation (HFCWO) system with full anterior and/or posterior thoracic region receiving simultaneous external oscillation (procedure code E0483) will not be prior authorized as first line treatment. The client must have trialed other percussion and postural drainage therapy, such as electric percussor or cough augmentation device, for a minimum of three months before a request for a HFCWO system will be considered for prior authorization.

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A request for a HFCWO system may be considered for prior authorization for rental or purchase when submitted with documentation addressing why prior therapy was ineffective and documentation of one of the following conditions.

- Bronchiectasis when it is confirmed by CT scan and characterized by either a continuous daily productive cough for 6 months or frequent exacerbations of pulmonary infections (i.e., more than 2 times per year) requiring antibiotic therapy
- Cystic fibrosis or other documented chronic supperative endobronchitis
- Chronic neuromuscular disorder affecting the client's ability to cough or clear respiratory secretions
- Weak ineffective or absent cough caused by chronic pulmonary disease or a neuromuscular disorder

Rental of the HFCWO System

An initial three-month rental may be prior authorized for the HFCWO system with hose and vest (procedure code E0483) when submitted with the following documentation of medical necessity that is completed, signed, and dated by the client's treating physician or allowed practitioner:

- A Texas Medicaid Prior Authorization Request for Secretion and Mucus Clearance Devices form (Initial or Renewal Request) form
- Client history of a chronic respiratory illness with exacerbation or change in baseline respiratory condition in the past 6 months, including extra nebulizer treatments for respiratory secretions, I.V. antibiotics, and hospitalizations
- Client history of school, work, or extracurricular activity absences due to diagnosis related symptoms, or pulmonary function testing in (PFTs) in past 6 months, if applicable
- Other appropriate (age, ability, skill) modes of chest physiotherapy (such as percussion and postural drainage therapy or mechanical device) that have been trialed by the client, parent, guardian, or caregiver for a minimum of three months before the HFCWO request and the reasons the trialed therapy was ineffective or contraindicated
- Documentation that any previous use of an HFCWO device did not result in aspiration, exacerbation of a gastrointestinal or pulmonary issue, or an exacerbation of seizure activity

If at the end of the initial three-month rental a determination of purchase cannot be made, an additional three month-rental may be considered for prior authorization when the request is submitted with the above documentation and documentation of compliance with ordered therapy.

Purchase of the HFCWO System

If at the end of the initial three-month rental, the HFCWO system (procedure code E0483) is documented to be effective, purchase of the system may be considered for prior authorization when submitted with all the following required documentation:

- A physician or allowed practitioner's statement of the HFCWO system trial in a clinic, hospital, or the home setting documenting:
  - The results of the HFCWO system therapy
  - The effectiveness and tolerance of the system that includes evidence of vest tolerance
  - An explanation of the trial outcome
- The treating physician or allowed practitioner's description and assessment of the effectiveness and tolerance of the system that includes the client's diagnosis and the following background history:
  - Respiratory related complications and evidence of a decrease in these complications

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- Medications used, including IV antibiotic therapy with dosage, frequency and duration, including evidence of decreased respiratory-related medication use
- Recent hospitalizations related to the client's respiratory condition and evidence of shorter hospital length(s) of stay
- Evidence of decreased hospitalizations
- Evidence of fewer school, work, or extracurricular activity absences due to a diagnostic related condition or other clinical evidence supporting natural deterioration to the level of requiring the use of a HFCWO system to clear the airways, such as a weak, ineffective cough as demonstrated by pulmonary function studies (PFTs)
- Evidence of the frequency and compliance graphs for the 3-month period showing the frequency prescribed by the physician or allowed practitioner for each day and use of the system at least 50 percent of the time

- A statement from the treating physician or allowed practitioner that the previous use of the HFCWO device has not resulted in aspiration, exacerbation of a gastrointestinal or pulmonary issue, or exacerbation of seizure activity.

A HFCWO system purchase will be reimbursed only once per lifetime, due to the lifetime warranty provided by the manufacturer. Requests for a vest replacement (procedure code A7025) must include documentation that supports the client can no longer wear the vest due to changes in the client's condition such as changes in height, weight, or skin abrasions.

2.2.23.12 Oxygen Therapy

Devices used for in-home oxygen therapy including stationary oxygen concentrators (procedure code E1390), compressed gas (procedure code E0424), liquid oxygen (procedure code E0439), portable compressed gas cylinder (procedure code E0431), or liquid oxygen reservoir (procedure code E0433) systems are a benefit when medically necessary and require prior authorization.

Oxygen system rental includes, but is not be limited to:

- Oxygen concentrator or oxygen tanks
- Regulator
- Flow meter
- Humidifier
- Cannula or mask
- Tubing

Oxygen system supplies, including but not limited to a cannula or mask, refills, and tubing do not require prior authorization for client owned equipment.

Devices used for in-home oxygen therapy may be considered for the treatment of hypoxemia which may be the result of, but not limited to:

- Bronchopulmonary dysplasia or other respiratory diagnoses due to prematurity
- Respiratory failure or insufficiency; musculoskeletal weakness, such as that caused by Duchenne's muscular dystrophy or spinal muscle atrophy
- Diagnosis of cluster headaches
- Severe lung disease, such as COPD, diffuse interstitial lung disease, cystic fibrosis, bronchiectasis, or widespread pulmonary neoplasm

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Humidification during oxygen therapy may be a benefit with prior authorization and is provided as a component of the oxygen therapy rental. Humidification during oxygen delivery with client-owned equipment may be a benefit for rental or purchase with prior authorization when medically necessary.

The following procedure codes will deny if billed in the same month by any provider as procedure codes E0424, E0431, E0433, E0434, E0439, E1390, and K0738:

Procedure Codes									
A4615	A4616	A4617	A4619	A4620	E0441	E0442	E0443	E0444	E0447
E0580	E1353	E1355							

2.2.23.12.1 Prior Authorization

Oxygen therapy criteria are based on AARC, American Thoracic Society, and British Thoracic Society Treatment Guidelines. Oxygen therapy related supplies, other than humidification, do not require prior authorization for client owned equipment. Humidification during oxygen delivery with client-owned equipment may be a benefit for rental or purchase with prior authorization when medically necessary.

All oxygen therapy equipment requires prior authorization and prior authorization may be considered for monthly rental only. A completed Texas Medicaid Prior Authorization Request for Oxygen Therapy Devices and Supplies form completed, signed, and dated by a the client's treating physician or allowed practitioner must be submitted.

Prescribing providers must maintain an original, completed, signed, and dated Texas Medicaid Prior Authorization Request for Oxygen Therapy Devices and Supplies form in the client's medical record. The DME provider must maintain a copy of the complete, signed, and dated in the client's record.

Stationary oxygen concentrators are the preferred oxygen therapy home delivery system. If other types of oxygen therapy home delivery systems are required, documentation of medical necessity to support an exception, such as frequent interruptions in electrical service or medical necessity for a higher oxygen concentration than can be obtained with a concentrator, must be provided. The other types of delivery systems include:

- Compressed gas cylinder systems (nonportable tanks).
- Liquid oxygen reservoir systems.

Multiple oxygen types (e.g., liquid and gas) will not be authorized concurrently.

Initial Oxygen Therapy Medical Necessity Certification

Oxygen ordered for 'as needed' or 'PRN' use does not provide a basis to determine if intermittent oxygen is reasonable and medically necessary for the client. Documentation must support the need for intermittent use of oxygen.

Prior authorization of home oxygen therapy for an initial three month rental period may be considered with submission of all of the following documentation in addition to the request:

- Evidence from the client's treating physician or allowed practitioner of a determination that the client has severe lung disease or hypoxia-related symptoms that are expected to improve with oxygen therapy and the client's blood gas studies meet the criteria indicated below
- A Texas Medicaid Prior Authorization Request for Oxygen Therapy Devices and Supplies form with Sections A and B that is completed, signed, and dated by the client's treating physician or allowed practitioner documenting the client's specific medical needs and the testing performed to determine the need for oxygen therapy including all of the following criteria:
  - The client's medical diagnosis requiring oxygen therapy
  - The oxygen flow rate

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  - An estimate of the frequency, duration of use (e.g., 2 liters per minute, 12 hours per day), and duration of need (e.g., 3 months)
- A qualifying blood gas assessment may be supported by the results of either pulse oximetry or an arterial blood gas and includes all of the following:
  - Date of the testing
  - Results of the testing
- If the blood gas assessment occurred during the client's inpatient hospital stay, a blood gas performed no more than two days before discharge is acceptable.
- If a blood gas is obtained while the client is at home, the assessment must be performed while the client is in a stable chronic state (i.e., not during a period of acute illness or an exacerbation of their underlying disease) within the 30 day period prior to the request for service.

Oxygen therapy coverage is available under one of the three group categories outlined below, if the client has an eligible condition as described above.

