SECTION 13 - BENEFITS AND LIMITATIONS

SECTION 13-BENEFITS AND LIMITATIONS

13.1 CONDITIONS OF PARTICIPATION

13.1.A PROVIDER PARTICIPATION

To participate in the MO HealthNet Durable Medical Equipment (DME) Program, only the following types of providers are reimbursed by MO HealthNet for items covered under the DME Program. Each of the following provider types *must* be enrolled as a DME provider:

- Rental and Sales Providers;
- Prosthetic Fabricators;
- Rehabilitation Centers;
- Orthotic Fabricators;
- Physicians (M.D., D.O., Podiatrists) (may dispense orthotic devices and artificial larynx);
- Pharmacies; and
- Hospitals.

The following providers may write a prescription for items covered under the DME Program, with the exception of diabetic shoes and inserts:

- Physicians (M.D., D.O., Podiatrists); and
- Advanced Practice Nurses who have a collaborative practice agreement with a physician that allows for prescription of such items.

Providers *must* be Medicare approved prior to enrollment with the MO HealthNet Division (MHD). Providers *must* enroll with the same name and address for which their Medicare number is issued. Each Medicare DME supplier *must* have a separate Medicare number and National Provider Identifier (NPI) for each location and *must* enroll each location where MHD services are provided. MHD will *not* backdate enrollment prior to the Medicare effective date. Representatives of a DME company or warehouse are *NOT* considered providers and are *not* eligible to enroll.

Additional information on provider conditions of participation can be found in Section 2 of this provider manual.

13.1.B OUT-OF-STATE SERVICES

Out-of-state (nonbordering) providers who render services to MO HealthNet participants located in Missouri are ONLY permitted to receive reimbursement if:

- Medicare coinsurance and/or deductible amounts on covered services provided to participants who have *BOTH* MO HealthNet and Medicare.

- Durable Medical Equipment (DME) or supplies is *NOT* available in Missouri or a bordering state of Missouri.

If prior authorization is approved or reimbursement made for a DME item(s) on behalf of a MO HealthNet participant who is *not* Medicare eligible, or for equipment and/or supplies that are available in Missouri or a bordering state, the reimbursement that was paid may be recouped.

13.1.C NONDISCRIMINATION

Providers *must* comply with the 1964 Civil Rights Act, as amended; Section 504 of the Rehabilitation Act of 1973; the Age Discrimination Act of 1975; the Omnibus Reconciliation Act of 1981 and the Americans with Disabilities Act of 1990 and all other applicable Federal and State Laws that prohibit discrimination in the delivery of services on the basis of race, color, national origin, age, sex, handicap/disability or religious beliefs.

Further, all parties agree to comply with Title VII of the Civil Rights Act of 1964 which prohibits discrimination in employment on the basis of race, color, national origin, age, sex, handicap/disability or religious beliefs.

13.1.D RETENTION OF RECORDS

MO HealthNet providers *must* retain for five (5) years, from the date of service, fiscal and medical records that coincide with and fully document services billed to the MO HealthNet Agency, and *must* furnish or make the records available for inspection or audit by the Department of Social Services or its representative upon request. Failure to furnish, reveal and retain adequate documentation for services billed to the MO HealthNet Program may result in recovery of the payments for those services *not* adequately documented and may result in sanctions to the provider's participation in the MO HealthNet Program. This policy continues to apply in the event of the provider's discontinuance as an active MO HealthNet provider through change of ownership or any other circumstance.

13.2 ADEQUATE DOCUMENTATION

All services provided *must* be adequately documented in the medical record. The Code of State Regulations, 13 CSR 70-3.030, Section (2)(A) defines "adequate documentation" and "adequate medical records" as follows:

> Adequate documentation means documentation from which services rendered and the amount of reimbursement received by a provider can be readily discerned and verified with reasonable certainty.
>
> Adequate medical records are records which are of the type and in a form from which symptoms, conditions, diagnoses, treatments, prognosis and the identity of the patient to which these things relate can be readily discerned and verified with reasonable certainty. All documentation *must* be made available at the same site at which the service was rendered.

13.3 PARTICIPANT NONLIABILITY

MO HealthNet covered services rendered to an eligible participant are *not* billable to the participant if MO HealthNet would have paid had the provider followed the proper policies and procedures for obtaining payment through the MO HealthNet Program as set forth in 13 CSR 70-4.030.

13.4 EMERGENCY SERVICES

Emergency services are services required when there is a sudden or unforeseen situation or occurrence or a sudden onset of a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that the absence of immediate medical attention could reasonably be expected to result in:

1. Placing the participant's health in serious jeopardy;
2. Serious impairment to bodily functions; or
3. Serious dysfunction of any bodily organ or part.

13.5 OUT-OF-STATE, NONEMERGENCY SERVICES

All nonemergency MO HealthNet covered services that are to be performed or furnished out of state for eligible MO HealthNet participants and for which MO HealthNet is to be billed, *must* be prior authorized before the services are provided. Services that are *not* covered by the MO HealthNet Program are *not* approved.

Out of state is defined as *not* within the physical boundaries of the State of Missouri or within the boundaries of any state that physically borders Missouri. Border-state providers of services (those

providers located in Arkansas, Illinois, Iowa, Kansas, Kentucky, Nebraska, Oklahoma and Tennessee) are considered on the same MO HealthNet participation basis as providers of services located within the State of Missouri.

A Prior Authorization (PA) Request form is *not* required for out-of-state nonemergency services. To obtain a PA for out-of-state, nonemergency services, a written request *must* be submitted by a physician to:

MO HealthNet Division
Participant Services Unit
P.O. Box 6500
Jefferson City, MO 65102-6500

The request may be faxed to (573) 526-2471.

The written request *must* include:

1. A brief past medical history;
2. Services attempted in Missouri;
3. Where the services are being requested and who will provide them; and
4. An explanation why services can't be provided in Missouri.

NOTE: The out-of-state medical provider *must* agree to complete an enrollment application and accept MO HealthNet reimbursement. Prior Authorizations for out-of-state services expire 180 days from the date the specific service was approved by the state.

13.5.A EXCEPTIONS TO OUT-OF-STATE PRIOR AUTHORIZATION (PA) REQUESTS

The following are exempt from the out-of-state PA requirement:

1. All Medicare/MO HealthNet crossover claims;
2. All Foster Care children living outside the State of Missouri. However, nonemergency services that routinely require a PA continue to require a PA by out-of-state providers even though the service was provided to a Foster Care child;
3. Emergency ambulance services; and
4. Independent laboratory services.

13.6 PARTICIPANT COPAY

Participants eligible to receive certain MO HealthNet services are required to pay a small portion of the cost of the services. Services of the Durable Medical Equipment Program described in this manual are *not* subject to a copay amount.

13.7 GENERAL INFORMATION

The MO HealthNet Program reimburses qualified participating Durable Medical Equipment (DME) providers for certain DME items, such as: prosthetics; orthotics; respiratory care equipment; parenteral nutrition; ostomy supplies; wheelchairs and hospital beds, etc. These items *must* be for use in the participant's home when ordered in writing by the participant's physician or advanced practice nurse.

Although an item is classified as DME, it may *not* be covered in every instance. Coverage is based on the fact that the item is reasonable and necessary for treatment of an illness or injury, or to improve the functioning of a malformed or permanently inoperative body part, the equipment meets the definition of DME or prosthesis, and the equipment is used in the participant's home.

Even though a DME item may serve some useful medical purpose, consideration *must* be given by the physician and the DME supplier to what extent, if any, it is reasonable for MO HealthNet to pay for the item as opposed to another realistically feasible alternative pattern of care.

Consideration should also be given by the physician and the DME provider as to whether the item serves essentially the same purpose as equipment already available to the participant.

If two (2) different items each meet the need of the participant, the less expensive item *must* be employed, all other conditions being equal. Equipment features of an aesthetic or medical nature, which are *not* medically necessary, are *not* reimbursable.

~~13.7.A LIMITED BENEFIT PACKAGE~~ *(text del. 6/07)*

~~13.7.B DURABLE MEDICAL EQUIPMENT FOR PARTICIPANTS UNDER A HOME HEALTH PLAN OF CARE~~ *(text del. 6/07)*

~~13.7.C NURSING HOME PARTICIPANTS~~ *(text del. 6/07)*

13.8 DEFINITIONS

MO HealthNet is designed to assist participants in obtaining medical care. Reimbursement may be made for expenses incurred for durable medical equipment provided the conditions in the following subsections are met.

13.8.A DURABLE MEDICAL EQUIPMENT (DME)

DME is equipment that:

- can withstand repeated use;
- is primarily and customarily used to serve a medical purpose;
- is *not* useful to a person in the absence of an illness or injury; and
- is appropriate for use in the home.

All requirements of the definition *must* be met in order for the equipment to be covered under MO HealthNet.

13.8.B PARTICIPANT'S HOME

A participant's home *may* be:

- his/her own dwelling;
- an apartment;
- a relative's home; or
- a boarding home.

An institution may *not* be considered a participant's home if the institution:

- meets at least the basic requirements of a hospital; or
- meets the basic requirements of a nursing home.

13.9 PURCHASE OF DURABLE MEDICAL EQUIPMENT (DME)

The participant *must* be eligible for MO HealthNet at the time the equipment or device is delivered or obtained. Items purchased become the property of the participant.

Some items are covered by MO HealthNet as purchase items only, while others are rental items only. Refer to Section 19 to determine if the item to be dispensed can be purchased or rented.

13.9.A PURCHASE OF USED DURABLE MEDICAL EQUIPMENT (DME)

Used equipment is covered only if the item has been solely used by the participant; i.e. the participant previously rented the equipment.

13.9.B DELIVERY OF ITEMS COVERED UNDER THE DURABLE MEDICAL EQUIPMENT (DME) PROGRAM

Items that are covered under the DME Program *must* be dispensed to the participant before the provider bills MO HealthNet for the item. Holding equipment until MO HealthNet payment is received constitutes a payment for a service *not* provided and is in violation of State Regulation 13 CSR 70-3.030 (23).

All charges for delivery, pickup, shipping, freight, C.O.D. and handling are included in the MO HealthNet allowed reimbursement amount and are *not* paid for separately or billable to the participant.

13.9.C REPLACEMENT OF PURCHASED ITEMS

Replacement of purchased items covered under the DME Program that are medically necessary and are lost, stolen, destroyed or required because of a change in the participant's condition are covered. Items with restriction of pre-certification *must* contact the MHD call center. The call center is available Monday through Friday from 8:00 am to 5:00 pm, excluding state holidays. Items requiring a Prior Authorization (PA) Request form or Certificate of Medical Necessity *must* contain the following information:

- Explanation for continuing need of the item;
- How the item was lost or destroyed;
- Copy of the police report if the item was stolen or destroyed in an automobile accident, fire, etc.;
- Nature of the change in the participant's condition.

Replacement of items resulting from participant abuse or neglect is *not* covered and may be billed to the participant.

13.10 RENTAL OF DURABLE MEDICAL EQUIPMENT (DME)

The Certificate of Medical Necessity attachment or Prior Authorization (PA) Request form for equipment are reviewed in order to determine initially if the item should be purchased or rented based on the diagnosis and prognosis of the participant and the anticipated period of need prescribed by the participant's physician. Items requiring pre-certification utilizes a management tool to determine the same. If the period of need indicates that it is less expensive to purchase the equipment, MHD may elect to purchase the equipment. Likewise, if it is less expensive to rent the equipment, MHD may elect to rent the equipment. If necessary, the routing modifier or service modifier on the PA Request form is changed by the consultant. An explanatory message appears on

the disposition letter. Providers *must* request the purchase or rental of equipment based on the anticipated period of need.

13.10.A ELIGIBILITY DURING DURABLE MEDICAL EQUIPMENT (DME) RENTAL

If a participant is not eligible for MO HealthNet services during a portion of the rental month, rental is paid only for the days each month the participant is eligible. A message appears on the Remittance Advice that reflects the reason for the reduced payment. The participant is responsible for the non-eligible rental period.

~~13.10.B DME RENTAL REQUIREMENTS~~ *(text del. 6/06)*

13.10.C REACHING THE PURCHASE PRICE OF A DURABLE MEDICAL EQUIPMENT (DME) ITEM

When the rental payments reach the MO HealthNet allowed purchase price, the item becomes the property of the participant. A message appears on the Remittance Advice stating that the equipment has been purchased by MO HealthNet and is the property of the participant.

13.10.D REPLACEMENT OF RENTED DURABLE MEDICAL EQUIPMENT (DME) ITEMS

MO HealthNet does *not* reimburse the provider or the participant for the replacement of a rented DME item that is stolen, lost or destroyed.

