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CHAPTER THIRTEEN

SUPPLIES, APPLIANCES, AND DURABLE EQUIPMENT

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Chapter 13. Supplies, Appliances, and Durable Equipment

Rule No. 560-X-13-.01. Supplies, Appliances, and Durable Medical Equipment - General.

(1) Effective July 1, 1978, supplies, appliances, and durable medical equipment are available as Medicaid program benefits to Medicaid eligibles of any age living at home.

(2) The covered medical supplies, appliances, and durable medical equipment are for medical therapeutic purposes, must be ordered by the attending physician in connection with his plan of treatment, and the items will minimize the necessity for hospitalization, nursing home, or other institutional care.

(3) A recipient does not have to be a Home Health Care patient in order to avail herself/himself of this program.

(4) The provider is responsible for educating the recipient in the use of the equipment. The provider is also responsible for delivery and set up of the equipment.

(5) Standard supplies, appliances, and durable medical equipment covered by Medicaid are listed in Chapter 14 of the Alabama Medicaid Provider Manual. Medical equipment, supplies, and appliances not listed as covered services in Chapter 14 of the Alabama Medicaid Provider Manual may be requested for coverage by submitting the request to the Clinical Services & Support Division for review and consideration. It will be the provider's responsibility to supply Medicaid with the necessary medical documentation which justifies the need of the requested items.

(6) Requests for items that are covered by Medicaid which are outside the normal benefit limits, due to damage beyond repair or other extenuating circumstances must be submitted to the Clinical Services & Support Division for review and consideration. It will be the provider's responsibility to supply Medicaid with the necessary documentation which justifies the need for the requested items.

(7) The provider may not bill the recipient for an item for which a prior authorization (PA) has been denied due to provider error or the provider's failure to submit the necessary medical documentation for the PA request.

Author: Vivian Bristow, Administrator, Pharmacy/ DME Unit

Statutory Authority: State Plan; 42 CFR Section 440.70; and Title XIX, Social Security Act.

History: Rule effective October 1, 1982. Amended November 11, 1985, March 10, 1997, July 9, 1997, September 15, 2004. **Amended:** Filed May 11, 2012; effective June 15, 2012

Rule No. 560-X-13-.02. Participating Providers.

(1) Participating providers are those Home Health Agencies, pharmacies and medical equipment suppliers contracted with Alabama Medicaid Agency for this program.

(2) Participating providers must meet the Medicare criteria as specified in the regulations of the Centers for Medicare and Medicaid Services, Department of Health and Human Services at 42 C.F.R. Section 424.57, which regulations are adopted by reference. Copies of these regulations may be obtained from the U.S. Government Printing Office, Washington, DC 20402-9328.

(3) The provider's business must be physically located within the state of Alabama or within a 30-mile radius of the state of Alabama. Providers may serve recipients only in all counties adjoining the county in which he/she has a business license and in the county where his/her business is physically located. Recipients living in areas where there is limited access to Durable Medical Equipment (DME) Supplies and Appliances may seek DME providers by contacting the Alabama Medicaid Agency's Pharmacy/ DME Unit. Recipients who have medical problems, disabilities or lack of transportation, may also seek DME providers by contacting the Alabama Medicaid's Pharmacy/ DME Unit.

Suppliers located more than 30- miles from the border of Alabama may be enrolled only as follows:

(a) For specialty equipment and supplies such as augmentative communication devices and vest airway clearance systems which are not readily available in state;

(b) For supplies and equipment needed as the result of a transplant or unique treatment approved out of state as the result of an EPSDT referral. Suppliers will be enrolled by the Medicaid fiscal agent on a temporary basis for these situations.

(4) There must be at least one employee present to conduct business at the physical location. Answering machines and/or answering services are not acceptable as personal coverage during normal business hours (8:00 a.m. – 5:00 p.m.) DME providers (as related to the provider specialty) must have durable medical equipment, appliances or supply items stocked in the physical store location that are readily available to Medicaid recipients presenting prescriptions for these items.

(5) Satellite businesses affiliated with a provider are not covered under the provider contract; therefore, no reimbursement will be made to a provider doing business at a satellite location. However, the satellite could enroll with a separate national provider number.

(6) The provider shall have no felony convictions and no record of noncompliance with Medicaid or Medicare regulations.

(7) The provider must submit a copy of a current business license to the Medicaid fiscal agent.

(a) Medicaid's fiscal agent enrolls supply, appliance, and durable medical equipment providers and issues provider contracts to applicants who meet the licensure or certification requirements of the State of Alabama, the Code of Federal Regulations, the Alabama Medicaid Agency Administrative Code, and the Alabama Medicaid Provider Manual.

(b) A copy of the approved Medicare enrollment application is required.

(8) Providers must notify Medicaid's fiscal agent in writing of any changes to the information contained in its application at least 30 business days prior to making such changes. These changes may include, but are not limited to, changes in ownership or control, federal tax identification number, or business address changes.

(9) All Alabama Medicaid DME and medical supply providers must submit copies of their Medicare Accreditation and their Medicare Surety Bonds to the Alabama Medicaid Agency's, Clinical Services and Support Division.