Group I Oxygen Therapy Category

Group I - Prior authorization may be considered for clients of any age with significant hypoxemia with documentation of any of the following:

- An arterial pO2 (partial pressure of oxygen) equal to or less than 55 mm Hg or an arterial oxygen saturation equal to or less than 88 percent, taken at rest, breathing room air
- An arterial pO2 equal to or less than 55 mm Hg or arterial oxygen saturation at or below 88 percent, taken during sleep and lasting for at least 5 continuous minutes for clients who have a pO2 at or above 56 mm Hg or an arterial oxygen saturation at or above 89 percent while awake
- A decrease in arterial pO2 more than 10 mm Hg, or a decrease in arterial oxygen saturation of more than 5 percent, for at least 5 continuous minutes taken during sleep with symptoms or signs reasonably attributable to hypoxemia (e.g., impairment of cognitive processes and nocturnal restlessness or insomnia)
- An arterial pO2 equal to or less than 55 mm Hg or an arterial oxygen saturation at or below 88 percent, taken during exercise for a member who demonstrates a pO2 at or above 56 mm Hg or an arterial oxygen saturation at or above 89 percent during the day while at rest. In this case, supplemental oxygen may be provided for use during exercise if there is evidence the use of oxygen improves the hypoxemia that was demonstrated during exercise when the client was breathing room air

Group I Oxygen Therapy for Clients who are 20 Years of Age and Younger

Prior authorization may be considered for clients 20 years of age and younger when evidenced by any of the above or the following documentation:

- A neonate, and premature infant of any age who have not reached their 40th week of gestational maturity with an arterial pO2 of less than 60 mmHg or an arterial oxygen saturation level is less than 92 percent
- An infant with chronic neonatal lung disease with an arterial oxygen saturation equal to or less than 92 percent
- Other medical conditions that may be considered with supporting documentation include, but are not limited to:
  - Infants with bronchopulmonary dysplasia
  - Infants with apnea of prematurity, or recurrent cyanotic apneic episodes

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- Children with severe pulmonary hypotension
- Children who have sickle cell anemia with respiratory conditions
- Infants or children who have idiopathic pulmonary hypertension with sleep associated desaturations or a documented need for an emergent use of oxygen

Oxygen Saturation	pO2 in mm HG	Required Parameters	Clients/Comments
Less than or equal to 88 percent	Less than or equal to 55	At rest on room air	Infants, children and adults
Less than or equal to 88 percent	Less than or equal to 55	For greater than or equal to 5 minutes during sleep, when "at rest" criteria not met	Infants, children and adults
Less than or equal to 88 percent	Less than or equal to 55	During exercise, when criteria for "at rest" is not met Tests provided must document the following results: At rest on room air Exercising without oxygen Exercising with oxygen	Infants, children and adults If only criteria - documentation from physician or allowed practitioner: client's hypoxemia improved with use of O2 with exercise
Decrease of greater than 5 percent	Decrease of greater than 10 mm HG	For greater than 5 minutes taken during sleep and Client has signs or symptoms attributable to hypoxemia	Infants, children and adults
Less than 92 percent	Less than 60	At rest on room air	Neonates, premature infants who are < than their 40 week gestational maturity
Less than or equal to 92 percent		At rest on room air Chronic neonatal lung disease	Infants and children
Greater than or equal to 89 percent	Greater than or equal to 56	Documentation from physician or allowed practitioner supporting the medical need for the oxygen therapy due to medical conditions requiring different parameters	Clients of any age

Intermittent acute oxygen therapy at home is not routinely recommended for seizures as there is no evidence that it reduces seizure duration, reduces harm from prolonged seizures, or improves quality of life for the child or family.

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Group II Oxygen Therapy Category

Group II-Prior authorization may be considered for clients of any age whose arterial pO2 is 56-59 mm Hg or whose arterial blood oxygen saturation is 89 percent with documentation of any of the following:

- Dependent edema suggesting congestive heart failure (CHF)
- Cor pulmonale (pulmonary hypertension)
- Erythrocythemia with a hematocrit greater than 56 percent

Group III Oxygen Therapy Category

Group III-Prior authorization may be considered for clients with a diagnosis of cluster headaches with documentation of all of the following:

- Neurological evaluation with diagnosis of cluster headache
- Documentation of failed medication therapy

For clients whose only diagnosis is OSA, documentation must support the client's oxygen sleep desaturation was not corrected with use of CPAP or other RADs.

Oxygen Therapy Recertification

Prior authorization of oxygen therapy rental after an initial three-month rental period may be considered for periods of six month at a time with the submission of all of the following documentation:

- A new Texas Medicaid Prior Authorization Request for Oxygen Therapy Devices and Supplies form with Sections A and B completed, signed, and dated by the client's treating physician or allowed practitioner
- Evidence of a continued need for oxygen therapy
- Evidence from the client's treating physician or allowed practitioner of the client's compliance with the oxygen therapy
- A new arterial blood gas assessment using either pulse oximetry or arterial blood gases
- Evidence that the client meets the criteria for any of the above Groups (I, II, or III) for oxygen therapy

If the above criteria for oxygen therapy are not met medical necessity for recertification of oxygen therapy will be considered by a medical director with documentation from the treating physician or allowed practitioner supporting the client's need for oxygen therapy.

Stationary Oxygen Systems

Rental of a stationary oxygen system includes, but is not limited to, the nasal cannula or mask, tubing, and a basic bubble humidification system.

The types of covered stationary oxygen delivery systems include:

- Oxygen concentrators
- Compressed oxygen gas cylinder systems
- Liquid oxygen cylinder systems

Portable Oxygen Systems

Portable oxygen therapy may be considered for prior authorization when medical necessity 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 of the home environment.

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Portable oxygen systems will not be considered for prior authorization for travel outside of the home environment for clients who qualify for oxygen usage based solely on oxygen saturation levels during sleep.

The types of covered portable oxygen and portable oxygen related delivery systems include:

- Portable tanks for compressed oxygen gas cylinder systems
- Portable tanks for liquid oxygen cylinder systems
- Home compressor attachment used on an oxygen compressor to fill oxygen tanks
- Portable gaseous oxygen system home compressor

2.2.23.13 Cardiorespiratory Monitor (CRM)

A cardiorespiratory monitor (CRM) (procedure codes E0618 and E0619) for purchase or rental may be a benefit when medically necessary and may be considered for clients who require moment-to-moment cardiac and respiratory monitoring due to potential for sudden unexpected deterioration. For infants who are four months of age and younger, a CRM with recording feature (procedure code E0619) may be considered for rental without prior authorization for a maximum of two months. Prior authorization is required for clients who are 5 months of age and older.

> ***Note:*** *The American Academy of Pediatrics (AAP) recommends that infant monitoring using an infant CRM should not be used as a strategy to prevent sudden infant death syndrome (SIDS).*

Procedure codes A4556 and A4557 will deny if billed in the same month by any provider as procedure codes E0618 and E0619.

2.2.23.13.1 Prior Authorization

For infants who are four months of age and younger, a CRM with recording feature (procedure code E0619) may be considered for rental without prior authorization for a maximum of two months with documentation of one of the following conditions:

- Central apnea (respiratory control disorders)
- Cardiac rhythm issues

A completed Title XIX Form signed and dated by the client's treating physician or allowed practitioner must be maintained in the client's medical record.

If a two-month rental has expired for infants who are 4 months of age and younger and continued CRM is medically necessary, a submitted prior authorization request on a completed Title XIX Form signed and dated by the client's treating physician or allowed practitioner (new with each request) must include the following:

- The client has on-going, documented cardiorespiratory episodes (e.g. apnea or dysrhythmia)
- A physician or allowed practitioner interpretation, signed and dated by the physician or allowed practitioner, of the most recent two-month's CRM data recorded downloads

A CRM with or without recording feature (procedure code E0618 or E0619) may be considered for prior authorization for rental or purchase for clients who are 5 months of age and older when submitted with a completed Title XIX Form signed and dated by the client's treating physician or allowed practitioner (new with each request) for one of the following conditions:

- An episode of apparent life-threatening event (ALTE) in an infant who is 12 months of age or younger
- Symptomatic central apnea
- Technology dependence such as:

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- Mechanical ventilation
- Tracheostomy with a critical airway obstruction
- Assisted ventilation dependence
- Cardiac dysrhythmia with significant risk of morbidity or mortality

2.2.23.14 Tracheostomy Tubes and Related Supplies

Tracheostomy tubes (procedure codes A7520, A7521, and A7522) are medically necessary for clients with a tracheostomy and are available for purchase with prior authorization.

Tracheostomy supplies, including inner cannulas, are available for purchase when medically necessary without prior authorization within the stated benefit limits.

A tracheostomy speaking valve is considered a medically necessary accessory that enhances the function of the tracheostomy and is available for purchase without prior authorization when requested within the stated benefit limits.

A tracheostomy speaking valve (procedure code L8501) is available for purchase and is limited to one per six months without prior authorization.

2.2.23.14.1 Prior Authorization

For the initial tracheostomy tube request, three tubes may be considered for prior authorization in the first month of service (two the same size and one smaller for emergencies).

For the next five months of the initial prior authorization period and for subsequent requests, one tracheostomy tube will be prior authorized per month.

More than one tracheostomy tube per month may be considered on a case-by-case basis with medical documentation supporting why the tracheostomy tube must be changed more frequently in order to meet the client's medical needs.

Requesting tracheostomy supplies above the defined limitation

Tracheostomy supplies requests for clients 20 years of age and younger that exceed the defined limits require prior authorization with documentation supporting the medical need of the quantity requested and may be considered under the Comprehensive Care Program and must be requested on a CCP Prior Authorization Request Form.

Tracheostomy supplies requests for clients who are 21 years of age and older that exceed the defined limits require prior authorization with documentation supporting the medical need of the quantity requested and may be considered by a medical director with documentation of medical necessity and must be requested on a Title XIX Form.

Modifiers for Tracheostomy Tubes

When requesting prior authorization for non-customized or non-specialized tracheostomy tubes without specialized functions, providers must submit the most appropriate procedure code with no modifier.

When requesting prior authorization for specialized but non-customized tracheostomy tubes with specialized functions, providers submit the request with modifier U1.

When requesting prior authorization for customized tracheostomy tubes, providers must submit the request with modifier U2.

With the use of either modifier U1 or U2, the following documentation is required:

- A physician or allowed practitioner statement of the reason the client cannot use a standard tracheostomy tube

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- The manufacturer's information on the specialized functions of the tracheostomy tube or the order form describing the customization of the tracheostomy tube

Manufacturer's retail or invoice pricing information is required when using modifier U2.

Tracheostomy Tube Inner Cannula and Required Modifier

Clients with a tracheostomy tube with a reusable inner cannula (procedure code A4623) are allowed one reusable inner cannula per month without prior authorization.

Requests for more than one reusable inner cannula per month require prior authorization and medical documentation from the client's physician or allowed practitioner to support the need for more than one reusable inner cannula per month.

