



**Medicaid Enterprise**

Iowa Department of Human Services

**Medical Equipment and  
Supply Dealer  
Provider Manual**

 Medicaid Enterprise Department of Human Services	Provider	Page
	<b>Medical Equipment and Supply Dealer</b>	1
		Date
		December 1, 2008

## TABLE OF CONTENTS

[Chapter I. General Program Policies](#)

[Chapter II. Member Eligibility](#)

[Chapter III. Provider-Specific Policies](#)

[Appendix](#)



**Medicaid Enterprise**

Iowa Department of Human Services

## **III. Provider-Specific Policies**



## TABLE OF CONTENTS

Page

<b>CHAPTER III. PROVIDER-SPECIFIC POLICIES</b> .....	<b>1</b>
A. DEALERS ELIGIBLE TO PARTICIPATE .....	1
B. COVERAGE OF SERVICES.....	1
1. Medically Necessary Services.....	1
2. Prior Authorization .....	2
a. Procedure for Requesting Authorization.....	3
b. Instructions for Completing Prior Authorization Request .....	4
c. Attachments for Electronic Requests.....	6
3. Durable Medical Equipment .....	7
a. Rental Equipment .....	7
b. Used Equipment .....	8
c. Repair and Replacement .....	9
d. Automated Medication Dispensers (A9280).....	10
e. Bath Equipment.....	11
f. Bed Pans and Urinals .....	11
g. Beds and Accessories .....	11
h. Bilirubin Lights* .....	14
i. Blood Pressure Monitors*.....	14
j. Canes .....	14
k. Chairs, Seat Lifts* .....	15
l. Commodes and Accessories .....	16
m. Crutches .....	16
n. Decubitus and Wound Care Equipment .....	16
o. Dialysis Equipment .....	18
p. Enuresis Alarm Systems (S8270)* .....	18
q. Hand-Held Inhaler Accessories.....	18
r. Heating Equipment .....	19
s. Helmets*.....	19
t. Infusion Pumps .....	19
u. Monitor Equipment* .....	20
v. Neuromuscular Stimulators and Supplies .....	21
w. Osteogenesis Stimulators.....	21
x. Oxygen .....	22
y. Patient Lifts .....	25
z. Peak Flow Meters.....	25
aa. Pneumatic Appliances and Accessories.....	25



	<u>Page</u>
bb. Respiratory Equipment and Accessories .....	26
cc. Standers .....	27
dd. Suction Machines.....	28
ee. Transcutaneous electrical nerve stimulators (TENS).....	28
ff. Thermometers* .....	28
gg. Traction Equipment and Accessories.....	28
hh. Urinary Collection Devices and Accessories.....	28
ii. Walkers.....	29
jj. Wheelchairs and Scooters .....	29
4. Prosthetic Devices.....	31
a. Augmentative Communication Systems .....	31
b. Nutritional Products and Supplies.....	33
c. Orthopedic Shoes*, Therapeutic Shoes for Diabetics, Accessories, and Modifications .....	36
d. Orthotic Devices .....	39
e. Prosthetics.....	40
5. Medical Supplies .....	41
a. Diabetic Equipment and Supplies .....	41
b. Diapers and Disposable Underpads* .....	43
c. Dressings and Surgical Supplies.....	45
d. Enema Supplies.....	45
e. Family Planning* .....	45
f. Hearing Aid Batteries* .....	45
g. Irrigation Solutions .....	46
h. IV Supplies .....	46
i. Ostomy Supplies and Accessories.....	46
j. Support Stockings* .....	46
6. Services to Members in a Medical Facility .....	46
C. BASIS OF PAYMENT FOR SERVICES.....	48
D. PROCEDURE CODES AND NOMENCLATURE .....	48
1. Modifiers .....	49
2. Local Codes .....	49
E. CLAIM FORM AND INSTRUCTIONS .....	49
1. Instructions for Completing the CMS-1500 Claim Form.....	49
2. Claim Attachment Control, Form 470-3969 .....	57
F. REMITTANCE ADVICE AND FIELD DESCRIPTIONS .....	58
1. Remittance Advice Explanation .....	58
2. Remittance Advice Samples and Field Descriptions .....	59



## CHAPTER III. PROVIDER-SPECIFIC POLICIES

### A. DEALERS ELIGIBLE TO PARTICIPATE

All dealers of durable medical equipment, supplies, and prosthetic devices in Iowa or in other states are eligible to participate in the Iowa Medicaid Program.

### B. COVERAGE OF SERVICES

Payment is made for items of durable medical equipment, supplies, and prosthetic devices subject to the following requirements. Unless otherwise stated, Medicaid follows Medicare coverage criteria. An **asterisk (\*)** identifies those items where Medicaid criteria are different.

#### 1. Medically Necessary Services

Durable medical equipment, supplies, and prosthetic devices must be required by the member because of the member's medical condition. The item shall be necessary and reasonable, as determined by Iowa Medical Enterprise (IME) medical staff.

An item is **necessary** when it can be expected to make a meaningful contribution to the treatment of a specific illness or injury or to the improvement in function of a malformed body member.

A prescription from a physician (doctor of medicine, osteopathy, or podiatry) physician assistant or advanced registered nurse practitioner is required to establish medical necessity. The prescription shall state the **diagnosis, prognosis, and length** of time the item is to be required.

Although an item may be necessary, it must also be a **reasonable** expenditure for the Medicaid program. The following considerations enter into the determination of reasonableness:

- ◆ Whether the expense of the item is clearly disproportionate to the therapeutic benefits which could ordinarily be derived from its use;
- ◆ Whether the item is substantially more costly than a medically appropriate and realistically feasible alternative plan of care; and
- ◆ Whether the item serves essentially the same purpose as an item already available to the member.



**Nonmedical** items are **not** covered. These include, but are not limited to:

- ◆ Physical fitness equipment, such as exercise bikes or weights.
- ◆ First-aid or precautionary equipment, such as preset portable oxygen units.
- ◆ Self-help devices, such as safety grab bars, raised toilet seats, shower benches, or transfer boards.
- ◆ Training equipment, such as speech-teaching machines or Braille-training texts.
- ◆ Equipment that basically serves functions of comfort or convenience or that is primarily for the convenience of a person caring for the member, such as elevators, stairway elevators, ramps, and posture chairs.
- ◆ Equipment used for environmental control or to enhance the environmental setting, such as room heaters, air conditioners, humidifiers, dehumidifiers, and electric air cleaners.
- ◆ Convenience items, such as breast pumps, eating utensils, or sharp disposal containers.

## 2. Prior Authorization

When Medicaid **requires** an item or service to have prior authorization, providers must also submit a request for prior authorization to Medicaid before billing. Prior authorization is required for the following items:

- ◆ Augmentative communication systems (speech-generating devices)
- ◆ Automated medication dispensers
- ◆ Enclosed beds
- ◆ Enteral products, feeding pumps, and supplies
- ◆ External insulin infusion pumps
- ◆ Oral nutritional products
- ◆ Vest airway clearance systems

Some medical equipment items, services, and supplies are the responsibility of health maintenance organizations (HMOs). When a member is enrolled in an HMO, contact the HMO before requesting a prior authorization from IME. Prior authorization by IME does not override the fact that the item or service is the responsibility of the HMO.



NOTE: With the exception of items listed in [Services to Members in a Medical Facility](#), medical equipment is not separately payable for members in nursing facilities. Prior authorization does not override this policy.

**a. Procedure for Requesting Authorization**

For items requiring prior authorization, make the request on form 470-0829, *Request for Prior Authorization*. To view a sample of this form on line, click [here](#). You may also submit this form if you are unsure whether an item meets coverage criteria. See [Instructions for Completing Prior Authorization Request](#).

Include a practitioner's written order or prescription and sufficient medical documentation (certificate of medical necessity, manufacturer's invoice, physical therapy evaluation, etc.) to permit an independent conclusion that:

- ◆ The requirements for the equipment or device are met, and
- ◆ The item is medically necessary and reasonable.

The IME Medical Services Unit will review the request and make a determination of coverage. When a determination has been made, the form will be returned to you.

If the service is approved for coverage, you may then submit your claim for reimbursement. Place the prior authorization number in the appropriate location on your claim form. (Consult the claim form instructions.) Using this number, IME will verify that the service has been approved for payment. **Important:** Do not return the prior authorization form.

Remember, Medicaid is the payer of last resort. You are responsible for determining whether the member is on Medicare or has other insurance. Providers must bill Medicare and other third-party insurance before submitting claims to Medicaid.

Prior authorization is not a guarantee of payment. Approval of a request does not indicate that the member continues to be eligible for Medicaid. You are responsible for verifying Medicaid eligibility for the dates of service.



You can verify eligibility by checking the Eligibility Verification System (ELVS) hotline, which is available 24 hours a day, 7 days a week at phone 1-800-338-7752 (323-9639 in the Des Moines area), or by accessing the IME Provider Web Portal Services at:  
<http://www.ime.state.ia.us/Providers/index.html>.

**b. Instructions for Completing Prior Authorization Request**

1. **Patient Name:** Complete the last name, first name, and middle initial of the patient. Use the *Medical Assistance Eligibility Card* for verification.
2. **Patient Medicaid Identification Number:** Copy this number directly from the *Medical Assistance Eligibility Card*. This number must be eight positions in length (seven digits and one letter).
3. **Date of Birth:** Copy the member's date of birth directly from the *Medical Assistance Eligibility Card*. Use two digits for each: month, day, year (MM, DD, YY).
4. **Provider Taxonomy No.:** Enter the [taxonomy number](#) used in your Medicaid agreement.
5. **Provider Phone No.:** This area is optional. Completing it may expedite the processing of your *Request for Prior Authorization*.
6. **Provider Fax:** This area is optional. Completing it may expedite the processing of your *Request for Prior Authorization*.
7. **Provider NPI:** Enter the ten-digit [national provider identifier](#) of the dispensing provider.
8. **Dates Covered by Request:** Enter the appropriate date span. Be sure to include the date of service. Complete this item using two digits for each: month, day, year (MM, DD, YY). If this request is approved, it will be valid only for this period.
9. **Dispensing Provider Name:** Enter the name of the provider that will provide and submit claims for the services.
10. **Service Location Street Address:** Enter the street address of the dispensing provider requesting prior authorization.



- 11. **Service Location City, State, Zip:** Enter the city, state, and ZIP code of the dispensing provider requesting prior authorization.
- 12. **Prior Authorization No.:** Leave blank. The Iowa Medicaid Enterprise will assign a number if the service is approved. You will then place this number in the appropriate area on the claim form.
- 13. **Reason for Request:** Provide the required information for the type of approval being requested in this area along with the "Services to Be Authorized" area.

Refer to the coverage sections of this manual. Include all items identified as required treatment plan information. For enteral products, enter a short description of the reason for the request.

**SERVICES TO BE AUTHORIZED:**

- 14. **Line No.:** No entry is required.
- 15. **Procedure, Supply, Drug to be Provided or NDC if applicable:** Enter the description of the service or services to be authorized. For enteral products, enter the product name and NDC number.
- 16. **Code, HCPS, CPT or CDT:** Enter the appropriate code. For prescription drugs, enter the appropriate NDC. For other services or supplies, enter the proper HCPCS code.
- 17. **Units of Service:** Complete with the amount or number of times the service is to be performed. For enteral products, enter the number of cans or packets dispensed for the time span requested.
- 18. **Authorized Units:** Leave blank. The IME will indicate the number of authorized units.
- 19. **Amount Requested:** Enter the amount that will be charged for this line item.
- 20. **Authorized Amount:** Leave blank. The IME will indicate the authorized amount or indicate that payment will be based on the fee schedule or maximum fee depending on the service provided.



21. **Status:** Leave blank. The IME will indicate "A" for approved or "D" for denied.
22. **IMPORTANT NOTE:** This is information to the benefit of the provider completing this form. Please read this carefully. This section explains that the prior authorization request is approved from the standpoint of medical necessity only. The provider continues to be responsible to establish the member's eligibility at the time of service. Directions are included on how to access this information.
23. **Requesting Provider:** Enter the signature of the provider or authorized representative requesting prior authorization and indicate the date the request was signed.

