NEBRASKA DEPARTMENT OF HEALTH AND HUMAN SERVICES
NOTICE OF PUBLIC HEARING

June 1, 2026
10:00 A.M. Central Time
Nebraska State Office Building – Lower Level
Meadowlark Conference Room
301 Centennial Mall South, Lincoln, Nebraska

The purpose of this hearing is to receive comments on proposed changes to Title 471, Chapter 7 of the Nebraska Administrative Code (NAC) – *Durable Medical Equipment, Prosthetics, Orthotics, and Medical Supplies (DMEPOS).* The proposed changes update definitions; clarify provider and service requirements; update prior authorization requirements; add mail order and direct delivery requirements; establish requirements for beneficiaries eligible for Medicare and Nebraska Medicaid; add requirements for electric personal-use breast pumps coverage; update terminology; remove unnecessary, redundant, or unclear language; add clarification language; correct typographical and punctuation errors; update formatting and section headings; and renumber the regulatory chapter.

Authority for these regulations is found in Neb. Rev. Stat. § 81-3117(7) and § 68-908.

Interested persons may attend the hearing and provide verbal or written comments, or mail, fax, or email written comments, no later than the day of the hearing to: DHHS Legal Services, PO Box 95026, Lincoln, NE 68509-5026, (402) 742-2382 (fax) or dhhs.regulations@nebraska.gov, respectively.

A copy of the proposed changes is available online at http://www.sos.ne.gov, or by contacting DHHS at the mailing address or email above, or by phone at (402) 471-8417. The fiscal impact statement for these proposed changes may be obtained at the office of the Secretary of State, Regulations Division, 1201 N Street, Suite 120, Lincoln, NE 68508, or by calling (402) 471-2385.

Auxiliary aids or reasonable accommodations needed to participate in a hearing can be requested by calling (402) 471-8417. Individuals who are deaf or hard of hearing may call DHHS via the Nebraska Relay System at 711 or (800) 833-7352 TDD at least 2 weeks prior to the hearing.

FISCAL IMPACT STATEMENT

Agency: Department of Health and Human Services	
Title: 471	Prepared by: Jeremy Brunssen
Chapter: 7	Date prepared: 11.18.2025
Subject: Durable Medical Equipment, Prosthetics, Orthotics, and Medical Supplies (DMEPOS)	Telephone: 402-540-0380

Type of Fiscal Impact:

	State Agency	Political Sub.	Regulated Public
No Fiscal Impact	(☐)	(☒)	(☒)
Increased Costs	(☒)	(☐)	(☐)
Decreased Costs	(☐)	(☐)	(☐)
Increased Revenue	(☐)	(☐)	(☐)
Decreased Revenue	(☐)	(☐)	(☐)
Indeterminable	(☐)	(☐)	(☐)

Provide an Estimated Cost & Description of Impact:

State Agency: As noted in the fiscal impact for Neb. Rev. Stat. § 68-911(8)(a), LB1215 (2024), which necessitated the changes to the regulations where the fiscal impact is created, the Department expects a nominal increase in expenditures for switching primary coverage of breast pumps from current coverage of rental pumps to personal use pumps.

The fiscal impact was developed based on historical coverage of breast pumps in the Nebraska Medicaid program. In the state fiscal year 2023 (SFY23), managed care organizations (MCO) provided approximately 4,985 breast pumps, 3,885 (personal use) as a value add, and 1,100 paid through the program. There is a 10% anticipated increase for the current coverage claims as the personal use of breast pumps becomes a covered benefit. This increase brings the estimated breast pumps supplied in SFY25 and SFY26 to 5,095 and 5,138, respectively. The current average hospital-grade breast pump rental cost is $295 per member. The average cost for the managed care organization (MCO) for a qualifying personal breast pump is $125 per member, resulting in a cost reduction of $205,700 due to the lower managed care organization (MCO) rate versus rental cost. Adding another 3,885 members that gain coverage under this bill, the total expense for SFY25 and SFY26 would increase by $279,925 ($115,320 in general funds,

$164,605 federal funds) and $281,760 ($115,807 in general funds and $165,952 in federal funds), respectively. The net cost would be absorbed by the Department.

Political Subdivision: N/A.

Regulated Public: N/A.

If indeterminable, explain why:

N/A.

PROPOSED REGULATION
POLICY PRE-REVIEW CHECKLIST

Agency: DHHS – Division of Medicaid and Long-Term Care
Title, Chapter of Regulation: 471 NAC 7 (Amend)
Subject: Durable Medical Equipment, Prosthetics, Orthotics, and Medical Supplies (DMEPOS)
Prepared by: Jacob Kawamoto
Telephone: 531-530-7153

A. Policy Changes and Impacts

1. What does the regulation do and whom does it impact? Provide a brief description of the proposed rule or regulation and its impacts on state agencies, political subdivisions, and regulated persons or entities.

   This regulation governs coverage criteria for, and provider requirements related to, durable medical equipment, prosthetics, orthotics, and medical supplies (DMEPOS) under Nebraska Medicaid. The regulation update would affect Nebraska Medicaid beneficiaries who receive these services, and providers who order and provide them. The proposed updates would expand coverage to include electric personal-use breast pumps for covered pregnant mothers (or covered child if the mother is not eligible for Nebraska Medicaid) and would also clarify coverage criteria for various other durable medical equipment, prosthetics, orthotics, and medical supplies (DMEPOS).

   No other entities would be impacted.

2. Describe changes being proposed to current policy and briefly provide rationale.

   This update is necessary to implement Nebraska Revised Statute (Neb. Rev. Stat.) § 68-911(8)(a) (LB1215 (2024)), which requires Nebraska Medicaid to cover electric personal-use breast pumps for every Nebraska Medicaid-covered pregnant woman (or covered child if the mother is not eligible for Nebraska Medicaid). The proposed changes update this regulation chapter to reflect this requirement. Additionally the proposed changes clarify coverage criteria for a number of durable medical equipment, prosthetics, orthotics, and medical supplies (DMEPOS). The updates also clarify a number of important provider requirements. Most importantly, definitions are revised, and language would be updated throughout the chapter to remove ambiguity regarding which providers can order durable medical equipment, prosthetics, orthotics, and medical supplies (DMEPOS), and which providers can provide durable medical

equipment, prosthetics, orthotics, and medical supplies (DMEPOS). Language would also be added to help improve oversight of mail-order durable medical equipment, prosthetics, orthotics, and medical supplies (DMEPOS), and terminology has been updated throughout the chapter.

Proposed changes to 471 NAC 7 would:

- Section 002: Clarify definitions, including distinguishing between providers authorized to provide durable medical equipment, prosthetics, orthotics, and medical supplies (DMEPOS) and providers authorized to prescribe durable medical equipment, prosthetics, orthotics, and medical supplies (DMEPOS). Sections 002.07 & 002.15 - New definitions added. Update terminology; update acronyms; update section headings; and renumber the section.
- Section 003: Clarify provider requirements, remove unnecessary language, and update terminology.
- Section 004: Clarify service requirements. Notably, this updated section would include coverage of personal-use breast pumps to meet the requirements of Neb. Rev. Stat. § 68-911(8)(a), (LB1215 (2024)). Also clarify prior authorization requirements, coverage criteria for durable medical equipment, prosthetics, orthotics, and medical supplies (DMEPOS) (such as wheelchairs, continuous glucose monitors, and durable medical equipment, prosthetics, orthotics, and medical supplies (DMEPOS) provided for beneficiaries in nursing facilities (NF)). Language is also added to this section to allow for electronic provider signatures and outline requirements for mail order and direct delivery of durable medical equipment, prosthetics, orthotics, and medical supplies (DMEPOS). New subsection 004.01(I) outlines beneficiaries eligible for both Medicare and Medicaid, Nebraska Medicaid discontinues paying for the beneficiary's co-insurance and deductibles for rental equipment when either the reimbursement amount reaches Medicare's reimbursement cap for the equipment or Medicare considers the equipment purchased. Update requirements for documentation requirements: proof of delivery, direct delivery and mail order and shipping service delivery. Update section headings, remove unnecessary language and sections, update terminology, update acronyms, correct typographical errors, and renumber the section.
- Section 005: Clarify requirements for billing and payment. Importantly, this updated section adds provider billing requirements related to mail order and direct delivery durable medical equipment, prosthetics, orthotics, and medical supplies (DMEPOS). Also updated terminology, removed unnecessary language and sections, and renumbered the section.

B. Why is the rule necessary? Explain and provide an identification of authorizing statute(s) or legislative bill(s).

1. Update of regulation (repeal of obsolete statutes, reflect current policy, editing or technical language changes, etc.)

   Update of regulation to comply with Neb. Rev. Stat. § 68-911(8)(a), (LB1215 (2024)), which requires Nebraska Medicaid to cover electric personal-use breast pumps for every Nebraska Medicaid-covered pregnant woman (or covered child if the mother is not eligible for Nebraska Medicaid).

2. Annual changes – cost of living, hunting season schedules, etc.

   No.

3. Law was changed – federal ___ or state _X_ [Cite authorizing statute(s) or legislative bill(s)]

   Neb. Rev. Stat. § 68-911(8)(a), (LB1215 (2024)).

4. Extension of established policy or program, new initiatives or changes in policy (within statutory authority) Yes.

5. Constituent initiated

   No.

6. Financial needs – increases/decreases in fees No.

7. Litigation requires changes in rules No.

8. Addresses legal or constitutional concerns of Attorney General's office

   No.

9. Implements federal or court mandate

   No.

10. Other (explain) N/A.

C. What happens if these rules are not adopted?

The regulations will not be in compliance with Neb. Rev. Stat. § 68-911(8)(a), (LB1215 (2024)).

D. Policy Checklist.

1. Is this an update or editorial change reflecting essentially no change in policy?

   No.

2. Does the policy in the proposed regulation reflect legislative intent?

   Yes.

3. Is the policy proposed in the regulation a state mandate on local government? No. Is it funded? N/A.

4. Is the policy proposed in the regulation a federal mandate on local government? No. Is it funded? N/A.

E. Fiscal Impact. In addition to completing the required Fiscal Impact Statement (a copy must be attached to this document), the agency must address the following:

1. Will the proposed regulation reduce, increase, or have no change in resources – funds, personnel or FTE? Yes, this will result in a slight increase in expenditures, with the State share impact estimated to be approximately $115,320 per year. (Additional information in the Fiscal Impact Statement).

2. Have initial contacts been made with citizens or organizations that may be impacted by the proposed regulation? No.

3. Does the proposed regulation impact another agency? No. Explain the impact.

4. Will the proposed regulation reduce, increase, or have no change on reporting requirements of businesses?

   No change.

5. What is the agency's best estimate of the additional or reduced spending? If there is none, please note. If receipt of federal funds is contingent upon approval of the proposed regulation, then indicate the amount and nature of the federal funds affected, and enclose laws or correspondence from federal officials substantiating the information.

The expected increase in expenditures is $281,760 ($115,807 in general funds and $165,952 in federal funds) per year. (Additional information in the Fiscal Impact Statement).

6. Include a description of the impact that the proposed regulation will have on the number of state employees and how the agency intends to address proposed increases or decreases in FTE.

   No impact.

F. Unique problems or issues and recommendations.

No.

G. Who is expected to be affected, or to oppose or support the proposed regulation? Explain what initial informal contacts have been made with organizations or citizens who may be affected by the regulation prior to the public hearing.

These proposed updates will affect providers of and beneficiaries who need durable medical equipment, prosthetics, orthotics, and medical supplies (DMEPOS). It is not expected that these updates will be opposed, since the nature of the updates is to expand coverage for mothers and new-borns (for breast pumps) and to clarify provider and service requirements.

The Department will solicit public comment on the proposed regulations before the public hearing.

H. Are these proposed rules a likely candidate for negotiated rulemaking? Explain. Has the process been completed? If so, explain how the issues were addressed.

No.

DHHS Division Director's Verification of Review

I have reviewed these proposals and verify that, at this stage of the regulation's development, these questions have been accurately addressed.

Drew Gonshorowski
Director
Division of Medicaid and Long-Term Care
Department of Health and Human Services

12.12.2025
Date

TITLE 471 NEBRASKA MEDICAL ASSISTANCE PROGRAM SERVICES

CHAPTER 7 DURABLE MEDICAL EQUIPMENT, PROSTHETICS, ORTHOTICS, AND MEDICAL SUPPLIES (DMEPOS)

001. SCOPE AND AUTHORITY. These regulations govern services provided under the Medical Assistance Act, Nebraska Revised Statute (Neb. Rev. Stat.) §§ 68-901 et seq.

002. DEFINITIONS. The following definitions apply.

002.01 APPARENT LIFE-THREATENING EVENT (ALTE). Apparent life threatening events (ALTE) are episodes that are frightening to the observer and characterized by some combination of central or obstructive apnea, color change, marked change in muscle tone, choking, or gagging.

002.02 AUGMENTATIVE COMMUNICATION DEVICES. Augmentative communication devices are any modes of communication other than speech.

002.03 AUTHORIZED ~~DURABLE MEDICAL EQUIPMENT, PROSTHETICS, ORTHOTICS, AND MEDICAL SUPPLIES (DMEPOS)~~ PROVIDER. Providers authorized to ~~prescribe~~ dispense durable medical equipment, prosthetics, orthotics, and medical supplies (DMEPOS) ~~include physicians, nurse practitioners, clinical nurse specialists, or physician assistants~~.

