

SECTION 7 BENEFITS & LIMITATIONS

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, 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.

- 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.

Services Provided in a Nursing Home

DME is not covered for participants residing in a nursing home. 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 accessoires
- custom wheelchairs
- power wheelchairs
- orthotic and prosthetic devices
- total parenteral nutrition (TPN)
- volume ventilators

Wheelchair Requirements For Participants Residing In A Nursing Home

To assist in ensuring MO HealthNet participants receive the least costly medically appropriate equipment, the following are requirements for wheelchairs for participants residing in a nursing home. Providers are reminded any item of durable medical equipment provided to a MO HealthNet participant must be the least costly medically appropriate alternative.

When submitting a prior authorization request for a custom or power wheelchair, there must be comprehensive written documentation submitted with the prior authorization request. Letters of medical necessity/medical necessity 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/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
- Description of existing equipment, age and specifically why it is not meeting the participant's needs
- 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
- Documentation/explanation as requested by the State consultant.

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 involvement in the wheelchair selection for the participant.

Physician Face-to-Face Evaluation

For a custom or power wheelchair to be covered for a participant residing in a nursing home, the 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 participants' chart in the format they use for other entries. Supplier or facility created forms 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 are 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;
 - musculoskeletal examination to include arm and leg strength and range of motion;
 - neurological examination to include documentation of functional ambulation and balance and coordination;
 - distance participant can walk without stopping;
 - pace of ambulation;
 - ability to stand up from a seated position without assistance; and,
 - description of the ability to perform activities of daily living.

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. A copy of the physical or occupational therapy evaluation completed by a licensed physical or occupational therapist may be utilized for the physical 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.) All areas noted above for the physical exam must be addressed. All face-to-face required documentation must be signed by the physician prior to the physician order for equipment being written.

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 prior authorization request.

Physician Order

For custom or power wheelchairs for participants residing in a nursing home, 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
- Physician's signature
- Date of the physician signature

A date stamp or equivalent must be used to document receipt date.

Power Wheelchairs and Accessories For Participants In A Nursing Home

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

- A. Document one of the following diagnoses:
- Spinal cord injury resulting in quadriplegia or paraplegia (344.00-344.1)
 - Other spinal cord diseases (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)
 - 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)
 - Severe orthopedic abnormality of the hip, spine or pelvis significantly affecting positioning (must be documented by the physician in the face-to-face visit)
- 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:

- All criteria for a Group 2 power wheelchair are met; and
- Medical justification provides extensive documentation of why a Group 2 power wheelchair and other less costly devices will not meet the participant's needs; and

- Documentation includes the length of time the participant has resided in the nursing home; and
- One of the following
 - Documentation includes a copy of the discharge plan from the nursing home's patient 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 OT/PT explaining the participant's discharge plans and mobility needs must accompany the discharge plan; or
 - The medical necessity justification provides clear documentation 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.

Custom Wheelchairs For Participants In A Nursing Home

When prior authorized, MO HealthNet will reimburse for medically necessary custom wheelchairs for participants residing in a nursing home. All prior authorization requests must indicate why a less costly wheelchair is unable to meet the participant's needs. Criteria A, B and C below describe the various 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 participant using a plaster model of a participant, a computer generated model of the participant (i.e. CAD-CAM technology), or the detailed measurements of the participant to create either:
 - a molded, contoured, or carved (foam or other suitable material) custom-fabricated seating system that is incorporated into the wheelchair base; or
 - 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 easily be 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 prior authorization request must document all of the following:

- Why a prefabricated system is not sufficient to meet the participant's seating and positioning needs.
- What orthopedic deformity is present and its fixed or flexible presentation.
- What altered muscle tone is present and its increased or decreased presentation that affects seating and positioning.
- 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:

- A wheelchair seat width of 25 inches or more; or
- A wheelchair with a weight capacity for 351 or more pounds; or
- A wheelchair with a seat to floor height of less than 15 ½ 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:

- Spinal cord injury resulting in quadriplegia or paraplegia (344.00-344.1)
- Other spinal cord diseases (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, 335-23-225.9)
- 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)
- 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 are being utilized)
- Severe orthopedic abnormality of the hip, spine or pelvis significantly affecting positioning (must be noted and described by the physician in the documentation of the face-to-face visit)

Wheelchair Option/Accessory Replacement and Repair

Reimbursement will be made for wheelchair option/accessory replacement and repair for patient owned custom or power wheelchairs for participants residing in a nursing home; however, the SC modifier must be included with the appropriate HCPCS code and RB modifier.

