2010

TEXAS MEDICAID

PROVIDER PROCEDURES MANUAL

Volume 2

PROVIDER HANDBOOKS

DURABLE MEDICAL EQUIPMENT, MEDICAL SUPPLIES, AND NUTRITIONAL PRODUCTS HANDBOOK

The Texas Medicaid & Healthcare Partnership (TMHP) is the claims administrator for Texas Medicaid under contract with the Texas Health and Human Services Commission.

DURABLE MEDICAL EQUIPMENT, MEDICAL SUPPLIES, AND NUTRITIONAL PRODUCTS HANDBOOK

TEXAS
Health and Human
Services Commission

DURABLE MEDICAL EQUIPMENT, MEDICAL SUPPLIES, AND NUTRITIONAL PRODUCTS HANDBOOK

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Note: *A comprehensive Index, including Volume 1 and all handbooks from Volume 2, is included at the end of Volume 1 (General Information).*

1. TEXAS MEDICAID (TITLE XIX) HOME HEALTH SERVICES

1.1 Enrollment

To enroll in the Home Health Services Program, home health services and Home and Community Support Services (HCSSA) providers must complete the Texas Medicaid Provider Enrollment Application. Medicare certification is required for providers that are licensed as a Licensed and Certified Home Health Agency. Providers that are licensed as a Licensed Home Health Agency are not required to enroll in Medicare as a prerequisite to enrollment with Texas Medicaid.

Licensed and certified home health agencies that are enrolled as Medicaid providers can provide personal care services (PCS) using their existing provider identifier. PCS for clients 20 years of age or younger will be provided by the Texas Health and Human Services Commission (HHSC) under the PCS benefit.

Refer to: Subsection 3.8, "Personal Care Services (PCS) (CCP)" in *Children's Services Handbook (Vol. 2, Provider Handbooks).*

To provide Comprehensive Care Program (CCP) services, HCSSA providers must follow the enrollment procedures in subsection 6.2.1, "THSteps Medical Provider Enrollment" in *Children's Services Handbook* (*Vol. 2, Provider Handbooks*).

Enrolled providers of durable medical equipment (DME) and/or expendable medical supplies will be issued a DME-Home Health Services provider identifier that is specific to home health providers. All DME providers must be Medicare-certified before applying for enrollment in Texas Medicaid.

Providers may download the Texas Medicaid Provider Enrollment Application at www.tmhp.com or request a paper application form by contacting TMHP directly at 1-800-925-9126.

Providers may also obtain the paper enrollment application by writing to the following address:

Texas Medicaid & Healthcare Partnership
Provider Enrollment
PO Box 200795
Austin, TX 78720-0795
1-800-925-9126
Fax: 1-512-514-4214

Providers may request prior authorization for home health services by contacting:

Texas Medicaid & Healthcare Partnership
Home Health Services
PO Box 202977
Austin, TX 78720-2977
1-800-925-8957
Fax: 1-512-514-4209

1.1.1 Change of Address/Telephone Number

A current physical and mailing address and telephone number must be on file for the agency/company to receive Remittance & Status (R&S) reports, reimbursement checks, Medicaid provider procedures manuals, the *Texas Medicaid Bulletin* (bimonthly update to the Texas Medicaid Provider Procedures Manual), and all other TMHP correspondence. Promptly send all address and telephone number changes to TMHP Provider Enrollment at the address listed above under subsection 1.1, "Enrollment " in this handbook.

1.1.2 Pending Agency Certification

Home health agencies and DME-Home Health Services (DMEH) suppliers submitting claims before the enrollment process is complete or without prior authorization for services issued by TMHP Home Health Services Prior Authorization Department will not be reimbursed. The effective date of enrollment is when all Medicaid provider enrollment forms are received and approved by TMHP.

Upon the receipt of notice of Medicaid enrollment, the agency/supplier must contact the TMHP Home Health Services Prior Authorization Department before serving a Medicaid client for services that require a prior authorization number. Prior authorization cannot be issued before Medicaid enrollment is complete. Regular prior authorization procedures are followed at that time.

Home health agencies that provide laboratory services must comply with the rules and regulations of the *Clinical Laboratory Improvement Amendments* (CLIA). Providers who do not comply with CLIA will not be reimbursed for laboratory services.

Providers must not submit home health services claims for payment until Medicaid certification is received and a prior authorization number is assigned.

Refer to: Subsection 2.1.1, "Clinical Laboratory Improvement Amendments (CLIA)" in *Radiology, Laboratory and Physiological Lab Services Handbook* (*Vol. 2, Provider Handbooks*).

1.2 Services/Benefits, Limitations and Prior Authorization

Home health services include Home Health Skilled Nursing (SN), Home Health Aide (HHA), Physical Therapy (PT) and Occupational Therapy (OT) services, Durable Medical Equipment (DME), and expendable medical supplies that are provided to eligible Medicaid clients at their place of residence.

Note: *THSteps-eligible clients who qualify for medically necessary services beyond the limits of this Home Health Services benefit may receive those services through CCP.*

Refer to: Subsection 6.1.1, "Overview" in *Children's Services Handbook* (*Vol. 2, Provider Handbooks*) for more information on clients birth through 20 years of age.

Section 3, "Home Health Services For Nursing and Therapy" in the *Nursing and Therapy Services Handbook* (*Vol. 2, Provider Handbooks*) for more information on nursing and therapy services.

1.2.1 Home Health Services

The benefit period for home health professional services is up to 60 days with a current Plan of Care (POC). In chronic and stable situations, the Home Health Services (Title XIX) Durable Medical Equipment (DME)/Medical Supplies Physician Order Form is valid for up to, but no more than, 6 months from the date of the physician's signature on the form. If necessary, DME and supplies ordered on a Home Health Services (Title XIX) Durable Medical Equipment (DME)/Medical Supplies Physician Order Form may be prior authorized for up to 6 months with medical necessity determination. Because a Medicaid client's eligibility period is for one month, providers should bill for a one month supply at a time, even though prior authorization may be granted for up to 6 months. This extended prior authorization period begins on the date that clients receive their first prior authorized home health service. Texas Medicaid allows additional visits, DME, or supplies that have been determined to be medically necessary and have been prior authorized by TMHP Home Health Services Prior Authorization Department. Providers must retain all orders, signed and dated Title XIX forms, delivery slips, and invoices for all supplies provided to a client and must disclose them to the HHSC or its designee on request. These records and claims must be retained for a minimum of five years from the date of service (DOS) or until audit questions, appeals, hearings, investigations, or court cases are resolved. Use of these services is subject to retrospective review.

1.2.1.1 Prior Authorization

Prior authorization must be obtained for all professional services, some supplies, and most DME from TMHP within three business days of start of care (SOC). Although providers may supply some DME and medical supplies to a client without prior authorization, they must still retain a copy of the Home Health Services (Title XIX) Durable Medical Equipment (DME)/Medical Supplies Physician Order Form that has Section B completed, signed, and dated by the client's attending physician.

The following prior authorization requests can be submitted on the TMHP website at www.tmhp.com:

- Home Health Services (Title XIX) Durable Medical Equipment (DME)/Medical Supplies Physician Order Form
- Medicaid Certificate of Medical Necessity for CPAP/BiPAP or Oxygen Therapy
- Medicaid Certificate of Necessity for Chest Physiotherapy Device Form—Initial Request
- Medicaid Certificate of Necessity for Chest Physiotherapy Device Form—Extended Request
- Statement for Initial Wound Therapy System In-Home Use
- Statement for Recertification of Wound Therapy System In-Home Use
- Wheelchair/Scooter/Stroller Seating Assessment Form (CCP/Home Health Services) (Attachments will be sent separately due to size and detailed information)
- Home Health Services POC

Refer to: Subsection 5.3.1, "Prior Authorization Requests Through the TMHP Website" in Section 5, "Prior Authorization" (*Vol. 1, General Information*) for more information, including mandatory documentation requirements.

If a client's primary coverage is private insurance, and Medicaid is secondary, prior authorization is required for Medicaid reimbursement. If the primary coverage is Medicare, Medicare approves the service, and Medicaid is secondary, prior authorization is not required. TMHP will pay only the coinsurance and/or deductible. If Medicare denied the service, then Medicaid prior authorization is required. TMHP must receive a prior authorization request within 30 days of the date of Medicare's final disposition. The medicare remittance advice notice (MRAN) containing Medicare's final disposition must accompany the prior authorization request. If the service is a Medicaid-only service, prior authorization is required within three business days of the DOS. The provider is responsible for determining if eligibility is effective by using AIS or an electronic eligibility inquiry through TMHP EDI gateway.

The provider must contact the TMHP Home Health Services Prior Authorization Department within three business days of the start of care (SOC) for professional services or the DOS for DME/medical supplies to obtain prior authorization following the registered nurse's (RN) assessment/evaluation of the client in the home setting. Although recommended, a home visit is not required if only DME or supplies are needed and requested by the physician on a Title XIX form. When contacting TMHP by telephone for prior authorization, the nurse who made the initial assessment visit in the client's home must make this call to answer questions about the client's condition as it relates to the medical necessity.

If inadequate or incomplete information is provided or medical necessity is lacking, the provider will be requested to furnish additional documentation as required to make a decision on the request. Because it often must be obtained from the client's physician, providers have two weeks to submit the requested documentation. If the additional documentation is received within the two-week period, prior authorization can be considered for the original date of contact. If the additional documentation is received more than two weeks from the request for the documentation, prior authorization is not considered before the date the additional documentation is received. It is the DME/supplier/home health agency's responsibility to contact the physician to obtain the requested additional documentation.

TMHP Home Health Services toll-free number is 1-800-925-8957. The Home Health Services Prior Authorization Checklist is a useful resource for home health agency providers completing the prior authorization process. This optional form offers the nurse a detailed account of the client's needs when completed. Contact TMHP In-Home Care Contact Center at 1-800-846-7470 for more information.

Refer to: Subsection 1.2.2.2, "Prior Authorization" in this handbook for DME prior authorization information.

Subsection 1.3.1, "Medicaid Relationship to Medicare " in this handbook.

Client eligibility for Medicaid is for one month at a time. Providers should verify eligibility every month. Prior authorization does not guarantee payment.

1.2.2 Durable Medical Equipment (DME) and Supplies

Texas Medicaid defines DME as:

> *Medical equipment or appliances that are manufactured to withstand repeated use, ordered by a physician for use in the home, and required to correct or ameliorate a client's disability, condition, or illness.*

Since there is no single authority, such as a federal agency, that confers the official status of "DME" on any device or product, HHSC retains the right to make such determinations with regard to DME benefits of Texas Medicaid. DME benefits of Texas Medicaid 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.

Requested DME may be a benefit when it meets the Medicaid definition of DME. The majority of DME and expendable supplies are covered Home Health Services. If a service cannot be provided for a client 20 years of age or younger through Home Health Services, these services may be covered through CCP if they are determined to be medically necessary.

To be reimbursed as a home health benefit:

- The client must be eligible for home health benefits.
- The criteria listed for the requested equipment or supply must be met.
- The requested equipment or supply must be medically necessary, and Federal Financial Participation (FFP) must be available.
- The client's health status would be compromised without the requested equipment or supply.
- The requested equipment or supplies must be safe for use in the home.
- The client must be seen by a physician within one year of the DOS.

The provider must sign and have the client sign Form DM.1, "DME Certification and Receipt Form (3 pages)" in Section 4, Forms, in this handbook for all purchased DME for Medicaid clients before submitting a claim for payment. The client's signature means the DME is the property of the client. The certification form must include the date the client received the DME, the name of the item, and the printed names and signatures of the provider and the client or primary caregiver. This form must be maintained by the DME provider in the client's record.

The signed and dated DME Certification and Receipt Form must be submitted to TMHP for claims and appeals for DME that meet or exceed a billed amount of $2,500.00. The form must also be submitted when multiple items that meet or exceed a total billed amount of $2,500.00 are billed for the same DOS. The form is required in addition to obtaining prior authorization, when applicable.

If the DME Certification and Receipt Form is not submitted to TMHP, the claim payment or appeal will be reviewed and will be eligible for recoupment. Incomplete forms will be returned to the provider for correction and resubmission.

TMHP will contact clients that received DME that meets or exceeds a billed amount of $2,500.00 to verify that services were rendered. If the delivery of the equipment cannot be verified by the client, the claim payment will be eligible for recoupment.

The provider must keep all Home Health Services (Title XIX) Durable Medical Equipment (DME)/Medical Supplies Physician Order Forms and Addendum to Home Health Services (Title XIX) DME/Medical Supplies Physician Order Forms on file. Providers must retain delivery slips or invoices and the signed and dated DME Certification and Receipt Form documenting the item and date of delivery for all DME provided to a client and must disclose them to HHSC or its designee on request.

- The DME must be used for medical or therapeutic purposes, and supplied through an enrolled DMEH provider in compliance with the client's POC.
- These records and claims must be retained for a minimum of five years from the DOS or until audit questions, appeals, hearings, investigations, or court cases are resolved. Use of these services is subject to retrospective review.

Note: *All purchased equipment must be new upon delivery to client. Used equipment may be utilized for lease, but when purchased, must be replaced with new equipment.*

HHSC/TMHP reserves the right to request the Home Health Services (Title XIX) Durable Medical Equipment (DME)/Medical Supplies Physician Order Form and/or Addendum to Home Health Services (Title XIX) DME/Medical Supplies Physician Order Form at any time.

DME must meet the following requirements to qualify for reimbursement under Home Health Services:

- The client received the equipment as prescribed by the physician.
- The equipment has been properly fitted to the client and/or meets the client's needs.
- The client, the parent or guardian of the client, and/or the primary caregiver of the client, has received training and instruction regarding the equipment's proper use and maintenance.

DME must:

- Be medically necessary due to illness or injury or to improve the functioning of a body part, as documented by the physician in the client's POC or the Home Health Services (Title XIX) Durable Medical Equipment (DME)/Medical Supplies Physician Order Form.
- Be prior authorized by the TMHP Home Health Services Prior Authorization Department for rental or purchase of supplies for most equipment. Some equipment does not require prior authorization. Prior authorization for equipment rental can be issued for up to six months based on diagnosis and medical necessity. If an extension is needed, requests can be made up to 60 days before the start of the new prior authorization period with a new Home Health Services (Title XIX) Durable Medical Equipment (DME)/Medical Supplies Physician Order Form.
- Meet the client's existing medical and treatment needs.
- Be considered safe for use in the home.
- Be provided through an enrolled DMEH provider/supplier.

Note: *THSteps-eligible clients who qualify for medically necessary services beyond the limits of this home health benefit will receive those services through CCP.*

DME that has been delivered to the client's home and then found to be inappropriate for the client's condition will not be eligible for an upgrade within the first six months following purchase unless there had been a significant change in the client's condition, as documented by the physician familiar with the client. All adjustments and modifications within the first six months after delivery are considered part of the purchase price.

All DME purchased for a client becomes the Medicaid client's property upon receipt of the item. This property includes equipment delivered which will not be prior authorized or reimbursed in the following instances:

- Equipment delivered to the client before the physician signature date on the POC or Home Health Services (Title XIX) Durable Medical Equipment (DME)/Medical Supplies Physician Order Form or Addendum to Home Health Services (Title XIX) DME/Medical Supplies Physician Order Form.
- Equipment delivered more than three business days before obtaining prior authorization from the TMHP Home Health Services Prior Authorization Department and meets the criteria for purchase.

Additional criteria:

- The TMHP Home Health Services Prior Authorization Department will make the final determination whether DME will be rented, purchased, or repaired based on the client's duration and use needs.
- Periodic rental payments are made only for the lesser of either the period of time the equipment is medically necessary, or when the total monthly rental payments equal the reasonable purchase cost for the equipment.
- Purchase is justified when the estimated duration of need multiplied by the rental payments would exceed the reasonable purchase cost of the equipment or it is otherwise more practical to purchase the equipment.
- If a DME/medical supply provider is unable to deliver a prior authorized piece of equipment or supply, the provider should allow the client the option of obtaining the equipment or supplies from another provider.

Items and/or services are reimbursed at the lesser of:

- The provider's billed charges
- The published fee determined by HHSC
- Manual pricing as determined by HHSC based on the following:
  - The MSRP less 18 percent or the average wholesale price (AWP) less 10.5 percent, whichever is applicable
  - The provider's documented invoice cost

If an item is manually priced, providers must submit documentation of one of the following for consideration of purchase or rental with the appropriate procedure codes:

- The MSRP or AWP, whichever is applicable
- The provider's documented invoice cost

Those who supply DME equipment and supplies to Medicaid Managed Care clients must obtain a prior authorization form. Services and supplies for STAR+PLUS Medicaid Qualified Medicare Beneficiary (MQMB) clients should be billed to Medicare first. If denied, submit them to TMHP for consideration. The STAR+PLUS health plan is not responsible for these services.

Purchased DME is anticipated to last a minimum of 5 years, unless otherwise noted, and may be considered for replacement when the time has passed and/or the equipment is no longer functional or repairable. A copy of the police or fire report, when appropriate, and the measures to be taken to prevent reoccurrence must be submitted.

1.2.2.1 Repairs

A DME repair will be considered based on the age of the item and cost to repair it.

A request for repair of DME must include a statement or medical information from the attending physician substantiating that the medical appliance or equipment continues to serve a specific medical purpose and an itemized estimated cost list from the vendor or DME provider of the repairs. Rental equipment may be provided to replace purchased medical equipment for the period of time it will take to make necessary repairs to purchased medical equipment.

Repairs will not be prior authorized in situations where the equipment has been abused or neglected by the client, client's family, or caregiver. Routine maintenance of rental equipment is the provider's responsibility. For clients requiring wheelchair repairs only, the date last seen by physician does not need to be filled in on the Home Health Services (Title XIX) Durable Medical Equipment (DME)/Medical Supplies Physician Order Form.

1.2.2.2 Prior Authorization

Prior authorization is required for most DME and supplies provided through Home Health Services. These services include accessories, modifications, adjustments, and repairs for the equipment.

Providers must submit a completed Home Health Services (Title XIX) Durable Medical Equipment (DME)/Medical Supplies Physician Order Form to the TMHP Home Health Services Prior Authorization Department.

A completed Home Health Services (Title XIX) Durable Medical Equipment (DME)/Medical Supplies Physician Order Form prescribing the DME and/or supplies must be signed and dated by a physician familiar with the client before requesting prior authorization for all DME equipment and supplies. All signatures and dates must be current, unaltered, original, and handwritten. Computerized or stamped signatures/dates will not be accepted. The completed Home Health Services (Title XIX) Durable Medical Equipment (DME)/Medical Supplies Physician Order Form must include the procedure codes and numerical quantities for services requested. The completed, signed, and dated form must be maintained by the DME provider and the prescribing physician in the client's medical record. The completed Home Health Services (Title XIX) Durable Medical Equipment (DME)/Medical Supplies Physician Order Form with the original dated signature must be maintained by the prescribing physician.

To complete the prior authorization process by paper, the provider must fax or mail the completed Home Health Services (Title XIX) Durable Medical Equipment (DME)/Medical Supplies Physician Order Form to the Home Health Services Prior Authorization Department and retain a copy of the signed and dated form in the client's medical record at the provider's place of business.

To complete the prior authorization process electronically, the provider must complete the prior authorization requirements through any approved electronic methods and retain a copy of the signed and dated Home Health Services (Title XIX) Durable Medical Equipment (DME)/Medical Supplies Physician Order Form in the client's medical record at the provider's place of business.

The date last seen by the physician must be within the past 12 months unless a physician waiver is obtained. The physician's signature on the Home Health Services (Title XIX) Durable Medical Equipment (DME)/Medical Supplies Physician Order Form is only valid for 90 days before the initiation of services.

Providers must obtain prior authorization within three business days of providing the service by calling TMHP Home Health Services Prior Authorization Department or faxing the Home Health Services (Title XIX) Durable Medical Equipment (DME)/Medical Supplies Physician Order Form. A determination will be made as to whether the equipment will be rented, purchased, repaired, modified, or denied based on the client's medical necessity.

To facilitate a determination of medical necessity and avoid unnecessary denials when requesting prior authorization, the physician must provide correct and complete information supporting the medical necessity of the equipment and/or supplies requested, including:

- Accurate diagnostic information pertaining to the underlying diagnosis/condition as well as any other medical diagnoses/conditions, to include the client's overall health status.

- Diagnosis/condition causing the impairment resulting in a need for the equipment and/or supplies requested.

Prior authorization is required for replacement.

Prior authorization for equipment replacement is considered within five years of equipment purchase when one of the following occurs:

- There has been a significant change in the client's condition such that the current equipment no longer meets the client's needs
- The equipment is no longer functional and either cannot be repaired or it is not cost-effective to repair

Replacement of equipment is also considered when loss or irreparable damage has occurred. The following must be submitted with the prior authorization request:

- A copy of the police or fire report, when appropriate
- A statement about the measures to be taken in order to prevent reoccurrence

Payment may be prior authorized for repair of purchased DME. Maintenance of rental equipment (including repairs) is the supplier's responsibility. The toll-free number for the TMHP Home Health Services Prior Authorization Department is 1-800-925-8957. Requests for repairs must include the cost estimate, reasons for repairs, age of equipment, and serial number.

1.2.3 Medical Supplies

Medical supplies are benefits of the Home Health Services Program if they meet the following criteria:

- A completed Home Health Services (Title XIX) Durable Medical Equipment (DME)/Medical Supplies Physician Order Form, prescribing the DME and/or supplies must be signed and dated by a physician familiar with the client before requesting prior authorization for all DME and supplies. All signatures and dates must be current, unaltered, original, and handwritten. Computerized or stamped signatures/dates will not be accepted. The completed Home Health Services (Title XIX) Durable Medical Equipment (DME)/Medical Supplies Physician Order Form must include the procedure codes and numerical quantities for the services requested.
- The provider must contact TMHP within 3 business days of providing the supplies to the client and obtain prior authorization, if required.
- The requesting provider and ordering physician must keep all Home Health Services (Title XIX) Durable Medical Equipment (DME)/Medical Supplies Physician Order Forms and Addendum to Home Health Services (Title XIX) DME/Medical Supplies Physician Order Forms on file. The physician must maintain the original signed and dated Home Health Services (Title XIX) Durable Medical Equipment (DME)/Medical Supplies Physician Order Form copy in their records. Providers must retain individual delivery slips or invoices for each DOS that document the date of delivery for all supplies provided to a client and must disclose them to HHSC or its designee upon request. Documentation of delivery must include one of the following:
  - Delivery slip or invoice signed and dated by client/caregiver.
  - A dated carrier tracking document with shipping date and delivery date must be printed from the carrier's website as confirmation that the supplies were shipped and delivered. The dated carrier tracking document must be attached to the delivery slip or invoice.

The dated delivery slip or invoice must include the client's full name and address to which supplies were delivered, and an itemized list of goods that includes the descriptions, and numerical quantities of the supplies delivered to the client. This document could also include prices, shipping weights, shipping charges, and any other description.

All claims submitted for DME supplies must include the same quantities or units that are documented on the delivery slip or invoice and on the Home Health Services (Title XIX) Durable Medical Equipment (DME)/Medical Supplies Physician Order Form. They must reflect the number of units by which each product is measured. For example, diapers are measured as individual units. If one package of 300 diapers is delivered, the delivery slip or invoice and the claim must reflect that 300 diapers were delivered and not that one package was delivered. Diaper wipes are measured as boxes/packages. If one box of 200 wipes is delivered, the delivery slip or invoice and the claim must reflect that one box was delivered and not that 200 individual wipes were delivered. There must be one dated delivery slip or invoice for each claim submitted for each client. All claims submitted for DME supplies must reflect the same date as the delivery slip or invoice and the same timeframe covered by the Home Health Services (Title XIX) Durable Medical Equipment (DME)/Medical Supplies Physician Order Form. The DME Certification and Receipt Form is still required for all equipment delivered.

Note: *These records and claims must be retained for a minimum of five years from the DOS or until audit questions, appeals, hearings, investigations, or court cases are resolved. Use of these services is subject to retrospective review.*

- The requesting provider or ordering physician must document medical supplies as medically necessary in the client's POC or on a completed Home Health Services (Title XIX) Durable Medical Equipment (DME)/Medical Supplies Physician Order Form and Addendum to Home Health Services (Title XIX) DME/Medical Supplies Physician Order Form.

HHSC/TMHP reserves the right to request the signed and dated Home Health Services (Title XIX) Durable Medical Equipment (DME)/Medical Supplies Physician Order Form and/or Addendum to Home Health Services (Title XIX) DME/Medical Supplies Physician Order Form at any time.

Note: *Client eligibility can change monthly. Providers are responsible for verifying eligibility before providing supplies.*

The DOS is the date on which supplies are delivered to the client and/or shipped by a carrier to the client as evidenced by the dated tracking document attached to the invoice for that date. The provider must maintain the signed and dated records supporting documentation that an item was not billed before delivery. These records are subject to retrospective review.

Note: *THSteps-eligible clients who qualify for medically necessary services beyond the limits of this home health benefit will receive those services through CCP.*

Refer to: Subsection DM.3, "Home Health Services (Title XIX) DME/Medical Supplies Physician Order Form Instructions (2 pages)" in Section 4, Forms, of this handbook.

Subsection DM.4, "Home Health Services (Title XIX) Durable Medical Equipment (DME)/Medical Supplies Physician Order Form" in Section 4, Forms, of this handbook.

Subsection 3.5, "Durable Medical Equipment (DME) Supplier (CCP)" in *Children's Services Handbook* (*Vol. 2, Provider Handbooks*) for specific information about certain DME and medical supplies.

Subsection 1.4.2.1, "Eligibility " in this handbook.

1.2.3.1 Supply Procedure Codes

When submitting supplies on the CMS-1500 claim form, itemize the supplies, including quantities, and also provide the Healthcare Common Procedure Coding System (HCPCS) national procedure codes.

Refer to: Subsection 6.3.3, "Procedure Coding" in Section 6, "Claims Filing", (*Vol. 1, General Information*) for more information about HCPCS procedure codes.

1.2.3.2 Prior Authorization

TMHP must prior authorize most medical supplies. They must be used for medical or therapeutic purposes, and supplied through an enrolled DMEH provider in compliance with the client's POC.

Some medical supplies may be obtained without prior authorization; however, the provider must retain a copy of the completed POC or Home Health Services (Title XIX) Durable Medical Equipment (DME)/Medical Supplies Physician Order Form in the client's file. For medical supplies not requiring prior authorization, a completed Home Health Services (Title XIX) Durable Medical Equipment (DME)/Medical Supplies Physician Order Form may be valid for a maximum of six months, unless the physician indicates the duration of need is less. If the physician indicates the duration of need is less than six months, then a new Home Health Services (Title XIX) Durable Medical Equipment (DME)/Medical Supplies Physician Order Form is required at the end of the determined duration of need.

For a list of DME/medical supplies that do not require prior authorization, providers can refer to Subsection 1.2.25, "Procedure Codes That Do Not Require Prior Authorization " in this handbook.

Clients with ongoing needs may receive up to six months of prior authorizations for some expendable medical supplies under Home Health Services when requested on a Home Health Services (Title XIX) Durable Medical Equipment (DME)/Medical Supplies Physician Order Form. Providers may deliver medical supplies as ordered on a Home Health Services (Title XIX) Durable Medical Equipment (DME)/Medical Supplies Physician Order Form for up to six months from the date of the physician's signature. In these instances, a review of the supplies requested by the physician familiar with the client's condition, and a new Home Health Services (Title XIX) Durable Medical Equipment (DME)/Medical Supplies Physician Order Form is required for each new prior authorization request. Requests for prior authorization can be made up to 60 days before the start of the new prior authorization period. Professional Home Health Services prior authorization requests require a review by the physician familiar with the client's condition and a physician signature every 60 days when requested on a POC.

Note: *These records and claims must be retained for a minimum of five years from the DOS or until audit questions, appeals, hearings, investigations, or court cases are resolved. Use of these services is subject to retrospective review.*

1.2.3.3 Cancelling a Prior Authorization

The client has the right to choose his DME/medical supply provider and change providers. If the client changes providers, TMHP must receive a change of provider letter with a new Home Health Services (Title XIX) Durable Medical Equipment (DME)/Medical Supplies Physician Order Form. The client must sign and date the letter, which must include the name of the previous provider and the effective date for the change. The client is responsible for notifying the original provider of the change and the effective date. Prior authorization for the new provider can only be issued up to three business days before the date TMHP receives the change of provider letter and the new Home Health Services (Title XIX) Durable Medical Equipment (DME)/Medical Supplies Physician Order Form.

1.2.4 Augmentative Communication Device (ACD) System

An ACD system, also known as an augmentative and alternative communication (AAC) device system, allows a client with an expressive speech language disorder to electronically represent vocabulary and express thoughts or ideas to meet the client's functional speech needs.

An ACD system is a benefit of Texas Medicaid (Title XIX) Home Health Services when the following criteria are met:

- The documentation submitted with the request supports the determination of medical necessity based on the criteria listed below.
- Federal financial participation is available.
- The requested equipment or supplies are safe for use in the home.

A digitized speech device (procedure codes E2500, E2502, E2504, and E2506), sometimes referred to as a "whole message" speech output device, uses words or phrases that have been recorded by someone other than the ACD system user for playback upon command of the ACD system user.

A synthesized speech device (procedure code E2508) requires the user to make physical contact with a keyboard, touch screen, or other display and translates a user's input into device-generated speech using algorithms representing linguistic rules. Users of synthesized speech ACD systems are not limited to prerecorded messages, but can independently create messages as their communication needs change. Synthesized speech devices containing letters may be reimbursed.

Other synthesized devices allow for multiple methods of message formulation and multiple methods of device access. Multiple methods of message formulation must include message selection by two or more of the following methods:

- Letters
- Words
- Pictures
- Symbols

Multiple methods of access must include the capability to access the device by direct physical contact with a keyboard or touch screen and one or more of the following indirect selection techniques:

- Joystick/switches
- Head mouse
- Optical head pointer
- Light pointer
- Infrared pointer
- Scanning device
- Morse code

Note: *ACD systems that do not meet the criteria through Title XIX Home Health Services may be considered for clients birth through 20 years of age under CCP.*

These synthesized speech devices may be reimbursed using procedure code E2510.

Items included in the reimbursement for an ACD system and not reimbursed separately include, but are not limited to, the following:

- ACD
- Basic, essential software (except for software purchased specifically to enable a client-owned computer or personal digital assistant [PDA] to function as an ACD system)
- Batteries
- Battery charger
- Power supplies
- Interface cables
- Interconnects
- Sensors
- Moisture guard
- Alternating current (A/C) and/or other adapters
- Adequate memory to allow for system expansion within a five-year timeframe
- Access device, when necessary

- Mounting device, when necessary
- All basic operational training necessary to instruct the client and family/caregivers in the use of the ACD system
- Manufacturer's warranty

1.2.4.1 ACD System Accessories

Accessories for rental or purchase (procedure code E2599) are a benefit of Texas Medicaid if the criteria for ACD system prior authorization are met and the medical necessity for each accessory is clearly documented in the speech language pathologist (SLP) evaluation.

All accessories necessary for proper use of an ACD system, including those necessary for the potential growth and expansion of the ACD system (such as a memory card), should be included in the initial prescription/Title XIX form. The following accessories for an ACD system may be covered:

- Access devices for an ACD system include, but are not limited to, devices that enable selection of letters, words, or symbols via direct or indirect selection techniques such as optical head pointers, joysticks, and ACD scanning devices.
- Gross motor access devices, such as switches and buttons, may be considered for clients with poor fine motor and head control.
- Fine motor, head control access devices, such as laser or infrared pointers, may be considered for clients with poor hand control and good head control.

1.2.4.1.1 Mounting Devices

Mounting systems (procedure code E2512) are devices necessary to place the ACD system, switches and other access devices within the reach of the client. Mounting devices may be considered for reimbursement when used to attach an ACD system or access device to a wheelchair or table.

A request for prior authorization of a wheelchair mounting device must include the manufacturer name, model, and purchase date of the wheelchair. One additional mounting device, separate from the one included in the system, may be considered for prior authorization for the same client.

1.2.4.1.2 Nonwarranty Repairs

Nonwarranty repairs of an ACD system may be considered for prior authorization using procedure code K0739 with documentation from the manufacturer explaining why the repair is not covered by the warranty.

1.2.4.1.3 Rental

To ensure the client's needs are met in the most cost-effective manner and to ascertain the most appropriate system and access device for the client, the ACD system will not routinely be prior authorized for purchase until the client has completed a six-month trial period that includes experience using the requested system. Prior authorization may be provided for rental during this trial period. All components necessary for use of the device, such as access devices, mounting devices, and lap trays, must be evaluated during this trial period.

In the situation where an ACD system is not available for rental and the client has recent documented experience with the requested ACD system, purchase can be considered. A trial period is not required when replacing an existing ACD system unless the client's needs have changed and another ACD system or access device is being considered.

1.2.4.1.4 Purchase

Purchase of an ACD system may be considered for prior authorization when all of the following ACD system criteria are met:

- The evaluation/re-evaluation includes documentation that the client has had sufficient experience with the requested ACD system through trial/rental, school, or another setting. When the SLP has confirmed the appropriateness of a specific device for the client, the trial/rental period can be cancelled.
- A Home Health Services (Title XIX) Durable Medical Equipment (DME)/Medical Supplies Physician Order Form listing the prescribed ACD system, access device, and accessories (such as a mounting device) must be completed, signed by the physician, and dated.

1.2.4.1.5 Replacement

ACD system equipment that has been purchased is anticipated to last a minimum of five years. Prior authorization for replacement may be considered within five years of purchase when one of the following occurs:

- The client's condition has changed such that the current device no longer meets his or her communication needs.
- The ACD system is no longer functional and cannot be repaired or it is not cost effective to repair.

Note: *Replacements for clients birth through 20 years of age that do not meet the criteria above may be considered through CCP.*

1.2.4.1.6 Software

Computer software that enables a client's computer or PDA to function as an ACD system may be covered as an ACD system using procedure code E2511. Requests for ACD software may be considered for prior authorization if the software is more cost effective than an ACD system.

If an ACD system is more cost effective than adapting the client's computer or PDA, an ACD system may be prior authorized instead of the ACD software.

Laptop or desktop computers, PDAs, or other devices that are not dedicated ACD systems are not a benefit of Texas Medicaid, because they do not meet the definition of DME.