**PRIOR AUTHORIZATION REVIEWER USE ONLY**

24. **Medicaid services are hereby:** Do not complete. The IME will complete this item after evaluating the request.
25. **Comments or Reason for Denial of Services:** Do not complete. The IME will complete this section if this request is denied.
26. **Signature:** Do not complete. The IME staff making the final decision on this request will sign and date.

**c. Attachments for Electronic Requests**

Under the Health Insurance Portability and Accountability Act, there is an electronic transaction for prior authorization requests (278 transaction).

However, there is no standard to use in submitting additional documentation electronically. Therefore, if you want to submit a prior authorization request electronically, the additional documentation must be submitted on paper using the following procedure:

- ◆ **Complete** form 470-3970, *Prior Authorization Attachment Control*. To view a sample of this form on line, click [here](#).

Complete the "attachment control number" with the same number submitted on the electronic prior authorization request. IME will accept up to 20 characters (letters or digits) in this field. If you do not know the attachment control number for the request, contact the person in your office responsible for electronic claims billing.



- ◆ **Staple** the additional information to the *Prior Authorization Attachment Control*.
- ◆ **Fax** the form with attachments to the Prior Authorization Unit at 800-574-2515 **or mail** the information to:

IME Medical Services Unit  
P.O. Box 36478  
Des Moines, Iowa 50319

Once the IME receives the paper attachment, it will manually be matched up to the electronic prior authorization using the attachment control number and then processed.

### 3. Durable Medical Equipment

Durable medical equipment (DME) is equipment that:

- ◆ Can withstand repeated use,
- ◆ Is appropriate for use in the home.
- ◆ Is primarily and customarily used to serve a medical purpose, and
- ◆ Is generally not useful to a person in the absence of an illness or injury.

All elements of this definition of durable medical equipment must be satisfied in order for the equipment to be covered under Medicaid. Durable medical equipment is not provided in a hospital, nursing facility, or intermediate care facility for the mentally retarded.

#### a. Rental Equipment

Consideration is given to rental or purchase based on the price of the item and the length of time it would be required. IME shall make the decision on rental or purchase based on the most reasonable method to provide the equipment.

EXCEPTION: Ventilators, apnea monitors, enteral feeding pumps, bilirubin lights, wound vac, and oxygen systems are maintained on a rental basis for the duration of use.

Bill rental equipment monthly with a monthly date span and one unit of service. EXCEPTION: Wound vacs, drug infusion pumps, and oxygen in nursing facilities should be billed on a daily basis with 1 unit = 1 day. All supplies and accessories are included in the fee for rental and cannot be billed separately.



If the member has a permanent or long-term diagnosis for which equipment is provided, the item should be billed as purchased and not rented on a monthly basis.

When the length of need for equipment is undetermined, the equipment may be rented up to 150% of the purchase allowance.

At the point that total rent paid equals 150% of the purchase allowance, the member is considered to own the item, and no further rental payments are made. It is your responsibility to track the number of rental payments and discontinue billing beyond the 150% point.

Payment may be made for the purchase of an item even though rental payments may have been made for prior months. It may be necessary to rent the item for a time to establish that it meets the identified need before the purchase.

When a decision is made to purchase after renting an item, the **full** rental allowance is applied to the purchase allowance.

#### **b. Used Equipment**

Consider used equipment when it can meet the needs of the member. "Used equipment" is any equipment that has been purchased or rented by another party before the current purchase or rental transaction. Payment is 80% of the purchase allowance.

To supply used equipment, you must:

- ◆ Offer the member the same warranty that is offered to buyers of new equipment with regard to the equipment's functional capabilities,
- ◆ Certify that the used equipment has been reconditioned as necessary and is in good working order, and
- ◆ Certify that the reasonable service and repair expenses will not exceed those for comparable new equipment.

If a procedure code for used equipment is listed, use the available code. If there is no code listed for the used item, give a complete description of the item, stating that the equipment is used. Add modifier "UE" to the procedure code to designate used equipment.



**c. Repair and Replacement**

Payment is made for necessary repair, maintenance, and supplies for member-owned equipment, including members who are in a nursing facility.

“Repair and maintenance” includes replacement of whole components, parts, or systems, such as seating systems that are worn out or broken and cannot otherwise be repaired, as long as the cost does not exceed 2/3 the cost of a new item. The age of the item and history of repairs are considered in determining whether to repair or replace an item.

Replacement of member-owned equipment, components, parts, or systems due to a change in size or condition of the member is not allowed for members in nursing facilities.

No payment is made for repairs covered under warranty. No payment is made for repairs, maintenance, or supplies when the member is renting the item. EXCEPTION: Rental of medical equipment while member-owned equipment is being repaired is a payable service. Procedure code K0462, temporary replacement for member owned equipment being repaired should be billed. One unit equals one day.

Labor is paid in addition to repairs or nonroutine service for member-owned equipment, orthotics, and prosthetics when the skill of a technician is required. 15 minutes = 1 unit of repair service.

Replacement of member-owned equipment is covered in cases of loss or irreparable damage or when required because of a change in the member’s condition. Loss of expensive items, such as power wheelchairs, must be reported to the police and any third-party insurance coverage.

Replacement of member-owned equipment is considered acceptable when repair parts would exceed 2/3 of the cost of new equipment.

Replacement equipment must be supported by the prescription of the physician and documentation supporting the medical necessity for the member to have the equipment.



Due to the potential for changes in the member's health conditions over time, mobility equipment provided as a replacement must be the appropriate form of mobility for the member at the time it is lost, damaged beyond repair, or outgrown.

If the replacement equipment is a manual wheelchair, power wheelchair, or POV and it has been six months or more since Medicaid provided payment for the equipment, the member must have a mobility re-evaluation.

**d. Automated Medication Dispensers (A9280)**

Prior authorization is required for automated medication dispensers. Approval will be granted when prescribed for members who meet **all** of the following conditions:

- ◆ The member is taking two or more medications prescribed more than once per day.
- ◆ The availability of a caregiver is limited or non-existent.
- ◆ The member has a diagnosis indicating cognitive impairment or age-related factors that affect the ability to remember to take medications.
- ◆ Less costly alternatives such as medisets and telephone reminders have failed.

**Telephone monitoring (S5185)** service may be allowed when:

- ◆ The medications prescribed and the member's condition necessitate that the medication be taken at a certain time to avoid complications, and
- ◆ The member lives alone or others living in the member's home are unable to provide assistance, and
- ◆ The member has no other services coming into the home or the frequency is insufficient.



**e. Bath Equipment**

Bath chairs and bath accessories are **not** covered.

**Shower commode chairs\*** (roll-about chairs, procedure code E1031) are covered for rental and purchase when a member's medical condition requires special positioning in a tub or shower. (Coverage differs from Medicare.)

**Whirlpool units** (both portable and nonportable) are covered if the member:

- ◆ Is homebound,
- ◆ Cannot receive physical therapy on an outpatient basis, and
- ◆ Has a condition for which the whirlpool bath can be expected to provide therapeutic benefit justifying the cost.

When the member is not homebound but has such a condition, payment is restricted to the cost of providing the services elsewhere, e.g., an outpatient department of a participating hospital, if that alternative is less costly.

Whirlpool pumps are included in the cost of the unit and are not payable separately.

**f. Bed Pans and Urinals**

Bedpans and urinals are covered when prescribed for a member who is bed-confined.

**g. Beds and Accessories**

Hospital beds and mattresses are covered when prescribed for a member:

- ◆ Who is bed-confined, or
- ◆ Whose condition:
  - Necessitates positioning the body in a way that is not feasible in an ordinary bed, or
  - Requires attachments that could not be used on an ordinary bed.



**Variable height hi-lo hospital beds** are covered when additional documentation shows a medical condition that necessitates the variable height feature.

**Semi-electric hospital beds** are covered when additional documentation shows that all of the following conditions are met:

- ◆ An immediate change in position is necessary to avert a life-threatening situation, *and*
- ◆ The change cannot be accomplished by the use of the bed side rails, trapeze, or the assistance of a caregiver, *and*
- ◆ The member is alert *and* capable of effecting this change by operating the controls in a safe manner, *and*
- ◆ Documentation shows the medical condition that necessitates the electric variable height feature.

The semi-electric feature is not reimbursable when it is used for the convenience of the caregiver.

**Total electric hospital beds\*** are covered if the medical need for a semi-electric bed is met **and** the need for height adjustment is required to meet the member's desire to remain independent in transfers. Electric beds are **not** covered to assist the caregiver.

**Enclosed beds\*** require prior authorization and are covered when all of the following conditions are met:

- ◆ There is a diagnosis-related cognitive or communication impairment such as traumatic brain injury, cerebral palsy, seizure disorder, developmental delay with cognitive impairment, or severe behavioral disorder that results in risk for safety, *and*
- ◆ There is evidence of mobility that puts the member at risk for injury.
- ◆ The documentation submitted supports that the bed request is appropriate to meet the member's needs



The following documentation must be submitted with the request for prior authorization:

- ◆ Prescription from the practitioner that includes a diagnosis.
- ◆ Documentation (more than just a statement) that details cognitive or communication impairment.
- ◆ Evidence of risk for injury due to mobility, such as climbing out of bed (more than just standing at the side of the bed).
- ◆ Documentation that less costly alternatives have been tried and were unsuccessful, or are contraindicated. Less costly alternatives may include putting a mattress on the floor, padding added to regular and hospital beds, lining of cribs, medications, helmets.
- ◆ When the bed will be used, what the time periods in bed are, and how the member will be monitored.
- ◆ Identification by relationship of all caregivers providing care to the member.
- ◆ Documentation of the sleep/wake pattern and response to awakening.
- ◆ For members with a behavior disorder, a copy of the behavioral management plan. (Coverage differs from Medicare.)
- ◆ A plan for random and ongoing reviews that ensures appropriate utilization of the bed.



**Mattresses** are covered when medically necessary. Mattresses cannot be billed separately with a hospital bed.

**Bed side rails\*** are covered when prescribed for a member who is bed-confined or disoriented. Side rails cannot be billed separately **in addition to** a hospital bed. (Coverage differs from Medicare.)

**Fracture frames** are covered when the member has an orthopedic impairment requiring traction equipment that prevents ambulation.

**Trapeze bars and accessories** are covered when prescribed for a member who is bed-confined and has a need to sit up because of a respiratory condition or a need to change body position for specified medical reasons, or to get in and out of bed.

**Used hospital beds** are covered according to the same criteria as new hospital beds. Use the UE modifier on the applicable code.

**h. Bilirubin Lights\***

A phototherapy (bilirubin) light with photometer is covered for home use when prescribed for short-term treatment of hyperbilirubinemia and this is the only reason hospitalization or frequent outpatient treatment would be required. For daily rental, 1 unit = 1 day, and supplies are included. (Coverage differs from Medicare.)


**i. Blood Pressure Monitors\***

Blood pressure monitors are covered when ordered for a condition or disease that warrants in-home monitoring daily to weekly and recording with review by the physician on a regular basis. Examples include polycystic renal disease, renal failure, cardiac defects, and medications that create hypertension or hypotension.

Monitors are also covered when prescribed for any member who has end-stage renal disease and the equipment is appropriate for home use. (Coverage differs from Medicare.)

**j. Canes**

Canes are covered when prescribed for a member whose condition impairs ambulation. White canes for the blind are **not** covered.

