

State Policy

The DMEPOS program covers medically necessary durable medical equipment, prosthetics, orthotics and disposable medical supplies (DMEPOS); which includes oxygen and related supplies, parenteral and enteral nutrition and medical foods.

The Medicaid Services Manual (MSM) is on the DHCFP website at <http://dhcfp.nv.gov> (click “Medicaid Manuals” on the DHCFP Index at left, then select “NV Medicaid Services Manual”).

MSM [Chapter 1300](#) provides DMEPOS policy including but not limited to:

- Documentation requirements
- Dispensing and delivery of items
- Recipient qualifications, coverage and limitations

MSM [Chapter 100](#) contains important information applicable to all provider types.



Products and services must be medically necessary and appropriate for the course and severity of the recipient’s condition, using the least costly and equally effective alternative to meet the recipient’s needs.

Providers are responsible to know the policies that are in effect on the date they provide services. Check <http://nevada.fhsc.com> and <http://dhcfp.nv.gov> at least weekly for updates, notices, Fee Schedules, policy changes and Web Announcements.

For your records, retain copies of the aforementioned documents. In the event of a future claims audit, these copies may be useful to show why a claim was billed the way it was. In accordance with MSM Chapter 3300, records supporting claims processing must be maintained for six years after payment.

DMEPOS Fee Schedule

The Provider Type 33 [DMEPOS Fee Schedule](#) identifies Healthcare Common Procedure Coding System (HCPCS), Level II codes which may be covered under the DMEPOS program. It is available online at <http://dhcfp.nv.gov/RatesUnit.htm> and provides the following information, as applicable:

The maximum allowable Medicaid rate

- Age criteria
- Service limits
- Prior authorization (PA) requirement type:
 - “00” means that PA is not required.
 - “01” means that PA is always required.
 - “02” means that PA is conditional and/or is required to exceed established service limits.

For questions related to rates in the fee schedule, refer to MSM [Chapter 700](#), “Rates.”

Prior Authorization

Some DMEPOS services/items require prior authorization. Requests may be submitted through the [Online Prior Authorization System \(OPAS\)](#) or by fax using:

- [Form FA-1A](#) to request continuing use of BIPAP and CPAP devices
- [Form FA-1B](#) to request mobility products with a per item reimbursement rate of \$500 or more
- [Form FA-1](#) for all other services

It is critical to submit complete and accurate clinical documentation on prior authorization requests. Documentation must include a physician’s/practitioner’s prescription or order and must fully support medical necessity of the item.

When submitting supporting medical documentation using OPAS, the name and credentials of the provider who supplied the information are required. Failure to provide this information may result in a denied request and/or may delay the determination.

MSM Chapter 1300, including Appendix B, lists specific prior authorization and documentation requirements. If you have any questions, please contact the Prior Authorization Department at (800) 525-2395.

Institutional Settings

Institutional settings include hospitals, nursing facilities (NFs) or intermediate care facilities for the mentally retarded (ICF/MRs).

Prior Authorization

DMEPOS provided or supplied to recipients in an ICF/MR or NF are included in the facility's per diem rate and are not separately payable by Medicaid. The facility's per diem rate is all-inclusive to cover all items needed during the stay.

The exceptions to this are as follows:

- Items provided in preparation for discharge to the community
- Custom fitted devices that are not suitable for use by any other individual
- Total Parenteral Nutrition (TPN)
- Enteral formulas administered via a feeding tube

When any DMEPOS item is provided in an institutional setting and will be billed by a DMEPOS provider to Nevada Medicaid or Nevada Check Up, a PA is required to determine exception, even if PA type is "00" on the DMEPOS Fee Schedule.

Place of Service Codes

The appropriate 2-digit place of service code must be used on prior authorization requests and in Field 24B on the CMS-1500 claim form to identify where the service was provided and if the recipient was in an institutional setting.

A recipient's "home" for DMEPOS purposes is not an institutional setting. For a list of codes, see <http://www.cms.hhs.gov/place-of-service-codes>

Claims/Billing

Claims must be submitted in accordance with the Healthcare Common Procedure Coding System (HCPCS) and national industry standards.

For HCPCS code descriptions that identify multiple components, the Nevada Medicaid rate includes all items in the description. Individual components may not be billed separately.