002.04 BED-CONFINED. The ~~client's~~ beneficiary's condition is such that the ~~client~~ beneficiary is ~~confined to bed, although not necessarily all of the time~~ unable to get up from a bed or unable to ambulate on their own.

002.05 CUSTOM FABRICATED. Made for a specific ~~client~~ beneficiary from his or her individualized measurements.

002.06 CUSTOM FITTED. Substantial adjustments are made to a prefabricated item by a specially trained professional to meet the needs and unique shape of an individual ~~client~~ beneficiary.

002.07 DESIGNEE. Any person authorized to sign and accept the delivery of durable medical equipment, prosthetics, orthotics, and medical supplies (DMEPOS) on behalf of a beneficiary.

002.0~~7~~8 DURABLE MEDICAL EQUIPMENT. Equipment which:

(A) Withstands repeated use;
(B) Is primarily and customarily used to serve a medical purpose;
(C) Is not useful to a person in the absence of an illness or injury; and
(D) Is appropriate for use in the ~~client's~~ beneficiary's home.

002.089 FACILITY. A nursing facility (NF) ~~regulated by Title 471 Nebraska Administrative Code (NAC) 12~~ or intermediate care facility for individuals with developmental disabilities (ICF/DD) regulated by these regulations ~~Title 471 NAC 31~~.

002.0910 MEDICAL SUPPLIES. Expendable or reusable supplies required for care of a medical condition in the ~~client's~~ beneficiary's home. This does not include personal care items or oral or injectable over-the-counter drugs and medications.

002.1011 ORTHOSIS. A type of brace which either prevents or assists movement of a limb or the spine.

002.1112 ORTHOTICS. Rigid or semi-rigid devices which prevent or correct physical deformity or malfunction, to support a weak or deformed part of the body or eliminate motion.

002.1213 PROSTHESES AND PROSTHETICS. An artificial device which replaces a missing body part lost through trauma, disease, or congenital conditions.

002.1314 REGISTERED NURSE (RN). A licensed registered nurse (RN) in the employment of a durable medical equipment, prosthetics, orthotics, and medical supplies (DMEPOS) provider.

002.15 TREATING PRACTITIONERS. Providers licensed and authorized to prescribe durable medical equipment, prosthetics, orthotics, and medical supplies (DMEPOS) include physicians, nurse practitioners (NP), clinical nurse specialists, and or physician assistants (PA).

002.1416 UTILIZATION MANAGEMENT ORGANIZATION. An organization under contract with ~~the Department~~ Nebraska Medicaid to review and approve prior authorization requests.

003. PROVIDER REQUIREMENTS.

003.01 GENERAL PROVIDER REQUIREMENTS. ~~Providers of~~ Authorized ~~durable medical equipment, prosthetics, orthotics, and medical supplies (DMEPOS)~~ providers must comply with all applicable provider participation requirements in this title ~~codified in Title 471 NAC 2 and 3. In the event that provider participation requirements in Title 471 NAC 2 or 3 conflict with requirements outlined in this chapter, the individual provider participation requirements in this chapter will govern~~.

003.02 SERVICE SPECIFIC PROVIDER REQUIREMENTS. To participate in Nebraska Medicaid, authorized providers must be enrolled as a rental and retail supplier with the appropriate primary specialty type as outlined on the appropriate Nebraska Medicaid approved provider agreement ~~F~~form ~~MC 19, Service Provider Agreement~~. Providers must meet any applicable state and federal laws governing the provision of their services.

004. SERVICE REQUIREMENTS.

004.01 GENERAL SERVICE REQUIREMENTS. ~~Medicaid covers m~~Medically necessary durable medical equipment, prosthetics, orthotics, and medical supplies (DMEPOS) are covered when appropriately prescribed by ~~an authorized durable medical equipment, prosthetics, orthotics, and medical supplies (DMEPOS) provider~~ a treating practitioner.

004.01(A) MEDICAL NECESSITY. The authorized provider must obtain written documentation from the ~~prescribing authorized durable medical equipment, prosthetics, orthotics, and medical supplies (DMEPOS) provider~~ treating practitioner which justifies the medical necessity for durable medical equipment, prosthetics, orthotics, and medical supplies (DMEPOS). The original documentation of medical necessity must be kept on file by the authorized provider. ~~In addition to meeting the requirements outlined in Title 471 NAC 1 t~~The documentation must:

(1) Be signed in writing or electronically by the ~~authorized durable medical equipment, prosthetics, orthotics, and medical supplies (DMEPOS) provider's~~ treating practitioner ~~own hand and dated,~~ using the date the documentation is signed;
(2) Specify the start date of the order;
(3) Include the ~~authorized durable medical equipment, prosthetics, orthotics, and medical supplies (DMEPOS) provider's~~ treating practitioner's name, address, and telephone number;
(4) Include the diagnosis and an estimate of the total length of time the item will be needed;
(5) Be sufficiently detailed, including all options or additional features which will be separately billed or will require an upgraded procedure code;
(6) Describe the ordered item(s) using either a narrative description or a brand name and model number, including all options or additional features;
(7) For supplies, include appropriate information on the quantity used, frequency of change, and duration of need; and
(8) Include information substantiating that all Nebraska Medicaid coverage criteria for the item(s) are met.

~~004.01(A)(i) MEDICAID CERTIFICATION OF MEDICAL NECESSITY FORMS. Use of the following Medicaid Certification of Medical Necessity (CMN) forms are required:~~

~~(1) Form MS-78, Augmentative Communication Device Selection Report;~~
~~(2) Form MS-79, Wheelchair and Wheelchair Seating System Selection Report; or~~
~~(3) Form MS-80, Air Fluidized and Low Air Loss Bed Certification of Medical Necessity.~~

~~004.01(A)(ii) MEDICARE CERTIFICATION OF MEDICAL NECESSITY FORMS. Use of the following Medicare Certification of Medical Necessity (CMN) form is required: Medicare Attending Physician's Certificate of Medical Necessity for Home Oxygen form.~~

004.01(A)(~~ii~~iii) RECERTIFICATION OF MEDICAL NECESSITY. Documentation of medical necessity must be updated annually or when the authorized ~~durable medical equipment, prosthetics, orthotics, and medical supplies (DMEPOS)~~ provider's estimated quantity, frequency, or duration of the ~~client's~~ beneficiary's need has expired, whichever occurs first unless otherwise specified in this chapter.

004.01(B) PRIOR AUTHORIZATION REQUIREMENTS. Services requiring prior ~~Prior~~ authorization ~~is required~~ for coverage ~~of~~ include the following items:

(1) Augmentative communication devices with related equipment and software;
(2) Spinal orthosis seating systems and back modules incorporated in or attached to a wheelchair base;
(3) Transcutaneous electrical nerve stimulators (TENS);

(4) Ultraviolet light therapy systems;
(5) All wheelchairs and wheelchair accessories, options, and components;
(6) Whirlpools; ~~and~~
(7) Not otherwise classified (NOC) durable medical equipment, prosthetics, orthotics, and medical supplies (DMEPOS)~~.~~ with a purchase price that exceeds $750;
(8) Durable medical equipment, prosthetics, orthotics, and medical supplies (DMEPOS) whose 12 month rental or purchase price exceeds $750; and
(9) Repair or modifications if parts combined with labor charges total $750 or more.

004.01(B)(i) REQUESTS FOR PRIOR AUTHORIZATION. The authorized provider will electronically submit requests for prior authorization to ~~the Department~~ Nebraska Medicaid or the appropriate utilization management organization using the appropriate ~~standard~~ electronic format ~~transaction~~ or by completing and submitting the appropriate Nebraska Medicaid approved prior authorization ~~F~~form ~~MS-77, Request for Prior Authorization, according to the form instructions. Documentation supporting the medical necessity of the durable medical equipment, prosthetics, orthotics, and medical supplies (DMEPOS) must be submitted with each prior authorization request. The provider will receive notification from the utilization management organization on the status of the request.~~ A copy of ~~this~~ documentation supporting medical necessity must ~~should~~ be submitted with the payment request.

004.01(B)(ii) PRIOR AUTHORIZATION LIMITATIONS. Approved prior authorizations are valid only when:

(1) The prior authorization is requested before the services are provided;
(2) The ~~client~~ beneficiary is Nebraska Medicaid-eligible at the time services are provided;
(3) The authorized provider is enrolled as a Nebraska Medicaid provider in accordance with this chapter at the time the services are provided;
(4) The ~~M~~managed ~~C~~care ~~O~~organization (MCO) or ~~the Department~~ Nebraska Medicaid has approved the prior authorization; and
(5) For the initial order of durable medical equipment, prosthetics, orthotics, and medical supplies (DMEPOS), a face-to-face encounter with the treating practitioner must occur within six months before or 30 days after the durable medical equipment, prosthetics, orthotics, and medical supplies (DMEPOS) order is written. The encounter must be documented and the document maintained by the authorized ~~durable medical equipment, prosthetics, orthotics, and medical supplies (DMEPOS)~~ provider.

004.01(C) SUPPLIES AND ACCESSORIES. Purchase or rental of durable medical equipment, prosthetics, orthotics, and medical supplies (DMEPOS) includes all items, supplies, and accessories necessary for proper and effective use of the durable medical equipment, prosthetics, orthotics, and medical supplies (DMEPOS). Additional items, supplies, and accessories are only provided for ~~client~~ beneficiary owned durable medical equipment, prosthetics, orthotics, and medical supplies (DMEPOS).

004.01(C)(i) MAXIMUM QUANTITY FOR SUPPLIES. The maximum allowable quantity of supplies that may be dispensed is limited to a three month supply, unless otherwise specified in this chapter ~~or in the Nebraska Medicaid Practitioner Fee Schedule~~.

004.01(D) MULTIPLE OR DUPLICATE ITEMS. ~~Medicaid does not cover~~ The purchase, rental, or repair of multiple durable medical equipment, prosthetics, orthotics, and medical supplies (DMEPOS) used for the same or similar purposes is not covered. ~~Medicaid does not cover b~~Back-up equipment is not covered. Back-up equipment may be supplied by the provider, but the provider may not bill Nebraska Medicaid.

004.01(E) REPLACEMENT. Replacement of Nebraska Medicaid-covered durable medical equipment, prosthetics, orthotics, and medical supplies (DMEPOS) items owned by the ~~client~~ beneficiary is covered if needed due to change in the ~~client's~~ beneficiary's medical condition, wear, loss, or irreparable damage.

004.01(F) REPAIR. ~~Medicaid covers r~~Repairs required for the effective use of Nebraska Medicaid covered durable medical equipment, prosthetics, orthotics, and medical supplies (DMEPOS) are covered when the item is owned by the ~~client~~ beneficiary and the ~~client~~ beneficiary meets the coverage criteria for the item. Repairs must meet the following requirements:

(1) The cost must not exceed 80 percent of the Nebraska Medicaid allowable purchase price for the item;
(2) All manufacturers and provider warranties must be pursued; and
(3) The authorized provider must indicate if the item is owned by the ~~client~~ beneficiary.

004.01(F)(i) EXCEPTION. Damage to durable medical equipment, prosthetics, orthotics, and medical supplies (DMEPOS) items, due to misuse by the ~~client~~ beneficiary or caregivers, will require a prior authorization request be submitted to either the ~~M~~managed ~~C~~care ~~O~~organization (MCO) or ~~the Department~~ Nebraska Medicaid before repair work begins.

004.01(F)(ii) RENTAL DURING REPAIR. ~~Medicaid covers r~~Rental of covered durable medical equipment, prosthetics, orthotics, and medical supplies (DMEPOS) is covered for a maximum of three months during which time the ~~client~~ beneficiary-owned equipment is being repaired. If the provider's usual business practice is to provide loaner equipment at no charge, the provider will not bill Nebraska Medicaid for rental during that period.

004.01(G) SUPPLIES AND ACCESSORIES FOR DURABLE MEDICAL EQUIPMENT, PROSTHETICS, ORTHOTICS, AND MEDICAL SUPPLIES (DMEPOS). Items required for the proper functioning and effective use of Nebraska Medicaid eligible durable medical equipment, prosthetics, orthotics, and medical supplies (DMEPOS) are covered. Supplies and accessories for rented Nebraska Medicaid durable medical equipment, prosthetics, orthotics, and medical supplies (DMEPOS) are included in the Nebraska Medicaid allowable payment unless stated.

004.01(H) RENTAL. Items with a purchase price under one hundred fifty dollars ($150) may be purchased rather than rented, unless the treating practitioner's ~~authorized durable medical equipment, prosthetics, orthotics, and medical supplies (DMEPOS) provider's~~ estimated duration of need is less than six months. Items with a purchase price of one hundred fifty dollars ($150) or greater must be rented, unless the treating practitioner's ~~authorized durable medical equipment, prosthetics, orthotics, and medical supplies (DMEPOS) provider's~~ estimated duration of need is 12 months or greater. ~~The Department~~ Nebraska Medicaid is not responsible for lost, stolen, or damaged rental items.

004.01(H)(i) RENTAL OPTION TO PURCHASE. All rentals must provide an option to purchase the durable medical equipment, prosthetics, orthotics, and medical supplies (DMEPOS) item, and meet the following criteria:

(1) ~~Providers~~ Authorized providers will cease submitting payment requests for rental items when the Nebraska Medicaid allowable purchase price is reached or after 12 monthly rental payments, whichever comes first;
(2) When converting a rental item to purchase before 12 months of rental, all rental monies paid to the authorized provider will be applied to the Nebraska Medicaid allowable purchase price; and
(3) When the conversion to purchase is completed, the item becomes the property of the ~~client~~ beneficiary.