13.10.E BILLING GUIDELINES FOR DURABLE MEDICAL EQUIPMENT (DME) RENTAL

When billing for the rental of a DME item, the from and to dates of the claim *must* always be completed. The units of service should always be "1," unless otherwise specified.

Once the Certificate of Medical Necessity has been submitted and approved, any claim submitted matching the information on the approved Certificate of Medical Necessity can be processed for payment. This includes all monthly claims for rental.

13.11 REPAIR OF DURABLE MEDICAL EQUIPMENT (DME)

Repair of participant-owned DME or prosthetic or orthotic device (whether purchased by MO HealthNet outright, purchased through rental payments or paid for by the participant) is covered if:

- The item to be repaired is a covered item under the DME Program.

- The repairs do *not* exceed 60% of the cost of a new piece of equipment, or orthotic or prosthetic device.
- The item is *not* under the provider's or manufacturer's warranty.
- The repairs are *not* required as a result of participant abuse.
- The participant is *not* in an institution unless the repair is for a custom or power wheelchair or augmentative communication, orthotic or prosthetic device.
- The equipment is *not* being rented.
- There is a continuing medical need for the equipment.
- The repairs are *not* a result of a defect in materials or workmanship.

Reimbursement for a repair is based on the reasonable charge for parts and the allowable reimbursement amount for labor.

13.11.A BILLING GUIDELINES FOR DURABLE MEDICAL EQUIPMENT (DME) REPAIR

The HCPCS code for the specific item along with the routing modifier, RB, *must* be used to bill when submitting a claim for repair of an item. If there is *not* a specific HCPCS code to use to bill the repair, the following repair codes may be used to bill for pieces and parts:

Z0160	Repair of equipment, replace or repair minor parts
L4210	Orthotic repair or replace minor parts
L7510	Prosthetic repair or replace minor parts

The amount of time required for the repair or modification may be billed under the following labor codes:

K0739	Repair or non-routine service for DME, other than oxygen equipment, requiring the skill of a technician, labor component, per 15 minutes
L4205	Repair of orthotic device, labor component, per 15 minutes
L7520	Repair of prosthetic device, labor component, per 15 minutes

List the actual time in the units field of the claim form in 15-minute increments.

A Certificate of Medical Necessity is required for most repair claims (refer to Section 19 for specific requirements). The Certificate of Medical Necessity may be submitted through the MO HealthNet Web Portal at www.emomed.com. Repairs under $500.00 do *not* require a physician's signature.

Medical necessity for replacement, a detailed description and the age of the item being repaired must be documented on the Certificate of Medical Necessity. If there is labor to be billed, a detailed explanation of the time involved must also be listed on the Certificate of Medical Necessity.

When billing for an approved repair, copies of the invoices showing the MSRP, or the invoice of cost, *must* be submitted with the claim form through the MO HealthNet Web Portal at www.emomed.com. Claims are manually priced at this time; *not* at the time of the approval of the Certificate of Medical Necessity.

13.12 WARRANTIES

When an orthotic device, prosthetic device or other equipment has been purchased, the following warranties *must* be provided by the provider, unless the manufacturer's warranty is for a greater length of time. If the manufacturer's warranty is less than the following, a statement from the manufacturer or copy of their printed policy *must* be submitted.

- 1 year for prosthetic devices
- 90 days for custom orthotics
- 30 days for standard braces
- 1 year for equipment such as walkers, wheelchairs, hospital beds, etc.

13.13 TRADE-IN OF DURABLE MEDICAL EQUIPMENT (DME)

When a DME item is traded in on a new item, the trade-in amount *must* be deducted from the purchase price and the reduced amount billed. An explanation *must* be noted on the Certificate of Medical Necessity or Prior Authorization (PA) Request form.

13.14 DURABLE MEDICAL EQUIPMENT (DME) PROGRAM REIMBURSEMENT GUIDELINES

- MO HealthNet payment is the lower of the provider's usual and customary charge to the general public or the MO HealthNet maximum allowed amount, less any third party resource.

- Sales tax is *not* covered by MO HealthNet, nor can it be billed to the participant. Providers should contact the Tax Administration Bureau on a regular basis to ensure that items covered under the DME Program are *not* subject to Missouri sales tax.

- Providers may *not* request or accept a deposit from a MO HealthNet participant and then refund it after payment is received from MO HealthNet. Accepting a deposit or portion of payment for services from a participant will only be allowed as outlined in State Regulation 13 CSR 70-4.040 and 13 CSR 70-4.050.

- Providers *must* accept the MO HealthNet payment as the full and complete payment and may *not* accept additional payment from the participant. Accepting a portion of payment for services from the participant is in violation of State Regulation 13 CSR 70-3.030.

- Charges for shipping, freight, C.O.D., handling, delivery and pickup are included in the reimbursement for items covered under the DME Program and are *not* billable to the MO HealthNet participant.

13.15 PAYMENT FOR CUSTOM-MADE ITEMS WHEN DELIVERY OR PLACEMENT CANNOT BE MADE PRIOR TO PARTICIPANT'S LOSS OF ELIGIBILITY OR DEATH

MO HealthNet payment may be made for custom-made items such as orthotics, prosthetics, custom wheelchairs and custom HCY equipment when the participant becomes ineligible (either through complete loss of MO HealthNet eligibility or change of assistance category to one for which the particular service is *not* covered) or dies after the item is ordered or fabricated and prior to the date of delivery or placement of the item.

13.15.A PREREQUISITE FOR PAYMENT OF CUSTOM-MADE ITEMS

The following prerequisites apply to all such payments:

- The participant *must* have been eligible when the service was first initiated (and following receipt of an approved Prior Authorization (PA) Request, if required) and at the time of any subsequent service, preparatory and prior to the actual ordering of fabrication of the device or item; and

- The custom-made device or item *must* have been fitted and fabricated to the specific medical needs of the user in such a manner so as to preclude its use for medical purpose by any other individual; and

- The custom-made device or item *must* have been delivered or placed if the participant is living; and
- The provider *must* have entered "see attachment" in Field #19 of the claim form and *must* have attached a provider-signed statement to the claim. The statement *must* explain the circumstances and include the date of actual delivery or placement for a living participant or the date of death when delivery or placement is *not* possible due to this reason. The statement *must* also include the total amount of salvage value, which the provider estimate is represented in case where delivery or placement is *not* possible.

13.15.B PAYMENT OF CUSTOM-MADE ITEMS AND DEVICES

a. If the item is received by the participant following loss of MO HealthNet eligibility or eligibility for the service, the payment is the lesser of the "net billed charge" or the MO HealthNet maximum allowable amount for the total service, less any applicable cost sharing or copayment.

b. If the item cannot be delivered or placed due to death of the participant, the payment is the lesser of the "net billed charge" or the MO HealthNet maximum allowable amount for the total service, less any applicable cost sharing or coinsurance. The "net billed charge" shall be the provider's usual and customary billed charge(s) as reduced by any salvage value amount.

- Salvage value exists whenever there is further profitable use that can be made by the provider of materials or components of the device or item. Dentures are an example of an item representing no reasonable salvage value, whereas a custom-made wheelchair may, in its components, represent salvage value. The salvage value *must* be clearly documented in the medical records.
- Any provider-determined retail salvage value of the unplaced or undelivered item *must* be subtracted by the provider from the charge for the item, and only the net reduced charge entered on the claim form line for the item. These items are subject to review as to salvage value adjustment represented in the billed charge.

c. The date of service that is shown on the claim form for the item (custom wheelchair, braces, etc.) when situation a. or b. applies *must* be the last date on which service is provided to the eligible participant (and following receipt of an approved PA, if required) prior to the ordering or fabrication of the item. The provider is responsible for verifying participant eligibility each time service is provided. Use of a date for which the

participant is no longer eligible for MO HealthNet coverage of the service results in a denial of the claim. The claim (with attachment) *must* be submitted to the fiscal agent in the same manner as other claims.

Payments made as described in a. or b. constitute the allowable MO HealthNet payment for the service, no further collection from the participant or other persons is permitted.

If the provider determines the participant has lost eligibility after the service is first initiated and before the custom-made item is actually ordered or fabricated, the participant *must* be immediately advised that completion of the work and delivery or placement of the item is *not* covered by MO HealthNet. It is then the participant's choice to request completion of the work on a private-payment basis. If participant death is the reason for loss of eligibility, the provider can, of course, proceed no further and there is no claim for the non-provided item of service.

If a participant refuses to accept the item/service, MO HealthNet does *not* reimburse the provider.

13.16 ITEMS/SERVICES INITIATED OR PRIOR AUTHORIZED BY THE STATE AGENCY PRIOR TO MO HEALTHNET MANAGED HEALTH CARE PLAN ENROLLMENT

Certain items and/or services that have been initiated or prior authorized by the MHD before the effective date in a MO HealthNet Managed Health Care plan are reimbursed on a fee-for-service basis by the state agency when placement occurs after MO HealthNet Managed Care enrollment is effective. The MHD is financially responsible for these items or services in accordance with the following:

- Augmentative communication devices and evaluations, prosthetic and orthotic devices that have been ordered, initiated or prior authorized prior to the enrollment effective date in the MO HealthNet Managed Care plan, but placement occurs after the effective date of the MO HealthNet Managed Care plan enrollment.
- Custom and power wheelchairs and custom HCY positioning equipment that have been prior authorized by MHD prior to the enrollment effective date in the MO HealthNet Managed Care plan, but placement occurs after the effective date of MO HealthNet Managed Care plan enrollment.

Providers *must* contact the Provider Communications Unit at (573) 751-2896 for instructions on how to bill for these items/services.

13.17 COVERAGE OF DURABLE MEDICAL EQUIPMENT (DME) FOR PARTICIPANTS IN A NURSING HOME

DME is *not* covered for those participants residing in a nursing home (place of service 12, 31 or 99 with level of care 1 or 2). DME is included in the nursing home per diem rate and *not* paid for separately with the exception of the following items:

- Augmentative Communication Devices and Accessories;
- Custom Wheelchairs;
- Power Wheelchairs;
- Orthotic and Prosthetic Devices;
- Total Parenteral Nutrition; and
- Volume Ventilators.

MO HealthNet requires all providers of custom and power wheelchairs provide equipment that meets the participant's needs for mobility and positioning in a cost-effective manner for participants in a nursing home. The Prior Authorization (PA) Request is denied if the chair is considered *not* medically necessary, if it is *not* a custom wheelchair or if a less expensive alternative wheelchair is available.

Supporting documentation for custom and power wheelchairs *must* be included with the PA Request. Section 1, Field #9 of the PA Request form *must* clearly list the name and address of the nursing home in which the participant resides.

13.17.A PRIOR AUTHORIZATION (PA) REQUESTS/LETTERS OF MEDICAL NECESSITY FOR CUSTOM OR POWER WHEELCHAIRS

When submitting a PA request for a custom or power wheelchair, there *must* be comprehensive written documentation submitted with the PA request. Letters of medical necessity and supporting documentation *must* be signed by the prescribing physician as well as the nursing home's director of nursing or the nursing home's employed or contracted licensed physical or occupational therapist (the physical or occupational therapist may have no financial relationship with the DME provider, except for hospital-based providers). In addition, letters of medical necessity generated by the supplier *must* be written on the supplier's letterhead and signed by both the supplier and the prescribing physician as well as the nursing home's director of nursing or the nursing home's

employed or contracted licensed physical or occupational therapist (the physical or occupational therapist may have no financial relationship with the DME provider, except for hospital-based providers).

Letters of medical necessity *must* clearly and specifically explain the following:

- The diagnosis/comorbidites and conditions relating to the need for a custom or power wheelchair;
- Description and history of limitations/functional deficits;
- Description of physical and cognitive abilities to utilize equipment;
- History of previous interventions/past use of mobility devices;
- Description of existing equipment, age and specifically why it is *not* meeting the participant's needs;
- Explanation as to why a less costly mobility device is unable to meet the participant's needs (i.e., cane, walker, manual wheelchair);
- Documentation and justification of medical necessity of recommended mobility device, accessories and positioning components;
- Documentation/explanation of participant's ability to safely tolerate/utilize the recommended equipment; and
- Documentation/explanation as requested by the State consultant.

13.17. B ASSISTIVE TECHNOLOGY PROFESSIONAL

Custom or power wheelchairs for participants residing in a nursing home *must* be supplied by a provider that employs a RESNA-certified Assistive Technology Professional (ATP) who specializes in wheelchairs. The ATP *must* have direct, in-person, face-to-face interaction and involvement in the wheelchair selection for the participant. The provider record should document how the ATP was involved and directed the wheelchair selection process.