Claims must include the appropriate physician's diagnosis code in accordance with policy.

Providers must bill their usual and customary charges.

Provider may not include additional charges for delivery, set-up or training and education to recipient/caregivers as these services are included in the established rates.

Only bill for the actual number of medically necessary units dispensed/delivered to a recipient, regardless of the number of units allowed by policy and/or prior authorization.

Rental Items

Rental rates (identified by modifier "RR" in the DMEPOS Fee Schedule) are "monthly" unless otherwise indicated on the Fee Schedule and/or by the HCPCS code definition.

Bill at monthly intervals beginning with the date item was dispensed/delivered to the recipient; subsequent claims would be on the same date of the following months. The "From" and "To" dates of service must be the same date.

Billing Example

The DMEPOS item was delivered to the recipient on April 27.

- For the time period of April 27-May 27, bill one claim line with "April 27" in the "From" and "To" dates of service. Bill one unit in Field 24G.
- The next month's claim would be for equipment rental between May 27 and June 27. Bill one claim line with "May 27" as the "From" and "To" dates of service. Bill one unit in Field 24G.

Special Instructions for Common Products/Services



Inclusion of a code below does not certify coverage. See the DMEPOS Fee Schedule for coverage and limitations.

BIPAP Devices

Use [OPAS](#) or submit [form FA-1A](#) to request continued services for BIPAP devices no sooner than 61 days and no later than 120 days after initiation of therapy. Form FA-1A or an attached physician's note must contain a signed and dated statement declaring that the recipient is:

- Compliantly using the device an average of 4 hours per 24 hour period; and
- Benefiting from its use.

CPAP Devices

Use [OPAS](#) or submit [form FA-1A](#) to request continued services for CPAP devices no sooner than 61 days and no later than 120 days after initiation of therapy. The request must include all of the following:

- The number of hours a day the machine is used;
- The number of months the recipient has used the machine;
- Whether the recipient will continue to use the machine; and
- The name of the person who answered these questions (cannot be the DMEPOS supplier).

Diabetic Supplies

Diabetic equipment and supplies such as but not limited to: glucometers, test strips, lancets/lancet devices, insulin syringes and reagents must be billed through the pharmacy program (provider type 28), not through the DMEPOS program (provider type 33). Exceptions to this are insulin pumps (E0784), insulin pump-related supplies (A4231, A4232 and K0552) and diabetic shoes/fittings/modifications (A5500-A5507, A5512-A5513).

Refer to MSM Chapter 1200 (Pharmacy) and MSM Chapter 1300 (DMEPOS) for additional information. Inappropriate payments issued to a DMEPOS provider are subject to post payment recoupment.

Enteral/Gastrostomy

Enteral Nutrition/Formula does not require prior authorization when the recipient has a feeding tube *through which enteral feeding is administered* and the recipient's diagnosis includes gastrostomy or other artificial opening of gastrointestinal tract, such as jejunostomy or attention to one of these sites.

The exception to this is:

- All enteral nutrition for recipients in an institutional setting requires prior authorization and *may not* use the bypass described.

For **non-institutionalized recipients**, the appropriate ICD-9 code (**V44.1, V44.4 V55.1 or V55.4**) must be entered in Field 21 on the CMS-1500 claim form. Leave Field 23 blank.

The **Enteral Feeding Supply Kit, Pump fed** (code B4035) is limited to 31 units per month (1 unit equals 1 day). The Enteral Feeding Supply Kit, **Gravity fed** (code B4036) is limited to 30 units per month.

To **bill a partial month** for an Enteral Feeding Supply Kit, enter the first date of the billing cycle in the "From" date (Field 24A). Enter the same date for the "To" date (Field 24A also). Enter one unit for each day in Field 24G. For example, to bill for March 12-31, enter a "From" date of March 12, a "To" date of March 12 and a "20" in Field 24G.

The following scenario shows how to **bill continued services (rolling months)** for code B4035 (a 31-day billing frequency). The same instructions would apply to code B4036, except a 30-day billing frequency would be used.