1.2.4.2 Non-Covered ACD System Items

Noncovered items that are not necessary to operate the system and are unrelated to the ACD system or software components are not benefits of Texas Medicaid. These items include, but are not limited to:

- Carrying case
- Printer
- Voice prosthetic or artificial larynx
- Wireless Internet access devices

Exception: *Carrying cases may be reimbursed for ambulatory clients with documentation of medical necessity.*

1.2.4.3 Prior Authorization

Prior authorization is required for ACD systems provided through Home Health Services. The prior authorization also includes all related accessories and supplies. The physician must provide information supporting the medical necessity of the equipment and/or supplies requested, including:

- Accurate diagnostic information pertaining to the underlying diagnosis or condition and any other medical diagnoses or conditions, including the client's overall physical and cognitive limitations.
- Diagnosis or condition causing the impairment of speech.

Prior authorization for an ACD system and accessories (rental or purchase) must be requested using the following information:

- Medical diagnosis and how it relates to the client's communication needs.
- Any significant medical information pertinent to ACD system use.
- Limitations of the client's current communication abilities, systems, and devices.
- Statement as to why the prescribed ACD system is the most effective, including a comparison of benefits using other alternatives.
- Complete description of the ACD system with all accessories, components, mounting devices, and/or modifications necessary for client use (must include manufacturer's name, model number, and retail price).
- Documentation that the client is mentally, emotionally, and physically capable of operating the device.
- An evaluation and assessment must be conducted by a licensed SLP in conjunction with other disciplines, such as physical or occupational therapies. The prescribing physician should base the prescription on the professional evaluation and assessment.

The prior authorization request must include the specifications for the ACD system, all component accessories necessary for the proper use of the ACD, and all necessary therapies and/or training. It is recommended that the preliminary evaluation for an ACD system include the involvement of an occupational therapist and/or physical therapist to address the client's seating/postural needs and the motor skills required to utilize the ACD system. An evaluation and assessment by a licensed SLP must include the following information:

- Communication status and limitations
- Speech and language skills assessment that includes the prognosis for speech and/or written communication
- Cognitive readiness
- Interactional/behavioral and social abilities
- Capabilities, including intellectual, postural, sensory (visual and auditory), and physical status
- Motivation to communicate
- Residential, vocational, and educational setting
- Alternative ACD system considered with comparison of capabilities
- How the ACD system will be implemented and integrated into environments
- Ability to meet projected communication needs, growth potential, and how long it will meet the client's needs
- Anticipated changes, modifications, or upgrades with projected time frames (short- and long-term)
- Training plan - who, what, when, where

Note: *The SLP evaluation must be signed and dated before the date on the physician's prescription or Title XIX form.*

1.2.4.4 Documentation Requirements

The prescribing physician familiar with the client must review the SLP evaluation of the client's cognitive and language abilities and base the prescription and treatment plan on the SLP's recommendations. Documentation of medical necessity for an ACD system includes a formal written evaluation performed by an SLP. The SLP evaluation must include the following information:

- Medical status/condition and medical diagnoses underlying the client's expressive speech-language disorder that gives rise to the need for an ACD system

- Current expressive speech-language disorder, including the type, severity, anticipated course of the disorder, and present language skills
- A description of the practical limitations of the client's current aided and unaided modes of communication
- Other forms of therapy/intervention that have been considered and ruled out
- The rationale for the recommended ACD system and each accessory, including a statement as to why the recommended device is the most appropriate, least costly alternative for the client and how the recommended system will benefit the client
- Documentation that the client possesses the cognitive and physical abilities to use the recommended system
- A comprehensive description of how the ACD system will be integrated into the client's everyday life, including home, school, or work
- A treatment plan that includes training in the basic operation of the recommended ACD system necessary to ensure optimal use by the client and, if appropriate, the client's caregiver, and a therapy schedule for the client to gain proficiency in using the ACD system
- A description of the client's speech-language goals and how the recommended ACD system will assist the client in achieving these goals
- A description of the anticipated changes, modifications, or upgrades of the ACD system necessary to meet the client's short- and long-term speech-language needs
- Identification of the assistance/support needed by, and available to, the client to use and maintain the ACD system
- A statement that the SLP is financially independent of the ACD system manufacturer/vendor

1.2.5 Bath and Bathroom Equipment

Bath and bathroom equipment is DME that is included in a treatment protocol, serves as a therapeutic agent for life and health maintenance, and is required to treat an identified medical condition. Bath and bathroom equipment may be considered for reimbursement for those clients who have physical limitations that do not allow for bathing, showering, or bathroom use without assistive equipment.

> ***Note:*** *THSteps-eligible clients who qualify for medically necessary services beyond the limits of this Home Health Services benefit may be considered under CCP.*

Bath seats are not considered for clients younger than one year of age or weighing less than 30 pounds.

Rental of equipment includes all necessary supplies, adjustments, repairs, and replacement parts.

A determination as to whether the equipment will be rented, purchased, replaced, repaired, or modified will be made by HHSC or its designee based on the client's needs, duration of use, and age of the equipment.

1.2.5.1 Hand-Held Shower Wand

A hand-held shower wand with attachments may be considered for prior authorization only if the client currently owns or meets the criteria for a bath or shower chair, tub stool or bench, or tub transfer bench. Prior authorization of a hand-held shower wand includes all attachments and accessories. Providers must use procedure code E1399 when billing for a hand-held shower wand. Hand-held shower wands with attachments are limited to one every five years.

1.2.5.2 Bath/Shower Chairs, Tub Stool/Bench, Tub Transfer Bench

A bath/shower chair, tub stool/bench, or tub transfer bench may be considered for those clients who cannot safely use a regular bath tub or shower. Bath/shower chairs, tub stool/benches and tub transfer benches are grouped into three levels of design to assist the client based on their physical condition and mobility status. Bath/shower chairs, tub stool/bench, and tub transfer benches are limited to one every five years.

Level 1 Group
A level 1 device is defined as stationary equipment. Level 1 devices may be considered if the client meets either of the following two criteria:

- Is unable to stand independently or is unstable while standing.
- Is unable to independently enter or exit the shower/tub due to limited functional use of the upper or lower extremities and one of the following:
  - Maintains the ability to ambulate short distances (with or without assistive device).
  - Has a condition that is defined as a short-term disability without a concomitant long-term disability (including, but not limited to postoperative status).

Providers must use procedure code E0240 without a modifier when billing for level 1 group bath/shower chairs.

Level 2 Group
A level 2 device is defined as mobile equipment with or without a commode cut out. A level 2 device may be considered if the client has good upper body stability and one of the following:

- Has impaired functional ambulation, including, but not limited to lower body paralysis, osteoarthiritis.
- Is nonambulatory.

The client must have a shower that is adapted for rolling equipment; ramps are not acceptable for access to showers. Providers must use procedure code E0240 with modifier TF (Intermediate Level) when billing for level 2 group bath/shower chairs.

Level 3 Group
A level 3 device is a custom stationary or mobile chair with or without a commode cut out. A level 3 device may be considered if the client meets one of the following:

- Requires trunk and/or head/neck support
- Positioning to accommodate conditions, including, but not limited to spasticity, or frequent/uncontrolled seizures

A bath/shower chair may be prior authorized for clients who meet the level 1, 2, or 3 criteria. Providers must use procedure code E0240 with the TG modifier (Complex/high level) when billing for level 3 group bath/shower chairs.

A level 3 custom bath/shower chair may be prior authorized only if the client does not also have any type of commode chair. The client must have a shower that is adapted for rolling equipment; ramps will not be prior authorized for access to showers.

A tub transfer bench may be considered if the client meets the Level 1 or 2 criteria. A tub stool/bench may be prior authorized for clients who meet the level 1 criteria. Providers must use procedure code E0245 when billing for a tub stool/bench. Providers must use procedure code E0247 when billing for a tub transfer bench.

A heavy duty tub transfer bench may be considered for clients who meet the level 1 or 2 criteria and who weigh more than 200 pounds. Providers must use procedure code E0248 when billing for a heavy duty tub transfer bench.

1.2.5.3 Bathroom Equipment

1.2.5.3.1 Non-fixed Toilet Rail, Bathtub Rail Attachment, and Raised Toilet Seat

Nonfixed toilet rails are limited to two every five years. A bathtub rail is limited to one every five years.

Raised toilet seats are limited to one every five years. Nonfixed toilet rails, bathtub rail attachments, and raised toilet seats may be considered for prior authorization for a client who has decreased functional mobility and is unable to safely self-toilet or self-bathe without assistive equipment. Providers must use procedure code E0243 when billing for non-fixed toilet rails, procedure code E0244 when billing for raised toilet seats, and procedure code E0246 when billing for bathtub rails.

1.2.5.3.2 Toilet Seat Lifts

A toilet seat lift mechanism (procedure code E0172) is designed for the top of the toilet to assist lifting the body from a sitting position to a standing position.

Procedure code E0172 must be prior authorized. To qualify for prior authorization, clients must meet all the following criteria:

- The client must have severe arthritis of the hip or knee or have a severe neuromuscular disease.
- The toilet seat lift mechanism must be a part of the physician's course of treatment and be prescribed to correct or ameliorate the client's condition.
- Once standing, the client must have the ability to ambulate.
- The client must be completely incapable of standing up from a regular armchair or any chair in the client's home.

The client's difficulty or incapability of getting up from a chair is not sufficient justification for a toilet seat lift mechanism. Almost all clients who are capable of ambulating can get out of an ordinary chair if the seat height is appropriate and the chair has arms.

Prior authorization will be given for either mechanical or powered toilet assist devices, not for both. If a client already owns one or more mechanical toilet-assist devices, a powered toilet seat lift mechanism will not be prior authorized unless there has been a documented change in the client's condition such that the client can no longer use the mechanical equipment.

Toilet seat lift mechanisms are limited to those types that operate smoothly, can be controlled by the client, and effectively assist a client in standing up and sitting down without other assistance. A toilet seat lift operated by a spring release mechanism with a sudden, catapult-like motion that jolts the client from a seated to a standing position is not a benefit of Texas Medicaid.

A toilet seat lift mechanism is limited to one purchase very five years.

1.2.5.3.3 Portable Sitz Bath

Portable sitz baths that fit over commode seats are limited to two per year. A portable sitz bath, may be considered for prior authorization if the client requires any of the following:

- Cleaning, irrigation, or pain relief of a perianal wound.
- Relief of pain associated with the pelvic area (hemorrhoids, bladder, vaginal infections, prostate infections, herpes, testicle disorders).
- Muscle toning for bowel and bladder incontinence.

Providers must use procedure codes E0160 or E0161 when billing for portable sitz baths.

1.2.5.3.4 Bath Lifts

The purchase of bath lifts are limited to one every five years. The rental of bath lifts are limited to one per month. A bath lift may be considered for prior authorization if the client has:

- An inability to transfer to the bathtub/shower independently using assistive devices including but not limited to, a cane, walker, bathtub rail.
- The client requires maximum assistance by the caregiver to transfer to the bathtub/shower.
- The client's bathroom and tub/shower meet the manufacturer's recommended depth, width, and height for safe bath lift installation and operation.

Providers must use procedure code E0625 when billing for the purchase or rental of bath lifts. The purchase of a lift sling is limited to one every five years. Providers must use procedure code E0621 when billing for the purchase of a lift sling. Home adaptation for use of medical equipment is not a benefit of Home Health Services.

The following are payable procedure codes for bath and bathroom equipment:

Procedure Code	Maximum Limitation
E0160	2 per year
E0161	2 per year
E0172	1 every 5 years
E0240	1 every 5 years
E0243	2 every 5 years
E0244	1 every 5 years
E0245	1 every 5 years
E0246	1 every 5 years
E0247	1 every 5 years
E0248	1 every 5 years
E0621	1 per 5 years
E0625	1 purchase every 5 years; 1 month rental
E0630	1 purchase every 5 years; 1 month rental
E1399	1 every 5 years

1.2.5.4 Prior Authorization

Prior authorization is required for all bath and bathroom equipment and related supplies, including any accessories, modifications, adjustments, replacements and repairs to the equipment. The bath and bathroom equipment must be able to accommodate a 20 percent change in the client's height and/or weight.

1.2.5.4.1 Modifications, Adjustments, and Repairs

Modifications are the replacement of components because of changes in the client's condition, not replacement because the component is no longer functioning as designed. All modifications/ adjustments within the first six months after delivery are considered part of the purchase price.

Modifications to custom equipment may be prior authorized should a change occur in the client's needs, capabilities, or physical/mental status which cannot be anticipated.

Documentation must include the following:

- All projected changes in the client's mobility needs
- The date of purchase, and serial number of the current equipment
- The cost of purchasing new equipment versus modifying the current equipment

All modifications within the first six months after delivery are considered part of the purchase price.

Adjustments do not require supplies. Adjustments made within the first six months after delivery will not be prior authorized. Adjustments made within the first six months after delivery are considered part of the purchase price. A maximum of one hour of labor for adjustments may be prior authorized as needed after the first six months following delivery.

Repairs to client-owned equipment may be prior authorized as needed with documentation of medical necessity. Technician fees are considered part of the cost of the repair. Repairs require the replacement of components that are no longer functional. Providers are responsible for maintaining documentation in the client's medical record specifying the repairs and supporting medical necessity.

Bathroom/toilet lift rentals may be prior authorized during the period of repair up to a maximum of four months per lifetime per client.

Prior authorization will not be considered for modifications, adjustments, or repairs to bath or bathroom equipment delivered to a client's home and then found to be inappropriate for the client's condition within the first six months after delivery. This applies unless there is a significant change in the client's condition that is documented by a physician familiar with the client.

Routine maintenance of rental equipment is the provider's responsibility.

1.2.5.4.2 Accessories

Equipment accessories including, but not limited to, pressure support cushions, may be prior authorized with documentation of medical necessity.

1.2.5.5 Documentation Requirements

To request prior authorization for bath or bathroom equipment, the following documentation must be provided:

- Accurate diagnostic information pertaining to the underlying diagnosis/condition, including the client's overall health status, any other medical needs, developmental level, and functional mobility skills and why regular bath or bathroom equipment will not meet the client's needs
- The age, height, and weight of the client
- Assessment of the client's home to ensure the requested equipment can be safely accommodated
- Anticipated changes in the client's needs, including anticipated modifications or accessory needs and the growth potential of any custom shower/bath equipment

1.2.5.5.1 Toilet Seat Lifts

The submitted documentation for a toilet seat lift must include an assessment completed by a physician, physical therapist, or occupational therapist that includes all of the following:

- A description of the client's current level of function without the device
- An explanation why a nonmechanical toilet elevation device, such as toilet rails or elevated toilet seat, will not meet the client's needs
- Documentation that identifies how the toilet seat lift mechanism will improve the client's function
- A list of the MRADLs the client will be able to perform with the toilet seat lift mechanism that the client is unable to perform without the toilet seat lift mechanism and how the device will increase the client's independence

- The client's goals for use of the toilet seat lift mechanism

Supporting documentation must be kept in the client's record that all appropriate therapeutic modalities (e.g., medication or physical therapy) have been tried and that they failed to enable the client to transfer from a chair to a standing position.

1.2.6 Blood Pressure Devices

Blood pressure devices are a payable benefit of Home Health Services when:

- The devices are medically necessary and appropriate.
- The devices are prescribed by a physician.
- The client has one of the following covered diagnoses: essential or secondary hypertension, hypertensive heart disease, hypertensive renal disease, chronic pulmonary heart disease, heart failure, nephritis or nephropathy, acute renal failure, or hypertension complicating pregnancy, childbirth, and the puerperium.

When billing for these devices providers must use procedure codes A4660 and A4670.

If the client is not eligible for home health services, blood pressure devices may be provided under CCP for clients 20 years of age or younger.

1.2.6.1 Prior Authorization

Prior authorization is required for blood pressure devices. An electronic blood pressure monitoring device (such as *Dynamap*) is not a benefit through Home Health Services. Rental of an electronic blood pressure monitoring device may be prior authorized through CCP for clients who are 11 months of age or younger.

Refer to: Subsection 3.5.7, "Electronic Blood Pressure Monitoring Device" in *Children's Services Handbook* (*Vol. 2, Provider Handbooks*).

1.2.7 Breast Pumps

A manual or non-hospital-grade electric breast pump may be considered for purchase only with the appropriate documentation supporting medical necessity. The purchase of a breast pump is limited to one every three years. Providers must use procedure code E0602 or E0603 when billing for the purchase of a manual or non-hospital-grade electronic breast pump. A hospital-grade breast pump (procedure code E0604) may be considered for rental, not purchase. Rental of a breast pump is not time-limited. If more than one type of breast pump is billed on the same day by the same provider, only one will be reimbursed.

To facilitate a determination of medical necessity and avoid unnecessary denials, the physician must provide correct and complete information, including accurate medical necessity of the equipment and/or supplies requested.

Breast pumps are also available through the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC).

1.2.7.1 Prior Authorization

Breast pumps require prior authorization. Replacement of the breast pump will be considered when loss or irreparable damage has occurred, with a copy of the police or fire report when appropriate, and with the measures to be taken to prevent reoccurrence. Replacement will not be authorized in situations where the equipment has been abused or neglected by the client, the client's family, or the caregiver.

1.2.8 Cochlear Implants

The following cochlear implant procedure codes may be reimbursed in the home setting to home health DME and medical supplier (DME) providers: L8615, L8616, L8617, L8618, and L8619.

Refer to: Subsection 6.3.17, "Cochlear Implants" in *Medical and Nursing Specialists, Physicians, and Physician Assistants Handbook* (*Vol. 2, Provider Handbooks*) for more information about cochlear implant services.

1.2.9 Continuous Passive Motion (CPM) Device

A CPM device is reimbursed on a daily basis and is limited to once per day. Reimbursement includes delivery, set-up and all supplies. Providers must use procedure code E0935 when billing for a CPM machine. THSteps-eligible clients who qualify for medically necessary services beyond the limits of this Home Health Services benefit may be considered under CCP.

1.2.9.1 Prior Authorization

A CPM device may be considered for prior authorization through Home Health Services. Reimbursement for a CPM device is considered after joint surgery, such as knee replacement, when prescribed by a physician and submitted with clinical documentation of medical necessity/appropriateness.

1.2.10 Diabetic Equipment and Supplies

Diabetic equipment and supplies are a benefit through Home Health Services and do not require prior authorization unless otherwise specified.

An internal insulin pump will not be prior authorized as it is considered part of the surgery to place the pump.

1.2.10.1 Glucose Testing Supplies

Glucose testing supplies may be reimbursed without prior authorization, up to the quantities listed in the procedure code table below, when provided for clients with a diagnosis from the diagnosis table below. The quantity of blood testing supplies billed for a one-month supply should relate to the number of tests ordered per day by the physician.

For items that do not require prior authorization, the prescribing provider must indicate on a completed detailed written order how many times a day the client is required to test blood glucose and/or ketone levels when applicable (not all supplies are related to testing glucose or urine [i.e. batteries]).

Blood glucose test/reagent strips (procedure code A4253) and home glucose disposable monitors with test strips (procedure code A9275) are limited to a combined total of four per month without prior authorization.

Glucose tablets or gel may be considered with prior authorization using procedure code A9150.

Diabetic Supplies and Limitations

Procedure Code	Maximum Limit
A4233	1 per 6 months
A4234	1 per 6 months
A4235	1 per 6 months
A4236	1 per 6 months
A4250	2 boxes/month
A4252	50 strips per month
A4253	4 boxes/month* *Combined total with A9275
A4256	2 per year
A4258	2 per year
A4259	2 boxes/month

Procedure Code	Maximum Limit
A9150	1 per 6 months* *Use this procedure code for Glucose tabs/gel
A9275	4 per month* *Combined total with A4253

Diagnosis Codes									
24900	24901	24910	24911	24920	24921	24930	24931	24940	24941
24950	24951	24960	24961	24970	24971	24980	24981	24990	24991
25000	25001	25002	25003	25010	25011	25012	25013	25020	25021
25022	25023	25030	25031	25032	25033	25040	25041	25042	25043
25050	25051	25052	25053	25060	25061	25062	25063	25070	25071
25072	25073	25080	25081	25082	25083	25090	25091	25092	25093
2512	2711	2777	27785	64800	64801	64802	64803	64804	64880
64881	64882	64883	64884	7751	79029	7915			

Note: *THSteps-eligible clients who qualify for medically necessary services beyond the limits of this home health benefit will receive those services through CCP.*

Glucose testing supplies no longer require a signed Title XIX form and may be obtained through a verbal order or a detailed written order.

1.2.10.1.1 Verbal Orders

If the provider does not have a detailed written order, then the provider is required to have a verbal or written order on file until the detailed written order is received from the authorized prescribing provider and before providing glucose testing supplies. The practitioner's order may be a written (original, fax, or electronic) or verbal order and must include all of the following components:

- A description of the item(s)
- The recipient's name
- The name of the physician or authorized prescribing provider
- The date of the order

1.2.10.1.2 Detailed Written Orders

A detailed written order must be received by the DME supplier within 90 days from the date of the prescribing provider's signature.

The detailed written order for diabetic glucose testing supplies is valid for 6 months from the date of the order or the date of the prescribing provider's signature whichever is earlier for initial orders, and from the start date for renewal orders. In absence of a start date then the authorized prescribing signature date will be the beginning DOS.

A completed detailed written order must be signed and dated by the authorized prescribing provider. All signatures and dates must be current, unaltered, original, and either handwritten or electronic. Stamped signatures and dates will not be accepted.

Note: *An authorized prescribing provider includes a physician, physician assistant, nurse practitioner, or clinical nurse specialist.*

A completed detailed written order must contain all of the following components:

- The client's name

- The date of the verbal order if different from the date the authorized prescribing provider signed the written order
- Description of item(s) to be provided
- Quantity to dispense (quantity required per day or month)

Before submitting a claim to Medicaid, DME providers must have a detailed written order with the required information in the client's medical record. No other documentation is required.

The prescribing provider is required to retain a copy of the signed and dated order in the client's medical record. The DME provider must retain the faxed, photocopied, electronic, or pen and ink signed and dated detailed written order in the client's medical record.

1.2.10.1.3 Prior Authorization

Glucose tablets or gel (procedure code A9150) requires prior authorization with documentation supporting medical necessity.

Glucose testing supplies may be considered for prior authorization with documentation of medical necessity for quantities beyond the limits listed in the procedure code table above or for diagnoses other than those listed in the diagnosis code table above in subsection 1.2.10.1, "Glucose Testing Supplies". Quantities will be prior authorized based on the documentation of medical necessity related to the number of tests ordered per day by the physician.

Quantities for glucose testing supplies beyond those listed in the procedure code table above, glucose monitors with integrated voice synthesizer, and glucose monitors with integrated lancing blood sample may be considered for prior authorization with the submission of the following:

- A completed and signed prescription
- A Home Health Services (Title XIX) Durable Medical Equipment (DME)/Medical Supplies Physician order Form with section A completed

Note: *A completed and signed prescription satisfies the requirement for additional documentation for requests for quantities beyond quantity limits.*

1.2.10.2 Blood Glucose Monitors

Home blood glucose monitor (procedure codes E0607, E2100, and E2101) are benefits of Home Health Services and are allowed reimbursement once every three years. A blood glucose monitor is a portable battery-operated meter used to determine the level of blood sugar (glucose).

Standard home glucose monitors (procedure code E0607):

- Do not require prior authorization.
- Are limited to the diagnoses listed above.
- May be obtained through a completed, signed, and dated prescription.
- Diagnoses not listed above may be considered for prior authorization with supporting documentation of medical necessity.

Blood glucose monitors with integrated voice synthesizers (procedure code E2100) and blood glucose monitors with integrated lancing blood sample (procedure code E2101) may be considered for prior authorization with documentation of medical necessity.

Invasive continuous glucose monitoring (CGM) is used for diagnostic purposes to assist the clinician in establishing or modifying the client's treatment plan. CGM device is worn up to 72 hours for the diagnostic purpose of collecting continuous blood sugar readings. These are later analyzed by the clinician.

Refer to: Subsection 6.3.18, "Continuous Glucose Monitoring (CGM)" in *Medical and Nursing Specialists, Physicians, and Physician Assistants Handbook* (*Vol. 2, Provider Handbooks*) for additional information.

1.2.10.2.1 Prior Authorization

Blood glucose monitors with special features (procedure code E2100 or E2101) may be considered for prior authorization with documentation supporting medical necessity for the special feature requested.

Purchase of a blood glucose monitor with integrated voice synthesizer (procedure code E2100) may be prior authorized with documentation that includes a diagnosis of diabetes and significant visual impairment.

Purchase of a blood glucose monitor with integrated lancing/blood sample (procedure code E2101) may be prior authorized with documentation that includes a diagnosis of diabetes and significant manual dexterity impairment related but not limited to neuropathy, seizure activity, cerebral palsy, or Parkinson's disease.

The invasive CGM device will not be prior authorized as it is considered part of the physician interpretation and report for CGM.

1.2.10.3 Insulin and Insulin Syringes

Insulin and insulin syringes, all sizes, are reimbursed through the Medicaid Vendor Drug Program pursuant to a physician's prescription. The Medicaid Vendor Drug Program (VDP) enrolls pharmacies only.

Refer to: Appendix B, "Vendor Drug Program" (*Vol. 1, General Information*) for more information about VDP.

1.2.10.4 External Insulin Pump and Supplies

An external insulin infusion pump is a programmable, battery-powered mechanical syringe/reservoir device controlled by a micro computer to provide a basal continuous subcutaneous insulin infusion (CSII) and release a "bolus" dose at meals and at programmed intervals. The pump is connected to an infusion set with an attached small needle or cannula that is inserted into the subcutaneous tissue. The purpose of the insulin pump is to provide an accurate, continuous, controlled delivery of insulin which can be regulated by the user to achieve intensive glucose control and prevent the metabolic complications of hypoglycemia, hyperglycemia and diabetic ketoacidosis. The typical external insulin pump capacity is two to three days of insulin.

An external insulin pump and supplies may be considered through Title XIX Home Health Services for prior authorization with documentation of medical necessity.

The external insulin pump must be ordered by, and the client's follow-up care must be managed by, a physician with experience managing clients with insulin infusion pumps and who works closely with a team including nurses, diabetic educators, and dieticians who are knowledgeable in the use of insulin infusion pumps.

The following procedure codes for the external insulin pumps and associated supplies are a benefit of Texas Medicaid and may be considered through Home Health Services. Note that a replacement leg bag may be requested with prior authorization using procedure code A9900. The initial leg bag is included in the purchase of the pump.

External Insulin Pump and Supplies Procedure Codes and Limitations

Procedure Code	Maximum Limitation
A4230	10 per month
A4231	15 per month

Procedure Code	Maximum Limitation
A4232	10 per month
A4601	1 per 6 months
A6257	15 per month
A6258	15 per month
A6259	15 per month
A9900	Leg bag replacement only
E0784	1 purchase every 3 years; 1 month rental

The external insulin pump supplies are not included in the external insulin pump rental. The routine maintenance of rental equipment is the provider's responsibility.

1.2.10.4.1 Prior Authorization

Prior authorization is required for external insulin pumps (procedure code E0784) with carrying cases and their related supplies. The external insulin pump supplies may be considered separately when an external insulin pump is rented.

The external insulin pump may be considered for prior authorization of purchase after it has been rented for three months. The physician must provide documentation that it is appropriate equipment for the client and the client is compliant with its use. This documentation and a newly completed Title XIX form and new External Insulin Pump form must be submitted to TMHP Home Health Services Prior Authorization Department.

Documentation of continued medical necessity of the external insulin infusion pump requires that the client be evaluated by the treating physician as medically necessary, but no less frequently than every 3 to 4 months during the first year and annually thereafter.

Replacement leg bag (procedure code A9900) must be prior authorized with documentation that supports medical necessity.

1.2.10.4.2 Documentation Requirements

The following information, which must be documented on the External Insulin Infusion Pump form, is the minimum documentation required for consideration of medical necessity:

- Lab values, current and past blood glucose levels, including glycosylated hemoglobin (Hb/A1C) levels
- History of severe glycemic excursions, hypoglycemic/hyperglycemic reactions, nocturnal hypoglycemia, any extreme insulin sensitivity and/or very low insulin requirements
- Any wide fluctuations in blood glucose before mealtimes
- Any Dawn phenomenon where fasting blood glucose level often exceeds 200 mg/dL
- Day-to-day variations in work schedule, mealtimes, and/or activity level which require multiple insulin injections
- Possesses the cognitive and physical abilities to use the recommended insulin pump
- An understanding of cause and effect and object permanence
- A family or caregiver(s) willing to support the client in the use of the external insulin pump
- History of gestational diabetes, or anticipation of pregnancy within 3 months in a previously diagnosed diabetic with one of the following indications:
  - Erratic blood sugars in spite of maximal compliance and split dosing

- Other evidence that adequate control is not being achieved

- Training plan and schedule. Clients with history of poor control due to challenges following a daily schedule of multiple injections can show improved compliance with pump therapy, but require additional training with the pump.

1.2.11 Hospital Beds and Equipment

Head/upper body elevation of less than 30 degrees does not require use of a hospital bed. Hospital beds and related equipment are considered for reimbursement for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member.

> ***Note:*** *If the client is not eligible for home health services, hospital beds may be provided under CCP for clients 20 years of age or younger.*

Hospital beds may be considered for those clients who cannot safely use a regular bed.

A hospital bed without side rails and/or mattress is not a benefit of Home Health Services. Side rails or mattresses may be considered for reimbursement for replacement only. A replacement mattress or side rails may be considered if a client's condition requires a replacement of an innerspring mattress or side rails and it is a client-owned hospital bed. A determination will be made by HHSC or its designee as to whether the equipment will be rented, purchased, repaired, or modified based on the client's needs, duration of use, and age of the equipment.

The following types of hospital beds are addressed in the following sections:

- A fixed height hospital bed with manual head and leg elevation adjustments but no height adjustment
- A variable height hospital bed with manual head and leg elevation adjustments and manual height adjustment
- A semielectric bed with manual height adjustment and with electric head and leg elevation adjustments
- A full electric bed has an electric head and leg adjustment, plus electric height adjustment
- A heavy-duty, extra wide hospital bed capable of supporting a client who weighs more than 350 pounds, but no more than 600 pounds
- An extra heavy-duty, extra wide hospital bed capable of supporting a client who weighs more than 600 pounds

A hospital bed is not one that is typically sold as furniture. A home furniture bed may consist of a frame, box spring and mattress. It is a fixed height and has no head or leg elevation adjustments. A fully electric hospital bed (procedure code E0265) may be considered if the manufacturer's product information and MSRP for manually priced items documentation is included for clients who cannot function without a fully electric bed. A heavy-duty, extra wide hospital bed (procedure code E0303) is capable of supporting a client who weighs more than 350 pounds, but no more than 600 pounds. An extra heavy-duty, extra wide hospital bed (procedure code E0304) is capable of supporting a client who weighs more than 600 pounds.

1.2.11.1 Equipment

A trapeze bar attached to a bed (procedure codes E0910 and E0911) may be considered for reimbursement if the client needs this device to sit up, to change body position, for other medical reasons, or to get in or out of bed with documentation of medical necessity.

Free standing trapeze equipment (procedure codes E0912 or E0940) may be considered for reimbursement if the client does not have a covered hospital bed but the client needs this device to sit up to change body position for other medical reasons, or to get in or out of bed. The purchase of an over-bed table (procedure code E0315) may be considered for reimbursement if the client is bed bound and needs the equipment for treatments.

A safety enclosure (procedure code E0316) used to prevent a client from leaving the bed is not a benefit of the Home Health Services. A safety enclosure may be considered through CCP.

Traction equipment, such as procedure codes E0890, E0947, and E0948, (excluding procedure codes E0910 and E0940 trapeze devices) are not a benefit of Home Health Services.

1.2.11.2 Pressure-Reducing Support Surfaces

Pressure-reducing support surfaces are a benefit of Home Health Services on a case-by-case basis. Pressure-reducing support surfaces containing multiple components are categorized according to the clinically predominant component (usually the topmost layer of a multilayer product).

A support surface that does not meet the characteristics specified in the criteria for grouping levels below may be denied as not medically necessary.

Home Health Services will only cover alternating air mattresses and low-air-loss beds when they meet the definition of DME. Air mattresses that are not durable or made to withstand prolonged use do not meet the definition of DME.

For all types of pressure-reducing support surfaces, the support surface provided for the client should be one in which the client does not bottom out. The Centers for Medicare & Medicaid Services (CMS) defines "bottoming out" as when an outstretched hand, palm up, between the undersurface of the overlay or mattress and in an area under the bony prominence can readily palpate the bony prominence (coccyx or lateral trochanter). This bottoming out criterion should be tested with the client in the supine position with their head flat, in the supine position with their head slightly elevated (no more than 30 degrees), and in the sidelying position.

1.2.11.2.1 Documentation Requirements

To request prior authorization for a pressure-reducing support surface the following documentation must be provided:

- Client's overall health status and all other medical diagnosis/condition (e.g., history of decubitus)
- Documentation of the client's limited mobility or confinement to a bed
- Previous use of pressure-reducing support surfaces with client outcome (e.g., wound improvement, stashes, or degradation)
- Current wound therapy, if any
- Wound measurements to include location, length, width, depth, any undermining and/or tunneling, and odor if applicable

1.2.11.3 Criteria for Grouping Levels

1.2.11.3.1 Group 1 Support Surfaces

A group 1 Support Surface may be considered if the client is completely immobile without assistance, or the client has limited mobility or existing pressure ulcer on the pelvis or trunk and at least one of the following conditions:

- Impaired nutritional status
- Fecal or urinary incontinence
- Altered sensory perception

- Compromised circulatory status

Each of the support surfaces described below are considered a benefit of the Home Health Services Program when medical necessity criteria for Group 1 support surfaces are met.