 Medicaid Enterprise Department of Human Services	Provider and Chapter <b>Medical Equipment and Supply Dealer</b> Chapter III. Provider-Specific Policies	Page 15
		Date May 1, 2010

**k. Chairs, Seat Lifts\***

Prior authorization is not required for seat lift chairs. A combination lift chair and mechanism is covered when:

- ◆ The chair is prescribed for a member with severe arthritis of the hip or knee, muscular dystrophy, or other neuromuscular disease, *and*
- ◆ The member can benefit therapeutically from use of the device, *and*
- ◆ The alternative would be chair or bed confinement, *and*
- ◆ A caregiver is not available to provide assistance as needed, *and*
- ◆ The member is completely incapable of standing up from a regular armchair or any chair in the member's home.
- ◆ The member can ambulate household distances in order to perform activities of daily living. Seat lift chairs are not covered for members who require a wheelchair in order to perform activities of daily living.

Lifts that have a spring-release mechanism with a sudden catapult-like motion are **excluded** from coverage.

When the mechanism is covered by Medicare, bill procedure code W0359 for the chair to Medicaid After Medicare has paid the claim for the mechanism, (E0627). The Medicare EOB and documentation of medical necessity are not required with the Medicaid claim when Medicare has paid for the mechanism.

For members who do not have Medicare coverage, bill procedure code E0627 to Medicaid with the documentation listed above. Do not bill E0627 to Medicaid for Medicare members. Documentation submitted with the claims must include:

- ◆ A completed [Form CMS-849](#), *Certificate of Medical Necessity—Seat Lift Mechanisms*.
- ◆ A physical therapy, occupational therapy, or physician evaluation, if there is any question regarding the member's ability to ambulate or rise from any chair in the home. Example: Member owns a wheelchair paid by Medicaid.



## I. **Commodes and Accessories**

Commodes and accessories are covered if the member is confined to bed or room (meaning that the member's condition is such that leaving the room is medically contraindicated). The accessibility of toilet facilities generally is not a factor. However, confinement to the member's home may be equated to room confinement when the home has no toilet facilities.

Payment may also be made if a member's medical condition confines the member to a specific floor of the member's home and there is no bathroom located on that floor.

**Extra wide commodes** are covered when the member's weight is more than 300 pounds or the width of a standard commode is not adequate.

## m. **Crutches**

All types of crutches are covered when prescribed for a member whose condition impairs ambulation.

Replacement items are payable for member-owned equipment only.

## n. **Decubitus and Wound Care Equipment**

Decubitus and wound care equipment are covered when prescribed for a member who is highly susceptible to decubitus ulcers. The prescribing physician must supervise its use in connection with the course of treatment.

**Wound vac systems** (negative pressure wound therapy)\* are covered for home use when one of the following conditions exist:

- ◆ There is a chronic, non-healing wound or ulcer with lack of healing for at least the previous 30 days despite standard wound therapy. The therapy is to include the application of moist topical dressings, debridement, and the maintenance of adequate nutritional status. In addition, the wound has been measured (length, width, and depth) and evaluated on a weekly basis to document no change.
- ◆ There is a traumatic or surgical wound that is in need of accelerated formation of granulation tissue (exposed bone, tendons, vessels, etc.) and the member has co-morbidities (diabetes mellitus, vascular disease, etc.) that will not allow the normal healing process.



Wound vac systems are not covered under the following conditions.  
(This list may not be all-inclusive.)

- ◆ A medical professional is not supervising, measuring, or assessing the wound or ulcer.
- ◆ Wound healing has progressed to the point where the wound vac is no longer necessary.
- ◆ The depth of the wound is 1 cm or less.
- ◆ The member cannot tolerate the use of the wound vac.
- ◆ Necrotic tissue is present in the wound.
- ◆ There is active bleeding in the wound or current anticoagulant therapy.
- ◆ The dimensions of the wound have not significantly changed from one monthly evaluation to the next.
- ◆ The member is noncompliant.

“Chronic wounds” are defined as wounds that have gone through the repair process without producing satisfactory anatomic and functional integrity. Chronic wounds could include

- ◆ Pressure ulcers
- ◆ Venous ulcers
- ◆ Diabetic ulcers
- ◆ Surgical and traumatic wounds
- ◆ Any other wound where the healing process is compromised.

For purposes of this policy, “medical professional” may be a physician, physician’s assistant, registered nurse (RN or ARNP), licensed practical nurse, or physical therapist. The medical professional is responsible for evaluation and management of the therapy that includes:

- ◆ Initial evaluation,
- ◆ Ongoing assessment, and
- ◆ Continuous monitoring to support the continuation of the therapy.

Documentation after the first month must show wound measurements of the month before and current wound measurements.

Payment is on a rental basis only. One unit = one day. A prior authorization is recommended but is not required.



**o. Dialysis Equipment**

Dialysis equipment and supplies are covered when prescribed for a member who has end-stage renal disease and the equipment is appropriate for home use.

**Dialysis water-purification systems** are covered when prescribed and necessary to render water used for dialysis chemically and organically safe.

**Deionizer water-purification systems** are covered when prescribed and necessary to soften water entering a reverse-osmosis unit when the quality of water is less than that required for the unit's proper functioning. The softener need not be built into the reverse-osmosis unit but must be an integral part of the dialysis system.

See also [Blood Pressure Monitors](#).

**p. Enuresis Alarm Systems (S8270)\***

Bed wetting alarm devices are covered when:

- ◆ The member is five years of age or older, and
- ◆ The member has experienced bed-wetting an average of three nights per week for the last three months, and
- ◆ The member has no daytime wetting, and
- ◆ Urinary tract infection, endocrine problems, neurological dysfunction, anatomic abnormalities, etc. and psychological stressors have been ruled out, and
- ◆ A licensed health care provider has prescribed the device.

**q. Hand-Held Inhaler Accessories**

Spacer units (inspirease, aerochamber) with and without masks are covered. A replacement mouthpiece is covered.



r. **Heating Equipment**

**Heat lamps** are covered when the member's medical condition is one for which the application of heat in the form of a heat lamp is therapeutically effective. The heat lamp cannot duplicate equipment or resources already available to the member (i.e., sunlight and warm moist heat).

**Electric heat pads** are covered when the member's medical condition is one for which the application of heat in the form of a heating pad is therapeutically effective and other means of applying heat are not appropriate. Information submitted must indicate why other resources cannot be used.

s. **Helmets\***

Protective helmets are covered when documentation indicates:

- ◆ The member is prone to seizures, or
- ◆ The member is prone to falling due to a neurological or neuromuscular disorder.

t. **Infusion Pumps**

**Ambulatory infusion pumps and supplies\*** are covered when prescribed for iron poisoning, chemotherapy, morphine for intractable pain, or antibiotic therapy. The documentation must indicate:

- ◆ The drug being infused
- ◆ The number of days used
- ◆ The medical justification for use of a pump versus gravity infusion

1 unit = 1 day. (Coverage differs from Medicare)

**IV poles** are covered on a rental basis short term and purchased long term.



**u. Monitor Equipment\***

**Apnea monitors** are rental only and are covered when prescribed for:

- ◆ Infants under one year of age with tracheotomies
- ◆ Children up to two years of age with bronchopulmonary dysplasia who:
  - Have a tracheotomy;
  - Require supplemental oxygen, continuously or for a specific activity such as feeding; and
  - Would require prolongation of their hospitalization (for monitoring) if home monitoring were unavailable.
- ◆ Young children past the age of one with:
  - Documentation that indicates a sibling died of SIDS between the ages of one and two, and
  - Signed physician documentation indicating:
    - The medical necessity, and
    - The date of interpretation of the last abnormal pneumogram within the previous six months.
- ◆ Infants who are considered high risk for sudden infant death syndrome (SIDS) with:
  - Documentation of the date of the last apneic episode or the date and results of the last pneumogram.
  - A statement from the physician indicating the medical necessity to continue monitoring.

Apnea monitor **installation** is covered one time only when:

- ◆ The dealer goes into the home to set up the monitor, and
- ◆ Instructs the family in its use, and
- ◆ It is the practice of the dealer to make such a charge to the general public.



One pair of electrodes and one pair of lead wires are allowed per month for the apnea monitor. Identify the items and quantity of each in the description box on the claim form.

Rental of **pneumogram equipment** for testing is included in the fee for circadian respiratory pattern recording, 12 to 24 hours when a home pneumoradiogram is performed. Procedure code 94662-TC should be billed and includes the technician fee as well as rental of the equipment.

**v. Neuromuscular Stimulators and Supplies**

Neuromuscular stimulators and supplies are covered for scoliosis.

**w. Osteogenesis Stimulators**

Nonspinal osteogenesis stimulators (E0747) are covered for the following indications:

- ◆ Nonunion of long-bone fractures. Nonunion is considered to exist only after three or more months have elapsed without healing of the fracture.
- ◆ Failed fusion exists after nine months or more.
- ◆ Congenital pseudoarthroses.

Spinal osteogenesis stimulators (E0748) are covered for the following indications:

- ◆ Failed spinal fusion where a minimum of nine months has elapsed since surgery
- ◆ Following a multilevel spinal fusion surgery
- ◆ Following spinal fusion surgery where there is a history of a previously failed spinal fusion at the same site

Ultrasonic osteogenesis stimulators (E0760) are covered when all of the following conditions are met:

- ◆ Nonunion of a fracture, and
- ◆ The fracture is other than the skull or vertebrae, and
- ◆ The fracture is not tumor-related.



## x. Oxygen

Medicaid coverage of home oxygen and oxygen equipment under the durable medical equipment benefit is considered reasonable and necessary only for members with significant hypoxemia, as defined by Medicare, shown by medical documentation of the member's existing health condition.

When random post payment review fails to support significant hypoxemia, the overpayment will be recouped.

Oxygen is payable when ordered in writing by a physician (MD or DO). Claims for oxygen services must be supported by documentation from a physician who has recently examined the member (normally within a month or two of the start of therapy).

The physician's prescription shall document that other forms of treatment have been tried and have not been successful, and that oxygen therapy is required. This documentation must be updated annually, kept on file, and made available to IME upon request. EXCEPTION : When the medical condition and physician prescription indicate lifetime use, an annual update is not required.

To identify the medical necessity for oxygen therapy, submit with the monthly billing Medicare [form CMS-484](#), *Certificate of Medical Necessity--Oxygen*, or a reasonable facsimile. The information requested on the form is required on each claim submitted to Medicaid.

All of the following information is required:

- ◆ A diagnosis of the disease requiring use of oxygen.
- ◆ The flow rate and concentration.
- ◆ The type of system ordered, i.e., cylinder gas, liquid gas, or concentrator.
- ◆ A **specific** estimate of the frequency and duration of use. ("Oxygen PRN" or "oxygen as needed" **is not** acceptable.)
- ◆ The initial reading on the meter clock on each concentrator, where applicable.



Oxygen prescribed PRN, or as needed, is not covered. If the member's condition or the need for oxygen services changes, the attending physician must adjust the medical documentation accordingly.

Payment for oxygen therapy is based on the premise that the reasonable charge for oxygen is no more than the least costly form of delivery, unless other forms were documented as medically necessary.

Medicaid payment is made for the rental of equipment only. All accessories, contents, and disposable supplies related to the oxygen delivery system, servicing and repairing of equipment are included in the Medicaid payment.

### **(1) Oxygen Contents**

Oxygen contents codes E0441 – E0444 are covered **only** for member-owned systems.

### **(2) Oxygen Delivery Equipment**

Oxygen equipment accessory items may be billed separately **only** when the member owns the equipment. All accessories contents, supplies, servicing and repairs are included in payment for the equipment.

Members may be provided with a portable oxygen system to complement a stationary oxygen system, or used by itself. Include with your claim:

- ◆ Documentation from the physician (MD or DO) of the medical necessity for portable oxygen for specific activities.
- ◆ A list of the specific activities that require the member to use portable oxygen.

Medicaid does not cover a second oxygen system when used as a backup for oxygen concentrators or as a standby in case of emergency.

To determine usage, maintain a log of meter or clock readings for each member. Update readings every four to six weeks. You may take readings during normal maintenance service calls. These logs are subject to review by Medicaid personnel.



All oxygen concentrator codes have the allowance for disposable supplies computed in Medicaid's allowance for use of any oxygen concentrator. Do not bill disposable supplies separately, unless the member owns the oxygen concentrator.

