DURABLE MEDICAL EQUIPMENT, PROSTHETICS, ORTHOTICS AND SUPPLIES

OVERVIEW

This manual is regarding coverage of durable medical equipment, prosthetics, orthotics, and supplies under the South Dakota Medicaid and CHIP state plans. Additional coverage may be available for individuals receiving extended state plan services through an HCBS waiver.

ELIGIBLE PROVIDERS

In order to receive payment, all eligible servicing and billing provider's National Provider Identifiers (NPI) must be enrolled with South Dakota Medicaid as a Durable Medical Equipment provider. South Dakota Medicaid has a streamlined enrollment process for eligible ordering, referring, and attending providers that may require no action on the part of the provider as submission of claims constitutes agreement to the South Dakota Medicaid Provider Agreement. Please refer to the provider enrollment chart for additional details on enrollment eligibility and supporting documentation requirement.

Providers desiring to supply durable medical equipment, prosthetics, orthotics and supplies (DMEPOS) must meet specific eligibility criteria. Providers and their given locations must be actively recognized and in good standing with Medicare as a supplier. Medical equipment and supplies may also be furnished incident to a physician's service.

Providers of hearing aid supplies such as batteries do not require Medicare recognition however, the provider must be licensed as a Hearing Aid Dispenser.

ELIGIBLE RECIPIENTS

Providers are responsible for checking a recipient's Medicaid ID card and verifying eligibility before providing services. Eligibility can be certified using South Dakota Medicaid's online portal.
The following recipients are eligible for medically necessary services covered in accordance with the limitation described in this chapter:

Coverage Type	Coverage Limitations
Medicaid/CHIP Full Coverage	Medically necessary services covered in accordance with the limitations described in this chapter.
Unborn Children Prenatal Care Program (79)	Coverage restricted to pregnancy related services only including issues that can harm the life of the mother or baby.

Eligibility information for specific services is provided in the Recipient Eligibility chapter.

COVERED ITEMS AND LIMITATIONS

General Coverage Principles
Providers should refer to the General Coverage Principles manual for basic coverage requirements all services must meet. These coverage requirements include:

- The provider being properly enrolled;
- Services being medically necessary;
- The recipient being eligible; and
- If applicable, the service must be prior authorized.

The manual also includes non-discrimination requirements providers must abide by.

General DMEPOS Coverage Criteria
Covered medical equipment includes medical equipment, prosthetic devices, and medical supplies required to improve the functioning of a malformed body part or treatment of an illness or injury that are listed on the South Dakota Medicaid's fee schedule website and prescribed by a physician or other licensed practitioner. Some items not listed on the fee schedule may be covered by South Dakota Medicaid and paid at a percent of the provider's usual and customary charge. The recipient's condition must meet applicable coverage criteria listed in the billing manual to be covered. Documentation substantiating the recipient's condition must be on file with the provider.

DME Face-to-Face Requirements
The initial ordering of medical equipment must comply with 42 CFR 440.70. For the initial ordering, a physician or other licensed practitioner must document a face-to-face encounter related to the primary reason the beneficiary requires the equipment. Authorized other licensed practitioner includes nurse practitioners, clinical nurse specialists, and physician assistants. The encounter must have occurred no more than 6 months prior to the start of services. The encounter may occur through telehealth. The face-to-face requirement is limited to DME items subject to such requirements under the Medicare program.

Prescription Requirements
DMEPOS must be prescribed in writing by a physician or other licensed practitioner for use in the recipient's residence. Per 42 CFR 440.70 a recipient's residence does not include a hospital, nursing facility, an intermediate care facility for individuals with developmental disabilities, or any setting in which payment is or could be made under Medicaid for inpatient services that include room and board. The prescription must be signed and dated by the physician or other licensed practitioner before the covered DMEPOS is provided. The effective date of the prescription is the physician or other licensed practitioner's signature date.

Documentation of medical necessity must be updated annually or when the physician or other licensed practitioner estimated quantity, frequency, or duration of the recipient's need has expired, whichever occurs first, unless otherwise specified in the South Dakota Medicaid's coverage criteria.

When equipment is rented, the initial prescription is valid for no more than one year and must be renewed at least annually thereafter or when the physician or other licensed practitioner estimated quantity, frequency, or duration of the recipient's need has expired, whichever occurs first. Documentation justifying continued use of rental equipment must be included in the medical record.

Supplies Coverage

Supplies necessary for the effective use or proper functioning of covered medical equipment are covered when:

- The equipment is covered by South Dakota Medicaid;
- The recipient's condition meets the coverage criteria for equipment; and
- The equipment is owned by the recipient.

Supplies Included in the Rental Payment

Per ARSD 67:16:29:02 supplies for rented DME are included in the rental payment, unless specifically exempted by South Dakota Medicaid.

- Ventilator supplies (A4611-A4613 and A4483) are included in the cost of the rental fee.
- Tracheostomy supplies (A4217, A4629, A4481, A7525, A4623-A4626, A4628, A4629, A7523-A7526, and A7520-A7522) may be billed separately.

Medical Equipment Maintenance and Repairs

Repairs to medical equipment are covered if:

- The item is covered by South Dakota Medicaid;
- The recipient's condition meets the coverage criteria for the item including medical necessity requirements. Medical necessity must be documented and a prescription for the replacement equipment must be on file;
- The item is owned by the recipient. Maintenance and repairs are not covered for equipment owned by a nursing facility or someone other than the recipient; and

The cost of repair may not exceed the purchase price of the new item. The cost of a repair to medical equipment that is under a warranty is not eligible for payment if the repair is covered by warranty. Providers must keep a copy of the warranty. The warranty must be provided upon request of the South Dakota Medicaid. Repairs or maintenance due to malicious damage or culpable neglect must be referred to South Dakota Medicaid for review.

Dispensing Supplies

Providers may not dispense more than one month of supplies at a time unless specifically permitted by coverage policy.

Refill Policy

Requests must come from the recipient or an authorized representative each time additional supplies are needed. The following guidelines must be used when dispensing refills through auto-shipment or delivery:

- It is acceptable for medical supply providers to call the recipient to verify a re-order but documentation indicating that the recipient or an authorized representative confirmed the need for the refill within the 30-day period prior to the end of the current supply is required.
- Automatically shipping supplies without an indication from the recipient or the recipient's authorized representative confirmation is not permitted.
- Dates of service for delivery of DMEPOS items are not allowed to be sooner than 10 calendar days before the expected end of the current supply.
- When shipping supplies, providers must note "10-day shipping window" in block 19 of the CMS 1500 claim form.

DME Education

HCPCS S9445 may be billed by DME providers when educating a South Dakota Medicaid recipient how to use durable medical equipment, providing safety information, or information regarding changing supplies.

Education is only reimbursable for items with an active South Dakota Medicaid rent to purchase payment, a continuous rental, or a DME item purchased by South Dakota Medicaid with a date of service of January 1, 2019 or later. Education is limited to 1 time per purchased item and 4 times per rent to purchase or continuous rental item per recipient in a state fiscal year.

S9445 is an encounter code. Encounters must be face-to-face and only one encounter is billable per date of service per recipient. Each encounter must be a minimum of 10 minutes. Education must be documented in the recipient's chart. Providers should obtain and maintain record of a signed and dated attestation from the recipient indicating that education was provided, the date it was provided, and the start and stop times of the service.

Back-up Equipment

Backup medical equipment is defined as an identical or similar device that is used to meet the same medical need for a recipient but is provided for precautionary reasons to deal with an emergency when the primary piece of equipment malfunctions. South Dakota Medicaid does not pay separately or make an additional payment for backup equipment.
For rental items in the Medicare frequent and substantial servicing payment category, the supplier must ensure there is an appropriate and acceptable contingency plan to address any emergency situations or mechanical failures of the equipment. Refer to the Medicare DMEPOS fee schedule for a list of these items.

The expectation is that an acceptable plan involves recipient and his/her treating physician or licensed practitioner's input and considers the severity of the condition and time restraints in providing emergency support. The supplier must ensure the recipient's medical needs for the equipment use will be met on a continuous and ongoing basis and have a plan in place to deal with any equipment failure/interruptions that may be life-threatening. The plan may include the supplier furnishing backup equipment; however, South Dakota Medicaid will not pay separately and/or make any additional payment for the backup equipment. The reimbursement for the primary piece of equipment includes the cost of that piece and the frequent and substantial servicing plan the supplier must provide to ensure

the recipient always has a working equipment. If the backup equipment is billed, it will be denied as not being reasonable and necessary.
Backup equipment is distinct from multiple medically necessary items that meet a different medical need for the recipient. South Dakota Medicaid does not pay separately for backup equipment but if the recipient's medical needs require it to serve a different purpose, South Dakota Medicaid may make separate payment for a second piece of equipment.

Requests for Coverage
Pursuant to 42 CFR 440.70(b)(3)(v), a provider may submit a prior authorization request for coverage of medical equipment, supplies, or appliances, that is generally not covered by South Dakota Medicaid.

DME Coverage Criteria

Apnea Machine
Apnea machines are covered for children under the age of three. The child needs to meet one or more of the following criteria:

- One or more apparent life-threatening events requiring mouth-to-mouth resuscitation or vigorous stimulation.
- An episode characterized by some combination of apnea or color change, choking or gagging.
- Symptomatic pre-term infants.
- Sibling of SIDS victim.
- Medical condition such as central hyperventilation and bronchopulmonary dysplasia.
- Infant with tracheostomy.
- History of recent vent requirement.
- Infant born to substance abusing mother.
- Infant/child with severe respiratory complications resulting in periods of apnea.

Pneumocardiograms are covered for diagnostic/evaluation purposes and when required to determine when the child may be removed from the monitor.

Apnea monitor rental exceeding six months requires a physician or other licensed practitioner's narrative report of the recipient's progress that must be maintained in the provider's file and submitted with the claim. A new progress report is required at least once every 90 days after the initial six months. The report must include:

- Number of apnea episodes during the previous 90 days period use;
- Tests and results of tests performed during the previous 90 days period of use; and
- Estimated additional length of time monitor would be needed.

Bath Aids and Commodes
Bath aids are covered for recipients under 21 years old.

Commodes are covered for all eligible recipients. Commodes/chairs are covered for recipients in the following conditions:

- The recipient is confined to a bed/room.

- The recipient is confined to a level of a home in which there are no bathroom facilities on that level.
- Bathroom facilities are inaccessible to the recipient.

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

Supplies and accessories are for replacement only for recipient owned commodes who meet our criteria for coverage.

Bedpan, Fracture Pans, and Urinals

Bedpans, fracture pans and urinals are covered for recipients who are bed confined.

Bone Growth Stimulators

Non-invasive (ultrasonic or electrical) bone growth stimulators (E0747, E0748, and E0760) are covered for skeletally mature individuals if one of the criteria below is met and South Dakota Medicaid prior authorizes the item. The nonunion cannot be related or due to malignancy.

- There is a nonunion of a long bone fracture and the fracture gap is less than or equal to 1 cm and it is greater than 90 days from the date of injury or initial treatment and cessation of healing is documented by 2 sets of radiographs with multiple views at least 90 days apart;
- There is a failed fusion of a joint (other than spine) and a minimum of nine months has elapsed since the last surgery;
- There is congenital pseudarthrosis;
- Closed fractures when there is suspected high risk for delayed fracture healing or nonunion as a result of either of the following:
    - due to location of fracture and poor blood supply (e.g. scaphoid, 5th metatarsal) or
    - presence of comorbidities likely to compromise healing (e.g. smoking, diabetes, renal disease, or other metabolic disease); or
- It is an adjunct to spinal fusion surgery for patients at high risk of pseudarthrosis due to a previously failed spinal fusion at the same site or for those undergoing multiple level fusions. For purposes of this authorization a multiple level fusion involves three or more vertebrae, for example: L2-L4, L3-L5, or L4-S1.

Prior Authorization Request

Providers must submit the following documentation with their prior authorization request:

- DME Prior Authorization Request Form
- All applicable medical records to support requirements.
    - These must include the appropriate x-ray reports and interpretations.

Blood Glucose Monitors and Sensors

Blood glucose self-testing equipment and supplies are covered for all people with diabetes, including non-insulin treated and gestational diabetes. The recipient or caregiver must be capable of learning to use the device prescribed and there is reason to anticipate the recipient will be compliant in testing. Voice-activated blood glucose monitors are covered when the recipient has a visual impairment severe enough to require use of this special monitoring system.

Covered equipment:

- Blood glucose monitors;
- Continuous blood glucose monitors if prior authorized by South Dakota Medicaid. Refer to the prior authorization criteria below;
- Blood glucose test strips;
- Lancet device and lancets; and
- Glucose control solutions for checking accuracy of testing equipment and test strips.

