Durable Medical Equipment, Prosthetics, Orthotics, and Medical Supplies (DMEPOS)

Medicaid and Other Medical Assistance Programs

MONTANA DPHHS
Healthy People. Healthy Communities.
Department of Public Health & Human Services

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Introduction

Thank you for your willingness to serve members of the Montana Medicaid program and other medical assistance programs administered by the Department of Public Health and Human Services.

This manual provides information specifically for providers of Durable Medical Equipment, Prosthetics, Orthotics, and Medical Supplies (DMEPOS). Other essential information for providers is contained in the separate *General Information for Providers* manual. Providers are responsible for reviewing both manuals.

Rule References

Providers must be familiar with all current Medicaid rules and regulations governing the Montana Medicaid program. Provider manuals are to assist providers in billing Medicaid; they do not contain all Medicaid rules and regulations. Rule citations in the text are a reference tool; they are not a summary of the entire rule. **In the event that a manual conflicts with a rule, the rule prevails.** Links to rule references are available on the Provider Information website. Paper copies of rules are available through the Secretary of State's office.

Providers are responsible for knowing and following current Medicaid rules and regulations.

The following rules and regulations are specific to the DMEPOS program.

- Administrative Rules of Montana (ARM)
  - ARM 37.86.1801 – ARM 37.86.1807 Prosthetic Devices, Durable Medical Equipment and Medical Supplies

Prior Authorization

What Is Prior Authorization?

To ensure federal funding requirements are met, certain items/services are reviewed before delivery to a Medicaid member. These items/services are reviewed for appropriateness based on the member's medical need. In determining medical appropriateness of an item/service, the Department or designated review organization may consider the type or nature of the service, the provider of the service, the setting in which the service is provided and any additional requirements applicable to the specific service or category of service.

If an item/service is considered medically necessary, payment authorization is based on when the request was received for review from the provider, not the delivery of the item/service to the member.

Prior authorization **is not** required for dispensing units over the maximum allowable; however, documentation supporting medical necessity must be kept on file.

When requesting prior authorization, remember:

- Only Medicaid enrolled DMEPOS providers may request prior authorization for items/services.
- In circumstances where another insurance carrier is primary and payment has been made, prior authorization is not required.
- Documentation must support medical necessity.
- Documentation must coincide with other documentation provided by those involved with the member.
- Documentation must be complete, including appropriate signatures and dates.
- Member must be eligible for Medicaid.
- Use the correct CMN for the item/service (if required).
- Use current correct coding.
- Use the appropriate place of service, 12 (Home) or 32 (Nursing Facility). See the Place of Service Code Set on the CMS website: https://www.cms.gov/Medicare/Coding/place-of-service-codes/Place_of_Service_Code_Set.html
- Do not submit a prior authorization request solely for denial in order to receive payment from another source. Instead, provide the requesting payer with documentation supporting noncoverage of the item (e.g., provider manuals, provider notices, newsletters, request documentation from Provider Relations).

Medicaid does not pay for services when prior authorization requirements are not met.

Granting of prior authorization does not guarantee payment for the item/service.

To request prior authorization for an item/service:

- Submit a completed DMEPOS Prior Authorization Request Form.
- Include appropriate supporting documentation with the request.
- Fax or mail the request and supporting documentation to the Mountain Pacific Quality Health. (See the PA Criteria table below.)

Upon completion of the review, the member and requesting provider are notified. The provider receives an authorization number that must be included on the claim. If the requesting provider does not receive the authorization number within 10 business days of being notified of the review approval, the requesting provider may call Provider Relations.

For the prior authorization criteria for DME, see the table below or on the Prior Authorization Information link in the left menu on the Provider Information website.

Prior Authorization Information

Serivice	Prior Auth Contact	Documentation Requirements

Durable Medical Equipment (DME)	MPQH
	
	Phone
	406.457.5887 Helena
	877.443.4021, X5887 Long-distance
	
	Fax
	406.513.1922 Helena
	877.443.2580 Long-distance
		Medical necessity documentation must include all of the following:
		• Completed DMEPOS Prior Authorization Request form
		• Supporting documentation, which must include at a minimum:
		  • Prescription
		  • Certificate of medical need (if required for the item)
		  • Narrative summary from the prescribing authority detailing the need for the item
		  • A manufacturers retail price sheet and product warranty information
		
		For members being treated by a licensed therapist, a copy of the member's plan of care in relation to the item/service is required; video if possible.

Covered Services

General Coverage Principles

This chapter provides covered services information that applies specifically to services and supplies provided by **Durable Medical Equipment, Prosthetic, Orthotic and Medical Supply (DMEPOS) providers**. Like all healthcare services received by Medicaid members, services rendered by these providers must also meet the general requirements listed in the Provider Requirements chapter of the *General Information for Providers* manual.

Montana Medicaid follows Medicare's coverage requirements for most items. A Medicare manual is available from the Durable Medical Equipment Regional Carriers (DMERC) website, https://med.noridianmedicare.com/web/jddme. Montana Medicaid considers Medicare Region D DMERC medical review policies as the minimum DMEPOS industry standard. This manual covers criteria for certain items/services which are either in addition to Medicare requirements or are services Medicare does not cover.

Montana Medicaid coverage determinations are a combination of Medicare Region D DMERC policies, Centers for Medicare and Medicaid Services (CMS) national coverage decisions (NCDs), local coverage determinations (LCDs), and Department designated medical review decisions. DMEPOS providers are required to follow specific Montana Medicaid policy or applicable Medicare policy when Montana Medicaid policy does not exist. When Medicare makes a determination of medical necessity, that determination is applicable to the Medicaid program.

