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

***Medicaid and Other Medical  
Assistance Programs***



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**My NPI/API:**

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# 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.

### ***Essential for Employment Program***

In limited circumstances, Medicaid will cover a DME service normally excluded under Basic Medicaid if it is essential to obtaining or maintaining employment. When this is the case, the member presents a signed Medicaid Services Essential for Employment form (DPHHS-HCS-782). Before receiving DME services as an Essential for Employment benefit, the member must obtain this form through their Local Office of Public Assistance.

See <http://dphhs.mt.gov/hcsd/OfficeofPublicAssistance.aspx>.

- Service/limitations, coverage, and reimbursement may be the same for approved services as they would be for a Full Medicaid member.
- Claims must be accompanied by a completed DPHHS-HCS-782. The member must obtain this form through their local Office of Public Assistance; a sample is available on the Provider Information [website](#).
- If the item/equipment requires prior authorization, the Essentials form and all documentation will be sent for prior authorization after the Essentials are approved.

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



**Services for Children (ARM 37.86.2201–2221)**

The Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) 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.

**Basic Medicaid**

Medicaid generally does not cover DMEPOS for members on Basic Medicaid. Providers should verify members’ eligibility before providing services.

**The only HCPCS codes covered under Basic Medicaid are:**

A4206 through A4259	A4310 through A4554	A4611 through A4629
A4772	A5051 through A5513	A6530 through A6544
A7027 through A7046	E0424 through E0450	E0457 through E0460
E0463 through E0480	E0550 through E0570	E0575 through E0601
E0605 through E0607	E0781	E0784
E1372	E1390	E1405 and E1406
K0455	K0552	L5000 through L8510

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

Other DME items for Basic Medicaid members may be covered under the Essentials for Employment program if they are necessary to obtaining or maintaining employment. When this is the case, the member will present a signed Medicaid Services Essential for Employment form. Prior to receiving DME items as an Essential for Employment benefit, the member must obtain this form through their eligibility specialist at their Local Office of Public Assistance. See <http://dphhs.mt.gov/hcsd/OfficeofPublicAssistance.aspx>.

**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.



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

***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.

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.

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. The CMN column of the Montana Medicaid fee schedule indicates if a CMN is required. 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*.

<b>Certificate of Medical Necessity (CMN) Forms</b>		
<b>Item</b>	<b>Form</b>	<b>Form Date</b>
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

<b>DME Information Forms</b>		
<b>Item</b>	<b>Form</b>	<b>Form Date</b>
External Infusion Pumps	CMS-10125	09/05
Enteral and Parental Nutrition	CMS-10126	09/05

# Billing Procedures

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## 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 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

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## Overview

Although providers do not need the information in this chapter in order to submit claims to the Department, 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 manufacturer'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, inpatient 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.

# Appendix A: Forms

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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