Blood glucose monitors must be ordered through a durable medical equipment provider. Blood glucose monitors ordered through a pharmacy are not covered.

One monitor is allowed every 4 years, only with documentation showing why a replacement is needed. Laser skin piercing device and urine strips are non-covered items.

Continuous Glucose Monitoring

South Dakota Medicaid covers the purchase of a continuous glucose monitoring system, including sensors, with a prior authorization for Medicaid recipients who meet the following conditions:

- The recipient has Type 1 diabetes mellitus;
- The recipient has Type 2 diabetes mellitus and is using rapid acting insulin (e.g., insulin lispro, insulin glulisine, insulin aspart/combination) and/or short acting insulin (e.g., insulin regular); or
- The recipient has gestational diabetes.

Continuation of CGM shall be reviewed at least every 12 months when the following criteria are met:

- For recipients with Type 1 diabetes mellitus:
    - Claims history review shows 50% of CGM compliance (6 fills out of 12 months) for recipients 21 year old and younger.
    - Claims history review shows 75% of CGM compliance (9 fills out of 12 months) for recipients 22 years and older.
- For recipients with Type 2 diabetes mellitus and using rapid acting insulin and/or short acting insulin claims history review shows 75% of CGM compliance (9 fills out of 12 months).
- For gestational diabetes mellitus the recipient must have an active pregnancy for renewal.

Expiration of warranty is not considered an automatic reason for replacement. When a CGM device (including sensor, receiver, transmitter, etc.) is defective, the manufacturer must be contacted in order to issue the replacement. Manufacturer contact information:

- Dexcom Customer Service: 1-888-738-3646
- Freestyle Libre Customer Service: 1-844-330-5535
- Guardian Customer Service: 1-800-646-4633.

Continuous Glucose Monitors should be ordered through a pharmacy and billed through a Point of Sale (POS) system unless the recipient is dual eligible (eligible for both Medicare and Medicaid). CGM claims for dual eligible must continue to be billed on a CMS 1500 form. Additionally, claims billed on a CMS 1500 form must be billed with both a HCPCS code and an 11-character NDC with no hyphens or spaces. An NDC is required as it allows the state to identify which manufacture should be billed for supplemental rebates. The NDC is found on the device package. The NDC submitted on the claim must

be the NDC number for the actual product dispensed. Refer to the CMS 1500 Claim Instructions for reporting the NDC on a claim.

South Dakota Medicaid does not cover remote monitoring systems for CGM devices for personal or family convenience.

Blood Pressure Home Monitoring Device

South Dakota Medicaid added coverage of blood pressure home monitoring devices (CPT codes A4660, A4663, and A4670) when used to assist a medical provider in making a diagnosis or for monitoring individuals with a condition or disease that requires in-home monitoring daily to at least weekly. Blood pressure devices and components are covered in the home setting for self-monitoring when the equipment is prescribed by a physician or other licensed practitioner for a recipient with one or more of the following conditions:

- Is suspected of having hypertension (labile or masked hypertension), or whose blood pressure is either elevated, or inconclusive when evaluated in the office alone;
- Is pregnant and meets one of the following conditions:
    - Has a history of gestational hypertension, preeclampsia, and/or eclampsia during prior pregnancy/pregnancies;
    - Is suspected of having gestational hypertension, chronic hypertension, preeclampsia, and/or eclampsia; or
    - Is suspected of having hypotension;
- Receives dialysis treatments at home;
- Receives medication that may cause hypertension or hypotension;
- Has an existing diagnosis of:
    - Hypertension;
    - Hypotension;
    - Polycystic renal disease;
    - Renal failure; or
    - Congestive Heart Failure

Providers must maintain documentation, including the diagnosis, that supports medical necessity of the requested equipment in the recipient's medical record and is subject to post payment review.

A blood pressure cuff monitor may be replaced after 12-months, only if the current monitor no longer functions properly and the device remains medically necessary.

Breast Pumps

Manual (E0602) and electric (E0603) breast pumps are covered when ordered by a physician or other licensed practitioner for any lactating mother wishing to nurse her newborn. The breast pumps should be used to promote lactation and to provide lactation support when natural feeding is not possible. Breast pumps are covered for women who are at least 28 weeks gestation or are currently breastfeeding. These items are available for purchase only and do not require prior authorization. Breast pumps should be billed under the mother's recipient ID number. If the mother is ineligible for Medicaid after delivery based on enrollment in the Unborn Children Prenatal Care Program Aid

Category (79), the provider should bill under the infant's recipient ID number. Coverage is limited to one manual breast pump per year, per family or one electric breast pump per family every 3 years.

Hospital Grade Electric Breast Pump

Hospital Grade electric pumps (E0604) are covered as a rental item only and are covered if medically necessary for 1 month. All supplies necessary to operate the hospital grade electric breast pump are included in the monthly rental fee. If a hospital grade electric breast pump is needed for more than 1 month, a prior authorization request must be submitted to South Dakota Medicaid. The authorization must include the reason why the hospital grade electric breast pump is needed and how long the breast pump is expected to be medically necessary.

The following prior authorization criteria must be met:

1. Mother has diagnosis of breast abscess, mastitis, engorgement or other medical problem that necessitates short-term rental of breast pump; or
2. Mother is hospitalized due to illness or surgery on a short-term basis; or
3. Mother will receive short-term treatment with medications that may be transmitted to the infant; or
4. Pediatric Healthcare provider determines need for short term rental of heavy-duty pump due to a serious medical condition of the infant.

Canes and Crutches

Canes and crutches are covered for recipients with a medical condition that causes instability or impairs balance. A white cane for use by a blind person is considered an identifying and self-help device rather than an item which makes a meaningful contribution to the treatment of an illness or injury and is therefore not covered.

Accessories such as tips, handgrips, etc. are payable only as replacement for use with recipient-owned canes or crutches for recipients whose condition meets the criteria for coverage of the item.

Compression Stockings

Compression stockings are a covered service. The prescribing physician or other licensed practitioner should specify on the prescription the number of pairs or single stockings the recipient requires. This number may be based on the length of need, how many hours per day the recipient is wearing the stockings, and other relevant factors. Compression stockings are limited to 4 units (2 pair) initially and up to 4 additional units (2 pair) annually, not to exceed 8 units in a 12-month period. If the prescriber does not specify a quantity, the recipient is limited to 4 units (2 pair).

For recipients with pregnancy only coverage, medical documentation must be submitted with the claim that indicates the compression stockings are medically necessary and related to the pregnancy.

CPAP/BIPAP Criteria

Recipients Age 21 or Older

South Dakota Medicaid will cover CPAP/BIPAP equipment when the recipient has a diagnosis of moderate to severe OSA, central or complex sleep apnea, neuromuscular condition, limited thoracic

expansion or restrictive lung disease, or hypoventilation syndrome and the following criteria have been met:

- Apnea/hypopnea index (AHI) or respiratory disturbance index (RDI) or respiratory event index (REI) is > or equal to 15 as documented by polysomnography (PSG) or home/portable sleep study; OR
- AHI/RDI/REI is > or equal to 5 and <15 as documented by PSG or home/portable sleep study and associated with documented symptoms of excessive daytime sleepiness as scored by the Epworth Sleepiness Scale greater than 10, impaired cognition, mood disorders or insomnia or when the individual has hypertension, ischemic heart disease, or history of stroke.

The AHI or RDI or REI is calculated based on at least two hours of continuous recorded sleep or, if calculated based on less than two hours of sleep, the total number of recorded events to calculate the AHI or RDI or REI must be at a minimum the number of events that would have been required in a 2-hour period.

Recipients Age 20 or Younger:
CPAP is allowed for recipients age 20 or younger who have a diagnosis of obstructive sleep apnea.

- Sleep study must show an apnea index of 1 or greater; and
- Adenotonsillectomy has been unsuccessful in relieving OSA, is inappropriate based on OSA being attributable to another underlying cause or is contraindicated or adenotonsillar tissue is minimal.

All Recipients
Equipment will be covered for an initial 12-week period at which time documentation is required that the recipient is compliant with usage for at least 4 hours per day, 70 percent of the nights and that symptom/s have improved. Usage criteria must be met to continue rental to purchase of the CPAP device. For BIPAP device, any diagnosis other than OSA must have additional documentation supporting the need for this device.

When there is a break in continuous rental payments of three or more consecutive months, a new CPAP order or prescription must include a qualifying sleep study. A qualifying sleep study performed within the last 5 years is sufficient. A qualifying sleep study performed more than 5 years ago must be repeated.

Supplies
The following supplies for CPAPs (E0601), BIPAPs (E0470, E0471), and humidifiers (E0562) are considered included in the rental fee and may not be billed separately at initial set-up:

- Tubing;
- Reusable filter; and
- Disposable filter.

A complete mask may be billed separately at initial set-up. The purchase of the mask includes headgear. Headgear may not be purchased separately at initial set-up. South Dakota Medicaid will not

purchase multiple types of masks at one time. Replacement tubing, reusable filters, disposable filters, and headgear may be purchased at the following intervals.

Code	CPAP Supply	Replacement Interval
A7037	Tubing	1 Per 6 Month Interval
A7039	Reusable Filter	1 Per 6 Month Interval
A7035	Headgear	1 Per 6 Month Interval
A7038	Disposable Filter	2 Per Month
A7031	Full Face Mask Cushion	1 Per Month
A7032	Nasal Mask Cushion	1 Per Month
A7033	Nasal Pillows	2 Per Month
A7027 or A7034 or A7030	Combination Oral Nasal Mask or Nasal Mask or Full-Face Mask	1 Per 6 Month Interval
A7036	Chin Strap	1 Per 6 Month Interval

Recipients under the age 21 may exceed the interval limits when medically necessary.

Continuous Passive Motion (CPM) Machine for Use on the Knee (E0935)
CPM machines are covered after a knee replacement/arthroplasty. The use of the CPM machine must begin within two days following surgery and is only covered for 10-21 days when used in the recipient's home. The daily rental rate includes all accessories necessary for proper functioning and effective use of the device. Prior Authorization of a CPM machine is required and the following medical necessity criteria must be met:

- It is consistent with the recipient's symptoms, diagnosis, condition, or injury;
- It is recognized as the prevailing standard and is consistent with generally accepted professional medical standards of the provider's peer group;
- It is provided in response to a life-threatening condition; to treat pain, injury, illness, or infection; to treat a condition that could result in physical or mental disability; or to achieve a level of physical or mental function consistent with prevailing community standards for diagnosis or condition;
- It is not furnished primarily for the convenience of the recipient or the provider; and
- There is no other equally effective course of treatment available or suitable for the recipient requesting the service which is more conservative or substantially less costly.

Prior Authorization Request
Providers must submit the following documentation with their prior authorization request:

- DME Prior Authorization Request Form
- Physician or other licensed practitioner's prescription
- Applicable medical records

External Insulin Pump
External Insulin Pumps and supplies necessary for the effective use and proper functioning of the device are covered for recipients with Type 1 or Type 2 diabetes who meet the following guidelines:

- Daily self-testing (at least 3-4 times a day) and quarterly Hgb A1C test for at least six months;
- Has completed a comprehensive diabetes education program (or caregiver for recipients under age 21);
- Has been on a program of multiple daily injections of insulin >3 per day with frequent self-adjustments of insulin dose;
- Is motivated and mentally capable of proper operation of the pump (or caregiver for recipients under age 21); and
- Meets at least two or more of the following:
    - Elevated A1c greater than 7%, or
    - Wide fluctuations in blood glucose before mealtime (e.g. pre-prandial blood glucose levels commonly exceed 140 mg/dl), or
    - Dawn phenomenon with fasting blood sugars frequently exceeding 200 mg/dl, or
    - History of severe glycemic events commonly associated with brittle diabetes, such as hypoglycemic unawareness, nocturnal hypoglycemia, extreme insulin sensitivity and/or very low insulin requirements.

Back-up insulin pumps and replacement of a functioning insulin pump are not covered.

Cough Stimulating Devices

Cough stimulating devices require prior authorization. Cough stimulating devices, also known as In-Exsufflation devices, are considered medically necessary for recipients with neuromuscular disease which causes a significant impairment of chest wall and/or diaphragmatic movement, and which results in an inability to clear secretions, when standard treatments have failed or are medically contraindicated. To be medically necessary, the covered service must meet the following conditions:

- It is consistent with the recipient's symptoms, diagnosis, condition, or injury;
- It is recognized as the prevailing standard and is consistent with generally accepted professional medical standards of the provider's peer group;
- It is provided in response to a life-threatening condition; to treat pain, injury, illness, or infection; to treat a condition that could result in physical or mental disability; or to achieve a level of physical or mental function consistent with prevailing community standards for diagnosis or condition;
- It is not furnished primarily for the convenience of the recipient or the provider; and
- There is no other equally effective course of treatment available or suitable for the recipient requesting the service which is more conservative or substantially less costly.