Pressure pads/nonpowered pressure-reducing mattress overlays for mattresses with the following features may be considered for reimbursement with documentation of medically necessity:

- A gel or gel-like layer with a height of two inches or greater
- An air mattress overlay with interconnected air cells that are inflated with an air pump and a cell height of three inches or greater
- A water mattress overlay with a filled height of three inches or greater
- A foam mattress overlay with all the following features:
  - Base thickness of two inches or greater and peak height of three inches or greater if it is a convoluted overlay (e.g., eggcrate) or an overall height of at least three inches if it is a nonconvoluted overlay
  - Foam with a density and other qualities that provide adequate pressure reduction
  - Durable, waterproof cover

Nonpowered pressure-reducing mattresses, with the following features, may be considered for reimbursement with documentation supporting medical necessity:

- A foam mattress with all the following features may be considered with documentation supporting medical necessity. Documentation must include all of the following features:
  - A foam height of five inches or greater
  - Foam with a density and other qualities that provide adequate pressure reduction
  - Durable, waterproof cover
  - Can be placed directly on a hospital bed frame
- An air, water, or gel mattress with all the following features may be considered for reimbursement:
  - A height of five inches or greater
  - Durable, waterproof cover

A powered pressure reducing mattress overlay system, with all the following features, may be considered for reimbursement when documentation supports medical necessity:

- The system includes an air pump or blower which provides either sequential inflation and deflation of air cells, or a low interface pressure throughout the overlay.
- Inflated cell height of the air cells through which air is being circulated is 2.5 inches or greater.
- Height of the air chambers, proximity of the air chambers to one another, frequency of air cycling (for alternating pressure overlays), and air pressure provide adequate client lift, reduces pressure, and prevents bottoming out.

1.2.11.3.2 Group 2 Support Surfaces

A Group 2 support surface may be considered if the client has multiple stage II ulcers on the trunk or pelvis and has been on a comprehensive ulcer treatment program for at least the past month which has included the use of a Group 1 support surface.

The client must also have at least one of the following:

- The ulcers have remained the same or worsened over the past month.

- There are large or multiple stage III or IV pressure ulcers on the trunk or pelvis.
- A myocutaneous flap or skin graft for a pressure ulcer on the trunk or pelvis within the last 60 days, and have been on a Group 2 or 3 support surface immediately before discharge from the hospital or a nursing facility (discharge within the past 30 days).

Each of the support surfaces described below are considered a benefit of the Home Health Services Program when medical necessity criteria for Group 2 support surfaces are met.

The powered pressure reducing mattress (alternating pressure low air loss, or powered flotation without air loss) device with all the following features may be considered for reimbursement when documentation supports medical necessity:

- The system includes an air pump or blower which provides either sequential inflation and deflation of the air cells or a low interface pressure throughout the mattress.
- Inflated cell height of the air cells through which air is being circulated is five inches or greater.
- Height of the air chambers, proximity of the air chambers to one another, frequency of air cycling (for alternating pressure mattress), and air pressure to provide adequate client lift, reduce pressure, and prevent bottoming out.
- A surface designed to reduce friction and shear.

A semi-electric hospital bed with fully integrated powered pressure-reducing mattress that has all of the features described above may be considered for reimbursement when documentation supports medical necessity.

The advanced nonpowered pressure-reducing mattress overlay device with all the following features may be considered for reimbursement when documentation supports medical necessity:

- Height and design of individual cells which provide significantly more pressure reduction than Group 1 overlay and prevent bottoming out
- Total height of 3 inches or greater
- A surface designed to reduce friction and shear
- Manufacturer product information that substantiates the product is effective for the treatment of conditions described by the coverage criteria for Group 2 support surfaces

The powered pressure-reducing mattress overlay device with all the following features may be considered for reimbursement when documentation supports medical necessity:

- The system includes an air pump or blower that provides either sequential inflation and deflation of the air cells or a low interface pressure throughout the overlay.
- Inflated cell height of the air cells through which air is being circulated is three and a half inches or greater.
- Height of the air chambers, proximity of the air chambers to one another, frequency of air cycling (for alternating pressure overlays), and air pressure to provide adequate client lift, reduce pressure and prevent bottoming out.

The advanced nonpowered pressure-reducing mattress device with all the following features may be considered for reimbursement when documentation supports medical necessity:

- Height and design of individual cells that provide significantly more pressure than a Group 1 mattress and prevent bottoming out
- Total height of 5 inches or greater
- A surface designed to reduce friction and shear

- Documented evidence substantiates that the product is effective for the treatment of conditions described by the coverage criteria for Group 2 support surfaces

Sheepskin and lambs wool pads are considered a benefit of the Home Health Services Program under the same conditions as alternating pressure pads and mattresses (Group 2 pressure-reducing support surfaces) when prior authorized.

1.2.11.3.3 Group 3 Support Surfaces

A Group 3 support surface may be considered if all the following criteria are met:

- There is a presence of a stage III or IV ulcer.
- Severely limited mobility rendering the client bed or chair bound.
- Without an air-fluidized bed, the client would be institutionalized.
- The client has been placed on a Group 2 support surface for at least a month before ordering the air-fluidized bed with the ulcer(s) not improving or worsening.
- There has been at least weekly assessment of the wound by the physician, a nurse or other licensed health-care professional and the treating physician has done a comprehensive evaluation of the client's condition within the week before ordering the air-fluidized bed.
- A trained adult caregiver is available to assist the client with activities of daily living, maintaining fluid balance, supplying dietary needs, aiding in repositioning and skin care, administering prescribed treatments, recognizing and managing altered mental status, and managing the air-fluidized bed system and its potential problems, such as leakage.
- The physician continues to reevaluate and direct the home treatment regimen monthly.
- All other alternative equipment has been considered and ruled out.

The existence of any one of the following conditions may result in noncoverage of the air-fluidized bed:

- Coexisting pulmonary disease (the lack of firm back support can render coughing ineffective and dry air inhalation thickens pulmonary secretions).
- Wounds requiring moist wound dressings that are not protected with an impervious covering such as plastic wrap or other occlusive material (if wet-to-dry dressings are being utilized, dressing changes must be frequent enough to maintain their effectiveness).
- For clients 21 years of age or older, the caregiver is unwilling or unable to provide the type of care required by the client on an air-fluidized bed.
- The home's structural support or electrical system cannot safely accommodate the air-fluidized bed.

Initial prior authorization for a Group 3 pressure-reducing support surface will be for no more than 30 days. Prior authorized extensions may be considered for reimbursement in increments of 30-day periods, up to a maximum of four months, when documentation supports continued significant improvement in wound healing. Coverage beyond four months will be on a case-by-case basis after review by the medical director or designee.

Air-fluidized beds may be considered for reimbursement when the medical necessity criteria for Group 3 support surfaces are met.

1.2.11.4 Decubitus Care Accessories

A bed blanket cradle may be considered for reimbursement when documentation supports medical necessity (e.g., diabetic ulcers, decubiti or burns, or gouty arthritis).

A heel or elbow protector may be considered for reimbursement when documentation supports medical necessity.

The staging of pressure ulcers is as follows:

Stage I: Observable pressure related alteration of intact skin whose indicators are as follows:

- Compared to the adjacent or opposite area on the body may include changes in one of more of the following: skin temperature (warmth or coolness), tissue consistency (firm or boggy feel), and/or sensation (pain, itching).
- The ulcer appears as a defined area of persistent redness in lightly pigmented skin, whereas in darker skin tones, the ulcer may appear with persistent red, blue, or purple hues.

Stage II: Partial thickness skin loss involving epidermis, dermis, or both. The ulcer is superficial and presents clinically as an abrasion, blister, or shallow crater.

Stage III: Full thickness skin loss involving damage to, or necrosis of, SQ/SC tissue that may extend down to, but not through, underlying fascia. The ulcer presents clinically as a deep crater with or without undermining of adjacent tissue.

Stage IV: Full thickness skin loss with extensive destruction, tissue necrosis, or damage to muscle, bone, or supporting structures (e.g., tendon, joint capsule). Undermining and sinus tracts also may be associated with Stage IV pressure ulcers.

1.2.11.5 Prior Authorization

Hospital beds require prior authorization. A fixed height bed (procedure code E0250) may be considered for prior authorization if the client requires the head of the bed to be elevated more than 30 degrees most of the time because of conditions such as congestive heart failure, chronic pulmonary disease, or problems with aspiration. Pillows or wedges must have been used and found to be ineffective. A variable height hospital bed (procedure code E0255) may be considered for prior authorization if the client meets the criteria for a fixed height hospital bed and requires a bed height different than a fixed height hospital bed to permit transfers to chair, wheelchair, or standing position.

A semi-electric hospital bed (procedure code E0260) may be considered for prior authorization if the client meets the criteria for a variable height bed and requires frequent changes in body position and/or has an immediate need for a change in body position. A fully electric bed may be considered for prior authorization if it is found to increase the client's ability to self-care and will not be prior authorized for the convenience of the caregiver.

A heavy-duty, extra wide hospital bed may be considered for prior authorization if the client meets the criteria for one of the other hospital beds. An extra heavy-duty, extra wide hospital bed may be considered for prior authorization if the client meets the criteria for one of the other hospital beds and whose weight meets the description of a heavy-duty hospital bed. A bed cradle (procedure code E0280) is a benefit of Texas Medicaid when prior authorized. All equipment must be prior authorized. Pressure-reducing support surfaces must be prior authorized.

1.2.11.6 Documentation Requirements

To request prior authorization for a hospital bed, the following documentation must be submitted:

- Accurate diagnostic information pertaining to the underlying medical diagnoses/conditions (e.g.,gastrostomy feeding, suctioning, ventilator dependent, other respiratory equipment/ventilation assistance devices) to include the client's overall health status
- The client's height and weight
- The client's functional mobility status
- The client's use of any pressure-reducing support surfaces, if applicable

1.2.11.7 Hospital Beds and Equipment Procedure Code Table

Procedure Code	Maximum Limitation
E0184	1 purchase every 5 years; 1 month rental
E0185	1 purchase every 5 years; 1 month rental
E0186	1 purchase every 5 years; 1 month rental
E0187	1 purchase every 5 years; 1 month rental
E0188	1 every year
E0189	1 every year
E0193	1 per month
E0194	1 per month
E0196	1 per month
E0197	1 per month
E0198	1 purchase every 5 years; 1 month rental
E0199	1 every 5 years
E0250	1 purchase every 5 years; 1 month rental
E0255	1 purchase every 5 years; 1 month rental
E0260	1 purchase every 5 years; 1 month rental
E0265	1 purchase every 5 years; 1 month rental
E0271	1 every 5 years
E0277	1 per month
E0280	1 purchase every 5 years; 1 month rental
E0303	1 purchase every 5 years; 1 month rental
E0304	1 purchase every 5 years; 1 month rental
E0305	1 every 5 years
E0310	1 every 5 years
E0315	1 every 5 years
E0371	1 purchase every 5 years; 1 month rental
E0372	1 purchase every 5 years; 1 month rental
E0373	1 purchase every 5 years; 1 month rental
E0910	1 purchase every 5 years; 1 month rental
E0911	1 purchase every 5 years; 1 month rental
E0912	1 purchase every 5 years; 1 month rental
E0920	1 purchase every 5 years; 1 month rental
E0940	1 purchase every 5 years; 1 month rental
E0946	1 purchase every 5 years; 1 month rental

1.2.12 Incontinence Supplies and Equipment

Incontinence supplies billed for a one-month period should be based on the frequency/quantity ordered by the physician on the Home Health Services (Title XIX) Durable Medical Equipment (DME)/Medical Supplies Physician Order Form.

Note: *THSteps-eligible clients who qualify for medically necessary services beyond the limits of this Home Health benefit will receive those services through CCP.*

Refer to: Subsection 1.4.2.1, "Eligibility " in this handbook.

1.2.12.1 Incontinence Supplies

1.2.12.1.1 Skin Sealants/Protectants/Moisturizers/Ointments

Skin sealants, protectants, moisturizers and ointments are limited to a maximum of two per month for clients 4 years of age or older.

1.2.12.1.2 Diapers/Briefs/Pull-ons/Liners

Diapers and briefs are defined as incontinence items attached with tabs. Protective underwear and pull-ons are defined as incontinence items that do not attach with tabs and are slip-on items. Liners are intended to be worn inside diapers, briefs, and pull-ons to increase absorbency. Reusable diapers/briefs are not a benefit of Home Health Services.

For clients 4 years of age or older who have a medical condition that results in chronic incontinence, up to a maximum total combination of 300 per month of diapers/briefs/liners may be considered without prior authorization. Additional quantities may be considered with documentation of medical necessity and prior authorization.

Note: *Gloves used to change diapers and briefs (including pull-ups) are not considered medically necessary unless the client has skin breakdown or a documented disease that may be transmitted through the urine or stool.*

1.2.12.1.3 Diaper Wipes

Diaper wipes, other than urinary skin cleansing products, are limited to a maximum of two boxes per calendar month. Exceptions will not be considered through Home Health Services. Additional quantities may be considered through CCP for clients who are 20 years of age or younger with documentation of medical necessity and prior authorization.

Providers are to bill procedure code A4335 instead of procedure code A5120 when providing diaper wipes. Inappropriate billing of procedure code A5120 will cause the claim to deny.

1.2.12.1.4 Underpads

Underpads may be considered for reimbursement without prior authorization for clients who also receive diapers/briefs/pull-ons or liners, urine collection devices, or bowel management supplies. Underpads are limited to a maximum of 150 per calendar month without prior authorization. Amounts greater than 150 per month may be considered for prior authorization with documentation of medical necessity. Reusable underpads are not a benefit of Home Health Services.

Note: *The Home Health Services (Title XIX) Durable Medical Equipment (DME)/Medical Supplies Physician Order Form for the supplies listed above must reflect a one month's supply of the incontinence product. More than the maximum allowed amount should not be on the Home Health Services (Title XIX) Durable Medical Equipment (DME)/Medical Supplies Physician Order Form without prior authorization.*

1.2.12.1.5 Ostomy Supplies

The physician must specify the type of ostomy device/system to be used and how often it is to be changed on the Home Health Services (Title XIX) Durable Medical Equipment (DME)/Medical Supplies Physician Order Form without prior authorization. The quantity of ostomy supplies billed for a one-month period should relate to the number of changes per month based on the frequency ordered by the physician.

1.2.12.1.6 Urine Collection Devices

The home setting is considered a clean environment, not a sterile one. Sterile incontinence supplies, including gloves, will not be reimbursed in the home setting except when requested by a physician familiar with the client for the following:

- Indwelling urinary catheters
- Intermittent catheters for clients who:
  - Are immunosuppressed
  - Have radiologically documented vesico-ureteral reflux
  - Are pregnant and have a neurogenic bladder due to spinal cord injury
  - Have a history of distinct, recurrent urinary tract infections, defined as a minimum of two within the prior 12-month period, while on a program of clean intermittent catheterization

Nonsterile/sterile gloves for use by a health-care provider in the home setting, such as an RN, licensed vocational nurse (LVN), or attendant, are not a benefit of Home Health Services.

Indwelling Catheters and Related Insertion Supplies
Indwelling catheters and related supplies are limited to a maximum of two per month. The physician must indicate on the Home Health Services (Title XIX) Durable Medical Equipment (DME)/Medical Supplies Physician Order Form how often the client is required to change their indwelling catheter.

Intermittent Catheters and Related Insertion Supplies
Intermittent catheters and related insertion supplies may be considered for reimbursement for those who have a documented medical condition that results in a permanent impairment of urination. Intermittent catheters and related supplies are limited to a maximum of 120 per month. The physician must indicate on the Home Health Services (Title XIX) Durable Medical Equipment (DME)/Medical Supplies Physician Order Form how often the client is required to perform intermittent catheterization.

Providers must use procedure codes A4351 and/or A4352 when billing for intermittent catheters. Providers must use procedure code A4353 when billing for Intermittent catheters with insertion supplies. When billing these codes for intermittent hydrophilic catheters use the SC modifier.

External Urinary Collection Devices
Male external catheters are limited to 31 per month. Female collection devices may be considered for reimbursement without prior authorization for a maximum of four per month. The physician must indicate on the Home Health Services (Title XIX) Durable Medical Equipment (DME)/Medical Supplies Physician Order Form how often the client is required to change their external urinary collection device.

Documentation of a medical condition that results in an increased urine and/or stool output beyond the typical output for this age group is required for reimbursement consideration.

1.2.12.2 Incontinence Equipment

Incontinence equipment may be considered for reimbursement for clients 4 years of age or older who have a medical condition that results in an inability to ambulate to the bathroom safely (with or without mobility aids).

1.2.12.2.1 Urinals and Bed Pans

Urinals and bed pans are considered as a purchase only.

1.2.12.2.2 Commode Chairs and Foot Rests

The client must meet the criteria for the level commode chair or foot rest requested.

Reimbursement may be considered for a commode chair with or without a foot rest if the client also has a stationary bath chair without a commode cutout.

1.2.12.2.3 Commode Chairs

Commode chairs are limited to one per five years. Documentation must support the medical necessity of a customized commode chair or the addition of attachments to a standard commode chair.

Level 1: Stationary Commode Chair
A stationary commode chair may be considered for reimbursement with prior authorization for clients who have a medical condition that results in an inability to ambulate to the bathroom safely (with or without mobility aids). Providers must use procedure codes E0163 or E0165 when billing for stationary or mobile commode chairs.

Level 2: Mobile Commode Chair
A mobile commode chair with fixed or removable arms may be considered for reimbursement for clients who have a documented medical condition that results in an inability to ambulate to the bathroom safely (with or without mobility aids).

A mobile commode chair with fixed or removable arms may be considered for prior authorization and reimbursement when:

- The client has a medical condition that results in the inability to ambulate to the bathroom safely (with or without mobility aids).
- The client must be on a bowel program and require a combination commode/bath chair for performing the bowel program and bathing after.
- 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.

If the client owns a bath chair and has medical necessity for a mobile commode chair, one may be considered through CCP for clients 20 years of age or younger.

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 and reimbursement when:

- The criteria for a Level 1 or 2 commode chair has been met.
- The client must have a medical condition that results in an inability to support their head, neck, and/or trunk without assistance.
- The client does not also have any type of bath chair.

If the client owns a bath chair and has medical necessity for a mobile commode chair, one may be considered through CCP for clients 20 years of age or younger. Providers must use procedure codes E0163 or E0165 and modifier TG (custom) when billing for the purchase of a custom stationary or mobile commode chair. Providers must use procedure codes E0163 or E0165 and modifier TF (non-custom mobile) when billing for the purchase of a non-custom mobile commode chair.

1.2.12.2.4 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 client who weighs 300 pounds or more. An extra wide/heavy-duty commode chair will be considered for prior authorization and reimbursement when the client has met the criteria for a Level 1, 2, or 3 commode chair and weigh 300 pounds or more. Providers must use procedure code E0168 and modifiers TF (mobile) or TG (custom) when billing for the purchase of an extra-wide/heavy-duty commode chair.

1.2.12.2.5 Foot Rest

A foot rest may be considered for prior authorization and reimbursement when:

- The client has met the criteria for a Level 1, 2, or 3 commode chair.
- The foot rest is necessary to support contractures of the lower extremities; for a client who is paraplegic or quadriplegic.

Providers must use procedure code E1399 when billing for the purchase of a foot rest.

1.2.12.2.6 Replacement Commode Pail and Pan

Providers must use procedure code E0167 when billing for the purchase of a commode pail or pan.

1.2.12.3 Prior Authorization

Incontinence supplies, urinals, and bed pans do not require prior authorization up to their allowed maximum limitations. Prior authorization is required for incontinence supplies if amounts greater than the maximum limits are medically necessary.

1.2.12.3.1 Incontinence Supplies

Skin Sealants/Protectants/Moisturizers/Ointments
Skin sealants, protectants, moisturizers, and ointments for clients 4 years of age or older may be considered for reimbursement with prior authorization for clients who have a medical condition that results in chronic incontinence and increased risk of skin breakdown. Prior authorization for clients 3 years of age or younger must be obtained through CCP.

Diapers/Briefs/Pull-ons/Liners
For clients 4 years of age or older with a medical condition that results in chronic incontinence, diapers, briefs, protective underwear, pull-ons, and liners may be considered for reimbursement without prior authorization up to a total combination of 300 per calendar month. Amounts beyond 300 per calendar month may be considered for reimbursement when prior authorized.

Diaper Wipes
Diaper wipes (procedure code A4335), other than urinary skin cleansing products, may be considered for reimbursement without prior authorization for clients who are 4 years of age or older and are also receiving diapers/briefs/pull-ons or liners.

Ostomy Supplies
Ostomy supplies may be considered for reimbursement without prior authorization.

Urine Collection Devices
Nonsterile gloves may be considered for reimbursement with prior authorization when a family member or friend is performing the catheterization.

Indwelling Catheters and Related Insertion Supplies
Indwelling catheters and related insertion supplies may be considered for reimbursement without prior authorization for clients who have a documented medical condition that results in a permanent impairment of urination. More than two indwelling catheters and related insertion supplies per month requires prior authorization.

Intermittent Catheters and Related Insertion Supplies
More than 120 intermittent catheters and related insertion supplies requires prior authorization.

External Urinary Collection Devices
External urinary collection devices for clients 4 years of age or older, such as male external catheters and female collection devices, and related supplies may be considered for reimbursement without prior authorization for clients who have a documented and/or diagnosed medical condition that results in a permanent impairment of urination. Prior authorization is required for medically necessary services beyond the limits listed in, Subsection 1.2.12.6, "Incontinence Procedure Codes with Limitations " in this handbook. External urinary collection devices for clients 3 years of age or younger require prior authorization through CCP.

1.2.12.3.2 Incontinence Equipment

Urinals and Bed Pans
Urinals and bed pans may be considered for reimbursement without prior authorization for clients who have a documented and/or diagnosed medical condition that results in an inability to ambulate to the bathroom safely (with or without mobility aids) up to a limit of two per year. Urinals and bed pans that exceed two per year may be considered with prior authorization.

Commode Chairs and Foot Rests
Commode chairs and foot rests may be considered for prior authorization and reimbursement based on the level of need.

Replacement Commode Pail and Pan
Replacement commode pails or pans may be considered for prior authorization once per year. Additional quantities may be considered for prior authorization with documentation of medical necessity.

1.2.12.4 Documentation Requirements

To request prior authorization for incontinence supplies/equipment, the following documentation must be provided:

- Diagnostic information pertaining to the underlying diagnoses/conditions, to include the client's overall health status
- Weight and height and/or waist size, when applicable
- Number of times per day the physician has ordered the supply be used
- Quantity of disposable supplies requested per month, or quantity of DME requested

Additional information may be requested to clarify or complete a request for the supplies and equipment.

1.2.12.5 Modifiers

Modifier		
TF	TG	SC

1.2.12.6 Incontinence Procedure Codes with Limitations

Any service or combination of services, except diaper wipes, requires prior authorization if the maximum limitation is exceeded. Requests for prior authorization of diaper wipes that exceed more than two boxes per month will not be considered through Home Health Services.

Procedure Code	Maximum Limitation
A4310	2 per month

Procedure Code	Maximum Limitation
A4311	2 per month
A4312	2 per month
A4313	2 per month
A4314	2 per month
A4315	2 per month
A4316	2 per month
A4320	2 per month
A4322	4 per month
A4326	31 per month
A4327	4 per month
A4328	4 per month
A4330	As needed
A4335	2 per month
A4338	2 per month
A4340	2 per month
A4344	2 per month
A4346	2 per month
A4349	31 per month
A4351	120 per month
A4352	120 per month
A4353	120 per month
A4354	2 per month
A4355	2 per month
A4356	2 per month
A4357	2 per month
A4358	2 per month
A4360	2 per month
A4361	As needed
A4362	As needed
A4363	As needed
A4364	As needed
A4367	As needed
A4368	As needed
A4369	As needed
A4371	As needed
A4372	As needed
A4373	As needed
A4375	As needed
A4376	As needed
A4377	As needed

Procedure Code	Maximum Limitation
A4378	As needed
A4379	As needed
A4380	As needed
A4381	As needed
A4382	As needed
A4383	As needed
A4384	As needed
A4385	As needed
A4387	As needed
A4388	As needed
A4389	As needed
A4390	As needed
A4391	As needed
A4392	As needed
A4393	As needed
A4394	As needed
A4395	As needed
A4396	As needed
A4397	As needed
A4398	As needed
A4399	As needed
A4400	As needed
A4402	4 per month
A4404	As needed
A4405	As needed
A4406	As needed
A4407	As needed
A4408	As needed
A4409	As needed
A4410	As needed
A4411	As needed
A4412	As needed
A4413	As needed
A4414	As needed
A4415	As needed
A4418	As needed
A4420	As needed
A4421	As needed
A4422	As needed
A4428	As needed

Procedure Code	Maximum Limitation
A4455	4 per month
A4456	50 per month
A4554	150 per month
A5051	As needed
A5052	As needed
A5053	As needed
A5054	As needed
A5055	As needed
A5061	As needed
A5062	As needed
A5063	As needed
A5071	As needed
A5072	As needed
A5073	As needed
A5081	As needed
A5082	As needed
A5083	As needed
A5093	As needed
A5102	2 per month
A5105	4 per year
A5112	2 per month
A5113	2 per month
A5114	2 per month
A5120	30 per month
A5121	As needed
A5122	As needed
A5126	As needed
A5131	1 per month
A5200	2 per month
T4521	*300 per Month
T4522	*300 per Month
T4523	*300 per Month
T4524	*300 per Month
T4525	*300 per Month
T4526	*300 per Month
T4527	*300 per Month
T4528	*300 per Month
T4529	*300 per Month
T4530	*300 per Month
T4531	*300 per Month

Procedure Code	Maximum Limitation
T4532	*300 per Month
T4533	*300 per Month
T4534	*300 per Month
T4535	*300 per Month
T4543	*300 per month
E0275	2 per year
E0276	2 per year
E0325	2 per year
E0326	2 per year

Refer to: Subsection 1.2.12.1.2, "Diapers/Briefs/Pull-ons/Liners" in this handbook for an explanation of the item limitations identified with an asterisk (*).

The following procedure codes always require prior authorization even if the maximum benefit limitation allowed has not been exceeded:

Procedure Code	Maximum Limitation
A4927	1 per month
A6250	2 per month
E0163	1 per 5 years
E0165	1 per 5 years
E0167	1 per year
E0168	1 per 5 years
E0175	1 per 5 years

1.2.13 Intravenous (IV) Therapy Equipment and Supplies

The following equipment and supplies are used in the delivery of IV therapy and are a benefit of Home Health Services. Additional supply procedure codes may be considered with documentation of medical necessity:

Procedure Code									
A4206	A4207	A4208	A4209	A4212	A4222	A4245	A4247	A4300	A4305
A4306	A4450	A4452	A4930	A6206	A6207	A6257	A6258	A6402	A9900
E0776	E0779	E0780	E0781	E0791	S1015				

Types of IV access devices include but are not limited to:

- Peripheral IV lines.
- Central IV lines, including but not limited to, peripherally-inserted central catheters, subclavian catheters, and vena cava catheters.
- Central venous lines, including but not limited to, tunneled and peripherally inserted central venous catheters.
- Implantable ports, including but not limited to, access devices with subcutaneous ports.

Stopcocks increase the risk of infection and should not be routinely used for infusion administration. Routine use of in-line filters is not recommended for infection control.

Note: *Nonsterile/sterile gloves for use by a health-care provider in the home setting, such as an RN, LVN, or attendant, are not a benefit of Home Health Services.*

Stationary infusion pumps may be a benefit when the infusion rate must be more consistent and cannot be obtained with gravity drainage. Ambulatory infusion pumps may be a benefit when the length of infusion is greater than two hours, the client must be involved in activities away from home, and when the infusion rate must be more consistent and cannot be obtained with gravity drainage. Elastomeric infusion pumps may be a benefit for short-term use when the caregiver cannot administer the infusion via pump. Dial flow regulators are a benefit and are incorporated into IV extension sets or IV tubing. Elastomeric devices may be reimbursed using procedure codes A4305 and A 4306.

Rental of an infusion pump may be prior authorized on a monthly basis for a maximum of four months per lifetime. Purchase of an infusion pump (ambulatory or stationary) may be prior authorized with documentation of medical necessity that supports repeated IV administration for a chronic condition.

For clients who require cardiovascular medications, infusion pumps will be rented, but not purchased.

Repairs to client-owned equipment may be prior authorized as needed with documentation of medical necessity. Technician fees are considered part of the cost of the repair. Providers are responsible for maintaining documentation in the client's medical record that specifies the repairs and supports medical necessity. All repairs within the first six months after delivery are considered part of the purchase price. Additional documentation, such as the purchase date, serial number, and manufacturer's information, may be required.

IV therapy, supplies, and equipment are not considered a benefit when the infusion/medication being administered:

- Is not considered medically necessary to the treatment of the client's illness.
- Exceeds the frequency and/or duration ordered by the physician.
- Is a chemotherapeutic agent or blood product.
- Is not FDA-approved, unless the physician documents why the off-label use is medically appropriate and not likely to result in an adverse reaction. In order to consider coverage of an off-label (non-FDA approved) use of a drug, documentation must include why a drug usually indicated for the specific diagnosis or condition has not been effective for the client.

Routine maintenance of rental equipment is included in the rental price.

1.2.13.1 Prior Authorization

Prior authorization of IV equipment and supplies may be considered when administration of the drug in the home is medically necessary and is appropriate in the home setting. IV equipment may be prior authorized for rental or purchase depending on the clinician's predicted length of treatment.

The following standards are used when considering prior authorization of IV supplies:

- The aseptic technique is acceptable for IV catheter insertion and site care; the sterile technique is not required:
  - Nonsterile gloves are acceptable for the insertion of a peripheral IV catheter and for changing any IV site dressing.
  - The sterile technique may be medically necessary. Examples of medical necessity include, but are not limited to, a client who is immuno-compromised.
- A peripheral IV site is rotated no more frequently than every 72 hours, but it is rotated at least weekly.

- The IV administration set (with or without dial flow regulator), extension set (with or without dial flow regulator), and any add-on devices are changed every 72 hours.
- One IV access catheter is used per insertion.
- Saline/heparin-locked catheters:
  - Use one syringe to flush the catheter before administration of an intermittent infusion to assess.
  - Use two syringes to flush the catheter after the intermittent infusion—one to clear the medication and one to infuse the anticoagulant or other medication used to maintain IV patency between doses, including, but not limited to, heparin.
- An injection port is cleaned before administering an intermittent infusion and capped after the infusion.
- IV catheter site care:
  - Disinfect the site with an appropriate antiseptic (including but not limited to 2 percent chlorhexidine-based preparation, tincture of iodine, or 70 percent alcohol).
  - Cover with sterile gauze, transparent dressing, or semi-permeable dressing.
  - Replace the dressing if it becomes damp, loosened, or visibly soiled.

Elastomeric devices and dial flow regulators are specialized infusion devices that may be considered for prior authorization when the device:

- Will be used for short-term medication administration (less than two weeks duration).
- Is expected to increase client compliance.
- Will better facilitate drug administration.
- Costs less than the cost of pump rental/tubing.
- The caregiver can not administer the infusion via pump.

The following criteria must be met for prior authorization of a stationary infusion pump:

- An infusion pump is required to safely administer the drug.
- The standard method of administration of the drug is through prolonged infusion or intermittent infusion, and the infusion rate must be more consistent than can be obtained with gravity drainage.
- The drug being administered requires IV infusion (i.e., the drug cannot be administered orally, intramuscularly, or by push technique).

The following criteria must be met for prior authorization of an ambulatory infusion pump:

- An infusion pump is required to safely administer the drug.
- The standard method of administration of the drug is through prolonged infusion or intermittent infusion and the infusion rate must be more consistent than can be obtained with gravity drainage.
- The drug being administered requires IV infusion (i.e., the drug cannot be administered orally, intramuscularly, or via push technique).
- The infusion administration is more than two hours and the client is involved in activities away from home, including, but not limited to, physician visits.

1.2.13.2 Documentation Requirements

To request prior authorization for IV supplies and equipment, the following documentation must be provided:

- Diagnostic information pertaining to the underlying diagnosis/condition

- A physician's order and documentation supporting medical necessity
- The medication and dose being administered, the duration of drug therapy, and the frequency of administration

If additional supplies are needed beyond the standards listed, prior authorization may be considered with documentation supporting medical necessity.

- For additional IV access catheters, supporting documentation should have evidence that includes, but is not limited to, the following:
  - Dehydration
  - Vein scarring
  - Fragile veins, including but not limited to, clients who are infants or elderly
- For more frequent IV site changes, supporting documentation should have evidence that includes, but is not limited to, the following:
  - Phlebitis
  - Infiltration
  - Extravasation
- For more frequent IV tubing or add-on changes, supporting documentation should have evidence that includes, but is not limited to, the following:
  - Phlebitis
  - IV catheter-related infection
  - The administered infusion requires more frequent tubing changes

1.2.14 Mobility Aids

Medical appliances and equipment including mobility aids such as canes, crutches, walkers, and wheelchairs (standard manual or power and custom manual or power, including those optimally configured for propulsion or custom seating) are reimbursed to assist clients to move about in their environment.

Note: *A mobility aid for a client 20 years of age or younger is medically necessary when it is required to correct or ameliorate a disability or physical illness or condition.*

1.2.14.1 Canes, Crutches, and Walkers

Canes, crutches, and/or walkers may be prior authorized as a home health service with documentation supporting medical necessity and appropriateness of the requested item. This documentation by a physician familiar with the client must include information on the clients impaired mobility.

1.2.14.2 Feeder Seats, Floor Sitters, Corner Chairs, and Travel Chairs

Feeder seats, floor sitters, corner chairs, and travel chairs are not considered medically necessary devices and are not a benefit of Texas Medicaid. If a child requires seating support and meets the criteria for a seating system, a stroller may be considered for reimbursement with prior authorization through CCP or a wheelchair may be considered for reimbursement with prior authorization from TMHP Home Health Services Prior Authorization Department.

1.2.14.3 Wheelchairs

A standard manual wheelchair may be prior authorized for rental or purchase if the client owns, or is requesting, a standard or custom power wheelchair.

A custom manual wheelchair may be prior authorized for rental or purchase if the client owns, or is requesting a custom power wheelchair.

Prior authorization for labor to create a custom-molded seating system is limited to a maximum of 15 hours.

1.2.14.3.1 Prior Authorization

A wheelchair may be prior authorized for short-term use or for purchase with documentation supporting medical necessity and an assessment of the accessibility of the client's residence to ensure that the wheelchair is usable in the home (i.e., doors and halls wide enough, no obstructions). The wheelchair must be able to accommodate a 20 percent change in the client's height and/or weight. This documentation by a physician familiar with the client must include information on the client's impaired mobility and physical requirements.

