MedStar Family Choice

Maryland HealthChoice
Provider Alert

As a participating MedStar Family Choice Maryland HealthChoice practitioner, we encourage you to review the attached document pertaining to Durable Medical Equipment Services.

Within the document you will find information pertaining to**:**

Section 1: Durable Medical Equipment

Section II: DME Rentals

Section III: Capped / Purchase of Rental Items

Section IV: Oxygen/Oxygen Equipment/CPAP & BIPAP Equipment

Section V: Payment for Parenteral and Enteral Nutrition (PEN) Items and Services

Section VI: Repairs & Replacement for DME, Corrective Appliances and Other Devices

Section VII: Miscellaneous Items

Section VIII: Audit and Disclaimer Information

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A copy of the full document may be viewed or printed from the MedStar Family Choice website at: https://www.medstarfamilychoice.com/maryland-healthchoice/for-maryland-healthchoice-physicians/provider-resources/provider-alerts

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DME-DMS-OXYGEN-CPAP-BIPAP-PARENTERAL NUTRITION- ORTHOTICS & PROSTHETICS

Section I Durable Medical Equipment (DME) Purchase

1. Durable Medical Equipment (DME): is covered as a medical or other health service and is equipment that:

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

        a. All requirements of the definition must be met before an item can be considered to be durable medical equipment.
        b. Prior authorization is required if the total billed amount of the claim is equal to or greater than $1,000.00 or the rental extends beyond 90 days.

2. Orthotics & Prosthetic devices: (other than dental) are covered as a medical or other health service and are devices that replace all or part of an internal body organ or replace all or part of the function of a permanently inoperative or malfunctioning internal body organ. Replacements or repairs of such devices are covered when furnished incident to physician's services or on a physician's orders.

    a. Prior authorization is required if the billed amount per HCPCS codes is equal to or greater than $500.00. Excludes foot orthotics, see item number three (3) on page two (2) of this alert.
    b. Reimbursement is based on the applicable fee schedule contracted/negotiated rate for orthotic or prosthetic devices dispensed. The design, material, fabrication, testing, fitting, and training in the use of the devices are included in the reimbursement of the device and are not reimbursed separately.
    c. Reimbursement is available for the repair of orthotic or prosthetic devices:

- When necessary to make the item serviceable;
- When the item is no longer covered under the suppliers or manufacturer's warranty; and
- Up to the estimated expense of replacement of the item.

d. Reimbursement is allowed for replacement of orthotics or prosthetics due to:

- Change in members condition;
- Substantial change in members growth and/or weight;
- Permanent and/or accidental damage; and
- Irreparable wear in consideration of the reasonable useful lifetime of the time (of not less than five years) based on when the item is delivered to the member.

3. Foot orthotics, custom shoes, diabetic orthotics or shoes, and CAM walking boots: Prior authorization is required regardless of cost.

4. Braces: Braces are covered as a medical or other health service when furnished incident to physician's services or on a physician's order. A brace includes rigid and semi-rigid devices that are used for the purpose of supporting a weak or deformed part of the body or restricting or eliminating motion in a diseased or injured part of the body. Use of an off the shelf brace should be given to the member in lieu of a custom brace. In the event there is a need to request prior authorization for a custom-made brace, clinical notes from the prescribing provider detailing the need for the custom brace **is required**. The prescribing provider signature is required on supporting clinical notes, written prescriptions, or referrals and must have a current date.

   a. Prior authorization is required if the billed amount per HCPCS code is equal to or greater than $500.00.

5. Hearing aids, cochlear implants, auditory ossintegrated devices: Prior authorization is required regardless of the cost.

6. Insulin Pumps or Continuous Glucose Monitors: Prior authorization is needed for all insulin pumps, continuous glucose monitors, sensors, transmitters, and receivers. This also includes any start-up or data interpretation.

7. Hospital beds, standard wheelchairs, suction machines, vents: Prior authorization is **not** required for the first 90 days use of equipment. Prior authorization must be obtained for use of equipment beyond the first 90 days and a request must be made within 75 days of the first 90 days use of equipment unless the rental item is purchased. In the event one of the above items is purchased, follow the Durable Medical Equipment prior authorization requirements on page one (1) of this alert.