Prior Authorization Request

Providers must submit the following documentation with their prior authorization request:

- DME Prior Authorization Request Form
- Medical records including:
    - Physician or other licensed practitioner's prescription;
    - Any previous hospitalizations for respiratory illness;

- All previous therapies tried (E.G. chest percussion and postural drainage, intermittent positive pressure breathing (IPPB), incentive spirometry, inhalers, positive expiratory pressure (PEP) mask therapy, or flutter devices); or
- Documentation supporting why other more conservative treatments have not been attempted.

Cranial Remolding Orthosis

Cranial Remolding Orthosis (CRO) are covered if medically necessary and documentation includes the following:

- Diagnosis must be consistent with the recipient's symptoms and condition and be rated as moderate to severe.
- Documentation of the initial evaluation and course of treatment with progress.
- Documentation of a 2 month trial of repositioning. If a 2 month trial of repositioning is not done, thorough documentation explaining why.
- Documentation of how other existing conditions (torticollis, complications at birth, prematurity, etc.) affect the condition and treatment.
- Documentation that justifies why a custom molded helmet is the most effective course of treatment and that there is no other equally effective course of therapy that is more conservative or substantially less costly, such as a prefabricated helmet.

Prefabricated helmets are covered for recipients under age 21 when medically necessary in conditions that include but are not limited to:

- Seizure disorders; and
- Head banging.

Prefabricated helmets may be considered with documentation of medical necessity if the childhood (under age 21) conditions transfer into adulthood (over age 21).
Helmets for sports or recreational activities are not covered.

Gait Trainers

Gait Trainers are a covered service for children 20 years of age and younger if prior authorized by South Dakota Medicaid if medical necessity is met.

Prior Authorization Request

Providers must submit the following documentation with their prior authorization request:

- DME Prior Authorization Request Form
- Medical records including:
  - Physician or other licensed practitioner's prescription;
  - Evaluation for the device;
- Therapy records (PT and OT);
  - Estimated amount of time per day they intend to use the device; and
  - Other durable medical devices that the child uses or anticipates using (e.g. Stander, power wheelchair, etc.).

Hearing Aids

Coverage for hearing aids is limited to the procedure codes contained on the South Dakota Medicaid's fee schedule and is subject to the following restrictions:

- The hearing aid must be prescribed either by a physician, other licensed practitioner, or by a certified clinical audiologist;
- The hearing loss must be equal to or greater than an average loss of 30 decibels at 500, 1,000, and 2,000 hertz or a loss of 30 decibels at 2,000 hertz or above;
- The hearing loss may be in either ear or both ears; however, the loss must be present in any ear being fitted with a hearing aid;
- Hearing aid services include the ear mold, fitting, follow-up services, and cleaning over a 24-month period and any services or repairs covered under the manufacturer's warranties;
- Hearing aid services are limited to one unit of service per procedure.

South Dakota Medicaid covers the following types of hearing aids; Monaural, Binaural and BaHa system, CROS (ages 0-20) and BiCROS (ages 0-99). All hearing aids are subject to the limits and payment provisions established in ARSD § 67:16:29.

Ear molds are considered an integral part of the initial hearing and are included in the reimbursement of the hearing aid. Ear molds may only be replaced for recipients under age 21 and 12 months after the initial dispense of the hearing aid or after the expiration of the manufacturer's warranty, whichever is greater. The provider must document that the ear mold requires replacement due to growth, breakage, or loss. V5264 is considered a per unit code. Providers should only bill 2 units if dispensing 2 ear molds.

A claim for hearing aids may not be submitted until 30 days after placement. A claim may not be submitted if the hearing aids are returned during a trial period.

Hearing aid batteries are covered for full coverage recipients who require hearing aids unless they reside in a nursing home. If the recipient resides in a nursing home, hearing aid batteries are an integral part of services provided by the nursing home.

Quantities of hearing aid batteries are limited to what is reasonably expected to be used in a monthly period.

Replacement Hearing Aids

Replacement hearing aids may be provided only after a minimum of three years has elapsed and the warranty has expired since the original fitting and if the original hearing aids are no longer serviceable.

Lost or Stolen Hearing Aid(s)

- Hearing aid(s) that are lost may be replaced prior to the three-year minimum and if the warranty has expired for recipients 0-21 years of age.
- Hearing aid(s) lost while residing in a skilled nursing facility (SNF), are the responsibility of the SNF.

- For recipients age 21 or older, a minimum of three years must have passed, prior to replacement.
- Stolen hearing aid(s) replacement(s) require documentation of a police report.

Broken Hearing Aids

Damaged/broken hearing aid(s) should always be repaired under the warranty if possible.

- Recipients under the age of 21 may receive new hearing aid(s) if the warranty has expired.
- For recipients aged 21 or older, the hearing aid(s) may be replaced prior to the three-year minimum when deemed as appropriate (not broken due to neglect or misuse) by the DME provider.

Providers should document in Box 19 of the HCFA claim that the hearing aid(s) were broken or broken beyond repair.

High Frequency Chest Wall Compression or Intrapulmonary Percussive Ventilation Devices

High frequency chest wall oscillation may be considered medically necessary when all of the following criteria are met:

- The diagnosis is cystic fibrosis, chronic diffuse bronchiectasis, ciliary dyskinesia, or certain chronic neuromuscular diseases with a history of pneumonia.
- Documented presence of bronchopulmonary secretions with need for airway clearance.
- Effective chest physiotherapy is required. If conventional manual Chest PT is unavailable, ineffective, or not tolerated, there should be documented failure of standard treatments (chest physiotherapy and, if appropriate use of an oscillatory positive expiratory pressure device), or valid reasons why standard treatment cannot be performed.
- A trial period is required to determine patient and family compliance. Sufficient and appropriate usage of the device during the trial period must be documented.
- The device is prescribed by a pulmonologist.
- The device should not be used prophylactically to prevent onset of respiratory symptoms.

Hospital Beds, Mattresses and Accessories

Hospital beds, mattresses and accessories are covered for recipients who require positioning of the body, in ways not feasible with ordinary beds, due to a medical condition. Hospital beds are not payable unless the recipient is confined to a bed for at least 75 percent of each 24-hour day.

Fixed height – manual head and leg elevation adjustments, but no height adjustment. Covered if one or more of the following criteria are met:

- Recipient has medical condition, which requires positioning of the body in ways not feasible with an ordinary bed. Elevation of the head/upper body less than 30 degrees does not usually require the use of a hospital bed, or
- Recipient requires positioning of the body in ways not feasible with an ordinary bed in order to alleviate pain, or
- Recipient requires the head of the bed to be elevated more than 30 degrees most of the time due to congestive heart failure, chronic pulmonary disease, or problems with aspiration. Pillows

or wedges must have been trialed and ruled out. An attempt must have been made at using pillows or wedges and there must be documentation as to why they did not work, or

- Recipient requires traction equipment, which can only be attached to a hospital bed.

Hospital Bed Type	Description
Variable height	Manual height adjustment and with manual head and leg elevation adjustment. Covered if recipient meets one of the criteria for a fixed height bed and requires a bed height different than a fixed height hospital bed to permit transfers to chair, wheelchair or standing position.
Semi-electric	Manual height adjustment and with electric head and leg elevation adjustment. Covered if recipient meets one of the criteria for a fixed bed and requires frequent changes in body position and/or has an immediate need for a change of body position.
Total electric	Electric height adjustment and with electric head and leg elevation adjustment. Covered if the medical need for a semi-electric bed is met and the need for height adjustment is required to meet the recipient's desire to remain independent in transfer. Documentation of the ability to transfer from a physical therapist or occupational therapist is required. Electric beds are not covered to assist the caregiver.
Heavy duty	Covered if recipient meets one of the criteria for a fixed height bed and the recipient's weight is more than 300 pounds but does not exceed 600 pounds.
Extra-Heavy-Duty	Covered if the recipient meets one of the criteria for a fixed height bed and the recipient's weight exceeds 600 pounds.
Trapeze	Covered if recipient need this device to sit up because of a respiratory condition, to change body position or for other medical reasons, or to get in or out of bed. Heavy-duty trapeze is covered if the recipient's weight is more than 250 pounds.
Bed cradles	Covered when necessary to prevent contact with bed coverings, for example gouty arthritis or burns.
Side Rails	Covered when required by recipient's condition and are an integral part of, or an accessory to, a covered hospital bed. Side rails that are not permanently attached to a hospital bed are covered for recipients who are at risk for injury due to one or more of the following conditions: • Disorientation; • Vertigo and • A neurological disorder resulting in convulsive seizures.
Overbed table	Not covered as they are not primarily medical in nature and are considered a convenience item.
Replacement beds or mattresses	May be provided only after a minimum of three years of service from the date of purchase of the original equipment. This limit applies for all replacement beds and mattresses, even if the equipment may be somewhat different, such as the replacement of a manual bed with an electric bed. An exception may be made

	to this subsection if the individual's physical condition requires earlier replacement of the equipment. The prescribing physician or other licensed practitioner must document the need for the replacement equipment on the prescription.

Incontinence Supplies

Eligible Individuals

Individuals must have a medical condition that involves loss of bladder or bowel control and be at least 3 years of age to receive incontinence supplies. Individuals residing in a nursing facility, intermediate care facility or hospital are not eligible for incontinence supplies as supplies are considered included in the institutional cost of care. All supplies must meet South Dakota Medicaid's medical necessity guidelines as described in ARSD 67:16:01:06:02.

Physician Order

Incontinence supplies must be ordered by a physician or other licensed practitioner. A face-to-face visit is not required. Documentation substantiating the recipient's condition and the diagnosis requiring incontinence supplies must be on file with the provider.

The prescriber must note a quantity or amount of supplies on the prescription for a 1 month supply. Information in the recipient's medical record should support the amount prescribed. If the prescriber is unsure of the amount to prescribe, the prescriber should write orders for a shorter duration of time and adjust the amount based on medical need. The provider should estimate the amount of supplies and associated dollar amount to be used by the recipient each month. The physician or the DME provider may populate the purchase price. Providers may put "N/A" in the "Manufacturer" and "Equipment Serial #" field.

A change to a different brand or size must be documented by the DME provider.

Coverage Restrictions

The following coverage restrictions apply:

- Supplies may only be dispensed in one month, or less, quantities based on the physician's order.
- Supplies cannot be auto refilled. The recipient has to request additional supplies.
- Gloves are covered for use by a primary caregiver (ex. Spouse, Parent, Child, Personal Care Attendant). Gloves are not covered for Medicaid providers. Products to practice infection control and ensure health and safety as it relates to universal precautions are the responsibility of the provider.
- Delivery is considered included in the cost of supplies per ARSD 67:16:29:07 and the recipient cannot be charged for delivery.
- Recipients must use both a Medicaid enrolled provider and an in-network provider for their private insurance to ensure Medicaid coverage of incontinence supplies.

South Dakota Medicaid does not have any restrictions regarding brands, but recipients should be mindful of the associated limits and budget accordingly.

Service Limits

Payments for incontinence supplies will be limited to $3,500 per recipient per plan year (July 1 to June 30) unless otherwise specified by the Department of Human Services. Recipients may exceed this limit with prior authorization from South Dakota Medicaid or the recipient's HCBS waiver. If the recipient is enrolled in a HCBS waiver operated by the Department of Human Services, authorization to exceed the limit must be obtained from the Department of Human Services. Enrollment in an HCBS waiver may be verified using the South Dakota Medicaid Online Portal.

Gloves (A4927) are not included in the service limit and do not currently have a quantity limit. Wipes (A4335) are included in the service limit.

Service Limit Inquiry

South Dakota Medicaid offers a Service Limit lookup tool through the "Recipient Info" tab on the Medicaid Portal. Providers have the ability to search incontinence supply service limits on a given recipient. The results returned on the "Service Limits" tool are not a guarantee of coverage or eligibility. For additional information see the Service Limits User Guide.