(a) The Alabama Medicaid DME and medical supply providers are required to have a \$50,000 Surety Bond for each NPI by October 1, 2010.

(b) DME providers requesting to enroll as an Alabama Medicaid provider will be required to have a \$50,000 Surety Bond for three years before qualifying for the \$100,000 two-year volume exemption as referenced in rule (12)(f) below.

(10) Failure of Medicaid DME and medical supply providers to comply with these requirements will result in their termination from the Alabama Medicaid Program.

(11) Alabama Medicaid DME and medical supply providers must renew their required surety bonds annually, before the day and month that the first bond was effective to avoid a lapse in coverage, a denial of Medicaid reimbursements and termination as a provider of Medicaid DME and medical supply services.

(a) Proof of the renewal must be submitted to the Alabama Medicaid Agency at least 30 days prior to the individual bond's termination date. The assigned Medicaid DME provider location number and current physical location address must be included on the surety bond renewal document for the individual DME and medical supply business location being bonded.

(b) If there is a lapse in surety bond coverage dates, the provider will be denied payment for services that may have been otherwise covered by Medicaid, and the individual DME location without a current surety bond on file will be terminated as a provider of Medicaid DME and medical supply services.

(12) A DME and medical supply business is exempt from surety bond requirements if the DME and medical supply business:

(a) Is a DME supplier who has been a Medicaid provider for five years or longer with no record of impropriety, and whose refund requests have been repaid as requested; or

(b) Is a government-operated Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS); or

(c) Is a state-licensed orthotic and prosthetic personnel in private practice making custom-made orthotics and prosthetics; or

(d) Are physicians and non-physician practitioners, as defined in section 1842(b)(18) of the Social Security Act; or

(e) Are physical and occupational therapists in private practice; or

(f) Are providers who received \$100,000 or less Medicaid payment in the past two calendar years; or

(g) Are pharmacy providers; or

(h) Are phototherapy providers who only provide phototherapy services for infants; or

(i) Are Federally Qualified Health Centers.

(13) DME suppliers who have been a Medicaid provider for five years or longer who are initially exempted from the Medicaid Surety Bond requirement as referenced in Rule (12)(a) of this section, will be subject to the Surety Bond requirement if the Medicaid Agency identifies a consistent problem with improper billing or fraudulent activity.

(14) Pharmacy providers seeking to enroll as Alabama Medicaid DME Providers are required to submit their Medicare enrollment letter only. They are not required to submit a Medicare Surety Bond, Medicare Accreditation or Medicaid Surety Bond.

Author: Vivian Bristow, Administrator, Pharmacy/ DME Unit.

Statutory Authority: State Plan Attachment 3.1-A; 42 CFR Section 434.6; and Title XIX, Social Security Act.

History: Rule effective October 1, 1982. Amended: Filed December 17, 2001; effective March 15, 2002. **Amended:** Filed November 19, 2002. Effective February 14, 2003. **Amended:** Filed September 20, 2006; effective December 13, 2006. **Amended:** Filed February 20, 2008; effective May 16, 2008. **Amended:** Filed October 20, 2008; effective January 16, 2009. **Amended:** Filed October 20, 2009; effective January 15, 2010. **Amended:** Filed April 20, 2010; effective July 16, 2010. **Amended:** Filed May 11, 2012; effective June 15, 2012. **Amended:** Filed November 9, 2012; effective December 14, 2012.

Rule No. 560-X-13-.03. Supplies and Appliances.

(1) A written order or a signed prescription by the attending physician to a participating supplier determines medical necessity for needed covered items of supplies and appliances. For acceptable formats of provider signature, refer to Medicaid Administrative Code, Rule 560-X-1-.18.

(2) A prescription is considered to be outdated by Medicaid when it is presented to the DME Provider/Medicaid's fiscal agent past ninety days from the date it was written.

(3) Medicaid considers a prescription to be valid for the dispensing of supplies for a period of twelve months. After the twelve month period of time, the recipient must be reevaluated by the physician to determine medical necessity for continued dispensing of medical supplies.

(4) Certain supplies and appliances require prior authorization by Alabama Medicaid Agency.

(5) Procedures for requesting and dispensing medical supplies and appliances for Medicaid recipients living at home are as follows:

(a) It is the responsibility of the recipient or authorized representative to obtain the prescription from the attending physician and take to a participating supplier.

(b) Upon receipt of the prescription, the supplier will:

1. verify Medicaid eligibility by checking the recipient's Medicaid number and verifying that number using AVRS or the Provider Assistance Center at Medicaid's fiscal agent. Recipient's eligibility must be verified on a monthly basis. Alabama Medicaid will not reimburse providers for items supplied to recipients in months where recipients have no eligibility;

2. obtain necessary managed care referrals and prior authorizations;
3. furnish the covered item(s) as prescribed;
4. collect the appropriate co-payment amount;
5. retain the prescription on file; and
6. submit the proper claim form to Medicaid's fiscal agent.

(6) Prescriptions are retained in patient's record or record file.

Author: Vivian Bristow, Administrator, Pharmacy/ DME Unit

Statutory Authority: State Plan Attachment 3.1-A; 42 CFR Section 440.70; and Title XIX, Social Security Act.