13.17. C PHYSICIAN FACE-TO-FACE EVALUATION

For a custom or power wheelchair to be covered for a participant residing in a nursing home, a treating physician *must* conduct a face-to-face examination of the participant before writing an order for the custom or power wheelchair. Physicians shall document the face-to-face examination in a detailed narrative note in the participant's chart in the format they use for other entries. Supplier or facility created forms that the physician completes are *not* a

substitute for the comprehensive medical record/chart note indicated above. The physician face-to-face examination *must* provide information about the following elements but may include other details:

History of the present condition(s) and past medical history that is relevant to mobility needs:

- Symptoms that limit ambulation;
- Diagnoses that is responsible for symptoms;
- Progression of ambulation difficulty over time;
- Other diagnoses that may relate to ambulatory problems;
- Cardiopulmonary examination; and
- Weight and height.

Physical examination that is relevant to mobility needs:

- Existing ambulatory assistance (cane, walker, wheelchair, caregiver) that is currently being utilized;
- Ability to stand up from a seated position without assistance;
- Description of the ability to perform activities of daily living;
- Distance the participant can walk without stopping;
- Pace of ambulation;
- Musculoskeletal examination to include arm and leg strength and range of motion; and
- Neurological examination to include documentation of functional ambulation and balance and coordination.

The physician examination *must* be tailored to the individual participant's condition. The history *must* clearly illustrate the participant's functional abilities and limitations on a typical day. It *must* contain as much objective data as possible. The physical examination *must* be focused on the body systems responsible for the participant's ambulatory difficulty or impact the participant's ambulatory ability.

After the face-to-face visit with the physician, the physician may choose to refer the participant to a licensed physical or occupational therapist for completion of the physical portion of the exam. (The physical or occupational therapist may have no financial relationship with the DME provider, except for hospital-based providers.) There is no separate reimbursement outside the nursing home per diem for a physical or occupational therapy evaluation). A prior evaluation completed by a licensed physical or occupational therapist within the past 90 days may also be utilized for the physical portion of the exam. All areas noted above for the physical exam *must* be addressed. If utilized, the physical or occupational therapy exam *must* be reviewed by the physician after completion, agreed on or amended, and signed before issuing the physician order.

The face-to-face examination *must* be completed prior to any examination performed by the DME provider. The DME provider *must* receive the written report of this examination within 90 days after completion of the face-to-face physician examination.

A date stamp or equivalent *must* be used to document the date that the provider receives the report of the face-to-face physician examination. The written report of the physician examination *must* be submitted with the PA request.

13.17.D PHYSICIAN ORDER

When requesting a custom or power wheelchair for a nursing home participant, a physician order *must* be received by the DME provider within 90 days after completion of the face-to-face physician examination and prior to any DME provider evaluation. The physician order *must* contain all of the following:

- Participant's name;
- Description of the item that is ordered (may be general such as power wheelchair, manual wheelchair);
- Date of the face-to-face examination;
- Pertinent diagnoses/conditions that relate to the need for the custom or power wheelchair;
- Length of need; and
- Physician's signature;

Date of the physician signature. A date stamp or equivalent *must* be used to document receipt date.

13.17.E POWER WHEELCHAIRS AND ACCESSORIES FOR NURSING HOME PARTICIPANTS

In addition to the requirements above, requests for Group 2 power wheelchairs for nursing home participants *must*:

A. Document one of the following diagnoses:

1. Spinal cord injury resulting in quadriplegia or paraplegia (344.00-344.1);
2. Other spinal cord diseases (336.0-336.3);
3. Multiple Sclerosis (340);
4. Other demyelinating disease (341.0-341.9);
5. Cerebral Palsy (343.0-343.9);
6. Anterior Horn Cell Diseases including Amyotrophic Lateral Sclerosis (335.0-335.21, 335.23-335.9);
7. Post-polio paralysis (138);
8. Traumatic brain injury resulting in quadriplegia (344.09);
9. Spina Bifida (741.00-741.93);
10. Childhood cerebral degeneration (330.0-330.9);
11. Current stage II or greater pressure ulcer (707.03, 707.04, 707.05) on the area of contact with the seating surface (trunk, spine or pelvis) (*must* be noted and described by the physician in the face-to-face visit; justification *must* document what other types of skin protection measures have been utilized); or
12. Severe orthopedic abnormality of the hip, spine or pelvis significantly affecting positioning (*must* be documented by the physician in the face-to-face visit); and

B. Explain why a less costly mobility device is unable to meet the participant's needs including a description of equipment trials and their effectiveness.

Requests for Group 3 power wheelchairs will only be considered when the following criteria are met:

A. All criteria for a Group 2 power wheelchair are met;

B. Medical justification provides extensive documentation of why a Group 2 power wheelchair and other less costly devices will *not* meet the participant's needs;

C. Documentation includes the length of time the participant has resided in the nursing home; and

D. One of the following:

Documentation includes a copy of the discharge plan from the nursing home's participant record that clearly states the participant's discharge date is in the next 90 days to an independent or less restrictive living environment and that the participant will be involved in activities that require the client to utilize a wheelchair in the community on a frequent basis (e.g. work, shopping, self-transport to appointments). Supporting documentation from a physician, social worker or occupational therapist/physical therapist explaining the participant's discharge plans and mobility needs *must* accompany the discharge plan; or

The medical necessity justification provides clear documentation that the participant requires specialty controls other than a joy stick to independently operate the wheelchair.

The following equipment is *not* considered medically necessary for participants residing in a nursing home:

- Group 1 power wheelchairs;
- Group 4 power wheelchairs;
- Multiple power seat function (i.e., power tilt and recline); and
- Power elevating leg rests/lower extremity power articulating platform.

13.17.F COVERAGE OF CUSTOM WHEELCHAIRS FOR NURSING HOME PARTICIPANTS

MHD will reimburse for medically necessary custom wheelchairs for participants residing in a nursing facility. A custom wheelchair is defined as a chair that is tailor made for one

participant and cannot be used by anyone else. Prior authorization is required. All PA requests *must* indicate why a less costly wheelchair is unable to meet the participant's needs. Criteria A, B, and C below describes the criteria utilized for a wheelchair to be considered custom. Criteria for individual HCPCS codes are listed following criteria A, B and C below.

A. Any wheelchair with a custom seating system. A custom seating system is a wheelchair seating system which is individually made for a patient using a plaster model of a patient, a computer generated model of the patient (i.e. CAD-CAM technology), or the detailed measurements of the patient to create either: (a) a molded, contoured, or carved (foam or other suitable material) custom-fabricated seating system that is incorporated into the wheelchair base; or (b) a custom seating system made from multiple pre-fabricated components or a combination of custom fabricated materials and pre-fabricated components which have been configured and attached to the wheelchair base or incorporated into a wheelchair seat and/or back in a manner that the wheelchair could *not* be easily re-adapted for use by another individual.

   To qualify for a custom seating system, an individual *must* meet all the requirements of a custom fabricated seat cushion or a custom fabricated back cushion as described in Section 13.29.G of the Durable Medical Equipment provider manual. The PA request *must* document the following:

   1. Why a pre-fabricated system is *not* sufficient to meet the participant's seating and positioning needs;
   2. What orthopedic deformity is present and its fixed or flexible presentation;
   3. What altered muscle tone is present and its increased or decreased presentation that affects seating and positioning; and
   4. Why any existing system is *not* meeting the participant's seating and positioning needs.

B. A specially-sized or constructed wheelchair that is provided to a participant whose anatomical measurements require the following:

   1. Wheelchair seat width of 25 inches or more;
   2. Wheelchair with a weight capacity for 351 or more pounds; or
   3. Wheelchair with a seat to floor height of less than 15 1/2 inches.

C. A wheelchair for a participant who has absent or impaired sensation in the area of contact with the seating surface or inability to carry out a functional weight shift due to one of the following diagnoses or conditions:

1. Spinal cord injury resulting in quadriplegia or paraplegia (344.00 344.1);
2. Other spinal cord diseases (336.0-336.3);
3. Multiple sclerosis (340);
4. Other demyelinating disease (341.0-341.9);
5. Cerebral palsy (343.0-343.9);
6. Anterior horn cell diseases including amyotrophic lateral sclerosis (335.0-335.21, 335.23-335.9);
7. Post-polio paralysis (138);
8. Traumatic brain injury resulting in quadriplegia (344.09);
9. Spina bifida (741.00-741.93);
10. Childhood cerebral degeneration (330.0-330.9);
11. Current stage II or greater pressure ulcer (707.03, 707.04, 707.05) on the area of contact with the seating surface (trunk, spine or pelvis). Current stage II or greater pressure ulcer *must* be noted and described by the physician in the face-to-face visit; justification *must* document what other types of skin protection measures have been utilized; or
12. Severe orthopedic abnormality of the hip, spine or pelvis significantly affecting positioning. Any or all of these abnormalities *must* be noted and described by the physician in the documentation of the face-to-face visit.

HCPCS code specific requirements are as follows:

- Wheelchairs described by HCPCS codes K0001, K0002, and K0003 will *not* be considered custom wheelchairs.
- Wheelchairs described by HCPCS code K0004 may be considered custom if criterion A, B or C above is met. Documentation for K0004 *must* justify why a less costly device cannot be used.

- Wheelchairs described by HCPCS code K0005 may be considered custom if criterion A or B above is met along with one of the following diagnosis codes:
    1. Spinal cord injury resulting in quadriplegia or paraplegia (344.00-344.1);
    2. Other spinal cord diseases (336.0-336.3);
    3. Multiple Sclerosis (340);
    4. Other demyelinating disease (341.0-341.9);
    5. Cerebral Palsy (343.0-343.9);
    6. Anterior Horn Cell Diseases including Amyotrophic Lateral Sclerosis (335.0-335.21, 335-23-335.9);
    7. Post-polio paralysis (138);
    8. Traumatic brain injury resulting in quadriplegia (344.09);
    9. Spina Bifida (741.00-741.93);
    10. Childhood cerebral degeneration (330.0-330.9);
    11. Current stage II or greater pressure ulcer (707.03, 707.04, 707.05) on the area of contact with the seating surface (trunk, spine or pelvis) (*must* be noted and described by the physician in the face-to-face visit documentation; justification *must* document what other types of skin protection measures have been utilized); or
    12. Severe orthopedic abnormality of the hip, spine or pelvis significantly affecting positioning (*must* be noted and described by the physician in the face-to-face visit documentation).
- Documentation for a K0005 *must* justify why a K0004 and other less costly device cannot be used.
- Wheelchairs described by HCPCS code E1161 may be considered custom if criterion C above is met.
- Wheelchairs described by HCPCS codes K0006 and K0007 may be considered custom if two (2) of the requirements stated in criterion B above are met.

- Wheelchairs described by HCPCS code K0009 will generally be considered noncovered for participants residing in a nursing home. Requests for K0009 wheelchairs will only be considered in extenuating circumstances and when the following exists:

    A. Extensive documentation explaining why no other manual wheelchair (K0001-K0007) will meet the participant's needs; and

    B. The participant's anatomical measurements are provided and document the participant requires one of the following:

        - A wheelchair seat width of 25 inches or more; or
        - A wheelchair with a weight capacity of 351 or more pounds.

13.17.G WHEELCHAIRS AND OPTIONS/ACCESSORIES FOR NURSING HOME PARTICIPANTS

Mo HealthNet requires use of the item-specific HCPCS code for all wheelchairs and wheelchair option/accessories for nursing home participants. The modifier SC *must* be added to the HCPCS code along with the appropriate NU (purchase) or RR (rental) modifier.

All wheelchair bases, initial options/accessories, and upgrade options/accessories for participants residing in a nursing home require prior authorization.

PLEASE NOTE: MO HealthNet reimbursement for wheelchairs and wheelchair options/accessories for participants residing in a nursing home is limited to participant-owned custom or power wheelchairs. Custom wheelchairs *must* meet the definition of a custom wheelchair as defined in Section 13.17.F in the MO HealthNet Durable Medical Equipment provider manual. Reimbursement for all other manual wheelchairs and options/accessories is included in the nursing home per diem.

13.18 COVERAGE OF DURABLE MEDICAL EQUIPMENT (DME) FOR PARTICIPANTS IN A HOSPITAL

DME items dispensed to a participant while receiving inpatient or outpatient care is included in the hospital payment and *not* paid for separately under the DME Program.

A hospital, which is enrolled as a DME provider, cannot be paid through the DME Program for any item covered under the DME Program that is used for inpatient/outpatient care.