In addition, the following information must be submitted with documentation of medical necessity:

- Why the client is unable to ambulate a minimum of 10 feet due to his/her condition (including AIDS, sickle cell anemia, fractures, a chronic diagnosis, or chemotherapy).
- If the client is able to ambulate further than 10 feet, why a wheelchair is required to meet the client's needs.
- A completed Wheelchair/Scooter/Stroller Seating Assessment Form with seating measurements that includes documentation supporting medical necessity, except when requesting a standard sling seat/sling back wheelchair.
- An itemized component list for custom manual or power wheelchairs.

1.2.14.4 Manual Wheelchairs—Standard, Standard Hemi, Standard Reclining, Tilt-in-Space

A standard manual wheelchair is defined as a manual wheelchair that:

- Weighs more than 36 pounds.
- Does not have features to appropriately accept specialized seating or positioning.
- Has a weight capacity of 250 pounds or less.
- Has a seat depth of between 15 and 19 inches.
- Has a seat width of between 15 and 19 inches.
- Has a seat height of 19 inches or greater.
- Is fixed height only, fixed, swing away, or detachable armrest.
- Is fixed, swing away, or detachable footrest.

A standard hemi (low seat) wheelchair is defined as a manual wheelchair that:

- Has the same features as a standard manual wheelchair.
- Has a seat to floor height of less than 19 inches.

A standard reclining wheelchair is defined as a manual wheelchair that:

- Has the same features as a standard or hemi manual wheelchair.
- Has the ability to allow the back of the wheelchair to move independently of the seat to provide a change in orientation by opening the seat-to-back angle and, in combination with leg rests, open the knee angle.

A tilt-in-space wheelchair is defined as a manual wheelchair that:

- Has the ability to tilt the frame of the wheelchair greater than or equal to 45 degrees from horizontal while maintaining a constant back to seat angle to provide a change of orientation and redistribute pressure from one area (such as the buttocks and the thighs) to another area (such as the trunk and the head).

- Adult size has a weight capacity of at least 250 pounds.
- Pediatric size has a seat width or depth of less than 15 inches.

1.2.14.4.1 Prior Authorization

A standard manual wheelchair may be considered for prior authorization for short-term rental or purchase when all the following criteria are met:

- The client has impaired mobility and is unable to ambulate more than 10 feet.
- The client does not require specialty seating components.
- The client is not expected to need powered mobility within the next 5-year period.

A standard hemi wheelchair may be considered for prior authorization for short-term rental or purchase when the client meets criteria for a standard manual wheelchair and the following criteria is met:

- The client requires a low seat-to-floor height.
- The client must use their feet to propel the wheelchair.

A standard reclining wheelchair may be considered for prior authorization for short-term rental or purchase when the client meets criteria for a standard manual wheelchair and one or more of the following criteria are met:

- The client develops fatigue with longer periods of sitting upright.
- The client is at increased risk of pressure sores with prolonged upright position.
- The client requires assistance with respirations in a reclining position.
- The client needs to perform activities of daily living (ADLs) in a reclining position.
- The client needs to improve venous return from lower extremity in a reclining position.
- The client has severe spasticity.
- The client has excess extensor tone of the trunk muscles.
- The client has quadriplegia.
- The client has a fixed hip angle.
- The client must rest in a reclining position two or more times per day.
- The client has the inability or has great difficulty transferring from wheelchair to bed.
- The client has trunk or lower extremity casts or braces that require the reclining feature for positioning.

A tilt-in-space wheelchair may be considered for prior authorization for short-term rental or purchase when all the following criteria are met:

- The client meets criteria for a standard manual wheelchair.
- The client has a condition that meets criteria for a tilt-in-space feature, including, but not limited to:
  - Severe spasticity.
  - Hemodynamic problems.
  - Quadriplegia.
  - Excess extensor tone.
  - Range of motion limitations that prohibit a reclining system, such as hip flexors, hamstrings, or even heterotopic ossification.

- The need to rest in a recumbent position two or more times per day and the client has an inability to transfer between bed and wheelchair without assistance.
- Documented weak upper extremity strength or a disease that will lead to weak upper extremities.
- Risk for skin break down because of inability to reposition body in chair to relieve pressure areas.

1.2.14.5 Manual Wheelchairs—Lightweight and High-Strength Lightweight

A lightweight manual wheelchair is defined as a manual wheelchair that:

- Has the same features as a standard or hemi manual wheelchair.
- Weighs 34 to 36 pounds.
- Has available arm styles that are height adjustable.

A high-strength lightweight wheelchair is defined as a manual wheelchair that:

- Has the same features as a lightweight manual wheelchair.
- Weighs 30 to 34 pounds.
- Has a lifetime warranty on side frames and cross braces.

1.2.14.5.1 Prior Authorization

A lightweight manual wheelchair may be considered for prior authorization for rental or purchase when all the following criteria are met:

- The client is unable to propel a standard manual wheelchair at home.
- The client is capable of independently propelling a lightweight wheelchair to meet their mobility related activities of daily living (MR-ADLs) at home.

A high-strength lightweight wheelchair may be considered for prior authorization for rental or purchase when all the following criteria are met:

- The client meets all the criteria for a lightweight manual wheelchair and meets one or more of the following:
  - The high-strength lightweight wheelchair will allow the client to self-propel while engaging in frequently performed activities that cannot otherwise be completed in a standard or lightweight wheelchair.
  - The client requires frame dimensions (seat width, depth, or height) that cannot be accommodated in a standard, lightweight, or hemi wheelchair and the wheelchair is used at least 2 hours a day.

1.2.14.6 Manual Wheelchairs—Heavy-Duty and Extra-Heavy-Duty

A heavy duty wheelchair is defined as a manual wheelchair that:

- Meets the standard manual wheelchair definition.
- Has a weight capacity greater than 250 pounds.

An extra-heavy-duty wheelchair is defined as a manual wheelchair that:

- Meets the standard manual wheelchair definition.
- Has a weight capacity greater than 300 pounds.

1.2.14.6.1 Prior Authorization

A heavy-duty wheelchair may be considered for prior authorization for short-term rental or purchase when the client has severe spasticity or all the following criteria are met:

- The client meets criteria for a standard manual wheelchair.
- The client weighs between 250 and 300 pounds.

An extra-heavy-duty wheelchair may be considered for prior authorization for short-term rental or purchase when all the following criteria are met:

- The client meets criteria for a standard manual wheelchair.
- The client weighs more than 300 pounds.

1.2.14.7 Manual Wheelchairs— Pediatric Size

A pediatric sized wheelchair is defined as a manual standard/custom wheelchair (including those optimally configured for propulsion or custom seating) that has a seat width or depth of less than 15 inches.

1.2.14.8 Manual Wheelchairs—Custom (Includes Custom Ultra-Lightweight)

A custom ultra-lightweight wheelchair is defined as an optimally configured wheelchair for independent propulsion which cannot be achieved in a standard lightweight or high-strength lightweight wheelchair that:

- Meets the high-strength lightweight definition and weighs less than 30 pounds.
- Has one or more of the following features to appropriately accept specialized seating and/or positioning:
  - Adjustable seat-to-back angle
  - Adjustable seat depth
  - Independently adjustable front and rear seat-to-floor dimensions
  - Adjustable caster stem hardware
  - Adjustable rear axle
  - Adjustable wheel camber
  - Adjustable center of gravity
- Lifetime warranty on side frames and cross braces

1.2.14.8.1 Prior Authorization

A custom (ultra lightweight) manual wheelchair may be considered for prior authorization for rental or purchase when the client meets all the criteria for a lightweight manual wheelchair and one or more of the following criteria:

- The client is able to self-propel, will have independent mobility with the use of an optimally configured chair, and meets all of the following criteria:
  - The client uses the wheelchair for a significant portion of their day to complete MR-ADLs.
  - The client uses the wheelchair in the community to complete MR-ADLs.
  - Powered mobility is not anticipated within the next 5-year period.
- The client is able to self-propel, will have independent mobility with the use of an optimally configured chair, has a medical condition that cannot be accommodated by the seating available on a standard, lightweight, or high-strength lightweight wheelchair and one or more of the following features needed by the client to ensure optimal independence with MR-ADLs:
  - Adjustable seat to back angle.

- Adjustable seat depth.
- Independently adjustable front and rear seat-to-floor dimensions.
- Adjustable caster stem hardware.
- Adjustable rear axle (adjustable center of gravity).
- Powered mobility is not anticipated within the next 5-year period.

- The client meets all of the following criteria:
  - The client is unable to self-propel.
  - The client has a documented condition that requires custom seating, including, but not limited to:
    - Poor trunk control.
    - Contractures of elbow or shoulders.
    - Muscle spasticity.
    - Tone imbalance through shoulders or back.
    - Kyphosis or Lordosis.
    - Lack of flexibility in pelvis or spine.
- The client requires custom seating that cannot be accommodated on a standard, lightweight, or hemi-wheelchair.

1.2.14.9 Seating Assessment for Manual and Power Custom Wheelchairs

A seating assessment and seating measurements including specifications for exact mobility/seating equipment and all necessary accessories, must be completed by a physician, licensed occupational therapist, or licensed physical therapist.

The accessibility of the client's residence must be assessed and included in the prior authorization of the wheelchair/mobility device. This assessment must include measurements of the doorways, hallways, and main living areas such as bedroom(s) and bathroom(s). The vendor must verify that the main living areas are wheelchair accessible and available to the client while in the mobility device.

> ***Note:*** *If a client who is birth through 20 years of age requires seating support and meets the criteria for a seating system, a stroller may be considered through CCP, or a wheelchair may be considered through Texas Medicaid Title XIX Home Health Services.*

1.2.14.9.1 Prior Authorization

Seating assessments must be prior authorized.

1.2.14.9.2 Documentation Requirements

A seating assessment and seating measurements must be completed, signed, and dated, by a physician or a licensed occupational or physical therapist before requesting prior authorization. All signatures and dates must be current, unaltered, original, and handwritten. Computerized or stamped signatures and dates will not be accepted.

To request prior authorization for a custom manual/power wheelchair, a Wheelchair/Scooter/Stroller Seating Assessment Form must be completed by a physician or a licensed physical or occupational therapist using the procedure codes 97001 and 97003.

The following documentation must be provided:

- A seating evaluation and seating measurements, performed by a physician or a licensed occupational or physical therapist, which includes specifications for exact mobility/seating equipment, all necessary accessories, and how the client and/or family will be trained in the use of the equipment.

- Anticipated changes in the client's needs, anticipated modifications, or accessory needs, as well as the growth potential of the wheelchair. A wheelchair must have a growth potential that will accommodate a 20-percent change in the client's height and/or weight.
- Significant medical information pertinent to mobility and requested equipment including intellectual, postural, physical, sensory (visual and auditory), and physical status. Address trunk and head control, balance, arm and hand function, existence and severity of orthopedic deformities, as well as any recent changes in the client's physical and/or functional status, and any expected/potential surgeries that will improve or further limit mobility.
- A description of the current mobility/seating equipment, how long the client has been in the current equipment and why it no longer meets the client needs.
- Client's height, weight, and a description of where the equipment is to be used. Include the accessibility of client's residence.
- Manufacturer's retail pricing information, with itemized pricing including the description of the specific base, any attached seating system components and any attached accessories as well as the manufacturer's retail pricing information and itemized pricing for manually priced components.

If the wheelchair assessment form is completed by a physician, reimbursement is considered part of the physician office visit and will not be prior authorized using the above therapy procedure codes.

1.2.14.10 Levels for Powered Wheelchairs

Level 1 is a basic power wheelchair (no modifier required). Level 2 is a custom system that meets the Level 1 definition with components for posture support (TF [Intermediate Level] modifier required). Level 3 is a custom system that meets the Level 2 definition with the addition of a molded seating system, tilt space and reclining capacities (TG [Complex, high-level] modifier required).

1.2.14.11 Power Wheelchairs—Standard

Standard power wheelchairs may be considered for short-term rental up to 6 months or for purchase for a client who meets criteria for a wheelchair when the client has a condition that does not require specialized seating, and is unable to self-propel a manual wheelchair. An attendant control is not a benefit of Home Health Services. Rental of a manual wheelchair may be prior authorized when the client's power wheelchair is being repaired or replaced.

1.2.14.11.1 Documentation Requirements

Prior authorization for a standard power wheelchair requires all documentation necessary for a custom manual wheelchair, as well as the following documentation:

- The client's physical and mental ability to receive and follow instructions related to responsibilities of using equipment. (The client must be able to operate a power wheelchair independently; the therapist must provide written documentation that the client is physically and cognitively capable of managing a power wheelchair)
- How the power wheelchair will be operated such as joystick, head pointer, puff-and-go
- The capability of the caregiver/client to care for the power wheelchair and accessories
- The capability of the caregiver/client to understand how the power wheelchair operates

1.2.14.12 Power Wheelchairs—Custom

Custom power wheelchairs may be considered for a client who meets criteria for a power wheelchair, has a condition that requires specialized seating, and cannot safely utilize a standard power wheelchair.

1.2.14.12.1 Documentation Requirements

Prior authorization for a custom power wheelchair requires all documentation necessary for a custom manual wheelchair, as well as the following:

- The client's physical and mental ability to receive and follow instructions related to responsibilities of using equipment. (The client must be able to operate a power wheelchair independently; the therapist must provide written documentation that the client is physically and cognitively capable of managing a power wheelchair)
- How the power wheelchair will be operated such as joystick, head pointer, or puff-and-go
- The capability of the caregiver/client to care for the power wheelchair and accessories
- The capability of the client to understand how the power wheelchair operates

1.2.14.13 Power Elevating Leg Lifts

Power elevating leg lifts may be prior authorized for clients who have compromised upper extremity function that limits the client's ability to use manual elevating leg rests. The client must meet criteria for a power wheelchair with a reclining back and at least one of the following:

- The client has a musculoskeletal condition such as flexion contractures of the knees and legs, or the placement of a brace that prevents 90-degree flexion at the knee.
- The client has significant edema of the lower extremities that requires elevating the client's legs.
- The client experiences hypotensive episodes that require frequent positioning changes.
- The client needs power tilt-and-recline and is required to maintain anatomically correct positioning and reduce exposure to skin shear.

1.2.14.13.1 Documentation Requirements

The submitted documentation must include an assessment completed, signed, and dated by a physician, physical therapist, or occupational therapist that includes the following:

- A description of the client's current level of function without the device
- Documentation that identifies how the power elevating leg lifts will improve the client's function
- A list of MRADLs the client will be able to perform with the power elevating leg lifts that the client is unable to perform without the power elevating leg lifts and how the device will increase independence
- The duration of time the client is alone during the day without assistance
- The client's goals for use of the power elevating leg lifts

1.2.14.14 Power Seat Elevation System

A power seat elevation system may be prior authorized to promote independence in a client who meets all of the following criteria:

- The client does not have the ability to stand or pivot transfer independently.
- The client requires assistance only with transfers across unequal seat heights, and as a result of having the power seat elevation system, the client will be able to transfer across unequal seat heights unassisted.
- The client has limited reach and range of motion in the shoulder or hand that prohibits independent performance of MRADLs (such as, dressing, feeding, grooming, hygiene, meal preparation, and toileting).

1.2.14.14.1 Documentation Requirements

The submitted documentation must include an assessment completed, signed, and dated by a physician, physical therapist, or occupational therapist that includes the following:

- A description of the client's current level of function without the device

- Documentation that identifies how the power seat elevation system will improve the client's function
- A list of MRADLs the client will be able to perform with the power seat elevation system that the client is unable to perform without the power seat elevation system and how the device will increase independence
- The duration of time the client is alone during the day without assistance
- The client's goals for use of the power seat elevation system

Note: *A power seat elevation system option will not be authorized for the convenience of a caregiver, or if the device will not allow the client to become independent with MRADLs and transfers.*

1.2.14.15 Seat Lift Mechanisms

A seat lift mechanism may be prior authorized for clients who meet all the following criteria:

- The client must have severe arthritis of the hip or knee or have a severe neuromuscular disease.
- The seat lift mechanism must be a part of the physician's course of treatment and be prescribed to correct or ameliorate the client's condition.
- Once standing, the client must have the ability to ambulate.
- The client must be completely incapable of standing up from a regular armchair or any chair in his or her home.

Note: *The fact that a client has difficulty or is even incapable of getting up from a chair, particularly a low chair, is not sufficient justification for a seat lift mechanism. Almost all clients who are capable of ambulating can get out of an ordinary chair if the seat height is appropriate and the chair has arms.*

Seat lift mechanisms are limited to those types that operate smoothly, can be controlled by the client, and can effectively assist a client in standing up and sitting down without other assistance. A seat lift operated by a spring release mechanism with a sudden, catapult-like motion and jolts the client from a seated to a standing position is not a benefit of Texas Medicaid.

1.2.14.15.1 Documentation Requirements

The submitted documentation must include an assessment completed, signed, and dated by a physician, physical therapist, or occupational therapist that includes the following:

- A description of the client's current level of function without the device
- Documentation that identifies how the seat lift mechanism will improve the client's function
- A list of MRADLs the client will be able to perform with the seat lift mechanism that the client is unable to perform without the seat lift mechanism and how the device will increase independence
- The duration of time the client is alone during the day without assistance
- The client's goals for use of the seat lift mechanism

Supporting documentation must be kept in the client's record that shows that all appropriate therapeutic modalities (such as medication, physical therapy) have been tried and that they failed to enable the client to transfer from a chair to a standing position.

1.2.14.16 Batteries and Battery Charger

A battery charger and initial batteries are included as part of the purchase of a power wheelchair.

Batteries and battery chargers will not be prior authorized for replacement within six months of delivery.

Replacement batteries or a battery charger may be considered for reimbursement under Home Health Services if they are no longer under warranty. A maximum of one hour of labor may be considered for reimbursement to install new batteries. Labor is not reimbursed with the purchase of a new power wheelchair, or with replacement battery chargers.

1.2.14.16.1 Documentation Requirements

To request prior authorization for replacement batteries or a battery charger, the provider must document the date of purchase and serial number of the currently-owned wheelchair as well as the reason for the replacement batteries or battery charger.

Documentation required supporting the need to replace the batteries or battery charger must include:

- Why the batteries are no longer meeting the client's needs, and/or
- Why the battery charger is no longer meeting the client's needs

1.2.14.17 Scooters

Scooters may be approved for a short-term rental or initial three-month trial rental period based on documentation supporting the medical necessity and appropriateness of the device. Scooters may be considered for reimbursement for ambulatory impaired clients with good head, trunk and arm/hand control, without a diagnosis of progressive illness such as progressive neuromuscular diseases (e.g., amyotrophic lateral sclerosis). All scooters must have a growth potential, which must accommodate 20 percent of height and weight changes. Custom seating for scooters is not a benefit of Home Health Services. Repairs to scooters may be considered only for those scooters purchased by Texas Medicaid.

1.2.14.17.1 Prior Authorization

Assessment of the accessibility of the client's residence must be completed and included in the prior authorization documentation to ensure that the scooter is usable in the home, such as doors and halls are wide enough and have no obstructions. To request prior authorization for a scooter the client must not own or be expected to require a power wheelchair within five years of the purchase of a scooter.

1.2.14.17.2 Documentation Requirements

When requesting prior authorization for a scooter, all documentation required for a standard power wheelchair must be provided, along with the following documentation:

- The client's physical and mental ability to receive and follow instructions related to the responsibilities of using the equipment
- The ability of the client to physically and cognitively operate the scooter independently
- The capability of the client to care for the scooter and understand how it operates
- A completed Wheelchair/Scooter/Stroller Seating Assessment Form with seating measurements that includes documentation supporting medical necessity, except when requesting a standard sling seat/sling back wheelchair

1.2.14.18 Client Lift

A client lift will not be prior authorized for the convenience of a caregiver. Hydraulic lifts and electric lifts are a benefit of Home Health Services.

> ***Note:*** *Portable hydraulic or electric lifts that can be used outside the home setting are not a benefit through Title XIX Home Health Services. For clients who are birth through 20 years of age, portable lifts that can be used outside the home setting may be considered through CCP.*

1.2.14.19 Electric Lift

Prior authorization for an electric lift may be considered when the client meets criteria for a hydraulic lift and additional documentation explains why a hydraulic lift will not meet the client's needs.

1.2.14.20 Hydraulic Lift

Hydraulic lifts require prior authorization.

1.2.14.20.1 Documentation Requirements

Prior authorization for a hydraulic lift may be considered with the following documentation:

- The inability of the client to assist in his own transfers
- The weight of the client and the weight capacity of the requested lift
- The availability of a caregiver to operate the lift
- Training by the provider to the client and the caregiver on the safe use of the lift

1.2.14.21 Standers

Standers, including all accessories, require prior authorization. Standers, gait trainers, and parapodiums will not be prior authorized for a client within one year of each other.

1.2.14.21.1 Documentation Requirements

Prior authorization may be considered for the standers with the following documentation:

- Diagnosis relevant to the requested equipment, including functioning level and ambulatory potential
- Anticipated benefits of the equipment
- Frequency and duration of the client's standing program
- Anticipated length of time the client will require this equipment
- Client's height, weight, and age
- Anticipated changes in the client's needs, anticipated modifications, or accessory needs, as well as the growth potential of the stander

1.2.14.22 Gait Trainers

Prior authorization for a gait trainer may be considered with documentation supporting medical necessity and an assessment of the accessibility of the client's residence to ensure that the gait trainer is usable in the home (i.e., doors and halls are wide enough and have no obstructions), when a physician familiar with the client documents that the client has ambulatory potential and will benefit from a gait training program, and when the client meets the criteria for a stander. Standers, gait trainers, and parapodiums/standing frames/braces/vertical standers that are covered through CCP will not be prior authorized for a client within one year of each other.

1.2.14.23 Accessories

Accessories, modifications, adjustments, and repairs are benefits as outlined below. All modifications, adjustments, and repairs within the first six months after delivery are considered part of the purchase price. Equipment accessories, including pressure support cushions, may be prior authorized with documentation of medical necessity.

1.2.14.24 Modifications

Modifications are replacement of components due to changes in the client's condition, not replacement due to the component no longer functioning as designed. Prior authorization may be considered for modifications to custom equipment should a change occur in the client's needs, capabilities, or physical/mental status that cannot be anticipated. Documentation must include the following:

- All projected changes in the client's mobility needs

- The date of purchase and serial number of the current equipment and the cost of purchasing new equipment versus modifying current equipment

All modifications within the first six months after delivery are considered part of the purchase price and will not be considered for prior authorization.

1.2.14.25 Adjustments

Adjustments must be prior authorized. Adjustments do not require supplies. A maximum of 1 hour of labor for adjustments may be considered for reimbursement through Home Health Services as needed after the first 6 months from delivery. All adjustments within the first 6 months after delivery are considered part of the purchase price and will not be considered for prior authorization.

1.2.14.26 Repairs

Repairs require replacement of components that are no longer functional. Repairs to client-owned equipment may be prior authorized as needed with documentation of medical necessity. Repairs to client-owned equipment may be considered for reimbursement with prior authorization under Home Health Services. Technician fees are considered part of the labor cost on the repair. Providers are responsible for maintaining documentation in the client's medical record specifying repairs. Rentals may be considered for reimbursement during the period of repair. Routine maintenance of rental equipment is the provider's responsibility.

1.2.14.27 Replacement

A request for replacement of equipment and/or accessories may be considered for reimbursement and must include an order from the prescribing physician familiar with the client and an assessment by a physician, licensed occupational or physical therapist with documentation supporting why the current equipment is no longer meeting the client's needs. Replacement, adjustments, modifications, and repairs will not be prior authorized in situations where the equipment has been abused or neglected by the client, client's family, or caregiver.

1.2.14.28 Wheelchair Ramp—Portable and Threshold

A portable ramp is defined as a ramp that is able to be carried as needed to access a home, weighs no more than 90 pounds, and/or measures no more than 10 feet in length. A threshold ramp provides access over elevated thresholds.

One portable and one threshold ramp for wheelchair access may be considered for prior authorization when documentation supports medical necessity. The following documentation supporting medical necessity is required:

- The date of purchase and serial number of the client's wheelchair or documentation of a wheelchair request being reviewed for purchase
- Diagnosis with duration of expected need
- A diagram of the house showing the access points with the ground-to-floor elevation and any obstacles

Ramps may be considered for rental for short term disabilities and for purchase for long term disabilities. Mobility aid lifts for vehicles and vehicle modifications are not a benefit of Texas Medicaid.

> ***Note:*** *Permanent ramps, vehicle ramps, and home modifications are not a benefit of Texas Medicaid.*

1.2.14.29 Procedure Codes and Limitations for Mobility Aids

Procedure Code	Maximum Limit
Canes	
E0100	1 per 5 years
E0105	1 per 5 years
Crutches	
A4635	As needed
E0110	1 purchase every 5 years
E0111	1 purchase every 5 years; 1-month rental
E0112	1 purchase every 5 years; 1-month rental
E0113	1 purchase every 5 years; 1-month rental
E0114	1 purchase every 5 years; 1-month rental
E0116	1 purchase every 5 years; 1-month rental
E0153	1 purchase every 5 years
Walkers	
A4636	As needed
A4637	As needed
E0130	1 purchase every 5 years; 1-month rental
E0135	1 purchase every 5 years; 1-month rental
E0141	1 purchase every 5 years; 1-month rental
E0143	1 purchase every 5 years; 1-month rental
E0144	1 purchase every 5 years; 1-month rental
E0147	1 purchase every 5 years; 1-month rental
E0148	1 purchase every 5 years; 1-month rental
E0149	1 purchase every 5 years; 1-month rental
E0154	1 per 5 years
E0155	1 per 5 years
E0157	1 per 5 years
E0158	1 per 5 years
E0159	1 per 5 years
Gait Trainers	
E8001	1 purchase every 5 years
Seating Assessments	
97001	As needed
97003	As needed
Wheelchairs	
E1050	1 purchase every 5 years; 1-month rental
E1060	1 purchase every 5 years; 1-month rental
E1070	1 purchase every 5 years; 1-month rental
E1083	1 purchase every 5 years; 1-month rental

Procedure Code	Maximum Limit
E1084	1 purchase every 5 years; 1-month rental
E1085	1 purchase every 5 years; 1-month rental
E1086	1 purchase every 5 years; 1-month rental
E1087	1 purchase every 5 years; 1-month rental
E1088	1 purchase every 5 years; 1-month rental
E1089	1 purchase every 5 years; 1-month rental
E1090	1 purchase every 5 years; 1-month rental
E1092	1 purchase every 5 years
E1093	1 purchase every 5 years; 1-month rental
E1100	1 purchase every 5 years; 1-month rental
E1110	1 purchase every 5 years; 1-month rental
E1130	1 purchase every 5 years; 1-month rental
E1140	1 purchase every 5 years; 1-month rental
E1150	1 purchase every 5 years; 1-month rental
E1160	1 purchase every 5 years; 1-month rental
E1161	1 purchase every 5 years; 1-month rental
E1170	1 purchase every 5 years; 1-month rental
E1171	1 purchase every 5 years; 1-month rental
E1172	1 purchase every 5 years; 1-month rental
E1180	1 purchase every 5 years; 1-month rental
E1190	1 purchase every 5 years; 1-month rental
E1195	1 purchase every 5 years; 1-month rental
E1200	1 purchase every 5 years; 1-month rental
E1220	1 per 5 years
E1229	1 per 5 years
E1231	1 purchase every 5 years; 1-month rental
E1232	1 purchase every 5 years; 1-month rental
E1233	1 purchase every 5 years; 1-month rental
E1234	1 purchase every 5 years; 1-month rental
E1235	1 purchase every 5 years; 1-month rental
E1236	1 purchase every 5 years; 1-month rental
E1237	1 purchase every 5 years; 1-month rental
E1238	1 purchase every 5 years; 1-month rental
E1239	1 per 5 years
E1240	1 purchase every 5 years; 1-month rental
E1250	1 purchase every 5 years; 1-month rental
E1260	1 purchase every 5 years; 1-month rental
E1270	1 purchase every 5 years; 1-month rental
E1280	1 purchase every 5 years; 1-month rental

Procedure Code	Maximum Limit
E1285	1 purchase every 5 years; 1-month rental
E1290	1 purchase every 5 years; 1-month rental
E1295	1 purchase every 5 years; 1-month rental
Power Wheelchairs	
K0010	1 per 5 years
K0011	1 per 5 years
K0012	1 per 5 years
K0813	1 purchase every 5 years; 1-month rental
K0814	1 purchase every 5 years; 1-month rental
K0815	1 purchase every 5 years; 1-month rental
K0816	1 purchase every 5 years; 1-month rental
K0820	1 purchase every 5 years; 1-month rental
K0821	1 purchase every 5 years; 1-month rental
K0822	1 purchase every 5 years; 1-month rental
K0823	1 purchase every 5 years; 1-month rental
K0824	1 purchase every 5 years; 1-month rental
K0825	1 purchase every 5 years; 1-month rental
K0826	1 purchase every 5 years; 1-month rental
K0827	1 purchase every 5 years; 1-month rental
K0828	1 purchase every 5 years; 1-month rental
K0829	1 purchase every 5 years; 1-month rental
K0835	1 purchase every 5 years; 1-month rental
K0836	1 purchase every 5 years; 1-month rental
K0837	1 purchase every 5 years; 1-month rental
K0838	1 purchase every 5 years; 1-month rental
K0839	1 purchase every 5 years; 1-month rental
K0840	1 purchase every 5 years; 1-month rental
K0841	1 purchase every 5 years; 1-month rental
K0842	1 purchase every 5 years; 1-month rental
K0843	1 purchase every 5 years; 1-month rental
K0848	1 purchase every 5 years; 1-month rental
K0849	1 purchase every 5 years; 1-month rental
K0850	1 purchase every 5 years; 1-month rental
K0851	1 purchase every 5 years; 1-month rental
K0852	1 purchase every 5 years; 1-month rental
K0853	1 purchase every 5 years; 1-month rental
K0854	1 purchase every 5 years; 1-month rental
K0855	1 purchase every 5 years; 1-month rental
K0856	1 purchase every 5 years; 1-month rental

Procedure Code	Maximum Limit
K0857	1 purchase every 5 years; 1-month rental
K0858	1 purchase every 5 years; 1-month rental
K0859	1 purchase every 5 years; 1-month rental
K0860	1 purchase every 5 years; 1-month rental
K0861	1 purchase every 5 years; 1-month rental
K0862	1 purchase every 5 years; 1-month rental
K0863	1 purchase every 5 years; 1-month rental
K0864	1 purchase every 5 years; 1-month rental
K0868	1 purchase every 5 years; 1-month rental
K0869	1 purchase every 5 years; 1-month rental
K0870	1 purchase every 5 years; 1-month rental
K0871	1 purchase every 5 years; 1-month rental
K0877	1 purchase every 5 years; 1-month rental
K0878	1 purchase every 5 years; 1-month rental
K0879	1 purchase every 5 years; 1-month rental
K0880	1 purchase every 5 years; 1-month rental
K0884	1 purchase every 5 years; 1-month rental
K0885	1 purchase every 5 years; 1-month rental
K0886	1 purchase every 5 years; 1-month rental
K0890	1 purchase every 5 years; 1-month rental
K0891	1 purchase every 5 years; 1-month rental
K0898	1 purchase every 5 years; 1-month rental
K0899	1 purchase every 5 years; 1-month rental
Scooters	
E1230	1 per 5 years
K0800	1 per 5 years
K0801	1 per 5 years
K0802	1 per 5 years
Wheelchair Parts	
E0942	1 per year
E0944	2 per year
E0945	2 per year
E0950	1 per year
E0951	2 per year
E0952	2 per year
E0955	As needed
E0957	As needed
E0958	1 per year
E0960	As needed

Procedure Code	Maximum Limit
E0961	2 per year
E0969	1 per 5 years
E0970	1 pair per year
E0971	2 per year
E0973	2 per year
E0974	2 per year
E0978	1 per year
E0980	1 per year
E0981	As needed
E0982	As needed
E0990	2 per year
E0992	1 per year
E0994	2 per year
E0995	2 per year
E1002	1 per 5 years
E1003	1 per 5 years
E1004	1 per 5 years
E1005	1 per 5 years
E1006	1 per 5 years
E1007	1 per 5 years
E1008	1 per 5 years
E1009	1 per 5 years
E1010	1 per 5 years
E1011	As needed
E1014	1 per 5 years
E1015	2 per year
E1016	2 per year
E1017	2 per year
E1018	2 per year
E1020	1 per 5 years
E1028	1 per 5 years
E1029	1 per 5 years
E1296	1 per 5 years
E1297	1 per 5 years
E1298	1 per 5 years
E2201	1 per 5 years
E2202	1 per 5 years
E2203	1 per 5 years
E2204	1 per 5 years

Procedure Code	Maximum Limit
E2205	1 per 5 years
E2206	1 per 5 years
E2207	1 purchase every 5 years
E2208	1 purchase every 5 years
E2209	1 purchase every 5 years
E2210	4 per year
E2211	2 per year
E2212	2 per year
E2213	2 per year
E2214	2 per year
E2215	2 per year
E2216	2 per year
E2217	2 per year
E2218	2 per year
E2219	2 per year
E2220	2 per year
E2221	2 per year
E2222	2 per year
E2224	2 per year
E2225	2 per year
E2226	2 per year
E2227	1 per 5 years
E2228	1 per 5 years
E2291	1 per 5 years
E2292	1 per 5 years
E2293	1 per 5 years
E2294	1 per 5 years
E2300	1 per 5 years
E2310	1 per 5 years
E2311	1 per 5 years
E2312	1 purchase every 5 years; 1-month rental
E2313	1 per 5 years
E2321	1 per 5 years
E2323	1 per 5 years
E2324	1 per 5 years
E2325	1 per 5 years
E2326	1 per 5 years
E2327	1 per 5 years
E2328	1 per 5 years

Procedure Code	Maximum Limit
E2329	1 per 5 years
E2330	1 per 5 years
E2340	1 per 5 years
E2341	1 per 5 years
E2342	1 per 5 years
E2343	1 per 5 years
E2351	1 per 5 years
E2368	1 per 5 years
E2369	1 per 5 years
E2370	1 per 5 years
E2373	1 per 5 years
E2374	1 per 5 years
E2375	1 per 5 years
E2376	1 per 5 years
E2377	1 per 5 years
E2381	2 per year
E2382	2 per year
E2383	2 per year
E2384	2 per year
E2385	2 per year
E2386	2 per year
E2387	2 per year
E2388	2 per year
E2389	2 per year
E2390	2 per year
E2391	2 per year
E2392	2 per year
E2394	1 per 5 years
E2395	1 per 5 years
E2396	1 per 5 years
Wheelchair/Pressure/Positioning Cushions	
E0190	1 per 5 years
E2601	1 per year
E2602	1 per year
E2603	1 per year
E2604	1 per year
E2605	1 per year
E2606	1 per year
E2607	1 per year

Procedure Code	Maximum Limit
E2608	1 per year
E2609	1 per year
E2611	1 per year
E2612	1 per year
E2613	1 per year
E2614	1 per year
E2615	1 per year
E2616	1 per year
E2617	1 per year
E2619	1 per year
E2620	1 per year
E2621	1 per year
K0734	1 per year
K0735	1 per year
K0736	1 per year
K0737	1 per year
Batteries	
E2361	1 per 5 years
E2363	1 per 5 years
E2366	1 per 5 years
E2371	1 per 5 years
K0733	2 per year
Safety Equipment	
E0700	2 per year
E0705	1 per 5 years
Lifts	
E0628	1 per 5 years
E0629	1 per 5 years
E0630	1 per 5 years
E0635	1 per 5 years
E0638	1 per 5 years
E0641	1 per 5 years
Miscellaneous	
A9900	As needed
E1399	As needed
K0108	As needed
K0739	As needed

The following mobility aids are not a benefit of Home Health Services:

- Feeder seats, floor sitters, corner chairs, and travel chairs are not considered medically necessary devices
- Items included but not limited to tire pumps, a color for a wheelchair, gloves, back packs, and flags are not considered medically necessary
- Mobile standers are not a benefit of Title XIX Home Health Services
- Vehicle lifts and modification
- Permanent ramps, vehicle ramps, and home modifications
- Stairwell lifts of any type
- Elevators or platform lifts of any type
- Barrier-free lifts
- Chairs with incorporated seat lifts
- An attendant control, for safety, all power chairs are to include a stop switch

Texas Medicaid does not reimburse separately for associated DME charges, including battery disposal fees or state taxes. Reimbursement for associated charges is included in the reimbursement for the specific piece of equipment. White canes for the blind are considered self help adaptive aids and are not a benefit of Home Health Services.