Provision of Services (ARM 37.86.1802)

Federal regulations require that items/services covered by the Department are reasonable and necessary in amount, duration, and scope to achieve their purpose. DMEPOS items/supplies must be medically necessary, prescribed in writing, and delivered in the most appropriate and cost effective manner, and may not be excluded by any other state or federal rules or regulations.

Supplier Documentation (ARM 37.86.1802)

All covered DMEPOS items for members with Medicaid as the primary payer, must be prescribed by a physician or other licensed practitioner of the healing arts within the scope of the provider's practice as defined by state law. The prescription must indicate the diagnosis, the medical necessity, projected length of need for the covered item, and utilization instructions. Prescriptions for oxygen must also include the liter flow per minute, hours of use per day and the member's PO2 or oxygen saturation blood test results.

Prescriptions for DMEPOS items must include the diagnosis, medical necessity, and projected length of need for the item.

DMEPOS suppliers must obtain a written prescription in accordance with ARM 37.86.1802. Suppliers should also maintain documentation showing the member meets the Medicare coverage criteria.

ARM 37. 86.1802 describes how prescriptions/orders can be transmitted. The prescription/order must indicate the diagnosis, the medical necessity, quantity and the length of need. The rule refers providers to the Medicare guidelines. Prescriptions can be oral, faxed, or hard copy. For items that are dispensed based on a verbal order, the supplier must obtain a written order that meets the requirements in Chapter 3 of the *Medicare Supplier Manual*. The rule refers to current Medicare rules and regulations in the Region D *Medicare Supplier Manual* (including the most current LCDs). Chapters 3 and 4 of the Medicare manual outline the documentation requirements for suppliers.

Although a prescription is required, coverage decisions are not based solely on the prescription. Coverage decisions are based on objective, supporting information about the member's condition in relation to the item/service prescribed. Supporting documentation may include, but is not limited to (if applicable) a Certificate of Medical Necessity (CMN), DME Information Form (DIF), and/or a physician's, therapist's or specialist's written opinion/attestation for an item/service based on unique individual need.

The member's medical record must contain sufficient documentation of the member's medical condition to substantiate the necessity for the prescribed item/service. The member's medical record is not limited to the physician's office records. It may include hospital, nursing home, or home health agency records and records from other professionals including, but not limited to, nurses, physical and occupational therapists, prosthetists, and orthotists. It is recommended that suppliers obtain (for their files) sufficient medical records to determine whether the member meets Medicaid coverage and payment rules for the particular item.

Proof of delivery is required in order to verify that the member received the DMEPOS item. Proof of delivery documentation must be made available to the Department upon request. Medicaid does not pay for delivery, mailing or shipping fees or other costs of transporting the item to the member's residence.

The effective date of an order/script is the date in which it was signed.

Providers must retain the original prescription, supporting medical need documentation and proof of delivery. For additional documentation requirements, see the *General Information for Providers* manual, Provider Requirements chapter, and Chapters 3 and 4 of the *Medicare Supplier Manual*.

Certificate of Medical Necessity

For a number of DMEPOS items, a certificate of medical necessity (CMN) is required to provide supporting documentation for the member's medical indications. Montana Medicaid adopts the CMNs used by Medicare DMERCs, approved by the Office of Management and Budget (OMB), and required by the Centers for Medicare and Medicaid Services (CMS).

These forms are available on the websites listed below:

- Provider Information website, http://medicaidprovider.mt.gov/forms
- CMS website, http://www.cms.gov
- Noridian website, https://med.noridianmedicare.com/web/jddme

The following is a list of items that require a CMN and the corresponding form. This reference list will be updated as changes are made. **If any discrepancies exist between these referenced forms and what is published by CMS and Medicare, the CMS and Medicare policy shall take precedence.** See Chapter 4 of the *Medicare Supplier Manual*.

Certificate of Medical Necessity (CMN) Forms

Item	Form	Form Date
Lymphedema Pumps (Pneumatic Compression Devices)	CMS-846	09/05
Osteogenesis Stimulators	CMS-847	09/05
Oxygen	CMS-484	09/05
Seat Lift Mechanisms	CMS-849	09/05
Section C Continuation Form	CMS-854	09/05
Transcutaneous Electrical Nerve Stimulators (TENS)	CMS-848	09/05

DME Information Forms

Item	Form	Form Date
External Infusion Pumps	CMS-10125	09/05
Enteral and Parental Nutrition	CMS-10126	09/05

Rental/Purchase (ARM 37.86.1801–1806)

The rental period for items identified by Medicare as capped, routine or inexpensive are limited to 13 months of rental reimbursement. After 13 months of continuous rental, the item is considered owned by the member and the provider must transfer ownership to the member. Total Medicaid rental reimbursement for items listed in Medicare's capped rental program or classified by Medicare as routine and inexpensive rental are limited to the

purchase price for that item listed on the Medicaid fee schedule. If purchasing the rental item is cost effective, the Department may cover the purchase of the item. See Chapter 5 of the *Medicare Supplier Manual*.

A statement of medical necessity for rental of DME equipment must indicate the length of time the equipment is needed, and all prescriptions must be signed and dated.

Servicing. During the 13-month rental period, Medicaid rental payment includes all supplies, maintenance, repair, components, adjustments, and services related to the item during the rental month. Separately billable supply items identified and allowed by Medicare are also separately billable to Medicaid under the same limitations. No additional amounts related to the item may be billed or reimbursed for the item during the 13-month period. During the rental period, the supplier providing the rental equipment is responsible for all maintenance and service. After the 13-month rental period when ownership of the item is transferred to the member, the provider may bill Medicaid for the supplies, maintenance, repair components, adjustment and services related to the items. Medicaid does not cover repair charges during the manufacturer's warranty period.