13.19 AUGMENTATIVE COMMUNICATION DEVICES (ACDs)

13.19.A AUGMENTATIVE COMMUNICATION DEVICE (ACD) DEFINITION

Augmentative Communication Devices (ACDs) are speech prostheses and are regarded as Durable Medical Equipment (DME). ACDs are alternative and supplemental communication equipment used to overcome or ameliorate an individual's inability to communicate due to a disease or medical condition that precludes or significantly interferes with the participant's participation in activities of daily living. Examples of ACDs are communication picture boards/books, speech amplifiers, speech enhancers and electronic devices that produce speech or written output. Related accessories such as overlays, batteries, wheelchair mounts, switches, cables, pointing devices, etc. are also considered. A portable or desktop computer is only considered when the primary use of the computer is the participant's communication device. Examples of noncovered items include, but are *not* limited to: printers, office/business software, software intended for academic purposes, Internet access and computer tables.

13.19.B ELIGIBILITY FOR AUGMENTATIVE COMMUNICATION EQUIPMENT

MHD reimburses for electronic or manual ACDs, regardless of the participant's age, when the device is deemed medically necessary through pre-certification. DME pre-certification criteria documents may be found at http://www.dss.mo.gov/mhd/cs/dmeprecert/pages/dmeprecert.htm. Refer to Section 13.31 for pre-certification guidelines.

The Manufacturer Suggested Retail Price (MSRP) is required for manually-priced procedure codes. Refer to Section 19 for specific procedure code restrictions. The MSRP should be submitted electronically with the claim. The attachment and completion of the MSRP instructions are available at www.emomed.com.

~~13.19.C PRIOR AUTHORIZATION REQUIREMENTS FOR AUGMENTATIVE COMMUNICATION DEVICES~~ *(text del. 02/11)*

13.19.D AUGMENTATIVE COMMUNICATION DEVICE (ACD) EVALUATION TEAM/SITE

For ACD team/sites currently enrolled as a speech-language pathologist, rehabilitation center or outpatient hospital but *not* previously approved by the Bureau of Special Health Care Needs (BSHCN) that wish to be considered as a MO HealthNet ACD evaluation team/site, contact the Provider Enrollment Unit via e-mail at: providerenrollment@dss.mo.gov.

Providers should state if they are currently enrolled as a MO HealthNet provider. Approval is given to speech-language pathologists, rehabilitation centers or outpatient hospitals that meet the following criteria:

- The ACD team/site leader *must* be a Missouri licensed speech-language pathologist who has a certificate of clinical competency from the American Speech-Language-Hearing Association.
- The speech-language pathologist *must* possess at a minimum two (2) years experience in the evaluation and selection of ACDs and *must* have expertise in the determination of which speech and specific ACD and strategies to use to maximize functional communication.
- In addition to the speech-language pathologist, team membership may include but is *not* limited to the following: Missouri licensed audiologist, educator, occupational therapist, physical therapist, physician, manufacturer's representative, social worker, case manager or a second speech pathologist. At least two (2) of these professionals *must* participate in the ACD evaluation. ACD team/site membership may change with each evaluation performed.
- The speech pathologist or any of the ACD team members may *not* be a vendor of ACDs or have a financial relationship with a vendor/manufacturer. This excludes the manufacturer's representative.

A description of the ACD team/site evaluation protocol as well as equipment available for an ACD evaluation *must* be submitted to MHD, Provider Enrollment Unit.

Approval is granted based on an ACD team evaluation concept and compliance with the requirements. The provider is notified in writing of any deficiencies. Approval may be granted upon correction of these deficiencies.

13.19.E AUGMENTATIVE COMMUNICATION EVALUATION FOR AUGMENTATIVE COMMUNICATION DEVICES (ACDs)

The ACD evaluation *must* be performed by a MO HealthNet approved ACD evaluation site. The ACD evaluation *must* be documented in the participant file and *must* include the following information:

- Medical diagnosis related to communication dysfunction leading to the need for an ACD;
- Current communication status and limitations;

- Speech and language skills, which *must* include prognosis for speech and/or written communication;
- Cognitive readiness for use of an ACD;
- Interactional/behavioral and social abilities both verbal and nonverbal;
- Cognitive, postural, mobility, sensory (visual and auditory), capabilities and medical status;
- Limitations of participant's current communication abilities without an ACD (if a device is currently in use, a description of the limitation of this device);
- Motivation to communication via use of an ACD;
- Residential, vocational, educational and other situations requiring communication;
- Participant's name, address, date of birth and MO HealthNet/MO HealthNet Managed Health Care plan ID number;
- ACD's ability to meet projected communication needs (e.g., ACD growth potential, how long it meets needs);
- Anticipated changes, modification or upgrades for up to two (2) years;
- Training plans;
- Plans for parental/caregiver training and support;
- Statement as to why prescribed ACD is the most appropriate and cost effective device. Comparison of the advantages, limitations and cost of alternative systems evaluated with the participant *must* be included; and
- Complete description of ACD prescribed including all medically necessary accessories or modification.

13.19.F MODIFICATION/REPLACEMENT/REPAIR OF AN AUGMENTATIVE COMMUNICATION DEVICE (ACD)

The initial prescription of an ACD should attempt to take into account all projected changes in a participant's communication abilities for at least two (2) years. However, if changes occur in participant needs, capabilities or potential for communication, necessary modifications/replacements may be considered.

Supporting documentation for the modification or replacement *must* include:

- Reevaluation of the participant by a MO HealthNet approved ACD evaluation team/site; and
- Changes in the participant's communication abilities that support the medical necessity/appropriateness of the requested changes.

If requesting a different ACD from the one currently being used by the participant, a new ACD evaluation by a MO HealthNet approved site *must* be performed. Pre-certification is required.

Replacement of an ACD is considered due to loss, non-repairable damage, or if the ACD is no longer functional. Pre-certification is required.

Routine repairs of an ACD *not* covered by warranty are covered. A Certificate of Medical Necessity *must* be submitted and *must* document the reason for the repair. The participant's physician *must* sign the Certificate of Medical Necessity if the repair is $500.00 and over. Battery replacement is considered a repair.

13.19.G RENTAL OF AN AUGMENTATIVE COMMUNICATION DEVICE (ACD)

Rental of an ACD is approved only if the participant's ACD is being repaired, modified or if the participant is undergoing a limited trial period (3 months) to determine appropriateness and ability to use the ACD. If a trial period (3 months) is recommended, the trial period and the subsequent purchase of an ACD require separate pre-certification. The treating speech-language pathologist *must* confirm the participant is utilizing the selected device daily and accurately in a variety of communication situations and demonstrates the cognitive and physical ability to effectively use the device during the trial period.

In addition to the modifier NU, new equipment, modifier NR, new when rented, will be assigned with the approved pre-certification for the purchase following the required trial period of an ACD. The DME provider *must* submit the appropriate procedure code with both NU and NR modifiers when billing the purchase of the device.

All rental payments are deducted from the MO HealthNet purchase price should the trial period indicate the need for purchase of the device. The combined reimbursement for each month of the trial period (3 months) and subsequent purchase is complete payment for the device.

~~13.20 DIABETIC SUPPLIES~~ *(text del. 6/06)*

13.21 EQUIPMENT

Canes, crutches, walkers, commodes, decubitus care equipment, hospital beds, bed side rails, bed pans, trapeze equipment, etc. are covered equipment. For specific equipment codes and billing requirements, refer to Section 19.

13.21.A MANUAL HOSPITAL BEDS

Manual hospital beds are reimbursed on a rent-to-purchase basis only and require pre-certification. Durable Medical Equipment (DME) pre-certification criteria documents may be found at http://www.dss.mo.gov/mhd/cs/dmeprecert/pages/dmeprecert.htm. Refer to Section 13.31 for pre-certification guidelines.

13.21.B SEMI-ELECTRIC HOSPITAL BED

Semi-electric hospital beds are reimbursed on a rent-to-purchase basis only and require pre-certification. DME pre-certification criteria documents may be found at http://www.dss.mo.gov/mhd/cs/dmeprecert/pages/dmeprecert.htm. Refer to Section 13.31 for pre-certification guidelines.

13.21.C TRAPEZE BAR

A trapeze bar is covered when the participant is bed confined and the device is needed to change body positioning or to get in and out of bed due to respiratory conditions or other medical reasons.

13.21.D MATTRESS AND SIDE RAILS

A mattress and/or side rails cannot be billed in addition to a hospital bed. Mattress and side rails may only be billed when the bed is owned by the participant or if needed for replacement.

Side rails may be covered if the participant is bed confined, disoriented, experiences vertigo, has a neurological disorder, or is paraplegic or quadriplegic.

13.21.E CANES AND CRUTCHES

Canes and crutches require pre-certification. DME pre-certification criteria documents may be found at http://www.dss.mo.gov/mhd/cs/dmeprecert/pages/dmeprecert.htm. Refer to Section 13.31 for pre-certification guidelines.

13.21.F COMMODES

Commodes require pre-certification. DME pre-certification criteria documents may be found at http://www.dss.mo.gov/mhd/cs/dmeprecert/pages/dmeprecert.htm. Refer to Section 13.31 for pre-certification guidelines.

13.21.G PATIENT LIFT (HYDRAULIC)

Hydraulic patient lifts are reimbursed on a rent-to-purchase basis only and require pre-certification. DME pre-certification criteria documents may be found at http://www.dss.mo.gov/mhd/cs/dmeprecert/pages/dmeprecert.htm. Refer to Section 13.31 for pre-certification guidelines.

Electric lifts are *not* covered.

13.21.H PRESSURE REDUCING SUPPORT SURFACES

Pressure reducing support surfaces, other than those listed below, require pre-certification. DME pre-certification criteria documents may be found at http://www.dss.mo.gov/mhd/cs/dmeprecert/pages/dmeprecert.htm. Refer to Section 13.31 for pre-certification guidelines.

Pressure reducing support surfaces such as a powered air flotation bed (low air loss therapy—E0193), powered pressure reducing mattresses, or air fluidized beds (E0194) are *not* covered under the HCY or DME Programs. These types of pressure reducing support surfaces may be requested through the Exceptions Process Program. Refer to Section 20, Exception Process, for requirements for consideration of coverage.

13.21.I COVERAGE CRITERIA FOR OSTEOGENESIS STIMULATOR, LOW INTENSITY ULTRASOUND, NON-INVASIVE (E0760NU)

Osteogenesis stimulators are covered for those participants who meet the DME pre-certified medical criteria. DME pre-certification criteria documents may be found at http://www.dss.mo.gov/mhd/cs/dmeprecert/pages/dmeprecert.htm. Refer to Section 13.31 for pre-certification guidelines.

Initial pre-certification is limited to the physician specified length of need up to a 3-month pre-certification. If the device continues to be medically necessary, subsequent pre-certification *must* be requested by the treating physician through the submission of a help ticket through CyberAccess[sm] or by contacting the MHD helpdesk at 800-392-8030.

The provider of the osteogenesis stimulator *must* assure that the participant utilizing the device is properly instructed in use of the device in support of the ordered treatment and is aware of and understands any emergency procedures regarding the use of the osteogenesis stimulator device. The provider *must* maintain written documentation in the participant's medical record regarding the instruction of use for the osteogenesis stimulator.

The device *must* be capable of producing a treatment log indicating the participant's use. This information *must* be available to MHD upon request.

The device is available as a rent-to-purchase item only and may only be supplied once in a lifetime.

13.22 HEALTHY CHILDREN AND YOUTH (HCY) EPSDT PROGRAM (FOR PARTICIPANTS 20 AND UNDER)

A medically necessary item or service that is normally noncovered that is identified as a result of a physician, or other health care professional visit or exam (interperiodic screen) may be covered for participants age 20 and under.

It is important to note that every MO HealthNet eligible child should have a complete HCY (EPSDT) screen. If the child has *not* had a full screen, the provider should refer the child for a full screen to be done at a later date. Refer to Section 9 for information about screening providers.

Refer to Section 19.1 for reimbursement guidelines, quantity limitations and specific restrictions for each HCY procedure code.

~~13.22.A AUTHORIZATION OF HCY ITEMS~~ *(text del. 2/11)*

13.22.B UNDER PADS, DIAPERS, BRIEFS AND PROTECTIVE UNDERWEAR/PULL-ONS

Underpads, diapers, briefs and protective underwear/pull-ons require pre-certification. Any combination of incontinence products is limited to 186 per month and will be pre-certified without the EP modifier. Claims submitted for quantities of 186 per month or less should exclude the EP modifier. For quantities exceeding 186 per month, justification of medical necessity *must* be submitted through a CyberAccess[sm] help ticket or a phone call to the help desk. If approved, pre-certification will include an EP modifier. Claims for quantities of greater than 186 per month should include the EP modifier. Durable Medical Equipment (DME) pre-certification criteria documents may be found at http://www.dss.mo.gov/mhd/cs/dmeprecert/pages/dmeprecert.htm. Refer to Section 13.31 for complete pre-certification guidelines.

