

Definition of Durable Medical Equipment

DME is considered equipment that can withstand repeated use. All DME must be prescribed by a physician. This equipment is primarily and customarily used to serve a medical purpose. This equipment is generally not useful to a client in the absence of illness, injury, or disability, and it is appropriate for use in the home or community setting. DME covered by the CSHCN Services Program must have either a well-established history of efficacy or, in the case of novel or unique equipment, valid, peer-reviewed evidence that the equipment corrects or ameliorates a covered medical condition or functional disability.

Since there is no single authority, such as a federal agency that confers the official status of DME on any device or product, the CSHCN Services Program within the Department of State Health Services (DSHS) retains the right to make such determination with regard to DME covered by the CSHCN Services Program. The CSHCN Services Program may reimburse both custom and noncustom DME.

Reimbursement

Items and/or services addressed in this policy are either reimbursed at a maximum fee determined by the Health and Human Services Commission (HHSC) or are manually priced. If an item is manually priced, the manufacturer's suggested retail price (MSRP) must be submitted for consideration of rental or purchase with appropriate procedure codes. Manually priced items are reimbursed at the retail price minus a discount of 18 percent as determined by HHSC.

Reimbursement rates for purchased DME are as follows:

- Providers must bill the delivery date as the date of service.
- Noncustomized equipment—The lower of the billed amount or the amount allowable by the Centers for Medicare & Medicaid Services (CMS), if available, or the Texas Medicaid Program.
- Customized, nonpowered equipment—The lower of the billed amount or the MSRP less 18 percent.
- Customized, powered equipment—The lower of the billed amount or the MSRP less 18 percent.
- Other—When no MSRP has been published, the lower of the billed amount or the dealer's cost plus 25 percent.
- Modifications will be reimbursed at the MSRP of the part minus 18 percent plus labor. Repairs will be reimbursed at the MSRP of the part minus 18 percent plus labor. Actual shipping costs may be paid if the component is serviced at a regional center. Replacement versus repair costs must be considered. Wheelchair modifications or repair requests for an existing seat system require assessment and a completed Wheelchair Seating Evaluation Form for authorization.
- Delayed delivery penalty—A claim submitted for customized DME that was delivered to the client more than 75 days after the authorization date shall be reduced by 10 percent.
- The CSHCN Services Program reimburses special needs car seats and travel restraints at the lower of the billed amount or the MSRP less 18 percent.
- The CSHCN Services Program requires that manufacturers' price sheets be submitted along with price quotes at the time of submission for authorization. If a price change occurs after authorization, the provider must submit a new price sheet with the claim to document the price changes so that the price discrepancy between the authorization and the claim can be manually reviewed.
- Any piece of DME that exceeds \$5,000.00 will require documentation that a less expensive alternative does not exist or, if one does exist, documentation must be submitted that clearly

states why any less expensive alternatives would not meet the client's needs. Occasionally, equipment under \$5,000.00 may require similar documentation when it is specifically requested by the CSHCN Services Program.

- A documentation of receipt form must be signed when the equipment is delivered. Providers must maintain a copy of this receipt in their file for the life of the piece of equipment or until the equipment is authorized for replacement.
- The CSHCN Services Program does not reimburse separately for associated DME charges including, but not limited to, battery disposal fees or state taxes. Reimbursement for associated charges is included in the reimbursement for the specific piece of equipment.

The following procedure codes are no longer a benefit of the CSHCN Services Program:

Procedure Codes					
L-E0160	L-E0161	L-E0167	J-E0200	J-E0202	L-E0210
J/L-E0215	L-E0220	J/L-E0225	L-E0230	L-E0235	L-E0238
J/L-E0239	L-E0325	L-E0607	L-E0710	L-E1031	9-E1084

The following procedure codes are no longer payable for a medical supply company:

Procedure Codes					
L-E0156	J/L-E0162	J/L-E0181	J/L-E0182	J-E0193	J/L-E0200
J/L-E0205	J/L-E0210	J/L-E0215	J/L-E0220	J/L-E0230	J/L-E0235
J/L-E0236	J/L-E0238	J/L-E0239	J/L-E0249	J-E0250	J/L-E0251
J/L-E0272	J/L-E0273	J-E0274	L-E0280	L-E0293	L-E0325
L-E0621	J-E0628	J/L-E0629	J-E0700	J-E0710	J/L-E0776
J/L-E0781	L-E0782	J-E0785	J/L-E0791	J/L-E0950	J/L-E0951
J/L-E0952	J/L-E0958	J/L-E0961	J/L-E0966	J/L-E0967	J/L-E0969
J/L-E0970	J/L-E0971	J/L-E0973	J/L-E0974	J/L-E0980	J/L-E0992
J/L-E1031	J/L-E1220				

The following procedure codes are no longer payable in the office setting:

Procedure Codes					
J-E0159	J/L-E0162	J/L-E0181	J/L-E0182	J-E0193	J/L-E0200
J-E0205	J-E0210	J/L-E0217	J/L-E0218	J-E0220	J-E0230
J/L-E0236	J-E0238	J/L-E0249	J-E0250	J-E0251	J-E0256
J-E0261	J-E0266	J-E0270	J-E0272	J-E0274	J-E0275
J-E0300	J/L-E0303	J/L-E0304	J-E0370	J-E0638	J-E0710
J/L-E0776	J/L-E0781	J/L-E0791	J-E0955	J-E0956	J-E0957
J-E0981	J-E0982	J-E1002	J-E1003	J-E1004	J-E2361
L-E2363	J-E2366				

The following procedure codes are no longer payable in other settings:

Procedure Codes					
J-E0300	J/L-E0303	J/L-E0304	J-E0638	J-E0710	J-E0955
J-E0956	J-E0957	J-E0981	J-E0982	J-E1002	J-E1003

J-E1004	J-E2361	L-E2363	J-E2366		
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Procedure codes J-E0187, J-E0199, J/L-E0231, and J-E0710 are no longer payable in the outpatient setting:

Additionally, procedure code J-E0710 is no longer payable to a medical supplier (DME) or in the inpatient hospital setting, and procedure code L-E0710 is no longer a benefit.

The following procedure codes may be reimbursed to custom DME providers:

Procedure Codes					
J/L-E0197	J/L-E0221	L-E0231	L-E0232	L-E0303	L-E0304
J/L-E0316	L-E0784	J-E1020	L-E1161	J-E1230	L-E1231
L-E1232	L-E1233	L-E1234	L-E1235	L-E1236	L-E1237
L-E1238	L-E2100				

The following procedure codes may be reimbursed to home health agencies:

Procedure Codes					
J-E0170	J-E0171	J-E0172	J/L-E0182	J-E0193	J/L-E0200
J/L-E0205	J/L-E0215	J/L-E0220	L-E0236	J/L-E0238	J/L-E0239
J/L-E0249	J/L-E0272	J/L-E0273	J/L-E0274	J/L-E0280	L-E0621
J-E0628	J/L-E0629	J-E0641	J-E0642	J-E0705	J-E1031
J/L-E2207	J/L-E2208	J/L-E2209	J-E2210	J-E2215	J-E2217
J-E2218	J-E2219	J-E2220	J-E2221	J-E2222	J-E2223
J-E2224	J-E2225	J-E2371	J/L-K0010	J/L-K0011	J/L-K0012
J-S8270	9-S8420	9-S8422	9-S8423	9-S8425	9-S8426

The following procedure codes may be reimbursed to home health DME, medical supplier (DME), and custom DME in the home:

Procedure Codes					
L-E0140	L-E0147	J/L-E0148	J/L-E0149	J-E0156	J/L-E0187
J-E0196	J-E0251	J-E0256	J-E0261	J-E0266	J/L-E0280
L-E0305	L-E0310	J/L-E0316	J-E0350	J-E0352	J-E0362
J/L-E0370	J/L-E0637	L-E0779	J-E0781	J-E0959	J-E0966
J-E0967	J-E0974	J-E0978	L-E0978	J-E0985	J-E0990
L-E0990	J-E1010	J-E1030	J-E1031	J/L-E1221	J/L-E1222
J/L-E1223	J/L-E1224	J/L-E1225	J/L-E1226	J/L-E1227	J/L-E1228

Procedure codes L-E0140, L-E0316, L-E0779, and L-E1221 are manually priced and reimbursed at the MSRP less 18 percent.