Note: *THSteps-eligible clients who have a medical need for services beyond the limits of this Home Health Services benefit may be considered under CCP.*

Refer to: Subsection 1.4.2.1, "Eligibility " in this handbook.

1.2.15 Nutritional (Enteral) Products, Supplies, and Equipment

1.2.15.1 Nutritional Products and Supplies

Enternal nutritional products are those food products that are included in an enteral treatment protocol. They serve as a therapeutic agent for health maintenance and are required to treat an identified medical condition. Nutritional products, supplies, and equipment may be provided in the home under Home Health Services.

Nutritional products may be reimbursed with procedure codes B4100, B4150, B4152, B4153, B4154, B4155, and B4157.

Nutritional supplies and equipment may be reimbursed with the following procedure codes and limitations:

Procedure Code	Limitation
A4322	4 per month
B4035	Up to 31 per month
B4087	2 per rolling year
B4088	2 per rolling year
B9000	1 purchase every 5 years; 1-month rental
B9002	1 purchase every 5 years; 1-month rental
B9998	As needed
T1999	Limited by authorization

Enteral products including nutritional formulas, food thickener, and related feeding supplies/equipment (enteral feeding pumps with and without alarms) are a benefit through Home Health Services for clients 21 years of age or older who require tube feeding as their primary source of nutrition.

If enteral tube feeding is not the sole source of nutrition, but oral caloric intake is inadequate (less than 30 percent) to maintain weight due to a medical condition, coverage may be considered on an individual basis for clients 21 years of age or older. The enteral product must be part of the medical POC outlined and maintained by the treating physician.

Nutritional products and supplies will not be reimbursed for clients receiving total parenteral nutrition (TPN). Any nutritional products or supplies are included as part of the reimbursement for TPN.

1.2.15.2 Enteral Nutritional Products

All enteral nutritional products paid under Texas Medicaid are paid based on units of 100 calories (as documented by the manufacturer) with the appropriate "B" code (as documented by the Pricing, Data Analysis and Coding (PDAC) Product Classification List for Enteral Nutrition in effect at the time) and with the appropriate modifier based on the product's AWP less 10.5 percent (as documented by the Red Book). The PDAC Product Classification List is located on the Noridian website at www.dmepdac.com.

It is the provider's responsibility to know the correct "B" code, the correct units of 100 calories, and the modifier for requesting prior authorization and for payment. Supporting documentation for these components must be maintained in the provider's records and be made available upon request by HHSC or TMHP.

It is the provider's responsibility to know when products are discontinued by the manufacturer, when container sizes change and when names change. Please submit requests for prior authorization and payment accordingly.

Miscellaneous procedure code B9998 may be used with the following modifiers when requesting prior authorization for certain items as described below that are indicated as necessary on the PDAC Product Classification List for a medical nutritional product. Providers are restricted to the following limitations when billing procedure code B9998 with any of the following modifiers:

Modifiers	Items	Limitations
B9998 with U1 modifier	Disposable G-tube adapter set	4 per month
B9998 with U2 modifier	Nonobturated gastrostomy or jejunostomy tube with insertion supplies and extensions	2 per rolling year
B9998 with U3 modifier	Low profile enteral extension set	4 per month
B9998 with U5 modifier	Standard enteral extension set	4 per month

1.2.15.3 Enteral Feeding Pumps

Enteral feeding pumps with and without alarms are a benefit of Home Health Services for those clients who require enteral feeding. Enteral feeding pumps may be leased or purchased with documentation that gravity or syringe feedings are not indicated. Criteria for the lease or purchase include the following:

- Reflux and/or aspiration
- Severe diarrhea
- Dumping syndrome
- Administration rate of less than 100 ml/hr
- Blood glucose fluctuations

- Circulatory overload
- Night time feedings

1.2.15.4 Enteral Supplies

Enteral feedings may require some or all the following supplies:

- Needleless syringes, any size
- Enteral extension tubing
- Gravity bags/nutritional containers
- Irrigation syringes (bulb or piston)

Feeding supply kits (procedure code B4035) are limited to a maximum of 31 per month, per client by any provider. Providers may not bill a quantity greater than the number of days in the month for which they are submitting a claim. Claims with a quantity greater than the number of days in that month may be subject to recoupment.

Note: *Gravity bags and pump nutritional containers are included in the feeding supply kits.*

Irrigation syringes, bulb or piston, for enteral administration of nutritional products are limited to four per month.

1.2.15.4.1 Nasogastric and Gastrostomy/Jejunostomy Tubes

Obturated gastrostomy tube replacements are performed in the physicians office or outpatient setting and are not a benefit of Home Health Services.

Refer to: *Children's Services Handbook* (*Vol. 2, Provider Handbooks*) for more information on nutritional products available for children under 21.

1.2.15.5 Prior Authorization

Nutritional Products and Supplies
Prior authorization is required for all enteral products, related feeding supplies, and services provided through Home Health Services. The prior authorization also includes all related accessories and/or supplies. Requests are reviewed for medically necessary amounts based on caloric needs as indicated by the client's physician.

The DME may be considered for prior authorization when criteria for nutritional products are met.

Prior authorization may be given for up to 6 months. Prior authorization may be recertified with documentation supporting ongoing medical necessity for the nutritional products requested.

Comparability will be determined from information provided by the manufacturer of the nutritional products. Documentation must include both the diagnosis indicating the metabolic disorder and the nutritional product which must be for use in metabolic disorders.

Enteral Feeding Pumps
Enteral feeding pumps with and without alarms require prior authorization.

Enteral Supplies
Enteral supplies require prior authorization.

Nasogastric and Gastrostomy/Jejunostomy Tubes
Nasogastric feeding tubes require prior authorization. Additional devices may be reimbursed if documentation submitted indicates medical necessity. Nonobturated gastrostomy/jejunostomy tubes must be prior authorized and will be limited to two per rolling year. Additional tubes may be prior authorized if documentation submitted indicates medical necessity, such as infection at gastrostomy site, leakage or occlusion.

1.2.15.6 Documentation Requirements

To request prior authorization for nutritional formula/supplies/equipment, the following documentation must be provided:

- Accurate diagnostic information pertaining to the underlying diagnosis/condition as well as any other medical diagnoses/conditions, including the client's overall health status
- Diagnosis/condition (including the appropriate ICD-9-CM code)
- A statement from the ordering physician noting that enteral nutritional products for tube feeding is the client's primary source of nutrition
- The goals and timelines on the medical POC when the tube feeding is not the sole source of nutrition and the client is 21 years of age or older

  Note: *Prior authorization may not be granted for more than six months at a time.*
- Total caloric intake prescribed by the physician
- Acknowledgement that the client has a feeding tube in place
- Necessary product information

  Note: *Pediatric nutritional products (procedure codes B4158, B4159, B4160, B4161, and B4162) are restricted to clients birth through 20 years of age.*

1.2.16 Osteogenic Stimulation

A noninvasive electrical osteogenic stimulator (procedure codes E0747 and E0748) and noninvasive ultrasound osteogenic stimulator (procedure code E0760) are benefits of Texas Medicaid for home health DME and medical supplier DME providers when provided in the home setting. An invasive electrical osteogenic stimulator (procedure code E0749) is a benefit of Texas Medicaid for freestanding and hospital-based ambulatory surgical centers when provided in the outpatient setting.

Electrical and ultrasonic osteogenic stimulator devices for the treatment of orthopedic and neurosurgical conditions are a benefit for Texas Medicaid clients when the client experiences nonunion of a fracture, requires an adjunct to spinal fusion surgery, or experiences congenital pseudoarthroses.

Nonunion is defined as a fractured bone that fails to heal completely. Diagnosis of nonunion is established when a minimum of six months has passed since the injury and the fracture site shows no progressive signs of healing for a minimum of three months and is not complicated by a synovial pseudoarthrosis. Serial radiographs must confirm that fracture healing has ceased for three months or longer before the client begins treatment with the osteogenic stimulator.

1.2.16.1 Ultrasound Osteogenic Stimulator

Procedure code E0760 is a benefit for the treatment of nonunion fractures, excluding fractures of the skull or vertebra, or fractures related to malignancy. The nonunion fracture must have occurred within five years of treatment with the ultrasound osteogenic stimulator.

The ultrasonic osteogenic stimulator will not be covered for the following indications:

- Fresh fractures
- Nonunion fractures of the skull, vertebrae and those that are tumor-related
- When used concurrently with other noninvasive osteogenic devices

1.2.16.2 Professional Services

Procedure codes 20974, 20975, and 20979 are a benefit of Texas Medicaid for the following diagnosis codes:

Diagnosis Codes									
73381	73382	73396	73397	73398	9052	9053	9054	9055	99640
V454									

Procedure codes 20974, 20975, and 20979 are limited to 1 per 6 months. During the 6-month limitation period, a subsequent fracture that meets the above criteria for an osteogenic stimulator may be reimbursed after the submission of an appeal with documentation of medical necessity that demonstrates the criteria have been met.

1.2.16.3 Prior Authorization

Procedure codes E0747, E0748, E0749, and E0760 require prior authorization.

1.2.16.3.1 Noninvasive Electrical Osteogenic Stimulator

Procedure codes E0747 and E0748 may be prior authorized for the following conditions:

- Nonunion of long bone fractures. Long bones include, but are not limited to, the humerus, femur, radius, ulna, tibia, fibula, clavicle, fifth metatarsal (when significant pain is present), carpal, and tarsal bones
- Failed fusion when a minimum of nine months has passed since the first surgery
- Delayed unions of fractures or failed arthrodesis at high-risk sites (e.g., open or segmental tibial fractures, carpal navicular fractures)
- Congenital pseudoarthroses
- As an adjunct to spinal fusion surgery for clients at high-risk for pseudoarthrosis because of previously failed spinal fusion at the same site or for clients undergoing multiple level fusion. A multiple level fusion involves three or more vertebrae (e.g., L3-L5, L4-S1)

A noninvasive electrical osteogenic stimulator may be prior authorized when one of the following criteria is met:

- There is no evidence of healing progression for six months or longer despite appropriate fracture care following a nonunion, failed fusion, or congenital pseudoarthrosis.
- Serial radiographs have demonstrated that there is no evidence of healing progression after a delayed union of fracture or a failed arthrodesis. Serial radiographs must include a minimum of two sets of radiographs separated by a minimum of 90 days. Each set must include multiple views of the fracture site.
- A radiograph demonstrates that the fracture gap is 1 cm or less, and the individual can be adequately immobilized and is likely to comply with non-weight-bearing requirements.
- The client has experienced a failed spinal fusion or is at high risk for fusion failure, and one of the following criteria is met:
  - The client has Grade III or higher spondylolisthesis.
  - A multiple level fusion with extensive bone grafting is required, and other risk factors exist. Other risk factors include, but are not limited to, gross obesity, degenerative osteoarthritis, severe spondylolisthesis, current smoking, previous spinal fusion, previous disc surgery, or gross instability.

1.2.16.3.2 Invasive Electrical Osteogenic Stimulator

Procedure code E0749 may be prior authorized for the following conditions:

- Nonunion of long bone fractures
- As an adjunct to spinal fusion surgery for clients at high-risk for pseudoarthrosis because of previously failed spinal fusion at the same site or for clients undergoing multiple level fusion. A multiple level fusion involves three or more vertebrae (e.g., L3–L5, L4–S1)

An invasive electrical osteogenic stimulator may be prior authorized when one of the following criteria is met:

- There is no evidence of healing progression for six months or longer despite appropriate fracture care following a nonunion.
- The client has experienced a failed spinal fusion or is at high-risk for pseudoarthrosis because of previously failed spinal fusion at the same site.
- Client has multiple level fusion involving three or more vertebrae (e.g., L3–L5, L4–S1).
- Serial radiographs have demonstrated that there is no evidence of healing progression. Serial radiographs must include a minimum of two sets of radiographs separated by a minimum of 90 days. Each set must include multiple views of the fracture site.

1.2.16.3.3 Ultrasound Osteogenic Stimulator

Procedure code E0760 may be prior authorized when all of the following criteria are met:

- There is demonstrated proof of skeletal maturity.
- A radiograph demonstrates that the fracture gap is 1 cm or less.
- Serial radiographs have demonstrated that there is no evidence of healing progression. Serial radiographs must include a minimum of two sets of radiographs separated by a minimum of 90 days. Each set must include multiple views of the fracture site.
- At least one surgical or medical intervention for the treatment of the fracture has failed.

1.2.16.4 Documentation Requirements

A summary of the radiology reports and the date the fracture occurred must be submitted with the prior authorization request for any osteogenic stimulator. The manufacturer will replace the osteogenic stimulator during the course of treatment should the device become nonfunctional. Repairs to purchased equipment will not be prior authorized. All repairs are considered part of the purchase price. Osteogenic stimulators may be replaced during the course of treatment if the device becomes nonfunctional. Repairs to purchased equipment are not prior authorized. All repairs are considered part of the purchase price. A new osteogenic stimulator may be considered for prior authorization with documentation supporting treatment of a different fracture site.

Documentation supporting medical necessity for an osteogenic stimulator is subject to retrospective review. Osteogenic stimulators that do not meet the criteria for coverage through Texas Medicaid (Title XIX) Home Health Services may be considered through CCP for clients 20 years of age or younger.

1.2.17 Phototherapy Devices

Phototherapy devices are not a benefit of Title XIX Home Health Services. Phototherapy devices are a benefit of Texas Medicaid through CCP for clients who are birth through 20 years of age.

Refer to: Subsection 3.5.12, "Phototherapy Devices" in the *Children's Services Handbook* (*Vol. 2, Provider Handbooks*) for more information on phototherapy devices.

1.2.18 Reflux Slings and Wedges

Home Health Services may cover reflux slings or wedges for clients who are 11 months of age or younger. These may be used as positioning devices for infants who require elevation after feedings when prescribed by a physician as medically necessary and appropriate. If the client is not eligible for home health services, reflux slings and wedges may be provided under CCP. Providers must use procedure code E1399 when billing for the purchase of reflux slings and wedges.

1.2.18.1 Prior Authorization

Reflux slings, wedges, or covers require prior authorization.

1.2.19 Respiratory Equipment and Supplies

Respiratory equipment and supplies may be provided in the home under Home Health Services. Rental of equipment includes all necessary supplies, adjustments, repairs, and replacement parts.

Note: *Respiratory equipment and related supplies that are not considered a benefit under Home Health Services may be considered for reimbursement through CCP for clients 20 years of age or younger, who are CCP eligible (e.g., clients residing in residential treatment centers).*

1.2.19.1 Prior Authorization

Most respiratory equipment and supplies require prior authorization.

1.2.19.2 Nebulizers

Nebulizers may be reimbursed for purchase only, and that purchase is limited to 1 every 5 years. Providers must use procedure code E0570 when billing for the purchase of the nebulizer.

Medications for use with the nebulizer will not be reimbursed to a DME company. These medications may be considered under the Vendor Drug Program.

Refer to: Appendix B, "Vendor Drug Program" (*Vol. 1, General Information*) for more information about VDP.

1.2.19.2.1 Prior Authorization

Nebulizers do not require prior authorization for the diagnoses listed below. Other diagnoses require prior authorization and may be considered based on review of documentation by HHSC or its designee.

Diagnosis Codes									
1363	27700	27701	27702	27703	27709	46611	46619	4801	4803
48242	486	4880	4881	4910	4911	49120	49121	49122	4918
4919	4920	4928	49300	49301	49302	49310	49311	49312	49320
49321	49322	49381	49382	49390	49391	49392	4940	4941	4950
4951	4952	4953	4954	4955	4956	4957	4958	4959	496
5070	5071	5078	5533	7707					

The following nebulizer supplies may be billed with the diagnosis codes listed above:

Procedure Codes									
A4617	A7003	A7004	A7005	A7006	A7007	A7011	A7013	A7015	A7018

Ultrasonic nebulizers do not require prior authorization for the diagnoses listed below, with documentation for failure of standard therapy. Providers must use procedure code E0574 or E0575 when billing for the purchase of the ultrasonic nebulizer. The ultrasonic nebulizer may be reimbursed only for diagnosis codes 1363, 27700, 27701, 27702, 27703, and 27709. The ultrasonic nebulizer requires prior authorization for all other diagnoses.

Providers must use procedure code A7009, A7014, or A7016 when billing supplies with an ultrasonic nebulizer.

1.2.19.3 Vaporizers

Vaporizers may be reimbursed for purchase only, and that purchase is limited to 1 every 5 years.

Providers must use procedure code E0605 when billing for vaporizers. Vaporizer use is associated with a risk of bronchospasm, infection, edema of the airway, and client/caregiver /parent/guardian exposure to airborne microorganisms.

1.2.19.3.1 Prior Authorization

Vaporizers require prior authorization for limited indications that includes one of the following:

- Laryngotracheobronchitis
- Subglotic edema
- Post-extubation edema
- Postoperative management of the upper airway
- The need for sputum specimens or mobilization of secretions
- The presence of a bypass upper airway

Prior authorization for use beyond the clinical indications listed above are only considered with clinical documentation that the benefit of the use of the device outweighs the noted risks.

1.2.19.4 Humidification Units

Humidification units for nonmechanically ventilated clients may be purchased when a purchase is determined to be more cost effective than leasing the device with supplies. Providers must use procedure code E1399 when billing for the purchase of humidification units for nonmechanically ventilated clients. Procedure code E1399 will be reimbursed with a maximum fee of $1,230.00 or MSRP less 18 percent, which ever is the lesser cost. Supplies to be used with client owned humidification units may be considered for purchase and must be billed with the appropriate HCPCS code for each item requested. Documentation of medical necessity must be included with submission of the request.

1.2.19.5 Secretion Clearance Devices

1.2.19.5.1 Incentive Spirometer

Incentive spirometers, including electronic spirometers, are a benefit of Home Health Services.

1.2.19.5.2 Intermittent Positive-Pressure Breathing (IPPB) Devices

Rental of the IPPB device includes all supplies, such as humidification and tubing.

Purchase of the IPPB device is not a benefit.

1.2.19.5.3 Mucous Clearance Valve

Providers must use procedure code S8185 when billing for the purchase of a mucous clearance valve.

The mucous clearance valve may be reimbursed for the following diagnosis codes only:

Diagnosis Codes									
27700	27701	27702	27703	27709	490	4910	4911	49120	49121
4918	4919	4920	4928	49300	49301	49302	49310	49311	49312
49320	49321	49322	49381	49382	49390	49391	49392	4940	4941
4950	4951	4952	4953	4954	4955	4956	4957	4958	4959
496									

Other diagnoses may be considered based on review of documentation by HHSC or its designee. Hypertonic saline 7 percent for inhalation therapy is a benefit of Texas Medicaid for clients with a diagnosis of cystic fibrosis.

Hypertonic saline 7 percent for inhalation therapy may be billed using procedure code T1999 and requires prior authorization. To request prior authorization, providers must submit either the MSRP, the provider's invoice cost, or the AWP. Providers may be reimbursed 82 percent of the MSRP or 85 percent of the AWP per ampoule or the provider's invoice cost if the MSRP is not available.

1.2.19.5.4 Prior Authorization

IPPB Devices
The rental of IPPB, procedure code E0500, requires prior authorization and may be given with documentation of ineffective response with other modalities such as treatment with a cough assist device for four months or longer.

The IPPB device may be prior authorized for the following diagnoses:

Diagnosis Codes									
27700	27701	27702	27703	27709	33510	33511	33519	3591	35921
35922	35923	35924	35929	496	514	515	5162	5163	5185

Other diagnoses may be considered based on review of documentation by HHSC or its designee.

Mucous Clearance Valve
The mucous clearance valve requires prior authorization and may be reimbursed for purchase only, and that purchase is limited to one every five years.

1.2.19.6 Electrical Percussor

The purchase of an electrical percussor is limited to one every 5 years and a rental is limited to once per month for a maximum of four months per lifetime. Providers must use procedure code E0480 when billing for the percussor.

1.2.19.6.1 Prior Authorization

The electrical percussor device requires prior authorization and may be reimbursed for rental or purchase depending on the physician's predicted length of treatment. In addition to the completed Home Health Services (Title XIX) Durable Medical Equipment (DME)/Medical Supplies Physician Order Form, a description of all previous courses of therapy and why they did not adequately assist the client in airway mucus clearance is required to obtain prior authorization for an electrical percussor.

1.2.19.7 Chest Physiotherapy Devices

Either a cough-stimulating device (cofflator) or the High-Frequency Chest Wall Compression System (HFCWCS) generator with vest may be prior authorized. These systems are not prior authorized simultaneously.

Chest physiotherapy to promote bronchial drainage that is performed by a therapist or any other healthcare professional, including a private duty nurse, will not be prior authorized during the period of time that the HFCWCS or cough-stimulating device is prior authorized.

Intrapulmonary percussive ventilation (IPV) is not a benefit of Texas Medicaid.

1.2.19.7.1 HFCWCS

An HFCWCS is limited to the following diagnosis codes:

Diagnosis Codes									
27700	27701	27702	27703	27709	33510	33511	33519	3430	3431
3432	3433	3434	3438	3439	34489	3591	515		

Other diagnoses may be considered based on review of documentation by HHSC or its designee.

A HFCWCS may be reimbursed only when it is demonstrated that other mechanical devices or chest physiotherapy by a client, parent, guardian, or caregiver have been ineffective.

Rental cost of the HFCWCS applies toward the purchase price. A HFCWCS generator purchase and vest purchase may be reimbursed only once per lifetime, due to the lifetime warranty provided by the manufacturer. Requests for a vest replacement due to growth may be considered with appropriate documentation.

In addition to a completed Home Health Services (Title XIX) Durable Medical Equipment (DME)/Medical Supplies Physician Order Form documenting the medical necessity and appropriateness of the device, providers must submit a completed Medicaid Certificate of Medical Necessity for Chest Physiotherapy Devices Initial or Extended form. These signed and dated forms must be maintained by the provider and the prescribing physician in the client's medical record.

Providers must use procedure code E0483 when billing for HFCWCS for either a rental or purchase.

1.2.19.7.2 Cough-Stimulating Device (Cofflator)

Providers must use procedure code E0482 when requesting rental of a cofflator.

1.2.19.7.3 Prior Authorization

Prior authorization for the rental or purchase of equipment in this section requires a Home Health Services (Title XIX) Durable Medical Equipment (DME)/Medical Supplies Physician Order Form and the Medicaid Certificate of Medical Necessity for Chest Physiotherapy Devices form completed, signed, and dated by a physician familiar with the client.

HFCWCS
The HFCWCS requires prior authorization. An initial three month rental may be authorized for the HFCWC. If the HFCWC is documented to be effective, at the end of the initial three month rental, purchase of the system may be prior authorized. If at the end of the initial three month rental a determination of purchase cannot be made, an additional three month rental may be given.

Cough-Stimulating Device (Cofflator)
The cofflator requires prior authorization and may be reimbursed for monthly rental only and includes all supplies. The cofflator may be prior authorized for those clients with chronic pulmonary disease and/or neuromuscular disorders that affect the respiratory musculature.

1.2.19.7.4 Documentation Requirements

HFCWCS
To obtain prior authorization for the initial three month rental of a HFCWCS generator and vest, all of the following information must be provided:

- A description of all previous therapy courses that have been tried and why these treatments did not adequately assist the client in airway mucus clearance. This must include the information that the client has used electrical percussor therapy for a minimum of four months before the request and that this therapy has been ineffective.
- A physician's statement of a trial of the HFCWCS in a clinic, hospital, or the home setting documenting the effectiveness and tolerance of the system, including a statement that the client has not exacerbated any gastrointestinal manifestations, nor caused aspiration and exacerbation of pulmonary manifestations, nor an exacerbation of seizure activity secondary to the use of the system.
- Diagnosis and background history including complications, medications used, history of any IV antibiotic therapy with dosage, frequency and duration, history of recent hospitalizations and/or history of school, work, or extracurricular activity absences due to diagnosis- related complications.
- Any recent illnesses and/or complications.
- Medical diagnosis or other limitations preventing the client/caregiver from doing chest physiotherapy.

Prior authorization for an extension of another three months rental may be considered with the above documentation. Requests for prior authorization of the purchase of a HFCWCS generator may be considered based on the outcome of a six-month rental period and the following required documentation. Documentation of vest tolerance and positive outcomes/results of therapy, including:

- Physician's description/assessment of the effectiveness such as decreased medication use, shorter hospital length of stay, decreased hospitalizations, and fewer school, work, or extracurricular activity absences due to diagnosis related complications.
- The frequency and compliance graphs for the six-month period showing use of the system at least 50 percent of the maximum time prescribed by the physician for each day.
- Respiratory status, including any recent hospitalization.
- A statement that the client has not exacerbated any gastrointestinal manifestations, nor caused aspiration and exacerbation of pulmonary manifestations, nor an exacerbation of seizure activity secondary to the use of the system.

Cough-Stimulating Device (Cofflator)
The cofflator may be approved initially for a three-month rental period based on the following required documentation:

- Diagnosis and background history including recent illnesses, complications, medications used, history of recent hospitalizations, results of pulmonary function studies if applicable, and/or history of school, work, or extracurricular activity absences due to diagnosis related complications.
- Medical reasons why the client, parent, or guardian/caregiver cannot do chest physiotherapy.

Requests for prior authorization of an extension must include documentation by the physician familiar with the client that the client is compliant with the use of the equipment and that the treatment is effective.

1.2.19.8 Positive Airway Pressure System Devices

In addition to the Home Health Services (Title XIX) Durable Medical Equipment (DME)/Medical Supplies Physician Order Form, a Medicaid Certificate of Medical Necessity for CPAP/BiPAP or Oxygen Therapy Form must be signed and dated by the physician familiar with the client and submitted by the provider for all positive pressure system devices. The original signed copy must be kept in the medical record.

1.2.19.8.1 Prior Authorization

Heated and Non-heated Humidification For Use With Positive Airway Pressure System
Humidification devices require prior authorization. Documentation of medical necessity including the diagnosis and expected outcome must be submitted with the request for prior authorization.

1.2.19.9 Continuous Positive Airway Pressure (CPAP) System

Purchase is limited to a maximum of once every five years with medical necessity. Reimbursement for rental is limited to once per month and includes all supplies and accessories.

Headgear, tubing, and filters are considered part of the rental and will not be reimbursed separately.

Providers must use procedure code E0601 when requesting prior authorization for the rental or purchase of the CPAP system.

1.2.19.9.1 Adult CPAP (19 years of age or older)

CPAP may be approved initially for three months for adults if one of the following conditions are met:

- A Sleep Study Respiratory Disturbance Index (RDI) or Apnea/Hypopnea Index (AHI) greater than or equal to 15 per hour
- A Sleep Study RDI or AHI greater than 5 per hour and at least one of the following:
  - Excessive daytime sleepiness (documented by either Epworth greater than 10 or multiple sleep latency test (MSLT) less than 6
  - Documented symptoms of impaired cognition, mood disorders, or insomnia
  - Documented hypertension (systolic blood pressure greater than 140 mm Hg and/or diastolic blood pressure greater than 90 mm Hg)
  - Documented ischemic heart disease
  - Documented history of stroke
  - Greater than 20 episodes of oxygen desaturation less than 85 percent during a full night sleep study
  - Any one episode of oxygen desaturation less than 70 percent

1.2.19.9.2 Pediatric CPAP Criteria

One of the following AHI and/or oxygen saturation levels may be used for clients 18 years of age or younger:

- Polysomnography documentation AHI greater than 1
- An oxygen saturation less than 92 percent, taken upon exertion breathing room air

1.2.19.9.3 Prior Authorization

The CPAP system requires prior authorization and may be prior authorized for rental or purchase depending on the physician's predicted length of treatment. Headgear, tubing, and filters used with patient owned positive airway pressure devices do not require prior authorization. Humidifiers may be prior authorized when used with a CPAP with documentation of medical necessity. Clients who have a current prior authorization for a CPAP/BiPAP S may continue to rent these items until the prior authorization period expires. After the current prior authorization period expires, then the criteria in the following paragraph applies to any further prior authorizations of CPAP/BiPAP. Providers must supply a new CPAP/BiPAP to clients at the beginning of the new prior authorization period.

The CPAP system may be approved initially for a three-month rental period based on documentation supporting the medical necessity and appropriateness of the device.

CPAP Prior Authorization Renewal

Prior authorization for purchase after the initial three-month rental period may be granted if the client is continuing to use the equipment at a minimum of four hours per night and symptoms are improved as documented by a physician familiar with the client. This documentation of compliance and effectiveness must be provided with a new completed Home Health Services (Title XIX) Durable Medical Equipment (DME)/Medical Supplies Physician Order Form and a Medicaid Certificate of Medical Necessity for CPAP/BiPAP or Oxygen Therapy form. Rental of a CPAP/BiPAP system includes all supplies. CPAP/BiPAP S may be rented up to a maximum of 13 months. The equipment is considered purchased after 13 months rental.

1.2.19.10 Bi-level Positive Airway Pressure System (BiPAP S) Without Backup

Purchase is limited to a maximum of once every five years with medical necessity. Reimbursement for rental is limited to once per month and includes all supplies.

Providers must use procedure code E0470 when requesting prior authorization for the rental or purchase of the BiPAP S.

The BiPAP S may be approved initially for a three-month rental period based on documentation supporting the medical necessity and appropriateness of the device.

The BiPAP S may be approved initially for three months if the following conditions are met:

- The client has demonstrated the inability to tolerate the CPAP system.
- The duration of symptoms is at least six months.
- The Sleep Study RDI or AHI is greater than 15 per hour.
- The Sleep Study RDI or AHI greater than 10 per hour with the lowest oxygen saturation during study is less than 80 percent.
- Oxygen saturation is equal to or less than 92 percent for clients 20 years of age or younger.

Rental of CPAP/BiPAP S includes all supplies. CPAP/BiPAP S may be rented up to a maximum of 13 months. The equipment is considered purchased after 13 months rental.

1.2.19.10.1 Prior Authorization

The BiPAP S requires prior authorization and may be reimbursed for rental or purchase depending on the physician's predicted length of treatment. The BiPAP S will not be prior authorized once a CPAP is purchased. Clients who have a current prior authorization for a CPAP/BiPAP S may continue to rent these items until the prior authorization period expires. After the current prior authorization period expires, then the criteria in the following paragraph applies to any further prior authorizations of CPAP/BiPAP. Providers must supply a new CPAP/BiPAP to clients at the time of purchase, if the item is purchased after a rental period.

Prior authorization for purchase after the initial three-month rental period may be granted if the client is continuing to use the equipment at a minimum of four hours per night and symptoms are improved as documented by a physician familiar with the client. This documentation of compliance and effectiveness must be provided with a new completed Home Health Services (Title XIX) Durable Medical Equipment (DME)/Medical Supplies Physician Order Form and a Medicaid Certificate of Medical Necessity for CPAP/BiPAP or Oxygen Therapy form.

1.2.19.11 Bi-level Positive Airway Pressure System With Backup (BiPAP ST)

Purchase of a BiPAP ST is not a benefit. The BiPAP ST may be approved initially for a three-month rental period based on documentation supporting the medical necessity and appropriateness of the device. Providers must use either procedure code E0471 or E0472 when requesting prior authorization for the rental of the BiPAP ST.

BiPAP ST may be approved initially for three months if the following conditions are met:

- A diagnosis of central sleep apnea or a neuromuscular disease producing respiratory insufficiency, *and*
- Sleep study records central apnea greater than 5 RDI or AHI per hour, *or*
- For clients 18 years of age or younger with:
  - Central apneas greater than 20 seconds regardless of bradycardia
  - Desaturation or central apneas of less than 20 seconds with desaturation greater than 4 percent
  - Bradycardia
- The client has an arterial PO2 at or below 56 mm Hg, or an arterial oxygen saturation at or below 89 percent by transcutaneous oximetry associated with a diagnosis of neuromuscular respiratory insufficiency or failure (not COPD).

1.2.19.11.1 Prior Authorization

The rental of a BiPAP ST requires prior authorization and may be reimbursed only once per month.