History: Rule effective October 1, 1982. **Amended:** November 11, 1985. Effective date of this amendment January 13, 1993. **Amended:** Filed October 20, 2008; effective January 16, 2009.

Amended: Filed May 11, 2012; effective June 15, 2012.

Rule No. 560-X-13-.04. Durable Medical Equipment.

(1) Prior authorization by Alabama Medicaid Agency is required for certain items of covered durable medical equipment.

(2) Medicaid covers the purchase of new durable medical equipment items for long term use. Long term use is defined as the use of durable medical equipment which exceeds six months. Medicaid covers the rental of new durable medical equipment items for the entire Medicaid population for six month or less. Selected medical equipment, which is prescribed as medically necessary, will be rented on a short-term basis for Medicaid eligible adults over age 21.

(3) Equipment may be purchased or rented for any Medicaid recipient meeting the established criteria.

- (4) Durable Medical Equipment (DME) is equipment which:
- (a) can stand repeated use;
 - (b) is used to serve a purpose for medical reasons; and
 - (c) is appropriate and suitable for use in the home.

(5) Durable Medical Equipment is necessary when it is expected to make a significant contribution to the treatment of the patient's injury or illness or to the improvement of his physical condition.

(6) The cost of the item must not be disproportional to the therapeutic benefits or more costly than a reasonable alternative. The item would not serve the same purpose as equipment already available to the recipient.

Author: Hattie M. Nettles, Associate Director, LTC Policy Advisory Unit.

Statutory Authority: State Plan Attachment 3.1-A; 42 CFR Section 440.70; and Title XIX, Social Security Act.

History: Rule effective October 1, 1982. Amended November 11, 1985; March 10, 1997; and July 9, 1997. Amended: Filed August 21, 2001; effective November 16, 2001. **Amended:** Filed June 21, 2004; effective September 15, 2004. **Amended:** Filed February 20, 2008; effective May 16, 2008. **Amended:** Filed October 20, 2008; effective January 16, 2009.

Rule No. 560-X-13-.05. Method of Requesting Durable Medical Equipment.

(1) A Medicaid recipient's attending physician is responsible for prescribing any covered durable medical equipment that is medically necessary for use in the patient's home.

(2) The physician must complete a written order or prescription and give to the recipient or sponsor to take to the DME provider of their choice. The physician may also fax the prescription to the provider of the recipient's choice. The provider must submit the appropriate Alabama Prior Review and Authorization Request Form, Form 342 and any other pertinent medical information to the Medicaid Fiscal Agent. The information may be transmitted electronically or by mail. The Fiscal Agent will assign a prior authorization tracking number and transmit the request to the Medicaid Agency or its designee for review and approval.

(3) The Medicaid Agency or its designee will review the request and assign a status of approved, denied, or pending.

(a) If the request is approved, the provider and recipient will receive an approval letter with a ten-digit PA number. This information should be referenced on the claim for billing.

(b) If the request is denied, written notice will be sent to the provider and the recipient indicating the reason for denial. Information giving them their right to appeal is also included in this notice.

(4) All prior authorization requests for the purchase of durable medical equipment must be received by the Medicaid Fiscal Agent within 30 calendar days after equipment is dispensed.

(5) All prior authorization requests for certification of rental services received beyond the 30 calendar days of beginning services will be authorized for reimbursement effective the date of receipt at the Medicaid Fiscal Agent.

(6) All prior authorization requests for recertification of DME rental services must be submitted to the Medicaid Fiscal Agent within 30 calendar days of recertification date. Completed recertifications received beyond the established time limit will be authorized for reimbursement effective the date of receipt at the Medicaid Fiscal Agent.

(7) All prior authorization requests returned to the DME provider by Medicaid, if resubmitted, must contain the following:

- (a) The appropriate Alabama Prior Review and Authorization Request Form,
- (b) The EPSDT Referral/PMP (Primary Managed Care Provider) Form, if applicable,
- (c) All necessary documentation to justify medical necessity,
- (d) Current prescription.

(8) Prior authorization requests that are lacking necessary information (EPSDT screening, referrals, required attachment) are placed in pending status. Prior authorization requests that are pended based on the need for additional information will be denied if information necessary to process the request is not received by the Medicaid Agency or its designee within 21 calendar days of the request.

Author: Hattie M. Nettles, Associate Director, LTC Policy Advisory Unit.

Statutory Authority: State Plan Attachment 3.1-A; 42 CFR, Section 440.70; and Title XIX, Social Security Act.

History: Rule effective October 1, 1982. Amended August 9, 1984; and March 10, 1997; and July 9, 1997. Amended: File August 21, 2001; effective November 16, 2001. **Amended:** Filed June 21, 2004; effective September 15, 2004. **Amended:** Filed October 20, 2008; effective January 16, 2009.

Rule No. 560-X-13-.06. Participating Supplier.

(1) The supplier furnishes only the approved item(s) indicated on the approval letter from the Alabama Medicaid Prior Approval Unit. This letter is generated and mailed by the Alabama Medicaid Fiscal Agent.

(2) The supplier is also responsible for verifying recipient's eligibility monthly.