HCPCS Codes

The following HCPC Codes may be billed for incontinence supplies:

HCPC	Description
T4521	Adult Diaper/Brief Small
T4522	Adult Diaper/Brief Medium
T4523	Adult Diaper/Brief Large
T4524	Adult Diaper/Brief XL
T4525	Adult Underwear/Pull-On Small
T4526	Adult Underwear/Pull-On Medium
T4527	Adult Underwear/Pull-On Large
T4528	Adult Underwear/Pull-On XL
T4529	Pediatric Diaper/Brief Small
T4530	Pediatric Diaper/Brief Large
T4531	Pediatric Underwear/Pull-On Small
T4532	Pediatric Underwear/Pull-On Large
T4533	Youth Diaper/Brief
T4534	Youth Underwear/Pull-On
T4535	Disposable liner/shield/pad
T4537	Reusable underpad bed size
T4539	Reusable diaper/brief any size
T4540	Reusable underpad chair size
T4541	Large disposable underpad
T4542	Small disposable underpad
T4543	Adult Diaper/Brief Above XL
T4544	Adult Underwear/Pull-On Above XL

T4545	Penile Wrap

Providers are expected to bill per piece for a 30-day supply and follow recognized coding guidelines for billing incontinence supplies, including use of a date span for the 30-day supply period. Gloves must be billed using HCPC A4927. Wipes must be billed using HCPC A4335. Providers may not use any other codes to bill for incontinence supplies. Billing for incontinence supplies under other HCPCS codes may be considered fraudulent or abuse of the program.

Claims

Providers must bill other third-party primary health insurance if applicable. A provider must attach the EOB to each claim form if there is a third-party payer. A claim cannot be processed without the EOB. Medicare does not cover incontinence supplies, so providers do not have to bill Medicare prior to billing South Dakota Medicaid.

Prior Authorization Request

Providers must complete the following:

- Prior Auth: Incontinence Supplies All Waivers document
- The physician or other licensed practitioner's order prescribing the supplies
- Available medical records or evaluation to support the above requirements

Low Air Loss/Pressure Reduction Therapy

Pressure reduction overlay or mattress, low-air-loss bed therapy, and air-fluidized therapy is covered with a prior authorization if the following criteria is met:

- The services must be provided in the recipient's place of residence;
- Services are limited to three months when prescribed by a physician or other licensed practitioner for the active healing and treatment of extensive stage III or stage IV pressure sores. South Dakota Medicaid may grant a one-time, three-month extension if the provider can provide evidence that the wound is healing, but has not completely healed;
- Services are limited to a maximum of one month when prescribed by a physician or other licensed practitioner for postoperative healing of skin grafts and flap closures;
- A low-air-loss bed or an air-fluidized system is limited to one which does not have a built-in scale;
- Services must include weekly wound care consultation by the provider with consultation available 24 hours a day;
- The provider must submit monthly documentation showing progress of the healing of the wound.

Prevention of pressure sores and pain control is not covered.

Prior Authorization Request

Providers must submit the following documentation with their prior authorization request:

- DME Prior Authorization Request Form

- The physician or other licensed practitioner's order prescribing the therapy, including the length of therapy;
- Medical Records including:
    - Diagnosis;
    - A history of the skin breakdown, including methods of prevention and other treatment used prior to consideration of pressure reduction or low-air-loss bed therapy and the recipient's response to those methods or treatments or documentation of why more conservative treatments have not been attempted;
    - Anticipated length of treatment;
    - Description of the wound, its site, stage, size, depth, and drainage; wound treatments;
    - General medical status and coexisting medical conditions; nutritional status and dietary consultation; recommended calorie intake with a summary of percent consumed; fluid intake; hydration; skin turgor; continence status;
    - Mobility status including amount of time off the therapy and ability to ambulate and reposition; and
    - Pictures of the pressure sore.

Monthly documentation must include the following:

- Physician or other licensed practitioner's documentation outlining the patient's progress and the specific medical reasons for the continued need for pressure reduction therapy. Progressive wound healing must be documented for continued approval;
- The patient's status, including a description of the wound, its site, stage, size, depth, and drainage; wound treatments; general medical status and coexisting medical conditions; nutritional status and dietary consultation; recommended calorie intake with a summary of percent consumed; fluid intake; hydration; skin turgor; continence status; mobility status; and amount of time off the therapy and ability to ambulate and reposition; and
- Pictures showing the wound healing process.

Lymphedema Pumps

Coverage of lymphedema pumps is subject to the following restrictions:

- The pump must be provided in the recipient's residence; and
- All other first-line treatments, such as salt restriction and wrapping, have failed.
- The item has been prior authorized by South Dakota Medicaid.

A non-segmental pump must be utilized first, unless medically contraindicated. A segmental pump may be authorized if the non-segmental pump fails to control the condition. Authorization for a segmental pump is based on documentation which substantiates the medical contraindication for the non-segmental pump or the failure of the non-segmental pump to control the condition.

The rental period is 90 days with re-authorization dependent on medical necessity and the recipient's compliance with treatment. At the end of six months, the South Dakota Medicaid will determine whether to purchase the pump. A determination to purchase is based on the recipient's compliance with treatment, medical necessity, and cost-effectiveness.

Before the South Dakota Medicaid authorizes a lymphedema pump, the provider must provide documentation to South Dakota Medicaid which substantiates the medical necessity of the pump. Medical documentation must include the diagnosis, the first line medical treatment attempted, and the anticipated length of treatment.

If the segmental pump is being required, documentation must substantiate the medical contraindication for the non-segmental pump.

Nebulizers

Nebulizers are covered to administer aerosol therapy when use of metered dose inhaler is not adequate or appropriate. If the drug(s) used with a nebulizer are not covered, the nebulizer is considered not medically necessary and not covered. For example, South Dakota Medicaid does not cover HCPCS Q4074, so the nebulizer is not covered for use with this drug. Nebulizers are limited to one purchase per recipient per 5 years.

A small volume nebulizer, E0570, is covered if:

- The recipient has a medical condition where it is medically necessary to deliver a prescribed medication via a nebulizer such as, Bronchiolitis, Bronchospasm, COPD, Cystic Fibrosis, Asthma, HIV, RSV etc.

A small Ultrasonic nebulizer, E0574, is covered only when other means of mobilization are documented by a physician or other licensed practitioner to be ineffective.

A heated nebulizer, E0585, is covered for clients with tracheotomies that require heated oxygen.

A large volume nebulizer, E0575, is covered if it:

- It is medically necessary to deliver humidity to a recipient with thick tenacious secretions, who has cystic fibrosis, bronchiectasis, a tracheotomy or tracheobronchial stent.

All supplies and accessories necessary for proper functioning and effective use of the device are included in the purchase price of the device. Supplies may be billed for recipient owned equipment include:

- Replacement/disposable neb-kits;
- Replacement tubing;
- Disposable mouthpieces; and
- Face mask.

Negative Pressure Wound Therapy Pumps

Negative pressure wound therapy pumps are covered if prior authorized by South Dakota Medicaid. To be medically necessary, negative pressure wound therapy pumps must meet the following conditions:

- It is consistent with the recipient's symptoms, diagnosis, condition, or injury;
- It is recognized as the prevailing standard and is consistent with generally accepted professional medical standards of the provider's peer group;

- It is provided in response to a life-threatening condition; to treat pain, injury, illness, or infection; to treat a condition that could result in physical or mental disability; or to achieve a level of physical or mental function consistent with prevailing community standards for diagnosis or condition;
- It is not furnished primarily for the convenience of the recipient or the provider; and
- There is no other equally effective course of treatment available or suitable for the recipient requesting the service which is more conservative or substantially less costly.

Prior Authorization Request

Providers must submit the following documentation with their prior authorization request:

- DME Prior Authorization Request Form
- Physician's prescription
- Applicable medical records or evaluation to meet above requirements.

Dressing Kits and Canister Sets

Dressing kits (HCPCS A6550) and canister sets (HCPCS A7000) are covered if the equipment was prior authorized by South Dakota Medicaid. Dressing kits are limited to a maximum of 15 units per wound per month. Canister sets are limited to 10 units per month unless there is documentation evidencing a large volume of drainage (greater than 90 ml of exudate per day). For high volume exudative wounds, a stationary pump with the largest capacity canister must be used. Regardless of utilization, a supplier must not dispense more than a 1-month quantity at a time.

Ostomy and Urological Supplies

Covered for recipients with an ostomy or need for catheters.

Oxygen and Oxygen Equipment

South Dakota Medicaid coverage of home oxygen and oxygen equipment under the durable medical equipment benefit is considered reasonable and necessary only for recipients with significant or severe hypoxemia. Significant or severe hypoxia is defined as a PO2 below 55mmHg or an O2 saturation of 89% or less. Oxygen for children under age 21 is covered when prescribed. In order for portable oxygen to be covered, the recipient must be mobile within the home.

All medically necessary oxygen equipment is rental only and exempt from capped rental. Additionally, the following information is required to be documented in the provider record:

- A diagnosis of the disease requiring use of oxygen;
- Flow rate in liters per minute;
- Type of system ordered, i.e. cylinder gas, liquid gas or concentrator;
- Results of blood gas studies (ABG or pulse oximetry) evaluated by the attending physician or other licensed practitioner including the condition of the test (at rest, during exercise, during sleep); and
- Frequency and duration ("PRN" or "as needed" are only acceptable with documentation of usage parameters).

Thermal Fuse

Thermal fuses are safety devices designed to prevent fires in home oxygen therapy setups. Thermal fuses are covered when billed using HCPCS code E0700. Coverage is limited to 2 units in a 2 year period, not to exceed 4 units per recipient.

Patient Lift

A lift is a portable transfer system used to move a non-ambulatory recipient over a short distance from bed to chair/wheelchair, chair/wheelchair to bed, or wheelchair to commode.

Hydraulic or Mechanical Lift (Standard lift)

The patient lift is covered if the following criteria are met:

- Recipient/caregiver must be able to use the lift and completed a successful trial.
- Without the use of a lift the recipient would be confined to the bed.

Electric Lift

An electric lift may be covered if the recipient meets the criteria for the hydraulic lift and if documentation is provided showing why a standard lift (Hoyer Type) will not work.

Seat/sling is a covered item for replacement on a patient-owned lift only and cannot be billed in addition to rental equipment.

Phototherapy (Bilirubin)

Home phototherapy (HCPCS E0202) is covered for treatment of jaundice in infants when medically necessary. E0202 is a daily rental and the rental period is limited to 7 days. The limit may be exceeded if the claim is submitted with supporting documentation that demonstrates medical necessity. If a claim is submitted with more than 7 units and without supporting documentation, the claim will be denied.

Pulse Oximeter

Pulse Oximeters are covered for recipients requiring a minimum of daily monitoring of arterial blood oxygen saturation levels for evaluating and regulating home oxygen therapy.

Finger probe is part of rental and should not be billed separately. Finger probes can only be billed for purchased, recipient owned equipment.

Safety Bed (Cubby Bed)

Safety beds must be billed under the most specific CPT codes for the product (e.g. E0328 and E0316). Safety beds will not be approved under E1399 as there are more specific codes available. Environmental controls and technology hubs (E1399) are not a covered service per Administrative Rule 67:16:01:08.

An enclosed bed or cubicle bed or canopy bed is considered medically necessary when all of the following 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 a safety risk;

- There is a risk of injury due to the member's mobility;
- At least one of the following are documented;
    - An active seizure disorder;
    - Uncontrolled movements related to a diagnosis that places the member at risk for injury;
    - Self-injurious behavior that would be expected to improve through use of the requested bed;
- Documentation that at least two safety measures have been considered and either ruled out as contraindicated or tried and failed including, but not limited to:
    - Side rails;
    - A mattress on the floor;
    - Protective helmet;
    - Posey vest;
    - Weighted blankets;
- A signed physician's order and documentation that the member has been assessed for appropriateness of the bed and has no contraindications.

A safety enclosure frame/canopy/bubble top may be covered when it is for safety use. It is not a covered benefit when it is used for purposes of confinement or for the convenience of family or caregivers. Enclosed bed systems that are not approved by the FDA are not a covered benefit**.**

Speech Generating Device

The individual's speech-language pathologist must obtain prior authorization from the South Dakota Medicaid before an augmentative communication device or a modification to a previously authorized device is provided. The individual's speech-language pathologist must submit the following information to South Dakota Medicaid:

- A copy of the physician or other licensed practitioner's order for the device; and
- An assessment containing the information specified below which has been completed by a speech-language pathologist which may contain input from other health professionals, as necessary.