Items classified by Medicare as needing frequent and substantial servicing are covered on a monthly rental basis only. The 13-month rental limit does not apply, and rental payment may continue as long as the item is medically necessary.

Interruptions in rental period. Interruptions in the rental period of less than 60 days will not result in the start of a new 13-month period or new purchase price limit. Periods in which service is interrupted do not count toward the 13-month rental limit.

Change in supplier. A change in supplier during the 13-month rental period will not result in the start of a new 13-month period or new purchase price limit. Providers are responsible for investigating whether another supplier has been providing the item to the member; Medicaid does not notify suppliers of this information. The provider may rely upon a separate written member statement that another supplier has not been providing the item, unless the provider has knowledge of other facts or information indicating that another supplier has been providing the item. The supplier providing the item in the 13th month of the rental period is responsible for transferring ownership to the member.

Change in equipment. If rental equipment is changed to different but similar equipment, the change will result in the start of a new 13-month period or new purchase price limit only when all of the following are met:

- The change in equipment is medically necessary as a result of a substantial change in the member's medical condition.
- A new certification of medical necessity for the new equipment is completed and signed by a physician.

No more than one month's medical supplies may be provided to a member at one time.

Coverage of Specific Services

The simplest way to verify coverage for a specific service is to check the Department's fee schedule for your provider type. Fee schedules are available on the Provider Information website.

In addition to being listed on the fee schedule, all services provided must also meet the coverage criteria listed in the Provider Requirements chapter of the *General Information for Providers* manual and in this chapter. **Use the fee schedule in conjunction with the detailed coding descriptions in the CPT and HCPCS coding books that pertain to the date of service.**

The following are specific criteria for certain items/services which are either in addition to Medicare requirements or are services Medicare does not cover.

Apnea Monitors

The rental of an apnea monitor will be covered initially for a six-month period from the date of the physician's order. Apnea monitors are covered under at least one of the following conditions:

- A sibling has died from SIDS.
- Infant has symptomatic apnea.
- Observation of apparent life-threatening events (ALTE).
- Infant is on oxygen.
- Symptomatic apnea due to neurological impairment.

For coverage after the initial six-month period, additional months coverage must be prior authorized by the Department and the following conditions must exist and be documented by the physician:

- Infant continues to have significant alarms. (Log must be kept on file.)
- Unresolved symptomatic apnea.

Billing of Miscellaneous Code B9998

Supplies listed below that are included in the daily kits but billed with B9998 will be denied. Providers should review supplies being billed with the miscellaneous code and bill according to the following guidelines.

Medicare Coding Guidelines. The codes for enteral feeding supplies (B4034–B4036) include all supplies, other than the feeding tube itself, required for the administration of enteral nutrients to the patient for one day.

Codes B4034–B4036 describes a daily supply fee rather than a specifically defined kit. Some items are changed daily; others may be used for multiple days. Items included in these codes are not limited to prepackaged kits bundled by manufacturers or distributors.

These supplies include, but are not limited to, feeding bag/container, flushing solution bag/container, administration set tubing, extension tubing, feeding/flushing syringes, gastrostomy tube holder, dressings (any type) used for gastrostomy tube site, tape (to secure tube or dressings), Y connector, adapter, gastric pressure relief valve, declogging device, etc.

These items must not be separately billed using the miscellaneous code (B9998) or by using specific codes for dressings or tape. The use of individual items may differ from patient-to-patient and from day-to-day.

Combination Shower Commode Chairs and Accessories, Screening Criteria

Use HCPCS Code E0240 when submitting prior authorization request and/or when billing for the shower commode chair. This code does require prior authorization and must meet the criteria listed below:

Description. A combination shower commode chair is used to meet an individual's toileting and hygiene needs.

Indications for Coverage of the Shower Commode Chair. All of the following criteria must be met:

- Unable to use a standard conventional toilet.
- Unable to get in/out of the shower independently and is unable to sit or stand in the bath/shower independently.
- Home assessment determines that shower/tub access is possible for the requested equipment.
- Home assessment determines that once the equipment is in the shower/tub enclosure caregiver access to the patient is adequate.
- Documentation to support that a less costly system will not meet the needs of the individual.

Indications for coverage of the tilt/recline feature. Documentation to support the medically necessity for the individual to be in a tilt/recline position for toileting or showering.

Indications for coverage of a non-standard seating system.

- Current decubitus that is a stage 3 or 4; **and**
- Shower/commode chair needed for a minimum of 30 minutes or longer; **or**
- No decubitus and use of the shower/commode chair for a minimum of 2 hours or longer per toileting session.

Indications for coverage of foot plates. No functional use of the lower limbs.

Indications for coverage of elevating leg rests. Musculoskeletal condition which prevents 90 degree flexion of the knee or meets medical necessity for the tilt/recline feature on the shower/commode chair.

Indications for coverage of a heavy duty shower/commode chair. Documentation from a medical resource of the patient's weight to determine justification for the requested chair.