The following reimbursements are effective:

Procedure Code	Reimbursement	Procedure Code	Reimbursement
J-E0148	\$126.42	J-E1223	\$500.80
J-E0149	\$222.09	J-E1224	\$549.10
J-E0187	\$100.00	J-E1225	\$373.73

Procedure Code	Reimbursement	Procedure Code	Reimbursement
J-E0251	\$740.80	J-E1226	\$463.80
J-E0256	\$833.50	J-E1227	\$235.88
J-E0261	\$1,369.40	J-E1228	\$280.20
J-E0266	\$1,775.90	L-E0147	\$36.98
J-E0280	\$38.20	L-E0148	\$12.66
J-E0316	\$1,929.60	L-E0149	\$22.21
J-E0350	\$5,442.80	L-E0187	\$31.43
J-E0352	\$36.43	L-E0280	\$4.11
J-E0362	\$36.43	L-E0305	\$17.79
J-E0370	\$24.89	L-E0310	\$22.41
J-E0637	\$2,104.97	L-E0370	\$2.50
J-E0781	\$2,435.72	L-E0637	\$210.50
J-E0959	\$43.25	L-E0978	\$4.15
J-E0966	\$71.37	L-E0990	\$11.24
J-E0967	\$65.66	L-E1222	\$64.81
J-E0974	\$73.58	L-E1223	\$74.02
J-E0985	\$202.85	L-E1224	\$81.15
J-E1010	\$1,143.79	L-E1225	\$38.42
J-E1030	\$1,165.27	L-E1226	\$47.74
J-E1031	\$505.10	L-E1227	\$23.59
J-E1222	\$458.60	L-E1228	\$28.02

The following procedure codes may be reimbursed in the office and outpatient hospital settings:

Procedure Codes					
J-E0100	L-E0111	L-E0112	L-E0113	L-E0114	J/L-E0116
L-E0130	L-E0135	L-E0140	L-E0141	L-E0143	L-E0144
L-E0147	J/L-E0148	J-E0153	J-E0154	J-E0156	J-E0157

The following procedure codes may be reimbursed without age limitation:

Procedure Codes					
J-E0193	J/L-E0200	J/L-E0205	J/L-E0215	J-E0220	L-E0236
J-E0238	J/L-E0249	J-E0272	J/L-E0280	J-E0300	J-E0621
J-E0627	J-E0628	J-E0629	J-E0958	J-E0967	J-E0969
J-E0992	J-E1031	J/L-E1221	J/L-E1222	J/L-E1223	J/L-E1224
J/L-E1225	J/L-E1226	J/L-E1227	J/L-E1228		

Authorization Requirements

No more than one powered wheelchair may be authorized in a five-year period without documentation of medical necessity for a second or replacement powered wheelchair. If the power wheelchair is stolen or damaged in an accident, a policy report is required to justify the replacement when it is less than five years from receipt of the previous power wheelchair.

When billing for DME, providers must bill the delivery date as the date of service and delivery must occur within the authorization time span.

Providers must use procedure code J-E0316 instead of J-E1399 when requesting a safety enclosure or canopy for a hospital bed or crib.

Adaptive strollers may only be authorized when medically necessary and when the following conditions are met:

- The stroller has a firm back and seat or insert.
- A stroller (rather than a wheelchair) is specifically recommended by the licensed therapist completing the wheelchair evaluation.
- The requested stroller meets *all* recommendations made in the wheelchair evaluation.
- The client is not expected to develop motor skills necessary for self-propulsion, and *one* of the following:
 - The client is not expected to need a travel chair or wheelchair within two years of the request date.
 - The client is expected to be ambulatory within one year of the request date.

Requests for clients who are older than two years of age must meet the above criteria, and there must be medical documentation of the need for a stroller versus a wheelchair. Medical documentation should indicate that a client's particular condition, stature, and need for positioning allow adequate support from a stroller (completion of the Wheelchair Seating Evaluation Form would serve as medical documentation).