Providers *must not* dispense any incontinence products unless the participant agrees replacement of the item is desired and necessary; no automatic shipping is allowed.

13.22.C RENT-TO-PURCHASE FOR CHEST WALL OSCILLATION DEVICES (E0483EPRR)

High frequency chest wall oscillation devices (E0483EPRR) are only covered for participants age 20 and under and are reimbursed on a rent-to-purchase basis only. If the device continues to be utilized and is medically necessary, it will be considered purchased after the total of all rental payments equals the purchase price. If the use of device is discontinued at any time, the provider *must* stop billing for the device.

Chest wall oscillation device rental (E0483EPRR) requires pre-certification. DME pre-certification criteria documents may be found at http://www.dss.mo.gov/mhd/cs/dmeprecert/pages/dmeprecert.htm. Refer to Section 13.31 for pre-certification guidelines.

~~13.22.C(1) Chest Wall Oscillation Device Criteria~~ *(text del. 2/11)*

13.22.D PULSE OXIMETER

13.22.D(1) Pulse Oximeter Reimbursement

Pulse oximeters are reimbursed on a rent-to-purchase basis. Pre-certification is required. DME pre-certification criteria documents may be found at http://www.dss.mo.gov/mhd/cs/dmeprecert/pages/dmeprecert.htm. Refer to Section 13.31 for pre-certification guidelines.

13.22.D(2) Pulse Oximeter Supplies

All oximeters that are rented include probes, cables, repair, education, maintenance and periodic downloading of recorded data, as requested by the participant's physician.

One (1) non-disposable probe per 12-month period or one (1) disposable probe per 60-day period is allowed per participant for pulse oximeters that have been purchased. A Certificate of Medical Necessity justifying the need for the replacement probe *must* be maintained in the file. The Certificate of Medical Necessity *must* also justify the use of disposable probes as opposed to non-disposable probes when disposable probes are utilized.

Providers *must not* just dispense supplies simply because the quantity limitations allow it. The participant *must* agree that replacement of supplies is desired and necessary; no automatic shipping of supplies is allowed. Billing for pulse oximeter probes above the quantity allowed as the usual maximum quantity, in the absence of documentation clearly explaining the medical necessity of the excess quantity, is denied as *not* medically necessary. A letter of justification from the participant's physician *must* be submitted with the claim form for probes in excess of those allowed.

13.22.E COUGH STIMULATING DEVICE

Cough stimulating devices are covered for participants age 20 and under and are reimbursed on a rent-to-purchases basis only. Pre-certification is required. DME pre-certification criteria documents may be found at http://www.dss.mo.gov/mhd/cs/dmeprecert/pages/dmeprecert.htm. Refer to Section 13.31 for pre-certification guidelines.

13.22.F CRANIAL REMOLDING ORTHOSIS

Cranial remolding orthosis, pediatric, rigid with soft interface material (S1040EPNU) is reimbursed as a purchase item only. A neurosurgeon and/or cranial facial team *must* prescribe use of the cranial remolding orthosis as an appropriate form of treatment for participants from birth through 12 months of age.

The orthotist providing the cranial orthosis *must* be trained and certified to evaluate, modify and dispense the cranial orthosis for proper fit. The fabricated cranial orthosis *must* have FDA 510(K) clearance.

Cranial remolding orthosis require pre-certification. Any replacement of the cranial orthosis due to growth during the post-operative period for the diagnosis of craniosynostosis will require a new pre-certification. DME pre-certification criteria documents may be found at http://www.dss.mo.gov/mhd/cs/dmeprecert/pages/dmeprecert.htm. Refer to Section 13.31 for pre-certification guidelines.

13.23 TOTAL PARENTERAL NUTRITION (TPN)

Total Parenteral Nutrition (TPN) is covered for participants with severe permanent disease of the gastrointestinal tract that prevents absorption of sufficient nutrients to maintain weight and strength.

The participant *must* have a condition involving the gastrointestinal tract that results in significant malabsorption. TPN is noncovered for conscious participants whose need for parenteral nutrition is

due to lack of appetite or a cognitive problem. The participant *must* require TPN to sustain life. Adequate nutrition *must not* be possible by dietary adjustment, oral supplements, or tube enteral nutrition.

TPN is covered under the Durable Medical Equipment (DME) Program for participants in a nursing home.

One (1) supply kit (B4220 or B4222) and one (1) administration kit (B4224) is covered for each day that parenteral nutrition is administered, when such kits are used and medically necessary.

When homemix TPN solutions are used the component carbohydrates amino acids, additives, and lipids are separately billable.

When premix TPN solutions are used there is no separate authorization for the carbohydrates, amino acids, or additives (vitamins, trace elements, heparin, electrolytes). However, lipids may be separately authorized with premix solutions. An invoice of cost is required when billing for B5200.

TPN procedure codes that are defined as one (1) unit equals one (1) day may be billed by date of service or by consecutive dates of service. Participant's receiving TPN on Monday, Wednesday and Friday *must* be billed by date of service while participants with daily infusions should be billed with from and through dates of service. The number of units billed *must* equal the number of days when billing consecutive from and through dates of service.

TPN procedure codes that are defined as one (1) unit equals 500 ml *must* be billed as such. These procedure codes should be billed on the date the item is initially dispensed regardless of the number of days it covers. Refer to Section 19 for TPN procedure codes and restrictions.

Parenteral nutrition infusion pump, portable or stationary, are reimbursed on a rent-to-purchase basis only. It will be considered purchased after the total of rental payments equals the purchase price. Refer to Section 19 for reimbursement guidelines. If use of the device is discontinued at any time, the provider *must* discontinue billing of the device.

TPN formula, supplies and infusion pump require pre-certification. DME pre-certification criteria documents may be found at http://www.dss.mo.gov/mhd/cs/dmeprecert/pages/dmeprecert.htm. Refer to Section 13.31 for pre-certification guidelines.

13.24 ORTHOTIC DEVICES

Orthotic devices are covered by MO HealthNet when prescribed by a physician (M.D. or D.O.) or a podiatrist (except for diabetic shoes and inserts). The orthotic device *must* be necessary and reasonable for the treatment of the participant’s illness or injury. It *must* be used to support a weak or

deformed body member, or restrict or eliminate motion in a diseased or injured part of the body. The orthotic device *must* be covered by MO HealthNet.

13.24.A ORTHOPEDIC SHOES

Orthopedic shoes, and modifications or additions to shoes, are covered only if they are an integral part of a brace, or the participant is diabetic or 20 years of age or under. "Integral" means that the shoes are necessary for completeness of the brace. A pair of shoes may be reimbursed even if only one (1) shoe is an integral part of a unilateral brace.

13.24.B SHOES FOR DIABETIC PARTICIPANTS

Shoes, inserts and and/or modifications for diabetic participants require pre-certification. Durable Medical Equipment (DME) pre-certification criteria documents may be found at http://www.dss.mo.gov/mhd/cs/dmeprecert/pages/dmeprecert.htm. Refer to Section 13.31 for pre-certification guidelines.

A modification of a custom molded or depth shoe may be covered as a substitute for an insert. Although *not* intended as a comprehensive list, the following are the most common shoe modifications: rigid rocker bottoms (A5503), roller bottoms (A5503), wedges (A5504), metatarsal bars (A5505) or offset heels (A5506). Other modifications of diabetic shoes (A5507) include, but are *not* limited to flared heels.

Quantities of shoes, inserts, and/or modifications greater than those allowed will be denied.

Inserts used in noncovered shoes are not covered.

Deluxe features of diabetic shoes (A5508) are not covered.

There is no separate reimbursement for certification of need or prescription of footwear, or for fitting of shoes, inserts, or modifications.

The particular type of footwear (shoes, inserts, modifications) which is necessary *must* be prescribed by a podiatrist or physician knowledgeable in the fitting of diabetic shoes and inserts. The footwear *must* be fitted and furnished by a podiatrist or other qualified individual, such as a pedorthist, orthotist or prosthetist.

The certifying physician provides the medical care for and manages the beneficiary's systemic diabetic condition. The certifying physician *must* be an M.D. or D.O. and may *not* be a podiatrist, physician assistant, nurse practitioner or clinical nurse specialist.

13.24.C SERVICES INCLUDED IN REIMBURSEMENT OF ORTHOTIC DEVICES

The following items are included in the MO HealthNet maximum allowable reimbursement for orthotic devices and are *not* reimbursed separately and may *not* be billed to the participant:

- Cost of the orthosis;
- Design of the orthosis;
- Required visits or fittings with the provider prior to receiving the orthosis; and
- Proper fitting of the orthosis.

13.24.D BILLING REQUIREMENTS FOR ORTHOTIC DEVICES

Refer to Section 19 for a list of covered orthotic procedure codes, the MO HealthNet maximum allowed amount and the billing guidelines for each procedure code.

13.25 OSTOMY SUPPLIES

Non-sterile ostomy supplies are covered for ostomates if prescribed by the participant's attending physician. Ostomy supplies are *not* covered for participants in a hospital or nursing home. Refer to Section 19 for a list of covered ostomy procedure codes, the MO HealthNet maximum allowed amount and the quantity limitations for each procedure code.

~~13.25.A COVERED OSTOMY SUPPLIES~~ *(text del. 6/06)*

13.25.B NONCOVERED OSTOMY SUPPLIES

The following ostomy supplies are *not* reimbursable under the Durable Medical Equipment (DME) Program:

Absorption Flakes, Absorption Pad, Aerszoin Spray, Allucotton Dressing, Benzoin Tincture, Carrying Case, Catheter Shields, Cellucotton, Chux, Cleansers, Covers, Cutting Tools, Deodorizers, Dilating Glove, Disposable Liners, Drain Eez, Drying Hanger, Drying Rack, Dusting Powder, Enema Bags, Fiberall, Filters, Finger Cots, Flanellets, Foxy Covers, Fresh Tales, Gauze Pads, Gauze Sponges, Germicide, Gloves, Hexon, Incontinent Pads, Lemon Hexon, Nitrazine Paper, Ostomy Skin Bond or Cement Remover, Oxy-Chinol Tablets, Ozium, Spray, Perma-Type, Post-Op Bags, Post-Op Pouches, Post-Op Sets, Skin Barrier Dispensers, Skin Conditioners, Soaking Tray, Spreader, Staphine Spray, Stericol Tablets, Sterile Gloves, Stoma Centering

Collars, Stoma Centering Guide, Surgical Sponges, Surge Pads, Syringes, Tape Dispensers, Toppers, Torbot Sanitizer, Travel Bag, Wash Bottle, and Waterproof Sheeting.

13.25.C BILLING AND REIMBURSEMENT OF OSTOMY SUPPLIES

An invoice of the provider's cost for manually-priced ostomy supplies *must* accompany each CMS-1500 claim for payment. The invoice *must* be legible, include the price that was paid for the ostomy supply, and document the quantity in a box or case. Manually-priced ostomy supplies are reimbursed at the provider's cost plus 20%.

13.26 OXYGEN AND RESPIRATORY EQUIPMENT

Oxygen and respiratory equipment is covered for home use when it is determined to be medically necessary and appropriate and prescribed by the participant's attending physician.

13.26.A OXYGEN

Home oxygen therapy is covered for participants who meet the Durable Medical Equipment (DME) pre-certified medical criteria. DME pre-certification criteria documents may be found at http://www.dss.mo.gov/mhd/cs/dmeprecert/pages/dmeprecert.htm. Refer to Section 13.31 for pre-certification guidelines.

If a participant travels out of their provider's usual service area, it is the participant's responsibility to arrange for oxygen during that time period. MO HealthNet will only pay one (1) provider for oxygen during any one (1) rental month.

13.26.A(1) Certification Requirements

Certification of the need for oxygen therapy will be completed when the authorized prescriber requests pre-certification as indicated below.

- The blood gas study reported for initial certification requests *must* be the most recent study obtained prior to the pre-certification request. This blood gas study *must* be obtained within 30 days prior to the date of the pre-certification request.
- For participants age 21 and older initially meeting criteria in Group I of the medical criteria document and for children meeting criterion 3A of the medical criteria document, the most recent qualifying blood gas study prior to the thirteenth month of therapy *must* be reported on the recertification request. Recertification of Group I participants is required

12 months after the initial certification. If the participant is *not* seen and reevaluated within 90 days prior to recertification, but is subsequently seen, payment may be made for dates of service between the scheduled recertification date and the physician visit date. No additional certification will be required after the 12-month recertification.