004.01(H)(ii) EXCEPTIONS. The following items remain the property of the authorized provider, and may be rented on a monthly basis:

(1) Oxygen delivery equipment;
(2) Ventilators;
(3) Air fluidized bed units;
(4) Apnea monitors;
(5) Compressors, including air power sources for equipment which is not self-contained, or cylinder driven;
(6) Low air loss bed units; and
(7) Oximeters.

004.01(I) MEDICARE AND MEDICAID BENEFICIARIES. For beneficiaries eligible for both Medicare and Medicaid, Nebraska Medicaid discontinues paying for the beneficiary's co-insurance and deductibles for rental equipment when either the reimbursement amount reaches Medicare's reimbursement cap for the equipment or Medicare considers the equipment purchased.

004.01(~~I~~J) USED EQUIPMENT. The authorized ~~durable medical equipment, prosthetics, orthotics, and medical supplies (DMEPOS)~~ provider must ensure that used durable medical equipment, prosthetics, orthotics, and medical supplies (DMEPOS) items meet the same standard of quality as new durable medical equipment, prosthetics, orthotics, and medical supplies (DMEPOS) items, and must provide comparable warranty, servicing, and return policies as those which are available with new durable medical equipment, prosthetics, orthotics, and medical supplies (DMEPOS).

~~004.01(J) SERVICES PROVIDED FOR CLIENTS ENROLLED IN NEBRASKA MEDICAID MANAGED CARE. See Title 471 NAC 1.~~

~~004.01(K) HEALTH CHECK SERVICES. See Title 471 NAC 33.~~

004.01(K~~L~~) DOCUMENTATION REQUIREMENTS. In addition to all other documentation requirements outlined in this chapter, the authorized provider must:

(i) Maintain documentation which substantiates all conditions for coverage are met; and
(ii) Maintain documentation that states the ~~client~~ beneficiary, or caregiver is capable of being trained to use the particular device prescribed in an appropriate manner.

004.01(L) PROOF OF DELIVERY. Proof of delivery is required for verification that equipment or supplies were received by the beneficiary. Authorized providers must

maintain proof of delivery documentation in their files for five years for every item provided. Authorized providers, their employees, or anyone who may have a financial interest in the delivery of the item are prohibited from acting as a designee and signing and accepting an item on behalf of the beneficiary. Documentation of any set-up fitting and instructions provided must be maintained in the authorized provider's beneficiary record.

004.01(L)(i) DIRECT DELIVERY. Authorized providers may deliver an item or supply directly to the beneficiary or their designee. A signed and dated delivery document must be used as proof of delivery made directly to a beneficiary. The delivery document must include the following: the beneficiary's name, quantity delivered, detailed description of the item being delivered, brand name of the item, and serial number if applicable. The date of signature on the delivery document must be the date that the item or supply was received by the beneficiary or designee.

004.01(L)(ii) MAIL ORDER AND SHIPPING SERVICE DELIVERY. Authorized providers may use a shipping or mail order service to deliver an item or supply to the beneficiary or their designee. In such cases, a delivery document must be used as proof of delivery and must include the shipping or mail order service's tracking slip and the authorized provider's own shipping invoice. The shipping or mail order service's tracking slip must reference each individual package, the delivery address, the corresponding package identification number given by the shipping or mail order service, and the date delivered.

004.01(L)(iii) DIRECT DELIVERY TO NURSING FACILITES (NF) OR INTERMEDIATE CARE FACILITY FOR INDIVIDUALS WITH DEVELOPMENTAL DISABILITIES (ICF/DD) ON BEHALF OF A BENEFICIARY. For items directly delivered by the authorized provider to a nursing facility (NF) or intermediate care facility for individuals with developmental disabilities (ICF/DD), or when a shipping or mail order service is used to deliver an item or supply to such facilities, the authorized provider must have an appropriate delivery document, determined by the method of delivery, demonstrating delivery of the item, or supply to the facility.

004.02 COVERED SERVICES.

004.02(A) COVERED SERVICES FOR ~~CLIENTS~~ BENEFICIARIES RESIDING IN A NURSING FACILITY (NF) OR INTERMEDIATE CARE FACILITY FOR INDIVIDUALS WITH DEVELOPMENTAL DISABILITIES (ICF/DD). ~~Medicaid will reimburse~~ Authorized ~~durable medical equipment, prosthetics, orthotics, and medical supplies (DMEPOS)~~ providers are reimbursed directly for the following items for ~~clients~~ beneficiaries residing in a nursing facility (NF) or intermediate care facility for individuals with developmental disabilities (ICF/DD):

(1) Orthotics, including lower and upper limb, foot, and spinal, as defined in this chapter; and

(2) Prosthetics, including breast, eye, and lower and upper limb, as defined in this chapter~~; and~~.

(3) ~~All other items, necessary for the care of clients residing in nursing facility (NF) or intermediate care facility for individuals with developmental disabilities (ICF/DD), are included in payments to the facility and cannot be billed directly by a durable medical equipment, prosthetics, orthotics, and medical supplies (DMEPOS) provider.~~

004.02(A)(i) COVERED SERVICES REIMBURSED DIRECTLY TO NURSING FACILITES (NF) OR INTERMEDIATE CARE FACILITIES~~Y~~ FOR INDIVIDUALS WITH DEVELOPMENTAL DISABILITIES (ICF/DD). The following items will be reimbursed directly to the nursing facility (NF) or intermediate care facility for individuals with developmental disabilities (ICF/DD):

(1) Air fluidized beds;
(2) Non-standard wheelchairs;
(3) Wheelchair accessories, options, and components;
(4) Power operated vehicles; ~~and~~
(5) Negative pressure wound therapy~~.~~; and
(6) Items included as part of the facility's per diem rate.

004.02(A)(ii) TRANSFER OR DISCHARGE. At the time of the ~~client's~~ beneficiary's transfer or discharge, the following items specifically purchased for and used by the ~~client~~ beneficiary will be transferred with the ~~client~~ beneficiary:

(1) Any non-standard wheelchair and wheelchair accessories, options, and components;
(2) Augmentative communication devices with related equipment and software;
(3) Supports; and
(4) Custom fitted or custom fabricated items.

004.02(B) SERVICES PROVIDED TO HOSPITAL PATIENTS. ~~Medicaid covers d~~Durable medical equipment, prosthetics, orthotics, and medical supplies (DMEPOS), including fittings, provided to hospital patients are covered~~, as defined in Title 471 NAC 10~~. Payment is not made separately to the authorized ~~durable medical equipment, prosthetics, orthotics, and medical supplies (DMEPOS)~~ provider. In the event a customized wheelchair for primary use in other than the hospital setting is needed for training purposes while the ~~client~~ beneficiary is a hospital inpatient, the non-hospital supplier or provider may deliver the wheelchair to the ~~client~~ beneficiary during the inpatient stay and bill Nebraska Medicaid. This exception does not apply to other items provided for use in the hospital setting.

004.02(C) AIR FLUIDIZED AND LOW AIR LOSS BED UNITS. Air fluidized and low air loss bed units are covered on a rental basis for active healing and treatment to assure progressive and consistent wound healing occurs.

004.02(C)(i) DOCUMENTATION PRIOR TO PLACEMENT. The following conditions must be met and documented prior to placement of an air fluidized or low air loss bed unit:

(1) Comprehensive ~~client~~ beneficiary assessment and evaluation by the ~~authorized durable medical equipment, prosthetics, orthotics, and medical supplies (DMEPOS) provider~~ treating practitioner has occurred;
(2) Treatment has been tried without success;
(3) Caregiver training on use of the bed by a registered nurse (RN) employed by the authorized provider has occurred; and
(4) Initial dietary consult has occurred, which includes recommended caloric intake and serum albumin level at or near the time of placement.

004.02(C)(ii) DOCUMENTATION DURING USAGE. The following conditions must be met and documented during use of air fluidized or low air loss bed units:

(1) A trained adult caregiver is available to assist the ~~client~~ beneficiary with activities of daily living, fluid balance, skin care, repositioning, recognition, and management of altered mental status, dietary needs, prescribed treatments, and management and support of the bed;
(2) Wound healing must begin within 14 days of placement on the bed unit. If progressive, consistent wound healing ceases during use of the bed, a new wound healing care plan must be reestablished within 14 days;
(3) The ~~client~~ beneficiary must remain on the bed unit at all times except for a maximum of one hour per day and when receiving medical treatment;
(4) On-site ~~client~~ beneficiary evaluation and wound care consultation by a registered nurse (RN) occurs weekly;
(5) Changes in the ~~client's~~ beneficiary's status, treatment, and diet is monitored and documented; and
(6) A written plan of care must be established within four weeks of placement of the bed unit. The plan of care must address skin care, pressure reducing devices and protocol, and dietary needs after use of bed unit has been discontinued.

004.02(C)(iii) ADDITIONAL DOCUMENTATION REQUIREMENTS. ~~Form MS-80, Air Fluidized and Low Air Loss Bed Certification of Medical Necessity,~~ The appropriate Nebraska Medicaid approved certification of medical necessity form must be completed on a monthly basis by a registered nurse (RN), signed by the ~~authorized durable medical equipment, prosthetics, orthotics, and medical supplies (DMEPOS) provider~~ treating practitioner, and kept on file with the authorized provider and submitted to the health plans upon request.

004.02(D) APNEA MONITORS. Apnea monitors are covered on a rental basis for infants up to one year of age who meet at least one of the following criteria:
(1) Infants with one or more apparent life-threatening events (ALTEs) requiring mouth-to-mouth resuscitation or vigorous stimulation;
(2) Symptomatic preterm infants;
(3) Siblings of one or more sudden infant death syndrome (SIDS) victims; or
(4) Infants with certain diseases or conditions~~, such as central hyperventilation, bronchopulmonary dysplasia, infants with tracheostomies, infants with substance-abusing mothers, or infants with less severe apparent life-threating events (ALTEs)~~.

004.02(D)(i) ADDITIONAL CRITERIA. Criteria for discontinuing apnea monitoring must be based on the infant's clinical condition. A monitor may be discontinued when apparent life-threating event (ALTE) infants have had ~~two to~~ three months free of significant alarms or apnea requiring vigorous stimulation or resuscitation. Pneumocardiograms are covered for diagnostic or evaluation purposes and when required to determine when the infant may be removed from the monitor. Payment does not include analysis and interpretation.

004.02(D)(ii) COVERAGE CONDITIONS. The following conditions must be met prior to initiation of home apnea monitoring:
(1) History and physical assessment by the infant's ~~authorized durable medical equipment, prosthetics, orthotics, and medical supplies (DMEPOS) provider~~ treating practitioner; and

(2) Parent or caregiver have successfully completed training on use of the equipment and any other ~~authorized durable medical equipment, prosthetics, orthotics, and medical supplies (DMEPOS) provider~~ treating practitioner recommended training.

004.02(D)(iii) DOCUMENTATION REQUIREMENTS. Apnea monitor rental exceeding two months requires a~~n authorized durable medical equipment, prosthetics, orthotics, and medical supplies (DMEPOS) provider's~~ treating practitioner's narrative report of ~~client~~ beneficiary progress to be kept on file with the authorized provider. A progress report is required every two months, and must include:

(1) The number of apnea episodes during the previous two-month period of use;
(2) Tests and results of tests performed during the previous two-month period of use;
(3) Estimated additional length of time the monitor will be needed; and
(4) Any additional pertinent information the ~~authorized durable medical equipment, prosthetics, orthotics, and medical supplies (DMEPOS) provider~~ treating practitioner may wish to provide.

004.02(E) BATH AND TOILET AIDS. Bathtub patient lifts and rehabilitation shower chairs are covered for ~~clients~~ beneficiaries with severe conditions who, without use of the equipment, would be unable to bathe or shower. The ~~client~~ beneficiary must be unable to use a stationary tub stool or bench, rails, or similar equipment. Covered bath and toilet aids include the following durable medical equipment, prosthetics, orthotics, and medical supplies (DMEPOS):

(i) Bath and toilet rails;
(ii) Raised toilet seats;
(iii) Tub stools and benches;
(iv) Transfer tub benches and attachments; and
(v) Bath support chairs.

004.02(F) BED SIDE RAILS. Bed side rails are covered for ~~clients~~ beneficiaries who are at risk for injury due to one of the following conditions:

(i) Disorientation;
(ii) Vertigo; or
(i) A neurological disorder resulting in convulsive seizures.

004.02(G) BED WEDGES. Bed wedges are covered for ~~clients~~ beneficiaries that require the head of the bed to be elevated more than 30 degrees due to congestive heart failure, chronic pulmonary disease, or problems with aspiration. Standard bed pillows must have been tried and failed.

004.02(H) BEDPANS AND URINALS. Bedpans and urinals are covered for ~~clients~~ beneficiaries who are determined by their ~~authorized durable medical equipment, prosthetics, orthotics, and medical supplies (DMEPOS) provider~~ treating practitioner to be bed-confined.

004.02(I) BLOOD GLUCOSE MONITORS. Blood glucose monitors are covered for ~~clients~~ beneficiaries with insulin-treated diabetes, non-insulin-treated diabetes, and gestational diabetes.

004.02(I)(i) DOCUMENTATION REQUIREMENTS. The authorized ~~durable medical equipment, prosthetics, orthotics, and medical supplies (DMEPOS)~~ provider must retain documentation stating the ~~client~~ beneficiary or caregiver is capable of being trained to use the particular device prescribed in an appropriate manner.