An assessment for an augmentative communication device must contain the following information:

- A description of the speech-language pathologist's qualifications and training, including experience and training in the area of augmentative communication devices;
- A description of the experience and training of other professionals involved in preparing the assessment;
- Information which identifies the individual, including the individual's name and the individual's birth date, social security number, or South Dakota Medicaid identification number;
- The date of assessment;
- The medical diagnosis, including primary, secondary, and tertiary and any significant medical history;
- The status of the individual's senses, including vision and hearing;
- A description of how vision, hearing, tactile, or receptive communication impairments or disabilities affect expressive communication;

- A description of the individual's postural, mobility, and motor status, including optimal positioning, integration of mobility with the augmentative communication device, and the individual's methods and options for accessing augmentative communication devices;
- A description of the individual's current speech, language, and expressive communication status, including the individual's expressive and receptive communication skills and a prognosis, and a description of past treatment, if any;
- A description of the individual's current and projected communication needs, including communication partners and tasks and the partner's communication limitations, if any;
- A description of the components needed on a device to meet the individual's needs, including:
    - Vocabulary requirements;
    - Representational systems;
    - Display organization and features;
    - Rate enhancement techniques;
    - Message characteristics, speech synthesis, printed output, display characteristics, feedback, auditory and visual output, and access techniques and strategies; and
    - Portability and durability;
- A summary of communication limitations that preclude or interfere with meaningful participation in current and projected daily activities;
- Identification of significant characteristics and features of the augmentative communication devices considered for the individual;
- Identification of the cost of the augmentative communication devices considered for the individual, including all required components, accessories, peripherals, and supplies;
- A description of the recommended device and the required components, accessories, peripheral devices, and supplies; and
- A statement which indicates why the recommended device is better able to overcome or ameliorate the individual's communication limitations.

Prior Authorization Request

Providers must submit the following documentation with their prior authorization request:

- DME Prior Authorization Request Form
- Evaluation by a speech pathologist meeting requirements above

Repairs

If the repair or maintenance of an augmentative communication device is expected to exceed $500, South Dakota Medicaid must authorize the services before they are provided. If seeking prior authorization, the speech-language pathologist must submit the following information to South Dakota Medicaid:

- A description of the problem and the repairs or maintenance needed;
- A statement as to the effectiveness or estimated durability of the repair or maintenance; and
- A written estimate of the cost of the repairs or maintenance, including parts and labor.

Purchase of Warranty

South Dakota Medicaid may purchase a warranty for a communication device South Dakota Medicaid will make the decision to purchase the warranty on a case-by-case basis and will consider existing circumstances such as the following:

- The age of the device;
- The age of the recipient;
- The type of device being purchased;
- The cost of the device being purchased; and
- The warranty being offered.

Specialty Mobility Devices

Specialty mobility devices/wheelchairs are listed in their own section later in this manual.

Standing Frames

Standing frames are covered for recipients under age 21 only. Coverage is allowed if the following conditions are present:

- Recipient can demonstrate tolerance for standing and partial weight bearing;
- Recipient must have a physical therapy evaluation;
- Recipient and/or caregivers demonstrate the capability, and motivation to be compliant;
- The equipment must match the user's need and ability level; and
- Recipient is unable to stand without the aid of adaptive equipment.

If a recipient has a gait trainer, they are not a candidate for a standing frame. This would be a duplicative service.

Suction Machine

Suction machines are covered when prescribed, medically necessary, and appropriate for home use without technical or professional supervision. Coverage for recipients who have difficulty raising and clearing secretions secondary to:

- Cancer or surgery of the throat or mouth
- Dysfunction of the swallowing muscles
- Unconsciousness or obtunded state
- Tracheotomy

Sterile saline is allowed for trach suctioning only. Sterile saline is not medically necessary for oropharynx suctioning.

Transcutaneous Electrical Nerve Stimulators (TENS) Units

A TENS unit is covered for recipients with chronic, intractable pain or acute post-operative pain who meet the following criteria:

- A TENS unit is not covered for acute pain (less than three months duration) other than post-operative pain.
- For chronic intractable pain, the medical record must document the location of the pain, the duration of time the recipient has had the pain and the presumed etiology of the pain. The

documentation must also include other treatments that have failed, including, medication names, dosages and length of trial.
- For acute post-operative pain, coverage is limited to no more than one month following the day of surgery.
- The electrode and lead wires are covered as replacement for recipient-owned equipment only and cannot be billed with rental equipment.

Ventilators
Ventilators are supplied on a continuous rental basis. All supplies, accessories, services, maintenance and required back-up equipment necessary for proper functioning and effective use of the equipment is included in the rental fee and cannot be billed separately.

Walkers
Walkers are covered for recipients with conditions that impair ambulation and there is a need for greater stability and security than provided by a cane or crutches that is clearly documented. Equipment must match needs and ability level.

Heavy-duty walkers are covered for a recipient with a weight (within one month of providing the walker) greater than 300 pounds.

Heavy-duty, multiple braking system and variable wheel resistance walkers are covered for recipients who meet coverage criteria for a standard walker and are unable to use a standard walker due to a severe neurologic disorder or other condition causing the restricted use of one hand.

Note: Obesity, by itself, is not enough reason for heavy duty, multiple braking system, variable wheel resistance walker. If heavy duty walker is provided and the coverage criteria for a standard walker are met, but the additional coverage criteria for a heavy duty, multiple braking system, variable wheel resistance walker are not met, payment will be denied.

Payment for purchase and rental of walkers includes all accessories necessary for proper functioning and effective use of the item.

The following supplies/accessories are covered as replacement for recipient-owned walkers only and cannot be billed in addition to new equipment or rental equipment.
- Handgrip
- Tip
- Platform attachment
- Wheels
- Leg extensions

Wound Care Dressings and Surgical Supplies
Dressings are covered medically necessary and 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. All bandages when used for strains, sprain, edema, or situations other than as a dressing for a wound are non-covered items.

SPECIALTY MOBILITY DEVICES

Mobility devices are covered for eligible South Dakota Medicaid recipients with a mobility limitation that significantly impairs their ability to participate in one or more mobility-related activities of daily living and the mobility limitation cannot be sufficiently resolved by the use of an appropriately fitted cane or walker. Daily living refers to activities such as toileting, feeding, grooming, education, working, or job training.

- The mobility device must enable the recipient to participate in mobility related activities of daily living and be appropriate to the recipient's needs and abilities.
- When a power wheelchair is purchased for a recipient who already has a manual wheelchair, South Dakota Medicaid will assume that the power wheelchair is replacing the manual wheelchair. Repairs to the manual wheelchair will not be covered.
- To be considered custom molded seating, the wheelchair must require significant customization to maintain the recipient in an appropriate position. The use of supports alone does not constitute customization.
- Wheelchairs may only be replaced on a five-year basis, unless there are extenuating circumstances such as:
    - Recipient has grown more than expected;
    - A change in the recipient's physical condition;
    - Extensive wear of the wheelchair; or
    - The mobility device is damaged beyond repair due to a fire, vandalism, or automobile accident. A police or fire department report is required.

Non-covered Mobility Devices

Mobility devices are not covered in the following circumstances:

- Power mobility devices if requested solely for the purpose of community outings such as attending social activities.
- Mobility devices requested to meet behavioral needs rather than mobility needs.
- Mobility devices requested solely for use in a public school if the device can be covered through an individualized education program (IEP).
- Backup devices if requested in case of equipment malfunction, unless the recipient's power chair has custom molded seating such that the recipient cannot be served by a loaner or rental chair.
- Mobility devices designed for sports or recreational purposes.
- Wheelchairs with stair climbing ability.
- Options and accessories to convert a manual chair to a power chair (E0983-E0984).
- Power operated vehicles.
- Adult power wheelchairs not reviewed by Medicare's Pricing, Data Analysis and Coding (PDAC) contractor or reviewed by the PDAC contractor and found not to meet the definition of a specific power mobility device. To determine the correct HCPCS code for a power mobility device, access the Durable Medical Equipment Coding System (DMECS) Product Classification List.

Wheelchairs in Long-Term Care Facilities

South Dakota Medicaid does not cover medical equipment for a resident in a nursing facility or an intermediate care facility for individuals with intellectual disabilities. If a recipient enters a long term care facility with a wheelchair he or she owns, South Dakota Medicaid covers repair or replacement of the device. Standard repair and replacement coverage and prior authorization criteria applies. If a recipient is being discharged to the community, a mobility device that meets the individual's needs may be approved.

Mobility Devices that Require Prior Authorization

Prior authorization is always required under the following circumstances:

- All mobility device purchases except for standard manual wheelchairs and custom manual wheelchairs (HCPCS K0001 and K0008). Claims for these wheelchairs must be submitted with documentation that support medical necessity. As K0001 is a rental the documentation must only be submitted with the claim for the first month.
- All power wheelchairs.
- All mobility device rentals after three months except standard manual wheelchairs.
- Modifications to an existing wheelchair if the submitted combined charges for parts and labor are $1,000.00 or more.
- Repairs or replacement of parts or accessories if the submitted combined charges for parts and labor are $1,000.00 or more.
- Repairs or replacement of parts or accessories that are less than 365 days old.
- Miscellaneous parts billed with HCPCS code K0108 when the submitted charge for the part is $400.00 or more, regardless of the submitted combined charges for repairs or modifications.
- Professional services associated with custom molded seating systems.
- Custom molded seating systems when the submitted charge is over $1,200.00. Mobility device authorization requests must include the signed and dated order for the device. Providers should check Medicare's list of durable medical equipment items subject to face-to-face encounter requirements.

An approved prior authorization from a primary payer may satisfy South Dakota's prior authorization requirements. The provider must submit the primary insurance approval documents for review.

Prior Authorization Requests

To request a prior authorization complete the Durable Medical Equipment Request Form. Providers must include with their request applicable information referenced below:

- Documentation of Recipient Ability to Use In-home
    - All prior authorization requests must demonstrate the mobility device fits in all necessary areas of the home and the recipient is able to use the mobility device in all necessary areas of the home:
        - The request must also address transportation of the mobility device in the recipient's vehicle if appropriate. If the recipient does not have a vehicle, address the recipient's primary transportation method.

  - For manual wheelchairs without seating or propulsion options, the demonstration may be performed with the same or similar equipment.
  - For other mobility devices, the demonstration must be performed with equipment with the same specifications as to measurement and maneuverability and power options.
  - If the recipient is homeless, there must be a plan for charging power mobility devices and for safe storage of the device.
  - In all cases, the proposed device must be medically necessary and appropriate for the recipient.
- Power mobility devices for recipients under age 4
  - Power mobility devices will not be considered for recipients under age 24 months. Authorization requests for power mobility devices for children under age 4 must include:
    - Documentation, including any relevant assessments, that the child is developmentally and cognitively ready to begin to operate a power wheelchair;
    - Documentation that the child is expected to use a powered mobility device as a primary means of mobility for several years. It is not necessary that there is no expectation or hope of functional walking in the future;
    - Documentation of the age-appropriate ADLs for which the child is expected to use the power mobility device; and
    - Documentation that the caregivers have carefully considered the risks and benefits of independent power mobility for very small children.
  - Due to the expense of mobility devices for very small children, it is particularly important that issues of transportation be addressed to eliminate the need for multiple mobility devices.
- Mobility devices for recipients under age 21
  - Authorization requests must include an assessment by a licensed or certified medical professional (physical therapist, occupational therapist, or physician with training in rehabilitation wheelchair evaluations). The assessment must address both the recipient's current and expected future mobility needs.
- Mobility devices for recipients with recent spinal cord or brain injuries
  - Authorization requests must include therapy notes detailing the recipient's progress toward goals, the expected outcome of therapy for the recipient, and the expected time until maximum benefit from therapy is achieved.
- Group 1 or Group 2 No Power Option wheelchairs
  - Authorization requests for recipients with progressive diseases or conditions must include an assessment by a licensed/certified medical professional of the effects of the disease's progress on the recipient's ability to use the requested mobility device and an estimate indicating how long the requested mobility device is expected to meet the recipient's mobility needs. Medical professional includes physical therapist, occupational therapist, or physician with training in rehabilitation wheelchair evaluations.
- Group 2, 3, 4 or 5 Single or Multiple Power Option power wheelchairs
  - Authorization requests must include a functional assessment by a licensed or certified medical professional (physical therapist, occupational therapist, or physician with training in rehabilitation wheelchair evaluations).

- Repair or modification prior authorization requests
    - When requesting prior authorization for repairs or modifications to a mobility device not originally authorized by South Dakota Medicaid, include documentation of medical necessity for the device, and the accessories to be repaired/replaced. Repairs must meet the requirements of ARSD 67:16:29:03. The cost of repair may not exceed the purchase price of the new item. The cost of a repair to a mobility device that is under a warranty is not eligible for payment if the repair is covered by the warranty. Repairs or maintenance due to malicious damage or culpable neglect must be referred to the department for review.
    - Replacement of worn batteries, battery chargers, wheels, tires or arm pads is not considered a repair. Prior authorization is not required, regardless of submitted charge, unless the part being replaced is less than one year old. Replacement of other components is considered a repair and is subject to the $1,000.00 limit.
    - Authorizations may be denied if:
        - The repairs or modifications are not cost effective because the age or condition of the device indicates replacement is more appropriate.
        - The frequency or extent of repairs requested indicates the recipient lacks the ability to safely and appropriately operate the device. It may be necessary to consider a different mobility device for the recipient.
        - The repairs or modifications are requested for a device that does not currently meet South Dakota Medicaid criteria for coverage

Standard Manual Wheelchairs (E1229 and K0001)

Standard Manual wheelchairs with standard options and accessories are covered without a prior authorization if the recipient meets the criteria for a mobility device and has one of the following:

- A caregiver who is available, willing and able to provide assistance; or
- Sufficient upper extremity function to propel an optimally configured manual wheelchair to participate in mobility-related activities of daily living during a typical day.