Compression Garments for the Legs

Inflatable compression garments, non-elastic binders, or individually fitted prescription graded compression stockings are considered medically necessary for members who have any of the following medical conditions:

- Treatment of any of the following complications of chronic venous insufficiency:
  - Lipodermatosclerosis
  - Stasis dermatitis (venous eczema)
  - Varicose veins (except spider veins)
  - Venous edema
  - Venous ulcers (stasis ulcers)
- Edema accompanying paraplegia, quadriplegia
- Edema following surgery, fracture, burns, or other trauma
- Persons with lymphedema
- Post sclerotherapy (applies only to pre-made or custom-made pressure gradient support stockings)
- Post-thrombotic syndrome (post-phlebetic syndrome)
- Postural hypotension
- Prevention of thrombosis in immobilized persons (e.g., immobilization due to surgery, trauma, general debilitation)
- Severe edema in pregnancy

Compression garments for the legs are considered experimental and investigational for all other indications (e.g., management of spasticity following stroke) and will not be covered.

Replacements. Are considered medically necessary when the compression garment cannot be repaired or when required due to a change in the member's physical condition. For pressure gradient support stockings, no more than 4 replacements per year are considered medically necessary for wear.

Two pairs of compression stockings are considered medically necessary in the initial purchase. The second pair is for use while the first pair is in the laundry. For a list of covered compression stocking codes, see the fee schedule on the Provider Information website.

Custom-Made Equipment, Prosthetics, or Orthotics

DME must be billed using the date of service the member receives the equipment or item.

The only exception is in the case of custom-made equipment, prosthetics or orthotics. In these instances the date when the item is casted, molded, and/or fitted may be used. **Before a provider can bill for any custom-made equipment, prosthetic or orthotic, the work on the item must be complete and the member must have signed the delivery ticket.**

Because Medicaid eligibility is determined on a month-to-month basis, providers must check eligibility **before** an item is ordered or work has begun and **document** the member's eligibility in their file.

Only one unit of service may be billed for any one day. Units of service in excess of one per day will be rejected as incorrect coding.

Gastrostomy/Jejunostomy Tube, Code B4088

This code has been incorrectly profiled in the HCPCS coding book. The code is described as just a tube, when in fact it is a complete kit. The manufacturer will not supply the tube separate from the kit. Medicare currently reimburses code B4088 as a tube, but suppliers are billed by the manufacturer for the complete kit. Therefore, the reimbursement to the suppliers is not adequate in comparison to the cost for the complete kit.

Medicaid recognizes the constraints this has put on suppliers when providing this item to members. Effective immediately, Medicaid will reimburse code B4088 at 75% of the Manufacturer's Suggested Retail Price (MSRP) in accordance with ARM 37.86.1807.

Diapers, Underpads, Liners/Shields

The T codes listed below are more specific to the type of incontinence products being distributed by Montana Medicaid DME providers. These codes will be paid the Manufacturer's Suggested Retail Price (MSRP). Also, maximum allowable amounts will be attached to each code. The allowables are 180 disposable diapers per month, 36 reusable diapers, underpads, liners/shields per year (3 per month), and 240 disposable underpads per month.

Diapers, underpads, and liners/shields are covered for individuals who have a medical need for the items based on their diagnosis. These items are not covered for members under 3 years of age or members in long-term care (nursing facility) settings. Disposable diapers are limited to 180 diapers per month. Disposable underpads, liners/shields are limited to 240 per month. Reusable diapers, under pads, liners/shields are limited to 36 units each per year (3 per month).

HCPCS Code	Description
T4521	Adult sized disposable incontinence product, brief/diaper, small, each
T4522	Adult sized disposable incontinence product, brief/diaper, medium, each
T4523	Adult sized disposable incontinence product, brief/diaper, large, each
T4524	Adult sized disposable incontinence product, brief/diaper, extra large, each
T4525	Adult sized disposable incontinence product, protective underwear/pull-on, small, each
T4526	Adult sized disposable incontinence product, protective underwear/pull-on, medium, each
T4527	Adult sized disposable incontinence product, protective underwear/pull-on, large, each
T4528	Adult sized disposable incontinence product, protective underwear/pull-on, extra large, each
T4529	Pediatric sized disposable incontinence product, brief/diaper, small/medium size, each
T4530	Pediatric sized disposable incontinence product, brief/diaper, large size, each
T4531	Pediatric sized disposable incontinence product, protective underwear/pull-on, small/medium size, each
T4532	Pediatric sized disposable incontinence product, protective underwear/pull-on, large size, each
T4533	Youth sized disposable incontinence product, brief/diaper, each
T4534	Youth sized disposable incontinence product, protective underwear/pull-on, each
T4535	Disposable liner/shield/guard/pad/ undergarment, for incontinence, each
T4536	Incontinence product, protective underwear/pull-on, reusable, any size, each
T4537	Incontinence product, protective underpad, reusable, bed size, each
T4539	Incontinence product, diaper/brief, reusable, any size, each
T4540	Incontinence product, protective underpad, reusable, chair size, each
T4541	Incontinence product, disposable underpad, large, each
T4542	Incontinence product, disposable underpad, small size, each
T4543	Disposable incontinence product, brief/diaper, bariatric, each

Electric Breast Pump

The use of an electric breast pump is considered medically appropriate if at least one of the following criteria is met:

- Member has a pre-term infant of 37 weeks or less gestation.
- Member's infant has feeding difficulties due to neurological or physical conditions which impairs adequate suckling.
- Illness of mother and/or infant that results in their separation.
- Mother is on medication that compromises milk supply.

Electric breast pump rental is limited for 2 months unless additional months are prior authorized by the Department. Medicaid covers all supplies, maintenance, repair, components, adjustments and services related to the pump. Payment may not be provided through the infant's eligibility for Medicaid.

