

# Covered Services

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## 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 health care services received by Medicaid clients, 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 DMERC web site. The Provider Information website contains a link to the DMERC site (see *Key Contacts*). 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, 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.

### ***Services for children (ARM 37.86.2201 – 2221)***

The Early and Periodic Screening, Diagnosis and Treatment Program (EPSDT) is a comprehensive approach to health care for Medicaid clients 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.

### ***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 clients with Medicaid as the primary payer, must be prescribed in writing prior to delivery 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, and projected length of need for the covered item. Prescriptions for medical supplies used on a continuous basis shall be renewed by a physician at least every 12 months and must specify the monthly quantity. Prescriptions for oxygen must also include the liter flow per minute, hours of use per day and the client's P02 or oxygen saturation blood test results.

Even though a prescription is required, coverage decisions are not based solely on the prescription. Coverage decisions are based on objective, supporting information about the client'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) and/or a physician's, therapist's or specialist's written opinion/attestation for an item/service based on unique individual need. The DMEPOS fee schedule indicates the items that require a CMN.

The client's medical record must contain sufficient documentation of the client's medical condition to substantiate the necessity for the prescribed item/service. The client'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 client meets Medicare coverage and payment rules for the particular item.

Proof of delivery is required in order to verify that the client 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 client's residence.

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.

**Certificate of medical necessity**

For a number of DMEPOS items, a certificate of medical necessity (CMN) is required to provide supporting documentation for the client's medical indication(s). The "CMN" column of the Montana Medicaid fee schedule indicates if a CMN is required. Montana Medicaid adopts the CMNs used by Medicare Durable Medical Equipment Regional Carriers (DMERCs), approved by the



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



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

Office of Management and Budget (OMB), and required by the Centers for Medicare & Medicaid Services (CMS). These forms are available in *Appendix A: Forms*, on the Provider Information website (see *Key Contacts*) and on the following web sites:

<http://www.cms.hhs.gov/providers/mr/cmnm.asp>

[http://www.cignamedicare.com/dmerc/dmsm/C04/sm04\\_INDEX.html](http://www.cignamedicare.com/dmerc/dmsm/C04/sm04_INDEX.html)

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 Cigna Medicare, then the CMS and Cigna Medicare policy shall take precedence.

<b>CMN Forms</b>		
<b>Item</b>	<b>Form</b>	<b>Date</b>
Continuous Positive Airway Pressure (CPAP)	CMS-845	04/96
Enteral Nutrition	CMS-853	04/96
External Infusion Pump	CMS-851	04/96
Hospital Beds	CMS-841	04/96
Lymphedema Pumps (Pneumatic Compression Devices)	CMS-846	05/97
Manual Wheelchairs	CMS-844	05/97
Motorized Wheelchairs	CMS-843	05/97
Osteogenesis Stimulators	CMS-847	05/97
Oxygen	CMS-484	11/99
Parenteral Nutrition	CMS-852	04/96
Power Operated Vehicles (POV)	CMS-850	04/96
Seat Lift Mechanisms	CMS-849	04/96
Section C Continuation Form	CMS-854	05/97
Support Surfaces	CMS-842	04/96
Transcutaneous Electrical Nerve Stimulators (TENS)	CMS-848	04/96

***Rental/purchase (ARM 37.86.1801 - 1806)***

The rental period for items identified by Medicare as capped, routine or inexpensive are limited to 12 months of rental reimbursement. After 12 months of continuous rental, the item is considered owned by the client and the provider must transfer ownership to the client. 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 120% of the purchase price for that item. If purchasing the rental item is cost effective, the Department may cover the purchase of the item.

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 12-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 12-month period. During the rental period, the supplier providing the rental equipment is responsible for all maintenance and service. After the 12-month rental period when ownership of the item is transferred to the client, 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 12-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 12-month period or new 120% of purchase price limit. Periods in which service is interrupted do not count toward the 12-month rental limit.

***Change in supplier.*** A change in supplier during the 12-month rental period will not result in the start of a new 12-month period or new 120% of purchase price limit. Providers are responsible to investigate whether another supplier has been providing the item to the client; Medicaid does not notify suppliers of this information. The provider may rely upon a separate written client 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 twelfth month of the rental period is responsible for transferring ownership to the client.

