CHAPTER 506 DURABLE MEDICAL EQUIPMENT, PROSTHETICS, ORTHOTICS, AND SUPPLIES (DMEPOS)

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BACKGROUND

This chapter combines the previous *Chapter 506 – Covered Services, Limitations, and Exclusions for DME Medical Supplies* and the previous *Chapter 516 – Covered Services, Limitations, and Exclusions for Orthotics/Prosthetic Services* and describes the West Virginia Bureau for Medical Services' (BMS) coverage policies for services provided by Durable Medical Equipment, Medical Suppliers, and Orthotic and Prosthetic enrolled providers.

POLICY

506.1 COVERED SERVICES

West Virginia Medicaid reimburses covered services to enrolled providers for durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) when services are medically necessary, cost effective and meets the Medicaid member's healthcare need. A face-to-face encounter justifying the medical necessity and a written order by the prescribing practitioner for the DMEPOS services requested is required. Documentation must be maintained in the member's record and available to BMS or their designee upon request.

Partnering by a provider of service with any DMEPOS supplier and/or manufacturer that may result in a personal financial gain is prohibited. "It is unlawful to knowingly and willfully offer, pay, solicit, or receive any remuneration to induce or reward referrals of items or services reimbursable by Medicaid. (See 42 U.S.C. § 1320a-7b(b)). Where remuneration is paid, received, offered, or solicited purposefully to induce or reward referrals of items or services payable by Medicaid, the Anti-Kickback Statute is violated. *Id.* Safe Harbors under the Medicare and Medicaid Patient and Program Protection Act of 1987, Public Law 100-93 (section 1128B(b)(3)(E)) of the Act, are listed at 42 CFR 1001.952. Safe harbors represent and permit certain non-abusive arrangements. (56 FR 35952, 35958; July 21, 1991).

The least expensive DMEPOS item that meets the members' needs is covered. Documentation must be maintained for a minimum of five years and must be made available to BMS or its designee upon request.

Detailed lists of covered DMEPOS services are available in Appendix 506A - Covered DME Supplies and Appendix 506B - Covered O&P Supplies.

506.1.1 Durable Medical Equipment

Covered services are based on product category not specific item, brand, or manufacturer. Following the established capped rental timeframe, DME items are determined purchased and the provider receiving the last cap rental reimbursement maintains responsibility for the item and must provide repairs and/or modification as needed. Only one mobility assistive equipment item of the same category will be maintained or repaired by BMS at any time.

Manufacturer's warranty for DME is required for not less than one year. When the item is under warranty and repair or replacement is required, the provider of service is responsible to provide the repair and/or replacement. The warranty begins on the date of the delivery to the member. The original warranty must be

given to the member and a copy is maintained in the member's individual medical record. A copy of the warranty must also be provided to Medicaid or its designee upon request.

Durable medical equipment and/or accessory repairs are limited to medically necessary items as follows (prior authorization is required):

- Items covered by West Virginia Medicaid;
- The appropriate HCPCS with "RP" modifier must be included with the request and pertinent documentation provided to the Utilization Management Contractor (UMC) for review of repairs;
- The warranty timeframe is exhausted;
- The medical need is expected to continue;
- The repair is more economical than replacement;
- The vendor must substitute comparable or like equipment at no additional cost when broken or damaged equipment is being repaired;
- No other party is financially liable for the needed repair; and,
- Damage to the item is not due to the member's abuse or misuse.

Providers may be reimbursed for materials necessary to complete the repair; however, providers are not eligible for reimbursement of setup or delivery following repair and service calls that do not involve actual labor time for repairs. Labor services are to be billed separately with the units equal to the number of labor hours. An unaltered cost invoice is required for covered services that are not priced and must be submitted to the UMC for pricing.

