



DIVISION OF MEDICAL SERVICES PROVIDER BULLETIN

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DURABLE MEDICAL EQUIPMENT BULLETIN

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ELECTRONIC ATTACHMENTS

Effective December 1, 2005 Certificate of Medical Necessity for Durable Medical Equipment and Oxygen and Respiratory Equipment attachments must be filed electronically with Missouri Medicaid. Both attachments are now available through the Medicaid Internet health care claims screens at www.emomed.com. Instructions on the completion of these attachments are available through the "Help" feature. Providers may begin using the electronic attachments immediately.

DURABLE MEDICAL EQUIPMENT (DME) UNDER A HOME HEALTH PLAN OF CARE

Providers were notified in the Provider Bulletin "Medicaid SFY 06 Program Changes", Volume 27, Number 26, dated July 12, 2005 that effective September 1, 2005, individuals in a reduced benefit category of assistance may receive non-covered items of DME while under a home health plan of care. The item must be included in the home health plan of care and must meet all other requirements of the DME Program. The DME Provider must have in the patient's file a copy of the Home Health Plan of Care signed by the physician.

Claims for reimbursement of the DME item must include the certification "from" date that is on the home health plan of care. The home health certification "from" date must be entered on the claim as follows based on the media through which the claim is filed:

HCFA 1500 claim form: field 10d

E-mo-med medical claim: HH cert date field

837 transaction: Populate data element LQ01 with UT;
LQ02 with 485;
FRM01 with 3; and
FRM04 with the beginning certification date in eight digit
CCYYMMDD format (20050701).

Claims will only be reimbursed when a Home Health Program claim that falls in the certification period indicated on the DME claim has been processed. If a home health claim for the certification period has not been processed when the DME claim is received, the DME claim will cycle for up to 45 days waiting for the system to process a home health claim. If a home health claim is not processed, the DME claim will deny.

PROTECTIVE UNDERWEAR/PULL-ON

Missouri Medicaid's maximum allowable amount for adult and youth size disposable protective underwear/pull-ons is 70 cents for children under age twenty-one and over age three. The applicable procedure codes are listed below and continue to require prior authorization.

T4525 EP -Adult size disposable incontinence product, protective underwear/pull-on, small

T4526 EP -Adult size disposable incontinence product, protective underwear/pull-on, medium

T4527 EP -Adult size disposable incontinence product, protective underwear/pull-on, large

T4528 EP -Adult size disposable incontinence product, protective underwear/pull-on, extra large

T4534 EP -Youth size disposable incontinence product, protective underwear/pull-on

A4534 EP is not a valid procedure code for youth size disposable pull-on protective underwear and continues to have a Medicaid Maximum Allowable Amount of 50 cents each.

Prior Authorization requests must include documentation of the medical necessity for pull-on protective underwear instead of diapers/briefs. Some examples may include a patient who is ambulatory, physically independent, or self-toileting. Providers are expected to dispense a product that is absorbent enough to meet most recipient's incontinence needs. Prior authorization may be requested for up to 12 months.

Any combination of incontinence products is limited to 186 per month. Quantities in excess of this limit must include documentation of medical need from a physician, indicating a condition causing excessive fecal or urine output. The same quantity rule applies to individuals who may require diapers/briefs in combination with pull-on protective underwear. Quantities in excess of 186 per month may only be approved for six months instead of 12 months.

PAYMENT

The approval of a Prior Authorization, Medical Necessity or Oxygen and Respiratory Equipment Justification form approves the medical necessity of the requested service only. It does not guarantee payment, nor does it guarantee that the amount billed will be the amount reimbursed. The recipient must be Medicaid eligible and eligible for the service on the date of service or the date the equipment or prosthesis is received by the recipient. It is the provider's responsibility to verify eligibility for the item or service.

UPDATED FEE SCHEDULE

Attachment A to this bulletin is an updated fee schedule for all covered procedure codes in the DME Program. This schedule has been incorporated into Section 19 of the DME Provider Manual.

Procedure codes B4162 NU EP BA and B4162 NU EP BO are revised to be manually priced effective July 1, 2005. One unit is equal to 100 calories. The provider must submit an invoice of cost with the claim that clearly identifies the cost, the number of cans, and the number of calories per can.

Provider Bulletins are available on the DMS Website at <http://www.dss.mo.gov/dms/pages/bulletins.htm>. Bulletins will remain on the Published Bulletin site only until incorporated into the [provider manuals](#) as appropriate, then moved to the Archived Bulletin site.

Missouri Medicaid News: Providers and other interested parties are urged to go to the DMS Website at <http://dss.missouri.gov/dms/subscribe/MedNewsSubscribe.htm> to subscribe to the list serve to receive automatic notifications of provider bulletins, provider manual updates, and other official Missouri Medicaid communications via e-mail.

MC+ Managed Care: The information contained in this bulletin applies to coverage for:

- MC+ Fee-for-Service
- Medicaid Fee-for-Service
- Services not included in MC+ Managed Care

Questions regarding MC+ Managed Care benefits should be directed to the patient's MC+ Managed Care health plan. Before delivering a service, please check the patient's eligibility status by swiping the red MC+ card or by calling the Interactive Voice Response (IVR) System at 1-573-635-8908 and using Option One.

Provider Communications Hotline
573-751-2896