310-P  MEDICAL SUPPLIES, DURABLE MEDICAL EQUIPMENT AND ORTHOTIC/PROSTHETIC DEVICES

**DESCRIPTION**

AHCCCS covers reasonable and medically necessary medical supplies, Durable Medical Equipment (DME) and orthotic/prosthetic devices when ordered by a primary care provider or practitioner within certain limits based on member age and eligibility, as specified in 9 A.A.C. 22, Article 2. For the purposes of this policy, medical supplies are consumable items that are designed specifically to meet a medical purpose. DME means sturdy, long lasting items and appliances that can withstand repeated use, are designed to serve a medical purpose and are not generally useful to a person in the absence of a medical condition, illness or injury. Prosthetics are devices prescribed by a physician or other licensed practitioner to artificially replace a missing, deformed or malfunctioning portion of the body. Orthotics is an AHCCCS covered service, within certain limitations, to support a weak, injured, or deformed portion of the body, pursuant to Laws 2015, Chapter 264, Section 3 (HB 2373) and as specified in §36-2907. Prosthetics are covered when medically necessary for rehabilitation.

DME is used to assist members in optimizing their independence and maintaining placement in the most integrated setting. This may include an institutional setting as appropriate. An example for the institutional setting is the authorization of customized medical devices such as wheelchairs. Criteria for the authorization of a customized wheelchair must be the same regardless of setting as each setting is considered the member’s home.

Personal care items include items of personal cleanliness, hygiene and grooming and are generally not covered unless needed to treat a medical condition.

**AMOUNT, DURATION AND SCOPE**

Examples of medically necessary medical supplies, durable medical equipment and orthotic/prosthetic devices are:
1. Medical supplies – such as incontinence briefs, surgical dressings, splints, casts and other consumable items, which are not reusable, and are designed specifically to meet a medical purpose.

2. Durable equipment – such as wheelchairs, walkers, hospital beds, and other durable items that are rented or purchased.

3. The Contractor shall provide orthotic devices for members as described below:
   a. Orthotics are covered for AHCCCS members under the age of 21 as outlined in AMPM Policy 430, EPSDT Services.
   b. Orthotics are covered for AHCCCS members 21 years of age and older if all of the following apply:
      i. The use of the orthotic is medically necessary as the preferred treatment option consistent with Medicare Guidelines.
      ii. The orthotic is less expensive than all other treatment options or surgical procedures to treat the same diagnosed condition.
      iii. The orthotic is ordered by a Physician or Primary Care Practitioner.

4. Prosthetic devices – such as artificial upper and lower limbs.

**COVERAGE DETERMINATIONS**

The Contractor must make timely determinations of coverage. The Contractor must not refuse to render a timely determination based on the member’s dual eligibility status or the providers’ contract status with the Contractor. If a dual eligible member resides in a nursing facility, the prior authorization request must not be denied on the basis that Medicare is responsible for coverage of DME.

**A. GENERAL REQUIREMENTS**

The following criteria must be used in determining coverage of medically necessary services:

1. Setting up and/or maintaining the member in the most appropriate setting while maximizing the member’s independence and functional level both physically and mentally, and

2. Authorizing the most reasonable and cost effective alternative in the most appropriate setting while maximizing the member’s independence.

Medical equipment may be purchased or rented only when there are no reasonable alternative resources from which the medically necessary medical equipment can be obtained at no cost. Additionally, the total expense of rental cannot exceed the purchase price of the item.
Rental fees must terminate no later than the end of the month in which the member no longer needs the medical equipment, or when the member is no longer eligible or enrolled with a Contractor, except during transitions as specified by the AHCCCS Chief Medical Officer or designee.

Reasonable repairs or adjustment of purchased medical equipment are covered when necessary to make the equipment serviceable and when the cost of the repair is less than the cost of rental or purchase of another unit.

B. REQUIREMENTS FOR SPECIFIC SERVICES

1. Incontinence Briefs for Members 21 years of age and older

Incontinence briefs, including pull-ups and incontinence pads, are covered when necessary to treat a medical condition. Contractors may require prior authorization.

For ALTCS members 21 years of age and older, incontinence briefs, including pull-ups and incontinence pads, are also covered in order to prevent skin breakdown when all the following are met:
   a. The member is incontinent due to a documented medical condition that causes incontinence of bowel and/or bladder,
   b. The PCP or attending physician has issued a prescription ordering the incontinence briefs,
   c. Incontinence briefs – including pull-ups and incontinence pads – do not exceed 180 in any combination per month, unless the prescribing physician presents evidence of medical necessity for more than 180 per month,
   d. The member obtains incontinence briefs from vendors within the Contractor’s network, AND
   e. Prior authorization has been obtained if required by the Administration, Contractor, or Contractor’s designee, as appropriate. Contractors shall not require a new prior authorization to be issued more frequently than every 12 months.