Replacement of DME may be covered by Medicaid, on an as-needed basis, due to acute rapid changes in the member's physical condition, wear, theft, irreparable damage, or loss by disasters. Prior authorization is required. A police or insurance report is required with all requests for replacement of stolen equipment and a report of insurance liability is required with requests for replacement of equipment lost or destroyed.

In cases of neglect and/or wrongful misuse of DME, requests for replacement will be denied if such circumstances are confirmed.

Medicaid's initial payment for DME includes all adjustments and modifications needed to make the item functional for delivery to the member. The provider must provide training and instruction to the member and/or caregiver on the safe, effective, and appropriate use of the item. The most economical DME items must be provided. Expensive items are not covered when less costly items/services are available.

Total Parenteral Nutrition (TPN) services are considered DME and are not pharmacy point-of-sale covered services.

506.1.2 Medical Supplies

Covered medical supplies are based on product category, not specific item, brand, or manufacturer. Medical supplies are purchased items, unlike equipment which may be initially purchased or reimbursed on a cap rental basis. Dispensing of medical supplies for more than a one month timeframe or shipping supplies on an unsolicited or automatic basis is prohibited.

506.1.3 Orthotics and Prosthetics

Prosthetic and orthotic devices/appliances are considered for reimbursement by the West Virginia BMS when requested by a prescribing practitioner and determined medically necessary to meet the basic health care needs of the member.

Prosthetic and orthotic repairs and replacements are limited to medically necessary devices/appliances covered by West Virginia Medicaid. All repairs and replacements require prior authorization by BMS UMC before devices/appliances are provided.

Medicaid's initial payment for devices/appliances includes all adjustment and modifications needed to make the item functional for delivery to the member. The provider must document training and instruction to the member and/or caregiver on the safe, effective, and appropriate use of the device/appliances.

The manufacturer's warranty for orthotic devices/appliances is required for not less than one year and begins on the date of delivery (date of service). The prosthetic and orthotic providers are responsible for repairs and replacement of devices/appliances for the first year under warranty. The original warranty must be given to the member with a copy maintained in the member's individual file. A copy must also be made available to the UMC and/or BMS upon request.

Medicaid's coverage for repair of prosthetic and orthotic devices/appliances is limited to:

- Items covered by West Virginia Medicaid;
- The medical need is expected to continue; and
- The repair is more economical than replacement.

Providers may be reimbursed for materials necessary to complete the repair; however, they are not eligible for reimbursement of setup or delivery following repair or service calls. Labor services are to be billed separately with the units equal to the number of labor hours.

Prior authorization for medical necessity must be obtained from the UMC for replacement prior to providing the device/appliance. Except when related to growth, changes in physical condition or loss by disaster, total replacement of an appliance will not be considered if less than three years after the original purchase. In addition to medical documentation to justify replacement, a police or insurance report is required for devices/appliances stolen; and, an insurance liability report is required for lost or destroyed devices/appliances. Note: In cases of neglect and/or wrongful misuse of the device/appliance, the request for replacement will be denied if such circumstances are confirmed.

506.1.4 Home Intravenous Infusion Therapy

Home IV infusion therapy equipment and medical supplies must be provided within service limits based on BMS pharmacy prior authorization vendor's number(s) of bags or cassettes approved within a specified time frame. Refer to *Chapter 518, Pharmacy Services* for additional information.

506.2 PRACTITIONER ENROLLMENT AND PARTICIPATION REQUIREMENTS

Provider participation requirements for prescribing practitioners, DME providers, prosthetics, and orthotics providers include, but not limited to:

Prescribing Practitioners
Prescribing Practitioners are enrolled physicians, podiatrists, advanced practice registered nurses, clinical nurse specialists, or physician assistants. Practitioners must:

- Verify member eligibility,
- Provide face-to-face encounter(s) with documented visit within the past six months,
- Provide the initial order for DMEPOS to the DMEPOS provider within 30 days of the encounter and,
- Submit pertinent clinical documentation for DMEPOS services requiring prior authorization to the BMS' Utilization Management Contractor (UMC) for review.