Clients with a tracheostomy tube with a disposable inner cannula (procedure code A4623 with modifier U3) are allowed 31 disposable inner cannulas per month without prior authorization. Request for more than 31 disposable inner cannulas per month require prior authorization and documentation from the client's treating physician or allowed practitioner to support the medical need for more than 31 disposable inner cannulas per month.

Custom tracheostomy tubes are manufactured with reusable inner cannulas. The reusable inner cannulas are included in the prior authorization for any custom tracheostomy tube authorized.

2.2.23.15 Suction Machines and Related Supplies

A suction machine (procedure code E0600) may be considered for purchase with prior authorization if medically necessary for clients who have difficulty raising and clearing secretions. Suction supplies (suction canisters, suction tubing, tracheal suction catheters, and oropharyngeal suction catheters) (procedure codes A4605, A4624, A4628, A7000, and A7002) are medically necessary for use with a suction machine. These supplies are available, if medically necessary, for purchase without prior authorization, up to the stated benefit limits unless otherwise indicated. Only one type of tracheal suction catheter is allowed per month.

In most cases in the home setting, sterile suction catheters (procedure codes A4605 and A4624) and sterile saline for suctioning (procedure code A4216) are considered medically necessary only for tracheostomy suctioning. Sterile saline for tracheal suctioning (procedure code A4216) does not require prior authorization when requested within the stated benefit limits.

Procedure code A4605 will deny if billed in the same month by any provider as procedure code A4624.

2.2.23.15.1 Prior Authorization

Suction machines, suction canisters, suction tubing, tracheal suction tubes, and oropharyngeal suction catheters are a benefit with documented medical need to have oral, nasopharyngeal, or tracheal suctioning performed. Suction supplies do not require prior authorization within the stated benefit limits.

Suction canister filters are limited to one every two months with prior authorization and should be requested using the miscellaneous DME procedure code A9900. Suction equipment and supplies requests for clients who are 20 years of age and younger that exceed the allowed limits require prior authorization with documentation supporting the medical need of the quantity requested, may be considered under Comprehensive Care Program, and must be requested on a CCP Prior Authorization Request Form.

Suction equipment and supplies requests for clients who are 21 years of age and older that exceed the allowed limits require prior authorization with documentation supporting the medical need of the quantity requested and may be considered by a medical director with documentation of medical necessity supporting the medical need of the quantity requested and must be requested on a Title XIX Form.

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2.2.23.16 Other Respiratory Supplies

Other respiratory supplies are a benefit when medically necessary and are available without prior authorization up to the stated quantity limitation unless otherwise indicated:

- Non-sterile (clean) respiratory supplies are considered standard of care and are clinically appropriate in the home setting
- Sterile respiratory supplies are a benefit with prior authorization when medically necessary and documentation clearly demonstrates that the client's medical needs cannot be met with non-sterile (clean) supplies

2.2.23.16.1 Prior Authorization

Respiratory supplies are included in the rental of the respiratory equipment and will not be prior authorized separately, but may be prior authorized for equipment that is owned by the client.

To request prior authorization for respiratory supplies for use with client-owned equipment, the following documentation must be provided by the client's treating physician or allowed practitioner:

- A completed Title XIX Form signed and dated by the client's treating physician or allowed practitioner (new with each request)
- 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
- The prescribed respiratory care regimen, to include frequency, duration, and supplies needed
- Treatment for infection, if present
- Quantity of disposable supplies prescribed per month by the physician or allowed practitioner
- Medical justification for the quantity and type of supply requested

2.2.23.17 Bag Valve Mask (BVM) Resuscitator

A bag valve mask (BVM) resuscitator or handheld resuscitation bag for a ventilator-dependent client (procedure code S8999) is commonly used when the client is temporarily removed from mechanical ventilation. A BVM for a ventilator dependent client may be a benefit for purchase when medically necessary without prior authorization.

A BVM for a non-ventilator client with or without a tracheotomy and with an appropriately sized face mask when appropriate who requires manual respiratory assistance due to inadequate or no breathing may be a benefit when medically necessary and requires prior authorization using the miscellaneous DME procedure code E1399 and will be reviewed by a medical director.

2.2.23.18 Short Term Pulse Oximetry Services, Benefits, and Limitations

A pulse oximeter (procedure code E0445) may be rented for short term use for no more than one calendar month in a six calendar month period. The short term rental of a pulse oximeter may be a benefit when medically necessary and does not require prior authorization for clients with one of the following conditions:

- Weaning the client from home oxygen
- Change in the client's condition that requires an adjustment in the liter flow of their home oxygen treatment
- To determine the client's appropriate home oxygen liter flow for ambulation, exercise, or sleep
- To determine the client's appropriate home oxygen liter flow for those who have neuromuscular disease involving the respiratory muscles, with chronic lung disease, or with severe cardiopulmonary disease.

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2.2.23.19 Long Term Pulse Oximetry Services, Benefits, and Limitations

Long term pulse oximetry (procedure code E0445 with modifier U4) may be a benefit of Texas Medicaid through the Comprehensive Care Program (CCP) with prior authorization. Long-term rental and purchase of a pulse oximeter is a benefit for clients who are birth through 20 years of age. A pulse oximeter for long-term use is defined as equipment rented for more than one calendar month in a six-month period. Long-term pulse oximetry is limited to clients eligible for CCP who qualify for medically necessary services beyond the limits of the home health benefit.

A long-term pulse oximeter must be a device that:

- Is a bedside or tabletop device.
- Provides continuous oxygen saturation monitoring.
- Requires use of wired probes.
- Has battery and alternating current (A/C) capability.

2.2.23.19.1 Long Term Pulse Oximeter Prior Authorization

Prior Authorization for Clients 21 Years of Age and Older

Pulse oximetry that is medically necessary for more than one calendar month in a six calendar month period requires prior authorization and will be considered for clients 21 years of age and older by a medical director when submitted with a complete Title XIX form, signed and dated by the treating physician or allowed practitioner and with documentation of medical necessity, such as:

- When weaning from a ventilator or oxygen and an earlier weaning attempt was unsuccessful that includes why it was unsuccessful
- Documentation of changes in the client's condition since the failed weaning attempt

Prior Authorization for Clients Birth through 20 Years of Age

Prior authorization is required for rental or purchase of a long-term pulse oximeter (procedure code E0445 with modifier U4) for clients who are birth through 20 years of age. HHSC or its designee will determine whether the long term pulse oximeter equipment will be rented, purchased, or repaired based on the client's needs and expected duration of use. Only new, unused equipment will be purchased.

The prior authorization request must include the following documentation:

- A completed CCP Prior Authorization Request form signed and dated by a physician or an allowed practitioner that includes the procedure codes and quantities for the services requested
- Documentation of the cause of the oxygen lability
- Documentation that a caregiver or medical healthcare provider is present who has been trained in use of the oximeter and how to respond to readings in a medically safe and appropriate manner, and the client meets one of the following criteria:
    - Client is oxygen or ventilator dependent and has respiratory system instability as noted in the documentation
    - Client experiences respiratory complications that require equipment that has oxygen saturation monitoring capabilities

A long-term pulse oximeter may be prior authorized for monthly rental up to a maximum of six months. Recertification for an additional six-month period may be considered for a maximum of six additional months.

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A long-term pulse oximeter will be considered purchased and owned by the client when the total monthly payments equal the purchase cost for the equipment. Prior authorization for purchase or continued rental of the long-term pulse oximeter at the end of a 12-month rental period will not be considered. A long-term pulse oximeter may be prior authorized for purchase when a purchase is determined to be more cost effective than leasing the device with supplies.

Long-term pulse oximeter equipment that has been purchased is anticipated to last a minimum of five years. Replacement of equipment may also be considered for prior authorization when loss or irreparable damage has occurred outside the warranty terms, conditions, and limitations. A copy of the police or fire report, when appropriate, and the measures to be taken to prevent reoccurrence must be submitted with prior authorization request.

A long-term pulse oximeter used to monitor a client with a history of seizure activity is not routinely recommended for seizures as there is no evidence that it reduces seizure duration, reduces harm from prolonged seizures, or improves quality of life for the child or family.

Pulse Oximetry Supplies

Pulse oximeter probes for client-owned equipment do not require prior authorization and are limited as follows:

- Disposable pulse oximeter probes (procedure code A4606) are limited to four per month
- Reusable pulse oximeter sensor probes (procedure code A4606 with modifier U5) are limited to one every six months

Procedure code A4606 and procedure code A4606 with modifier U5 will deny if billed in the same month by any provider as procedure code E0445.

Prior authorization may be considered for quantities greater than four per month with documentation supporting medical necessity.

Pulse oximeter probes (procedure code A4606 [disposable] or A4606 [reusable] with modifier U5) are included in the pulse oximeter equipment rental. Pulse oximeter probes will be denied if billed with rental of pulse oximeter equipment (procedure code E0445 or E0445 with modifier U4) in the same month of service by any provider.