2. Incontinence Briefs for Members under the Age of 21 Years
   a. AHCCCS covers incontinence briefs when necessary to treat a medical condition. In addition, AHCCCS also covers incontinence briefs for preventative purposes for members over the age of three and under 21 years of age as described in AMPM Policy 430.

3. Orthotics Limitations
   a. Reasonable repairs or adjustments of purchased orthotics are covered for all members to make the orthotic serviceable and/or when the repair cost is less than purchasing another unit. The component will be replaced if, at the time
authorization is sought, documentation is provided to establish that the component is not operating effectively.

4. Lower Limb Prosthetics

The following applies for members 21 years of age and older regarding coverage for lower limb prosthetics:

a. Factors for coverage of a lower limb prosthetic include but are not limited to:
   i. Consideration of the member’s:
      a) Past history (including prior prosthetic use, if applicable)
      b) Current condition (including status of the residual limb and the nature of other medical problems)
      c) Degree of motivation to ambulate with a prosthetic, and
   ii. Assessment of the member’s functional level as described below (please note that within the functional classification hierarchy, bilateral amputees often cannot be strictly bound by functional level classifications):
      a) Level 0: Does not have the ability or potential to ambulate or transfer safely with or without assistance and prosthesis. Does not enhance their quality of life or mobility.
      b) Level 1: Has the ability or potential to use prosthesis for transfers or ambulation on level surfaces at fixed cadence. Typical of the limited and unlimited household ambulator.
      c) Level 2: Has the ability or potential for ambulation with the ability to traverse low-level environmental barriers such as curbs, stairs or uneven surfaces. Typical of the limited community ambulator.
      d) Level 3: Has the ability or potential for ambulation with variable cadence. Typical of the community ambulator who has the ability to traverse most environmental barriers and may have vocational, therapeutic, or exercise activity that demands prosthetic utilization beyond simple locomotion.
      e) Level 4: Has the ability or potential for prosthetic ambulation that exceeds basic ambulation skills, exhibiting high impact, stress, or energy levels. Typical of the prosthetic demands of the child, active adult, or athlete.

b. Limitations (Lower Limb Prosthesis):
   i. Lower limb prosthesis is not considered medically necessary for members with a functional level of zero.
   ii. If more than one prosthetic device can meet the enrollee’s functional needs, benefits are only available for the prosthetic device that meets the minimum specifications for the member’s needs.
   iii. Microprocessor controlled lower limb or microprocessor-controlled joints for lower limbs are not covered for members 21 years of age and older.
C. AHCCCS DOES NOT COVER THE FOLLOWING ITEMS:

1. Personal care items when not medically necessary to treat a medical condition except as otherwise specified for incontinence briefs pursuant to AMPM Policy 310-P, Policy 430, Policy 1240, and AHCCCS Rules,

2. First aid supplies (except under a prescription),

3. Hearing aids for members who are 21 years of age and older,

4. Prescriptive lenses for members who are 21 years of age and older (except if medically necessary following cataract removal), and/or

5. Penile implants or vacuum devices for AHCCCS members who are 21 years of age or older.

D. AS OF 10/1/2010 PER A.R.S. 36-2907, the following prosthetics are not covered for members 21 years of age and older:

1. Bone Anchored Hearing Aids (BAHA), also known as osseointegrated implants

2. Cochlear implants

3. Percussive vests

E. EQUIPMENT MAINTENANCE AND REPAIR

Equipment maintenance and repair of component parts will continue for orthotics and the prosthetic devices listed in Section A. Components will be replaced if at the time authorization is sought documentation is provided to establish that the component is not operating effectively.

F. NON-COVERED PROSTHETIC/ORTHOTIC DEVICES are not included when determining whether an inpatient stay qualifies as an outlier. If an inpatient stay does qualify as an outlier without considering charges for non-covered devices, the charges for those devices are not included in the outlier payment calculations.

Refer to AMPM Policy 430 for further information related to EPSDT.

Refer to AMPM Chapter 800 for prior authorization requirements for FFS providers.

Refer to AMPM Chapter 1200 for further information related to ALTCS and HCBS.