004.02(I)(ii) ADDITIONAL FEATURES. ~~Medicaid covers b~~Blood glucose monitors with the following additional features are covered ~~such as~~:

(a) Voice synthesizers;
(b) Automatic timers; and
(c) Specially designed arrangements of supplies and materials to enable ~~clients~~ beneficiaries with visual impairments to use the equipment without assistance.

004.02(I)(ii)(1) DOCUMENTATION REQUIREMENTS. ~~An authorized durable medical equipment, prosthetics, orthotics, and medical supplies (DMEPOS) provider~~ treating practitioner must certify the ~~client~~ beneficiary has a visual impairment and requires use of a blood glucose monitor with additional features. The certification must identify the additional features are necessary.

004.02(J) BLOOD PRESSURE MONITORS. Blood pressure monitors are covered for ~~clients~~ beneficiaries with a hypertension diagnosis that must be self-monitored at home. An electronic blood pressure monitor is covered only if the ~~client~~ beneficiary is unable to use a standard cuff and stethoscope due to medical conditions.

004.02(J)(i) ACCESSORIES. Accessories are covered only as replacement for use with ~~client~~ beneficiary-owned monitors for ~~clients~~ beneficiaries whose condition meets the criteria for coverage of the monitor.

004.02(J)(ii) DOCUMENTATION REQUIREMENTS. The documentation must specify the cuff size, that the ~~authorized durable medical equipment, prosthetics, orthotics, and medical supplies (DMEPOS) provider~~ treating practitioner will be monitoring its use in connection with the ~~client's~~ beneficiary's continuing course of treatment, and that the ~~client~~ beneficiary or caregiver will be instructed in use of the equipment by the authorized ~~durable medical equipment, prosthetics, orthotics, and medical supplies (DMEPOS)~~ provider, their office staff, or other qualified health professional.

004.02(K) EXTERNAL BREAST PROSTHESES AND SUPPLIES. Breast prostheses and supplies are covered for ~~clients~~ beneficiaries who have had a mastectomy.

004.02(L) BREAST PUMPS. ~~Breast pumps are covered for clients who are breast feeding if one or more of the following conditions are met for either short term or long term rental.~~ Electric personal-use breast pumps are covered for pregnant women, or for a Nebraska Medicaid-eligible child whose mother is not Nebraska Medicaid-eligible, beginning at thirty-six weeks gestation or the child's date of birth, whichever is earlier. Hospital grade breast pumps are covered only on a rental basis.

004.02(L)(i) ELECTRIC PERSONAL-USE BREAST PUMP SPECIFICATIONS. The electric personal-use breast pump provided by an authorized provider shall be capable of:

(1) Sufficiently supporting mild supply;
(2) Double and single side pumping; and

(3) Suction power ranging from zero millimeters of mercury (mm Hg) to two hundred fifty millimeters of mercury (mm Hg).

004.02(L)(ii) SHORT TERM RENTAL OF HOSPITAL GRADE BREAST PUMPS. Short term rental of hospital grade breast pumps for up to two months is covered in the following instances:

(1) Infant or neonate with abnormal weight loss;
(2) Hyperbilirubinemia;
(3) Inadequate milk supply;
(4) Mastitis;
(5) Acutely ill infant;
(6) Infant food allergy;
(7) Medical condition of mother that precludes feeding infant at breast; or
(8) Maternal post-partum complications.

004.02(L)(iii) LONG TERM RENTAL OF HOSPITAL GRADE BREAST PUMPS. Long term rental of hospital grade breast pumps is covered for up to six months, with one additional six month period in the following instances:

(1) Congenital abnormality of the infant that impedes the infant's ability to suck or swallow;
(2) Neurologic abnormality of the infant;
(3) Prematurity; or
(4) Latch difficulties.

004.02(M) CANES AND CRUTCHES. Canes and crutches are covered for ~~clients~~ beneficiaries with conditions that impair ambulation.

004.02(N) CAR SEATS. Specialized ~~C~~car seats are covered for ~~clients~~ beneficiaries age 20 and younger with physical disabilities when required for positioning during transportation when standard seat belts and car seats are not appropriate.

004.02(O) COMMODES. Commodes are covered for ~~clients~~ beneficiaries who are confined to bed, to a room, or to a home without accessible bathroom facilities. A commode chair with detachable arms is covered when medically necessary.

004.02(P) COMMUNICATION DEVICES, AUGMENTATIVE. Communication devices are covered for ~~clients~~ beneficiaries who are unable to use natural oral speech as a primary means of communication. Non-portable devices may be covered only if required for visual enhancement or accommodated by a portable device. The specific device recommended, and all accessories required for use of the device must be identified and medically necessary. ~~Communication boards, dedicated speech-generating devices, and related accessories are durable medical equipment (DME). Artificial larynx, voice amplification, and related devices are prostheses.~~

004.02(P)(i) EVALUATION. A licensed speech-language pathologist must evaluate the ~~client's~~ beneficiary's communication needs. The evaluation must identify the ~~client's~~ beneficiary's:

(1) Medical diagnosis:
(2) Speech-language diagnosis;
(3) Physical status;

(4) Communication abilities;
(5) Vision and hearing acuity; and
(6) Other skills required for use of the specific device selected.

004.02(P)(ii) DOCUMENTATION REQUIREMENTS. ~~Form MS-78, Augmentative Communication Device Selection Report,~~ The appropriate Nebraska Medicaid approved device selection report form must be completed and signed by the evaluating speech-language pathologist and the authorized ~~durable medical equipment, prosthetics, orthotics, and medical supplies (DMEPOS)~~ provider~~.~~, ~~Form MS-78 is~~ and submitted with the request for prior authorization. Documentation from the speech-language pathologist must show that the device meets the ~~client's~~ beneficiary's communication needs, the ~~client~~ beneficiary has the ability to use the device, and the device meets the functional communication goals established by the speech-language pathologist.

004.02(P)(ii)(1) TRIAL PERIOD. The provider must maintain documentation showing the results of the selected device during a trial period lasting a minimum of one month.

004.02(Q) CONTINUOUS GLUCOSE MONITORS (CGM). Continuous glucose monitors (CGM) are covered for eligible beneficiaries who have ~~D~~diabetes mellitus, including gestational diabetes, ~~use multiple daily doses of insulin or are on an insulin pump~~ are insulin-treated or have a history of problematic hypoglycemia, are being assessed at least every six months by the ~~healthcare~~ treating practitioner for this condition, and for whom the treatment is medically indicated and appropriate. The continuous glucose monitor (CGM) is used for diagnostic and therapeutic purposes when medically necessary. The initial authorization period for the therapeutic continuous glucose monitor (CGM) is six months and the renewal authorization period is 12 months. ~~For therapeutic continuous glucose monitors (CGM), beneficiaries must be able to hear and view the continuous glucose monitor (CGM) alerts and respond accordingly or have a caregiver who is able to do so.~~

004.02(R) CONTINUOUS PASSIVE MOTION. Continuous passive motion devices are covered for ~~clients~~ beneficiaries who have received a total knee replacement. Coverage is limited to the first three weeks following surgery.

004.02(R)(i) DOCUMENTATION. The provider must retain documentation showing the device was provided to the ~~client~~ beneficiary within two days following surgery.

004.02(S) CONTINUOUS POSITIVE AIRWAY PRESSURE SYSTEMS (CPAP). Continuous positive airway pressure systems (CPAP) are covered for ~~clients~~ beneficiaries with ~~moderate or~~ mild to severe obstructive sleep apnea for whom surgery is a likely alternative to continuous positive airway pressure systems (CPAP). Intermittent assist devices with a continuous positive airway pressure systems (CPAP) are covered for ~~clients~~ beneficiaries who, after trial use with continuous positive airway pressure systems (CPAP), cannot tolerate use of continuous positive airway pressure systems (CPAP) without the intermittent assist devices. Humidifiers for use with continuous positive airway pressure systems (CPAP) are covered for ~~clients~~ beneficiaries who require supplemental humidification with continuous positive airway pressure systems (CPAP).

004.02(S)(i) DOCUMENTATION REQUIREMENTS. The authorized provider must maintain documentation showing ~~authorized durable medical equipment, prosthetics, orthotics, and medical supplies (DMEPOS) provider~~ treating practitioner approval of intermittent assist devices and humidifiers.

004.02(T) DRESSINGS. Dressings are covered for ~~clients~~ beneficiaries that require treatment of a wound or surgical incision.

004.02(U) ELECTROMYOGRAPHY BIODFEEDBACK DEVICES. Electromyography biofeedback devices are covered for muscle re-education of specific muscle groups or for treating pathological muscle spasm, or weakness.

~~004.02(V) ENTERAL AND PARENTERAL NUTRITION, AND NUTRITIONAL SUPPLEMENTS. Enteral nutritional supplements are covered for clients with normal gastrointestinal absorptive capacity who, due to permanent or temporary non-function or disease of the structures which normally permit food to reach the small bowel and requires tube feeding to provide sufficient nutrients.~~

~~004.02(V)(i) PARENTERAL NUTRITION. Parenteral nutritional supplements are covered for clients with disease of the gastrointestinal tract which prevents absorption of sufficient nutrients. No more than one month supply of parenteral nutrients, equipment, or supplies may be provided in advance.~~

~~004.02(V)(ii) NUTRITIONAL SUPPLEMENTS. Nutritional supplements are covered for clients who require nutritional supplementation to maintain weight and strength commensurate with the client's general condition.~~

~~004.02(V)(iii) CLIENTS ELIGIBLE FOR SUPPLEMENTAL FEEDING AND NUTRITION PROGRAM. Clients eligible for Supplemental Feeding and Nutrition Program for Women, Infants, and Children (WIC), enteral nutrients are covered if the product is not covered by Women, Infants, and Children (WIC) or to the extent the quantity required exceed the maximum quantity provided by Women, Infants, and Children (WIC).~~

~~004.02(V)(iv) DOCUMENTATION REQUIREMENTS. Authorized durable medical equipment, prosthetics, orthotics, and medical supplies (DMEPOS) provider approval must be documented for:~~

~~(1) Use of a pump; and~~

~~(2) Clients age 20 and younger with special delivery needs.~~

004.02(V) ENTERAL NUTRITION, PARENTERAL NUTRITION, AND NUTRITIONAL SUPPLEMENTS.

004.02(V)(i) ENTERAL NUTRITION. Enteral nutrition is covered for beneficiaries who require feedings via an enteral access device to provide sufficient nutrients due to:

(1) Full or partial non-function or disease of the structures that normally permit food to reach the small bowel; or

(2) Disease that impairs digestion or absorption of an oral diet, directly or indirectly, by the small bowel.

004.02(V)(i)(a) DOCUMENTATION REQUIREMENTS. For use of an infusion pump with enteral feedings, documentation from the treating practitioner must show a medical reason that gravity feeding is an unsuitable delivery method.

004.02(V)(ii) PARENTERAL NUTRITION. Parenteral nutrition is covered for beneficiaries who require feedings via an intravenous catheter to provide sufficient nutrients due to:

(1) A condition involving the small intestine or its exocrine glands which significantly impairs the absorption of nutrients; or

(2) Disease of the stomach or intestine which is a motility disorder and impairs the ability of nutrients to be transported through and absorbed by the gastrointestinal system.

004.02(V)(iii) ADVANCE SUPPLIES. No more than a one-month supply of enteral or parenteral nutrients, equipment, or supplies may be provided in advance.

004.02(V)(iv) NUTRITIONAL SUPPLEMENTS. Nutritional supplements are covered for beneficiaries who require nutritional supplementation to maintain weight and strength commensurate with the beneficiary's general condition.

004.02(V)(iv)(a) INFANT FORMULA. Infant formula for oral nutritional supplements is covered for beneficiaries age 20 and younger only if medically necessary for special dietary needs.

004.02(V)(iv)(b) DOCUMENTATION REQUIREMENTS. Documentation from the treating practitioner must show:

(1) The beneficiary's nutritional needs cannot be met by a regular food diet, standard commercial formula, food products, or supplementation with commercially available product; and

(2) The beneficiary has clinical signs and symptoms of impaired digestion, malabsorption, or nutritional risk.

004.02(V)(v) BENEFICIARIES ELIGIBLE FOR SUPPLEMENTAL FEEDING AND NUTRITION PROGRAM. For beneficiaries eligible for the Supplemental Feeding and Nutrition Program through the Women, Infants, and Children (WIC) program, enteral, parenteral, or nutritional supplements are covered if:

(1) The product is not covered by the Women, Infants, and Children (WIC) program; or

(2) The quantity required exceeds the maximum quantity provided by the Women, Infants, and Children (WIC) program.

004.02(W) EYE PROSTHESES. Eye prostheses are covered for ~~clients~~ beneficiaries with absence or shrinkage of an eye due to birth defect, trauma, or surgical removal.

004.02(X) FAMILY PLANNING SUPPLIES. Prescribed family planning supplies are covered when medically necessary and required to prevent or delay pregnancy.

004.02(Y) FOOT ORTHOSES. Foot orthoses are covered when required to support a weak or deformed foot or leg, or to restrict or eliminate motion in a foot or leg. Coverage of orthopedic shoes is limited to one pair in a one-year period, except when documentation indicates excessive wear or size change is necessary due to growth.

004.02(Z) HEARING AID BATTERIES. Hearing aid batteries are covered for ~~clients~~ beneficiaries who use hearing aids.

004.02(AA) HEAT AND COLD APPLICATION DEVICES. Heat and cold application devices are covered for ~~clients~~ beneficiaries with medical conditions requiring heat or cold therapy.