- a) You begin your billing cycle on February 3. February has 28 days in it and 31 days from February 3 is March 5. Therefore, March 5 will be the last day of your billing cycle. On the claim form, enter "February 3" (the first day of the billing cycle) as the From date and as the To date (Field 24A). Enter "31" in Field 24G.
- b) The next 31-day billing cycle would start on March 6. March has 31 days in it and 31 days from March 6 is April 5. Therefore, April 5 will be the last day of your billing cycle. On the claim form, enter "March 6" as the From date and as the To date (Field 24A). Enter "31" in Field 24G.
- c) The next 31-day billing cycle would start on April 6. April has 30 days in it and 31 days from April 6 is May 6. Therefore, May 6 will be the

last day of your billing cycle. On the claim form, enter “April 6” as the From date and as the To date (Field 24A). Enter “31” in Field 24G.

For the following Enteral Formula codes, **100 calories equals 1 unit**. Enter the units in Field 24G on the CMS-1500 claim form.

- B4149
- B4150
- B4152
- B4153
- B4154
- B4155
- B4157
- B4158
- B4159
- B4160
- B4161
- B4162

For **Feeding Tubes**, use code B4087 to bill for standard gastrostomy/jejunostomy tubes and code B4088 without a modifier to bill for a low-profile gastrostomy/jejunostomy feeding tube. For the **Low Profile Gastrostomy Feeding Tube, MIC-KEY® Button** only, use B4088 with modifier BA. Prior authorization is required to exceed 1 unit every 3 months. Use B9998 to bill for Extension Sets.

Percutaneous Catheter/Tube Anchoring Devices (code A5200) and dressing holders (A4461 or A4463) used in conjunction with a gastrostomy or enterostomy tube are included in supply kit codes B4034-B4036 and may not be billed separately.

Incontinent Products

PA requests and claims must include a physician’s diagnosis of urinary or bowel incontinence and, when applicable, the primary diagnosis causing the incontinence. See MSM Chapter 1300 for details.

The prescriber’s order must also indicate the *number* of changes required per day or per month.

Providers must use the appropriate HCPCS “T codes” for incontinent care products; the use of “A codes” is no longer acceptable.

Supporting documentation must be maintained by the supplier for auditing purposes.

Limitations

The maximum allowable quantities for incontinent supplies are as follows and may only be supplied in accordance with established policies based on medical necessity:

Diapers and briefs are limited to 186 units in a rolling month and include any combination of codes T4521-T4524, T4529-T4530, T4533 and T4543.

Pull-ons or protective underwear are limited to 100 units per rolling month and include any combination of codes T4525-T4528, T4531-T4532 and T4534.

When diapers/briefs are used in combination with pull-ons/protective underwear, the maximum combined total cannot exceed 186 units in a rolling month.

For example, a recipient uses pull-ons during the day and diapers at night. The recipient changes the pull-ons 3 times per day x a 31 day month = 93 units per rolling month. The same recipient uses 1 diaper/brief during the night x a 31 day month = 31 units per rolling month. The maximum in each category does not exceed the maximum allowed per category; the maximum combined units total 124 and do not exceed 186 units.

Liners/shields, guards, pads, undergarments or underpads are limited to 100 units per rolling month and include any combination of products for codes T4535, T4541 and T4542. These may be billed in addition to diapers/briefs or pull-ons/protective underwear.

Product Sizes

The **size** of the product dispensed must:

- Be in accordance with the recipient’s weight, waist/girth measurement and belt-to-belt measurement;
- Be specifically indicated on the prescriber’s order; and
- Be in accordance with manufacturer’s size recommendations. Refer to a HCPCS book for exact sizing (small, med, large, etc.) for each code.



Code T4543 (bariatric size brief/diaper) is for individuals age 21 years and older with a minimum waist size of 60”. This code *always* requires prior authorization.

PA is required 1) for all individuals less than 4 years of age, 2) for any bariatric-size product (code T4543) or 3) when quantity limits need to be exceeded.

Non-Covered Items

Medicaid does not pay for products used for menses or for disposable gloves, wipes or washcloths used for incontinent care.

Intravenous Therapy Supplies

Intravenous therapy supplies including all HCPCS “S” codes listed on the [DMEPOS Fee Schedule](#) are billed through the DMEPOS program (provider type 33), not through provider type 37.

Medications added to TPN solution immediately prior to administration are billed through provider type 37 using the pharmacy Point of Sale (POS) system. See the [Provider Type 37 Billing Guidelines](#) and MSM [Chapter 1200](#) for coverage and limitations.