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

2.2.23.20 Procedure Codes and Limitations for Respiratory Equipment and Supplies

Procedure Code	Maximum Limitations	Requires Prior Authorization
A4216	60 per calendar month	No
A4481	31 per calendar month	No
A4483	15 per calendar month	Included in ventilator rental, No prior authorization for client-owned equipment if within policy limit
A4556	15 per calendar month	No
A4557	2 per calendar month	No
A4605	10 per calendar month Only 1 type of tracheal catheter is allowed per month. A4605 will deny as part of A4624 if billed in same month.	No
A4606	4 per calendar month	Included in pulse oximeter rental, No prior authorization for client-owned equipment if within policy limit

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Procedure Code	Maximum Limitations	Requires Prior Authorization
A4606 with modifier U5	1 per 6 calendar months	Included in pulse oximeter rental, No prior authorization for client-owned equipment if within policy limit
A4611	1 per 5 rolling years	Included in ventilator rental, No prior authorization for client-owned equipment if within policy limit
A4612	1 per 5 rolling years	Included in ventilator rental, No prior authorization for client-owned equipment if within policy limit
A4613	1 per 5 rolling years	Included in ventilator rental, No prior authorization for client-owned equipment if within policy limit
A4614	1 per 6 calendar months	No
A4615	2 per calendar month	Included in O2 rental, No prior authorization for client-owned equipment if within policy limit
A4616	4 per calendar year	Included in O2 rental, No prior authorization for client-owned equipment if within policy limit
A4617	2 per calendar month	Included in O2 rental, No prior authorization for client-owned equipment if within policy limit
A4618	4 per calendar month	Included in ventilator rental, No prior authorization for client-owned equipment if within policy limit
A4619	2 per calendar month	Included in O2 rental, No prior authorization for client-owned equipment if within policy limit
A4620	2 per calendar months	Included in O2 rental, No prior authorization for client-owned equipment if within policy limit
A4623	1 per calendar month	No
A4623 with modifier U3	31 per month	No
A4624	85 per calendar month Only 1 type of tracheal catheter is allowed per month	No
A4627	1 per 6 calendar months	No
A4628	2 per calendar month	No
A4629	30 per calendar month	No
A7000	10 per calendar month	No
A7002	8 per calendar month	No
A7003	2 per calendar month	No
A7004	2 per calendar month	No
A7005	1 per 6 calendar months	No
A7006	1 per calendar month	No
A7007	2 per calendar month	No

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Procedure Code	Maximum Limitations	Requires Prior Authorization
A7009	1 per calendar year	No
A7010	1 per 2 calendar months	No
A7012	2 per calendar month	No
A7013	2 per calendar month	No
A7014	1 per 3 calendar months	No
A7015	1 per calendar month	No
A7016	2 per calendar year	No
A7017	1 per 3 rolling years	No
A7018	4 per calendar month	No
A7025	1 per lifetime	Yes
A7026	1 per 6 calendar months	No
A7027	1 per 3 calendar months	No
A7028	1 per calendar month	No
A7029	2 per calendar month	Included in CPAP or RAD rental, No prior authorization for client-owned equipment if within policy limit
A7030	1 per 3 calendar months	Included in CPAP or RAD rental, No prior authorization for client-owned equipment if within policy limit
A7031	1 per calendar month	Included in CPAP or RAD rental, No prior authorization for client-owned equipment if within policy limit
A7032	2 per calendar month	Included in CPAP or RAD rental, No prior authorization for client-owned equipment if within policy limit
A7033	2 per calendar month	Included in CPAP or RAD rental, No prior authorization for client-owned equipment if within policy limit
A7034	1 per 3 calendar months	Included in CPAP or RAD rental, No prior authorization for client-owned equipment if within policy limit
A7035	1 per 6 calendar months	Included in CPAP or RAD rental, No prior authorization for client-owned equipment if within policy limit
A7036	1 per 6 calendar months	Included in CPAP or RAD rental, No prior authorization for client-owned equipment if within policy limit
A7037	1 per calendar month	Included in CPAP or RAD rental, No prior authorization for client-owned equipment if within policy limit
A7038	2 per calendar month	Included in CPAP or RAD rental, No prior authorization for client-owned equipment if within policy limit
A7039	1 per 6 calendar months	Included in CPAP or RAD rental, No prior authorization for client-owned equipment if within policy limit
A7520	1 per calendar month	Yes

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Procedure Code	Maximum Limitations	Requires Prior Authorization
A7520 with modifier U1	1 per calendar month	Yes
A7520 with modifier U2	1 per calendar month	Yes
A7521	1 per calendar month	Yes
A7521 with modifier U1	1 per calendar month	Yes
A7521 with modifier U2	1 per calendar month	Yes
A7522	4 per calendar year	Yes
A7523	1 per 2 years	No
A7525	4 per calendar month	No
A7526	20 per calendar month	No
A9900	As needed	Yes
A9284	1 per 6 calendar months	No
E0424 (Rental)	1 per calendar month	Yes
E0431 (Rental)	1 per calendar month	Yes
E0433 (Rental)	1 per calendar month	Yes
E0434 (Rental)	1 per calendar month	Yes
E0439 (Rental)	1 per calendar month	Yes
E0441	1 per calendar month	Yes
E0442	1 per calendar month	Yes
E0443	1 per calendar month	Yes
E0444	1 per calendar month	Yes
E0447	1 per calendar month	Yes
E0445 (Rental)	1 per 6 calendar months	Yes
E0457 (Purchase)	1 per 5 rolling years	Yes
E0457 (Rental)	1 per calendar month	Yes
E0459 (Purchase)	1 per lifetime	Yes
E0459 (Rental)	1 per calendar month	Yes
E0465 (Rental)	1 per calendar month	Yes
E0466 (Rental)	1 per calendar month	Yes
E0467 (Rental)	1 per calendar month	Yes
E0468 (Rental)	1 per calendar month	Yes
E0470 (Purchase)	1 per 5 rolling years	Yes
E0470 (Rental)	1 per calendar month	Yes
E0471 (Rental)	1 per calendar month	Yes
E0472 (Rental)	1 per calendar month	Yes
E0480 (Purchase)	1 per rolling 5 years	Yes
E0480 (Rental)	1 per calendar month	Yes
E0482 (Rental)	1 per calendar month	Yes

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Procedure Code	Maximum Limitations	Requires Prior Authorization
E0483 (Purchase)	1 per lifetime	Yes
E0483 (Rental)	1 per calendar month	Yes
E0500 (Rental)	1 per calendar month	Yes
E0500	1 per 5 rolling years	Yes
E0550 (Rental)	1 per calendar month	Yes
E0550 (Purchase)	1 per 3 rolling years	Yes
E0561 (Purchase)	1 per 5 rolling years	Yes
E0561 (Rental)	1 per calendar month	Yes
E0562 (Purchase)	1 per 5 rolling years	Yes
E0562 (Rental)	1 per calendar month	Yes
E0565 (Purchase)	1 per 5 rolling years	Yes
E0565 (Rental)	1 per calendar month	Yes
E0570 (Purchase)	1 per 5 rolling years	No for conditions listed in policy. Yes for conditions not listed in policy.
E0574 (Purchase)	1 per 5 rolling years	Yes
E0575 (Purchase)	1 per 5 rolling years	Yes
E0580 (Purchase)	1 per 3 rolling years	Yes Included in O2 rental.
E0580 (Rental)	1 per calendar month	Yes Included in O2 rental.
E0585 (Purchase)	1 per 3 rolling years	Yes
E0600 (Purchase)	1 per 5 rolling years	Yes
E0601 (Purchase)	1 per 5 rolling years	Yes
E0601 (Rental)	1 per calendar month	Yes
E0618 (Purchase)	1 per 5 rolling years	Yes
E0618 (Rental)	1 per calendar month	Yes
E0619 (Purchase)	1 per 5 rolling years	Yes Exception: No prior authorization required for maximum 2 months for infants birth through 4 months of age
E0619 (Rental)	1 per calendar month	Yes
E1353 (Purchase)	1 per rolling year	No. Included in O2 rental, No prior authorization for client-owned equipment if within policy limit
E1355 (Purchase)	1 per 3 rolling years	No. Included in O2 rental, No prior authorization for client-owned equipment if within policy limit
E1372 (Purchase)	1 per 3 rolling years	Yes
E1390 (Rental)	1 per calendar month	Yes
E1399 (Rental)	As needed	Yes
E1399 (Purchase)	As needed	Yes
K0462 (Rental)	1 per calendar month	Yes

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Procedure Code	Maximum Limitations	Requires Prior Authorization
K0730 (Purchase)	1 per 5 rolling years	Yes
K0738 (Rental)	1 per calendar month	Yes
K0739	2 hours per day	Yes
L8501	1 per 6 calendar months	No
S8101	1 per 6 calendar months	No
S8185 (Purchase)	1 per 5 rolling Years	No
S8189 (Purchase)	As needed	Yes
S8999 (Purchase)	1 per calendar year	No

2.2.23.21 Services that are not a Benefit

The following are not a benefit of Title XIX Home Health Services:

- Respiratory equipment or supplies requested primarily for the convenience of the caregiver
- Rental of:
  - Mucus clearance valved chamber
  - Medication small volume nebulizer
  - Intrapulmonary percussive ventilation (IPV) system
  - Ultrasonic nebulizers
  - Oxygen supplies for rented equipment
  - Intermittent or spot-check pulse oximetry
- Purchase of:
  - Bi-level PAP with set backup respiratory rate
  - Intrapulmonary percussive ventilation (IPV)
  - Ventilators
  - Pulse oximeter as a Home Health benefit
  - Intermittent or spot-check pulse oximetry
  - Long term (greater than 1 calendar month) pulse oximeter is not a benefit of Home Health services.

Note: *Clients 20 years of age and younger who qualify for medically necessary services beyond the limits of the short-term pulse oximeter benefit may request those long-term pulse oximeter services through the Comprehensive Care Program (CCP).*

The following items are not a benefit of Title XIX Home Health Services because they either have no federal financial participation (FFP) available, are considered environmental equipment, or are considered ineffective or detrimental and as such are not considered medically necessary:

- Cool mist humidifiers
- Room air humidifiers
- Vaporizers
- Dehumidifiers
- Air conditioners

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- Back-up generators

Sterile water is not medically necessary for humidifiers in the home setting and is therefore not a benefit.

2.2.24 Special Needs Car Seats and Travel Restraints

2.2.24.1 Special Needs Car Seats

A special needs car seat may be considered for reimbursement with prior authorization for a client who has outgrown an infant car seat and is unable to travel safely in a booster seat or seat belt.

A special needs car seat must have a top tether installed. The top tether is essential for proper use of the car seat. The installer is reimbursed for the installation by the manufacturer.

Providers must use procedure code E1399 for a special needs car seat.

Car seat accessories available from the manufacturer may be considered for reimbursement with prior authorization when medically necessary for correct positioning.

A stroller base for a special needs car seat is not a benefit of Texas Medicaid.