- For participants age 21 and older initially meeting criteria in Group II of the medical criteria document, the most recent blood gas study which was performed between the 61st and 90th day following the initial certification *must* be reported on the recertification request.
- Recertification of Group II participants is required every three (3) months. Any Group II participant who meets Group I criteria on recertification will be subject to Group I recertification requirements. If a qualifying test is *not* obtained between the 61st and 90th day of home oxygen therapy, but the participant continues to use oxygen and a test is obtained later, and if that test meets Group I or II criteria, coverage resumes with the date of that test.
- The participant *must* be seen and evaluated by the treating physician within 30 days prior to the date of the initial certification request. The participant *must* be seen and reevaluated by the treating physician within 90 days prior to any recertification.
- For any revised certification, the blood gas study reported on the revised certification request *must* be the most recent test performed prior to the revised date.
- A revised certification is required when there is a change in the type of oxygen delivery system or there is the addition of a portable system to a stationary system.

A revised oxygen therapy certification *must* be filed when the prescribed maximum flow rate changes from one of the following categories to another: (a) less than one (1) Liter Per Minute (LPM); (b) one (1) to four (4) LPM; (c) greater than four (4) LPM. If the change is from category (a) or (b) to category (c), a repeat blood gas study with the participant on four (4) LPM *must* be performed within 30 days prior to the start of the greater than four (4) LPM flow rate.

13.26.A(2) Testing Specifications

The qualifying blood gas study *must* be performed by a physician or a qualified provider of laboratory services. Blood gas studies performed by a provider of oxygen equipment are *not* acceptable. In addition, the qualifying blood gas study may *not* be paid for by any provider of oxygen equipment.

For sleep oximetry studies, the oximeter provided to the participant *must* be tamper-proof and *must* have the capability to download data that allows documentation of the duration of oxygen desaturation below a specified value.

When oxygen therapy meets criteria based on an oxygen study obtained during exercise, there *must* be documentation of three (3) oxygen studies in the participant's medical record – i.e., testing at rest without oxygen, testing during exercise without oxygen, and testing during exercise with oxygen applied (to demonstrate the improvement of the hypoxemia).

The qualifying blood gas study may be performed while the participant is on oxygen as long as the gas values meet the Group I or Group II criteria.

13.26.A(3) Modifier

The monthly payment amount for stationary oxygen is subject to adjustment depending on the gen prescribed (liters per minute or LPM) and whether or *not* portable oxygen is also prescribed.

If a participant qualifies for additional payment for greater than four (4) LPM of oxygen and also meets the requirement for portable oxygen, payment will *not* be made for the portable oxygen. The provider *must* use the QF modifier on the stationary code.

The following modifiers *must* be used when billing oxygen for a participant who requires more than four (4) LPM:

- QF – greater than four (4) LPM and portable oxygen is prescribed
- QG – greater than four (4) LPM

13.26.A(4) Oxygen Contents

Oxygen contents (stationary and portable) are *not* billable with any type of oxygen system rental (i.e., if participant owns stationary but rents portable all

contents are included in the rental of the portable; if the participant owns the portable and rents the stationary all contents are included in the stationary rental).

13.26.A(5) Oxygen Therapy *Not* Covered

1. Angina pectoris in the absence of hypoxemia.
2. Dyspnea without cor pulmonale or evidence of hypoxemia.
3. Severe peripheral vascular disease resulting in clinically evident desaturation in one (1) or more extremities but in the absence of systemic hypoxemia. There is no evidence that increased PO2 will improve the oxygenaton of tissues with impaired circulation.
4. Terminal illnesses that do *not* affect the respiratory system.

~~**13.26.B OXYGEN AND RESPIRATORY EQUIPMENT MEDICAL JUSTIFICATION (OREMJ) FORM** ***(text del. 2/11)***~~

13.26.C OXYGEN SUPPLIES, MAINTENANCE AND REPAIR

Cannulas, masks, or any supply used with an oxygen concentrator, portable or stationary oxygen system is included in the monthly rental of that device and is *not* paid for separately.

Delivery, set-up, maintenance and repair fees are also included in the monthly rental reimbursement and are *not* paid for separately.

~~**13.26.D LIQUID OXYGEN** **(*text del. 2/11*)**~~

~~**13.26.E COMPRESSED GAS TANKS** ***(text del. 6/07)***~~

13.26.F PORTABLE OXYGEN SYSTEMS

Portable oxygen systems are only covered for participants when:

- The qualifying ABG/oximetry testing is performed at rest or exercise; and
- There is a physician prescription for portable oxygen.
- The provider record *must* include a description of the activities or exercise routine (e.g., amount and frequency of ambulation) that the participant undertakes on a regular basis, and that requires the portable system in the home (i.e., the documentation *must* describe the medical therapeutic purpose to be served by the portable system that cannot be met by a stationary system).

13.26.G VENTILATOR

A volume ventilator or pressure support ventilator may be covered by MO HealthNet if prescribed and pre-certified by the participant's attending physician. DME pre-certification criteria documents may be found at http://www.dss.mo.gov/mhd/cs/dmeprecert/pages/dmeprecert.htm. Refer to Section 13.31 for pre-certification guidelines.

The monthly reimbursement includes **but is *not* limited to the following:**

- All Circuits, Brackets and Filters
- Ambu Bag
- Batteries and Battery Charger
- Cleaning Solution and Supplies
- Initial Set-Up and Participant Training
- Maintenance of the Ventilator
- Professional Support
- Sterile Water
- All Trach Care Supplies
- Tubing
- Ventilator Unit

Non-invasive ventilators such as BiPap ST may *not* be billed under the ventilator code.

Equipment that may be billed in addition to a ventilator when medically appropriate and necessary are:

- Humidifiers;
- Oxygen, Oxygen Concentrators and Oxygen Delivery Systems; or
- Suction Pumps.

Ventilators are covered for participants residing in a nursing home.

13.26.H BACK-UP VENTILATOR

A back-up ventilator may be covered if a volume or pressure support ventilator has been previously pre-certified and the participant requires ventilation 24 hours per day. The monthly rental reimbursement shall include all items, supplies and services as listed for the ventilator.

For participants residing in a nursing home, a back-up ventilator is included in the nursing home per diem rate and is *not* paid separately.

A back-up ventilator requires pre-certification. DME pre-certification criteria documents may be found at http://www.dss.mo.gov/mhd/cs/dmeprecert/pages/dmeprecert.htm. Refer to Section 13.31 for pre-certification guidelines.

13.26.I NEBULIZER, COMPRESSOR, SUCTION PUMP AND IPPB

Delivery, set-up, maintenance, pick-up and repair are included in the monthly rental reimbursement and are *not* reimbursed separately. All supplies, with the exception of disposable breathing circuits (A4618) for an IPPB, are also included in the monthly rental reimbursement and are *not* reimbursed separately.

Two (2) nebulizer kits per month are allowed for participant-owned equipment. Additional supplies for participant-owned equipment are *not* covered under the DME Program.

For respiratory equipment that has been purchased through monthly rental payments or has been purchased outright, supplies for this equipment, with the exception of a nebulizer kit, may be requested through the Exceptions Process. Refer to Section 20 for Exception Process instructions.

Nebulizers, compressors and suction pumps require pre-certification. DME pre-certification criteria documents may be found at http://www.dss.mo.gov/mhd/cs/dmeprecert/pages/dmeprecert.htm. Refer to Section 13.31 for pre-certification guidelines.

~~13.26.J PULMONARY FUNCTION TEST (PFT)~~ *(text del. 6/06)*

13.26.K APNEA MONITOR

Apnea monitors are defined as cardiorespiratory monitoring devices capable of providing continuous or periodic two-channel monitoring of heart rate and respiratory rate an *must* meet current Food and Drug Administration (FDA) guidelines for products in this class. Apnea monitors *must* have alarming mechanisms to alert care givers of cardiorespiratory

distress or other events which require immediate intervention and *must* be capable of recording and storing events and of providing event recording downloads or printouts of such data.

Apnea monitors may be authorized for infants. An infant is described as a child whose age ranges from birth to 12 months of age. Infant Cardiopulmonary Resuscitations (CPR) training of caregivers by certified trainers is recommended.

The following diagnosis or conditions alone are *not* indications for monitoring, and are ***not*** covered:

1) Seizure disorders (without life threatening events);
2) Hydrocephalus, uncomplicated;
3) Mental Retardation;
4) Irreversible terminal conditions;
5) Congenital heart defects, with or without associated arrhythmias;
6) Distant family history of apnea or SIDS (other than an immediate sibling);
7) History of apnea monitor use with other siblings;
8) History of apnea with other sibling(s);
9) Parental anxiety or family member request of a monitor; and
10) Monitoring of blood oxygen saturation.

Apnea monitors require pre-certification. DME pre-certification criteria documents may be found at http://www.dss.mo.gov/mhd/cs/dmeprecert/pages/dmeprecert.htm. Refer to Section 13.31 for pre-certification guidelines.

13.26.K(1) Apnea Monitor Reimbursement

Apnea monitors are reimbursed on a rental basis. The maximum months of rental which may be reimbursed for an apnea monitor is limited to a total of 12 months. Pre-certification is required for months one (1) through four (4). Additional pre-certification is required for months five (5) through 12. For the appropriate procedure code, reference Section 19.

All supplies such as electrodes, wires and belts are included in the monthly rental reimbursement and are *not* reimbursed separately. Repair, maintenance, initial set-

up, event recording, pnuemogram and professional support are also included in the monthly rental reimbursement.

~~**13.26.K(2) Coverage For Apnea Monitor Beyond Initial Four Months** *(text del. 2/11)*~~

13.27 RESPIRATORY ASSIST DEVICES (RAD) AND CONTINUOUS POSITIVE AIRWAY PRESSURE (CPAP) DEVICES

Any RAD or CPAP device that has been rented by MO HealthNet for 12 or more months is considered purchased. No further rental payments are made and providers may only bill for supplies and repairs needed for continued use after the initial 12-month rental period. If utilization of the RAD or CPAP device is discontinued at any time, the provider *must* stop billing for the equipment, related accessories and supplies.

RAD and CPAP devices require pre-certification. Durable Medical Equipment (DME) pre-certification criteria documents may be found at http://www.dss.mo.gov/mhd/cs/dmeprecert/pages/dmeprecert.htm. Refer to Section 13.31 for pre-certification guidelines.

13.27.A COVERAGE FOR A CONTINUOUS POSITIVE AIRWAY PRESSURE (CPAP) DEVICE (E0601RR)

A single-level CPAP device (E0601RR) may be covered if the participant has a diagnosis of Obstructive Sleep Apnea (OSA) documented by an attended, facility-based polysomnogram and is pre-certified.

Polysomnographic studies *must* be performed in a facility-based sleep study laboratory and *not* in the home and may *not* be performed by a DME provider. Portable multi-channel home sleep testing devices are also *not* acceptable.

13.27.B CONTINUED COVERAGE FOR A CONTINUOUS POSITIVE AIRWAY PRESSURE (CPAP) DEVICE BEYOND THE FIRST THREE (3) MONTHS (E0601KJRR)

Continued coverage for a CPAP device beyond the first three (3) months of therapy requires that, no sooner than the 61st day after initiating therapy, the DME provider ascertain from either the participant or the treating physician that the participant is continuing to use the CPAP device. This information *must* be documented in the DME provider's record. If this criterion is met, pre-certification *must* be obtained and services should be billed utilizing the KJ modifier.

If the above criterion is *not* met, continued rental coverage of the device is *not* approved.

13.27.C COVERAGE FOR A RESPRIATORY ASSIST DEVICE (RAD) (E0470 AND E0471) FOR THE FIRST THREE (3) MONTHS OF THERAPY

The treating physician *must* be qualified by virtue of experience and training in non-invasive respiratory assistance to order and monitor use of a RAD. Physicians who treat participants for other medical conditions may or may *not* be so qualified, and if *not*, though they may be the treating physician of the participant for other conditions, they are *not* considered the treating physician for the prescribing of Non-invasive Positive Pressure Respiratory Assistance (NPPRA) therapy.

In order for a RAD (E0470 or E0471) to be covered, the treating physician *must* fully document in the participant's medical record symptoms characteristic of sleep-associated hypoventilation, such as daytime hypersomnolence, excessive fatigue, morning headache, cognitive dysfunction, dyspnea, etc, in addition to a copy of the polysomnogram.

A RAD (E0470or E0471) used to administer NPPRA therapy is covered for participants with clinical disorder groups characterized as restrictive thoracic disorders (i.e., progressive neuromuscular diseases or severe thoracic cage abnormalities), severe Chronic Obstructive Pulmonary Disease (COPD), Central Sleep Apnea (CSA) or OSA (E0470 only), and participants that meet criteria in the DME pre-certification criteria document.

Polysomnographic studies *must* be performed in a facility-based sleep study laboratory and *not* in the home and may *not* be performed by a DME provider. Portable multi-channel home sleep testing devices are also *not* acceptable.