Note: The practitioner may complete a mobility evaluation OR may refer the member to an enrolled licensed/certified medical professional such as a physical or occupational therapist who has experience and training in mobility evaluation. A therapist evaluation cannot take the place of the practitioner's examination.

DMEPOS Providers
DMEPOS Providers are individuals or groups enrolled in West Virginia Medicaid to provide and be reimbursed for covered DMEPOS services. Providers must:

- Maintain a current West Virginia State/Local business license,
- Maintain a retail store with inventory (display at least one item listed on the inventory and made readily available for delivery); maintain a visible sign of hours of operation; remain open to the public not less than 40 hours per week; have a toll free telephone number; have accessibility for the physically challenged; and be located within 30 miles of the West Virginia border,
- Obtain individual Medicaid provider numbers for each physical facility under the same ownership,
- Obtain a written order/prescription documenting the member's name, description of the item ordered, date of face-to-face encounter, pertinent diagnosis/conditions that relate to the need for an item, length of need, practitioner's signature, and date of signature (Reference 42 CFR 410.38(g)).
- Provide durable equipment, prosthetic, orthotic, and supplies per the prescribing practitioner's order(s),
- Maintain a written detailed product description that includes, but is not limited to, the model name/number; the supplier's charge for each item; and the signature and date signed for equipment/device/appliance/supplies provided to each member, which must be documented in the medical record at each occurrence.
- Provide the most economical items that meet the member's healthcare need. Expensive items are not covered when less costly items/services are available.
- Provide an appropriate replacement at no cost if the member is unable to use the equipment provided.
- Employ current licensed or credentialed orthotist, prosthetist, pedorthotist, and/or mastectomy or orthotic fitter by the National Commission for Certifying Agencies (NCCA), the American Board for Certification in Orthotics and Prosthetics (ABC), or Board for Orthotist/Prosthetist Certification (BOC), or Board for Certification in Pedorthics (BCP) if orthotics or prosthetics are provided.

- Maintain all documentation; proof of delivery of equipment/device; training on use of equipment/device; and tracking of serial, lot, and product numbers for purposes of recall.
- Participate in on-site reviews and provide individual member medical records upon request by BMS or its designee;
- Accept Medicaid's reimbursement as payment in full.

In addition, DME Providers must:

- Complete a written DME home assessment before authorization is requested, which includes, but is not limited to, the access to and physical layout of the home, doorway width, doorway thresholds, floor surfaces, and turning radius. The home must be able to accommodate the DME. Providers must document in the medical record at each occurrence.
- Provide weight/height appropriate wheelchairs for both children and adults that include capabilities for growth of the member.
- Employ West Virginia current licensed respiratory therapist, registered professional nurse, or physician to provide 24 hour coverage if respiratory/related accessory services or items are provided. A maximum call response time should be within 30 minutes to the member's home.

Additional considerations for all providers:

- Hospitals, hospital pharmacies, long term care facilities, physicians, physical therapists, speech therapists, or occupational therapists cannot be enrolled as medical equipment, prosthetic, orthotic, or medical supply providers. Home Health agencies can supply only medical supplies, not equipment, and appliances.

Refer to *Chapter 300, Provider Participation Requirements* for additional information.

506.3 FACE-TO-FACE ENCOUNTER

A face-to-face encounter justifying the medical necessity and a written order by the prescribing practitioner for the DMEPOS services requested is required. Documentation must be maintained in the member's record and be available to BMS or their designee upon request. Provision of equipment, devices, and supplies is determined solely by the member's needs within the home. BMS recommends DME and medical supplies that may require maintenance be provided from within the geographical area of the member's home. Service limits and prior authorization may apply. Prior authorization is required when service limits are exceeded.

