SERVICES AND LIMITATIONS

Durable medical Equipment (DME) is covered when medical necessity criteria are met for use as part of the medical care of a beneficiary. Equipment and supplies which are payable under Louisiana Medicaid require prior authorization (PA) by the Prior Authorization Unit (PAU). Refer to section 18.5 for more information on PA.

In compliance with the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) requirements, DME items, regardless of their inclusion in this manual or on the DME fee schedule, will be considered for beneficiaries under the age of 21 based on medical necessity. A provider may submit a PA request for beneficiaries under the age of 21 for items not specified in this manual or on the DME fee schedule.

Covered Services

The covered items and services include:

1. Durable medical equipment (DME);
2. Medical supplies;
3. Home dialysis supplies and equipment;
4. Therapeutic shoes;
5. Enteral nutrition, enteral/parenteral equipment and supplies;
6. Transfusion medicine; and
7. Prosthetic devices, prosthetics and orthotics.

NOTE: DME and supplies are not covered for residents in intermediate care facilities for individuals with intellectual disability (ICF/IID) and nursing facilities.

Durable Medical Equipment and Supplies

DME is furnished by a supplier or a home health agency and is equipment that meets the following criteria:

1. Can withstand repeated use;
2. Is primarily and customarily used to serve a **medical** purpose;
3. Generally is not useful to a beneficiary in the absence of an illness or injury; and
4. Is appropriate for use in the home.

Supplies, including but not limited to one-time use supplies, are also covered under the DME Program when medical necessity criteria are met for use as part of the medical care of a beneficiary.

Supplies must meet following criteria:

1. Is primarily and customarily used to serve a **medical** purpose;
2. Generally is not useful to a beneficiary in the absence of an illness or injury; and
3. Is appropriate for use in the home.

Providers of DME and supplies must obtain PA from the fiscal intermediary (FI).

Prosthetics and Orthotics

Louisiana Medicaid defines prosthetic and orthotics devices as leg, arm, back and neck braces, artificial legs, arms and eyes; including replacements, if required because of a change in the beneficiary's physical condition.

Providers of durable prosthetics and orthotics must obtain PA from the FI for all services. This requirement includes, but is not limited to, equipment that is rented, purchased, repaired or modified.

Service Limitations for Nursing Facilities and Intermediate Care Facilities

The Bureau of Health Services Financing (BHSF) has instructed the PAU to deny all requests for DME and supplies for beneficiaries residing in nursing facilities and ICF/IIDs. The sole exception pertains to prosthetic and orthotic services for residents of nursing facilities. Louisiana Medicaid **will only pay** DME providers for **prosthetic and orthotic devices** supplied to residents of nursing facilities. DME providers should bill Medicaid directly for these services. Payments for prosthetic and orthotic devices are included in the payment made to ICF/IID facilities.

Edits are in place to prevent payment on claims for beneficiaries who move into an ICF/IID or nursing facility after authorization for DME or supplies have been given, but prior to the delivery date.

Non-Covered DME Services and Items

A non-covered service, item or supply is not available for reimbursement. Listed below are items and services **not** reimbursed by Medicaid through the DME program:

1. Clinically unproven equipment;
2. Comfort or convenience equipment;
3. Dentures;
4. Disposable supplies customarily provided as part of a nursing or personal care service or a medical diagnostic or monitoring procedure;
5. Electric lifts (manual lifts are covered);
6. Emergency and non-emergency alert devices;
7. Environmental modifications (e.g. home, bathroom, ramps, etc.);
8. Equipment designed for use by a physician or trained medical personnel;
9. Experimental equipment;
10. Facilitated communications (FC);

11. Furniture and other items which do not serve a medical purpose;

12. Hand held showers;

13. Investigational equipment;

14. Items used for cosmetic purposes;

15. Personal comfort, convenience, or general sanitation items;

16. Physical fitness equipment;

17. Precautionary-type equipment (e.g. power generators, backup oxygen equipment provided outside of an official state and/or federally declared emergency);

18. Rehabilitation equipment;

19. Reimbursement for delivery or delivery mileage of medical supplies;

20. Routine and first aid items;

21. Safety alarms and alert systems/buttons;

22. Scooters;

23. Seat lifts and recliner lifts;

24. Standard car seats;

25. Supplies or equipment covered by Medicaid per diem rates (nursing home residents maybe approved for orthotics and prosthetics, but not for DME and supplies);

26. Televisions, telephones, video cassette recorder (VCR) machines and devices designed to produce music or provide entertainment;

27. Training equipment or self-help equipment;

28. Van lifts;

29. Wheelchair lifts; and

30. Wheelchair ramps.

NOTE: This list is not all inclusive.

If coverage is uncertain, the provider should contact the PAU prior to dispensing the item.

Purchase versus Rental

If equipment is needed temporarily, it may be more cost effective for Medicaid to pay for the rental expenses of the equipment. Consideration will be given to:

1. Length of time the equipment is needed;

2. Total rental cost for that period of time; and

3. Purchase price of the item. If the total cost of the rental exceeds the purchase price, the equipment will be purchased rather than rented.