Standard options and accessories for manual wheelchairs include:

- Calf rests or pads
- Fixed height arm rests (fixed, swing-away or detachable)
- Footrests and footplates (fixed, swing-away or detachable)
- Hand rims with or without projections
- Wheel lock assemblies

Nonstandard options and accessories for manual wheelchairs may include:

- Adjustable height arm rests
- Anti-rollback device
- Elevating leg rests
- Head rest extensions
- Nonstandard seat frames (standard is 15” – 19” width and depth)
- One-arm drive attachments

- Positioning accessories
- Push activated power assist
- Safety belts/straps
- General use seat and back cushions
- Skin protection seat and back cushions

Do not bill the following manual wheelchair accessory codes within 30 days of initial issue of a manual wheelchair:

Manual Wheelchair Accessory Codes				
E0967	E2210	E2226	K0044	K0070
E0981	E2220	K0015	K0045	K0071
E0982	E2221	K0017	K0046	K0072
E0995	E2222	K0018	K0047	K0077
E1011	E2223	K0019	K0050	
E2205	E2224	K0042	K0052	
E2206	E2225	K0043	K0069	

Do not bill K0195 with any manual wheelchair that is billed with modifier NU.

Hemi-wheelchairs (K0002)
Hemi-wheelchairs are covered if the recipient has one of the following needs:

- Requires a lower seat height (less than 19 inches) because of short stature; or
- To propel the chair with their feet.

Lightweight or Ultra-lightweight Manual Wheelchairs (K0003 and K0005)
Lightweight (34 – 36 lbs.) or ultra-lightweight (less than 30 lbs.) manual wheelchairs are covered if the recipient:

- Primarily uses a manual wheelchair rather than a power mobility device;
- Can propel him or herself in the requested chair; and
- May be at risk for shoulder pain or injury related to propelling the wheelchair.

High Strength, Lightweight Wheelchairs (K0004)
High strength, lightweight wheelchairs are covered if the recipient primarily uses a manual wheelchair rather than a power mobility device and:

- Can propel themselves in the requested chair; or
- Needs a high strength wheelchair to be safe because of medical conditions such as spasticity or seizures.

Heavy Duty or Extra Heavy Duty Wheelchairs (K0006-K0007)
Heavy duty or extra heavy duty wheelchairs are covered if the recipient has one of the following needs:

- Requires the chair because of weight; or
- Has a medical condition such as spasticity, which requires a heavier duty chair for safety.

Tilt in Space Manual Wheelchairs (E1161)

Tilt in Space manual wheelchairs are covered if the recipient has one of the following needs:

- Is at high risk for pressure ulcers and is unable to perform a functional weight shift; or
- Has increased or excess muscle tone or spasticity related to a medical condition that is anticipated to be unchanging for at least one year.

Power Wheelchairs (K0813-K0898)

All power wheelchairs require a prior authorization. A power wheelchair may be covered if the recipient has a specific medical need that cannot be met with a less costly alternative.

Power wheelchairs are covered if the recipient:

- Meets the criteria for a mobility device;
- Does not have sufficient upper extremity function to self-propel an optimally configured manual wheelchair to perform mobility-related activities of daily living;
- Has a caregiver who cannot push a manual chair;
- For a recipient under age 4, has been evaluated and found to be developmentally ready to begin to operate a power chair equipped with appropriate attendant control and safeguards;
- Is able to bring the power wheelchair into the home for use and storage or if homeless, has demonstrated a plan to safely charge and store the power wheelchair.

Standard equipment includes:

- All types of tires and wheels
- Any back width
- Any seat width and depth
- Weight-specific components required by the patient-weight capacity of the wheelchair
- Battery charger
- Fixed swing-away or detachable footrests or foot platform, including angle adjustable footrests for group 1 or 2 power wheelchairs
- Fixed swing-away or detachable non-adjustable armrests with arm pad
- Fixed swing-away or detachable non-elevating leg rests with or without calf pad
- Lap belt or safety belt
- Non expandable controller
- Standard integrated or remote proportional joystick
- All labor charges involved in the assembly of the wheelchair

Nonstandard options or accessories may include:

- Adjustable height arm rests
- Elevating leg rests
- Angle adjustable footrests for group 3, 4 or 5 power wheelchairs
- Manual fully reclining back option
- Power tilt
- Power recline
- Seat elevator

- Shoulder harness or straps or chest straps or vest
- Skin protection seat cushions, position accessories
- Standing feature
- Expandable controller
- Nonstandard joystick or alternative control device

Do not bill the following codes within 30 days of initial issue of a power wheelchair:

Power Wheelchair Accessory Codes				
E0971	E2369	E2386	E2396	K0043
E0978	E2370	E2387	K0015	K0044
E0981	E2374	E2388	K0017	K0045
E0982	E2375	E2389	K0018	K0046
E0995	E2376	E2390	K0019	K0047
E1225	E2381	E2391	K0020	K0051
E2366	E2382	E2392	K0037	K0052
E2367	E2384	E2394	K0041	K0098
E2368	E2385	E2395	K0042	

Do not bill E2377 when used with a Group 1 or Group 2 no power option power wheelchair and do not bill K0040 when used with a Group 1 or Group 2 power wheelchair.

Group 1 (K0813-K0816) or Group 2 No Power Option (K0820-K0829) Power Wheelchairs

Group 1 or Group 2 no power option power wheelchairs are covered if the recipient:

- Meets the criteria for a power wheelchair;
- Does not require a single or multiple power option wheelchair; and
- Does not require a drive control interface other than a hand operated standard proportional joystick.

Group 2 Single Power Option Power Wheelchairs (K0835-K0840)

Group 2 single power option power wheelchairs are covered if the recipient has one of the following:

- Meets coverage criteria for a power tilt or power recline seating system; or
- Requires a drive control interface other than a hand operated standard proportional joystick (examples include but are not limited to chin control, head control, sip and puff, switch control).

Group 2 Multiple Power Option Power Wheelchairs (K0841-K0843)

Group 2 multiple power option power wheelchairs are covered if the recipient has one of the following:

- Meets coverage criteria for power tilt and recline seating system;
- Requires a drive control interface other than a hand operated standard proportional joystick and meets criteria for a power tilt or power recline seating system; or
- Uses a ventilator mounted on the wheelchair.

Group 3 No Power Option Power Wheelchairs (K0848-K0855)

Group 3 no power option power wheelchairs are covered if the recipient:

- Has mobility limitations due to a neurological condition, myopathy, congenital skeletal deformity or the recipient has a significant medical condition which requires the use of seating, positioning or other accessories that cannot be adequately accommodated by a Group 1 or Group 2 power wheelchair.

Group 3 Single Power Option Power Wheelchairs (K0856-K0860)

Group 3 single power option power wheelchairs are covered if the recipient:

- Has mobility limitations due to a neurological condition, myopathy, congenital skeletal deformity or the recipient has a significant medical condition which require the use of seating, positioning or other accessories that cannot be adequately accommodated by a Group 1 or Group 2 power wheelchair; and
- The Group 2 single power option criteria are met.

Group 3 Multiple Power Option Power Wheelchairs (K0861-K0864)

Group 3 multiple power option power wheelchairs are covered if the recipient:

- Has mobility limitations due to a neurological condition, myopathy, congenital skeletal deformity or the recipient has a significant medical condition which require the use of seating, positioning or other accessories that cannot be accommodated by a Group 1 or Group 2 power wheelchair; and
- The Group 2 multiple power option criteria are met.

Group 4 No Power Option Power Wheelchairs (K0868-K0871)

Group 4 no power option power wheelchairs are covered if the recipient:

- Cannot safely use an equivalent Group 3 power wheelchair without significant modifications to the recipient's living environment;
- Has mobility limitations requiring the use of seating and positioning items that cannot be accommodated by a Group 1 or Group 2 power wheelchair; and
- Meets the criteria for a power wheelchair.

Group 4 Single Power Option Power Wheelchairs (K0877-K0880)

Group 4 single power option power wheelchairs are covered if the recipient:

- Has mobility limitations due to a neurological condition, myopathy, congenital skeletal deformity or the recipient has a significant medical condition which require the use of seating, positioning or other accessories that cannot be accommodated by a Group 1 or Group 2 power wheelchair;
- Cannot safely use an equivalent Group 3 power wheelchair without significant modifications to the recipient's living environment or meets criteria for accessories that are not available on a Group 3 power wheelchair; and
- Meets the Group 2 single power wheelchair criteria.

Group 4 Multiple Power Option Power Wheelchairs (K0884-K0886)

Group 4 Multiple Power Option Power Wheelchairs are covered if the recipient:

- Has mobility limitations due to a neurological condition, myopathy, congenital skeletal deformity or the recipient has a significant medical condition which require the use of seating, positioning or other accessories that cannot be accommodated by a Group 1 or Group 2 power wheelchair;
- Cannot safely use an equivalent Group 3 power wheelchair without significant modifications to the recipient's living environment or meets criteria for accessories that are not available on a Group 3 power wheelchair; and
- Meets the Group 2 multiple power options criteria.

Group 5 power wheelchairs (K0890-K0891)

Group 5 power wheelchairs are covered if the recipient:

- Meets the criteria for a power wheelchair;
- Meets the criteria for a single or multiple power option; and
- Is expected to grow in height or whose size is best served by a Group 5 power wheelchair.

Specialty Mobility Devices, Options and Accessories

Specialty mobility device options/accessories are covered when medically necessary for use with a medically necessary rental or recipient-owned wheelchair base, to allow the recipient to perform activities of daily living, or to function in the home. An option/accessory that is beneficial primarily in allowing the recipient to perform leisure or recreational activities or for the convenience of the recipient or caregiver is not covered. The following list of options and accessories is not all-inclusive; many additional options and accessories may be covered if medically necessary. Provider may be requested to submit additional documentation of medical necessity beyond what is typically required. Mounting hardware is covered when it corresponds to appropriate, covered options and accessories.

One Arm Drive Attachments (E0958)

One arm drive attachments are covered with a prior authorization if:

- The recipient meets the criteria for a manual wheelchair, but is unable to use both arms or at least one lower extremity to safely propel the manual wheelchair; and
- A trial demonstrated the recipient has the strength, stamina and cognitive ability to propel the wheelchair using the one arm drive attachment.

A separate review for medical necessity is not required when part of a new wheelchair.

Push Activated Power Assist (E0986)

Push activated power assist is covered with a prior authorization if the recipient:

- Has expressed an unwillingness to operate a power wheelchair; and
- Was self-propelling in a manual wheelchair but no longer has sufficient upper extremity function to self-propel a manual wheelchair or has weakness or repetitive motion stress to the shoulders or upper arms.

Documentation must include:

- An assessment of the distance the recipient is expected to need to operate the manual wheelchair;

- A trial sufficient to demonstrate the recipient is able to operate the manual wheelchair for that distance; and
- An estimate indicating how long the push activated power assisted manual wheelchair is expected to meet the recipient's mobility needs.

Seating Systems/Cushions General Criteria

Seating/cushions are covered when medically necessary for use with a medically necessary wheelchair base, for a recipient who has a diagnosed medical condition that impairs their ability to sit.

A wheelchair seating system may be covered to:

- Support the recipient in a position that minimizes the development or progression of musculoskeletal impairment;
- Relieve pressure; or
- Provide support in a position that improves the recipient's ability to perform functional activities.

Additional criteria is provided below for certain seating systems/cushions.

Power Tilt (E1002)

Power tilt is covered with a prior authorization if the recipient:

- Meets criteria for a power wheelchair;
- Is able to independently operate the power tilt system; and
- Has one of the following needs:
    - Is at risk for pressure ulcers and is unable to perform a functional weight shift;
    - Has a fixed hip angle; or
    - Has increased or excess muscle tone or spasticity related to a medical diagnosis which impairs their ability to tolerate the fully upright sitting position for significant periods of time.