004.02(BB) HOSPITAL BEDS. Fixed height, variable height, and semi-electric hospital beds are covered for ~~clients~~ beneficiaries who:

(1) Require positioning of the body due to a medical condition or pain which is expected to last at least one month;
(2) Require the head of the bed to be elevated most of the time, due to a medical condition;
(3) Require equipment which can only be attached to a hospital bed;
(4) Require a bed height different from the height provided by a fixed height bed in order to permit transfer to a chair, wheelchair, or standing position; or
(5) Require frequent changes in body position.

004.02(BB)(i) SUPPLIES AND ACCESSORIES. ~~Medicaid covers~~ Hospital bed supplies and accessories are covered including:

(1) An innerspring or foam rubber mattress;
(2) Side rails;
(3) Trapeze bar; and
(4) Bed cradle.

004.02(CC) IMPOTENCE TREATMENT DEVICES. Impotence treatment devices are covered for ~~clients~~ beneficiaries with organic impotence and without conditions that contraindicate use of the device.

004.02(DD) INCONTINENCE APPLIANCES AND CARE SUPPLIES. Incontinence appliances and care supplies are covered for ~~clients~~ beneficiaries without control over bladder or bowel function. Incontinence diapers or briefs and liners are not covered for ~~clients~~ beneficiaries under age three.

004.02(EE) INSULIN INFUSION PUMPS, EXTERNAL. External continuous subcutaneous insulin infusion (CSII) pumps are covered for ~~clients~~ beneficiaries with conditions which require administration of parenteral medication when reasonable and necessary.

004.02(EE)(i) DOCUMENTATION REQUIREMENTS. The authorized provider will obtain written documentation from the ~~prescribing authorized durable medical equipment, prosthetics, orthotics, and medical supplies (DMEPOS) provider~~ treating practitioner which ~~includes at minimum,~~ must include the following:

(1) Diabetes team evaluation summary, which addresses:
    (a) Diagnosis;
    (b) Complications and compounding issues;
    (c) Failure of adequate blood glucose control in spite of demonstrated compliance with multiple daily injections;
    (d) Hemoglobin (Hgb) A_{1c} levels; and
    (e) ~~Patient's~~ Beneficiary's ability and motivation to use the pump; and

(2) Treatment plan, which includes:
(a) Inpatient initiation of continuous subcutaneous insulin infusion (CSII) pump or rationale for outpatient initiation with all policies and procedures involved;
(b) ~~Client~~ Beneficiary and family diabetes education plan; and
(c) Monitoring plan post-initiation of continuous subcutaneous insulin infusion (CSII) pump.

004.02(FF) INTERMITTENT POSITIVE PRESSURE BREATHING (IPPB) MACHINES. Intermittent positive pressure breathing (IPPB) machines are covered for ~~clients~~ beneficiaries who require respiratory therapy treatment for hypoventilation.

004.02(GG) PATIENT LIFTS. Patient lifts are covered for ~~clients~~ beneficiaries when assistance is required for transfers in the home ~~residence~~.

004.02(GG)(i) DOCUMENTATION REQUIREMENTS. Lift ~~D~~documentation must verify all of the following:
(1) The home can accommodate the lift;
(2) The caregiver is able and willing to use the equipment; and
(3) The ~~client~~ beneficiary can tolerate using the equipment.

004.02(HH) LOWER AND UPPER LIMB ORTHOSES. Lower and upper limb orthoses are covered when required to support a weak or deformed arm or segments of the lower or upper limb. Myoelectric and electronically switch-controlled prosthetic devices are not covered.

004.02(II) LOWER AND UPPER LIMB PROSTHESES. ~~Medicaid covers l~~Lower and upper limb prostheses are covered for ~~clients~~ beneficiaries to replace a missing body part. Myoelectric and electronically switch-controlled prosthetic devices are not covered.

004.02(JJ) MEDICAL AND SURGICAL SUPPLIES. Medical and surgical supplies are covered for ~~clients~~ beneficiaries who require home treatment of a specific medical condition, protection or support of a wound, surgical incision, or diseased or injured body part.

004.02(KK) NEBULIZERS AND COMPRESSORS. ~~Medicaid provides coverage of n~~Nebulizers and compressors are covered in the following situations:
(1) When the ~~client's~~ beneficiary's ability to breathe is severely impaired;
(2) To administer aerosol therapy when a metered dose inhaler is not adequate or appropriate;
(3) When required for use in connection with durable medical equipment, prosthetics, orthotics, and medical supplies (DMEPOS) for purposes of moisturizing oxygen; or
(4) For ~~clients~~ beneficiaries who require heated nebulizers with tracheostomies.

004.02(KK)(i) DOCUMENTATIO~~I~~N REQUIREMENTS. ~~Authorized durable medical equipment, prosthetics, orthotics, and medical supplies (DMEPOS) provider~~ The treating practitioner's approval must be documented for portable compressors with internal battery features and ultrasonic nebulizers when other means of nebulization is ineffective.

004.02(LL) NEUROMUSCULAR ELECTRICAL STIMULATORS (NMES). Neuromuscular electrical stimulators (NMES) are covered for treatment of disuse atrophy where nerve supply to the muscle is intact, including brain, spinal cord and peripheral nerves, and other non-neurological reasons for disuse are causing atrophy. Neuromuscular electrical stimulators (NMES) are not covered for treatment of scoliosis.

004.02(LL)(i) SUPPLIES AND ACCESSORIES. Supplies and accessories for rented neuromuscular electrical stimulators (NMES) units, the lead wires, and supplies must be billed on the same claim as the neuromuscular electrical stimulators (NMES) rental.

004.02(LL)(ii) DOCUMENTATION REQUIREMENTS. ~~Authorized durable medical equipment, prosthetics, orthotics, and medical supplies (DMEPOS) provider~~ Treating practitioner approval must be documented for a conductive garment.

004.02(MM) OSTEOGENIC STIMULATORS. Osteogenic stimulators are covered for ~~clients~~ beneficiaries with at least one of the following indications:

(i) Non-union of long bone fractures lasting six or more months;
(ii) Failed fusion lasting six or more months without healing of the fusion; and
(iii) Congenital pseudo arthrosis.

004.02(NN) OSTOMY SUPPLIES. Ostomy supplies are covered for ~~clients~~ beneficiaries with an ostomy.

004.02(NN)(i) DOCUMENTATION REQUIREMENTS. ~~Authorized durable medical equipment, prosthetics, orthotics, and medical supplies (DMEPOS) provider~~ Treating practitioner approval must be documented for skin moisturizers, protectants, and sealants for ~~clients~~ beneficiaries with ostomies.

004.02(OO) OXIMETERS, EAR, AND PULSE. Oximeters are covered on a rental basis for ~~clients~~ beneficiaries who require a minimum of daily monitoring of arterial blood oxygen saturation levels for evaluation and regulation of home oxygen therapy. Coverage for other indications will be determined on a case-by-case basis.

004.02(OO)(i) DOCUMENTATION REQUIREMENTS. A monthly updated certification of medical necessity is required when the oximeter is required for evaluation and regulation of home oxygen therapy. The documentation submitted by the ~~authorized durable medical equipment, prosthetics, orthotics, and medical supplies (DMEPOS) provider~~ treating practitioner must specify the ~~client's~~ beneficiary's medical condition which substantiates the need for in-home use of oximeter, estimated length of need for monitoring and frequency of monitoring required.

004.02(PP) OXYGEN AND OXYGEN EQUIPMENT. Portable oxygen systems alone or to complement a stationary oxygen system will be covered if the ~~client~~ beneficiary is mobile within the home ~~residence~~. Oxygen and oxygen equipment are covered for ~~clients~~ beneficiaries with significant hypoxemia in the chronic stable state, when the following conditions are met:

(1) The ~~authorized durable medical equipment, prosthetics, orthotics, and medical supplies (DMEPOS) provider~~ treating practitioner has determined that the ~~client~~ beneficiary suffers severe lung disease or hypoxia-related symptoms that might be expected to improve with oxygen therapy;

(2) The ~~client's~~ beneficiary's blood gas levels indicate the need for oxygen therapy; and
(3) The ~~client~~ beneficiary has appropriately tried other alternative treatment measures without complete success.

004.02(PP)(i) STATIONARY AND PORTABLE SYSTEM RENTAL. When both a stationary and portable system is being rented, the Nebraska Medicaid allowable for all contents is included in the Nebraska Medicaid allowable for the stationary system. Stationary contents are covered only when the ~~client~~ beneficiary owns the gaseous or liquid stationary system. Portable contents are covered only when the ~~client~~ beneficiary uses a portable system only.

004.02(PP)(ii) OXYGEN THERAPY. Oxygen therapy is covered for ~~clients~~ beneficiaries with significant hypoxemia evidenced by the following:

(1) An arterial partial pressure of oxygen (PO2) at or below 55 millimeters of mercury (mm Hg), or an arterial oxygen saturation at or below 88 percent, taken:
    (a) At rest;
    (b) During sleep for a ~~client~~ beneficiary who demonstrates an arterial partial pressure of oxygen (PO2) at or above 56 millimeters of mercury (mm Hg);
        (i) An arterial oxygen saturation at or above 89 percent, while awake; or
        (ii) A greater than normal fall in oxygen level during sleep:
            (1) A decrease in arterial partial pressure of oxygen (PO2) more than 10 millimeter of mercury (mm Hg); or
            (2) A decrease in arterial oxygen saturation more than five percent associated with symptoms or signs reasonably attributable to hypoxemia. In either of these cases, coverage is provided only for nocturnal use of oxygen; or
    (c) During exercise:
        (i) For a ~~client~~ beneficiary who demonstrates an arterial partial pressure of oxygen (PO2) at or above 56 millimeters of mercury (mm Hg); or
        (ii) An arterial oxygen saturation at or above 89 percent, during the day while at rest. In this case, supplemental oxygen is provided for during exercise if it is documented that the use of oxygen improves the hypoxemia which was demonstrated during exercise when the ~~client~~ beneficiary was breathing without assistance; or
(2) An arterial partial pressure of oxygen (PO2) of 56 to 59 millimeter of mercury (mm Hg); or an arterial blood oxygen saturation of 89 percent if any of the following are documented:
    (a) Dependent edema suggesting congestive heart failure;
    (b) Pulmonary hypertension or cor pulmonale, determined by measurement of pulmonary artery pressure, gated blood pool scan, echocardiogram, "P" pulmonale of electrocardiogram; or
    (c) Erythrocythemia with a hematocrit greater than 56 percent.

004.02(PP)(iii) DOCUMENTATION REQUIREMENTS. The ~~authorized durable medical equipment, prosthetics, orthotics, and medical supplies (DMEPOS) provider~~ treating practitioner must provide documentation that shows the conditions to qualify for oxygen therapy outlined in this chapter have been met. Documentation for oxygen therapy must include:

(a) The results of a blood gas study that has been ordered and evaluated by the ~~authorized durable medical equipment, prosthetics, orthotics, and medical supplies (DMEPOS) provider~~ treating practitioner; or

(b) A measurement of pulse arterial oxygen saturation when ordered and evaluated by the ~~authorized durable medical equipment, prosthetics, orthotics, and medical supplies (DMEPOS) provider~~ treating practitioner and performed under his or her supervision or when performed by a qualified provider or supplier of laboratory services.

004.02(PP)(iii)(1) ADDITIONAL DOCUMENTATION REQUIREMENTS. For the purposes of these documentation requirements:

(a) An authorized ~~durable medical equipment, prosthetics, orthotics, and medical supplies (DMEPOS) supplier~~ provider is not considered a qualified provider or supplier of laboratory services; and ~~for purposes of these guidelines.~~

(b) When a ~~client's~~ beneficiary's initial certification for oxygen is approved based on an arterial partial pressure of oxygen (PO2) of 56 millimeter of mercury (mm Hg) or greater or an oxygen saturation of 89 percent or greater, retesting between the 61st and 90th day of home oxygen therapy is required in order to establish continued medical necessity.

004.02(QQ) PACEMAKER MONITORS, SELF-CONTAINED. Pacemaker monitors are covered for ~~clients~~ beneficiaries with cardiac pacemakers.

004.02(RR) PARAFFIN BATH UNITS, PORTABLE. Paraffin bath units are covered for ~~clients~~ beneficiaries who have undergone a successful trial period of paraffin therapy.

004.02(RR)(i) DOCUMENTATION REQUIREMENTS. The ~~authorized durable medical equipment, prosthetics, orthotics, and medical supplies (DMEPOS) provider~~ treating practitioner must provide documentation of a successful trial period of paraffin therapy.

004.02(SS) PEAK FLOW METERS. Peak flow meters are covered for ~~clients~~ beneficiaries with chronic asthma.

004.02(TT) PERCUSSORS. Percussors are covered for mobilizing respiratory tract secretions in ~~clients~~ beneficiaries with cystic fibrosis, chronic obstructive lung disease, chronic bronchitis, or emphysema when no one competent to administer manual therapy is available or when manual therapy does not adequately assist in airway mucus clearance.

004.02(TT)(i) DOCUMENTATION REQUIREMENTS. The authorized ~~durable medical equipment, prosthetics, orthotics, and medical supplies (DMEPOS)~~ provider must provide documentation showing the ~~client~~ beneficiary or operator of a powered percussor has received appropriate training by ~~an authorized durable medical equipment, prosthetics, orthotics, and medical supplies (DMEPOS) provider~~ a qualified healthcare practitioner or therapist ~~when no one else competent to administer manual therapy is available~~.