Gait Trainers

A gait trainer (GT) is a device used to support a patient during ambulation. Critera for coverage of a gait trainer include:

- The member is unable to ambulate independently with a standard front or reverse walker because of the need for postural support, due to a chronic neurological condition including abnormal movement patterns, poor balance, poor endurance, or other clearly documented reasons.
- The anticipated functional benefits of walking are not attainable with the use of a walker.
- Must demonstrate tolerance for standing and weight bearing through the lower extremities.
- Potential benefits to the individual of assisted walking must be clearly documented as follows:
- The member must be involved in a therapy program established by a physical therapist. The program must include measurable documented objectives and functional goals related to the member and equipment that includes a written carry over plan to be utilized by the member and/or caregiver. The equipment must match the user's needs and ability level.
- The member has had a trial of the requested gait trainer (GT) and the member shows compliance, willingness, and ability to use the GT in the home.
- Video of member using the requested GT home demonstrating ability to use GT by showing potential for progress to meet goals and objectives.

Group 2 Support Surfaces

Rentals will be reviewed on a monthly basis for members. In the event that Prior Authorization staff receives additional medical information directly from the care provider, that information will be included in the cover letter to the DME vendor along with a copy of the authorization.

The criteria for "reasonable and necessary" for Group 2 support surfaces are defined by the indications and limitations of coverage below and/or medical necessity.

A Group 2 support surface is covered if the patient meets:

- Criterion 1 and 2 and 3; or
- Criterion 4; or
- Criterion 5 and 6.

1. Multiple Stage II pressure ulcers located on the trunk or pelvis.
2. Patient has been on a comprehensive pressure ulcer treatment program for at least the past month which has included the use of an appropriate Group 1 support surface.
3. The pressure ulcers have worsened or remained the same over the past month.
4. Large or multiple Stage III or IV pressure ulcers on the trunk or pelvis.
5. Recent myocutaneous flap or skin graft for a pressure ulcer on the trunk or pelvis (surgery within the past 60 days).
6. The patient has been on a Group 2 or 3 support surface immediately prior to a recent discharge from a hospital or nursing facility (discharge within the past 30 days).

The comprehensive pressure ulcer treatment described in #2 above should generally include:

- Education of the patient and caregiver on the prevention and/or management of pressure ulcers.
- Regular assessment by a nurse, physician, or other licensed healthcare practitioner (usually at least weekly for a patient with a Stage III or IV ulcer).
- Appropriate turning and positioning.
- Appropriate wound care (for a Stage II, III, or IV ulcer).
- Appropriate management of moisture/incontinence.
- Nutritional assessment and intervention consistent with the overall plan of care.

If the patient is on a Group 2 surface, there should be a care plan established by the physician or home care nurse which includes the above elements. The support surface provided for the patient should be one in which the patient does not "bottom out."

When a Group 2 surface is covered following a myocutaneous flap or skin graft, coverage generally is limited to 60 days from the date of surgery.

Montana Department of Public Health and Human Services

When the stated coverage criteria for a Group 2 mattress or bed are not met, ***an authorization will not be issued*** unless there is clear documentation which justifies the medical necessity for the item in the individual case.

Continued use of a Group 2 support surface ***is determined on a case-by-case basis.*** It is covered until the ulcer is healed or, if healing does not continue, there is documentation in the medical record to show that: (1) other aspects of the care plan are being modified to promote healing, or (2) the use of the group 2 support surface is medically necessary for wound management.

A Group 2 support surface will be considered for purchase if the following criteria are met:

- Has met the above Indications and Limitations of Coverage and/or Medical Necessity for rental and is necessary for wound management for more than six months; or
- Has met the above indications of Coverage and/or Medical Necessity for rental and the ulcers have healed. However, the member has a history of previous decubitus ulcers and is at significant risk for recurrent breakdown if the surface is removed.

The purchase of a Group 2 support surface will be reviewed on a case-by-case basis. It must be determined that:

- The member is compliant with the use of the surface; and
- Other factors have been addressed that are/may be contributing to the recurrent breakdown such as infection, nutrition, incontinence management, repositioning, etc.

Home Oxygen Therapy for Members Residing in Skilled Nursing Facility

In accordance with ARM 37.86.1802, Montana Medicaid has adopted Medicare coverage criteria for Medicare covered durable medical equipment as outlined in the Region D Supplier Manual, *Medicare Supplier Manual*, and local and national coverage determinations (LCDs and NCDs).

For prosthetic devices, durable medical equipment, and medical supplies not covered by Medicare, coverage will be determined by the Department and published on the Department's fee schedule in accordance with ARM 37.86.1807.

The Department will follow criteria set forth in the LCD for Oxygen and Oxygen Equipment (L11457) for members residing in a skilled nursing facility. The only exception is that the Department will allow oximetry tests ordered by a physician and performed by qualified nursing personnel at the skilled nursing facility as an acceptable blood gas study. To be reimbursed for this service, DME providers shall follow all other criteria set forth in L11457.

Medicaid Policy on 36-Month Oxygen Cap

To preserve member access, Montana Medicaid will not be following the Medicare 36-month cap policy on oxygen for Medicaid-only members. This policy will include eligible Medicaid nursing home dual-eligible (both Medicare and Medicaid coverage) members for Medicare non-covered oxygen. Medicaid pays only Medicare co-insurance and deductibles up to the Medicaid allowable for QMB-only members. The Department will follow established policy for this member group. For example, once the 36-month cap starts, Medicare rules apply and the Department will follow.

