**Section 140.475 Medical Equipment, Supplies, Prosthetic Devices and Orthotic Devices**

a) Payment for the provision of medical equipment, supplies, prosthetic devices and orthotic devices shall be made only to participating providers who are licensed or exempt from licensure under any licensure Act, including but not limited to the Home Medical Equipment and Services Provider License Act [225 ILCS 51].

b) Payment for medical equipment, supplies, prosthetic devices and orthotic devices shall be made:

1) when:

A) they are essential to enable a client to remain at home or to function in the community;

B) the client's physician has recommended in writing to the Department or in a patient care plan that the supplies or equipment be provided and that they are medically necessary; and

C) the Department has approved payment based on consideration of:

i) the client's medical condition;

ii) the benefits the item is expected to effect;

iii) the client's ability to adjust to and to use the item recommended; and

iv) in the case of a communication device, whether the device will increase the client's potential for full participation in health care by assisting in cause and effect awareness, or training physical movements or improving the client's understanding and comprehension of his or her health needs and responsibilities; or

2) when the Individual Program Plan (IPP) of an individual with developmental disabilities residing in an ICF/MR or a long term care facility identifies the equipment, supplies, prosthetic devices and orthotic devices that are necessary for his or her participation in active treatment as described in 42 CFR 483.440, Condition of Participation: Active Treatment Service.

c) Payment shall be made for the repair of prosthetic devices, orthotic devices and medical equipment owned by recipients if the item is out of warranty and the sum of the individual repair parts and the labor does not exceed 75 percent of the cost of a new unit. Labor charges are to be included in the repair price. A guarantee of at least 180 days must be provided. Charges shall not include tax, delivery, rebate, packaging or freight. The Department may agree to assume repair costs of a rented or loaned communication system if such an agreement is required by the manufacturer's or vendor's rental or loan terms. The Department may deny payment for repairs if evidence indicates that damage has resulted from abuse of the equipment.

d) Payment shall be made for loaner items issued pending repair or replacement of prosthetic devices, orthotic devices and medical equipment owned by recipients if it is the usual practice of the supplier to provide and charge for such items.

e) Covered services are:

1) Non-durable medical supplies for an individual's life maintenance care and treatment;

2) Durable medical equipment essential to expedite a hospital discharge and to enable the person to be cared for at home;

3) Prosthetic and orthotic devices, including communication devices, that are essential to enhance functional mobility or medically necessary communication, or are essential for employment;

4) Respiratory equipment and supplies necessary as a life saving measure or for prevention of a medical emergency, institutionalization, or to facilitate deinstitutionalization;

5) Repair of durable medical equipment, prosthetic devices and orthotic devices; and

6) Effective July 1, 2024, pursuant to 305 ILCS 5/5-16.8a, continuous glucose monitors that are:

A) Ordered by a provider:

i) who is a licensed physician, a certified nurse practitioner, or a physician assistant who has a collaborative agreement with the physician; and

ii) who is not required to obtain additional or specific continuing medical education in order to prescribe a continuous glucose monitor;

B) Not required to have:

i) an alarm when glucose levels are outside the pre-determined range;

ii) the capacity to generate predictive alerts in case of impending hypoglycemia; or

iii) the ability to transmit real-time glucose values and alerts to the patient and designated other persons;

C) Provided to a patient who has:

i) diabetes mellitus; and meets the coverage requirement established in Section 356z.59(a) of the Illinois Insurance Code [215 ILCS 5]; or

ii) gestational diabetes, regardless of suboptimal glycemic control that is likely to harm the patient or the fetus;

D) Provided to a patient on a case-by-case basis for medical necessity, and approved if appropriate, when the patient has diabetes mellitus but:

i) does not meet the coverage requirement; or

ii) is in a population in which continuous glucose monitor usage has not been well-studied;

E) Provided to a patient who is not required to:

i) need intensive insulin therapy; or

ii) have a recent history of emergency room visits or hospitalizations related to hypoglycemia, hyperglycemia, or ketoacidosis; and

F) Prescribed only with prior authorization when covered under Medical Assistance. Once a continuous glucose monitor is prescribed, the prior authorization shall be approved for a 12-month period.

f) Payment shall be made for covered services on a prior approval basis, except as provided under Section 140.477.

g) Effective July 1, 2017, to be eligible for reimbursement by the Department, certain medical equipment and supplies will be subject to a face-to-face encounter. The Department will, at a minimum, require a face-to-face encounter for equipment and supplies for which Medicare requires a face-to-face encounter. A list of medical equipment and supplies subject to a face-to-face encounter will be published on the Department's website. The face-to-face encounter must meet the following conditions:

1) The face-to-face patient encounter that is related to the primary reason the patient requires medical equipment, supplies or appliances must have occurred no more than six months prior to start of services.

2) The face-to-face encounter must be performed by the certifying physician, a nurse practitioner or clinical nurse specialist who is working in collaboration with the physician in accordance with State law, a physician assistant under the supervision of the physician, or, for patients admitted to home health immediately after an acute or post-acute stay, the physician who cared for the patient in an acute or post-acute facility.

A) If the certifying physician does not perform the face-to-face encounter personally, the non-physician practitioner or the physician who cared for the patient in an acute or post-acute facility performing the face-to-face encounter must communicate the clinical findings of that face-to-face patient encounter to the certifying physician. The clinical findings must be incorporated into a written or electronic document in the patient's medical record.

B) The certifying physician must document that the face-to-face encounter is related to the primary reason the patient requires medical equipment, supplies or appliances and occurred within the timeframes described in subsection (g)(1). The documentation must indicate the practitioner who conducted the encounter and the date of the encounter.

3) The face-to-face patient encounter may occur through telehealth, in compliance with Section 140.403.

h) Starting June 1, 2019, payment for the provision of medical equipment, supplies, prosthetic devices and orthotic devices will only be made to enrolled providers that are accredited by a healthcare accrediting body approved by the federal Centers for Medicare and Medicaid Services and recognized by the Department. Accrediting bodies approved by the federal Centers for Medicare and Medicaid Services and recognized by the Department may be found on the DMEPOS Accreditation website at https://www.cms.gov/medicare/enrollment-renewal/providers-suppliers/durable-medical-equipment-prosthetics-orthotics-supplies-dmepos.

(Source: Amended at 49 Ill. Reg. 1819, effective January 30, 2025)