Continued prior authorization for rental after the initial three-month rental period may be granted if the client is continuing to use the equipment at a minimum four hours per night and has a transcutaneous saturation greater than 88 percent while using the equipment as documented by a physician familiar with the client or 92 percent or less for clients 20 years of age or younger. This documentation of compliance and effectiveness must be provided with the above documentation plus a new completed Home Health Services (Title XIX) Durable Medical Equipment (DME)/Medical Supplies Physician Order Form and a Medicaid Certificate of Medical Necessity for CPAP/BiPAP or Oxygen Therapy form.

1.2.19.12 Home Mechanical Ventilation Equipment

Continuous use ventilators are used for 12 or more hours per day. Intermittent use ventilators are used for less than 12 hours per day. Mechanical ventilation is either provided by positive pressure ventilation (volume ventilator) or negative pressure ventilation (iron lung).

1.2.19.12.1 Prior Authorization

All ventilators require prior authorization. The completed, signed, and dated Home Health Services (Title XIX) Durable Medical Equipment (DME)/Medical Supplies Physician Order Form must specify all ventilator settings and must be maintained by the DME provider and the prescribing physician in the client's medical record.

1.2.19.13 Volume Ventilators

A volume ventilator may be operated in any of the following:

1.2.19.13.1 Ventilation Modes

- Control
- Assist control
- Synchronized intermittent mandatory ventilation (SIMV)
- CPAP

1.2.19.13.2 Breath Types

- Spontaneous (client triggered and cycled)
- Ventilator assisted (client or machine triggered and/or cycled) (e.g., pressure support or pressure-assisted)
- Mandatory (machine triggered and/or machine cycled)

The monthly ventilator rental includes all ventilator supplies, such as (but not limited to):

- Internal filters
- External filters
- Ventilator circuits with an exhalation valve
- High and low pressure alarms
- All humidification systems including supplies and solutions (i.e., sterile/distilled water)
- Compressors and supplies
- Tracheostomy filters/heat moisture exchangers
- Humidifiers

Note: *Oxygen rental is not considered a ventilator supply and may be considered for separate prior authorization.*

1.2.19.13.3 Prior Authorization

The volume ventilator may be prior authorized for rental only for those clients who have a tracheostomy. Providers must use procedure codes E0450, E0463, and E0464 when requesting prior authorization for the rental of a volume ventilator.

1.2.19.14 Negative Pressure Ventilators

The ventilator rental includes all component parts (pillow, mattress, gaskets, etc.).

Providers must use procedure code E0460 when requesting prior authorization for the rental of a negative pressure ventilator.

Application devices may be purchased following the initial 3-month rental period depending on the physician's predicted length of treatment and the client's compliance.

The purchase of a chest shell (cuirass) and chest wrap is limited to a maximum of 1 every 5 years. Reimbursement for rental is limited to once per month for a total of 4 months.

1.2.19.14.1 Prior Authorization

Negative pressure ventilators may be prior authorized for rental only for individuals who have the ability to speak, eat, drink, and do not have a tracheostomy. One of the following devices may be prior authorized with a portable negative pressure ventilator using procedure codes E0457 and E0459. These devices may be reimbursed for an initial three-month rental period. Application devices may be prior authorized for rental of an initial period of three months.

1.2.19.15 Ventilator Service Agreement

A ventilator service agreement may be reimbursed only once per month. Providers must use procedure code A9900 when requesting the ventilator service agreement. The ventilator service agreement contract may be considered for renewal every six months.

The provider must agree to include all of the following components in the ventilator service agreement:

- Ensure that all routine service procedures as outlined by the ventilator manufacturer are followed
- Provide all internal filters, external filters, and tracheostomy filters
- Provide all ventilator circuits (with the exhalation valve) as a part of the ventilator service agreement
- Provide a respiratory therapist and back-up ventilator on a 24-hour call basis
- Provide monthly home visits by a certified respiratory therapist to verify proper functioning of the ventilator system and the client's status (and maintain documentation of monthly visits)

- Provide a substitute ventilator while the manufacturer's recommended preventive maintenance is being performed on the client-owned ventilator

1.2.19.15.1 Prior Authorization

A ventilator service agreement may be prior authorized for a client who owns their own ventilator, when documentation supports medical necessity/appropriateness for continued ventilator usage. A ventilator service agreement requires prior authorization, which must include submission of a completed Title XIX form and the ventilator service agreement. The completed Home Health Services (Title XIX) Durable Medical Equipment (DME)/Medical Supplies Physician Order Form must include all ventilator settings.

1.2.19.15.2 Documentation Requirements

The completed, signed, and dated Home Health Services (Title XIX) Durable Medical Equipment (DME)/Medical Supplies Physician Order Form and the Ventilator Service Agreement form must be maintained by the provider and the prescribing physician in the client's medical record. The client-owned ventilator must be functional at the time of the request for prior authorization and documentation must include the make, model number, serial number, and the date of ventilator purchase and all ventilator settings. Requests for a continued six-month prior authorization of a ventilator service agreement must include the above documentation and the following:

- The recommended preventive maintenance schedule for the ventilator make and model
- Documentation of the monthly ventilator/client assessments
- Documentation of all service performed during the previous service agreement

1.2.19.16 Oxygen Therapy

Oxygen therapy home delivery systems may be reimbursed for rental only once per month.

Moisture exchangers for use with non-mechanically ventilated clients may be considered for reimbursement when billed with procedure code A9900.

Rental of oxygen equipment includes all supplies and refills.

One of the following clinical indications should be present when requesting approval for in-home oxygen therapy:

- Bronchopulmonary dysplasia and other respiratory diagnoses due to prematurity
- Respiratory failure or insufficiency
- Musculoskeletal weakness, such as that caused by Duchenne's or spinal muscle atrophy
- Diagnosis of cluster headaches
- Hypoxemia-related symptoms and findings that might be expected to improve with oxygen therapy (examples of these symptoms and findings are pulmonary hypertension, recurring congestive heart failure due to chronic corpumonale, erythrocytosis, impairment of the cognitive process, nocturnal restlessness, and morning headache)
- Severe lung disease, such as COPD, diffuse interstitial lung disease, whether known or unknown etiology such as cystic fibrosis, bronchiectasis or widespread pulmonary neoplasm

1.2.19.17 Oxygen Therapy Home Delivery System

Providers must use procedure code E1390 when billing for the rental of an oxygen concentrator system. The reimbursement payment for the rental of the oxygen concentrator system includes, but is not limited to, cannula or mask, tubing, and humidification. These items will not be reimbursed separately.

If other types of oxygen therapy home delivery systems are required, documentation of medical necessity exception must be provided.

Other types of delivery systems include:

- Compressed gas cylinder systems (nonportable tanks) (procedure code E0424)
- Liquid oxygen reservoir systems (procedure code E0439)

  Note: *The reimbursement for compressed gas cylinder and liquid oxygen reservoir systems includes all of the supplies that are noted in the procedure code description.*

- Portable oxygen systems—Portable oxygen therapy may be prior authorized if the medical necessity conditions are met and the medical documentation indicates that the client requires the use of oxygen in the home and would benefit from the use of a portable oxygen system when traveling outside the home environment.
  - Portable oxygen systems are not considered a benefit of the Home Health Services Program for clients who qualify for oxygen solely based on blood gas studies obtained during sleep.
  - Providers must use procedure codes E0431, E0434, and K0738 when billing for the portable oxygen systems. When procedure code K0738 is billed for the same dates of service as procedure code E0431, procedure code E0431 will be denied.

Rental of the portable oxygen system includes all supplies and refills. Refills for a client-owned system must be obtained from a DSHS-licensed vendor.

1.2.19.18 Prior Authorization

All oxygen therapy, supplies, and related equipment requires prior authorization. Humidifiers may not be prior authorized separately for rental for use with oxygen equipment. Multiple oxygen delivery systems (e.g., liquid or gas) will not be prior authorized concurrently. Supplies and refills may be prior authorized for those clients that own their own oxygen systems.

Note: *In addition to the completed Home Health Services (Title XIX) Durable Medical Equipment (DME)/Medical Supplies Physician Order Form, a Medicaid Certificate of Medical Necessity for CPAP/BiPAP or Oxygen Therapy form must be completed, signed, and dated by the physician familiar with the client and submitted by the provider.*

1.2.19.19 Documentation Requirements

Prior authorization of home oxygen therapy for the initial period of three months will be granted if the Home Health Services (Title XIX) Durable Medical Equipment (DME)/Medical Supplies Physician Order Form and the Medicaid Certificate of Medical Necessity for CPAP or BiPAP or Oxygen Therapy form is completed and all of the following conditions are met:

- Symptoms have a duration of at least three months (or less with special circumstances).
- For clients 20 years of age or younger, one of the following parameters must be used:
  - An oxygen saturation of 89 to 92 percent, taken at rest, breathing room air.
  - An oxygen saturation less than 92 percent with documentation of medical necessity provided by a physician familiar with the client.
- An arterial PO2 at or below 56 mm Hg or an arterial oxygen saturation at or below 89 percent, taken at rest, breathing room air, or during sleep and associated with signs or symptoms reasonably attributed to hypoxemia.
- Hypoxemia associated with obstructive sleep apnea must be unresponsive to CPAP or BiPAP S therapy before oxygen therapy can be approved. In these cases, coverage is provided only for use of oxygen during sleep, and then only one type of delivery system will be considered a benefit under the Home Health Services Program.

- Portable oxygen systems are considered a benefit of the Home Health Services Program when the medical documentation indicates that the client requires the use of oxygen in the home and would benefit from the use of a portable oxygen system when traveling outside the home environment. Portable oxygen systems are not considered a benefit of the Home Health Services Program when traveling outside the home environment for clients who qualify for oxygen usage based solely on oxygen saturation levels during sleep.
- A client who demonstrates an arterial PO2 at or above 56 mm Hg, or an arterial oxygen saturation at or above 89 percent, during the day while at rest and who subsequently experiences a decreased arterial PO2 of 55 mm Hg or below, or decreased arterial oxygen saturation of 88 percent or below during exercise. In this case supplemental oxygen can be provided if there is evidence that the use of oxygen improves the hypoxemia that was demonstrated during exercise when the client was breathing room air.

In-home oxygen therapy can be approved for cluster headaches with the documentation of both the following clinical indications:

- Neurological evaluation with diagnosis
- Documented failed medication therapy

Note: *Lab values are not indicated with this diagnosis*

1.2.19.19.1 Oxygen Therapy Recertification

Prior authorization of oxygen therapy after an initial three-month rental period may be granted with the submission of a new completed Home Health Services (Title XIX) Durable Medical Equipment (DME)/Medical Supplies Physician Order Form and a new Medicaid Certificate of Medical Necessity for CPAP/BiPAP or Oxygen Therapy form and the following:

- Documentation of continued need
- Documentation of client compliance by the physician familiar with the client

Note: *The initial Medicaid Certificate of Medical Necessity for CPAP/BiPAP or Oxygen Therapy Form cannot be used for recertification purposes.*

1.2.19.20 Tracheostomy Tubes

A tracheostomy tube may be reimbursed for purchase only and is limited to one per month. Add modifier TF when billing a tracheostomy with specialized functions. Add modifier TG when billing a custom made tracheostomy. The MSRP information and a physician statement addressing the reason the client cannot use a standard tracheostomy tube are required when requesting prior authorization.

Disposable tracheostomy inner cannula's are considered a convenience item and are not a benefit.

1.2.19.20.1 Prior Authorization

Prior authorization requests for tracheostomy tubes must provide sufficient information to support the determination of medical necessity for the requested item. Prior authorization for a tracheostomy tube will be considered with procedure codes A7520, A7521, or A7522. Providers must use procedure code A4623 when requesting prior authorization for the tracheostomy tube inner cannula. An inner cannula is limited to one per month and will not be prior authorized when a custom manufactured tracheostomy tube (procedure code A7520-TG or A7521-TG) is requested.

1.2.19.21 Pulse Oximetry

Pulse oximeters are not a benefit of Title XIX Home Health Services. Pulse oximeters are a benefit of Texas Medicaid through CCP for clients who are birth through 20 years of age.

Refer to: Subsection 3.5.5, "Croup Tent/Pulse Oximeter" in the *Children's Services Handbook* (*Vol. 2, Provider Handbooks*) for more information on pulse oximeters.

1.2.19.21.1 Prior Authorization

Pulse oximeter sensor probes (procedure code A4606) for client owned equipment are limited to four per month without prior authorization. If additional sensor probes are needed, prior authorization must be requested through Home Health Services with documentation supporting medical necessity.

1.2.19.22 Procedure Codes and Limitations for Respiratory Equipment and Supplies

Procedure Code	Limitations
Nebulizers	
A4617	2 per month
A7003	2 per month
A7004	2 per month
A7005	1 per 6 months
A7006	1 per month
A7007	2 per month
A7010	1 unit (100 ft) per 2 months
A7011	1 per year
A7012	2 per month
A7013	2 per month
A7015	1 per month
A7017	1 every 3 years
A7018	4 per month
E0570	Every 5 years
E0585	Every 3 years
S8101	2 per month
Ultrasonic Nebulizers	
A7009	4 per month
A7014	1 every 3 months
A7016	2 per year
E0574	Every 2 years
E0575	Every 5 years
Vaporizers	
E0605	Every 5 years
Nonelectric Spirometer	
A9284	1 per 6 months
Intermittent Positive-Pressure Breathing (IPPB) Device	
E0500	4 months per life
Mucous Clearance Valve (i.e., Flutter)	
S8185	Every 5 years
Chest Physiotherapy Devices	
A7026	1 per 6 months
E0480	1 purchase every 5 years; 1-month rental

Procedure Code	Limitations
E0481	1 per month
E0482	1 per month
E0483	1 purchase per lifetime; 1-month rental
CPAP/BiPAP	
A7027	1 per 3 months
A7028	1 per month
A7029	2 per month
A7030	1 per 3 months
A7031	1 per month
A7032	2 per month
A7033	2 per month
A7034	4 per year
A7035	Every 6 months
A7037	1 per month
A7038	2 per month
A7039	1 per 6 months
E0470	1 purchase every 5 years; 1-month rental
E0471	1 purchase every 5 years; 1-month rental
E0472	1 purchase every 5 years; 1-month rental
E0561	1 purchase every 5 years; 1-month rental
E0562	1 purchase every 5 years; 1-month rental
E0601	1 purchase every 5 years; rental allowed 4 per lifetime
Home Mechanical Ventilator Equipment	
A4481	31 per month
A4483	31 per month
A4611	Every 5 years
A4612	Every 5 years
A4613	Every 5 years
A4614	1 per 6 months
A4623	1 per month
A4629	31 per month
A7520	1 per month
A7521	1 per month
A7522	4 per year
E0450	4 per lifetime
E0457	1 purchase every 5 years; 1-month rental
E0459	1 purchase every 5 years; 1-month rental
E0460	4 per lifetime
E0463	1 per month

Procedure Code	Limitations
E0464	1 per month
E0580	1 per 3 years
S8189	Limited per policy
Ventilator Maintenance Agreement	
A9900	1 per month
Oxygen Therapy	
A4615	2 per month
A4616	4 per year
A4618	4 per month
A4619	2 per month
A4620	2 per month
E0424	4 per lifetime
E0431	4 per lifetime
E0433	1 per month
E0434	4 per lifetime
E0439	4 per lifetime
E0441	4 per lifetime
E0442	4 per lifetime
E0443	1 per month
E0444	1 per month
E0565	1 purchase every 5 years; rental allowed 4 per lifetime
E1353	1 per year
E1355	1 purchase every 3 years; 1-month rental
E1372	1 every 3 years
K0730	1 every 5 years
Suction Pumps	
A4605	10 per month
A4624	90 per month
A4628	2 per month
A7000	4 per month
A7002	8 per month
E0600	Every 5 years
Miscellaneous	
A4606	4 per month
A4627	Every 6 months
E1399	Limited by policy
S8999	1 per year

1.2.20 Special Needs Car Seats and Travel Restraints

Special needs car seats and travel restraints are not services available under Home Health Services.

Refer to: Subsection 3.5.13, "Special Needs Car Seats and Travel Restraints" in *Children's Services Handbook* (*Vol. 2, Provider Handbooks*) for details about coverage through CCP.

1.2.21 Subcutaneous Injection Ports

A subcutaneous injection port is a sterile medication delivery device through which physician-prescribed medications can be injected directly into the subcutaneous tissue using a standard syringe and needle, an injection pen, or other manual injection device. The device can be used for multiple subcutaneous injections for a period of up to 72 hours, thereby avoiding repeated needle punctures of the skin. The device cannot be used with an injection pump.

A subcutaneous injection port, such as the *I-Port* or *Insuflon*, is a benefit of Texas Medicaid as a Title XIX Home Health service with prior authorization. Claims for a subcutaneous injection port must be submitted with procedure code A4211 and modifier U4.

Texas Medicaid may reimburse the device for clients who require multiple daily injections of a physician-prescribed medication and who meet the medical necessity criteria.

The subcutaneous injection port is not a benefit of Texas Medicaid as an item of convenience or for clients already receiving the medication through an ambulatory infusion pump. The device is considered an item of convenience if the client does not meet the criteria for medical necessity.

1.2.21.1 Prior Authorization

Prior authorization is required for a subcutaneous injection port. Initial prior authorizations will be issued for a trial period of up to 3 months. Prior authorizations that are issued after the successful completion of the initial trial period may be issued for a period of up to 6 months. Prior authorizations for subcutaneous injection ports are limited to a quantity of 10 individual ports per month. Additional ports will be considered for prior authorization with documentation of medical necessity.

1.2.21.2 Documentation Requirements

The initial request for prior authorization must include documentation that indicates the client meets the following criteria for medical necessity:

- The client has a medical condition that requires multiple (i.e., 2 or more) subcutaneous, self-administered injections on a daily basis and has a current prescription for the injectable medication. Documentation must indicate the specific medical condition that is being treated, the name of the injectable medication, and the dosage and frequency of the injections.

  Note: *"Self-administered" includes those injections administered by the client through a subcutaneous injection or by the caregiver to the client through a subcutaneous injection.*

- The client or the caregiver has been unsuccessful with the self-administration of injections using a standard needle and syringe because the client demonstrates trypanophobia (i.e., severe needle phobia), as evidenced by documented physical or psychological symptoms. Documented symptoms may include, but are not limited to, the following:

Condition	Possible Exhibited Symptoms
Vaso-vagal trypanophobia	Physical symptoms such as changes in blood pressure, syncope, sweating, nausea, pallor, and tinnitus
Associate trypanophobia	Psychological symptoms such as extreme anxiety, insomnia, and panic attacks
Resistive trypanophobia	Signs and symptoms such as combativeness, elevated heart rate, high blood pressure, and violent resistance to procedures involving needles or injections

The prescribing physician must include with the prior authorization request a written statement of medical necessity that identifies the client as an appropriate candidate for the subcutaneous injection port device. The physician's statement or medical record documentation that is submitted with the prior authorization request must indicate the following:

- The client or caregiver has received instruction during an office visit on the proper placement and use of the device, with successful return demonstration. (Prior authorization requests for skilled nursing visits for the sole purpose of client instruction on the use of the subcutaneous injection port device will not be approved. Necessary instruction must be performed as part of the office visit with the prescribing physician.)
- The client has no known allergies or sensitivities to adhesives, silicone, or similar materials.
- The client has no skin infection at potential injection sites.
- The client's most recent lab results related to the medical condition requiring treatment with daily subcutaneous injections must also be submitted with the prior authorization request. Lab results may include, but are not limited to, hemoglobin A1c (HbA1c) levels for clients with insulin dependent diabetes mellitus (IDDM) and partial thromboplastin time (PTT) for clients receiving anticoagulant therapy.

Requests for the renewal of the prior authorization after the initial trial period has ended must include documentation of the following:

- Ongoing signs and symptoms associated with the client's trypanophobia.
- Improved compliance with the physician-prescribed injection regimen.
- Successful use of the device with no persistent pattern of the client's dislodging the device during the initial trial period.
- Results of relevant lab tests performed upon completion of the initial trial period, including, but not limited to, HbA1c levels for clients with IDDM and PTT for clients who are receiving anticoagulant therapy.

Note: *For clients with IDDM, if the HbA1c level has not declined with use of the subcutaneous injection port, additional documentation must be submitted by the physician who documents the clinical determination about the lack of significant improvement in the HbA1c level. The renewal of the prior authorization will not be approved without this information.*

1.2.22 Total Parenteral Nutrition (TPN) Solutions

In-home TPN is a benefit for eligible clients who require long-term support because of extensive bowel resection or severe advanced bowel disease in which the bowel cannot support nutrition. For clients who are birth through 20 years of age who do not meet these criteria, additional diagnoses may be considered through CCP.

Parenteral nutrition solution services may be reimbursed using the following procedure codes:

Procedure Codes									
B4164	B4168	B4172	B4176	B4178	B4180	B4185	B4189	B4193	B4197
B4199	B4216	B5000	B5100	B5200					

Covered services must be medically necessary, appropriate, and prescribed by a physician. TPN is not available through the Texas Medicaid fee-for-service program when oral intake will maintain adequate nutrition.

Hospitals administering TPN in the hospital outpatient department should refer to subsection 2.3.3.14, "Total Parenteral Nutrition" in *Hospital Services Handbook* (*Vol. 2, Provider Handbooks*) for the policies and billing instructions.

No more than a one-week supply of solutions and additives may be reimbursed if the solutions and additives are shipped and not used because of the client's loss of eligibility, change in treatment, or inpatient hospitalization. Any days that the client is an inpatient in a hospital or other medical facility or institution must be excluded from the daily billing. Payment for partial months will be prorated based upon the actual days of administration.

The administration of intravenous fluids and electrolytes cannot be billed as in-home TPN.

Outpatient hospital TPN is a covered benefit when medically indicated as specified under in-home TPN criteria. Outpatient hospital TPN should be billed using the appropriate revenue code.

Reimbursement to hospital outpatient departments furnishing in-home TPN services may not exceed the maximum yearly fee established by the HHSC or its designee.

Claims for TPN must contain the 9-character prior authorization number in Block 23. Providers must consult with their vendor for the location of this field in the electronic claims format. The prescribing physician name and provider identifier must be in Block 17 and 17a or in the appropriate field of the provider's electronic software.

1.2.22.1 Prior Authorization

TPN and lipids must be prior authorized.

1.2.22.2 Documentation Requirements

The physician must maintain documentation of medical necessity in the client's medical record, to include the following:

- Medical condition necessitating the need for TPN, and documentation of any trials with oral/enteral feedings
- Percent of daily nutritional needs from TPN
- A copy of the TPN formula or prescription, including amino acids and lipids, signed and dated by the physician
- A copy of the most recent laboratory results (to include potassium, calcium, liver function studies and albumin)

All supporting documentation must be included with the request for authorization. The requesting provider may be asked for additional information to clarify or complete a request for TPN services.

Retrospective review may be performed to ensure documentation supports the medical necessity of the TPN services. Renewal will be considered based on medical necessity.

Refer to: Form DM.4, "Home Health Services (Title XIX) DME/Medical Supplies Physician Order Form" in Section 4, Forms, of this handbook.

1.2.23 Wound Care Supplies and/or Systems

Wound care supplies and wound care systems may be considered for reimbursement through Home Health Services.

1.2.23.1 Wound Care Supplies

Nonsterile/clean wound care supplies may be considered for prior authorization when documentation supports medical necessity. The home setting is considered a clean environment, not a sterile environment.

Sterile wound care supplies, other than those required with a wound care system, may be considered for prior authorization when documentation supports medical necessity and justifies that nonsterile/clean wound care supplies will not meet the client's needs.

Note: *Established tracheostomies and/or gastrostomies/buttons are not considered wounds, therefore dressing supplies will not be considered for prior authorization. Dressing supplies for tracheostomies and/or gastrostomies may be considered for prior authorization with documentation of medical necessity.*

Nonsterile gloves may be considered for prior authorization when necessary to perform medical wound care provided by the client, a family member, or a friend. The home health nursing agency must provide their staff with the appropriate safety supplies as stated in the Occupational Safety and Health Administration (OSHA) requirements. Nonsterile/sterile gloves for use by a health-care provider in the home setting, such as an RN, LVN, or attendant are not a benefit.

1.2.23.2 Wound Care System

Wound care systems may be considered for reimbursement when prior authorized.

A wound care system may be considered for reimbursement for clients with a Stage III or IV chronic, nonhealing wound, such as a pressure, venous stasis, diabetic ulcer, postsurgical wound dehiscence, nonadhering skin grafts, or surgical flaps required for covering such wounds.

Types of wound care systems include the following:

- Thermal wound care system
- Sealed suction wound care system

Portable hyperbaric oxygen chambers that are placed directly over the wound and provide higher concentrations of oxygen to the damaged tissue are not a benefit of Home Health Services.

1.2.23.3 Thermal Wound Care System

Thermal wound care systems and associated supplies (procedure codes A6000, E0231, and E0232) are benefits of Home Health Services. Electric temperature control units are rented on a monthly basis. Clients, family members, or caregivers can be taught to perform a thermal wound care system dressing change (performed every one to three days).

1.2.23.4 Sealed Suction Wound Care System

Sealed suction wound care systems and associated supplies (procedure codes E2402 and A6550) are benefits of Home Health Services. The computerized vacuum pump is rented on a monthly basis. An RN is required to perform a sealed suction wound care system dressing change (performed every one to three days).

1.2.23.5 Pulsatile Jet Irrigation Wound Care System

Pulsatile jet irrigation wound care systems (procedure code E1399) are a benefit of Home Health Services for rental only. An RN is required to perform a pulsatile jet irrigation wound care system dressing change (performed one to three days).

1.2.23.6 Prior Authorization

Prior authorization is required for all the medical supplies and wound care systems addressed below and provided through TMHP Home Health Services Prior Authorization Department.

Note: *THSteps-eligible clients who qualify for medically necessary services beyond the limits of this home health benefit will receive those services through CCP.*

1.2.23.6.1 Wound Care System Prior Authorization Criteria

Initial Criteria
Initial prior authorization for a wound care system may be considered for reimbursement for up to a 30-day period.

Recertification Criteria
Medically necessary prior authorized extensions may be considered for reimbursement for 30-day periods up to a maximum of four months when documentation supports continued significant improvement in wound healing. Wound care systems may be considered for reimbursement beyond four months of treatment on a case-by-case basis after review by the medical director or designee with documentation of medical necessity.

1.2.23.6.2 Wound Care Supplies

Wound care system supplies are limited to a maximum of:

- 15 dressing kits or supplies per wound per month unless documentation supports that the wound size requires more than one dressing kit for each dressing change or if the physician has ordered more frequent dressing changes.

When documentation supports evidence of high-volume drainage, defined as greater than 90 ml per day, a stationary pump with the largest capacity canister must be used. Extra canisters related to the equipment failure are not considered medically necessary.

Wound care systems and related supplies will not be prior authorized nor considered for reimbursement when:

- The client has one of the following contraindications:
  - A fistula to the body
  - Wound ischemia
  - Gangrene
  - Skin cancer in the wound margins
  - Presence of necrotic tissue, including bone (nonapplicable to the pulsatile jet irrigation wound care system)
  - Osteomyelitis (unless it is being treated; the treatment must be identified)
  - Less than six months to live
- In the documented judgement of the treating physician, adequate wound healing has occurred and the wound care system is no longer required.
- No measurable wound healing has occurred over the previous 30-day period.
- A wound care system was used for four months or more in the inpatient setting before discharge, except when documentation supports continued significant improvement in wound healing.
- The wound care equipment and supplies are no longer being used by the client. Stand-by use equipment and supplies are not a benefit of Home Health Services.

1.2.23.7 Documentation Requirements

Wound Care Supplies
To request prior authorization for wound care supplies, the following documentation must be provided:

- Accurate diagnostic information pertaining to the underlying diagnosis/condition as well as any other medical diagnoses/conditions, to include the client's overall health status

- Appropriate medical history related to the current wound:
  - Wound measurements to include length, width and depth, any tunneling and/or undermining
  - Wound color, drainage (type and amount) and odor, if present
  - The prescribed wound care regimen, to include frequency, duration and supplies needed
  - Treatment for infection, if present
- The client's use of a pressure reducing mattress and/or cushion, when appropriate
- Identification of the client or caregiver who will be instructed how to perform and will be responsible for the wound care

Wound Care System Documentation
To request prior authorization for a wound system, the documentation listed below must be provided on the Statement for Initial Wound Therapy System In-Home Use Form in this handbook. An initial or recertification request must be submitted with the signed and dated Home Health Services (Title XIX) Durable Medical Equipment (DME)/Medical Supplies Physician Order Form. The original documentation must be maintained by the prescribing physician in the client's medical record. A copy of these documents must be maintained by the requesting provider.

- Accurate diagnostic information pertaining to the underlying diagnosis/condition and any other medical diagnoses/conditions, including the client's overall health status.
- The client's use of a pressure reducing mattress, when appropriate.
- Albumin level within the last 30 days:
  - If the albumin level is below 3.0, documentation must show that nutritional supplement is in place.
- Hemoglobin A1c obtained within last 30 days if the client has a diagnosis of diabetes mellitus.
- Appropriate medical history related to the current wound:
  - Documentation that the wound is free of necrotic tissue and infection, or if infection is present, that it is being treated with antibiotics, including the name of the antibiotic, dosage, frequency, and route of administration.
  - Wound measurements to include length, width, and depth, any tunneling and/or undermining.
  - For recertification, documentation that the wound is improving.
  - Wound color, drainage (type and amount), and odor if present.
- The prescribed wound care regimen, to include frequency, duration, and supplies needed.
- Identification of the caregiver who agrees to be available to assist client during this time and agreement of this person not to operate the negative pressure or the pulsatile jet irrigation system if used.
- Documentation that an RN who is certified in the use of the wound care system is performing the wound care when a negative pressure or pulsatile jet irrigation wound care system is used. All requirements for skilled nursing care must be met.

1.2.23.8 Wound Care Procedures and Limitations

Procedure Code	Maximum Limitation
A4213	As needed
A4217	As needed

Procedure Code	Maximum Limitation
A4244	1 per month
A4245	Per box as needed
A4246	1 per month
A4247	1 per month
A4450	20 per month
A4452	20 per month
A4455	4 per month
A4461	As needed
A4657	As needed
A4930	As needed
A6000	15 per month
A6010	As needed
A6011	As needed
A6021	As needed
A6022	As needed
A6023	As needed
A6024	As needed
A6025	As needed
A6154	As needed
A6196	As needed
A6197	As needed
A6198	As needed
A6199	As needed
A6200	As needed
A6201	As needed
A6202	As needed
A6203	As needed
A6204	As needed
A6205	As needed
A6206	As needed
A6207	As needed
A6208	As needed
A6209	As needed
A6210	As needed
A6211	As needed
A6212	As needed
A6213	As needed
A6214	As needed
A6215	As needed

Procedure Code	Maximum Limitation
A6216	As needed
A6217	As needed
A6218	As needed
A6219	As needed
A6220	As needed
A6221	As needed
A6222	As needed
A6223	As needed
A6224	As needed
A6228	As needed
A6229	As needed
A6230	As needed
A6231	As needed
A6232	As needed
A6233	As needed
A6234	As needed
A6235	As needed
A6236	As needed
A6237	As needed
A6238	As needed
A6239	As needed
A6240	As needed
A6241	As needed
A6242	As needed
A6243	As needed
A6244	As needed
A6245	As needed
A6246	As needed
A6247	As needed
A6248	As needed
A6251	As needed
A6252	As needed
A6253	As needed
A6254	As needed
A6255	As needed
A6256	As needed
A6257	As needed
A6258	As needed
A6259	As needed

Procedure Code	Maximum Limitation
A6260	As needed
A6261	As needed
A6262	As needed
A6266	As needed
A6402	As needed
A6403	As needed
A6404	As needed
A6407	As needed
A6410	As needed
A6411	As needed
A6412	As needed
A6441	As needed
A6442	As needed
A6443	As needed
A6444	As needed
A6445	As needed
A6446	As needed
A6447	As needed
A6448	As needed
A6449	As needed
A6450	As needed
A6451	As needed
A6452	As needed
A6453	As needed
A6454	As needed
A6455	As needed
A6456	As needed
A6550	15 per month
E0231	1 per month
E0232	1 per month
E1399	1 per month (for use with Pulsatile Jet Irrigation Wound Care System)
E2402	1 per month
T1999	As needed

1.2.24 Limitations, Exclusions

Payment cannot be made for any service, supply or equipment for which FFP is not available. For clients who are 20 years of age or younger and who are eligible to receive THSteps services, refer to subsection 3.2, "CCP Overview" in *Children's Services Handbook* (*Vol. 2, Provider Handbooks*) to find which of these items are a benefit for CCP.

Home Health Services does not cover the following:

- Adaptive strollers, travel seats, push chairs, and car seats
- Administration of non-FDA-approved medications/treatments or the supplies and equipment used for administration
- Any services, equipment, or supplies furnished to a client who is a resident of a public institution or a client in a hospital, SN facility, or intermediate care facility
- Any services or supplies furnished to a client before the effective date of Medicaid eligibility as certified by HHSC or after the date of termination of Medicaid eligibility
- Any services or supplies furnished without prior approval by TMHP, except as listed
- Any supplies or equipment used in a physician's office, or inserted by a physician (e.g., low profile gastrostomy tube)
- Apnea monitors
- Blood products (the administration or the supplies and equipment used to administer blood products)
- Cardiac telemetry monitoring
- Chemotherapy administration or the supplies and equipment used to administer chemotherapy
- Diapers and wipes for clients 3 years of age or younger
- Dynamic orthotic cranioplasty (DOC)
- Environmental equipment, supplies, or services, such as room dehumidifiers, air conditioners, heater/air conditioner filters, space heaters, fans, water purification systems, vacuum cleaners, treatments for dust mites, rodents, and insects
- Home whirlpool baths, spas, home exercisers/gym equipment, hemodialysis equipment, safety wall rails, toys/therapy equipment
- IPV
- Nutritional counseling
- Orthotics, braces, prosthetics including but not limited to voice prosthetic, and artificial larynx
- Parapodiums
- Pneumocardiograms
- Seat lift chairs
- Shipping, freight, delivery travel time
- Structural changes to homes, domiciles, or other living arrangements
- Vehicle mechanical and/or structural modifications, such as wheelchair lifts

Refer to: Subsection 1.7, "Texas Medicaid Limitations and Exclusions" in Section 1, Provider Enrollment and Responsibilities (*Vol. 1, General Information*).