Dual-eligible members will follow the 36-month cap as outlined by Medicare rules. Medicaid members with QI-1 and SLMB do not have Medicaid oxygen coverage. Medicaid will follow all of the Medicare oxygen changes outlined in the Medicare Improvements for Patients and Providers Act (MIPPA) of 2008 except for the 36-month cap as stated above.

Oral Nutrition

Medicaid may cover oral nutritional products for members under the age of 21 who have had an EPSDT screen resulting in a diagnosed medical condition that impairs absorption of a specific nutrients. The member must also have a measurable nutrition plan developed by a nutritionist and the member's primary care provider (PCP). Use modifier -BO when nutrition is orally administered, not by a feeding tube (only for members under age 21).

Phototherapy (Bilirubin) Light with Photometer

The E0202 RR will be reimbursed for infants ages 0–2. One unit of service is billed for each day and units billed are not to exceed a 5-day limit. To assure correct coding, providers are encouraged to refer to the current HCPCS coding manual. DMEPOS suppliers must obtain a written prescription in accordance with ARM 37.86.1802. Suppliers should also maintain supporting documentation showing the member meets the Medicaid coverage criteria. Services for adults and children over age 1 will be reviewed for medical necessity by the DME Program Officer at the Health Resources Division.

Pulse Oximetry Meter

A pulse oximetry meter measures oxygen saturation levels using a noninvasive probe. Pulse oximetry meters provide an estimate of arterial oxyhemoglobin saturation (SaO2), using selected wavelengths of light, to determine the saturation of oxyhemoglobin (SpO2).

Continuous read oximetry meters and any meter used for diagnostic purposes are not covered.

A pulse oximetry meter is covered for pediatric patients when all of the following criteria are met:

- The member has a chronic, progressive respiratory or cardiovascular condition that requires continuous or frequent oxygen therapy.
- Oxygen need varies from day to day or per activity (e.g., feeding, sleeping, movement), and a medical need exists to maintain oxygen saturation within a very narrow range in which unpredictable, sub-therapeutic fluctuations of oxygen saturation levels occur that cannot be clinically determined and have an adverse effect if not treated.
- A trained caregiver is available to respond to changes in oxygen saturation.

Wheelchair Seating in the Nursing Facility

Indications and limitations for a wheelchair seating system for an existing wheelchair such as a facility wheelchair, patient owned wheelchair or a donated wheelchair. The seating system would be the least costly alternative that is able to be adapted to meet the positioning needs of a resident in a nursing home and will be covered if there is a comprehensive written evaluation by a licensed clinician who is not an employee of or otherwise paid by a supplier.

Included in the evaluation referenced above would be the following:

- Seating systems for increased independence
  - Documentation must support all of the following:
    - The member must be able to self-propel to specific destinations (e.g., to and from the dining room, to and from the activity room).
    - Be able to do a functionally independent task as a result of the seating system such as feed self.
    - The member must be evaluated to determine that he/she is able to safely self-propel and does not have the potential cause harm.
    - Be alert and oriented and capable of being completely independent in use of the wheelchair after adapted seating system is placed.

OR

- Seating systems for positioning purposes
  - Seating for positioning purposes will be reviewed on a case-by-case basis.
  - Documentation must support that all other less costly alternatives have been ruled out, to include but not be limited to use of the following:
    - Use of mobile geriatric chairs (geri chairs) provided by nursing home and use of standard off-the-shelf seating products have been tried and ruled out; and
    - Use of rolled towels, blankets, pillows, wedges, or similar devices by facility caregivers to reasonably position and reposition member; and

- Documentation that has determined that nursing staff is unable to accomplish repositioning by any other means while resident is up and out of bed; and
- Resident is not incapacitated to the point that he/she is bedridden.

Wheelchairs

In addition to the Medicare Region D DMERC Medical Review Policies for wheelchairs, to meet the needs of a particular individual, various wheelchair options or accessories are typically selected. The addition of options or accessories does not deem the wheelchair as a custom wheelchair.

Wheelchairs in Nursing Facilities

Nursing facilities are expected to make available wheelchairs with typical options or accessories in a range of sizes to meet the needs of its residents. If a typical option or accessory is not available for a currently owned nursing facility wheelchair, an accommodating wheelchair is expected to be made available by the nursing facility. Only wheelchairs (including power chairs) that cannot be reasonably used by another nursing home resident will be considered for purchase. Wheelchairs must be used primarily for mobility. Roll-about chairs which cannot be self propelled are specifically designed to meet the needs of ill, injured, or otherwise impaired individuals and are considered similar to wheelchairs. Roll-about chairs may be called by other names such as transport or mobile geriatric chairs (geri chairs). Roll-about chairs are not wheelchairs; however, many of the same options and accessories can be found for use on them. Like standard wheelchairs, roll-about chairs are expected to be available to residents by the nursing facility.

Children's Services (ARM 37.86.2201–2235)

The Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services program is a comprehensive approach to healthcare for Medicaid members under age 21. It is designed to prevent, identify, and then treat health problems before they become disabling. Under EPSDT, Medicaid-eligible children may receive any medically necessary covered service, including DMEPOS items/services described in this manual. All applicable prior authorization requirements apply.

Children's (EPSDT) Coverage Criteria for Specified DME

ARM 37.86.2201 allows for coverage of a durable medical equipment (DME) item/service that is typically considered non-covered, does not meet coverage criteria, or is over the Medicaid allowable units if the item/service is determined medically necessary for an eligible child under 21.

MDI Spacers (EPSDT), Code A4627

A spacer device will be allowed for a child if he/she is using metered dose inhalers prescribed by his/her physician for medication delivery, and the spacer is medically necessary.