A special needs car seat may be considered for reimbursement with prior authorization for a client who has outgrown an infant car seat and is unable to travel safely in a booster seat or seat belt. Consideration must be given to the manufacturer's weight and height limitations and must reflect allowances for at least 12 months of growth.

The provider must maintain a statement that has been signed and dated by the client's parent or legal guardian in the client's medical record that states the following:

- A top tether has been installed in the vehicle in which the client will be transported, by a manufacturer-trained vendor.
- Training in the correct use of the car seat has been provided by a manufacturer-trained vendor.
- The client's parent or legal guardian has received instruction and has demonstrated the correct use of the car seat to a manufacturer-trained vendor.

To request prior authorization for a special needs car seat or accessories, the following documentation must be provided:

- The client's weight must be at least 40 pounds, or the client's height must be at least 40 inches.
- Supporting documentation must include the following and must be submitted for prior authorization:
    - 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.
    - A description of the client's postural condition specifically including head and trunk control (or lack of control) and why a booster chair or seatbelt will not meet the client's needs (the car seat must be able to support the head if head control is poor).
    - The expected long-term need for the special needs car seat.
    - A copy of the manufacturer's certification for the installer's training to insert the specified car seat.

A request for a client who does not meet the criteria may be considered on a case-by-case basis on review by HHSC or its designee.

2.2.24.2 Travel Safety Restraints

Providers must use procedure code E0700 for the purchase of travel safety restraints, such as ankle and wrist belts.

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A travel safety restraint and ankle or wrist belts may be considered for reimbursement through CCP without prior authorization for clients with a medical condition requiring them to be transported in either a prone or supine position. The DME provider and the prescribing physician or allowed practitioner familiar with the client must maintain documentation in the client's medical record supporting the medical necessity of the travel safety restraint.

2.2.25 Subcutaneous Injection Ports

A subcutaneous injection port is a sterile medication delivery device through which medications prescribed by a physician or allowed practitioner 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 medications prescribed by a physician or allowed practitioner 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.

Note: *For clients who are 20 years of age or younger and do not meet criteria for coverage through Title XIX Home Health Services may be considered through the Texas Health Steps Comprehensive Care Program (THSteps-CCP).*

Note: *For clients who are 21 years of age or older, requests that do not meet the criteria for coverage through Title XIX Home Health Services may be considered under the Texas Medicaid Home Health - Durable Medical Equipment (DME) Exceptional Circumstances process.*

2.2.25.1 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.

2.2.25.2 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., two 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:

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Condition	Possible Exhibited Symptoms
Vaso-vagal trypanophobia	Physical symptoms such as changes in blood pressure, syncope, sweating, nausea, pallor, and tinnitus
Associate trypanophobia	Psychological symptoms such as extreme anxiety, insomnia, and panic attacks
Resistive trypanophobia	Signs and symptoms such as combativeness, elevated heart rate, high blood pressure, and violent resistance to procedures involving needles or injections

The prescribing provider 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 or allowed practitioner'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 provider.)
- 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 injection regimen prescribed by the physician or allowed practitioner.
- 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 or allowed practitioner 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.*

2.2.26 Total Parenteral Nutrition (TPN) Solutions

2.2.26.1 Services, Benefits, and Limitations for Clients Birth through 20 Years of Age

In-home TPN for clients who are birth through 20 years of age may be considered through CCP. Eligible clients may receive short-term or long-term nutritional support when oral or enteral intake are unable to maintain adequate nutrition. Covered services must be medically necessary and prescribed by the physician or allowed practitioner.

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Parenteral nutrition solution, supplies, and infusion pumps services may be reimbursed with the following procedure codes:

Procedure Codes									
Solution Procedure Codes									
B4164	B4168	B4172	B4176	B4178	B4180	B4185	B4187	B4189	B4193
B4197	B4199	B4216	B5000	B5100	B5200				
Supply Procedure Codes									
B4220	B4222	B4224	B9999						
Infusion Pump Procedure Codes									
B9004	B9006								

Note: *Procedure code B4187 is a benefit for clients who are birth through 18 years of age.*

2.2.26.2 Prior Authorization and Documentation Requirements for Clients Birth through age 20

Prior authorization is required for TPN solutions, lipids, supply kits, and infusion pumps that are provided through CCP for clients birth through 20 years of age. Renewal of the prior authorization will be considered on the basis of medical necessity.

TPN solutions, lipids, supply kits, and infusion pumps will be considered with prior authorization when documentation submitted clearly shows that it is medically necessary and will correct or ameliorate the client's disability or physical or mental illness or condition. Documentation must include the following:

- Conditions that result in a loss of function of the gastrointestinal (GI) tract and the inability to obtain adequate nutrition by the enteral route, such as:
  - Infections of the pancreas, intestines, or other body organs that result in a loss of GI function
  - Inflammatory bowel disease
  - Necrotizing enterocolitis
  - Malnutrition
  - Trauma
  - Overwhelming systemic infections
  - Serious burns
- Conditions that result in an inability of the bowel to absorb nutrition, such as:
  - Extensive bowel resection
  - Severe, advanced bowel disease. Examples include short bowel syndrome (SBS), chronicintestinal pseudo-obstruction (CIPS), Hirshprungs disease (HD), Crohn's disease, and ulcerative colitis
  - Prematurity
  - Leukemias
  - Congenital gastrointestinal anomalies
  - Acquired immunodeficiency syndrome

To facilitate determination of medical necessity and avoid unnecessary denials, the physician or allowed practitioner must provide correct and complete information, including documentation of medical necessity for the equipment and supplies requested.

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Prior authorization requests for TPN must include the following information:

- Medical condition for which TPN is necessary
- Documentation of any trials with oral and enteral feedings
- Percent of daily nutritional needs from TPN
- A copy of the TPN formula or prescription that includes amino acids and lipids and is signed and dated by the physician or allowed practitioner
- A copy of the most recent laboratory results that includes potassium, calcium, liver function studies, and albumin

Note: *Conditions or durations of need that are not listed above may be considered by HHSC or its designee with documentation of medical necessity.*

The requesting provider may be asked for additional information to clarify or complete a request for TPN services.

To facilitate the determination of medical necessity and avoid unnecessary denials, the physician or allowed practitioner must provide correct and complete information, including documentation of medical necessity for the equipment and/or supplies requested and is subject to retrospective review. The physician or allowed practitioner 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 TPN and related services.

Retrospective review may be performed to ensure that the documentation supports the medical necessity of the TPN services.

2.2.26.3 Services, Benefits, and Limitations for Clients 21 years of age and older

In-home TPN for clients who are 21 years of age and older may be considered through home health services. Eligible clients may receive long-term nutritional support when oral or enteral intake are unable to maintain adequate nutrition. "Long-term nutritional support" refers to treatment lasting 30 days or longer. Covered services must be medically necessary and prescribed by the physician or allowed practitioner.

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:

Procedure Codes									
B4164	B4168	B4172	B4176	B4178	B4180	B4185	B4189	B4193	B4197
B4199	B4216	B5000	B5100	B5200					

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2.2.26.4 Prior Authorization and Documentation Requirements for Clients who are 21 Years of Age and Older

TPN solutions, lipids, supply kits, and infusion pumps must be prior authorized. Renewal of the prior authorization will be considered on the basis of medical necessity.

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 or allowed practitioner's name and NPI must be in Block 17 and 17a or in the appropriate field of the provider's electronic software.

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 or allowed practitioner.
- 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.

Retrospective review may be performed to ensure that the documentation supports the medical necessity of the TPN services.

2.2.26.5 Infusion Pumps and Supplies (All Ages)

Parenteral nutrition supplies may be reimbursed using procedure codes B4220, B4222, B4224, and B9999.

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.

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- or allowed practitioner-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.

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The infusion pump may be rented once a month or purchased once every five years.

2.2.26.6 Backpack or Carrying Case (All Ages)

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.

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.

2.2.26.7 Reimbursement and Claims (All Ages)

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 or allowed practitioner's name and NPI must be in Block 17 and 17a or in the appropriate field of the provider's electronic software.

Retrospective review may be performed to ensure that the documentation supports the medical necessity of the TPN services.

2.2.27 Vitamin and Mineral Products

Vitamin and mineral products prescribed or ordered by a physician or allowed practitioner to treat various conditions are a benefit of Texas Medicaid through CCP for clients who are 20 years of age and younger. Vitamin and mineral products must be submitted with procedure code A9152 or A9153, the appropriate modifier, and the corresponding National Drug Code. Units must be based on the quantity dispensed, for up to a 30-day supply.

> ***Note:*** *It is acceptable for providers to bill in excess of a 30-day supply when billing for liquid formulations due to variances in container size.*

For purposes of billing, one unit is equal to one dose. The total billable units are equal to the total doses requested on the prior authorization.

Providers must dispense the most cost-effective product prescribed in accordance with a prescription from a licensed physician or allowed practitioner. Organic products will not be reimbursed unless medical documentation is provided to substantiate the need for that formulation.