Orthotic and Prosthetic Devices

With the exception of “repair” codes and items with \$0.00 rates, DMEPOS providers (provider type 33) are not required to request prior authorization for “L codes” with a reimbursement rate of less than \$250.00. This does not negate the provider or supplier’s responsibility to practice within their scope and to follow DHCFP policy in MSM [Chapter 1300](#).

With the exception of codes L3260 and L3265, covered codes L3000-L3649 are limited to recipients under age 21. This includes orthopedic shoe inserts, arch supports, footwear, lifts, wedges, heels and related services.

Oxygen and Related Services

Oxygen contents (codes E0441, E0443 and E0444) are limited to one unit per month regardless of the actual number of refills provided. Claims submitted with more than one unit will be denied.

Power Mobility Devices (PMD)

Prescribing physician/practitioners may bill an additional fee using HCPCS code G0372 on the claim for the office visit (CPT 99211) during which the Medicare-required face-to-face examination/evaluation was completed.

For any PMD, exceptions to “included” items listed below must be prior authorized to determine medical necessity for an alternate, non-included substitution. Documentation must specify why the “included” item cannot be utilized to meet the recipient’s basic medical needs.

Power Operated Vehicle (POV), Basic Equipment Package

Upon initial issue, each POV must include all items below; separate billing/payment is not acceptable.

- Battery or batteries required for operation
- Battery charger, single mode
- Weight appropriate upholstery and seating system
- Tiller steering
- Complete set of tires
- All accessories needed for safe operation
- Non-expandable controller with proportional response to input

Power Wheelchair (PWC), Basic Equipment Package

The PWC Basic Equipment Package for each power wheelchair code is required to include all these items on initial issue (i.e., no separate billing/payment at the time of initial issue). The statement that an item may be separately billed does not necessarily indicate coverage.

- Lap belt or safety belt. Shoulder harness/straps or chest straps/vest may be billed separately.
- Battery charger, single mode.
- Complete set of tires and casters, any type.
- Legrests. There is no separate billing/payment if fixed, swingaway or detachable non-elevating legrests with or without calf pad are provided. Elevating legrests may be billed separately only if determined medically necessary.
- Footrests/foot platform. There is no separate billing/payment if fixed, swingaway or detachable footrests or a foot platform without angle adjustment are provided. There is no separate billing for angle adjustable footplates with Group 1 or 2 PWCs. Angle adjustable footplates may be billed separately with Group 3, 4 and 5 PWCs when determined medically necessary.
- Armrests. There is no separate billing/payment if fixed, swingaway or detachable non-adjustable height armrests with arm pad are provided. Adjustable height armrests may be billed separately when determined to be medically necessary.

- Any weight-specific components (braces, bars, upholstery, brackets, motors, gears, etc.) as required by patient weight capacity.
- Any seat width and depth. Exception: for Group 3 and 4 PWCs with a sling/solid seat/back, the following may be billed separately when determined medically necessary:
 - For Standard Duty, seat width and/or depth greater than 20 inches;
 - For Heavy Duty, seat width and/or depth greater than 22 inches;
 - For Very Heavy Duty, seat width and/or depth greater than 24 inches;
 - For Extra Heavy Duty, no separate billing.
- Any back width. Exception: for Group 3 and 4 PWCs with a sling/solid seat/back, the following may be billed separately when determined medically necessary:
 - For Standard Duty, back width greater than 20 inches;
 - For Heavy Duty, back width greater than 22 inches;
 - For Very Heavy Duty, back width greater than 24 inches;
 - For Extra Heavy Duty, no separate billing.
- Controller and Input Device. There is no separate billing/payment if a non-expandable controller and a standard proportional joystick (integrated or remote) is provided. An expandable controller, a nonstandard joystick (i.e., non-proportional or mini, compact or short throw proportional) or other alternative control device may be billed separately if determined to be medically necessary.

Ventilators (Code E0463)

When one unit is provided, the prior authorization and claim must indicate one unit and the claim must be billed using the provider's usual and customary charge.

Providers who deliver one unit for use and one unit on site as a back-up are required to have an approved prior authorization for 2 units. Providers must complete the claim form indicating 2 units on the same claim line using their usual and customary charge.