13.27.D CONTINUED COVERAGE CRITERIA FOR A RESPIRATORY ASSIST DEVICE (RAD) BEYOND THE FIRST THREE (3) MONTHS OF THERAPY

Participants covered for the first three (3) months of a RAD without a backup rate feature (E0470) or a RAD with a backup rate feature (E0471) *must* be reevaluated to establish the medical necessity of continued coverage by MO HealthNet. While the participant may certainly need to be evaluated at earlier intervals after therapy is initiated, the reevaluation upon which MO HealthNet will base a decision to continue coverage beyond this time *must* occur no sooner than 61 days after initiating therapy by the treating physician. MO HealthNet will *not* continue coverage for the 4th and succeeding months of NPPRA therapy until this reevaluation has been completed.

Continued coverage for RAD beyond the first three (3) months of therapy requires additional pre-certification. If the medical criteria is met, services should be billed utilizing the KJ modifier for months four (4) through 12.

~~**13.27.D(1) RAD With A Backup Rate Feature (E0471) Coverage For COPD Diagnosis** *(text del. 2/11)*~~

13.27.E SUPPLIES FOR RESPIRATORY ASSIST DEVICES (RADs) AND CONTINUOUS POSITIVE AIRWAY PRESSURE (CPAP) DEVICES

Supplies used with RAD and CPAP devices are covered when the coverage criteria for the device is met. If the coverage criteria are *not* met, the supplies are *not* covered. Supplies, repairs and maintenance are included in the first 12 months of rental reimbursement and are *not* reimbursed separately. Providers *must not* dispense supplies simply because the quantity limitations allow. The participant *must* agree that replacement of supplies is desired and necessary; no automatic shipping of supplies is allowed.

The supplies provided *must* be based on the type of delivery system the participant utilizes. Supplies billed that are inconsistent with the delivery system utilized by the participant are subject to denial or recoupment.

Procedure codes A7044 (oral interface used with positive airway pressure device, each) and A7045 (exhalation port with or without swivel used with accessories for positive airway devices, replacement only) are covered up to one every 180 days; however, these items are rarely needed.

A non-heated (E0561) or heated humidifier (E0562) is covered separately when ordered by the treating physician and pre-certified for use with a covered BIPAP device. A replacement water chamber for a humidifier used with a positive airway pressure device (A7046) may also be covered (a maximum of one per 180 days) when this replacement item is medically necessary.

13.28 PROSTHETIC DEVICES

Prosthetic devices (excluding dentures, hearing aids and artificial eyes) are covered by MO HealthNet when prescribed by a physician (M.D./D.O) and when the device replaces all or a portion of the function of a permanently inoperative or malfunctioning body member.

13.28.A PROSTHETIC SOCKS AND SHEATHS

Prosthetic socks and sheaths are limited to six (6) socks and sheaths per limb per participant per 12-month period.

13.28.B MASTECTOMY BRAS AND BREAST PROSTHESIS

Mastectomy bras are limited to three (3) per year, per participant.

Silicone breast prostheses are limited to one (1) per side, every 24 months. Form prostheses are limited to one (1) per side every six (6) months.

Mastectomy bras and breast prosthesis require pre-certification. Durable Medical Equipment (DME) pre-certification criteria documents may be found at http://www.dss.mo.gov/mhd/cs/dmeprecert/pages/dmeprecert.htm. Refer to Section 13.31 for pre-certification guidelines.

The modifier LT (left) or RT (right) along with the appropriate procedure code *must* be used when submitting a claim for a breast prosthesis. If filing for a bilateral prosthesis, bill on two (2) separate lines of the claim form.

13.28.C SERVICES INCLUDED IN REIMBURSEMENT

The following items/services are included in the MO HealthNet maximum allowable reimbursement for a prosthetic device:

- Cost of the prosthesis;
- Design of the prosthesis;
- Required visits or fittings with the provider prior to receiving the prosthesis;
- Proper fitting of the prosthesis;
- All necessary post-fitting and adjustment visits for one (1) year after receiving the prosthesis;
- Necessary modifications for one (1) year after receiving the prosthesis, unless the required because of physical growth or excessive stump shrinkage; and
- One-year warranty to cover defects in materials and workmanship.

Refer to Section 19 for a complete list of covered prosthetic codes, the MO HealthNet maximum allowed amount and the billing guidelines for each procedure code.

~~13.28.D BILLING REQUIREMENTS FOR PROSTHETIC DEVICES~~ *(text del. 6/06)*

13.29 WHEELCHAIRS

Standard, power and custom wheelchairs are covered by MO HealthNet when determined to be medically appropriate and necessary and is prescribed by the participant's attending physician.

13.29.A STANDARD WHEELCHAIRS

Standard wheelchairs are covered when the participant's condition is such that the alternative is chair or bed confinement. A Certificate of Medical Necessity is required for the purchase or rental of a manual wheelchair. Refer to Section 19 for a complete list of covered codes and the MO HealthNet maximum allowed amount.

13.29.A(1) Manual Wheelchair Basic Equipment Package

Manual wheelchairs are required to include certain items as part of the basic equipment package. There is no separate reimbursement for these items at the time of initial issue.

To keep in alignment with Medicare guidelines, below is a list of items included in the basic equipment package for manual wheelchairs.

- Seat width: 15"-19"
- Seat depth: 15"-19"
- Calf rests
- Wheel lock assembly
- Hand rims
- Upholstery
- Bearings
- Complete set of tires and casters (with the exception of the items listed below that can be billed separately)
    - Insert for pneumatic propulsion tire (removable), any type
    - Foam-filled propulsion tire, any size
    - Foam-filled caster tire, any size
    - Foam propulsion tire, any size

- Foam caster tire, any size
- Front caster assembly with solid tire

- Armrests: fixed, swingaway or detachable; fixed height
- Footrests: fixed, swingaway or detachable

13.29.B POWER WHEELCHAIRS

Power mobility devices are covered by MO HealthNet if prescribed by the participant's attending physician and prior authorized. The participant's condition is such that a power mobility device is medically appropriate and necessary and the participant is unable to propel a manual wheelchair.

13.29.B(1) Power Wheelchair Basic Equipment Package

Power wheelchairs are required to include certain items as part of the basic equipment package. There is no separate reimbursement at the time of initial issue for these items unless otherwise noted.

To keep in alignment with Medicare guidelines, below is a list of the items included in the basic equipment package for power wheelchairs.

- Lap belt or safety belt (shoulder harness/straps or chest straps/vest may be billed separately)
- Battery charger
- Complete set of tires and casters, any type
- Leg rests (no separate reimbursement if fixed, swingaway, or detachable non-elevating leg rests with or without calf pad are provided, elevating leg rests may be billed separately)
- Footrests/foot platform (no separate reimbursement if fixed, swingaway or detachable footrests or a foot platform without angle adjustment are provided)
- Angle adjustable footplates (no separate reimbursement for Group 1 or 2 power wheelchairs, angle adjustable footplates may be billed separately for Group 3, 4 and 5 power wheelchairs)

- Armrests (no separate reimbursement if fixed, swingaway, or detachable non-adjustable height armrests with arm pad are provided, adjustable height armrests may be billed separately)
- Weight specific components (braces, bars, upholstery, brackets, motors, gears, etc. as required by participant weight capacity)
- Any seat width and depth (with the exception of the list of items below that may be billed separately for Group 3 and 4 power wheelchairs with a sling/solid seat/back)
    - For Standard Duty, seat width and/or depth greater than 20 inches
    - For Heavy Duty, seat width and/or depth greater than 22 inches
    - For Very Heavy Duty, seat width and/or depth greater than 24 inches
    - For Extra Heavy Duty, no separate billing
- Any back width (with the exception of the items listed below for Group 3 and 4 power wheelchairs with a sling/solid seat/back that may be billed separately)
    - For Standard Duty, back width greater than 20 inches
    - For Heavy Duty, back width greater than 22 inches
    - For Very Heavy Duty, back width greater than 24 inches
    - For Extra Heavy Duty, no separate billing
- Controller and Input device. There is no separate billing/reimbursement if a non-expandable controller and a standard proportional joystick (integrated or remote) is provided. An expandable controller, a non-standard joystick (i.e., nonproportional or mini, compact or short throw proportional), or other alternative control device may be billed separately.

Non-standard seat dimensions and non-standard back dimensions should be billed with code K0108. No separate billing at the time of initial issue is to be submitted for these items unless otherwise noted.

13.29.C POWER WHEELCHAIR ACCESSORIES

Wheelchair accessories for power chairs *must* be billed under the specific code(s). If there is no specific code(s), K0108 may be used. K0108 may only be listed one (1) time on the Prior Authorization (PA) Request form.

13.29.C(1) Power-Operated Vehicle (Scooters) Basic Equipment Package

Power-operated vehicles (scooters) are required to include certain items as part of the basic equipment package. There is no separate reimbursement for these items at the time of initial issue.

To keep in alignment with Medicare guidelines, below is a listing of the items included in the basic equipment package for power-operated vehicles.

- Battery or batteries required for operation
- Battery charger
- Weight appropriate upholstery and seating system
- Tiller steering
- Non-expandable controller with proportional response to input
- Complete set of tires
- All accessories needed for safe operation
- All options and accessories are included in the initial issue.

13.29.D WHEELCHAIR BATTERIES

Providers may bill up to a half-hour of labor under K0739 when billing for the replacement of batteries.

13.29.E CUSTOM WHEELCHAIRS

A custom wheelchair is defined as a chair that is tailor made for one (1) participant and cannot be used by anyone else. Custom wheelchairs and accessories are covered if prescribed by the participant's attending physician and prior authorized.

Custom wheelchairs are covered for participants in a nursing home when certain criteria are met. Refer to Section 13.17 for additional nursing home guidelines.

13.29.F WHEELCHAIR ACCESSORIES *NOT* OTHERWISE LISTED

Procedure code K0108 may only be used in the following circumstances and always requires prior authorization.

- When there is no specific accessory code(s) for the wheelchair accessory to be dispensed for custom or standard wheelchairs.

13.29.F(1) Wheelchair Option/Accessory Replacement And Repair

The following are claim filing requirements for replacement of wheelchair options/accessories.

- The appropriate HCPCS code for the specific option/accessory *must* be billed. The routing modifier, RB, *must* always be used when the accessory is a replacement for the same part. The RB modifier and the SC modifier *must* be used for participants residing in a nursing home.
- The procedure code Z0160RB or Z0160RBSC may be used for replacement items that do *not* have a HCPCS code and have an MSRP of $500 or less. Items with an MSRP greater than $500 *must* be prior authorized utilizing procedure code K0108RB and K0108RBSC.
- Items that are new additions or upgrades to a wheelchair *must not* be billed with the RB modifier. The RB modifier is only utilized for replacement of existing options/accessories.
- Labor required for replacement of an option or accessory, or repair of a wheelchair maybe billed under the procedure code K0739RB or K0739RBSC (Repair or non-routine service for DME, other than oxygen, requiring the skill of a technician, labor component, per 15 minutes). One unit of labor is equal to 15 minutes of time.
- A Certificate of Medical Necessity is required for most option/accessory replacement codes and labor code. The labor code and option/accessory codes should be included on the same Certificate of Medical Necessity. The Certificate of Medical Necessity *must* document the following:
    - Make and model name of the wheelchair;
    - The initial date of service for purchase of the wheelchair;

- Medical necessity for replacement for each option/accessory code; and
- An explanation of the time involved.

13.29.G WHEEL CHAIR SEAT AND BACK CUSHIONS

MO HealthNet utilizes the following coverage criteria when reviewing PA requests for wheelchair seat and back cushions.

A general use seat cushion (E2601, E2602) and a general use wheelchair back cushion (E2611-E2612) may be covered for a participant who has a manual wheelchair or who has a power wheelchair with a sling/solid seat/back which meets MO HealthNet coverage guidelines. If the participant has a power-operated vehicle or a power wheelchair with a captain's chair seat, a general use seat and back cushion is *not* covered.

A skin protection seat cushion (E2603, E2604, K0734, K0735) is covered for a participant who meets both of the following criteria:

1. The participant has a manual wheelchair or a power wheelchair with a sling/solid seat/back and meets MO HealthNet coverage guidelines for it; and
2. The participant has either of the following:
    - Current pressure ulcer (707.03, 707.04, 707.05) or past history of a pressure ulcer (707.03, 707.04, 707.05) on the area of contact with the seating surface; or
    - Absent or impaired sensation in the area of contact with the seating surface or inability to carry out a functional weight shift due to one of the following diagnoses: spinal cord injury resulting in quadriplegia or paraplegia (344.00-344.1), other spinal cord disease (336.0-336.3), multiple sclerosis (340), other demyelinating disease (341.0-341.9), cerebral palsy (343.0-343.9), anterior horn cell diseases including amyotrophic lateral sclerosis (335.0-335.21, 335.23-335.9), post-polio paralysis (138), traumatic brain injury resulting in quadriplegia (344.09), spina bifida (741.00-741.93), childhood cerebral degeneration (330.0-330.9), Alzheimer’s disease (331.0), or Parkinson’s disease (332.0).