***Change in equipment.*** If rental equipment is changed to different but similar equipment, the change will result in the start of a new 12-month period or new 120% of 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 client's medical condition.
- A new certification of medical necessity for the new equipment is completed and signed by a physician.

***Non-covered services (ARM 37.86.1802)***

The following 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 the U.S. Department of Health and Human Services, 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
- Scales
- Items/services provided to a client in a nursing facility setting (see the *Nursing Facility Services* manual for details)

***Verifying coverage***

The easiest way to verify coverage for a specific service is to check the Department's fee schedule for your provider type. 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 Provid-*



Use the current fee schedule for your provider type to verify coverage for specific services.

ers manual and in this chapter. Use the current fee schedule in conjunction with the more detailed coding descriptions listed in the current CPT-4 and HCPCS Level II coding books. Take care to use the fee schedule and coding books that pertain to the date of service.

Current fee schedules are available on the *Provider Information* web site, disk, or hardcopy. For disk or hard copy, contact Provider Relations (see *Key Contacts*).

## Coverage of Specific Services

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, 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

### ***Diapers, under pads, liners/shields***

Diapers, under pads, liners and shields are covered for individuals who have a medical need for the items based on their diagnosis. These items are not covered for clients under three years of age or clients in long term care (nursing facility) settings.

Disposable diapers are limited to 180 diapers per month. Disposable under pads, liners/shields are limited to 240 per month. Reusable diapers, under pads, liners/shields are limited to 36 units each per year.

### ***Electric breast pump***

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

- Client has a pre-term infant of 37 weeks or less gestation

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



- Client'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 two 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.

### ***Oral nutrition***

Medicaid may cover oral nutritional products for clients under the age of 21 who have had an EPSDT screen resulting in a diagnosed medical condition that impairs absorption of a specific nutrient(s). The client must also have a measurable nutrition plan developed by a nutritionist and the client's primary care provider (PCP).

### ***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 (SaO<sub>2</sub>), using selected wavelengths of light, to determine the saturation of oxyhemoglobin (SpO<sub>2</sub>).

A pulse oximetry meter is covered for ventilator dependent patients. Continuous read oximetry meters and any meter used for diagnostic purposes are not covered.

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

- The client has a chronic, progressive respiratory or cardiovascular condition that requires continuous or frequent oxygen therapy.
- A medical need exists in which unpredictable, sub-therapeutic fluctuations of oxygen saturation levels occur that cannot be clinically determined and have an adverse effect if not immediately treated.
- A trained caregiver is available to respond to changes in oxygen saturation.

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

- The client 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.

### ***Standing frame***

A standing frame is used to develop weight bearing through the legs for those who cannot stand independently. Standers may be fixed or adjustable in their design. Accessories must contribute significantly to the therapeutic function of the device. Designs and accessories primarily for a caregiver's convenience are not considered medically necessary. For the coverage of a standing frame, the following conditions must be met:

- Client can demonstrate tolerance for standing and partial weight bearing
- Client and/or caregivers demonstrate the capability and motivation to be compliant in the use of the standing frame
- Client is unable to stand without the aid of adaptive equipment
- Clients must be involved in a therapy program established by a physical or occupational therapist. The program must include measurable documented objectives related to the client and equipment that includes a written carry over plan to be utilized by the client and/or caregiver. The equipment must match the user's needs and ability level.

### ***Wheelchairs***

In addition to the Medicare, Region D, DMERC Medical Review Policies for wheelchairs, the following also applies. In order 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 one that is custom.

### ***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. 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 wheel-

Roll-about chairs are not wheel-chairs; however, many of the same options and accessories can be found for use on them. Like wheelchairs, roll-about chairs are expected to be available to residents by the nursing facility.

## Other Programs

This is how the information in this manual applies to Department programs other than Medicaid.

### ***Mental Health Services Plan (MHSP)***

The information in this manual does not apply to the Mental Health Services Plan (MHSP). For more information on the MHSP program, see the *Mental Health Manual* available on the Provider Information website (see *Key Contacts*).

### ***Children's Health Insurance Plan (CHIP)***

The information in this manual does not apply to CHIP clients. For a CHIP medical manual, contact BlueCross BlueShield of Montana at (800) 447-7828 x8647. Additional information regarding CHIP is available on the CHIP website (see *Key Contacts*).