Power Recline (E1003-E1005)

Power recline is covered with a prior authorization if the recipient:

- Meets criteria for a power wheelchair;
- Is able to independently operate the power recline system; and
- Has one of the following:
    - Is unable to tolerate a full upright position due to a medical condition which impairs their ability to tolerate the fully upright sitting position for significant periods of time;
    - Uses intermittent catheterization; or
    - Has edema and is unable, for physical or other reasons, to periodically transfer from the wheelchair to elevate the legs.

If a reclining seating system is approved because a recipient has edema, manual or power elevating leg rests must be requested.

Power Tilt and Recline Seating Systems (E1006-E1008)

Power Tilt and Recline Seating Systems, with or without power elevating legs rests (E1006-E1008) are covered with a prior authorization if the recipient:

- Meets criteria for a power wheelchair;
- Is able to independently operate the power tilt and recline system; and
- Meets criteria for both power tilt and power recline.

If a reclining seating system is approved because a recipient has edema, manual or power elevating leg rests must be requested.

Mechanical Leg Elevation Systems (E1009)
Mechanical leg elevation systems are covered if the recipient:

- Meets criteria for a wheelchair; and
- Has one of the following:
- Has a medical condition which prevents 90 degrees of knee flexion;
- A treatment program to decrease flexion contractures of the knee; or
- Leg edema which cannot be treated by an edema control wrap, a recline feature as part of the wheelchair and is unable, for physical or other reasons, to periodically independently transfer from the wheelchair to elevate legs.

A separate review for medical necessity is not required when part of a new wheelchair.

Power Leg Elevation Systems (E1010, E1012)
Power leg elevation systems are covered with a prior authorization if the recipient:

- Meets criteria for a power wheelchair;
- Is able to independently operate the power leg elevation system; and
- Has one of the following:
    - A medical condition which prevents 90 degree of knee flexion;
    - A treatment program to decrease flexion contractures of the knee; or
    - Leg edema which cannot be treated by an edema control wrap, a recline feature as part of the wheelchair and is unable for physical or other reasons, to periodically independently transfer from the wheelchair to elevate the legs.

Manual, Fully or Semi-Reclining Backs (E1014, E1225, E1226)
Manual, fully or semi-reclining backs are covered with a prior authorization if the recipient has one of the following:

- At high risk for pressure ulcers and is unable to perform a function weight shift;
- Uses intermittent catheterization for bladder management and is unable to independently transfer from the wheelchair; or
- Is unable to tolerate a full upright position due to a medical condition.

Gear Reduction Drive Wheels (E2227)
Gear reduction drive wheels are covered with a prior authorization if the recipient:

- Meets criteria for a manual wheelchair; and
- Is at risk for weakness or repetitive motion injury to the arms or shoulders.

A separate review for medical necessity is not required when part of a new wheelchair.

Dynamic Seating Frame (E2295)
Dynamic Seating Frame is covered with prior authorization when:

- The requested dynamic seating frame is made by the same manufacturer as the requested pediatric wheelchair;
- The requested pediatric wheelchair independently meets all criteria for medical necessity and least costly appropriate equipment;
- The recipient does not require tilt-in-space or reclining back; and
- The recipient is able to engage in some hip or knee extension.

Seat Elevation Feature (E2300)
Seat elevation feature is covered with a prior authorization if the recipient has one of the following:

- Must routinely transfer between uneven surfaces and the surfaces cannot be adjusted and the seat elevation feature allows them to independently transfer;
- Cannot be safely transferred using a patient lift or standing transfer but can safely transfer with the seat elevation feature; or
- The seat elevation feature has been demonstrated to allow the recipient to independently access areas in the home necessary for completion of activities of daily living (ADLs) (cupboards, closets, etc.).

Documentation must specify where uneven transfers will be needed in the recipient's home, or where in the home safe transfers cannot be made using a patient lift or standing transfer.

A seat elevation feature is not covered when requested solely to allow the recipient to socialize with peers.

If a seat elevation feature is approved for a recipient, the provider must obtain documentation from the recipient or the recipient's authorized representative acknowledging that he or she understands that the seat elevation function may affect future requests for personal care services or home care services before dispensing and billing for this item. This documentation must be made available to South Dakota Medicaid upon request.

Alternative Interface Devices (E2312, E2321-E2330, E2373, E2399)
Alternative interface devices are covered with a prior authorization if a recipient meets criteria for a power wheelchair and cannot safely operate the wheelchair using a hand or chin-operated standard proportional joystick, but can safely operate the wheelchair using the alternative device. Alternative interface devices cannot primarily be for leisure or recreation activities.

A separate review for medical necessity is not required when part of a new wheelchair.

Power Wheelchair Attendant Control (E2331)
Power wheelchair attendant control is covered with a prior authorization if the recipient:

- Meets criteria for a mobility device but is unable to operate a manual or power wheelchair;

- Requires a power wheelchair or lacks a caregiver able to propel a manual chair; and
- Has a caregiver willing and able to operate the power wheelchair and assist the recipient.

A power wheelchair attendant control is not covered for individuals under the age of five.

Wheelchair Component or Accessory, Not Otherwise Specified (K0108)
Miscellaneous items are covered if medically necessary or if required for the functioning of other covered items. For example, if a high mount footrest is needed because the chair has a power or manual tilt, the high mount bracket is covered. Prior authorization is required only if the submitted charge for an individual item is $400.00 or more.

Custom Molded Seating Systems
Custom molded seating systems provide positioning or pressure relief that cannot be met with a prefabricated cushion. They are fabricated from an impression or digital image of the recipient using molded-to-patient techniques.

Custom molded seating systems may be entirely created by the provider or may be purchased from the manufacturer. Seating systems that are purchased from the manufacturer must have been coded E2609 / E2617 by the Medicare Pricing, Data Analysis and Coding (PDAC) to be considered custom molded seating.

Prior authorization is always required for professional services associated with custom molded seating systems. Include a statement and certification number to verify the provider is certified by the American Board for Certification of Orthotics or by the RESNA with the authorization request**.**

Professional services associated with custom molded seating systems include evaluating the recipient's seating needs, taking impressions or creating digital images, and making any necessary adjustments to the seating system.

Custom molded seating systems (E2609/E2617) require authorization when the submitted charge is over $1,000.00.

Bill labor and material costs associated with fabricating an individually made sitting support spinal orthosis to South Dakota Medicaid using one of the following HCPCS codes:

- K0108 with modifier UD: professional services associated with the evaluation, molding and fitting of custom molded seating systems.
- E2609: Seat module molded to fit a recipient, custom fabricated for attachment to wheelchair base.
- E2609, E2617: Seat and back sections molded as one piece, custom fabricated for attachment to wheelchair base.
- E2609, E2617 for repairs: Repair to custom seating systems. Detail the cost of material. Use modifier RB.
- K0739: repairs to seating systems, per 15 minutes labor. Clearly state in the documentation that the repairs are for a seating system and not for the wheelchair.

ORTHOTICS COVERAGE CRITERIA

Orthotics are covered when they are required to support a weak or deformed body member or to restrict or eliminate motion in a diseased or injured part of the body.

Orthopedic shoes or shoe corrections are a covered service for recipients under age 21.

Stock orthopedic shoes or shoe corrections for adults are not a covered service unless they are built into a leg brace.

PROSTHETICS COVERAGE CRITERIA

Breast Prosthesis
Breast Prosthesis are covered for recipients who have had a single or double mastectomy. Mastectomy supplies includes but not limited to, all breast prosthesis such as mastectomy bra, mastectomy sleeve, mastectomy form, and silicone or equal.

Eye Prosthesis
Eye Prosthesis are covered for recipients with absence or shrinkage of eye due to birth defect, trauma, or surgical removal.

Lower Limb Prosthesis
A prescription and CNM must be on file before the prosthesis is fitted. South Dakota Medicaid may request medical records for determination of medical necessity. When medical records are requested, letters of support and/or explanation are often useful but are not sufficient documentation unless all specific information needed to make a medical necessity determination is included. Coverage exceptions to the potential functional levels will be considered on an individual basis if documentation justifies the medical necessity.

When submitting a prosthetic claim, the billed code for knee, foot, and ankle components must be submitted with modifiers K0-K4. The expected functional level must be clearly documented and retained in the provider's records. Medical records that document the functional capabilities and expected functional potential, must include an explanation for the difference, if there is one. The entry of a K modifier in those records is not sufficient.

The following items will require additional documentation and comply with the Expectation of Functional level: L5930, L5969, L5979, L5986, L5981, L5999, L6026, L6920, L6646, L6648, L7259, L7499

More than 2 test (diagnostic) sockets for an individual prosthesis are not medically necessary unless there is documentation in the medical record which justified the need.

Prior Authorization

The following prosthetics require a prior authorization: L5856, L5857, L5858, L5859, L5973, L5980, and L5987. The following criteria must be met for these prosthetics to be prior authorized by South Dakota Medicaid:

- A standard permanent limb prosthesis requires prior authorization through the Division of Medical Services and is considered medically necessary when all of the following criteria are met:
    - The recipient will reach or maintain a defined functional state within a reasonable time period; and
    - Lower limb prosthesis are considered medically necessary for performing normal daily activities when all the following criteria are met:
        - Recipient is motivated to ambulate; and
        - Has a functional level classification (measurement of the capacity and potential of the recipient to accomplish expected post-rehabilitation and daily function to help establish the medical necessity only for prosthetic knees, feet and ankles) of at least a Functional Level of 1.
    - Prosthesis will be denied as not medically necessary if the recipient's potential Functional Level is "0" (does not have the ability or potential to ambulate or transfer safely with or without assistance, and a prosthesis does not enhance their quality of life or mobility).

- Consideration for medical necessity of certain components/additions for a prosthesis based on the ordering physician and prosthetist's expectations of potential functional abilities include, but are not limited to the recipient's:
    - Past history (including prior prosthetic use, if applicable); and
    - Current condition including the status of the residual limb and the nature of other medical problems.

- Lower Limb Prosthesis requires prior authorization and is considered medically necessary for the following:
    - A solid ankle-cushion heel (SACH) foot is considered medically necessary for recipients whose Functional Level is 1* or above.
    - A flex foot system, energy storing foot, multi-axial foot, dynamic response foot with multi-axial ankle, shank foot system with vertical-loaded pylon or flex-walk system or equal is considered medically necessary for recipients whose Functional Level is 3* or above.
    - A microprocessor-controlled ankle foot system (L5973), flex foot system (L5980), flex-walk system (L5980), or shank foot system with vertical loading pylon (L5987) is covered for recipient's whose Functional Level is 3* or above.

- Knee Prosthesis requires prior authorization and is considered medically necessary for the following:
    - L5856, L5857, L5858 is considered medically necessary for recipients whose Functional Level is 3* or above.

- A single axis constant friction knee and other basic knee systems are considered medically necessary for recipients whose Functional Level if 1* or above.
- An addition (L5859) to a lower extremity prosthesis, endoskeletal knee-shin system, powered and programmable flexion/extension assist control, including any type of motor is only covered when the recipient meets all of the following criteria:
  - Recipient has a microprocessor (swing and stance phase type (L5856) controlled electronic knee; and
  - Functional Level 3*; and
  - Weight greater than 110 lbs. and less than 275 lbs.; and
  - Recipient has a documented comorbidity of the spine and/or sound limb affecting hip extension and/or quadriceps function that impairs functional level 3* with the use of a microprocessor-controlled knee alone; and
  - Recipient is able to understand and respond to error alerts and alarms indicating problems with the function of the unit.

Expectation of Functional Level*

- Level 0 – Does not have the ability or potential to ambulate or transfer safely with or without assistance and prosthesis does not enhance their quality of life or mobility.
- Level 1 – Has the ability or potential to use prosthesis for transfers or ambulation on level surfaces at fixed cadence. Typical of the limited and unlimited household ambulator.
- Level 2 – Has the ability or potential for ambulation with the ability to traverse low-level environmental barriers such as curbs, stairs or uneven surfaces. Typical of the limited community ambulator.
- Level 3 – Has the ability or potential for ambulation with variable cadence. Typical of the community ambulator who has the ability to transverse most environmental barriers and may have vocational, therapeutic, or exercise activity that demands prosthetic utilization beyond simple locomotion.
- Level 4 – Has the ability or potential for prosthetic ambulation that exceeds basic ambulation skills, exhibiting high impact, stress, or energy levels. Typical of the prosthetic demands of the child, adult, or athlete.

Determination of the type of prosthesis to be made by treating physician, other licensed practitioner, and/or prosthetist based upon functional needs of the recipient. Prostheses will be denied as not medically necessary if the recipient's potential functional level is 0.