If the above criteria are met, the item does not require prior authorization. Medicaid will reimburse this code at 75% of the Manufacturer's Suggested Retail Price (MSRP), in accordance with ARM 37.86.1807.

Nebulizers/Nebulizer Kit (EPSDT), Codes E0570 RR/A7005

Nebulizers and supplies should be considered for in-home treatment of children when prescribed by their medical provider and when the child has been diagnosed with acute bronchiolitis or respiratory syncytial virus (RSV).

The nebulizer and supplies should be considered for a rental of prescribed length of need as indicated by the provider; typically, 1–3 months.

If the above criteria are met, the item does not require prior authorization and the claim can be submitted directly to Medicaid. Medicaid will reimburse these codes at 75% of the Manufacturer's Suggested Retail Price (MSRP), in accordance with ARM 37.86.1807.

Orthotics (EPSDT) Codes L3002, L3010, L3020, and L3040

Devices and instruments to help a child maintain his/her level of mobility, correct physical issues, or decrease pain should be considered when prescribed by their medical provider and the following conditions apply. This list is not all-inclusive, and each case is determined on a case-by-case review of medical necessity:

- Knee or hip subluxation, dislocation
- Spastic movement
- Correct, limit or prevent deformities
- Low-tone pronation (fallen arches, outward-turned foot due to muscle weakness)
- High-tone pronation (high arch, outward-turned foot due to increased muscle tone)
- Swing-phase inconsistency (erratic movements in the foot)
- Drop-foot (drop of the front of the foot due to weakness)
- Eversion (outward turn)

- Inversion (inward turn)

If the child is not having symptoms or pain associated with the above conditions, foot orthotics are not considered medically necessary.

If the above criteria are met, the item does not require prior authorization and the claim can be submitted directly to Medicaid. Medicaid will reimburse these codes at 75% of the Manufacturer's Suggested Retail Price (MSRP), in accordance with ARM 37.86.1807.

Pulse Oximeter Probes (EPSDT), Code A4606

If a child has a pulse oximeter that was paid for by Montana Medicaid, a replacement probe (A4606) will be covered if the pulse oximeter is still medically necessary and prescribed by their medical provider.

If above criteria are met, the item does not require prior authorization; however, the claim needs to be submitted via fax to the Department at 406-444-1861 for processing. Indicate on the fax cover sheet that this is a non-covered item that meets medically necessary criteria coverage. Medicaid will reimburse this code at 75% of the Manufacturer's Suggested Retail Price (MSRP), in accordance with ARM 37.86.1807.

Thick It (EPSDT), Code B4100

The addition of a thickening agent should be considered medically necessary when prescribed by his/her medical provider and the following diagnosis applies:

- Oropharyngeal dysphagia;
- Reflux disease; or
- Any diagnosis that indicates child is at risk for life threatening aspiration.

If a criterion is met, the item does not require prior authorization; however, the claim needs to be submitted via fax to the Department at 406-444-1861 for processing. Indicate on the fax cover sheet that this is a non-covered item, and describe how the request meets medical necessity criteria. Medicaid will reimburse this code at 75% of the Manufacturer's Suggested Retail Price (MSRP), in accordance with ARM 37.86.1807.

Non-Covered Services (ARM 37.86.1802)

Below are items and/or categories of items that are not covered through the DMEPOS program. All coverage decisions are based on federal and state mandates for program funding by CMS, including the Medicare program or the Department's designated review organization.

- Adaptive items for daily living
- Environmental control items
- Building modifications
- Automobile modifications
- Convenience/comfort items
- Disposable incontinence wipes
- Sexual aids or devices
- Personal care items
- Personal computers
- Alarms/alert items
- Institutional items
- Exercise/therapeutic items
- Educational items
- Items/services provided to a member in a nursing facility setting. (See the *Nursing Facility Services* manual for details.)
- Furniture associated with the use of a seat lift mechanism.
- Scales (covered if monitoring weight is part of any congestive heart failure (CHF) treatment regimen)
- Backup equipment
- Items included in the nursing home per diem

Requesting an Item/Code Be Added to the Fee Schedule

DME providers and suppliers can request that the Department consider adding non-covered supplies and equipment to the DME plan of benefits or to modify existing coverage criteria. The procedure must allow the Department to make a well informed decision in regard to considering coverage based primarily on medical necessity. The policy is not a guarantee of coverage.

Requester/Supplier Responsibility

Requester must submit a written request to the DPHHS DME program officer. The request must include the following:

- HCPCS code and a detailed description of the item.
- Clear and concise statement of why the item is needed. This could include a letter of medical necessity (LMN) if available.

- Supporting information documenting the medical necessity for the requested item from peer reviewed national compendia or publication. Evidence must support the need for this equipment to meet the intended medical need.
- A statement addressing if there is a least costly alternative and why it cannot be used.
- Recommended coverage criteria of the requested item.
- Recommended limits. This would include any limits that could apply such as lifetime, units per month, age limits, weight.
- Estimated (per unit) cost of the requested item.
- Estimated number of people that would utilize the item.
- Expected medical outcome.
- Estimated overall cost/cost savings (if any).

The request may include any other pertinent information the requester would like the Department to consider.