Monthly maintenance and replacement of filters are not considered repairs.

### **(3) Oxygen in a Nursing Facility\***

Oxygen systems and contents for Medicaid residents of a nursing facility are not covered unless the member has a medical need for oxygen for 12 or more hours per day for at least 30 days or more. (Coverage differs from Medicare.) Payment will be made when all of the following requirements and conditions have been met:

- ◆ A physician's prescription documents that a resident of a nursing facility requires oxygen for 12 hours per day or more.
- ◆ The oxygen provider and the physician must both keep Medicare [form CMS-484](#), *Certificate of Medical Necessity--Oxygen*, or a reasonable facsimile in their files. Documentation must contain the following:
  - The number of hours oxygen is required per day. ("PRN" is not covered.)
  - The diagnosis of the disease requiring continuous oxygen.
  - The prognosis.
  - The length of time the oxygen will be needed.
  - The oxygen flow rate and concentration.
  - The type of system ordered (cylinder gas, liquid gas, or concentrator).
  - A specific estimate of the frequency and duration of use.
  - The initial reading on the time meter clock on each concentrator, where applicable.
- ◆ The oxygen provider must maintain logs of oxygen use. The nursing facility must document oxygen use in its records according to [481 Iowa Administrative Code 58.21\(8\)](#).



When random postpayment review of the oxygen log and the nursing facility records fails to support that an average of 12 hours per day of oxygen was provided over a 30-day period, the overpayment will be recouped. Oxygen that does not meet this criterion is the responsibility of the nursing facility.

Oxygen systems in a nursing facility should be billed E1390,  
1 unit = 1 day.

**(4) Oximeter\***

Documentation submitted with a claim for an oximeter must include hypoxemia conditions. Oximeter probes are included in the rental.

**(5) Respiratory Therapists**

Respiratory therapist services are **not covered** under the provisions for coverage of oxygen services as durable medical equipment. The durable medical equipment benefit provides for coverage of home use of oxygen and oxygen equipment, but does not include a professional component in the delivery of such service.

**y. Patient Lifts**

Patient lifts are covered when prescribed for a member who is bed-confined and requires periodic movement to affect improvement or to retard deterioration in the member's condition. Documentation must include the member's height, weight, diagnoses, and caregivers available.

**z. Peak Flow Meters**

Coverage for peak flow meters is limited to one device every six months.

**aa. Pneumatic Appliances and Accessories**

Pneumatic appliances and accessories are covered when prescribed for a member who has intractable edema of the extremities.



**bb. Respiratory Equipment and Accessories**

Respiratory assist devices are covered when prescribed because the member's ability to breathe is severely impaired.

Nasal continuous airway pressure (**CPAP**) device is covered when the member has a diagnosis of sleep apnea. Three months rental is required before purchase. The trial period must be successful.

Intermittent assist device with continuous positive airway pressure device (**Bi-Pap**) is covered when physician documentation indicates a failed trial on CPAP or test results indicate that only a Bi-Pap unit will meet the medical needs of the member.

Intermittent assist device with continuous positive airway pressure device and back-up rate feature (**Bi-Pap ST**) is covered according to Medicare criteria and is rental only.

All types of **IPPB** machines are covered.

A home model, electric or pneumatic **percussor** is covered (for purchase only) when:

- ◆ Prescribed for mobilizing respiratory tract secretions in-patients with chronic obstruction lung disease, chronic bronchitis, or emphysema, and
- ◆ The member or operator of powered percussor has received appropriate training by a physician or therapist, and
- ◆ No one competent to administer manual therapy is available, and
- ◆ Medical necessity for **long-term** chest therapy is indicated.

**Nebulizers** are covered when the member requires aerosol medication therapy because of a chronic respiratory condition. Rental may be allowed for acute conditions where the ability to breathe is severely impaired.

**Inhalation accessories** are covered separately *only* for member-owned equipment.

**Vaporizers** are covered when prescribed for a member who has a chronic severe respiratory impairment that would benefit from the use of a vaporizer.



**Vest airway clearance** systems require prior authorization and must be prescribed by a physician for the member. There must be a medical diagnosis related to a lung disorder and documentation of **each** of the following:

- ◆ Pulmonary function tests prior to initiation of the vest demonstrate and overall significant decrease of lung function,  
NOTE: If pulmonary function tests are not applicable, the reason must be documented.
- ◆ The member resides in an independent living situation or has a medical condition that precludes the caregiver from administering traditional chest physiotherapy,
- ◆ Chest physiotherapy has not been effective,
- ◆ Treatment by flutter device failed or is contraindicated,
- ◆ Treatment by intrapulmonary percussive ventilation failed or is contraindicated,
- ◆ All other less costly alternatives have been tried.

If all the criteria are met, a trial period of three months will be authorized.

At the end of the trial period, a usage log detailing at least 67% compliance of the original prescription and a re-evaluation by the physician regarding the effectiveness of the vest must be submitted to extend the authorization or consider purchase approval.

A stationary or portable **volume ventilator** is covered when prescribed and determined the type of equipment specified is medically required and appropriate for **home** use without technical or professional supervision. Payment is for rental only.

**cc. Standers**

**Standers** may require a three-month trial rental period before consideration for purchase. Sit-to stand, mobile and tri-standers must have supporting documentation for these features. A request for prior authorization is recommended but not required.



**dd. Suction Machines**

Suction machines are covered when prescribed, medically necessary, and appropriate for home use without technical or professional supervision.

**ee. Transcutaneous electrical nerve stimulators (TENS)**

Tens are covered when:

- ◆ Prescribed for the relief of acute post-operative pain, or chronic intractable pain, *and*
- ◆ Documentation shows that other forms of treatment have been attempted.

**TENS unit supplies** are separately payable only for member-owned equipment. Coverage includes four leads per month and disposable patches.

**ff. Thermometers\***

Basal thermometers are covered for family planning purposes only. Oral or rectal thermometer are covered for members under 21 years of age when prescribed by a physician.

**gg. Traction Equipment and Accessories**

Traction equipment and accessories are covered when prescribed for a member who has an orthopedic impairment requiring equipment that prevents ambulation during period of use.

**hh. Urinary Collection Devices and Accessories**

Urinary collection devices and accessories are covered when prescribed because of urinary incontinence or urinary retention. If the limits are exceeded, the SC modifier must be used with documentation of the medical necessity submitted with the claim.



## ii. Walkers

**Walkers** are covered when prescribed for a member whose condition impairs ambulation.

**Posture control walkers (E0140 – E0143)** are covered when prescribed for a member whose condition impairs ambulation and whose diagnosis indicates that posture or gait control is a problem, e.g., cerebral palsy.

**Pediatric gait trainer walkers\*** (E8000, E8001, E8002) are covered for children through 12 who need upper and lower body support to walk due to developmental delay in gross and fine motor skills relating to a neurological or neuromuscular disease. (Coverage differs from Medicare.)

**Gait trainer walkers** for members 13 years of age and older should be billed using procedure code E1399. A three-month trial rental period before purchase may be appropriate if there is concern about the member's continued use of the walker.

## jj. Wheelchairs and Scooters

Wheelchairs, accessories, and modifications are covered when necessary for mobility within the home. Documentation submitted must include all of the following:

- ◆ Prescription from the member's physician
- ◆ The member's present condition warranting each particular feature or type of wheelchair.
- ◆ The member's place of residence.
- ◆ Caregiver availability.
- ◆ Current physical therapy or occupational therapy evaluation if the physician's evaluation regarding mobility is not descriptive or complete.
- ◆ Whether this is the first wheelchair or a replacement wheelchair.
- ◆ For a replacement wheelchair, why the original chair is being replaced.



Wheelchairs may be covered for children in school who have limited ambulation. Pertinent sections of the child's Individual Education Plan (IEP) must be included with the claim or prior authorization request to determine coverage.

Replacement will not be considered unless the cost of repairs exceeds 2/3 the cost of replacement. An itemized list of repair parts and costs must be included to support replacement. Like parts are replaced with like parts. For example: a manual elevating leg rest will be replaced with the same, not a replacement power elevating leg rest.

E1340 for labor should not be billed for assessment and fitting with initial purchase of the chair. If labor is needed to attach separate accessories to the wheelchair, a labor charge is allowed.

Prior authorization may be requested, but is not required. Claims submitted without prior authorization must include supporting documentation.

All accessories are included in the reimbursement of the POV HCPCS code and cannot be billed separately (gel batteries, seating, flat free inserts, oxygen holder).

Some accessories are included in the manual wheelchair/power wheelchair HCPCS codes and cannot be billed separately.

The member's home and community environment must be considered when providing the appropriate mobility equipment. (e.g. Mobility device does not fit within each room of the member's home or it cannot be transported).

**Wheelchair repair\* (E1340)** is covered for member-owned equipment, 1 unit = 15 minutes. (Coverage differs from Medicare.) If the member is in a nursing facility, Medicaid will replace parts with the exact same part. If new accessories are being requested due to change in condition or size of the member, accessories will be denied, as they are the responsibility of the facility.

**Specialized car seats\* (T5001)** are covered for children up to 120 pounds in weight when special positioning is required for safe transportation and there is not a way to transport the member in his/her wheelchair in the vehicle. (Coverage differs from Medicare)



A power-operated vehicle that is beneficial primarily in allowing the member to perform leisure or recreational activities is **not** covered. Durable medical equipment is primarily and customarily used to serve a medical purpose.

#### 4. Prosthetic Devices

“Prosthetic devices” mean replacement, corrective, or supportive devices to:

- ◆ Artificially replace a missing portion of the body,
- ◆ Prevent or correct a physical deformity or malfunction, or
- ◆ Support a weak or deformed part of the body.

Enteral nutrition therapy is considered to be a prosthetic. Prior authorization is required. Enteral nutrition therapy is payable for members in nursing facilities, intermediate care facilities, or private homes.

Prosthetic devices must be prescribed by a physician (doctor of medicine, osteopathy, or podiatry) within the scope of practice as defined by state law.

Prosthetic devices are covered even if the member’s condition may change sometime in the future. Prosthetic devices are not covered when dispensed to a member before the member undergoes a procedure that makes the use of the device necessary.

##### a. Augmentative Communication Systems

Augmentative communication systems (speech generating devices) are covered for persons unable to communicate their basic needs through oral speech or manual sign language. Coverage is allowed for members in nursing facilities, intermediate care facilities for the mentally retarded, and private homes.

Personal computers and software are not considered a communication device and are not covered.

**Communication device carrying cases** are covered when necessary to protect the device.

**Communication device wheelchair attachments** are covered when necessary for persons who use a wheelchair.



Augmentative communication systems require prior authorization. In addition to the *Request for Prior Authorization*, you must also complete and submit form 470-2145, *Augmentative Communication System Selection*.

To view a sample of form 470-2145 on line, click [here](#). Providers are asked to photocopy the sample as needed. No supply of the form is printed for ordering.

Information requested on form 470-2145 includes a medical history, diagnosis, and prognosis completed by a physician. In addition, a speech or language pathologist needs to describe current functional abilities in the following areas:

- ◆ Communication skills,
- ◆ Motor status,
- ◆ Sensory status,
- ◆ Cognitive status,
- ◆ Social and emotional status, and
- ◆ Language status.

Also needed from the speech or language pathologist is information on:

- ◆ Educational ability and needs,
- ◆ Vocational potential,
- ◆ Anticipated duration of need,
- ◆ Prognosis regarding oral communication skills,
- ◆ Prognosis with a particular device,
- ◆ Recommendations.

IME's consultant with expertise in speech pathology evaluates each request. The consultant may request a trial period with a particular device. Reimbursement for the rental of the equipment for up to three months for a trial period is available.

A minimum one-month trial period is recommended during which time the member should have access to the device daily in a variety of communication situations. Previous communication device use, cognitive level, and age of the member are considered in determining whether the trial period is adequate.



Payment is made for the most cost-effective item which meets basic communication needs commensurate with the person's cognitive and language abilities. Separate payment is not allowed for the initial evaluation by the speech therapist to determine need.