(3) Upon furnishing durable medical equipment/supplies, the supplier must obtain a signature on any form he/she desires indicating that the equipment/supplies have been received by the recipient. If the recipient is unable to sign for the equipment/supply items, the supplier should verify the identity of the person signing for the items, e.g., relative, home health worker, neighbor.

(4) All forms and documentation must be retained in the patient record file by the supplier.

Author: Patricia Harris, Administrator, LTC Program Management Unit.

Statutory Authority: State Plan; 42 CFR Section 440.70; and Title XIX, Social Security Act.

History: Rule effective October 1, 1982. Amended November 11, 1985; October 12, 1988; November 15, 1989; January 13, 1993; and March 10, 1997. Amended: Filed August 21, 2001; effective November 16, 2001. **Amended:** Filed June 21, 2004; effective September 15, 2004.

Rule No. 560-X-13-.07. Noncovered Items and Services.

- (1) Items of a deluxe nature.
- (2) Replacement of usable equipment.
- (3) Items for use in hospitals, nursing homes, or other institutions.
 - (a) DME items may be provided in nursing homes or other institutions for children through the EPSDT Program.
- (4) Items for patient/caring person's comfort and convenience.

Author: Hattie Nettles, Associate Director, LTC Policy Advisory Unit.

Statutory Authority: State Plan Attachment 3.1-A; 42 CFR Section 441.15; and Title XIX, Social Security Act.

History: Rule effective October 1, 1982. Effective date of this amendment March 10, 1997.

Amended: Filed February 20, 2008; effective May 16, 2008.

Rule No. 560-X-13-.08. Medicare-Medicaid Eligibles and/or Qualified Medicare Beneficiaries.

- (1) Refer to Rule No. 560-X-1-.14.

Authority: 42 CFR Section 431.625; State Plan, Attachment 3.2-A; and Title XIX, Social Security Act. Rule effective October 1, 1982. Amended January 8, 1985, and October 13, 1987. Emergency rule effective February 1, 1989. Effective date of this amendment May 12, 1989.

Rule No. 560-X-13-.09. Patient Identification.

- (1) Refer to Rules 560-X-1-.09. and 560-X-1-.11.

Authority: State Plan; 42 C.F.R. Section 435.10; and Title XIX, Social Security Act. Rule effective October 1, 1982. Effective date of this amendment September 9, 1988.

Rule No. 560-X-13-.10. Reimbursement.

(1) Medicaid will reimburse for only those DME items indicated on the approval letter from the Alabama Medicaid Agency or its designee.

(2) Reimbursement will be made for item(s) covered by the Alabama Medicaid Agency for purchase or rentals as indicated on the DME Fee Schedule, using limits as established by Medicaid.

(3) Request for reimbursement must be submitted on the appropriate claim form.

(4) The contract supplier agrees to accept as payment in full the amount paid by Medicaid for covered items.

(a) The provider (or their staff) must advise each patient prior to services being rendered when Medicaid payment will not be accepted and the patient will be responsible for the bill.

(b) The fact that Medicaid payment will not be accepted must be recorded in the patient's record. Refer to Rule No. 560-X-1-.07.

(5) Medicaid recipients may be billed for noncovered items.

(6) Medicaid recipients may be billed for items provided by noncontract suppliers.

Author: Hattie M. Nettles, Associate Director, LTC Policy Advisory Unit.

Statutory Authority: State Plan, Attachment 4.19-B, page 5; 42 C.F.R., Section 447.50; Section 447.252; and Title XIX, Social Security Act.

History: Rule effective October 1, 1982. Amended July 9, 1984 and June 8, 1985. Amended: Filed August 21, 2001; effective November 16, 2001. **Amended:** Filed June 21, 2004; effective September 15, 2004. **Amended:** Filed October 20, 2008; effective January 16, 2009.

Rule No. 560-X-13-.11. Non-reimbursement.

(1) DME item(s) furnished by a supplier without receipt of an authorization to purchase by the Alabama Medicaid Agency will not be approved for reimbursement.

(2) Item(s) supplied to an individual who is not eligible during the month in which the item(s) are furnished, are not reimbursable.

(3) Medicaid recipients cannot be reimbursed directly by the Alabama Medicaid Agency.

Author: Patricia Harris, Administrator, LTC Program Management Unit.

Statutory Authority: 42 C.F.R., Section 447.252; and Title XIX, Social Security Act.

History: Rule effective October 1, 1982. Amended January 8, 1985 and March 10, 1997.

Amended: Filed June 21, 2004; effective September 15, 2004.

Rule No. 560-X-13-.12. Cost-Sharing.

(1) Medicaid recipients are required to pay and suppliers are required to collect the designated co-pay amount for the rental/purchase of services, supplies, appliances and equipment, including crossover claims.

(2) The co-payment fee does not apply to services provided for pregnant women, recipients less than 18 years of age, emergencies, surgical fees, and family planning.

(3) A provider may not deny services to any eligible recipient due to the recipient's inability to pay the cost-sharing amount imposed.

Author: Hattie M. Nettles, Associate Director, LTC Policy Advisory Unit.

Statutory Authority: State Plan Attachment 4.19-B, page 5; 42 CFR Section 447.50; and Title XIX, Social Security Act.