004.02(UU) PHOTOTHERAPY SERVICES. Phototherapy is covered on a rental basis for infants who meet the following criteria:

(1) Neonatal hyperbilirubinemia;
(2) Bilirubin level at initiation of phototherapy is 14-18 milligrams (mgs) per deciliter. Home phototherapy is not covered if the bilirubin level is less than 12 milligrams (mgs) at 72 hours of age or older; or
(3) Direct bilirubin level is less than two milligrams (mgs) per deciliter.

004.02(UU)(i) PHOTOTHERAPY HOME TREATMENT. The following conditions must be met prior to initiation of home phototherapy:
(1) The treating practitioner has performed a ~~H~~history and physical assessment ~~by~~ of the infant's ~~authorized durable medical equipment, prosthetics, orthotics, and medical supplies (DMEPOS) provider has occurred~~;
(2) Required laboratory studies have been performed, including, complete blood count (CBC), blood type on mother and infant, direct Coombs test, direct and indirect bilirubin;
(3) The ~~authorized durable medical equipment, prosthetics, orthotics, and medical supplies (DMEPOS) provider~~ treating practitioner certifies that the parent or caregiver is capable of administering home phototherapy;
(4) A ~~P~~parent or caregiver has successfully completed training on use of the equipment; and
(5) Equipment must be delivered and set up within four hours of discharge from the hospital or notification of the provider, whichever is more appropriate. There must be a 24-hour per day repair and replacement service available.

004.02(UU)(ii) DOCUMENTATION REQUIREMENTS. ~~An authorized durable medical equipment, prosthetics, orthotics, and medical supplies (DMEPOS) provider's~~ treating practitioner's narrative report outlining the ~~client's~~ beneficiary's progress and the circumstances necessitating extended therapy must be submitted with the claim when billing for home phototherapy exceeding three days.

004.02(VV) PNEUMATIC COMPRESSORS AND APPLIANCES. Pneumatic compressors and appliances are covered for ~~clients~~ beneficiaries with intractable edema of the extremities and are intended for single person use only.

004.02(WW) POSTURAL DRAINAGE BOARDS. Postural drainage boards are covered for ~~clients~~ beneficiaries with chronic pulmonary conditions.

004.02(XX) POWER-OPERATED VEHICLE (POV). A power-operated vehicle (POV) is covered instead of a standard wheelchair when all of the following criteria are met:
(1) The ~~client~~ beneficiary has a diagnosed medical condition which impairs their ability to walk;
(2) The ~~client~~ beneficiary requires a power-operated vehicle (POV) for the purpose of:
(a) Increasing their independence with mobility, resulting in significant difference in their ability to perform major life activities; or
(b) Providing assisted mobility for ~~clients~~ beneficiaries who show no means of safe independent mobility;
(3) The ~~client~~ beneficiary has significant limitation of limb function such that the ~~client~~ beneficiary is not able to propel a manual wheelchair. Compared to their use of a manual wheelchair, the ~~client's~~ beneficiary's use of a power-operated vehicle (POV) must result in a significant improvement in independent mobility and ability to perform major life activities; and

(4) The ~~client~~ beneficiary has demonstrated, through a trial period with a similar power-operated vehicle (POV):
(a) The ability to safely and independently operate the controls of a power-operated vehicle (POV);
(b) The ability to transfer safely in and out of a power-operated vehicle (POV); and
(c) Adequate trunk stability to be able to safely ride in the power-operated vehicle (POV).

~~004.02(XX)(i) DOCUMENTATION REQUIREMENTS. The authorized durable medical equipment, prosthetics, orthotics, and medical supplies (DMEPOS) provider must complete Form MS-79, Wheelchair and Wheelchair Seating System Selection Report, and must:~~
~~(1) Justify the type of wheelchair seating system; and~~
~~(2) Provide evidence of a coordinated assessment, which includes communication between the client, caregiver(s), authorized durable medical equipment, prosthetics, orthotics, and medical supplies (DMEPOS) provider, physical or occupational therapist, and equipment supplier. The assessment should address:~~
~~(a) Physical;~~
~~(b) Functional;~~
~~(c) Cognitive issues;~~
~~(d) Accessibility; and~~
~~(e) Cost effectiveness of equipment.~~

004.02(XX)(~~ii~~) PRIOR AUTHORIZATION. All power-operated vehicles (POVs) and power-operated vehicle (POV) accessories require prior authorization before items are provided to the ~~client~~ beneficiary.

004.02(YY) PRESSURE REDUCING SUPPORT SURFACES. Pressure reducing support surfaces include pressure reducing mattresses and pressure reducing cushions.

004.02(YY)(i) PRESSURE REDUCING MATTRESSES. Pressure reducing mattresses are covered for ~~clients~~ beneficiaries who meet one of the following conditions:
(1) Completely immobile;
(2) Limited mobility; or
(3) Any stage pressure ulcer on the trunk or pelvis~~; or~~
(4) ~~Pressure reducing cushions are covered for clients with or highly susceptible to decubiti~~.

004.02(YY)(ii) ADDITIONAL CRITERIA. If the ~~client~~ beneficiary meets criteria two or three above, he or she must also meet at least one of the following criteria:
(1) Impaired nutritional status;
(2) Fecal or urinary incontinence;
(3) Altered sensory perception; or
(4) Compromised circulatory status.

004.02(YY)(iii) PRESSURE REDUCING CUSHIONS. Pressure reducing cushions are covered for beneficiaries who have or are highly susceptible to decubiti.

004.02(YY)(iv~~i~~) REPLACEMENTS. Replacements for pressure reducing support surfaces are covered when the anticipated length of need is at least one year or the original pressure reducing ~~mattress~~ support surface is not supportive enough for the ~~client~~ beneficiary.

004.02(YY)(v~~iii~~) DOCUMENTATION REQUIREMENTS. The ~~authorized durable medical equipment, prosthetics, orthotics, and medical supplies (DMEPOS) provider~~ treating practitioner must provide an approved care plan. Adherence to the care plan or treatment is not to be construed as elements for coverage criteria. ~~Authorized durable medical equipment, prosthetics, orthotics, and medical supplies (DMEPOS) provider~~ The treating practitioner's supervision during the use in connection with the ~~client's~~ beneficiary's course of treatment must be documented. The care plan must include the following:

(1) Education of the ~~client~~ beneficiary and caregiver on the prevention and management of decubiti;
(2) Regular assessment by a licensed health healthcare practitioner;
(3) Appropriate turning and positioning;
(4) Appropriate wound care for stage II, III, or IV ulcer;
(5) Moisture and incontinence control needed; and
(6) Nutritional assessment and intervention consistent with the overall plan of care if there is impaired nutritional status.

004.02(ZZ) SEAT LIFTS. Seat lifts are covered if all of the following criteria are met:

(1) The ~~client~~ beneficiary must have severe arthritis of the hip or knee or have a severe neuromuscular disease;
(2) The seat lift chair must be a part of the ~~authorized durable medical equipment, prosthetics, orthotics, and medical supplies (DMEPOS) provider's~~ treating practitioner's course of treatment and be prescribed to effect improvement, or arrest or hinder deterioration in the ~~client's~~ beneficiary's condition;
(3) The ~~client~~ beneficiary must be completely incapable of standing up from a regular armchair or ~~A~~any chair in their home; and
(4) Once standing, the ~~client~~ beneficiary must have the ability to ambulate.

004.02(ZZ)(i) ADDITIONAL CRITERIA. Coverage is limited to seat lifts which:

(1) Provide smooth transition in movement of the ~~client~~ beneficiary;
(2) Can be controlled by the ~~client~~ beneficiary; and
(3) Effectively assist a ~~client~~ beneficiary in standing up and sitting down without other assistance.

004.02(ZZ)(ii) DOCUMENTATION REQUIREMENTS. The authorized ~~durable medical equipment, prosthetics, orthotics, and medical supplies (DMEPOS)~~ provider must provide documentation that shows the criteria outlined in this chapter for seat lifts have been met.

004.02(ZZ)(iii) MEDICARE AND NEBRASKA MEDICAID ~~CLIENTS~~ BENEFICIARIES. For ~~clients~~ beneficiaries eligible for both Medicare and Nebraska Medicaid, the seat portion of the seat lift chair will be covered by Nebraska Medicaid if the seat lift mechanism has been approved by Medicare. Prior authorization of payment is not required. Documentation of Medicare coverage must be submitted on or with the Nebraska Medicaid claim when billing for the chair portion.

004.02(AAA) SITZ BATHS. Sitz baths are covered for ~~clients~~ beneficiaries with infection or injury of the perineal area.

004.02(AAA)(i) DOCUMENTATION REQUIREMENTS. Documentation must have ~~an authorized durable medical equipment, prosthetics, orthotics, and medical supplies (DMEPOS) provider~~ treating practitioner ordered plan of care in the ~~client's~~ beneficiary's ~~residence~~ home.

004.02(BBB) SPINAL ORTHOSES. Spinal orthoses are covered for ~~clients~~ beneficiaries who require a wheelchair seating system to ~~for one of the following reasons~~:

(1) ~~Supporting the client in a position that m~~Minimize~~s~~ the development or progression of musculoskeletal impairment;
(2) Relieve~~ing~~ pressure; or
(3) Provide~~ing~~ support in a position that improves the ~~client's~~ beneficiary's ability to perform functional activities.

004.02(BBB)(i) DOCUMENTATION REQUIREMENTS. Documentation for wheelchair seating systems must follow the criteria outlined in this chapter. ~~must be provided using Form MS-79, Wheelchair and Wheelchair Seating System Selection Report, which:~~

~~(1) Justifies the type of wheelchair seating system; and~~
~~(2) Provides evidence of a coordinated assessment. A coordinated assessment includes communication between the client, caregiver(s), authorized durable medical equipment, prosthetics, orthotics, and medical supplies (DMEPOS) provider, physical or occupational therapist, and equipment supplier. The assessment should address:~~
~~(a) Physical;~~
~~(b) Functional;~~
~~(c) Cognitive issues;~~
~~(d) Accessibility; and~~
~~(e) Cost effectiveness of equipment.~~

004.02(BBB)(ii) PRIOR AUTHORIZATION. All wheelchair and wheelchair accessories require prior authorization before items are provided to the ~~client~~ beneficiary.

004.02(CCC) SUCTION PUMPS. Suction pumps are covered for ~~clients~~ beneficiaries who have difficulty raising and clearing secretions caused by:

(i) Cancer or surgery of the throat or mouth;
(ii) Dysfunction of the swallowing muscles;
(iii) Unconsciousness or obtunded state; or
(iv) Tracheostomy.

004.02(DDD) SUPPORTS. Support items include elastic supports, elastic surgical stockings, slings, and trusses. Supports are covered for post-surgical ~~clients~~ beneficiaries, and ~~clients~~ beneficiaries with intractable edema of the lower extremities or other circulatory disorders.

004.02(EEE) TRACHEOSTOMY CARE SUPPLIES. Tracheostomy care supplies are covered for ~~clients~~ beneficiaries with an open surgical tracheostomy. A tracheostomy care or cleaning starter kit is covered following an open surgical tracheostomy for a two week

post-operative period. An artificial larynx is covered for ~~clients~~ beneficiaries that have had a laryngectomy or whose larynx is permanently inoperable. Artificial larynx and tracheostomy speaking valves are prostheses.

004.02(FFF) TRACTION EQUIPMENT. Traction equipment is covered for ~~clients~~ beneficiaries with orthopedic impairments requiring traction equipment that prevents ambulation during the period of use. Cervical pillows are covered only when required for use with traction equipment.

004.02(GGG) TRANSCUTANEOUS ELECTRICAL NERVE STIMULATORS (TENS). Transcutaneous electrical nerve stimulators (TENS) are covered for ~~clients~~ beneficiaries with chronic, intractable pain, or acute post-operative pain. The presumed etiology of the pain must be a type which is accepted as responding to transcutaneous electrical nerve stimulators (TENS) therapy.

004.02(GGG)(i) ACUTE POST-OPERATIVE PAIN. For acute post-operative pain, a transcutaneous electrical nerve stimulator (TENS) unit is generally covered for no more than one month following the day of surgery. Approval for more than one month will be determined on a case-by-case basis, based on the documentation provided by the ~~authorized durable medical equipment, prosthetics, orthotics, and medical supplies (DMEPOS) provider~~ treating practitioner, and submitted with the prior authorization request. A four-lead transcutaneous electrical nerve stimulator (TENS) unit may be used with either two leads or four leads, depending on the character of the ~~patient's~~ beneficiary's pain.

004.02(GGG)(ii) DOCUMENTATION REQUIREMENTS. Documentation for a transcutaneous electrical nerve stimulator (TENS) must show:

(a) The pain is present for at least three months;
(b) Other appropriate treatment modalities have been unsuccessful;
(c) Names of treatment modalities and length of time each treatment modality was used;
(d) Results of the treatment modalities;
(e) Trial basis of one month the transcutaneous electrical nerve stimulator (TENS) unit was used;
(f) Monitor report from the ~~authorized durable medical equipment, prosthetics, orthotics, and medical supplies (DMEPOS) provider~~ treating practitioner to determine the effectiveness of the transcutaneous electrical nerve stimulator (TENS) unit in modulating the pain; and
(g) A reevaluation of the ~~client~~ beneficiary at the end of the trial period which indicates:
    (i) How often the ~~client~~ beneficiary used the transcutaneous electrical nerve stimulator (TENS) unit;
    (ii) Typical duration of use each time; and
    (iii) Results.