**Repairs** for augmentative communication devices are covered in accordance with the repair policy in Section B of this manual. Requests for reimbursement should include a simple description of the repair, the need for the repair, and ongoing use of the device.

#### **b. Nutritional Products and Supplies**

Enteral nutrition and supplies require prior authorization. They are considered a prosthetic and are separately payable for nursing facility and intermediate care facility (ICF/MR) residents.

Enteral feeding pumps require prior authorization. Separate payment for the pump is not allowed when the nursing facility owns the pump. Medicaid follows Medicare criteria for enteral feeding pumps, with some exceptions for children.

The basis of payment for nutritional therapy supplies is the least expensive method of delivery that is reasonable and medically necessary based on the documentation submitted. Prior authorization may be granted for up to one year for persons who have chronic conditions.

The prior authorization form and the claim form must show one unit per month for the infusion pump rental and one unit per day for the supply kits. Enteral product units must indicate the number of calorie units (1 unit = 100 calories) needed for the total request.

Daily **enteral nutrition** therapy is considered reasonable and necessary when the member has:

- ◆ A metabolic or digestive disorder that prevents the member from obtaining the necessary nutritional value from usual foods in any form and cannot be managed by avoidance of certain food products, or
- ◆ Severe pathology of the body that will not allow ingestion or absorption of sufficient nutrients from regular food to maintain weight and strength commensurate with the member's general condition.



Obtain prior authorization for enteral nutrition therapy before submitting claims for the nutritional products and the administration supplies.

Submit the following documentation with the *Request for Prior Authorization*, form 470-0829:

- ◆ Form 470-4210, *Certification of Enteral Nutrition*. Click [here](#) to see a sample of this form on line.
- ◆ Documentation of the medical necessity for an **enteral pump**, if applicable. Pumps are not covered for the convenience of the caregiver.

The medical reasons for not using a roller-clamp-controlled gravity feeding set must be identified (e.g., gravity feeding unsatisfactory due to reflux or aspiration, severe diarrhea, dumping syndrome, administration rate less than 100 ml/hr, blood glucose fluctuations, circulatory overload, jejunostomy tube used for feeding, or lipid based formula).

In addition, Medicaid considers whether home health services are available to the member.

- ◆ For children under age five, a statement indicating eligibility for the WIC program has been denied or the amount of enteral products provided by WIC.

Examples of conditions that do **not** justify approval of enteral nutrition therapy are:

- ◆ Weight-loss diets.
- ◆ Wired-shut jaws.
- ◆ Diabetic diets.
- ◆ Milk or food allergies for members five years of age and older.
- ◆ The use of enteral products for convenience reasons when regular food in pureed form would meet the medical need of the member.
- ◆ Nutritional supplementation to boost calorie or protein intake in the absence of severe pathology of the body.



**Oral supplementation\*** of a regular diet is reimbursable when a member:

- ◆ Is unable to ingest or absorb sufficient nutrients from regular food due to a metabolic, digestive, or psychological disorder or pathology, and
- ◆ Documentation to support the fact that 51% or more of the daily caloric intake is provided by the supplement. (Coverage differs from Medicare.)
- ◆ Oral supplementation may also be allowed when otherwise determined medically necessary in accordance with evidence-based guidelines for treatment of the member's condition. Such conditions include:
  - Acquired immunodeficiency syndrome (AIDS);
  - Burns;
  - Cancer;
  - Failure to thrive syndrome;
  - Problems with the kidney, liver, lungs, pancreas or stomach;
  - Prolonged infections;
  - Prolonged vomiting.
  - Surgery; and
  - Trauma.

Use the "BO" modifier for nutritional products administered orally.

Daily **parenteral nutrition** therapy is considered reasonable and necessary for a member with severe pathology of the alimentary tract that does not allow absorption of sufficient nutrients to maintain weight and strength commensurate with the member's general condition.

Since the alimentary tract of such a member does not function adequately, this therapy is administered via an intravenous catheter placed during a hospitalization. The member and other caregivers are trained in the care of the intravenous catheter and administration of the care of the intravenous catheter and administration of the solution.

Parenteral nutrition does not require a prior authorization.



**Enteral supplies\*** are covered as follows. (Coverage differs from Medicare). Items with an \* require prior authorization.

Code	Description	Normal Quantity
B4034*	Syringe feeding kit*	1 unit per day
B4035*	Pump feeding kit*	1 unit per day
B4036*	Gravity feeding kit*	1 unit per day
B4087	Standard gastrostomy or jejunostomy tube	1 unit per 3 months
B4088	Low profile button kits	1 unit per 3 months
B9998	12-inch extension set	1 unit (1 case of 5 per month)
B9998	24-inch extension set	1 unit (1 case of 5 per month)
B9998	Bard decompression tube	2 per month

Amounts that exceed the normal quantities listed above are covered when medically necessary. The claim must include documentation of the medical necessity. The code must be billed with the "GD" modifier for "medically necessary units exceed the norm."

B9998 must include a description of 12-inch extension set, 24-inch extension set, or decompression tubes.

**c. Orthopedic Shoes\*, Therapeutic Shoes for Diabetics, Accessories, and Modifications**

Medicaid coverage of **orthopedic shoes**, accessories, and modifications differs from Medicare. Orthopedic shoes, inserts, arch supports, and modifications are covered when:

- ◆ A written prescription by a doctor of medicine, podiatry or osteopathy includes the date, diagnosis, reason the orthopedic shoes are needed, probable duration of need, and specific description of any modification the shoes must include, *and*
- ◆ The diagnosis indicates an orthopedic, neuromuscular, vascular, or insensate foot condition (a diagnosis of flat feet is **not** covered.)



Women's and men's **orthopedic shoes not attached to a brace** are covered when the second shoe is attached to a brace and is covered by other third party payment.

**Therapeutic shoes** for persons with diabetes are covered according to Medicare criteria. The appropriate HCPCS "A" code should be billed for therapeutic shoes for diabetics with one unit as one shoe.

Orthopedic shoes, therapeutic shoes for diabetics, and inserts are limited as follows:

- ◆ Two pair of custom-molded shoes (which include inserts provided with these shoes) per member are allowed in a rolling 12-month period unless documentation of change in size or evidence of excessive wear is submitted. Two additional pairs of inserts for custom-molded shoes are allowed in a rolling 12-month period.
- ◆ Only two pair of depth shoes per member are allowed in a rolling 12-month period unless documentation of change in size or evidence of excessive wear is submitted. Three pairs of inserts in addition to the non-customized removable inserts provided with depth shoes are allowed in a rolling 12-month period.
- ◆ The "GD" modifier should be used when billing for more than the normal quantities in a 12-month period.

EXCEPTION: When required for participation in school sport activities, **athletic shoes** (T1999) for school age children under age 21 are allowed in addition to orthopedic shoes.

A "**custom" shoe** is one that is made for a specific person. A shoe with only a premolded or molded to patient model removable insert is not a custom shoe.

An off-the-shelf shoe that has been modified with attachments, such as arch supports, lifts, edges and heels, specific to the member is a custom shoe. Inserts and attachments may be billed separately in addition to the code for the shoe when a custom shoe is provided.



**Custom-molded shoes** are shoes that:

- ◆ Are constructed over a positive model of the member's foot, and
- ◆ Are made of leather or other suitable material of equal quality, and
- ◆ Have some form of closure such as laces or Velcro, and
- ◆ Have inserts that can be altered or replaced as the member's condition warrants.

Custom-molded shoes, inserts, and modifications are allowed only for members with a foot deformity that cannot be accommodated by a depth shoe. The nature and severity of the deformity must be well documented in the supplier's records.

If there is insufficient justification for a custom-molded shoe but the general coverage criteria are met, payment will be based on the allowance for the depth shoe.

**"Depth shoes"** are shoes that meet all of the following requirements:

- ◆ Have a full length, heel-to-toe filler that when removed provides a minimum of 3/16" of additional depth used to accommodate custom-molded or customized inserts.
- ◆ Are made from leather or other suitable material of equal quality.
- ◆ Have some form of shoe closure.
- ◆ Are available in full and half sizes with a minimum of three widths so that the sole is graded to the size width of the upper portions of the shoe according to the American standard sizing schedule or its equivalent.

**Metatarsal bars** are exterior bars that are placed behind the metatarsal heads in order to remove pressure from the metatarsal heads. The bars are of various shapes, heights, and construction depending on the exact purpose.

**Offset heel** is a heel flanged at its base either in the middle, to the side, or a combination, that is then extended upward to the shoe in order to stabilize extreme positions of the hind foot.



**Rigid rocker bottoms** are exterior elevations with apex position for 51% to 75% distance measured from the back end of the heel. The apex is a narrowed or pointed end of an anatomical structure. The apex must be positioned behind the metatarsal heads and tapering off sharply to the front tip of the sole.

Apex height helps to eliminate pressure at the metatarsal heads. The steel in the shoe ensures rigidity. The heel of the shoe tapers off in the back in order to cause the heel to strike in the middle of the heel.

**Roller bottoms** (sole or bar) are the same as rocker bottoms, but the heel is tapered from the apex to the front tip of the sole.

**Wedges** (posting) are either of hind foot, fore foot, or both and may be in the middle or to the side. The function is to shift or transfer weight bearing upon standing or during ambulation to the opposite side for added support, stabilization, equalized weight distribution, or balance.

**Plaster impression foot orthotics** are covered when they:

- ◆ Are constructed of more than one layer of a material that is soft enough and firm enough to hold an impression during use, and
- ◆ Are molded to the member's foot or made over a model of the foot.

**Molded digital orthotics** are covered.

#### d. **Orthotic Devices**

Orthotic devices are covered when prescribed for the purpose of:

- ◆ Supporting a weak or deformed body member, or
- ◆ Preventing or correcting a physical deformity or malfunction, or
- ◆ Restricting or eliminating motion in a diseased or injured part of the body.

**Continuous passive motion device** is covered only when prescribed and initiated within two days of total knee replacement surgery. Documentation submitted must show the date of knee replacement surgery and the date the device was initiated. Up to 21 days of rental are allowed.



**Cranial orthotic devices (S1040)** are covered when medical documentation submitted with the claim supports that either of the following condition exists:

- ◆ The device is medically necessary for the post-surgical treatment of synostic plagiocephaly.
- ◆ Photographic evidence supports the medical necessity for treatment of moderate to severe non-synostotic positional plagiocephaly and all of the following conditions exist:
  - The child is between 3 and 5 months of age and has failed to respond to a two-month trial of repositioning therapy, or
  - The child is between 6 and 18 months of age, and there is documentation of either of the following criteria:
    - Cephalic index of at least two standard deviations above the mean for the appropriate gender and age, or
    - Asymmetry of 12 millimeters or more in one of the following measures:
      - Cranial vault, or
      - Skull base, or
      - Orbitotragial depth.

Cranial orthotic devices do not require prior authorization.

**e. Prosthetics**

**Breast prostheses** are covered, including mastectomy bras, sleeves, and forms.

**Electronic speech aids** are covered for members who have had a laryngectomy or whose larynx is permanently inoperative.

**Prosthetic eyes** are covered.

**Fitting charges** are included in the fee.

**Tracheotomy speaking valves**, e.g. Passey Muire, are limited to one every four months.



## 5. Medical Supplies

“Medical supplies” are nondurable items consumed in the process of giving medical care. They include nebulizers, gauze, bandages, sterile pads, adhesive tape, and sterile absorbent cotton but do not include food or drugs.

Medical supplies are payable for a specific medical purpose. Supplies that are provided on a recurring basis should not automatically be dispensed. The Medicaid member, health care practitioner, or caretaker must request the supplies to be dispensed.

Do not dispense medical supplies at any one time in quantities exceeding a three-month supply. EXCEPTION: Oral nutritional products, enteral nutrition products, and supplies should be dispensed only in a one-month quantity.

Quantities of medical supplies in excess of established normal amounts should be billed with the “GD” modifier. Documentation of medical necessity for the additional quantity must be submitted with the claim.