History: Rule effective June 8, 1985. Amended: Filed March 20, 2001; effective June 15, 2001. **Amended:** Filed October 20, 2008; effective January 16, 2009.

Rule No: 560-X-13-.13. Reimbursement for EPSDT-referred Wheelchair Systems.

(1) If no Medicare price is available for EPSDT-referred wheelchair systems, the reimbursement rate is established based on a discount from Manufacturers Suggested Retail Price (MSRP) instead of a "cost-plus" basis.

(2) Providers are required to submit MSRPs from three manufacturers for wheelchair systems (excluding seating system and add-on products) appropriate for the individual's medical needs.

(3) Requests submitted with less than three prices from different manufacturers must contain documentation supporting the appropriateness and reasonableness of equipment requested for a follow-up review by Medicaid professional staff. Provider must document nonavailability of required MSRPs to justify not sending in three prices.

- (4) The established rate will be based on the MSRP minus the following discounts:
1. Manual Wheelchair Systems - 20% discount from MSRP.
 2. Power Wheelchair Systems - 15% discount from MSRP.
 3. Ancillary (add-on) products - 20% discount from MSRP.

(5) Suppliers requesting approvals for medical items must provide Medicaid with an expected date of delivery.

(6) For medical items approved based on medical necessity, Medicaid will indicate the time frame allowed for providers to dispense equipment on the approval letter.

(7) When a provider is unable to dispense equipment within the time frame specified on the approval letter, an extension may be requested with written justification as to the specific reason(s) why the equipment cannot be supplied timely. All requests for extensions must be submitted to Medicaid prior to the expiration date indicated on the approval letter.

(8) Medicaid will cancel approvals for medical items that are not dispensed timely when there is no justifiable reason for delay.

(9) The Medicaid screening provider and recipient will be notified when an approved request for equipment is cancelled due to provider noncompliance and the recipient will be referred to other Medicaid providers to obtain medical items.

Author: Patricia Harris, Administrator, LTC Program Management Unit

Statutory Authority: Title XIX, Social Security Act; 42 C.F.R. Section 440.70; State Plan, Attachment 4.19-B; and OBRA '89.

History: Emergency rule effective September 1, 1993. Amended December 14, 1993. Emergency rule effective July 5, 1994. Effective date of this amendment August 12, 1994.
Amended: Filed June 21, 2004; effective September 15, 2004.

Rule No: 560-X-13-.14 Augmentative Communication Devices

(1) Effective July 1, 1998 coverage is provided for Augmentative Communication Devices (ACD) for eligible individuals who meet criteria set out herein. Prior authorization for the ACD service is required. Requests for prior authorization must be made on the appropriate Alabama Prior Review and Authorization Request Form. The request must include documentation regarding the medical evaluation by the physician and speech language pathologist and recipient information.

(2) ACDs are defined as portable electronic or non-electronic aids, devices, or systems determined to be necessary to assist a Medicaid-eligible recipient to overcome or improve severe expressive speech-language impairments/limitations due to medical conditions in which speech is not expected to be restored, and which enable the recipient to communicate effectively. These impairments include but are not limited to: apraxia of speech, dysarthria, and cognitive communication disabilities. These devices are reusable equipment items which must be a necessary part of the treatment plan consistent with the diagnosis, condition or injury, and not furnished for the convenience of the recipient or his family. ACD components and/or accessories prescribed or intended primarily for vocational, social, or academic development/enhancement and which are not necessary as described above will not be covered.

- (3) The scope of services includes the following elements:
- (a) Screening and evaluation,
 - (b) ACD, subject to limitations, and
 - (c) Training on use of equipment.

(4) Candidates under the age of 21 must meet all of the following criteria:

- (a) EPSDT referral by Medicaid-enrolled EPSDT provider. Referral must be within one year of application for ACD. The EPSDT provider must obtain a referral from the *Patient 1st* primary care provider where applicable;
- (b) Medical condition which impairs ability to communicate;
- (c) Evaluation by required qualified, experienced professionals; and
- (d) Physician prescription to be obtained after the evaluation and based on documentation contained in the evaluation.

(5) Candidates over the age of 21 must meet all of the following criteria:

- (a) Referral from a primary care physician (*Patient 1st* PCP/PMP where applicable). Referral must be within one year of application for ACD;
- (b) Medical condition which impairs ability to communicate;
- (c) Evaluation required by qualified experienced professionals; and
- (d) Physician prescription to be obtained after the evaluation and based on documentation provided in the evaluation.

(6) The candidate must be evaluated by qualified interdisciplinary professionals. Interdisciplinary professionals *must* include all of the following:

(a) Speech/Language Pathologist: This professional must meet all of the following criteria:

1. Have a master's degree in speech/language pathology from an accredited institution;
2. Have a Certificate of Clinical Competence in Speech/Language Pathology from the American Speech, Language, Hearing Association;
3. Have an Alabama license in speech/language pathology;
4. Have no financial or other affiliation with a vendor, manufacturer, or manufacturer's representative of ACDs; and
5. Have current continuing education.