- The appropriate HCPCS code for the specific option/accessory must be billed. The RB modifier must always be used when the accessory is a replacement for the same part.
- Procedure code Z0160RB or Z0160RBSC may be used for replacement items that do not have a HCPCS code and have a Manufacturer's Suggested Retail Price (MSRP) of \$500.00 or less. Items with an MSRP greater than \$500.00 must be prior authorized using 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 to be used for replacement of existing options/accessories.
- Labor required for replacement of options or accessories, or repair of a wheelchair, may be billed under procedure code K0739RB or K0739RBSC, repair or non-routine service for DME 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 Form (MN) is required for most option/accessory replacement codes and the labor code. The labor and option/accessory codes should be included on the same MN form. The MN 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.

Repair of Durable Medical Equipment

Repair of participant-owned durable medical equipment 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 item.
- The repairs are not a result of a defect in materials or workmanship.

Prior Authorization Request Wheelchairs

When submitting a PA request for a custom wheelchair or power mobility device, there must be comprehensive written documentation submitted with the PA request that clearly and specifically explains **all** 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
- Description of existing equipment, age and specifically why it is not meeting the participant's needs
- Why a less costly mobility device is unable to meet the participant's needs (i.e., cane, walker, standard 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

Basic Equipment Package

Power wheelchairs, power operated vehicles and manual wheelchairs are required to include certain items on initial issue. These items are considered the basic equipment package. There is no separate billing/reimbursement for these items at the time of initial issue. MO HealthNet follows Medicare's guidelines regarding basic equipment packages. A complete list of items included in the basic equipment package for power wheelchairs, power operated vehicles and manual wheelchairs can be found in Section 13 of the DME provider manual located on the MO HealthNet Web page at <http://manuals.momed.com/manuals/>.

Coverage of 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 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.

Orthopedic Shoes/Modifications

Orthopedic shoes and modifications or additions to shoes are covered only in the following situations:

- The shoe(s) is an integral part of a brace. "Integral" means the shoe(s) is necessary for completing the brace. A pair of shoes may be reimbursed even if only one shoe is an integral part of a unilateral brace.
- The shoe(s) and/or modification are medically necessary for a participant under the age of 21.

Modifiers

All claims submitted to MO HealthNet for consideration of payment must be submitted with a modifier in addition to the HCPCS procedure code. Services covered in the DME program may be approved for purchase, rental, or repair. Section 19 of the MO HealthNet DME Manual documents coverage of services. One of the following modifiers is required for billing services through the DME program:

NU = Purchase

RR = Rental

RB = Repair

Rental of Durable Medical Equipment

The Certificate of Medical Necessity (CMN) or PA request 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. If the period of need indicates it is less expensive to purchase the equipment, the MO HealthNet Division (MHD) elects to purchase the equipment; likewise, if it is less expensive to rent the equipment, MHD elects to rent the equipment. The following are guidelines for rental of DME.

- If a participant is ineligible for the MO HealthNet program during a portion of the rental month, rental is paid only for the days the participant is eligible.
- When rental payments reach the MO HealthNet allowed purchase price, the item becomes the property of the participant.
- With the exception of electronic crossover claims, DME providers are to bill by calendar month. Billing for the rental of equipment should state only one month for each line item, billing multiple line items for multiple months on the same claim is acceptable. Claims for participants who are on spenddown will deny if they are not billed by calendar month.
- The MO HealthNet program does not reimburse the provider or the participant for replacement of a rented DME item that is stolen, lost or destroyed.
- 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.

Pre-Certification Process for Durable Medical Equipment

The MHD is implementing pre-certification (Smart PA™) requirements for DME services. 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 MO HealthNet participants.

Pre-certification requests for DME is a two-step process. Requests for pre-certification are initiated by enrolled MO HealthNet providers who write prescriptions for items covered under the DME program. Authorized DME prescribers include physicians or nurse practitioners who have a collaborative practice agreement with a physician allowing for prescription of such items. The enrolled DME provider accesses the pre-certification initiated by the prescriber to complete the second step of the pre-certification process. All requests must be approved by the MHD.

Requests for pre-certification must meet medical criteria established by the MHD in order to be approved. Medical criteria is published in the DME Pre-Certification Criteria Documents on the MHD Web site located at <http://dss.mo.gov/mhd/cs/dmeprecert/>.

Manual Pricing

DME items, services or supplies, which do not have a MO HealthNet maximum allowed amount established, are manually priced according to the following guidelines:

- HCY = cost + 20%
- Ostomy = cost + 20%
- Manually priced custom wheelchairs and accessories = 80% of the MSRP
- Manually priced power mobility devices and accessories = 85% of the MSRP
- Augmentative communication devices and accessories = 85% of the MSRP
- Orthotics and prosthetics = cost + 20%
- K0108NUSC = wheelchair accessory code for nursing home residents, 40% of the MSRP for custom wheelchairs and 45% of the MSRP for power wheelchairs