The following criteria must be met for the level of stroller requested:

Level 1: Basic stroller

- The client meets the criteria for a stroller.
- Bill procedure code J-E1035 without a modifier for a basic stroller - Level 1.

Level 2: Stroller with tray for oxygen and/or ventilator

- The client meets the criteria for a Level 1 stroller and is oxygen or ventilator dependent.
- Bill procedure code J-E1035 for a stroller with tray for oxygen and/or ventilator with modifier TF – Level 2.

Level 3: Stroller with positioning inserts

- The client meets the criteria for a Level 1 or Level 2 stroller and requires additional positioning support.
- Bill procedure code J-E1035 for a stroller with positioning inserts with modifier TG – Level 3.

The following criteria must be met for the level of commode chair requested:

Level 1: Stationary Commode Chair

- A stationary commode chair with fixed or removable arms may be considered for prior authorization when the following criteria are met:
- The client has a medical condition that results in an inability to ambulate to the bathroom safely (with or without mobility aids).
- Bill a commode chair procedure code without a modifier for a stationary commode chair.

Level 2: Mobile Commode Chair

- A mobile commode chair with fixed or removable arms may be considered for prior authorization when the following criteria are met:
- In addition to meeting the criteria for a Level 1 commode chair, the client must be on a bowel program and require a combination commode/bath chair for performing the bowel program and bathing after.
- A mobile commode chair will be considered for reimbursement with prior authorization only if the client does not also have any type of bath chair. If the client meets the criteria for a stationary bath chair, prior authorization of a stationary chair may be considered.
- Bill a commode chair procedure code with modifier TF for a mobile commode chair:

Level 3: Custom Commode Chair

- A custom stationary or mobile commode chair with fixed or removable arms and head, neck and or trunk support attachments may be considered for prior authorization when the following criteria are met:
- In addition to meeting the criteria for a Level 1 or 2-commode chair, the client must have a medical condition that results in an inability to support their head, neck, and/or trunk without assistance.
- A mobile custom commode chair may be considered for reimbursement only if the client does not also have any type of bath chair.
- Bill a commode chair procedure code with modifier TG for a custom stationary or mobile commode chair.

Extra-wide/Heavy Duty Commode Chair

- An extra wide/heavy duty commode chair is defined as one with a width greater than or equal to 23 inches and capable of supporting a patient who weighs 300 pounds or more.
- The client must meet the criteria for a Level 1, 2 or 3-commode chair and weigh 300 pounds or more.

Foot Rest

- A footrest is used to support feet during use of commode chair and may be considered when:
- The client meets the criteria for a Level 1, 2, or 3-commode chair and the footrest is necessary to support contractures of the lower extremities; for a client who is paraplegic or quadriplegic.

Replacement Commode Pail/Pan

- Replacement commode pails or pans may be prior authorized once per year. With documentation of medical necessity, additional quantities may be considered for prior authorization.

Continuous Passive Motion Device (CPM)

A CPM device will be authorized for rental for no more than a two-week period after knee surgery. Recertification for additional services may be considered with documentation of medical necessity. A CPM device will be authorized for rental only.

Hospital Beds without a Mattress

A hospital bed without a mattress may be considered with documentation of medical necessity for a custom or positioning mattress. A hospital bed without a mattress may be authorized only if a custom mattress or bed positioning system is also authorized due to medical necessity.

Wheelchair Modifications, Repairs, and Replacement

A Wheelchair Seating Evaluation Form completed by the occupational therapist or physical therapist who completed the seating assessment and who is not employed by the DME provider requesting the equipment modification must be submitted with the authorization request. Assessments will also be required when an existing seating system is being modified. CSHCN Services Program approved custom DME providers will be required to submit these forms with their requests for prior authorization of custom equipment.

If the power wheelchair is stolen or damaged in an accident, a police report is required to justify replacement when it is less than five years from receipt of the previous power wheelchair.

The CSHCN Services Program does not reimburse separately for associated DME charges including but not limited to battery disposal fees or state taxes. Reimbursement for associated charges is included in the reimbursement for the specific piece of equipment.

For more information, call the TMHP-CSHCN Services Program Contact Center at 1-800-568-2413.