Prior Authorization Request

Providers must submit the following documentation with their prior authorization request:

- DME Prior Authorization Request Form
- Physician or other licensed practitioner's prescription;
- All applicable medical records to support requirements.

Upper Limb Prosthetics

Upper limb prostheses are a covered service based on the medical necessity and clinical assessment of the recipient's rehabilitation potential. A prescription and CNM must be on file before the prosthesis

is fitted. South Dakota Medicaid may request medical records for determination of medical necessity. When medical records are requested, letters of support and/or explanation are often useful but are not sufficient documentation unless all specific information needed to make a medical necessity determination is included.

Any switch, myoelectric, or microprocessor-controlled devices must be preapproved, and documentation must clearly show medical necessity. Only one type of terminal device is reimbursable.

More than 2 test (diagnostic) sockets for an individual prosthesis are not medically necessary unless there is documentation in the medical record which justified the need.

Replacement of Prosthesis or Prosthetic Components
Replacements of Prosthesis or prosthetic components are covered when medically necessary. Documentation of medical necessity includes, but is not limited to functional and/or physiological needs such as:

- Changes in residual limb
- Functional need changes
- Irreparable damage or wear/tear due to excessive recipient weight or prosthetic demands of very active amputees.

Claims involving the replacement of a prosthesis or major component must be supported by a new physician or other licensed practitioner's order.

NONCOVERED SERVICES

General Non-Covered Services
Providers should refer to ARSD 67:16:01:08 or the General Coverage Principles manual for a general list of services that are not covered by South Dakota Medicaid.

Non-covered Items
Per 42 CFR 440.70 DME items to be used in a hospital, nursing facility, intermediate care facility for individuals with developmental disabilities, or any setting in which payment is or could be made under Medicaid for inpatient services that include room and board are not covered.

The following items are not considered medical equipment or medical supplies and are not covered:

- Self-help devices. A self-help device is an article of equipment which neither corrects nor improves a condition, but which provides assistance to the user, such as bathtub or shower safety rails;
- Exercise equipment;
- Protective outerwear;
- Book bags, stairway elevator chairs, or other convenience items;
- Air conditioners, humidifiers, dehumidifiers, heaters, furnaces, or other personal comfort or environmental control equipment;
- Tumble form roll and other items not used primarily for medical purposes;

- Computers, hook-ups to a computer system, or a computer printer, except for augmentative communication devices that meet the requirements listed on the South Dakota Medicaid's billing guidance website;
- Teaching or training on the operation of equipment;
- First-aid or precautionary-type equipment;
- Training equipment, such as speech teaching machines, braille training texts; and
- Stock orthopedic shoes, unless covered under chapter 67:16:11 for children less than twenty-one years of age, or built into a leg brace.

Documentation Requirements

General Requirements

Providers must keep legible medical and financial records that fully justify and disclose the extent of services provided and billed to South Dakota Medicaid. These records must be retained for at least 6 years after the last date a claim was paid or denied. Please refer to the Documentation and Record Keeping manual for additional requirements.

DME Prescription and Clinical Record

The DME prescription must be completed according to ARSD 67:16:29:04.02. A combination of the prescription and clinical record must contain;

1. Recipient name and Medicaid number;
2. Diagnosis, including an explanation of the particular condition resulting from the diagnosis which relates to the equipment request;
3. Prognosis;
4. Length of time the item is expected to be required;
5. Justification of medical necessity;
6. Equipment prescribed;
7. Prescribing provider's National Provider Identification (NPI) number, signature, and date signed;
8. Description of equipment; and
9. Explanation of equipment functions.

Reimbursement and Billing

Timely Filing

South Dakota Medicaid must receive a provider's completed claim form within 6 months following the month the service was provided. Requests for reconsiderations will only be considered if they are received within the timely filing period or within 3 months of the date a claim was denied. The time limit may be waived or extended by South Dakota Medicaid in certain circumstances. Providers should refer to the General Claim Guidance manual for additional information.

Third-Party Liability

Medicaid recipients may have one or more additional source of coverage for health services. South Dakota Medicaid is generally the payer of last resort. Providers must pursue the availability of third-party payment sources and should use the Medicare Crossover or Third-Party Liability billing

instructions when applicable. Providers should refer to the General Claim Guidance manual for additional information.

The following codes are not covered by Medicare may be billed to South Dakota Medicaid prior to Medicare:

A4250	A6535	A6549	E0240	E0637	J8515	L3221	L7600	T4525	T4534
A4335	A6536	A9275	E0244	E0638	L0210	L3222	Q0144	T4526	T4535
A4490	A6537	A9276	E0245	E0641	L1800	L3651	Q5108	T4527	T4537
A4495	A6538	A9277	E0247	E0642	L1825	L3652	Q5110	T4528	T4539
A4500	A6540	A9278	E0248	E0936	L1901	L3700	V5336	T4529	T4540
A4510	A6541	B4100	E0270	J1055	L3215	L3701	T4521	T4530	T4541
A4627	A6542	E0172	E0273	J3520	L3216	L3909	T4522	T4531	T4542
A4927	A6543	E0191	E0481	J3535	L3217	L3911	T4523	T4532	T4543
A6534	A6544	E0203	E0625	J3570	L3219	L1815	T4524	T4533	T4544
									T4545

Reimbursement

A claim must be submitted at a provider's usual and customary charge. Reimbursement is the lesser of the provider's usual and customary charge or the amount listed on the DMEPOS fee schedule. The fee schedule reflects that DME subject to the limit described in Section 1903(i)(27) of the Social Security Act are reimbursed at the lesser of the provider's usual and customary amount or 90% of the South Dakota rural rate as published by Medicare effective January of 2019 and then January of each year starting after 2019. If no amount is established, payment will be the following:

- 75 percent of the lesser of the provider's usual and customary charge for medical equipment, orthotics, and prosthetics or MSRP. Provider's may not bill South Dakota Medicaid at a rate higher than MSRP.
- 90 percent of the lesser of the provider's usual and customary charge for supplies or MSRP. Provider's may not bill South Dakota Medicaid at a rate higher than MSRP.

Capped rental items are considered purchase after 12 rental payments have been made without break in rental payments of three or more consecutive months. A new rental period begins when a break in rental payments of three or more consecutive months occurs.

Payment for the purchase or monthly rental of medical equipment includes the following:

- The manufacturer and dealer warranty;
- Any cost associated with assembling an item or part used for the assembly of an item;
- Any adjustment and modification required within 90 days of the dispensing date for purchases or during the total rental period, except those due to a major change in the recipient's condition;
- Instruction to the recipient in the safe use of the medical equipment;
- Cost of delivery to the recipient's residence and, when appropriate, to the room in which the item will be used; and
- Cost of return to the provider if rented.

Payment for equipment maintenance and repairs is the lesser of the provider's usual and customary charge or the purchase price of a new piece of equipment. Purchase price is established according to this section.

Incontinence Suppies

Payments for incontinence supplies are limited to $3,500 per plan year (July 1 to June 30) unless otherwise authorized. Incontinence supply HCPCS codes T4521-T4545 and A4335 are reimbursed at 90 percent of billed charges for recipients meeting the qualifying criteria when billed by DME providers. HCPCS A4927 is reimbursed at the fee schedule rate and is not subject to the $3,500 limit.

Claim Instructions

DME equipment and supplies must be billed on a CMS 1500 claim form or electronically using an 837P. Refer to our website for claim instructions.

Unless South Dakota Medicaid has provided specific guidance to the contrary, providers must follow the guidelines in the CPT or HCPCS manual. Providers must select the name of the procedure or service that accurately identifies the service performed. Do not select a procedure code that merely approximates the service provided. If no specific code exists, the provider should use the appropriate unlisted procedure code. Any service or procedure must be adequately documented in the medical record. Billing with an unlisted procedure code when a more specific procedure code exists is considered abuse of the program and may be investigated by the Medicaid Program Integrity Unit or Medicaid Fraud Control Unit.

A provider may not submit a claim to South Dakota Medicaid until the equipment has been delivered to the recipient. A copy of the physician or other licensed practitioner’s written prescription, the invoice showing the purchase price of the equipment, and other documentation does not need to be submitted with the claim unless required; however, it must be maintained by the provider in the recipient's record and made available on request.

If equipment is stolen or loss occurs due to a fire, a police or fire department report from the time of the loss is required in order for South Dakota Medicaid to consider replacement of the equipment. The police or fire department report must be submitted with the claim. Documentation that the warranties and insurance have expired must accompany the claim.

The following modifier codes must be used as applicable:

Modifier	Description
NU	New equipment
RB	Replacement or repair
RR	Rental
UE	Used medical equipment

HCBS Waiver Program

For recipients enrolled in an HCBS waiver, South Dakota Medicaid must be billed first prior to billing the HCBS waiver. The waiver program may only be billed if the provider receives a denial from South Dakota Medicaid. The following denials on an electronic remittance advice satisfy this requirement:

- N425 - Statutorily excluded service(s);
- N643 - The services billed are considered not covered or non-covered (NC) in the applicable state fee schedule;
- N182 - This claim/service must be billed according to the schedule for this plan.

If you use the online provider portal to view remittance advice, the following errors reasons are applicable:

- Service not covered by Medicaid;
- Procedure/NDC not covered by Medicaid;
- Service limitation error for this procedure.

Claims billed to South Dakota Medicaid must use the applicable CPT code. However, when billing an HCBS waiver, the provider must use the pre-assigned CPT code listed on the Authorization for Service.

A denial for Prior Authorization is not an eligible reason to bill a HCBS waiver.

DEFINITIONS

1. "Maintenance," servicing performed at routine intervals based on hours of use or calendar days to ensure that equipment is in working order;

2. "Medical equipment," equipment which withstands repeated use, is primarily and customarily used to serve a medical purpose, generally is not useful to a person in the absence of illness or injury, is appropriate for use in the recipient's home;

3. "Medical supplies," health care related items that are consumable or disposable that are required for care of a medical condition. This does not include personal care items (such as deodorants, talcum powders, bath powders, soaps, eyewashes, contact solutions) or oral or injectable over-the-counter drugs and medications; and

4. "Other licensed practitioner" a physician assistant, nurse practitioner, clinical nurse specialist, nurse midwife, or nurse anesthetist who is licensed by the state to provide services and is performing within their scope of practice under the provisions of SDCL title 36.

5. "Repair," parts and labor necessary to restore a piece of medical equipment to its original working order, but not add-on equipment or enhancements.

REFERENCES

- Administrative Rule of South Dakota (ARSD)
- South Dakota Medicaid State Plan

- Code of Federal Regulations

QUICK ANSWERS

1. **If equipment is stolen or lost due to a fire, can it be replaced?**

   Yes, a police report must be submitted with the claim.

2. **South Dakota Medicaid's fee schedule indicates an item is a rental. Can I bill it as a purchase?**

   No, rental items can only be billed as a rental.

3. **Can I bill for hearing aids the same day they are dispensed to the recipient?**

   A claim for hearing aids may not be submitted until 30 days after placement. A claim may not be submitted if the hearing aids are returned during a trial period.

4. **What is the incontinence supplies limit for individuals on the Family Support 360 HCBS waiver?**

   For recipients on the Family Support 360 HCBS waiver the incontinence supplies limit is $3,500 due to the historical need of supplies for these individuals. A provider can determine if a recipient is on the Family Support waiver by utilizing the Eligibility Inquiry on the Medicaid Online Portal.

5. **Can a DME provider bill South Dakota Medicaid for DME provided to recipients residing in a nursing facility?**

   No, DME is only covered for recipient's in their residence. A residence does not include a nursing facility per ARSD 67:16:29:04 and 42 CFR 440.70(c). DME for a recipient residing in a nursing facility is provided by the nursing facility per ARSD 67:16:04:41. In addition, maintenance and repairs are not covered for equipment owned by a nursing facility or someone other than the recipient. If the DME item is owned by the recipient, maintenance and repairs are reimbursable; the claim must be submitted with documentation that supports the recipient owns the equipment. For Medicare crossover claims, South Dakota Medicaid will reimburse coinsurance/deductible if Medicare paid for the item.

   Covered prosthetics and prosthetic supplies provided for an individual nursing facility resident that are prescribed by a physician or other licensed practitioner and that cannot be separately altered for use by other residents may be billed to South Dakota Medicaid by a DMEPOS provider per ARSD 67:16:04:42.

6. **Does South Dakota Medicaid's replace children's hearing aids that are lost or stolen?**

   South Dakota Medicaid will replace hearing aids that are lost or stolen for recipients under the age of 21. In box 19 of the CMS 1500 claim form the provider must enter "Lost" or "Stolen. For

837P claims this information should be entered in loop 2300. Verify the segment with your electronic clearinghouse.