8. Durable Medical Supplies and Disposable Items: These items are covered as a medical or other health service when furnished incident to physician's services or on a physician's order. These include, but not limited to durable medical soft supplies and disposable items including enteral / parenteral supplies. These items are used in conjunction with a DME item or separately for care.

a. Prior authorization is required for claim billed amounts equal to or greater than $750.00 Per Month/Per Vendor/Per Member.
b. This prior authorization requirement is in addition to the prior authorization requirements for the DME item, as applicable.
c. For DME items that require durable medical soft supplies with their use, a prior authorization must be obtained for the DME item as well as for the durable medical soft (disposable) supplies.

9. Prior authorization is required for any repair services.

10. If the HCPCS code is billed without a modifier on the claim, MedStar Family Choice considers this is a purchased item.

11. Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) – RT/LT Modifiers:

    a. HCPCS codes defined as "pair" should not be billed with a RT or LT modifier;
    b. Orthotics or prosthetics that may be billed bilaterally, RT (Right side of body) or LT (Left side of body) modifier must be used to denote which side is being supported (orthotic) or replaced (prosthetic); and
    c. Orthotics or prosthetics should not be billed with modifier 50.

Section II DME Rentals

For all rented items listed above, the following policies apply.

1. Prior authorization is required when:

    a. The requested amount of claim is equal to or greater than $1,000.00; or
    b. The DME item is rented beyond 90 days.

2. Items rented beyond 13 months will fall under the Capped Rental Rules.

3. If a rented item is subsequently approved for purchase, the total of all rental payments will be applied toward the final purchase price. The purchase price of the item will be based on the applicable fee schedule or contracted/negotiated allowed amount and adjustments will be made to subtract for all rental payments.

4. Provider is responsible to monitor and maintain all rental equipment. If not in proper working order, the provider can either fix or replace the item, which will require prior authorization.

Section III Capped / Purchase of Rental Items

1. Capped/Purchase of Monthly Rentals: After 13 months of reimbursement at the applicable fee schedule or contracted/negotiated rate for a rental item, for a single member, the rental item shall revert to capped or purchase status up until the purchase price established in the applicable fee schedule or contracted/negotiated rate has

been reached. Reimbursement will not exceed the purchase price or the 13-month rental period, whichever comes first.

a. If the purchase price has been exceeded, then the last month's rental will be adjusted to meet the established applicable fee schedule purchase price.

EXCEPTION: Total payments for a rental item may not exceed its allowable purchase price, except for those items identified as life-sustaining DME (i.e. ventilators).

2. In the event that a purchase price has not been established and the reimbursement rate for a rental only exists, the provider shall be reimbursed at **no more than the rental rate up to 13 consecutive months**. MedStar Family Choice shall not make any additional rental payments beyond the 13th rental month.

3. Provider is responsible to monitor and maintain all rental equipment. If not in proper working order, the provider may either fix or replace the item. Prior authorization is required.

4. A capped rental item of equipment that has been in continuous use by the patient, on either a rental or purchase basis, for the equipment's useful lifetime or if the item is lost or irreparably damaged, the patient may elect to obtain a new piece of equipment. MedStar Family Choice determines the reasonable useful lifetime for capped rental equipment but in no case can it be less than five years.

5. Providers are required to use the following length of rental modifiers on Capped Rental items:

   a. KH- DME items, first rental month, use in addition to RR modifier;
   b. KI- DME items, second or third months rental, use in addition to RR modifier;
   c. KJ- DME or PEN or capped rental, months fourth to 13th, use with RR modifier; and
   d. If a capped rental item is not submitted with the RR modifier, the claim line item will deny indicating the HCPCS code requires two modifiers.

Section IV Oxygen/Oxygen Equipment/CPAP & BIPAP Equipment

1. Oxygen and oxygen equipment: MedStar Family Choice will pay a monthly rate based on the applicable fee schedule or contracted/negotiated reimbursement amount per member. Unless otherwise noted below, the applicable fee schedule or contracted/negotiated reimbursement amount covers oxygen equipment, oxygen contents and oxygen supplies. Refer to the applicable fee schedule or contracted/negotiated reimbursement amount to determine if oxygen equipment, oxygen contents, and oxygen supplies are for purchase or rental only.

2. Authorization is **not** required for oxygen and related respiratory equipment. E0424-E0585, E1355, E1372, E1390, E1391, E1392, E1399, E1405, E1406, and K0738.

3. In the event miscellaneous DME equipment is dispensed, HCPCS code E1399 will require prior authorization if the total billed amount of the claim equals or is greater than $1,000.00 or the DME equipment is rented beyond 90 days.