004.02(GGG)(ii)(1) ADDITIONAL DOCUMENTATION REQUIREMENTS. ~~Authorized durable medical equipment, prosthetics, orthotics, and medical supplies (DMEPOS) provider~~ Treating practitioner approval is required for use of four leads with the transcutaneous electrical nerve stimulator (TENS) unit. The documentation must include why two leads are insufficient to meet the ~~client's~~ beneficiary's needs. ~~Authorized durable medical equipment, prosthetics, orthotics,~~

~~and medical supplies (DMEPOS) provider~~ Treating practitioner approval is required for a conductive garment for use with a transcutaneous electrical nerve stimulator (TENS) unit.

004.02(HHH) TRANSFER EQUIPMENT. Transfer equipment is covered for ~~clients~~ beneficiaries who require assistance with transfer.

004.02(III) TRAPEZE EQUIPMENT. Trapeze equipment is covered for ~~clients~~ beneficiaries to:

(i) Sit up due to a respiratory condition;
(ii) Change body position for other medical reasons; or
(iii) To get in or out of bed.

004.02(JJJ) ULTRAVIOLET CABINETS. Ultraviolet cabinets are covered for ~~clients~~ beneficiaries with generalized, intractable psoriasis.

004.02(JJJ)(i) DOCUMENTATION REQUIREMENTS. Documentation must justify treatment at home rather than alternative site.

004.02(KKK) UTERINE MONITORS, HOME. Home uterine monitors are covered on a rental basis for ~~clients~~ beneficiaries that meet the following criteria:

(1) The treating practitioner has completed a ~~C~~comprehensive ~~client~~ beneficiary assessment and evaluation of the beneficiary ~~by the authorized durable medical equipment, prosthetics, orthotics, and medical supplies (DMEPOS) provider has occurred~~;
(2) The ~~client~~ beneficiary has successfully completed training on the use of the equipment;
(3) The ~~client~~ beneficiary is at high risk for preterm labor and delivery and must be a candidate for tocolytic therapy. Others at high risk for preterm labor and delivery may be covered upon approval by Nebraska Medicaid through written communication from the ~~client's~~ beneficiary's ~~authorized durable medical equipment, prosthetics, orthotics, and medical supplies (DMEPOS) provider~~ treating practitioner;
(4) The pregnancy must be greater than 20 weeks gestation; and
(5) The ~~client~~ beneficiary must have one of the following medical conditions:
    (a) Recent preterm labor with hospitalization and discharge on tocolytic therapy;
    (b) Multiple gestations;
    (c) History of preterm delivery;
    (d) Anomalies of the uterus;
    (e) Incompetent cervix;
    (f) Previous cone biopsy;
    (g) Polyhydramnios; or
    (h) Diethylstilbestrol exposure.

004.02(KKK)(i) DOCUMENTATION REQUIREMENTS. Documentation must show ~~the treatment~~ uterine monitoring meets both medical necessity and the criteria outlined in this chapter.

004.02(LLL) VAPORIZERS. Vaporizers are covered for ~~clients~~ beneficiaries with a respiratory illness. Coverage includes cool mist and warm mist vaporizers.

004.02(MMM) VENTILATORS. Ventilators are covered for treatment of:

(i) Neuromuscular diseases;
(ii) Thoracic restrictive diseases;
(iii) Chronic respiratory failure consequent to chronic obstructive pulmonary disease; and
(iv) Respiratory paralysis.

004.02(NNN) WALKERS. Walkers are covered for ~~clients~~ beneficiaries with conditions which impair ambulation and there is a need for greater stability and security than provided by a cane or crutches. A heavy duty, multiple braking system, variable wheel resistance walker is covered for ~~clients~~ beneficiaries who are unable to use a standard walker due to one of the following:

(i) Obesity;
(ii) Severe neurologic disorders; or
(iii) Restricted use of one hand.

~~004.02(OOO) WHEELCHAIRS, MANUAL AND POWER. Manual and power wheelchairs are covered for clients who have a diagnosed medical condition which impairs their ability to walk. A powered wheelchair may be approved in the event the client has significant limitation of limb function which prohibits the client from being able to propel a manual wheelchair.~~

~~004.02(OOO)(i) DOCUMENTATION REQUIREMENTS. Documentation must follow the criteria outlined in this chapter.~~

~~004.02(OOO)(ii) PRIOR AUTHORIZATION. All wheelchair and wheelchair accessories require prior authorization before items are provided to the client.~~

004.02(OOO) WHEELCHAIRS AND WHEELCHAIR ACCESSORIES. Wheelchairs are covered for beneficiaries who have a diagnosed medical condition which impairs their ability to walk when:

(1) A wheelchair would increase their independence with mobility and major life activities, and
(2) A wheelchair would provide assisted mobility for beneficiaries who show no means of safe independent mobility.

004.02(OOO)(i) PRIOR AUTHORIZATION. All wheelchairs and wheelchair accessories require prior authorization before items are provided to the beneficiary.

004.02(OOO)(ii) DOCUMENTATION REQUIREMENTS. An evaluation of the beneficiary's wheelchair needs by a licensed physical therapist (PT) or occupational therapist (OT) is required. Documentation must be provided using the appropriate Nebraska Medicaid approved wheelchair selection report form and must:

(a) Justify the type of wheelchair as well as any options or accessories; and
(b) Provide evidence of a coordinated assessment. A coordinated assessment includes communication between the beneficiary, caregiver(s), physician, physical therapist (PT), occupational therapist (OT), and equipment supplier. The assessment should address physical, functional, and cognitive issues, as well as accessibility and cost effectiveness of equipment.

004.02(OOO)(ii)(1) EXCEPTION FOR SHORT-TERM WHEELCHAIRS. Use of the appropriate Nebraska Medicaid approved wheelchair selection report form is not required for short-term standard wheelchair prior authorization requests.

004.02(OOO)(iii) POWER WHEELCHAIRS. Power wheelchairs may be approved when the beneficiary:

(1) Has significant limitation of limb function which prohibits the beneficiary from being able to propel a manual wheelchair; and

(2) Has demonstrated through a trial period with a similar powered wheelchair, the ability to safely and independently operate the controls of a powered wheelchair.

004.02(OOO)(iv) STANDARD WHEELCHAIR PARTS AND ACCESSORIES. The following standard parts and accessories come with a wheelchair at the time of purchase:

(1) A sling or solid seat with back, a captain's chair, or a stadium-style seat;
(2) Standard casters or wheels with tires;
(3) Standard armrests;
(4) Standard front rigging; and
(5) Wheel locks or brakes.

004.02(OOO)(v) POWER WHEELCHAIR PARTS AND ACCESSORIES. The following standard parts and accessories come with a power wheelchair at the time of purchase:

(1) A sling or solid seat with back, a captain's chair, or a stadium-style seat;
(2) Standard casters or wheels with tires;
(3) Standard armrests;
(4) Standard front rigging;
(5) Wheel locks or brakes;
(6) Motors;
(7) A non-expandable controller;
(8) A battery charger;
(9) A standard proportional joystick; and
(10) Batteries.

004.02(OOO)(vi) SHORT-TERM STANDARD WHEELCHAIR. Short-term standard manual wheelchairs are covered for a duration of three months or less on a rental basis when all other criteria for a standard wheelchair are met.

004.02(OOO)(vii) CUSTOM WHEELCHAIRS. Custom wheelchairs, related equipment and items, as well as services related to those products, are covered when a beneficiary’s unique physical and functional characteristics require specific features and modifications for the safe use of the wheelchair. A custom wheelchair is one that cannot be easily used or adapted for use by another beneficiary. Items such as seat cushions and other removable positioning aids do not by themselves constitute a customized wheelchair.

004.02(OOO)(vii)(1) COMPLEX REHABILITATION TECHNOLOGY (CRT). Complex rehabilitation technology (CRT) wheelchairs are covered for beneficiaries for which individual evaluation, fitting, configuration, adjustment, or programming is needed to meet the specific medical and functional needs of the user.

004.02(OOO)(vii)(2) WHEELCHAIR SEATING SYSTEM. Wheelchair seating systems are covered for beneficiaries who have a diagnosis which impairs their ability to sit. Wheelchair seating systems include a wheelchair seat, wheelchair back, or combination of wheelchair seat and back that has been tailored specifically to the particular body shape and positioning needs of a beneficiary. Customization may be achieved by means of molding, contouring, carving, or other forms of fabrication or by the integration of prefabricated components into the wheelchair frame. The wheelchair seating system may be covered to:

(a) Minimize the development or progression of musculoskeletal impairment;
(b) Relieve pressure; or
(c) Provide support in a position which improves the beneficiary's ability to perform functional activities.

004.02(OOO)(vii)(2)(a) WHEELCHAIR-RECLINING BACK OR TILT-IN-SPACE WHEELCHAIR FRAME. Tilt-in-space and reclining back wheelchairs are covered for beneficiaries with a diagnosis which impairs their ability to tolerate the fully upright sitting position for significant amounts of time due to lack of necessary passive hip flexion for use of a standard tilt-in-space or inability to tolerate a significantly greater hip extension angle during sitting. Combination power recline and tilt-in-space wheelchair frames, if unavailable in manually operated forms, are covered for beneficiaries who require both recline and tilt-in-space features.

004.02(OOO)(vii)(2)(a)(i) DOCUMENTATION REQUIREMENTS. Documentation must show:

(1) The beneficiary needs to remain in a wheelchair for purposes of mobility or other interaction with their environment;
(2) The beneficiary requires frequent, significant adjustment of their position in the wheelchair, either to change hip angle or their sitting position relative to the ground; and
(3) For power operation of elevating leg rests, the beneficiary has the cognitive and motor ability to operate the power required control switches and is routinely in situations where caregivers are not available to manually recline or tilt them as needed.

004.02(OOO)(vii)(2)(b) CONTROL SYSTEMS. Custom control systems are covered for beneficiaries when limited hand mobility or dexterity impairs their ability to safely control their wheelchair.

004.02(OOO)(vii)(2)(b)(i) DOCUMENTATION REQUIREMENTS. Documentation must show:

(1) The beneficiary is unable to operate a power wheelchair using a standard proportional joystick due to an impairment of body structures or functions; and
(2) The beneficiary has adequate cognition and physical abilities required to operate the wheelchair using the recommended alternative drive control system.
    (i) If the beneficiary requires assistance with the use of a custom control system, an attendant control may be covered in place of or in addition to a beneficiary-operated control system.

~~004.02(PPP) WHEELCHAIR SEATING SYSTEM. Wheelchair seating systems are covered for clients who have a diagnosis which impairs their ability to sit. The wheelchair seating system may be covered for the following purposes:~~

~~(1) Supporting the client in a position which minimizes the development or progression of musculoskeletal impairment;~~

~~(2) Relieving pressure; or~~

~~(3) Providing support in a position which improves the client's ability to perform functional activities.~~

~~004.02(PPP)(i) DOCUMENTATION REQUIREMENTS. Documentation must follow the criteria outlined in this chapter.~~

~~004.02(QQQ) WHEELCHAIR RECLINING BACK OR TILT-IN-SPACE WHEELCHAIR FRAME. Tilt-in-space and reclining back wheelchairs are covered for clients with a diagnosis which impairs their ability to tolerate the fully upright sitting position for significant amounts of time. Combination power recline and tilt-in-space wheelchair frames, if unavailable in manually operated forms, are covered for clients who require both recline and tilt-in-space features.~~

~~004.02(QQQ)(i) DOCUMENTATION REQUIREMENTS. Documentation must show:~~

~~(1) The client needs to remain in a wheelchair for purposes of mobility or other interaction with their environment;~~

~~(2) The client requires frequent, significant adjustment of their position in the wheelchair, either to change hip angle or their sitting position relative to the ground; and~~

~~(3) For power operation of elevating leg rests, the client has the cognitive and motor ability to operate the power required control switches and is routinely in situation where caregivers are not available to manually recline or tile them as needed.~~

004.02~~(RRR)~~(PPP) BUILT-IN TYPE WHIRLPOOL BATH EQUIPMENT STANDARD. Built-in whirlpool bath equipment is ~~C~~covered for ~~clients~~ beneficiaries who have a condition for which the whirlpool bath is expected to provide substantial therapeutic benefit.

004.02~~(SSS)~~(QQQ) NEGATIVE PRESSURE WOUND THERAPY ~~WOUND THERAPY NEGATIVE PRESSURE~~. A negative pressure wound therapy system is ~~C~~covered for ~~clients~~ beneficiaries with stage III and IV decubiti, which does not respond to usual wound dressing. The negative pressure wound therapy system ~~This~~ is a rental in which the authorized provider is responsible for training the ~~client~~ beneficiary, caregivers, or facility staff and monitoring the use of the equipment.

004.02~~(TTT)~~(RRR) NOT OTHERWISE CLASSIFIED (NOC) CODES. Coverage of items for which no specific procedure code exists will be determined by Nebraska Medicaid on a case-by-case basis.

004.02~~(TTT)~~(RRR)(i) DOCUMENTATION REQUIREMENTS. Manufacturer's invoice and ~~authorized durable medical equipment, prosthetics, orthotics, and medical supplies (DMEPOS) provider~~ treating practitioner approval must be submitted as a part of the Nebraska Medicaid staff review.