The following vitamin and mineral products may be a benefit when submitted with the corresponding procedure code and state-identified modifier:

Vitamin or Mineral	Procedure Code	State-Identified Modifier
Beta-carotene	A9152	U1

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Vitamin or Mineral	Procedure Code	State-Identified Modifier
Vitamin A (retinol)	A9152	U1
Biotin	A9152	U2
Boric acid	A9152	U3
Copper	A9152	U3
Iodine	A9152	U3
Phosphorus	A9152	U3
Zinc	A9152	U3
Calcium	A9152	U4
Chloride	A9152	U5
Iron	A9152	U6
Magnesium	A9152	U7
Vitamin B1 (thiamin)	A9152	U8
Vitamin B2 (riboflavin)	A9152	U8
Vitamin B3 (niacin)	A9152	U8
Vitamin B5 (pantothenic acid)	A9152	U8
Vitamin B6 (pyridoxine, pyridoxal 5-phosphate)	A9152	U8
Vitamin B9 (folic acid)	A9152	U8
Vitamin B12 (cyanocobalamin)	A9152	U8
Vitamin C (ascorbic acid)	A9152	U9
Vitamin D (ergocalciferol)	A9152	UA
Vitamin E (tocopherols)	A9152	UB
Vitamin K (phytonadione)	A9152	UC
Multiminerals	A9153	U1
Multivitamins	A9153	U2
Trace elements	A9153	U3
Miscellaneous	A9152 or A9153	UD

Note: *Claims for multivitamins with any combination of additives must be submitted with modifier U2.*

Vitamin and mineral products may be indicated for, but are not limited to, treatment of the following conditions:

Vitamin or Mineral	Condition
Beta-carotene	Vitamin A deficiency
	Cystic fibrosis
	Disorders of porphyrin metabolism
	Intestinal malabsorption
Biotin	Biotin deficiency
	Biotinidase deficiency
	Carnitine deficiency

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Vitamin or Mineral	Condition
Boric acid	Recalcitrant vulva vaginitis
Calcium	Calcium deficiency
	Disorders of calcium metabolism
	Chronic renal disease
	Pituitary dwarfism, isolated growth hormone deficiency
	Hypocalcemia and hypomagnesaemia of the newborn
	Intestinal disaccharidase deficiencies and disaccharide malabsorption
	Allergic gastroenteritis and colitis
	Hypocalcemia due to use of Depo-Provera contraceptive injection
Chloride	Hypochloremia
	Hypercapnia with mixed acid-base disorder
	Bronchopulmonary dysplasia
Copper	Disorders of copper metabolism
Iodine	Iodine deficiency
	Simple and unspecified goiter and nontoxic nodular goiter
Iron	Disorders of iron metabolism
	Iron deficiency anemia
	Sideroachrestic anemia
Magnesium	Magnesium deficiency
	Hypoparathyroidism
Phosphorus	Disorders of phosphorus metabolism
Vitamin A (retinol)	Vitamin A deficiency
	Intestinal malabsorption
	Disorders of the biliary tract
	Cystic fibrosis
Vitamin B1 (thiamin)	Vitamin B1 deficiency
	Disturbances of branched-chain amino-acid metabolism (e.g., maple syrup urine disease)
	Disorders of mitochondrial metabolism
	Wernicke-Korsakoff syndrome
Vitamin B2 (riboflavin)	Vitamin B2 deficiency
	Disorders of fatty acid oxidation
	Riboflavin deficiency, ariboflavinosis
	Disorders of mitochondrial metabolism
Vitamin B3 (niacin)	Vitamin B3 deficiency
	Disorders of lipid metabolism, (e.g., pure hypercholesterolemia)
Vitamin B5 (pantothenic acid)	Vitamin B5 deficiency
Vitamin B6 (pyridoxine, pyridoxal 5-phosphate)	Vitamin B6 deficiency
	Sideroblastic anemia

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Vitamin or Mineral	Condition
Vitamin B9 (folic acid)	Vitamin B9 deficiency
	Folate-deficiency anemia
	Combined B12 and folate-deficiency anemia
	Disorders of mitochondrial metabolism
	Sickle-cell disease
	Pernicious anemia
Vitamin B12 (cyanocobalamin)	Vitamin B12 deficiency
	Disturbances of sulphur-bearing amino-acid metabolism (e.g., homocystinuria and disturbances of metabolism of methionine)
	Pernicious anemia
	Combined B12 and folate-deficiency anemia
Vitamin C (ascorbic acid)	Vitamin C deficiency
	Anemia due to disorders of glutathione metabolism
	Disorders of mitochondrial metabolism
Vitamin D (ergocalciferol)	Vitamin D deficiency
	Galactosemia
	Glycogenosis
	Disorders of magnesium metabolism
	Intestinal malabsorption
	Chronic renal disease
	Cystic fibrosis
	Disorders of phosphorus metabolism
	Hypocalcemia
	Disorders of the biliary tract
	Hypoparathyroidism
	Intestinal disaccharidase deficiencies and disaccharide malabsorption
	Allergic gastroenteritis and colitis
Vitamin E (tocopherols)	Vitamin E deficiency
	Inflammatory bowel disease (e.g., Crohn's, granulomatous enteritis, and ulcerative colitis)
	Disorders of mitochondrial metabolism
	Chronic liver disease
	Intestinal malabsorption
	Disorders of the biliary tract
	Cystic fibrosis

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Vitamin or Mineral	Condition
Vitamin K (phytonadione)	Vitamin K deficiency
	Congenital deficiency of other clotting factors
	Hypoprothrombinemia of the newborn
	Hemorrhagic disease of the newborn
	Intestinal malabsorption
	Acquired coagulation factor deficiency
	Cystic fibrosis
	Disorders of the biliary tract
	Chronic liver disease
Zinc	Zinc deficiency
	Wilson's disease
	Acrodermatitis enteropathica
Multi-minerals	Other and unspecified protein-calorie malnutrition
Multi-vitamins	Cystic fibrosis
	Other and unspecified protein-calorie malnutrition
Trace elements	Mineral deficiency

Prior authorization for vitamin and mineral products must be requested using the CCP Prior Authorization Request Form. Requests for prior authorizations must be submitted and approved before the date of dispensing the vitamin or mineral products. Prior authorization requests for vitamin and mineral products that are initiated before the date of the physician or allowed practitioner's order will not be approved.

The following documentation must be submitted with the prior authorization request:

- A physician's or allowed practitioner's prescription with the name of the vitamin or mineral product, dosage, frequency, duration, and route of administration
- The MSRP or average wholesale price (AWP), whichever is applicable, or the provider's documented invoice price
- The calculated price per dose
- Documentation that supports the medical necessity of the requested vitamin or mineral

The following sample tables, taken from the CCP Prior Authorization Request Form, are examples of the information that is required to submit a request for vitamin and mineral products:

- Example 1: Vitamin D

HCPCS Code	Brief Description of Requested Services	Retail Price
A9152 UA	Vitamin D (ergocalciferol) 10 ml bottle (8000 units/ml)	$40.00/bottle
	Dose: 400 units (0.05 ml)	$0.20/dose
	Route: PO	
	Frequency: QD	
Note: HCPCS codes and descriptions must be provided.		

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- Example 2: Multivitamin Tablets

HCPCS Code	Brief Description of Requested Services	Retail Price
A9153 U2	Centrum Kids (80 tablets/bottle)	$8.99/bottle
	Dose: 1 tablet	$0.11/dose
	Route: PO	
	Frequency: QD	
Note: HCPCS codes and descriptions must be provided.		

Prior authorization requests for products, conditions, or quantities other than those described in the "Benefits" section of this handbook will be considered on a case-by-case basis after review by the medical director. Providers must submit documentation that the prescribed products are for a medically accepted indication. Documentation must include one of the following:

- FDA approval
- The use is supported by one or more citations that are included or approved for inclusion in the following compendia:
  - The American Hospital Formulary Service Drug Information
  - The United States Pharmacopoeia-Drug Information (or its successor publications)
  - The DRUGDEX Information System
  - Two articles from major medical peer-reviewed literature that demonstrate validated, uncontested data for the use of the agent in a specific medical condition that is safe and effective

Prior authorization of vitamin and mineral products may be granted for up to six months, and for a quantity up to a 30-day supply.

Note: *Texas Medicaid fee-for-service requires providers to review for medical necessity of DME every six months. An MCO may approve an initial DME prior authorization request for a period of 6 months, unless otherwise stated, and may authorize an extension of 12 months after the initial 6 months, if medically necessary.*

Note: *Quantities in excess of these limitations may be considered when requesting liquid formulations due to variances in container size.*

Requests for additional vitamin and mineral products must be submitted before the current authorized period expires, but no more than 30 days before the expiration.

2.2.28 Wound Care Supplies or Systems

Wound care equipment and supplies may be a benefit under Texas Medicaid Title XIX Home Health services.

To be considered a Home Health benefit, all of the following criteria must be met:

- The client must be eligible for home health benefits.
- The criteria listed in this handbook for the requested equipment and supplies must be met.
- The equipment and supplies requested must be medically necessary.
- Federal financial participation must be available.
- The requested equipment and supplies must be safe and appropriate for use in the home.

This handbook addresses wound care equipment and supplies provided to the client by a Durable Medical Equipment (DME) provider in the home and outpatient hospital setting.

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Wound care equipment and supplies are designed to assist in healing of wounds in conjunction with an individualized wound care regimen prescribed by a provider familiar with the client.

Comprehensive wound care regimens include but are not limited to:

- Maintenance of a clean, moist bed of granulation tissue
- Debridement to remove devitalized tissue
- Any necessary treatment to resolve infection
- Optimization of nutrition, circulation, ambulation, and chronic disease management

Providers are to consider the clinical efficacy of the wound care product, the client's functional status, as well as the measurable signs of effective wound management when ordering products to treat wounds. Measurable signs of wound management include, but are not limited to:

- A decrease in wound size, either in surface area or volume
- A decrease in amount of exudate
- A decrease in amount of necrotic tissue
- Improved infection status

Wounds are defined as acute or chronic:

- Acute wounds progress through the normal stages of wound healing and show definite signs of healing within four weeks
- Chronic wounds do not progress normally through the stages of healing (often getting "stalled" in one phase) and do not show evidence of healing within four weeks

Skin ulcers represent the majority of chronic wounds. Skin ulcers include but are not limited to:

- Venous ulcers (also known as venous insufficiency ulcers or stasis ulcers)
- Arterial ulcers
- Diabetic ulcers
- Pressure injuries or pressure ulcers

2.2.28.1 Wound Care Supplies

Medically necessary wound care equipment and supplies include, but are not limited to, cleansing agents, wound packing, dressings and coverings, compression garments, and negative pressure wound therapy (NPWT) systems.