(b) Physician: This professional must meet all of the following criteria:

1. Be a doctor of medicine or osteopathy legally authorized to practice medicine and surgery by the state in which the doctor performs such functions; and
2. Have no financial or other affiliation with a vendor, manufacturer, or manufacturer's representative of ACDs.

Interdisciplinary professionals *should* also include, but may not be limited to, the following:

(c) Physical Therapist: This professional must meet all of the following criteria:

1. Have a bachelor's degree in physical therapy from an accredited institution;
2. Have an Alabama license in physical therapy; and
3. Have no financial or other affiliation with a vendor, manufacturer, or manufacturer's representative of ACDs.

(d) Social Worker: This professional must meet all of the following criteria:

1. Have a bachelor's degree in social work from an accredited institution;
2. Have an Alabama license in social work; and
3. Have no financial or other affiliation with a vendor, manufacturer, or manufacturer's representative of ACDs.

(e) Occupational Therapist: This professional must meet all of the following criteria:

1. Have a bachelor's degree in occupational therapy from an accredited institution;
2. Have an Alabama license in occupational therapy; and
3. Have no financial or other affiliation with a vendor, manufacturer, or manufacturer's representative of ACDs.

(7) ACDs and services are only available through the Alabama Medicaid Agency prior authorization process. Requests for authorization must be submitted to Medicaid for review. Documentation must support that the client is mentally, physically, and emotionally capable of operating/using an ACD. The request must include documentation regarding the medical evaluation by the physician and recipient information:

(a) Medical Evaluation by Interdisciplinary Professionals must meet all of the following criteria:

1. Medical examination by physician to assess the need for an ACD to replace or support the recipient's capacity to communicate;
2. Status of respiration, hearing, vision, head control, trunk stability, arm movement, ambulation, seating/positioning and/or ability to access the device; and
3. Must have been conducted within 90 days of request for ACD.

(b) Recipient Information must include all of the following:

1. Name;
2. Medicaid number;
3. Date(s) of assessment;
4. Medical diagnoses (primary, secondary, tertiary); and
5. Relevant medical history.

(c) Sensory Status (by physician) must include all of the following:

1. Vision status;
2. Hearing status; and
3. Description of how vision, hearing, tactile, and/or receptive communication impairments affect expressive communication (e.g., sensory integration, visual discrimination).

(d) Postural, Mobility, and Motor Status must include all of the following:

1. Motor status;
2. Optimal positioning;
3. Integration of mobility with ACD; and
4. Recipient's access methods (and options) for ACD.

(e) Developmental Status must include all of the following:

1. Information on the recipient's intellectual/cognitive/developmental status; and
2. Determination of learning style (e.g., behavior, activity level).

(f) Family/Caregiver and Community Support Systems must include all of the following:

1. A detailed description identifying caregivers and support;
2. The extent of their participation in assisting the recipient with use of the ACD; and
3. Their understanding of the use and their expectations of the ACD.

(g) Current Speech, Language, and Expressive Communication Status must include all of the following:

1. Identification and description of the recipient's expressive or receptive (language comprehension) communication impairment diagnosis;
2. Speech skills and prognosis;
3. Communication behaviors and interaction skills (i.e., styles and patterns);
4. Description of current communication strategies, including use of an ACD, if any; and
5. Previous treatment of communication problems.

(h) Communication Needs Inventory must include all of the following:

1. Description of recipient's current and projected (e.g., within five years) speech/language needs;

2. Communication partners and tasks, including partners' communication abilities and limitations, if any; and

3. Communication environments and constraints which affect ACD selection and/or features.

(i) Summary of Recipient Limitations which must contain a description of the communication limitations.

(j) ACD Assessment Components must contain a justification for and use to be made of each component and accessory requested.

(k) Identification of *at least* three ACDs considered for recipient to include all of the following:

1. Identification of the significant characteristics and features of the ACDs considered for the recipient;

2. Identification of the cost of the ACDs considered for the recipient (including all required components, accessories, peripherals, and supplies, as appropriate);

3. Identification of manufacturer;

4. Justification stating why a device is the least costly, equally effective alternative form of treatment for the recipient; and

5. Medical justification of device preference, if any.

(l) Treatment Plan and Follow-Up must include all of the following:

1. Description of short-term and long-term therapy goals;

2. Assessment criteria to measure the recipient's progress toward achieving short-term and long-term communication goals;

3. Expected outcomes and description of how device will contribute to these outcomes; and

4. Training plan to maximize use of ACD.

(m) Documentation of recipient's trial use of equipment must include all of the following:

1. Amount of time;

2. Location; and

3. Analysis of ability to use equipment.

(n) Documentation of qualifications of speech/language pathologists and other professionals submitting portions of the evaluation must be present. Physicians are exempt from this requirement.

(o) A signed statement by submitting professionals that they have no financial or other affiliation with manufacturer, vendor, or sales representative of ACDs must be present. One statement signed by all professionals will suffice.

(8) Medicaid reserves the right to request additional information and/or evaluations by appropriate professionals.

(9) ACDs are subject to the following limitations. ACDs, including components and accessories, will be modified or replaced only under the following circumstances:

(a) Medical Change: Upon the request of recipient if a significant medical change occurs in the recipient's condition which significantly alters the effectiveness of the device.