004.03 NON-COVERED SERVICES.

004.03(A) GENERAL COVERAGE RESTRICTIONS. ~~Medicaid does not cover d~~Durable medical equipment, prosthetics, orthotics, and medical supplies (DMEPOS) items are not covered for the following uses:

(i) Personal comfort;
(ii) Convenience;
(iii) Education;
(iv) Hygiene;
(v) Safety;
(iv) Cosmetic;
(vii) New equipment of unproven value; or
(viii) Equipment of questionable current usefulness or therapeutic value.

004.03(B) EQUIPMENT NOT PRIMARILY MEDICAL IN NATURE. ~~Medicaid does not cover t~~The following items are not covered because they are not primarily medical in nature:

(i) Air cleaners and purifiers;
(ii) Air conditioners;
(iii) Bed baths;
(iv) Bed lifters;
(v) Beds or lounge;
(vi) Beds oscillating;
(vii) Bed tables;
(viii) Bed boards;
(ix) Braille teaching texts;
(x) Carafes;
(xi) Cradles;
(xii) Dehumidifiers, room, or central heating type;
(xiii) Elevators;
(xiv) Emesis basins;
(xv) Enuresis alarms;
(xvi) Environmental control equipment;
(xvii) Exercise equipment;
(xviii) Heating and cooling plants or equipment;
(xix) Humidifiers, room, or central heating type;
(xx) Hypodermic jet pressure injectors for insulin;
(xxi) Lifts or wheelchair equipment;
(xxii) Massage devices;
(xxiii) Mattress and pillow covers;
(xxiv) Medical identification items;
(xxv) Pillows;
(xxvi) Restraints;
(xxvii) Sauna baths;
(xxviii) Sheets, disposable or reusable;
(xxix) Shower attachments, handheld;
(xxx) Speech teaching machines;
(xxxi) Stairway elevators;
(xxxii) Telephone arms; ~~or~~ and
(xxxiii) Whirlpool pumps, portable.

004.03(C) DIATHERMY MACHINES, STANDARD AND PULSED WAVE TYPES. ~~Medicaid does not cover d~~Diathermy machines are not covered as part of the durable medical equipment, prosthetics, orthotics, and medical supplies (DMEPOS) benefit.

004.03(D) ESOPHAGEAL DILATORS. ~~Medicaid does not cover e~~Esophageal dilators are not covered as part of the durable medical equipment, prosthetics, orthotics, and medical supplies (DMEPOS) benefit.

004.03(E) OXYGEN THERAPY. Respiratory therapist services are not covered. The durable medical equipment, prosthetics, orthotics, and medical supplies (DMEPOS) benefit provides for coverage of oxygen and oxygen equipment but does not include a professional component in the delivery of such services. Oxygen therapy is not covered for:

(i) Angina pectoris in the absence of hypoxemia;
(ii) Dyspnea without cor pulmonale or evidence of hypoxemia;
(iii) Severe peripheral vascular disease resulting in clinically evident desaturation in one or more extremities;
(iv) Terminal illness that does not affect the lungs; and
(v) Items that are considered precautionary and not therapeutic in nature including:
  (1) Spare tanks of oxygen;
  (2) Emergency oxygen inhalators; and
  (3) Preset portable oxygen delivery unit where flow rate is not adjustable.

004.03(F) PARALLEL BARS. ~~Medicaid does not cover p~~Parallel bars are not covered as part of the durable medical equipment, prosthetics, orthotics, and medical supplies (DMEPOS) benefit. ~~Parallel bars are primarily intended for institutional use, not in a home setting.~~

004.03(G) PRESSURE REDUCING SUPPORT SERVICES. ~~Medicaid does not cover p~~Powered mattress pads or overlays and mattress replacements are not covered, except alternating pressure pads, as part of the durable medical equipment, prosthetics, orthotics, and medical supplies (DMEPOS) benefit.

004.03(H) PULSE TACHOMETERS. ~~Medicaid does not cover p~~Pulse tachometers are not covered as part of the durable medical equipment, prosthetics, orthotics, and medical supplies (DMEPOS) benefit when they are not reasonable or necessary for monitoring pulse of ~~client~~ beneficiary with or without a cardiac pacemaker.

004.03(I) SEAT LIFTS. ~~Excluded from coverage is the type of l~~Lifts which operate~~s~~ by a spring release mechanism with a sudden, catapult-like motion, and jolts the ~~client~~ beneficiary from a seated to standing position are not covered.

004.03(J) TELEPHONE ALERT SYSTEMS. ~~Medicaid does not cover e~~Emergency communication systems that do not serve a diagnostic or therapeutic purpose are not covered.

004.02(K) TOOTHBRUSHES. ~~Medicaid does not cover p~~Personal hygiene items including toothbrushes are not covered.

005. BILLING AND PAYMENT FOR DURABLE MEDICAL EQUIPMENT, PROSTHETICS, ORTHOTICS, AND MEDICAL SUPPLIES (DMEPOS).

005.01 BILLING.

005.01(A) GENERAL BILLING REQUIREMENTS. Providers must comply with all applicable billing requirements codified in Title 471 NAC 3. In the event that individual billing requirements in Title 471 NAC 3 conflict with billing requirements outlined in this chapter, the individual billing requirements in this chapter will govern.

005.01(B) SPECIFIC BILLING REQUIREMENTS. Providers must bill the Department Nebraska Medicaid on the appropriate Nebraska Medicaid approved claim form or electronic format. Any item billed to Nebraska Medicaid must actually be dispensed or directly supplied by the provider that bills for the item. This does not preclude a provider from contracting with billing agents. Providers may not bill for durable medical equipment, prosthetics, orthotics, and medical supplies (DMEPOS) dispensed in advance.

005.01(AB)(i) PROCEDURE CODES AND MODIFIERS. The provider will bill the Department Nebraska Medicaid using the Healthcare Common Procedure Coding System (HCPCS) and Current Procedural Terminology (CPT) procedure codes and modifiers.

005.01(B)(ii) RENTAL BILLING PROCEDURES. Providers must use the following rental billing procedures:

(1) Bill for rental only while the item continues to be medically necessary and appropriately used by the client beneficiary;
(2) Rental items not used by the client beneficiary for more than a one month period, during inpatient hospitalization, may not be billed to Nebraska Medicaid. The authorized provider is responsible for determining whether the item continues to be used by the beneficiary client;
(3) Bill Rrental is on a monthly basis unless the item is used for less than a one-month period. When billing for monthly rental, the unit of service "1" indicates a one-month rental period. The provider will use the appropriate procedure code modifier when billing for monthly rental. The beginning rental date for each month will be the day of the month on which the item was initially provided. A monthly rental period is not necessarily a calendar month or a standard number of days. The monthly billing period begins the day of rental and extends to the day prior to the corresponding numerical day the following month. When rental equipment is needed at any time by the client beneficiary for less than a one-month rental period, the rental is paid on a daily pro-rated basis. The provider will use the appropriate procedure code modifier when billing for daily rental. The unit of service must reflect the number of days the item was actually used; and
(4) When billing for rental items, indicate both from and to dates of service and the initial rental date.

005.01(CB)(iii) USED ITEMS. When billing for used durable medical equipment, prosthetics, orthotics, and medical supplies (DMEPOS) items, the provider must use the used equipment (UE) procedure code modifier.

005.01(DB)(iv) APNEA MONITOR SUPPLIES. Apnea monitor supplies are covered for use with rented and client beneficiary-owned apnea monitors. For rented apnea monitors, the apnea monitor supplies must be billed on the same claim as the apnea monitor rental.

005.01(EB)~~(v)~~ HOME PHOTOTHERAPY. The provider must bill for home phototherapy daily rental on a single claim and indicate the total number of rental days as the units of service.

005.01(FB)~~(vi)~~ UTERINE MONITORS, HOME. The provider must indicate on the claim the condition which necessitates use of the monitor and, when billing for the final rental period, the date of discontinuation of the monitor.

005.01(GB)~~(vii)~~ OXYGEN THERAPY. When billing for oxygen therapy, the durable medical equipment, prosthetics, orthotics, and medical supplies (DMEPOS) provider must use the appropriate unit of service as described in the procedure code. Units of service should be rounded to the nearest unit of the procedure code description.

005.01(H) PROOF OF DELIVERY REQUIREMENTS. Authorized providers shall not bill for an item prior to receipt of proof of delivery documentation. For items and supplies that require fitting, set-up, or instructions, the authorized provider shall not bill Nebraska Medicaid prior to providing the beneficiary with the proper set-up, fitting, and instruction. In instances where the item or supply is delivered directly by the authorized provider, or when a shipping or mail order service is used to deliver the item or supply, the actual date the beneficiary, or their designee, received and signed for the item or supply shall be the date of service on the claim.

~~005.02 PAYMENT.~~

~~005.02(A) GENERAL PAYMENT REQUIREMENTS. Medicaid will reimburse the provider for services rendered in accordance with the applicable payment regulations codified in Title 471 NAC 3. In the event that individual payment regulations in Title 471 NAC 3 conflict with payment regulations outlined in this chapter, the individual payment regulations in this chapter will govern.~~

005.02~~(B)~~ SPECIFIC PAYMENT REQUIREMENTS. ~~Medicaid pays for c~~Covered durable medical equipment, prosthetics, orthotics, and medical supplies (DMEPOS) are paid at the lower of:

(1) The provider's submitted charge; or
(2) The allowable amount for that procedure code in the Nebraska Medicaid Practitioner Fee Schedule in effect for that date of service.

~~005.02(B)(i) MEDICARE AND MEDICAID CROSSOVER CLAIMS. Information on payment of Medicare and Medicaid crossover claims is found in Title 471 NAC 3.~~

005.02(AB)~~(ii)~~ ORTHOSES AND PROSTHESES. ~~Medicaid p~~Payment for orthoses and prostheses includes:

(1) Evaluations only when no device, orthosis, prosthesis, part, repair, or adjustment is provided;
(2) Fitting;
(3) Cost of parts and labor;
(4) Repairs due to normal wear and tear for a minimum of 90 days from the date dispensed; and
(5) Adjustments made when fitting and for a minimum of 90 days from the date dispensed when the adjustments are not necessitated by changes in the ~~client's~~ beneficiary's medical condition or the ~~client's~~ beneficiary's functional abilities.

005.02(B)~~(iii)~~ RENTAL PAYMENT. Payment for rental includes:

(1) All necessary repair and replacement parts; and

(2) All accessories and supplies necessary for the effective use of the equipment, unless specifically allowed as outlined in the coverage criteria for the item.

005.02(C~~B~~)~~(iv)~~ AIR FLUIDIZED AND LOW AIR LOSS BED UNITS. ~~Medicaid r~~Rental payment for air fluidized and low air loss bed units includes:

(1) Air fluidized or low air loss bed unit and all accessories and services necessary for proper functioning and effective use of the bed;

(2) Weekly on-site ~~client~~ beneficiary evaluation and wound care consultation by a registered nurse (RN) employed by the provider, with 24 hour per day availability; and

(3) Complete caregiver training on use of equipment, wound care, and prevention.

005.02(D~~B~~)~~(v)~~ APNEA MONITORS. ~~Medicaid r~~Rental payment for apnea monitors includes complete parent or caregiver training on use of the equipment and record keeping. ~~Medicaid does not make s~~Separate payment is not made for remote alarms. When provided, payment for a remote alarm is included in the monitor rental payment.

005.02(E~~B~~)~~(vi)~~ HOME PHOTOTHERAPY PAYMENT. ~~Medicaid d~~Daily rental payment for home phototherapy includes:

(1) Phototherapy unit and all supplies, accessories, and services necessary for proper functioning and effective use of the therapy;

(2) A minimum of one daily visit to the home by a licensed or certified health care professional is required. The daily visits must include:

(a) A brief home assessment; and

(b) Collection and delivery of blood specimens for bilirubin testing when ordered by the ~~authorized durable medical equipment, prosthetics, orthotics, and medical supplies (DMEPOS) provider~~ treating practitioner to be collected in the home. The authorized ~~durable medical equipment, prosthetics, orthotics, and medical supplies (DMEPOS)~~ provider must ~~be~~ inform~~ed by~~ the ~~provider~~ treating practitioner that this service is available. An outside agency or laboratory with whom the authorized provider contracts for collection and delivery of blood specimens may not bill Nebraska Medicaid directly since payment is included in the daily rental payment. Daily home visits must occur for home assessment even if the blood collection is done outside the home; and

(3) Complete caregiver training on use of equipment and completion of necessary records.

005.02(F~~B~~)~~(vii)~~ RATE NOT ESTABLISHED CODES. For rate not established (RNE) codes on the Nebraska Medicaid Practitioner Fee Schedule, payment will be determined based on manufacturer's invoice cost.

005.02(G~~B~~)~~(viii)~~ SEAT LIFTS. Payment for seat lift chairs which incorporates a recliner feature along with the seat lift is limited to the amount payable for a seat lift without this feature.

005.02(H~~B~~)~~(ix)~~ UTERINE MONITORS, HOME. ~~Medicaid r~~Rental payment for home uterine monitors includes all equipment, supplies, and services necessary for the effective use of the monitor. This does not include medications or ~~authorized durable medical~~

~~equipment, prosthetics, orthotics, and medical supplies (DMEPOS) provider's~~ treating practitioner's professional services.

005.02(~~I~~B)~~(x)~~ DIALYSIS EQUIPMENT AND SUPPLIES. ~~Medicaid reimburses for d~~Dialysis systems, related supplies, and equipment are reimbursed only to approved renal dialysis facilities under the Medicare Method I composite rate payment methodology. Payment cannot be made to suppliers, pharmacies, or home health agencies for dialysis systems, related supplies, and equipment.