Department's Responsibility and Process

Upon receipt of a request for coverage of a non-covered item, the Department:

- Submits the request and associated documentation to the Department's DME Utilization Review contractor for evaluation of the request.
  - Upon completion of the review, the contractor makes a coverage recommendation to the Department.
- May forward the request to the State Medical Director (SMD) for review.
  - If SMD recommends coverage denial, the Department sends letter to the requester explaining why.
  - If SMD recommends coverage, the Department determines whether the current budget can fulfill the expense of the item's expected utilization.
- An adverse budget impact results in a letter to the requester explaining why the item cannot be added.
- Department approval of the request initiates the Administrative Rule and State Plan Amendment process. These are required steps for new items to be added to the DME fee schedule allowing for public comment.
- The Department is responsible for preparing a written response within a reasonable time period to inform all applicable parties of the decision.
- The process could take up to six months. The Department provides quarterly progress reports to the DME workgroup.

Billing Procedures

Using the Medicaid Fee Schedule

When billing Medicaid, it is important to use the Department's fee schedule for your provider type in conjunction with the detailed coding descriptions listed in the current CPT and HCPCS coding books. In addition to covered services and payment rates, fee schedules often contain helpful information such as appropriate modifiers. Fee schedules are available on the Provider Information website.

Place of Service

Place of service must be entered correctly on each line. Medicaid typically reduces payment for services provided in hospitals and ambulatory surgical centers since these facilities typically bill Medicaid separately for facility charges.

For a list of place of service codes for professional claims, see the link under Coding/Place of Service Codes at http://www.cms.gov/Medicare/Medicare.html.

Date of Service

The date of service for custom molded or fitted items is the date upon which the provider completes the mold or fitting and either orders the equipment from another party or makes an irrevocable commitment to the production of the item.

Rental

Payment includes the entire initial month of rental even if actual days of use are less than the full month. Payment for second or subsequent months is allowed only if the item is used at least 15 days in such months.

How Payment Is Calculated

Overview

Although providers do not need the information in this chapter in order to submit claims to Montana Medicaid, the information allows providers to understand how payment is calculated and to predict approximate payment for particular claims.

Usual and Customary Charge (ARM 37.85.406 and ARM 37.86.1806)

Providers should bill Medicaid their usual and customary charge for each service; that is, the same charge that is made to other payers for that service. The amount of the provider's usual and customary charge may not exceed the reasonable charge usually and customarily charged by the provider to all payers. For DMEPOS providers, a charge is considered reasonable if it is less than or equal to the manufacturer's suggested list price.

For items without a manufacture's suggested list price, the charge is considered reasonable if the provider's acquisition cost from the manufacturer is at least 50% of the charge amount. For items that are custom fabricated at the place of service, the amount charged will be considered reasonable if it does not exceed the average charge of all Medicaid providers by more than 20%.

Payment for DMEPOS Items/Services (ARM 37.86.1807)

Payment for DMEPOS is equal to the lowest of either the provider's usual and customary charge for the item or the Medicaid fee schedule amount in effect for the date of service.

Medicaid payment is equal to 100% of Medicare Region D fee schedule for current procedure codes where a Medicare fee is available, less applicable cost sharing, incurment and/or other applicable fees. Generic or miscellaneous procedure codes are excluded from the Medicare fee schedule. Payment for such excluded procedure codes is 75% of the provider's submitted charge. For all other procedure codes where no Medicare fee is available, payment is 75% of the submitted charge.

Rental Items

If the purchase of a rental item is cost effective in relation to the patient's need of the item, the purchase may be negotiated. The purchase price would be the amount indicated on the applicable fee schedule, less previous payments made to the provider of the item.

Total Medicaid rental reimbursement for items listed in Medicare's capped rental program or classified by Medicare as routine and inexpensive rental is limited to the purchase price for that item. Monthly rental fees are limited to 10% of the purchase for the item, limited to 13 monthly payments. Interruptions in the rental period of less than 60 days do not result in the start of a new 13-month period or new purchase price limit, but periods during which service is interrupted will not count toward the 13-month limit.

How Cost Sharing Is Calculated on Medicaid Claims

Member cost sharing for services provided by DMEPOS providers is $5.00 per visit. The member's cost sharing amount is shown on the remittance advice and deducted from the Medicaid allowed amount. (See the Remittance Advices and Adjustments chapter in the *General Information for Providers* manual.)

How Payment Is Calculated on TPL Claims

When a member has coverage from both Medicaid and another insurance company, the other insurance company is often referred to as third party liability or TPL. In these cases, the other insurance is the primary payer (as described in the Member Eligibility and Responsibilities chapter of the *General Information for Providers* manual), and Medicaid makes a payment as the secondary payer.

How Payment is Calculated on Medicare Crossover Claims

When a member has coverage from both Medicaid and Medicare, Medicare is the primary payer as described in the Member Eligibility and Responsibilities chapter of the *General Information for Providers* manual. Medicaid then makes a payment as the secondary payer. For the provider types covered in this manual, Medicaid's payment is calculated so that the total payment to the provider is either the Medicaid allowed amount less the Medicare paid amount or the sum of the Medicare coinsurance and deductible, whichever is lower. This method is sometimes called "lower of" pricing.

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Appendix A: Forms

See the Forms page of the Provider Information website for the forms listed below.

Certificates of Medical Necessity

- Lymphedema Pumps (Pneumatic Compression Devices) (CMS-846)
- Osteogenesis Stimulators (CMS-847)
- Oxygen (CMS-484)
- Seat Lift Mechanisms (CMS-849)
- Section C Continuation Form (CMS-854)
- Transcutaneous Electrical Nerve Stimulators (TENS) (CMS-848)

DME Information Forms

- External Infusion Pumps DME 09.03 (CMS-10125)
- Enteral and Parenteral Nutrition DME 10.03 (CMS-10126)
- DMEPOS Medical Review Request Form

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