Cleansers

Wound cleansing helps create an optimal healing environment and decreases the potential for infection. Cleansing agents and methods vary based on effectiveness and individual client needs. Wound cleansing agents may include, but are not limited to:

- Normal Saline
- Commercial wound cleansers
- Povidone Iodine
- Hydrogen peroxide
- Sodium Hypochlorite

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Dressings

A dressing is a wet or dry, sterile or non-sterile, pad or compress that is designed to be in direct contact with the wound. A dressing is applied to promote healing and protect the wound from further harm. Dressings and related supplies may include, but are not limited to:

- Wound packing and fillers
- Gauze, impregnated or non-impregnated, sterile or non-sterile
- Dry dressings
- Collagen dressings
- Alginate or other fiber gelling dressings
- Composite dressings
- Antimicrobials
- Foam dressings
- Contact layers and transparent films
- Hydrocolloid, Hydrofiber, and Hydrogel dressings
- Specialty absorptive dressings
- Compression dressings and wraps
- Tape to secure dressings

Compression

Compression dressings, wraps or stockings apply pressure to body parts to control edema and aid circulation by redirecting blood centrally. Below the knee and above the knee compression stockings may be benefits for Texas Medicaid clients. Compression dressings or stockings may be used, but not limited to the following indications:

- Edema in Pregnancy
- Postural Hypotension
- Lymphedema
- Treatment of any of the following complications of chronic venous insufficiency:
  - Venous edema
  - Stasis Ulcers
  - Varicose veins (not including spider veins)
  - Lipodermatosclerosis

Custom burn compression garments may be a benefit with prior authorization and documentation supporting medical necessity.

2.2.28.2 Negative-Pressure Wound Therapy (NPWT) System

An NPWT system provides and maintains a moist wound environment and protects the wound during the healing process.

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 electric vacuum pump. An NPWT system uses continuous or intermittent sub-atmospheric pressure to remove excess interstitial

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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.

Drainage from the wound is collected in a canister. Typically, each wound dressing is changed two to three times per week. NPWT is often referred to as a "wound-vac."

NPWT may be considered for clients with wounds including but not limited to:

- Pressure
- Arterial
- Venous stasis
- Diabetic ulcers
- Post-surgical wound dehiscence; non-adhering skin grafts; or surgical flaps required for covering such wounds

Prior authorization is not required for the initial 90 days of NPWT. Prior authorization is required for continued therapy after the initial 90 days, with the submission of the Wound Care Equipment and Supplies Order Form.

Providers must submit the required documentation for the NPWT system for any prior authorization periods after the initial 90 days of treatment. All documentation required for prior authorization must be maintained in the client's medical record with the prescribing provider.

2.2.28.3 Exclusions

The following services are not a benefit of Texas Medicaid:

- Wound care supplies for use in the office or outpatient setting
- Equipment and supplies for stand-by or back-up use
- Topical or portable hyperbaric oxygen chambers (procedure code A4575) that are placed directly over the wound and provide higher concentrations of oxygen to the damaged tissue
- Non-contact normothermic wound therapy (NNWT) systems and associated supplies (procedure codes A6000, E0231, E0232)
- 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
- Contact or non-contact ultrasound treatment for wounds
- Electrochemical low-dose tissue oxygenation systems
- Metabolically and non-metabolically active skin equivalents used in wound care are not reimbursed in the home setting
- Procedure code A6545 billed without AW modifier

2.2.28.4 Authorization Requirements

Requests for medically necessary wound care equipment or supplies for any eligible client that does not meet criteria as outlined in this handbook for requests for supplies above the defined limitations will be considered through the comprehensive care program. These requests require prior authorization with documentation supporting the medical necessity of the equipment and the quantity requested.

Note: *For clients who are 21 years of age or older, requests for wound care equipment and supplies that do not meet the criteria through Title XIX Home Health Services may be considered under the Texas Medicaid Home Health - Durable Medical Equipment (DME) Exceptional Circumstances process.*

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A completed Wound Care Equipment and Supplies Order Form prescribing the DME and/or supplies must be signed and dated by a physician or allowed practitioner familiar with the client, before requesting prior authorization for all DME equipment and supplies. The completed Wound Care Equipment and Supplies Order Form must include the procedure codes and quantities for services requested.

The completed Wound Care Equipment and Supplies Order Form with the original dated signature must be maintained by the prescribing physician or allowed practitioner in the client's medical record. A copy of the completed, signed, and dated form must be maintained by the DME provider in the client's medical record.

To complete the prior authorization process by paper, the DME provider must fax or mail the completed form to the Home Health Services Prior Authorization Department. To complete the prior authorization process electronically, the DME provider must submit the prior authorization requirements through any approved electronic methods.

To facilitate determination of medical necessity and avoid unnecessary denials, the physician or allowed practitioner must provide correct and complete information, including documentation of medical necessity for the equipment and/or supplies requested and is subject to retrospective review. The physician or allowed practitioner 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 wound care supplies or wound care system.

Unless otherwise specified, wound care equipment and supplies are available without prior authorization up to the stated quantity limitations. Prior authorization is required for any quantities exceeding the limitations.

Prior authorization or additional documentation is required for:

- Quantities of wound care supplies exceeding the quantity limits listed in the Procedure Codes and Limitations table.
- Disposable wound suction (procedure code A9272). Submitted documentation must include justification addressing why no other wound care equipment and supplies will meet the client's need.
- Continued use of negative pressure wound therapy (NPWT) for more than 90 days requires documentation outlined in NPWT Greater than 90 Days section of this handbook.
- Compression burn garments require documentation of an appropriate diagnosis and evidence of medical necessity. These requests will be reviewed by the medical director.

Prior Authorization is required for the following procedure codes:

Procedure Codes								
A6215	A6260	A6501	A6503	A6504	A6505	A6506	A6507	A6508
A6509	A6510	A6511	A6512	A6513	A6515	A6516	A6517	A6518
A6519	A6549	A6611	A9272	T1999				

2.2.28.5 Documentation Requirements

Information from the following four categories must be submitted anytime that prior authorization is required. If prior authorization is not required, this documentation must be maintained in the client's medical record and is subject to retrospective review.

Category 1: Medical History and Compliance

A comprehensive treatment plan, including the prescribed wound care and management planned for the client including, but not limited to:

- Any medical diagnosis or chronic condition that effects wound healing

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- History of previous wound care treatments and outcomes with dates, including therapies initiated in a hospital or Skilled Nursing Facility (SNF)
- Continued management of unresolved compliance issues (i.e., missed medical appointments, refusing dressing changes, repositioning, smoking, poor nutritional intake or choices)
- Whether a family member/friend/caregiver agrees to be available to assist the client

Category 2: Wound Care Interventions

Relevant information related to the current wound, including:

- Any mechanical, surgical, enzymatic or autolytic tissue debridement (if performed)
- Treatment for infection (if present)

Category 3: Wound Description & Details

Detailed description of the wound including:

- Dates of previous and current assessments
- The measurements at the initiation of wound care and the current measurements, including length, width, depth and any undermining or tunneling
- Wound color
- Amount, quality, quantity, and odor of drainage (if present)
- Presence of granulation or eschar (if appropriate)
- The currently prescribed wound care regimen, to include types of dressings, frequency of dressing changes and supplies needed for each dressing change
- Frequency client will be seen by a licensed medical professional to assess wound healing and current wound treatment regimen

Category 4: Contraindications

Absence of the following contraindications:

- Untreated osteomyelitis within the vicinity of the wound
- Wound ischemia
- Gangrene
- Presence in the wound of necrotic tissue with eschar (if debridement has not been attempted)
- Cancer present in the wound or around the margins
- Presence of a fistula to an organ or body cavity within the vicinity of the wound
- Documentation explaining the appropriateness of wound care is required if any of the above contra-indications are present

The requesting DME provider may be asked for additional information to clarify or complete a request for the wound care equipment or supplies including but not limited to:

- Overall health status of clients whose wounds are not progressing through the normal stages of healing, including but not limited to:
  - Albumin or pre-albumin (within 30 days)
  - Hemoglobin A1C (within 30 days)
  - Use of pressure reducing surfaces, repositioning, and encouraged ambulation

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All services outlined in this section are subject to retrospective review to ensure that the documentation in the client's medical record supports the medical necessity of the service(s) provided.

Reauthorization will be considered based on medical necessity, with a new prior authorization request.

NPWT Greater than 90 Days

NPWT may be considered beyond the initial 90-day treatment period for additional 30 day treatment periods with prior authorization justifying continued use.

For NPWT of greater than 90 days, providers must submit justification for continued use of NPWT including:

- The measurements at the initiation of NPWT and the current measurements, including length, width, depth and any undermining or tunneling

Additionally, providers must make note if any of the following contraindications are present:

- No measurable improvement of wound status occurring over the prior 90-day period.
- The wound care equipment or supplies are no longer being used by the client as prescribed.

NPWT Supplies

NPWT supplies are limited to a maximum of:

- 15 dressing kits or supplies (procedure code A6550) per wound per month; unless documentation supports that the wound size requires more than one dressing kit for each dressing change or if the provider has ordered more frequent dressing changes.
- 10 disposable canisters (procedure code A7000) per month; unless documentation provided indicates medical necessity for additional canisters.

2.2.28.6 Reimbursement and Billing Guidelines

Wound care equipment and supplies addressed in this section are reimbursed only when provided as a Title XIX Home Health Benefit. Supplies provided in an outpatient setting, such as a wound care clinic, are part of the facility fee and are not reimbursed separately.

Providers should only bill for one month of supplies at a time, even though prior authorization may be granted for up to six months.

> ***Note:*** *Texas Medicaid fee-for-service requires providers to review for medical necessity of DME every six months. An MCO may approve an initial DME prior authorization request for a period of 6 months, unless otherwise stated, and may authorize an extension of 12 months after the initial 6 months, if medically necessary.*

Procedure code A6545 must be billed with modifier AW, claims will deny if billed without the modifier.