1.2.25 Procedure Codes That Do Not Require Prior Authorization

The procedure codes listed in the following table do not require prior authorization for clients receiving services under Home Health Services. Although prior authorization is not required, providers must retain a completed Home Health Services (Title XIX) Durable Medical Equipment (DME)/Medical Supplies Physician Order Form for these clients. For medical supplies not requiring prior authorization, a completed Home Health Services (Title XIX) Durable Medical Equipment (DME)/Medical Supplies Physician Order Form may be valid for a maximum of six months unless the physician indicates the duration of need is less. If the physician indicates the duration of need is less than six months, then a new

Home Health Services (Title XIX) Durable Medical Equipment (DME)/Medical Supplies Physician Order Form is required at the end of the duration of need. It is expected that reasonable, medically necessary amounts will be provided.

The use of these services is subject to retrospective review. This is not an all inclusive list.

Procedure Codes									
Nebulizer Supplies/Equipment*									
E0570	E0575	E0580	S8101						
Incontinence Supplies**									
A4310	A4311	A4312	A4313	A4314	A4315	A4316	A4320	A4321	A4322
A4326	A4327	A4328	A4330	A4335	A4338	A4340	A4344	A4346	A4351
A4352	A4353	A4354	A4355	A4356	A4357	A4358	A4402	A4554	A5102
A5105	A5112	A5113	A5114	A5120	A5121	A5122	A5131		
Inhaler Equipment									
A4614	A4627								

*** Prior authorization is required for certain diagnoses and if limitations are exceeded. Refer to Subsection 1.2.19.2, "Nebulizers " in this handbook.**

**** Prior authorization is required for some procedure codes if the maximum limitation is exceeded. Refer to Subsection 1.2.12.6, "Incontinence Procedure Codes with Limitations " in this handbook.**

1.3 Other/Special Provisions

1.3.1 Medicaid Relationship to Medicare

1.3.1.1 Possible Medicare Clients

It is the provider's responsibility to determine the type of coverage (Medicare, Medicaid, or private insurance) that the client is entitled to receive. Home health providers should follow these guidelines:

- Clients 64 years of age or younger without Medicare Part A or B:
  - If the agency erroneously submits an SOC notice to Medicare and does not contact TMHP for prior authorization, TMHP does not assume responsibility for any services provided before contacting TMHP. The SOC date is no more than three business days before the date the agency contacts TMHP. Visits made before this date are not considered a benefit of the Home Health Services Program.
- Clients 65 years of age or older without Medicare Part A or Part B and clients with Medicare Part A or B regardless of age:
  - In filing home health claims, home health providers may be required to obtain Medicare denials before TMHP can approve coverage. When TMHP receives a Medicare denial, the SOC is determined by the date the agency requested coverage from Medicare. If necessary, the 95-day claims filing deadline is waived for these claims, provided TMHP receives notice of the Medicare denial within 30 days of the date on the MRAN containing Medicare's final disposition.
  - If the agency receives the MRAN and continues to visit the client without contacting TMHP by telephone, mail, or fax within 30 days from the date on the MRAN, TMHP will provide coverage only for services provided from the initial date of contact with TMHP. The SOC date is determined accordingly. TMHP must have the MRAN before considering the request for prior authorization.

1.3.1.2 Benefits for Medicare/Medicaid Clients

For eligible Medicare/Medicaid clients, Medicare is the primary coinsurance and providers must contact Medicare first for prior authorization and reimbursement. Medicaid pays the Medicare deductible on Part B claims for qualified home health clients.

Home health service prior authorizations may be given for HHA services, certain medical supplies, equipment, or appliances suitable for use in the home in one of the following instances:

- When an eligible Medicaid client (enrolled in Medicare) who does not qualify for home health services under Medicare because SN care, PT, or OT are not a part of the client's care.
- When the medical supplies, equipment, or appliances are not a benefit of Medicare Part B and are a benefit of Home Health Services.

Federal and state laws require the use of Medicaid funds for the payment of most medical services only after all reasonable measures have been made to use a client's third party resources or other insurance.

Note: *If the client has Medicare Part B coverage, contact Medicare for prior authorization requirements and reimbursement. If the service is a Part B benefit, do not contact TMHP for prior authorization. Texas Medicaid will only pay the coinsurance and deductible on the electronic crossover claim.*

TMHP will not prior authorize or reimburse the difference between the Medicare payment and the retail price for Medicare Part B eligible clients.

Refer to: Subsection 4.11, "Third Party Resources (TPR)" in Section 4, Client Eligibility (*Vol. 1, General Information*).

1.3.1.3 Medicare and Medicaid Prior Authorization

Contact TMHP for prior authorization of Medicaid services (based on medical necessity and benefits of Home Health Services) within 30 days of the date on the MRAN.

Note: *For MQMB clients, do not submit prior authorization requests to TMHP if the Medicare denial reason states "not medically necessary." Medicaid only will consider prior authorization requests if the Medicare denial states "not a benefit" of Medicare.*

Qualified Medicare Beneficiaries (QMB) are not eligible for Medicaid benefits. Texas Medicaid is only responsible for premiums, coinsurance, and/or deductibles on these clients. Providers should not submit prior authorization requests to the TMHP Home Health Services Prior Authorization Department these clients.

To ensure Medicare benefits are used first in accordance with Texas Medicaid regulations, the following procedures apply when requesting Medicaid prior authorization and payment of home health services for clients.

Contact TMHP for prior authorization of Medicaid services (based on medical necessity and benefits of Home Health Services) within 30 days of the date on the MRAN. Fax a copy of the original Medicare MRAN and the Medicare appeal review letter to the TMHP Home Health Services Prior Authorization Department for prior authorization.

Note: *Claims for STAR+PLUS MQMB clients (those with Medicare and Medicaid) should always be submitted to TMHP as noted on these pages. The STAR+PLUS health plan is not responsible for these services if Medicare denies the service as not a benefit.*

When the client is 65 years of age or older or appears otherwise eligible for Medicare such as blind and disabled, but has no Part A or Part B Medicare, the TMHP Home Health Services Prior Authorization Department uses regular prior authorization procedures. In this situation, the claim is held for a midyear status determined by HHSC. The maximum length of time a claim may be held in a "pending status" for Medicare determination is 120 days. After the waiting period, the claim is paid or denied. If denied, the EOB code on the R&S report indicates that Medicare is to be billed.

Refer to: Subsection 3.2.4, "Home Health Skilled Nursing (SN) Services" in *Nursing and Therapy Services Handbook* (*Vol. 2, Provider Handbooks*).

1.4 Claims Filing and Reimbursement

1.4.1 Claims Information

Providers must use only type of bill (TOB) 331 in Form Locator (FL) 4 of the UB-04 CMS-1450. Other TOBs are invalid and result in claim denial.

Home Health services must be submitted to TMHP in an approved electronic format or on a CMS-1500 or a UB-04 CMS-1450 paper claim form. Submit home health DME and medical supplies to TMHP in an approved electronic format, or on a CMS-1500 or on a UB-04 CMS-1450 paper claim form. Providers may purchase UB-04 CMS-1450 and CMS-1500 paper claim forms from the vendor of their choice. TMHP does not supply them.

When completing a CMS-1500 or a UB-04 CMS 1450 paper claim form, providers must include all required information on the claim, as TMHP does not key information from attachments. Superbills, or itemized statements, are not accepted as claim supplements.

Refer to: Section 3, TMHP Electronic Data Interchange (EDI) (*Vol. 1, General Information*) for information on electronic claims submissions.

Section 6, Claims Filing (*Vol. 1, General Information*) for general information about claims filing.

Subsection 6.6, "UB-04 CMS-1450 Claim Filing Instructions" in Section 6, "Claims Filing" (*Vol. 1, General Information*).

Subsection 6.5, "CMS-1500 Claim Filing Instructions" in Section 6, "Claims Filing" (*Vol. 1, General Information*) for instructions on completing paper claims.

Outpatient claims must have the appropriate revenue code and, if appropriate, the corresponding HCPCS code or narrative description. The prior authorization number must appear on the UB-04 CMS-1450 claim in Block 63 and in Block 23 of the CMS-1500 claim. The certification dates or the revised request date on the POC must coincide with the DOS on the claim. Prior authorization does not waive the 95-day filing deadline requirement.

1.4.1.1 Benefit Code

Home health DME providers must use benefit code DM2 on all claims and authorization requests. All other providers must use benefit code CSN on all claims and authorization requests.

1.4.2 Reimbursement

Home health agencies are reimbursed for DME and expendable supplies in accordance with 1 TAC §355.8021. Providers can refer to the Online Fee Lookup (OFL) or the applicable fee schedule on the TMHP website at www.tmhp.com. Providers may also request a hard copy of the fee schedule by contacting the TMHP Contact Center at 1-800-925-9126.

DME and expendable supplies, other than nutritional products, that have no established fee, are subject to manual pricing at the documented MSRP less 18 percent or the AWP less 10.5 percent, which ever is applicable, or the provider's documented invoice cost.

Nutritional products that have no established fee are subject to manual pricing at the documented AWP less 10.5 percent or at the provider's documented invoice cost.

For reimbursement, providers should note the following:

- Claims are approved or denied according to the eligibility, prior authorization status, and medical appropriateness.

- Claims must represent a numerical quantity of 1 month for supplies according to the billing requirements.
- DME/supplies *must* be provided by either a Medicaid enrolled home health agency's Medicaid/DME supply provider or an independently-enrolled Medicaid/DME supply provider. Both *must* enroll and bill using the provider identifier enrolled as a DME supplier. File these services on a CMS-1500 claim form.

  Note: *Medical social services and speech-language pathology services are available to clients 20 years of age or younger and are not a benefit of Home Health Services. These services may be considered a benefit for clients who qualify for CCP.*

Texas Medicaid does not reimburse separately for associated DME charges, including but not limited to, battery disposal fees or state taxes. Reimbursement for any associated charges is included in the reimbursement for a specific piece of equipment.

Refer to: Subsection 2.2, "Reimbursement Methodology" in Section 2, Texas Medicaid Reimbursement (*Vol. 1, General Information*) for more information about reimbursement.

1.4.2.1 Eligibility

To verify client Medicaid eligibility and retroactive eligibility, the home health agency or DMEH/medical supplier should contact the Automated Inquiry System (AIS) at 1-800-925-9126 or the TMHP Electronic Data Interchange (EDI) Help Desk at 1-888-863-3638.

Home health clients do not need to be homebound to qualify for services.

The Medicaid client must be eligible on the DOS and must meet all the following requirements to qualify for Home Health Services:

- Have a medical need for home health professional services, DME, or supplies that is documented in the client's POC and considered a benefit under Home Health Services
- Receive services that meet the client's existing medical needs and can be safely provided in the client's home
- Receive prior authorization from TMHP for most home health professional services, DME, or supplies

Certain DME/supplies may be obtained without prior authorization although providers must retain a Home Health Services (Title XIX) Durable Medical Equipment (DME)/Medical Supplies Physician Order Form reviewed, signed, and dated by the treating physician for these clients.

Refer to: "Automated Inquiry System (AIS)" in TMHP Telephone and Address Guide (*Vol. 1, General Information*).

Section 6, "THSteps Medical" in *Children's Services Handbook* (*Vol. 2, Provider Handbooks*) for more information on clients birth through 20 years of age.

1.4.2.2 Retroactive Eligibility

When a home health agency is providing services to a client who is pending Medicaid coverage, the agency is responsible for finding out the effective dates for eligibility, which can be done by contacting AIS at 1-800-925-9126 or the TMHP EDI Help Desk at 1-888-863-3638. TMHP must receive all documentation and claims for clients with retroactive eligibility within 95 days from the date eligibility was added to TMHP's eligibility file.

1.4.2.3 Prior Authorization of Retroactive Eligibility

After the client's eligibility is on TMHP's eligibility file, the agency has 95 days from the add date to obtain prior authorization for services already rendered. The agency must contact the TMHP Home Health Services Prior Authorization Department to obtain prior authorization for current services

within three business days of the client's eligibility being added to TMHP's eligibility file. When contacting TMHP by telephone for prior authorization, the nurse who made the initial assessment visit in the client's home must make this call.

1.4.3 Prohibition of Medicaid Payment to Home Health Agencies Based on Ownership

Medicaid denies home health services claims when TMHP records indicate that the physician ordering treatment has a significant ownership interest in, or a significant financial or contractual relationship with, the nongovernmental home health agency billing for the services. Federal regulation Title 42 CFR §424.22 (d) states that "a physician who has a significant financial or contractual relationship with, or a significant ownership in a nongovernmental home health agency may not certify or recertify the need for home health services care services and may not establish or review a plan of treatment."

A physician is considered to have a significant ownership interest in a home health agency if either of the following conditions apply:

- The physician has a direct or indirect ownership of five percent or more in the capital, stock, or profits of the home health agency.
- The physician has an ownership of five percent or more of any mortgage, deed of trust, or other obligation that is secured by the agency, if that interest equals five percent or more of the agency's assets.

A physician is considered to have a significant financial or contractual relationship with a home health agency if any of the following conditions apply:

- The physician receives any compensation as an officer or director of the home health agency.
- The physician has indirect business transactions, such as contracts, agreements, purchase orders, or leases to obtain services, supplies, equipment, space, and salaried employment with the home health agency.
- The physician has direct or indirect business transactions with the home health agency that, in any fiscal year, amount to more than $25,000 or 5 percent of the agency's total operating expenses, whichever is less.

When providing CCP services and general home health services, the provider must file these on two separate UB-04 CMS-1450 paper claim forms with the appropriate prior authorization number, and should send them to the appropriate address.

Claims denied because of an ownership conflict will continue to be denied unless the home health agency submits documentation indicating that the ordering physician no longer has a significant ownership interest in, or a significant financial or contractual relationship with, the home health agency providing services. Documentation should be sent to TMHP Provider Enrollment at the address indicated in "Written Communication With TMHP" in TMHP Telephone and Address Guide (*Vol. 1, General Information*).

2. CLAIMS RESOURCES

Refer to the following sections and/or forms when filing claims:

Resource	Location
Acronym Dictionary	Appendix E (*Vol. 1, General Information*)
Automated Inquiry System (AIS)	TMHP Telephone and Address Guide (*Vol. 1, General Information*)
CMS-1500 Claim Filing Instructions	Subsection 6.5 (*Vol. 1, General Information*)

Resource	Location
DME Certification and Receipt Form (3 pages)	Form DM.1, Section 4 of this handbook
External Insulin Pump	Form DM.2, Section 4 of this handbook
Home Health Services (Title XIX) DME/Medical Supplies Physician Order Form Instructions (2 pages)	Form DM.3, Section 4 of this handbook
Home Health Services (Title XIX) Durable Medical Equipment (DME)/Medical Supplies Physician Order Form	Form DM.4, Section 4 of this handbook
Addendum to Home Health Services (Title XIX) DME/Medical Supplies Physician Order Form	Form DM.5, Section 4 of this handbook
Home Health Services DME/Medical Supplies Claim Form Example	Form DM.19, Section 5 of this handbook
Home Health Services Plan of Care (POC) Instructions	Form DM.6, Section 4 of this handbook
Home Health Services Plan of Care (POC)	Form DM.7, Section 4 of this handbook
Home Health Services Prior Authorization Checklist	Form DM.8, Section 4 of this handbook
Medicaid Certificate of Medical Necessity for Chest Physiotherapy Device Form—Initial Request	Form DM.9, Section 4 of this handbook
Medicaid Certificate of Medical Necessity for Chest Physiotherapy Device Form—Extended Request	Form DM.10, Section 4 of this handbook
Medicaid Certificate of Medical Necessity for CPAP/BiPAP or Oxygen Therapy	Form DM.11, Section 4 of this handbook
Pulse Oximeter Form	Form DM.12, Section 4 of this handbook
State and Federal Offices Communication Guide	Appendix A (*Vol. 1, General Information*)
Statement for Initial Wound Therapy System In-Home Use (2 pages)	Form DM.13, Section 4 of this handbook
Statement for Recertification of Wound Therapy System In-Home Use	Form DM.14, Section 4 of this handbook
TMHP Electronic Data Interchange (EDI)	Section 3 (*Vol. 1, General Information*)
TMHP Electronic Claims Submission	Subsection 6.2 (*Vol. 1, General Information*)
UB-04 CMS-1450 Claim Filing Instructions	Subsection 6.6 (*Vol. 1, General Information*)
Ventilator Service Agreement	Form DM.15, Section 4 of this handbook
Wheelchair/Scooter/Stroller Seating Assessment Form (CCP/Home Health Services) (6 pages)	Form DM.16, Section 4 of this handbook

3. CONTACT TMHP

The TMHP Contact Center at 1-800-925-9126 is available Monday through Friday from 7 a.m. to 7 p.m., Central Time.

4. FORMS

DM.1 DME Certification and Receipt Form (3 pages)

(Page 1 of 3—Required)

This certification is required by section 32.024 of the *Human Resources Code* and must be completed before the DME provider can be paid for durable medical equipment provided to a Medicaid client.

Esta certificación es necesaria bajo la Sección 32.024 del Código de Recursos Humanos y se debe llenar antes de pagarle al proveedor de equipo médico duradero por el equipo entregado al cliente de Medicaid.

Section A: Client Information			
Name:	Medicaid ID Number:		
Address:	City:	State:	ZIP:
Telephone Number:	Alternate Telephone Number:		

Section B: Provider Information	
Provider Name:	Prior Authorization Number (PAN):
NPI/API:	TPI:

Section C: Product Information		
Date of Service:		
Procedure Code:	Description:	Serial No.:
Procedure Code:	Description:	Serial No.:
Procedure Code:	Description:	Serial No.:
Procedure Code:	Description:	Serial No.:
Procedure Code:	Description:	Serial No.:

Section D: Certification

This is to certify that on (month/day/year) _____ the client received the _____ (equipment) as prescribed by the physician. The equipment has been properly fitted to the client and/or meets the client's needs.

The client, parent, guardian of the client, and/or caregiver of the client has received training and instruction regarding the equipment's proper use and maintenance.

_____	_____
Printed name of DME Supplier	Printed name of Client, Parent, Guardian, or Primary Caregiver
_____	_____
Signature of DME Supplier	Signature of Client, Parent, Guardian, or Primary Caregiver

Section D (Optional) : Certification (Spanish)

Esto certifica que el: (mes/día/año) _____ el cliente recibió _____ (equipo) que el doctor recetó. El equipo fue adaptado correctamente para el cliente y satisface sus necesidades.

El cliente, padre, tutor o cuidador principal del cliente recibió entrenamiento e instrucción en el uso y mantenimiento correcto del equipo.

_____	_____
Nombre del proveedor de equipo médico duradero	Nombre del cliente, padre, tutor o cuidador principal
_____	_____
Firma del proveedor de equipo médico duradero	Firma del cliente, padre, tutor o cuidador principal

This form must be submitted to TMHP for DME products with an allowed amount of $2500 dollars or more. Submit this form with claim form or fax this form to 512-506-6615. Information submitted in this form must match the claim form.
This form must be filled out completely; place none or N/A where applicable. Incomplete forms will be returned and will cause a delay in the verification and payment process. **Failure to submit this form will affect claim payment.**

Notice to Clients: You may be contacted to verify receipt of the equipment provided.

Aviso al cliente: Es posible que lo contactemos para verificar que recibió equipo.

Effective Date_06/01/2008/Revised Date_08/20/2008

(Page 2 of 3—Required only for requests containing six or more items)

Client Information
Medicaid ID Number:

Provider Information	
Provider Name:	Prior Authorization Number (PAN):
NPI/API:	TPI:

Product Information (Continuation)		
Date of Service:		
Procedure Code:	Description:	Serial No.:
Procedure Code:	Description:	Serial No.:
Procedure Code:	Description:	Serial No.:
Procedure Code:	Description:	Serial No.:
Procedure Code:	Description:	Serial No.:
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Procedure Code:	Description:	Serial No.:
Procedure Code:	Description:	Serial No.:
Procedure Code:	Description:	Serial No.:

Certification

This is to certify that on (month/day/year) _____ the client received the _____ (equipment) as prescribed by the physician. The equipment has been properly fitted to the client and/or meets the client's needs.

The client, parent, guardian of the client, and/or caregiver of the client has received training and instruction regarding the equipment's proper use and maintenance.

_____ Printed name of DME Supplier

_____ Printed name of Client, Parent, Guardian, or Primary Caregiver

_____ Signature of DME Supplier

_____ Signature of Client, Parent, Guardian, or Primary Caregiver

Certification (Spanish)

Esto certifica que el: (mes/día/año) _____ el cliente recibió _____ (equipo) que el doctor recetó. El equipo fue adaptado correctamente para el cliente y satisface sus necesidades.

El cliente, padre, tutor o cuidador principal del cliente recibió entrenamiento e instrucción en el uso y mantenimiento correcto del equipo.

_____ Nombre del proveedor del equipo médico duradero

_____ Nombre del cliente, padre, tutor o cuidador principal

_____ Firma del proveedor del equipo médico duradero

_____ Firma del cliente, padre, tutor o cuidador principal

Effective Date_06/01/2008/Revised Date_08/20/2008

(Page 3 of 3—Not for submission to TMHP)
High Cost DME Call Verification

Your provider has sent you some medical equipment. We want to make sure that you got what you wanted and that it works well. We need to talk to you about the equipment before we can pay for it.

Call TMHP at 1-888-276-0702.

Please call us toll-free at 1-888-276-0702 as soon as you can. We are open Monday through Friday from 8 a.m. to 5 p.m., Central Time. If you call us after hours, you can leave a message. Tell us your name, phone number, and the best time to call you back.

Required Information

Please have this information with you when you call:

- Name
- Medicaid Number
- Date of birth
- Address (street, city, state, ZIP)
- Provider's name
- Date you got the equipment
- Details about the equipment

Su proveedor le envió equipo médico. Queremos saber si recibió lo que pidió y si funciona bien. Necesitamos hablar con usted sobre este equipo antes de que paguemos por él.

Llámenos al 1-888-276-0702.

Por favor, llámenos gratis lo antes posible al 1-888-276-0702. Nuestras oficinas están abiertas de lunes a viernes, de 8 a.m. a 5 p.m., Hora del Centro. Si nos llama después de estas horas, puede dejar un mensaje con su nombre, número de teléfono y el mejor momento para volver a llamarlo.

Información que necesitamos

Cuando llame, tenga esta información a la mano :

- Nombre.
- Número de Medicaid.
- Fecha de nacimiento.
- Dirección (calle, ciudad, estado, código postal).
- Nombre del proveedor.
- Fecha en que recibió el equipo.
- Detalles sobre el equipo.

Effective Date_06/01/2008/Revised Date_08/20/2008

DM.2 External Insulin Pump

Client Name:	Date of birth: / /	Medicaid number:
Physician Information		
Name :	Physician specialty:	
Telephone:	Fax number:	License number:
TPI:	NPI:	

The following information is the minimum documentation required for consideration of medical necessity and must be submitted with a completed and signed Home Health Services (Title XIX) DME/Medical Supplies Physician Order Form.

1. Lab values: current and past blood glucose levels, and glycosylated hemoglobin (Hb/A1C) levels—note date of lab draws

2. Client history of severe glycemic excursions, brittle diabetes, hypoglycemic/hyperglycemic reactions, nocturnal hypoglycemia, any extreme insulin sensitivity, and/or very low insulin requirements

3. Client history of any wide fluctuations in blood glucose level before mealtimes

4. Client history of any dawn phenomenon where fasting blood glucose level often exceeds 200 mg/dL

5. Day-to-day variations in client's work/school schedule, mealtimes and/or activity level, which require multiple insulin injections

6. For purchase after the initial trial period a statement of client's compliance and effectiveness of the pump is required

Physician signature:	Date: / /

Effective Date_07302007/Revised Date_06012007

DM.3 Home Health Services (Title XIX) DME/Medical Supplies Physician Order Form Instructions (2 pages)

General Instructions

This form must be completed and signed as outlined in the instructions below before DME/medical supplies providers contact TMHP Home Health Services for prior authorization.

Either the DME supplier/Medicaid provider or the prescribing physician may initiate the form. This completed form must be retained in the records of both the DME supplier/medical provider and the prescribing physician, and is subject to retrospective review. This form becomes a prescription when the physician has signed section B.

Note: *This form cannot be accepted beyond 90 days from the date of the prescribing physician's signature.*

The supplier or prescribing physician can complete Section A. Include the most appropriate procedure code description using the Healthcare Common Procedure Coding System (HCPCS). In addition, include the appropriate quantity and the manufacturer's suggested retail price (MSRP) if the item requires manual pricing. A price is not required for those items with a maximum fee listed in the Texas Medicaid Fee Schedule. The appropriate box must be completed to indicate whether this section was completed by the physician or the supplier. If the item requested is beyond the quantity limit or a custom item, additional documentation must be provided to support determination of medical necessity.

All fields must be filled out completely. The prescribing physician's TPI (if a Texas Medicaid provider), NPI, and license number must be indicated.

Section A: Requested Durable Medical Equipment and Supplies

The supplier or prescribing physician can complete Section A. Include the most appropriate procedure code description using the Healthcare Common Procedure Coding System (HCPCS). In addition, include the appropriate quantity and the manufacturer's suggested retail price (MSRP) if the item requires manual pricing. A price is not required for those items with a maximum fee listed in the Texas Medicaid Fee Schedule. The appropriate box must be completed to indicate whether this section was completed by the physician or the supplier. If the item requested is beyond the quantity limit or a custom item, additional documentation must be provided to support determination of medical necessity.

Requested Durable Medical Equipment and Supplies

Item number	HCPCS Code	Description of DME/medical supplies	Quantity	Price
1	J-E1399	Appropriate HCPCS code description	1	$50.00
2	J-E1220	Appropriate HCPCS code description	1	$2500.00
3				
4				
5				

Examples of Supplies

Item number	HCPCS Code	Description of DME/medical supplies	Quantity	Price
1	9-A4253	Appropriate HCPCS code description	2 boxes	N/A
2	9-A4259	Appropriate HCPCS code description	1 box	N/A
3	9-A4245	Appropriate HCPCS code description	1 box	N/A
4				
5				

Physicians must indicate their professional license number. If the prescribing physician is out of state, the physician must provide the license number and state of professional licensure. Texas Medicaid TPI and UPIN numbers are not acceptable as licensure. The *Addendum to the Home Health Services (Title XIX) DME/Medical Supplies Physician Order Form* must be used when prescribing more than 5 items. The *Addendum to the Home Health Services (Title XIX) DME/Medical Supplies Physician Order Form* must accompany *the Home Health Services (Title XIX) DME/Medical Supplies Physician Order Form.*

Note: *Addendums received without this form will not be accepted.*

Reminder: *Home health services are not a benefit for clients residing in a nursing facility, hospital, or intermediate care facility.*

Note for DME: *The DME company must also complete the DME Certification and Receipt Form. All equipment is to be assembled, installed, and used pursuant to the manufacturer's instructions and warning.*

Effective Date_10212008/Revised Date_10212008

Section B: Diagnosis and Medical Information

Section B is a prescription for DME/supplies and must be filled out by the prescribing physician.

The prescribing physician must indicate the corresponding item number requested from Section A, an ICD-9 code with a brief description, and complete justification for determination of medical necessity for the requested item(s). If applicable, include height/weight, wound stage/dimensions and functional/mobility.

The physician is not required to repeat the procedure code or description of the requested DME or supplies in this section.

Note: *The date last seen must be within the past 12 months.*

The prescribing physician must indicate the duration of need for the prescribed supplies/DME. The estimated duration of need should specify the amount of time the supplies/DME will be needed, such as six weeks, three months, lifetime, etc. The prescribing physician's TPI (if a Texas Medicaid provider), NPI, and license number must be indicated.

Note: *Signatures from nurse practitioners, physician assistants, and chiropractors will not be accepted. Signature stamps and date stamps are not acceptable.*

Diagnosis and Medical Need Information

Item No. [2] (From Section A)	ICD-9	Brief Diagnosis Description	Complete justification for determination of medical necessity for requested item(s). Refer to Section A: Requested Durable Medical Equipment and Supplies.[1,2]
1,2	438	Appropriate diagnosis description	Unable to get in and out of the tub or shower.
2	27801	Appropriate diagnosis description	Need swing-away arms and legs for transfer secondary to hemiparesis and need oversize chair for clients weighing 400 lbs.

1. Refer to Footnote 1 of the Home Health Services (Title XIX) DME/Medical Supplies Physician Order Form.
2. Refer to Footnote 2 of the Home Health Services (Title XIX) DME/Medical Supplies Physician Order Form.

Examples of Supplies

Item No. [2] (From Section A)	ICD-9	Brief Diagnosis Description	Complete justification for determination of medical necessity for requested item(s). Refer to Section A: Requested Durable Medical Equipment and Supplies.[1,2]
1,2,3	25001	Appropriate diagnosis description	Client has frequent variation of blood glucose levels and needs monitoring several times a day.

1. Refer to Footnote 1 of the Home Health Services (Title XIX) DME/Medical Supplies Physician Order Form.
2. Refer to Footnote 2 of the Home Health Services (Title XIX) DME/Medical Supplies Physician Order Form.

Effective Date_1021208/Revised Date_10212008

DM.4 Home Health Services (Title XIX) Durable Medical Equipment (DME)/Medical Supplies Physician Order Form

See instructions for completing Title XIX Home Health Durable Medical Equipment (DME)/Medical Supplies Physician Order Form. This order form cannot be accepted beyond 90 days from the date of the physician's signature. Fax completed form to 1-512-514-4209.

Section A: Requested Durable Medical Equipment and Supplies

This section was completed by (check one): □ Requesting Physician □ Supplier

Client name:	Client date of birth: / /
Client Medicaid number:	Is client under 21 years of age? YES □ NO □

Supplier name:	Supplier address:	
Supplier telephone:	Supplier Fax:	Supplier TPI:
Supplier NPI:	Supplier Taxonomy:	Supplier Benefit Code:
Physician name:	Physician telephone:	Physician Fax:

I certify that the services being supplied under this order are consistent with the physician's determination of medical necessity and prescription. The prescribed items are appropriate and can safely be used in the client's home when used as prescribed.

DME/medical supplies provider representative signature:	Date: / /

DME/medical supplies provider representative name (Typed or Printed):

Item Number	HCPCS Code	Description of DME/medical supplies	Quantity	Price	Prior authorization required?	Beyond quantity limit?[1]	Custom item?[1]
1					□ Y □ N	□ Y □ N	□ Y □ N
2					□ Y □ N	□ Y □ N	□ Y □ N
3					□ Y □ N	□ Y □ N	□ Y □ N
4					□ Y □ N	□ Y □ N	□ Y □ N
5					□ Y □ N	□ Y □ N	□ Y □ N

1. If "Yes," additional documentation must be provided to support determination of medical necessity.

□ Check if additional documentation is attached as outlined in the TMPPM.

Is the DME Provider Medicare certified? YES □ NO □	If yes, indicate Medicare number:

Section B: Diagnosis and Medical Need Information

This is a prescription for DME/supplies and must be filled out by the prescribing physician.

Item Number[2] (From Section A)	ICD-9	Brief Diagnosis Descriptor	Complete justification for determination of medical necessity for requested item(s)[2] (Refer to Section A, footnote 1)
	_ _ _ . _ _		
	_ _ _ . _ _		
	_ _ _ . _ _		
	_ _ _ . _ _		

2. Each item requested in Section A must have a correlating diagnosis and medical necessity justification. Enter all *Item numbers* from the table in Section A that pertain to each diagnosis.

If applicable, include height/weight, wound stage/dimensions and functional/mobility status in table below.

Height	Weight	Wound stage/dimensions	Functionality/mobility status

***Note:** The "Date last seen" and "Duration of need" items below **must** be filled in.*

Date last seen by physician: / /

Duration of need for DME: _____ month (s)	Duration of need for supplies: _____ month (s)

By signing this form, I hereby attest that the information completed in Section "A" is consistent with the determination of the client's current medical necessity and prescription. By prescribing the identified DME and/or medical supplies, I certify the prescribed items are appropriate and can safely be used in the client's home when used as prescribed.

Signature and attestation of prescribing physician:	Date: / /

Signature stamps and date stamps are not acceptable

Prescribing physician's license number:

Prescribing physician's TPI:	Prescribing physician's NPI:

□ Check if all of the information in Section A was complete at the time of the prescribing provider signature

Effective Date_10212008/Revised Date_10212008

DM.5 Addendum to Home Health Services (Title XIX) DME/Medical Supplies Physician Order Form

Section A: Requested Durable Medical Equipment and Supplies

This section was completed by (check one): ☐ Requesting Physician ☐ Supplier

Client name:	Client date of birth: / /
Client Medicaid number:	Is client under 21 years of age? Yes ☐ No ☐

Supplier Information

Name:	Telephone:	Fax number:
Address:		
TPI:	NPI:	
Taxonomy:	Benefit Code:	

Prescribing Physician Information

Name:	Telephone:	Fax number:

I certify that the services being supplied under this order are consistent with the physician's determination of medical necessity and prescription. The prescribed items are appropriate and can safely be used in the client's home when used as prescribed.

DME/medical supplies provider representative signature:	Date: / /

DME/medical supplies provider representative name (Typed or Printed):

Item Number	HCPCS Code	Description of DME/medical supplies	Quantity	Price	Prior authorization required?	Beyond quantity limit?[1]	Custom item?[1]
6					☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N
7					☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N
8					☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N
9					☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N
10					☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N
11					☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N
12					☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N
13					☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N
14					☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N
15					☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N
16					☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N
17					☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N
18					☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N
19					☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N
20					☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N
21					☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N
22					☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N
23					☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N
24					☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N
25					☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N
26					☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N

1. If "Yes," additional documentation must be provided to support determination of medical necessity.

☐ Check if additional documentation is attached as outlined in the TMPPM.

Is the DME Provider Medicare certified? YES ☐ NO ☐	If yes, indicate Medicare number:

Section B: Diagnosis and Medical Need Information

This is a prescription for DME/supplies and must be filled out by the prescribing physician.

By signing this form, I hereby attest that the information completed in Section "A" is consistent with the determination of the client's current medical necessity and prescription. By prescribing the identified DME and/or medical supplies, I certify the prescribed items are appropriate and can safely be used in the client's home when used as prescribed.