(b) Age of Equipment: ACDs outside the manufacturer's or other applicable warranty which do not operate to capacity will be repaired. At such time as repair is no longer

cost-effective, upon request by the recipient, replacement of identical or comparable component or components will be made. Full documentation of the history of the service, maintenance, and repair of the device must accompany such requests.

(c) Technological Advances: No replacements or modifications will be approved based on technological advances unless the new technology would meet a significant medical need of the recipient which is currently unmet by the present device.

(10) All requests for replacement or modification as outlined in A-C above will require a new evaluation and complete documentation. If new equipment is approved, the old equipment must be turned in.

(11) Invoice: The manufacturer's invoice must be forwarded to the Medicaid Agency or its designee before the prior authorization is approved.

(12) Trial Period: No communication components will be approved unless the client has used the equipment and demonstrated an ability to use the equipment. Prior authorization for rental may be obtained for a trial period. This demonstrated ability can be documented through periodic use of sample/demonstration equipment. Adequate supporting documentation must accompany the request.

(13) Repair: Repairs are covered only to the extent not covered by the manufacturer's warranty. Repairs must be prior authorized. Battery replacement is not considered repair and does require prior authorization.

(14) Loss/Damage: Replacement of identical components due to loss or damage must be prior authorized. These requests will be considered only if the loss or damage is not the result of misuse, neglect, or malicious acts by the users.

(15) Component/Accessory Limits: Components or accessories which are not medically required will not be approved. Examples of non-covered items include, but are not limited to, printers, modems, service contracts, office/business software, software intended for academic purposes, workstations, or any accessory that is not medically required.

Author: Hattie M. Nettles, Associate Director, LTC Policy Advisory Unit.

Statutory Authority: State Plan Attachment 4.19-A; 42 CFR, Section 440.70; Title XIX, Social Security Act.

History: April 26, 1999. Amended: Filed August 21, 2001; effective November 16, 2001.

Amended: Filed October 20, 2008; effective February 3, 2009.

Rule No: 560-X-13-.15 Oxygen Therapy Coverage

(1) Effective December 1, 2000, Oxygen Therapy is covered for the entire Medicaid population based on medical necessity and must be prior authorized by the Medicaid Agency. Requests for prior authorization must be made on the appropriate Alabama Prior Review and Authorization Request Form. The request must be accompanied by appropriate medical and other required documentation.

(2) The medical diagnosis must indicate a chronic debilitating medical condition, with evidence that other forms of treatment (such as medical and physical therapy directed at secretions, bronchospasm and infection) were tried without success and that continuous oxygen therapy is required. Oxygen will not be approved for PRN use only.

Author: Hattie M. Nettles, Associate Director, LTC Policy Advisory Unit.

Statutory Authority: State Plan Attachment 4.19-A; 42 CFR, Section 440.70; Title XIX, Social Security Act.

History: New Rule: Filed August 21, 2001; effective November 16, 2001. **Amended:** Filed October 20, 2008; effective January 16, 2009.

Rule No. 560-X-13-.16 External Breast Prostheses

(1) Effective June 1, 2001, external breast prostheses following mastectomy for breast cancer are covered for all Medicaid-eligible recipients meeting the criteria.

(2) Coverage is available for the external breast prostheses when all of the following criteria are met:

(a) Recipient must be eligible for Medicaid on the date of service for provision of prostheses;

(b) The date of the mastectomy and the ICD-9 diagnosis code for which was performed (174.0-174.9, 198.81, 233.0) is provided in the clinical statement section of the appropriate Alabama Prior Review and Authorization Request Form; and

(c) The appropriate procedure codes are billed as indicated below:

Procedure Code	Description	Limits
L8000	Breast prosthesis, mastectomy bra, Maximum of 4 on initial request.	6/year
L8015	External breast prosthesis garment, with mastectomy form	2/year
L8020	Breast prosthesis, mastectomy form	**
L8030	Breast prosthesis, silicone or equal	**
*L8035	Custom breast prosthesis, post mastectomy, molded to patient model	
*L8039	Breast prosthesis, not otherwise classified evaluated on a case-by-case basis with submission of pricing information and medical documentation	

*These codes will be reviewed on a case-by-case basis. Additional documentation may be requested to determine medical necessity for coverage.

**Limited to two of L8020 per year or one L8020 and one L8030 per year or two of L8030 per year or one L8030 and one L8020 per year.

(3) Requests for prior authorization must be made on the appropriate Alabama Prior Review and Authorization Request Form and submitted to the Fiscal Agent, Prior Authorization Unit to obtain approval before providing the prosthetic devices.

(4) Maximum calendar year limits apply to each of the procedures as indicated above.

(5) Durable Medical Equipment (DME) providers of external breast prostheses devices for adults must be enrolled as an Alabama Medicaid Agency (AMA) provider and Mastectomy Fitters must be licensed by the Alabama Board of Prosthetics, Orthotics and Pedorthics.

Author: Vivian Bristow, Administrator, Pharmacy/ DME Unit

Statutory Authority: State Plan; 42 CFR, Section 440.70; Title XIX, Social Security Act.