Providers are reimbursed for items addressed in this section by the lesser of:

- The providers billed charges
- The published fee determined by HHSC

Manual price is determined by HHSC, which is based on:

- The manufacturer's suggested retail price (MSRP) less 18 percent or average wholesale price (AWP) less 10.5 percent, whichever is applicable, or
- The provider's documented invoice cost.

If manual pricing is used, the provider must request prior authorization and submit documentation of one of the following:

- The MSRP or AWP, whichever is applicable.

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- The provider's documented invoice cost.

DME Certification

The DME Certification and Receipt Form is required and must be completed before reimbursement can be made for any equipment or appliance delivered to a client. The certification form must include the name of the item, the date the client received the equipment or appliance, and the dated signatures of the provider and the client or primary caregiver. This signed and dated form must be maintained by the DME provider in the client's medical record.

The DME Certification and Receipt Form must be submitted for DME claims and appeals when:

- A single item meets or exceeds a billed amount of $2,500.00
- Multiple items submitted on the same date of service meet or exceed a total billed amount of $2,500.00

Claims submitted without the DME Certification and Receipt Form will be denied.

Clients who receive DME meeting or exceeding a total billed amount of $2,500.00 may be contacted to verify receipt of the equipment. If receipt of the equipment cannot be verified, the claim payment is eligible for recoupment.

2.2.28.7 Wound Care Procedures and Limitations

The procedure codes listed in the following table do not require prior authorization when requested within allowable limits.

Note: *Quantities that exceed the limitations identified in the table will require prior authorization with documentation supporting medical necessity.*

Procedure Code	Limitation
A4213	30 per month
A4216	60 per month
A4217	10 per month
A4244	4 per month
A4246	4 per month
A4247	1 per month
A4320	15 per month
A4322	30 per month
A4364	8 per month
A4450	100 per month
A4452	100 per month
A4455	4 per month
A4456	60 per month
A4461	30 per month
A4465	4 per month
A4490	4 per year
A4495	4 per year
A4500	4 per year
A4510	4 per year
A4927	1 per month

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Procedure Code	Limitation
A5120	50 per month
A5121	30 per month
A5122	15 per month
A5126	40 per month
A6010	10 per month
A6011	30 per month
A6021	10 per month
A6022	10 per month
A6023	2 per month
A6024	4 per month
A6025	15 per month
A6196	30 per month
A6197	15 per month
A6198	4 per month
A6199	15 per month
A6203	30 per month
A6204	30 per month
A6205	10 per month
A6206	60 per month
A6207	30 per month
A6208	4 per month
A6209	30 per month
A6210	15 per month
A6211	4 per month
A6212	30 per month
A6213	30 per month
A6214	10 per month
A6216	200 per month
A6217	200 per month
A6218	15 per month
A6219	120 per month
A6220	30 per month
A6221	15 per month
A6222	60 per month
A6223	60 per month
A6224	60 per month
A6228	120 per month
A6229	30 per month
A6230	15 per month
A6231	60 per month

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Procedure Code	Limitation
A6232	30 per month
A6233	10 per month
A6234	30 per month
A6235	15 per month
A6236	10 per month
A6237	30 per month
A6238	10 per month
A6239	15 per month
A6240	8 per month
A6241	15 per month
A6242	30 per month
A6243	15 per month
A6244	4 per month
A6245	30 per month
A6246	30 per month
A6247	10 per month
A6248	8 per month
A6251	60 per month
A6252	30 per month
A6253	15 per month
A6254	60 per month
A6255	30 per month
A6256	15 per month
A6257	30 per month
A6258	30 per month
A6259	15 per month
A6261	8 per month
A6262	8 per month
A6266	120 per month
A6402	200 per month
A6403	100 per month
A6404	15 per month
A6407	60 per month
A6410	30 per month
A6411	30 per month
A6412	30 per month
A6441	60 per month
A6442	120 per month
A6443	120 per month
A6444	120 per month

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Procedure Code	Limitation
A6445	120 per month
A6446	120 per month
A6447	120 per month
A6448	30 per month
A6449	60 per month
A6450	30 per month
A6451	30 per month
A6452	60 per month
A6453	30 per month
A6454	60 per month
A6455	30 per month
A6456	60 per month
A6457	60 per month
A6530	16 per year
A6531	16 per year
A6532	16 per year
A6533	16 per year
A6534	16 per year
A6535	16 per year
A6536	16 per year
A6537	16 per year
A6538	16 per year
A6539	16 per year
A6540	16 per year
A6541	16 per year
A6544	4 per year
A6545-AW	8 per year
A6550	15 per month
A7000	10 per month
E2402	1 per month

The procedure codes in the following table require prior authorization.

Note: *Providers must provide appropriate documentation of medical necessity and documentation for the quantity requested.*

Procedure Code	Limitation
A6215	As Needed
A6260	As Needed
A6501	As Needed
A6503	As Needed
A6504	As Needed

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Procedure Code	Limitation
A6505	As Needed
A6506	As Needed
A6507	As Needed
A6508	As Needed
A6509	As Needed
A6510	As Needed
A6511	As Needed
A6512	As Needed
A6513	As Needed
A6549	As Needed
A9272	As Needed
T1999	As Needed

2.2.29 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 2.2, "Services, Benefits, Limitations and Prior Authorization" in this handbook 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

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- 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*).

2.2.30 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) DME/Medical Supplies Prescribing Provider Order Form for these clients. For medical supplies not requiring prior authorization, a completed Home Health Services (Title XIX) DME/Medical Supplies Prescribing Provider Order Form may be valid for a maximum of six months unless the physician or allowed practitioner indicates the duration of need is less. If the physician or allowed practitioner indicates the duration of need is less than six months, then a new Home Health Services (Title XIX) DME/Medical Supplies Prescribing Provider 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.

Procedure Codes									
Nebulizer Supplies/Equipment*									
E0570	E0575	E0580	S8101						
Incontinence Supplies**									
A4310	A4311	A4312	A4313	A4314	A4315	A4316	A4320	A4321	A4322
A4326	A4327	A4328	A4330	A4331	A4333	A4334	A4335	A4338	A4340
A4344	A4346	A4351	A4352	A4353	A4354	A4355	A4356	A4357	A4358
A4402	A4554	A5102	A5105	A5112	A5113	A5114	A5120	A5121	A5122
A5131	A5200								
Inhaler Equipment									
A4614	A4627								

*** Prior authorization is required for certain diagnoses and if limitations are exceeded. Refer to subsection 2.2.23.2, "Small Volume Nebulizers (SVN)" in this handbook.**

**** Prior authorization is required for some procedure codes if the maximum limitation is exceeded. Refer to subsection 2.2.15.9, "Incontinence Procedure Codes with Limitations" in this handbook.**

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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: "Section 8: Third Party Liability (TPL)" (*Vol. 1, General Information*).

Subsection 2.7, "Medicare Crossover Claim Reimbursement" in "Section 2: Texas Medicaid Fee-for-Service Reimbursement" (*Vol. 1, General Information*).

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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*).

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.

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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.

Subsection 6.6, "UB-04 CMS-1450 Paper Claim Filing Instructions" in "Section 6: Claims Filing" (*Vol. 1, General Information*).

Subsection 6.5, "CMS-1500 Paper Claim Filing Instructions" in "Section 6: Claims Filing" (*Vol. 1, General Information*) for instructions on completing paper claims.

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 §355.8023. 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 NPI 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.

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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/resources/rate-and-code-updates/rate-changes.

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 §355.8023. 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 subsection A.11, "Written Communication With TMHP" in "Appendix A: State, Federal, and TMHP Contact Information" (*Vol. 1, General Information*).

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3 Claims Resources

Refer to the following sections or forms when filing claims:

Resource	Location
Acronym Dictionary	"Appendix C: Acronym Dictionary" (*Vol. 1, General Information*)
Automated Inquiry System (AIS)	Subsection A.10, "TMHP Telephone and Fax Communication" in "Appendix A: State, Federal, and TMHP Contact Information" (*Vol. 1, General Information*)
CMS-1500 Paper Claim Filing Instructions	Subsection 6.5, "CMS-1500 Paper Claim Filing Instructions" in "Section 6: Claims Filing" (*Vol. 1, General Information*)
State, federal, and TMHP contact information	"Appendix A: State, Federal, and TMHP Contact Information" (*Vol. 1, General Information*)
TMHP electronic claims submission information	Subsection 6.2, "TMHP Electronic Claims Submission" in "Section 6: Claims Filing" (*Vol. 1, General Information*)
TMHP Electronic Data Interchange (EDI) information	"Section 3: TMHP Electronic Data Interchange (EDI)" (*Vol. 1, General Information*)
UB-04 CMS-1450 Paper Claim Filing Instructions	Subsection 6.6, "UB-04 CMS-1450 Paper Claim Filing Instructions" in "Section 6: Claims Filing" (*Vol. 1, General Information*)

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:

Forms
Addendum to Home Health Services (Title XIX) DME/Medical Supplies Prescribing Provider Order Form
CCP Prior Authorization Request Form
DME Certification and Receipt Form
External Insulin Pump Prior Authorization Form
Home Health Services (Title XIX) DME/Medical Supplies Prescribing Provider Order Form Instructions
Home Health Services (Title XIX) DME/Medical Supplies Prescribing Provider Order Form
Home Health Plan of Care (POC) Instructions
Home Health Plan of Care (POC)
Home Health Prior Authorization Checklist
Texas Medicaid Prior Authorization Request for CPAP or RAD (Bi-level PAP)

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Forms
Texas Medicaid Prior Authorization Request for Oxygen Therapy Devices and Supplies form
Texas Medicaid Prior Authorization Request for Secretion and Mucus Clearance Devices—Initial Request form
Texas Medicaid Prior Authorization Request for Secretion and Mucus Clearance Devices -Renewal Request form
Texas Medicaid Provider Surety Bond and Instructions
Wheelchair/Scooter/Stroller Seating Assessment Form (CCP/Home Health Services)
Wound Care Equipment and Supplies Order Form

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:

Claim Form Examples
Home Health Services DME/Medical Supplies

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