A limited variety of supplies is approved for payment for members receiving care in a nursing facility or an intermediate care facility for the mentally retarded. See [Services to Members in a Medical Facility](#).

### a. Diabetic Equipment and Supplies

Diabetic equipment and supplies, including needles and syringes, blood glucose test strips and diabetic urine test supplies are covered when prescribed for use in the control of a diabetic condition. Items that are considered convenience items are **not** covered.

**Diabetic supplies** are covered as follows.

Code	Description	Normal Quantity
A4253	Blood glucose test or reagent strips	6 units per month (1 unit = 50 strips)
A4250	Urine glucose test strips	3 units per month (1 unit = 100 strips)
A4259	Lancets	4 units per month (1 unit = 100 lancets)
A4215	Needles	500 units per month (1 unit = 1 needle)



Amounts that exceed the normal quantities listed are covered when medically necessary. The claim must include documentation of medical necessity and be billed using the "GD" modifier.

**Home blood glucose monitors and supplies** are covered when the member meets all of the following criteria:

- ◆ The member is diabetic, *and*
- ◆ The device is designed for home rather than clinical use, *and*
- ◆ The member's physician states that the member is capable of being trained to use the particular device prescribed in an appropriate manner.

If the member is not able to perform this function, a responsible family member can be trained to use the equipment and monitor to ensure that the intended effect is achieved. The record must contain proper documentation by the member's physician.

**Home blood glucose monitors with special features** such as voice synthesizers, automatic timers, and specially designed arrangements of supplies and materials are covered when all of the following conditions are met:

- ◆ The member and the device meet the conditions listed for coverage of standard home blood glucose monitors, *and*
- ◆ The member can use the equipment without assistance, *and*
- ◆ The member's physician certifies that the member has a visual impairment severe enough to require use of this special monitoring system. The degree and type of visual impairment must be specified.

**Disposable insulin pens** may be covered as a medication under the pharmacy program. Prior authorization from the IME Pharmacy Unit is required.

**Reusable insulin pens** \* are allowed once every six months when documentation submitted with the claim indicates that:

- ◆ The member's visual or motor skills are impaired to such that they cannot accurately draw up their own insulin, *and*
- ◆ There is no caregiver available to provide assistance. (Coverage differs from Medicare.)



**Insulin, insulin cartridges, and insulin pens** must be billed on a pharmacy claim.

**External insulin infusion pumps\*** require prior authorization and are covered according to Medicare criteria. Additionally, a request for rental may be submitted for members who have pregnancy induced diabetes (\*Coverage differs from Medicare).

**Supplies\*** for a member-owned insulin pump do not require a prior authorization. (\*Coverage differs from Medicare). If the quantities allowed are exceeded, the "GD" modifier must be used and documentation of the medical necessity must be submitted with the claim.

**b. Diapers and Disposable Underpads\***

Diapers, briefs, panty liners, and disposable underpads (e.g., Chux) are covered when:

- ◆ They are prescribed and determined to be appropriate for a member who has lost control over bowel or bladder function, *and*
- ◆ A bowel or bladder training program was not successful, *and*
- ◆ The member is four years of age or older. (Coverage differs from Medicare.)

Requesting a prior authorization cannot override the criteria above.

Incontinence products are not covered for stress, urge, or overflow incontinence.

"Briefs" and panty liners are covered when the criteria for diapers are met (lost control over bowel or bladder function, bowel bladder training program was not successful, over four years of age).

Disposable underpads may be used simultaneously with diapers or briefs if warranted by the member's medical condition. Examples include: when needed for nighttime use, for nonambulatory members, when frequent changing is not available.



The following table indicates the maximum units that can be provided in a 90-day period when no other incontinence products are used. For example, a member may receive 1080 diapers in a 90-day period when this member does not also use liners or pull-ons. If a member uses diapers and pull-ons, these maximum units do not apply.

Category	Description	Codes	Maximum units
A	Diaper/brief	T4521 T4522 T4523 T4524 T4529 T4543	1080 per 90-day supply
B	Liner/shield/guard/pad	T4535	450 per 90-day supply
C	Pull-on	T4525 T4526 T4527 T4531	450 per 90-day supply
D	Disposable underpads	A4554	600 per 90-day supply
E	Reusable underpads	T4537 T4540	48 per 12 months

The following table indicates the maximum units that can be provided in a 90-day period when a combination of incontinence products are used.

Category combinations	Maximum combined total per 90 days	Individual maximums within combined maximum
A and B	1080	Category B = 450 maximum
B and C	450	N/A
A and C	1080	Category C = 450 maximum
A and B and C	1080	Category B and C= combined maximum of 450
A and D	1260	Category A = 1080 maximum Category D = 180 maximum
B or C with D	630	Category B or C = 450 maximum Category D = 180 maximum
E (T4537 & 4540)	48	48 maximum



A maximum of 48 reusable bed pads and chair pads, codes T4537 and T4540, are allowed per year in addition to the individual or combined disposable product maximums above. The "GD" modifier cannot be used with reusable underpads. Reusable underpads are washable and therefore should not be necessary in additional quantities.

When more than the normal limits are medically necessary, documentation, including the failure of other modalities or treatments and a description of the member's medical condition related to the incontinence, must be maintained in the provider's records. Examples of such situations include prescribed diuretics, bowel medications, or a history of skin problems.

The "GD" modifier for "normal quantities exceeded" should be used when quantities billed have exceeded limits and the documentation supports the medical necessity. The documentation should be submitted with the claim.

**c. Dressings and Surgical Supplies**

**Dressings** are covered when prescribed to be used for the therapeutic and protective covering for a wound or surgical incision, considered necessary for the proper treatment of a diseased or injured body part, and used as a protective wrapping and support.

**Surgical supplies** are covered when medically necessary.

**d. Enema Supplies**

Enema supplies are covered when prescribed for medicinal purposes.

**e. Family Planning\***

Basal thermometers are covered for family planning purposes only. Diaphragms for contraceptive use are covered.

**f. Hearing Aid Batteries\***

Hearing aid batteries are covered for members with hearing aids. Up to 30 batteries *per aid* are covered in a 90-day period. 1 battery = 1 unit of service. (Coverage differs from Medicare.)



**g. Irrigation Solutions**

Sterile or saline **water** is covered.

**Catheter irrigation solutions** are covered when prescribed for use with medically necessary urinary equipment.

**h. IV Supplies**

IV supplies are covered when prescribed for home antibiotic or parenteral therapy.

**i. Ostomy Supplies and Accessories**

Ostomy supplies and accessories are covered when medically necessary. One unit per day of regular wear or three units per month of extended wear are allowed. If the limits are exceeded, documentation of the medical necessity must be submitted with the claim.

**j. Support Stockings\***

Support stockings are **not** considered an orthotic and are **not** covered in nursing facilities. (Coverage differs from Medicare.)

**Anti-embolism surgical stockings** (i.e., Ted hose) are covered when prescribed for post-surgical members.

**Graduated compression stockings** (i.e., Jobst) are covered when prescribed for members with intractable edema of the lower extremities as well as other circulatory disorders.

**Custom-made gradient compression stockings** are covered only when prescribed for members whose measurements exceed manufactured sizes. The manufacturer must be identified on the claim. The invoice should be attached for pricing.

**6. Services to Members in a Medical Facility**

No payment is made to medical suppliers for medical supplies or durable medical equipment for members receiving inpatient or outpatient care in a hospital.



No payment is made for medical supplies or durable medical equipment for members for whom the facility is receiving skilled nursing care payment, except for orthotic and prosthetic services, orthopedic shoes, and therapeutic shoes for diabetics.

No payment is made for durable medical equipment or supplies for members in an intermediate care facility for the mentally retarded or a facility receiving nursing facility payments, except for the following:

- ◆ Catheter (indwelling Foley).
- ◆ Colostomy and ileostomy appliances.
- ◆ Colostomy and ileostomy care dressings, liquid adhesive, and adhesive tape.
- ◆ Diabetic supplies (disposable or retractable needles and syringes, test-tape, clinitest tablets, and clinistix).
- ◆ Disposable catheterization trays or sets (sterile).
- ◆ Disposable bladder irrigation trays or sets (sterile).
- ◆ Disposable saline enemas (sodium phosphate type, for example).
- ◆ Hearing aid batteries.
- ◆ Orthotic and prosthetic services, including augmentative communication devices.
- ◆ Orthopedic shoes.
- ◆ Repair of member-owned equipment.
- ◆ Oxygen services. (See [Oxygen](#).) Oxygen services for residents in an ICF/MR are included in the per diem and are not payable separately.
- ◆ Therapeutic shoes for diabetics.

For members in nursing facilities who have member-owned equipment, replacement of components, parts, or systems for the equipment is allowed as long as:

- ◆ The cost does not exceed two-thirds the cost of a new item, and
- ◆ The replacement is not due to change in size or condition of the member.



**C. BASIS OF PAYMENT FOR SERVICES**

The basis of payment for most items is a fee schedule.

For those services and items furnished both under Part B of Medicare and under Medicaid, the fee shall be the lowest charge recognized under Medicare.

For those services and items furnished only under Medicaid, the fee shall be the lowest charge determined by the Iowa Department of Human Services according to the Medicare reimbursement method.

Payment for supplies with no established Medicare fee is at the average wholesale pricing less 10%. Payment for items with no established Medicaid fee, Medicare fee, or average wholesale price is the manufacturer’s suggested retail price less 15%.

Payments for items with no average wholesale price, Medicare or Medicaid fee, or manufacturer’s suggested retail price is at the dealer cost on the invoice plus 10%. The actual invoice from the manufacturer for the item provided invoice must be submitted with the claim must be an. Catalog pages or print outs supplied by the provider are not considered invoices.

Payment for used equipment is 80% of the purchase allowance.

The amount payable is based on the least expensive item that meets the member’s medical needs. Payment is not approved for duplicate items. No allowance is made for delivery, freight, postage, or other provider operating expenses for durable medical equipment, prosthetic devices, or sickroom supplies.

For selected medical services, supplies, and equipment, including equipment servicing, which in the judgment of the Secretary of the U.S. Department of Health and Human Services generally do not vary significantly in quality from one provider to another, the fee for payments shall be the lowest price for which such devices are widely and consistently available in a locality.

**D. PROCEDURE CODES AND NOMENCLATURE**

Claims submitted without a procedure code are denied. Medicaid recognizes Medicare’s National Level II Healthcare Common Procedure Coding System (HCPCS). However, all HCPCS codes are not covered.



Covered codes not listed in HCPCS (local "W" codes) are identified on this page as well in as the fee schedule. Refer to the current fee schedule for a list of covered codes. The fee schedule can be accessed on line at [http://www.ime.state.ia.us/Reports\\_Publications/FeeSchedule.html](http://www.ime.state.ia.us/Reports_Publications/FeeSchedule.html). If you do not have Internet access, you can obtain a copy from the IME Provider Services Unit upon request.

The provider is responsible for selecting the code that best describes the item dispensed. Refer coverage questions to the Provider Services Unit.

**1. Modifiers**

Place the following modifiers after the five-position procedure code as appropriate:

- BO Oral administration of nutritional product
- DD Powdered enteral nutrition product
- RR Rental equipment
- UE Used equipment
- EP Items or services provided as a result of a Care for Kids (EPSDT) examination
- FP Family-planning-related item or service
- GD Normal quantities exceeded

**2. Local Codes**

- W0359 Seat lift chair without mechanism

**E. CLAIM FORM AND INSTRUCTIONS**

Claims for medical equipment and supplies shall be submitted on form CMS-1500, *Health Insurance Claim Form*. To view a sample of this form on line, click [here](#).

**1. Instructions for Completing the CMS-1500 Claim Form**

The table below follows the CMS-1500 claim form by field number and name, and gives a brief description of the information to be entered and whether providing information in that field is required, optional, or conditional of the individual member's situation.

For electronic media claim (EMC) submitters, refer also to your EMC specifications for claim completion instructions.