NOTE: Rental reimbursement – The provider cannot charge for features on equipment not medically necessary by the beneficiary's condition.

Purchasing Guidelines – Equipment

Medicaid requires that all DME supplied to eligible beneficiaries must come with a warranty from the provider that lasts a minimum of one year. Providers who make or sell prosthetic or orthotic items must provide a warranty which lasts at least 90 days from the time the item is delivered to the beneficiary. If the item fails to work during those 90 days, the manufacturer or dealer must repair or replace the item. Medicaid does not reimburse for costs associated with replacement parts or repairs to the equipment.

Medicaid reimbursement includes:

1. All elements of the manufacturer's warranty;

2. All routine or special equipment servicing, to the extent the same servicing is provided to non-Medicaid persons;

3. All adjustments and modifications needed to make the item safe, useful and functional for the beneficiary during the entire first year (including customized wheelchairs);

4. Delivery, set-up and installation of the DME by trained and qualified provider staff, in the area of the home where the equipment will be used or the appropriate room within the home;

5. Adequate training and instruction provided to the beneficiary or the beneficiary's responsible caregiver by the provider's trained and qualified staff, in a language understood by the beneficiary or caregiver regarding the manufacturer's recommendations for the safe, sanitary, effective, and appropriate use of the item; and

6. Honoring the required one-year provider warranty for all requests or prescriptions requesting equipment repair made on or before the 366th day of service.

Providers cannot disregard a beneficiary's requests for warranty equipment repairs or modifications and may not delay needed repairs or modifications, otherwise permitted by DME policy, until the provider's or manufacturer's warranty has expired.

Provider Responsibilities – Rental Equipment

When rental equipment is furnished to a beneficiary the provider must:

1. Ensure and maintain documentation on file that the equipment is routinely serviced and maintained by qualified provider staff, as recommended by the product manufacturer;

2. Repair, or replace all expendable parts or items, such as masks, hoses, tubing and connectors, and accessory items necessary for the effective and safe operation of the equipment;

3. Substitute similar equipment at no additional cost to Medicaid if the equipment becomes broken because of normal use while the original rental equipment is being repaired;

4. Replace equipment that is beyond repair at no additional charge and maintain documentation of the replacement;

5. Maintain documentation that is signed and dated by both the provider and the beneficiary or beneficiary's responsible caregiver at the time of delivery, which attests to the fact that instruction has been provided by trained and qualified provider staff to the beneficiary or caregiver regarding the beneficiary's or caregiver's responsibility for cleaning the equipment and performing the general maintenance on the equipment, as recommended by the manufacturer; and

6. Maintain documentation that is signed and dated by both the provider and the beneficiary or beneficiary's responsible caregiver, which attests that the beneficiary or the caregiver was provided with the manufacturer instructions, servicing manuals, and operating guides needed for the routine service and operation of the specific type or model of equipment provided.

Limitations for Replacement of Equipment

Medicaid will **not** replace equipment that is lost, destroyed or damaged as a result of misuse, abuse, neglect, loss, or wrongful disposition of equipment by the beneficiary, the beneficiary's caregiver(s), or the provider. At a minimum, examples of equipment misuse, abuse, neglect, loss or wrongful disposition by the beneficiary, the beneficiary's caregiver, or the provider include, but are not limited to the following:

1. Failure to clean and maintain the equipment as recommended by the equipment manufacturer;

2. Failure to store the equipment in a secure and covered area when not in use; and

3. Loss, destruction or damage to the equipment caused by the malicious, intentional or negligent acts of the beneficiary, the beneficiary's caregiver, or the provider.

If equipment is stolen or destroyed in a fire, the provider must obtain, in a timely manner, a completed police or insurance report that describes the specific medical equipment that was stolen or destroyed. The police or insurance report must be submitted with the new PA request.

Medicaid may replace equipment when the beneficiary's medical necessity changes. The provider must submit the documentation required to justify the purchase of the replacement equipment.

Equipment Maintenance and Repair

Medicaid will reimburse for the maintenance and repair of equipment only when the following conditions are met:

1. Equipment is covered by Medicaid;
2. Equipment is the personal property of the beneficiary;
3. Item is still medically necessary;
4. Equipment is used exclusively by the beneficiary;
5. No other payment source is available to pay for the needed repairs;
6. Equipment damage is not due to misuse, abuse, neglect, loss or wrongful disposition by the beneficiary, the beneficiary's caregiver, or the provider (see examples of misuse, abuse, neglect, loss or wrongful disposition under "Limitations for Replacement of Equipment" above);
7. Equipment maintenance is performed by a qualified technician;
8. Maintenance is not currently covered under a manufacturer's or provider's warranty agreement; and
9. Maintenance is not performed on a duplicate type of item already being maintained for the beneficiary during the maximum limit period.

NOTE: Refer to Section 18.2 of this chapter for specific coverage criteria.