History: New Rule: Filed October 12, 2001; effective November 16, 2001. **Amended:** Filed August 11, 2004; effective September 15, 2004. **Amended:** Filed May 11, 2012; effective June 15, 2012

Rule No. 560-X-13-.17 Motorized/Power Wheelchairs

(1) Motorized/power wheelchairs are a covered benefit for patients who meet full Medicaid eligibility criteria and medical necessity. The patient must meet criteria applicable to wheelchairs pursuant to this chapter and the Medicaid Provider Manual and the following additional criteria:

- (a) Documentation that a manual wheelchair cannot meet medical needs; and
- (b) Documentation of long term need for the chair (6 months or longer).

(2) Application process: All requests for motorized/power wheelchairs are subject to the Medicaid Prior Approval provisions and the following additional provisions:

(a) Medical documentation to support diagnosis from the patient's attending physician who has conducted a medical evaluation consisting of medical history, physical examination, assessment, and plan of care.

(b) An evaluation by a Physical Therapist or Occupational Therapist who meets credentialing requirements as provided in the Motorized/Power Wheelchair section of the Medicaid Provider Manual, conducted at sites specified therein and in accordance with, and the completion of, a form approved and provided by Medicaid.

(c) A supplier providing motorized/power wheelchairs to recipients must be registered as a Rehabilitation Technology Supplier (RTS) by the National Registry of Rehabilitation Technology Suppliers (NRRTS). As an alternative, a supplier shall be certified as a Certified Rehabilitation Technology Supplier (CRTS) or Assistive Technology Professional (ATP) from Rehabilitation Engineering and Assistive Technology Society of North America (RESNA). After October 1, 2004, only suppliers who are certified may participate.

(d) Itemized list of items with pricing.

(3) Reimbursement will be made pursuant to Rule 560-X-13-.10.

(4) Limitations and Exclusions

(a) Patients may be approved for one motorized/power wheelchair every seven years based on medical necessity/criteria.

(b) Home/environmental and vehicle adaptations, equipment and modifications are not covered.

(c) Repairs and/or replacement of parts require Prior Authorization.

Author: Vivian Bristow, Administrator, Pharmacy/DME Unit.

Statutory Authority: State Plan Attachment 4.19-A; 42 CFR, Section 440.70; Title XIX, Social Security Act.

History: New Rule: Emergency Rule filed and effective June 20, 2003. Amended: Filed July 21, 2003; effective October 24, 2003. Amended: Filed June 21, 2004; effective September 15, 2004. Amended: Filed July 20, 2005; effective October 14, 2005. Amended: Filed October 20, 2008; effective January 16, 2009. Amended: Filed January 21, 2009; effective April 17, 2009. Amended: Filed November 9, 2012; effective December 14, 2012.

Rule No. 560-X-13-.18 Basic Level Prosthetics, Orthotics, and Pedorthics for Adults.

(1) Basic level prosthetics, orthotics and pedorthics are covered benefits to Medicaid eligible recipients between the ages of 21 and 65 in a non-institutional and institutional setting. The recipients must meet established Medicaid criteria applicable to prosthetic, orthotic, and pedorthic devices pursuant to this chapter and the Medicaid Provider Manual.

(a) For items to be covered, recipients must meet eligibility requirements, the devices must be reasonable and necessary to improve the functioning of a malformed body member or replace an absent body member, and meet all other applicable Medicaid statutory and regulatory requirements.

(b) Durable Medical Equipment (DME) providers of prosthetic, orthotic, and pedorthic devices for adults must be enrolled as an Alabama Medicaid Agency (AMA) provider and licensed by the Alabama Board of Prosthetics, Orthotics and Pedorthics.

(c) The provider must be practicing as a prosthetic, orthotic, or pedorthic practitioner in the State of Alabama at an accredited facility.

(d) Providers must keep a copy of the written prescription from the primary physician for the prosthetic or orthotic device in the recipient's file.

(e) The provider must have documentation of the education follow-up provided to the recipient of the use of the prosthetic and orthotic device in the recipient's file.

(2) For Medicaid to approve lower limb prosthesis, medical documentation must be submitted substantiating that a prosthesis is essential in order for the recipient to ambulate and that the recipient is motivated to ambulate.

(3) For Medicaid to approve an orthotic device, medical documentation must be submitted to show that the device supports or aligns movable parts of the body, prevents or corrects deformities, or improves functioning.

(4) For Medicaid to approve therapeutic shoes for diabetes, medical documentation must be submitted showing that the recipient has diabetes mellitus and other medical conditions

justifying the need. Refer to DME Fee Schedule on the Alabama Medicaid Web site for Prosthetic, Orthotics, and Pedorthic reimbursement rates and benefit limits.

Author: Felicha Fisher, Medicaid Administrator, LTC Provider/Recipient Services Unit, Long Term Care Division.

Statutory Authority: State Plan Attachments 3.1-A and 4.19-B; 42 CFR Section 440.70; Title XIX, Social Security Act.

History: New Rule: Filed February 11, 2008; effective March 17, 2008. **Amended:** Filed December 30, 2008; effective February 3, 2009. **Amended:** Filed March 20, 2012; effective June 15, 2012.