FIELD NUMBER	FIELD NAME/ DESCRIPTION	INSTRUCTIONS
1.	CHECK ONE	<b>REQUIRED.</b> Check the applicable program block.
1a.	INSURED'S ID NUMBER	<b>REQUIRED.</b> Enter the Medicaid member's Medicaid number, found on the <i>Medical Assistance Eligibility Card</i> . The Medicaid "member" is defined as a recipient of services who has Iowa Medicaid coverage. The Medicaid number consists of seven digits followed by a letter, e.g., 1234567A.  Verify eligibility by visiting the web portal or by calling the Eligibility Verification System (ELVS) at 800-338-7752 or 515-323-9639, local in the Des Moines area. To establish a web portal account, call 800-967-7902.
2.	PATIENT'S NAME	<b>REQUIRED.</b> Enter the last name, first name, and middle initial of the Medicaid member.
3.	PATIENT'S BIRTHDATE	<b>OPTIONAL.</b> Enter the Medicaid member's birth month, day, year, and sex. Completing this field may expedite processing of your claim.
4.	INSURED'S NAME	<b>OPTIONAL.</b> For Medicaid purposes, the "insured" is always the same as the patient. For Iowa Medicaid purposes, the member receiving services is always the "insured." If the member is covered through other insurance, the policyholder is the "other insured."
5.	PATIENT'S ADDRESS	<b>OPTIONAL.</b> Enter the address and phone number of the patient, if available.
6.	PATIENT RELATIONSHIP TO INSURED	<b>OPTIONAL.</b> For Medicaid purposes, the "insured" is always the same as the patient.
7.	INSURED'S ADDRESS	<b>OPTIONAL.</b> For Medicaid purposes, the "insured" is always the same as the patient.
8.	PATIENT STATUS	<b>REQUIRED, IF KNOWN.</b> Check boxes corresponding to the member's current marital and occupational status.



FIELD NUMBER	FIELD NAME/ DESCRIPTION	INSTRUCTIONS
9a-d.	OTHER INSURED'S NAME	<b>SITUATIONAL.</b> Required if the Medicaid member is covered under other additional insurance. Enter the name of the policyholder of that insurance, as well as the policy or group number, the employer or school name under which coverage is offered, and the name of the plan or program. If 11d is "yes," these boxes must be completed.
10.	IS PATIENT'S CONDITION RELATED TO	<b>REQUIRED, IF KNOWN.</b> Check the applicable box to indicate whether or not treatment billed on this claim is for a condition that is somehow work-related or accident-related. If the member's condition is related to employment or an accident, and other insurance has denied payment, complete 11d, marking the "yes" and "no" boxes.
10d.	RESERVED FOR LOCAL USE	<b>OPTIONAL.</b> No entry required.
11a-c.	INSURED'S POLICY GROUP OR FECA NUMBER AND OTHER INFORMATION	<b>OPTIONAL.</b> For Medicaid purposes, the "insured" is always the same as the patient.
11d.	IS THERE ANOTHER HEALTH BENEFIT PLAN?	<p><b>REQUIRED.</b> If the Medicaid member has other insurance, check "yes" and enter the payment amount in field 29. If "yes," then boxes 9a-9d must be completed.</p> <p>If there is no other insurance, check "no."</p> <p>If you have received a denial of payment from another insurance, check <b>both</b> "yes" and "no" to indicate that there is other insurance, but that the benefits were denied. Proof of denials must be included in the patient record.</p> <p>Request this information from the member. You may also determine if other insurance exists by visiting the web portal or by calling the Eligibility Verification System (ELVS) at 800-338-7752 or 515-323-9639, local in the Des Moines area. To establish a web portal account, call 800-967-7902.</p> <p>NOTE: Auditing will be performed on a random basis to ensure correct billing.</p>



FIELD NUMBER	FIELD NAME/ DESCRIPTION	INSTRUCTIONS
12.	PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE	<b>OPTIONAL.</b> No entry required.
13.	INSURED OR AUTHORIZED PERSON'S SIGNATURE	<b>OPTIONAL.</b> No entry required.
14.	DATE OF CURRENT ILLNESS, INJURY, PREGNANCY	<b>SITUATIONAL.</b> Enter the date of the onset of treatment as month, day, and year. For pregnancy, use the date of the last menstrual period (LMP) as the first date. This field is not required for preventative care.
15.	IF THE PATIENT HAS HAD SAME OR SIMILAR ILLNESS...	<b>SITUATIONAL.</b> Chiropractors must enter the current X-ray as month, day, and year. For all others, no entry is required.
16.	DATES PATIENT UNABLE TO WORK...	<b>OPTIONAL.</b> No entry required.
17.	NAME OF REFERRING PHYSICIAN OR OTHER SOURCE	<b>CONDITIONAL.</b> Required if the referring provider is not enrolled as an Iowa Medicaid provider. "Referring provider" is defined as the health care provider that directed the member to your office.
17a.		<b>LEAVE BLANK.</b> The claim will be returned if any information is entered in this field.
17b.		<b>SITUATIONAL</b> <ul style="list-style-type: none"> <li>◆ If the patient is a MediPASS member and the MediPASS provider authorized service, enter the 10-digit NPI of the referring provider.</li> <li>◆ If this claim is for consultation, independent laboratory services, or medical equipment, enter the NPI of the referring or prescribing provider.</li> <li>◆ If the patient is on lock-in and the lock-in provider authorized the service, enter the NPI of the authorizing provider.</li> </ul>



FIELD NUMBER	FIELD NAME/ DESCRIPTION	INSTRUCTIONS
18.	HOSPITALIZATION DATES RELATED TO...	<b>OPTIONAL.</b> No entry required.
19.	RESERVED FOR LOCAL USE	<b>OPTIONAL.</b> No entry required. Note that pregnancy is now indicated with a pregnancy diagnosis code in box 21. If you are unable to use a pregnancy diagnosis code in any of the fields in box 21, write in this box, "Y – Pregnant."
20.	OUTSIDE LAB	<b>OPTIONAL.</b> No entry required.
21.	DIAGNOSIS OR NATURE OF ILLNESS	<b>REQUIRED.</b> Indicate the applicable ICD-9-CM diagnosis codes in order of importance (1-primary, 2-secondary, 3-tertiary, and 4-quaternary), to a maximum of four diagnoses.  If the patient is pregnant, one of the diagnosis codes must indicate pregnancy. The pregnancy diagnosis codes are as follows:  640 through 648, 670 through 677, V22, V23
22.	MEDICAID RESUBMISSION	No entry required. This field will be required at a future date. Instructions will be provided before the requirement is implemented.
23.	PRIOR AUTHORIZATION NUMBER	<b>SITUATIONAL.</b> If there is a prior authorization, enter the prior authorization number. Obtain this number from the prior authorization form.
24. A	DATE(S) OF SERVICE/NDC  TOP SHADED PORTION          LOWER PORTION	<b>SITUATIONAL</b> Required for provider-administered drugs. Enter qualifier "N4" followed by the NDC for the drug referenced in 24d (HCPCs). No spaces or symbols should be used in reporting this information.  <b>REQUIRED</b> Enter the month, day, and year under both the "From" and "To" categories for each procedure, service or supply. If the "From-To" dates span more than one calendar month, enter each month on a separate line.  Because eligibility is approved on a month-by-month basis, spanning or overlapping billing months could cause the entire claim to be denied.



FIELD NUMBER	FIELD NAME/ DESCRIPTION	INSTRUCTIONS
24. B	PLACE OF SERVICE	<p><b>REQUIRED.</b> Using the chart below, enter the number corresponding to the place service was provided. Do not use alphabetic characters.</p> <ul style="list-style-type: none"> <li>11 Office</li> <li>12 Home</li> <li>21 Inpatient hospital</li> <li>22 Outpatient hospital</li> <li>23 Emergency room – hospital</li> <li>24 Ambulatory surgical center</li> <li>25 Birthing center</li> <li>26 Military treatment facility</li> <li>31 Skilled nursing</li> <li>32 Nursing facility</li> <li>33 Custodial care facility</li> <li>34 Hospice</li> <li>41 Ambulance – land</li> <li>42 Ambulance – air or water</li> <li>51 Inpatient psychiatric facility</li> <li>52 Psychiatric facility – partial hospitalization</li> <li>53 Community mental health center</li> <li>54 Intermediate care facility/mentally retarded</li> <li>55 Residential substance abuse treatment facility</li> <li>56 Psychiatric residential treatment center</li> <li>61 Comprehensive inpatient rehabilitation facility</li> <li>62 Comprehensive outpatient rehabilitation facility</li> <li>65 End-stage renal disease treatment</li> <li>71 State or local public health clinic</li> <li>72 Rural health clinic</li> <li>81 Independent laboratory</li> <li>99 Other unlisted facility</li> </ul>
24. C	EMG	<b>OPTIONAL.</b> No entry required.



FIELD NUMBER	FIELD NAME/ DESCRIPTION	INSTRUCTIONS
24. D	PROCEDURES, SERVICES OR SUPPLIES	<b>REQUIRED.</b> Enter the codes for each of the dates of service. <b>Do not</b> list services for which no fees were charged.  Enter the procedures, services, or supplies using the CMS Healthcare Common Procedure Coding System (HCPCS) code or valid Current Procedural Terminology (CPT) codes. When applicable, show the HCPCS code modifiers with the HCPCS code.
24. E	DIAGNOSIS POINTER	<b>REQUIRED.</b> Indicate the corresponding diagnosis code from field 21 by entering the number of its position, e.g., 3. <b>Do not</b> write the actual diagnosis code in this field. Doing so will cause the claim to deny. There is a maximum of four diagnosis codes per claim.
24. F	\$ CHARGES	<b>REQUIRED.</b> Enter the usual and customary charge for each line item. This is defined as the provider's customary charges to the public for the services.
24. G	DAYS OR UNITS	<b>REQUIRED.</b> Enter the number of times this procedure was performed or number of supply items dispensed. If the procedure code specifies the number of units, then enter "1." When billing general anesthesia, the units of service must reflect the total minutes of general anesthesia.
24. H	EPSDT/FAMILY PLANNING	<b>SITUATIONAL.</b> Enter "F" if the service on this claim line is for family planning. Enter "E" if the services on this claim line are the result of an EPSDT Care for Kids screening.
24. I	ID QUAL.	<b>LEAVE BLANK.</b> The claim will be returned if any information is entered in this field.
24. J	RENDERING PROVIDER ID #  TOP SHADED PORTION  LOWER PORTION	<b>LEAVE BLANK</b>  <b>REQUIRED</b> Enter the NPI of the provider rendering the service when the NPI given in field 33a does not identify the treating provider.



FIELD NUMBER	FIELD NAME/ DESCRIPTION	INSTRUCTIONS
25.	FEDERAL TAX ID NUMBER	<b>OPTIONAL.</b> No entry required.
26.	PATIENT'S ACCOUNT NUMBER	<b>FOR PROVIDER USE.</b> Enter the account number you have assigned to the patient. This field is limited to 10 alphabetical or numeric characters.
27.	ACCEPT ASSIGNMENT?	<b>OPTIONAL.</b> No entry required.
28.	TOTAL CLAIM CHARGE	<b>REQUIRED.</b> Enter the total of the line-item charges. If more than one claim form is used to bill services performed, each claim form must be separately totaled. Do not carry over any charges to another claim form.
29.	AMOUNT PAID	<b>SITUATIONAL.</b> Enter only the amount paid by other insurance. Do not list member copayments, Medicare payments, or previous Medicaid payments on this claim. Do not submit this claim until you receive a payment or denial from the other carrier. Proof of denial must be kept in the patient record.
30.	BALANCE DUE	<b>REQUIRED.</b> Enter the amount of total charges less the amount entered in field 29.
31.	SIGNATURE OF PHYSICIAN OR SUPPLIER	<b>REQUIRED.</b> Enter the signature of either the provider or the provider's authorized representative and the original filing date. The signatory must be someone who can legally attest to the service provided and can bind the organization to the declarations on the back of this form.  If the signature is computer-generated block letters, the signature must be initialed. A signature stamp may be used.
32.	SERVICE FACILITY LOCATION INFORMATION	<b>REQUIRED.</b> Enter the name and address associated with the rendering provider.