4. Continuous Positive Airway Pressure (CPAP) and Bilevel Positive Airway Pressure (BIPAP): Prior authorization is **not** required for the first 90 days use of equipment. Prior authorization must be obtained for use of equipment beyond the first 90 days and the request must be made within 75 days of the first 90 days use of equipment. The following information is critical and required when requesting prior authorization for continued use of CPAP and BIPAP equipment:

    a. Member Name and address;
    b. MedStar Family Choice Identification number;
    c. Date of Birth;
    d. Referring physicians name, address, NPI, contact name at the physician's office, and telephone number;
    e. Diagnosis codes with description;
    f. Date when rental reaches 90 days or date current authorization number expires;
    g. Date of the original set up of the CPAP or BiPAP equipment;
    h. HCPCS code with description;
    i. Is the request for continued rental or purchase;
    j. Name of organization requesting prior authorization, contact name, and contact telephone number;
    k. Date of prior authorization request; and
    l. Updated and current clinical/progress notes and the current/up to date compliance data must accompany all prior authorization requests for continued use of CPAP or BiPAP equipment. If the updated clinical/progress notes and current/up to date compliance data are not included in the request for prior authorization, the request will pend for additional information. If the required information is not received within the Maryland Department of Health required timelines for a standard prior authorization requests, the request for prior authorization will be denied.

The above required information is critical to the review of all requests for prior authorization to continue use of CPAP or BIPAP equipment. Be sure to use the attached form when requesting prior authorization.

It is incumbent upon the requestor/supplier to ensure the member is compliant prior to requesting prior authorization to continue use of CPAP or BIPAP equipment. This would include the requestor/supplier sending a Respiratory Therapist to assess any ongoing compliance issues.

MedStar Family Choice will follow up with the member to ensure there are no issues with using the CPAP or BIPAP equipment. If there are issues, the member will be instructed to follow up with the ordering physician prescribing the use of the CPAP or BIPAP equipment.

Upon review of the request, if there are no issues, prior authorization will be granted, and a prior authorization number issued for a 10-month span. Once prior authorization is given to the requestor/supplier, there is no need for added prior authorization requests during the 10-month span. Any additional prior authorization requests beyond the 10-month span must be made within 75 days of the 10-month span ending.

Prior authorization requests may be faxed to MedStar Family Choice's Care Management Team at 410-933-2274 or 888-243-1790.

It is the responsibility of the requestor/supplier to ensure the member remains complaint during the use of CPAP or BIPAP equipment before requesting prior authorization. Any prior authorization requests received solely with the intent of MedStar Family Choice issuing a denial to force the member to become compliant is not appropriate.

Section V Payment for Parenteral and Enteral Nutrition (PEN) Items and Services:

1. Payment for PEN items and services is made monthly for nutrients and supplies that are purchased. One (1) PEN supply kit will be made for each day the member is using a pump. These supplies and nutritional replacement therapy do not follow the Capped Rental limitation.

2. Payment is made for the PEN Pump on a monthly basis for equipment that is rented.

Section VI Repairs and Replacements for DME, Corrective Appliances and Other Devices:

1. Repairs to medically necessary DME, corrective appliances and other devices are covered up to the replacement cost when necessary to make the equipment/device serviceable.

2. A new Medical Necessity Form (MNF) and/or physician's order is not needed for repairs to an item.

3. When the DME, corrective appliance, or other device is under the manufacturer's warranty, repairs are the responsibility of the manufacturer, and are not covered.

4. DME and orthotic equipment rental charges cover the expenses of maintaining the equipment. Separately itemized charges for repair of rented equipment are **not covered**. This includes items in the categories of the following:

    a. Frequent and substantial servicing;
    b. Oxygen equipment;
    c. Capped rental and low-cost associated items; and
    d. Inexpensive or routinely purchased for payment.

5. Repairs are billed by repair units of service (UOS) in 15-minute increments. Prior authorization is required for all repairs.

    a. Units of service include basic troubleshooting and problem diagnosis;
    b. This allowance applies to non-rented and out-of-warranty items; and
    c. Claims for repairs must include narrative information itemizing each repair and the time taken for each repair.

Section VII Miscellaneous Items:

1. Useful Life Cycle of DME Items: Each item of DME has an established life expectancy period. It is up to the provider to work with the Utilization Management Department in replacing those items it deems no longer in proper working order.