Signature and attestation of prescribing physician:	Date: / /

Signature stamps and date stamps are not acceptable

Prescribing physician's license number:	
Prescribing physician's TPI:	Prescribing physician's NPI:

☐ Check if all of the information in Section A was complete at the time of the prescribing provider signature

Effective Date_07302007/Revised Date_06012007

DM.6 Home Health Services Plan of Care (POC) Instructions

Use the guidelines below in filling out the Home Health Plan of Care (POC) form.	
Client Information	
Client's name	Last name, first name, middle initial
Date of birth	Date of birth given by month, day and year
Date last seen by doctor	Client must be seen by a physician within 30 days of the initial start of care and at least once every 6 months thereafter unless a diagnosis has been established by the physician and the client is currently undergoing physician care and treatment
Medicaid number:	Nine-digit number from client's current Medicaid identification card.
Home Health Agency Information	
Name	Name of Home Health agency
License number	Medical license number issued by the state of Texas
Address	Agency address given by street, city, state and ZIP code
Telephone	Area code and telephone number of agency
TPI	Texas Provider Identifier number (10-digit) of agency
NPI	National Provider Identifier number (10-digit) of agency
Taxonomy	Ten-character Taxonomy code showing service type, classification, and specialization of the medical service provided by the agency
DME TPI	Texas Provider Identifier number (10-digit) of agency DME
Benefit Code	Code identifying state program for the service provided
Physician Information	
Name	Name of Physician
License number	Physician's medical license number issued by the state of Texas
Telephone	Area code and telephone number of physician
TPI	Texas Provider Identifier number (10-digit) of physician
NPI	National Provider Identifier number (10-digit) of physician
Plan of Care Information	
Status	Indicate with a check mark if POC is for a new client, extension (services need to be extended for an additional 60 day period) or a revised request
Original SOC date	First date of service in this 365 day benefit period
Revised request effective date	Date revised services, supplies or DME became effective
Services client receives from other agencies	List other community or state agency services client receives in the home. Examples: primary home care (PHC), community based alternative (CBA), etc.
Diagnoses	Diagnosis related to ordered home health services. For reimbursement, diagnoses must match those listed on the claim and be appropriate for the services ordered (Include ICD-9 code if PT/OT is ordered)
Functional Limitations/ Permitted Activities	Include on revised request only if pertinent
Prescribed medications	List medications, dosages, routes, and frequency of dosages (Include on revised request if applicable)
Diet Ordered	Examples: Regular, 1200 cal. ADA, pureed, NG tube feedings, etc. (Include on revised request if applicable)
Mental Status	Examples: alert and oriented, confused, slow to learn, etc. (include on revised request if applicable)
Prognosis	Examples: good, fair, poor, etc. (include on revised request if applicable)
Rehabilitation potential	Potential for progress, examples: good, fair, poor, etc. (include on revised request if applicable)
Safety precautions	Examples: oxygen safety, seizure precautions, etc. (include on revised request if applicable)
Medical necessity, clinical condition, treatment plan	Describe medical reason for all services ordered, nursing observations pertinent to the plan of care, and the proposed plan of treatment. For PT, list specific modalities and treatments to be used.
SNV, HHA, PT, OT visits requested:	State the number of visits requested for each type of service authorized
Supplies	List all supplies authorized
DME	List each piece of DME authorized, check whether DME is owned, if DME is to be repaired, purchased, or rented, and for what length of time the equipment will be needed
RN signature	The signature and date this form was filled out and completed by the RN
From and To dates	Dates (up to 60 days) of authorization period for ordered home health services
Conflict of Interest Statement	Relevant to the physician signing this form; physician should check box if exception applies.
Physician signature, Date signed, Printed physician name	The physician's signature and the date the form was signed by the physician ordering home health services, and the physician's printed name

Effective Date_07302007/Revised Date_06292007

DM.7 Home Health Services Plan of Care (POC)

Write legibly or type. Claims will be denied if POC is illegible or incomplete.

Client's name:		Date of birth: / /	
Date last seen by doctor: / /		Medicaid number:	
Home Health Agency Information			
Name:	Fax number:	Telephone:	
Address:			
TPI:	NPI:	Taxonomy:	
DME TPI:	Benefit Code:		
Physician Information			
Name:		Telephone:	
TPI:	NPI:	License number:	
Status (check one):	New client ☐	Extension ☐	Revised Request ☐
Original SOC date: / /		Revised request effective date: / /	
Services client receives from other agencies:			
Diagnoses (include ICD-9 codes if PT/OT is ordered):			
Function Limitations/Permitted Activities/Homebound Status:			
Prescribed medications:			
Diet ordered:		Mental status:	
Prognosis:		Rehabilitation potential:	
Safety Precautions:			
Medical Necessity, clinical condition, treatment plan (Brief narrative of the medical indication for the requested services and instructions for discharge, etc., include musculoskeletal/neuromuscular condition if PT/OT requested):			
SNV visits requested:			
HHA visits requested:			
PT visits requested:			
OT visits requested:			
Supplies:			

DME Item No. 1	Own ☐	Repair ☐	Buy ☐	Rent ☐	How long is this DME item needed?
DME Item No. 2	Own ☐	Repair ☐	Buy ☐	Rent ☐	How long is this DME item needed?
DME Item No. 3	Own ☐	Repair ☐	Buy ☐	Rent ☐	How long is this DME item needed?
DME Item No. 4	Own ☐	Repair ☐	Buy ☐	Rent ☐	How long is this DME item needed?

RN signature:	Date signed: / /	
I anticipate home care will be required:	From: / /	To: / /

Conflict of Interest Statement

By signing this form, I certify that I do not have a significant ownership interest in, or a significant financial or contractual relationship with, the billing Home Health Services agency if Home Health Services for the above client are to be covered by the Texas Medicaid Program.
Check if this exception applies.

☐ Exception for governmental entities (Home Health Services agency operated by a federal, state or local governmental authority) or exception for sole community Home Health Services agency as defined by 42CFR 424.22.

Physician signature:	Date signed: / /

Effective Date_07302007/Revised Date_06292007

DM.8 Home Health Services Prior Authorization Checklist

Home Health Prior Authorization Checklist

Contact Medicaid Home Health Services at 1-800-925-8957

To facilitate the authorization process, the home health agency nurse should have completed the following tasks before contacting TMHP for prior authorization of home health services:

- Completion of this optional form
- Evaluation of the client in the home (preferably by the same nurse requesting services)

PLEASE DO NOT SUBMIT THIS FORM TO TMHP.

Date:_____ Agency Nurse Name:_____
Client Medicaid Number:_____ Client Name: _____
Client Medicare Number:_____ Date Last Seen by Physician: _____
Start of Care Date: _____ Date of Last Hospitalization:_____
Date of Home Evaluation: _____
Diagnoses:_____

_____

(If PT/OT is requested, please provide ICD-9-CM diagnosis codes)
Skilled Nursing functions to be provided: _____

_____

_____

_____

Pertinent Nursing Observations (prior teaching, size and descriptions of wounds, functional limitations, etc.): _____

_____

_____

Observations of home setting that may effect care (i.e., cleanliness, availability of running water, electricity and refrigeration, etc.): _____

_____

_____

Availability and capability of caregiver(s): _____

_____

Services client receives from other sources (i.e., Primary Home Care): _____

_____

Services Requested: ___ Skilled Nursing Frequency _____
___ Home Health Aide Frequency _____
___ Physical Therapy Frequency _____
___ Occupational Therapy Frequency _____
___ DME_____ Repair _____Rent _____ Purchase
_____Bid #1
_____Bid #2
___ Supplies: _____

TMHP Nurse: _____ PAN: _____

Effective Date_01012009/Revised Date_01262010

DM.9 Medicaid Certificate of Medical Necessity for Chest Physiotherapy Device Form—Initial Request

Section A: To be completed by the physician or physician staff

Client Information

Name:	Medicaid number:
Primary diagnosis:	
Client respiratory diagnosis:	

Physician Information

Name:	Telephone:	Fax number:
Address:		
License number:	TPI:	NPI:

Section B: To be completed by the physician

Device requested	☐ High frequency chest wall compression system (HFCWCS)
	☐ Cough stimulating device (cofflator)

☐	Client had respiratory illness or complication in the past 6 months (provide additional information in narrative section, i.e., nebs for respiratory secretions, I.V. antibiotics, hospitalizations).	Yes ☐ No ☐
☐	Client or family unable to do chest physiotherapy (provide medical reasons in narrative section).	Yes ☐ No ☐
☐	Client has tried other modes of chest physiotherapy, including the use of electrical percussor therapy or flutter valve for a minimum of four months prior to the request and that the therapy has been ineffective (provide information on other therapies and why they are ineffective in narrative section).	Yes ☐ No ☐
☐	Device use has not resulted in, nor exacerbated any gastrointestinal, manifestations, aspiration, pulmonary manifestation, nor seizure activity.	Yes ☐ No ☐
☐	Client had pulmonary function studies in last 6 months, if applicable (provide results in narrative section).	Yes ☐ No ☐
☐	Client has frequently missed work, school or extracurricular activities in the last 6 months due to respiratory illnesses and ineffective chest physiotherapy (provide medical reasons in narrative section).	Yes ☐ No ☐

Clients can have only one chest physiotherapy device at a time. The HFCWCS is available for purchase after the initial rental period with additional documentation. Use of these devices may affect the number of private duty nursing hours for chest physiotherapy the client is receiving through the Comprehensive Care Program (CCP). Refer to the complete policy in the Texas Medicaid (Title XIX) Home Health Services section of the Texas Medicaid Provider Procedures Manual.

Section C: The physician prescribing a chest physiotherapy device must complete the narrative information regarding the medical necessity as requested above, or attach a letter with this information.

Narrative note for medical necessity (write legibly):

Physician signature:	Date: / /

Submit with completed Title XIX Home Health Services (Title XIX) DME/Medical Supplies Physician Order Form

Effective Date_01012009/Revised Date_12172008

DM.10 Medicaid Certificate of Medical Necessity for Chest Physiotherapy Device Form—Extended Request

Section A: To be completed by the physician or physician staff		
Client Information		
Name:	Medicaid number:	
Primary diagnosis:		
Respiratory diagnosis:		
Physician Information		
Name:	Telephone:	Fax number:
License number:	TPI:	NPI:

Section B: To be completed by the physician			
Device requested	☐ High frequency chest wall compression system (HFCWCS)		
	☐ Cough stimulating device (cofflator)		
☐	Client had respiratory illness or complications **since** initial authorization (include additional information in narrative section, i.e., nebs for respiratory secretions, I.V., antibiotics, and hospitalizations).		Yes ☐ No ☐
☐	Physicians description/assessment of the effectiveness indicates decreased medication use, shorter hospital length of stay (LOS), decreased hospitalizations, and fewer school, work, or extracurricular activity absences due to diagnosis related complications.		Yes ☐ No ☐
☐	System has not exacerbated any gastrointestinal manifestations, nor caused aspiration and exacerbation of pulmonary manifestation, nor an exacerbation of seizure activity.		Yes ☐ No ☐
☐	Client has been **compliant** in use of device (document minutes logged per treatment, times per day of treatments, and number of days used for entire trial period).		Yes ☐ No ☐
☐	Client has achieved the desired health outcome with device.		Yes ☐ No ☐

Clients can have only one chest physiotherapy device at a time. The HFCWCS is available for purchase after the initial rental period with additional documentation. Use of these devices may affect the number of private duty nursing hours for chest physiotherapy the client is receiving through the Comprehensive Care Program (CCP). Refer to the complete policy in the Texas Medicaid (Title XIX) Home Health Services section of the Texas Medicaid Provider Procedures Manual.

Section C: The physician prescribing a chest physiotherapy device must complete the narrative information regarding the medical necessity as requested above, or attach a letter with this information.	
Narrative note for medical necessity (write legibly):	
Physician signature:	Date: / /
Submit with completed Title XIX Home Health Services (Title XIX) DME/Medical Supplies Physician Order Form	

Effective Date_01012009/Revised Date_12172008

DM.11 Medicaid Certificate of Medical Necessity for CPAP/BiPAP or Oxygen Therapy

Section A - (To Be Completed By Physician or Physician's Staff)		
Client Name:	Client Medicaid Number:	
Physician Information		
Name:	Telephone:	
Address:		
License Number:	TPI:	NPI:
Supplier Information		
Name:	Contact Person:	
Address:		
Telephone:	Fax number:	
TPI:	NPI:	
Taxonomy:	Benefit Code:	
SECTION B- (To Be Completed By Physician)		
CPAP/BIPAP S Request		
Diagnosis:		
Date of Polysomnogram: (Polysomnogram required for all CPAP requests) / /		
If request is for BIPAP, explanation of the inability to tolerate CPAP:		
AHI/RDI:	Sleep Time (hours):	Total Apneas:
Obstructive apneas:	Lowest Oxygen Saturation (percent):	
BIPAP ST Request		
Diagnosis:		
If request is for BIPAP ST, explanation of the inability to tolerate BIPAP S:		
Date of Polysomnogram (If Applicable): / /		
Lowest Oxygen Saturation (percent): or Arterial PO2 (mm Hg):		
If prescribed for central sleep apnea	Central apneas/hr:	Longest central apnea: sec.
Oxygen Therapy Request		
Diagnosis:		
Lowest Oxygen Saturation at rest or with exercise (percent): or Arterial PO2 (mm Hg):		
Lowest Oxygen Saturation during sleep (percent): or Arterial PO2 (mm Hg):		
Flow rate (l/min.):	Hours of treatment per day (estimated):	
Is oxygen therapy required for mobility within the home?	☐ Yes	☐ No
Is oxygen therapy required for mobility when leaving the home?	☐ Yes	☐ No
Prescribing Physician Signature:	Date: / /	
Submit with completed Title XIX Home Health Services (Title XIX) DME/Medical Supplies Physician Order Form		

Effective Date_07302007/Revised Date_08062007

DM.12 Pulse Oximeter Form

Pulse Oximeter Form

Client Name:		Medicaid number:
DME Provider Information		
	Telephone:	Fax number:
Address:		
TPI:		NPI:
Taxonomy:		Benefit Code:

Equipment Information

HCPCS Code	Product Name and Model Number	Retail Price

New device provided for purchase? ☐ Yes ☐ No

Equipment designated for clinical use only is not considered appropriate for use in the home

Note: *Oxygen dependent is defined as ongoing, regular need for use of supplemental oxygen for a significant portion of the day to maintain oxygen saturation. This does not include: PRN use; use only when sick; use only when suctioning; use for desaturation that occurs only when crying; use for desaturation that occurs only with seizure activity.*

The following information must be completed by the physician

Diagnosis and Basis for Medical Necessity of requested services:

Dates of Service requested for Prior Authorization		From: / /		To: / /		
☐	Client is ventilator and/or oxygen dependent					
	Client is ventilator dependent		hours per day	Client is oxygen dependent		hours per day
☐	Client is weaning from oxygen and/or a ventilator					
☐	Anticipated length of monitor need:	☐ Months:		☐ 1-3 years	☐ More than 3 years	
☐	Who will respond to the monitor alarm?					
☐	Can the patient's medical needs be met with intermittent "spot check" of oxygen saturations?				☐ Yes ☐ No	
☐	What is the medical basis for need of continuous monitoring?					
☐	Is the client receiving any nursing services such as PDN, Home Health Visits, MDCP, CBA, or Private Insurance?					
	Please indicate services:					
	Number of hours/visits:					

Signature:		Date: / /
Name (printed):		Telephone:
Address:		
TPI:	NPI:	License number:

Must be submitted with a CCP Prior Authorization Request Form

Effective Date_01012009/Revised Date_04072010

DM.13 Statement for Initial Wound Therapy System In-Home Use (2 pages)

Statement for Initial Wound Therapy System In-Home Use (Page 1 of 2)

Patient Name:	Patient Medicaid Number:
Patient Diagnosis:	Date of birth: / /

Home Health Agency Information

Name:	Telephone:
Address:	
TPI:	NPI:
Taxonomy:	Benefit Code:

Indicators for Continuation of Treatment

Must be completed by the physician familiar with the client and prescribing the wound care system. Answer "Yes" or "No" for each question and any answers which apply.

1. Was the initial medical necessity justified by one of the following? **Yes** ☐ **No** ☐

- ☐ Stage III or Stage IV pressure ulcer
- ☐ Pre-operative myocutaneous flap or graft
- ☐ Recent (within 14 days) myocutaneous flap or graft
- ☐ Diabetic ulcer
- ☐ Chronic open wound
- ☐ Venous stasis ulcer

2. The patient's history reflects one or more of the following: **Yes** ☐ **No** ☐

- ☐ Previous failed wound care interventions, how long ago_____, how was it resolved_____
- ☐ Severe coexisting chronic illness
- ☐ Frequent reoccurrence of advanced pressure ulcers related to severely limited mobility
- ☐ Wound care therapy was initiated in the hospital or skilled nursing facility (SNF). If "Yes," provide the following:

Admission date: / /	Admitting diagnosis:	Discharge date: / /

3. The patient uses a pressure-reducing surface: **Yes** ☐ **No** ☐

- ☐ Non-powered mattress overlay
- ☐ Non-powered mattress replacement
- ☐ Powered mattress overlay
- ☐ Powered mattress replacements
- ☐ Powered bed system
- ☐ Air fluidized bed

NOTE: If "No," why not?

4. The patient has an albumin greater than 3 mg/dl. **Yes** ☐ **No** ☐

Date of last albumin (within the past 30 days): / / Result:

NOTE: If the patient has an albumin level less than 3 mg/dl, please list the albumin level and describe the type of nutritional treatment which the patient is receiving:

5. The patient has diabetes mellitus. **Yes** ☐ **No** ☐

Hemoglobin A1c level:	Date Hemoglobin A1c drawn (within the past 30 days): / /

6. The patient's wound is free of necrotic tissue. **Yes** ☐ **No** ☐

NOTE: If the wound has recently been debrided, identify the type and date of debridement:

- ☐ Surgical Date: / /
- ☐ Chemical Date: / /
- ☐ Physical Date: / /
- ☐ Autolytic Date: / /

7. The patient's wound is free of infection. **Yes** ☐ **No** ☐

NOTE: If the wound is infected, identify the wound treatment, include dosage, frequency, route and duration of any medications (including, but not limited to, antibiotics):

8. The patient's overall health status will allow wound healing. **Yes** ☐ **No** ☐

NOTE: Describe all medical conditions which might affect wound healing, address incontinence if pertinent, and what is being done to decrease contamination of the wound:

9. Name of family member/friend/caregiver who agrees to be available to assist patient:

Physician Information

Signature:		Date: / /
Name (print):		Telephone:
License number:	TPI:	NPI:

Effective Date_01012009/Revised Date_12172008

Statement for Initial Wound Therapy System In-Home Use (Page 2 of 2)

Patient Name:	Patient Medicaid Number:
Patient Diagnosis:	Date of birth: / /

Contraindicators to Initial Wound Therapy

Must be completed by the physician familiar with the client and prescribing the wound care system or the registered nurse (RN). Check any that apply.

Does the patient have any of the following conditions: **Yes** ☐ **No** ☐

- ☐ Fistulas to the body
- ☐ Wound is ischemic
- ☐ Gangrene
- ☐ Osteomylelitis (unless being treated – describe below)
- ☐ Skin cancer in the margins
- ☐ Presence of necrotic tissue, including bone
- ☐ Less than six months to live

Initial Wound Profile

Must be completed by the physician familiar with the client and prescribing the wound care system or the RN.
NOTE: Use additional paper if more than two wounds are currently being treated.

Wound No. 1

Type of wound:
- ☐ Pressure ulcer
- ☐ Pre-operative myocutaneous flap or graft
- ☐ Recent (within 14 days) myocutaneous flap or graft
- ☐ Diabetic ulcer
- ☐ Chronic open wound
- ☐ Venous stasis ulcer

Location:	Stage:	Age of wound:
Date of surgery (if flap or graft): / /	Type of debridement and date: / /	
Wound color:	L x W x D:	Odor: / Drainage:
Tunneling (depth and position):	Undermining (depth and position):	

List all previous wound interventions: (use additional space if necessary):

Wound No. 2

Type of wound:
- ☐ Pressure ulcer
- ☐ Pre-operative myocutaneous flap or graft
- ☐ Recent (within 14 days) myocutaneous flap or graft
- ☐ Diabetic ulcer
- ☐ Chronic open wound
- ☐ Venous stasis ulcer

Location:	Stage:	Age of wound:
Date of surgery (if flap or graft): / /	Type of debridement and date: / /	
Wound color:	L x W x D:	Odor: / Drainage:
Tunneling (depth and position):	Undermining (depth and position):	

List all previous wound interventions: (use additional space if necessary):

Physician Signature:	Date: / /
RN Signature: **REQUIRED** **IF APPROPRIATE**	Date: / /

Effective Date_01012009/Revised Date_12172008

DM.14 Statement for Recertification of Wound Therapy System In-Home Use

Patient Name:	Patient Medicaid Number:
Patient Diagnosis:	Date of birth: / /

Home Health Agency Information

Name:	Telephone:
Address:	
TPI:	NPI:
Taxonomy:	Benefit Code:

Indicators for Continuation of Treatment

Must be completed by the physician familiar with the client and prescribing the wound care system. Answer "Yes" or "No" for each question and any answers which apply.

1. Was the initial medical necessity justified by one of the following? **Yes** ☐ **No** ☐

- ☐ Stage III or Stage IV pressure ulcer
- ☐ Pre-operative myocutaneous flap or graft
- ☐ Recent (within 14 days) myocutaneous flap or graft
- ☐ Diabetic ulcer
- ☐ Chronic open wound
- ☐ Venous stasis ulcer

2. Is the wound showing progress? **Yes** ☐ **No** ☐

- ☐ 30 days or longer since myocutaneous flap or graft
- ☐ 30 days with no demonstrated improvement
- ☐ wound healed, no depth
- ☐ wound healing with improvement

Location:	Stage:	Age of wound:	
Wound color:	L x W x D:	Odor:	Drainage:
Tunneling (depth and position):		Undermining (depth and position):	

Wound description (i.e. formation of granulation and date and type of debridement done in last 30 days):

NOTE: Include above information for each wound if more than one.

3. The patient continues to use a pressure-reducing surface. **Yes** ☐ **No** ☐

NOTE: If "no," why not?

4. Name of family member/friend/caregiver who continues to agree to assist patient:

Contraindicators to Continuation of Treatment

(Check any that apply)

Does the patient have any of the following conditions? **Yes** ☐ **No** ☐

- ☐ Fistulas to the body
- ☐ Wound is ischemic
- ☐ Gangrene
- ☐ Osteomylelitis (unless being treated – describe below)
- ☐ Skin cancer in the margins
- ☐ No demonstrable improvement in wound over past 30 days
- ☐ Presence of necrotic tissue, including bone
- ☐ Less than six months to live

Physician Information

Signature:		Date: / /
Name (Print):		Telephone:
License number:	TPI:	NPI:

Effective Date_07302007/Revised Date_07212008

DM.15 Ventilator Service Agreement

Client Information		
Name:	Medicaid number:	
Provider Information		
Name:		
NPI:	TPI:	
Ventilator Information		
Date of Purchase: / /	Date of Request: / /	Serial number:
Manufacturer:	Model number:	

Service Agreement

The Manufacturer's recommended preventive maintenance schedule for the ventilator make and model must be submitted with the Ventilator Service Agreement request.

If this is a renewal Ventilator Service Agreement, in addition to the above, the following documentation must also be submitted:

1. Documentation of the monthly ventilator service procedures performed by a respiratory therapist and client assessments by a respiratory therapist.
2. Description of ventilator preventive maintenance performed during the last ventilator service agreement period:

Provider Responsibilities

Provider responsibilities for maintaining the ventilator service agreement Include:

1. Ensure routine service procedures outlined by the ventilator manufacturer are followed.
2. Provide all internal filters, all external filters and all ventilator circuits, (with the exhalation valve), as part of the ventilator service agreement payment.
3. Provide a respiratory therapist and a back-up ventilator on a 24-hour on call basis.
4. Provide monthly visits to the client's home by a respiratory therapist to perform routine service procedures, monitor functioning of the ventilator system and assess client's status. The provider must maintain documentation of monthly visits in accordance with Medicaid Records Retention Policy.
5. Provide a substitute ventilator while the manufacturers recommended preventative maintenance is being performed on the client owned ventilator.

The ventilator service agreement must be prior authorized every six (6) months.

Provider Representative Signature:	Date / /

Submit with completed Title XIX Home Health Services (Title XIX) DME/Medical Supplies Physician Order Form

Effective Date_01152008/Revised Date_08072007

DM.16 Wheelchair/Scooter/Stroller Seating Assessment Form (CCP/Home Health Services) (6 pages)

Instructions
A current wheelchair seating assessment conducted by a physician, physical or occupational therapist must be completed for purchase of or modifications (including new seating systems) to a customized wheelchair. Please attach manufacturer information, descriptions, and an itemized list of retail prices of all additions that are not included in base model price. Complete Sections I-VI for manual wheelchairs. Complete Sections I-VII for power wheelchairs.

Client Information	
First name:	Last name:
Medicaid number:	Date of birth:
Diagnosis:	
Height:	Weight:

I. Neurological Factors
Indicate client's muscle tone: ☐ Hypertonic ☐ Absent ☐ Fluctuating ☐ Other
Describe client's muscle tone:
Describe active movements affected by muscle tone:
Describe passive movements affected by muscle tone:
Describe reflexes present:

II. Postural Control				
Head control:	☐ Good	☐ Fair	☐ Poor	☐ None
Trunk control:	☐ Good	☐ Fair	☐ Poor	☐ None
Upper extremities:	☐ Good	☐ Fair	☐ Poor	☐ None
Lower extremities:	☐ Good	☐ Fair	☐ Poor	☐ None

III. Medical/Surgical History And Plans:
Is there history of decubitis/skin breakdown? ☐ Yes ☐ No *If yes, please explain:*
Describe orthopedic conditions and/or range of motion limitations requiring special consideration (i.e., contractures, degree of spinal curvature, etc.):
Describe other physical limitations or concerns (i.e., respiratory):
Describe any recent or expected changes in medical/physical/functional status:
If surgery is anticipated, please indicate the procedure and expected date:

IV. Functional Assessment:		
Ambulatory status:	☐ Nonambulatory	☐ With assistance
	☐ Short distances only	☐ Community ambulatory
Indicate the client's ambulation potential:	☐ Expected within 1 year	
	☐ Not expected	
	☐ Expected in future within ___ years	

IV. Functional Assessment:		
Wheelchair Ambulation: Is client totally dependent upon wheelchair? ☐ Yes ☐ No *If no, please explain:*		
Indicate the client's transfer capabilities:	☐ Maximum assistance ☐ Minimum assistance	☐ Moderate assistance ☐ Independent
Is the client tube fed? ☐ Yes ☐ No *If yes, please explain:*		
Feeding:	☐ Maximum assistance ☐ Minimum assistance	☐ Moderate assistance ☐ Independent
Dressing:	☐ Maximum assistance ☐ Minimum assistance	☐ Moderate assistance ☐ Independent
Describe other activities performed while in wheelchair:		

V. Environmental Assessment
Describe where client resides:
Is the home accessible to the wheelchair? ☐ Yes ☐ No
Are ramps available in the home setting? ☐ Yes ☐ No
Describe the client's educational/vocational setting:
Is the school accessible to the wheelchair? ☐ Yes ☐ No
Are there ramps available in the school setting? ☐ Yes ☐ No
If client is in school, has a school therapist been involved in the assessment? ☐ Yes ☐ No
Name of school therapist:
Name of school:
School therapist's telephone number:

V. Environmental Assessment
Describe how the wheelchair will be transported:
Describe where the wheelchair will be stored (home and/or school):
Describe other types of equipment which will interface with the wheelchair:

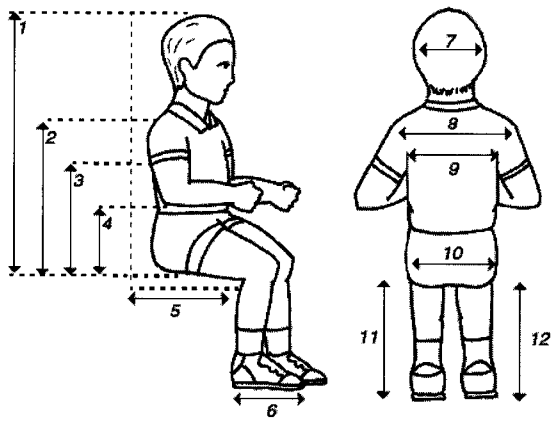
VI. Requested Equipment:	
Describe client's current seating system, including the mobility base and the age of the seating system:	
Describe why current seating system is not meeting client's needs:	
Describe the equipment requested:	
Describe the medical necessity for mobility base and seating system requested:	
Describe the growth potential of equipment requested in number of years:	
Describe any anticipated modifications/changes to the equipment within the next three years:	
Physician/Therapist's name:	Physician/Therapist's signature:
Physician/Therapist's title:	Date:
Physician/Therapist's telephone number: ( ) -	
Physician/Therapist's employer (name):	Physician/Therapist's address (work or employer address):

VII. POWER WHEELCHAIRS: *Complete if a power wheelchair is being requested*	
Describe the medical necessity for power vs. manual wheelchair: *(Justify any accessories such as power tilt or recline)*	
Is client unable to operate a manual chair even when adapted? ☐ Yes ☐ No	
Is self propulsion possible but activity is extremely labored? ☐ Yes ☐ No *If yes, please explain:*	
Is self propulsion possible but contrary to treatment regimen? ☐ Yes ☐ No *If yes, please explain:*	
How will the power wheelchair be operated (hand, chin, etc.)?	
Has the client been evaluated with the proposed drive controls?	
Does the client have any condition that will necessitate possible change in access or drive controls within the next five years?	
Is the client physically and mentally capable of operating a power wheelchair safely and with respect to others? ☐ Yes ☐ No	
Is the caregiver capable of caring for a power wheelchair and understanding how it operates? ☐ Yes ☐ No	
How will training for the power equipment be accomplished?	
Physician/Therapist's name:	Physician/Therapist's signature:
Physician/Therapist's title:	Date:
Physician/Therapist's telephone number: ( ) -	
Physician/Therapist's employer (name):	Physician/Therapist's address (work or employer address):

Home Health/CCP Measuring Worksheet

General Information	
Client's name:	Date of birth:
Client's Medicaid number:	Height:
Date when measured:	Weight:
Measurer's name:	Measurer's telephone number: ( ) -

Measurements



1:	Top of head to bottom of buttocks
2:	Top of shoulder to bottom of buttocks
3:	Arm pit to bottom of buttocks
4:	Elbow to bottom of buttocks
5:	Back of buttocks to back of knee
6:	Foot length
7:	Head width
8:	Shoulder width
9:	Arm pit to arm pit
10:	Hip width
11:	Distance to bottom of left leg (popliteal to heel)
12:	Distance to bottom of right leg (popliteal to heel)

Additional Comments

5. CLAIM FORM EXAMPLES

DM.17 Home Health Services DME/Medical Supplies

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA

1. MEDICARE (Medicare #)	MEDICAID (Medicaid #)	TRICARE CHAMPUS (Sponsor's SSN)	CHAMPVA (Member ID#)	GROUP HEALTH PLAN (SSN or ID)	FECA BLK LUNG (SSN)	OTHER (ID)
	X					

1a. INSURED'S I.D. NUMBER (For Program in Item 1): 123456789

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Doe, Jane

3. PATIENT'S BIRTH DATE MM DD YY: 11 22 1934 — SEX: M [ ] F [X]

4. INSURED'S NAME (Last Name, First Name, Middle Initial): Doe, Jane

5. PATIENT'S ADDRESS (No., Street): 123 North Main Street

6. PATIENT RELATIONSHIP TO INSURED: Self [X] Spouse [ ] Child [ ] Other [ ]

7. INSURED'S ADDRESS (No., Street): 123 North Main Street

CITY: Dallas — STATE: TX

8. PATIENT STATUS: Single [X] Married [ ] Other [ ]; Employed [ ] Full-Time Student [ ] Part-Time Student [ ]

CITY: Dallas — STATE: TX

ZIP CODE: 75236 — TELEPHONE (Include Area Code): (214) 555-1234

ZIP CODE: 75236 — TELEPHONE (Include Area Code): (214) 555-1234

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial): N/A

10. IS PATIENT'S CONDITION RELATED TO: IDDM, Asthma

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous): YES [ ] NO [X]

a. INSURED'S DATE OF BIRTH MM DD YY: 11 22 1934 — SEX: M [ ] F [X]

b. OTHER INSURED'S DATE OF BIRTH MM DD YY — SEX: M [ ] F [ ]

b. AUTO ACCIDENT? YES [ ] NO [X] PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES [ ] NO [X]

c. INSURANCE PLAN NAME OR PROGRAM NAME: Medicaid

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES [ ] NO [X] *If yes*, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED _____ DATE _____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED _____

14. DATE OF CURRENT: MM DD YY — ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM — TO

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE: Home Health Services Associates

17a.

17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM — TO

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES [ ] NO [X] $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)

1. 493.90
2. 250.00
3.
4.

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER: 7123220000

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1 07 01 2009	08 31 2009	02		A9150			5.00	00		NPI	
2										NPI	
3										NPI	
4										NPI	
5										NPI	
6										NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN: 451 23 4567

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES [X] NO [ ]

28. TOTAL CHARGE: $ 5.00

29. AMOUNT PAID: $

30. BALANCE DUE: $

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

Jane Doe SIGNED — 07 01 2009 DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. b.

33. BILLING PROVIDER INFO & PH # (214) 234-7900

Home Health Services Associates & DME
555 Broadway
Dallas, TX 75234

a. 9876543021 b. 1234567-01

PATIENT AND INSURED INFORMATION — CARRIER

PHYSICIAN OR SUPPLIER INFORMATION

NUCC Instruction Manual available at: www.nucc.org

APPROVED OMB-0938-0999 FORM CMS-1500 (08/05)

TMHP

TEXAS MEDICAID & HEALTHCARE PARTNERSHIP
12357 - B RIATA TRACE PARKWAY STE 150
AUSTIN, TX 78727
A STATE MEDICAID CONTRACTOR