FIELD NUMBER	FIELD NAME/ DESCRIPTION	INSTRUCTIONS
32a.	NPI	<b>OPTIONAL.</b> Enter the NPI of the facility where services were rendered.
32b.		<b>LEAVE BLANK.</b> The claim will be returned if any information is entered in this field.
33.	BILLING PROVIDER INFO AND PHONE #	<b>REQUIRED.</b> Enter the complete name and address of the billing provider or service provider. The "billing provider" is defined as the provider that is requesting to be paid for the services rendered.  NOTE: The ZIP code must match the ZIP code confirmed during NPI verification or during enrollment. To view the confirmed ZIP code, access <a href="http://imeservices.org">imeservices.org</a> .
33a.	NPI	<b>REQUIRED.</b> Enter the ten-digit NPI of the billing provider.  NOTE: The NPI must match the NPI confirmed during NPI verification or during enrollment. To view the confirmed NPI, access <a href="http://imeservices.org">imeservices.org</a> .
33b.		<b>REQUIRED.</b> Enter qualifier "ZZ" followed by the taxonomy code of the billing provider. No spaces or symbols should be used.  The taxonomy code must match the taxonomy code during NPI verification or during enrollment. To view the confirmed taxonomy code, access <a href="http://imeservices.org">imeservices.org</a> .

## 2. Claim Attachment Control, Form 470-3969

If you want to submit electronically a claim that requires an attachment, you must submit the attachment on paper using the following procedure:

- ◆ **Staple** the additional information to form 470-3969, *Claim Attachment Control*. (To view a sample of this form on line, click [here](#).)
- ◆ Complete the "attachment control number" with the same number submitted on the electronic claim. IME will accept up to 20 characters (letters or digits) in this number. If you do not know the attachment control number for the claim, please contact the person in your facility responsible for electronic claims billing.
- ◆ **Do not** attach a paper claim.



- ◆ Mail the *Claim Attachment Control* with attachments to:

Iowa Medicaid Enterprise  
PO Box 150001  
Des Moines, IA 50315

Once IME receives the paper attachment, it will manually be matched up to the electronic claim using the attachment control number and then processed.

## F. REMITTANCE ADVICE AND FIELD DESCRIPTIONS

### 1. Remittance Advice Explanation

To simplify your accounts receivable reconciliation and posting functions, you will receive a comprehensive *Remittance Advice* with each Medicaid payment. The *Remittance Advice* is also available on magnetic computer tape for automated account receivable posting.

The *Remittance Advice* is separated into categories indicating the status of those claims listed below. Categories of the *Remittance Advice* include paid, denied and suspended claims.

- ◆ **Paid** indicates all processed claims, credits and adjustments for which there is full or partial reimbursement.
- ◆ **Denied** represents all processed claims for which no reimbursement is made.
- ◆ **Suspended** reflects claims which are currently in process pending resolution of one or more issues (member eligibility determination, reduction of charges, third party benefit determination, etc.).

Suspended claims may or may not print depending on which option was specified on the Medicaid Provider Application at the time of enrollment. You chose one of the following:

- ◆ Print suspended claims only once.
- ◆ Print all suspended claims until paid or denied.
- ◆ Do not print suspended claims.

Note that claim credits or recoupments (reversed) appear as regular claims with the exception that the transaction control number contains a "1" in the twelfth position and reimbursement appears as a negative amount.



An adjustment to a previously paid claim produces two transactions on the *Remittance Advice*. The first appears as a credit to negate the claim; the second is the replacement or adjusted claim, containing a “2” in the twelfth position of the transaction control number.

If the total of the credit amounts exceeds that of reimbursement made, the resulting difference (amount of credit – the amount of reimbursement) is carried forward and no check is issued. Subsequent reimbursement will be applied to the credit balance, as well, until the credit balance is exhausted.

An example of the *Remittance Advice* and a detailed field-by-field description of each informational line follows. It is important to study these examples to gain a thorough understanding of each element as each *Remittance Advice* contains important information about claims and expected reimbursement.

Regardless of one’s understanding of the *Remittance Advice*, it is sometimes necessary to contact the IME Provider Services Unit with questions. When doing so, keep the *Remittance Advice* handy and refer to the transaction control number of the particular claim. This will result in timely, accurate information about the claim in question.

## 2. Remittance Advice Samples and Field Descriptions

Two different remittance advice formats may be issued, depending on whether the claims are for members and items that are also covered by Medicare Part B.

To view a sample of the standard RA-1500 remittance advice on line, click [here](#). The fields are described as follows:

Field Name		Field Description
A	R.A. No.	<i>Remittance Advice</i> number
B	Warrant Number	Check number (usually zeros). Contact IME for check number.
C	Provider Name	Name of the pay-to provider as registered with IME
D	Provider Address	Address registered with IME
E	Important IME Information	Reminders and updates from IME
F	Run Date	Date the <i>Remittance Advice</i> was created



Field Name		Field Description
G	Date Paid	Date the <i>Remittance Advice</i> and check were released
H	Prov. Number	National provider identifier (NPI) of the billing (pay-to) provider
I	Page	Page number
J	Number of Claims	Number of claims processed for each defined status
K	Billed Amount of All Claims	Total dollar amount of claims billed for each defined status
L	Subtotal Amount Paid	Amount paid for each defined status
M	Amount of Deposit	Total check amount for claims paid on this <i>Remittance Advice</i>
N	EOB Code	Explanation of benefits (EOB) code or denial code
O	EOB Description	Description of the denial EOB
P	Number of Claims Posting EOB	Number of claims that denied for the EOB code described
Q	Number of Claims	Total number of claims within same claim type or status
R	Total Billed Amt.	Total billed amount of all claims within same claim type or status
S	Total Other Sources	Total third-party insurance payments within same claim type or status
T	Total Paid by Mcaid	Total dollar amount paid within same claim type or status
X	Copay Amt.	Total copayment amount within same claim type or status
1	Patient Name	Last, first name or initial of the member as shown on the Medical Assistance Eligibility Card
2	Recip ID	Member identification number (7 digits+letter)
3	Trans-Control-Number	17-digit transaction control number assigned to each claim
4	Billed Amt.	Total billed amount on claim
5	Other Sources	Total "other sources" on claim (for example: TPL, spenddown)



	Field Name	Field Description
6	Paid by Mcaid	Total amount paid by Iowa Medicaid on claim
7	Copay Amt.	Total member copayment on claim
8	Med Rcd Num	Medical record number or patient account number
9	EOB	Explanation of benefits denial reason code if entire claim denied (Full description of denial can be found on the last page of the <i>Remittance Advice</i> statement.)
10	Line	Claim line number
11	Svc-Date	Date of service
12	Proc/Mods	CPT or HCPCS code and modifier billed
13	Units	Number of units billed
14	Billed Amt.	Billed amount on this line
15	Paid by Mcaid	Amount paid by Medicaid on this line
16	Copay Amt.	Copayment amount on this line
17	Perf. Prov.	Treating provider national provider identifier (NPI) number
18	S	Source of payment. Allowed charge source codes are as follows: A Anesthesia B Billed charge C Percentage of charges D Inpatient per diem rate E EAC priced plus dispense fee F Fee schedule G FMAC priced plus dispense fee H Encounter rate I Prior authorization rate K Denied L Maximum suspend ceiling M Manually priced N Provider charge rate O Professional component P Group therapy Q EPSDT total over 17 R EPSDT total under 18 S EPSDT partial over 17 SP Not yet priced



Field Name		Field Description
		T EPSTD partial under 18 U Gynecology fee V Obstetrics fee W Child fee X Medicare or coinsurance deductibles Y Immunization replacement Z Batch bill APG 0 APG 1 No payment APG 3 HMO/PHP rate 4 System parameter rate 5 Statewide per diem 6 DRG auth or new 7 Inlier/outlier adjust 8 DRG ADR inlier 9 DRG ADR
19	EOB	Explanation of benefits denial reason code

To view a sample of the Medicare Part B crossover remittance advice format on line, click [here](#). The fields are described as follows:

Field Name		Field Description
A	R.A. No.	<i>Remittance Advice</i> number
B	Warrant Number	Check number (usually zeros). Contact IME for check number.
C	Provider Name	Name of the pay-to provider as registered with IME
D	Provider Address	Address registered with IME
E	Important IME Information	Reminders and updates from IME
F	Run Date	Date the <i>Remittance Advice</i> was created
G	Date Paid	Date the <i>Remittance Advice</i> and check were released
H	Prov. Number	National provider identifier (NPI) of the billing (pay-to) provider
I	Page	Page number
J	Number of Claims	Number of claims processed for each defined status



	<b>Field Name</b>	<b>Field Description</b>
K	Billed Amount of All Claims	Total dollar amount of claims billed for each defined status
L	Subtotal Amount Paid	Amount paid for each defined status
M	Amount of Deposit	Total check amount for claims paid on this <i>Remittance Advice</i>
N	EOB Code	Explanation of benefits (EOB) code or denial code
O	EOB Description	Description of the denial EOB
P	Number of Claims Posting EOB	Number of claims that denied for the EOB code described
Q	Number of Claims	Total number of claims within same claim type or status
R	Mcare Paid Amt	Total Medicare payment within same claim type or status
S	Mcare Apprd	Total Medicare approved within same claim type or status
T	Deductible	Total deductible amount within same claim type or status
U	Coins. Amt.	Total coinsurance amount within same claim type or status
V	Copay	Total copayment amount within same claim type or status
X	Mcaid Paid Amt	Total Medicaid payment within same claim type or status

1	Patient	Name of the member as shown on the Medical Assistance Eligibility Card (last name and first initial)
2	Recipient Ident Num	Member identification number (7 digits+letter)
3	Trans-Control-Number	17-digit transaction control number assigned to each claim
4	Mcare Paid Amt	Total paid by Medicare on claim
5	Mcare Apprd	Total amount Medicare approved
6	Deductible	Total Medicare deductible on claim
7	Coins Amt.	Total Medicare coinsurance on claim
8	Copay	Total Iowa Medicaid copayment on claim



	<b>Field Name</b>	<b>Field Description</b>
9	Mcaid Paid Amt	Total amount paid by Medicaid on claim
10	Med Rcd Num	Medical record number OR patient account number
11	Line	Line number
12	Svc-Date	Date of service on line
13	Proc Mods	CPT or HCPCS code and modifier billed
14	Units	Number of units billed
15	Mcare Paid Amt	Medicare paid amount on line item
16	Mcare Apprd	Medicare approved amount on line item
17	Deductible	Medicare deductible amount on line item
18	Coins. Amt.	Medicare coinsurance amount on line item
19	Copay	Iowa Medicaid copayment on line item
20	Mcaid Paid Amt	Total amount paid by Medicaid on line
21	S	Source of payment. Allowed charge source codes are as follows: A Anesthesia B Billed charge C Percentage of charges D Inpatient per diem rate E EAC priced plus dispense fee F Fee schedule G FMAC priced plus dispense fee H Encounter rate I Prior authorization rate K Denied L Maximum suspend ceiling M Manually priced N Provider charge rate O Professional component P Group therapy Q EPSDT total over 17 R EPSDT total under 18 S EPSDT partial over 17 SP Not yet priced T EPSDT partial under 18 U Gynecology fee V Obstetrics fee W Child fee



Field Name		Field Description
		X Medicare or coinsurance deductibles Y Immunization replacement Z Batch bill APG 0 APG 1 No payment APG 3 HMO/PHP rate 4 System parameter rate 5 Statewide per diem 6 DRG auth or new 7 Inlier/outlier adjust 8 DRG ADR inlier 9 DRG ADR
22	EOB	Explanation of benefits denial reason code. A full description of denial can be found on the last page of the <i>Remittance Advice</i> statement.