2. DME add-ons or upgrades: Intended primarily for convenience, or upgrades beyond what is necessary to meet the member's medical needs are not covered.

3. E0604: Breast pumps: Heavy duty, hospital grade, piston operated, pulsatile vacuum suction/release cycles, vacuum regulator, supplies, transformer, electric (AC and/or DC) is for INPATIENT use only and cannot be billed for outpatient or in-home use. Providers must bill E0602: Breast Pump, manual, any type or E0603: Breast Pump, electric (AC and/or DC), any type for in-home and outpatient use.

4. Gradient Compression Garments: Considered specialized elastic knit two-way stretch stockings, sleeves, gloves, gauntlets or non-elastic binders that provide pressure compression. These garments are either ready-to-wear or customer made.

    a. Use of an off the shelf garment/elastic stocking should be given to the member in lieu of a custom garment/elastic stocking. In the event there is a need to request prior authorization for a custom-made garment/elastic stocking, clinical notes from the prescribing provider detailing the need for the custom garment/elastic stocking **is required**. The prescribing providers signature is required on supporting clinical notes, written order, or referral and must have a current date.
    b. Must bill each individual garment/elastic stocking separately and not as a pair.
    c. HCPCS codes used to bill claims for garment/elastic stockings:

Code	Description
A4465	Non-elastic binder for extremity
S8420	Gradient pressure aid (sleeve & glove combination), custom made
S8421	Gradient pressure aid (sleeve & glove combination), ready made
S8422	Gradient pressure aid (sleeve), custom made, medium weight
S8423	Gradient pressure aid (sleeve), custom made, heavy weight
S8424	Gradient pressure aid (sleeve), ready made
S8425	Gradient pressure aid (glove), custom made, medium weight
S8426	Gradient pressure aid (glove), custom made, heavy weight
S8427	Gradient pressure aid (glove), ready made
S8428	Gradient pressure aids (gauntlet), ready made
S8429	Gradient pressure exterior wrap
A4490	Surgical stockings above knee length, each
A4495	Surgical stockings thigh length, each
A4500	Surgical stockings below knee length, each
A4510	Surgical stockings full length, each
A6530	Gradient compression stocking, below knee 18-30 mmHg, each
A6531	Gradient compression stocking, below knee, 30-40-mmHg, each
A6532	Gradient compression stocking, below knee, 40-50-mmHg, each
A6533	Gradient compression stocking, thigh length, 18-30 mmHg, each
A6534	Gradient compression stocking, thigh length, 30-40 mmHg, each
A6535	Gradient compression stocking, thigh length, 40-50 mmHg, each

A6536	Gradient compression stocking, full length/chap style, 18-30 mmHg, each
A6537	Gradient compression stocking, full length/chap style, 30-40 mmHg, each
A6538	Gradient compression stocking, full length/chap style, 40-50 mmHg, each
A6539	Gradient compression stocking, waist length, 18-30 mmHg, each
A6540	Gradient compression stocking, waist length, 30-40 mmHg, each
A6541	Gradient compression stocking, waist length, 40-50 mmHg, each
A6544	Gradient compression stockings, garter belt
A6545	Gradient compression wrap, non-elastic, below knee, 30-50 mmHg, each
A6549	Gradient compression stocking/sleeve, not otherwise specified

5. **All of the above items requiring prior authorization must be submitted to the Care Management team using the attached prior authorization form.**

6. **Prior authorization requests may be faxed to 888-243-1790 or 410-933-2274.**

7. **In order to determine the number of units allowed and billable for a DME or DMS item, MedStar Family Choice follows the Centers for Medicaid and Medicare Services (CMS) *Medicaid* Medically Unlikely Edits (MUE). Follow the MUE's to determine if a billed claim requires a single date of service or a date of service span.**

Section VIII: Audit and Disclaimer Information

1. Routine claim audits will be conducted by MedStar Family Choice to ensure claims are being paid according to this policy.

2. This policy provides information on claims processing guidelines. Every claim is unique and the use of this policy is not a guarantee of payment, nor a predictor of how claims will be finalized.

3. Warranty information and purchased item repairs will be coordinated by Care Management through the prior authorization process.

Section IX: References

MedStar Family Choice follows industry standard recommendations from sources such as the Centers for Medicare and Medicaid Services (CMS), Current Procedural Terminology (CPT), the American Medical Association (AMA), and/or other professional organizations and societies. National Correct Coding Initiative (NCCI) editing is followed when applicable.