Detailed written orders for face-to-face encounters must be in accordance with *42 CFR 410.38(g)*. A physician must document that the physician, the podiatrist, a physician assistant (PA), a nurse practitioner (NP) or a clinical nurse specialist (CNS) has had a face-to-face encounter with the member within six months prior to completing the detailed written order or the request will be denied.

If the face-to-face encounter documentation does not include information supporting that the member was evaluated or treated for a condition that supports the item(s) of DME ordered, the request will be denied. When conducting a review of a covered DME item, ordered by a PA, NP, or CNS, the UMC contractor shall verify that a physician (MD or DO) documented the occurrence of a face-to-face encounter by signing/co-

signing and dating the pertinent portion of the medical record indicating the occurrence of a face-to-face. If this information is not included, the request will be denied.

506.4 RESIDENTIAL FACILITIES

Any service required in an Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) or Psychiatric Residential Treatment Facility (PRTF) by the member is reimbursed as an all-inclusive rate. However, if the ICF/IID or PRTF does not provide the required DMEPOS, a written agreement between the ICF/IID or PRTF and an outside source must be developed and implemented to provide these items and services. The ICF/IID or PRTF is responsible for reimbursement for these items and services to the provider. Services provided by outside source(s) are included in the ICF/IID or PRTF rate and must not be billed separately. Refer to *Chapter 511, Intermediate Care Facility for Individuals with Intellectual Disabilities* or *Chapter 531, Psychiatric Residential Treatment Facility Services* for more information.

DME and/or medical supplies are not eligible for reimbursement as a direct billing to Medicaid if the Medicaid member is a resident of a nursing facility or a hospice facility at the time the DME is provided. Prosthetic and orthotic devices/appliances are subject to service limits and prior authorization requirements for members residing in a Long Term or Intermediate Care Facility. Refer *to* *Chapter 514, Nursing Facility Services* for additional information.

506.5 OUT-OF-NETWORK

For members receiving medically necessary covered services from an enrolled out-of-network facility or practitioner, a written prescription must be presented to a West Virginia enrolled provider for DMEPOS follow up care. West Virginia DMEPOS policies apply.

506.6 SCHOOL-BASED HEALTH SERVICES

For DMEPOS services requiring prior authorization, the prescribing practitioner must submit the order/request to the BMS UMC for medical necessity review. The member's Individual Education Plan (IEP), developed by the West Virginia Department of Education, must be available to BMS or its designee upon request.

506.7 PRIOR AUTHORIZATION

All requests for covered services requiring prior authorization must be submitted to the UMC for medical necessity determination. Nationally accredited, evidence-based, medically appropriate criteria, such as InterQual, or other medical appropriateness criteria approved by BMS, is utilized for reviewing medical necessity of services requested.

Retrospective authorization is available by the UMC in the following circumstances:

- A procedure/service denied by the member's primary payer, providing all requirements for the primary payer have been followed, including appeal processes; or
- Retroactive West Virginia Medicaid eligibility.

Refer to *Chapter 100, General Administration and Information* for additional information

506.8 BILLING AND REIMBURSEMENT

Medicare fee schedules are used to pay for DME, medical supplies, orthotic and prosthetic devices. Medicaid payment is made on a rental or purchase basis. The total payment for rented equipment may not exceed the cost of purchasing the equipment. Medical supplies are purchased items, while equipment may be initially purchased or reimbursed on a cap-rental basis.

Reimbursement for medical equipment, medical supplies, orthotics and prosthetics is based, when possible, on a percentage of the Medicare fee schedule. Medicaid payment is based on the lowest of the amount the provider charges for an item or the fee schedule amount less any third party payment. This same rule applies to payments for repairs. Reimbursement for unlisted/unpriced codes is based on an unaltered cost invoice including all discounts. All DMEPOS providers are reimbursed according to the published fee schedule, which may be accessed at http://www.dhhr.wv.gov/bms.