A positioning seat cushion (E2605, E2606) and positioning back cushion (E2613-E2616, E2620, E2621) are covered for a participant who meets both of the following criteria:

1. The participant has a manual wheelchair or a power wheelchair with a sling/solid seat/back and the meets MO HealthNet guidelines for it; and
2. The participant has any significant postural asymmetries that are due to a diagnosis listed in criterion 2b above or to one of the following diagnoses: monoplegia of the lower limb (344.30-344.32, 438.40-438.42), hemiplegia (342.00-342.92, 438.20-438.22) due to stroke, traumatic brain injury or other etiology, muscular dystrophy (359.0, 359.1), torsion dystonias (333.4, 333.6, 333.71), or spinocerebellar disease (334.0-334.9).

A combination skin protection and positioning seat cushion (E2607, E2608, K0736, K0737) is covered for a participant who meets the criteria for both a skin protection seat cushion and a positioning seat cushion. A custom fabricated seat cushion (E2609) is covered if criteria (1) and (3) are met.

A custom fabricated back cushion (E2617) is covered if criteria (2) and (3) are met.

1. Participant meets all of the criteria for a prefabricated skin protection seat cushion or positioning seat cushion.
2. Participant meets all of the criteria for a prefabricated positioning back cushion.
3. There is comprehensive written documentation submitted with the PA request that clearly and specifically explains the following:
    - Why a prefabricated system is *not* sufficient to meet participant's seating and positioning needs;
    - What orthopedic deformity is present; and it's fixed or flexible presentation;
    - What altered muscle tone is present; and it's increased or decreased presentation that affects seating and positioning; and
    - Why any existing system is *not* meeting participant seating and positioning needs.

If the above information is *not* included with the documentation submitted or if additional documentation is needed, the PA request is denied and additional information requested.

13.29.H CUSTOM MOLDED SEAT AND BACK CUSHION REIMBURSEMENT

Custom molded wheelchair seat (E2609) and back (E2617) cushions are reimbursed at 80% of the Manufacturer's Suggested Retail Price (MSRP) for manual wheelchairs and 85% of

MSRP for power wheelchairs. The maximum reimbursement for each code is $1,300. Charges for all modifications and mounting hardware is added together to determine the total MSRP. Charges for molding fees and other labor charges are *not* to be included in the MSRP rate. These charges are *not* reimbursed separately for cushions for new wheelchairs. Labor is allowed for repairs and replacement cushions.

13.29.I DOCUMENTATION FOR WHEELCHAIR PRIOR AUTHORIZATION (PA) REQUESTS

Justification *must* accompany the PA Request form when requesting prior authorization for a custom or power wheelchair. Justification *must* include comprehensive written documentation that clearly and specifically explains all of the following:

- The diagnosis/comorbidities and conditions relating to the need for a custom or power wheelchair;
- Description and history of limitations/functional deficits;
- Description of physical and cognitive abilities to utilize equipment;
- History of previous interventions/past use of mobility devices;
- Descriptions of existing equipment, age and specifically why it is *not* meeting participant needs;
- Why a less costly mobility device is unable to meet participant needs (i.e., cane, walker, standard wheelchair);
- Documentation and justification of medical necessity of recommended mobility device, accessories and positioning components; and
- Documentation/explanation of participant's ability to safely tolerate/utilize the recommended equipment.

If the participant has been evaluated by a physical therapist, occupational therapist or in a wheelchair clinic, the information obtained in the evaluation *must* also be included. The DME provider *must* ensure that the wheelchair being requested is adequate to meet the participant’s physical needs as well as environmental needs (e.g., the wheelchair fits through the doors of the participant’s home).

13.30 PRIOR AUTHORIZATION

Prior authorization approves the medical necessity of the requested service only. It does *not* guarantee payment, nor does it guarantee that the amount billed is the amount reimbursed. The participant *must* be MO HealthNet eligible and eligible for the service on the date of the service or the date the equipment or prosthesis is received by the participant.

13.30.A SUBMISSION OF DURABLE MEDICAL EQUIPMENT (DME) PRIOR AUTHORIZATION (PA) REQUEST

DME PA Requests and supporting documentation *mus*t be submitted to MO HealthNet's claim processing agent, Infocrossing Healthcare Services, Inc. by facsimile (fax) to (573) 659-0207 or by mail at P.O. Box 5700, Jefferson City, MO 65102. Disposition letters for PA Requests received by fax will be returned via the fax number through which the request was sent. Providers are encouraged to ensure requests are sent only from fax numbers *not* blocked. Disposition letters that cannot be successfully returned via fax will be mailed to the provider.

A PA request for an HCY item *must* clearly be marked as an HCY request.

The following documentation *must* be included on, or submitted with, the PA Request form:

- A detailed explanation from the prescribing physician and/or therapist that includes the nature of the item to be provided, the duration of time the item is needed, and the projected outcome the item should provide. Listing only a diagnosis code and description does *not* provide sufficient information to determine the medical necessity of the item being requested; and
- An invoice showing the provider’s cost of the item(s) being requested, unless Section 19.1 indicates that a prior authorized code has a maximum allowed amount established. The invoice *must* indicate the number of items in a box or case if applicable.

DME items that require prior authorization can be identified by the abbreviation "PA" (prior authorization) under the "Reimbursement Guidelines" column in Section 19 of the DME Provider Manual.

13.30.B CLARIFICATION OF PRIOR AUTHORIZATION (PA) CHANGES

Providers should only submit a change to an approved PA Request when there is something on the disposition letter that needs to be corrected, changed or discontinued. Only the disposition letter should be submitted with the changes made directly on the disposition letter. Invoices *must* be included if a price has changed. A PA change request should be submitted when:

- A correction needs to be made to the modifier;
- A procedure code needs to be corrected or changed;
- A new item needs to be added to an existing PA Request;
- A correction or change to the from and/or through date;
- An increase or decrease in requested units or dollars; or
- Services have been discontinued to a participant.

DO *NOT* submit a PA change request when:

- Services continue to be medically necessary beyond the current approved period of time (recertification or renewal);
- The participant's MO HealthNet number is incorrect. (The existing PA Request *must* be closed and a new PA Request submitted under the correct number); or
- An initial PA Request or renewal request is denied then resubmitted with corrections.

In the above situations, a new PA Request *must* be submitted. (text new 6/06)

13.31 PRE-CERTIFICATION PROCESS FOR DURABLE MEDICAL EQUIPMENT (DME)

Pre-certification serves as a utilization management tool allowing payment for services that are medically necessary, appropriate and cost-effective without compromising the quality of care to participants. Pre-certification of specific items and services will be implemented incrementally by individual HCPCS code or groups of codes.

Pre-certification of DME is a two-step process. Requests for pre-certification *must* be initiated by an authorized DME prescriber who writes prescriptions for items covered under the DME Program. Authorized DME prescribers include physicians, podiatrists and nurse practitioners who have a

collaborative practice agreement with a physician that allows for prescription of such items. Speech pathologists are an authorized prescriber for augmentative communication devices only. The enrolled DME provider will access the pre-certification process. All requests *must* be approved by the MHD. Providers are encouraged to sign up for the MO HealthNet Web tool - CyberAccess℠- which automates the pre-certification process. To become a CyberAccess℠ user, contact the ACS-Heritage help desk at 1-888-581-9797 or 573-632-9797 or send an e-mail to MOHealthNetCyberaccess@heritage-info.com. The CyberAccess℠ tool allows each pre-certification to automatically reference the participant's claim history including ICD-9 diagnosis codes and CPT procedure codes. Requests for pre-certification are also received by the MO HealthNet call center at 800-392-8030. Requests for pre-certification *must* meet medical criteria established by the MHD in order to be approved. Medical criteria is published in provider bulletins and posted on the MHD web site at www.dss.mo.gov/mhd prior to implementation. DME pre-certification criteria documents may be found at http://www.dss.mo.gov/mhd/cs/dmeprecert/pages/dmeprecert.htm. If a pre-certification request submitted through CyberAccess℠ is denied, providers may click on the help ticket box to have a MO HealthNet call center representative contact them. The call center is available Monday through Friday from 8:00 am to 5:00 pm, excluding state holidays.

Items of DME that require pre-certification can be identified by the abbreviation "PC" (pre-certification) under the "Reimbursement Guidelines" column in Section 19 of the DME Provider Manual.

PLEASE NOTE: An approved pre-certification request does *not* guarantee payment. The provider *must* verify participant eligibility on the date of service using the Interactive Voice Response (IVR) System at (573) 751-2896 or by logging in to the MO HealthNet Web portal.

13.32 DURABLE MEDICAL EQUIPMENT (DME) PROGRAM BILLING REMINDERS

Prior authorization approves the medical necessity of the item. It does *not* guarantee payment for the item as the participant *must* be MO HealthNet eligible on the date the equipment is dispensed. It is the responsibility of the MO HealthNet provider to ascertain the participant's MO HealthNet status.

Charges for delivery, pick-up, shipping, freight, handling and COD are included in the MO HealthNet reimbursement of all purchased or rented equipment, medical supplies, oxygen, orthotics and prosthetics, TPN, IV therapy and enteral therapy and cannot be billed to the participant.

DME provided to participants in a nursing home is not covered under the DME Program with the exception of: volume ventilators, TPN, custom and power wheelchairs, orthotics, prosthetics, and augmentative communication devices.

Reimbursement for items through the DME Program is the lower of the provider's usual and customary charge or the MO HealthNet allowable amount.

For participants with both Medicare and MO HealthNet coverage, a Medicare denial is *not* required for submitting a MO HealthNet claim for volume ventilators for participants in a nursing home.

A Certificate of Medical Necessity is valid for six (6) months. A new Certificate of Medical Necessity *must* be completed every six (6) months.

For specific equipment codes and billing requirements refer to Section 19.

Medical criteria documents for items requiring pre-certification may be found at http://www.dss.mo.gov/mhd/cs/dmeprecert/pages/dmeprecert.htm.

13.33 NONCOVERED SERVICES UNDER THE DURABLE MEDICAL EQUIPMENT (DME) PROGRAM

13.33.A NONCOVERED ITEMS

MO HealthNet does *not* cover items which primarily serve the following purposes: personal comfort, convenience, education, hygiene, safety, cosmetic, new equipment of unproven value and equipment of questionable current usefulness or therapeutic value.

- Air conditioners
- Bathtub rails
- Canopy beds
- Computers (unless determined to be used for an augmentative communication device)
- Dialysis equipment
- Electric bathtub lifts
- Elevators
- Environmental control systems
- Equipment used in non-medical context
- External power or electronic prosthetic devices
- Furniture
- Home modifications

- Labor for the assembling of wheelchairs or equipment
- Massage equipment
- Medical alert system
- Medical necessity bags
- Motivation-type devices
- Pacemaker monitor
- Refrigerators
- Repair, replacement or continued rental of equipment for which a continuing need *cannot* be established
- Sales tax
- Seat lift chairs
- Stair lifts or glides
- Standers
- Sunshade/canopies
- Treadmill
- Water softening systems
- Wheelchair lifts
- Wheelchair ramps
- Whirlpool tubs or pumps

This list is *not* all-inclusive. If there is *not* a specific code listed in Section 19, the item is *not* covered.

13.33.B DUAL ELIGIBLES IN MEDICARE COMPETITVE BIDDING AREA (CBA)

Medicare implemented a competitive bidding program in January 2011, for certain Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS). For Medicare beneficiaries whose permanent residence is in a statistical area affected by the CBA program, only contract suppliers will be eligible to provide competitive bid items and receive payment

from Medicare. Complete information on the competitive bidding process can be found on the Center for Medicare & Medicaid Services (CMS) website at http://www.cms.hhs.gov/DMEPOSCompetitiveBid/.

MO HealthNet will align policy with Medicare for dual-eligible participants who reside in a CBA. If Medicare denies reimbursement for a DME competitively bid service that was provided to a participant by a non-contract or non-demonstration supplier, the service is not covered by MO HealthNet and *must* not be billed to MO HealthNet for reimbursement. The participant is not liable for payment unless the non-contract supplier in a CBA has informed the participant in writing prior to receiving the item that there would be no Medicare or MO HealthNet coverage due to the supplier's contract status, and the participant understands that he/she will be liable for all costs that the non-contract supplier may charge the participant for the item.

END OF SECTION

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