506.9 NON-COVERED SERVICES

Non-covered DMEPOS HCPCS codes are available in Appendix 506C - Non-Covered DMEPOS Supplies. This is not an all-inclusive list of non-covered codes.

Non-covered services are not eligible for a DHHR member fair hearing or provider desk/document reviews.

GLOSSARY

Definitions in *Chapter 200, Definitions and Acronyms* apply to all West Virginia Medicaid services, including those covered by this chapter. Definitions in this glossary are specific to this chapter.

Customized Equipment/Devices: DMEPOS is uniquely constructed for a specific Medicaid member based on the description and order of the member's treating practitioner.

Durable Medical Equipment: Equipment that can withstand repeated use; it 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.

DME, Prosthetics, Orthotics and Supplies Provider: An individual or group enrolled in West Virginia Medicaid to provide and be reimbursed for covered DMEPOS services provided to Medicaid members.

Face-to-Face Encounter: The prescribing practitioner conducts a face-to-face encounter for the purpose of evaluating and treating the member for their medical condition and determining the medical necessity of the DMEPOS services requested. A Telehealth encounter may be considered a face-to-face encounter.

Home Assessment: An on-site evaluation of the member's home by the supplier prior to the delivery of the prescribed DMEPOS.

Mastectomy Fitter: An individual trained and certified by the American Board of Certification in Orthotics and Prosthetics (ABC) or the Board for Orthotics and Prosthetics (BOC) in the fitting and delivery of breast prosthesis and mastectomy products and services.

Medical Necessity: Services and supplies that are: (1) appropriate and necessary for the symptoms, diagnosis or treatment of an illness; (2) provided for the diagnosis or direct care of an illness; (3) within the standards of good practice; (4) not primarily for the convenience of the plan, member, caregiver, or provider; (5) the most appropriate level of care that can be safely provided; and (6) the most efficient and cost effective services or supplies to meet the member's need.

Medical Supplies: Prescribed non-durable medical or surgical items that are consumable, expendable and appropriate for use by enrolled Medicaid members.

Mobility Assistive Equipment (MAE): Item(s) that offer assistance to individuals with a physical impairment resulting in a mobility defect (i.e., canes, crutches, walkers, manual wheelchairs, power wheelchairs, power operated vehicles, and strollers). Provision of equipment is determined solely by the member's needs within the home.

Orthotic Device: A device that is fabricated to comprehensive measurements and/or a mold or patient model in accordance with a prescription that requires substantial clinical and technical judgment in its design, fabrication, and fitting.

Orthotist: An individual certified by the American Board for Certifications in Orthotics and Prosthetics (ABC) or the Board for Certification of Orthotics and Prosthetics (BOC) to manage the provision of the comprehensive orthotic care based on clinical assessment.

Pedorthotist: An individual trained and certified by the Board of Certification in Pedorthics Inc., (BCP) in the design, manufacture, modification and/or fit of footwear, including shoes, orthoses and foot devices, to prevent or alleviate foot problems caused by disease, congenital defect, over use, or injury**.**

Power Mobility Device: A class of wheelchairs that includes both power wheelchairs and power operated vehicles that a member uses in the home.

Prosthetist: An individual trained and certified by the American Board for Certifications in Orthotics and Prosthetics (ABC) or the Board for Orthotics and Prosthetics (BOC) to manage the provision of the comprehensive prosthetic care based on clinical assessment.

Prosthetic Device: An artificial appliance or device to replace all or part of permanently inoperative or missing body part.

REFERENCES

West Virginia State Plan references DMEPOS at sections 3.1-A(7)(c), 3.1-B(7)(c), supplement 2 to attachments 3.1-A and 3.1-B(7)(c) and reimbursement at 4.19-B(7)(c).

CHANGE LOG

REPLACE	TITLE	CHANGE DATE	EFFECTIVE DATE
Entire Chapter	Durable Medical Equipment, Prosthetics, Orthotics, And Supplies (DMEPOS)		October 1, 2015